West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Meeting of the Board of Directors

Wednesday 31 January 2024 at 15:00 hours
To be held at Millennium Point, Brierley Hill, Dudley 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)
Mr A C Marsh*****	CEO	Chief Executive Officer
Ms W Farrington Chadd*	WFC	Non Executive Director (Deputy Chair)
Ms C Beechey*	CB	Director of People
Mrs C Eyre*	CE	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	Director of Performance and Improvement
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*	RS	Interim Medical Director
Dr A Walker	AW	Medical Director

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

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

In attendance

Ms D. Scott	DJS	Interim Organizational Assurance Director
Ms K. Freeman	KF	Private Secretary – Office of the Chief Executive
Mr M Billington	MB	Advanced Paramedic (For staff story item)
Ms R Farrington	RF	Staff Side Representative
Mr P. Higgins	PH	Governance Director & Trust Secretary

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	15:00
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	**Any Questions from the Public**	Chair	Verbal	
04	**Patient or Staff Story**	Mr M Billington Advanced Paramedic	Verbal	15:05
05	**Board Minutes**			
	To agree as a correct record the Minutes of the following meetings of the Board of Directors: a) Ordinary meeting held 25 October 2023. b) The Extraordinary meeting held on 29 November 2023.	Chair	Papers 01 a & b	15:25
	Board Log and also any matters arising from the Minutes not on the Agenda for this meeting.	Interim Organisational Assurance Director	Paper 02	
06	**Board Assurance Framework**			
	To receive and approve the Board Assurance Framework .	Director of Nursing/ Head of Risk	Paper 03	15:30
07	**Report of the Director of People**			
07a	The Board Skills Matrix Action: To receive and approve for publication the revised Board skills matrix.	Director of People	Paper 04	15:35
08	**Chief Executive Officers Reports**			
08a	To receive the report of the Chief Executive Officer.	CEO	Paper 05	15:40

Item No	Description		Lead	Paper No	Timings
	Action	• To receive and note the contents of the paper seeking clarification where necessary. • To approve the EPRR Policy statement			
08b	Pandemic Plan		CEO	Paper 06	15:50
	Action	To receive and approve the Pandemic Plan			
08c	Executive Scorecard and ICS Scorecard relating to performance for the month of December 2023.		CEO	Paper 07 a&b	15:55
	Action	To receive and review the Scorecards.			
08d	Trust Charter of Expectations		Governance Director & Trust Secretary	Paper 08	16:00
	Action	To approve the content to enable publication			
08e	Review of the Foundation Trust Constitution		Governance Director & Trust Secretary	Paper 09	16:05
	Action	To review and if appropriate approve the Foundation Trust Constitution			
09	**Reports of the Strategy & Engagement Director**				
09a	WMAS Strategic Plan Update		Strategy & Engagement Director	Paper 10	16:10
	Action	To receive update on progress			
09b	Review of Enabling Strategies		Strategy & Engagement Director	Paper 11	16:15
	Action	a) To review and sign off the proposed consolidation of enabling strategies and reporting lines b) To review the governance arrangements and to reflect on its involvement in the development and oversight of underpinning strategies.			

Item No	Description		Lead	Paper No	Timings
		c) To consider a recommendation on a named executive lead and link non executive lead for each strategic objective.			
10	**Report of the Communications Director**				
10a	Communications Data – Quarterly Report		Communications Director	Paper 12	16:25
	Action	To receive and note the Quarterly update from the Communications Director on the activities of the Press Office between October and December 2023 and it also reviews the Trust's interaction with the media, our social media presence, and the work we carry out with external partners.			
11	**Reports of the Director of Finance**				
11a	To receive a report from the Director of Finance on the 2023/24 financial position (Month 09)		Director of Finance	Paper 13	16:30
	Action	To receive the update			
11b	Revised Scheme of Delegation		Director of Finance	Paper 14	16:35
	Action	a) Approve the revisions to the Scheme of Delegation. b) Note that there will still be contracts/items of expenditure that require Board approval other than the opening budget approvals. c) Note the review of effectiveness to take place.			
11c	Finance Strategy and Commissioning Strategy		Director of Finance	Paper 15	16:40
	Action	The Board is requested: • To approve the Finance Strategy • To approve the Commissioning Strategy (2023-2025) • To approve the Director of Finance as the owner of both Strategies pending any update • To note that both Strategies will be included in the overall			

Item No	Description	Lead	Paper No	Timings
	review of Strategies to be undertaken			
12	**Quality Report**			
	Combined Clinical Directors Quality Report	The Interim Medical Director/ Paramedic Practice and Patient Safety Director/ Director of Nursing	Paper 16	16:45
13	**Service Delivery Report**			
	To receive the report from the Director of Performance & Improvement on the following a) Emergency and Urgent operations b) Integrated Emergency & Urgent Care c) Non Emergency Operational Update	Director of Performance & Improvement	Paper 17	16:50
14	**Board Committee Reports and Minutes**			
14a	Quality Governance Committee			
	i. To receive the approved minutes of the meeting held on 18 October 2023	Chair of the Quality Governance Committee	Paper 18	16:55
	ii. To receive the Report of the Chair of the Quality Governance Committee on the meeting of the Cttee held on 24 January 2024		Paper 19	
14b	Performance Committee			
	i. To receive the approved minutes of the meeting held on 24 October 2023	Chair of the Performance Committee	Paper 20	17:00
	ii. Report of the Chair of the Committee on the salient matters for the meeting held 23 January 2024		Paper 21	
14c	People Committee			
	i. To receive the approved minutes of the meeting held on 4 September 2023	Chair of the People	Paper 22	17:05

Item No	Description	Lead	Paper No	Timings
	ii. Report of the Chair of the Committee on the salient matters for the meeting held on 20th November 2023	Committee	Paper 23	
14d	Audit Committee			
	i. To receive the approved Minutes of the meeting held on 18 July and 7 November 2023	Chair of the Audit Committee	Paper 24 a&b	17:10
	ii. Report of the Chair of the Committee on the salient matters for the meeting held on 7th November 2023 and 24 January 2024		Paper 25	
15	**Board of Directors Schedule of Business**			
	To receive the Schedule of Business and Development Sessions. To review and note the Board Schedule of Business	Trust Secretary	Paper 26	17:15
16	**Any Other Business** (Previously notified to the Trust Secretary)	Chair		
16a	**Freedom To Speak Up Report and Action Plans FTSU Guardian**	FTSU Guardian	Paper 27	17:20
	Action Members consider the Guardian report and note the following updates: a) The recommendations of the National Guardian's Office and NHS England and the associated action plans, updated versions of which are included for information b) Confirmation that the Reflection and Planning Tool has been completed and approved by the Board of Directors, thus meeting nationally determined requirements, and that the agreed actions will form the basis of our FTSU Strategy during 2024/25 c) Ongoing discussion and development of metrics to analyse in a more in-depth way, the cases that are reported through throughout the Trust d) Our continuing work to expand FTSU Ambassador representation and our plans to work more closely with other staff networks			
17	**Date and time of the next meeting:** **The next meeting will be on 29 MARCH 2024 from 09:00 hours.**	Chair		
18	**Review of the meeting & identify any new or**	All present led by the Chairman	Verbal	

Item No	Description	Lead	Paper No	Timings
	Increased Risks arising from the Meeting			

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

Paper 01a

Minutes of the Meeting of the Board of Directors held on 25 October 2023, at 10:40 hours, Trust HQ Millennium Point & Via MS Teams

Present:		
Prof I Cumming*	Chairman	Non-Executive Director (Chairman)
Mr A C Marsh*	CEO	Chief Executive Officer
Ms W Farrington Chadd*	WFC	Non-Executive Director (Deputy Chair)
Ms C Beechey	CB	People Director
Mrs C Eyre	CE	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*	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
Dr R Steyn*	RS	Interim Medial 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 Sandwell Hub		
Ms D Scott	DJS	Interim Organisational Assurance Director
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms L Harrison	LH	CQC
Ms K Delhom	KD	CQC
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Ms R Farrington	RF	Staff Side Representative
Mrs J Watson	JW	GGI (part of meeting)
Ms R Parker-Williams	RPW	NEOC Manager (part of meeting)
Mr E Middleton	EM	Senior Operations Manager (part of meeting)
Mrs P Wall	PW	Head of Strategic Planning / FTSU Guardian (part of meeting)
Mr M Brown	MB	Head of Risk (part of meeting)
Mr M Docherty	MD	Clinical Director
Mr B Goddard	BG	Journalist

10/23/01	**Welcome, Apologies and Announcements**	
	Apologies for absence received from Dr Alison Walker.	

	The Chairman gave an update and said as Directors are aware we are currently going through an election process to the Council of Governors, in both the public and staff constituencies. In addition the appointing bodies, that appoint to the Council, have been requested to mandate a candidate to serve on the Council. This was the first year since being established as a foundation trust that all the seats on the Council had been declared vacant. The Chairman was pleased to report that there had been significant interest from both the public and the staff and this was a testament to the high esteem with which the Ambulance Service was regarded. The "new" Council of Governors (CoG) will be constituted from 1 January 2024. Until that date the current Council of Governors will remain. This meant that next meeting of the Council of Governors on 1 November will be the last of the current governing body. The Chairman on behalf of the Trust and the Board of Directors thanked the current Council of Governors for everything they have done and the support they have given whilst continuing to challenge in the interests of the patients, the public and staff who they represent, particularly the support they gave during the covid period. The Chairman indicated that he would report the outcome of the elections and the appointment process formally to the next ordinary meeting of the Board of Directors. The Chairman took the opportunity to report to the Board of Directors that as part of the Council of Governors duty of engagement he had written to all of the ICB Chairs in the region seeking their support to enable the Trusts governors to engage with and through the ICBs in the region. He was pleased to report that the response had been positive and publicly thanked his colleagues in the ICBs for such a positive response. The Chairman indicated that Suzie Wheaton the Membership and Governor Engagement Officer was taking this method of engagement forward with her colleagues in the ICBs`. On the theme of engagement with the ICBs the Chairman explained that he and the CEO thought it would be helpful to meet with the Chairs and CEOs of each of the ICBs. Those meetings have gone well. One of the challenges the Trust has which is unique to ambulance trusts in the new system, is that we are one organisation with 6 ICBs. There is a nominated Exec Lead for each ICB. The Chairman and CEO attend ICB meetings when there is a significant item for the Trust. In addition in terms of engagement with provider partners, the Chairman explained that a meeting took place yesterday with Sir David Nicholson and David Loughton Chair and CEO of acute trusts in the region. The Chairman advised the Board that the meeting was productive and that they had agreed several matters of common interest. The Chairman was now arranging to meet with all Acute	

	Chairs across the West Midlands Region and will report back to the Board on progress at future meetings. The Chairman advised the Board that Mrs Farrington-Chadd, after serving her term of office as allowed for under the NHSE Code of Governance, had informed him she would be retiring from the Board of Directors on 31 January 2024. The Chairman said Mrs Farrington-Chadd has been a constant support to him and the Trust both in the role of Deputy Chair, Senior Independent Director, and previously Chair of Audit Committee. Mrs Farrington-Chadd will be leaving the Board and taking up a significant national role. The Chairman said Mrs Farrington-Chadd will be a difficult to replace. The Governors led by the Chairman have begun the process to replace Mrs Farrington-Chadd and make an appointment to the Board. The Chairman pointed out that the Board does not meet in December. The Chairman and Chief Executive Office (CEO) has requested that a meeting of the Board is convened to discharge business at the end of November. Currently a Board Briefing day is scheduled for the end of November, so he had agreed that as the next ordinary meeting to discharge its business is not until the end of January, the Briefing day will now be a Board meeting. Given that that any business will need to be discharged via email or an extraordinary meeting must be convened if required given the time between meetings; he had requested the Board Secretary to reconfigure the meetings schedule so that there was not such a gap between the October meeting and the January meeting. So, the November day will now be a two part meeting – a public meeting followed by a Board briefing. The Chairman informed the Board that he had now completed his visits to all Hubs except one which was scheduled in his diary. The learning from the visits has been fed back into the Trust and he took the opportunity to remind Board members to visit the hub that they are buddied with to engage with staff, the patients where possible and most importantly to feed any learning back to the Trust. The Chairman indicated that he will now be starting the cycle of visits again.	
10/23/02a	**Declarations of Interest**	
	There were no conflicts of interest declared by anyone attending the meeting in relation to any matters on the agenda.	
10/23/02b	**Review of Registers**	
	The Register of Directors Interests and Register of Governors Interests were submitted.	

	The Governance Director / Trust Secretary advised the Board that the registers will now be published on the website and requested directors to advise him of any inaccuracies or additions to the register as soon as possible.	
	Resolved:	
	a) That the Register of Directors Interests be received and noted. b) That the Register of Governors Interests be received and noted.	
10/23/03	**Questions from the Public**	
	None received.	
10/23/04	**Minutes of previous meetings**	
	To approve the Minutes of the meetings of the Board of Directors held on 26 July 2023 and the Extraordinary meeting held on 27 September 2023.	
	Resolved:	
	That the Minutes of the meeting of the Board of Directors held 26 July 2023 and the extraordinary meeting held on 27 September 2023 be approved as a correct record of those meetings.	
10/23/05	**Board Decisions 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 07/23/16 – Non-Emergency Services Operations Delivery & Improvement Director Update. It was reported that the report requested had been circulated via email to Board Members on 27 July 2023. On this basis the Board agreed that this item could be discharged.	**Discharged**
10/23/06	**Board Assurance Framework (BAF) & Good Governance Institute Well Led Action Plan Review**	
	a. Board Assurance Framework	

The Chairman welcomed Mrs Watson (Good Governance Institute) to the meeting. The Chairman indicated that Mrs Watson and the Good Governance Institute had carried out a review of the Trust in preparation for the CQC Well Led Review. Amongst the matters on which they had advised the Board was the content and purpose of the BAF based on experience and examples across the NHS.

Mrs Watson indicated that the Trust had made good progress in reviewing the BAF based on the Well Led review that they had undertaken. The review of the BAF had focused on reviewing the number of risks submitted to the Board as part of the BAF so that the risks and mitigation are at a strategic level. This meant that risks were stratified within the governance structure. In addition the strategic objectives were also reviewed. In conclusion Mrs Watson encouraged the Board to continually review its BAF and use it as a means to set its agenda and to use it to focus discussions at Board and its committees on the Trust's strategic objectives and the risks to meeting those objectives.

The Head of Risk informed the Board that the review of the BAF has been undertaken in partnership with the GGI. Within the Trust a new risk template allowing greater clarity and a more appropriate and direct recording of strategic risks to allow for a focused discussion at Board had been developed. This new template and the process underpinning it will enable greater assurance and reflect the Trust's Risk Appetite. The overall aim of the review was to implement the recommendations arising out of the GGI report and to revise the BAF to include a smaller number of strategic risks ensuring that risks in relation to each of the strategic objectives have adequately been considered, as well as identifying and communicating the correct governance arrangements for the BAF. Several actions have been undertaken to ensure the process is fully understood within the Trust.

The governance around the BAF was also being reviewed to enable the Board to receive appropriate assurance through its committee structure.

The Chairman thanked Mrs Watson and the Head of Risk for the expeditious way that the BAF has been reviewed following the discussion at the Board Briefing day in September. The Chairman stated that in his opinion the document submitted today is much better than the previous iteration. The Chairman sort reassurance that the Board is not missing anything given the reduction in the number of risks the Board received. The Head of Risk indicated that the new system and processes was based on the risk being reviewed at the correct level in the governance structure, and that assurance is

	provided to the Board, and of course the risk can be escalated. The Head of Risk further explained that the top 20 graded risks will be reviewed monthly. They will look at the rationale for the grading and that will then be reported to the Board via EMB. The Chairman noted the need to consider how cumulative risks are picked up. The Head of Risk explained this will be discussed with the Risk owner and operational senior management teams and also at the appropriate committees. Mrs Jasper provided reassurance to the Board that she has worked on this review with the Head of Risk and Mrs Watson. The document to the next Board will have greater refinement and will show where we should be challenging. It will provide greater assurance and focus to the Board in terms of strategic direction and the associated risks. It was indicated that the Performance Committee held the day before this Board meeting it was stated that the agenda was revised to have the risks in the same format as the BAF. The Board of Directors agreed with the changes made to the BAF and were content the document was moving in the right direction. Further iteration will be provided to the next meeting.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That approval be given to latest iteration of the Board Assurance Framework.	
	b – GGI Well Led Action Plan A report attaching the latest iteration of the GGI Well Led Action Plan was submitted. The Governance Director / Trust Secretary gave an update and informed the Board that the latest version of the action plan is presented to the Board for their information and to review progress against each of the recommendations. Mrs Watson congratulated the Trust on the progress it had made in applying the recommendations of the GGI Well Led Review as it shows real Board ownership. The Chairman acknowledged that work was still in progress but was satisfied with the progress todate and thanked the Interim Organisational Assurance Director for the stewardship of the Action Plan.	
	Resolved:	

	a) That the contents of the paper be received and noted. b) That the GGI Well-Led Action Plan Update be received.	
10/23/07	**Staff Survey Action Plan Update**	
	A report of the People Director was submitted. The People Director highlighted the salient matters contained in the report. The Board was informed that the 2022 Staff Survey was carried out by Picker Europe Ltd for WMAS. It closed on 25 November 2022 with 39% response rate. Local Actions Plans and the Trust wide action plan have been shared for information. Three priorities were identified for the Trust wide action plan: 1. Health and Wellbeing of staff 2. Safety of staff 3. Improve engagement between staff, managers, and leaders. The action plan for 2022 has now been closed. The 2023 staff survey opened on 20 September and will run until 24 November 2023. The current response rate is 27.7%. The People Director explained that Mr Ed Middleton and Ms Rebecca Parker-Williams sit on the Staff Survey Response Action Group (SSRAG), and they are attending today to provide some feedback from that Group. Ms Parker-Willaim and Mr Middleton explained how the Trust has responded to the staff survey results. The Director of Nursing enquired about those staff that had been less engaged in terms of them responding to the staff survey and how has the Trust addressed this area. The People Director explained that historically given the transient nature of the service, it has been a challenge to engage with front line operational staff to respond to the staff survey. However, the roll out of Ipads has helped, plus taking the added proactive approach of an incentive this year of protected time and a prize draw which we hope will help. Mrs Kooner asked the following questions: 1. When we met the CQC they did their own survey have we had the results from this. Can it be circulated. 2. When staff have their PDC, and they raise areas of weaknesses do we refer back to the PDC and look at what	

	we did before. 3. JustB calls – are we looking at what to do with these. 4. Feedback from staff is that there is a lot of variation with the SOMs and OMs. Some staff say they are not visible enough. Have we identified the barriers etc so we can improve the engagement with staff and managers. 5. Incentives to complete the survey. If staff felt by completing the survey their voices will be heard. What can we do to ensure staff that their voices are heard. The People Director provided the following responses. 1. No, we have not yet received the CQC survey results. 2. The previous PDC is used to support this conversation. 3. JustB telephone calls are voluntary. Staff do not have to participate. Some people do not need the calls. 4. Comments on variance that is why the local action plans are important to drill down to identify and address the issues. 5. Incentives are about people completing the survey not the outcomes. How we communicate the actions that have put in place as a result of the staff survey results is vital in staff knowing their voices have been heard. Mrs Farrington-Chadd asked about the question in the survey on whether our workforce is becoming disconnected and if this was a significant regarding newer staff. Mrs Farrington-Chadd said the WRES is quite disappointing around this matter, but she is aware this is being discussed elsewhere. The People Director indicated that there had not seen a lack of engagement with newer staff but different ways of engagement. The newer staff are the ones more likely to speak out. The People Director said a culture review is underway currently assessing against our behavioural framework and culture statement. A sample audit report on the quality of PDCs goes to the People Committee annually not just the numbers completed which forms part of the workforce KPI's. Mr Fessal agreed with the comments made so far and pointed out that the pulse survey showed staff were feeling demotivated and demoralised. This is linked to the performance of the organisation / system, and it is not a surprise as the demoralising effect of handover delays is feeding into our workforce. Mr Fessal said when he has visited Hubs, he has found everyone to be open and honest and there have been some negative comments which he has fed back. Mr Fessal has asked staff about their relationship with their line managers, and it has always been very positive. Mr Fessal said in relation to the PDC (Personal Development Discussion) the Board and People	

	Committee receives a lot of quantitative side data being presented that shows the number of PDC but not as much the qualitative data. The Director of Performance & Improvement indicated that he was aware and he is looking is looking at this area in terms of operational staff to strengthen the reporting on the qualitative element as well as quantitative. Professor Hopkins asked if in meetings with the ICB Chairs the high level topics coming out of the Staff Survey are raised with them. The CEO confirmed these topics are raised with the ICBs and nationally. The Chairman confirmed these topics had been raised during meetings with the Chairs of Acutes and ICBs. The Chairman pointed out that one of the challenges hospital handover delays causes is tensions with A&E and our own staff. Crews want to off load the patient as soon as possible and this builds a tension. The Chairman had discussed this with Chairs of acute trusts that he had met. The Director of Performance & Improvement explained that no discussion with staff cannot be discussed without understanding their working environment. Most days the Trust is at Surge level 4 due to the handover delays and this places an added burden on operational staff. Mrs Kooner agreed with Mr Fessal's comments and said and there are lots of issues out of our hands. Mr Khan agreed and said what the Director of Performance and Improvement said is key to this. The working environment is important and we must listen to what our staff are saying. It was acknowledged that the Trust was putting in measures to mitigate the issues, but it was not something the Trust alone can mitigate. Indeed the Trust cannot provide an appropriate level of service and care until handover delays are resolved. The Chairman indicated that when we get the staff survey results, we can focus on those areas that are not doing well but we should also focus and publicise those areas where staff responses are better. The People Director suggested that she would speak Mrs Kooner outside the meeting on the subject of the JustB telephone calls. Mr Middleton explained how challenging it is to work with a large workforce where you are asking Operational Managers to undertake approximately a 100 PDCs when due to handover delays most staff are finishing their shifts 2 hours late which means they are working 14 hours a day. This is leading to greater levels of stress and anxiety. Ms Parker-Williams explained that when she received her JustB telephone call it was a busy day, but she was able to reschedule it for another day. Staff are so busy carrying out their duties and more and more of	

	her time is spent not only on staff work issues but personal issues as well. Reena Farrington pointed out that we have talked about road staff and crews, but EOC staff are at pressure point most days as well. There is a younger workforce across the Trust with more mental health and stress issues prevalent. There is much more pressure and demand this is a national problem. The Chairman acknowledged the strength of debate on this subject, and in the interests of time asked the Board to move on to the next item of business which was linked to the discussion this discussion.	
	Resolved:	
	That the contents of the paper be received and noted.	
	Matt Brown and Joanna Watson left the meeting.	
10/23/08	**Workforce Race Equality Standard (WRES) Annual Report 2023 & Action Plan 2023/24**	
	A report of the People Director was submitted. The People Director gave an update and informed the Board that by 31 October 2023, Trusts must publish their Board ratified 2023/24 WRES Action Plan on their website. The action plan was developed in conjunction with the One Network staff group, and also the Trusts Diversity & Inclusion Steering and Advisory Group and other relevant stakeholders responsible for the actions assigned. It was noted that the number of BME staff has decreased compared to the previous year which was primarily attributed to the loss of the 111 contract. Areas of concern highlighted were related to harassment and bullying of staff by the public. The CEO advised the Board that the Trust will take firm action against any staff treated in this way including Police involvement when it was clearly hate crime. The Trust will also support the staff abused in this way. The Strategy & Engagement Director informed the Board that he was working on improving the diversity of FTSU Ambassadors to assist in reporting events. Mr Fessal indicated that he felt that the action plans developed do seem to be making inroads. Engagement is working. In addition, Mr	

	Fessal welcomed the move to a target of 2% per year. The Midlands is quite diverse but a could be a challenge to hit the target in 2031 as we have never hit 2% in any year. Mrs Kooner said it would be useful to understand the numbers next to the percentages. The People Director explained that the 23% was taken from the census for the West Midlands Region. The People Director agreed that the 2% target year on year was ambitious but it would enable the Trust to focus resources. The People Director indicated that the September 2023 KPIs will be circulated to Board members. Mrs Farrington-Chadd welcomed this discussion and felt it was useful to see the underlying themes and it needs to be within the context of a wider discussion around people.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the People Director will circulate the September 2023 KPIs to Board Members. c) That the Board of Directors received and approved the WRES data 2023 and Action Plan 2023/24. d) That the Board of Directors received and closed down the WRES Action Plan 2022/23. e) That the Board of Directors approved the above for publication on the Trusts internet by 31 October 2023.	**CB**
10/23/09	**Workforce Disability Equality Standard (WDES) Annual Report & Action Plan 2023/24**	
	A report of the People Director was submitted. The People Director gave an update and informed the Board that the action plan was developed in conjunction with the Disability and Carers network and the Trusts Diversity & Inclusion Steering and Advisory Group and other relevant stakeholders responsible for the relevant actions.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the Board of Directors approved the WDES Data 2023 and Action Plan for 2023/24. c) That the Board of Directors approved the close down of the WDES Action Plan for 2022/23. d) That the Board of Directors approved the above for publication on the Trust internet by 31 October 2023.	
10/23/10	**Diversity & Inclusion (D&I) Annual Report 2022/23**	

	A report of the People Director was submitted. The People Director explained that the Annual Report highlights our achievements during the past year. The Trust has a statutory responsibility to publish an annual Equality report and demonstrates the Trust's compliance with the Public-Sector Equality Duty [PSED].	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the Board of Directors approved the Diversity & Inclusion Annual Report 2022/23. c) That the Board of Directors agreed to the publication on the Trusts internet.	
10/23/11	**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 that the EMB are starting to set out the plans for the next financial year.	
	Resolved:	
	That the contents of the report be received and noted	
10/23/12	**Executive Scorecard & ICS Scorecard relating to Performance for the Month of September 2023**	
	The Executive Scorecard of KPIs for the month of September 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. The Strategy & Engagement Director informed the Board that he also shares the pack with each of the ICBs. The Chairman pointed out that hear and treat was higher for Birmingham and see and treat was higher in Shropshire. The Chairman asked if this had been explored. The CEO explained that hear and treat is higher due to the wide ranging facilities available.	
	Resolved:	

	That the Executive Scorecards be received and noted.	
10/23/13	**Care Quality Commission (CQC) Inspection Feedback – Core Services & Well-Led**	
	A report of the Chief Executive Officer was submitted. The CEO said that there were some areas of concern highlighted which the Trust has addressed. The action plan submitted today has been shared with the CQC and there is one action outstanding, but this is not overdue. An update will be sent to the CQC early November. The feedback letter from the well led inspection in October 2023 was generally positive. The CEO said the Trust now awaits the report from CQC and once received we will respond on accuracy and develop an action plan. It was hoped that the report and rating will be received before the end of this year. Mrs Kooner asked in relation to 3.2 on the action plan which was valuing difference training, and sought clarity on who will deliver this training. The People Director advised the board that the plan was to do the same as with the sexual safety charter and incorporate into induction training and open it to all staff.	
	Resolved	
	a) That the contents of the paper be received and noted. b) That the Board of Directors received the updated Action Plan.	
10/23/14	**Review of Enabling Strategies**	
	A report of the Strategy & Engagement Director was submitted. The Strategy & Engagement Director was asking the Board to consider having an annual update and whether we should consolidate several of the strategies. Mrs Farrington-Chadd saw this as a positive and welcome move and supported the theming of the strategies and encouraged the Executive Team to do this and reduce the number of strategies to enable greater focus. The Chairman agreed and suggested that we should look at consolidation and whether there are any missing strategies such as a Research Strategy. The Paramedic Practice & Patient Safety Director advised the Board that the Clinical Strategy is currently being reviewed and that incorporates the Research Strategy. The Strategy & Engagement Director will work on the consolidation and submit a paper back to a future Board meeting. Mrs Farrington-Chadd	

	offered help on the consolidation if required.	
	Resolved	
	That the contents of the paper be received and noted.	
10/23/15	**Reports of the Director of Finance**	
	15a - Financial Update from the Director of Finance	
	The Director of Finance gave an update and informed the Board that the financial position at the end of September is £3.767M underspent against a planned underspend of £0.813M. The surplus is £2.954M ahead of the plan. 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 regarding their Patient Transport Services. The Trust capital programme is underspent in month by £2.010M due to minimal capital purchases in month 6 although spend is expected to increase as plans progress. The FIP/CIP programme has an in month over performance of £0.162M and a year-to-date overperformance of £1.328M. Whilst the Trust has met it is CIP target for month 6 and continues to do so year to date, a significant proportion of this is non-recurrent. The cash position remains strong and has remained static from month 5. The Director of Finance said there is no reason we should not break even or have a slight surplus at year end. The Director of Finance said the ICB are not worried about us. Full details are in the Trust Information Pack and detailed discissions occurred at the meeting of the Performance Committee held the previous day. The Chairman asked for clarification on the £3.7M underspend. The Director of Finance explained some of this is budget profiling. The People Director said Graduate Paramedics entry is in Q3 and Q4. Mrs Farrington-Chadd noted that the plan is predicated on £7M for handover delays and the financial exposure of the Trust. The Director of Finance this is still on the agenda as we are continuing to seek funding the current position is not a risk to achieving break even at this stage. Mr Khan confirmed this was discussed at the Performance Committee meeting held on the previous day and there was a lot of challenge from Committee Members. Mrs Jasper confirmed and said members drilled down on the numbers and was confident the Trust's forecast outturn of breakeven is still achievable. We as a Trust remain low risk across the system. The Director of Finance explained a process was recently undertaken to select new External Audit provider for the 2023/24 financial year.	

	The selection process included the Chair of Audit Committee and two governors. A supplier was selected, and the Council of Governors have been asked to approve the appointment and the Trust procurement function are currently undertaking the necessary checks prior to a contract being signed. Regarding Internal Audit, the Director of Finance explained that due to a number of senior audit staff retiring and other staff taking up other employment opportunities, a new means of internal audit provision is under discussion. The Chair of Audit Committee is fully aware of and involved in these discussions. Updates will be provided at subsequent Board meetings once confirmed. The Director of Finance confirmed there will be no gap in the audit provision. Mrs Farrington-Chadd pointed out that audit provision is a problem for the sector and industry wide.	
	Resolved	
	That the contents of the paper be received and noted.	
	15b - Review of Scheme of Delegation Process	
	The Director of Finance advised the board that due to the current delegated limits listed in the Scheme of Delegation and the lack of clarity in the opening budget detail, it has been necessary to seek Board approval of a significant number of items when the financial value breaches the Chief Executive's listed approval threshold. This has resulted in some delays to orders being placed and invoices being approved, while the approval has been sought. It is suggested that the Scheme of Delegation is expanded as follows: • All areas of spend approved in the opening budget (where identifiable in sufficient detail) do not require another approval by the Board. This would include regular payments such as rent and rates. • The values afforded to each signatory level are increased for those areas covered above. • Any new business or a change from that approved in the opening budget would still require Board approval once above the CEO approval limit. • Approval of contracts is separate to the limits applied to purchasing activities with a limited number of signatories with the ability to agree. This Director of Finance pointed out that the expansion to the Scheme of Delegation is not intended to reduce the financial governance around approvals but to reduce the current duplication and to enable the business to operate efficiently where areas of spend have been approved in the opening budget. In addition, the separation of contracting approvals from purchasing approvals will improve the	

	effective flow of documentation, particularly in relation to lease agreements and contracts that have a duration that is longer than the current financial year. The proposed schedules are being compiled linking to procurement activity and current contract values. The amended Scheme of Delegation will follow the approval route through EMB to Audit Committee to the Board, ensuring that the appropriate governance is applied.	
	Resolved	
	a) That the contents of the paper be received and noted. b) That the Board of Directors approved the process for the review of the Scheme of Delegation.	
10/23/16	**Quality Reports – Combined Clinical Directors Quality Report – October 2023**	
	The combined Clinical Directors Report for October 2023 was submitted. The CEO pointed out that the Trust is all up to date with no backlog on SI's, ER54's, complaints, coroners or learning from deaths.	
	Resolved	
	That the contents of the report be received and noted.	
10/23/17	**Freedom to Speak Up (FTSU) Guardian Reports**	
	The Freedom to Speak Up Guardian gave an update and informed the Board that activity has continued to rise. Concerns continue to be around behaviours followed by systems and processes. The paper includes a table for each service area. 14 of the 33 concerns (42%) during the first half of the year were raised anonymously. Some of these were attributable to relevant service areas and hubs, 2 identified the service area and not the hub, and 1 did not identify any service or location at all. These are reflected in the tables. It is important that we monitor the trends in anonymous concerns, including the type of concerns that are raised in this way, as this is a good measure of whether staff are using the best means of speaking out, or are fearful of being identified. Indications are that the use of the anonymous route at WMAS is slightly higher than elsewhere. We will continue our work to improve the culture throughout the organisation to provide assurance that concerns will be taken seriously and treated sensitively. We are developing our reporting capabilities to produce a regular trend analysis. This will be	

	produced and tested in Quarters 3 and 4. The analysis of emerging trends will continue, and over time, will be used to understand common themes at a greater depth, to fully understand matters that are being reported through FTSU and, importantly, those that are not. There will be a particular focus on cases relating to patient or staff safety, and correlation will be analysed across all metrics. Among the cases during the first half of 2023/24, two concerns have identified a form of detriment following raising concerns. We continue to provide assurance to people who step forward to raise a concern that their concern will be handled with sensitivity and will only be progressed with their agreement. Furthermore, we are promoting the work of the staff networks and demonstrating the need to approach difficult conversations in the right way, and to ensure respect and dignity at work for colleagues. M FTSU month is breaking barriers. We continue to look at different ways to engage with staff. The FTSU Guardian explained that we have advertised pre-bookable appointments for personal discussions. We have not done this before but only had limited take up of this. The FTSU Guardian was asking Board Members and the FTSU Ambassadors to make a personal pledge. This is a good opportunity for people to see what impact they could make. Thank you to those who have already made pledges but ask everyone else to make a pledge. The FTSU Guardian informed the Board that the Trust has 48 named Ambassadors across the Trust with a further 10 expressions of interest. We are focusing on the ethnic mix to ensure we have a more balanced mix across the Trust. The FTSU Guardian gave an update on the following: • NGO Action Plan – one outstanding action which is amber, and this is related to the end of year report. In March this will be green and complete. • NHSE Action Plan – the only item ongoing is the development of our reports and triangulation of metrics. This work has commenced. • Reflection & Planning Tool – this has been to the Board twice and EMB recently. Any items scored 3 out of 5 we have agreed actions to improve the score. • Letters to Key Stakeholders regarding the Quality Account - The Quality Account has been updated to include a FTSU section. • Lucy Butler joined as a new FTSU Guardian in September. The FTSU Guardian also updated the BoD on the progress on implementing the actions arising from the NHSE review into the management of concerns by WMAS, with one action left scheduled for implementation. On a related matter, the Guardian also updated the BoD on the update to the quality account issued to the recipients of the Quality Account regarding the NHS England review and FTSU.	

	The Chairman thanked the FTSU Guardian for her very comprehensive and clear presentation. Mrs Kooner thanked the FTSU Guardian for all the work she is doing trying to engage with staff. Mrs Kooner was pleased about the work being undertaken on representation of the Ambassadors. Mrs Kooner asked if racism should also be included as a category. The FTSU Guardian explained that the categories are nationally mandated so that is what we must report on. We could do something locally as a sub-set. The FTSU Guardian would see if they would also be interested in changing this nationally. The self-assessment tool has been updated since Mrs Butler took up her post. It is planned to see the impact of Mrs Butler joining and the workload before this item is moved to a 5. Professor Hopkins said with raising awareness we have such a lot of activity. The Board should be reassured with the amount of evidence. We are on a journey this is good investment for the Trust. The CEO thanked the FTSU Guardian for the work she is doing and asked her to email round the link to the pledges so these can be completed. The CEO advised the Board that feedback from the Region on our action plans has been very complementary. Mrs Jasper explained that she had been out and about during the month and met with several Ambassadors who were very positive. Mrs Jasper had attended the Ambulance Leaders Forum and she explained that a lot of what was raised there we have already done. The National Guardian was very positive of the work being undertaken at WMAS by our FTSU Guardian.	
	Resolved	
	a) That the contents of the report be received and noted. b) That the FTSU Guardian would email round the link to the pledges so these can be completed. c) That the Board of Directors received and approved the Self-Assessment.	**PW/VK**
10/23/18	**Operations Update**	
	A report of the Director of Performance & Improvement was submitted. The Director of Performance & Improvement highlighted the salient matters contained in the report submitted. Mr Khan thanked the Director of Performance & Improvement and said this is a core area of activity for the Trust. Activity is up by 6% and asked for clarity on the impact on response times. The Director of Performance & Improvement explained that it exacerbates the impact on hospital delays. On average operational staff used to respond to 7-8 jobs per shift, now responding to 4 jobs per shift was positive. Currently as at that time, the Trust 200 patients waiting for an	

	ambulance.	
	Resolved:	
	a) That the contents of the paper be received and noted. b) That the Board of Directors received the update on the following: 1. Emergency & Urgent Operations. 2. Integrated Emergency & Urgent Care. 3. Non-Emergency Operational Update.	
10/23/19	**Board Committee Reports & Minutes**	
	19a - Quality Governance Committee (QGC) The minutes of the QGC meeting held on 19 July 2023 was submitted. Professor Hopkins advised the Board that there were the same issues of concern at both meetings. There has been an increase in assaults on staff. We are hoping for a better uptake on staff wearing body cameras. Concerns have been raised around the delays for callers to Language Line. Work is ongoing, meeting arranged to discuss options, and how improvements can be made. There is focus on the Post Resuscitation care bundle to improve the national position of the Trust. There is a national benchmarking day to ensure all standards are clear and internal discussions on how to improve documentation of Post Resuscitation elements on EPR. Clinical Audit is showing several areas with assurance rating 'insufficient'. Improvements are noted from previous report and actions are in place. Positive assurance as per the list on page 2. Professor Hopkins was pleased to hear some of the strategies may be consolidated.	
	Resolved:	
	a) That the minutes of the Quality Governance Committee held on 19 July 2023 be received and noted. b) That the Report of the Chair of the Quality Governance Committee be received and noted.	
	19b - Performance Committee The minutes of the Performance Committee meeting held on 25 July 2023 were submitted. Mr Khan the Chairman of the Committee said that the consolidation of the enabling strategies was welcome. The Committee discussed the BAF going forward and using it as a guide to the agenda going forward. Unrecovered debts and how we can improve the process was discussed by the Committee. The risk	

	assessment for hospital handover delays and call stacking incidents needs to be reassessed and may go back up to 25.	
	Resolved:	
	a) That the minutes of the Performance Committee meeting held on 25 July 2023 be received and noted. b) That the Report of the Chair of the Performance Committee be received and noted.	
	Mr Fessal left the meeting.	
	19c – People Committee The minutes of the People Committee meeting held on 22 May 2023 were submitted. The People Director advised the Board that the NHS EDI Improvement Plan is still draft and does not have completed named responsible individuals or timeframes agreed.	
	Resolved:	
	a) That the minutes of the People Committee held on 22 May 2023 be received and noted. b) That the Report of the Chair of the People Committee be received and noted.	
	19d – Audit Committee Mrs Jasper explained that the next meeting is scheduled for 7 November 2023.	
10/23/20	**Board of Directors Schedule of Business**	
	The Schedule of Business was submitted. The Chairman explained three will now be a short Board meeting held on 29 November 2023 to deal with urgent items.	
	Resolved:	
	a) That the Board Schedule of Business be received and noted.	
10/23/21	**Any Other Business**	
	There was no other business.	
10/23/22	**Review of the Meeting & Identify Any New or Increased Risks Arising from the Meeting**	
	This item was deferred today and will be picked up under different	

	forums. We can discuss and debate what was good.	
10/23/23	**The Date of the next meeting**	
	Wednesday 29 November 2023 – 10:00 hours.	
	There being no other business for this meeting the Chairman brought proceedings to a close and thanked members for their attendance.	

Minutes of the Meeting of the Board of Directors held on 29 November 2023, at 11:10 hours, Sandwell Hub & Via MS Teams

Present:		
Prof I Cumming*	Chairman	Non-Executive Director (Chairman)
Mr A C Marsh*	CEO	Chief Executive Officer
Ms C Beechey	CB	People Director
Mrs C Eyre	CE	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*	NH	Emergency Services Operations Delivery Director
Mrs J Jasper*	JJ	Non-Executive Director
Mr V Khashu	VK	Strategy & Engagement Director
Mr M. MacGregor	MM	Communications Director
Mrs K Rutter*	KR	Director of Finance
Dr R Steyn*	RS	Interim Medial 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 Sandwell Hub		
Ms D Scott	DJS	Interim Organisational Assurance Director
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Ms R Farrington	RF	Staff Side Representative
Mr M Brown	MB	Hed of Risk (part of meeting)
Mr C Cooke	CC	Operational Support Services Director (part of meeting)
Mr D Robertson	DR	Journalist (part of meeting)

11/23/01	**Welcome, Apologies and Announcements**	
	Apologies for absence received from Dr Alison Walker Mr Mushtaq Khan, Mrs Wendy Farrington-Chadd, and Mrs Narinder Kooner. The Chairman gave an update and welcomed everyone to the extraordinary meeting which had been convened due to the gap between October and January Board for the discharge of ordinary business. He indicated that going forward the intention was to revise the cycle of meetings of the Board of Directors so that from next year we do not have such a large gap between October and January in terms of ordinary meetings. From next year we shall make the November meeting an ordinary meeting.	

	The elections to the CoG have been completed. The Council of Governors will be recommended to invite Eileen Cox to continue in the role of lead Governor until the next AGM at which point, when the election for Lead Governor will occur. The Chairman reported that as discussed previously, Wendy Farrington-Chadd will be stepping down at the end of January 2024. The recruitment process for the replacement NED is under way led by the Chairman and the Governors.	
11/23/02a	**Declarations of Interest**	
	There were no conflicts of interest declared by anyone attending the meeting in relation to any matters on the agenda.	
11/23/11	**Chief Executive Officer (CEO) Update**	
	A report of the Chief Executive Officer was submitted. The Chief Executive explained that the National Ambulance Coordination Centre (NACC) is a National Ambulance Resilience Unit (NARU) asset. It is hosted and provided by WMAS and for a number of years, NHS England have provided additional funding for the NACC to be activated during emergencies such Covid-19, increasing system pressures, etc. NHS England formally communicated that the NACC will be stood down on 1 November 2023. This is primarily due to them wanting to move urgent & emergency care (UEC) escalation to a National Operations Centre (NOC) function. The five WMAS paramedics will have their secondments ended and will revert to their substantive roles. The 'NARU NACC plan' details the indications and procedures for the NACC to be stood up, for example in the event of a major incident in the ambulance sector requiring mutual aid. WMAS, and the NACC will remain prepared to stand up the NACC, as part of the NARU contract.	
	Resolved:	
	a) That the contents of the report be received and noted	
11/23/13	**Board Assurance Framework (BAF)**	
	A report of the Director of Nursing was submitted. The Head of Risk presented an the updated and revised BAF. The Chairman indicated that the document submitted was much improved. The Chairman questioned the variation in risks scoring contained in the BAF and sought clarity on the discrepancy in future reports. The Head	

	of Risk explained that the revised BAF and Risks reflects the Board's strategic objectives and focuses the Board's attention on the areas to concentrate on at Board meetings. The Board welcomed the revisions to the BAF. The Head of Risk explained that the Executive Management Board (EMB) had recently reviewed the risks related to hospital handover delays and call stacking and given the risks to patient safety had recommended that the two risks to 25, given the increase in hospital handover delays and call stacking.	
	Resolved	
	a) That the contents of the Board Assurance Framework be received and noted. b) That approval be given to the revised Board Assurance Framework. c) That given the risk to patient safety, the recommendation of the EMB be approved and that the Board Assurance Risk ratings for both hospital delays and calls stacking be increased to 25 and that the appropriate mitigation be put in place and reported to the next meeting of the Board.	
11/23/14	**Supporting Strategies**	
	05a - Clinical Strategy A report of the Medical Director was submitted	
	Resolved	
	a) That the contents of the paper be received and noted. b) That approval be given to the content of the Clinical Strategy.	
	05 – Communications & Engagement Strategy A report of the Strategy & Engagement Director was submitted. The strategy had been updated in several areas, for example to take on board relevant areas of the well led review by the Good Governance Institute and the refreshed set of Values the Trust signed off in 2023. Following Executive Management Board (EMB) review, the one area of further work to take forward is around patient participation and engagement in service design and decision making. Whilst WMAS has a patient experience strategy in place, the Executive Team will review what further actions we can take to build patient representation in the development work.	

	The Chairman referred to staff communications given the transient nature of the service. The Director of Performance & Improvement informed the Board that the Digital Transformation Group are working on this matter and how it can be better facilitated utilizing the Ipads that have been rolled out. Mrs Jasper asked if the Trust has a legal responsibility for consultation as there is no reference to this in the Strategy. The Strategy and Engagement Director and Communications Director confirmed that if the Trust is making a significant service change, then it has a responsibility for consultation. The Strategy & Engagement Director will add a sentence into the strategy on legal responsibility for consultation. Mr Fessal explained that at the recent meeting of the People Committee concern was raised that not all Students have access to the weekly briefing as they do not all have a WMAS email address. With this regard it was agreed that as part of the review the document needed to include this; Professor Hopkins agreed, and noted the need to ensure all Students can access everything that was appropriate for their development. The Chairman requested that the strategy was reviewed to include reference to students. The Operational Support Services Director joined the meeting at this point. The Chairman asked colleagues to ensure as the strategies are reviewed that they all follow the same format. The Strategy & Engagement Director would pick this up.	
	Resolved	
	a) That the contents of the papers be received and noted. b) That subject to the comments raised at this meeting approval be given to the Communications and Engagement Strategy. c) That the further work being undertaken on how WMAS approaches patient participation and staff and student engagement be noted.	
11/23/15	**Estates Update**	
	A report of the Director of Finance was submitted. The Operational Support Services Director gave an update and informed the Board that the paper submitted provides an overview of the current estate portfolio. The Operational Support Services Director advised the Board in relation to the break clauses for Cheshire PTS. The Trust uses five properties for the Cheshire PTS Contract. The contract ends on 31	

	March 2024. The EMB had taken the decision to enact the break clauses at Crewe and Ellesmere Port and the decision on serving notice under the break clause is required by 13 December 2023. The Trust's Solicitors, Mills & Reeve have prepared the break clause notice in readiness to serve on the landlord. In relation to Shropshire, the CEO informed the Board that the Trust is absolutely committed to a site in Shrewsbury and a site in Telford. The lease for the current site in Shewsbury ends in 2027. The Operational Support Services Director will submit a report to the Board in January 2024 setting out the options for the new site and timeline. The Trust attended a local meeting in Shrewsbury recently and Shrewsbury Council will work with the Trust to identify a new site. The Chairman asked why two sites are required. The CEO explained that the County is too big and busy for one site and there is no argument to reduce from 15 Hubs.	
	Resolved	
	a) That the contents of the paper be received and noted.	
11/23/16	**Appointment of WMAS External Audit Providers**	
	A report of the Director of Finance was submitted. Following a procurement exercise led by the Audit Committee Chair, the Council of Governors had appointed Bishop Fleming as the Trust's auditors. They have been engaged on a 2 year plus 2-year contract. . So, in terms of the process and given the timing of the appointment, the Trust will have two auditors: KPMG for the first half and Bishop Fleming for the second half of the financial year. Mrs Jasper as Chair of the Audit Committee assured the Board on the process followed and whilst the new firm are relatively new to the NHS two of their Team working with the Trust do have experience in the NHS.	
	Resolved	
	a) That the Board noted the appointment of Bishop Fleming as the Trusts Auditors.	
11/23/21	**Any Other Business**	
	There was no other business.	
11/23/22	**The Date of the Next Meeting**	

	Wednesday 31 January 2024	
	There being no other business for this meeting the Chairman brought proceedings to a close and thanked members for their attendance.	

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Paper 02

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 for approval.	**KR**	**Update to Nov 2023**	An agenda item. The Board are requested to delete this item from the Board Action Log.
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**	**Nov 2023**	ICB has agreed and a scoping exercise underway led by Strategy & Engagement Director
10/23/08	**Workforce Race Equality Standard (WRES) Annual Report 2023 & Action Plan 2023/24** The People Director will circulate the September 2023 KPIs to Board Members.	**CB**		Complete
10/23/17	**Freedom to Speak Up (FTSU) Guardian Reports** The FTSU Guardian would email round the link to the pledges so these can be completed.	**PW/VK**		Update at the meeting

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06 MONTH: January 2024 PAPER NUMBER: 03

BOARD ASSURANCE FRAMEWORK	
Sponsoring Director	Caron Eyre
Author(s)/Presenter	Matt Brown, Head of Risk
Purpose	The Board Assurance framework has been revised into a new format The Board is asked to note the risks and the actions and comment and advise if any further work is required to control and reduce those risks
Previously Considered by	N/A
Report Approved By	Executive Director of Nursing

Executive Summary

Following both internal and external (Good Governance Institute) discussions, it has been agreed that a revised BAF is developed. This new risk template is reported here after previous discussions and work undertaken by both EMB and Board.

Several actions took place to ensure the process is fully understood provides improved assurance to the Board, and that all key stakeholders are engaged and can comment and advise on the content of the documentation with the governance arrangements involved moving forward.

All risks have been reviewed and updated, the report also includes a risk trend graph to chart the risk score journey, supporting information on the BAF process as well as an overall update on page 7 for ease of review.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06 MONTH: January 2024 PAPER NUMBER: 03

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 are asked to note the risk updates, offer any comment on content and actions and determine whether any further action is required against the risks to mitigate.	

Board Assurance Framework

January 2024

The Board Assurance Framework is an agreement between the board and management which summarises:

- the organisation's strategic objectives,
- the risks to achieving the objectives,
- the controls management are required 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.

This Document comprises of the following sections:

Strategic Objectives

Safety, Quality and Excellence	A Great Place to Work for all	Effective Planning and use of Resources	Innovation and Transformation	Collaboration and Engagement
Our commitment to provide the best care for all patients.	Creating the best environment for staff to flourish.	Continued efficiency of operation and financial control.	Developing the best technology and services to support patient care.	Working in partnership to deliver seamless patient care.

Identified Risks mapped to Committees of the Board and Executive Directors

Ref	Risk	Strategic Objectives					Committee(s)	Exec Lead(s)
		1	2	3	4	5		
SR1	Handover Delays	✓	✓	✓		✓	Performance Committee	Nathan Hudson
SR2	Call Stacking	✓	✓	✓		✓	Performance Committee	Nathan Hudson
SR3	Occupational Stress	✓	✓	✓			People Committee	Carla Beechey
SR4	Organisational Culture	✓	✓	✓			People Committee	Carla Beechey
SR5	Financial Duties		✓	✓		✓	Performance Committee	Karen Rutter
SR6	Innovation	✓	✓	✓	✓	✓	Quality and Governance Committee	Nathan Hudson
SR7	Engagement			✓	✓	✓	Quality and Governance Committee	Vivek Khashu

Key:

✓ - Primary link to strategic objectives

✓ - Secondary link to strategic objectives

Effect of Controls

Ref	Risk	Inherent Rating	Oct 23	Dec 23	Jan 24	Apr 24	Jun 24	Trend	Target Score
SR1	Hospital Delays	25	20	25	25			No Change	16
SR2	Call Stacking	25	20	25	25			No Change	16
SR3	Occupational Stress	16	12	12	12			No Change	8
SR4	Organisational Culture	16	12	12	12			No Change	4
SR5	Financial Duties	16	12	12	12			No Change	8
SR6	Innovation	12	8	8	8			No Change	4
SR7	Engagement	16	12	12	12			No Change	8


Staff & Patient Experience


Education and Training


Clinical Effectiveness & Research


Audit & Compliance


Risk Management


Staff Management


Business Intelligence

Reporting Cycle

The Board Assurance Framework will be presented to each meeting of the Board (Bi-Monthly) for review. A summary of changes since the last report, will be provided, as well as the direction which the risk is travelling.

Between the meetings of the Board the risks in the Assurance Framework will be continually reviewed by the committees of the Board. For each of the committee meetings, any BAF risks that are aligned to the committee will be included in the Committee Chairs Report to ensure appropriate opportunity to review and update the BAF risks, ensuring that the Board are informed in an accurate and timely way.

The Audit Committee will also receive a copy of the Board Assurance Framework at each of its quarterly meetings to provide oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes.

	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Board Meeting	✓			✓			✓			✓		
Assurance Committees	✓				✓			✓		✓		
EMB (interim reviewing group)		✓				✓		✓		✓		

Risk Updates

January 2024 - All risks have been reviewed and updated by Owners.

S01 and S02 remain at 25 as significant impact continues, call waiting, and hospital delays affect patients with incidents and SI's increasing, Trust remaining at Surge 4. A report to EMB in December detailed several plans for improvement which included proposals for dispatch, healthcare referral tier, OREO desk amongst others. It is thought that the many changes to current systems and processes will have an impact on Hospital Delays and Category 2 performance.

13th December NHS England Midlands requested that the ICB (with partners) confirmed that relevant escalation protocols were in place, robust and articulated how the ICB oversee, manage and resolve any excessive waits against agreed thresholds. There were suggestions on what information would be useful and relevant actions to ensure the plans were thorough. Information was required to be returned by the 18th December. The Trust is awaiting NHSE to share submissions with us and our host ICB. On the 29th December 2023 the Trust sent letters to each acute within our Region highlighting the specific lost hours at their site, lost hours recorded for WMAS in November 2023 and details regarding the impact of these on WMAS (amount of vehicles sent to release crews/cohort at their hospital due to delays). In these letters, the Trust has offered any support needed to each of the acutes to work collaboratively across the system to reduce delays and improve patient safety and system performance.

High Risk (graded 20) review process continues to ensure that risk ratings are appropriate and identify where any relevant actions can be applied to reduce. This was initiated by EMB and the panel consists of Patient Safety Director, Interim Executive Medical Director, Executive Medical Director of Nursing and Head of Risk. Since its inception, the number of risks has reduced from 11 to 6.

Staff stress linked to hospital delays, increased late finishes and call waiting where patients are encountering extended delays – number of work streams in place including staff survey, culture review and FTSU action plans. The Trust has been chosen to be an exemplar organisation as part of the People Promise retention programme, meaning that funding has been designated for a People Promise Manager to carry out this work.

Finance - action extended regarding structures and contracting and commissioning actions, and work started for consolidation of contracting within each area for greater understanding across the Trust. The risk has a new action added regarding next years CIP's identification and impact as discussed at EMB in January.

Engagement workstreams continue, one of these involves a paper to EMB regarding establishing Patient Participation Group. Discussions with ICB's regarding the challenges faced by WMAS given the geography of the area covered. Decision to create individual risk assessments for each service level change and its impact on WMAS.

Strategic Risks 1-7

Strategic Objective 1: Safety, Quality and Excellence – Our commitment to provide the best care for all patients.	Risk Score 25
Strategic Risk No. 1: Handover Delays	

If … handover and offload delays at hospital continue	***Then*** … this will lead to a failure to provide safe and effective care	***Leading to/Resulting in*** … poor patient outcomes, low staff morale and negative impact on performance.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**5**	**25**
Target	4	4	16

Risk Trend

Risk Lead	Nathan Hudson – Director of Performance and Improvement	Assurance Committee	Performance Committee

Controls

- Ambulance handover delays board report
- Reducing ED congestion workgroup – workstreams include, "Reducing Demand and Enhancing Patient Flow
- Gold Commander "reactive protocol" to specific cases in the event of significant Patient delays & Ambulance Turnarounds
- Hospital desk 24/7 hours of operation.
- SOC & EOC management of Hospital delays, escalation of each delay to NHSE, CCG and Hospital Directors to gain resolutions on delays.
- WMAS escalation process – HALO to OM/SOM
- Director of Clinical Commissioning and Service Development
- EMS levels monitoring - Escalation Management system used to monitor pressures within an acute trust.
- Intelligent conveyance - a conveyance method used to spread the workload across all acute trusts during times of pressure.
- Declaration of Major Incident in extremis.
- Patient with ambulance clinician whilst on vehicle
- Ambulance clinician able to provide nursing care.
- Ambulance equipped with heating and air con.
- Intelligent conveyance

Assurances reported to Board and Committees

First and second line (internal) assurances)

Reports to:

- HALO Cohorting SOP
- Communication between WMAS staff and hospital staff (HALO, Navigator, Nurse etc)
- Divert processes.
- Implementation and monitoring of the conveyance policy
- REAP and surge plan
- Operational performance plans
- Local SOM's rota demand management
- Meal break and end of shift management in place to protect category 1 and 2 patients.
- REAP escalation procedure.
- 24-hour SOC provision
- Surge demand management plan (SDMP) now embedded within the EOC and utilised as required.
- Category 3 and 4 clinical validation
- Introduction and embedding of Category 2 segmentation – clinical navigation and validation of a specific subset category 2 dispositions as provided by NHSE.

Third line (external) assurances

- NASMED guidance on delayed handover

• Supporting RA's covering handover delays and IPC prolonged exposure • Ambulance decision areas in place at several sites • Immediate offload to free up crews to respond to outstanding patients. • End of shift tasking memorandum of understanding across footprint	• AACE IPC precautions during hospital handover delays • Professional care standards for patients waiting in Ambulances. • Regular meetings between WMAS and hospital • Regular liaison with hospital leads from WMAS • Improved partnership working with all stake holders through SOC. • Engagement with partner agencies (111, commissioners, GP's, police and hospitals) to understand what can be done in the future during periods of intense demand to take a more holistic approach in reducing demand upon the Ambulance Service. • Continued positive dialogue and collaboration between WMAS, acutes and ICB and NHSE. • Continuous engagement with SCC and wider system level calls
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Continued hospital delays. • Patient harm. • Failure of category 2 performance. • HALO cover reduced to pre COVID Levels. • SCC Resourcing and cover to manage increased demand. • Crew late finishing	

Action	Owner
Trial ongoing for 3 months for BBC on opening borders to share resources across both county borders to enable more timely response to patients, including a higher priority of calls e.g., Cat 1 and Cat 2. Results to be shared post-trial.	Nathan Hudson March 2024
OREO Desk now renamed Operational Support Desk (OSD) which focusses on supporting staff following difficult cases, increasing productivity, and reducing downtime on scene at hospital, as well as improving resourcing. Outcomes and performance impact to be reported with relevant business case to support.	Nathan Hudson March 2024

Risk Updates

Since the last review several actions have taken place to try and improve the hospital handovers, and staff and patient safety. The Trust has now implemented the HCRT tier (November 2023) which has seen an increase in resourcing to ensure that referrals are moved timely (at time of review there were 10 HCRT Crews available with no referrals outstanding. It is believed that this will continue to have a positive impact on resourcing and the lower acuity patients who can deteriorate quickly, and who need hospital attendance. Whilst handover delays have continued to worsen (with 30,000 hours lost in December 2023) the Trust continue to identify actions to try and reduce all risks where possible – these were included in paper to EMB in November and include a review of border limitations within BBC, category 2 performance and the renaming and refocus of the OREO (now OSD) desk. Unfortunately, the decision to remove the ADAs within West Mercia and Shropshire has remained, impacting the worsening delays for those regions.

Associated Risks on the Operational Risk Register

Risk no.	Description	Current Score
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	**15**

Strategic Objective 1: Safety, Quality and Excellence – Our commitment to provide the best care for all patients.	Risk Score **25**
Strategic Risk No. 2: Call Stacking	

If … delays responding to emergency calls continue	***Then*** … this will cause long waits in the call stack	***Leading to/Resulting in*** … poor patient and staff experience and potential serious incidents.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**5**	**25**
Target	4	4	16

Risk Trend

Risk Lead	Nathan Hudson – Director of Performance and Improvement	Assurance Committee	Performance Committee

Controls

- Significant investment and increases in operational staffing levels
- Significant increase in Call Assessor numbers. Current establishment circa 420 trained call assessors.
- Strong hospital turnaround management in place including additional investment into HALO provision and ADA functions.
- Resource output producing around 350 frontline ambulances at peak per day
- Full establishment of VPO's across all HUBS
- There are no EOC vacancies across any function.
- Surge demand management plan (SDMP) now embedded within the EOC and utilised as required.
- Implementation of the SCC (excluding Staffordshire)
- OSD Team in place to manage resource availability and crew downtime.

Assurances reported to Board and Committees

First and second line (internal) assurances)

Reports to:

- Fleet availability 100% continually
- Meal break and end of shift management in place to protect category 1 and 2 patients.
- 24-hour SOC provision at all times
- On call Tactical Command function always
- Surge demand management plan (SDMP) now embedded within the EOC and utilised as required.
- Category 3 and 4 Clinical Validation
- Embedding of Category 2 segmentation – clinical navigation and validation of a specific subset Category 2 dispositions as provided by NHSE.

Third line (external) assurances

- Engagement with partner agencies (111, Commissioners, GP's, Police and Hospitals) to understand what can be done in the future during periods of intense demand to take a more holistic approach in reducing demand upon the Ambulance Service

Gaps in Controls and Assurances	Actions to address control / assurance gaps	
• Continued stacking of calls. • Failure of category 2 performance. • Continued patient delay and harm. • Poor staff morale	Action	Owner
	Additional recruitment of CVT to improve resource availability and opportunity to manage calls	IEUC Director March 2023.

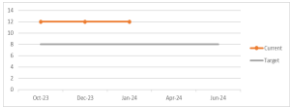
Risk Updates

Since the last review call waiting volumes remain significant and continue to present a high risk, which has seen the Trust remain at SURGE 4 for the majority of December. This continues to impact patients with continuing extended delays and patient harm, including an increase in SI's and patient safety ER54's.
The Operational Support Desk has been implemented which has shown an improvement in resource availability and a reduction in downtime, this
Additional CVT clinicians have been recruited with this recruitment continuing over the next few months to improve resilience.
Engagement with the NHS England regional teams continue as well as talks with the ICB's with a view to finding solutions across the healthcare system to reduce the hospital handover delays and calls waiting, and ultimately improve patient safety, experience and overall performance.
All associated EOC risks have been reviewed and updated accordingly, which includes an increase of risk score on EOC-022

Associated Risks on the Operational Risk Register

Risk no.	Description	Current Score
EOC-003	Clinical validation for Cat 3 and Cat 4 incidents	**12**
EOC-022	Clinical validation for Cat 2 999 Calls impacting patient safety and performance	**20**
EOC-024	Risk associated with not staying on the line with callers, resulting in patient harm, litigation, stress and SI's	**10**
EOC-027	Consideration for Category 2 IEUC Closing Instructions impacting patient safety, performance and staff wellbeing	**10**

Strategic Objective 2: A Great Place to Work for all – Creating the best environment for staff to flourish.				Risk Score **12**
Strategic Risk No. 3: Occupational Stress				
If … staff experience occupational stress and exposure to psychological hazards	***Then*** … this may increase sickness, staff turnover and demand on other staff		***Leading to/Resulting in*** …an inability to cope with other demands and sickness within other areas of the Trust.	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	
Current	**4**	**3**	**12**	
Target	4	2	8	

Risk Lead	Carla Beechey – People Director	Assurance Committee	People Committee
Controls		Assurances reported to Board and Committees	

• Development and improvement of effective communication pathways within the organisation, through intranet sites, weekly briefing, webinars, network forums • Freedom to Speak Up Advocates / Guardian • Leave/Time Off for Domestic Reasons Policy • Stress Risk Assessment Questionnaires • Return to Work Risk Assessments • Risk Assessment process reviewed and being applied where necessary to identify required support for staff. • Training for managers has been provided in occupational stress, absence management and reasonable adjustments. • Mental Wellbeing Service, including Mental Wellbeing Practitioners and option to refer for private counselling via The Listening Centre. • Dedicated WMAS Wellbeing Internet site hosting wide range of support materials and specialist signposting, events, webinars, podcasts. • Health and Wellbeing Champions • Online 24/7 wellbeing resource, subscriptions for all WMAS Staff (Qwell) • Inclusion in PDC to have specific conversation on Health and Wellbeing • Increase in mental wellbeing staffing • Interviews testing suitability • Mandatory training with mental health information • Ongoing review of HWB initiatives and interventions targeted at specific areas of identified need. • HWB Roadshows • Just B Proactive HWB conversations • Decider Skills Training delivered in EOC and now incorporated into AAP and Grad Induction Programmes • Mandatory Training • Back Up available to staff at jobs where required Post Incident De-Briefs • Automated message from control to officers where ION is identified. • Support for EOC staff from a supervisor on any call if needed etc and timeout of control after a traumatic / difficult job • SALS	**First and second line (internal) assurances)** Reports to: • Occupational Stress Policy • Sickness Absence Policy and procedures • Dignity at Work Policy • Flexible Working Policy • Well Being Handbook • Personal Development Review • Resolutions procedure • SALS advice service • Incident reporting process • People Strategy • Health and Wellbeing Strategy • Sickness Absence Data • Turnover Data • HWB Uptake • Mandatory Training Compliance (inc CRT) • Launch of The Decider Skills Training (and training uptake) • Corporate Induction with mental health information/Mentorship / Clinical Team Mentors • Designate line manager on 24/7 • PDC's with Health and Well Being (HWB) conversations • Stress policy and stress risk assessments, **Third line (external) assurances** • Support from external organisations/professions in provision of counselling and psychological support • Single contact provider for occupational health provision. • Occupational Health for support during employment • The Listening Centre • Pre employment screening by OH • Team of trained mediators to assist with resolving workplace conflict
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Staff Survey Performance • Unable to control and manage attendance where exposure to possible stressors may be present.	• Trust wide Staff Survey action plan and local action plans in place. • WiinningTemp data. • Culture Review.

Risk Updates
The 2023 staff survey results have been received but currently embargoed, therefore once full results received the relevant action plans (local and organisational) can be devised accordingly. As referenced in S01 and S02 the Trust are seeing an increase in staff late finishes and extended times at hospital, resulting in increasing patient welfare tasks and missed meal breaks, which is having an impact on staff wellbeing and stress. There are actions in place from an operational perspective to try and recue demand/activity but from a Health and Wellbeing perspective signposting to relevant support mechanisms and resources continues, including within the Staff PDC, as well as management development programmes to empower and encourage relevant conversations with staff.

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current Score
ORG-027	Failure to succession Plan for Senior Management leading to contingency concerns, increased sickness and concerns of task completion	**9**
ORG-048	Risks associated with increased workload due to reduced management capacity and support Staff capacity	**9**

Strategic Objective 2: A Great Place to Work for all – Creating the best environment for staff to flourish.	Risk Score 12
Strategic Risk No. 4: Organisational Culture	

If … the organisational culture within the Trust is unsuitable	***Then*** …there will be a failure to provide a suitably safe, healthy and rewarding place to work	***Leading to/Resulting in*** … low staff morale, increased sickness, increased turnover and complaints.

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	
Current	**4**	**3**	**12**	
Target	4	2	8	

Risk Lead	Carla Beechey – People Director	Assurance Committee	People Committee

Controls

- All sites displaying posters describing what sexual assault and harassment are and detailing what help is available.
- Regular updates and development about the importance of civility and respect at work (Engaging Managers and Leaders and other Organisational Development interventions such as Having Vital Conversations.
- Safeguarding arrangements in place to ensure safety of patients, staff and students.
- 7-minute Safeguarding briefing covering sexual safety and people in a position of trust
- Information on sexual safety and support issued to all new students and apprentices.
- Update to Managing Safeguarding Allegations Policy and Procedure
- Regular communications about the importance of speaking up.
- Regular updates for managers about how to respond if someone raises a concern.
- Reviewing managers' responses to ensure consistency and openness.
- Regular updates about the importance of civility and respect at work
- Pulse surveys to measure fear of detriment.
- Sharing success stories from concerns that have been raised.
- Multidisciplinary review process with HR, Management and Safeguarding
- Sexual Safety and Managing Allegations Sessions provided across the Trust
- Supportive education package around behaviour impact awareness led by Organisational Development
- Sexual Safety awareness and education delivered to Managers, Supervisors, Networks, ETOs, Mentors and CTMs
- Engaging Leaders and Engaging Managers Programmes incorporate encouraging staff to raise concerns and how to deal with them, and how to 'hold to account'

Assurances reported to Board and Committees

First and second line (internal) assurances)

Reports to:

- Sexual Safety Charter
- Occupational Stress Policy
- Sickness Absence Policy and procedures
- Dignity at Work Policy
- Flexible Working Policy
- Wellbeing Handbook
- Personal Development Conversations
- Sickness Absence Data
- Turnover Data and Trends
- Resolution procedure
- Freedom To Speak Up Policy (Whistleblowing)
- Incident reporting Process
- People Strategy
- Health and Wellbeing Strategy
- New Values and Behaviours
- Values and behavioural framework refreshed with Values Self-Assessment and new Culture Statement launched.
- Sexual Safety incorporated into the Induction and Mandatory Workbook
- Corporate Induction updated to include sexual safety.
- Staff Survey Results and Staff Survey Response Action Group (SSRAG)

- Vital Conversations development for CTMs and OMs
- CTM annual update training updated to include reference to declaration of interest if a consensual relationship is formed with a student
- Infographic displayed on Trust TV screens to raise awareness to staff
- Sexual Safety awareness and education delivered to Board to Directors
- Development and improvement of effective communication pathways within the organisation, through intranet sites, weekly briefing, webinars, network forums
- Freedom to Speak Up Advocates / Guardian.
- Online 24/7 wellbeing resource, subscriptions for all WMAS Staff (Qwell)
- Promoting "You Said, We Did Together" regularly for Staff Survey, All Ideas Matter (AIM), Freedom to Speak Up (FTSU) campaigns linked for greater awareness.
- Triangulation of data to highlight areas of increased concerns or where no concerns are raised.

- Winningtemp platform
- Employee Relations Casework Data
- Culture Statement Values and Behavioural Framework

Third line (external) assurances

- Support from external organisations/professions in provision of Counselling and Psychological support
- Single contact provider for Occupational health provision.
- Occupational Health for support during employment
- The Listening Centre
- Review undertaken and action plan implemented following Independent Culture Review of London Fire Brigade report in January 2023
- Review undertaken and action plan implemented following Met Police review
- Letter sent to all partner HEI Vice Chancellors
- CEO Managers Briefing presentation.
- All Staff Briefing

Gaps in Controls and Assurances

- Staff Survey Performance
- Reports of Harassment
- Potential underreporting of concerns by staff

Actions to address control / assurance gaps

Action	Owner
FTSU Action Plan implementation – future updates to be captured within review of RA (reported via EMB)	HR and FTSU April 2024
Culture review and action plan as a result to be completed.	April 2024

Risk Updates

The Trust has been chosen to be an exemplar organisation as part of the People Promise retention programme, meaning that funding has been designated for a People Promise Manager to carry out this work. The 2023 staff survey results have been received but currently embargoed, therefore once full results received the relevant action plans (local and organisational) can be devised accordingly. January 2024 will also see the introduction of the Race, Equality and Inclusion Charter with associated training package rolled out. Work continues on the FTSU action plan, and the next review will see a full update on actions and implementation. Culture Review and proposed recommendations is to be reported at EMB on 23rd January and this will be detailed in the next review of the BAF.

Associated Risks on the Operational Risk Register

Risk no.	Description	Current Score
ORG-035	Risk associated with the Trust failing to follow the Freedom to Speak Up Process and procedure leading to staff wellbeing issues, failure to learn and implement appropriate measures to reduce issues, and possible litigation	**9**

WF-033	Risk of an individual feeling uncomfortable, frightened or intimidated in a sexual way within the workplace, resulting in psychological and/or physical harm, litigation, reputational harm, loss of trust and/or confidence	**12**

Strategic Objective 3: Effective Planning and use of Resources – Continued efficiency of operation and financial control				Risk Score **12**
Strategic Risk No. 5: Financial Duties				
If … the Trust fails to undertake appropriate financial and workforce planning	***Then*** …there may be an impact on the ability to ensure the availability of sufficient resources		***Leading to/Resulting in*** … sub optimal patient care, workforce impact and failure to achieve strategic objectives	
	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	
Current	**4**	**3**	**12**	
Target	4	2	8	
Risk Lead	Karen Rutter – Director of Finance		Assurance Committee	Performance Committee

Controls	Assurances reported to Board and Committees
• Annual business plan, workforce plan and financial plan and their in-year monitoring and management • Finance team – structure, functions, roles, and regular review of finance risk register by senior finance management team • Reviewing cost base of Trust activities • More timely, accurate and relevant information provided to operations - e.g., Re overtime working. • Business Case process for all projects including post project benefit realisation assessment. • Cost Improvement Programme including regular scrutiny. • Senior Finance staff to maintain and be aware of current technical accounting and developments. • SFIs, Scheme of Delegation, Standing Orders • Medium- and long-term financial planning processes. • Regular cycle of budgetary control, financial management and support. • Efficiency audits. • Workforce Planning – Finance/HR/Ops.	**First and second line (internal) assurances)** Reports to: • Standing Financial Instructions, Standing Orders and Scheme of Delegation • Policies and Procedures • Audit Committee • Performance committee • Internal Audit plan • Monitoring throughout the committee structure up to EMB and Board level • Efficiency & Transformation Group • Financial Investments Group • Monitor achievement of the CIP schemes • Identify sources of funding to meet new areas of work. • People committee. **Third line (external) assurances** • External Audit Opinion. • Collaboration and engagement with host ICB and ICS. • NHSE Use of Resources Framework.

Gaps in Controls and Assurances	Actions to address control / assurance gaps
• Gaps within financial systems and improvements to ways of working • Establishing Contracts and Commissioning • Improvements required to current internal audit provision. • Education/Training capacity	Action: Review of Finance structures and systems within WMAS — Owner: Karen Rutter, March 2024 Action: Once next year's CIP's are identified, actions will be referenced on BAF, given the proposed impact on training, staffing and operations — Owner: Karen Rutter, March 2024

Risk Updates

Review of Finance structures ongoing and action extended due to changes around internal audit provision, and establishing contracting and commissioning systems and process management, following retirement of previous Director. It is expected all updates will be in place by March 2024 following review and agreement by relevant stakeholders including staff side and other committees. Once changes are agreed, work will begin on a consolidated approach and understanding of contracting across departments to embed good financial governance. This will include review and update of all finance risk assessments to ensure consistency and accurate risk identification. Action added regarding next years CIP's and actions required to minimise impact across the Trust.

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current Score
FI-007	Funding Allocations require year on year efficiency improvements with increasing demand. The Trust fails to achieve its CIPs/EPs fully and on a recurrent basis	**15**
FI-009	Patient activity is increasing at a rate which exceeds the cost base the Trust is funded for.	**20**
SR-002	As a result of increasing financial challenges to the NHS, The Trust fails to meet its financial duties resulting in risks to planning, commissioning and patients	**12**

Strategic Objective 4: Innovation and Transformation – Developing the best technology and services to support patient care	Risk Score **8**
Strategic Risk No. 6: Innovation	

If … the Trust encounters competing priorities, and a lack of resource and budget availability.	***Then*** … it will face development and implementation challenges	***Leading to/Resulting in*** … a failure to innovate and transform.

	Impact	Likelihood	Score
Inherent	4	4	12
Current	**4**	**2**	**8**
Target	4	1	4

Risk Trend

Risk Lead	Nathan Hudson – Director of Performance and Improvement	Assurance Committee	Quality and Governance Committee

Controls	Assurances reported to Board and Committees
• Innovation and transformation a key focus for the Organisation. • University Trust and continuing growth with partner Universities. • All Trust Strategies have a clear and ambitious focus on growth, innovation and transformation. • Continued drive for vehicle efficiency aligned to Green Plan and Sustainability • No Trust Vehicles older than 5 years • Introduction of E-DCA • The lightest van conversion ambulance vehicle in England, continually working with our convertor to reduce weight to improve fuel consumption and emissions. • Paramedic on every vehicle • Intelligent Conveyance • Ambulance Decision Areas and ADA Paramedics • Collaborative approach and understanding between Financial and Operational priorities with a focus on innovation including “Invest to Save” schemes.	**First and second line (internal) assurances)** Reports to: • Trust Strategy – innovation features centrally • Fleet strategy • Green Plan • Operational Strategy • Sustainability Strategy • Estates Strategy • Patient Safety Strategy • Quality and Improvement Strategy • Waste Management Policy • Digital Transformation Group

- Clinical Validation.
- Significant investment in mental health provision including specialist response vehicles, specialist team and resources.
- Paper Free Scheme.
- Level 6 Bsc Honours Paramedic Apprenticeships scheme and awarded 2023 (to commence 2024)
- Reduction of waste
- Driver Simulation from 2024 to reduce carbon footprint.
- Investment in 2 x Anatomage Tables.
- Digital Make Ready
- KIT Bag and HeadSet App
- Operational Resource Efficiency Officers
- First English Ambulance Service to implement control room solution.

Third line (external) assurances

- CQC Rating
- OFSTED Rated
- Global Digital Exemplar
- Official medical providers for Birmingham 2022 Commonwealth Games

Gaps in Controls and Assurances

- Financial constraints to innovate.
- Resource availability and impact on ability to complete innovation.
- Appetite for innovation and competing priorities.
- Potential change in Regulatory ratings if Trust fails to innovate.

Actions to address control / assurance gaps

Action	Owner
Explore feasibility of funding budget solely for innovation – that can be accessed by project leads	Karen Rutter – Director of Finance – April 2024
Refresh Quality and Improvement Strategy to include Innovation to focus on Staff suggestions and involvement	Michelle Brotherton – Non-Emergency Services Delivery and Improvement Director – April 2024

Risk Updates

There have been no changes to this risk – actions have been extended to the next review due to impact of other work streams and risk score of this risk.

Associated Risks on the Operational Risk Register

Risk no.	Description	Current Score
F&W-054	Operational Trial of E-DCA A&E Ambulance (Fiat Ducato 2019 build)	**6**
EOC-022	Clinical validation for Cat 2 999 Calls impacting patient safety and performance	**15**

Strategic Objective 5: Collaboration and Engagement - Working in partnership to deliver seamless patient care	Risk Score 12
Strategic Risk No. 7: Engagement	

If … the Trust continues to encounter system challenges	***Then*** … collaboration could prove difficult at a local place or neighborhood level	***Leading to/Resulting in*** … a failure to respond to local needs and relationship friction at a place / neighborhood level between the Trust and Public.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**3**	**12**
Target	4	2	8

Risk Trend

Risk Lead	Vivek Khashu – Strategy and Engagement Director	Assurance Committee	Quality and Governance Committee

Controls

- Strong engagement with ICS
- Professional engagement with other external groups and Networks
- Governor engagement with specific area
- SOM engagement with local communities and partnerships locally
- Consistent engagement approach across regional footprint, setting expectations.
- CFR Community engagement
- School and College engagement at Hub level.
- HALO engagement locally at Hospitals
- Alternative Pathway engagement via CVT work
- Hospital Flow Lead engagement with local systems
- WMAS is a “partner” member on the board of our host ICB – the black country, we have a host to minimise the transaction impact of operating in a complex system, a lead / host ICS was the preferred model during consultation with the sector.

Assurances reported to Board and Committees

First and second line (internal) assurances)

Reports to:

- Engagement Strategy
- Annual Stakeholder Survey
- PALS patient surveys
- Public Health Strategy
- EDI Strategy and Network
- Engagement with other sectors through NARU, JESIP, AACE et al.
- ICS Links Assurance to Board
- ICS Engagement Reports
- Quality Account

Third line (external) assurances

• Significant partnership / collaboration through our research programmes • Continued Board discussion and agreement on expected levels of engagement at local level	• Engagement with ICS • Engagement at Professional Groups • Lead ICB engagement • WMAS Chair, CEO and Strategy Engagement Lead meet with CEO and Chair of each ICB twice yearly. • WMAS CEO meets monthly with Black Country ICB counterpart. • WMAS Chair meets monthly with Black Country ICB Chairs. • WMAS joins the ICB and partners for its own quarterly review with NHS England • Local Authorities and Healthwatch

Gaps in Controls and Assurances	Actions to address control / assurance gaps
• Lack of capacity at local level. • Lack of engagement at local level. • Lack of Engagement with Third Sector such as major charities • Loss of DOS Leads who were WMAS representatives at a local level and led on engagement. • Capacity within geographical footprint.	Action: Identify key groups to engage and collaborate with — Owner: Vivek Khashu & Caron Eyre March 2024 Action: Identify opportunities where other staff groups can engage and collaborate e.g., Governors, SOMs with Councils — Owner: Vivek Khashu & Caron Eyre March 2024

Risk Updates

Since the last review various discussions have taken place regarding increased engagement and collaboration opportunities. One of these involves a paper to EMB regarding establishing Patient Participation Group and how this will fit within the current Trust structure, to included decision making and feedback. Other meetings ongoing with ICB's regarding the challenges faced by WMAS given the geography of the area covered. ICB's have also been updated on their nominated Executive Lead.
ORG-028 – Changes to Services has also been reviewed with the decision to create indivudlas risk assessments for each service level change and its impact on WMAS (there are currently only 2 major service reconfigurations which are Sandwell and West Birmingham Hospital & Shropshire Site reconfiguration).

Associated Risks on the Operational Risk Register

Risk no.	Description	Current Score
ORG-028	Changes to Services – Wider NHS, resulting in delay to treatment, complaint, and litigation	9
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	20
WF-030	The devolution of workforce planning and educational commissioning could potentially have a detrimental effect on services, such as ambulance, that operate on a regional footprint	4

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 07a MONTH: January 2024 PAPER NUMBER: 04

Board Skills Matrix	
Sponsoring Director	Carla Beechey, Director of People
Author(s)/Presenter	Carla Beechey, Director of People
Purpose	To consider and approve the content of the board skills matrix for publication in the Annual Report 2023 / 2024
Previously Considered by	N/A
Report Approved By	Carla Beechey, Director of People

Executive Summary

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

This report is submitted to the Board of Directors to cover the required annual review of the Board Skills Matrix for consideration, approval and publication in the Trust's Annual Report 2024.

The Board Skills Matrix is attached at **appendix 1**.

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)	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)	
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 report provides assurance and no risks are identified.			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 07a MONTH: January 2024 PAPER NUMBER: 04

Legal implications/ regulatory requirements	All actions are compliant with the Equality Act 2010 and Employment Law.
Financial Implications	There are no financial risks associated directly within this report.
Workforce & Training 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. The skills matrix will be published in the annual report 23/24.
Diversity & Inclusivity Implications	No adverse equality and diversity matters have been identified.
Quality Impact Assessment	Not required for this report.
Data Quality	Electronic Staff Record system [ESR] and E-HR Personal File Records. (Filestore).
Action required: Members of the Board of Directors are requested to consider and approve the content of the attached Board Skills Matrix for publication in the Trust's Annual Report 2023 / 2024.	

Skills Audit Matrix

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

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

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

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

The Skills Matrix of the Board of Directors for 2023/24 is set out below.

Non-Executive Directors

Skill	Professor Ian Cumming	Wendy Farrington-Chadd (until 31.01.24)	Mohammed Fessal	Mushtaq Khan	Julie Jasper	Narinder Kooner	Professor Alexandra Hopkins
Strategic Leadership	✓	✓	✓	✓	✓	✓	✓
Informed and Sound Judgment	✓	✓	✓	✓	✓	✓	✓
Ethics, Integrity and Accountability	✓	✓	✓	✓	✓	✓	✓
Impact and Influence	✓	✓	✓	✓	✓	✓	✓
Risk Management	✓	✓	✓	✓	✓	✓	✓
Financial qualification		✓			✓		
Financial acumen	✓	✓	✓	✓	✓	✓	✓
Public policy	✓	✓	✓	✓	✓	✓	✓
Knowledge and Application of	✓	✓	✓	✓	✓	✓	✓

Skill	Professor Ian Cumming	Wendy Farrington-Chadd (until 31.01.24)	Mohammed Fessal	Mushtaq Khan	Julie Jasper	Narinder Kooner	Professor Alexandra Hopkins
Diversity and Inclusion							
Clinical and Health Experience	✓		✓				✓
Health Experience: Non Clinical		✓		✓	✓		
Legal awareness		✓	✓	✓	✓		
Corporate Communications and Media				✓		✓	
Commercial focus		✓		✓	✓	✓	
Human Resource Management	✓					✓	
Clinical Registration/ Professional Membership	Graduate Member Sports Therapy Association Chartered Scientist – The Science Council Fellow - Chartered Institute of Management Fellow - Institute of Biomedical Sciences HCPC Registered – Biomedical Scientist, PIN: BS31759	Chartered Institute of Public Finance and Accountancy	General Pharmaceutical Council – Pharmacist PIN: 2061184	The Law Society [England and Wales] SRA ID:26073	Chartered Institute of Public Finance and Accountancy	None	Master of Science in the Faculty of Medicine Nursing & Midwifery Council registration – PIN 0573742
Professional/ Business Qualification/ Experience	MSc in Sports and Exercise Medicine PgDip in Sports and Exercise Medicine Doctor of Health (DH) Doctor of Science (DSc) Doctor of the University (D Univ) HNC in Biomedical Sciences	Qualified Accountant. BA(Hons) English Lit Certificate in Executive Coaching	Master of Sciences of Pharmacy Independent Prescriber Course	Solicitor (England & Wales); BSc. (Hons) Social Policy; Post Graduate Diploma in Law; Legal Practice Certificate, Post graduate Diploma in Management Studies; Certificate in Advanced Corporate Governance.	Qualified Accountant	Business Experience. Local Authority Councillor	Master of Business Administration in Higher Education Management Doctor of Philosophy

Executive Directors

Skill	Professor Anthony Marsh *(Voting)*	Mark Docherty *(until 31.12.23 - voting from 5.6.23 – 22.8.23)*	Karen Rutter (Voting)	Dr Alison Walker Medial Director *(Voting)*	Carla Beechey *(Voting from 01.12.23)*	Michelle Brotherton *(secondment) (until 31.07.23)*	Jeremy Brown *(secondment) (until 31.07.23)*	Nathan Hudson *(secondment until 31.07.23, substantive Voting from 01.08.23)*	Vivek Khashu	Murray MacGregor	Nick Henry	Caron Eyre *(Voting from 23.8.23)*	Dr Richard Steyn *(Interim Voting from 01.06.23)*
Strategic Leadership	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Informed and Sound Judgment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethics, Integrity and Accountability	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Impact and Influence	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial qualification			✓										
Financial acumen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Public policy	✓	✓							✓				
Diversity and Inclusion					✓				✓			✓	
Clinical and Health Experience	✓	✓		✓		✓	✓	✓			✓	✓	✓
Health Experience: Non Clinical			✓		✓				✓	✓			
Legal awareness			✓		✓								
Corporate Communications and Media	✓	✓							✓	✓			
Commercial focus	✓	✓							✓				
Human Resource Management	✓				✓				✓			✓	

Professional/ Business Qualification/ Experience	Clinical Registration/ Professional Membership	Skill
National Ambulance Strategic Advisor Extended Ambulance Aid [NHSTA] (former Paramedic) Professor (Honorary) Wolverhampton University. MSc Strategic Leadership, MBA. MA.	None	Professor Anthony Marsh *(Voting)*
BSc, (Hons) Nursing MSc Healthcare Commissioning	Registered Nurse (Adult) NMC PIN 83L3134E	Mark Docherty *(until 31.12.23 - voting from 5.6.23 – 22.8.23)*
Qualified accountant (CIMA) with associated designation of Chartered Global Management Accountant	Chartered Institute of Management Accounts	Karen Rutter (Voting)
Emergency Medicine (A&E) Consultant. MB BChir, FRCEM, FIMCRCS, FRCS, FDSRCS, MA, MFSEM. Dip Health Research, Cert Medicolegal.	GMC Registration 4210643	Dr Alison Walker Medial Director *(Voting)*
Post Graduate Diploma Human Resource Management	Chartered Institute of Personnel Development (MCIPD)	Carla Beechey *(Voting from 01.12.23)*
Diploma in Health & Social Services Management NHS Leadership Academy Award Multi Agency Gold Incident Command	HCPC Registered Paramedic (PIN PA01243)	Michelle Brotherton *(secondment) (until 31.07.23)*
MSc Health and Social Care Management (current study) Post Graduate Diploma Health and Social Care Management Multi Agency Gold Incident Command	HCPC Registered Paramedic (PIN PA10354)	Jeremy Brown *(secondment) (until 31.07.23)*
MSc Business Psychology (current study) Post Graduate Diploma Health and Social Care Management Multi Agency Gold Incident Command	HCPC Registered Paramedic (PIN PA00832)	Nathan Hudson *(secondment until 31.07.23, substantive Voting from 01.08.23)*
BSc Medical Biochemistry MSc Healthcare Leadership	None	Vivek Khashu
None	None	Murray MacGregor
MSc Healthcare Management (current study) Professional Development Diploma Multi Agency Gold Incident Command	HCPC Registered Paramedic (PIN PA02768)	Nick Henry
Msc in Clinical Practice Post Grad certificate in Workforce Planning BSc in Nursing Studies	Registered Nurse (Adult) NMC PIN 86D0621E	Caron Eyre *(Voting from 23.8.23)*
	GMC Registration 2921688	Dr Richard Steyn *(Interim Voting from 01.06.23)*

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08 MONTH: January 2024 PAPER NUMBER: 05

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. WMAS EPRR Policy Statement
2. Black Country & Birmingham Solihull Core Standards Final Report
3. CEO Meetings – 20 November 2023 to 19 January 2024

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.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08 MONTH: January 2024 PAPER NUMBER: 05

Action required

The Board of Directors is asked to:

- Receive and note the contents of the paper seeking clarification where necessary.

1. West Midlands Ambulance Service (WMAS) EPRR Policy Statement

The Trust's Emergency Preparedness Resilience and Response (EPRR) Statement (Appendix 1) has been updated to reflect the changes to Hazardous Area Response Team (HART). West Midlands Ambulance Service University NHS Foundation Trust (WMAS) has in place an EPRR policy which establishes the intent of the organisation to deliver its obligations and discharge its duties under the Civil Contingencies Act 2004, Health and Social Care Act 2012 and the Department of Health Emergency Planning Guidance 2005. (Superseded by EPRR NHS Framework 2015 and subsequently updated July 2022 – V3.0) WMAS have a robust work Programme in place which is aligned to the organisations overall planning cycle ensuring the effective delivery of EPRR standards are met in line with current National guidance. WMAS have processes to monitor effective delivery of the EPRR requirements via a clear management structure and reporting mechanisms to assure the organisation. This is undertaken by reporting through Operational Management Team (OMT) monthly meetings, quarterly updates to the EMB and onward reporting to the Board of Directors. All new risks and concerns are immediately escalated to the CEO.

2. Black Country & Birmingham Solihull Core Standards Final Report

The paper attached at Appendix 2 provides final confirmation of WMAS position relating to core standards submission for 2023-2024. WMAS confirms a substantially compliant position with only one standard being confirmed as 'partially compliant'. This relates to the WMAS Pandemic Plan requiring a small update to include 'DATER' which relates to phases of a Pandemic (detection, assessment, treatment, escalation, recovery). This work has been undertaken to bring the Pandemic plan into a fully compliant position.

3. Chief Executive Officer Meetings – 20 November 2023 to 19 January 2024

<u>Staff</u>

- All Staff Briefing
- Staff Side Representatives
- Eileen Cox, Lead Governor
- NARU Team

- HART Management Team Event
- Network Chairs
- Staff Governors
- NEDs Meeting
- New Governor Induction

National Meetings

- NHS England - UEC Check In
- NHS England – UEC Programme Recovery Board – National Delivery Advisor Meeting
- NHS England – Integrated Urgent & Emergency Care Away Day
- 1-1 Sarah Jane Marsh
- NHS England National Ambulance Team Meeting
- NHS England – IUEC Senior Leadership Team Meeting
- Association of Ambulance Chief Executives – Ambulance Chief Executive Group Meeting
- NHS England – IEUC Check In – Medium Term Priorities
- NHS England – National Ambulance Advisory Group
- NHS England - IUEC Daily Check In
- Martin Flaherty & Dan Gore, Association of Ambulance Chief Executives
- Charlotte Rudge & Alison Giles, CQC

Regional Meetings

- MERIT Conference
- Systems CEO Meeting
- Mark Axcell, Black Country ICB
- Jeremy Wright MP
- Ebrahim Adia, Vice Chancellor, University of Wolverhampton
- Glen Burley, CEO, Worcestershire Acute
- Midlands CEOs Update Call with Dale Bywater, NHS Midlands

Anthony C. Marsh
Chief Executive Officer
January 2024

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

EPRR Policy statement

Version 1.7 Dec 2023

Version	Version 1.7 December 2023 FINAL
Ratified By	Executive Management Board (EMB)
Date Ratified	12.12.2023
Lead Author	Head of Emergency Preparedness, Resilience and Response
Responsible Officer	James Williams – Head of EPRR
Date for Review	December 2024
Intended Audience	West Midlands Ambulance Service UNHSFT Staff
Protective Marking	OFFICIAL
Supporting Documentation and Drivers	Civil Contingencies Act 2004 NHS Act 2006 Health and Social Act 2012 NHS EPRR Framework 2015 (updated 2022) NARU Quality Assurance Framework National Security Risk Assessment (NRSA)
Supporting Internal Documents	WMAS Business Continuity Plan WMAS Major Incident Plan

Version	Name/ Department	Changes	Date
V1.0	EPRR	Initial document	Aug. 2021
V1.1	EPRR	CC review	Aug. 2021
V1.2	EPRR	Final review by CC before submission to committee	Aug. 2021
V1.3	EPRR	Grammatical changes	Aug. 2021
V1.4	EPRR	Review & Update	Sep. 2022
V1.5	EPRR	Further update and inclusion of annual work plan	Dec. 2022
V1.6	EPRR	Review and Update	Jan 2023
V1.7	EPRR	Annual review and update	Dec 2023

Contents

1 Introduction

West Midlands Ambulance Service University NHS Foundation Trust (WMAS) has in place an Emergency Preparedness Resilience and Response (EPRR) policy which establishes the intent of the organisation to deliver its obligations and discharge its duties under the Civil Contingencies Act 2004, Health and Social Care Act 2012 and the Department of Health Emergency Planning Guidance 2005. (Superseded by EPRR NHS Framework 2015 and subsequently updated July 2022 – V3.0)

2 EPRR Governance

WMAS will be responsible for the delivering the National Ambulance Resilience Unit (NARU) service specification for NHS Ambulance Services and the supporting Quality Assurance Framework which consists of following requirements:

- Emergency Operations Centre
- Emergency Logistics
- National Mutual Aid Arrangements
- Business Continuity Arrangements
- Event Management (Incl. Major Incident Response)
- Training
- Partnerships and exercising
- Occupational Health / Human Resources

Resource is reviewed and approved through the reporting structures indicated in section 11. A monthly budget review assures financial capabilities, and an annual budgetary planning meeting is approved by the Accountable Executive Officer (AEO) and Board of Directors to suitability meet the EPRR resourcing requirements.

WMAS will be responsible for delivery and risk mitigation balanced against the current NHS EPRR framework Version 3, July 2022. WMAS has a robust Management structure allowing the organisation to discharge its duties as follows:

Named Accountable Emergency Officer (AEO)
Mr. Anthony Marsh, WMAS Chief Executive Officer

Named Non-Executive Director (NED) for EPRR
Prof Ian Cumming OBE, WMAS Chairman

Under the AEO command sits Head of Emergency Preparedness, Resilience & Response (EPRR)
James Williams is a sitting member of the Executive Management Board (EMB) and reports directly to the AEO along with overseeing the day-to-day duties of:

WMAS Emergency Planning Managers (EPM)

- Keith Nevitt – Birmingham and Black Country
- David Levesley – Warwickshire and Staffordshire
- Robert Stevens – West Mercia

Hazardous Area Response Team (HART)

- HART Manager – Ben Pallante
- HART Operations Manager – Louise Lancaster
- HART Training Manager – Philip Skews

Specialist Operations Response Team (SORT)

- SORT Manager – Anthony Carswell

Tactical Incident Commanders (TIC)

- TIC Lead – John Woodhall
- TIC / Tactical Command Cell Commanders (TCCC) x9 commanders

The WMAS Head of EPRR reports to EMB, chaired by the AEO every quarter and to public Board annually on WMAS EPRR assurance.

WMAS is required to submit on an annual basis assurance of compliancy to all the above via NHS core standards for EPRR, an evidence-based audit forms part of the submission process. Core standards submission is presented to EMB and Public Board annually.

3 Funding

WMAS undertake annual Capital and Revenue planning through internal control groups which set priorities for both revenue and capital. These are then approved by the Board of Directors. WMAS also receive specific pass-through funding via NARU for interoperability and resilience for specialist assets. WMAS ensure these funds are made directly available to the designated resource enabling the organisation to meet its statutory requirements under the National EPRR core requirements. In addition, WMAS self-funds specific functions and additional capacities to ensure an appropriate and effective response can be mounted for events which arise.

4 Capability

WMAS ensure a capability to respond to any emergency at any given time by assuring the following cadre of staff and resources are available 24/7 – 365 days a year:

- Frontline staff – trained and equipped, with sufficient resource to meet demand
- Commanders – At all levels, suitability trained, and equipped to discharge command duties
- HART – Maintain 100% tactical capability in line with National capability matrices
- Major Incident vehicle assets – Operational readiness with a no notice to deploy
- Mutual Aid capability – Service or support other Ambulance Services if a request was to be made, ensuring supporting assets have interoperable capability

5 Risk Assessments

WMAS holds a comprehensive local risk register, which encompasses risks focused on the regional footprint. The WMAS risk register is aligned to the National Risk Register (NRR) which provides National oversight a range of potential emergencies which may have a major impact on significant parts of the United Kingdom (UK). The NRR was

originally designed to complement the Local Resilience Forum (LRF) community risk registers which are in place. The driver for this work falls under the Civil Contingencies Act (CCA) 2004.

The link below directs you to the WMAS local risk register (available internally):

https://wmas365.sharepoint.com/sites/RiskManagement/SitePages/Risk%20Register.aspx

WMAS has several avenues to report risks both internally and externally via partner stakeholders, Local Health resilience Partnership (LHRP) and Midlands health Resilience Partnership Board (MHRPB). The WMAS Risk Policy provides assurance on risk reporting mechanisms.

6 Local health Resilience Partnerships (LHRP)

These partnerships support Strategic health planning and risks within the WMAS regional footprint. These are attended by the Head of EPRR.

- West Midlands – (Birmingham, Solihull, and Black Country)
- Hereford and Worcester
- Staffordshire
- Shropshire (incl. Telford & Wrekin)
- Arden (Warwickshire)

There are five LHRP groups within the region. James Williams attends meetings on behalf of WMAS on a quarterly basis, with minutes and actions recorded appropriately. Any pertinent updates are fed into the organisation via Operational Management Team (OMT) updates. LHRP groups will fall under the guidance and responsibility of the local Integrated Care Board (ICB), with transition of responsibility from NHSE Midlands during 2023.

7 Integrated Care Boards (ICB)

Below are the six ICB's that fall within the organisation's footprint, note the Black Country ICB (Green) are the lead commissioner group for West Midlands Ambulance Service University NHS Foundation Trust.

(1) Integrated Care Board	(2) Local Government Areas
NHS Birmingham and Solihull Integrated Care Board	City of Birmingham, Borough of Solihull
NHS Black Country Integrated Care Board	Borough of Dudley, Borough of Sandwell, Borough of Walsall, City of Wolverhampton
NHS Coventry and Warwickshire Integrated Care Board	City of Coventry, Borough of North Warwickshire, Borough of Nuneaton and Bedworth, Borough of Rugby, District of Stratford-on-Avon, District of Warwick
NHS Herefordshire and Worcestershire Integrated Care Board	District of Bromsgrove, County of Herefordshire, District of Malvern Hills, Borough of Redditch, City of Worcester, District of Wychavon, District of Wyre Forest

(1) Integrated Care Board	(2) Local Government Areas
NHS Shropshire, Telford and Wrekin Integrated Care Board	County of Shropshire, Borough of Telford and Wrekin
NHS Staffordshire and Stoke-on-Trent Integrated Care Board	District of Cannock Chase, Borough of East Staffordshire, District of Lichfield, Borough of Newcastle-Under-Lyme, District of South Staffordshire, Borough of Stafford, District of Staffordshire Moorlands, City of Stoke-on-Trent, Borough of Tamworth

8 Local resilience Forums (LRF)

LRF's are based on Police force boundaries and WMAS are embedded into all four LRF's within the WMAS regional footprint. Each LRF consists of a Strategic (SCG) and Tactical (TCG) element for the delivery of multi-agency risk identification & mitigation, planning, training & exercising, response, and recovery.

- West Midlands
- West Mercia
- Warwickshire
- Staffordshire

WMAS have an assigned Strategic Commander / Assistant Chief Officer for each LRF who will also represent the Trust at planned SCGs in these footprints. The immediate response to an SCG arising from a no-notice incident will be undertaken through the On-Call Strategic Commander cadre. The TCGs and working groups are predominantly serviced by the locality EPMs indicated above.

9 Annual Business Planning

WMAS have a robust work Programme in place which is aligned to the organisations overall planning cycle ensuring the effective delivery of EPRR standards are met in line with current National guidance.

10 Annual Work Plan

An annual plan will be developed and approved by EMB for each year in relation to the EPRR workstream of the trust ensuring the organisation is fully prepared and has resilience to respond appropriately to all emergencies. On a quarterly basis an EPRR update is provided to EMB to report on progress and record dynamic taskings which arise within the geographical footprint, such as specific operations/events/national support requirements. (Annual template – Appendix 1)

11 Monitoring

WMAS have processes to monitor effective delivery of the EPRR requirements via a clear management structure and reporting mechanisms to assure the organisation. This is undertaken by reporting through OMT monthly meetings, quarterly updated to the EMB and onward reporting to the Board of Directors. All new risks and concerns are

immediately escalated to the AEO which can fall out of the regular reporting.

12 EPRR Program delivery

- Maintain response plans and policies.
- Training – JESIP / Command competency / SORT / JOL
- Exercises – planning and schedule
- HART – as per National specification (NARU)
- CBRN audits of all Acute sites within WMAS footprint
- Major Incident asset management (Operational readiness)
- Ensuring Multi-Agency Engagement and Interoperability at Strategic / Tactical / Operational levels, aligned to JESIP.
- 24/7 C^3 Response Capability – Strategic / Tactical / NILO / Operational
- Regional Casualty Regulation chart
- Business Continuity
- Mutual Aid agreements nationally with all UK Ambulance Services via NARU and National Ambulance Co-ordination centre (NACC)
- Annual assurance – Core Standards / NARU Key lines of enquiry audits
- Resilience Direct – sharing of information.
- Reviewing key sites within geographical footprint in line with MAI recommendations.

13 Local risk sites

- 14 Upper Tier COMAH sites with offsite plans as defined under the Control of Major Accident Hazards Regulations 1999 (COMAH)
- 43 Lower Tier COMAH sites as defined under the COMAH regulations Control of Major Accident Hazards Regulations 1999 (COMAH)
- Birmingham International Airport, Coventry Airport, Wolverhampton International Business Airport
- Major centres of population – Birmingham, Wolverhampton, Stoke, Worcester, Coventry
- Extensive road and rail transport infrastructure, including future terminus of HS2.
- Liquid and Gas fuel pipelines
- International sporting, leisure, exhibition, and shopping venues
- Special Event plans – regional and national festivals, political party conferences
- Numerous military establishments
- Numerous stadia including sporting / athletic venues
- Numerous arenas for concerts etc

14 Business Continuity

WMAS has a robust Business Continuity management system in alignment to the ISO standard 22301. This includes an overarching strategy for the organisation and individual site-specific plans. Site Specific BCPs are subject to an annual review and update and there these plans are exercised at a local level. EMB regularly monitor the compliance of these BCP Plans.

15 Forward Look

WMAS is committed to continuous improvement in relation to discharging its statutory responsibilities under the EPPR framework. This will be met through the following workstreams:

- Review and maintenance of existing plans
- Maintain operational readiness
- Maintain command competencies against National Occupational Standards (NOS) including JESIP compliance
- Continue multi-agency interoperability
- Undertake reviews of live deployments, exercises and recommendations published from statutory bodies (specifically Manchester Arena Inquiry (MAI) and the CCA), to guide and enhance the current WMAS response
- WMAS is committed to engage, communicate, and support the Integrated Care Systems (ICS) and Integrated Care Boards (ICB), ensuring the organisation remains linked to key stakeholders and commissioners
- Maintain engagements and support all Local Resilience Forums (LRF) within regional footprint

16 Appendix 1

WMAS EPRR Work Plan 2023-2024 - Update Nov 23

	2023										2024	
Action	April	May	June	July	August	Sept	October	November	December	January	Feburary	March
Major Incident Plan	V14. review										Publish	
MTA Plan	V7.4 review							Publish				
MTA JOPS				owned by JESIP JOPS 3 release				Publish				
CBRN/HAZMAT Plan					Publish							
Mutual Aid Plan												
Casualty Regulation plan												
RAMP Plan												
Fuel Plan							Publish					
Resource Escalation Action Plan (REAP)									Publish			
Adverse Weather Plan				Publish								
Business Continuity Plan - EP				Publish				Publish				
Pandemic Influenza Plan									Publish			
Protected Persons Visit (Operation Consort)												
C3 Deployment						Publish						
ECS Deployment									Publish			
Operation Whittle												
NACC Plan			Owned by NARU									
Tactical Command Cell Arrangements									NACC cease			
Response to Public safety & Public Order Incidents												
High Consequence Infectious Diseases SOP												
Resilience Direct Procedure							Publish					
Operation Bridge Plan												
Special Operations Vehicle list (SOVA)											TST	
Wasps and Coventry City FC Conops					Publish							
Alexander Stadium Birmingham Plan						Awaiting updates to stadia completion						
Aston Villa FC Stadium Plan					Publish							
Birmingham City FC Stadium Plan					Publish							
Warwickshire Cricket (Edgbaston) Stadium Plan		Publish										
West Bromwich Albion FC Stadium Plan					Publish							
Wolverhampton Wanderers FC Stadium Plan					Publish							
Walsall Town FC Stadium Plan					Publish							
Stoke City FC Stadium Plan					Publish							
Shrewsbury Town FC Stadium Plan					Publish							
Worcester Warriors RFC Stadium Plan					Publish							
Uttoxeter race course					Publish							
Burton Albion FC Stadium Plan					Publish							
Port Vale FC Stadium Plan					Publish							
NARU command training (Ops & Tac)												
MAGIC training												
Radiation Protection Supervisor courses	All TIC/NILO/HART T/L trained in date for 3 years											
CBRN Tac/Strategic training												
WMAS Annual command training				SBAR								
Commanders logs/CPD review												
Security Clearance review												
JESIP quarterly review/return												
Annual Internal Audit report												
ISU M annual review/service											TST	
ISU E annual review/service												
ISU D annual review/service												
ISU B annual review/service												
Command vehicle annual review												
NHSE Core standards submission								FINAL				
NARU KLoE assurance	Postponed for this year, Core standards Interop will bridge gap											
Acute Site CBRN Audits								Training	Submit			
EP & TIC team meetings												
LRF engagement	W Mids/WM		Warks/Staff	W Mids/WM		Warks/Staff	W Mids/WM		Warks/Staff	W Mids/WM		Warks/Staff
Protect & Prepare Meetings (regional)	W Mids											
ICB Midlands Partnership meeting												
HEPOG Meetings (monthly)												
LHRP meetings		All regions										
Annual Personal Development Conversations		TIC/EP									End of yr reviews	
Annual Live exercises	Alliance	Fortitude	BHX TTX	Impertior	Refresh	Floodex		Lillibet		MTA Tel	Royal Oak	
Quarterley EMB Update												
Monthly OMT update												
Ballistic Kit 6 monthly Audit												
Actions related to current year												
TST / MTT									e learning		Go live 01 April 24	
MAI Inquiry actions			Awaiting funding release via ICB post national guidance									
MAROG												
NHSE Health Command courses												
JOPSS Tri service training								Publish	JOL action			
IOR - RAR implementation				JOL action								

Ref	Domain	Standard name	Standard Detail	NHS Ambulance Service Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work	Comments
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Nominated AEO (Named in EPRR Policy Statement - CSE01) Mr. Anthony Marsh (Chief Executive Officer) AEO Responsibilities: As the CEO, Mr A. Marsh maintains oversight of all Trust activity, including that of EPRR. He also maintains a national role as the National Strategic Advisor for UK Ambulance Services. Supported by: Prof. Ian Cumming OBE (Chairman - Non-Executive Director for EPRR / Board member) Mr. James Williams (Head of Emergency Planning - Job Description submitted as evidence - CSE02)	Fully compliant	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc	The Trust has an EPRR Policy Statement which has been approved by EMB & the Public Board in January 2023. Submitted evidence includes the current WMAS EPRR Policy Statement (CSE01)	Fully compliant	
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	WMAS EPRR Annual Report (22-23, Public Board) (CSE03) WMAS Annual Report & Accounts (22-23) (CSE04)	Fully compliant	
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	WMAS have a robust work programme in place (CSE05) which is aligned to the organisations overall planning cycle, ensuring the effective delivery of EPRR standards are met in line with current National guidance (WMAS EPRR Policy Statement CSE01). This is supported by monthly reporting to the Operational Management Team (OMT, May 2023 Report submitted as evidence CSE06), which links directly to EMB (June 2023 Report submitted as evidence CSE07)	Fully compliant	
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The WMAS EPRR Policy Statement (CSE01) outlines which indivuduals are responsible for fulfilling EPRR functions Organisational Chart (CSE08) - Updated organisational structures shared at EMB and Board - Quarterley EMB Update referencing all EPRR activity, which forms part of the CEO's update to the Board (CSE07) - Continued commitment to Commander Training and Exercise regime to ensure constant state of learning and review is undertaken (CSE07)	Fully compliant	
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	WMAS has an internal debrief and learning process (CSE09) which identifies both good practice and learning opportunities. This involves utilsing the PROCLUS Learning Identification (LID) process and also the Joint Organisational Learning process (JOL), to ensure lessons learned are shared with external organisations. Further evidenced by: - Planned Reviews (CSE33) - National Learning Review Group Process (JOL - CSE010) - WMAS Debrief & Learning Process (v3.5) (CSE09) - All WMAS EPRR Policies are reviewed for effectiveness and revised following learning from planned exercises or live deployment (STOP Example - CSE11) PDF of ongoing Learning Log from Exercises (CSE133) and Incidents (CSE134). Ongoing review of actions is performed as per the WMAS Response Learning Process (CSE09), which includes a 6-month review of implemented actions to assure that lessons have been learned. A further incident debrief has been included from the Babbs Mill Lake incident (CSE135), which shows the identification of learning and actions taken. Completed actions are located within the incident learning log	Fully compliant	
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	EPPR risks recorded and on the Trusts Risk Register (CSE12) - continuously reviewed to ensure capture of emerging and changing threats, pressures and intel.	Fully compliant	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risk Management is referenced within the EPRR Policy, which also contains a link to the WMAS Local RIsk Register (CSE01) - NHSE / NARU National Risk Register - with planned mitigation in response arrangements - LRF sub group risk membership - Internal WMAS Risk Assessment & Managemrnt Policy in place, including an ER54 incident reporting system in place (CSE13) - EPPR risks recorded and on the Trusts risk register	Fully compliant	
Domain 3 - Duty to maintain Plans								

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9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	WMAS regularly engage with partner organisations to ensure awareness of planning arrangements. To further support this: - Planned LRF Meetings - Planned ICS Meetings - Multi-Agency Debriefing following Testing & Exercising - Dedicated partner networking lead to promote awareness of the Trust's Major Incident Capabilities (CSE19) - The Strategic Capacity Cell (SCC) is a 24/7 function within the WMAS EOC which provides the direct link between the Trust and acute organisations - Regional MTA working group, led by WMAS (CSE20 / CSE21) - Midlands Mass Casualty Sub Group ToR (CSE18) Changes to plans are recorded within the document control, which is located at the beginning of each Trust Plan / Procedure / Policy Major Incident Respomse Plans all shared on WMAS RD Page (CSE14) Casualty Regulation plan submitted as evidence (CSE15) Numerous multi-agency engagements with external partners prior to high profile events (P!NK Ops Order Submitted as example - CSE16) Trust has a Agency Sitrep Template to share with the Multi-Agency Information Cell to ernsure partners receive an accurate and current situation report for any ongoing incident (CSE17) A scheduled review of Trust Response Plans is outlined in CSE33, which quantifies when each plan will be reviewed and updated as required. Each plan has its own tracker included at the start, to ensure any changes made are recorded appropriately (Example – CSE25). To further support the consultation process, before each plan is ratified and implemented, Keith Prior (Director of NARU) is consulted for advice from a National Governing Body perspective, who also forms part of the WMAS Strategic Command group, whereby feedback is provided	Fully compliant	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WMAS Major Incident Plan (v14) (CSE25) outlines the Trust repsonse to a Major Incident. It has been signed off by the approproate mechanism and is rigorously tested with live exercises. It is informed with the Trust's debrief and learning process. This document is accessible electronically on the Trust Sharepoint platform Further supported by: - MTA Plan v7.4 (CSE22) - CBRN Plan v11.3 (CSE23) - Tactical Cell Arrangements v5.0 (CSE24) The current major inicdent plan remains fit for purpose, within its review date and is due for further update to align with triage processes (TST & MITT), TBC Q3. The current MTA plan remains fit for pupose, however will be reviewed and updated following the rlease of the updated JESIP joint operating procedures. The CBRN plan is currently under review to reflect the changes to the recent IOR updated guidance from JESIP	Fully compliant	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	WMAS has an Adverse Weather Plan (v9.6) which covers all aspects of Adverse Weather CSE26	Fully compliant	
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Supporting Documents: - Management of Infectious Diseases Procedure (CSE28 PolicyStat) - Procedure for the Management of High Consequence Infectious Diseases Procedure (CSE29 - PolicyStat) - Infection Prevention & Control Policy (CSE 27 - PolicyStat) WMAS do not utilise FFP3 as part of the stadard PPE for infectious diseases. Staff have axccess to PRPH kits (3x per ambulance) and personal issue hoods	Fully compliant	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The WMAS Pandemic Plan (v6.1 - CSE31) is used in conjunction with WHO / UKHSA and NHSE guidance, based on the threat. This plan outlines the alerting mechanims and trigger points for emerging pandemics, and also the steps to be taken in order to ensure preparedness. The Organisation's Pandemic Plan (CSE31) was updated in June 2021 to ensure COVID Pandemic lessons identified (National and internal) were implemented This plan is used in conjunction with WHO / UKHSA and NHSE guidance, based on the threat. This plan outlines the alerting mechanisms and trigger points for emerging pandemics, and also the steps to be taken in order to ensure preparedness This Response Plan is currenlty under review as planned for November 2023 and will incorporate further lessons learned as required, however should be considered as fully compliant against the current core standard	Partially compliant	

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14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	WMAS currently has access to a range of countermeasures, designed for use in specific scenarios to enable the protection and treatment of the public and our staff, should CBRN materials be released. WMAS held: DuoDote (CSE35): 120 carried on each mass casualty vehicle 160 carried by HART 30 carried by each Operational Commander (Total of 450) 30 carried by the Tactical Incident Commander 4 carried on each operational ambulance (Total of 1916 on 479 DCAs) WMAS also carries Methylthioninium Chloride (PGD for use by HART only). WMAS are the only UK ambulance service to carry this countermeasure (CSE34) National Reserve: Atropine / Palidoxime / Dicobalt Edetate / Glucose / Ciprofloxacin / Doxycyline / Potassium Iodide / Prussian Blue / Botulinium Antitoxin National countermeasures are available upon request placed by the Trust and are subject to a maximum 5hr delay before arrival at the incident, with delivery organised by UKHSA There is a memorandum of understanding between WMAS and the BCICB, which discharges the duties of WMAS to the BCICB, where there is a requirement for WMAS staff to receive a countermeasure, no matter whether this is via the 'push' or 'pull' model.	Fully compliant	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Supporting Evidence: - Mass Casualty arrangements are embedded within Trust response plans (Major Incident Plan v14.0 CSE25 / MTA Plan v7.4 CSE22 / Hazmat & CBRN Plan v11.3 CSE23) The Trust maintains its Major Incident / Mass Casualty assets in a state of readiness, checked weekly recorded on WMAS Fleet Tracker (CSE36) - Major Incident Vehicle Asset Map (v18.4 - March 2023) (CSE37) - Special Operations Response Team (SORT) deployment (CSE25) - Casualty Regulation & Capability Chart (v15.0 CSE15) - The Strategic Capacity Cell (SCC) is a 24/7 function within the WMAS EOC which provides the direct link between the Trust and acute organisations		
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WMAS only requires the evacuation of staff from dedicated work sites and therefore this is covered within Business Continuity Plans. This cites the transporation of staff to other operational sites to ensure that critical activity can continue - The Strategic Capacity Cell (SCC) is a 24/7 function within the WMAS EOC which provides the direct link between the Trust and acute organisations An example of the dynamic creation of an evacuation plan was the Sudanese Evancuation Flights in April 2023 (CSE38 / 39)- This relates to the collaborative engagement with the local authority & LRF around the repatriation of Sudanese Refugees to the UK BCP for Tollgate Hub (CSE136), which highlights an evacuation point at the front of the building	Fully compliant	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a Lockdown procedure (CSE40 PolicyStat), outlining the templates for Ambulance Premises. Each site has it's own business continuity plan, which details the lockdown procedure for that specific site. Day to day access is maintained by electronic swipe cards, which are also used for ease of lockdown implemention - which has a function in place to achieve effective site lock-downs electronically The overarching lockdown procedure (CSE040) provides information on the actions required for lock 'in' and 'out'. Attached is additional evidence for a specific operational site (Tollgate hub), detailing how to activate the electronic lockdown system (CSE137)	Fully compliant	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WMAS has a dedicated set of arrangements for protected individuals: - Single Point of Contact for the Trust - Duty NILO 24/7. Personnel working within the Tactical Command Cell have the appropriate security clearance to liaise directly with the Duty NILO and filter information as required into operations - Protected Persons Visit protocol (v2.0 CSE41) - This is also linked to Op CONSORT Arrangements	Fully compliant	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Management of the Deceased is covered within the WMAS Major Incident Plan (v14 CSE25), which states that mass fatality plans are held by each local authority and implemented when required. Casualties who are clearly deceased should not be moved by WMAS clinicians, unless this is in order gain access to injured casualties. WMAS will work with Police forensic teams to preserve forensic evidence wherever possible at a scene. Such information is embedded within Trust response plans All WMAS Commanders attend national command training (CSE30), where excess fatality management is delivered as part of the course objectives and embedded in all LRF's, who each hold mass fatalities plans	Fully compliant	
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has a number of on-call arrangements to ensure the proportionate and required response to any type of incident: - The Tactical Command Cell (TCC), located at Trust HQ, is operational 24/7 and provides an oversight of the organisation's repsonse to any incident - There is a dedicated on-call Tactical Incident Commander and NILO provision 24/7 - The Trust has 5 on-call teams who rotate on a weekly basis, covering the Executive, Strategic and Tactical levels - 15 Operational Managers are based at the operational sites across the region, available 24/7 - Regular testing (weekly) is completed to ensure on-call availability across the command levels On-Call Rota Screenshot provided as evidence (CSE42) Screenshot of Everbridge Testing provided as evidence (CSE43 / CSE44 / CSE45 / CSE46)	Fully compliant	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	All on-call staff are trained to the National Occupational Standards (NOS) for their respective level of command. This is evidenced through training and ongoing CPD. Individual decision logs are maintained and the requirement to record such is outlined in the individual's action cards within the Trust Major Incident Plan On-Call personnel qualifications from C2 Database provided as evidence (CSE49), which are continually monitored to affirm assurance. Further evidenced with CPD Logs from the Operational (CSE51) Tactical (CSE50) & Strategic Level (CSE47)	Fully compliant	

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Domain 5 - Training and exercising								
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	WMAS are committed to ensure regular training for staff, including those fulfilling a role within EPRR. All commanders are required to maintain an individual electronic CPD log, which is based around the NOS and illustrates compliance. Training needs are under continuous review, with yearly mandatory updates based on common themes emerging from incident debriefing and lessons learned. This trainnig is also informed by incidents of significance from around the world. Command Training 2023 Proposal CSE48 Commander CPD Portfolio CSE47 / CSE50 / CSE51 PDF of C2 Database outlining trained staff (CSE138). The TNA relating to this is quantified by the roles / requirements of the Trust response plans, e.g. Major Incident Plan which requires commanders across all tiers of command to fulfil specialist roles. The Database submitted includes: Strategic / Tactical Incident Commander (Command SME) / Tactical On-Call Commanders / NILO, as these staff are the critical decision makers and also fulfil roles within the ICC	Fully compliant	
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Regular testing and exercising takes place within the organisation to ensure response plans are fit for purpose and in line with current threats, methodologies and intelligience. All exercises have had debriefing documents completed which identify good practice and lessons learned for implementation into such plans. EX Debriefs provided (CSE52-60) Actions that are required following a debrief / review of the exercise are recorded on the ongoing Exercise Action Log (CSE133). They are recorded and assigned a RAG status, with an appropriate owner and reviewed regularly to ensure that actions are implemented accordingly.	Fully compliant	
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	The Trust holds electronic records of staff training, including those who have completed specialist courses to fulfill roles in EPRR functions. C2 Master Database (CSE49) Commander CPD Portfolios (CSE47 / CSE50 / CSE51) Mandatory Update Certificates (CSE61 / CSE62 / CSE63 / CSE64) Commanders within the organisation are required to complete a suite of qualifications that relate to their respective command roles. Evidence (dates) of completed courses are captured within a Master C2 Database (CSE138), which outlines the minimum skill qualification requirements and ongoing progress development to execute the role.	Fully compliant	
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Staff receive training which ensures that they have an awareness of any updates to response plans, their responsibilities within such plans and also where they can find Trust arrangements when appropriate Staff can access the Major Incident Plan through the intranet on their own personal issue iPads, which contains all of the action cards fot the neccessary functional roles to ensure staff are aware of their roles within an incident. Staff who are not in a frontline responding role (e.g. EOC Call Assessors / Dispatchers) still must complete mandatory training which contains JESIP & major incident updates. Duty managers and Incident Command Desk Supervisors must attend annual Command Update Training as they are directly involved in incident repsonse. Command Training SBAR 2023 CSE48 Online Training (incl. JESIP - All Staff) CSE65 Clinical Update Certificate (All Staff) CSE66 / CSE61 / CSE62 / CSE63 / CSE64) Command & Control Newsletter Example (CSE67) Commanders working in a functional command role trained in 2022 was at 100% compliance. Note that there was a second additional major incident refresher session which was aligned to the Birmingham 2022 Commonwealth Games. This year's training is well underway and on target for 100% completion by the end of Q3	Fully compliant	
Domain 6 - Response								
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Trust has a Tactical Command Cell (TCC) located at Trust HQ, which can deal with a range of different incidents 24/7. They have direct links to the Senior Command Team and also Commanders responding to any incident. There is a Strategic Briefing Room also within Trust HQ, whereby the Duty Director is located during operating hours - outside of this time the on-call Strategic arrangements are followed. Dedicated action cards are available for such functions and resilience arrangements are in place in the event of loss of utilities etc. Secondary and tertiary sites are detailed within plans TCC Arrangements v5.0 (CSE24)	Fully compliant	

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27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	In line with the Trust's 'paperless' strategy, all plans are held electronically and are accessible to the appropriate members of staff through dedicated MS Teams Groups. As an example, the 'Officer App' contains all of the current Trust Plans and also links to relevant information such as on-call arrangements and Trust Debrief and Learning information. Plans can also be accessed when offiline. Hard copies of plans are held as local resilience on all Command RRVs located at the 15 operational hubs and the on-call officer lease vehicles Screenshot of Officer App File Structure (CSE68)	Fully compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	BC incidents are organised under command and control arrangements within the organisation (noted in the MIP) along with relevant links to external organisations via escalation to ensure JESIP and co-ordination of other assets are appropriately notified Business Continuity Policy v8.0 (CSE69) Each operational site has it's own dedicated BC Plan which contains information of escalation processes Example of Hub BC Plan (CSE70)	Fully compliant	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	Commanders have access to decision logs within command equipment on response vehicles Action Cards contained within Trust response plans outline the requirements to keep accurate decision logs (CSE25) The Trust has a cadre of trained loggists that are accessaed through the Everbridge Recall to Duty System, to provide support to off-scene functions including the Strategic Commander, Tactical Cell Command Commander, EOC Duty Dispatch Manager). The Tactical Command Cell will perform this task where appripriate and detail the availability of trained personnel. There are a minimum of 3 trained loggists on duty at any one time (CSE71) Loggists are sought for Major incident exercises to ensure they are afforded testing and exercising (CPD Log Included as evidence - CSE72) The organisation has developed and utilised a digital decision log and reporting application - Evidence provided of app user guide (CSE73) The organisation has 36 trained operational loggists, and are committed to having a minimum of 3 on duty at any one time, to support the key decision makers. All Commanders who have completed the NARU Operational Command course have a decision logging module included on their course,	Fully compliant	
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	The Trust utilies an Incidents of Note (ION) system, via the 24/7 Incident Command Desk. This provision sends a message to all managers for internal notifications. - The Tactical Command Cell co-ordinates external requests for situational reports, which are all formally logged and recorded. - The Duty Strategic Commnader will approve all formal submissions required. - EOC utilisie the ESICTRL Airwave Talkgroup to share critical situational awareness messages between all Blue Light Servcies within our region and Nationally The organisation has developed and utilised a digital decision log and reporting application during the recent CWG, with a plan to implement as a legacy benefit in BAU and event operations Agency SitRep for the MAIC (CSE17) ION Example (CSE74) App User Guide (CSE73) ESICTRL Test Example (CSE75) Repoting templates are sent out by NHSE when information is required and templates differ dependent on what information is required. For response METHANE is used generically as per Incidents of note evidence. Dynamic Sit rep submissions are approved by the duty Strategic commander. WMAS has a Critical information officer role embedded in the MIP which also has its own dedicated action card with template and electronic logging vis the CAD system (CSE25)	Fully compliant	
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The communications and engagement strategy outlines the trusts internal and external communications delivery plan (CSE76). On call Press Officer is available 24/7 to co-ordinate any communications requests, available through the on-call roster included (CSE42) Incidents of significance are passed to the press team through the Emergency operations Centre (EOC), via a dedicated messaging system (CSE74) The Tactical Command Cell (24/7) are available to gather any relevant information or intelligience to ensure that communications are consistent and accurate with regards to any ongoing incident. The on-call NILO works across the partnership to ensure that any relevent sensitive information is captured, filtered and disseminated acorss the organisation (accessed through the on-call roster included) Record of training provided to the Communications Team, completed by JW (CSE141 / CSE142)	Fully compliant	

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34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Specific incident communications plans are embedded within the Trust's Major Incident Plan v14 (CSE25). There are multiple plans in the event of a multi-sited incident These plans are tested during exercising and training sessions to ensure staff have a good working knowledge and have familiairised themselves with the associated action cards linked to such roles. The Press Officer Action Card contains actions including contact with external partners to activate existing health messages and formulate and communicate public health information (CSE25) Escalations from the Strategic Capacity Cell (SCC) within EOC ensures that receiving hospitals and also NHSE and ICBs are aware of patient acutiy and demand. They also escalate any incidents of note to NHSE and ICBs for situational awareness and the potential for media interest	Fully compliant	
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	The trust coordinates information requests through the Tactical Command Cell and the Duty NILO (24/7) in conjunction with the Trust press office and On-Call Press Officer (24/7) All commanders have acces to Resilience Direct (CSE92) WMAS Communications and Engagement Strategy v2 Oct 2021 (CSE76) AACE guidance to social media (CSE77) WMAS Social and Digital Policy (CSE78) LRF multi agency press policies (CSE79-82) WMAS Press Officers are part of the LRF comms working groups - The Strategic Capacity Cell (SCC) is a 24/7 function within the WMAS EOC which provides the direct link between the Trust and acute organisations. The comms team maintain direct links with the ICBs and NHSE Mids. There is also a member of the WMAS commuications team embedded into LRF subgroups (communications) to ensure partner engagement The Midlands EPRR Contact Directory (v5.0) is readily accessible to the Tactical Command Cell Commanders (CSE143), which contains all of the key contacts. LRFs covered by WMAS also provide key contacts in a communications document, with an example attached as evidence from the West Midlands LRF (CSE144). Contact details for Internal key stakeholders are also held centrally in the event that the TCCC (RESOURCED 24/7) need to make contact with someone from a specific directorate (CSE145).	Fully compliant	
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The trust coordinates information requests through the Tactical Command Cell and the Duty NILO (24/7) in conjunction with the Trust press office and On-Call Press Officer (24/7) All commanders have acces to Resilience Direct (CSE92) WMAS Communications and Engagement Strategy v2 Oct 2021 (CSE76) AACE guidance to social media (CSE77) WMAS Social and Digital Policy (CSE78) LRF multi agency press policies (CSE79-82) WMAS Press Officers are part of the LRF comms working groups - The Strategic Capacity Cell (SCC) is a 24/7 function within the WMAS EOC which provides the direct link between the Trust and acute organisations. The comms team maintain direct links with the ICBs and NHSE Mids. There is also a member of the WMAS commuications team embedded into LRF subgroups (communications) to ensure partner engagement	Fully compliant	
Domain 8 - Cooperation								
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	LHRP meetings are regularly attended by an Assistant Chief Ambulance Officer (ACAO) who maintains the appropriate authority to commit resources on behalf of WMAS Minutes to show attendance (CSE83-86)	Fully compliant	
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	WMAS engage with all LRFs across the Trust footprint, with all minutes and actions recorded as required. There is an ACAO assigned to each LRF who attend the regular meetings. Minutes to show attendance (CSE87 / CSE88)	Fully compliant	
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual Aid arrangements are outlined: - WMAS Major Incident Plan V14 (CSE25) - WMAS Mutual Aid plan V8, which is aligned with the National Mutual Aid plan (CSE89) - NACC Plan (CSE90) - Coordinated through the Tactical Command Cell which is operaitonal 24/7 - Recall to duty of staff managed by Everbridge system Mutual Aid agreements between Ambulance Trusts are discussed and agreed at the Strategic Command level. These agreements are dynamic, according to the ongoing / foreseen incident and are in line with National processes outlined in the NARU National Ambulance Co-Ordination Centre Plan (CSE146) and the Memorandum of Understanding (MOU) between Ambulance Trusts (CSE147). In addition to this, a MOU for CBRN Countermeasures has been agreed with the BCICB (CSE148).	Fully compliant	
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	Covered within the Trust Major Incident Plan v14 / casualty regulation plan / mutual aid plan (CSE25 / CSE15 / CSE89)	Fully compliant	
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Information is shared through LRFs (CSE91) Further supported by: - Representation at any SCG or TCG conviened WMAS represented by appropiate level Trust Officers - Agency Sitrep when requested from the MAIC during a significant / major incident (CSE17) - Use of Resilience Direct (WMAS RD procedure CSE92) - EOC utilisie the ESICTRL Airwave Talkgroup to share critical situational awareness messages between all Blue light servcies in our region (CSE75) - Sharing of sensitive information via the National NILO network - WMAS utilise the electronic patient record forms (EPRF), which are shared with hopsitals at handover and also GPs upon EPRF case closure. We are also able to view information from integrated care record systems	Fully compliant	
Domain 9 - Business Continuity								

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44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Covered in the WMAS Business Continuity Policy v11 CSE93 WMAS have a dedicated BC lead - Shane Roberts. He provides regular updates to OMT and EMB which report into the board (quarterly). West Midlands Ambulance Service University NHS Foundation Trust 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.	Fully compliant	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	WMAS BC Policy V11 June 2023 CSE93 - SCOPE - This policy applies to all employees, interested parties, contractors and suppliers to the Trust and must be followed by all Trust departments and directorates. - Each operational site has its own specific BC plan including exercising process - Regular review of BC Plan Compliance at EMB and onward reporting to Board annually WMAS have a dedicated BC lead - Shane Roberts. He provides regular updates to OMT and EMB which report into the board (quarterly).	Fully compliant	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	CSE93 - WMAS has a robust BC system in place which is aligned with ISO 22301 and BCI GPG2018. Within the BC policy, BIAs are completed and submitted by each department and form part of the BCMS. Submitted evidence includes a summary of the information taken directly from the WMAS Business Continuity Policy v11, relating to the BIA for the organisation Each department will complete a Business Impact Analysis as part of the Business Continuity Management System. An example of a BIA has been included for Tollgate Hub (CSE149)	Fully compliant	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	WMAS Business Continuity Policy v11 CSE93 The BCP Review Cycle has been included for 23-24 (CSE150), as well as an example of an operational site (CSE136)	Fully compliant	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Annual exercise of plans Internal review of BC plans when activated - with learning and revised planning WMAS BC Policy V11 June 2023 CSE93 Post Exercise / Learning Report all submitted to reflect lessons learned, with example attached as evidence of a BC exercise at a local hub (CSE94-97, CSE126) The Business Continuity Manager will oversee an annual exercise programme for all Trust departments and provide support to Nominated Leads and their teams. Actions and learning are captured in BC incident logs, which are attached as examples (CSE151, CSE152, CSE153, CSE161), collated in a action tracker (CSE154)	Fully compliant	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Recorded on NHS Digitial return (CSE97) WMAS Data Protection Policy v2 July 2022 (CSE98)	Fully compliant	

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50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	WMAS Business Continuity Policy v11 CSE93 Key Performance Indicators KPI's will form part of the Plan / Do / Act / Check methodology for continuous improvement. The 5 KPIs that are monitored are outlined within the WMAS BC Policy (CSE93) These KPIs can only be considered as 100%, taking into account the Plan / Do / Act / Check methodology, outlined in the plan All 6 KPIs are maintained at 100%, monitored by the responsible officer for BC – Shane Roberts	Fully compliant	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	RAG Rating is published quarterly and shared with EMB via OMT. Reported to the Board Annually (CSE99 / CSE 100) An internal audit of the Trust's Business Continuity Management System (CSE101) will be carried out at regular intervals by the Trust's Internal Audit Team and the Business Continuity Manager will be responsible for providing any documentation and support required (last audit attached Feb 2022 - Next review expected in the next 2 years) The BC internal audit is completed on a 3-year cycle. The last audit was completed in Feb 2022 and is attached as supporting evidence (CSE155) Current NHSE Guidance (NHSE BC Management Toolkit v2.0, April 2023) outlines (6.3 – Internal Audits) that: Undertaking internal audits annually is considered good practice in the NHS, as you are able to identify areas for improvement, as well as identifying the appropriate resource and budget required to maintain a healthy BCMS It is recommended that external audits are undertaken every 3 years Internal audits should be undertaken in agreement with your organisations audit team/programme. The frequency of internal audits should be reflective of the size and type of organisation Therefore the organisation should be considered as compliant against this core standard when balanced against the current National guidance	Fully compliant	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Annual exercise of plans CSE126 Internal review of BC plans when activated - with learning and revised planning WMAS BC Policy v11 June 2023 Continuous Improvement - The methodology for continuous improvement is based on the cyclical process of Plan / Do / Act / Check. This cycle aims to establish, implement, operate, monitor, exercise, maintain and improve the effectiveness of the BCMS Activation evidence required	Fully compliant	
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Completed as part of the procument processes. WMAS Procument Policy & Procedure (PolicyStat CSE102) The Trust Procurement Lead will be responsible for overall key supplier business continuity arrangements and updates on this will be covered in the annual review process. The NHSE BC Tookit Business Continuity Capability of Suppliers Questionnaire will be adopted List of suppliers and assessment process is attached (CSE156 / CSE157 / CSE158). This process is managed by the Head of purchasing & contracts within the procurement & distribution department. There is set governance around this process, including assessments that are required to be completed by suppliers before they are accepted by the organisation. Completed assessment available through request as they are classified as OFF-SEN.	Fully compliant	
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	CAD systems within EOC are tested during all Trust Live exercises and the EOC directorate are embedded within the current exercise debriefing process. The EX IMPERTIOR series is dedicated to the EOC function to ensure testing of multi-agency communications through interoperability talkgroups. Learning from these exercises is reviewed and pland updated accordingly where appropriate Ex IMPERTIOR CAD Entries provided (CSE103) as evidence to show training entered onto the Live CAD system. Learning from all exercises is captured in the main debrief document and implemented accordingly CAD failure, failover and generator testing evidence also provided (CSE127-132) Lessons that are captured from exercise learning are recorded in formal exercise reviews / debriefs. Actions are then entered onto the tracker (CSE159) with an appropriate owner to ensure exploration and implementation of actions required.	Fully compliant	
Domain 10 - CBRN								
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	The roles and responsibilities highlighted within the required standard are detailed within the CBRN Plan. CBRN governance is detailed within the HAZMAT & CBRN Plan v11.3 (CSE23) (1.2, Page 7 of 82)	Fully compliant	

Ref	Domain	Standard name	Standard Detail	NHS Ambulance Service Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work	Comments
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response.	Y	Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).	The Trust is commmitted to supporting Acute sites with their training to ensure that they maintain HazMat Tactical Capabilities. Throughtout the last 12 months, self assessments and physical on-site audits have been completed to ensure compliance. Some acute sites declined to physically test their capabilities. This was reported to the regional team. Attahced as evidence are some reports from acute site visits & audits (CSE104-109)	Fully compliant	
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.	Y	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	At the commencement of each year, a regional viretual meeting is held for all partners to provide a brief of the year's planning. This is also attended by the Deputy EPRR Regional Lead for oversight. A summary of the above described audits / site assurance visits has been provided as evidence (CSE104)	Fully compliant	
69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).	Y	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. Evidence of progress/close-out of actions.	As an annual process, at the commencement of each year, a regional viretual meeting is held for all partners to provide a brief of the year's planning. This is also attended by the Deputy EPRR Regional Lead for oversight. A summary of the above described audits / site assurance visits has been provided as evidence (CSE104)	Fully compliant	
70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.	Y	Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.	Email confirmation provided as evidence which was sent to the Regional EPRR Lead. A sample of the last 10 years audits have also been supplied. (CSE110-118)	Fully compliant	
71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.	Y	Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.	The Trust is commmitted to supporting Acute sites with their training to ensure that they maintain HazMat Tactical Capabilities. Throughtout the last 12 months, sessions have been arranged for every site within the WMAS footprint (register of attendance attached - noting that some acutes did not attend, despite confirming their place on the course. A training date has been scheduled for this year - 8th November 2023 (CSE119-124)	Fully compliant	
72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.	Y	NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.	A suitable training package has been developed, aligned with the NARU specifications & PRPS capabilities. This has been evidenced in the course joining instructions provided as evidence (CSE119-124)	Fully compliant	
73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.	Y	Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).	This training package is for annual delivery, evidenced with 2022 data and confirmation for course revalidation later this year in November 2023. All acute sites are aware of this requirement (CSE125)	Fully compliant	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08b MONTH: January 2024 PAPER NUMBER: 06

WMAS Pandemic Plan	
Sponsoring Director	Chief Executive Officer
Author(s)/Presenter	Nathan Hudson
Purpose	Maintain in date and current response plans relating to Pandemic
Previously Considered by	EMB annually
Report Approved By	James Williams – Head of Emergency Preparedness Resilience and Response (EPRR)

Executive Summary

WMAS Pandemic Plan

The attached Plan has been reviewed by system partners and EMB; it is submitted for approval.

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	Maintaining current and fit for purpose plans. NHSE/ICB requirement for assurance			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08b MONTH: January 2024 PAPER NUMBER: 06

Legal implications/ regulatory requirements	To maintain compliance with both regulations and the conditions of licence and registration from the Regulators.
Financial Implications	Nonspecific to documents
Workforce & Training Implications	None.
Communications Issues	Plans – shared internally across all directorates including Trust Board. Shared externally with NHSE/ICB's for external assurance
Diversity & Inclusivity Implications	N/A
Quality Impact Assessment	Not required
Data Quality	James Williams – Head of EPRR
Action required That the contents of the Pandemic Plan be approved.	

West Midlands Ambulance Service
University NHS Foundation Trust

WMAS
Pandemic Plan

V 6.3

2023-2024

This plan must be used in conjunction with World Health Organisation (WHO), United Kingdom Health and Security Agency (UKHSA) and National Health Service England (NHS England) current guidance based on the threat.

Version	6.3 FINAL
Ratified By	Executive Management Board (EMB)
Date Ratified	November 2023
Author/s	Emergency Preparedness Team / Public Health & IPC
Responsible Officer	Head of Public Health and IP&C
Date for Review	November 2024
Intended Audience	West Midlands Ambulance Service Staff NHSE Midlands Black Country ICB Blue light Partners
Supporting Documentation (See Microsoft Teams Commanders for live plan versions)	WMAS Major Incident Plan WMAS Business Continuity Plan WMAS REAP Plan WMAS Mutual Aid Plan WMAS Fuel Plan WMAS Move to Critical Plan WMAS Adverse Weather Plan WMAS CBRN Plan WMAS Infection Prevention and Control Policy WMAS Infection Prevention and Control Procedures WMAS HCID Procedure WMAS Management of Infectious Diseases Procedure WMAS Outbreak Management Plan WMAS COVID-19 lessons identified action Plan WHO guidance JESIP Doctrine V3
Plan Held	Digitally, stored within WMAS response plans

Version control	Name / Department	Changes	Date
V5	EP and IP&C	N/A (prior to WMAS Regional Service merger)	March 2019
V6	EP and IP&C	Update with COVID pandemic lessons identified internally as well as Nationally. Combining VHF plan into this document.	June 2021
V6.1	EP and IP&C	Feedback and comments from Medical Director	November 2021
V6.2	David Levesley	JESIP graphic changes	November 2021
V6.2.1	James Williams	Review and terminology update	December 2022
V6.3	IP&C & EPRR	Update to include DATER expansion and a review of terminology, including approaches undertaken during the pandemic of COVID-19.	November 2023

Plan exercised or used on:		
COVID 19	Pandemic	June 2021 onwards

V6.3 Plan reviewed by:		
Strategic Cadre	As per EMB approval	28-11-2023
NILO Cadre	Content review, changes and plan format changes	10-11-2023
Nursing director and IP and C lead	Plan re-write post covid lessons and annual update.	10-11-2023
NHSE Midlands	Reviewed and changes	21-11-2023
ICB Black Country	Reviewed and changes	21-11-2023
WMAS EMB	Approved for publish	28-11-2023
WMAS Trust Board	Update from EMB	29-11-2023

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Chief Executive Foreword

The pandemic of COVID-19 has highlighted the stark inequalities that exist amongst the global population, including those here locally in the West Midlands. It is therefore vital that we plan for such emerging emergency situations, using the learning from the COVID-19 pandemic to ensure plans are tested and are robust to minimise infectivity, isolation, hospitalisation and death of both healthcare workers and our patients.

Throughout the pandemic response, Health and Social Care services have been stretched to the limit of staff, knowledge and understanding but have coped by innovating and re-organising to ensure that the public get the service they need. This effort was co-dependent on all other agencies to deliver their services. The combination of communications, emergency services, childcare and schooling, enabled our staff to provide an effective response. This learning must be instilled into organisational memory to ensure future preparedness to emerging threats.

This plan aims to consider the complex interdependencies of the West Midlands Health Economy and WMAS in supporting each other to deliver continued high-quality care. The plan now includes all routes of infection and allows the Trust to choose a pathway to support the current disease threat. The plan is linked to those of other organisations (WHO) and coordinated through NHSE and the Local Resilience Forums (LRF).

Whilst every effort has been made to make this plan as operational as possible, it will need to be read in conjunction with current guidance from internationally and nationally recognised sources. Therefore, printing of the document is not recommended. It is the readers responsibility to ensure that they are aware for the current situation and use this plan together with that guidance.

WMAS University NHS Foundation Trust will find itself under immense pressure during a pandemic. By reading this plan, attending appropriate IPC/PPE training and remining up to date with guidance, you will ensure you are able to support the Trust in its efforts.

Anthony Marsh
Chief Executive Officer

Caron Eyre (DIPC)
Executive Nursing Director

November 2023

1. Introduction.

The threat of a pandemic remains at the top of National and LRF risk registers for good reason. The potential of a pandemic or High Consequence Infectious Disease (HCID) returning to the UK remains high due to the size of the global population as a breeding ground and the ease and frequency of international travel. The nature, timing and severity of a pandemic remains unpredictable although a huge number of lessons have been learnt throughout the COVID 19 pandemic.

The first steps in managing a pandemic are summarised in the World Health Organisations (WHO) Pandemic Risk Management Guidance. This focuses on enhanced surveillance, with collection of clinical, virologic and epidemiological data to assess the extent of Human-to-Human transmission.

A pandemic of any origin can arise anywhere across the globe. Two of the three pandemics of the twentieth century have emerged in China (1957, 1968), whereas 2009 pandemic emerged in Central America. The 2019 COVID 19 pandemic arose in China but spread globally with extreme speed and ease. Most H5N1 and H7N9 avian flu cases were identified in Asia, H5N1 have been detected elsewhere, e.g., poultry and humans in Egypt.

Pervious modelling had been based on Asian outbreaks, but we now have a huge amount of data on airborne disease spread globally. It is worth noting at this point, COVID 19 was an airborne disease, there are many equally virulent contact spread diseases which will act and spread differently. HCID such as the Haemorrhagic fever variants are still prevalent in parts of Africa.

Modelling of pandemics continues to evolve as more data becomes available. As social models, travel habits and population densities change, so does the accuracy of models. However, all infectious disease control relies on breaking the transmission cycle.

This plan will allow WMAS to provide an effective response, regardless of the transmission route.

Demands on the Health and Social care sector, both public, private and voluntary, will be significant. Lessons identified from the COVID-19 pandemic have significantly improved WMAS preparedness, response and management of a pandemic.

2. Aims and Objectives.

This plan enables WMAS to respond to an outbreak or pandemic through planning, preparation and integrated working with partner agencies in the West Midlands locality. This plan must be used in conjunction with the Trust Business Continuity Plans.

The objectives are:

- Contribute and add value to the effective multi-agency response to an infectious disease, maintaining BAU as closely as possible.
- Assisting in reducing the spread of an infectious disease, by supporting current and developing preventative measures, self-care and the provision of healthcare in the WMAS footprint.
- Ensure the Trust utilises robust infection control measures suitable for the disease transmission type.
- Makes targeted and effective use of scarce skills, facilities and resources.
- Support staff in reducing risk of infection transmission, through robust communication, training, delivery of effective and appropriate PPE.
- Supporting suitable working practices including track and trace, contact tracing and staff testing / monitoring. It is also key to support our staff with welfare provision, ensuring that mental health care, which is as important as their physical health care.

- Provide engineering solutions to reduce transmission in estate and fleet when appropriate.
- Adopt the five stages of the DATER approach (detection, assessment, treatment, escalation and recovery).
- Reflect necessary changes in models of service delivery, providing continued delivery of essential services, including those not directly involved in the pandemic response.
- Apply transparent, consistent and equitable triage criteria that assists in reserving hospital capacity for the most critically ill.
- Provide accurate, timely and authoritative communication and information, supporting national messages, to staff, the public and the media.

3. Background and Planning.

A pandemic relates to a widespread occurrence of an infectious disease over a whole country or the world at a particular time. Viral respiratory diseases, such as those caused by a new influenza type virus or the coronavirus, are the most likely to result in the declaration of a pandemic. WMAS must be able to react and protect staff and casualties as quickly as possible. Therefore, it is prudent to plan for a range of options, based on transmission method.

Viral Haemorrhagic Fevers (VHF) are a group of HCID classed as the highest risk level of disease, category 4, they are normally limited to a geographical area of the host animal. However, there is a chance of spread as Ebola did in 2017. VHF is spread by contact with bodily fluids and an increase in virulence towards the end of life of the infected host. The WHO states that all health providers should be prepared for VHF cases. The Royal Free Hospital in London is the first point of treatment. The national contingency is to use the level 3 units at Newcastle, Liverpool and Sheffield.

In the case of casualties requiring transport, it is agreed nationally that HART will carry out the transfers. This action is supported in the WMAS HCID procedure where action cards for the WMAS staff involved are located. NARU also produce guidance on HCID transport which is followed by WMAS plans.

It is important to note that healthcare workers are at a much higher risk of exposure both in the frequency of contact with infected population and by the nature of treatment required for those individuals affected. The likelihood is that healthcare workers will also have an increased rate of absenteeism due to the disease or due to the restrictions placed on other economic sectors directly affecting the individuals.

The UK Pandemic Preparedness Strategy is dependent on the following:

- Detection.
- Surveillance.
- Information Gathering.
- Development of diagnosis tools.
- Communications.
- Assessment of risk and transmission routes, measures to reduce spread.
- Treatment development and roll out.
- Escalation- surge management, prioritisation, triage to maintain essential services.
- Recovery- plan to return to the new normal.

This WMAS plan is to offer options to the commanders based on the transmission routes, primarily Contact and Airborne, although there are other methods such as Waterborne, Foodborne. This will allow some planning assumptions to be made based on the experience from the COVID 19 Pandemic and its effects on Staff, Trust and casualties.

4. WMAS information.

WMAS employs operational staff for the provision of planned, non-planned and immediate medical transport. In addition to operational staff, support staff undertake non-operational duties to ensure the continued provision of pre-hospital care.

The likely impacts on WMAS, which this plan and associated documents aim to provide contingencies for, are:

- Increase in the number of emergency calls.
- Requests for staff addition to support units such as a Nightingale Hospital.
- Requirement to request retired staff return to active duties, where appropriate.
- Review workforce plan to increase frontline capacity such as Community First Responders (CFR) to Patient Transport Services (PTS).
- Employment drive to recruit additional workforce.
- Fear and anxiety amongst staff.
- Potential for compromised access to consumables due to acute demand, logistics disruption or stockpiling by others.
- Staff absenteeism due to illness, carer responsibility and anxiety.
- Staff fatigue.
- Inability to respond to calls within response times due to increased demand.
- Increased hospital turnaround times due to capacity restrictions.
- Potentially compromised access to fuel.
- Staff working from home and increased specialist IT requirement to allow this to be effective.

Staffing establishment
WMAS staffing by role and locality. A snapshot view from October 2023

Service Delivery	4020
EOC and integrated urgent care	950
Non-Emergency Services	1260
Central Functions	550
Recharges	20
Total	6800

International Phases

The World Health Organisation (WHO) has developed a 6-phase international escalating approach to planning and response proportionate to the risk from the emergence of a novel virus. Once a pandemic is declared at Phase 6, UK action will depend on whether cases have been identified in the UK, and how extensively it has spread.

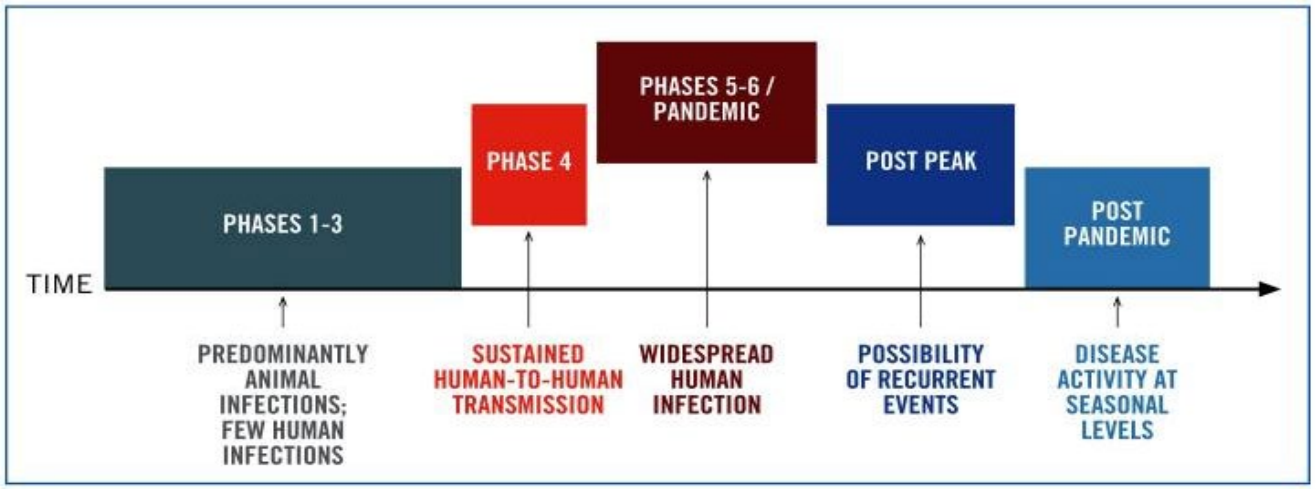
UK Alert Levels

Should the UK have cases during the pre-pandemic period, the international phases apply. Once a pandemic has been declared (Phase 6), a four-point UK-specific alert mechanism has been developed, consistent with the alert levels used in other UK infectious disease response plans.

Level 0	No cases anywhere in the world	Matches WHO levels 1-3
Level 1	Cases only outside the UK	Matches WHO levels 1-3
Level 2	New virus isolated only in the UK	Matches WHO levels 4
Level 3	Outbreak(s) in the UK	Matches WHO levels 5-6
Level 4	Widespread activity across the UK	Matches WHO levels 5-6

5. Pandemic Phases, Alerting and Trigger Points.

Who International phases



6. UKHSA Response Phases.

Detect	Surveillance, information gathering, development of diagnosis, Communications
Assess	Collection and analysis of data, reducing risk of transmission and infection.
Treat	Treating individual cases, enhancing health response, public health measures to disrupt transmission.
Escalate	Surge management, prioritisation and triage to maintain essential services, BCPs.
Recover	Normalisation, restoration of services, debrief and review, address staff exhaustion, prepare for resurgence of activity.

6.1 – Pandemic Phases and Associated Activities (DATER)

Phase	National Actions
Detection	- Intelligence gathering from countries already affected. - Enhanced surveillance within the UK - The development of diagnostics specific to the new virus - Information, specific advice and communications to the public and professionals - The indicator for moving to the next stage would be the identification of the novel influenza virus in patients in the UK
Assessment	- The collection and analysis of detailed clinical and epidemiological information on early cases on which to base early estimates of impact and severity in the UK (First few hundred) - Reducing the spread of transmission and infection with the virus within the local community by: - actively finding cases - advising community voluntary self-isolation of cases and suspected cases - advising on the treatment of cases/suspected cases and use of antiviral prophylaxis for close/vulnerable contacts, based on risk assessment of the possible impact of the disease.
The indicator for moving from this stage would be evidence of sustained community transmission of the virus, i.e., cases not linked to any known or previously identified cases.	

Treatment	- Advising of the treatment of individual cases and population treatment, if necessary, using the National Pandemic Flu Service (NPFS). - Enhancement of the health response to deal with increasing numbers of cases. - To consider enhancing public health measures to disrupt local transmission of the virus as appropriate, such as localised school closures based on public health risk assessment. - Arrangements will be activated to ensure that necessary detailed surveillance activity continues in relation to samples of community cases, hospitalised cases and deaths
The indicator to move to the next stage would be when demands for services start to exceed the available capacity and additional measures will need to be taken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity.	
Escalation	- Escalation of surge management arrangements - UKHSA to advise the NHS. - Prioritisation and triage of service delivery with aim to maintain essential services. - Resiliency measures, encompassing robust contingency plans. - Consideration of de-escalation of UKHSA response if the situation is judged to have improved sufficiently.
Recovery	- Normalisation of services – perhaps a new definition of what constitutes normal service. - Restoration of business-as-usual services, including an element of catch up with activity that may have been scaled down as part of the pandemic response e.g., reschedule routine appointments. - Post incident review of response, and sharing information on what went well, what could be improved, and lessons learnt. - Taking steps to address staff exhaustion. - Planning and preparation for resurgence of influenza, including activities carried out in the detection phase. - Continuing to consider targeted vaccination when available. - Preparing for post-pandemic seasonal influenza.

7. Planning Assumptions.

The flowing planning assumption is for Flu as pre 2019/2020 no data was available for a pandemic in the 21st century. Other virus will have other factors and will vary the results on this table. Assumptions provided in the Department of Health and Social Care - Pandemic Flu guidance 2017 (section 2):

Timing And Duration	• A pandemic is most likely to be caused by a new, unknown and rapidly emerging pathogen. • A pandemic could emerge at anytime, anywhere in the world, including in the UK. It could emerge at any time of the year. Regardless of where or when it emerges, it is likely to reach the UK very quickly. It will not be possible to stop the spread of, or to eradicate, a pandemic virus, either in the country of origin or in the UK, as it will spread too rapidly and too widely. • From arrival in the UK, it will probably be a further one to two weeks until sporadic cases and small clusters of disease are occurring across the country. • Pandemic activity in the UK may present for months or years and may present in waves of infection. There may be subsequent substantial activity for a period of time after, even after the WHO has declared the pandemic to be over.

	• The disease may be classed as endemic which means it is now embedded within the population and regulated by vaccines or barrier practices. • Although it is not possible to predict in advance what proportion of the population will become infected with the new virus, previous studies suggest that between 50% to 80% may display symptoms of some kind (ranging from mild to severe). • The transmissibility of the pandemic virus and the proportion of people in which severe symptoms are produced will not be known in advance.
Infectivity **&** **Mode of Spread**	• Regardless of the nature of the virus, it is likely that members of the population will exhibit a wide spectrum of illness, ranging from asymptomatic to minor symptoms to pneumonia and death. • All ages are likely to be affected but those with certain underlying medical conditions, pregnant women, children and otherwise fit younger adults could be at relatively greater risk as older people may have some residual immunity from previous exposure to a similar virus earlier in their lifetime. The exact pattern will only become apparent as the pandemic progresses. • Spread could be via inhalation of droplets in the atmosphere, Contact with contaminated surfaces or contact / inhalation / absorption of contaminated bodily fluids.
Attack Rate, **Severity of Illness** **&** **Deaths**	• Health services should continue to prepare for up to 30% of symptomatic patients requiring assessment and treatment in usual pathways of primary care, assuming the majority of symptomatic cases do not require direct assistance from healthcare professionals. • Symptomatic patients may require hospital care, depending on how severe the illness caused by the virus is. There is likely to be increased demand for intensive care services. • For deaths, the analysis remains that up to 2.5% of those with symptoms would die with no treatment identified. • These figures might be expected to be reduced by the impact of countermeasures, but the effectiveness of such mitigation is not certain. The combination of particularly high attack rates and a severe disease is also relatively (but unquantifiable) improbable. Taking account of this, and the practicality of different levels of response, when planning for excess deaths, local planners should prepare to extend capacity on a precautionary but reasonably practicable basis and aim to cope with a population mortality rate of up to 210,000 – 315,000 additional deaths, possibly over as little as a 15-week period and perhaps half of these over three weeks at the height of the outbreak. • More extreme circumstances would require the local response to be combined with facilitation or other support at a national level. In a less widespread and lower impact pandemic, the number of additional deaths would be lower. • Be aware of the virus ability to mutate. More victims increase the chance for the virus to mutate. This may result in unexpected complications or

	changes to previous information. Messaging and protective measures must keep up with the mutations.
Absenteeism	• Up to 50 per cent of the workforce may require time off at some stage over the entire period of the pandemic. In a widespread and severe pandemic, affecting 35-50 per cent of the population, this could be even higher as some with caring responsibilities will need additional time off. • Some staff will have existing medical conditions that would mean they will have to shield or self-isolate to protect themselves. • Staff absence should follow the pandemic profile. In a widespread and severe pandemic, affecting 50 per cent of the population, between 15 per cent and 20 per cent of staff may be absent on any given day. These levels would be expected to remain similar for one to three weeks and then decline. • Some small organisational units (5 to 15 staff) or small teams within larger organisational units where staff work in proximity are likely to suffer higher percentages of staff absences. In a widespread and severe pandemic, affecting 50 per cent of the population, 30-35 per cent of staff in small organisations may be absent on any given day. • Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants, to look after children in the event of schools and nurseries closing, family bereavement, practical difficulties in getting to work and/or other psychosocial impacts.

8. Demographic Profile.

The Trust serves a population of 6.1 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country conurbation. In addition to this the West Midlands has a significant number of homeless people, 400,000 tourists per normal day and 130,000 students. 500,000 people also commute into the region to work using the large variety of public transport systems, some of which may also require treatment whilst in our region.

Within the West Midlands there are airports (ranging from relatively minor to international), which may be the primary point of entry of the virus into the UK. These airports are involved in Pandemic planning and surveillance with (UKHSA). There are set actions to be taken, listed in the BHX port protection plan available on the Trust Teams page, should returning travellers present with symptoms of HCID.

9. Impact of a Pandemic on the West Midlands.

Health services should prepare for up to 50% of symptomatic patients, requiring assessment and treatment in usual pathways of primary care. 1-4% of symptomatic patients will require hospital care, depending on how severe the illness caused by the virus is. There is to be an expected increase in demand for intensive care and long-term recovery.

- Impact of a pandemic is likely to be intense, sustained and nationwide resulting in health agencies quickly becoming quickly overwhelmed.
- Increased workload of patients.
- Greater demand for high dependency and IPC facilities.
- Depletion of workforce due to direct and indirect effects of the disease.

- Logistical problems or interruption to supplies, utilities, fuel, blood and other essential supplies.
- High demand for mortuary facilities, delays in cremation, burials etc.

Based on population demographics there is likely to be some localised variation in the scale of impact of the pandemic. Population centres with a highly transient population (high incidence of commuters, international travel, national logistics, students etc) will most likely be the first major areas affected by the pandemic.

Projected Impact Analysis

Locality	Population 2021	25 % Attack Rate			35 % Attack Rate			50 % Attack Rate		
		Clinical Cases	Deaths 2.5%	Hospitalisation 0.55%	Clinical Cases	Deaths 2.5%	Hospitalisation 2.5%	Clinical Cases	Deaths 2.5%	Hospitalisation 3.5%
BBC inc Cov.	2,928,592	732,880	18,322	29,315	1,026,032	25,650	41,041	1,465,760	36,644	58,630
Warks	577,933	5,785	3,615	5785	202,478	5,061	8,174	289,255	7,231	11,570
H&W	875,378	219,063	5,476	8,762	306,688	7,667	12,267	438,126	10,953	17,525
Shrop.	502,990	125,873	3,146	5,034	176,222	4,405	7,048	251,746	6,293	10,069
Staffs.	1,135,935	284,267	7,106	11,370	397,974	9,949	15,918	568,535	14,213	22,741
Total	6,020,828	1,506,712	37,667	60,268	2,109,397	52,934	84,375	3,013,424	75,335	120,536

Note: The information in the above table has been calculated from the modelling in the Cabinet Office Strategy to respond to Pandemic Influenza, with population information from the early 2021 population data from Office of National Statistics (ONSI)

Out of the First Wave

It is likely that the pandemic will occur in several waves, several weeks or months apart, and that subsequent waves may be more severe than the first.

Following the first wave of the pandemic, on the downgrading from UK Alert Level 4 to 3 or below, the priority should be on support to staff and providing rest, restoration of depleted supplies, essential maintenance/replacement to essential facilities and fleet. Learning points identified at internal and multi-agency debriefs should also be collated and any vital amendments made to the Pandemic plan.

It is important for all sites to be cleaned intensively and frequently, on outbreak or following each pandemic wave.

If sufficient resources are deemed to be available by the Strategic Commander, in collaboration with NHSE Strategic Command, curtailed services or areas of work should be reintroduced in a phased and sustainable manner. This reintroduction, including the reintroduction of performance targets, should consider the loss of staff (pandemic related mortality), their family, the wider community and their experiences during the first wave.

Subsequent Waves

Informed by epidemiological modelling the UK Alert Levels 1 - 4 will be applicable. WMAS should ensure that any guidance or reviews published by the DHSC, and other agencies are used to inform subsequent health response to pandemic.

10. Alerting Mechanisms and Trigger Points.

The WMAS Pandemic Plan is not limited to Pandemic but also covers HCID. It comprises of several levels of response and predetermined actions which are predicated on the UK Alert Levels as described in the table above. The predefined actions are meant to be used as a guide to ensure an effective and proportionate response, the Strategic Commander can implement additional measures and to request actions be carried out sooner (or later) than is set out in this plan.

International/National Alerting

As soon as international phases are confirmed, WHO will announce the phase to its member states via existing alerting routes. On receipt, from the WHO, of the onset of a pandemic (i.e., Phase 6), the Department of Health and Social Care (DHSC) will immediately cascade this information to Devolved Administrations, UKHSA, Civil Contingencies Secretariat, Other Government Departments and the NHS in England and Wales.

Regional/Local Alerting

On receipt of the confirmation of WHO escalation to Phase 6 from the DHSC, WMAS will issue a briefing to all staff via email and will make this available as hard copy in all Trust Estate. This initial communication will detail information known to date regarding:

- Infection rates and any know method or route of infection.
- Any groups of staff particularly vulnerable.
- Immediate actions required.

11. Roles and Responsibilities of the Ambulance Service.

- Act as the main gateway to NHS healthcare provision.
- Work in partnership, considering the possibility of mutual aid, with local ICB, out of hours Services, Emergency Departments, Minor Injury Units, Walk-In Centres and Community Services, Nightingale units.
- Maintain Policies and Procedures to enable safe delivery of care to those affected and maintaining business as usual casualties, as well as WMAS Staff and families.
- Consider the extent to which support can be provided to the wider delivery of home care.
- Set up Tactical Command Cell to support and coordinate the activity of the Trust.
- Provide specialist advice and support in the early days of the spread when information on effective PPE or treatment is scarce.
- Develop effective and consistent communications strategies, providing advice and information. This must be robust enough to cope with constantly changing information and guidance.
- Aid in the planning and scheduling of healthcare provision to vulnerable patients in the home setting.
- Maintain services to other patients, for example those receiving life-sustaining outpatient treatment, those injures because of accidents, and those receiving maternity care.

- Assist in the safe transportation of patients away from acute settings to assist with accelerated discharge policy.

12. Command and Control Structures.

It is important that WMAS ensures it has robust and coherent Command, Control, Communication, Coordination and Information system in place to respond to any situation, and to engage in the local health economy and multi-agency response arrangements.

As HCID are not geographically contained, regional Command, Control, Communication, Coordination and Information will be required from the outset.

National Ambulance Coordination Centre (NACC) will need to be activated (if not already) to support the coordination of the National Ambulance responses.
The NACC would be activated in response to an activation of pre-agreed triggers set by NARU and would have three main functions:

- Maintain a database of information detailing the level of pressure within the ambulance sector.
- Coordinate requests for mutual aid between Ambulance trusts.
- Provide a conduit between the Ambulance Sector and the DHSC / NHSE England to highlight problems and disseminate agreed solutions.

Regional Command and Control Communication, Coordination and Information arrangements will take the same format as those described by the Trust Major Incident Plan. Namely, the Chief Executive or nominated deputy is identified as Strategic Commander and supported by an Incident Management Team.
All meetings wherever possible will be conducted via digital means, wherever possible, to minimise the potential for cross infection. Meeting times will be chosen to reflect the regional and national reporting and response structures requested.

Strategic Command team meetings can be activated as soon as practical to support the implementation of National or Regional guidance. This is scalable from daily to weekly dependant on the guidance from the CEO.
Tactical Command and Control may be based at the Tactical Command Cell (TCC).. Operational Command and Control will be based at individual Hubs and Department level. It is essential logbooks are maintained and completed to allow an accurate and timely account of decision making across all WMAS business, especially in relation to decisions of restricted assets. The Power Apps logging tool already in use by WMAS will fulfil that role of coordination of multiple inputs from multiple sites and Officers.

The TCC provides an intermediate level of coordination which is an escalation from day-to-day business but a step-down from formal Strategic Command arrangements as described in the Major Incident Plan. This also acts as an early escalation system and allows the transition from co-ordination to Command and Control seamlessly. The TCC should ideally contain the following during a pandemic:

- Incident Director (Strategic Commander) – responsible for overall management of WMAS response.
- Head of IPC – provide specialist advice to the Strategic Commander and coordinate the outbreak management response.
- National Interagency Liaison Officer (NILO) or suitably trained Officer – responsible for providing tactical advice to the Strategic Commander and maintaining liaison with multi-agency partners.
- Testing Manager – to coordinate the testing and reporting requirements for all WMAS staff as required.

- Risk Assessment Manager – provide constant updates to RA for PPE, IP&C requirements, Estate and Fleet.
- Information and Forecasting – responsible for collating information on operational demand, staff absenteeism, forecasting future demand etc.
- Loggist – to maintain a contemporaneous record of information, decisions and rationale.
- Administrative Support – to undertake admin duties as required.

However, consideration needs to be given to the resilience of Command and Control ensuring its continuing functionality for the duration of the response which could be months or years.

Use of staff with existing skills

There will be changes to Command-and-Control arrangements at the Tactical and Operational levels as the whole region is the scene. All clinical staff working in non-operational roles can be provided with refresher training and mobilised to undertake a period of temporary redeployment to ensure the continued delivery of essential services. All non-clinical staff working in non-operational roles can also be expected to support the delivery of care at the Strategic Commanders discretion.

Service Provision

Prioritisation of services in line with the REAP plan and EOC Surge plans will be required to ensure continued business continuity.

Strategic Responsibilities

- Coordinate operational service delivery to ensure maintenance of essential services.
- Assist in the control of admissions to the acute sector.
- Identify strategies to manage increased demand, absenteeism and recovery.
- Ensure honest, accurate and reassuring messages are given to the public, media and staff.
- Provision of enough supplies of suitable PPE for the transmission type, matching the daily consumption rate.
- Determine which contracts/SLAs can be suspended or renegotiated.
- Maintain liaison with multi-agency partners as required.
- Respond appropriately to political and legal requests.

Tactical Responsibilities

- Maintain log of staff availability using GRS.
- Maintain a regional incident log in the Tactical Command Cell.
- Teleconference daily with Operational Management each shift ensuring all information is shared both ways.
- Ensure local resourcing and performance delivery is maximised and robust in line with Strategic Commanders plan.
- Provide Strategic Commanders with timely and accurate information as requested.
- Complete and return all requests for information from NHSE, UKHSA or other governmental organisations.

Operational Responsibilities

- Support Hospital Ambulance Liaison Officers

- Liaise with local antiviral distribution centres or vaccination centres as required
- Reassure Staff and ensure PPE, policies and Procedures are adhered to.
- Maintain stock and complete audits of any item as requested.

13. Multi Agency Structure in Midlands region.

LRFs will be charged with the coordination of the multi-agency response. The COVID pandemic showed just how many agencies not normally associated with health care have a role to play in dealing with the outbreak. As with WMAS, other agencies will have to re-role staff to fill designated functions. This may impact on the organisation's normal functionality. As the LRF are based on Police service boundaries, WMAS could have to coordinate the attendance at, five SCG and TCG requests. The meeting frequency depends on the rhythm set by national reporting requirements.

SCG Representation is required from a Senior Commander, or a suitable Officer designated by the Incident Director.

TCG representation is required from a Tactical level Commander.

The coordination of attendance and meeting details are to be held by the TCC. After each SCG/TCG a report must be sent back to the Senior Command team. Those nominated individuals attending both SCG and TCG must use a standard format of report form to maintain the situational awareness of the Command team.

It is worth mentioning that during the COVID pandemic, the setup and management of hotels to deal with quarantining those coming not the country also made a large demand on WMAS officers.

The role of SCG is to:

- Determine and promulgate clear strategic aim and objectives.
- Overall responsibility for multi-Agency management of the emergency.
- Establish strategic framework of operations.
- Act as a reporting route to regional and central government.
- Minimise humanitarian, social and economic disruption.
- Formulate and implement media-handling and public communication plans.
- Planning beyond the immediate response to facilitate recovery.

The role of the TCG is to coordinate the local actions of Agencies as directed by the SCG plan.

14. Emergency Preparedness Response and Resilience (EPRR) - NHS England – Midlands.

EPRR provides a region-wide structure for the strategic command, control, communication, and coordination for all NHS organisations in the Midlands in response to a major incident. The EPRR structure is scalable to ensure that command arrangements are resilient and can be escalated or de-escalated as appropriate in response to an incident – they are based on 4 levels:

Level 0 - Incident contained to one health provider organisation.
Level 1 - Incident contained to one LRF or County boundary.
Level 2 - Regional level incident.
Level 3 - National level Incident.

15. Reporting arrangements.

It is likely that once UK Alert Level 3 is reached, the Department of Health and Social Care will request all NHS organisations to provide daily reporting to their NHSE Team for collation and feedback to the DH, this will be via existing data capture systems.

It is therefore important that WMAS has access to information such as:

- Total number of cases per 24 hours.
- Breakdown of suspected/confirmed cases.
- Resources available and absenteeism levels (HR).
- Information on all suspected & confirmed cases.
- Information on Cases and Deaths as recorded.
- Information on other impacts occurring for the previous day.
- Issues arising.

The requirements for reporting will be set by NHS England as the pandemic emerges. Incident reporting is fundamental to the identification of risk and response management and all staff are actively encouraged to use the WMAS existing incident reporting mechanisms. As the pandemic reaches the UK and numbers of cases increases, there will be a requirement for regular situation reports (SITREP) from all organisations, including WMAS. The frequency of reports required, will be defined by DHSC instruction depending on the severity of the pandemic.

No information or statistical statements should be released either internally or externally without the prior authorisation of the Chief Executive Officer or his nominated Strategic Commander.

16. WMAS reduction of transmission strategies.

Segregation

The transmission of virus material is accelerated where people work in proximity or in confined areas. Those staff identified as vulnerable will be self-isolating and given suitable work to continue from home when appropriate.

Upon the declaration of UK Alert level 3, WMAS should consider the cessation of all non-essential meetings, training and CPD events (thus making staff available for essential pandemic-specific training) The Strategic Commander will determine when that training starts, and which departmental staff will receive training. The use of digital media will be essential to maintain business. This will help reduce the potential for cross-infection.

Where possible and authorised, home working for all non-operational departmental staff will be encouraged. The Trust IT department will coordinate and supply suitable equipment.

Where remote working is not possible, WMAS will seek to implement the hierarchy of controls necessary and suitable to minimise transmission in non-clinical settings / the workplace.

EOCs and Command rooms will be designated Out of Bounds to all staff except those directly employed in this area. The Duty Manager in EOCs should implement strict entry control, limiting access to EOC staff only. This advice will be communicated internally to all staff and clear and prominent signage to this effect will be displayed at the entrance to EOCs.

Cleaning schedules and those products used for cleaning will be guided by Scientific advice. They will be adapted to suit the cause of the pandemic and its transmission method.

Outbreak management

Any staff member displaying signs or symptoms suggestive of respiratory infectious disease whilst at work should be immediately provided with a Type IIR mask, their line manager informed, tested (if available) and the staff member sent home to await confirmation.

This action will depend on the guidance appropriate for the disease type prevalent at the time.

All details of staff becoming ill at work should be cascaded to EOC (where operational) and to Strategic Control. Strategic Control will maintain a list of the numbers of staff off sick and identify any specific clustering which may need to be filled by redistribution of remaining staff. The WMAS Outbreak Management Plan must be followed.

The Trusts Test and Trace team must be informed of all occurrences and a dedicated inbox will be setup to ensure an accurate log and record of evidence is maintained.

Air Conditioning

There is no evidence to support that air conditioning systems need to be shut down however, as the situation develops and more information becomes available in relation to routes of transmission, this guidance may change. However, where air conditioning units serve more than one room their use should be minimised. Air Conditioning systems must be draw from a fresh air supply and set to extract, not recirculate.

In ambulance vehicles, the air conditioning units provide 20 changes of air per hour which is above hospital specification. Physical ventilation used if required, and consideration should be given to the use of saloon heaters if crew are wearing PPE and the patient has a fever. Welfare should be a consideration on longer duration transfers of patients or if higher levels of PPE are required for that virus.

Ventilation

Various organisations including the Health and Safety Executive have emphasised that adequate ventilation reduces how much virus is in the air. It helps to reduce the risk of transmission through aerosol pathways. Aerosol transmission can happen when someone breathes in small particles in the air. Measures, including the opening of windows where appropriate, should be taken to ensure ventilation is optimum. The Head Estates of Fleet will ensure vehicle design specification for ambulance vehicles is in line with the BS EN standards and where possible, Estates are suitably equipped with air handling systems.

Environmental considerations

On declaration of UK Alert Level 3, public access to all WMAS estate will be restricted to reduce population mixing and virus transmission. This message will be clearly communicated to staff and the public. The Strategic Commander will have the responsibility for approving public access during the remainder of the pandemic.

Enhanced cleaning will be undertaken across all WMAS estate. This will help reduce environmental contamination and the potential for vector transmission of contact-based transmission.

All staff will also be required to regularly clean their office space etc using appropriate processes using products such as Clinell wipes and alcohol hand gel, focusing on touchy points. The process must follow the guidelines set out by the Trust, based on the current guidance.

17. Ambulance Service Patient Pathway Options.

All patients contacting WMAS via 999 will be triaged to ensure the most appropriate action can be taken. WMAS will maintain normal service provision as far as practicable, however, for patients with symptoms, options include:

111 / 111- online

Casualties with relevant travel history displaying symptoms must access 111 and be screened as per Pathway's guidance. Patients will be directed to the most appropriate pathway.

Self-Care

If the ambulance crew deem that the patient is suitable for management in the community or other care facility and capable of performing self-care, casualties will advise on the best actions to take, ensuring that all actions taken are recorded on the EPRF.

NHS 111 POD assessment

As a successful trial during COVID 19, Casualties may be referred to NHS 111 Pods, located usually within hospital grounds, whereby a further assessment can be made by hospital-based staff without the requirement to enter the premises.

Hospital Conveyance

If the crew find that the casualty meets the acute admission criteria, transport will be arranged, via EOC, to the nearest hospital with appropriate isolation facilities. If appropriate, the hospital should be alerted prior to the arrival. The hospital may have instigated a "red or green" access system to segregate those with potential or actual infection from those without.

No escorts will be allowed to travel except for medical escorts, Police Officers, Prison Officers, designated family carer or Mental Health Nursing staff. These escorts must comply with Trust policy on PPE and reduce numbers travelling to a minimum.

Usually, no HEMS aircraft should be used to transport HCID or pandemic casualties due the difficulty and time taken to decontaminate the aircraft which will deny this valuable asset to other casualties. Current CAA guidance does not allow crews to fly without helmets. Therefore, WMAS aircrew will not be able to wear the PRPS hood unit. FFP3 masks are available to aircrew, risk assessments and advice should be sought for the suitability of the aircrew PPE relevant to the disease type being transported.

N.B. It is noted that symptoms described at the start of an outbreak may not be an exhaustive list or remain the same during the outbreak. To this end the Trust must work with NHSE and UKHSA to ensure that Pathways are updated with current symptoms and guidance.

Direction maybe given from NHS around changes to patient conditions attending specific acute sites these will be communicated to staff via Ops notices issued electronically to all staff.

18. Ambulance transport for Pandemic cases.

Initially, when cases are identified in the UK and our region, there may not be a fully evolved PPE plan or knowledge on transmission type. In these cases, the Trust should utilise higher levels of PPE and training that are available to HART and SORT. There are already plans in place to transfer HCID casualties across the country to specialist units. This also includes a disinfection plan for the vehicles and staff involved.
HART is a finite resource and has a primary role. The de-escalation of the requirement for HART to transport casualties should be considered as soon as possible.

Once information on appropriate PPE and transmission methods is understood and can be managed by WMAS crews, HART should be returned to normal duties.

WMAS staff should be trained and confident in dealing with the PPE required and when it is appropriate or not to wear that PPE. This guidance may change regularly and could appear contradictory. This must be managed through the TCC to ensure a single message origin, which allows for speed, control and accuracy of the information and PPE advised to all WMAS staff.

The cleaning of vehicles post transport should also be considered. The Trust has invested in equipment that will effectively disinfect rooms and vehicles during the COVID pandemic. The lessons learnt from this allow a quick and effective method of dealing with outbreaks. The cleaning fluids used by this system may need to be reviewed to ensure it matches with the issued guidance on that virus.

19. Communication.

Internal Communications with Staff

Intranet - A designated Pandemic page is accessible from the homepage of the WMAS intranet. At WHO Phase 3, this page will function as a portal to national guidance documents on pandemic planning. At WHO Phase 4 and above, the page will be regularly updated to include the latest information, guidance and strategies taken by WMAS to manage the demand. Information will be supplied by Tactical Command cell and added to site by comms dept. Updated IPC guidance can be found on the IPC SharePoint site.

Weekly Briefing - The Weekly Briefing will continue to be issued during a pandemic, although in a much-shortened format. This will include updates on the pandemic situation, and response actions, which need to be taken by all staff. The weekly briefing is also delivered, where requested, to staff's personal email accounts.

Updates - Regular updates will be made with staff from the Strategic Commander who will describe the latest situation, and actions which staff can take to help manage the demand. A range of technologies are available, which, if used, would reduce the risk of infection from large gatherings of staff. Briefing information will be provided by the Tactical Command cell and produced by comms dept.

External Communications

In addition to communicating with staff, it is essential that WMAS keeps the public aware of preventative measures, impact of the pandemic on Health Services and the strategies for prioritising resources. The LRF are also responsible for coordination and distribution of communication. WMAS will issue information specific to the Ambulance service, which is consistent with the National and Regional messages, this will help ensure transparent communications with the public and will be consistent with the Strategic plan.

20. Departments.

Finance

The Finance department will allocate the specific cost code for a pandemic, to be used by all departments, for all non-routine purchases during the response and recovery to the pandemic. This will help monitor costs incurred and will be useful for ongoing preparations of the accounts and reviewed by the responsible Strategic Commander and CEO.

Press Office

A pandemic communications strategy has been developed which outlines the arrangements, which will be taken by the WMAS Press and PR team to communicate with staff, stakeholders, media and the public. This has been developed in line with national and regional frameworks to ensure consistency of messages, but from a local, ambulance service, perspective. The WMAS Press and PR team will work from home at WHO Phase 5 and above.

Emergency Preparedness

The key role for Emergency Preparedness during the response to the pandemic, is to provide both Tactical and Strategic advice and support to the Command teams and to maintain effective communications with multi-agency colleagues, where possible, this will be undertaken remotely. A rota will be established to ensure Emergency Preparedness resilience.

It is likely that most event meetings will be cancelled, however, WMAS must ensure representation where essential meetings take place (these may or may not be related to the pandemic).

Distribution

Distribution will need to expect a huge increase of incoming stock sent from central NHS stores in addition to the increase in demand from the workload. These deliveries will need to be quality checked prior to going out to hubs. Sending details and photos to the TCC for verification and amendment of operational or clinical notices and adapting risk assessments as required. These deliveries from Central stock (push stock) will need to be checked to ensure they are used by the Trust. If not, they need to be held pending sharing out to other Trusts within the region. This will be managed by NHS midlands.

Due to the amount of stock arriving daily, there is an option to hold stock at hubs. The additional stock held will need to be managed daily. Fleet tracker (or similar) needs to be used to track the stock levels and create twice daily updates.

Early consideration may be given to increasing warehouse capacity, extension of working hours or use of other organisations to assist with the distribution of non-regular stock.

Patient Transport Service (PTS)

To maintain maximum capability to respond to emergency calls made by the public, WMAS could consider the phased redeployment of PTS resources.

This must be matched by the fact that requests for hospital discharges will be significantly increased. Sufficient capacity should be retained in PTS to fulfil these requests as it will assist with the overall management of the response. Where requests are received from Trusts who do not have a WMAS PTS contract, authorisation will be required from the Strategic Commander on a case-by-case basis. Any decision to reduce service provision

must be agreed with the Strategic Commander and CEO having consideration of the potential to cause risk to a partner organisation.

Current PTS activity has been assessed and levels of priority have been assigned, if PTS support to A&E was required, activity would be scaled down in accordance with the following model:

Level 1 – Routine / Rehabilitative: Day Hospital, Physiotherapy
Level 2 – Remedial / Invasive Treatments: Diabetics, Endoscopy
Level 3 – Priority / Critical: Cancer, CHD, Renal, Mental Illness, most of which will need to continue.

If PTS resources are used to provide support to A&E, these will be subject to the same cleaning and infection control guidelines as the A&E staff and vehicles this will include the same PPE. It should be considered that even if PTS are not directly supporting frontline operations, then the PPE used by PTS staff must be proportionate and appropriate.

Workshops and Fleet

The services provided by the Fleet department will be prioritised to ensure that essential work can continue. Less essential services, such as major vehicle services, maybe postponed, to ensure safety checks, essential maintenance and emergency repairs can be undertaken. During the COVID pandemic the Department of Transport suspended the requirement for MOTs and extended current MOT certifications. This risk needs to be assessed by the Head of Fleet Services and the Strategic Director of Operations and balanced against the staff absence rate incurred as the Trust may see staff shortages both in Operations (less vehicles required to be staffed) and Fleet Services.

When major vehicle services are stopped, advice will be issued to all VPO staff instructing them to regularly check all vehicle fluid levels, especially that of engine oil, to reduce the likelihood of engine problems.

The WMAS Fleet department, at WHO Phase 4, should ensure the maximum numbers of vehicles are serviced and available for operational use. At WHO Phase 6 out of hours fleet capability should be reviewed to ensure emergency repairs can be undertaken as soon as possible and the vehicle returned to operational service.

WMAS has the facility to utilise authorised private sector garages to undertake routine maintenance and repairs. However, it a consideration that these garages will have comparable issues around the resilience of staffing and availability of parts and instructions to close on Governmental instruction.

Infection, Prevention and Control (IPC)

It is vital during a pandemic that robust infection control procedures are adhered to which will reduce the likelihood of transmission of the virus.

The Trusts PPE procedure has been developed which sets out which PPE should be used by WMAS staff to reduce their personal risk and control the spread of infection. This will be bolstered by specific clinical and operational notices.

On confirmation of WHO Phase 5, WMAS will increase stocks of consumables as supply chains face significant disruption. These stocks will be ordered against the pandemic cost code, held by the finance department, to monitor expenditure in response to the pandemic.

The communications strategy outlines the mechanisms by which these infection control messages will be communicated, primarily to staff.

Human Resources

An all-encompassing HR Policy has been developed which describes the actions that will be required during the pandemic to maximise the availability and flexibility of WMAS staff. This document has been classified as confidential previously, if a copy of the Policy is required then representation to the HR department should be made.

This document will include the policy for those staff required to shield, as well as those required for staff self-isolating due to family illness, Test and Trace and actual illness.

With the agreement of the Chief Executive Office and the Director of HR and OD, the Pandemic Policy will be automatically initiated at UK Alert Level 2.

Other Departments

Other departments maybe required to take on additional work or duties for which they must be adequality trained and supported. The workload of some departments may increase dramatically and provision for this should be planned in at an early stage.

WMAS staff

Elevated stress levels amongst all staff can be expected during a pandemic, which may persist for considerably longer than the pandemic itself. Enhanced workforce occupational health and SALS support will help staff remain effective and manage stress.

During normal operations, approved external providers provide WMAS occupational health / SALS support, this arrangement will continue as normal.

In addition to this, support will also be provided via:

- Ongoing and current information on the pandemic and self-care strategies.
- Rest and recuperation areas at all workplaces to decrease burnout.
- Written and web-based workforce support and tip sheets.
- Contact details for other support agencies.

Before, during and after the pandemic, information will be made available to all staff regarding the likely impacts of the pandemic, self-coping mechanisms and methods of obtaining additional support. In addition to this, all staff should pay attention to the welfare of their colleagues and report any concerns to their line manager, who will take appropriate action.

21. Multi-agency Response.

Mass Treatment and Vaccination Centres

At UK Alert Level 2, WMAS will request from all ICS within the West Midlands, location details for all their Antiviral Distribution Centres. The locations of these centres should be provided to both Strategic Command, TCC and EOCs to ensure that CAD can be updated. WMAS will not have an onsite presence at antiviral or vaccination units.

Alternative Care Facilities

In response to the demand observed, it may be necessary for facilities to be set up to provide care to patients in addition to hospital Emergency Departments. These facilities may be NHS, Local Authority or privately owned. Details of these centres will be requested

at UK Alert level 2 from all ICS in the West Midlands; however, it is acknowledged that these arrangements may vary over the duration of the pandemic.

If a patient meets the criteria for consideration of admission to these facilities, the crew should contact SCC who will inform the CCG Local Coordination Centre as appropriate.

Antivirals

When applicable, UKHSA will deliver the criteria for antiviral medication and or vaccines for both the public and WMAS staff.

22. End of the Pandemic – Return to Normality.

As the impact of the pandemic subsides and it is considered by NHSE and UKHSA that there is no threat of further waves, WMAS will move into the recovery phase.

It is important that HR issues are monitored during the pandemic in order that vacancies can be filled. Return of non-operational staff to their posts must be monitored as they will returning to a large amount of work outstanding.

Delayed training activities will need to be reinstated quickly to ensure continued professional registration.

Again, the emphasis is on the rapid return to pre-pandemic service levels, whilst bearing in mind the residual impacts that the pandemic will have had across all sectors of the economy. The priority will be to restore pre-pandemic levels of service delivery in emergency activity first, with a gradual resumption of non-urgent and routine activity as resources become available. It is also important to note that staff may have been deskilled in activities they have not undertaken for the duration of the pandemic and additional training may be required.

It has been seen that post pandemic, those people avoiding hospital admission or contacting the acute services will return to calling the service. As they have deteriorated clinically, the need for hospital admission and the consequent bed blocking will have a huge impact on all NHS services. This may last for months and create considerable issues for WMAS.

The reintroduction of performance targets and curtailed services should be agreed between the WMAS Strategic Commander and NHSE Strategic Command.

23. Review and Inquiry.

WMAS will conduct an internal review to identify positive and negative learning. All staff will be invited to participate in this review via feedback forms, which will be made available. A structured debrief will be conducted by an appropriately trained and objective colleague from outside of WMAS possibly requested from LRF staff. The Emergency Preparedness team will be responsible for producing a report outlining the WMAS response, this report will be shared as appropriate.

All audit trail materials will be reviewed and archived in preparation for any wider inquiry that takes place. These documents will be stored in accordance with the trusts Data Protection Policy.

24. Exercising the plan.

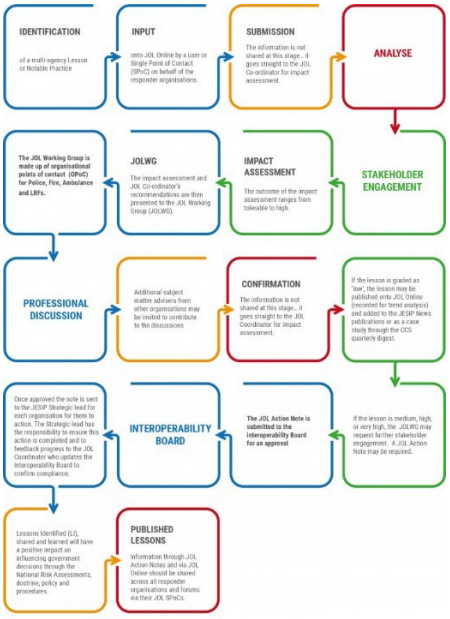
This plan will be circulated to all senior management for checking and verification.

WMAS Officers will participate in local and national exercises and workshops where appropriate. Which will ensure the plan is regionally understood and fits into LRF, NHSE and NHIP (UKHSA) regional planning assumptions.

The arrangements in this plan should only be deemed robust once they have been exercised, it is however, not possible to exercise all elements of this plan (e.g. cessation of services).

WMAS has a well-developed process of ensuring that the lessons identified from exercises and incidents can be appropriately considered in subsequent planning. Please see changes table on page 3.

Nationally the Joint Organisational Learning platform, hosted by Resilience Direct, is set up to collate national multi-agency lessons identified and ensure that lessons are shared quickly and effectively. WMAS has a SPOC for JOL and a process to ensure that any national lessons identified are brought into WMAS and acted upon.



Some elements of this plan are tested separately under the WMAS Business Continuity Plan. These are critical in the preparation for such an outbreak where human resource will be limited and will be the limiting factor in our response and management of such an outbreak.
Please note, the following appendices are example documents under Command-and-Control arrangements and will be instructed for use by the Senior Command Team in the event of standing up a Command Suite.

Annex A TCG/SCG Handover (stored on teams)

Once Completed, ensure the following are sent a copy:

1. . gold Commanders
2. . gold 1,2,3,4,5 depending on which team is on call
3. . operational tactical Commanders
4. . NILO

SCG or TCG	LFR	EVENT	Date	Time, start and end	Conference call, type. digital / phone	Meeting recorded?
Chair name	Chair Organisation					
Immediate issues affecting WMAS						
Immediate issues affecting other agencies						
Overview of incident or event						
Situational Update						
Agency update						

Actions				
Documents available on RD pages? YES / NO		Host organisation of RD pages		
Next Meeting				
Time	Date	Conference call type. digital / phone	Telephone number and pin or link	Who is covering

Annex B Report matrix example used during COVID 19

Time & Day	Document Title	Purpose	For whom	From whom	Distribution internal	Distribution External
0600 Daily	PPE audits	Monitor PPE stock and usage	Deputy Chief Officer	All Hubs and distribution	Distribution, Purchasing / Procurement	
When required	MIDSROC or Mids incident report	Immediate issues	All Midland Trusts	Midlands Region NHSE	Report checked with Strategic before sending	Return to MIDSROC
0830 Daily	Tactical Command Cell (ICC) daily return	Daily status report of PPE, Staffing issues, disease impact on hubs and or staff.	Strategic team, HR, NILO, Staff testing	Collation from ICC	Strategic team, HR, NILO, Staff testing	
1000 Daily	National COVID report	Staffing impact across PTS, EOC HART and Ops.	NACC	ICC	Strategic team, Report checked with Gold before sending	NACC to all Ambulance Trusts
1200 Daily	National PPE Submission	Submit the current IPC PPE status to the Foundry System for push stock delivery	National PPE Foundry Team	ICC	Strategic team, COVID Incident Director, TCC	
As required	Outbreak report	Record and monitor any outbreaks on Trust property	Strategic team, Staff Testing	IP&C lead	Strategic team, Staff Testing	
Weekly Monday	COVID board Report	Update board, summary of all reports	Strategic team, board	ICC	Strategic team, Board Members	
1600 Daily	Staff in hospital	Monitor and support staff and family links.	CEO	ICC, Staff Testing, SOM and OM.	CEO	
1700 Daily	Strategic Daily Update	Identify the Command arrangements and also highlight the abstraction / sickness changes	Strategic Team, HR, NILO, Staff Testing, TCC	ICC	Strategic Team, HR, NILO, Staff Testing, TCC	

Weekly	Midlands COVID 19 Summary	Inform all NHS regional Trusts on infection rates, vaccination rates and hot spots	All NHS Trusts regionally.	NHSE and National Institute for Health Protection (NIHP)	Strategic team	All NHS Trusts regionally.
Monthly	Board report	Summary of information	Board Chair	ICC	Board Chair, CEO	
Monthly	Alternative PPE	Summary of requests for alternate PPE for approval.	IP&C lead for approval and sample test	Hubs	Distribution, IP&C lead, ICC	
Monthly	PRPS audit	Current stock of PRPS suits and hoods.	Strategic team	ICC HART and Hubs		

Annex C **Daily Situation report example.**

COVID 19 SITREP	22/10/2021	@	0830

Surge
2

Data added on	UK Confirmed	UK Dead	
		28 Days	Certificated
21/10/2021	8,641,221	139,146	162,620

Totals as of	0600	COVID Extraction	EOC & Performance	A&E	PTS	Other	WMAS Staff total	WMAS in Hospital	WMAS In ICU/HDU
Staff Sickness Type		COVID Abstraction	7	30	1	1	49	0	0
		COVID Shielding	0	0	0	0	0		
		COVID T & T	0	1	1	0	2		
		COVID Sickness	11	41	12	2	80		
		Normal Sickness	35	124	67	14	295		
		Total	53	196	81	17	426		

Daily Swabbing Tests	Current Positive in Trust (last 10 days)	Total	WMAS PCR following LFT	Test & Release	Asymptomatic Testing	Self-Arranged Tests	WMAS Test	Pending results	Last Positive Case Recorded in Trust	
21/10/2021	32	67	3	20	0	15	29	33	22/10/2021	2 x NP, 1 X A&E Donnington, 1 x A&E Lichfield, 1 x A&E Hollymoor, 1 x A&E Stoke (uni student).

All Areas Stage 4 of Roadmap

Resourcing	Plan (Orb45)
	395@1800

	Health Advisors (Orb1161)	Clinical Advisors (Orb1178)
	56@1000	25@1400

EOC	Call Takers (Orb168)	Dispatch (Orb607)
	44@1300	31

Item	UOM qty	In Stock	Due in 7/7	Item	UOM qty	In Stock	Due in 7/7
PRPH Full Kits 3M (service spares in yellow bags, no battery)	Each	33	0	Tyvek Suit- XXXL	Each	50	0
PRPH Full Kits 3M	Each	21	0	Specialwear Tyvex compatible- Med	Each	154	0
PRPH 3M Filters	Each	6,280	0	Specialwear Tyvex compatible- Large	Each	500	0
PRPH Centurion Particulate filters	Each	69	0	Generic Tyvex Compatible type 3B- S	Each	0	0
PRPH Hoods (Asst styles)	Each, asst styles	412	0	Generic Tyvex Compatible type 3B- M	Each	0	0
Green PVC Rigid Sided Bag (empty)	Each	450	0	Generic Tyvex Compatible type 3B- L	Each	0	0
Green PVC Rigid Sided Bag inc 3M Hood	Each	14	0	Generic Supertouch Coverall XXL	Each	100	0
Aprons (manufactured blue thick style)	Each	26,000	30000	Generic Supertouch Coverall 3XL	Each	220	0
Aprons (Blue Tint Disposable Aprons)	Each	750	0	Generic supertouch coverall 4XL	Each	324	0
Aprons (Push Stock Green or White Ambulance Style)	Each	5,694	0	Infectious packs	Each	541	0
Halyard/Superieur/Unicare/Polyco Disposable Gloves (all sizes)	Box of 100/200	770	0	Shoe covers (qty is prs)	Pairs	0	0
Surgical Face Mask IIR (Push Stock)	Each	162,500	0	Boot Covers (qty is prs)	Pairs	530	0
Surgical Face Mask IIR (Winter Pressure Stock)	Each	31,800	0	Safety glasses	Each	27,960	0

Surgical Type IIR Sensitive Face Mask Crosstex	Each	16,250	0	Mop Heads	Each	9,200	3000
Surgical Type IIR Hypoallergenic Face Mask Dochem	Each	13,550	0	Red soluble bags	Packs of 50	70	0
Surgical Mask with ties (Type IIR)	Each	23,962	0	White laundry bags	Boxes of 300	30	0
Generic face visors (DS)	Each	3,986	0	1ltr Gentlewash for wall dispensers	Each	72	0
Alcohol Gel Tottles 50ml (personal size)	Each	1,248	0	1ltr Sanitiser Foam for wall dispensers	Each	426	0
Purell 300ml Desk Gel (compatible)	Each	1430	0	1ltr Moisturiser for Wall Dispensers	Each	373	0
Purell 500ml Desk Gel (compatible)	Each	192	0	Body Bags	Each	593	0
Packet Clinell wipes	Each pckt of 200	1797	0	Braun Thermoscan 7 IRT 6520	Each	219	0
Packet wipes PDI (compatible)	Each pckt of 200	0	0	Clinical waste bags (large)	Rolls of 25	160	0
Tyvex suit- small	Each	100	0	Clinical waste bags (small)	Rolls of 25	1416	0
Tyvek Suit - Med	Each	300	0	Clinical waste seals	Each	10,500	0
Tyvek Suit - Large	Each	0	0	Clorox Total 360 Disinfecting Cleaner	Each	40	0
Tyvek Suit - XL	Each	365	0				
Tyvek Suit - XXL	Each	446	0				

Annex D Board report example

Monthly COVID-19 Sitrep

dd/mm/yyyy – dd/mm/yyyy
Report Created dd/mm/yyyy

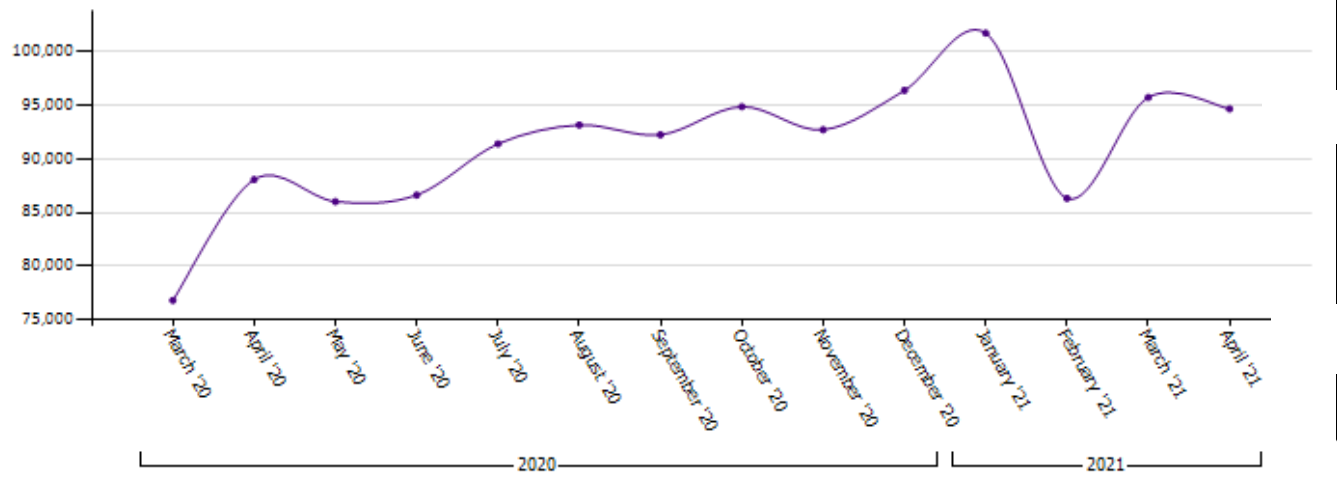
Welcome to the WMAS Covid-19 monthly report.

The information contained in this report has been condensed and summarised from the main activities of the Senior Incident Response Management team and key information feeds for the Operational Delivery units of the Trust.

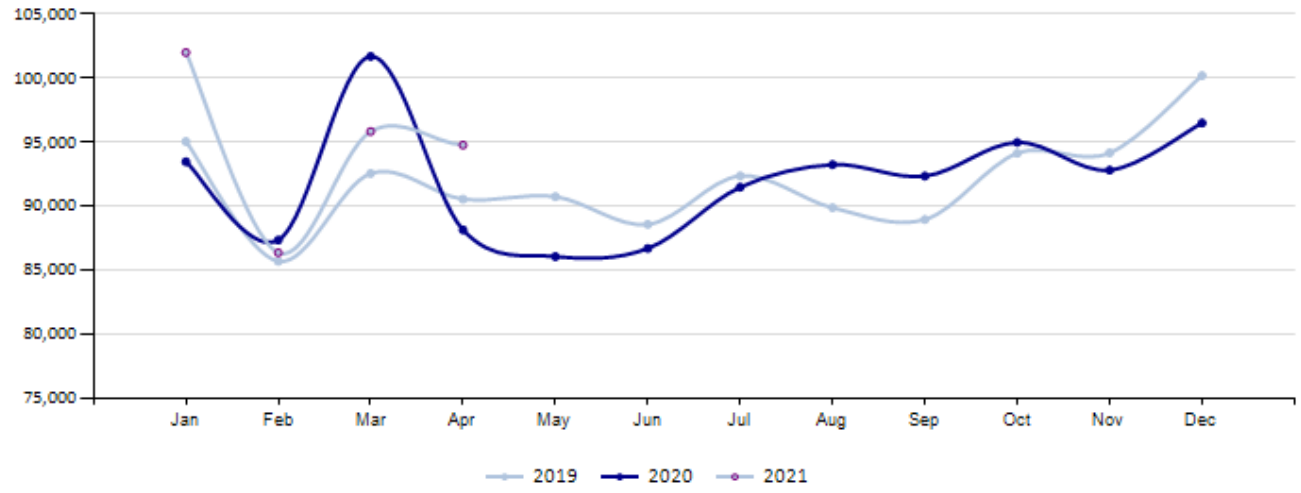
Data captured in this report has been taken from ORBIT report 1120 (unless otherwise stated), which provides information on a monthly basis.

Welcome to the WMAS Covid-19 monthly report. The information contained in this report has been condensed and summarised from the main activities of the Senior Incident Response Management Team and key information feeds for the Operational Delivery units of the Trust.

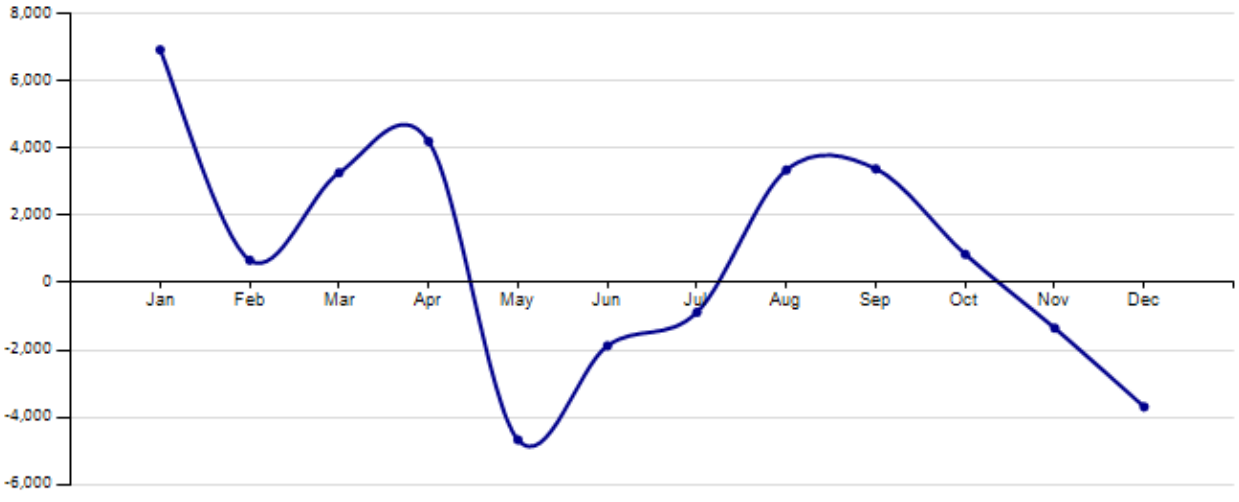
Monthly 999 Incident Activity



Monthly Emergency & Urgent Incidents Compared to Previous Year



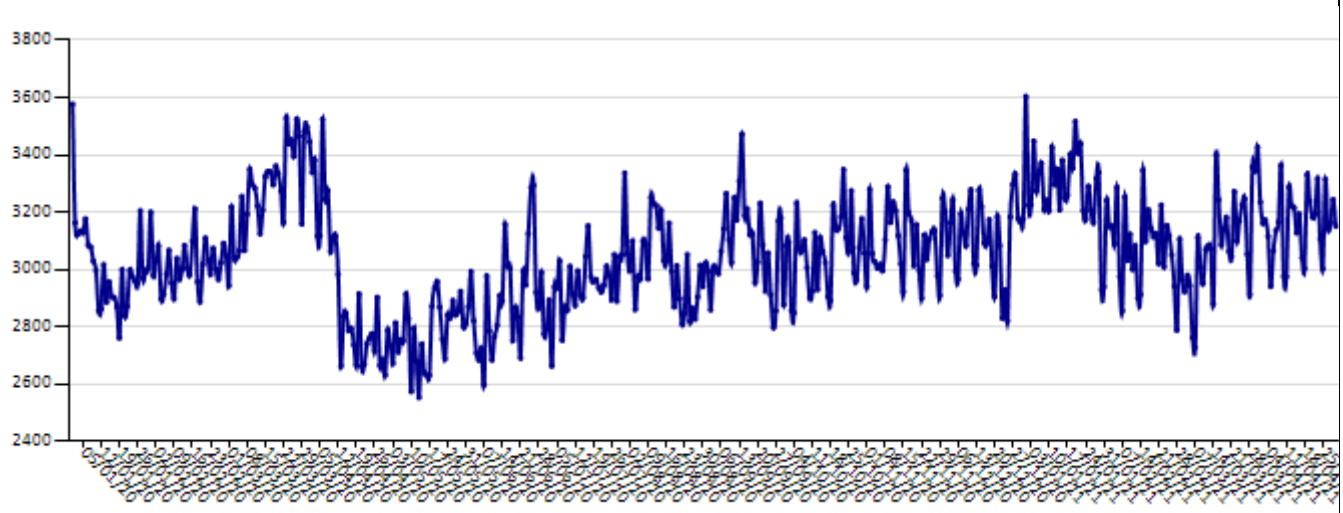
Monthly Case Difference Compared to Previous Year



Example Text

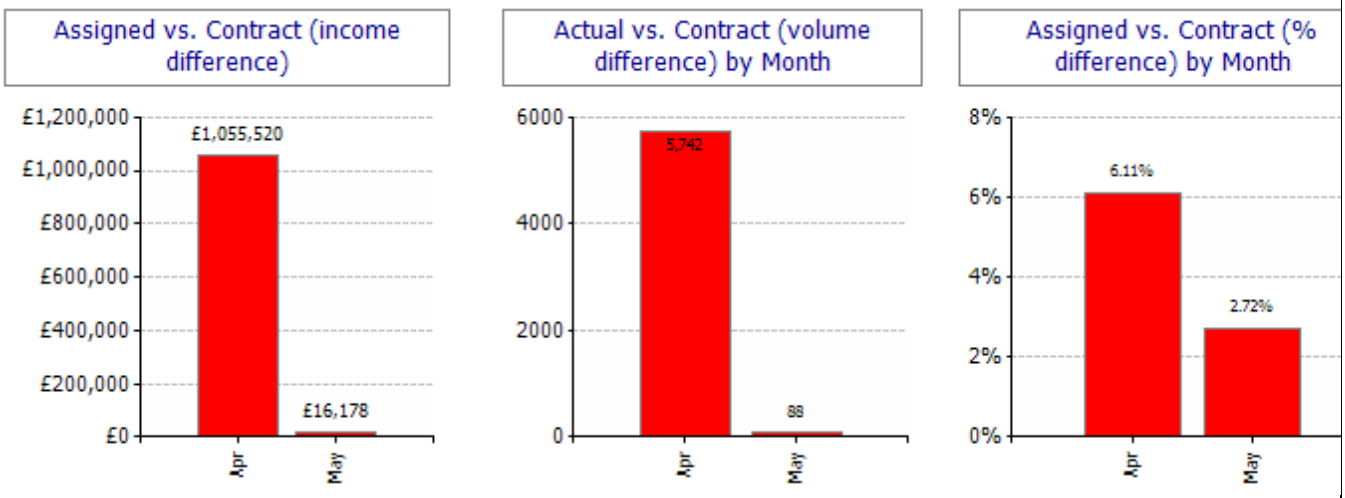
During April, 999 activity plateaued and has started to declined in comparison to March. Monthly emergency and Urgent incidents compared to 2019 have been significantly higher. In comparison to 2020, incident numbers have been more stable, mirroring the pattern of activity in 2019.

Daily Incident Volumes



The daily incident volumes decreased significantly in March 2020 which coincided with the commencement of the first lockdown. There was a gradual increase, followed by a plateau in November, which again coincided with the second lockdown. Incidents then increased in December to the highest volume since January 2020, and then decreased over the next two months, in line with the third lock down. Incidents increased from then until late March where there was a slight decrease.

Year to date Contract Position 01/04/2021 to 30/04/2021



WMAS Response Status

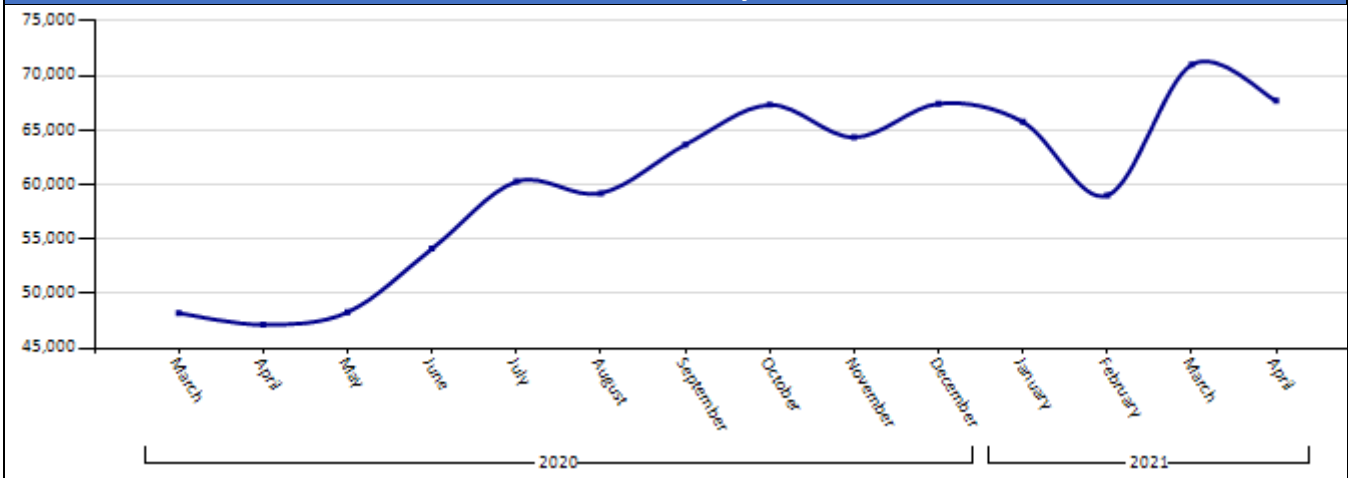
WMAS REAP Level	WMAS Surge Level	WMAS COVID-19 Level
Level 1	**Level 1**	**Level 1**

Throughout most of March and April, WMAS was the only ambulance trust be at REAP Level to 1. The below is a national summary of REAP statuses as of the 30th April 2021, taken from the Proclus Dashboard. All 7 ambulance trusts who were set to REAP Level 3 in February, remained at REAP level 2, with all trusts set to REAP 2 or below. WMAS remains at REAP 1 along with one other Ambulance Trust.

Trust Status

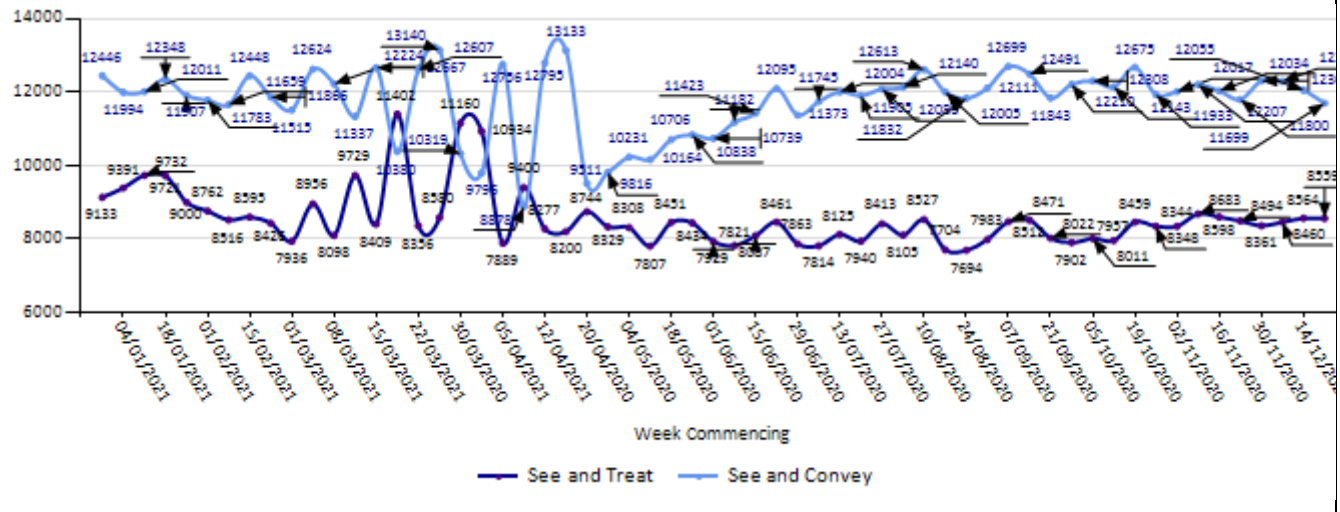
	EE	EM	LA	NE	NW	SC	SE	SW	WM	YA	IW	WA	S
REAP	2	2	2	2	2	1	2	2	1	2	2	2	

PTS Activity



PTS activity has decreased throughout April, although activity remains above demand seen in October and December. Hospitals are balancing routine outpatients' appointments against significant increases in demand due to admissions since the release of lockdown.

Conveyances & Non-Conveyances (VNR)



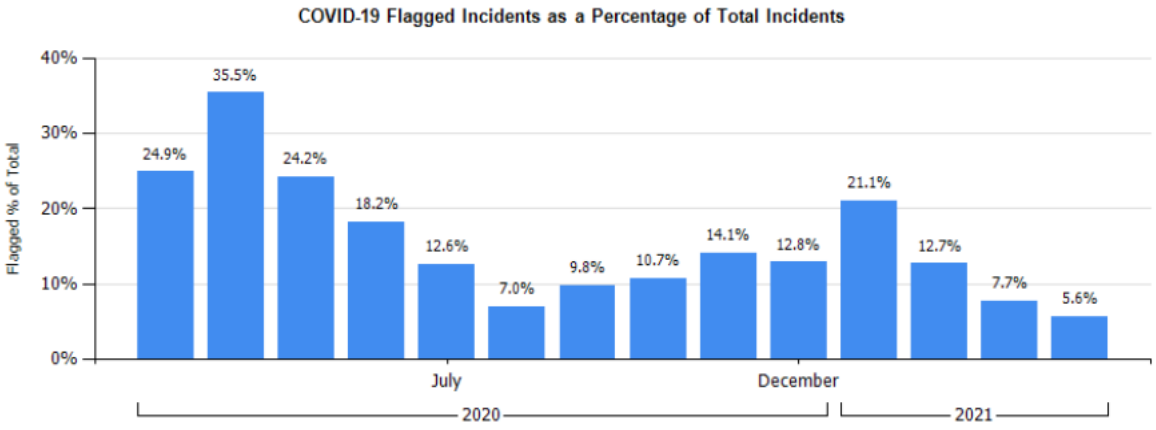
Both see and treat and see and convey cases fluctuated between March and April – during the period of the first lockdown. See and treat cases then remained reasonably stable, whereas see and convey incidents gradually rose.

Calls Answered Vs Contract

Increased calls at the beginning of April was a result of easter weekend. Call volumes has settled throughout the month peaking on each weekend.

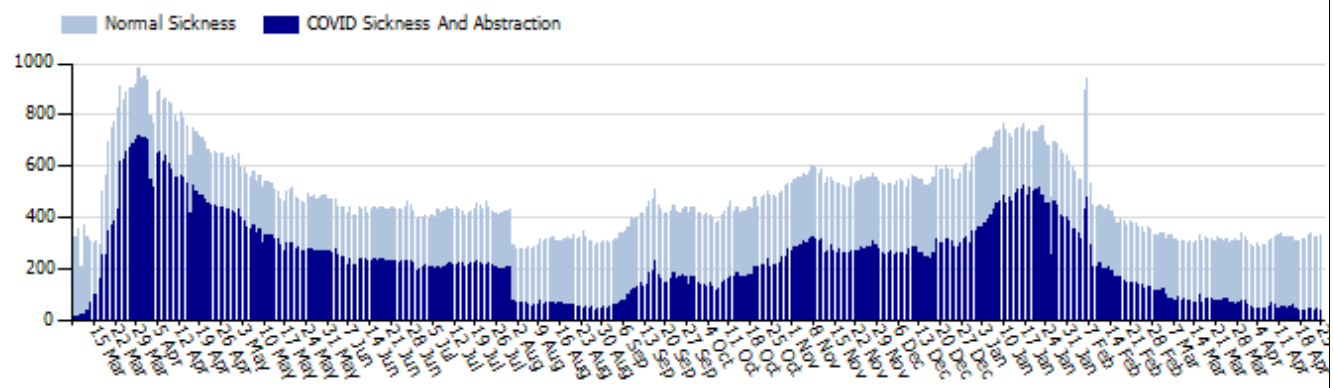
COVID-19 Incidents March 1st 2020 - April 2021 (ORBIT 1090)

Incidents	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	Total
All Incidents	96823	95506	87671	88416	93129	94564	93531	96032	93691	97419	103215	87351	96823	95506	1319677
Cases flagged in CAD	24149	33880	21229	16083	11726	6619	9173	10255	13227	12513	21770	11067	7443	5393	204527
Flagged % of Total	24.9%	35.5%	24.2%	18.2%	12.6%	7.0%	9.8%	10.7%	14.1%	12.8%	21.1%	12.7%	7.7%	5.6%	15.5%



Over the last 12 months, the number of COVID related cases that the trust responded to matches the trend seen throughout the UK with regards to the number of positive COVID cases reported. COVID-19 flagged incidents are currently the lowest seen since March 2020 at 5.6%.

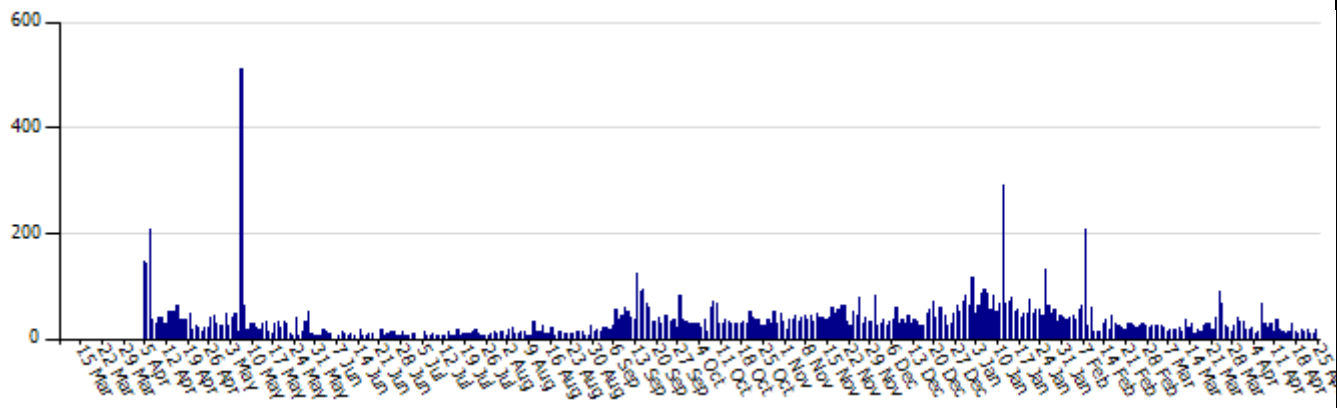
Staff Sickness



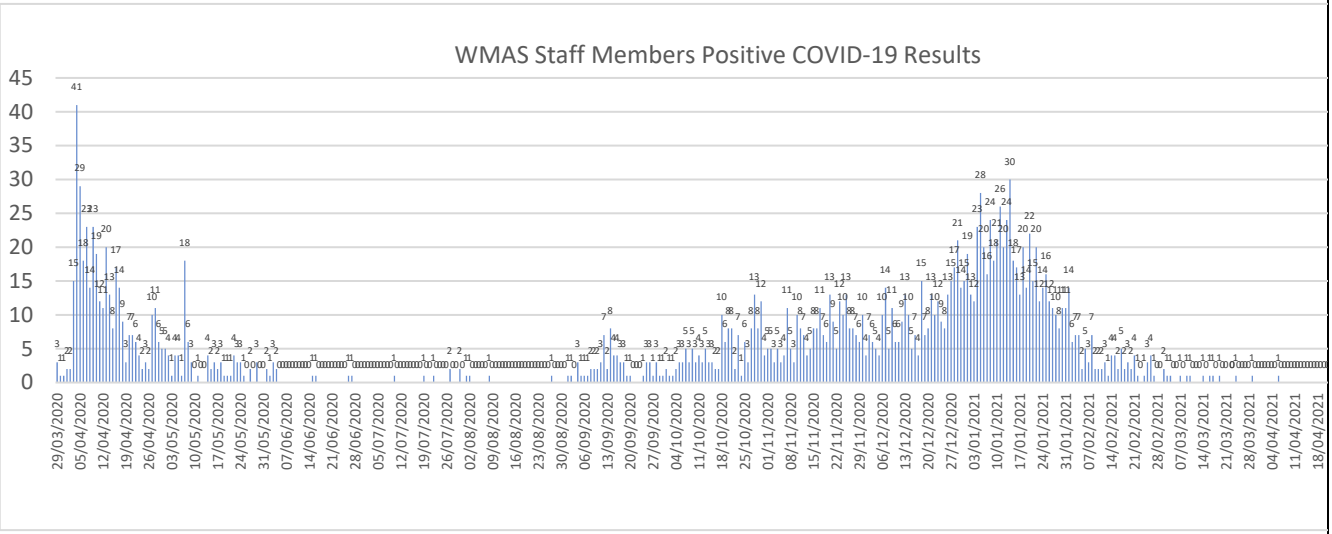
Staff Sickness Breakdown (30/4/2021)

	MP/TG	NP	A&E	PTS	Other	WMAS Staff Total	WMAS in Hospital	WMAS in ICU / HDU
COVID Test and Trace	3	2	8	1	0	14	0	0
COVID Abstraction	0	0	0	0	0	0		
COVID 12 Week Abstraction	0	0	0	0	0	0		
COVID Sickness	0	2	10	2	0	14		
Normal Sickness	30	57	142	45	15	289		
TOTAL	33	61	160	48	15	317		

Staff Swabbing Summary (01/03/2020 – 30/04/2021)



Staff Positive COVID-19 Cases



During April there were x9 detected COVID-19 infections which is a 76% reduction on cases reported in March, only x1 of these infections was detected in a WMAS staff member and the remaining x8 was infections were detected in the family members of WMAS staff. There were 609 PCR laboratory Tests completed which was a 27% reduction on the total completed in March. The majority of tests PCR Tests were arranged by WMAS and only 16% were completed by second pillar providors, as the majority of PCR tests are being processed by WMAS and UHB results are often quicker and staff are able to return to work.

The Test and Trace Team liase with UKHSA, who are highlighting Variants of Concern within the West Midlands, current the South African variant remains the variant of most concern and addresses are being flagged.
The strategy of Testing within West Midlands Service continues to be PCR Testing for all new staff and those attending significant training or exercises, twice weekly asymptomatic testing using LFT and PCR Testing for any symptomatic colleague or family member. Test and Trace activity continues using principles laid down by UKHSA, however the Trust is interested to understand how T&T guidance now alter dependant on vacination status.

Summary of Testing by Provider

	Total Offered	Total	Positive	Negative	Awaiting	Invalid	DNA
Wolverhampton Drive-In	1606	1281	300	937	0	10	34
Better2Know Home Test	190	190	65	125	0	0	0
Edgbaston	240	188	75	108	0	1	4
WMAS Community Test	7148	7148	921	6114	0	55	57
WMAS LFT PCR	670	670	562	108	0	0	0
Asymptomatic Test	2087	2087	29	2051	0	7	0
Self-arranged Test	1971	1971	562	1337	0	57	14
City & Sandwell	180	106	25	81	0	0	0

Summary of Testing Results

(YTD)	Swabs Offered	Swabs Sent	Positive	Negative	Awaiting	Invalid	DNA
Count	206177	13,641	2539	10,861	0	130	109
% of Swabs Sent		100%	18.6%	79.6%	0.0%	1.0%	0.8%

Test Results by NHS Ethnic Categories (Period Start to 30.04.21)

* Exclude DNA, Invalid and Wait	Total	Positive	% Positive	Negative	% Negative
Total of all Tests*	13,588	2,536	19.0%	10,814	81.0%
Non BAME Total*	7,770	1,544	20.1%	6,125	79.9%
BAME Total*	948	199	21.6%	721	78.4%
Unknown and Not Stated	4,870	793	16.7%	3968	83.3%

Fleet Availability (30/04/2021)

	% Available	VOR	Due Back	Predicted	Target %	Total Fleet
A&E DMA	99.06	5	0	5	98.44	514
A&E RRV	100.00	0	0	0	100.00	22
PTS	94.00	25	?	?	97.68	386

The fleet department continue to work effectively in ensuring a low VOR rate, ensuring that all vehicles are returned to service at the earliest opportunity. The available percentage of fleet as of the 30/04/2021 is shown above target.

NHS Foundry Submission (30/04/2021)

STOCKTAKE SUBMISSION FORM

Choose Region Midlands

Choose Reporting Entity WEST MIDLANDS AMBULANCE SERVI...

Reporting Date 30 April, 2021

You can now submit weekend stock on Fridays

Load Last Processed Submission

Submit

View 0 Pending Submissions

Latest reporting date: 2021-04-29
Submitted at: 2021-04-29T12:06:53.3
*** Please note that successful submissi**
15 minutes for processing and cleanin
available in the 'Load Last Submission
does not load future entries for dates

Key Reporting Categories	Current Stock Level (?)	Estimated Daily Usage (?)	Days Until Stockout Override	Days Until Stockout	Last delivery feedb
Aprons - Heavy Duty 35 Microns - Green - Flat Pack	0	0			no delivery require
Aprons - Heavy Duty 35 Microns - White - Roll	0	0			no delivery require
Aprons Standard Thickness - White - Flat Pack	0	0			no delivery require
Aprons Standard Thickness - White - On Roll	0	0			no delivery require
Body Bags (Adult)	833	1		833	no delivery require
Body Bags (Bariatric)	0	0			no delivery require
Body Bags (Child)	0	0			no delivery require
Body Bags (Infant)	0	0			no delivery require
Clinical Waste Bags – Orange (Large 59L+)	0	0			no delivery require
Eye Protection (Goggles)	33193	32		1037	no delivery require
Eye Protection (Visors)	27609	89		310	no delivery require
Face Mask FFP2	0	0			no delivery require
Face Mask IIR (Ear Loops)	215600	15014		14	no delivery require
Face Mask IIR (Ties)	13750	0			no delivery require
FFP3 Mask 3M 1863+	0	0			no delivery require
FFP3 Mask 3M 9330+	0	0			no delivery require
FFP3 Mask Alpha Solway H	0	0			no delivery require
FFP3 Mask AlphaSolway MM3S ALP 3030V	0	0			no delivery require
FFP3 Mask Draeger X-Plor 1730	0	0			no delivery require
FFP3 Mask Fang Tian FT-045A	0	0			no delivery require
FFP3 Mask GVS F31000	0	0			no delivery require
FFP3 Mask Honeywell 3207-D NR	0	0			no delivery require
FFP3 Mask HY9330	0	0			no delivery require
FFP3 Mask HY9632	0	0			no delivery require
FFP3 Mask Medcom M53010S-wh	0	0			no delivery require
FFP3 Mask Medcom M53014S-WH	0	0			no delivery require
FFP3 Mask Medicom M53214S-WH-UK	0	0			no delivery require
FFP3 Mask Meixim 2016V	0	0			no delivery require
FFP3 Mask Valmy VSP352TF-07C	0	0			no delivery require
General Purpose Detergent - Granules	0	0			no delivery require
General Purpose Detergent - Liquid	0	0			no delivery require
General Purpose Detergent - Tablets	0	0			no delivery require
Gloves (L) - Non-Sterile Nitrile (6N) Standard Cuff	470000	5090		92	no delivery require
Gloves (M) - Non-Sterile Nitrile (6N) Standard Cuff	311300	13341		23	no delivery require
Gloves (S) - Non-Sterile Nitrile (6N) Standard Cuff	165200	6558		25	no delivery require
Gloves (XL) - Non-Sterile Nitrile (6N) Standard Cuff	199200	1192		167	no delivery require

Gowns (XXL) - Non Sterile - surgical // Isolation // Without Towel	0	0			no delivery require
Gowns Sterile	0	0			no delivery require
Hand Hygiene Alcohol Gel - 151-500ml	4523	32		141	no delivery require
Hand Hygiene Alcohol Gel - 50-150ml	19830	163		121	no delivery require
Hand Hygiene Alcohol Gel - 501-1250ml	3352	10		335	no delivery require
Hand Hygiene Hand Wash 151-500ml	1338	0			no delivery require

Stock Levels on 30.04.21

Item	UOM qty	In Stock	Due in 7/7	Item	UOM qty	In Stock	Due in
PRPH Full Kits 3M (service spares in yellow bags, no battery)	Each	35	0	Tyvek Suit- XXXL	Each	52	0
PRPH Full Kits 3M	Each	37	0	Specialwear Tyvex compatible- Med	Each	575	0
PRPH Centurion filters	Each	442	0	Specialwear Tyvex compatible- Large	Each	1000	0
PRPH 3M Filters	Each	7,763	0	Generic Tyvex Compatible type 3B- S	Each	200	0
PRPH Hoods (Asst styles)	Each, asst styles	932	0	Generic Tyvex Compatible type 3B- M	Each	330	0
Green PVC Rigid Sided Bag inc 3M Hood	Each	92	0	Generic Tyvex Compatible type 3B- L	Each	590	0
Aprons (manufactured blue thick style)	Each	32,000	0	Generic supertouch coverall 3XL	Each	195	0
Aprons (Blue Tint Disposable Aprons)	Each	14,750	0	Generic supertouch coverall 4XL	Each	65	0
Aprons (Push Stock Green or White Ambulance Style)	Each	750	0	Infectious packs	Each	507	0
Halyard/Superieur/Unicare/Polyco Disposable Gloves (all sizes)	Box of 100/200	7361	0	Shoe covers (qty is prs)	Pairs	4700	0
Surgical Face Mask IIR (Push Stock)	each	113,400	0	Boot Covers (qty is prs)	Pairs	200	0
Surgical Face Mask IIR (Winter Pressure Stock)	each	0	0	Safety glasses	Each	3192	0
Surgical Type IIR Sensitive Face Mask Crosstex	each	43,150	0	Mop Heads	Each	15,000	0
Surgical Type IIR Hypoallergenic Face Mask Dochem	each	16,250	0	Red soluble bags	Packs of 50	23	0
Surgical Mask with ties (Type IIR)	each	13,750	0	White laundry bags	Boxes of 300	11	0
Generic face visors (DS)	Each	10,328	0	1ltr Gentlewash for wall dispensers	Each	184	0
Alcohol Gel Tottles 50ml (personal size)	Each	7,982	0	1ltr Sanitiser Foam for wall dispensers	each	773	0
Purell 300ml Desk Gel (compatible)	Each	1440	0	1ltr Moisturiser for Wall Dispensers	Each	192	0
Purell 500ml Desk Gel (compatible)	Each	778	0	Body Bags	each	223	0
Packet Clinell wipes	Each pckt of 200	1970	0	Braun Thermoscan 7 IRT 6520	each	457	0
Packet wipes PDI (compatible)	Each pckt of 200	0	0	Clinical waste bags (large)	rolls of 25	213	0
Tyvex suit- small	Each	150	0	Clinical waste bags (small)	rolls of 25	1362	0
Tyvek Suit - Med	Each	450	0	Clinical waste seals	Each	5,200	0
Tyvek Suit - Large	Each	900	0	Clorox Total 360 Disinfecting Cleaner	Each	58	0
Tyvek Suit - XL	Each	825	0				
Tyvek Suit - XXL	Each	825	0				

Stock held on A&E Operational Hubs (30/04/2021)

Mask	Thick Aprons	Blue Tint Aprons	Gloves XS	Gloves S	Gloves M	Gloves L	Gloves XL	Goggles	Visors	Body Bags	Coveralls S	Coveral
54150	43600	31150	450	519	617	885	631	27212	14100	610	1043	1015

Coveralls L	Coveralls XL	Coveralls XXL	Coveralls XXXL	Clinical Waste	Hand Soap	Moisturiser	Hand Sanitiser	Tottles	Desk Pump	Tympanic	Clinell Wipes	Swa
1207	1319	1634	1420	867	725	629	2047	7835	845	35	572	3

Stock held on PTS Operational Hubs (30/04/2021)

Mask	Clinell Wipes	Thick Aprons	Blue Tint Aprons	Tottles	DeskGel	Wall Hand Sanitiser	Moisturiser	Liquid Soap	Tissues	Gloves XS	Glove
35900	661	29040	22450	3998	1413	528	399	421	2016	279	47

Gloves M	Gloves L	Gloves XL	PPE Kits	Goggles	Visors	Clinical Waste	Swab Kits	Tympar Thermom
456	498	425	1248	2789	3177	523	0	1

PPE Mutual Aid (ORBIT 1069)

Stock Sent in Last 14 Days			
Trust	**Arranged By**	**Date**	**Stock**
None	None	N/A	None

PPE Mutual Aid Summary - 9th March 2020 – 30th April 2021	
Summary Type	**Volume**
3M PRPH Hoods	200
Aprons	439,480
Body Bags	65
Clinical Waste Bags	43,700
Coveralls	14,100
FFP3 Masks	48,770
Fit Test Kits	70
Glasses/ Goggles	72,940
Gloves (boxes)	2,310
Gowns	6,610
Hand Hygiene	4,070
PRPH Centurion Filters	312
PRPH Centurion Kits	80
Surgical Masks	57,000
Tympanic Therm.	30
Visors	30,163
Wipes	80

General Notes & Commentary

- The Tactical Command Cell has recently been relocated to Navigation Point, and is now co-located in the same room as the NACC (National Ambulance Co-ordination Centre) Manager, who is on duty from 0800-2000 daily. The Tactical Command Cell is staffed by one of the Tactical Incident Commanders at all times on rotation. Since the relocation, and movement in the Senior Command Team, the room is now overseen by Jeremy Brown (ACAO and Integrated Emergency and Urgent Care Director).
- April saw the implementation of Step 2 of the the roadmap out of lockdown. On the 12th of the month, non-essentail retail stores, personal care premises, public buildings, indoor leisure facilities and outdoor hospitality venues reopened.
- From the 1st April the shielding advice for the clinically extremely vulnerable ceased.
- To date, more than 34 million people in the UK have received at least one dose of the coronavirus vaccine, with Government plans in place to vaccinate the rest of the adult population, a further 21 million people by the end of July. Almost 15 million people in the UK have received their second coronavirus vaccine.
- Social distance arrangements in all Trust locations continue as does the regualr COVID secure monitoring.
- There is ongoing focus to ensure that the level of PPE being provided to the Trust remains adequate, with regular monitoring of staff compliance with PPE.

End of Document

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Executive Performance Dashboard
December 2023

Activity and Performance

Measure	Month	YTD	Monthly Trend
Category 1 - Mean Target 7 mins	08:22	08:14	
Category 1 - 90th Target 15 mins	14:39	14:29	
Category 1 T - Mean Target 19 mins	09:46	09:29	
Category 1 T - 90th Target 30 mins	17:39	17:05	
Category 2 - Mean Target 18 mins	46:22	35:33	
Category 2 - 30 mins Target 30 mins	46:22	35:33	
Category 2 - 90th Target 40 mins	105:35	79:46	
Category 3 - Mean Target 60 mins	214:55	161:25	
Category 3 - 90th Target 120 mins	569:22	420:43	

Measure	Month	YTD	Monthly Trend
Category 4 - Mean Target 180 mins	251:31	189:02	
Category 4 - 90th	604:51	490:02	
HCP 2hr - 90th	625:06	597:59	
HCP 4hr - 90th	553:51	807:13	
Call Answer (999 only) 95th	00:28	00:05	
Number of 2 min call delays	378	1017	
Number of Handovers >60 minutes (ED only, NHSE compliant post Oct 23)	9105	55825	
% of Handovers < 30 mins (ED only, NHSE compliant post Oct 23) Target 95%	62.1%	69.7%	
% of Handovers < 15 mins (ED only, NHSE compliant post Oct 23) Target 65%	27.5%	31.6%	

Workforce

Measure	Month	YTD	Monthly Trend
Sickness (Target - top quartile of all Amb Services)	5.7%	4.5%	
Appraisals (YTD)	95.8%	95.8%	
Mandatory Training E&U (YTD)	74.1%	74.1%	

Measure	Month	YTD	Monthly Trend
Mandatory Training PTS (YTD)	76.8%	76.8%	
Number of Freedom to Speak up Enquiries	3	62	

Clinical Quality & Safety

Measure	Month	YTD	Monthly Trend
Total Incident Forms	906	7740	
No. of RIDDORS	11	73	
No. of Verbal Assaults	153	1304	
No. of Physical Assaults	45	511	
Complaints	32	312	
PALS	184	1714	
Compliments	171	1770	

Measure	Month	YTD	Monthly Trend
Patient Safety (Total)	579	4409	
Patient Safety Harm	98	719	
Being Open (low harm only)	64	367	
Duty of Candour (moderate harm and above)	11	186	
Serious Incidents	42	187	
Claims	1	41	

Financial

Measure	Month	YTD	Monthly Trend
EBITDA £million (Plan £27.60m)	2.02	23.85	
Delivery of CIP Programme £million (Target £12.7M)	3.59	13.76	
Capital Expenditure £million (2023/24 £14.6m)	0.96	5.64	

Measure	Month	YTD	Monthly Trend
Better Payment Practice Code	94.2%	94.2%	
Agency Spend	0	0	

Clinical Quality & Safety

Measure	Month	YTD	Monthly Trend
Return of Spontaneous Circulation At Hospital (Comp)	not yet available	46.11%	
Cardiac Arrest Survival to discharge (Comp)	not yet available	22.70%	
Post ROSC Care Bundle	Not required in month	64.38%	

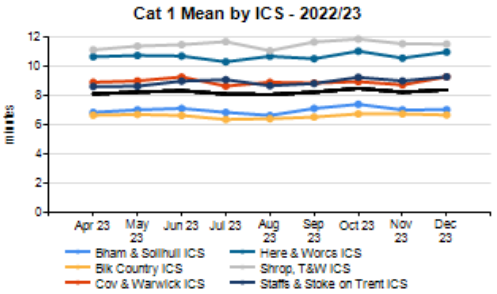
Measure	Month	YTD	Monthly Trend
STEMI Care Bundle	94.01%	96.00%	
Stroke Diagnostic Bundle	99.63%	99.45%	

PTS

Measure	Nov-23	YTD	Monthly Trend
Achieved KPIs	46	43	

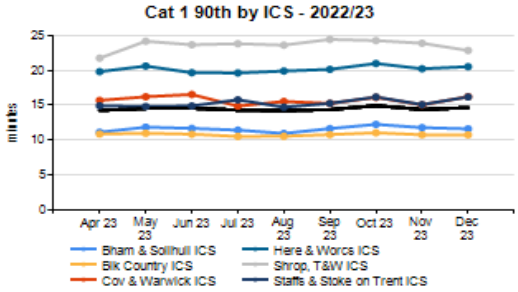
Measure	Nov-23	YTD	Monthly Trend
Failed KPIs	23	26	

Executive ICS Scorecard
December 2023



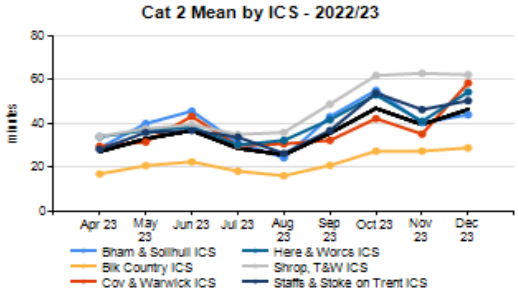
Priority	ICS	MTD	QTD	YTD
Cat 1 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	7:01	7:08	6:59
	NHS BLACK COUNTRY ICS	6:39	6:42	6:35
	NHS COVENTRY AND WARWICKSHIRE ICS	9:15	8:59	8:56
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	10:57	10:50	10:40
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	11:29	11:36	11:27
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	9:16	9:09	8:55
	WMAS	8:22	8:21	8:14

--------- WMAS



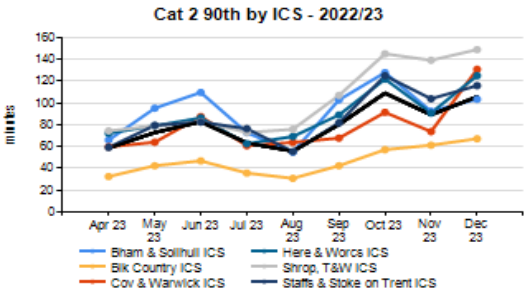
Priority	ICS	MTD	QTD	YTD
Cat 1 90th	NHS BIRMINGHAM AND SOLIHULL ICS	11:37	11:52	11:38
	NHS BLACK COUNTRY ICS	10:45	10:49	10:48
	NHS COVENTRY AND WARWICKSHIRE ICS	16:13	15:53	15:43
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	20:31	20:31	20:07
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	22:50	23:47	23:40
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	16:11	15:48	15:18
	WMAS	14:39	14:38	14:29

--------- WMAS



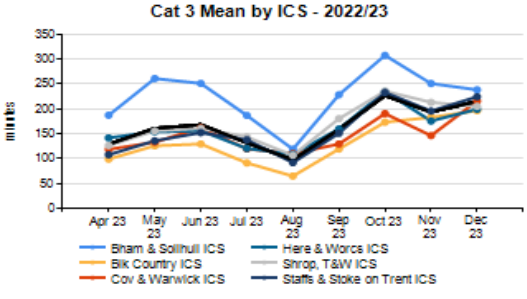
Priority	ICS	MTD	QTD	YTD
Cat 2 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	43:58	46:20	39:01
	NHS BLACK COUNTRY ICS	28:54	27:55	22:13
	NHS COVENTRY AND WARWICKSHIRE ICS	58:23	45:22	37:03
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	54:19	49:28	40:13
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	62:12	62:17	46:28
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	50:21	50:14	38:45
	WMAS	46:22	44:18	35:33

--------- WMAS



Priority	ICS	MTD	QTD	YTD
Cat 2 90th	NHS BIRMINGHAM AND SOLIHULL ICS	103:19	107:45	91:44
	NHS BLACK COUNTRY ICS	67:04	62:14	46:42
	NHS COVENTRY AND WARWICKSHIRE ICS	130:39	96:02	76:42
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	124:48	111:25	88:01
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	148:44	144:30	103:36
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	115:43	115:08	87:03
	WMAS	105:35	100:48	79:46

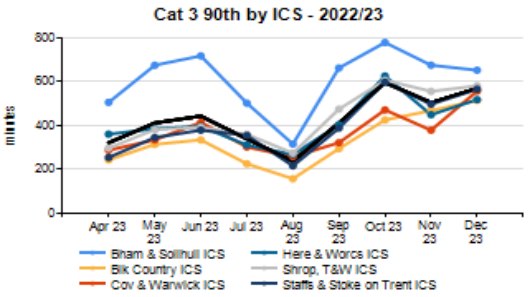
--------- WMAS



Priority	ICS	MTD	QTD	YTD
Cat 3 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	238:14	263:48	219:20
	NHS BLACK COUNTRY ICS	196:20	184:03	126:40
	NHS COVENTRY AND WARWICKSHIRE ICS	215:29	183:20	144:56
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	199:05	202:27	158:51
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	204:53	217:48	166:39
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	224:16	218:05	156:10
	WMAS	214:55	212:04	161:25

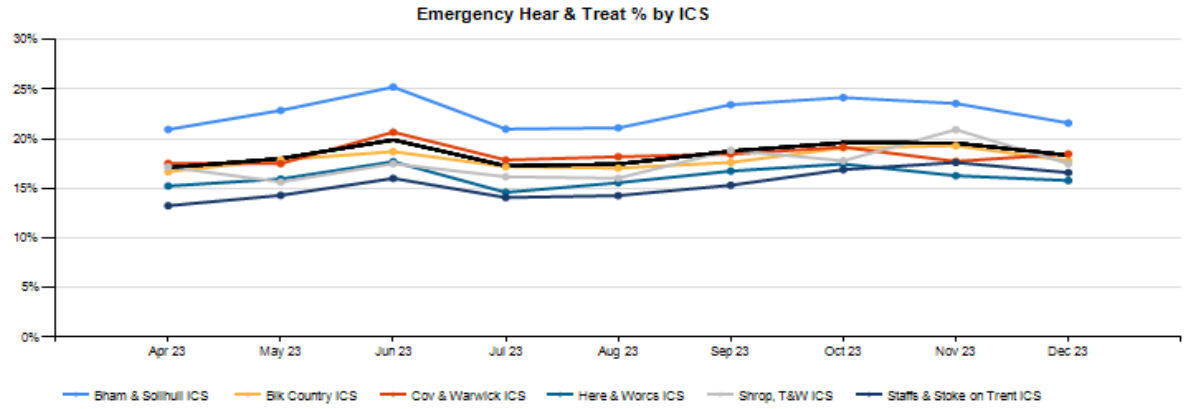
--------- WMAS

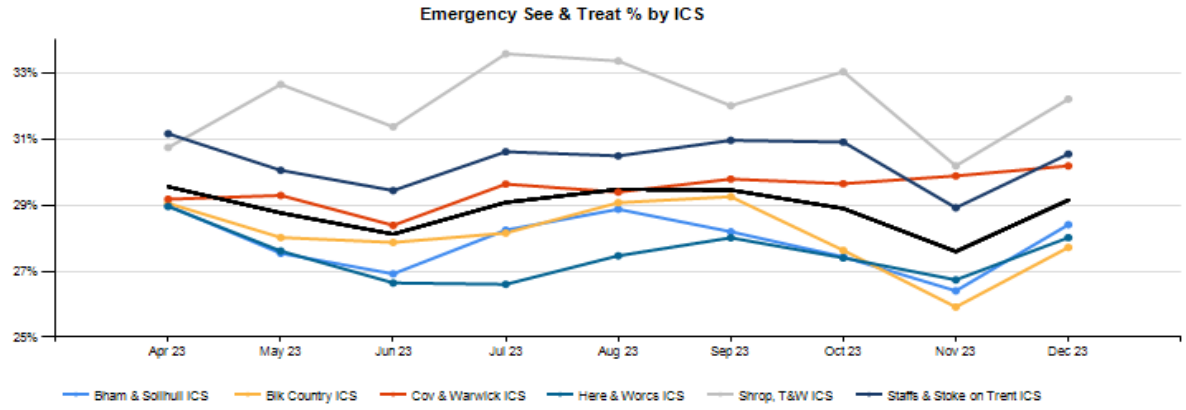
Executive ICS Scorecard
December 2023

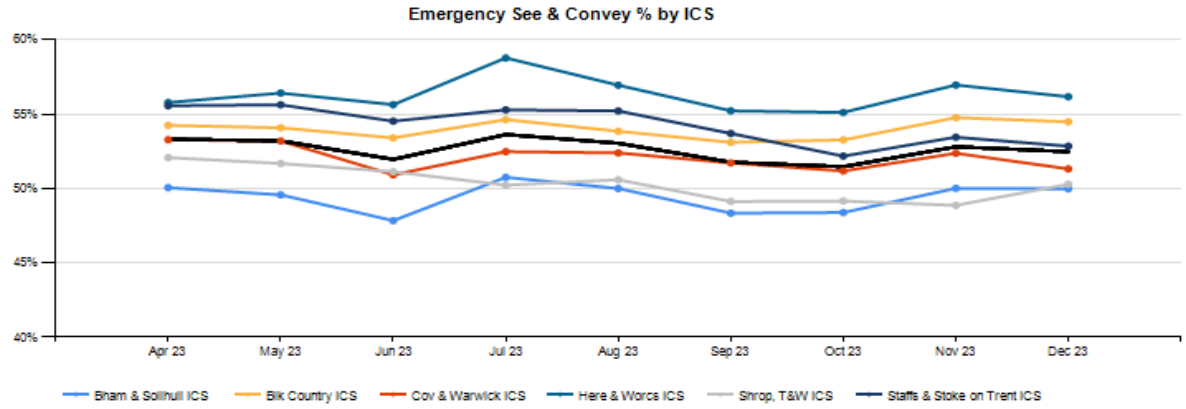


Priority	ICS	MTD	QTD	YTD
Cat 3 90th	NHS BIRMINGHAM AND SOLIHULL ICS	651:47	716:50	613:34
	NHS BLACK COUNTRY ICS	514:22	470:39	321:47
	NHS COVENTRY AND WARWICKSHIRE ICS	556:31	463:28	365:34
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	517:38	518:20	401:18
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	580:49	587:02	424:48
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	565:16	556:38	401:47
	WMAS	569:22	557:26	420:43

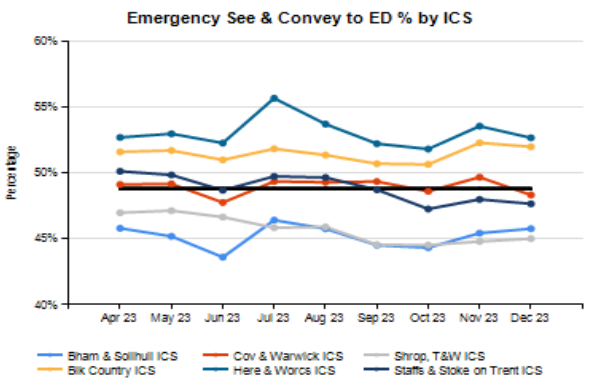
--------- WMAS

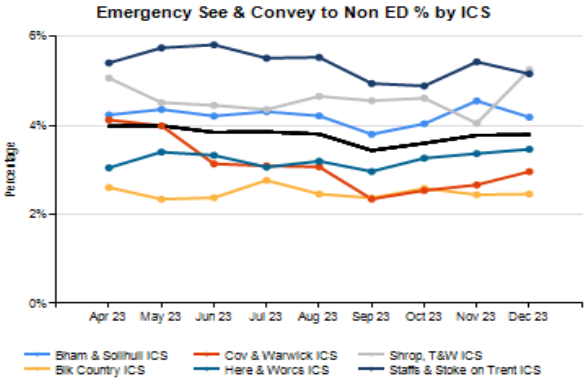


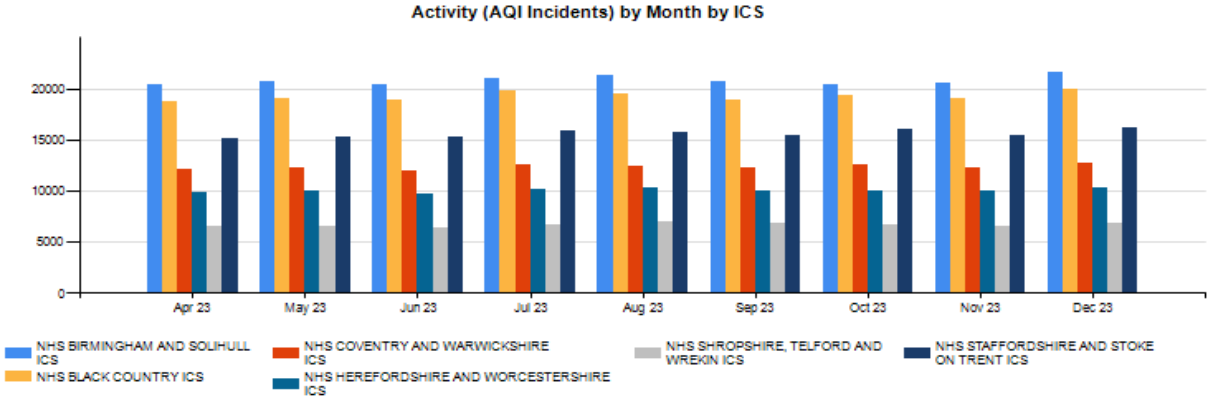


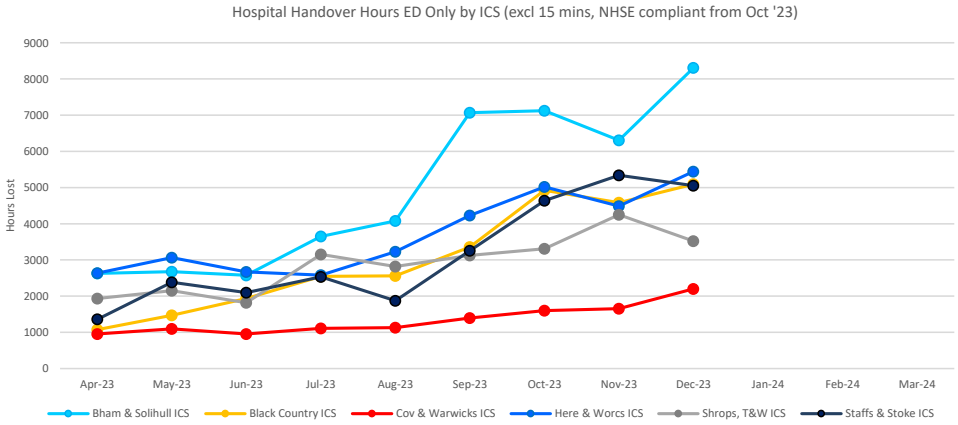


Executive ICS Scorecard
December 2023









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 08d DATE JANUARY 2024 PAPER NUMBER 08

Title	The Trust Charter of Expectations
Sponsoring Director	Chairman/Chief Executive Officer
Author	Governance Director and Trust Secretary
Purpose	To present the updated Trust Charter of Expectations for review and approval.
Previously Considered by	EMB has regularly reviewed the Trust Charter of Expectations pending approval by the Board of Directors and the Council of Governors.
Report approved by:	The Charter has been previously circulated to EMB colleagues for review.

Executive Summary

The Trust Charter of Expectations was first published by the Trust in 2011. It was drawn up to assist and explain the interaction between the various and linked governance of a Foundation Trust. At the time, the Trust was seeking authorisation as a foundation trust and it was regarded as good governance to have such a document to explain and clarify the various roles of not only the Board and Council, but also the Membership, Directors collectively and individually and the role of Governor. It also clarified the difference between the executive led by the CEO and non-executive roles and in particular the role of the Chairman. The document is primarily a resource document that is available as part of the induction programme for directors and governors. In addition, it has been a useful learning tool for those on development courses for aspiring directors.

The document is not required by regulation and forms part of a suite of governance documents complementing the NHSE Code of Governance (reviewed and published by the NHSE in April 2023, and reported to Board and the CoG), the Constitution and also Standing Financial Instructions. This version of the Charter aims to reflect the changes in the NHS landscape and also incorporate reference to the implementation of the Kark review as part of the review of the Fit & Proper Persons regulations, previously reported to Board by the Director of People in September and October 2023.

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)	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 08d DATE JANUARY 2024 PAPER NUMBER 08

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)				X
Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☐	Inclusivity	☒
	Accountability		☒	

Related Trust Objectives/ National Standards	This document is a useful reference document as part of the Well Led suite of documents, complementing the the Constitution, Standing Financial Instructions, the NHSE Code of Governance. It can be a useful evidence document as to how the Trust applies the above documents. In addition the governance structure of a foundation trust is prescribed in regulations (Schedule 7 to the NHS Act 2006, and as amended by regulations from time to time). The Trust Charter of Expectations shows how we apply the regulations.
Risk and Assurance	The Trust must remain compliant with its Constitution, CQC Registration and its regulations, in addition the published licence conditions. In terms of the NHSE Code of Governance it is compliance on the basis of "comply or explain". The Charter aims to clarify the various roles and functions within the governance structure of the Trust to maintain compliance. The Trust must review decision making processes in line with changes in the NHS structure.
Legal implications/ regulatory requirements	The Trust through its Constitution and governance structures are compliant with existing regulations, licence conditions and good governance as published from time to time.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 08d DATE JANUARY 2024 PAPER NUMBER 08

Financial Planning	There are no financial implications arising from this document.
Workforce & Training Implications	The document is a useful resource to explain the role and duties of individuals as part of the governance of the Trust. It has been used in the past by students undertaking development programmes.
Communications Issues	There are no direct implications.
Diversity & Inclusivity Implications	Not directly applicable although the Trust will always comply with regulations.
Quality Impact Assessment Undertaken	Not directly applicable within the context of this matter.
Data and Information Sources	The attached document is a resource and is accessible for all staff and governors.
The Board is requested to review the Trust Charter of Expectations, and pending the approval of the Council of Governors authorise its publication on the Trust's datix document system.	

TRUST CHARTER OF EXPECTATIONS

DATE APPROVED:	
APPROVED BY:	**Board of Directors**
IMPLEMENTATION DATE:	
REVIEW DATE:	
LEAD DIRECTOR:	**Chief Executive Officer**

Document Reference Number:	**CG – Policy – 001 (Version 6)**

Change Control:

Document Number	CG – Policy – 002
Document	Trust Charter of Expectations
Version	Version 5
Owner	Chief Executive Officer
Distribution list	All
Issue Date	
Next Review Date	
File Reference	CG – Policy – 002
Author	Trust Secretary

Change History:

Date	Change	Authorised by
29/09/2011	Agreed	Trust Board
/01/14	Agreed	Council of Governors
29/01/2014	Agreed	Board of Directors
27/05/2015	Agreed	Board of Directors
30/03/2016	Agreed	Board of Directors
08/03/2018	Reviewed and Role profile of SID updated and approved	Director & Governor Development Constitution Panel
28/03/2018	Reviewed and Role profile of SID updated and approved	Board of Directors
09/01/2024	Reviewed Updated to reflect the guidance on Fit & Proper Persons Test and also to reflect the Trust's revised licence and also the NHSE Code of Governance published in April 2023.	EMB
31/01/2024	Reviewed/approved	Board of Directors

CONTENTS

1 The Board of Directors

Role of the Board Directors

The primary responsibility of the Board of Directors of the West Midlands Ambulance Service NHS Foundation Trust (The Trust) is to provide governance and stewardship to the Trust in accordance with UK laws and regulations. It is established pursuant to the NHS Act 2006 as amended by the Health and Social Care Act 2012 and regulations implementing the Act.

There is a general duty of the Board of Directors to exercise its judgment in promoting the success of the foundation trust so as to maximise the benefits for the members of the Trust as a whole and for the public. NHS Improvement's Code of Governance emphasises that the role of the Board of Directors is to provide entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

It is crucial the Board of Directors at all times acts as a unitary board which is a concept where the Board of Directors – both Non-Executives and Executives – have agreed by taking the position of director to share the same liability. All directors have responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk, mitigation, values, standards and strategy and are collectively responsible for the exercise of the powers and the performance of the Trust. All directors have collective responsibility for taking actions which legally bind the Trust. All members of the Board as a unitary board are responsible for every decision of the board regardless of their individual skill or status. Non-Executive directors and executive directors alike share the same degree of accountability. All directors have a responsibility to challenge constructively the information and proposals made to the Board, but Non-Executive directors have a particular duty to challenge executive directors and should scrutinise their performance accordingly. The Board of Directors is also responsible for establishing the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, including the Nolan Principles and most importantly align those values with the NHS Constitution.

In a foundation trust, the Membership elects governors and the governors serve collectively as members of the Council of Governors. The Chair and Non-Executive directors are then appointed by the Council of Governors, and the Chief Executive is then appointed by the Non-Executive directors, which is subject to the approval of the Council of Governors, and the executive directors are then

appointed by the Non-Executive directors and the Chief Executive.

The Trust's business is conducted by employees and an executive team led by the Chief Executive Officer (CEO) with oversight from the Board.

The Board of Directors is responsible for the planning, organising, delivering and evaluating emergency healthcare provision within its region. It is accountable for the overall management and control of the service provision and is accountable to the Council of Governors for achieving the national and regional goals and objectives for the Trust.

The role of the Board of Directors, which sets the context for the profiles and expectations that are contained in this document, is to have collective responsibility for:

(a) Providing proactive and effective leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed;

(b) Making sure that the Trust complies with the conditions of its licence, its constitution, guidance issued by the Regulator, relevant statutory requirements and contractual obligations;

(c) Setting the Trust's strategic aims at least annually (in the forward plan), taking into consideration the views of the Council of Governors.

(d) Ensuring that the quality and safety of health care services, education, training and research delivered by the Trust;

(e) Ensuring the Trust exercises its functions effectively, efficiently and economically;

(f) Setting the Trust's vision, values and standards of conduct and ensure the Trust meets its obligations to its members, patients and other stakeholders and communicates them to these people clearly;

(g) Taking decisions objectively in the interests of the Trust;

(h) Taking responsibility for every decision of the board regardless of their individual skills or status;

(i) Always constructively challenging the decisions of the board and help develop proposals on priorities, risk mitigation, values, standards and strategy.

(j) Sponsoring, driving and modelling the appropriate culture, setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance.

(k) Safeguarding values and ensuring the organisation's obligations to its

key stakeholders are met.

(l) Facilitating the understanding on the part of Governors of the role of the Board and the systems supporting its oversight of the Trust.

(m) Monitoring and driving the implementation of Equality and inclusivity in the operation of services and employment opportunities with the Trust.

Specifically, the Board carries out the role envisaged within the NHS Improvement Code of Governance, namely that its role is to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed.

Board Composition

The number of members of the board of directors, the minimum required membership and also the period of office of the Chair and Non-Executive directors, as well as the process of appointment to the Board of Directors are set out in the Trust's Constitution. The size of the board is a matter for the Trust and is also set out in the constitution. However, the size of the board should provide for diverse views and opinions among directors whilst enabling the participation of each director in a substantive manner. A balance is required between the board being too small to enable diverse views and opinions and too large to prevent each director being able to participate.

Directors on the board of directors should meet the "fit and proper" persons test as described in the provider licence issued by the Regulator and also the CQC fundamental standards requirements as set out in regulations. It is essential that in making an appointment to the Board of Directors that the Trust abides by the CQC fundamental standards which include provisions on appointments to senior positions in organizations' that are subject to CQC regulations. The duty on providers not appoint a person or allow a person to continue to be an Executive or Non-Executive Director or equivalent unless they are a fit and proper person. The ultimate responsibility rests with the Chair.

Fit and Proper Persons

- The Individual must:
  - Be of good character
  - Have qualifications, competence, skills and experience necessary for the office/position
  - Be able by reason of their health, after reasonable adjustments, to properly perform intrinsic tasks
  - Not be excluded
  - Not have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement in the course of carrying on a regulated activity or providing an equivalent service outside England
- When assessing 'good character' the matters to be referred to include:
  - Whether the person has been convicted in the UK of any offence or convicted elsewhere of an offence that would be an offence in the UK
  - Whether the person has been erased, removed or stuck off a professional register maintained by a regulator of health care or social work professionals.
- Element of discretion – can the person be relied on to do the right thing.

When the Governors are considering the appointment of a Chair or Non-Executive Director, the Council of Governors should take into account the views of the board of directors on the qualifications, skills and experience required for each position and also the obligations under the CQC fundamental standards requirements.

Board Member Duties and Responsibilities

Directors are in a position of Trust and as such they owe certain duties to the Trust. Their primary duty is to the success of the Trust and it is in the best interests of the Trust that directors must have in mind in their decision making.

There are serious consequences of non-compliance. There is a Statutory duty of Candour owed by the Trust. The Board should make sure that there are systems in place to ensure all staff, regardless of seniority or permanency know about the organisations responsibilities. Being open and transparent consists of:

- 'Open' means
  - Enabling concerns and complaints to be raised freely without feet and questions asked to be answered.
- 'Transparent' means
  - Allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

All directors should be able to allocate sufficient time to the Trust to discharge their responsibilities effectively.

Non-Executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

The Non-Executive directors are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, executive directors, and in succession planning.

The Remuneration and Nominations Committee should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the members of the committee should evaluate the balance of skills, knowledge and experience of the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both Executive and Non-Executive directors, including the chair.

One of the Non-Executive directors must be appointed as the Senior Independent Director (SID) by the Board in consultation with the Council of Governors. The SID should be available to members of the board (and governors) if they have concerns which contact through the normal channels has failed to resolve or for which such contact is inappropriate.

The Chair will also convene regular meetings with the Non-Executive directors without the executive directors being present. At least annually the SID will lead the Non-Executive directors in carrying out an evaluation of the chair's performance, after consulting the Council of Governors. The evaluation can be undertaken on such other occasions as are deemed appropriate by the Senior Independent Director following representations' made by other members of the Board of Directors or the Council Governors.

The key duties of each member of the Board that are set out in the Health and Social Care Act 2012 include a duty on the individual member of the Board to:

- act within powers set out in the constitution and other governance documents such as the Standing Financial Instructions;
- promote the success of the Trust for the benefit of the population it serves through its Membership, especially in the following areas:
    - The likely consequences of any decision on the long term sustainability of the Trust
    - The interests of the employees of the Trust
    - To foster the Trusts business relationships with partners
    - To consider the impact of the Trusts operations on the community we serve and the environment.
    - To maintain a reputation for high standards' of business conduct.
- exercise independent judgment in decision making;
- exercise reasonable care, skill and diligence, this standard is increased for directors who may possess a higher standard of knowledge, skill or experience;
- avoid conflicts of interest with the interests of the Trust and to declare any conflict of interest that exists or arises;
- not benefit from third parties by reason of being a director or his doing anything as a director of the Trust;
- maintain knowledge and understanding of the organisation's business to properly discharge their duties;

The Trust will provide indemnity cover for directors and the Constitution specifically provides for such cover for actions taken honestly and in good faith, but not for reckless or criminal action.
There are a number of other duties that require Board appointments and these are available on request to the Trust Secretary.

Division of responsibility between the Board and Management

The Chief Executive Officer (CEO) is responsible, in accordance with the directions of the Board, for the implementation of the business plan and general day-to-day management and conduct of the affairs of the organisation, through the Executive team. The CEO is the board's link to the administration of the Trust. The CEO is accountable to the board as a whole and all communications on behalf of the board is through the CEO. The CEO ultimately is responsible for exercising all powers delegated by the board.

The Chief Executive is also the Accounting Officer for the Trust. The Accounting Officer has responsibility for the overall organisation, management and staffing of the Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

a. there is a high standard of financial management in the Trust as a whole
b. financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust; and
c. financial considerations are fully taken into account in decisions on the Trust policy proposals.

In the context of the above, the board shall:

- delegate authority to the CEO to conduct the business and operations of the board;

- with the exception of matters reserved to the Board of Directors as set out in Standing Financial Instructions, authorise the CEO to delegate authority, implement policy, establish procedures, make all decisions, take all actions, establish all practices, and direct all activities for the board;
- direct the CEO to achieve results consistent with the strategic plan, corporate performance indicators and performance monitoring processes established by the board or the national performance targets;
- direct the CEO to provide regular reports on organisational succession planning;
- ensure that only decisions of the board acting as a single body are binding upon the CEO; and
- authorise the CEO to enter into employment agreements with staff, setting out terms and conditions of employment, and salary and benefits which fall below Very Senior Management (VSM) levels or an Agenda for Change salary that exceeds VSM levels

The Chair and Chief Executive have complementary roles in board leadership. These are set out in more detail in Appendix 1 and the essence of these two roles is:

- The chair leads the board and ensures the effectiveness of the board

- The chair also chairs the Council of Governors.

- The Chief Executive Officer leads the executive and the organisation.

Appendix 2 sets out in detail the specific roles of board members within the context of the "NHS Healthy Board".

Ethical Behaviour

The members of the Board of Directors shall act in the best interest of the organisation and the interests of patients; and uphold their fiduciary responsibilities and general duty of care. This involves not disclosing confidential information, avoiding real and perceived conflicts of interest, and favouring the interests of the organisation over the interests of others and themselves. The board shall act honestly and in good faith in a manner that is in the best interest of the organisation. It will also subscribe to the following core values of the NHS as set out in the NHS Constitution:

Respect and dignity.
We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care.
We earn the Trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion.
We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.

Improving lives.
We strive to improve health and well-being and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

Working together for patients.
We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

Everyone counts.
We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

Source: NHS Constitution

The Board reviews its behaviour at the conclusion of each meeting using the "Board Guiding Principle" attached as Appendix 3

Induction Programme

There is a structured process for induction of new Board members and Governors. This is an opportunity to begin to develop Board members and Governors in terms of their understanding of the NHS both within the local and national context. This can include mentoring by more experienced Board and Governors, and is led by the Chair of the Foundation Trust. It is essential that the Induction is commenced within the first month of the director or governor commencing with the Foundation Trust, but not overload the director or governor with information.

The purpose of a successful induction is to enable the director and governor to become effective as soon as possible.

Board of Directors – Code of Conduct

Introduction

High standards of corporate and personal conduct are an essential component of public services. The Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/Health Sector and with any relevant code of practice. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all directors of the Trust.

This code, along with the code of conduct for governors and the NHS Constitution, forms part of the ethical framework designed to promote the highest possible standards of conduct and behaviour by the directors of the Trust. The code is intended to operate in conjunction with the NHS Improvement Code of Governance, the Trust's Constitution and with the Trust's Standing Financial Instructions. The code applies at all times when directors and employees are carrying out the business of the Trust or representing the Trust.

Principles of Public Life
All directors and employees are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

General Principles
The Board of the Trust has a duty to conduct business with probity, to respond to staff and patients impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximize the benefits for the members of the corporation as a whole and for the public.

The Board of Directors therefore undertake to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the provisions of the Constitution, the Standing Financial Instructions and the accompanying scheme of delegation conform to best practice and serve to enhance standards of conduct. The board of directors expects that this code will inform and govern the decisions and conduct of all directors.

Confidentiality & Access to Information

Directors and employees must comply with the foundation Trust's confidentiality policies and procedures. Directors and employees must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the Board of Directors and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and directors and employees must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Trust has adopted policies and procedures to protect confidentiality of personal Information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by board of directors and all staff.

Register of Interests

Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the constitution. It is the responsibility of each director to update entries if their interests change. The Trust Secretary will provide an appropriate pro forma or guidance.

Failure to register a relevant interest in a timely manner may constitute a breach of this code.

Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or for doing (or not doing) anything in that capacity.

If a director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Chair will advise directors in respect of any conflicts of interest that arise during board of directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Trust Secretary will provide advice on any conflicts that arise between meetings.

Gifts & Hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. As a matter of principle the use of trust funds for hospitality and entertainment, including hospitality at conferences or

seminars, must be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community.

Whistle-blowing

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board of directors has adopted a Whistle-blowing Policy in compliance with the Public Disclosures Act, on raising matters of concern which will be followed at all times by directors and all staff.

Personal Conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute

Specifically directors must:

- Act in the best interests of the Trust and adhere to its values and this code of conduct.
- Respect others and treat them with dignity and fairness.
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the board of directors as a board of director's member in order for it to fulfil its role and functions.
- Recognise that the board of directors is collectively responsible for the exercise of its powers and the performance of the Trust.
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the chair, senior independent director, chief executive, executive directors and Non-Executive directors.
- Make every effort to attend meetings where practicable.

- Adhere to good practice in respect of the conduct of meetings and respect the views of others.

- Take and consider advice on issues where appropriate.

- Acknowledge the responsibility of the Council of Governors to represent the interests of the Trust's members and partner organisations in the governance and performance of the Trust, and to have regard to the views of the council of governors.

- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.

- Accept responsibility for their performance, learning and development.

Compliance

The members of the board of directors will satisfy themselves that the actions of the Board of Directors and directors in conducting business at the board fully reflect the values, general principles and provisions in this code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All directors, on appointment, will be required to give an undertaking to abide by the provisions of this code of conduct.

Role Profiles

Board Role Profile - Chair

Main Accountabilities

1. Provide leadership of the Board, inculcating a sense of individual and collective responsibility on the part of all Directors, through personal example and practice.

2. Manage the business of the Board and set its agenda, taking full account of the issues and the concerns of Board members. Ensure that agendas strike the right balance between patient safety and quality, performance, governance and strategic issues

3. Ensure that members of the Board receive accurate, timely and clear information in particular about the Trust's performance, to enable the Board to take sound decisions, monitor effectively and provide advice to promote the success of the Trust
4. Keep under review, with the Board, the general progress and long term development of the Trust

5. Ensure effective communication with Governors and other stakeholders and the community in general and ensure that members of the Board develop and maintain an understanding of the views of Governors and key stakeholders

6. Manage Board meetings to ensure that sufficient time is allowed for discussion of complex or contentious issues, where appropriate arranging for informal meetings beforehand to enable thorough preparation for Board discussion

7. Promote the highest standards of corporate governance, identifying and encouraging the adoption of best practice from both the public and private sectors

8. Ensure that the Board is able to discharge its duties and comply with the requirements of statutory/regulatory bodies that affect the functioning and responsibilities of the Board, including NHS Improvement and the Care Quality Commission, in particular the duty of the Chair under the Fit and Proper Persons requirements

9. Build an effective and complementary Board, initiating change and planning succession and Board appointments; leading the process for the appointment and development of Chief Executive and Executive Directors; and working with and facilitating the appropriate Board of Directors and the Council of Governors panels as appropriate.

10. Ensure that a properly constructed induction programme is provided for new Directors and Governors.

11. Consider and address the development needs of individual Non-Executive Directors, and the Board as a whole, to maintain the necessary depth and breadth of knowledge and skills, and enhance the effectiveness of the Board as a team.

12. Lead the Board in the on-going monitoring, and evaluation, of the performance of the Chief Executive

13. Establish a close partnership relationship of Trust with the Chief Executive, providing support and advice while respecting executive responsibility

14. Establish effective working relations and open lines of communication with other Board and Executive members and in particular the Deputy Chair and with Governors

15. In line with the NHS Healthy Board document ensure that alongside board performance evaluation, board members undergo at least an annual appraisal of their individual contribution and performance.

16. Ensure that a process is in place for the planned development of the Board
17. Encourage active engagement by members of the Board

18. Chair the Board's Remuneration and Nominations Committee, and other committees considered appropriate

19. Uphold the highest standards of integrity and probity

20. Develop and maintain an ethos of and commitment to corporate and collective responsibility on the part of all Board members

21. Promote effective relationships and open communication, both inside and outside the Boardroom, between Non-Executive Directors, Executive Directors, the Executive and with Governors

22. Ensure clear structure for the effective running of Board committees.

23. Provide coherent leadership for the Trust, including representing the Trust and understanding the views of key stakeholders.

24. Chair the Council of Governors, applying the principles set out in this role profile to ensure the effective functioning of the Council, and seeking synergy of purpose between the Board and the Council

25. Taking into account the views of the Board of Directors, work with the Council of Governors in the process for appointment of Non-Executive Directors

26. Make an appropriate recommendation to the Council of Governors, through the Board Remuneration and Nominations Committee, the process for, and the appointment of the Chief Executive

27. Encouraging and facilitating the Council of Governors involvement in furthering the ambassadorial role of Governors and their participation in Council Panels and other groups developed to facilitate their role

Chair: Expectations

1. Role Requirements

- *Time commitment;* the Chair is expected to commit whatever time is necessary to fulfil the duties of the position.
- *Experience;* experience on a Board of a substantial public or private sector organisation.
- *Knowledge;* the Chair must have a demonstrable and practical knowledge of boardroom, strategy development and corporate governance issues

2. Key Competencies and Behaviours

In addition to the required competencies and behaviours of a Non-Executive Director, the Chair must demonstrate the following;

1. Provision of effective leadership to the Board

    - Ensures, in conjunction with the Board of Directors and Council of Governors , high quality Board composition with an appropriate balance of skills and experience

    - Ensures, in conjunction with the Board, the appointment of high quality Executive Directors

    - Pro-actively manages the annual calendar of business to ensure the most appropriate use of the Board's time

    - Engages and supports individual members to enhance Board activities and discussion

    - Ensures that the Board operates effectively as a team

    - Ensures that membership of the Board is a stimulating and enjoyable experience for Board members

    - Ensures, in conjunction with the Board of Directors and Council of Governors, high quality Board composition with an appropriate balance of skills and experience

2. Effective Chairing of Meetings

    - Empowers all Board members to challenge issues openly. .
    - Has the skills to chair the Annual Members Meeting and other public meetings and deal with challenging and diverse members questions

    - Encourages and manages vigorous debate and achieves resolution.

    - Ensures time is allocated appropriately, ensuring business of the meeting is completed on time whilst allowing appropriate discussion of individual items

3. Be a respected ambassador for the Trust

    - Is comfortable in dealing with political and regulatory interests

    - Is able to command the respect of local, regional and national opinion formers

4. Develops communications between the Board and Council of Governors

    - Chair meetings of the Council of Governors.

- Engages with and develops effective working links with the Council of Governors.

- Has the skill to develop a relationship of mutual trust and assurance.

Board Role Profile – Deputy Chair

The Deputy Chair will deputise for and support the Chair in respect of the authorities and responsibilities conferred or delegated to the Chair by the Board, as set out in the Chair's role profile, and any other authority of responsibility that the Board, the Constitution may, from time to time, confer.

The key areas of focus for this role will include;

1. Acting as ambassador for the Board, particularly in terms of developing and maintaining relationships with key opinion formers

2. Providing support to the Chairman in building an open relationship with the Council of Governors based on mutual trust

3. Providing support and advice to the Chair of the Board

4. Keeping under review the performance of the specific parts of the Trust or Board Committees for which he or she has responsibility/sponsors

5. Creating an appropriate information flow and feedback to be able to advise the Chair on their performance and that of the Board and the Council of Governors.

In addition, the Deputy Chair will support the Chair as required in carrying out the following areas of responsibility

6. Managing the business of the Board and ensuring that the Board operates effectively in driving forward the Trust's strategic objectives

7. Keeping under review, with the Board, the general progress and long term development of the Trust

8. Representing the Trust and the collective views of the Board externally

9. Chairing the Council of Governors in the absence of the Chair

The Deputy Chair will also attend and answer questions as appropriate at the Annual Members Meeting and serve on such Board Committees or perform any additional task as agreed with the Chair or the Board.

Deputy Chair: Expectations

1. <u>Role Requirements</u>

- *Time commitment;* the Deputy Chair will be expected to commit whatever time is necessary to fulfil the duties of the position.

- *Experience;* experience of serving on a Board of a large public or private sector organisation.

- *Knowledge;* the Deputy Chair must have a demonstrable and practical knowledge of boardroom and corporate governance issues

2. Key Competencies and Behaviours

- the Deputy Chair will act as an ambassador for the Trust

- the Deputy Chair must have the skills to be able to Chair the Council of Governors in the absence of the Chair.

- Supporting the Chair*;* the Deputy Chair should, at all times, be prepared to support, and where necessary, provide counsel to the Chair on the achievements of their own role and Charter of Expectations

- Trust/respect; the Deputy Chair must be able to command the trust and respect of fellow Directors and be seen as an individual to whom Directors, Governors and stakeholders can raise concerns which contact through normal channels has failed to resolve or for which contact is inappropriate

- the Deputy Chair must have experience of managing politically sensitive situations in a large and complex organisation

- Judgement; the Deputy Chair must be able to demonstrate excellent judgement under pressure.

The above expectations are in addition to the Charter of Expectations for Directors and any other Board position held.

Board Role Profile - Senior Independent Director

Regulator's Code of Governance states that:

"In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate." The SID also acts as the main point of contact when discussing with governors the Chair's performance appraisal and his remuneration and allowances.

The Standing Orders of the Board of Directors states that "The Board of Directors (in consultation with the Council of Governors) may appoint any Non Executive Director as the "senior independent director" for such period not exceeding the remainder of their term as a Non Executive Director. Any person appointed to the position may resign by giving notice in writing to the Chair, thereupon another Non Executive Director may be appointed as senior independent director. (Sections 3.7 and 3.8 refer)

There is clearly no requirement to have a SID, but it will be a comply or explain matter, in other words whilst there is no legal obligation there is an obligation under the Code of Governance and as such failure to comply requires the Trust to explain its non compliance to the Regulator.

In addition to the above guidance, the Trust itself has developed at the request of the Governors, a complaints process which includes within that process a role for the Senior Independent Director. As such it is now timely to review the role profile.

Board Role Profile - Senior Independent Director

The Senior Independent Director is appointed by the Board, subject to consultation with the Council of Governors and is required to meet the independence criteria for directors that is set out in the NHS Improvement Code of Governance.

In addition to the duties as a Non-Executive Director, the role of the Senior Independent Director is to:

- Be available to Directors, Governors, members of the Trust or other stakeholders if they have concerns relating to matters which contact through the normal channels of Chair, Chief Executive, Secretary or Director of Finance has failed to resolve, or for which such contact is inappropriate.
- Be accessible to Governors, Directors and Stakeholders.
- Lead on the annual appraisal the Chair; the Senior Independent Director will follow the procedure agreed with the Council of Governors for the evaluation of the Chair.
- To lead a meeting of the Non Executive Directors without the Chair at least annually to evaluate the Chair's performance
- To carry out the obligations for the SID as set out in the approved Governors Complaints Procedure

Senior Independent Director: Expectations

1 Role Requirements

- Time commitment – There is no set time limit, and the SID should commit be able to undertake the duties required of the role and be able to commit significantly more time to the role should the need arise.

- Experience – Significant experience of serving on a Board.

2 Key competencies and behaviours

- Trust/respect – Must be able to command the trust and respect of their fellow Directors and be seen as an individual to whom Directors, Governors, Members of the Trust and other stakeholders can raise concerns which contact through normal channels has failed to resolve or for which such contact is inappropriate

- Political awareness – Must have experience in managing politically sensitive situations in a large and complex organisation

- Judgement – must have ability to demonstrate excellent judgement.

Board Role Profile – Board of Directors

The Board is responsible for creating and delivering sustainable value in the provision of healthcare through the management of the Trust's business. It should, therefore, ensure that the Trust's way of operating is based on a sound set of common beliefs and also demonstrate commitment to those beliefs through its actions. It should determine the strategic direction of the Trust and the policies and objectives required to deliver such long term value. It should enhance this value within a framework of rewards, incentives and controls. The Board must ensure that management strikes an appropriate balance between promoting long term growth and delivering short term objectives.

The Board is also responsible for ensuring that management maintain a system of internal control which provides assurance of effective and efficient operations, internal financial controls and compliance with law and regulation. In carrying out this responsibility, the Board must have regard to what is appropriate for the Trust's business and reputation, the financial and other risks inherent in the business and the relative costs and benefits of implementing specific controls.

<u>General to all Directors</u>

1. Provide social entrepreneurial leadership of the Trust, within a framework of prudent and effective controls which enable risk to be managed and assessed

2. Provide, through personal example and practice, individual and collective leadership to the work of the Trust
3. Contribute to the development of and approve the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance

4. Ensure the delivery of the strategic and annual plans and results and objectives within the financial and other parameters set

5. Set the Trust's values and standards to ensure that its obligations to its stakeholders and others are understood and met, demonstrating those values and standards in all its actions

6. Demonstrate a commitment to corporate and collective responsibility, operating corporately to support Board decisions

7. Ensure the operation of the Trust is based on sound business processes and best practice and undertake training to develop a full understanding of the corporate role of Directors

8. Offer challenge and support to Executive and Non-Executive Board colleagues. The purpose being to strengthen the Board of Directors as a unitary board, and raise individual and collective performance.

9. Under the Companies Act 2006the key duties of Directors include;

    (i) duty to act within their powers in particular:
    - act in accordance with the Trust's constitution
    - only exercise powers for the purposes for which they are conferred.

    (ii) Duty to promote the success of the Company

    (iii) Duty to exercise independent judgement

    (iv) Duty to exercise reasonable care, skill and diligence.
    (v) Duty to avoid conflicts of interest

    (vi) Duty not to accept benefits from third parties.

10. Under the Health and Social Care Act 2012 the duties of the directors include:
    (i) The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public.

    (ii) The duties that a director of a public benefit corporation has

by virtue of being a director include in particular –

- A duty to avoid a situation in which the director has or can have a direct or indirect interest that conflicts or possibly may conflict with the interests of the corporation;
- A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity

Specific to Non-Executive Directors

Non-Executive Directors bring an external perspective to Board discussions and have specific roles to play in the following:

11. Applying judgement to the business of the Board, using their knowledge of the Trust and their external experience and expertise for the benefit of the Trust

12. Satisfying themselves on the integrity of financial and performance information and that financial controls and systems of risk management are robust and defensible

13. Determining the appropriate levels of remuneration for the Chief Executive and Executive Directors and having a prime role in appointing and, where necessary, removing the Chief Executive and Executive Directors and in succession planning for these positions
14. Complementing the experience and skills of the Executive Directors, in particular by bringing to bear a different range of knowledge, experience and insight from the private sector, other parts of the public sector and from the professions

15. Supporting the Chair in building a constructive and effective relationship with Governors

In carrying out these duties, the Board endorses the view of the Higgs Report that the specific role of Non-Executive directors is;

(a) Constructively challenge and contribute to the development of strategy
(b) Scrutinising the performance of management in meeting goals and standards, and monitoring the reporting of performance and service quality

(c) Satisfying themselves that financial, clinical and other information is accurate and that internal systems and controls to carry out this duty are robust and defensible

(d) Satisfy themselves that the board acts in the best interest of the public and other stakeholders and is fully accountable for the services provided and the public funds used

Non-Executive Director: Expectations

1. Role Requirements

    1. *Time commitment;* a Non-Executive Director will be expected to commit up to four days a month to the role, additional responsibility may require additional time commitments.

    2. *Attendance;* attendance at all Board and Board Committee meetings is expected unless exceptional circumstances prevail. Meetings will be arranged with sufficient notice to allow this

    3. *Independence;* maintenance of own independence is expected, whilst operating corporately to support Board decisions

    4. *Conflict of Interest;* takes all reasonable action to avoid potential conflicts of interest and discloses any that may arise.

    At least half the board of directors, excluding the chairman, should comprise Non-Executive directors determined by the board to be independent.

    The board of directors should identify in the annual report each Non-Executive director it considers to be independent. The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent notwithstanding the existence of relationships or circumstances which may appear relevant to its determination, including if the director:

    - has been an employee of the Trust within the last five years;
    - has, or has had within the last three years, a material business relationship with the Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust;
    - has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme;
    - has close family ties with any of the Trust's advisers, directors or senior employees;
    - holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
    - has served on the board of the Trust for more than six years from the date of their first appointment; or

- is an appointed representative of the Trust's university medical or dental school.

2. Key Competencies and Behaviours

- Is well informed about the Trust and the external environment, bringing that knowledge to bear in the development of Trust strategy
- Raises relevant strategic issues influencing the shaping of the Trust strategy
- Effectively contributes to the evolution of the corporate strategy and assists in its implementation through advice and counsel
- Uses relevant experience to add value to all strategic discussions.
- Demonstrates independence of judgement
- Willing to stand up for and defend own beliefs and values in the face of opposition
- Able to challenge effectively outside own area of expertise
- Demonstrates the courage to take a stand and challenge others' assumptions, beliefs or viewpoints as necessary for the good of the Trust.
- Questions intelligently, debates constructively, challenges rigorously and decides dispassionately
- Asks searching questions which are focused on the key issues facing the Trust
- Willing to challenge openly and rigorously, without leading to unnecessary conflict
- Takes difficult decisions dispassionately whilst also being aware of the political implications
- Able to deal effectively with complexity and assimilates knowledge quickly.
- Has the Trust and respect of other members of the Board
- Immediately commands the respect of Board colleagues
- Comments and observations are valued by Executive Directors and management alike

- Is seen as even-handed in all dealings with the Board and management
- Supports executives in their leadership of the Trust whilst monitoring their conduct and performance.
- Demonstrates openness to being challenged on assumptions, beliefs, viewpoints and is willing to re-examine them in order to reach new conclusions
- Will participate in robust and rigorous debates and then work with peers to arrive at new solutions
- Listens sensitively to the views of others, inside and outside the Board.

- Is always alert to how network of contacts may be utilised for the benefit of the Trust
- Is able to make an effective contribution to the wider operation of the Trust through, for example, taking an interest in sponsoring a specific service or part of the Trust, chairmanship of committees and attendance at other events such as official openings, visits and hearings

Specific to Executive Directors

Executive Directors bear the responsibility for making and implementing operational decisions and running the Trust's business on a day-to-day basis. They have a key role for delivering and overseeing the delivery of the results expected within the Trust plans in a manner which enables the Chief Executive to assure the Board that it is achieving its priorities. The requirements and behaviours set out below are in addition to:

(a) the duties applicable to Directors as heads of functional departments and senior employees of the Trust
(b) the general duties applicable to all Directors as set out above

This is not, therefore, intended to be a definitive list of the responsibilities of Directors. Rather, it defines the expectations and behaviours of those individuals selected as Executive Directors.

1. <u>Role Requirements</u>

1. *Time commitment;* Executive Directors are expected to attend all Board meetings, unless exceptional circumstances prevail, each year and to be available to attend meetings of Board Committees as members or when required to do so by the Chair of the Committee.
2. *Trust view;* be able to take a Trust wide view, and operate corporately

notwithstanding personal responsibility for a function or activity

3. *Knowledge;* be knowledgeable of own areas of responsibility as well as understanding the strategic priorities facing the Trust

2. Key Competencies and Behaviours

4. Use their specialist knowledge and experience, of their own function and more generally, to assist the Board in consideration of strategic issues, and ensuring that decisions are taken in the Trust's best interests

5. Help ensure that the Board receives appropriate and timely information and presentations necessary for it to fulfil its duties

6. Put the interest of the Trust before those of specific areas of responsibility, in particular being prepared to participate fully in the Board's collective decision taking as a team member rather than a functional advocate

7. Manage any conflicts of interest between their role as a Board member and as an executive

8. Be sensitive to the collective responsibility of the Board and be mindful of having all of the responsibilities of a Director

Board Role Profile: Chief Executive Officer

Whilst also being required to demonstrate the competencies of an Executive Director, the Chief Executive has unique responsibilities and expectations arising from their pivotal role as the link between the Board and the organisation in general.

In addition, the Board recognises that good governance practice requires a distinction to be drawn between the roles and responsibilities of the Chair and the Chief Executive. It is appropriate, therefore, to set out the role of the Chief Executive as a Board member.

The Chief Executive must;

9. Be the Trust's Accounting Officer

10. Act as the link between the Board, the Executive and the organisation in general, taking full responsibility and accountability for overseeing the delivery of Board priorities through the Directorates.

11. Develop an effective working partnership with the Chair ensuring clarity with regard to the respective roles and responsibilities

12. Act as the fulcrum for the provision of advice from the Executive to the

Board

13. Appraise and hold Executive Directors to account for their performance

14. Lead the Executive in the day to day management of the organisation

15. Demonstrate entrepreneurial flair and vision in developing the Trust and its activities.

Board Role Profile - Committee Chair

The Chair of Board Committees will preside at meetings of the Committees and ensure that the work of the Committee is performed in an efficient and timely manner.

The key duties of a Board Committee Chair will be;

1. The provision of effective leadership to the Committee:

    - Ensures high quality committee membership with an appropriate balance of skills and experience
    - Pro-actively manages an annual calendar of business to ensure the most appropriate use of the committee's time
    - Engages and supports individual members to enhance committee activities and discussions
    - Ensures that the committee operates effectively as a team and is appropriately supported by the Executive
    - Ensures that membership of the Committee is a stimulating and enjoyable experience.

2. Effective Chairing of meetings

    - Empowers all Committee members to challenge issues openly whilst preventing unnecessary or acrimonious conflicts
    - Encourages and manages vigorous debates whilst achieving closure on issues
    - Ensures time is allocated appropriately and ensures the business of the meeting is completed whilst allowing appropriate discussion of individual items
    - Ensures that the Committee's work is in accordance with best practice so that the Committee is able to discharge its duties to comply with statutory/regulatory requirements
    - Ensures an appropriate flow of information to the Committee

- Ensures the Committee is able to provide appropriate assurance to the Board on the issues within its terms of reference

- Ensures Committee members receive appropriate training to support them in their role as members of the committee

1 Reporting to the Board

- Ensure high quality reporting to the Board on the work of the Committee including the identification of solutions to issues and concerns identified by the Committee

Board Role Profile: Audit Committee Chair

Specific Responsibilities and Requirements:

- Ensures that the Committee effectively reviews the appropriateness and completeness of the Trust's system of internal control including risk management

- Ensures that the Committee effectively reviews the appropriateness and completeness of the Trust's statutory accounts and other published financial statements

- Ensures that the Committee effectively and appropriately monitors the working relationship between the external auditors, the internal auditors and the Trust

- Ensures that the Committee effectively reviews the scope, nature and effectiveness of the work of the Trust's Internal and External Auditors and their terms of reference and performance against objectives and those terms of reference

- Meets regularly with the lead audit partner of the External Auditors and of the Internal Auditors to discuss their audit work and any issues of concerns arising in between meetings of the Committee

- Monitors, through the Executive, the implementation of internal and external audit recommendations

- Ensures that the Council of Governors receives appropriate information and advice on the appointment and performance of the External Auditors

- Ensures that the Committee keeps under review the work of Board assurance committees in the Trust

Expectations

- *Time commitment;* the Audit Committee Chair may have to commit up one day a month in addition to those expected of every other member of the Committee

- *Financial acumen;* the Chair must be comfortable in dealing with complex financial issues and make every effort to keep up to date with financial and accounting best practice developments

- *Internal and external audit;* the Chair must liaise regularly with internal and external audit to discuss their work

- *Available in time of crisis;* the Chair must be available outside meetings of the Committee in case urgent issues are raised by the Trust management or by the Internal or external Auditors

- *Annual Members Meeting;* the Chair must attend the Annual Members meeting to answer stakeholder questions

- *Experience;* the Chair must have experience of Boards and Board Committee work in a major organisation.

Board Role Profile: Remuneration and Nominations Committee Chair

Specific Responsibilities and Requirements

- Consults regularly with the Chief Executive of the Trust to ensure that the Committee effectively reviews the policy of the Trust on the remuneration of Executive Directors
- Ensures that the Committee effectively considers and approves the remuneration of any other members of the Trust senior positions whom the Board decide should fall within its scope
- Ensures that the Committee effectively considers and approves packages on termination for employees
- Ensures that the Committee effectively reviews the policy relating to all employee benefit and long term incentive schemes, particularly insofar as any such schemes involve the executives or employees referred to above.

Role Requirements

- This committee will always be chaired by the Chair of the Board of Directors.

- *Regular meetings;* the Chair must meet regularly with the Chief Executive to ensure that the Committee is effectively reviewing the remuneration of Executive Directors in line with Trust policy

- *Annual Members Meeting;* the Chair must attend the Annual Members Meeting to answer questions from stakeholders on the Trust's remuneration policy

- *Knowledge;* the Chair must be knowledgeable about current best practice in executive remuneration and understand the importance of aligning executive reward to the achievement of the Trust's strategic objectives

- *HR best practice;* the Chair must be aware of current best practice in HR polices and executive recruitment and understand its role in the effective execution of the Trust's strategy

- *Experience;* the Chair must have experience of Boards and Board Committee work in a major organisation.

Board Role Profile - Quality Governance Committee Chair

Specific Responsibilities and Requirements

- Consults regularly with the Director of Nursing, Medical Director to ensure that the Committee effectively reviews the Clinical and Quality Strategy.

- To ensure that the committee provides assurance to the Board that analysis and learning from incidents, complaints, claims, PALS, clinical audit and surveys has taken place and that subsequent actions are implemented and monitored for effectiveness.

- To ensure that the Board is provided with the appropriate information to monitor clinical and quality standards within the Trust and to enable the Board to challenge compliance.

- To ensure that the committee receives reports monitoring the effectiveness and compliance with the clinical Strategy and policies.

- To ensure that the committee considers and incorporates the clinical and patient safety recommendations from external bodies' investigations and research into the clinical policies and quality systems of the Trust.

- To provide the Board with the assurance that risks to patients are minimised through application of a comprehensive clinical risk management system.

- By the committee monitoring trends in key clinical quality indicators and clinical outcome measures provide assurance to the Board that the quality of care is continuously improved.

- To ensure reports on the Clinical Strategy and Governance Framework are submitted to the Committee.

- To ensure that at the appropriate time reports on the Trust's Quality

Accounts and dashboards are submitted to the Committee.

Role Requirements

- *Regular meetings;* the Chair must meet regularly with the Chair and Director of Nursing, Medical Director and Head of Governance and Risk to ensure that:
    - The Committee is effectively reviewing clinical standards and CQC registration requirements and providing the Board with the appropriate assurance.
    - Review monitoring progress against the Clinical Governance Strategy, Clinical Audit and Research Programme and Infection Prevention & Control Group Work plan.
- *Annual Members Meeting;* the Chair must attend the Annual Members Meeting to answer questions from stakeholders on the Trust's commitment to patient quality.
- *Knowledge;* the Chair must be knowledgeable about current best practice in quality and clinical standards
- *Experience;* the Chair must have experience of Boards and Board Committee work in a major organisation.

2 The Council of Governors

Role of the Council of Governors

NHS Improvement's Code of Governance states that the Council of Governors is responsible for representing the interests of the members and partner organisations in the governance of the Trust.

The statutory function of the Council of Governors is to hold the Non-Executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of the members of the Trust as a whole and the interests of the public.
What is Holding to Account?

To hold to account is to receive an account or explanation and a justification for actions taken or not taken. To test the account through questioning and to form a judgement and to feed back. Being able to demonstrate the effectiveness of a local chain of accountability from the public and the membership through the Governors to the Board of Directors is important in demonstrating the value of the Foundation Trust model.

What holding to account is not:

To hold to account does not require a management relationship, so while Governors appoint non-executive directors and can in appropriate circumstances remove them from office; and are responsible for holding them to account; there is no management relationship.

Holding to account is not the same process as the appraisal of non-executive directors. There has been some confusion in some quarters because the Act stipulates that non-executive directors must be individually and collectively held to account for the performance of the board, leading some governors to believe that they will need to meet with individual Non-Executive Directors to discuss their individual performance. This is a misapprehension; it is the collective performance of the Board of Directors for which non-executive directors are jointly and severally accountable to governors, not their own individual performance. The appraisal process is the means by which the individual performance of each Non-Executive Director is discussed. Appraisal is usually led by the Chair or in the absence of the Chair, by the senior independent director. The views of governors will be sought as part of the process, and the process will be one endorsed by the Council of Governors; it is not part of the governor role to appraise directors directly.

Unlike annual appraisal, holding to account should not be just a set-piece or annual event. Governors will need to use the full range of interaction with Non-Executive Directors, and the Board generally, to properly hold the Non-Executive Directors to account.

Good accountability relationships provide checks and balances to reduce the scope for flawed decision making. This is done **not** by exposing the Board of Directors to experts who will test their competence, but by requiring Boards to produce evidence that it is doing as it should in assuring itself or making decisions appropriately and in accordance with the provisions of good Board governance.

For Governors the outcome that they should be seeking from holding the Non-Executive Directors to account is assurance about the performance of the Board. Specifically they will be looking for assurance, confidence backed by sufficient evidence, that the Board is setting strategy, controlling the Trust, establishing the right culture and delivering accountability.

For Boards of Directors the outcome will be related to the amount of effort they put into making the relationship work and making accountability real. Being properly accountable is good both for organisations and individuals. It helps them to focus on what is important to their stakeholders, it promotes a thorough self-appraisal and it can help to avoid the dangers of ‘group think’ and promote an appropriate level of vigilance. In NHS Improvement’s quarterly reviews of foundation trust performance, consistent themes can be identified in those foundation trusts that run into performance problems. Lack of evidence of appropriate boardroom challenge, the adoption of action plans that prove to be overly optimistic, insufficient attention being given to the oversight of key risks to strategic objectives are common examples. Boards can learn from the accountability process to review whether any of these could be true of their trust and take remedial action where necessary. So for Boards it does not have to be “yet another’ responsibility” it can be an opportunity to review, learn and change.

Whatever approach the Board takes the first step in being held to account is to actually give an account; to relate to Governors what actions the Board has taken to lead and govern the Trust to deliver effective healthcare. This might include how the Board manages risk and risk appetite; how the Board gains assurance; how directors triangulate to gain assurance, use of external assurance and stress testing. Boards will want to tell Governors about Trust performance and quality: what has gone well and also what has not – and why. Examples of where the Board has intervened to deal with issues of performance can provide Governors with evidence leading to assurance far more readily than undiluted performance information.

Probably the most important factor in making the interaction between Governors and Directors positive is a common understanding and acceptance of the roles and responsibilities of each party. A positive relationship can be promoted by being clear about the respective roles of each body and then agreeing ground rules on how the relationship will work, including how disagreements will be resolved. Governors will need the right level of information and support to carry out their role effectively, but just as importantly will need time and space to question, challenge and reflect on and debate what they have heard so that they are able to form a conclusion and feed back to the Board.

One of the circumstances levelled at the governor role is that Boards could misinform or mislead their Governors with relative ease. This is undoubtedly true, but any short term advantage in doing so would be outweighed by the disadvantages that would accrue once the issue became public, as it inevitably would. Such a Board would also forgo the very real advantages that a proper relationship with Governors could afford them. Good relationships that will produce results depend on honesty, candour and trust and a commitment to behaviours consistent with agreed ways of working.

Governors are a key community link for the Trust. They carry out a vitally important role ensuring that the Trust gains the views of the people it serves. By keeping in touch with local people and communities, they are responsible for feeding back to the Trust, via the Council of Governors, the views and ideas of members.

The Governors also lead on developing the membership in their constituency and also communicating with their local members and the public on issues from the Council of Governors and the Trust. The Governors also advise the Trust on what information service users and carers need and the best way to involve the public in service developments.

The Council of Governors is also now responsible under statute for monitoring that the Trust will conduct its business in a way that reflects its purpose.

Governors are an important community link for the Trust part of this role is to make sure that the views of people who use the Trust's services and local communities are taken into account when plans for services are being developed.

The Council of Governors help plan and steer the direction of the Trust. This

includes working with the Board of Directors to set priorities for improvements and changes. In this role, governors act as 'critical' friends. 'Critical' friends support, challenge and ask questions in a positive way, and give immediate support and help when necessary.

The size and shape of the Council of Governors is a matter for the Trust subject to the following statutory positions:

- The overall majority of places must be made up of representatives elected from the public membership
- At least three staff governors are elected from the staff membership.
- At least one local authority governor

Over and above these minimum requirements there can be as many other governors as an individual Foundation Trust sees fit provided there are more public governors than all other governors put together. However, NHS Improvement's Code of Governance does emphasise that the Council of Governors should not be so large that it becomes unwieldy. Governors can serve a term of three years on the Council of Governors and can then seek re-election or reappointment.

The Council of Governors currently has the following statutory roles. These roles cannot be delegated and can only be exercised at meetings of the Council of Governors:

- Appointing, removing and deciding the terms of office of the chair and other NEDs and approving the appointment of a new Chief Executive.
- Appointing and removing the auditor
- Receiving the annual accounts, auditor's report and annual report at a general meeting
- expressing a view on Board of Directors' forward plans for the Trust
- Approve "significant transactions"
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non NHS work would significantly interfere with its principal purpose which is to provide goods and service in England, or performing its other functions.
- Approve amendments to the Trust's constitution.

Governors Cannot :

- veto or over-rule decisions made by the Board of Directors

- involve themselves in the day-to-day running of the Trust, setting budgets, staff pay or other operational matters. These responsibilities lie with the Board of Directors.

- inspect the Trust's services. This task is carried out by the Care Quality Commission although Governors may wish to forward any concerns on the quality of patient care to the Chair of the Trust.

- raise complaints on behalf of individuals.

- represent the interests of single pressure groups or political parties. They are required to represent a broad range of interests in their constituency.

Unlike directors, governors are not paid and are not ultimately responsible for the performance of the Trust. The Board of Directors remain ultimately responsible for the Trust's operations and performance.

A Governor - Role Profile

Role Requirements

- *Time commitment;* a governor is expected to commit whatever time is necessary to fulfil the duties of the position and must attend at least four meetings of the Council of Governors each year. It is expected that Governors will find time to read documents sent to them to enable them to undertake their duties and it will suit a person with a probing mind. There is also the added expectation that governors will attend training sessions provided by the Trust to assist them in discharging their duties.

- *Experience;* the real added value of the Governor of course is in representing the interests of members and the broader community or the appointing body in providing advice, guidance and support to the board of directors.

- *Knowledge;* a basic concept the principles of the National Health Service and the Foundation Trust concept would be helpful, although the experience of life is far more important.

Key competencies and behaviours

Governors must be at least 16 years old and public governors must live in the area they represent.

Governors are a key component of the link between a foundation trust and its members, and are therefore key agents in the process of accountability. This is achieved by providing positive challenge.

Governors are responsible for canvassing the views of the membership on key issues facing the Trust, and also feeding back members' views to the Board of Directors.

There are no specific qualifications required to be a governor. Governors bring their life experience into the Trust to influence strategic direction and exercise independent judgement and validation on performance. In this way governors support the board in its leadership of the Trust.

There are restrictions on who may hold office as Governor and these are set out in detail within the Constitution.

Elected Governors
Public and Staff elected governors are elected by the membership to represent their views. They are responsible for:

- Representing the interests and views of the Membership and local people

- Giving the public information about the Trust, its visions and its performance.

As members of the Council of Governors:

- Selecting and appointing Non-Executive directors and the chairman of the corporation.
- Take the Lead on appraising the performance of the chair with the Senior Independent Director leading the actual appraisal and agree with the Chair the process for evaluating the Non-Executive directors. The Chair will undertake the actual appraisals.
- Approving the appointment of a chief executive.
- Attending meetings of the council of governors and other committees.
- Monitoring performance against the Trust's Service Development Strategy and other targets

Staff Elected Governors

Staff Elected Governors have the same role as the other governors on the Council of Governors. That role is primarily to represent the interests of the membership, in this case the staff constituency in holding the Non-Executive Directors to account for the performance of the Board of Directors. It is important though that we distinguish the role from the staff representative or a Trade Union representative. A governor should not seek to represent staff on employment issues as there are legally binding alternative means for dealing with staff terms and conditions of employment within the Trust. The real value of Staff Elected Governors to the Trust is in bringing the views of staff into the Council of Governors debate on the strategic planning and future of this Trust; and to also ensure that in its deliberations the Council of Governors are focussed on the needs of the patient and the quality of service provided by the Trust. In terms of appointing the Chair and Non-Executive Directors, the Staff Elected Governors bring the views of the staff into that process; again these views should reflect those of the staff that they

represent. It is through this role that the views of staff our most valuable resource is heard in terms of the leadership and future direction of the Trust.

The Staff Elected Governor is therefore along with their colleagues on the Council of Governors, the conscience of the Trust. In carrying out their role the governors should place the views of the people or organisations they represent in front of the Council of Governors and seek to influence the debate. In terms of the Staff Elected Governors who else within the Trust has a better understanding of the interface with the patient than our operational staff both in terms of urgent and non-urgent contracts. This is why out of five staff governors, it was determined that four of the five Staff Elected Governors must have direct interface with the patient on a daily basis. This gives the staff governors a wonderful insight into the issues faced by patients and staff on a daily basis and through the staff elected governors those issues have a voice at meetings of the Council of Governors.

Time off for carrying out the duties of governor should be discussed with line managers as the demands of the service and in particular patient care must come first and approval of time off should not be unreasonably denied by managers. However, the Board of Directors in recognition of the importance of the role have agreed as a starting point of at least 30 hours or four days a year should be allowed to carry out these duties.

Appointed Governors
Appointed governors are those appointed by individual organisations that have some aligned interests or shared agenda relating to the health and healthcare of the population. They have exactly the same responsibilities and duties of the other members of the Council of Governors.

The Role of the Lead Governor and Deputy Lead Governor

It is not anticipated that there will be regular direct contact between NHS Improvement and the Council of Governors in the ordinary course of business. If this did become necessary the Trusts own systems and means of communication have been compromised or failed. In such circumstances it is essential that any communication happens quickly and in an effective manner.

The lead governor has a role to play in facilitating direct communication between NHS Improvement and the Trust's Council of Governors. This will be in a limited number of circumstances and in particular where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Trust Secretary.

NHS Improvement may well choose to contact the lead governor where NHS Improvement has concerns as to board leadership provided to an NHS foundation trust, and those concerns may in time lead to the use by NHS Improvement's Board of its formal powers to remove the Chair or Non-Executive Directors.

It is therefore essential that the Lead Governor should take steps to understand NHS Improvement's role, and also the available guidance and the basis on which NHS Improvement may take regulatory action. Similarly, where individual

governors wish to contact NHS Improvement, this would be expected to be through the Lead Governor but any governor may contact NHS Improvement if they wish.

The other circumstance where NHS Improvement may wish to contact the Lead Governor is where, as the regulator it has been made aware that the process for the appointment of the chair or other members of the board, or elections for governors, or other material decisions, may not have complied with the NHS Foundation Trust's Constitution, or alternatively, whilst complying with the Trust's Constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the Trust Secretary may have been involved in the process by which these appointments or other decisions were made, The Lead Governor may provide an independent point of contact for NHS Improvement. Accordingly the Governors should elect a Lead Governor and Deputy Lead Governor and advise NHS Improvement of their contact details and continually update the information as and when these change.

CODE OF CONDUCT FOR GOVERNORS

Introduction

The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all governors. The code, with the Code of Conduct for Directors and Employees and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The code is intended to operate in conjunction with the NHS Improvement Code of Governance, the Constitution and with Standing Financial Instructions. This code applies at all times when governors are carrying out the business of the Trust or representing the Trust. However, Governors should consider their actions and or comments made at all time so that any actions or comments made do not undermine the confidence of the public or the Trust in the integrity of a Governor.

Governors must recognise that that the Trust is an apolitical public benefit organisation that seeks to promote social inclusion. The promotion of any personal or political view that is at odds with this principle will be grounds for dismissal from the Council of Governors. Given the confidential, and often sensitive nature of the issues considered by the Council of Governors, governors both individually and collectively must always act with total discretion and integrity, and the interests of the greater good of the Trust and the people who use its services.

Elected Governors who are members or affiliates of any Trade Union, Political Body or other organisation that seeks to influence public opinion must recognise that they will not be representing the views of such organisations: rather they are elected to represent the views of their constituency's members.

The principle role of the Council of Governors is to:

- represent the interests of the members of the Trust as a whole and the interests of the public
- hold the Non-Executive directors individually and collectively to account for the performance of the board of directors.

In representing the interests of the members of the Trust as a whole and the interests of the public, governors will actively engage with their constituents and will not seek to promote or pursue issues of personal interest.

The power and authority of the Council cannot be delegated to individual Governors or any other body such as its panels or working groups. The role of the Council of Governors is set out in detail in the constitution; the NHS Improvement publication entitled the Foundation Trust Code of Governance and is further addressed in NHS Improvement's guide for NHS Foundation Trust governors. In carrying out its work the Council of Governors must take account of and respect the statutory duties and liabilities of the Board of Directors and individual Directors. This means also recognising the rights of the Chief Executive and Executive Directors to manage the Trust and that they are held to account by the Non-Executive Directors. It is not the role of the Governor to be involved in the management of the Trust. The roles and responsibilities of the Governors are set out clearly in this document and within the Constitution.

The Principles of Public Life

The West Midlands Ambulance Service NHS Foundation Trust promotes the Principles of Public Life, and expects that its governors, in keeping with the Board members and officers, will apply the principles at all times.

The 'Seven Principles of Public Life' are as follows:

Selflessness

Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability

Holders of public office are accountable for their decisions and actions to the public

and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

In addition the Trust has a number values that underpin everything that it does and governors should exhibit these values in delivering their statutory duties and when representing the Trust.

The Constitution
Governors as part of carrying out their duties are expected to comply with the contents of Constitution and as such it is expected that Governors will take time to read the contents. The Chair or the Trust Secretary is available to answer any queries or concerns that the Governor may have in relation to the content, or to clarify any matters.

Confidentiality
Governors must comply with the Trust's employee confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled. The Trust will clarify whether a matter is confidential.

Register of Interests
Governors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the constitution. It is the responsibility of each governor to advise the Trust Secretary so that the register entry of their interests is changed. A pro forma is available from the Trust Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

Conflicts of interest
Governors have duty to avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Governors have a further duty not to accept a benefit from a third party by reason of being a governor or for doing (or not doing) anything in that capacity.

Governors must declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the chair to advise the governor whether it is necessary for the governor to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this code.

Meetings
Governors have a responsibility to attend council of governors meetings. When this is not possible apologies should be submitted to the Trust Secretary in advance of the meeting. Persistent absence from council of governors meetings without good reason may be grounds for removal from the council of governors and this is set out in the Trust's Constitution

Personal conduct
Governors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically governors must:

- treat others with respect;
- be mindful of conduct that could be deemed to be unfair or discriminatory (The Trust seeks to promote social inclusion and therefore governors will not discriminate against any part of the communities they serve on any grounds;
- not breach the equality enactments and not bully any person;
- respect the conduct of meetings respecting the views of fellow governors and channelling questions through the Chair so that business can be conducted in an orderly fashion
- recognise the respective roles of the Board of Directors and the Council of Governors and that both parties have common interest in the success of the Trust;
- demonstrate and evidence to the Council of Governors that they have engaged with the Trust membership and members of the public, and, in the case of elected public governors, can genuinely represent the wider views of the public rather than purely their own or those of a small circle(it is important in this respect that governors do not have, and are not seen to have, a personal interest that conflicts them or inappropriately influences their judgement;
- Seek to ensure that membership of the public constituency, staff constituency or partner organisation that they represent are properly informed and that their views are fed back to the Trust;
- Have due regard to the advice provided by the Chair or Trust Secretary.

In the event that a governor fails to comply with one or more of these requirements then the Trust Chair reserves the right to discuss the issues with the individual concerned.

Should the Trust Chair consider that the governor has brought their office or the Trust into disrepute, for example through a serious breach of this Code or repeated breaches of a less serious nature, then he/she will also have the right to escalate the issue(s) to the full Council of Governors where continuance of the governors role will be determined with reference to the Constitution.

Training & Development
West Midlands Ambulance Service NHS Foundation Trust is committed to providing appropriate training and development opportunities for governors to enable them to carry out their role effectively. Governors are expected to

undertake and participate in training and development opportunities that have been identified as appropriate for them. To that end governors will participate in the appraisal process and any skills audit carried out by the Trust.

Undertaking & Compliance
Governors are required to give an undertaking that they will comply with the provisions of this code. Failure to comply with the code may result in disciplinary action in accordance with the Constitution.

Interpretation & Concerns
Questions and concerns about the application of the code should be raised with the Trust Secretary. At meetings the Chair will be the final arbiter of interpretation of the Code.

Review and revision of the Code
The Trust Secretary will periodically review the code. It is for governors to agree to any amendments or revisions to the code.

Appendix One – The specific roles of the Chair and Chief Executive

Chair	Chief Executive
Reports to the board of directors.	Reports to the chair and to the board of directors directly.
Other than the chief executive, no executive reports to the chair.	All members of the management structure report either directly or indirectly, to the Chief Executive Officer.
The effective running of the board of directors and Members Council.	Running the Trust's business
Ensuring that the board of directors as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.	Responsible for proposing and developing the Trust's strategy and overall objectives
The guardian of the board of directors' decision-making processes.	Implementing the decisions of the board of directors and its committees.
General leadership of the board of directors and the Council of Governors.	Provision of information and support to the board of directors and Council of Governors and ensuring that Board of Director's decisions are implemented.
Ensuring that the Board of Directors and Council of Governors work together effectively.	Facilitating and supporting effective joint working between the board of directors and the Council of Governors.
Running the board of directors and setting its agenda.	Providing input to the board of director's agenda from themselves and other members of the executive team.
Ensuring that Board agenda of the meetings of the Board of Directors and also the Council of Governors take full account of the important issues facing the Trust.	Ensuring the chair is aware of the important issues facing the Trust and proposing agenda which reflect these.

Chair	Chief Executive
Ensuring that the Board of Directors and Council of Governors receives accurate, timely and clear information	Ensuring that the executive team provides reports to the Board of Directors which contain accurate, timely and clear information.
Ensuring compliance with the Board of Director's approved procedures.	Ensuring that the executive team comply with the Board of Director's approved procedures.
Arranging informal meetings of the directors to ensure that sufficient time and consideration are given to complex, contentious or sensitive issues.	Ensuring that the chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust
Proposing a schedule of matters reserved to the board of directors, terms of reference for each board of directors committee and other board policies and procedures.	Providing input on appropriate changes to the schedule of matters reserved to the board of directors and committee terms of reference.
Facilitating the effective contribution of all members of the board of directors and the Council of Governors to ensure that constructive relations exist between executive and Non-Executive members of the board of directors, elected and appointed members the council of governors and between the board of directors and the council of governors.	Supporting the chair in their tasks of facilitating effective contributions and sustaining constructive relations between executive and Non-Executive members of the board of directors, elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors.
Chairing the remuneration committee, and initiating change and succession planning of the board and the appointment of effective and suitable members and chairs of Board of Directors committees.	Providing information and advice on succession planning, to the chair, the remuneration committee, and other members of the board of directors, particularly in respect of executive directors.
Proposing the membership of board of directors committees and their chairs.	If so appointed by the board of directors, serving on any committee.
Ensuring that there is effective communication by the Trust with patients, members, clients, staff and other stakeholders.	Leading the communication programme with members and stakeholders.

Chair	Chief Executive
Taking the lead in providing a properly constructed induction programme for new directors,	Contributing to induction programmes for new directors and ensuring that appropriate management time is made available for the process.
Taking the lead in identifying and seeking to continually update the skills and knowledge, and meet the ongoing development needs both of individual directors and of the board of directors as a whole.	Ensuring that the development needs of the executive directors and other senior management reporting to him/her are identified and met.
Ensure that members of the council of governors have the skills, knowledge and familiarity with the Trust to fulfill their role.	Ensuring the provision of appropriate development, training and information.
Ensuring that the performance of the board of directors and Members Council as a whole, their committees, and individual members of both are periodically assessed.	Ensuring that performance reviews are carried out at least once a year for each of the executive directors. Providing input to the wider board of directors and Members Council evaluation process.
Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at board of director's level.	Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance.
Ensuring good information from and between the board of directors, committees, council of governors and member of both and between senior management and Non-Executive directors, members of the council of governors and senior management.	Provision of effective information and communication systems

Appendix Two – The specific roles of members of the Board

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external skills and perspectives, and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for delivery of strategy Ensures board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability.	Leads implementation of strategy within functional areas.
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision making.	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour and provides a safe point of access to the board for whistle-blowers	Actively supports and Promotes a positive culture for the organisation and reflects this in their own behaviour.

	Chair	Chief Executive	Non-Executive Director	Executive Director
	Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors.			
External Context	Ensures all board members are well briefed on external context.	Ensures all board members are well briefed on external Context.		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors are clear to executive.	Ensures provision of accurate, timely & clear information to board/ directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board.
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: • Patients and public • Clinicians and Staff • Key institutional stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Clinicians and Staff • Key institutional stakeholders • Regulators	Ensures board acts in best interests of the public.	Leads on engagement with specific internal or external stakeholder groups.

Source: The NHS Healthy Board (NLC 2010)

Appendix Three – Board Guiding Principles

WE WILL	WE WILL NOT
1 Respect one another as possessing individual and corporate skills, knowledge and responsibilities.	1 Refer to past systems or mistakes as being responsible for today's situation.
2 Learn from mistakes.	2 Act as 'stoppers' or 'blockers'.
3 Show determination, tolerance and sensitivity – rigorous and challenging questioning, tempered by respect.	3 Regard any arrangements as unchangeable or unchallengeable
4 Show group support and loyalty towards the Trust and each other.	4 Adopt territorial attitudes – any member of the team has the right to challenge/question another.
5 Listen carefully to all ideas and comments and be tolerant to other points of view – be sensitive to colleagues' needs for support when challenging or being challenged.	5 Give offence
6 Be honest, open and constructive; any member of the Team has the right to question another	6 Take offence
7 Be courteous and respect freedom to speak, disagree or remain silent and treat all ideas with respect and stay open to discussion.	7 Regard papers presented as being 'rubber stamped' without discussion and agreement.
8 Regard challenge as a test of the robustness of arguments – ensure no one becomes isolated in expressing their view. Treat all ideas with respect.	8 Act in an attacking, crushing or dismissive manner.
9 Read all papers before the meeting and clarify any points of detail with the relevant author before the meeting, arrive on time and participate wholeheartedly.	9 Become obsessed by detail and lose the strategic picture.
10 Focus discussion on material issues and on the resolution of issues, allow differences to be forgotten.	10 Breach confidentially
11 Make the most of time – support the Chair, colleagues and guests in maximising scope and variety of viewpoints heard. Individual points are relevant and short	

WE WILL	WE WILL NOT
12 Never intentionally be offensive, but will be open to discussion and apologise if necessary	
13 Never act in an attacking or crushing or dismissive manner.	
14 Never breach confidentiality – be candid not secret	
15 Support the implementation of government Health Service Policy	
16 Remain open to best practice in other Ambulance Services including Europe and other international Countries	
17 Consult and/or listen to Members, Governors and stakeholders in our decision making process'.	
18 Actively encourage all sections of the diverse communities that we serve to become members of the NHS Foundation Trust and seek election to its governing body.	
19 Actively promote equality and social inclusion in employing people from all backgrounds, ages and diverse communities to ensure West Midlands Ambulance Service is representative of the communities that we serve.	
20 Promote and encourage evidence based academic training for our Healthcare professionals	
21 Encourage the use of environmentally friendly working practices.	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08e MONTH: January 2024 PAPER NUMBER: 09

Review of the Foundation Trust Constitution	
Sponsoring Director	Chief Executive Officer
Author(s)/Presenter	Governance Director and Trust Secretary
Purpose	To review and approve the contents of the Foundation Trust Constitution
Previously Considered by	The Constitution has evolved and developed, and each time approved by the Trust (the Board of Directors and the Council of Governors). The current Constitution was approved by the Board of Directors in 2021. The version submitted has been reviewed by the Trust's Lawyers.
Report Approved By	Governance Director and Trust Secretary

Executive Summary

The Foundation Trust Constitution should be reviewed and maintained so that the content reflects any changes in the regulations or guidance issued by the NHSE or CQC.

The Trust Constitution sets out the powers and functions of the Trust and is reviewed regularly to ensure that the Trust remains compliant. This current review takes into account the need to reflect developments in corporate governance and the development of integrated care systems. These developments have been underpinned changes to the Code of Governance for NHS provider trusts which has been previously reported to the Board and also the changes to the NHS provider licence, both of which came into force in 2023. (the Code) which came into effect from 1 April 2023, proposed amendments to address changes introduced by the Code.

The track changes to the Constitution are contained within the attached document so that there is complete transparency in relation to the changes. The rationale for the changes are:

- Material amendments to reflect changes to the Code of Governance for NHS provider trusts following significant regulatory changes introduced by the Health and Care Act 2022;
- Updating the content to remove references that are outdated such as the references to the applicant trust, and delete references to Monitor and substitute therefore the NHSE.
- Slight variation to the Election Rules as recommended by NHS Providers.
- Various updates and typographical errors.

The Trust Lawyers have reviewed the content of the Constitution and made the following comments: "***I've had the chance to review the amended constitution and largely the changes look fine. I have, however, indicated some areas where you might want to consider further updates and/or amends to bring it in line with the various changes within the licence conditions, NHS Act and code of governance."***

In addition we have consulted NHS Providers who have produced the Model Election Rules and they have provided advice on a relatively small change to the election rules, otherwise they are still compliant.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08e MONTH: January 2024 PAPER NUMBER: 09

The Board are now requested to review the contents of the Constitution and determine if they are minded to approve the content (or seek further review) prior to requesting the Council of Governors to approve the content, prior to publication.

Related Trust Objectives/ National Standards	The NHS Act 2006 as amended provides the authority and power to establish a Foundation Trust. The contents of the Constitution must reflect Schedule 7 of the NHS Act 2006, as amended. In addition the Constitution and corporate governance documents must be compliant with the NHSE Provider Licence and Code of Governance and also the CQC Registration as an NHS provider.

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)	X
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)	X

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☐	Inclusivity	☒
	Accountability	☒		
Risk and Assurance	The Constitution enables the Trust to remain compliant. Failure to review the Constitution in the light of changes will mean that the Trust may no longer be compliant with its Provider Licence.			
Legal implications/ regulatory requirements	Legal advice has been sought and the comments of the Trust Lawyers have been incorporated.			
Financial Implications	The Constitution should be read in conjunction with the Trust's Standing Financial Instructions and Scheme of Delegation. The Terms of Reference for the Board and its Committees also give effect to NHSE Code of Governance.			
Workforce & Training Implications	Not directly applicable, although the Constitution requires the Foundation Trust to have a Staff Constituency representation on the Council of Governors.			
Communications Issues	We are required to published our final and approved iteration of the Constitution.			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08e MONTH: January 2024 PAPER NUMBER: 09

Diversity & Inclusivity Implications	Not directly applicable, but the Constitution requires the Trust to be compliant with regulations and our licence conditions require the Trust to incorporate guidance issued from time to time by the NHSE and the CQC.
Quality Impact Assessment	Not undertaken
Data Quality	Background documentation is held by the Trust Secretary
Action required The Board are now requested to review the contents of the Constitution and determine if they are minded to approve the content (or seek further review) prior to requesting the Council of Governors to approve the content, prior to publication.	

Status Draft PolicyStat ID 14994443

West Midlands Ambulance Service University NHS Foundation Trust

Origination	11/2018
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A
Owner	Phil Higgins: Trust Secretary
Area	Policies
References	Corporate

Constitution

1. Name

1. The name of the foundation trust is West Midlands Ambulance Service University NHS Foundation Trust (the Trust).

2. Principal purpose

1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England, subject to the terms of its Licence, and to promote its long-term sustainability as part of the Integrated Care System (ICS) and wider healthcare system in England, generating value for members, patients service users and the public.
2. In carrying out its purpose, the Trust will provide any information that is required by the ICB and will have regard to the likely effects of any decision in relation to:
3. (a)the health and well-being of the people it serves;
(b)the quality of services provided to individuals—
(i)by relevant bodies, or
(ii)in pursuance of arrangements made by relevant bodies,
for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
(c)efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.
4. in the exercise of its functions the Trust shall have regard to the need to:
(a)contribute towards compliance with—
(i)section 1 of the Climate Change Act 2008 (UK net zero emissions target), and
(ii)section 5 of the Environment Act 2021 (environmental targets), and
(b)adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008

5. The Trust does not fulfil its principal purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.
6. The Trust may provide goods and services for any purposes and on such terms as it considers appropriate, of any of its functions jointly with any other person related to:
    1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
    2. the promotion and protection of public health
7. The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3. Powers

1. ~~The powers of the Trust are set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation.~~The powers of the Trust shall shall be exercised to ensure compliance with its licence conditions and and the 2006 Act, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.
2. The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.
3. Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4. Framework

1. The affairs of the Trust are to be conducted in accordance with this Constitution by:
    1. The Membership
    2. The Council of Governors
    3. The Board of Directors.
2. The Membership
    1. Members may vote in elections to, and may stand for election to, the Council of Governors and may take such other part in the affairs of the Trust as is provided in this Constitution.
3. The Council of Governors
    1. The roles and responsibilities of Governors on the Council of Governors which are to be carried out in accordance with this Constitution are contained in Annex 5, Appendix 2.
4. The Board of Directors
    1. All business shall be conducted in the name of the Trust
    2. The powers of the Trust shall be exercised by the Board of Directors either in public or private session except as provided for within this Constitution.
    3. Certain powers and decisions may only be exercised or made by the Board of

Directors. These powers and decisions are to be set out in the Trust's Scheme of Delegation.

5. Membership and Constituencies

1. The Trust shall have Members, each of whom shall be a member of one of the following constituencies:
    1. a Public Constituency
    2. a Staff Constituency

6. Application for Membership

1. An individual who is eligible to become a Member of the Trust may do so on application to the Trust.

7. Public Constituency

1. An individual aged not less than 14 years who lives in the area specified in Annex 1 as an area for a Public Constituency may become or continue as a Member of the Trust.
2. Those individuals who live in an area specified as an area for any Public Constituency are referred to collectively as the Public Constituency
3. The minimum number of Members in each area for the Public Constituency is specified in Annex 1.
4. An eligible member shall become a Member on entry to the Trust's register of public members pursuant to an application by them. The Trust Secretary may require any individual to supply supporting evidence to confirm eligibility.
5. The Trust Secretary shall normally within 14 days of receipt of an application for membership, and subject to being satisfied that the applicant is eligible, cause the applicant's name to be entered in the Trust's register of Members.

8. Staff Constituency

1. An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided:
    1. he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
    2. he has been continuously employed by the Trust under a contract of employment for at least 12 months.
2. Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency
3. The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

4. The minimum number of Members in the Staff Constituency is specified in Annex 2.
5. An individual who is:
    1. eligible to become a member of the Staff Constituency, and
    2. invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate class within the Staff Constituency,

    Shall become a Member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

9. Restriction on Membership

1. An individual, who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class
2. An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.
3. An individual must be at least 14 years old to become a Member of the Trust.
4. No Member may represent themselves in writing or verbally as belonging to any category of membership of the Trust:
    1. in a manner which might associate the Trust with the personal opinions expressed by the Member in question; and
    2. save for members of the Staff Constituency no Member shall designate the Trust as their personal or professional postal address in any published works or communication to the media.
5. Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Annex 8, Appendix 5.

10. Annual Members Meeting

1. The Trust shall hold an annual meeting of its members (Annual Members Meeting). The Annual Members Meeting shall be open to members of the public.

11. Council of Governors - Composition

1. The Trust is to have a Council of Governors which shall comprise both Elected and Appointed Governors.
2. The composition of the Council of Governors is specified in Annex 3.
3. The Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

12. Council of Governors - election of Governors

1. Elections for elected Members of the Council of Governors shall be conducted in accordance with the Model Election Rules as may be varied from time to time.
2. The Model Election Rules as published from time to time by NHS Providers form part of this constitution. The Model Election Rules current at 1 October 2014 are attached at Annex 4.
3. A subsequent variation of the Model Election Rules by the Foundation Trust Network shall not constitute a variation of the terms of this Constitution for the purposes of paragraph ~~45~~42 of the Constitution (amendment of the Constitution).
4. An election, if contested, shall be by secret ballot.

13. Council of Governors - Tenure

1. An Elected Governor may hold office for a period of up to 3 years.
2. An Elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which they were elected.
3. An Elected Governor shall be eligible for re-election at the end of their term.
4. An elected Governor may not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.
5. An Appointed Governor may hold office for a period of up to 3 years.
6. An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship.
7. An Appointed Governor shall be eligible for re-appointment at the end of his term.
8. For the purposes of the tenure provisions above, a “year” means a period of twelve consecutive calendar months commencing immediately on the date of Authorisation and each successive period of 12 months thereafter.

14. Council of Governors - Disqualification and Removal

1. The following may not become or continue as a member of the Council of Governors:
    1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
    2. a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
    3. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;
    4. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for

a period of not less than three months (without the option of a fine) was imposed.

2. Governors must be at least 16 years of age at the date they are nominated for election or appointment.
3. A Governor may resign from office at any time during the term of that office by giving notice in writing to the Trust Secretary.
4. If a Governor is considered to have acted in a manner inconsistent with:
    1. the values of the Trust or in a manner detrimental to the interests of the Trust; or
    2. the Standing Orders of the Council of Governors; or
    3. the Governors Code of Conduct; or
    4. they have failed to declare an interest as required by this Constitution or the Standing Orders of the Council of Governors, or they have spoken or voted at a meeting on a matter in which they had an interest contrary to this Constitution or the Standing Orders for the Council of Governors, and in this paragraph "interest" includes a pecuniary and a non-pecuniary interest and in either case whether direct or indirect,

    and they are adjudged to have so acted by not less than 75% of the Council of Governors present and voting at a meeting of the Council of Governors then the Governor shall vacate the role of Governor immediately.
5. The Standing Orders for the Council of Governors shall provide for the process to be adopted in relation to the Governor's tenure.
6. A Governor, who is removed from office or resigns from office under paragraph 14.3 above, shall not be eligible to stand for election or appointment to the Council of Governors for a period of three years ~~form~~from the date of their removal or resignation from office unless a majority at a meeting of the Council of Governors agrees to waive this period.
7. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5 – Appendix 3.

15. Council of Governors - Duties of Governors

1. The general duties of the Council of Governors are:
    1. To hold the non executive directors individually and collectively to account for the performance of the Board of Directors, and
    2. To represent the interests of the members of the trust as a whole and the interests of the public.
2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

16. Council of Governors - Meetings of Governors

1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with

the provisions of ~~paragraph~~paragraphs 25.1 or paragraph 26.1 below) or, in their absence the Deputy Chair (appointed in accordance with ~~the provisions~~provision of paragraph 27 below), shall preside at meetings of the Council of Governors.

2. Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial or individual confidentiality, or other proper grounds. Members of the public may be excluded from a meeting if it is considered that their behaviour prevents the proper conduct of the meeting.
3. For the purposes of obtaining information about the trust's performance of its functions or directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

17. ~~Council of Governors - Standing Orders~~Council of Governors - Standing Orders

1. The Standing Orders for the practice and procedure of the Council of Governors are attached at Annex 6.

18. Council of Governors - ~~Referral to the Panel~~Referral to the Panel

1. In this paragraph, the Panel means a panel of persons appointed by the ~~Monitor~~NHSE to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing:
    1. To act in accordance with its constitution, or
    2. To act in accordance with provision made by or under chapter 5 of the 2006 Act
2. A governor may refer a question to the panel only if more than half of the members of the Council of Governors voting approve the referral.

19. Council of Governors - Conflicts of Interest of Governors

1. ~~If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the Council of Governors as soon as he becomes aware of it.~~

   If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the Council of Governors as soon as he becomes

aware of it.

2. ~~The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.~~

   The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. Council of Governors - Travel and Other Expenses

1. The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

21. Council of Governors - Further Provisions

1. Further provisions with respect to the Council of Governors are set out in Annex 5.

22. Board of Directors - Composition

1. The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.
2. The Board of Directors is to comprise:
   1. a non-executive Chair; and,
   2. up to six other Non-Executive Directors; and
   3. up to six Executive Directors
3. One of the Executive Directors shall be the Chief Executive.
4. The Chief Executive shall be the Accounting Officer.
5. One of the Executive Directors shall be the Director of Finance ~~Director~~.
6. One of the Executive Directors is to be a Registered Medical Practitioner or a Registered Dentist (within the meaning of the Dentists Act 1984).
7. One of the Executive Directors is to be a Registered Nurse or a Registered Midwife.

23. Board of Directors - General Duty

~~1. The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the Trust as a whole and for the public.~~

1. The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

2. The Terms of Reference of the Board of Directors describes the specific duties of the Board, which include:
3. promoting the long-term sustainability of the Trust as part of the Integrated Care System and wider healthcare system in England, generating value for Members, patients, service users and the public.
4. ensuring that adequate systems and processes are maintained to measure and NHSE the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and that risk is managed effectively, including those agreed through place-based partnerships and provider collaboratives.
5. to develop, embody and articulate a clear vision and values for the Trust, with reference to the Integrated Care Partnership's integrated care strategy and the Trust's role within system and place-based partnerships and provider collaboratives.
6. in assessing and NHSEing the culture of the Trust and where it is not satisfied seek assurance that corrective action is being taken the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant.
7. have regard to, and comply with its NHSE Provider licence.

24. Board of Directors - Qualification for Appointment as a Non-Executive Director

1. A person may be appointed as a Non-Executive Director only if:
    1. they are a member of the Public Constituency, or
    2. they are not disqualified by virtue of paragraph ~~30~~27 below.

25. Board of Directors - Appointment, Suspension and Removal of the Chair and other Non-Executive Directors

1. The Council of Governors at a general meeting of the Governors shall appoint, suspend or remove the Chair of the Trust and the other Non-Executive Directors, and the process is set out in Annex 8, Appendix 1.
2. Removal or suspension of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.
3. ~~The initial Chair and the initial Non-Executive Directors are to be appointed in accordance with paragraph 26 below.~~

~~26. Board of Directors - appointment of initial Chair and initial other Non Executive Directors~~

1. ~~The Council of Governors shall appoint the Chair of the Applicant Trust as the initial Chair of the Trust, if he wishes to be appointed.~~
2. ~~The power of the Council of Governors to appoint the other Non-Executive Directors of the Trust is to be exercised, so far as possible, by appointing as the initial Non-Executive Directors of the Trust any of the Non-Executive Directors of the Applicant Trust (other than the Chair) who wish to be appointed.~~
3. ~~The criteria for qualification for appointment as a Non-Executive Director set out in paragraph 24 above (other than disqualification by virtue of paragraph 30 below) do not apply to the appointment of the initial Chair and the initial other Non-Executive Directors in accordance with the procedures set out in this paragraph.~~
4. ~~An individual appointed as the initial Chair or as an initial Non-Executive Director in accordance with the provisions of this paragraph shall be appointed for the unexpired period of their term of office as Chair or (as the case may be) Non-Executive Director of the Applicant Trust; but if, on appointment, that period is less than 12 months, they shall be appointed for 12 months.~~

27. Board of Directors - appointment of Deputy Chair

The Council of Governors at a general meeting shall appoint one of the Non-Executive Directors as a Deputy Chair for a period not exceeding their term of office as a Non-Executive Director as the Council of Governors may specify upon making the appointment.

28. Board of Directors - appointment and removal of the Chief Executive and other Executive Directors

1. The Non-Executive Directors shall appoint or remove the Chief Executive.
2. The appointment of the new Chief Executive shall require the approval of the Council of Governors.
3. The initial Chief Executive is to be appointed in accordance with paragraph 29 below.
4. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.
5. The process for the appointment to (and dismissal from) the post fulfilling the function of Trust Secretary shall be a matter for the whole Board of Directors.

~~29. Board of Directors - appointment and removal of initial Chief Executive~~

1. ~~The Non-Executive Directors shall appoint the Chief Executive of the Applicant Trust as the initial Chief Executive of the Trust, if he wishes to be appointed.~~
2. ~~The appointment of the Chief Executive of the Applicant Trust as the initial Chief Executive of the Trust shall not require the approval of the Council of Governors.~~

30. Board of Directors - disqualification

1. The following may not become or continue as a member of the Board of Directors:
    1. a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
    2. a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.
    3. a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.
    4. a person who does not meet all the requirements prescribed in regulations for a director of a Care Quality Commission registered service provider in particular CQC Regulation 5: Fit and Proper Persons Test as amended.

31. Board of Directors - Meetings

1. Meetings of the Board of Directors shall be open to members of the public.
2. Members of the public may be excluded from a meeting for special reasons.
3. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

32. Board of Directors - standing orders

1. The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

33. Board of Directors - conflicts of interest of Directors

1. The duties that a Director of the trust has by virtue of being a director include in particular:
    1. ~~If~~With reference to the NHSE Published document on Managing Conflicts in the NHS, Guidance for staff and organisations (Publications Gateway Reference: 06419), if a

Director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the Director shall disclose that interest to the members of the Board of Directors as soon as he becomes aware of it.

2. The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.
3. A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.
4. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

2. The duty referred to in sub paragraph ~~33~~30.1.3 above is not infringed if:
    1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
    2. The matter has been authorised in accordance with the constitution.
3. The duty referred to in sub paragraph ~~33~~30.1.4 above is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
4. In sub paragraph ~~33~~30.1.4 "third party" means a person other than:
    1. The Trust
    2. A person acting on its behalf.
5. If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other Directors.
6. If a declaration under this paragraph proves to be, or becomes inaccurate, or incomplete, a further declaration must be made.
7. Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.
8. This paragraph does not require a declaration of an interest of which the Director is not aware or where the director is not aware of the transaction or arrangement in question.
9. A Director need not declare an interest:
    1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
    2. If, or to the extent that the directors are already aware of it;
    3. If or to the extent that it concerns terms of the directors appointment that have been or are to be considered:
        1. By a meeting of the Board of Directors, or
        2. By a committee of the Directors appointed for the purpose under the constitution.

34. Board of Directors - remuneration and terms of office

1. The Council of Governors at a general meeting shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors; but pending its decision on these matters, these matters are to continue in accordance with the remuneration and allowances, and other terms and conditions of office of the respective individuals as engaged by the Applicant Trust.
2. The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors; but pending its decision on these matters, these matters are to continue in accordance with the remuneration and allowances, and other terms and conditions of office of the respective individuals as engaged by the Applicant Trust.

35. Registers

1. The Trust shall have:
    1. a register of Members showing, in respect of each Member, the constituency to which they belong and, where there are classes within it, the class to which they belong;
    2. a register of members of the Council of Governors;
    3. a register of interests of Governors;
    4. a register of Directors; and
    5. a register of interests of the Directors.

36. Admission to and removal from the registers

1. The Trust Secretary shall remove from the register of Members the names of any Members who cease to be Members under the provisions of this Constitution.

37. Registers - inspection and copies

1. The Trust shall make the registers specified in paragraph ~~35~~32 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
2. The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the Trust, if the Member so requests.
3. So far as the registers are required to be made available:
    1. they are to be available for inspection free of charge at all reasonable times; and
    2. a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

4. If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Documents available for public inspection

1. The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
    1. a copy of the current Constitution;
    2. a copy of the latest Annual Accounts and of any report of the auditor on them;
    3. a copy of the latest Annual Report;
2. The Trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:
    1. A copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
    2. A copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.
    3. A copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.
    4. A copy of any statement provided under section 65F (administrators draft report) of the 2006 Act.
    5. A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirement), 65J (power to extend time), 65KA (~~Monitor~~NHSE's decision), 65KC (action following Secretary of State's rejection of final report), or 65KD (Secretary of State's response to re submitted final report) of the 2006 Act.
    6. A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act
    7. A copy of any final report published under section 65I (administrator's final report)
    8. A copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary state's rejection of final report) of the 2006 Act.
    9. A copy of any information published under section 65M (a replacement of trust special administrator) of the 2006 Act.
3. Subject to 38.4 below any person who requests a copy of or extract from any of the above documents is to be provided with a copy.
4. If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

39. Auditor

1. The Trust shall have an auditor.
2. The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit Committee

1. The Trust shall establish a committee of non-executive directors as an audit committee to perform such ~~monitoring~~NHSEing, reviewing and other functions as are appropriate. One of the Non-Executive Director members of the Audit Committee must satisfy the UK Corporate Governance Code requirement of having relevant and recent financial experience.

41. Accounts

1. The Trust shall keep proper accounts and proper records in relation to such accounts.
2. The ~~Monitor~~NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts
3. The accounts are to be audited by the Trust's Auditor.
4. The Trust shall prepare in respect of each Financial Year Annual Accounts in such form as the ~~Secretary of State~~NHSE may direct.
5. The functions of the Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

42. Annual Report, forward plans and non NHS work

1. The Trust shall prepare an Annual Report ~~and send it to Monitor~~following guidance issued by NHSE annually.
2. The Trust shall give information as to its forward planning in respect of each financial year to the ~~Monitor~~NHSE.
3. The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.
4. In preparing the document, the directors shall have regard to the views of the Council of Governors.
5. Each forward plan must include information about:
    1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
    2. the income it expects to receive from doing so.
6. Where a Forward Plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph ~~42~~39.5.1 the Council of Governors must:

1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and
2. notify the Directors of the Trust of its determination.

7. A Trust which proposes to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the governors and members.

1. The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
    1. the Annual Accounts
    2. any report of the auditor on them
    3. the annual report.
2. The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.
3. The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph ~~43~~40.1 with the Annual Members Meeting.

44. Instruments

1. The Trust shall have a seal.
2. The seal shall not be affixed except under the authority of the Board of Directors.

45. Amendment of the Constitution

1. The Trust may make amendments of its constitution only if:
    1. More than half of the members of the Council of Governors of the trust voting approve the amendments, and
    2. More than half of the Board of Directors of the trust voting approve the amendments.
2. Amendments made under paragraph ~~46~~42.1 above take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would as a result of the amendment ~~would~~ not accord with schedule 7 of the 2006 Act.
3. Where an amendment is made to the constitution in relation to the powers ~~of~~and duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):
    1. At least one member from the Council of Governors (Normally the Lead Governors)

must attend the next Annual Members' Meeting and present the amendment, and

2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

4. If more than half the members voting approve the amendment the amendment continues to have effect; otherwise it ceases to have effect and the trust must take such steps as are necessary as a result.
5. Amendments by the trust of its constitution are to be notified to ~~Monitor~~NHSE. For the avoidance of doubt, ~~Monitor~~NHSE's functions do not include a power or duty to determine whether or not the constitution as a result of the amendments accord with Schedule 7 of the 2006 Act.
6. Any queries raised by either a Member, a Governor, or a Director on questions regarding the interpretation of the Constitution shall be determined by the Chair in their absolute discretion. In reaching their determination the Chair shall have regard to the views of the Senior Independent Director and the Chief Executive.

46. Mergers etc and significant transactions

1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.
2. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.
3. "Significant transaction" means a transaction which meets any one of the below criteria:
    1. the total of the fixed assets and current assets subject to the transaction represents more than 25% of the value of the total fixed assets and current assets of the Trust;
    2. the increase or decrease in income attributable to:

       the assets; or

       the contract

       associated with the transaction represents more than 25% of the value of the Trust's income; or
    3. the gross capital of the company or business being acquired/ divested represents more than 25% of the total capital of the Trust following completion (where gross capital is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets).
    4. That the transaction is of nature that the Board of Directors in its absolute discretion consider to be in its opinion a novel or contentious matter

47. Interpretation and definitions

1. Questions of interpretation of this Constitution shall be decided by the Chair, who shall seek the advice of the Chief Executive and the Trust Secretary before determining the matter.

2. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act.
3. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.
4. **The '2006 Act'** is the National Health Service Act 2006;
5. **The '2012 Act'** is the Health and Social Care Act 2012;
6. **The "2022 Act"** is the Health and Care Act 2022.
7. **'Accounting Officer'** means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
8. **'Annual Accounts'** means the accounts kept by the Trust in such form as ~~Monitor~~NHSE may ~~with the approval of the Secretary of State~~ direct;
9. **'Annual Report'** means the annual report prepared by the Trust ~~and sent to Monitor~~as directed by the NHSE;
10. ~~**'Applicant Trust'** means the West Midlands Ambulance Service NHS Trust that made the application to become an NHS Foundation Trust;~~
11. **'Appointed Governors'** means those Governors appointed by the Appointing Organisations;
12. **'Appointing Organisations'** means those organisations named in this Constitution who are entitled to appoint Appointed Governors;
13. **'Area'** means the counties of Shropshire, Staffordshire, Warwickshire and Worcestershire; the unitary authorities of Herefordshire, Stoke-on-Trent and Telford and Wrekin; and the seven metropolitan districts of Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton as specified in Annex 1;
14. **'Auditor'** means a person appointed at a general meeting of the Council of Governors to audit the Trust's accounts;
15. **'Board of Directors'** means the Board of Directors as constituted in accordance with this Constitution;
16. **'Chair'** means the chairman of the Board of Directors of the Trust, appointed in accordance with paragraph 26 of this Constitution;
17. **'Chief Executive'** means the chief officer of the Trust, appointed in accordance with paragraph 28 or 29 of this Constitution;
18. **'Constitution'** means this constitution and all annexes to it;
19. **'Deputy Chair'** means the person appointed by the ~~Board of Directors~~Council of Governors to take on the Chair's duties if the Chair is absent for any reason;
20. **'Director'** means a member of the Board of Directors;
21. **'Elected Governors'** means those Governors elected by the Public Constituency and the classes of the Staff Constituency;
22. **'Executive Director'** means a member of the Board of Directors of the Trust and a voting member;
23. **'Finance Director'** means the chief financial officer of the Trust, appointed to discharge the

usual functions of its chief finance officer;

24. **'Financial Year'** means:
    1. A period beginning with the date on which the Trust is authorised and ending with the next 31 March; and
    2. Each successive period of twelve months beginning with 1 April.
25. **'Forward Plan'** means the document prepared by the Trust pursuant to paragraph 27 of schedule 7 to the 2006 Act.
26. **'Governor'** means a person who is a member of the Council of Governors of the Trust, being either an Elected Governor or an Appointed Governor;
27. **Integrated Care Board** means a statutory organisations that bring NHS and care organisations together locally improve population health and establish shared strategic priorities within the NHS.
28. **Integrated Care Partnership an Integrated Care Partnership (ICP)** is a formal partnership of organisations which brings together NHS organisations (providers and commissioners), local authorities and key voluntary sector and independent partners, working together to improve the health and care of the whole population they serve.
29. **Integrated Care System** an Integrated Care System (ICS) in England is a statutory partnership of organisations who plan, buy, and provide health and care services.
30. **Licence** means the Trust's Provider Licence granted by NHSE under the 2012 Act, reissued by NHS England in April 2023 to align with modified licence standard conditions.
31. **'Member'** means a member of the Trust;
32. **NHS England** means the organisational body for oversight of NHS Foundation Trusts, NHS Trusts, as w ell as independent providers that provide NHS-funded care and which operationally brings together a number of former corporate bodies, including (inter alia) NHSE.The Health and Care Act 2022 merged the former body corporate known as 'NHSE' and the Trust Development Authority into NHS England.
33. '**Council of Governors**' means the Council of Governors as constituted in accordance with this Constitution, which has the same meaning as the Council of Governors in the 2006 Act, as amended by the Health and Social Care Act 2012;
34. ~~**'Monitor'** means the body corporate known as Monitor, as provided by Section 61 of the 2012 Act;~~
35. **'Non-Executive Director'** means a member of the Board of Directors of the Trust who is not an executive officer of the Trust;
36. **'Partner'** means, in relation to another person, a member of the same household living together as a family unit;
37. **'Partnership Governor'** means a Governor appointed by a Partnership Organisation;
38. **'Partnership Organisation'** means those organisations nominated by the Trust to be designated as partnership organisations for the purposes of this Constitution;
39. **'Public Constituency'** means (collectively) those members living in one of the areas of the Trust;

40. **'Public Governor'** means a Governor elected by the members of one of the Public Constituencies;
41. **'Registered Medical Practitioner'** means a fully registered person within the meaning of the Medicines Act 1983 who holds a licence to practice under that Act;
42. **'Staff Constituency'** means (collectively) those members of the five classes comprising the Staff Constituency;
43. **'Staff Governor'** means a Governor elected by the members of one of the classes of the Staff Constituency.
44. **The 'Trust'** means West Midlands Ambulance Service University NHS Foundation Trust;
45. **'Trust Secretary'** means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;

ANNEX 1 - THE PUBLIC CONSTITUENCY

1. There are five constituent areas of the Trust that make up the Public Constituency. The constituent areas reflect the boundaries of the following areas:
    1. Birmingham (Comprising Birmingham City Council, Solihull MBC);
    2. Coventry and Warwickshire (Comprising Coventry City Council, Warwickshire County Council, North Warwickshire District Council, Nuneaton & Bedworth District Council, Rugby District Council, Stratford on Avon District Council and Warwick District Council);
    3. Herefordshire, Shropshire and Worcestershire (Comprising Herefordshire County Council, Shropshire County Council, Worcestershire County Council, Bromsgrove District Council, Malvern Hills District Council, Redditch District Council, Worcester City Council, Wychavon District Council, Wyre Forest District Council and Telford & Wrekin Council);
    4. Staffordshire (Comprising Staffordshire County Council, Stoke on Trent City Council, Cannock Chase District Council, East Staffordshire District Council, Lichfield District Council, Newcastle under Lyme District Council, South Staffordshire District Council, Stafford District Council, Staffordshire Moorlands District Council, Tamworth District Council.);
    5. The Black Country (Comprising Dudley Metropolitan Council, Sandwell Metropolitan Council, Walsall Metropolitan Council and Wolverhampton City Council).
2. Membership of the Public Constituency is open to individuals who:
    1. live within in the relevant area of the Trust;
    2. Are not eligible to be members of any of the classes of the Staff Constituency.
3. The minimum number of members of each of the constituent areas is to be 100 (one hundred).

ANNEX 2 - THE STAFF CONSTITUENCY

1. The Staff Constituency may elect five (5) Governors to represent the following four classes:

1. Emergency and Urgent Operational Staff **(This class may elect two (2) Governors at least one of which must be a state registered paramedic.)**
2. Emergency Operations Centre staff.
3. Non-emergency operational staff (including patient and courier transport services and non-emergency call centre staff).
4. Support staff and those not included in one of the categories above.

2. All individuals who are entitled under this Constitution to become members of one of the classes of the Staff Constituency, and who:
    1. have been invited by the Trust to become a member of the appropriate class; and
    2. have not informed the Trust that they do not wish to do so
    3. Shall become members of the appropriate class.
3. A person who is eligible to be a member of one of the classes of the Staff Constituency may not become or continue as a member of the Public Constituency, and may not become or continue as a member of more than one class of the Staff Constituency.
4. The minimum number of members of each class of the Staff Constituency is to be 20.

ANNEX 3 - COMPOSITION OF COUNCIL OF GOVERNORS

1. The Council of Governors of the Trust shall comprise Elected Governors and Appointed Governors.
2. Elected Governors include those elected by the Members of the areas within the Public Constituency, and those elected by the Members of the classes within the Staff Constituency.
3. Appointed Governors will include those appointed by bodies as required by statute, and also those appointed by Partnership Organisations identified by the Trust. More than half the aggregate number of Governors within the Council of Governors shall be those within the Public Constituency:

Elected Governors:

Electoral Areas within the Public Constituency	**Number**
Birmingham (Comprising Birmingham City Council, Solihull MBC);	2
Coventry and Warwickshire (Comprising Coventry City Council, Warwickshire County Council, North Warwickshire District Council, Nuneaton & Bedworth District Council, Rugby District Council, Stratford on Avon District Council and Warwick District Council);	2
Herefordshire, Shropshire and Worcestershire (Comprising Herefordshire County Council, Shropshire County Council, Worcestershire County Council, Bromsgrove District Council, Malvern Hills District Council, Redditch District Council, Worcester City Council, Wychavon District Council, Wyre Forest District Council and Telford & Wrekin Council)	2

Staffordshire (Comprising Staffordshire County Council, Stoke on Trent City Council, Cannock Chase District Council, East Staffordshire District Council, Lichfield District Council, Newcastle under Lyme District Council, South Staffordshire District Council, Stafford District Council, Staffordshire Moorlands District Council, Tamworth District Council.)	2
The Black Country Comprising Dudley Metropolitan Council, Sandwell Metropolitan Council, Walsall Metropolitan Council and Wolverhampton City Council)	2
Classes within the Staff Constituency	**Number**
Emergency and Urgent Operational Staff **(This class may elect two (2) Governors, at least one of which must be a State Registered Paramedic who will have received the greatest number of votes for the paramedic nominated within this class.)**	2
Emergency Operations Centre staff	1
Non-emergency operational staff (including patient and courier transport services and non-emergency call centre staff)	1
Support Staff and those not included in one of the categories above.	1

Appointed Governors:

Statutory - 1	**Number**
At its sole discretion, the Board of Directors shall invite one qualifying local authority to appoint a Governor, who shall be appointed to serve a three year term. A qualifying local authority shall mean a local authority for an area which includes the whole or part of an area specified in this Constitution as an area for a Public Constituency.	1
Partnership Organisations - ~~5~~1	**Number**
At its sole discretion, the Board of Directors shall invite the following organisations to appoint a Governor, who shall be appointed for a three year term:	
The West Midlands Community First Responders Regional Forum may appoint one (1) Governor	1

ANNEX 4 - NHS PROVIDERS NETWORK MODEL ELECTION RULES 2014

PART 1: INTERPRETATION	
1.	Interpretation
PART 2: TIMETABLE FOR ELECTION	
2.	Timetable
3.	Computation of time

PART 1: INTERPRETATION

1. **Interpretation**

    1. In these rules, unless the context otherwise requires:

        "2006 Act" means the National Health Service Act 2006;

        "corporation" means the public benefit corporation subject to this constitution;

        "council of governors" means the council of governors of the corporation;

        "declaration of identity" has the meaning set out in rule 21.1;

        "election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

        "e-voting" means voting using either the internet, telephone or text message;

        "e-voting information" has the meaning set out in rule 24.2;

        "ID declaration form" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

        "internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of

enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (~~Monitor~~NHSE, December 2013) or any later version of such code.

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"~~Monitor~~NHSE" means the corporate body known as ~~Monitor~~NHSE as provided by section 61 of the 2012 Act;

"numerical voting code" has the meaning set out in rule 64.2(b)

"polling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

"telephone short code" means a short telephone number used for the purposes of submitting a vote by text message;

"telephone voting facility" has the meaning set out in rule 26.2;

"telephone voting record" has the meaning set out in rule 26.5 (d);

"text message voting facility" has the meaning set out in rule 26.3;

"text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"voting information" means postal voting information and/or e-voting information

2. Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. **Timetable**

    1. The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

    2. Notwithstanding the terms on which Elected and Appointed Governors were elected of appointed, and in order for the Trust to bring all Governor elections on to a revised timetable, all Elected and Appointed Governor's terms of office shall cease with effect from 31st December 2022 and that the term of office of all Elected and Appointed Governors shall be 3 years from 1st January 2023.

3. **Computation of time**

    1. In computing any period of time for the purposes of the timetable:

        a. a Saturday or Sunday;

        b. Christmas day, Good Friday, or a bank holiday, or

        c. a day appointed for public thanksgiving or mourning,

    shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

    2. In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. **Returning Officer**

    1. Subject to rule 69, the returning officer for an election is to be appointed by the

corporation.

2. Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. **Staff**

    1. Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. **Expenditure**

    1. The corporation is to pay the returning officer:

        a. any expenses incurred by that officer in the exercise of his or her functions under these rules,

        b. such remuneration and other expenses as the corporation may determine.

7. **Duty of co-operation**

    1. The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. **Notice of election**

    1. The returning officer is to publish a notice of the election stating:

        a. the constituency, or class within a constituency, for which the election is being held,

        b. the number of members of the council of governors to be elected from that constituency, or class within that constituency,

        c. the details of any nomination committee that has been established by the corporation,

        d. the address and times at which nomination forms may be obtained;

        e. the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

        f. the date and time by which any notice of withdrawal must be received by the returning officer

        g. the contact details of the returning officer

        h. the date and time of the close of the poll in the event of a contest.

9. **Nomination of candidates**

    1. Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

2. The returning officer:
    a. is to supply any member of the corporation with a nomination form, and
    b. is to prepare a nomination form for signature at the request of any member of the corporation,

    but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. **Candidate's particulars**
    1. The nomination form must state the candidate's:
        a. full name,
        b. contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
        c. constituency, or class within a constituency, of which the candidate is a member.

11. **Declaration of interests**
    1. The nomination form must state:
        a. any financial interest that the candidate has in the corporation, and
        b. whether the candidate is a member of a political party, and if so, which party,

    and if the candidate has no such interests, the paper must include a statement to that effect.

12. **Declaration of eligibility**
    1. The nomination form must include a declaration made by the candidate:
        a. that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
        b. for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. **Signature of candidate**
    1. The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
        a. they wish to stand as a candidate,
        b. their declaration of interests as required under rule 11, is true and correct, and
        c. their declaration of eligibility, as required under rule 12, is true and correct.
    2. Where the return of nomination forms in an electronic format is permitted, the

returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. **Decisions as to the validity of nomination**

    1. Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

        a. decides that the candidate is not eligible to stand,

        b. decides that the nomination form is invalid,

        c. receives satisfactory proof that the candidate has died, or

        d. receives a written request by the candidate of their withdrawal from candidacy.

    2. The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

        a. that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

        b. that the paper does not contain the candidate's particulars, as required by rule 10;

        c. that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

        d. that the paper does not include a declaration of eligibility as required by rule 12, or

        e. that the paper is not signed and dated by the candidate, if required by rule 13.

    3. The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

    4. Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

    5. The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. **Publication of statement of candidates**

    1. The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

    2. The statement must show:

        a. the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate

standing, and

b. the declared interests of each candidate standing,

as given in their nomination form.

3. The statement must list the candidates standing for election in alphabetical order by surname.
4. The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. **Inspection of statement of nominated candidates and nomination forms**

1. The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.
2. If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. **Withdrawal of candidates**

1. A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. **Method of election**

1. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.
2. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.
3. If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

a. the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

b. the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. **Poll to be taken by ballot**

1. The votes at the poll must be given by secret ballot.
2. The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.
3. The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.
4. The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.
5. Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:
    a. if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
        i. configured in accordance with these rules; and
        ii. will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;
    b. if telephone voting is to be a method of polling, the telephone voting system to be used for the purpose of the election is:
        i. configured in accordance with these rules; and
        ii. will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;
    c. if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
        i. configured in accordance with these rules; and
        ii. will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. **The ballot paper**

1. The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.
2. Every ballot paper must specify:
    a. the name of the corporation,
    b. the constituency, or class within a constituency, for which the election is being held,
    c. the number of members of the council of governors to be elected from that constituency, or class within that constituency,

d. the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

e. instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

f. if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

g. the contact details of the returning officer.

3. Each ballot paper must have a unique identifier.

4. Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. **The declaration of identity (public and patient constituencies)**

1. The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

a. that the voter is the person:

i. to whom the ballot paper was addressed, and/or

ii. to whom the voter ID number contained within the e-voting information was allocated,

b. that he or she has not marked or returned any other voting information in the election, and

c. the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

2. The voter must be required to return his or her declaration of identity with his or her ballot.

3. The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. **List of eligible voters**

1. The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who

are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

2. The list is to include, for each member:
    a. a postal address; and,
    b. the member's e-mail address, if this has been provided

    to which his or her voting information may, subject to rule 22.3, be sent.
3. The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. **Notice of poll**
    1. The returning officer is to publish a notice of the poll stating:
        a. the name of the corporation,
        b. the constituency, or class within a constituency, for which the election is being held,
        c. the number of members of the council of governors to be elected from that constituency, or class with that constituency,
        d. the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
        e. that the ballot papers for the election are to be issued and returned, if appropriate, by post,
        f. the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
        g. the address for return of the ballot papers,
        h. the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
        i. the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
        j. the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
        k. the date and time of the close of the poll,
        l. the address and final dates for applications for replacement voting information, and
        m. the contact details of the returning officer.

24. **Issue of voting information by returning officer**
    1. Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by

post to each member of the corporation named in the list of eligible voters:

a. a ballot paper and ballot paper envelope,

b. the ID declaration form (if required),

c. information about each candidate standing for election, pursuant to rule 61 of these rules, and

d. a covering envelope;

("postal voting information").

2. Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

a. instructions on how to vote and how to make a declaration of identity (if required),

b. the voter's voter ID number,

c. information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,

d. contact details of the returning officer,

("e-voting information").

3. The corporation may determine that any member of the corporation shall:

a. only be sent postal voting information; or

b. only be sent e-voting information; or

c. be sent both postal voting information and e-voting information;

for the purposes of the poll.

4. If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

5. The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. **Ballot paper envelope and covering envelope**

1. The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

2. The covering envelope is to have:
    a. the address for return of the ballot paper printed on it, and
    b. pre-paid postage for return to that address.
3. There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
    a. the completed ID declaration form if required, and
    b. the ballot paper envelope, with the ballot paper sealed inside it.

26. **E-voting systems**

1. If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").
2. If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).
3. If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).
4. The returning officer shall ensure that the polling website and internet voting system provided will:
    a. require a voter to:
        i. enter his or her voter ID number; and
        ii. where the election is for a public or patient constituency, make a declaration of identity;

    in order to be able to cast his or her vote;
    b. specify:
        i. the name of the corporation,
        ii. the constituency, or class within a constituency, for which the election is being held,
        iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
        iv. the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
        v. instructions on how to vote and how to make a declaration of identity,

vi. the date and time of the close of the poll, and

vii. the contact details of the returning officer;

c. prevent a voter from voting for more candidates than he or she is entitled to at the election;

d. create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

i. the voter's voter ID number;

ii. the voter's declaration of identity (where required);

iii. the candidate or candidates for whom the voter has voted; and

iv. the date and time of the voter's vote,

e. if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

f. prevent any voter from voting after the close of poll.

5. The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

a. require a voter to

i. enter his or her voter ID number in order to be able to cast his or her vote; and

ii. where the election is for a public or patient constituency, make a declaration of identity;

b. specify:

i. the name of the corporation,

ii. the constituency, or class within a constituency, for which the election is being held,

iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,

iv. instructions on how to vote and how to make a declaration of identity,

v. the date and time of the close of the poll, and

vi. the contact details of the returning officer;

c. prevent a voter from voting for more candidates than he or she is entitled to at the election;

d. create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

i. the voter's voter ID number;

ii. the voter's declaration of identity (where required);

iii. the candidate or candidates for whom the voter has voted; and

iv. the date and time of the voter's vote

e. if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

f. prevent any voter from voting after the close of poll.

6. The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

a. require a voter to:

i. provide his or her voter ID number; and

ii. where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

b. prevent a voter from voting for more candidates than he or she is entitled to at the election;

c. create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

i. the voter's voter ID number;

ii. the voter's declaration of identity (where required);

iii. the candidate or candidates for whom the voter has voted; and

iv. the date and time of the voter's vote

d. if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

e. prevent any voter from voting after the close of poll.

The poll

27. **Eligibility to vote**

1. An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. **Voting by persons who require assistance**

1. The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

2. Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. **Spoilt ballot papers and spoilt text message votes**

1. If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.
2. On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.
3. The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:
    a. is satisfied as to the voter's identity; and
    b. has ensured that the completed ID declaration form, if required, has not been returned.
4. After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):
    a. the name of the voter, and
    b. the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
    c. the details of the unique identifier of the replacement ballot paper.
5. If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a “spoilt text message vote”), that voter may apply to the returning officer for a replacement voter ID number.
6. On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.
7. The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter’s identity.
8. After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list (“the list of spoilt text message votes”):
    a. the name of the voter, and
    b. the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
    c. the details of the replacement voter ID number issued to the voter.

30. **Lost voting information**

1. Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.
2. The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:
    a. is satisfied as to the voter's identity,
    b. has no reason to doubt that the voter did not receive the original voting information,

c. has ensured that no declaration of identity, if required, has been returned.

3. After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

    a. the name of the voter

    b. the details of the unique identifier of the replacement ballot paper, if applicable, and

    c. the voter ID number of the voter.

31. **Issue of replacement voting information**

1. If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

2. After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

    a. the name of the voter,

    b. the unique identifier of any replacement ballot paper issued under this rule;

    c. the voter ID number of the voter.

32. **ID declaration form for replacement ballot papers (public and patient constituencies)**

1. In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. **Procedure for remote voting by internet**

1. To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

2. When prompted to do so, the voter will need to enter his or her voter ID number.

3. If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

4. To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

5. The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. **Voting procedure for remote voting by telephone**

1. To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.
2. When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.
3. If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.
4. When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.
5. The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. **Voting procedure for remote voting by text message**

1. To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.
2. The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.
3. The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. **Receipt of voting documents**

1. Where the returning officer receives:
    a. a covering envelope, or
    b. any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

   before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.
2. The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
    a. the candidate for whom a voter has voted, or
    b. the unique identifier on a ballot paper.
3. The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. **Validity of votes**

1. A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.
2. Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
    a. put the ID declaration form if required in a separate packet, and
    b. put the ballot paper aside for counting after the close of the poll.
3. Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:
    a. mark the ballot paper "disqualified",
    b. if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
    c. record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and
    d. place the document or documents in a separate packet.
4. An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.
5. Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.
6. Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:
    a. mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
    b. record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
    c. place the document or documents in a separate packet.

38. **Declaration of identity but no ballot paper (public and patient constituency)**[1]

1. Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:
    a. mark the ID declaration form "disqualified",
    b. record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter

without a ballot paper, and

c. place the ID declaration form in a separate packet.

39. **De-duplication of votes**

1. Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.
2. If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
    a. only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
    b. mark as “disqualified” all other votes that were cast using the relevant voter ID number
3. Where a ballot paper is disqualified under this rule the returning officer shall:
    a. mark the ballot paper “disqualified”,
    b. if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
    c. record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
    d. place the document or documents in a separate packet; and
    e. disregard the ballot paper when counting the votes in accordance with these rules.
4. Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
    a. mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
    b. record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
    c. place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
    d. disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. **Sealing of packets**

1. As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
    a. the disqualified documents, together with the list of disqualified documents inside it,

b. the ID declaration forms, if required,

c. the list of spoilt ballot papers and the list of spoilt text message votes,

d. the list of lost ballot documents,

e. the list of eligible voters, and

f. the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

41. **STV41 Interpretation of Part 6**

1. In Part 6 of these rules:

"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

a. on which no second or subsequent preference is recorded for a continuing candidate,
or

b. which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned

below:

a. "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

b. "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

c. in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule STV46,

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

“stage of the count” means:

a. the determination of the first preference vote of each candidate,

b. the transfer of a surplus of a candidate deemed to be elected, or

c. the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate

"*transfer value*' means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.

42. **Arrangements for counting of the votes**

1. The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.
2. The returning officer may make arrangements for any votes to be counted using vote counting software where:
    a. the board of directors and the council of governors of the corporation have approved:
        i. the use of such software for the purpose of counting votes in the relevant election, and
        ii. a policy governing the use of such software, and
    b. the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. **The count**

1. The returning officer is to:
    a. count and record the number of:
        i. ballot papers that have been returned; and
        ii. the number of internet voting records, telephone voting records

and/or text voting records that have been created, and

b. count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

c. The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

2. The returning officer is to proceed continuously with counting the votes as far as is practicable.

44. **STV44 Rejected ballot papers and rejected text voting records**

1. Any ballot paper:

a. which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

b. on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

c. on which anything is written or marked by which the voter can be identified except the unique identifier, or

d. which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

2. The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

3. Any text voting record:

a. on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

b. on which anything is written or marked by which the voter can be identified except the unique identifier, or

c. which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

4. The returning officer is to endorse the word "rejected" on any text voting record

which under this rule is not to be counted.

5. The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44 Rejected ballot papers and rejected text voting records

1. Any ballot paper:
    a. which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
    b. on which votes are given for more candidates than the voter is entitled to vote,
    c. on which anything is written or marked by which the voter can be identified except the unique identifier, or
    d. which is unmarked or rejected because of uncertainty,

    shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.
2. Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.
3. A ballot paper on which a vote is marked:
    a. elsewhere than in the proper place,
    b. otherwise than by means of a clear mark,
    c. by more than one mark,

    is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.
4. The returning officer is to:
    a. endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and
    b. in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.
5. The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:
    a. does not bear proper features that have been incorporated into the ballot paper,

b. voting for more candidates than the voter is entitled to,

c. writing or mark by which voter could be identified, and

d. unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

6. Any text voting record:

    a. on which votes are given for more candidates than the voter is entitled to vote,

    b. on which anything is written or marked by which the voter can be identified except the voter ID number, or

    c. which is unmarked or rejected because of uncertainty,

    shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

7. Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

8. A text voting record on which a vote is marked:

    a. otherwise than by means of a clear mark,

    b. by more than one mark,

    is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

9. The returning officer is to:

    a. endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

    b. in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

10. The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

    a. voting for more candidates than the voter is entitled to,

    b. writing or mark by which voter could be identified, and

    c. unmarked or rejected because of uncertainty,

    and, where applicable, each heading must record the number of text voting records rejected in part.

45. **STV45 First stage**

1. The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.
2. The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.
3. The returning officer is to also ascertain and record the number of valid ballot documents.

46. **STV46 The quota**

1. The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.
2. The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").
3. At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

47. **STV47 Transfer of votes**

1. Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:
    a. according to next available preference given on those ballot documents for any continuing candidate, or
    b. where no such preference is given, as the sub-parcel of non- transferable votes.
2. The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.
3. The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.
4. The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:
    a. reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
    b. is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).
5. Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which

was last received by that candidate into separate sub-parcels so that they are grouped:

a. according to the next available preference given on those ballot documents for any continuing candidate, or

b. where no such preference is given, as the sub-parcel of non- transferable votes.

6. The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

7. The vote on each ballot document transferred under rule STV47.6 shall be at:

a. a transfer value calculated as set out in rule STV47.4(b), or

b. at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

8. Each transfer of a surplus constitutes a stage in the count.

9. Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

10. Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

a. less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

b. less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

This rule does not apply at an election where there is only one vacancy.

48. **STV48 Supplementary provisions on transfer**

1. If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

a. The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

b. the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the

lot falls shall be transferred first.

2. The returning officer shall, on each transfer of transferable ballot documents under rule STV47:
    a. record the total value of the votes transferred to each candidate,
    b. add that value to the previous total of votes recorded for each candidate and record the new total,
    c. record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non- transferable votes, and
    d. compare:
        i. the total number of votes then recorded for all of the candidates, together with the total number of non- transferable votes, with
        ii. the recorded total of valid first preference votes.
3. All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.
4. Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non- transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

49. **STV49 Exclusion of candidates**

1. If:
    a. all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
    b. subject to rule STV50, one or more vacancies remain to be filled,

    the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).
2. The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:
    a. ballot documents on which a next available preference is given, and
    b. ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who

are deemed to be elected or are excluded).

3. The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.
4. The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.
5. If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.
6. The returning officer shall transfer those ballot documents in the subparcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).
7. The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.
8. Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.
9. After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.
10. The returning officer shall after each stage of the count completed under this rule:
    a. record:
        i. the total value of votes, or
        ii. the total transfer value of votes transferred to each candidate,
    b. add that total to the previous total of votes recorded for each candidate and record the new total,
    c. record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
    d. compare:
        i. the total number of votes then recorded for each candidate together with the total number of non- transferable votes, with
        ii. the recorded total of valid first preference votes.
11. If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

12. Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.
13. If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:
    a. regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
    b. where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

50. **STV50 Filling of last vacancies**
    1. Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.
    2. Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.
    3. Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

51. **STV51 Order of election of candidates**
    1. The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.
    2. A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.
    3. Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.
    4. Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

1. Where, after the counting of votes is completed, an equality of votes is found to exist

between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52 Declaration of result for contested elections

1. In a contested election, when the result of the poll has been ascertained, the returning officer is to:
    a. declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
    b. give notice of the name of each candidate who he or she has declared elected:
        i. where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or
        ii. in any other case, to the chairman of the corporation; and
    c. give public notice of the name of each candidate whom he or she has declared elected.
2. The returning officer is to make:
    a. the total number of votes given for each candidate (whether elected or not), and
    b. the number of rejected ballot papers under each of the headings in rule FPP44.5,
    c. the number of rejected text voting records under each of the headings in rule FPP44.10,

    available on request.

52. **STV52 Declaration of result for contested elections**
    1. In a contested election, when the result of the poll has been ascertained, the returning officer is to:
        a. declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
        b. give notice of the name of each candidate who he or she has declared elected
        c. give public notice of the name of each candidate who he or she has declared elected.

2. The returning officer is to make:
    a. the number of first preference votes for each candidate whether elected or not,
    b. any transfer of votes,
    c. the total number of votes for each candidate at each stage of the count at which such transfer took place,
    d. the order in which the successful candidates were elected, and
    e. the number of rejected ballot papers under each of the headings in rule STV44.1,
    f. the number of rejected text voting records under each of the headings in rule STV44.3,

    available on request.

53. **Declaration of result for uncontested elections**
    1. In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:
        a. declare the candidate or candidates remaining validly nominated to be elected,
        b. give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and
        c. give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. **Sealing up of documents relating to the poll**
    1. On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:
        a. the counted ballot papers, internet voting records, telephone voting records and text voting records,
        b. the ballot papers and text voting records endorsed with "rejected in part",
        c. the rejected ballot papers and text voting records, and
        d. the statement of rejected ballot papers and the statement of rejected text voting records,

        and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.
    2. The returning officer must not open the sealed packets of:
        a. the disqualified documents, with the list of disqualified documents inside it,

b. the list of spoilt ballot papers and the list of spoilt text message votes,

c. the list of lost ballot documents, and

d. the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

3. The returning officer must endorse on each packet a description of:

a. its contents,

b. the date of the publication of notice of the election,

c. the name of the corporation to which the election relates, and

d. the constituency, or class within a constituency, to which the election relates.

55. **Delivery of documents**

1. Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. **Forwarding of documents received after close of the poll**

1. Where:

a. any voting documents are received by the returning officer after the close of the poll, or

b. any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

c. any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. **Retention and public inspection of documents**

1. The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

2. With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

3. A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. **Application for inspection of certain documents relating to an election**

1. The corporation may not allow:

a. the inspection of, or the opening of any sealed packet containing -
    i. any rejected ballot papers, including ballot papers rejected in part,
    ii. any rejected text voting records, including text voting records rejected in part,
    iii. any disqualified documents, or the list of disqualified documents,
    iv. any counted ballot papers, internet voting records, telephone voting records or text voting records, or
    v. the list of eligible voters, or

b. access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

2. A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.
3. The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to -
    a. persons,
    b. time,
    c. place and mode of inspection,
    d. production or opening,

    and the corporation must only make the documents available for inspection in accordance with those terms and conditions.
4. On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:
    a. in giving its consent, and
    b. in making the documents available for inspection

    ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established -
        i. that his or her vote was given, and
        ii. that ~~Monitor~~NHSE has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59 Countermand or abandonment of poll on death of candidate

1. If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:
    a. countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
    b. order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.
2. Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.
3. Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.
4. The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.
5. The returning officer is to:
    a. count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
    b. seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

    ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.
6. The returning officer is to endorse on each packet a description of:
    a. its contents,
    b. the date of the publication of notice of the election,
    c. the name of the corporation to which the election relates, and
    d. the constituency, or class within a constituency, to which the election relates
7. Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

59. **STV59 Countermand or abandonment of poll on death of candidate**

1. If, at a contested election, proof is given to the returning officer's satisfaction before

the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

a. publish a notice stating that the candidate has died, and

b. proceed with the counting of the votes as if that candidate had been excluded from the count so that -

i. ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

ii. ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

2. The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. **Election expenses**

1. Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to ~~Monitor~~NHSE under Part 11 of these rules.

61. **Expenses and payments by candidates**

1. A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

a. personal expenses,

b. travelling expenses, and expenses incurred while living away from home, and

c. expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. **Election expenses incurred by other persons**

1. No person may:

a. incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

b. give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

2. Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. **Publicity about election by the corporation**

1. The corporation may:

    a. compile and distribute such information about the candidates, and

    b. organise and hold such meetings to enable the candidates to speak and respond to questions,

    as it considers necessary.

2. Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

    a. objective, balanced and fair,

    b. equivalent in size and content for all candidates,

    c. compiled and distributed in consultation with all of the candidates standing for election, and

    d. must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

3. Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. **Information about candidates for inclusion with voting information**

1. The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

2. The information must consist of:

    a. a statement submitted by the candidate of no more than 250 words,

    b. if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

    c. a photograph of the candidate.

65. **Meaning of "for the purposes of an election"**

1. In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase

"for the purposes of a candidate's election" is to be construed accordingly.

2. The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

1. ~~An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).~~The corporation will reach agreement with a neighbouring corporation or trust (the arbitrator) to determine any claim of breach of these rules or election irregularity
2. An application may only be made once the outcome of the election has been declared by the returning officer.
3. An application may only be made to ~~Monitor~~the arbitrator by:
    a. a person who voted at the election or who claimed to have had the right to vote, or
    b. a candidate, or a person claiming to have had a right to be elected at the election.
4. The application must:
    a. describe the alleged breach of the rules or electoral irregularity, and
    b. be in such a form as the independent panel may require.
5. The application must be presented in writing within 21 days of the declaration of the result of the election. ~~Monitor will refer the application to the independent election arbitration panel appointed by Monitor.~~
6. If the ~~independent election arbitration panel~~arbitrator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.
7. ~~Monitor~~The Arbitrator shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.
8. The determination by the ~~IEAP~~person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.
9. The ~~IEAP~~Arbitrator may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

1. The following persons:
    a. the returning officer,
    b. the returning officer's staff,

    must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:
        i. the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
        ii. the unique identifier on any ballot paper,
        iii. the voter ID number allocated to any voter,
        iv. the candidate(s) for whom any member has voted.
2. No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.
3. The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. **Prohibition of disclosure of vote**
    1. No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. **Disqualification**
    1. A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:
        a. a member of the corporation,
        b. an employee of the corporation,
        c. a director of the corporation, or
        d. employed by or on behalf of a person who has been nominated for election.

70. **Delay in postal service through industrial action or unforeseen event**
    1. If industrial action, or some other unforeseen event, results in a delay in:
        a. the delivery of the documents in rule 24, or
        b. the return of the ballot papers,

    the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 - ADDITIONAL PROVISIONS COUNCIL OF GOVERNORS

Appendix 1
Objectives of the Council of Governors

1. The Trust shall seek to ensure, subject to the requirements of the 2006 Act (as amended), that the composition of the Council of Governors meets the following objectives:
    1. the interests of the community served by the Trust are appropriately represented and the values of the Trust are upheld; and
    2. the level of representation of the Public Constituency, the Staff Constituency, and the Partnership Organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs and, to this end, the Council of Governors:
        1. shall at all times maintain a policy for the composition of the Council of Governors and the Non-Executive Directors which takes account of the Trust's membership strategy, and
        2. shall from time to time, and not less than every three years, review the Membership Strategy;
        3. when appropriate, shall propose to the Board of Directors amendments to this Constitution;
        4. shall provide to the Members relevant information concerning the performance and Forward Plan of the Trust;
        5. shall act as an ambassador for the Trust at all times and act as guardians for the Members by ensuring that the Trust acts in accordance with the regulatory framework;
        6. shall act in an advisory capacity to the Board of Directors concerning the wishes of the Members and the wider community,
        7. shall act as a guardian of the Trust on behalf of the local community; and
        8. shall undertake a strategic role to inform the development of the future strategy of the Trust.

Appendix 2
Roles and Responsibilities of the Council of Governors

1. The roles and responsibilities of the Council of Governors are:
    1. at a general meeting:
        1. to appoint or remove the Chair and the other Non-Executive Directors;
        2. to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors;

3. to appoint or remove the Auditor;
4. to be presented with the approved Annual Accounts, any report of the Auditor on them and the Annual Report;
5. to consider disputes as to membership referred to it pursuant to Appendix 3 of Annex 8; and
6. to consider resolutions to remove a Governor pursuant to paragraph 14 of this Constitution.
7. approve (by a majority of the Council of Governors present and voting) an appointment (by the Non-Executive Directors) of the Chief Executive (and Accounting Officer) other than the initial Chief Executive appointed in accordance with paragraph 19 (5) of Schedule 7 to the 2006 Act;
8. ~~Approve by more than half of the members of the Council of Governors voting to refer to the panel constituted for that purpose by Monitor a question as to whether the trust has failed or is failing to either:~~
    1. ~~Act in accordance with its constitution, or~~
    2. ~~To act in accordance with provision made under Chapter 5 of the 2006 Act.~~
9. To give the views of the Council of Governors to the Directors for the purposes of the preparation (by the Directors) of the forward plan in respect of each Financial Year; and if the forward plan contains a proposal that the trust carry on an activity of a kind other than the provision of goods and services for the purposes of the health service in England then the Council of Governors must:
    1. determine whether the activity will not to any significant extent interfere with the fulfilment by the trust of its principle purpose or the performance of its other functions and then notify the Board of Directors of its determination; and,
    2. if the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods or services for the purposes of the health service in England, then the trust may only implement the proposal if more than half of the members of the Council of Governors voting approve its implementation.
10. Approve by more than half of the members of the Council of Governors voting any merger, acquisition, separation or dissolution.
11. The trust may make amendments of its constitution only if -
    1. More than half of the members of the Council of Governors of the trust voting approve the amendments, and
    2. More than half of the Board of Directors of the trust voting approve the amendments.
12. The Trust may enter into a significant transaction only if more than half of

the members of the Council of Governors of the Trust voting approve entering into the transaction.

1. "Significant transaction" means a transaction which meets any one of the below criteria:
    A. the total of the fixed assets and current assets subject to the transaction represents more than 25% of the value of the total fixed assets and current assets of the Trust; or
    B. the increase or decrease in income attributable to the assets or the contract associated with the transaction represents more than 25% of the value of the Trust's income; or
    C. the gross capital of the company or business being acquired/divested represents more than 25% of the total capital of the Trust following completion (where gross capital is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets). or
    D. That the transaction is of nature that the Board of Directors in its absolute discretion consider to be in its opinion a novel or contentious matter
13. consider the approved Annual Accounts, any report of the Auditor on them and the Annual Report; and
14. respond as appropriate when consulted by the Directors.
15. For the purposes of obtaining information about the trust's performance of its functions or directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

2. The Council of Governors also have the specific role and function of:
    1. providing views to the Board of Directors on the strategic direction of the Trust and targets for the Trust's performance and in ~~monitoring~~NHSEing the Trust's performance in terms of achieving those strategic aims and targets which have been set;
    2. developing and recruiting a representative membership;
    3. represent the interests of the Members of the trust as a whole and the interests of the public;
    4. holding ~~thenon~~the non-executive directors individually and collectively to account for the performance of the Board of Directors.
    5. Every three years reviewing the Membership Strategy of the Trust and its policy for the composition of the Council of Governors and the Non-Executive Directors, save

for the first versions of these, which shall be prepared and approved by the Board of Directors of the Trust;

6. Notwithstanding the provisions of paragraphs above, the Council of Governors may exercise any other functions at the request of the Board of Directors.

Appendix 3
Eligibility to be a Governor

Appendix 3

1. A person may not become a Governor of a Foundation Trust, and if already holding such office will immediately cease to do so, if:
    1. they are under sixteen years of age;
    2. in the case of an Elected Governor, they cease to be a member of the constituency or (where relevant) the class within the constituency they represent;
    3. in the case of an Appointed Governor, the sponsoring organisation withdraws their sponsorship of them;
    4. In the case of an Appointed Governor their primary place of business is located in an area other than an area specified in Annex 1 as an area for a Public Constituency;
    5. the relevant Partnership Organisation which they represent ceases to exist;
    6. they ~~are either~~have been a Director of the Trust~~, or a~~ in the preceding 3 years prior to the date of their nomination to stand for election as an Elected Governor, ~~Executive Director~~or in the case of an Appointed Governor, ~~Non-Executive Director, Chair, Chief Executive Officer of another NHS Foundation Trust or other Health Service Body~~the date of their appointment by a Partnership Organisation (~~unless they are appointed by a sponsoring organisation which is an NHS Foundation Trust or Health Service Body) (~~in this clause the terms "Director" include a person holding that title whether or not they are a voting member of the Board of Directors);~~ or~~
    7. ~~they have been a Director of the Applicant Trust or after Authorisation a Director of the Trust in the preceding 3 years prior to the date of their nomination to stand for election as an Elected Governor, or in the case of an Appointed Governor, the date of their appointment by a Partnership Organisation (in this clause the terms "Director" include a person holding that title whether or not they are a voting member of the Board of Directors);~~
    8. subject to paragraph 5 below they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;
    9. they have refused without reasonable cause to undertake any training which the Trust and/or Council of Governors requires all Governors to undertake;
    10. they have been expelled from the post of Governor of another NHS foundation trust;
    11. they are the spouse, Partner, parent or child of a member of the Board of Directors of the Trust;
    12. they are a member of a local authority's Scrutiny Committee covering health matters

within the Trust area;

13. they are a member of the Healthwatch;
14. being a member of one of the Public Constituencies, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a Member of the Trust, ~~and~~ that they are not prevented from being a member of the Council of Governors;
15. being a person who by reference to information revealed by a ~~Criminal Records Bureau~~Disclosure Barring Service DBS check is considered by the Chief Executive to be inappropriate on the grounds that their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute
16. if they are subject to a sex offender order;
17. being a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006 or who is in an equivalent list maintained under the laws of Scotland or Northern Ireland;
18. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
19. they have been disqualified from being a member of a relevant authority under the provisions of the Local Government Act 2000;
20. they have made a composition or arrangement with, or granted a trust deed for, their creditors and have not been discharged in respect of it;
21. they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;
22. being a person who is the subject of a disqualification order made under the Company Directors' Disqualification Act 1986;
23. they have within the preceding three years been dismissed, otherwise than by reason of redundancy or incapacity, from any paid employment with a health service body;
24. they are a person whose tenure of office as the chair or as a member or director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for nonattendance at meetings, or for non-disclosure of a pecuniary interest (in this clause the terms "director" include a person holding that title whether or not they are a voting member of the Board of Directors);
25. being a person who is an active member of a body or organisation with policies or objectives such that their membership would be likely to cause the Trust to be in breach of its statutory obligations or to bring the Trust into disrepute.
26. they are eligible to become a member of the Staff Constituency and have either sought election from the Public Constituency or appointment as a Partnership Governor.
27. If they are a CFR who are registered and actively respond on behalf of the Trust, if they are already holding office will immediately cease to do so.

2. Where a person has been elected or appointed to be a Governor and they become disqualified

from office under paragraph 14 of the Constitution or paragraph 1 above, they shall notify the Trust Secretary in writing of such disqualification and/or (as the case may be), removal as soon as is practicable and, in any event, within 14 days of first becoming aware of those matters which rendered them disqualified.

3. If it comes to the notice of the Trust Secretary at the time of their taking office or later that the Governor is so disqualified, the Trust Secretary shall immediately declare that the person in question is disqualified and notify that person in writing to that effect as soon as is practicable.
4. Upon dispatch of any such notification under paragraphs 2 or 3 above, that person's tenure of office, if any, shall be terminated immediately and they shall cease to act as a Governor, and the Trust Secretary shall cause their name to be removed from the register of the Council of Governors.
5. Where an individual is deemed by the Trust Secretary, in his/her absolute discretion, to be incapable by reason of mental disorder, illness or injury of managing and/or administering their property and/or affairs for the purposes of paragraph 1.8 above the Trust Secretary shall either:
    1. temporarily suspend the individual from office until such time as the Trust Secretary, in her/his absolute discretion, considers that person to be capable of managing and/or administering their property and affairs; or
    2. (where the Trust Secretary, in his/her absolute discretion, considers that person to be permanently incapable of managing and/or administering their property and affairs), declare that the individual is disqualified from office:
        1. In the case of a Governor, in accordance with paragraphs 3 and 4 above; and
        2. In the case of a Director, in accordance with the individual's terms and conditions of employment, service or engagement (as the case may be).
        3. In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering their property and/or affairs, the Trust Secretary shall take appropriate professional advice from internal Trust advisors, and/or external advisors, as necessary on this matter.
6. If a Governor fails to attend three meetings of the Council of Governors in any rolling 12 month period they cease to hold office unless the Chair is satisfied that:
    1. The absence was due to a reasonable cause; and
    2. The person will be able to start attending meetings of the Council of Governors again within such a period as the Chair considers reasonable.

Appendix 4
The Council of Governors (Further Provisions)

1. **Composition of the Members' Council and Declaration**
    1. Elected Governors

1. Public Governors are to be elected by members of their Public Constituency, and Staff Governors are to be elected by members of their class of the Staff Constituency. Each class/constituency may elect any of their number to be a Governor in accordance with the provisions of this Constitution.
2. If contested, the elections must be by secret ballot.
3. Elections shall be carried out in accordance with the rules set out in Annex 4 using the single transferable vote method of voting.
4. An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a Member of the Trust and that they are not prevented from being a member of the Council of Governors. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Elected Governors.

2. Appointed Governors
    1. Local authorities whose area includes the whole or part of one of the areas of the Trust will nominate individuals for appointment as Governors in accordance with the terms of this Constitution. Prior to appointment the nominations will be reviewed by the Trust Secretary in consultation with the Chair and Chief Executive.
    2. Partnership Organisations will nominate individuals for appointment as Partnership Governors. Prior to appointment the nominations will be reviewed by the Trust Secretary in consultation with the Chair and Chief Executive.

2. **Terms of office for Governors**
    1. Elected Governors
        1. shall normally hold office for a period of three years;
        2. are eligible for re-election at the end of that period;
        3. ~~may not hold office for more than nine consecutive years, and shall not be eligible for re-election if they have already held office for more than six consecutive years.~~Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles, therefore Governors may not hold office for more than nine consecutive years (three consecutive terms).

    2. Appointed Governors
        1. shall normally hold office for a period of three years commencing from the general meeting at which their appointment is announced;

2. are eligible for re-appointment at the end of that period;
3. ~~may not hold office for longer than nine consecutive years, and shall not be eligible for re-appointment if they have already held office for more than six consecutive years.~~Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles, therefore Governors may not hold office for more than nine consecutive years (three consecutive terms).

3. ~~Notwithstanding the terms on which Elected and Appointed Governors were either elected or appointed, and in order for the Trust to bring all Governor elections on to a common timetable, all Elected and Appointed Governor's terms of office shall cease with effect from 31st December 2022 and that the term of office of all Elected and Appointed Governors shall be 3 years from 1st January 2023.~~

3. **Remuneration**
    1. The Trust may reimburse Governors for travelling and other costs and expenses incurred in carrying out their duties at such rates as the Board of Directors decides. These are to be disclosed in the Annual Report.
    2. Governors are not to receive remuneration.

4. **Vacancies**
    1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provision will apply.
        1. Where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.
        2. Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:
            1. to call an election within three months to fill the seat for the remainder of that term; or
            2. to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat for any unexpired period of the term of office.
            3. or at the sole discretion of the Council of Governors, to carry the vacancy until such time as elections are held.

5. **Meetings of the Council of Governors**
    1. The Council of Governors is to meet at least four times (one of which shall be the Annual Members Meeting) in each Financial Year. Save in the case of emergencies or the need to conduct urgent business, the Trust Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.
    2. An annual meeting of the Council of Governors shall be convened each Financial Year (the "Annual Members' Meeting") by no later than 30 September ~~apart from the~~

~~first year~~; the Annual Members' Meeting is to receive and consider the Annual Accounts and any report of the Auditor on them, and the Board of Directors are to present the Annual Report to the Annual Members' Meeting.

3. Subject to paragraph 5.4 below, any meeting of the Council of Governors requires a quorum of one-third of the total number of Governors to be present.
4. For the avoidance of doubt and subject to paragraph 5.5 below, no business shall be carried out at a meeting which is not quorate.
5. If at any meeting of the Council of Governors, there is no quorum present within 30 minutes of the time fixed for the start of the meeting the meeting shall stand adjourned for a minimum period of 5 Clear Days and the Trust Secretary shall give or shall procure the giving of notice to all Governors of the date, time and place of that adjourned meeting. Notwithstanding paragraph 5.3 above, upon reconvening, those present shall constitute a quorum.

6. **Governor Panels of the Council of Governors**
    1. The Council of Governors may appoint panels consisting of its members to assist it in carrying out its functions.
    2. The Council of Governors may appoint members to serve on joint committees or panels with the Board of Directors or committees thereof.
    3. The Council of Governors may call upon outside advisers to help them in their tasks, provided that the financial and any other implications of seeking outside advisers have been discussed and agreed by the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph will be determined in accordance with Appendix 3 of Annex 8 of this Constitution.

ANNEX 6 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. **Interpretation**
    1. Save as otherwise permitted by law, at any meeting of the Council of Governors, the Chair of the Trust shall be the final authority on the interpretation of the Standing Orders.
    2. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these Standing Orders shall bear the same meaning as in the Constitution.
    3. The provisions of paragraphs of the Constitution apply to these Standing Orders save that any reference to "Constitution" shall be read as a reference to these "Standing Orders".

2. **Council of Governors**
    1. The objective, roles and responsibilities of the Council of Governors are set out in Annex 5 of the Constitution and have effect as if incorporated into these Standing

Orders. Certain powers and decisions may only be exercised by the Council of Governors in formal session. These powers and decisions are set out in Appendix 2 of Annex 5 of the Constitution.

3. **These Standing Orders**
    1. These Standing Orders for the Practice and Procedures of the Council of Governors are the Standing Orders referred to in paragraph 17 of the Constitution. They may be amended in accordance with the procedure set out in paragraph ~~45~~42 of the Constitution. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

4. **Meetings of the Council of Governors**
    1. **Convening meetings of the Council of Governors**
        1. Meetings of the Council of Governors shall be convened by the Trust Secretary at such times and places as the Council of Governors may determine.
        2. The Chair may instruct the Trust Secretary to call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least eight Governors, of which two must be Elected Governors, and specifying the business to be transacted at the meeting, has been presented to him, or if, without so refusing, the Chair does not call a meeting within 5 Clear Days after such requisition has been presented to him/her at the Trust's Headquarters, the eight Governors or more may forthwith call a meeting for the purpose of conducting that business.
        3. The Council of Governors may invite the Chief Executive, members of the Board of Directors or a representative of the Auditor or other advisors to attend a meeting of the Council of Governors.
        4. The Council of Governors may agree that Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of a quorum.
    2. **Notice of meetings and agenda**
        1. Before each meeting of the Council of Governors, the Trust Secretary in consultation with the Chair will give notice of the meeting, specifying the business proposed to be transacted at it. The notice will be signed by the Chair or by an officer authorised by the Chair to sign on his/her behalf, and it shall be delivered to, or sent by post to the usual place of residence of every Governor; or sent electronically, so as to be available to them at least five clear days before the meeting save in the case of emergencies.
        2. Before each meeting of the Council of Governors the Secretary shall cause to be displayed on the Trust website and at the Trust Offices a public notice of the time and place of the meeting; and the public part of the agenda and available papers shall be displayed on the Trust's website at

least five clear days before the meeting, save in the case of emergencies.

3. Want of service of the notice of meeting on any Governor shall not affect the validity of a meeting. A notice of meeting shall be presumed to have been served one day after posting or, in the case of a notice sent electronically, on the date of transmission.
4. In the case of a meeting called by Governors in default of the Chair in accordance with Standing Order 4.1.2 the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.
5. The Trust Secretary shall arrange for agenda to be sent to Governors before the meeting and supporting papers (including draft minutes of the previous meeting), whenever possible shall accompany the agenda, but will certainly be dispatched no later than five clear days before the meeting, save in the case of emergencies, papers may be tabled only with the express permission of the Chair of the meeting.
6. In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in these Standing Orders shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom, and the agenda for the meeting shall be restricted to matters arising in that emergency.

3. **Annual Members' Meeting**

1. In accordance with paragraph 5.2 of Appendix 4 to Annex 5 of the Constitution, the Council of Governors shall hold an Annual Members' Meeting in each Financial Year (apart from the first year) and shall present to that meeting:
    1. a report by the Chair on the proceedings of its meetings held since the last Annual Members' Meeting;
    2. a report by the Trust Secretary on the progress since the last Annual Members' Meeting in developing the Membership Strategy including the steps taken to ensure that the actual membership of the Public Constituencies is representative of the persons who are eligible to be Members under the Constitution;
    3. a report by the Trust Secretary on any change to the Governors which has taken place since the last Annual Members' Meeting; and
    4. a report by the Chair, the Chief Executive and the Finance Director containing such comments as they wish to make regarding the performance of the Trust and the accounts of the Trust for the preceding Financial Year and the future service development plans of the Trust.
2. ~~The reports set out in Standing Orders 4.3.1.1 to 4.3.1.4 for the first Annual~~

~~Members' Meeting shall cover the period from the date of Authorisation to the date of that meeting.~~

4. **Setting the agenda**
    1. The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").
    2. A member of the Council of Governors desiring a matter other than a Standing Item to be included on an agenda, including a formal motion for discussion and voting on at a meeting, shall make the request in writing to the Trust Secretary at least 10 Clear Days before the meeting. For these purposes any such requests via electronic communications is acceptable. A request for a formal motion must be signed or transmitted by at least 2 Governors. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.
    3. All requests received by the Trust Secretary pursuant to Standing Order 4.4.2 will be acknowledged by the Trust Secretary in writing to the Governors who have signed or transmitted the same.

5. **Petitions**
    1. Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

6. **Written motions**
    1. In urgent situations and with the consent of the Chair, business may be affected by a Governor's written motion to deal with business otherwise required to be conducted at a meeting of the Council of Governors.
    2. If all members of the Council of Governors have been notified of the proposal and a majority of Governors who are normally entitled to attend and vote at a meeting of the Council of Governors confirms acceptance of the written motion either in writing or electronically to the Trust Secretary within five clear Days of dispatch then the motion will be deemed to have been resolved, notwithstanding that the Governors have not gathered in one place.
    3. The effective date of the resolution shall be the date that the five clear days in paragraph 4.6.2 expires and, until that date, a Governor who has previously indicated acceptance can withdraw, and the motion shall fail.
    4. Once the resolution has been passed, a copy certified by the Trust Secretary shall be recorded in the minutes of the next ensuing meeting.

7. **Chair of meetings**

1. At any meeting of the Council of Governors, the Chair of the Board of Directors, if present, shall preside.
2. If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chair shall preside.
3. If the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director as shall be appointed by the Council of Governors at that meeting shall preside at that meeting.

8. **Motions**

1. Where a Governor has requested inclusion of a matter on the agenda in accordance with Standing Order 4.4.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this Standing Order shall apply in respect of the motion.
2. Subject to Standing Order 4.8.6 below, the mover of the motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto, or to raise a point of order.
3. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move (without prior notice having been given):
    1. that the motion be withdrawn; or
    2. an amendment to the motion; or
    3. the adjournment of the discussion or the meeting; or
    4. that the meeting proceed to the next item of business on the agenda; or
    5. the appointment of an ad hoc panel of the Council of Governors be constituted to deal with a specific item of business; or
    6. that the motion be now put; or
    7. that the public be excluded from the meeting subject to stating the reasons for excluding the public.
4. In the case of Standing Orders 4.8.3.4 and 4.8.3.6 above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.
5. No amendment to the motion shall be admitted if, in the opinion of the Chair the amendment negates the substance of the motion.
6. Subject to paragraph 4.11.3.1 the mover of a motion shall have a maximum of five minutes to move and three minutes to reply. Once a motion has been moved, no Governor shall speak more than once or for more than three minutes.
7. For the avoidance of doubt, the following motions may be moved at a meeting of the Council of Governors without the notice required under

Standing Order 4.4.2 above:

1. the accuracy of the minutes of the previous meeting of the Council of Governors;
2. to change the order of business in the agenda for that meeting;
3. to refer a matter discussed at a meeting to an appropriate body or individual;
4. to seek to appoint an ad hoc panel to deal with a specific item of business and make an appropriate recommendation to a subsequent meeting of the Council of Governors or to determine a matter under Standing Order 4.6;
5. to receive reports or adopt recommendations made by the Board of Directors;
6. to withdraw a motion
7. to amend a motion
8. to proceed to the next item of business on the agenda;
9. that the question be now put;
10. to adjourn a debate;
11. to adjourn a meeting;
12. to suspend a particular Standing Order subject to the reasons for doing so being recorded in the minutes;
13. to exclude the public and press from the meeting in question subject to the reasons for doing so being recorded in the minutes;
14. to not hear further from a Governor, or to exclude them from the meeting in question; if a Governor persistently disregards the ruling of the Chair or behaves improperly or offensively or deliberately obstructs business, the Chair, in his/her absolute discretion, may move that the Governor in question be not heard further at the meeting in question and if seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting in question is adjourned for a specified period and if seconded, the motion will be voted on without discussion; and
15. a motion to give the consent of the Council of Governors to any matter where its consent is required pursuant to the Constitution.

9. **Admission of the public**

1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by resolution, the reasons for doing so are to be recorded in the

minutes of the meeting, that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

1. any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or
2. for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

2. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public and representatives of the press to electronically record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chair.

10. **Reports from the Board of Directors**

1. Unless otherwise agreed in writing between the Council of Governors and the Board of Directors, at each meeting of the Council of Governors, the Board of Directors through the Chair or an Executive Director (or a nominated officer of the Trust) is required to report to the Council of Governors on the Trust's general progress in relation to its Forward Plan.
2. At any meeting a Governor may ask any question through the Chair without notice on any report made pursuant to Standing Order 4.10.1 above after that report has been received by or while such report is under consideration at the meeting. Unless the Chair decides otherwise no statements will be made other than those which are strictly necessary to define any question posed and in any event no statements will be allowed to last longer than three minutes each. A Governor who has put such a question may also put one supplementary question, if the supplementary question arises directly out of the reply given to the initial question.

   The Chair may, in his/her absolute discretion reject any question from any Governor if in his/her opinion the question is substantially the same and relates to the same subject matter as a question which has already been put to that meeting or a previous meeting. At the absolute discretion of the Chair questions may, at any meeting which is held in public, be asked of the Executive Directors present by Members of the Trust or any other members of the public present at the meeting.

11. **Chair's ruling**

1. Subject to Standing Order 4.11.2 below, statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time, and subject to Standing Order 1.2, the decision of the Chair on questions of order, relevancy, regularity and any other matters shall be final.
2. This Standing Order applies to all forms of speech/debate by Governors in

relation to motions or questions under discussion at a meeting of the Council of Governors.

3. Content and length of speeches
    1. any approval to speak must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Chair it would not be desirable or appropriate to limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech nor any reply may exceed three minutes. In the interests of time the Chair may, in his/her absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

4. When a person may speak again
    1. A person who has already spoken on a matter at a meeting may not speak again at that meeting in respect of the same matter, except:
        1. in exercise of a right of reply; or
        2. on a point of order

5. Identification
    1. All speakers must state their name and role before starting to speak to ensure the accuracy of the minutes

12. **Voting**

1. A Governor may not vote at a meeting of the Council of Governors unless prior to the commencement of the meeting he/she has:
    1. made a standing declaration that has been received by the Secretary in the form specified within Annex A of these Standing Orders, that he/she is a member of the constituency which elected him/her; and
    2. that he/she is not prevented from being a member of the Council of Governors under this Constitution.

2. If necessary and subject to Standing Order 4.12.3 below, any question at a meeting shall be determined by a majority of the votes of the Chair and the Governors present and voting on the question.
3. Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a second or casting vote.
4. A resolution for the removal of the Chair or a Non-Executive Director shall be passed only if three-quarters of the total number of Governors vote in favour of it and the provisions of paragraphs 25.1 to 25.3 of the Constitution have been complied with

5. All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.
6. If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.
7. If a Governor so requests, the vote shall be recorded by name upon any vote (other than by paper ballot).
8. A Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link or computer and so is therefore entitled to vote.
9. All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a panel shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

13. **Special provisions relating to termination of Governors' tenure:**
    1. Where a person has been elected or appointed to be a Governor and they become disqualified from office under paragraph 14 of the Constitution, or the provisions of Appendix 3 of Annex 5 of the Constitution, they shall notify the Trust Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of first becoming aware of those matters which render them disqualified. The Trust Secretary shall forthwith remove the name from the register of Members of the Council of Governors.
    2. If it comes to the notice of the Trust Secretary that the Governor is disqualified from office in accordance with the provisions of paragraph 14 of this Constitution, whether at the time of the Governor's appointment or (as the case may be) election, or later, the Trust Secretary shall immediately declare that the individual in question is disqualified and give notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the Governor shall dispute that they are disqualified the Governor may refer the matter to the dispute resolution procedure set out in Appendix 3 of Annex 8 of the Constitution within 28 days of the date upon which the notice was given to the Governor.
    3. The Chair shall be authorised to take such action as may be immediately required, including but not limited to exclusion of the Governor concerned from the meeting so that any allegation made against a Governor under paragraph 14.4 of the Constitution can be investigated.
    4. Where any allegations under paragraph 14.4 of the Constitution are made, it shall be open to the Council of Governors to decide, by two-thirds majority of those present and voting at the meeting, to lay a formal charge of non-compliance or misconduct.

5. The Governor in question will be notified in writing of the allegations and grounds upon which the charges referred to in Standing Order 4.13.4 are made, inviting and considering his response within a defined, appropriate and reasonable timescale.
6. The Governor may be invited to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence.
7. The Governors, by three-quarters majority of those present and voting can decide whether to uphold the charge.
8. Should the Governors uphold the charge in accordance with Standing Order 4.13.7, the Governors can impose such sanctions as shall be deemed appropriate. Such sanctions may range from the issuing of a written warning as to the Governor's future conduct and consequences, to non-payment of expenses, or removal of the Governor from office in accordance with paragraph 14 of the Constitution.
9. Upon disqualification, removal or termination of a Governor's office under this Standing Order, the Trust Secretary shall cause their name to be removed immediately from the register of members of the Council of Governors.
10. Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by the Governor concerned to the dispute resolution procedure set out in paragraph 1.2.2 of Appendix 3 of Annex 8 of the Constitution within 28 days of the date upon which notice in writing of the Council of Governors decision made in accordance with Standing Orders 4.13.7 and 4.13.8 is communicated to the Governor concerned.
11. A Governor may resign from that office at any time during the term of that office by giving notice to the Trust Secretary in writing, upon which that person shall cease to hold office.
12. A Governor who resigns under Standing Order 4.13.11 above or whose office is terminated under this Standing Order or paragraph 14 of the Constitution shall not be eligible to stand for re-election or re-appointment to the Council of Governors for a period of 3 years from the date of their resignation or removal from office or the date upon which any appeal against their removal from office is disposed of whichever is later, unless a majority at a meeting of the Council of Governors agrees to waive this period.
13. Where a vacancy arises on the Council of Governors, the provisions of paragraph 4 of Appendix 4 of Annex 5 of the Constitution shall apply.

14. **Minutes**

1. The minutes of the proceedings of a meeting of the Council of Governors shall be drawn up by the Trust Secretary (or his/her nominee) and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

2. No discussion shall take place upon the minutes except upon their accuracy or where the person chairing the meeting considers discussion appropriate.
3. Any amendment to the minutes shall be agreed and recorded.

15. **Suspension of Standing Orders**
    1. Except where this would contravene any provision of the regulatory framework or any guidance or best practice advice issued by ~~Monitor~~NHSE, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Governors are present, and there is a majority of Governors who are members of the Public Constituency in attendance, and that a majority of those present vote in favour of suspension.
    2. A decision to suspend the Standing Orders shall be recorded in the minutes of the meeting and shall only be suspended for the duration of the meeting in question.
    3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be made available to the Chair and Governors.

16. **Variation and amendment of Standing Orders**
    1. These Standing Orders shall be amended in compliance with section ~~45~~42 of the Constitution

17. **Record of attendance**
    1. The names of the person chairing the meeting and Governors present at the meeting shall be recorded in the minutes.

18. **Quorum**
    1. No business shall be transacted at a meeting unless at least one-third of the total number of Governors is present.
    2. If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum period of 5 Clear Days and the Trust Secretary shall give or shall procure the giving of notice to all Governors of the date, time and place of the adjourned meeting. Notwithstanding Standing Order 4.18.1 above, upon reconvening, those present shall constitute a quorum.
    3. If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in Standing Order 7, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. **Lead Governor and Deputy Lead Governor**

    1. The Governors shall appoint a lead Governor and a deputy lead Governor at each Annual Meeting of the Council of Governors.
    2. The role and responsibilities of the lead Governor will be produced by the Board of Directors following consultation with the Council of Governors and consideration of their views ~~(save for the first version of this, which shall be produced by the Applicant~~and should include the relevant provisions of Appendix B of the NHS Foundation Trust~~) and should include the relevant provisions of Appendix B of the NHS Foundation Trust~~ Code of Governance.
    3. The deputy lead Governor shall be responsible for supporting the lead Governor in the role and for performing the responsibilities of the lead Governor whenever he/she is known to be unavailable.
    4. The appointments of the lead Governor and deputy lead Governor shall be made from those Governors who have been elected as Governors from the Public Constituency only.
    5. The lead Governor and deputy lead Governor so appointed shall hold office until the next Annual Members Meeting but shall be eligible for reappointment at that time.
    6. Nomination forms for appointment as lead Governor and deputy lead Governor shall be sent out with the papers for the Annual Members Meeting. Each nomination shall be made in writing by the Governor seeking appointment and must be returned to the Trust Headquarters addressed to the Secretary to arrive 3 Clear Days before the meeting.
    7. There shall be separate forms of nomination for appointment to the position of lead Governor and the position of deputy lead Governor and eligible Governors may be nominated for both positions.
    8. In the event of there being two or more nominations for either appointment a secret ballot shall be held of all the Governors present at the meeting with each Governor present having one vote for each contested appointment.
    9. The meeting shall adjourn while the ballots are counted by the person chairing the meeting in the presence of the Trust Secretary, and the Governor whose nomination receives the largest number of votes for each position shall be appointed.
    10. In the event of an equality of votes the meeting shall adjourn for a further ten minutes and then a second ballot shall take place, if an equality of votes still occurs then the matter shall be determined by each candidate drawing lots for the position.
    11. If one Governor receives the largest number of votes for appointment as both the lead Governor and the deputy lead Governor that Governor shall be appointed as lead Governor.
    12. The results of the ballot shall be announced at the reconvened meeting referred to in paragraph 5.9 above.
    13. Any individual appointed under the provisions of paragraphs 5.10 to 5.12 above may at any time resign from the office of lead Governor or deputy lead Governor by giving notice in writing to the Trust Secretary. The Council of Governors shall thereupon

appoint another lead Governor or deputy lead Governor (as required) at either the next meeting of the Council of Governors or the Annual Meeting (whichever is the earlier) in accordance with the provisions of paragraphs 5.7 to 5.12 above.

6. **Council of Governors Establishment of Member Panels**

    1. Subject to any guidance or best practice advice as may be issued by ~~Monitor~~NHSE, the Council of Governors may and, if directed by ~~Monitor~~the NHSE, shall appoint panels of the Council of Governors to assist it in the proper performance of its functions under the regulatory framework, consisting of the Chair and Governors.
    2. These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any panel established by the Council of Governors with the terms:
        1. Chair to be read as a reference to the Chair of the Panel
        2. Governor to be read as a reference to a member of the Panel as the context permits.
    3. Each Panel shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the regulatory framework and any guidance or best practice advice issued by ~~Monitor~~NHSE, but the Council of Governors shall not delegate to any Panel any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.
    4. Any Panel established under this Standing Order 6 may call upon outside advisors to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the dispute resolution procedure set out in Appendix 3 of Annex 8 of the Constitution.
    5. The Council of Governors shall approve the appointments to each of the panels which it has formally constituted.
    6. Where the Council of Governors is required to appoint persons to a panel to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance or best practice advice issued by ~~Monitor~~NHSE.
    7. Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed as an advisor to a panel, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.
    8. The Council of Governors may appoint Governors to serve on committees or panels with members of the Board of Directors at the request of the Chair.

7. **Declarations of Interests and Register of Interests**

    1. Declaration of interests

1. The regulatory framework requires each Governor to declare to the Trust Secretary:
    1. any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in Standing Order 7.2.1; and
    2. any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, as described in Standing Order 7.2.2 and 7.2.3; and
    3. any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in Standing Order 7.2.5.
2. Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, and in a form prescribed by the Trust Secretary attached at Annex B to these Standing Orders.
3. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.
4. Subject to Standing Order 7.2.4, if a Governor has declared a pecuniary interest (as described in Standing Order 7.2.2 and 7.2.3) they shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the minutes of the meeting. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.
5. This Standing Order 7 applies to the members of any panel of the Council of Governors or a committee or panel established jointly with the Board of Directors and applies to any member of any such panel or Committee (whether or not they are a Governor).
6. The interests of Governors in companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

2. Nature of interests
    1. Governors should have regard to the NHSE Published document entitled *Managing Conflicts of Interest in the NHS, Guidance for staff and organisations* (Publications Gateway Reference: 06419).
    2. Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by ~~Monitor~~the NHSE or the Trust from time to time; the following list is not meant to be exhaustive but is meant as guidance, the advice of the Trust Secretary should be sought in the event of any doubt:

1. directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or
2. ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust; or
3. majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS or the Trust; or
4. a position of authority in a charity or voluntary organisation in the field of health and social care; or
5. any connection with a voluntary or other organisation contracting for NHS or Trust services or commissioning NHS or services; or
6. any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

3. A Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
    1. he/she is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
    2. he/she is a Partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.
4. A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:
    1. of their membership of a company or other body, if they have no significant beneficial interest in any securities of that company or other body; or
    2. of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or
    3. of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.
5. Where a Governor:
    1. has an indirect pecuniary interest in a contract, proposed

contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
3. if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,
4. they shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however ~~to~~they have duty to disclose their ~~duty to disclose their~~ interest which shall be recorded in the minutes of the meeting.

6. A family interest is an interest of an Immediate Family Member of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of his/her.
7. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of Partners in professional partnerships should also be considered.

3. **Register of members of the Council of Governors**
    1. The register of members of the Council of Governors shall list:
        1. the names of Governors,
        2. their category of membership of the Council of Governors, and;
        3. an address through which they may be contacted which may be the Trust Secretary.
4. **Register of interests of the Council of Governors**
    1. The Trust Secretary shall keep a register of interests of Members of the Council of Governors which shall contain the names of each Governor, whether they have declared any interest, and in relation to public Elected Governors any party political affiliation.

8. **Standards of Business Conduct**
    1. Members shall comply with the Governors' Code of Conduct and any guidance or best practice advice issued by ~~Monitor or~~ the Trust or the NHSE.
    2. **Appointments and Recommendations**
        1. A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order shall not preclude a Governor from giving written

testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

2. Any informal discussions outside the Remuneration, Terms of Service and Nominations panel, whether solicited or unsolicited in relation to the appointment or nomination of an individual should be declared to the meeting of the panel determining the appointment or nomination of the individual, any advice should be sought from the Trust's Director that has responsibility for personnel and employment matters of the Trust.
3. Every Governor shall disclose to the Chief Executive or his delegated Officer any relationship between himself and a candidate for appointment or nomination as soon as they become aware of the candidature. It shall be the duty of the Chief Executive or his delegated Officer to report to the Council of Governors any such disclosure made.
4. On appointment, members of the Council of Governors should disclose to the Trust Secretary whether they are related to any other member of the Council of Governors or holder of any office in the Trust.
5. Where the relationship to a member of the Council of Governors is disclosed, Standing Order 7 shall apply.

9. **Miscellaneous**
    1. The Trust Secretary shall provide a copy of these Standing Orders to each Governor and endeavour to ensure that each Governor understands their responsibilities within these Standing Orders and the Constitution.
    2. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors and Officers of the Trust have a duty to disclose any noncompliance with these Standing Orders to the Chair as soon as possible.

ANNEX A
Declaration to the Trust Secretary of West Midlands Ambulance Service University NHS Foundation Trust

Please see the attached Annex A: Declaration to the Trust Secretary of West Midlands Ambulance Service University NHS Foundation Trust.

Annex B: Prescribed Form of Declaration of Interests

Please see the attached Annex B: Prescribed Form of Declaration of Interests.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF

DIRECTORS

1. **Introduction**
    1. **Statutory Framework**
        1. The Trust became a Public Benefit Corporation on 1st January 2013 and a licensed provider of NHS services on 1st April 2013.
        2. The Trust's principal place of business is the Trust Headquarters.
        3. Paragraph 27 of the Constitution requires the Board Directors to adopt Standing Orders for the regulation of its proceedings and business.
        4. As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.
        5. The Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework for the administration of the Trust's affairs, and these need to be read in conjunction with this Constitution. All Directors and nominated officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions contained within them.
        6. The Trust will deal with ~~Monitor~~partners in an open and co-operative manner and must promptly notify ~~Monitor~~NHSE or the CQC of anything relating to the Trust which ~~Monitor~~NHSE or the CQC would reasonably expect prompt notice of, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under the terms of its licence or any financial or performance thresholds which ~~Monitor~~the NHSE may specify from time to time.
    2. **Delegation of Powers - Scheme of Delegation**
        1. Under SO 5 (arrangements for the exercise of functions by delegation) the Board of Directors exercises its power to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee of the Board of Directors appointed by virtue of SO 6 or by an Executive Director of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated powers are covered in the Scheme of Delegation.
2. **Interpretation**
    1. Questions of interpretation of these Standing Orders shall be decided by the Chair, who shall seek the advice of the Chief Executive and/or the Trust Secretary before making his determination.
    2. Unless a contrary intention is evident or the context requires otherwise, words or

expressions contained in these Standing Orders shall bear the same meaning as in the Constitution.

3. ~~The provisions of Paragraphs 45 and 47 of the Constitution apply to these Standing Orders, save that any reference to "Constitution" shall be read as a reference to these "Standing Orders".~~

3. **The Foundation Trust Board of Directors**

    1. All business shall be conducted in the name of the Trust.
    2. All funds received in trust shall be in the name of the Trust as corporate trustee. Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees.
    3. In relation to Funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust. Accountability for charitable funds held on trust is to the Charity Commission.
    4. The Trust has the functions conferred on it by the regulatory framework.
    5. The powers of the Trust shall be exercised by the Board of Directors meeting either in public or private session as provided for in Standing Order 4.1.
    6. The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors. These powers and decisions are set out in the Scheme of Delegation.
    7. The Board of Directors (in consultation with the Council of Governors) may appoint any Non-Executive Director as the "senior independent director", for such period not exceeding the remainder of their term as a Non-Executive Director, as they may specify on appointment.
    8. Any Non-Executive Director appointed under Standing Order 3.7 may at any time resign from the office of "senior independent director" by giving notice in writing to the Chair. The Board of Directors (in consultation with the Council of Governors) may thereupon appoint another Non-Executive Director as "senior independent director" in accordance with the provisions in SO 3.7.

4. **Meeting of the Board of Directors**

    1. **Admission of the public and the press**

        1. Meetings of the Board of Directors shall be held in public unless the Board of Directors in its absolute discretion determines that any meeting of the Board of Directors shall be held in private.
        2. Where a meeting of the Board of Directors is held in public, the public and representatives of the press shall be afforded facilities to attend such meeting of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

            "...that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest".

3. The Chair shall give such directions as he thinks fit (including a decision to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting) in regard to the arrangements for meetings of the Board of Directors and (where relevant) accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business shall be conducted without interruption or disruption and, without prejudice to the power to exclude the public and representatives of the press under Standing Order 4.1.2 above, members of the public and representatives of the press will be required to withdraw upon the Board of Directors resolving as follows:

   *".that in the interests of public order the meeting adjourn for [**the period to be specified**] to enable the Board of Directors to complete business without the presence of the public or press."*

4. Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Chair.
5. Matters to be dealt with by the Board of Directors following the exclusion of the public and representatives of the press under Standing Orders 4.1.2 or 4.1.3 above shall be confidential to the Directors. Members of the Board of Directors, nominated officers, officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.
6. The Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board of Directors, and may change, alter or vary these terms and conditions as it deems fit.

2. **Calling meetings**

   1. Subject to Standing Order 4.2.2 below, meetings of the Board of Directors shall be held at such times and places as the Board of Directors may, in its absolute discretion, determine.
   2. The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors and specifying the business to be transacted at the meeting, and this has been presented to him, or if, without so refusing, the Chair does not call a meeting within 5 Clear Days after such requisition has been presented to him, at the Trust's Headquarters, such one-third or more members of the Board of Directors may forthwith call a meeting for the

purpose of conducting that business.

3. **Notice of meetings**

    a. Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every Director, or sent by post to the usual place of residence of every Director or sent electronically so as to be available to him at least 5 (five) Clear Days before the meeting, save in the case of emergencies.

    b. Before a public meeting of the Board of Directors, a public notice of the time and place of the meeting shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 5 Clear Days before the meeting, save in the case of emergencies.

    c. Want of service of the notice on any one member of the Board of Directors shall not affect the validity of a meeting but failure to serve such a notice on more than 2 Executive Directors and also 2 NonExecutive Directors will invalidate the meeting. A notice of the meeting shall be presumed to have been served one day after posting or, in the case of a notice sent electronically, on the date of transmission.

    d. In the case of a meeting called by the Directors in default of the Chair in accordance with Standing Order 4.2.2 above, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the requisition.

    e. In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in Standing Order 4.3.1 and (where relevant) Standing Order 4.3.2 above shall not prevent the calling of, or invalidate, such a meeting provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4. **Agendas and supporting papers**

    1. Agendas will be ~~sent to members of the Board of Directors~~published 5 Clear Days before the meeting and supporting papers (including the minutes of the previous meeting of the Board of Directors), shall accompany the agenda, save in an emergency giving rise to the need for an immediate meeting of the Board of Directors, as set out in Standing Order 4.3.5 above. The agenda and supporting papers shall be presumed to have been served one day after posting or, in the case of a notice being sent electronically, on the date of transmission.

5. **Setting the agenda**

    1. The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted ("Standing Items").

    2. A Director desiring a matter to be included on an agenda, other than a

Standing Item or a motion under Standing Order 4.10 (emergency motions and written motions) below, including a formal proposition for discussion and voting on at a meeting, shall make his request in writing to the Chair at least 14 Clear Days before the meeting. Requests made less than 14 Clear Days before a meeting may be included on the agenda at the sole discretion of the Chair.

3. No business may be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chair, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Board of Directors as a matter of urgency. A decision by the Chair to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

6. **Petitions**

    1. Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

7. **Presiding at meetings of the Board of Directors**

    1. At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and present, shall preside. If the Chair and Deputy Chair are absent such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.
    2. If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose shall preside.
    3. If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or the Non-Executive Directors as a class, neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair and the NonExecutive Directors) shall elect one of their number to preside during that period and that person shall exercise all the rights and obligations of the Chair, including (for the avoidance of doubt) the right to exercise a second or casting vote where the numbers of votes for and against a motion is equal.

8. **Conduct of the meeting**

    1. Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and subject to SO 2.1, the decision of the person presiding at the meeting on questions of order, relevancy, regularity and any other matters shall be final.

9. **Notices of motion**
    1. Notwithstanding the provisions of Standing Order 4.5 above, and subject to the provisions of Standing Order 4.11 (Motions: procedure at and during a meeting) and Standing Order 4.12 (Motion to rescind a resolution) below, a member of the Board of Directors wishing to move (or amend) a motion shall send a written notice to the Chair.
    2. The notice shall be delivered at least 14 Clear Days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these Standing Orders. Subject to Standing Order 4.3.4, this Standing Order shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.
10. **Emergency motions and written motions**
    1. Subject to the agreement of the Chair, and subject also to the provisions of Standing Order 4.11 (Motions: procedure at and during a meeting), a member of the Board of Directors may give the Chair written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared by the Chair to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.
    2. **Written motions**
        1. In urgent situations and with the consent of the Chair, business may be effected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.
        2. If all members of the Board of Directors have been notified of the proposal and a majority of Directors that would be entitled to attend and vote at a meeting of the Board of Directors confirm acceptance of the written motion either in writing or electronically to the Trust Secretary within 5 Clear Days of dispatch then the motion will be deemed to have been resolved not with standing that the Directors have not gathered in one place.
        3. The effective date of the resolution shall be the date on which the five days for determining the matter expires, and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.
        4. Once the resolution is passed, a copy certified by the Trust Secretary shall be recorded in the minutes of the next ensuing meeting.
11. **Motions: procedure at and during a meeting**

1. **Who may propose**
    1. A motion properly notified under Standing Order 4.9 above may be proposed by the Chair of the meeting or any other member of the Board of Directors present at the meeting. All motions so proposed must be seconded by another member of the Board of Directors.
2. **Contents of motions**
    1. The Chair may exclude from the debate at his sole discretion any motion of which notice was not given on the notice summoning the meeting other than a motion relating to:
        1. the reception of a report;
        2. consideration of any item of business before the Board of Directors;
        3. the accuracy of minutes;
        4. that the Board of Directors proceed to the next item of business on the agenda;
        5. that the Board of Directors adjourn the discussion or the meeting; or
        6. that the question be now put.
3. **Amendments to motions**
    1. A motion for amendment shall not be discussed unless it has been proposed and seconded.
    2. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board of Directors.
    3. If there are a number of amendments proposed and seconded to a motion, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.
4. **Rights of reply to motions**
    1. Amendments
        1. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.
    2. **Substantive/original motion**
        1. The mover who proposed the substantive motion shall have a right of reply at the close of any debate on the

motion.

5. **Withdrawing a motion**

    1. A motion or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

6. **Motions once under debate**

    1. When a motion is under debate, no motion may be moved other than:

        1. an amendment to the motion; or
        2. the adjournment of the discussion, or the meeting; or
        3. that the meeting proceed to the next item of business on the agenda; or
        4. the appointment of an ad hoc committee to deal with a specific item of business; or
        5. that the motion be now put; or
        6. (where relevant), a motion under Standing Order 4.1 above resolving to exclude the public (including the press); or
        7. that a member of the Board of Directors be not further heard.

    2. In the case of motions under Standing Order 4.11.6.1.3 (proceed to next business) or 4.11.6.1.5 (motion be now put), in the interests of objectivity these motions should only be put forward by a member of the Board of Directors who has not previously taken part in the debate and who is eligible to vote.
    3. If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.
    4. The mover of a motion shall have a maximum of 5 minutes to move and 5 minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak more than once or for more than 5 minutes.

12. **Motion to rescind a resolution**

    1. Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to an

appropriate committee of the Board of Directors or the Chief Executive for recommendation.

2. When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within 6 calendar months. However, the Chair may do so if he considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a committee of the Board of Directors or the Chief Executive.

13. **Voting**

1. Subject to Standing Order 4.15 (Suspension of Standing Orders), or as otherwise provided by the Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair shall have a second or casting vote.
2. All questions put to the vote shall, at the discretion of the Chair, be determined by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.
3. If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.
4. If a Director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).
5. In no circumstances may:
    1. an absent Director vote by proxy (absence is defined as being absent at the time of the vote); or
    2. a resolution be passed if it is opposed by all of the NonExecutive Directors present and voting, or by all of the Executive Directors present and voting.
6. If an Executive Director is temporarily unable to perform his/her duties due to illness or some other reason (the "Absent Director")
    1. the Board of Directors agree that it is appropriate to terminate the Absent Director's term of office and appoint a replacement Director; and,
    2. the Board of Directors agree that the duties of the Absent Director need to be carried out;
    3. then the Chair (if the Absent Director is a Chief Executive) or the Chief Executive (in any other case) may appoint an acting Director as an additional Director to carry out the Absent Director's duties temporarily.

7. For the purposes of paragraph 4.13.6 above the maximum number of Directors that may be appointed under 22.2.3 of the Constitution shall be relaxed accordingly.
8. The acting Director shall vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint that person under this paragraph notifies the acting Director that he/she is no longer to act as an acting Director.
9. The acting Director shall be an Executive Director for the purposes of the 2006 Act. He/she will be responsible for his/her own acts and defaults and he/she shall not be deemed to be the agent of the Absent Director.

14. **Minutes**

1. The minutes of the proceedings of a meeting of the Board of Directors shall be drawn up by the Trust Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.
2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.
3. Any amendment to the minutes shall be agreed and recorded at the next meeting.
4. Minutes of the meetings of the Board of Directors shall be retained by the Trust Secretary.
5. Minutes shall be circulated in accordance with Directors' wishes
6. Where providing a record of a public meeting the minutes shall be made available to the public, save for items discussed by the Directors following the exclusion of the public and representatives of the press under Standing Order 4.1.2 and 4.1.3.

15. **Suspension of Standing Orders**

1. Except where this would contravene any provision of the regulatory framework or any guidance or best practice advice issued by ~~Monitor~~NHSE, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.
2. A decision to suspend the Standing Orders shall be recorded in the minutes of the meeting.
3. A separate record of matters discussed during the suspension of Standing Orders shall be made by the Trust Secretary and shall be available to the Directors.
4. No formal business may be transacted while the Standing Orders are suspended.
5. The audit committee shall review every decision to suspend these

Standing Orders.

16. **Variation and amendment of Standing Orders**

    1. These Standing Orders shall be amended in compliance with section ~~45~~42 of the Constitution

17. **Record of attendance and apologies**

    1. The names of the Directors present at the meeting shall be recorded in the minutes, together with the names of any nominated officers, officers and others invited by the Chair to be in attendance, save for members of the public or representatives of the press.
    2. Directors who are unable to attend a meeting of the Board of Directors shall notify the Trust Secretary in advance of the meeting in question so that their apologies may be submitted.

18. **Quorum**

    1. No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors is present, including at least one Executive Director, one Non-Executive Director and the Chair.
    2. For the avoidance of doubt an "acting Director" under 4.13.6 to 4.13.9 shall count towards the quorum.
    3. If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest as provided in Standing Order 8 below, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration and Terms of Service Committee established under Standing Order 6.1.7.2 below).

19. **Meetings: electronic communication**

    1. In this Standing Order "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or reenactment thereof.
    2. A Director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic

communication.

3. A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.
4. Meetings held in accordance with this Standing Order are subject to Standing Order 4.18 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.
5. The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

20. **Adjournment of meetings**
    1. The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting.
    2. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.
    3. When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted and the date, time and place of the adjournment.

21. **Reports from the Executive Directors**
    1. At any meeting of the Board of Directors a Director may ask any question through the Chair without notice on any report by an Executive Director, or other officer of the Trust, after that report has been received by or while such report is under consideration by the Board of Directors at the meeting. The Chair may, in his absolute discretion, reject any question from any Director if, in his opinion, the question is substantially the same and relates to the same subject matter as a question which has already been put to that meeting or a previous meeting.

5. **Arrangements for the exercise of functions by delegation**
    1. Subject to Standing Order 3.6, the regulatory framework and such guidance or best practice advice as may be issued by ~~Monitor~~the NHSE, the Board of Directors may make arrangements for the exercise of any of its functions by a committee appointed by virtue of Standing Order 5.3 below or by an Executive Director subject to such restrictions and conditions as the Board of Directors considers appropriate.
    2. **Emergency powers**
        1. The powers which the Board of Directors has retained to itself within these Standing Orders or the Scheme of Delegation may, in emergency or for an

urgent decision, be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

3. **Delegation to committees**
    1. The Board of Directors shall agree from time to time to the delegation of powers to be exercised by committees of the Board of Directors consisting of voting members of the Board of Directors, which it has been formally constituted in compliance with the terms of this Constitution and terms of reference of these committees and their specific powers shall be approved by the Board of Directors.

4. **Delegation to Nominated Officers**
    1. Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Board of Directors.
    2. The Chief Executive shall prepare a Scheme of Delegation which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.
    3. Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements.
    4. The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders, but for the avoidance of doubt, the Scheme of Delegation does not form part of the Constitution.

5. **Duty to report non-compliance with Standing Orders**
    1. If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and all officers (including nominated officers) have a duty to disclose any noncompliance with these Standing Orders to the Trust Secretary as soon as possible.

6. **Committees**
    1. Appointment of committees

1. Subject to Standing order 3.6, the regulatory framework and such guidance or best practice advice issued by ~~Monitor~~the NHSE, the Board of Directors may and, if directed by ~~Monitor~~the NHSE, shall appoint committees of the Trust consisting wholly or partly of Directors or wholly of persons who are not Directors.
2. A committee appointed under Standing Order 6.1.1 may, subject to the regulatory framework and such guidance and/or best practice advice as may be issued by ~~Monitor~~the NHSE or the Board of Directors, appoint subcommittees consisting wholly or partly of Directors or wholly of persons who are not Directors.
3. These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees (and any subcommittees appointed under Standing Order 6.1.2) established by the Board of Directors, in which case the term "Chair" is to be read as a reference to the Chair of the committee (or sub-committee) as the context permits, and the term "member" is to be read as a reference to a member of the committee (or sub-committee) also as the context permits.
4. Each such committee, sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation, and/or regulations and/or such guidance or best practice advice issued by ~~Monitor~~the NHSE. Such terms of reference shall have effect as if incorporated into the Standing Orders, but for the avoidance of doubt, these terms of reference do not form part of the Constitution.
5. Where committees are authorised to establish sub-committees they may not delegate powers to the sub-committee unless expressly authorised by the Board of Directors.
6. The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and the regulatory framework permits, those persons, who are neither Directors nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the regulatory framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.
7. The committees established by the Board of Directors are:
    1. Audit Committee; and
    2. Remuneration~~, Terms of Service~~ and Nominations Committee.
8. The Constitution and terms of reference of the committees listed in Standing order 6.1.7 above shall be agreed by the Board of Directors.
9. Notwithstanding the provisions of Standing Order 6.1.7 above, and subject

to the Constitution and terms of reference of the committees being agreed by the Board of Directors, the Board of Directors may establish other committees, sub committees, including ad hoc committees, sub-committees from time to time at its discretion.

2. **Confidentiality**
    1. A member of a committee (including sub-committees) shall not disclose any matter dealt with, by, or brought before, the committee, subcommittee without its permission until the committee, sub-committee (as appropriate) shall have reported to the Board of Directors or shall otherwise have concluded on that matter.
    2. A Director or a member of a committee, sub-committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee resolve that it is confidential.

7. **Interface between the board of directors and the council of Governors**
    1. The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the regulatory framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:
        1. The Directors, having regard to the views of the Council of Governors are to prepare the Forward Plan in respect of each Financial Year to be given to ~~Monitor~~the NHSE;
        2. The Directors are to present to the Council of Governors at the Annual General Meeting of the Council of Governors the Annual Accounts, any report of the Auditor on them, and the Annual Report.
    2. The Annual Report is to give:
        1. information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership; and
        2. any other information which ~~Monitor~~the NHSE requires.
    3. In order to comply with the regulatory framework in all respects and in particular in relation to the matters which are set out in Standing Orders 7.1 and 7.2 above, the Council of Governors may request that a matter which relates to paragraphs 42 and 43 of the Constitution is included on the agenda for a meeting of the Board of Directors.
    4. If the Council of Governors so desires such a matter as described within Standing Order 7.3 above is to be included on an agenda item, they shall make their request in writing to the Chair at least 14 Clear Days before the meeting of the Board of Directors, subject to Standing Order 4.3. The Chair shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 14 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

8. **Declarations of interests and register of interests of the members of the board of Directors**

    1. The Constitution with reference to the guidance prublished by the NHSE on managing conflicts of interest in the NHS, requires members of the Board of Directors to declare:

        1. any pecuniary interest in any contract, proposed contract or other matter which is under consideration or is to be considered by the Board of Directors; and
        2. any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust, irrespective of whether those interests are direct or indirect, actual or potential.

    2. All members of the Board of Directors must declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently to the date of Authorisation must do so on appointment.
    3. Such a declaration shall be made by completing and signing a form, as prescribed by the Trust Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the Standing Orders and delivering it to the Trust Secretary on appointment or as soon thereafter as the interest arises, but within 7 Clear Days of becoming aware of the existence of a relevant and material interest.
    4. In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, he must at the meeting and as soon as practicable after its commencement disclose the fact and he must then withdraw from the meeting and play no part in the relevant discussion and he shall not vote on any question with respect to the matter.
    5. If a Director has declared a pecuniary interest in accordance with Standing Order 8.8 below he shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that matter is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.
    6. Subject to any guidance or best practice advice issued by ~~Monitor~~the NHSE, interests which should be regarded as "relevant and material" for the purposes of these Standing orders are:

        1. Directorships, including non-executive directorships held in private companies or public listed companies (with the exception of those of dormant companies);
        2. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust;
        3. majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS or the Trust;
        4. a position of authority in a charity or voluntary organisation in the field of

health and social care;

5. any connection with a voluntary or other organisation contracting for NHS or Trust services or commissioning NHS or Trust services;
6. any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks;
7. research funding or grants that may be received by an individual or their department; and
8. interests in pooled funds that are under separate management.

7. Members of the Board of Directors who hold directorships in companies likely or possibly seeking to do business with the NHS or the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.
8. A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
    1. he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
    2. he is a Partner or associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.
9. A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:
    1. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or
    2. of an interest in any company, body or person with which he is connected which is ~~soremote~~so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.
10. Where a Director:
    1. has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
    2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and
    3. if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

4. the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest in accordance with the Constitution and these Standing Orders.

11. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed for the purposes of the Constitution and these Standing Orders to be also an interest of the other.
12. If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Trust Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of Partners in professional partnerships should also be considered.
13. Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 to Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of these Standing Orders.
14. Standing Order 8 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee, sub-committee (whether or not he is also a Director).
15. **Register of interests of the members of the Board of Directors**
    1. The register of interests of members of the Board of Directors shall contain the names of each Director, whether he has declared any interests and, if so, the interests declared in accordance with the Constitution or these Standing Orders.
    2. In accordance with Standing Order 8.3 above, it is the obligation of the Director to inform the Trust Secretary in writing within 7 Clear Days of becoming aware of the existence of a relevant or material interest. The Trust Secretary must then amend the register of interests of members of the Board of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 days of receipt.
    3. The register of interests of members of the Board of Directors will be available to the public in accordance with paragraph 33 of the Constitution.

9. **Standards of business conduct**
    1. **Policy**
        1. Directors shall ensure that they follow any guidance and best practice advice issued by ~~Monitor~~the NHSE or the Trust.
    2. **Interest of Directors and Officers in contracts**
        1. Any Director or Officer who comes to know that the Trust has entered into or proposes to enter into a contract in which he has any pecuniary interest, direct or indirect, shall give notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable, but in any event within 7 days of first becoming aware of the fact. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if

known to the other, be deemed to be also the interest of that Immediate Family Member.

2. A Director or officer must also declare to the Chief Executive or Trust Secretary any other employment or business or other relationship of his, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with Standing Order 8. The Trust shall require such interests to be recorded in the register of interests of members of the Board of Directors.

3. **Canvassing of, and recommendations by, Directors in relation to appointments**

    1. Canvassing of Directors or members of any committee, subcommittee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

    2. A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

    3. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

4. **Relatives of Directors or Officers**

    1. Directors and officers shall bear in mind that candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

    2. Directors and officers shall disclose to the Trust Secretary any relationship between himself and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Trust Secretary to report to the Board of Directors any such disclosure made.

    3. On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) must disclose to the Trust Secretary whether they are related to any other member of the Board of Directors, the Council of Governors, or holder of any office in the Trust.

    4. Where the relationship to an officer, Governor, or another Director is disclosed, Standing Order 8 shall apply.

5. **External consultants**

    1. Standing Order 9 will apply equally to all external consultants or other

agents acting on behalf of the Trust.

10. **Custody of seal and sealing of documents**

    1. **Custody of seal**

        1. The common seal of the Trust shall be kept by the Trust Secretary or his nominated officer in a secure place.

    2. **Sealing of documents**

        1. The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers in accordance with the Scheme of Delegation.
        2. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or his nominated officer) and authorised and countersigned by the Chief Executive (or his nominated officer who shall not be within the originating directorate).
        3. Where it is necessary that a document shall be sealed, the common seal of the Trust shall be affixed in the presence of two officers duly authorised by the Chief Executive, and also not from the originating department, and shall be attested by them.

    3. **Register of Sealing**

        1. The Trust Secretary or his nominee shall make an entry of every sealing (numbered consecutively) in a book provided for that purpose, and shall ensure that each entry is signed by the persons who shall have approved and authorised the document and those who attested the seal. The Trust Secretary shall make a report of all sealings to the Board of Directors at least annually (the report shall contain details of the seal number, the description of the document and date of sealing).

11. **Signature of documents**

    1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.
    2. The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee of the Board of Directors to which the Board of Directors has delegated appropriate authority.
    3. Notwithstanding the generality of Standing Orders 11.1 and 11.2 above, in land transactions the signing of certain supporting documents may be delegated to nominated officers, as set out in the Scheme of Delegation, but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works, or main warranty agreements) or any

document which is required to be executed as a deed.

12. **Miscellaneous**

    1. **Standing Orders to be given to Directors and nominated officers**

        1. It is the duty of the Chief Executive to ensure that existing Directors and nominated officers and all new appointees are notified of and understand their responsibilities within these Standing Orders.
        2. Copies of the Standing Orders shall be issued to Directors and nominated officers designated by the Trust Secretary. The Trust Secretary shall ensure that new Directors and nominated officers are informed of these Standing Orders in writing and shall receive copies of these Standing Orders.

    2. **Documents having the standing of Standing Orders**

        1. The Standing Financial Instructions and the Scheme of Delegation shall have the effect as if incorporated into these Standing Orders, but for the avoidance of doubt, neither the Standing Financial Instructions nor the Scheme of Delegation form part of this Constitution.

ANNEX 8 - FURTHER PROVISIONS

Appendix 1
Board of Directors - Further Provisions

1. **Process for appointing, removing and agreeing the remuneration of the Non Executive Directors and the Chair**

    1. Subject to the provisions of paragraphs 21 to 25 ~~to 30~~ of the Constitution, the process for appointing, removing and agreeing the remuneration of the Non-Executive Directors and the Chair will be as follows:

        a. That

            1. in relation to the re appointment of the Chair or NonExecutive Director, then not less than six months before the end of the term of office of the Chair or a NonExecutive Director (as the case may be), or;
            2. in relation to the appointment of the Chair or a NonExecutive Director as a result of a vacancy, or;
            3. in relation to considering the remuneration and terms of service of the Chair or a Non-Executive Director;

        the Council of Governors will convene a Remuneration, Terms of Service and Nominations Panel to seek a suitable replacement or agree the remuneration of the Chair or Non-Executive Director.

        b. The Chair of the Council of Governors will normally preside at meetings of

the Remuneration, Terms of Service and Nominations Panel unless the panel is considering the appointment or reappointment of a Chair of the Board of Directors or their remuneration and terms of service, in which case the Deputy Chair will preside at the meeting of the Remuneration, Terms of Service and Nominations Panel.

c. Each member of the Remuneration, Terms of Service and Nominations Panel will have one vote and, in the event of equality in votes, the person chairing the Remuneration, Terms of Service and Nominations Panel will have a second or casting vote

d. Where the Remuneration, Terms of Service and Nominations Panel considers that either the Chair or the Non-Executive Director coming to the end of their term of office should be reappointed for a further term, the Remuneration, Terms of Service and Nominations Panel shall make a recommendation to the Council of Governors to that effect,~~savethatthe~~ save that the Remuneration, Terms of Service and Nominations Panel may not make any such recommendation other than for a first reappointment of the Chair or the Non-Executive Director in question.

e. Where:

   1. the Panel does not make a recommendation that the Chair or a Non-Executive Director should be reappointed in accordance with paragraph 1.1.4 above; or
   2. the Chair or (as the case may be) the Non-Executive Director in question does not want to be reappointed; or
   3. A vacancy arises due to the resignation of the Chair or a Non-Executive Director; or
   4. the Council of Governors rejects a recommendation that the Chair or (as the case may be) a Non-Executive Director should be reappointed in accordance with paragraph 1.1.4 above,

the Remuneration, Terms of Service and Nominations Panel shall initiate a process of open competition for the appointment of the Chair and/or Non-Executive Director, and the post will be advertised. Further, the Remuneration, Terms of Service and Nominations Panel shall identify the balance of individual skills, knowledge and experience that is required at the time a vacancy arises and, accordingly, draft a job description and person profile for each new appointment.

f. The Remuneration, Terms of Service and Nominations Panel of the Council of Governors will also make recommendations to the Council of Governors on the level of remuneration and allowances to be paid to the Chair and the Non-Executive Directors, ~~the Remuneration, Terms of Service and Nominations Panel shall~~with reference to the NHSE guidance issued from time to time~~, and at least every 3 years, consult, at the Trust's expense, with external professional advisors recognised as experts at appointments and/or remuneration to identify the proper level of remuneration and~~

~~allowances to be paid to the Chair and/or the Non-Executive Directors, as recommended by the Trust Secretary and the Trust's Director of Workforce (or equivalent position)~~.

g. The Remuneration, Terms of Service and Nominations Panel constituted under paragraphs 1.1.1 above may, if it considers it appropriate, be supported by appropriate advice from a human resources specialist and it may also engage an external organisation or individual recognised as expert to identify the qualifications, skills and experience required for the positions of Chair and/or Non-Executive Director to assist in the process generally.

h. The Remuneration, Terms of Service and Nominations Panel may invite an independent assessor to attend its meetings in an advisory capacity only.

i. The Council of Governors will not consider nominations for ~~membershipofthe Boardof~~membership of the Board of Directors or ~~determinethe~~determine the remuneration or allowances other than those made by the Remuneration, Terms of Service and Nominations Panel.

2. **Criteria for suspension and removal of Non-Executive Directors and the Chair**

1. **General criteria**

1. The Council of Governors, when exercising the powers of suspension or removal in accordance with paragraph ~~25~~24 of this Constitution, shall have regard to the following criteria (this is not an exhaustive list and each case shall be considered on its own merits taking into account all relevant factors, including any representations made by the Non-Executive Directors or Chair in question):

1. if a Non Executive Director fails to attend 3 consecutive ordinary meetings of the Board of Directors in any Financial Year they may be removed from office unless the Council of Governors is satisfied by a 75% majority of the Council of Governors present and voting that:

1. the absence was due to a reasonable cause; and

2. the person will be able to start attending meetings of the Board of Directors again within such a period as the Council of Governors considers reasonable;

2. failure to disclose an interest in accordance with paragraph ~~29~~30 of this Constitution and Standing Order 8 of the Standing Orders for the Board of Directors (Annex 7 of this Constitution);

2. **Further criteria: suspensions**

1. Suspension is a temporary measure which shall be used to prevent a Non-Executive Director or Chair from exercising his or her functions pending the completion of an investigation or removal from office under paragraph ~~25~~26 of the Constitution. The Council of Governors, when exercising the

power of suspension in accordance with paragraph ~~25~~26 of the Constitution, shall have regard to the following criteria (this is not an exhaustive list and each case shall be considered on its own merits taking into account all relevant factors, including any representations made by the Non-Executive Director or the Chair in question);

1. the criteria referred to in paragraph 2.1.1 above;
2. where the Trust or the Council of Governors is in receipt of information which gives cause for concern about a Non-Executive Director or Chair continuing to hold office;
3. where there is sufficient evidence to warrant removal from office under paragraph ~~25~~26 of the Constitution, but before the removal takes effect; or
4. where there is an allegation of fraud or other impropriety or other alleged misconduct that would require the Non-Executive Director or Chair to be suspended in order to protect patients, staff or public funds, or which is likely to impair the work of the Trust.

3. During any general meeting of the Council of Governors at which the Chair may be suspended or removed, the Deputy Chair shall preside, or if the Deputy Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director, as shall be appointed by the Council of Governors, shall preside.
4. The Governors sponsoring the resolution to either suspend or remove the Chair or a Non-Executive Director shall provide written reasons to the Trust Secretary in support of the resolution. The Chair or other Non-Executive Director in question shall be given the opportunity to respond to such reasons at the meeting of the Council of Governors that is to consider and determine the resolution. If the individual in question fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.
5. In making any decision to remove either the Chair or a Non-Executive Director the Council of Governors shall:
    1. take into account the results (if any) of any appraisals concerning the Chair or (as the case may be) the Non-Executive Director in question;
    2. have regard to the criteria set out in section 2.1 .above; and
    3. follow the relevant Trust procedures for investigating and handling concerns and complaints.
6. If any resolution to suspend or remove either the Chair or a Non-Executive Director is not approved at a meeting of the Council of Governors no further resolution can be put forward to remove such Non-Executive Directors, or the Chair which is based on the same reasons within twelve calendar months of the meeting of the Council of Governors at which the recommendation was considered.

Appendix 2
Further Provisions: Indemnity

1. **Indemnity**
    1. The Council of Governors, the Board of Directors and the Trust Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions save where they have acted recklessly. Any costs arising in this way will be met by the Trust.
    2. The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of the Council of Governors, the Board of Directors and the Trust Secretary.
    3. The Trust may take out insurance either through the NHS ~~Litigation Authority~~Resolution or otherwise in respect of Directors and officers liability, including liability arising by reason of the Trust acting as a corporate trustee of a charity.

Appendix 3
Further Provisions: Dispute Resolution Procedures

1. **Dispute Resolution Procedures**
    1. **Membership disputes**
        1. In the event of any dispute about the entitlement to membership, the dispute shall be referred to the Trust Secretary who shall make a determination on the point in issue. If the Member or applicant (as the case may be) is aggrieved at the decision of the Trust Secretary they may appeal in writing within 14 days of the Trust Secretary's decision to a panel of the Council of Governors formally constituted to consider the appeal and make an appropriate recommendation to the Council of Governors, The decision of the Council of Governors shall be final.
2. **Other disputes**
    1. Any dispute in relation to this Constitution shall be referred to the Chair who shall make a determination on the point in issue. If the Member or complainant (as the case may be) is aggrieved at the decision of the Chair they may appeal in writing within 14 days of the Chair's decision to the Board of Directors whose decision shall, subject to the provisions of paragraphs 1.2.2 and 1.2.3 below, be final.
    2. In the event of a dispute being referred to the Chair under Standing Order 4.13.10 of Annex 6 of this Constitution and a determination being made in accordance with the procedure set out in paragraph 1.2.1 above, if the Governor in question is aggrieved at the decision of the Board of Directors they may apply in writing within 7 days to the Board of Directors for the decision to be referred to an independent assessor (to be agreed by the Governor in question and the Board of Directors). The independent

assessor will then consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

3. On receipt of an application under paragraph 1.2.2 above the Board of Directors and the applicant Governor will co-operate in good faith to agree on the appointment of the independent assessor. The independent assessor's decision will be binding and conclusive on the parties.

3. **Disputes between the Council of Governors and the Board of Directors**
    1. In the event of dispute between the Council of Governors and the Board of Directors:
        1. in the first instance the Chair on the advice of the Trust Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;
        2. if the Chair is unable to resolve the dispute then a joint committee comprising equal numbers of Directors and Governors shall be convened to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute (the joint Committee will be called the "Special Committee" and will meet at the call of the Chair);
        3. if the recommendations (if any) of the Special Committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

Appendix 4
Further Provisions: Notices

1. **Notices**
    1. Save where a specific provision of the Constitution otherwise requires or permits; any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose.
    2. "electronic communication" shall have the meaning ascribed to it in statute.
    3. Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice served pursuant to paragraph 1.1 above shall be deemed to have been received 48 hours after the envelope containing it was posted, or in the case of a notice contained in an electronic communication, 48 hours after it was sent.

Appendix 5
Membership

1. **Disqualification from membership of the Trust**
    1. A person may not become or continue as a Member of the Trust if:
        1. they are under 16 years of age at the date of the application or invitation to

become a Member (as the case may be);

2. It comes to the attention of the Trust that they have been convicted by the courts of aggressive or violent behaviour (such as verbal assault, physical assault, violence or harassment) at any NHS hospital, NHS premises or NHS establishment against any of the Applicant Trust's or (as the case may be) the Trust's employees or other persons who exercise functions for the purposes of the Trust whether or not in circumstances leading to their removal or exclusion from any NHS hospital, premises or establishment;
3. they have been removed as a member from another NHS foundation trust;
4. they fail or cease to fulfil the criteria for membership of the Public Constituency or the Staff Constituency; or
5. they have been dismissed (otherwise than by reason of redundancy) from a position of employment with the Trust.

2. Where the Trust is on notice that a Member may be disqualified from membership, or may no longer be eligible to be a Member, or it appears to the Trust Secretary that a Member no longer wishes to be a Member, the Trust Secretary shall give the Member 14 days written notice to show cause why their name should not be removed from the Trust's register of Members. On receipt of any such information supplied by the Member, the Trust Secretary may, if they consider it appropriate, remove the Member from the Trust's register of Members. In the event of any dispute about entitlement to membership, the dispute shall be resolved in accordance with the procedure set out in Appendix 3 of this Annex 8.
3. All Members of the Trust shall be under a duty to notify the Trust Secretary of any change in their particulars which may affect their entitlement as a Member.

2. **Expulsion from membership of the Trust**

1. A Member may be expelled by a resolution approved by not less than two- thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:
    1. Any Member may complain to the Trust Secretary that another Member has acted in a way detrimental to or contrary to the interests of the Trust, or is otherwise disqualified as set out in paragraph 1 above.
    2. Subject to paragraphs 2.2 to 2.6 below, if a complaint is made, the Council of Governors and the Board of Directors will consider the complaint, having taken such steps as it (or they) consider appropriate, to ensure that each Member's point of view is heard and may either:
        1. dismiss the complaint and take no further action; or
        2. arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors.
2. If a resolution to expel a Member is to be considered at a meeting of the Council of Governors pursuant to paragraph 2.1.2.2 above, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and to attend the meeting.

3. At the meeting referred to in paragraph 2.2 above, the Council of Governors will consider the evidence and any representations made in support of the complaint and such other evidence and any representations made by the Member making the complaint which is placed before them.
4. If the Member complained of fails to attend the meeting mentioned in paragraph 2.2 above without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.
5. A person expelled from membership under the provisions of paragraphs 2.1 to 2.4 above will cease to be a Member upon the declaration by the person chairing the meeting that the resolution to expel them is carried.
6. No person who has been expelled from membership pursuant to the provisions of paragraphs 2.1 to 2.5 above is to be re-admitted as a Member except by a resolution of the Council of Governors carried by a vote of two- thirds of the Council of Governors present and voting at a general meeting of the Council of Governors.

3. **Termination of Membership**
    1. A Member shall cease to be a Member on:
        1. death; or
        2. resignation by notice in writing to the Trust Secretary; or
        3. being disqualified pursuant to paragraph 1 above, or being expelled pursuant to paragraph 2 above.

Appendix 6
Members' Meetings

1. **Members' Meetings**
    1. Notwithstanding any provisions contained in this Constitution regarding meetings of the Council of Governors (including the Annual Members' Meeting) and the Board of Directors, the Board of Directors may resolve to call special meetings of the Trust for the benefit of its Members (a "Special Members' Meeting") for the purpose of providing Members with information and to offer Members an opportunity to provide feedback to the Trust.
    2. Special Members' Meetings are open to all Members of the Trust, Governors, Directors and representatives of the Auditor and any external consultant, but not to members of the general public or representatives of the press unless the Board of Directors determines otherwise.
    3. Notwithstanding the provisions of paragraph 1.2 above, the Board of Directors may invite representatives of the press and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a Special Members' Meeting.
    4. All Special Members' Meetings are to be convened by the Trust Secretary by order of the Board of Directors and the following provisions of paragraphs 1.5 and 1.6 below

shall apply for these purposes.

5. Notice of a Special Members' Meeting is to be given to all Members, Governors, Directors, the Auditor and any external consultant personally, or:
    1. And by notice prominently displayed at the Trust's Headquarters;
    2. by notice on the Trust's website, at least 14 Clear Days before the date of the meeting.
6. The notice referred to in paragraph 1.5 above must:
    1. state the time, date and place of the meeting; and
    2. indicate the business to be dealt with at the meeting.
7. No business may be conducted at a Special Members' Meeting unless a quorum is present. The quorum for Special Members' Meetings is the Chair (or Deputy Chair) and at least one Member from each of the Staff Constituency and the Public Constituencies.
8. It is the responsibility of the person chairing the meeting to ensure that:
    1. any issues to be decided upon at the meeting are clearly explained; and
    2. sufficient information is provided to those in attendance to enable rational discussion to take place.
9. The Chair, or in his absence the Deputy Chair, shall act as Chair at all Special Members' Meetings. If neither the Chair nor the Deputy Chair is present, the members of the Board of Directors present shall elect one of their number to chair the meeting. If there is only one Director present and willing to act, then he/she shall chair the meeting.
10. If at any Special Members' Meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned to such date, time and place as the person chairing the meeting shall in his/her absolute discretion determine, and the Trust Secretary shall give or shall procure the giving of notice to all Members, Governors, Directors, the Auditor and any external consultant of the date, time and place of that adjourned meeting. Notwithstanding the provisions of paragraph 1.7 above upon reconvening, those present shall constitute a quorum.
11. Any resolution put to the vote at a Special Members' Meeting shall be decided upon by a poll.
12. Every Member present and every Member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the person chairing the meeting is to have a second or casting vote.
13. The result of any vote will be declared by the person chairing the meeting and the Trust Secretary shall cause the result to be entered in the minute book. The minute book will be conclusive evidence of the result of that vote.
14. In this Appendix 6 "electronic communications" shall have the meaning ascribed to it in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

Appendix 7
The Role and Responsibilities of the Trust Secretary

1. The Trust shall have a Secretary who may not be a Governor or Director of the Trust.
2. Notwithstanding the specific functions of the Trust Secretary, as set out in this Constitution, the Trust Secretary (or their nominee as appropriate) will be expected inter alia to:
    1. ensure good information flows within the Board of Directors and its committees and between senior management and the Council of Governors, and Members;
    2. ensure that the procedures of the Board of Directors (as set out in this Constitution and the Standing Orders for the Board of Directors) are complied with;
    3. ensure that the procedures of the Council of Governors (as set out in this Constitution and the Standing Orders for the Council of Governors) are complied with;
    4. advise the Board of Directors and the Council of Governors (through the Chair or the Deputy Chair, as the case may be) on all governance matters;
    5. be available to give advice and support to individual Directors and Governors and assistance with professional development;
    6. be available to give advice and guidance to Directors and Governors on their respective statutory duties and corporate governance-related matters;
    7. attend as necessary all meetings of the Board of Directors and Council of Governors including their committees, sub-committees panels and joint committees, and to keep accurate minutes of these meetings; and
    8. attend Members' meetings and keep accurate minutes of these meetings.

Attachments

Annex A: Declaration to the Trust Secretary of West Midlands Ambulance Service University NHS Foundation Trust

Annex B: Prescribed Form of Declaration of Interests

Approval Signatures

Step Description	Approver	Date

History

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: JANUARY 2024 PAPER NUMBER: 10

Update to the Trusts Organisational Strategy and Strategic Priorities	
Sponsoring Director	Strategy and Engagement Director
Author(s)/Presenter	Strategy and Engagement Director
Purpose	Following on from the Board of Directors development work on refreshing our organisational strategy and strategic priorities during 2023/24, the purpose of this paper is to update on the feedback and engagement received on the draft strategic priorities the Board approved to engage partners on.
Previously Considered by	EMB and Board of Directors (BoD)
Report Approved By	Strategy and Engagement Director

Executive Summary

During the course 2023/24 the BoD developed a draft new set of strategic priorities and approved a set for WMAS to engage external and internal partners on.

This paper sets out the engagement that has taken place to date, the feedback received and what else is planned to take place in advance of a sign off for implementation.

Related Trust. Objectives/ National Standards	The document supports the delivery of all strategic objectives
Risk and Assurance	An updated organisational strategy with stakeholder buy in must be achieved in order for the Board to be assured its strategic direction is aligned to internal and external requirements.
Legal implications/ regulatory requirements	The Trust's strategy is based upon all legal and regulatory requirements. All enabling strategies will be adjusted as required to continue to deliver upon our legal and regulatory responsibilities
Financial Implications	The draft strategic priorities are designed to support the achievement of our financial duties
Workforce & Training Implications	The People Strategy will incorporate necessary work streams to ensure the requirements of the Trust Strategy are provided for
Communications Issues	The Communications and Engagement Strategy identifies means of communication with internal and external stakeholders
Diversity & Inclusivity Implications	The needs of staff and members of the public will be reflected within the work streams of the People Strategy, the Diversity and Inclusion Strategy and the Communications and Engagement Strategy

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Quality Impact Assessment	Individual Quality Impact Assessments will be required for each of the enabling strategies prior to presentation at the Governance Committees
Data Quality	The data on which each enabling strategy is based will be authorised by each Director

Action required

For the Board to note the partners engaged with to date and the activity that is planned to take place during February.

For the Board to note a further final update will be presented at the March 2024 Public Board of Directors with a request for sign off.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: JANUARY 2024 PAPER NUMBER: 10

Introduction

During the course of 2023/24 the BoD has been reviewing our existing organisational strategy, specifically our strategic priorities.

The BoD has reflected on our strategic context, now and into the future, with a view to adapting our priorities for the medium and longer term, so we ensure that our strategy and linked decision is drives the success of the Trust, medium and long term, for our patients and colleagues alike.

The Board reviewed information including national policy context, staff survey results and stakeholder views, strategic objective, by objective. In doing so, there has been some significant proposed changes to the strategic priorities, the paper will cover those in detail further down.

In developing a set of medium to long terms priorities, it is important that the Trust engages with key stakeholders, both internally and externally, this paper will set out who we have engaged with, there feedback, and who is to be engaged with going forwards.

Draft strategic plan on a page

The plan set out overleaf represents a consolidated view of all the work the BoD has undertaken and is the basis of what has been briefed to our stakeholders for feedback.

This consolidated view was the outcome of the final discussion of the BoD held in the November 2023 Board Strategy day.

WEST MIDLANDS AMBULANCE SERVICE
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REPORT TO THE BOARD OF DIRECTORS

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The future ?

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Strategic Objective 1: Safety, Quality and Excellence	Strategic Objective 2: A great place to work for all	Strategic Objective 3: Effective planning and use of resources	Strategic Objective 4: Innovation and Transformation	Strategic Objective 5: Collaboration and Engagement
Our commitment to provide the best care for all patients	**Creating the best environment for staff to flourish**	**Continued efficiency of operation and financial control**	**Developing the best technology and services to support patient care**	**Working in partnership to deliver seamless patient care**
Expand leadership development across clinical and corporate areas and further develop training and supervision for clinical staff Recover and sustain response times Develop joint posts with our partners – e.g. lectureship posts Further develop capability around frailty and mental health	Creating more roles that enable staff to work at top of their license By 2030 have a workforce that is representative of the population we serve Mental Health and wellbeing to be prioritised Meet the 'millennial challenge' creating flexible career options to support retention of staff	System and Trust pproductivity measures to be defined and monitored by the Board Undertake an independent capacity review during 2024 to inform longer term funding and capacity requirements Continue to expand alternative pathway utilisation to reduce higher cost acute care. Maintain position on backlog maintenance and fleet life cycle	Move to a zero emissions fleet by 2030 in line with NHS England requirement Deliver net carbon zero by 2040 Further develop data sharing arrangements to support public health interventions Continue to embedded technology to improve patient experience, outcomes and reduce cost Further expansion of R&D	Support out Integrated Care Systems to further integrate care pathways Involve our host Integrated Care System in decision making Work with partners to improve public health and reduce health inequalities Develop partnership arrangements to support communities to access employment with the ambulance service and wider NHS

Trust us to care.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: JANUARY 2024 PAPER NUMBER: 10

Engagement plan – 'who' and what was the feedback?

Who?	What was the feedback	For discussion
Black Country ICB Organisational Development meeting – involving directors from across the ICB and partners, so other provider acute, community and mental health Trusts, the Local Authorities and Council of Voluntary Services Meeting also attended by WMAS Non Executive Director, Julie Jasper	Presentation on WMAS, who we are and our future direction very well received, the forum positively received our draft strategic priorities and welcomed the engagement	
Lead Commissioning Team within the Black Country ICB Via the lead commissioner, the regional UEC commissioning forum which has representation from all ICBs in the West Midlands	Strategic priorities well received, feedback received specifically on response times and recovery, it's not solely within our gift to achieve and having a priority that was deliverable Having seen our draft priorities, a request to link our Public Health lead to the commissioning team (action	**Does the wording around recovering performance on SO1 need to be amended to reflect what is within our gift to achieve?**

	completed) improving public health and reducing health inequalities being a key objective of all ICBs across the West Midlands.	
WMAS staff	Draft priorities and the process briefed into the December 2023 all staff briefing, no further Qs received by colleagues	
Regional Partnership Forum - (our unions)	Draft priorities and the process briefed to union colleagues, no further Qs received to date	
WMAS Council of Governors (CoG)	Scheduled for February CoG meeting	
WMAS Staff	Two discussions scheduled in February	

Next Steps

So far, the main point on feedback is around our ability to recover response times alone, our lead commissioner was supportive of our intention to do so, but felt we needed to consider some amended wording which would focus the point on WMAS doing the things to support recovery of performance, which were within our gift, accepting things like lost hours to handover delays were largely not.

Other than the point mentioned above, the feedback has been positive from the stakeholders engaged with to date, so the likelihood of significant change with the discussions to come via our Council of governors and staff again is low.

There is further engagement to take place with staff and our council of governors during February 2023

The act of engaging itself on our proposed priorities has been well received by partners and appreciated.

Conclusion

Subject to further engagement and feedback during February 2024, a finalised version of the strategic priorities will be brought back to the March 2024 Board of Directors for sign off.

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REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 09b MONTH: JANUARY 2024 PAPER NUMBER: 11

Review of Enabling Strategies	
Sponsoring Director	Strategy and Engagement Director
Author(s)/Presenter	Strategy and Engagement Director
Purpose	Following the update to the Board of Directors BoD in September on enabling strategies, an action to return to the BoD was proposal on how the number of strategies could be consolidated into a smaller, more management number for the BoD to have closer oversight and input into.
Previously Considered by	EMB and the BoD.
Report Approved By	Strategy and Engagement Director

Executive Summary

As various workstreams have taken hold within the organisation, we now have twenty underpinning strategies to support the delivery of our strategic objectives.

To balance the need for board involvement and oversight in strategy formulation and delivery, it was recommended to the BoD that the twenty underpinning strategies are reviewed with a view to consolidating the ones which have natural synergies.

This paper sets out a proposal on where the strategies could be consolidated, the governance lines for reporting purposes and which strategic objectives and priorities they currently align to (accepting that the strategic priorities are currently review)

The Board briefing session also asked that strategies have a consistent format going forwards, modelled on the latest clinical strategy and that where changes are made, they occur when the review dates come around, so the work is done once only.

Related Trust. Objectives/ National Standards	The document supports the delivery of all strategic objectives
Risk and Assurance	A reduced set of underpinning strategies should enable the board to have greater oversight and input into their formulation and delivery.
Legal implications/ regulatory requirements	The Trust's strategy is based upon all legal and regulatory requirements. All enabling strategies will be adjusted as required to continue to deliver upon our legal and regulatory responsibilities
Financial Implications	The Finance Strategy will incorporate necessary work streams to ensure the requirements of the Trust Strategy are accounted for

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Workforce & Training Implications	The People Strategy will incorporate necessary work streams to ensure the requirements of the Trust Strategy are provided for
Communications Issues	The Communications and Engagement Strategy identifies means of communication with internal and external stakeholders
Diversity & Inclusivity Implications	The needs of staff and members of the public will be reflected within the work streams of the People Strategy, the Diversity and Inclusion Strategy and the Communications and Engagement Strategy
Quality Impact Assessment	Individual Quality Impact Assessments will be required for each of the enabling strategies prior to presentation at the Governance Committees
Data Quality	The data on which each enabling strategy is based will be authorised by each Director

Action required

a) For the board to review and sign off the proposed consolidation of enabling strategies and reporting lines

b) For the Board to review the governance arrangements and to reflect on its involvement in the development and oversight of underpinning strategies.

c) For the board to consider a recommendation on a names executive lead and link non executive lead for each strategic objective.

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Introduction

Over the years, WMAS has been developing strategies to support our five organisational objectives, they have over time grown in number to twenty.

Whilst it is entirely appropriate certain workstreams sit within dedicated strategies, having reviewed them, several have synergies with one another and could therefore be aggregated into a single strategy covering a wider workstream.

Having fewer, higher level strategies, linked to our organisational objectives, will enable the BoD to have greater input and oversight of their delivery and outcomes. It will also make monitoring and reporting simpler, with fewer, higher level strategic plans to govern.

Current position

The current list of underpinning strategies, the 'owners' and which board sub-committees they report into is set out in the table below:

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Enabling Strategy	Responsible Director	Reports to
Clinical Strategy	Medical Director, Director of Nursing, Paramedic Practice and Patient Safety Director	Quality Governance Committee
Quality Strategy	Medical Director and Director of Nursing	Quality Governance Committee
Communications and Engagement Strategy	Strategy and Engagement Director and Communications Director	QGC and EMB
Risk Management Strategy	Director of Nursing and Clinical Commissioning	Quality Governance Committee
Security Strategy	Director of Strategic Operations and Digital integration	Quality Governance Committee
Sustainability Strategy	Director of Strategic Operations and Digital integration	Quality Governance Committee
Operations Strategy	Director of Performance and Improvement	Performance Committee
Commissioning Strategy	Director of Finance	Performance Committee
Finance Strategy	Director of Finance	Performance Committee
IT Strategy	Operational Support Services Director	Performance Committee
Procurement Strategy	Director of Finance	Performance Committee
Estates Strategy	Director of Strategic Operations and Digital integration	Performance Committee
Commercial Services Strategy	Non Emergency Services Delivery	Performance Committee

	Director / Asst Chief Ambulance Officer	
Fleet Strategy	Director of Strategic Operations and Digital integration	Performance Committee
People Strategy	People Director	People Committee
Equality and Inclusion Strategy	People Director	People Committee
Public Health Strategy	Medical Director	Quality Governance Committee
Freedom to Speak up improvement strategy	Strategy and Engagement Director / Exec Lead for FTSU	Quality Governance Committee
Volunteering Strategy	Patient Safety and Paramedic Practice Director & Strategy and Engagement Director	Quality Governance Committee
Patient Experience Strategy	Director of Nursing	Quality Governance Committee

Proposal

Several enabling strategies do have synergies with one another, in one case, the commissioning strategy, needs to be subsumed into a financial strategy, given the move to block contracting.

To reduce the burden of oversight and reporting and to ensure strategies remain strategic in nature, it is proposed several are consolidated.

The table below sets out a proposal on how this could look like

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Updated Enabling Strategy	Including the following existing strategies	Executive Lead(s)	Board subcommittee for monitoring
Clinical Strategy	Clinical, Quality and patient experience	Medical Director, Director of Nursing, Director of Paramedic Practice and Patient Safety	Quality Governance Committee
Support services strategy	Estates, fleet and sustainability	Director of Finance	Performance Committee *Currently sustainability with Quality Governance Committee and estates and Fleet with Performance Committee
Operational strategy	Operational	Director of Performance and Improvement	Performance Committee
Finance Strategy	Finance, procurement and commissioning	Director of Finance	Performance committee
People Strategy	People and Equality and Inclusion	People Director	People Committee
Risk Strategy	Risk Strategy	Director of Nursing	Quality Governance Committee
IT Strategy	IT	Director of Finance	Performance Committee
Freedom to Speak up Strategy	Freedom to Speak up	Strategy and Engagement Director (Executive lead for FTSU)	Quality Governance Committee
Volunteering Strategy	Volunteering strategy	Director of Paramedic Practice and Patient Safety	Quality Governance Committee
Public Health Strategy	Public Health Strategy	Medical Director	Quality Governance Committee

Communication and Engagement Strategy	Communications and Engagement	Strategy and Engagement Director and Communications Director	EMB
Commercial strategy	Commercial strategy	Non Emergency Services Delivery Director / Asst Chief Ambulance Officer	Performance Committee
NA	Commissioning strategy	NA	Proposed to be subsumed within the Finance strategy and removed as a stand-alone strategic plan.

It is proposed that the support services strategy be re-aligned to the performance committee, two of the three sub components are homed there, with the current sustainability strategy being governed through Quality Governance Committee.

It is also proposed that the Commissioning Strategy is withdrawn with any on-going relevant elements subsumed into the finance strategy.

How would the revised set of strategies link to the draft strategic priorities?

The Board signed off a refreshed set of strategic priorities in November for the Trust to engage both external and internal stakeholders on, the consolidated underpinning strategies need to support their progress and delivery.

Given they are new, they will need updating, for example the operations strategy covering off our recovery of the Category 2 response standard. Another example would be the support services strategy need to plan the transition to zero tailpipe emission fleet from 2030 onwards.

The table below reflects how the consolidated strategies would align to the new priorities:

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Strategic Objective	Strategic Priority	Clinical Strategy	Support services strategy	Operations strategy	Finance Strategy	Risk Strategy	People strategy	IT Strategy	FTSU strategy	Public Health strategy	Volunteering strategy	Communications and Engagement
Safety, Quality and Excellence	**Leadership development, enhanced training, development, and supervision**	x	x	x	x	x	x	x	x	x	x	x
	Recovery and sustaining of response times	x	x	x	x		x	x			x	x
	Joint posts with partners, eg lecturer / clinical posts	x		x			x					
	Improved capability in Frailty and Mental Health	x		x			x			x	x	
A great place to work	**Creating more roles for staff to work at the 'top of their license'**	x		x			x			x		
	By 2030 have a workforce that is representative of the population we serve						x		x		x	
	Mental Health and Wellbeing to be prioritised						x					
	Meet the 'millennial challenge' creating	x	x	x			x	x	x		x	x

	flexible career options to support recruitment and retention											
Effecting planning and use of resources	**Define system and trust productivity measures to be overseen by the Board**	x	x	x	x			x				
	Undertake an independent capacity review in 2024 to inform longer term funding and capacity requirements	x	x	x	x		x					
	Continue to expand the utilisation of alternative care pathways to reduce higher cost acute care	x		x	x							x
	Maintain position on backlog maintenance and fleet life cycle age		x		x					x		
Innovation and Transformation	**Move to zero emissions fleet in line with NHS England requirements by 2030**		x		x					x		
	Deliver net carbon zero by 2040		x		x					x		

	Further data sharing agreements to support public health interventions	x		x				x		x		x
	Continue to embed technology to improve patient experience, outcomes and reduce cost	x		x	x			x		x		
	Further expansion of R&D	x		x		x	x			x		
Collaboration and engagement	**Support our Integrated Care Systems to further integrate care**	x		x	x	x		x		x		
	Involve our Integrated Care Board in decision making	x		x	x					x		x
	Work with partners to improve public health and reduce health inequalities									x		x
	Develop partnership arrangements to support communities to gain employment with WMAS and the wider NHS						x					x

The consolidated set up of underpinning strategies as they currently exist do align to our strategic objectives, however, some will need updating now on the back of the new priorities.

The new priorities are currently being discussed with stakeholders, once they are signed off for implementation, individual directors will need to make sure the strategies they are responsible for cover off the priorities the Board has signed off on.

It was also agreed at the November 2023 board briefing session that new strategies should be formatted in the same way, but that this should only happen once a strategy is up for review, to minimise the burden of doing so.

Governance and Board involvement

Underpinning strategies are presented to and approved by the BoD, the deliverables within them are governed via the respective sub committees through quarterly monitoring coordinated by the Head of Strategic Planning.

Beyond approving a strategy, the BoD delegates the oversight of the delivery of underpinning strategies to its sub-committees to execute.

One GGI recommendation was for the BoD to consider how it involves itself in the formulation of and oversight of strategies.

There is a balance to strike in terms of BoD input and oversight, given there are currently twenty underpinning strategies within the organisation, it feels appropriate that they are governed in the main through Board sub-committees.

However, the ability of Board Sub-committees to govern twenty individuals strategies, including all of the other items of responsibility is a challenge, so reducing the number that have to be governed, from 20 to 12 should assist the Board of Directors.

Whilst the underpinning strategies have clear leads and governance structure and do overlay the strategic priorities and objectives, it is currently less clear for our five strategic priorities.

To strengthen the delivery of priorities within each of the five strategic priorities, one recommendation could be a lead executive and a linked non-executive Director to be assigned to each one to drive there delivery.

Whilst some have an obvious exec lead, the priorities underneath them do cut across portfolios, so this will require a degree of matrix working and collaboration to be successful.

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Conclusion and recommendations

Through reviewing our underpinning strategies in terms of alignment, it is recommended they are consolidated to the proposed 11.

Rather than just re-writing them all now, it is also recommended that the consolidation takes place when a relevant strategy expires, so the work is done just once.

A further recommendation is that they are all set out in a consistent format when this update work is completed.

Finally, that the Board of Directors considers a recommendation to have a lead executive director and a link Non-executive director to lead in an overarching manner on each of the five strategic objectives.

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REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 10 MONTH: JANUARY 2024 PAPER NUMBER: 12

Communications Data – Quarterly Report	
Sponsoring Director	Communications Director
Author(s)/Presenter	Murray MacGregor, Communications Director
Purpose	The report at the third quarter of the current year and the work of the Communications Team and is for noting only.
Previously Considered by	Executive Management Board
Report Approved By	Murray MacGregor

Executive Summary

The paper sets out the activities of the Press Office between October and December. It highlights the number of articles and viewing rates for publications such as the Weekly Briefing. It also looks at the Trust's interaction with the media, our social media presence and the work we carry out with external partners.

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)	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)	
SO 5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)	X

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☒	Inclusivity	☒
	Accountability	☒		
Risk and Assurance	N/A			
Legal implications/ regulatory requirements	None			

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Financial Implications	None
Workforce & Training Implications	None
Communications Issues	The report is for noting only
Diversity & Inclusivity Implications	This report notes the work the Press Office does in supporting the work of our various Networks and working in partnership with the six ICBs to ensure messages get to all communities within the region.
Quality Impact Assessment	N/A
Data Quality	The background documentation is held by the Communications Director
Action required That the Board note the report and seek any clarification required.	

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REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 10 MONTH: JANUARY 2024 PAPER NUMBER: 12

Communications Update

Introduction

West Midlands Ambulance Service has the smallest Communications Team of any ambulance service in England with five staff: a director, three communications officers and a communications apprentice. Despite this, we are one of the most successful in terms of engagement, particularly through social media and television.

The team has four main areas of work, though it should however be noted that in many cases, work may fit into multiple workstreams, which is why the team is not split into internal and external staffing:

- Internal communications
- Media relations
- Social media and website
- Work with external partners, engagement and public relations

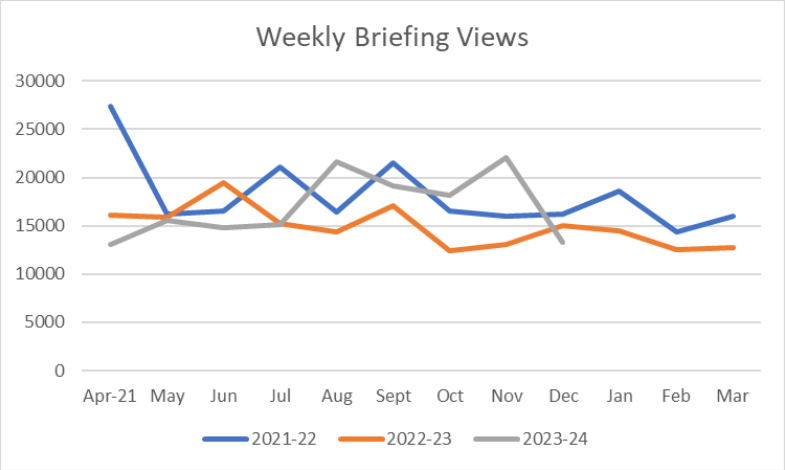
Internal Communications

Weekly Briefing

The Briefing remains the Trusts primary means of spreading information about what is happening across the organisation. In the last quarter, (Oct – Dec 23) the team wrote a total of 763 articles covering all manner of subjects, which works out at an average of 64 stories per week, or 11,000 words.

As part of the sign-off process the draft Briefing is shared with the Chief Executive and the lead representatives of the three recognised unions. This partnership approach continues to prove successful in ensuring messages are appropriate and where challenge is made, answers are provided so that agreement can be made prior to publication.

The Briefing is distributed in an email to all Trust emails with a link to the intranet. It is also sent to over 1,000 home email addresses. In addition, it is sent to all Hubs and other work places. It has been viewed on the intranet almost 180,000 times this year. Viewing numbers have largely been higher this year compared to previous years – December was an exception as there were only three editions due to the festive break. It is pleasing to see numbers increasing, particularly as our workforce is smaller after the departure of colleagues to DHU as part of our withdrawal from 111.



Other Internal Workstreams

Is the Patient Breathing
We currently have an advanced apprentice working with the team and one of her main projects highlighted the work of our EOCs. It involved writing a press release that was picked up by the media widely, as well as specific videos with call handlers, dispatchers and clinical validation team. The work was welcomed by many.

Staff Journeys
We have been working with Workforce to highlight the journeys that a number of staff have undertaken within their career with WMAS. The videos have been made available both internally and via our social media channels. They highlight the advancement that is available withing the Trust.

All Staff Briefings
We continue to get between 200 – 250 staff joining the online briefing sessions each month. Ther has been some discussion as ot how these could be developed. Work includes getting other directors and members of their teams to talk about new developments as well as updates on the likes of Freedom to Speak Up. The sessions continue to offer staff the chance to ask senior leaders about areas that they are interested in, which is to be welcomed.

Staff Survey – This year we ran a series of videos with staff explaining why they felt it was important that colleagues completed the survey. We ran it both internally but also via our social media channels as we know staff use both.

Support for Recruitment – The team continue to support the recruitment team with content for our social media pages and website in an effort to recruit staff. This has involved filming videos and creating graphics, hosting Q&A sessions on Facebook and the like. We have assisted in jobs such as student paramedics, PTS, mechanics, CFRs and HR staff

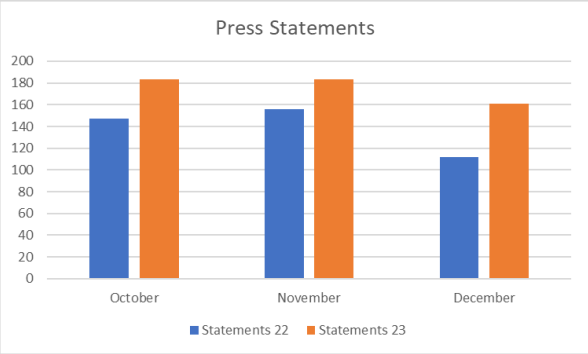
Supporting Staff Networks
We do all we can to support the six networks within the Trust. This has included the Culture Day which BBC Asian Network attended;

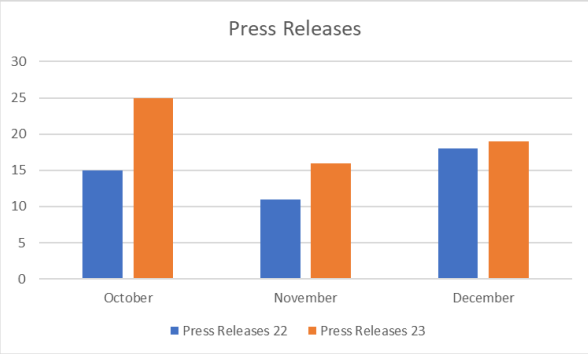
Other Projects – The team continues to assist other departments on a wide range of projects such as: Disability Awareness Month; International Control Room Week; staff meet ups with patients; highlighting violence against staff and any subsequent court cases; placement of new defibrillators in locations including Birmingham Central Mosque; the state of the art childbirth simulation mannequins that BBC Midlands Today attended; and the launch of our new mental health cars.

Media Relations

We continue to be very busy with media enquiries about incidents that have happened across the region. Media organisations continue to use social media as their primary source of information which can lead to misinterpretations of what might have happened. The team work hard to ensure that our presence at incidents receives appropriate coverage. As you can see, the number of press releases and incident statements have both risen year on year.

	Statements	Press Releases	If Asked Statements
Oct-23	183	25	3
Nov-23	183	16	2
Dec-23	161	19	2





Social Media and Website

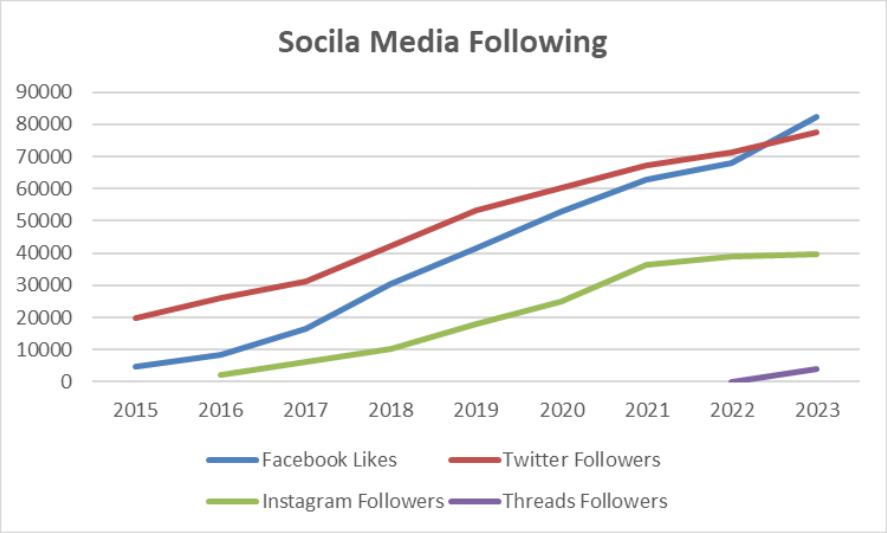
We continue to have a very substantial presence in social media compared to other NHS organisations. Our channels are useful for engaging with the public but also for getting messages to our staff; we know that many follow our accounts.

We highlight a very wide range of issues on our channels, tailoring the content for each one. We are able to use them to highlight what our staff have been up to, from school visits to receiving gifts at Christmas. We also use the channels to highlight health information and advice on many topics from 'Help Us, Help You', stroke, sepsis, heart matters etc.

We also got an excellent reaction from a poem that one of the comms team wrote about working at Christmas – she got staff from across the Trust to voice it. The positivity from the public and indeed their colleagues should not be underestimated. Add to that Christmas parties, training courses being completed and we are able to show lots of positivity within the organisation.

Colleagues may be aware that Meta, the owners of Facebook, launched a new channel called 'Threads' which is a direct challenge to Twitter. It is largely based on Instagram. Our follower numbers continue to grow each week with over 4,000 followers, the second highest in the ambulance sector. Our Facebook following continues to rise nicely, though with the changes at Twitter / X, we have seen a slowing of the increase in follower numbers. Instagram increases have also slowed.

Twitter / X:	77,525
Facebook:	82,387
Instagram:	39,724
Threads:	4,093



Website

The Press Office keeps the content of the website up-to-date and correct and regularly edit pages upon guidance from relevant departments such as Clinical, Patient Experience, Recruitment, HR and the Chief Executive's Office to reflect changes, new information and updates. The front page of the website is regularly changed to reflect the latest priority for the service whether this is recruiting student paramedics, highlighting an award or advertising a new campaign.

One of the main issues we have bene working on is updating the site so that it meets the latest accessibility criteria. This will involve upgrading the site so that it meets the needs of those who might wish to access the site without using a mouse, for example.

During 2023, the website had 871,1447 views from just shy of 400,000 visitors with aaverage view per visitor of 2.18, slightly up on the previous year.

External Work

Monthly Briefing

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 10 MONTH: JANUARY 2024 PAPER NUMBER: 12

The Team continues to produce a monthly briefing that is sent to stakeholders within the NHS, local authorities, MPs and the like letting them know about the key developments over the previous month; it is also available on the Trust website.

TV Programmes

The Trust continues to embrace the use of television as a way of gaining positive publicity but also as a recruitment tool. Series 10 of '999 On The Frontline', which is made by Curve Media, is due to be shown on Channel 4 when it starts broadcasting at the end of January. It is the first time that it has been shown on the main channel rather than More 4. They have already filmed series 11 – 13! We are also in talks with two other TV companies about potential new programmes.

FOI Requests

The Trust receives hundreds of requests for information, many from companies seeking information to help them win future contracts. We also receive enquiries from media organisations looking for stories. Each week, the Comms team is asked to review around a dozen or more FOI responses to ensure they answer the questions asked and to give an early warning for contentious issues.

Murray MacGregor

Communications Director

January 2024

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11a MONTH: JANUARY 2024 PAPER NUMBER: 13

Finance Update Month 09 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 and
Previously Considered by	n/a – this paper is for update purposes only
Report Approved By	Karen Rutter – Director of Finance

FINANCE UPDATE

2023-24 Month 09 (December 2023)

At the end of Quarter 3, the Trust is reporting an overall surplus, is ahead of the planned surplus and is forecasting an end of year surplus, as required by Black Country ICB. The Trust results form part of the overall Black Country ICS position reported to NHS England.

Key points to note are:

- The financial position at the end of December is £5.3m underspent against a planned underspend of £616k. Thus, the reported surplus is £4.7m ahead of the plan.
- This position reflects the level of income represented in the plan. All contracts, including the Patient Transport Services, have now been agreed for this financial year.
- Pay remains underspent against budgets as a direct result of reduced overtime spend and the level of vacancies held due to the current recruitment restrictions.
- The Trust capital programme is underspent in month by £2.7m due to a low value of fleet purchase while the VCS converter issues were resolved. Capital is expected to fully spend against the 23-24 allocation.
- The FIP/CIP programme has an in month over performance of £2.5m and a year-to-date overperformance of £4.2m. Whilst the trust has met it's CIP target for month 9 and continues to do so year to date, a significant proportion of this is non-recurrent.
- The cash position remains strong.

- The forecast end of year surplus is reported as £1.6m. This movement is as a result of a balance sheet release (c600k) following a system balance sheet review and a request from Black Country ICB to deliver a £1m deficit.
- Since the Month 09 financial systems reported, and at the request of the ICB, all Black Country ICS organisations were asked to deliver a proportionate share of an additional £1m savings associated with workforce control measures. For WMAS, this equates to an increase in the forecast surplus by £149k, increasing the outturn forecast from £1.628m to £1.777m. Due to the timing of the request, the M9 results, which are presented based on the output of the financial systems, do not reflect the change. The forecast will thus be adjusted at M10.

Whilst the year-to-date financial position is positive, there remain a number of risks including:

- Ensuring the capital schemes can deliver by the end of March.
- Activity and available staffing levels over the winter period and until the end of the financial year
- System financial performance and impact on the Trust of additional measures imposed.

Please note that the Month 09 finance detailed information is included in the Trust pack.

External Audit

This is Bishop Flemings first year with the Trust and the preliminary work is underway. The interim audit will begin early in the final quarter of the financial year.

Planning and Budgeting for 24-25

NHSE are yet to issue the 24-25 technical financial planning guidance. In the absence of formal guidance, a number of assumptions have been applied to enable a draft budget to be produced.

This is very much work in progress alongside the Financial Recovery Plan work that is underway across the Black Country system.

The FRP applies an agreed set of assumptions such as inflation levels, tariff efficiencies and local efficiency requirements. The results inform the overall ICS financial plan for 24-25.

With in the Trust, a set of budget setting principles have been issued covering the approach to treatment of pay awards, cost pressures, developments, and CIPs.

Finance staff are working with operational/budget managers to produce budget requirements for next financial year. Currently, pending the planning guidance and applying system assumptions, a CIP requirement of a 19m. The Board will be kept updated with planning and budgeting information, and a startpoint budget will be required to be approved at the March meeting..	
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 BOARD OF DIRECTORS

AGENDA ITEM: 11b MONTH: January 2024 PAPER NUMBER: 14

Revised Scheme of Delegation	
Sponsoring Director	Director of Finance
Author(s)/Presenter	Director of Finance
Purpose	Revisions have been made to the existing Scheme of Delegation to ensure that the Trust business can be undertaken in a timely manner and that the financial governance is not compromised.
Report Approved By	Director of Finance

Executive Summary

The attached revised Scheme of Delegation is proposed to increase the approval limits delegated by the Board to the Chief Executive and the subsequent cascade of delegation to Trust officers. These increases will reduce the number of approvals that are presented to the Board and will ensure that procurement and contracting arrangements can proceed in the most timely manner so that the delivery of areas of the business can be progressed.

The majority of the items that this revision will relate to are in the IT, estates and fleet areas of the business. For example, rent and rates which are in excess of the current approval limit but which are required to be paid within a timeframe so as to not generate penalty payments.

It should be noted that the Chief Executive will only give approval under the advice of the Director of Finance to ensure that there is no single approval applied to items of high value. The Director of Finance will ensure that the appropriate records of approvals are kept and maintained.

These revised limits for expenditure only apply to the values included in the opening budgets that have been approved by the Board at the beginning of the financial year, and only if those budgets have been presented in sufficient detail.
Any change to the use of the approved budget will still require approval by the Board.

The attached Scheme also includes a contract value to which each delegated level can sign a contract on behalf of the Trust, having undertaken the appropriate business case approval and procurement processes.

Delegation records will be held within the Finance Department and those staff with delegated responsibilities are expected to ensure that they remain aware of their responsibilities as set out in the Trust's Standing Financial Instructions.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11b MONTH: January 2024 PAPER NUMBER: 14

There will be a number of items that still require Board approval and the intention is to monitor the number and frequency of those over the next six months to ensure that the change in approval levels has been effective. As such, further amendments may be proposed after this review.	
Related Trust Objectives/ National Standards	To deliver against the Trust's Strategic objectives. Maintain compliance with SFIs.
Risk and Assurance	This report is to remain compliant with SFIs and The Constitution.
Legal implications/ regulatory requirements	Maintain compliance SFIs and Scheme of delegation. Any legal advice required is included within the report.
Financial Implications	Delegated authority and responsibilities to work within the approved budget levels
Workforce & Training Implications	Not directly applicable
Communications Issues	Not directly applicable.
Diversity & Inclusivity Implications	The Trust obligations are set out in the Public Sector Equality Duty and the Equalities Act 2010. This paper is not directly affected by these regulations.
Quality Impact Assessment	Not directly applicable within the context of this paper.
Data Quality	All data and background documentation is held by the Director of Finance.

Action required

The Board are requested to:

- **Approve** the revisions to the Scheme of Delegation
- **Note** that there will still be contracts/items of expenditure that require Board approval other than the opening budget approvals
- **Note** the review of effectiveness to take place

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Appendix 1

SFIs - Appendix 1 - Scheme of Reservation and Delegation

REF	DECISIONS RESERVED TO THE BOARD
	General Enabling Provision The Board may determine any matter for which it has delegated or statutory authority in full session within its statutory powers.
	Regulations and Control
	1. The Constitution of the Foundation Trust requires the Board to approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.
SO 4.15	2. Suspend Standing Orders of the Board of Directors
SO 4.16	3. Vary or amend the Standing Orders of the Board of Directors
SO 4.10.1	4. Ratify in public any urgent decisions taken by the Chairman and Chief Executive
SO 5.3 and 6	5. Approve a scheme of delegation of powers from the Board to committees
	6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration
	7. Require and receive the declaration of officers' interests that may conflict with those of the Trust.
	8. Approve arrangements for dealing with complaints.
	9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
	10. Receive reports from committees.
	11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.
	12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
	13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.
	14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
	15. Authorise use of the seal.
SO 5.5	16. Ratify or otherwise instances of failure to comply with Standing Orders brought to

	the attention of the Board
	17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
	Appointments/ Dismissal
	1. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.
	2. Appoint, appraise, discipline and dismiss Executive Directors.
	3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
	4. Appoint, appraise, discipline and dismiss the Secretary
	5. Approve proposals of the Board's Remuneration and Nominations Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by that Committee.
SFI 4.1.1 SFI 8.10 SFI 10.2.2	Strategy, Plans and Budgets 1. Prepare an Annual Report and submit this to NHSE 2. Subject to having regard to the views of the Council of Governors, to give information as to its forward planning in respect of each financial year to NHSE. 3. Where the Board agree a forward plan that contains a proposal that the Trust carry out an activity other than the provision of goods and services for the provision of health services in England, and also the income it expects from doing so, the Council of Governors must determine whether it is satisfied that the carrying out of that activity will not to any significant extent interfere with the fulfilment by the Trust of its principle purpose or the performance of its other functions, and then notify the Board of its determination. 4. If the Board proposes to increase by 5% or more the proportion of its total income in any financial year attributable to an activity other than the provision of goods and services for the provision of health services in England, it may implement the proposal only if more than half of the members of the Council of Governors voting approve of its implementation. 5. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued from time to time. 6. Approve the Trust's policies and procedures for the management of risk. 7. Approve Outline and Final Business Cases for Capital Investment subject to any proposal that the Trust consider significant is approved by the Council of Governors 8. Approve budgets. 9. Approve annually Trust's proposed organisational development proposals.

	10. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 11. Approve PFI proposals. 12. Approve the opening of bank accounts. 13. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000. However emergency approval can be sought for payments in excess of £500,000 through compliance with SO 5.2.1. 14. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board. 15. Approve individual compensation payments. 16. Approve proposals for action on litigation against or on behalf of the Trust. 17. Review use of NHSR risk pooling schemes (LPST/CNST/RPST).
	Policy Determination 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. 2. Policies so adopted shall be listed and appended to this document by the Secretary
	Audit 1. Receive the Independent Auditor's Report sent by the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
	Annual Reports and Accounts 1. Receipt and approval of the Trust's Annual Report and Annual Accounts, but if necessary to delegate authority to the Audit Committee to recommend authorisation of Accounts with approval noted by the Trust Board at the following meeting. 2. Receipt and approval of the Annual Report and Accounts for Funds held on Trust. 3. To present to the Council of Governors the Annual Accounts, and the report of the auditor on those accounts, and the Trust's Annual Report.
	Monitoring 1. Receive such reports as the Board sees fit from committees in respect of

	their exercise of delegated powers. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board of such information as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the appropriate regulatory bodies and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from the Director of Finance on financial performance against budget and other external and internal financial targets. 4. Receive reports from the Chief Executive on actual and forecast income.
The decisions and duties delegated by the board to committees are laid out in the appropriate Terms of Reference which should be considered to be part of this document.	

Scheme of Delegation Derived from the NHS Foundation Trust Accounting Officer Memorandum

REF	DELEGATED TO	DUTIES DELEGATED
1	CHIEF EXECUTIVE	Designated as the Accounting Officer
3	CHIEF EXECUTIVE	To prepare the accounts in accordance with the Act and has the personal duty of signing the Trust's accounts. By virtue of this duty, the accounting officer also has the duty of being a witness before the Public Accounts Committee (PAC).
5	CHIEF EXECUTIVE	Responsible to Parliament for the resources under their control.
7	CHIEF EXECUTIVE	The accounting officer has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters. The accounting officer must ensure that: • there is a high standard of financial management in the NHS Foundation Trust as a whole • the NHS Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation • financial considerations are fully taken into account in decisions taken by the NHS Foundation Trust.
9	CHIEF EXECUTIVE	As accounting officer there is a requirement to:

		• personally sign the accounts and, in so doing accepts personal responsibility for ensuring their proper form and content as prescribed by NHSE in accordance with the Act • comply with the financial requirements of the NHS provider licence • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonable accuracy, at any time, the financial position of the NHS Foundation Trust) • ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official • ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate • ensure that any protected property (or interest in) is not disposed of without the consent of NHSE • ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, or council of governors or in the actions or advice of the NHS Foundation Trust's staff, including yourself • ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.
10	CHIEF EXECUTIVE	To ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. An accounting officer should also ensure that managers at all levels: • have a clear view of their objectives, and the

		means to assess and, wherever possible, measure outputs or performance in relation to those objectives • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own areas of responsibility and any made available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	CHIEF EXECUTIVE	To ensure that arrangements for delegation promote good management and that managers are supported by the necessary staff with an appropriate balance of skills.
12	CHIEF EXECUTIVE	The particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity and more broadly as to all considerations of prudent and economical administration, efficiency, and effectiveness.
13	BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS	The duty to act in accordance with the requirements of propriety or regularity.
13	CHIEF EXECUTIVE	Where the Board of Directors, or Council of Governors, is contemplating a course of action involving a transaction which the CEO as Accounting Officer consider would infringe upon the requirements of propriety or regularity, the CEO should set out in writing his/her objection. If the Board of Directors or Council of Governors decides to proceed, the CEO should seek a written instruction to take the action in question and should also inform NHSE of the position, if possible before the action is taken.
14	CHIEF EXECUTIVE	If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to the CEO's wider responsibilities for economy, efficiency and effectiveness, it is his/her duty to draw the relevant factors to the attention of the Board of Directors and the Council of Governors and to advise them in whatever way he/she deems appropriate. If the advice is overruled, and the proposal is one which as Accounting Officer the CEO would not feel able to defend to the PAC as representing value for money, he/she should seek a written instruction before proceeding. NHSE should be informed of such an instruction, if possible, before the decision is implemented. It will then be for NHSE to consider the matter, and decide whether or not

		to intervene.
21	CHIEF EXECUTIVE	To ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS Foundation Trust who can act on his/her behalf if required
22	BOARD OF DIRECTORS	If the Accounting Officer is so incapacitated that he or she will be unable to discharge their responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Director of Finance, pending the Accounting Officer's return.

Scheme of Delegation Derived from the Codes of Conduct and Accountability

Based on NHS Business Services Authority Codes of Conduct and Accountability
https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
THE BOARD OF DIRECTORS	Public Service Values in Management Ensure that public funds are properly safeguarded and that all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.
	Public Business and Private Gain Chairs and Board Directors should act impartially and should not be influenced by social or business relationships. Where a conflict of interest is established, the director should withdraw and play no part in the relevant discussion or decision.
	Hospitality and Other Expenditure Board Directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. NHS Boards should be aware that expenditure on hospitality or entertainment is the responsibility of the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.
	Relations with Suppliers NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of the contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

	Staff NHS Boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The Board must establish a climate: • that enables staff who have concerns to raise these reasonably and responsibly with the right parties; • that gives a clear commitment that staff concerns will be taken seriously and investigated;and • where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.
	Compliance Board Directors should satisfy themselves that the actions of the Board and its Directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Board Directors of NHS organisations are required, on appointment, to subscribe to the code of conduct.
	Code of Conduct All Board Directors of NHS organisations are required, on appointment, to subscribe to the code of conduct. NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. The Chair and Non-Executive Directors of the Board are responsible for taking firm, prompt and fair disciplinary action against any Executive Director in breach of the Code of Conduct for NHS Managers.
	The Board of Directors Boards are required to meet regularly and to retain full and effective control over the organisation; the Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation. The duty of an NHS Board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. The role of an NHS Board is to: • be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisations affairs • provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed • set the organisation's strategic aims ensuring that the necessary

	financial and human resources are in place for the organisation to meet its objectives, and to review management performance • set the organisation's values and standards and ensure that its obligations to patients, the local community and regulatory bodies are understood and met.
	The Role of the Chair The overall role of the chair is one of enabling and leading so that the specific roles of the Executive team and the Non-Executives are brought together in a constructive partnership to take forward the business of the organisation The key responsibilities are: • leadership of the Board, ensuring its effectiveness on all aspects of its role and setting its agenda; • ensuring the provision of accurate, timely and clear information to Directors; • ensuring effective communication with staff, patients, and the public; • arranging the regular evaluation of the performance of the Board, its committees and individual Directors; and • facilitating the effective contribution of Non Executive Directors and ensuring constructive relations between Executive Directors and Non-Executive Directors. The Chief Executive is accountable to the chair and Non- Executive Directors of the Board for ensuring that the Board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled Executive action.
	Non-Executive Directors The duties of Non Executive Directors are to: • constructively challenge and contribute to the development of strategy; • scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance; • satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible; • determine appropriate levels of remuneration of Executive Directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and • ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

	Reporting and Controls It is the Board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to stakeholders
	Declaration of Interests It is a requirement that Chairs and all Board Directors should declare any conflict of interest that arises in the course of conducting NHS business. All Board members are, therefore, expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgment
	Employee Relations The Board should ensure through the appointment of a Remuneration and Nominations Committee that Executive Board Directors' remuneration can be justified as reasonable.

Scheme of Delegation from Standing Orders

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
2.1	CHAIR	Final authority in interpretation of Standing Orders (SOs).
3.7	BOARD AND COUNCIL OF GOVERNORS	Appointment of Senior Independent Director (SID)
4.2.2	CHAIR	Call meetings.
4.5.1	BOARD	Determine standing items
4.7.1	CHAIR	Chair all Board meetings and associated responsibilities.
4.8.1	CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
4.10.1	CHAIR	Approve emergency items to be added to the agenda
4.13.1	CHAIR	Having a second or casting vote
4.15	BOARD	Suspension of Standing Orders
4.15.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
4.16	BOARD	Variation or amendment of Standing Orders subject to the approval of the Council of Governors
5.1	BOARD AND CHIEF EXECUTIVE	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. Constitution and terms of reference of sub committees may be approved by the Chief Executive.
5.2	CHAIR AND CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-

		Executive members.
5.4.1	CHIEF EXECUTIVE	Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee of the board shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.
5.4.2	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.5	ALL	Disclosure of non-compliance with Standing Orders to the Board of Directors for action or ratification. All members of the Board of Directors and all officers have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.
8.1	BOARD	Declare relevant and material interests.
8.15.2	TRUST SECRETARY	Maintain Register(s) of Interests.
9.1.1	ALL STAFF	Comply with national guidance contained in NHS England's "Standards of Business Conduct Policy 2017".
9.4.2	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
10.1/ 10.3	TRUST SECRETARY	Keep Trust seal in safe place and maintain a register of sealing.
11.1	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

Scheme of Delegation from Standing Financial Instructions

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
1.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
1.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with the Standing Financial Instructions to the Director of Finance as soon as possible.
1.2.3.2	CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
1.2.3.1	CHIEF EXECUTIVE AND	Accountable for financial control but will, as far as

	DIRECTOR OF FINANCE	possible, delegate their detailed responsibilities.
1.2.4	CHIEF EXECUTIVE	Seek approval from the Council of Governors for mergers, acquisitions, separation, dissolution or significant transfers, in accordance with the Trusts constitution.
1.2.5	CHIEF EXECUTIVE	Ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
1.2.6	DIRECTOR OF FINANCE	Responsible for: a. Implementing the Trust's financial policies and coordinating corrective action; b. Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c. Ensuring that sufficient records are maintained to explain the Trust's transactions and financial position; d. Providing financial advice to members of Board and staff; e. Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
1.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
1.2.9	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income is made aware of the Standing Financial Instructions and their requirement to comply.
2.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
2.1.2	CHAIR OF THE AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided and involve the Audit Committee in the selection process where an internal audit service provider is changed.
2.2.1.1	DIRECTOR OF FINANCE	Ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control

		including the establishment of an effective Internal Audit function
2.2.1.3	DIRECTOR OF FINANCE	Decide at what stage to involve Police in cases of misappropriation and other irregularities not involving fraud or corruption.
2.3.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.
2.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
2.5	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Monitor and ensure compliance with trust policies on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
2.6	CHIEF EXECUTIVE	Monitor and ensure compliance with trust policies on security management including appointment of the Local Security Management Specialist.
3.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan. The plan shall also have regard to the views of the Council of Governors
3.1.1 to 3.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an ongoing basis to budget holders.
3.2	CHIEF EXECUTIVE	Delegate budget to budget holders.
3.2.2	CHIEF EXECUTIVE AND BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
3.3.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
3.3.2	BUDGET HOLDERS	Ensure that a. no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b. approved budget is not used for any other than specified purpose subject to rules of virement; c. no permanent employees are appointed

		without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.
3.3.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the annual plan and agreed budget.
3.5	CHIEF EXECUTIVE	Submit monitoring returns
4.1	DIRECTOR OF FINANCE	Prepare annual accounts and reports.
5.1.1	DIRECTOR OF FINANCE	Manage banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of bank signatories.
5.1.2	THE BOARD	Approve banking arrangements
6	DIRECTOR OF FINANCE	Responsible for income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
6.2.3	ALL EMPLOYEES	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
7	CHIEF EXECUTIVE	Ensure there is an appropriate tendering and contract procedure.
7.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
7.5.4 /7.5.5	CHIEF EXECUTIVE/DIRECTOR OF FINANCE	Report waivers of tendering procedures to the Audit Committee
7.5.7	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
7.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
7.6.3.7	CHIEF EXECUTIVE	Maintain a register to show each set of competitive tender invitations despatched.
7.6.4.2	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received, assess for value for money and fair price.
7.6.6.4	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of the Chief Executive.
7.6.8.1	CHIEF EXECUTIVE	Appoint a manager to maintain a list of approved firms.
7.6.9.1	CHIEF EXECUTIVE	Ensure that appropriate checks are carried out as to the

		technical and financial capability of those firms that are invited to tender or quote.
7.7.2.4	CHIEF EXECUTIVE	The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money.
7.7.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of the Chief Executive or Director of Finance
7.10.1.1	CHIEF EXECUTIVE	Demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
7.10.1.3	BOARD	All PFI proposals must be agreed by the Board.
7.11.1.7	CHIEF EXECUTIVE	Nominate an officer who shall oversee and manage each contract on behalf of the Trust.
7.12	CHIEF EXECUTIVE	Nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.15.1	CHIEF EXECUTIVE	Responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
7.15.5	CHIEF EXECUTIVE	Nominate an officer to oversee and manage the contract on behalf of the Trust.
7.13.2 & 8.1.2	CHIEF EXECUTIVE	Ensure the Trust enters into suitable Service Level Agreements (SLAs)/contracts with service commissioners for the provision of NHS services
8.1.1	CHIEF EXECUTIVE	Responsible for establishing contracts for the provision of services to patients in accordance with the Annual Plan, and for establishing the arrangements for providing extra-contractual services.
8.1.3	CHIEF EXECUTIVE	As the Accounting Officer, ensure that regular reports are provided to the Board detailing actual and forecast income contracts held by the trust
9.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
9.1.2	REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual

		arrangements for such staff, including proper calculation and scrutiny of termination payments.
9.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
9.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
9.2.2	CHIEF EXECUTIVE AND THE BOARD	Approval of variation to funded establishment of any department below £250,000. The Board shall approve any variation over this limit
9.3	CHIEF EXECUTIVE	Authorise the engagement, reengagement or regrading of Staff, and the hiring of agency staff.
9.4.1 and 9.4.2	DIRECTOR OF FINANCE	Payroll: a. specifying timetables for submission of properly authorised time records and other notifications; b. final determination of pay and allowances; c. making payments on agreed dates; d. agreeing method of payment; e. issuing instructions as listed in SFI 9.4.2.
9.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submit termination forms in prescribed form and on time.
9.4.4	DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
10.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.

10.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.1.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Authority for the approval of foreign travel funded by the trust; authorisation should be reported to the Audit Committee
10.2.1	REQUISITIONER*	In choosing the item to be supplied, or the service to be performed, shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
10.2.3	DIRECTOR OF FINANCE	Responsible for the prompt payment of accounts and claims.
10.2.3	DIRECTOR OF FINANCE	a. Advise the Board regarding the setting of thresholds above which quotations, competitive or otherwise, or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b. Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; c. Responsible for the prompt payment of all properly authorised accounts and claims; d. Responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e. Prepare a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f. Prepare instructions to employees regarding the handling and payment of accounts within the Finance Department; g. Responsible for ensuring that payment for goods and services is only made once the goods and services are received, unless prepayment is allowed by SFI 10.2.4
10.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
10.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
10.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform the Director of

		Finance if problems are encountered).
10.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
10.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
10.2.9	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
11.1.1	DIRECTOR OF FINANCE	Advise the Board on the Trust's ability to pay dividend on PDC and interest on loans, and report periodically concerning the PDC debt, and all loans and overdrafts.
11.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
11.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.1.5	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising one other member for short term borrowing approval. Ensure board are made aware at next Board meeting.
11.2.1	BOARD	Authorise investments of temporary cash surpluses
11.2.2	DIRECTOR OF FINANCE	Advise the Board on investments and report, periodically, on performance of investments held.
12.1.1/ 12.1.2	CHIEF EXECUTIVE	Capital investment programme: a. ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b. responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c. ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d. ensure that a business case is produced for each proposal and submitted to the Capital Control Group
12.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.

12.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
12.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
12.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
12.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
12.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
12.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector and ensure NHSE guidance is applied to any such proposal.
12.2.1	BOARD	Approve proposal to use PFI
12.3.1	CHIEF EXECUTIVE	Ensure maintenance of asset registers, on advice from DoF.
12.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with NHSE requirements.
12.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
12.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
12.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
13.2.1	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores, subject to DoF responsibility for systems of control. Further delegation for day-to-day responsibility subject to such delegation being recorded.
13.2.1	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
13.2.1	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
13.2.1	DESIGNATED ESTATES OFFICER/FLEET OFFICER	Responsible for control of stocks of fuel oil and diesel.
13.2.2	NOMINATED OFFICERS*	Security arrangements and custody of keys.

13.2.3	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
13.2.4	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
13.2.5	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
13.2.6	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemning, disposal and replacement of all unserviceable items.
13.2.6	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
13.3	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
14.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemning and ensure that these are notified to managers.
14.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
14.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department/nominated officer should then inform the Chief Executive and DoF.
14.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, the DoF must inform the police if theft or arson is involved. In cases of fraud and corruption the DoF must inform the relevant LCFS and NHS Counter Fraud Authority
14.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit of all frauds.
14.2.3	DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
14.2.4	BOARD	Approve write off of losses.
14.2.4	DIRECTOR OF FINANCE	Inform Board if NHSE Notification required in relation to write off of losses
14.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
14.2.7	DIRECTOR OF FINANCE	Maintain losses and special payments register.
15.1.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
15.1.2	DIRECTOR OF FINANCE	Satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained

		from them prior to implementation.
15.1.3	DIRECTOR OF NURSING AND CLINICAL COMMISSIONING	Publish and maintain a Freedom of Information Scheme.
15.2	DIRECTOR RESPONSIBLE FOR IT	Establish appropriate Policies and Procedures for IT to ensure protection of data and systems, controls over data processing, and due attention to it and systems resilience.
15.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
15.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
15.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy him/herself that: a. systems acquisition, development and maintenance are in line with corporate policies; b. data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c. DoF and staff have access to such data; and d. Such computer audit reviews are being carried out as are considered necessary.
16.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property.
16.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
17.1.3	DIRECTOR OF FINANCE	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
18.1	DIRECTOR OF FINANCE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
19.1	CHIEF EXECUTIVE	Retention of document procedures in accordance with guidelines issued by relevant bodies.
20.1.1	CHIEF EXECUTIVE	Ensure a programme of Risk management in line with assurance framework requirements.

20.1.1	BOARD	Approve and monitor risk management programme
20.2.1	DIRECTOR OF FINANCE	Ensure that insurance arrangements exist in accordance with the risk management programme and that documented procedures cover these arrangements.
20.2.5	BOARD	Consider and approve the insurance and risk management arrangements for the Trust.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

Delegation Limits and Other Key Financial Controls

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST					
DELEGATED LIMITS AND OTHER KEY FINANCIAL CONTROLS					
ISSUE	LIMITS	TO BE AUTHORISED BY:	Contracts	Capital £	Revenue £
Authorising expenditure (including approval of requisitions, purchase orders and invoices) Agreeing and signing contracts to the approval value (where the Trust Board agrees contracts >£1m, this includes specific approval for the contract signature to be provided by the Director of Finance or Chief Executive)		Trust Board	Over £1m	Over £500k	Over £500k
		Chief Executive (under advice from and agreed with the Director of Finance)	Up to £1m	Up to £500k	Up to £500k
		Director of Finance	Up to £500k	Up to £250k	Up to £250k
		Voting Director	Up to £100k	NIL	Up to £100k
		Non Voting Directors and EMB members In addition: Legal Services advisor Head of IT Deputy Director of Finance	Up to £50k	NIL	Up to £50k
		Designated budget holder or budget manager (following formal delegation from relevant Director)	Up to £20k	NIL	Up to £20k
Limit above which formal tendering shall occur	£20k	Tenders will be opened by any two of: Executive Director, Trust Board Secretary, Chief Financial Accountant, Head of Procurement, Senior representative of procuring department		-	
Minimum number of firms invited to tender – where appropriate	At least two			-	
Limit above which competitive quotes	£5k	Procedures for handling of quotes to be managed within relevant		-	

are invited		Department			
Minimum number of firms invited to competitively quote	At least three			-	

ISSUE	LIMIT	APPROVAL REQUIRED BY:	NOTES
Business cases and capital expenditure Approval will follow the process as set out within the Trust's Investment Approval Process	Capital programme including annual updates	Trust Board	Detailed scrutiny delegated to Performance Committee
	Individual capital and/or revenue proposals <£250k	Financial Investment Group	These limits relate strictly to the ability to vire existing capital funding within the approved capital programme – NOT to proposals requiring new capital funding
	Capital and/or revenue proposals between £250k and £500k	EMB	
	Capital expenditure and/or Revenue proposals > £500k	Trust Board	
	In-year increases in capital budget	Trust Board	
	Note: Trust Board reserves the right to consider any novel, unusual, or contentious business case referred to it by the Director of Finance, irrespective of capital or revenue costs		
Authorising disposal of fixed assets	Programme of disposal	Trust Board	Eg, vehicle replacement programme, sale of redundant buildings
	Individual or group of item(s) <£20k	Financial Investment Group	
	Individual or group of item(s)	Director of Finance, Director of Strategic Operations and Digital	Disposal must have formed part of capital programme previously agreed by Board

	> £20k	Integration. Re-refer to Executive Management Board if expected receipt less than 90% of programmed or budgeted receipt	
Petty cash – maximum individual reimbursement	£30	Designated petty cash holder	
Payment runs/CHAPs payments; standing orders, manual cheques, and payments to HMRC	All	Any two senior members of finance department	1st signatory must be Band 8a and above; 2nd signatory to be Band 7 and above; paper CHAPs payments – signatory must be on banking panel
Credit card requests	All	Director of Finance	Must be on banking panel

Note – Board can delegate specific areas of responsibility to committees. Please see their respective Terms of Reference (which will be subject to annual review).

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11c MEETING: JANUARY 2024 PAPER NUMBER: 15

Finance Strategy and Commissioning Strategy	
Sponsoring Director	Director of Finance
Author(s)/Presenter	Karen Rutter – Director of Finance
Purpose	To approve the Finance Strategy plus Commissioning Strategy, which will be consolidated along with other existing strategies as part of the overall Trust Strategy review.
Previously Considered by	Finance Strategy - Board – for review – October 23 Commissioning Strategy - EMB – January 24
Report Approved By	Karen Rutter – Director of Finance

Executive Summary

The previous financial strategy is overdue for review and reflected a different pre-pandemic NHS financial structure and funding regime.

This updated Strategy has been produced to enable the Trust's Strategic Objectives to be underpinned by Finance and with the National, Local and Organisational context reflected to illustrate the current and evolving NHS financial environment.

The finance objectives included are deliverable and measurable with an improvement focus to ensure that the Trust is future focussed.

There are a number of other strategies in existence which will part of the Trust Strategy review due to take place to align some of the content where current policies overlap. One of these is the Commissioning Strategy 2023-2025 which was updated by the former Director of Nursing and Clinical Commissioning and is currently held for approval. The majority of the Strategy objective responsibilities sit under the Medical and Nurse Director remits with the remaining spread across a number of Directors.

Due to the change in the NHS landscape, commissioning is not undertaken in the same way as previously and the collaborative ICS approach to commissioning is not yet fully established.

Ensuring that the contents of this strategy are reviewed, updated and included in the most appropriate document going forward will be included in the Strategy work. This will also ensure that the Strategy owner is aligned to the content.

An interim step is to align the Finance and Commissioning Strategies until the consolidation that is proposed in the review is fully established.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 11c MEETING: JANUARY 2024 PAPER NUMBER: 15

Related Trust Objectives/ National Standards	Enabling Strategies to support the Trust Objectives
Risk and Assurance	Risk that the Trust fails to operate adequately and effectively if there is no strategic direction
Legal implications/ regulatory requirements	Robust financial processes are required to be in place to ensure that the Trust is operating effectively
Financial Implications	Failure to deliver financial responsibilities 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

The Board is requested:

- To **approve** the Finance Strategy
- To **approve** the Commissioning Strategy (2023-2025)
- To **approve** the Director of Finance as the owner of both Strategies pending any update
- To **note** that both Strategies will be included in the overall review of Strategies to be undertaken

Appendix 15a

FINANCE STRATEGY

To enable the Trust to maximise our potential to improve and deliver best value

INTRODUCTION

This strategy underpins and supports the delivery of all previous strategies developed.
The three year timescale to deliver the Financial Strategy allows a focussed and driven approach, aligning to the medium planning approach taken by commissioners. Furthermore, this has also enabled us to develop our Financial Strategy with the benefit of post pandemic knowledge and in line with the changing landscape of NHS funding streams nationally with the introduction of Integrated Care Boards (ICBs).

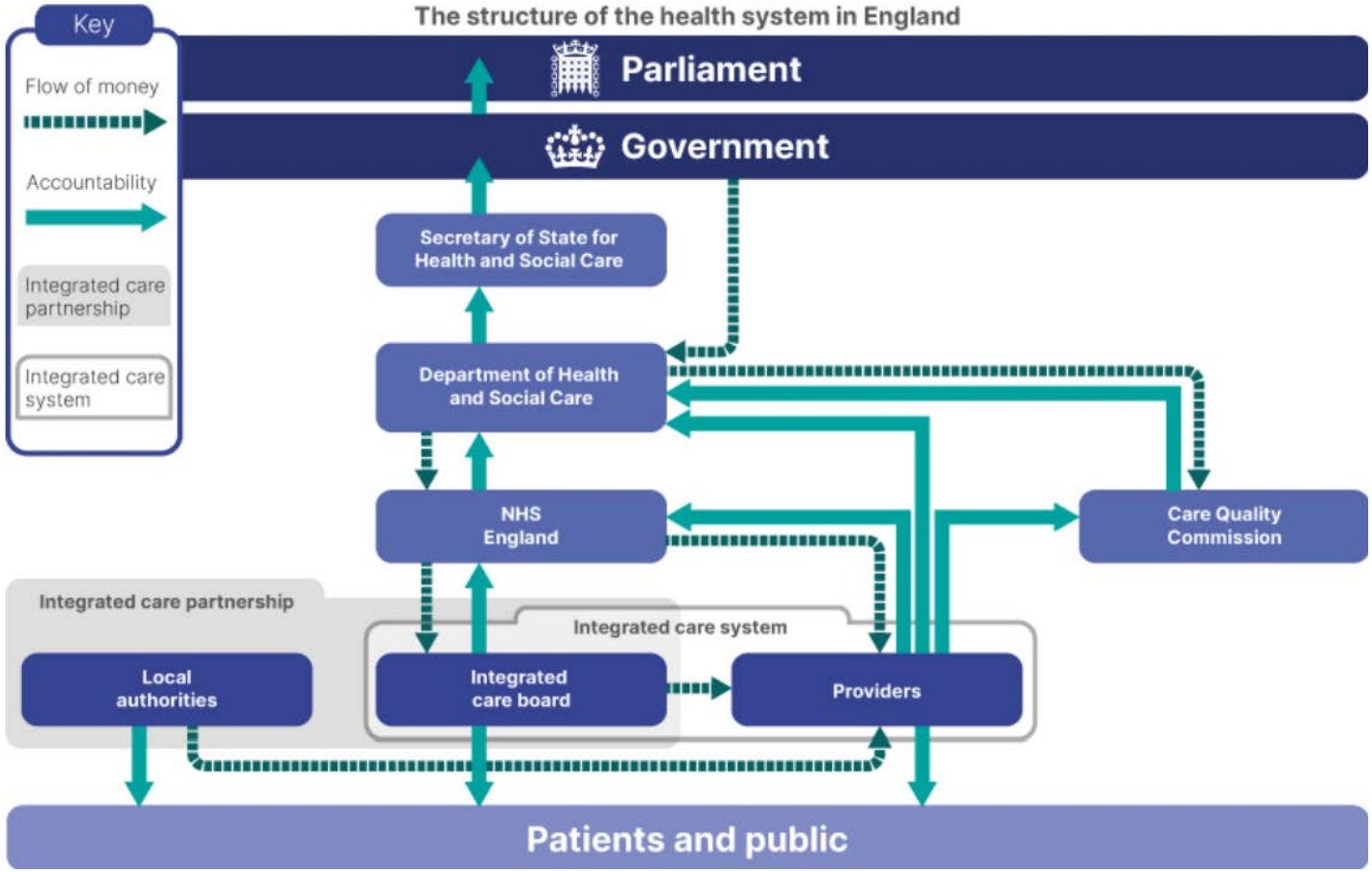
Finance at WMAS is led by the Director of Finance driven by the Finance Team, managed by budget holders across each business area, and delivered by all staff across the organisation.
Managing available resources is essential to ensure WMAS can provide healthcare services to our patients Therefore, financial sustainability and delivering best value is central to ensuring continued healthcare provision to the population we serve.

Following a time of considerable change for the NHS, with the implementation of Integrated Care Systems and the introduction of ICBs as the new funding structure, the Trust is working with its partners across the West Midlands to support system wide financial sustainability. Black Country Integrated Care system is facing significant financial challenges with overall deficits reported and, although WMAS delivers activity across the regional footprint and not just the Black Country, we have developed the Financial Strategy to not only reflect our own priorities, but to acknowledge these system challenges.

NATIONAL FINANCE CONTEXT

Health Services across England are funded from the Department for Health and Social Care's budget, with funding streams illustrated in figure 1. The majority of this budget is passed to NHS England, and the remainder funds public health, local authority grants, training and development and regulation of care.

Figure 1 The Structure of the Health System in England



Healthcare Financial Management Association [HFMA], (2023)

The introduction of ICSs and ICBs was brought forward by the white paper *Integration and innovation working together to improve health and social care for all*, with implementation of this new structure from 1 July 2022 allowing NHS England to set financial allocations and other financial objectives at a system level.

Reset & Recovery

Post-pandemic operational planning nationally prioritises on reducing backlogs, increasing capacity, growing the workforce, and expanding joined up healthcare. These national priorities carry with them considerable financial implications.

The NHS manages within overall resource limits that are determined by the government each year, and is challenged to meet unlimited demand, with finite resource. There are current further pressures to consider including:

- Learning to live with COVID 19
- Inflation and cost of living crisis
- European Union Exit
- Industrial Action

LOCAL FINANCE CONTEXT

Commissioning organisations have changed substantially over the recent years with Clinical Commissioning Groups (CCGs) transitioning onto Integrated Care Boards (ICBs). ICBs are statutory organisations bringing the NHS together locally to improve population health and establish shared strategic priorities with the NHS.

WMAS is part of Black Country ICB, working with other provider organisations across Dudley, Wolverhampton, Sandwell and Walsall (the Black Country system).
It is recognised that service delivery for WMAS does not stop at the Black Country borders as it spans the whole of the West Midlands.

Black Country ICB acts as lead commissioners for WMAS working with the 5 other WM ICBs to ensure funding and contracting arrangements are in place.

It is important to consider the demographic of the patients we serve, in order to understand how that might affect the financial pressure on the services we provide.
WMAS operates and holds contracts with all West Midlands based ICBs incorporating the core UEC (Urgent and Emergency Care) activity and related funding plus any other commercial type arrangements (ie Non Emergency Patient Transport Services).

Working as part of a system has seen and will continue to see an increasing shift to enhanced collaborative working, expanding through traditional organisational boundaries. This influences the way we work and the decisions we make, as partners increasingly join forces where it makes sense to do so and where this will make a positive difference to our patients, staff and our wider population to positively change lives.

Provider funding is now routed through ICS allocations with the acute Provider Collaboratives already developed. This presents significant opportunities and risks for the Trust working alongside the established acute Trust partnerships in a deficit system.

NHS England require financial planning to continue to be delivered on a system basis. WMAS must ensure, in these plans, that the efficiencies realised from collaborative working are maximised and that the specific needs of WMAS as an individual organisation are protected.

TRUST STRATEGY

The strategic objectives underpinning the Trust Strategy are as follows:

The Trust must continuously review and improve the way it uses its resources so that we can maximise the benefits of our patients for every pound that we spend.

Finance and the related functions will be an enabler to delivery of the above organisational strategic objectives.

A sustainable financial position is crucial in delivering high quality care but our aim is to embed a culture where finance is everyone's business. Finance isn't something to be delivered separately and is only part of the discussion. Some of the work is technical and we have staff with the skills and knowledge to do this, but this should be alongside all other WMAS functions in order to deliver for the organisation.

WMAS FINANCE and PROCUREMENT

The roles and teams can be summarised as:

Financial Accounts including Payables	Financial Management	Purchasing and Procurement	Contracting and Commissioning
What we do: • Statutory duty to provide year end accounts • Ensures Trust has sufficient cash • Sales ledger and income • Ensures tax and VAT obligations are met • Ensure staff and suppliers are paid correctly and on time **Organisation support:** • Invoice payment/chasing debts • Limits vulnerability to financial fraud • Interprets national guidance and regulation • Ensure external reporting is undertaken accurately and to timetable • Provide advice and management of the Trusts charitable funds	**What we do:** • Provide support and guidance to budget holders • Monitors and reports the financial position • Costs new services and contracts • Lead on budget setting for all areas • Monitor and account for capital spend • Ensure staff and suppliers are paid correctly and on time **Organisation support:** • Lead on budget setting for all areas • Ensure external reporting is undertaken accurately and to timetable • Ensure capital funding is fully utilised – lease v purchase	**What we do:** • Advise and support in purchasing goods and services • Ensure the Trust obtains value for money • Ensure that government guidance is followed when purchasing for public sector bodies **Organisation support:** • Help budget holders to obtain best value when making purchases • Advise on and support tender and bid processes to ensure governance is followed to obtain best value • Identify efficient ways of purchasing to fully utilise available resources	**What we do:** • Assist contract managers to monitor all service related contracts • Provide support with contract related queries • Support the financial elements of tender submissions where business is planned **Organisation support:** • Negotiation assistance with commissioners • Ensure contracts are listed on the Trusts contract database **NEW AREA – TO BE DEVELOPED**

FINANCE STRATEGIC OBJECTIVES

Ensuring that financial objectives are developed to underpin the delivery of the Trust Strategic Objectives allows the financial elements required to be an integral part of each one and for the finance function to be recognised and embedded as an enabling function to the organisation.

Core deliverables for the finance function are to operate a full procure to pay service, produce and monitor a robust budget each year and to produce an unqualified set of Financial Statements. Maintaining this stability and continuing to improve is key to success.

The key objectives for the Finance Strategy are:

1) Achieve financial sustainability by delivering the financial plan

If we maintain long-term healthy finances, we will ensure a healthy foundation for the Trust, both in relation to revenue and capital. Financial stability also enables us to invest more to improve the safety and quality of our services, to explore new innovative opportunities and to make the Trust a stable place to receive continuity in funding and to work in a place which offers job security.

To achieve success we will:

- Set a robust, reasonable and deliverable financial plan, subject to continual monitoring of financial risk.
- Use our strong financial delivery and cash position to enable the Trust to support approved developments within the confines of the NHS England and Black Country ICB parameters, including investment in our estate and digital innovation.
- Work closely with budget holders to build skills and competence and ensure an environment with sound financial control.
- Work in collaboration with auditors to adopt best practice to optimise our current systems and standardise our processes to ensure we are working as efficiently as possible.
- Utilise networks to support horizon scanning to aid the proactive initiation of change and support a sound financial risk management approach.

2) Maximise available resources

In order to achieve financial stability and to maximise investment in the services that we provide, we will need to manage our cost base, including overheads.

To achieve success we will:

- Protect the public purse through tackling inefficiencies and maintain the objective independence of the finance function
- Develop the use of benchmarking metrics to enable meaningful comparison with other organisations and support the identification of opportunities for further development and efficiency, in addition to delivering the required cost improvement targets
- Explore digital solutions to maximise efficiency and effectiveness within the team, and where applicable, wider across the Trust.
- Support operational services to identify areas of efficiency which will lead to better use of available resources
- Utilise procurement tools and in house expertise to ensure the most competitive supplier costs to achieve optimum value for money and enable optimal investment in front line care.

3) Operate effectively within the local system and with region wide system partners

Work collaboratively with the ICSs, commissioners and partners to ensure effective investment in front line services which achieves positive outcomes for our patients. We will do this by:

- Providing up to date and accurate financial plans and forecasts to inform planning and financial allocations across systems;
- Working with partners to secure any new funding – recurrent and non-recurrent – to support the delivery of strategic plans and/or operational pressures.
- Identifying opportunities to develop joint approach or services across a system which are more economic and efficient and support patient care.
- Managing financial risk to the Trust whilst supporting collaborative working.

4) Ensuring a fit for purpose function

To enable the function to provide the support to the organisation and to work in the most effective way we will future proof the function by:

- Embedding the customer focussed, enabling ethos across the whole function
- Reviewing the structure so that each element of the finance function will be appropriately resourced to deliver the current and future commitments. Develop the contracting and commissioning part of the function
- Review and update, where necessary, the systems, processes and ways of working across the function including expanding on the Business Partner model
- Embedding a continuous improvement focus across all activities
- Supporting the learning and career progression of all staff in the function
- Ensure that good financial governance is the base of all that we do
- Build on the Future Focussed Finance accreditation achieved at Level 1 by progressing to Level 2 then 3.

5) Identify opportunities for business development and growth

To ensure that the Trust can remain stable and, despite there not being an alternative local provider for core emergency services, opportunities for growth will be explored. This may be where there are synergies with the current Trust operations or as a result of newly identified business that could be provided. The current NHS financial regime aims to reduce the amount of tendering activity within the health and public health market, proposing that partners work together to commission improvements in population health by working in collaboration to redesign and deliver care. This may present the Trust with opportunities for business development and growth, but any such opportunities will need to be informed by a clear business development strategy so that they are in line with our overall vision and values.

Equally, the Trust may need to concede that some areas of business will not be possible to deliver within the resources or timescales available. Any growth opportunities should not be considered if they would compromise the Trust's existing activities.

The development of a business development strategy would need to be supported by a clear financial framework. We will support this by:

- Working in partnership with commissioners and providers on the financial envelopes available to inform future business development
- Assessing and mitigating any financial risk to growth or shrinkage of business to the Trust.
- Ensuring that finance is embedded in all business development plans

NEXT STEPS

Deliver the above objectives ensuring that a measurable plan in place for each one;

Further develop and build on this plan for future years to ensure the continuity; and

Be **flexible** both to the needs of the organisation and the requirements of commissioners and regulators.

Appendix 15b

Commissioning Strategy 2023 - 2025

Executive Summary

West Midlands Ambulance Service University NHS Foundation Trust (the Trust) is committed to delivering an efficient, cost-effective, high-quality health care service which fully integrates all the threads of quality, performance and governance as detailed in the Trust's values (Appendix 1).

The role of commissioning, as a key driver of quality, efficiency and outcomes for patients has become increasingly important to the health system in England. Through regular engagement with key stakeholder groups, the Trust aims to attain the best possible health outcomes for the local population by assessing local needs, agreeing priorities and the best means of service delivery. This strategy is an enabler as part of the framework within the Trust's Five-Year Strategic Plan. The healthcare environment is continuously changing. Whilst we have tried to anticipate future challenges, we understand that there may be many changes during the next three to five years that cannot be foreseen at this stage.

We have tried to make this strategy as flexible as possible whilst identifying the aims and objectives for clinical commissioning. This will provide the basis for monitoring and evaluation, the results of which will be reported through the pillar committee structure as outlined on the Strategic Framework (Appendix 2).

Definitions

1. Clinical Commissioning relates to a series of actions to identify and deliver the best outcomes for patients. This incorporates the assessment of local health needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as ambulance services, hospitals, clinics, community health bodies, etc. Securing services is much more complicated than securing goods and the diversity and intricacy of the services delivered by the NHS is unparalleled. The process includes the development of service specification and contract negotiation or procurement, with continuous quality assessment. Commissioners must constantly respond and adapt to changing local

circumstances. Integrated Care Systems (ICSs) are now responsible for the commissioning of healthcare across England.

2. Our Commissioning Strategy Shows the Trust's aspirations, and guides how resources are best invested both to deliver services for patients and to effectively manage and run the organisation.
3. Integrated Care Systems (ICSs) Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Following several years of locally led development, recommendations of NHS England and passage of the Health and Care Act (2022), 42 ICSs were established across England on a statutory basis on 1 July 2022. There are 6 ICSs in the West Midlands:

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

Scope Copy Link

According to the Commissioning Cycle (See Appendix 1), this strategy describes the overarching behaviours, structures, systems and processes that the Trust will utilise in order to achieve the delivery of the elements of Clinical Commissioning, these are:

- Strategic Planning and Procurement of Services
- Monitoring and Evaluation

The document forms the framework upon which the Trust will:

- Review performance
- shape priorities and service improvement proposals
- make strategic decisions
- create our annual delivery plans
- influence the ICS commissioning intentions

The strategy has been formulated by a process of listening to patients and commissioners. The outcomes from these discussions are included in Appendix 2 (CCG Priorities Relevant to WMAS) and Appendix 3 (Patient Expectations). The strategy will be consulted widely to ensure our priorities are recognised and supported by others.

Clinical Commissioning Aims and Objectives

The Trust will continue to strive to achieve its vision through informed clinical commissioning that engages staff within the organisation and works in partnership with commissioners and in collaboration with external stakeholders. This will be supported by robust and transparent commissioning governance arrangements to support service delivery models.

The following objectives form the basis of the delivery plan of this strategy:

- Work in partnership with commissioners to implement new models of care
- Work pro-actively with relevant groups and Urgent and Emergency Care Boards in the governance of systems of care
- Deliver excellence in clinical outcomes and provide measurement of these
- Ensure the organisation has robust contract and procurement processes in place, in the context of a block contract arrangement

Risks

Risk management is a key component of enhancing patient care and is therefore central to the Trust's Commissioning Strategy. It is the process whereby the Trust methodically addresses the risks attached to its activities with the goal of achieving sustained benefits to patient care within each activity and across the portfolio of all Trust activities.

The identified challenges that are relevant to the Commissioning Strategy are captured within all three significant risks:

- Significant Risk 1: Failure to achieve Operational Performance Standards
- Significant Risk 2: The Trust fails to manage its Finances appropriately
- Significant Risk 3: The Trust fails to comply the Regulatory Body Standards and Quality Indicators

These risk assessments are influenced by a variety of risks which are incorporated into the significant risk assessments, which are reviewed on a regular basis through the Trust committee structure.

Research and Audit

The promotion and conduct of research is a core NHS function, and The Trust recognises that a commitment to research and innovation is vital if it is to play a lead role in the development of urgent and emergency care.

The Trust will promote research activity that seeks to address the healthcare priorities for urgent and emergency care relevant to an ambulance service particularly where this leads to improvements in treatments and care for our service users. We will focus on raising awareness among patients and the public, so they are informed on research studies that are relevant to their health needs, and of the opportunities available for them to become involved.

The Trust recognises that effective healthcare commissioning requires access to the best evidence, appropriate data, and service evaluation. Research and evaluation evidence will therefore guide and inform our decisions about the commissioning and decommissioning of services. Our commitment to research will be consolidated by the activities of a research and development office, continued in partnership with local research networks, and by robust research governance arrangements to safeguard the wellbeing of those who participate.

Delivery Plan

Objective 1 - Work in partnership with commissioners to design and implement new models of care

Deliverables		Responsibility	Timescale
1.	Make changes to the services we deliver to ensure they provide the greatest impact on health outcomes • We will work pro-actively to implement mental health response cars with partner agencies, subject to the necessary resource investment • We will continually review training requirements, ensuring that programmes are delivered according to emerging themes and trends and commissioned activity • Clinicians access the primary care summary care record and advanced care plans and directions electronically	Director of Nursing Medical Director	Ongoing
2.	• Identify opportunities for enhancing patient care by developing business opportunities	Director of Nursing Medical Director Director of Finance	Ongoing
3.	• Changing the way we deliver services to ensure seamless care is delivered within the healthcare system, according to STP priorities	Director of Nursing Medical Director	Ongoing
4.	• Any mandated ambulance interventions are delivered	Paramedic Practice & Patient Safety Director	Ongoing
5.	• WMAS will play an active role within the six Integrated Care Systems (ICSs) across	Director of Strategy and	Ongoing

	the West Midlands, where we will have an associate role on the ICS Boards • An Executive Director will be allocated as the WMAS lead for each ICS	Engagement	

Objective 2 - Work pro-actively with Key Stakeholders in the governance of systems of care Copy Link

Deliverables		Responsibility	Timescale
1.	Support commissioners in the review of pathways for patients following a fall, ensuring robustness, effectiveness, consistency and timeliness of follow up and falls prevention strategies In line with Safeguarding processes, support commissioners in the identification of frequent callers and onward planning for future care	Director of Nursing Medical Director	Ongoing
2.	• In line with Stakeholder Engagement Strategy, listen to our patients and use their experiences and feedback to improve our service and their experience	Director of Strategy and Engagement	Ongoing
3.	• Appropriate engagement with key stakeholders including: o Patients (Responsibility: All Directors) o Staff (Responsibility: People Director) o Governors (Responsibility: Director of Strategy & Engagement) o Commissioners (Director of Finance)	All Directors - As specified according to each stakeholder group	Ongoing

	○ Other healthcare providers (All Directors) ○ HealthWatch (Responsibility: Director of Strategy and Engagement)		
4.	• WMAS is represented at the ICS Boards by an Executive Director (see deliverable 5 of Objective 1)	Director of Strategy and Engagement	Ongoing
5.	• WMAS is represented at the Urgent & Emergency Care Boards • Where health economies are identified as 'troubled' the Urgent & Emergency Care Board is also attended by the Medical Director or Director of Nursing	Director of Nursing Medical Director	Ongoing
6.	• Develop mechanisms to ensure that decision-making and priority setting are transparent and support the principles of the accountability for reasonableness framework	Director of Finance	Ongoing
7.	• Work collaboratively with partner organisations to ensure we maximise health outcomes ○ Patients with undiagnosed long-term conditions are referred for more specialised support via their GP	Medical Director	Ongoing
8.	• Making Every Contact Count - Work with Public Health England to deliver a	Director of Nursing	Ongoing

	programme of work that maximises health promoting opportunities o Sharing of Health Intelligence o Joint health promotion activity		

Objective 3 - Deliver excellence in clinical outcomes and provide measurement of these

Deliverables		Responsibility	Timescale
1.	Work with commissioners and national bodies to define performance metrics, ensuring: • Appropriate national suite of clinical performance measures is in place • Research programmes that provide evidence-based measures of ambulance service interventions are being delivered	Medical Director	Ongoing

Objective 4 - Ensure the organisation has robust contract and procurement processes in place

Deliverables		Responsibility	Timescale
1.	• Work in partnership with ICSs to review service provision and develop a robust set of commissioning intentions • Commissioning intentions are refreshed and in place by December each year	Director of Finance	Annually in December
2.	• Ensure robust commissioning and contract management processes are in	Director of Finance	According to NHS England Timescales

	place		

Commissioning Strategy on a Page Copy Link

Purpose	To ensure that patients receive the highest standards of clinical care at the right place at the right time in partnership with the local health economies. The Trust will achieve this through informed clinical commissioning that engages clinical staff within the organisation and works in partnership with commissioners and in collaboration with external stakeholders.					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
Objectives	Objective 1 Work in partnership with commissioners to design and implement new models of care	Objective 2 Work pro-actively with key stakeholders in the governance of systems of care		Objective 3 Deliver excellence in clinical outcomes and provide measurements of these.	Objective 4 Ensure the organisation has robust contract and procurement processes in place	
Outcomes	1. The Trust's continued work towards becoming a world-class emergency care provider where staff work together to deliver the highest standards of health care and achieve excellent outcomes 2. The Trust's strategic objectives: trusted on quality, delivering for tax payers and providing excellence in healthcare 3. Delivery of the Trust's statutory objectives as an emergency ambulance provider. 4. Improvements in clinical outcomes for patients.					
Key Areas	Clinical Quality	New Models of Care	System Governance	Clinical Outcomes	Contract and Procurement	

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

Appendix 1 The Commissioning Cycle

Reviewing service provisions
Deciding priorities
Designing services
Shaping structure of supply
Planning capacity and managing demand
Supporting patient choice www.nhs.uk
Managing performance
Seeking public and patient views
Assessing needs
Strategic Planning
Procuring Services
Monitoring and Evaluation
Patients/ Public

Appendix 2 Clinical Commissioning Group Priorities for WMAS

Self-Care and Self-Management	• Supporting people to stay healthy and have healthy lifestyles • Educating people to manage long-term conditions • Making information and guidance readily available • Supporting the third sector to deliver programmes of prevention and support • Assistive technologies • Falls prevention
Primary Care Services	• Supporting innovation in the delivery of care through locality based urgent care centres • Primary Care as part of integrated locality teams supporting vulnerable and older people • Improved premises and IT systems • Supporting formal federations/collaboration of member practices • Workforce reconfiguration
Integrated Care	• Integrated care delivered by locality teams • Risk stratification and case management

	• Personalised Care Plans Seven day a week access to services • Supporting frail older people • Supporting people living with dementia • Anticipatory care
Urgent Care	• Urgent care coordination centre • Crisis response services • Direct access GP beds • Acute GP service • Same day emergency care (SDEC)
Supporting People to improve their Mental Health	• Reduced stigma and discrimination with parity of esteem • Prevention and early intervention • Improved recovery and enhanced Mental Health Re-ablement • Suicide Prevention • Child and Adolescent Mental Health Services
System recovery following the global COVID pandemic	• Recovery of the elective programme of work, this will impact on the PTS service

	• New models of working to meet the health needs of the population • Population health management
Other Service Areas and Key Enablers	• Children • Planned care • Safeguarding • Information technology • Workforce development and cultural change • Carers • Patient engagement

Appendix 3 Patient Expectations

- Provide a high quality and responsive 999 service to everybody in the West Midlands
- Ensure our staff are highly trained and competent
- Provide vehicles and equipment that are of a high quality
- Maintain public confidence in the brand:

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

	• Ensure that we ‘Make Every Contact Count’ • Make our service equally accessible to everybody
	• Optimise levels of ‘Hear & Treat’ • Provide a Clinical Support desk to clinicians ‘on the road’ and call takers • Ensure that we achieve high levels of satisfaction • Encourage user and public involvement • Engage with our wider public and population
	• Optimise levels of patient care managed on scene • Work in partnership with service users and other stakeholders to identify alternatives to 999 care • Implement evidence-based systems that safely enable patients to be treated outside of hospital • Develop the digital patient record to integrate patient care with the wider health system
	• Identify services that most appropriately meet the needs of service users • Work collaboratively to signpost service users to alternative services • Utilise a Directory of Services that allows alternative services to be identified for specific patient need • Identify opportunities for WMAS to deliver alternative services (e.g. Urgent Care Centres)

	• Deliver the 999 service for the West Midlands and promote the use of 111 services for people who have non-emergency care needs
	• Ensure that patients are only taken to an acute hospital when this is needed • Patients will be taken to the most appropriate hospital for their needs • WMAS will work in partnership with hospitals to ensure the most appropriate pathways of care are implemented • Pathways of care will be designed to achieve the best patient outcome • We will develop measures of the outcomes of pathways of care (e.g. Stroke, Trauma)
	• WMAS will be an ambulance provider that is 'Best in Class' • We will deliver performance that is consistently in the upper quartile • We will provide a service that patients rate highly, and would recommend to their Friends and Family • There will be parity of esteem for all service users

Attachments

Appendix 3: The Commissioning Cycle

Image 01

Image 02

Approval Signatures

Step Description
Approver
Date
Executive Management Board
Phil Higgins: Trust Secretary
Pending

Mark Docherty: Director of Nursing, Quality and Clinical Commissi
08/2023

Record My Optional Approval/Review

History

Edits

Approvals

Comments
Edited by Mark Docherty: Director of Nursing, Quality and Clinical Commissi on August 15 2023 at 09:15am GMT-4
update of strategy to include new commissioning landscape
Approved by Mark Docherty: Director of Nursing, Quality and Clinical Commissi on August 15 2023 at 09:15am GMT-4
Approval Workflow
Effective Date Schedule Changed by Mark Docherty: Director of Nursing, Quality and Clinical Commissi on August 15 2023 at 09:15am GMT-4
Effective date delay removed. Policy scheduled to become active immediately upon final approval.

Comments

Subscribed to comments notifications
Add Comment

Comment

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WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 12 MONTH: JANUARY 2024 PAPER NUMBER: 16

Interim Executive Medical Director Paramedic Practice and Patient Safety Director, 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. Caron Eyre, 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 continued to increase since August, meaning increased hours lost to operational activity results in patient harm and the impact of these delays resulting in long patient waiting times also causes harm, including death.
- Due to the increasing number of hours lost with delayed handover times this resulted in a formal review of the risk assessment for hospital handover delays, which resulted in the Trust risk being raised to 25. This will remain under constant review going through the winter months.
- Trends and themes for serious incidents remain as delayed response and call management.
- The number of Serious Incidents (SI's) reached 74 open incidents during December, this required a new process being agreed with Black Country ICB to enable a three tier approach to managing SI's.
- Prevalence of measles within the West Midlands and its potential impact upon service delivery.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 12 **MONTH: JANUARY 2024** **PAPER NUMBER: 16**

	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)	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.			

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 12 **MONTH: JANUARY 2024** **PAPER NUMBER: 16**

Action required:
Quality Governance Committee 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 rising risks of patient harm being caused as the result of delayed responses, long handover delays and stacking calls in EOC.
4. Endorse the three-tier approach to managing SI's that has been agreed by Executive Management Board and Black Country ICB

Introduction

The Trust strives to provide the best quality and care for our patients, and a safe environment for our staff to work in. Areas that remain key focus' for the Trust are patient and staff safety, that include wellbeing issues related to continuing Hospital Handover Delays. The resulting long waiting times for patients to be handed over are causing ongoing harm to patients, impacting patients waiting in the community for an ambulance response and resulting in staff not finishing shift on time, that further impacts patients the following day due to a requirement for 11-hour breaks between shifts for staff.

Patient Handover Delays

The issue of patient handover delays continues to remain above pre-pandemic average of 7,000 hours, with December seeing near 30,000 hours lost. This being the 4th month on month increase and seeing a worse trajectory of lost hours of winter of 2021/22.

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.

Serious Incident Investigation Work

The Trust has seen a continued increasing trend in open serious incidents being reported since October and this theme follows the trend of increasing Hospital Handover delays, just a month later. The themes for December are delayed response, call management and clinical concerns.

Mental Health update

Early December saw the launch of the 5 Mental Health Response Vehicles (MHRV) in Staffordshire, Shropshire, Coventry, Worcestershire, and Birmingham. This having positive outcomes for Mental Health patients in these areas. The Black Country Mental Health 2-hour urgent response pilot is due to start mid-January and this is being implemented through EOC. This will be evaluated against the MHRV model before future funding is confirmed.

Advanced Care Practitioners

The Trust now has 17 Non-Medical Prescribers within Clinical Validation Team and MERIT. WMAS is the only ambulance service to provide this for 999 callers, with other ambulance services only providing this for 111 and this provides further support for patients. There is an increasing number of Non-Medical Prescribers in the Trust, and this will require further workforce planning with an additional 13 staff in training, this work is being developed.

Introduction of 'Call before convey' scheme for over 75-year-old patients.

The 18th December saw the Trust commence an all ICB's, regionally agreed approach to supporting patients over 75 years old and focusing that any patient in this identified group who did not have any priority symptoms requiring an Emergency Department, were stable and ambulance clinician arrived on scene between 0800-1800hrs, the crew would call the relevant ICB single telephone number to identify if a community service could manage the patient. This to try to identify an appropriate community service and reduce the number of conveyances to hospital. Over 700 calls have been made in the first 2 weeks, a positive start for the scheme.

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 of the 223 learning recommendations there is 1 overdue.

Serious Incident Summary Dashboard

Total Serious Incidents 2020 - 2024		%
SI's Declared	944	100%
SI's Open	65	7%
SI Closure Req	23	2%
SI's Closed	839	89%
SI's Stand Down Req	1	0%
SI's Stood Down	16	2%
Not Open but Query raised by ICB	6	1%
Total	944	100.0%

Total Open SI's by Single Area		%
A&E	11	22%
PTS	0	0%
IEUC	40	78%
Other	0	0%
Total	51	100%

Total Open SI's by Multiple Area		%
A&E Multiple	3	23%
A&E+IEUC	9	69%
PTS+IEUC	1	8%
IEUC Multiple	0	0%
Total	13	100%

SI's Split by Harm 2020-2024		%
Death	11	1%
Severe	818	87%
Moderate	19	2%
Low	41	4%
No Harm	55	6%
Total	944	100%

Summary Actions	Jul-23	Aug-23
No. New SI's Open	13	12
No. SI's Req Closure	20	10
No. SI's Closed by ICB	11	23
No. SI's Req Stand down	0	0
No. SI's Stood Down by ICB	0	0

Open SI's by Year		Overdue
2020-2021	0	0
2021-2022	0	0
2022-2023	0	0
2023-2024	65	0
Total	65	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.

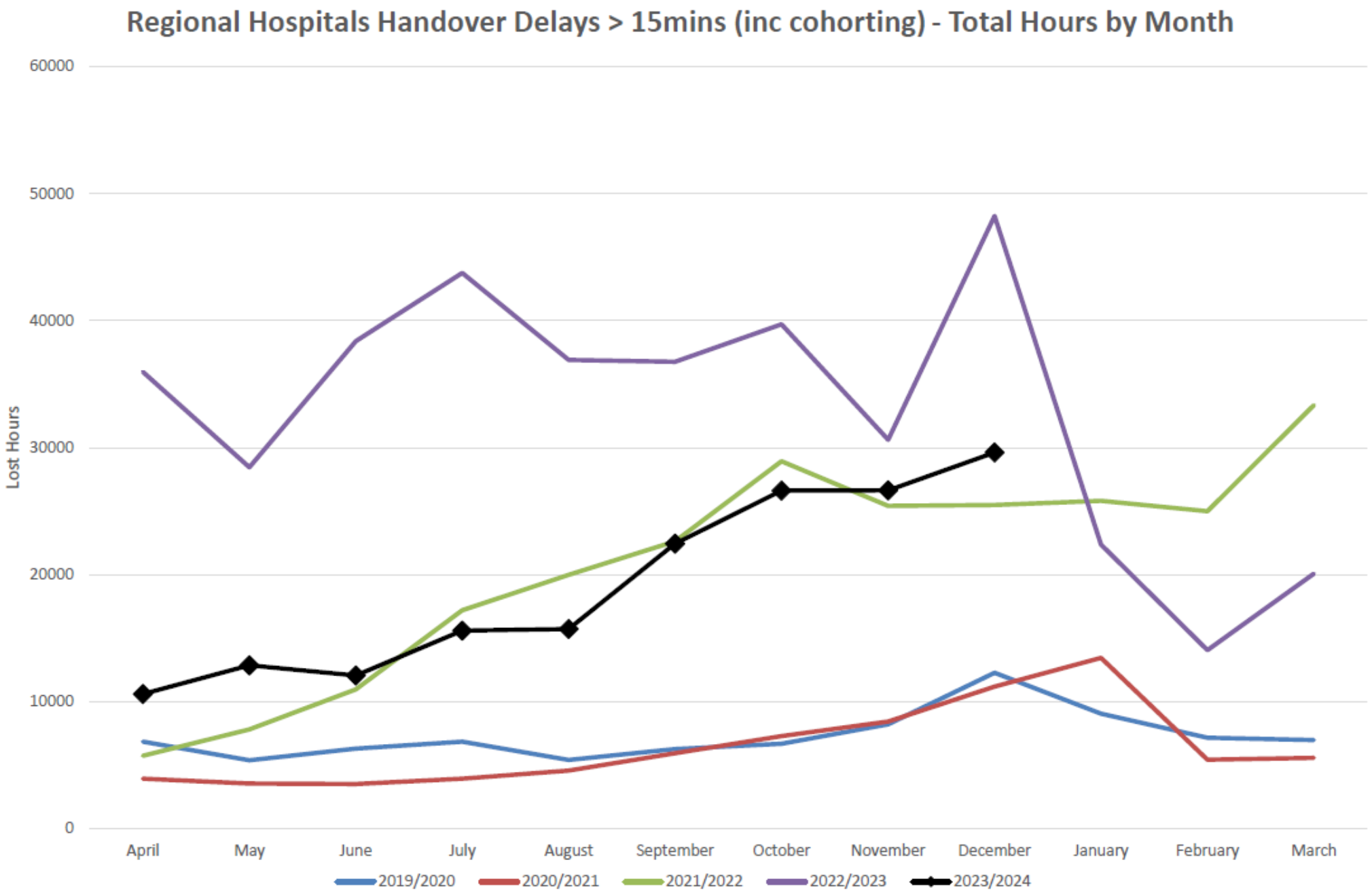
Year to Date ER54 Incidents by Status

% Open	% Closed
9%	91%

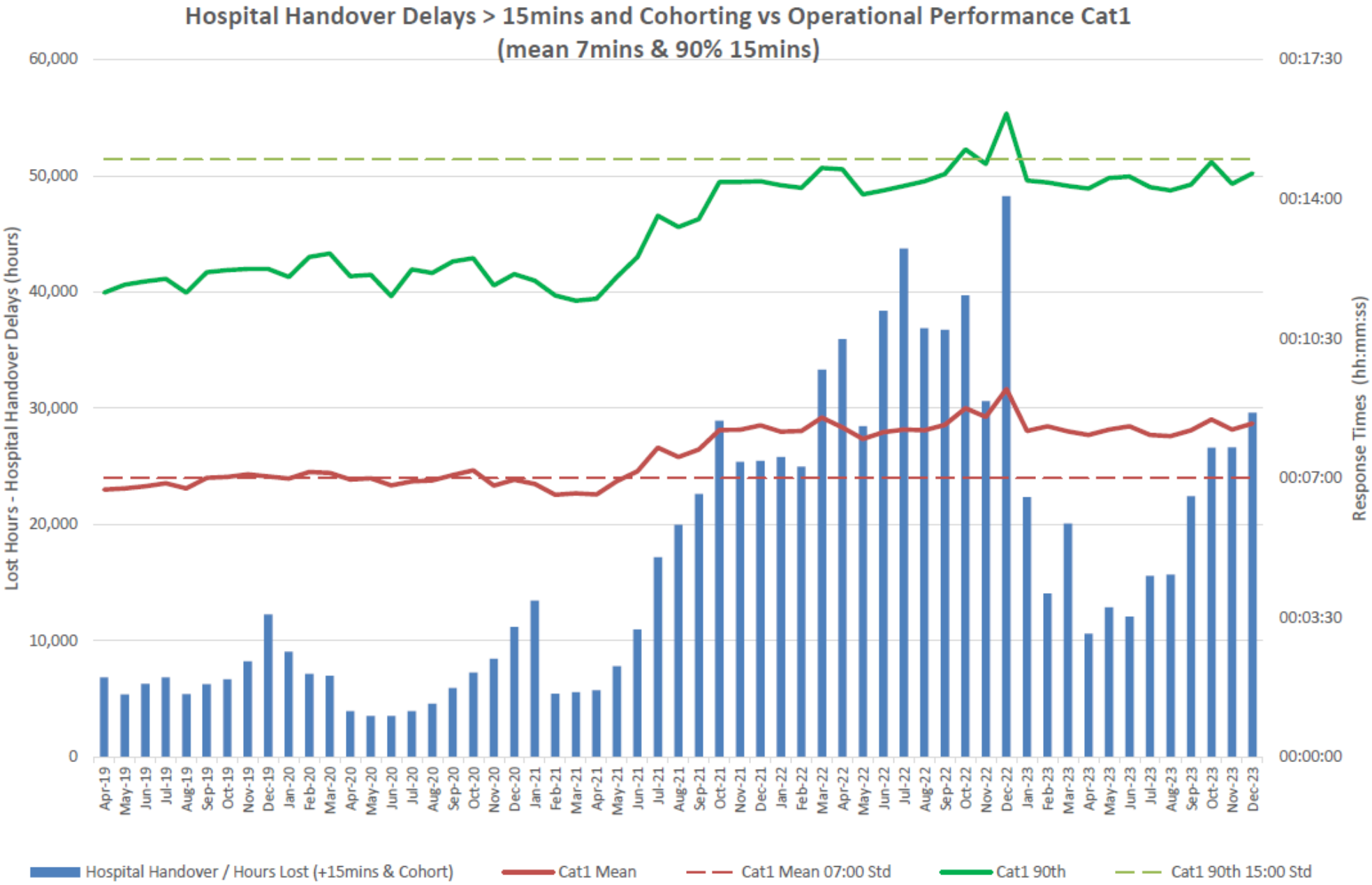
	Open	Closed	NHS to NHS Awaiting review	Awaiting Managers actions	Serious Incident Under Investigation	Awaiting review as Potential SI	Awaiting department response	Under investigation	Total
Detail of Status	11	4015	252	52	18	26	30	5	4409

The oldest open ER54s are from September 2023 of which there are 2, this excluding the outgoing NHS to NHS concerns.

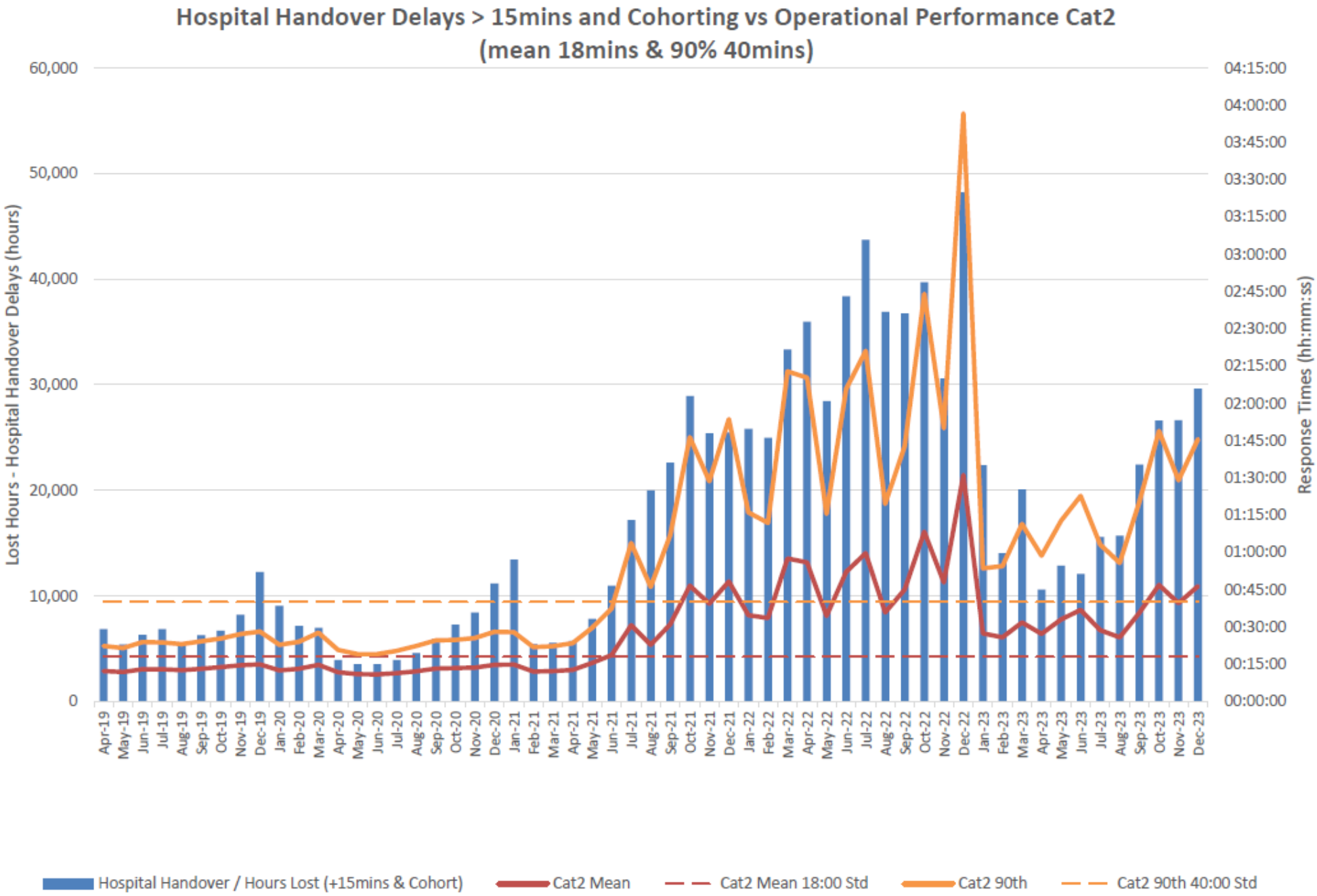
Graph – Time lost due to handover delays exceeding 15 minutes and cohorting for the last 5 financial years



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.

November 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	34,464	19,866	4,684	23.6%	5,246	26.4%	9,936	50.0%	9,031	45.5%	905	4.6%
NHS BLACK COUNTRY ICS	27,879	18,315	3,537	19.3%	4,747	25.9%	10,031	54.8%	9,583	52.3%	448	2.4%
NHS COVENTRY AND WARWICKSHIRE ICS	18,001	11,702	2,076	17.7%	3,497	29.9%	6,129	52.4%	5,817	49.7%	312	2.7%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	15,228	9,615	1,567	16.3%	2,571	26.7%	5,477	57.0%	5,153	53.6%	324	3.4%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	10,564	6,294	1,318	20.9%	1,900	30.2%	3,076	48.9%	2,821	44.8%	255	4.1%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	23,866	14,803	2,609	17.6%	4,281	28.9%	7,913	53.5%	7,109	48.0%	804	5.4%
ICS Total	130,002	80,595	15,791	19.6%	22,242	27.6%	42,562	52.8%	39,514	49.0%	3,048	3.8%

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	272,573	160,746	36,626	22.8%	44,737	27.8%	79,383	49.4%	72,602	45.2%	6781	4.2%
NHS BLACK COUNTRY ICS	212,067	148,103	26,587	18.0%	41,651	28.1%	79,865	53.9%	76,166	51.4%	3699	2.5%
NHS COVENTRY AND WARWICKSHIRE ICS	142,843	94,630	17,409	18.4%	27,828	29.4%	49,393	52.2%	46,441	49.1%	2952	3.1%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	119,774	77,338	12,530	16.2%	21,214	27.4%	43,594	56.4%	41,114	53.2%	2480	3.2%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	79,001	51,209	8,970	17.5%	16,456	32.1%	25,783	50.3%	23,460	45.8%	2323	4.5%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	179,794	119,490	18,212	15.2%	36,231	30.3%	65,047	54.4%	58,585	49.0%	6462	5.4%
ICS Total	1,006,052	651,516	120,334	18.5%	188,117	28.9%	343,065	52.7%	318,368	48.9%	24,697	3.8%

Table – Longest waiting times December 2023

Category 1

CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	0:57:37	WR11	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Maternity	Cat1
[redacted]	0:53:27	LD8	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Arrest Peri Arrest	Cat1
[redacted]	0:52:27	LD7	POWYS TEACHING LHB	Category 1	Cat1
[redacted]	0:51:14	SY7	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Breathing Problems	Cat1
[redacted]	0:46:45	LE10	NHS WEST LEICESTERSHIRE CCG	Under 16 Unconscious	Cat1
[redacted]	0:46:04	SY13	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Medical	Cat1
[redacted]	0:43:12	SY8	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Unconscious	Cat1
[redacted]	0:42:32	WR10	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Arrest Peri Arrest	Cat1
[redacted]	0:41:22	SY12	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Chest Pain Cardiac Back Pain Pb	Cat1
[redacted]	0:41:19	SY9	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]	26:04:34	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Medical	Cat2
[redacted]	25:33:05	ST5	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical Minor	Cat2
[redacted]	23:46:39	CV6	NHS COVENTRY AND WARWICKSHIRE ICS	Overdose	Cat2
[redacted]	23:03:06	TF10	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	Medical	Cat2
[redacted]	22:28:44	ST11	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical	Cat2
[redacted]	21:48:31	WR4	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Fall Injuries Unknown	Cat2
[redacted]	20:54:51	B27	NHS BIRMINGHAM AND SOLIHULL ICS	Back Pain Lower	Cat2
[redacted]	20:00:35	ST1	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical	Cat2
[redacted]	19:54:05	CV5	NHS COVENTRY AND WARWICKSHIRE ICS	Chest Pain Cardiac Back Pain Pb	Cat2
[redacted]	19:07:11	ST4	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Abdominal Flank Pain Lower	Cat2

Category 3

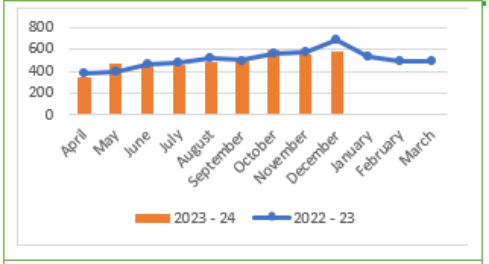
CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	57:39:25	B11	NHS BIRMINGHAM AND SOLIHULL ICS	Hazchem	Cat3
[redacted]	50:24:55	B21	NHS BIRMINGHAM AND SOLIHULL ICS	Abdominal Flank Pain Lower	Cat3
[redacted]	48:01:24	B38	NHS BIRMINGHAM AND SOLIHULL ICS	Concern For Welfare	Cat3
[redacted]	46:56:21	CV2	NHS COVENTRY AND WARWICKSHIRE ICS	Medical	Cat3
[redacted]	44:58:45	CV3	NHS COVENTRY AND WARWICKSHIRE ICS	Medical	Cat3
[redacted]	42:24:02	CV3	NHS COVENTRY AND WARWICKSHIRE ICS	Abdominal Flank Pain Lower	Cat3
[redacted]	42:16:43	WV11	NHS BLACK COUNTRY ICS	Mental Health	Cat3
[redacted]	42:10:12	B27	NHS BIRMINGHAM AND SOLIHULL ICS	Medical	Cat3
[redacted]	41:53:13	CV11	NHS COVENTRY AND WARWICKSHIRE ICS	HCP	Cat3
[redacted]	41:09:22	B21	NHS BIRMINGHAM AND SOLIHULL ICS	Medical	Cat3

Category 4

CAD ID	Best Response hh:mm:ss	Incident Postcode	ICB	Chief Complaint	Inc Initial Sub Priority
[redacted]	36:10:59	ST2	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Fall Injuries Unknown	Cat4
[redacted]	25:42:47	WS2	NHS BLACK COUNTRY ICS	Fall Injuries Unknown	Cat4
[redacted]	24:31:21	WR15	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Fall Non Injury	Cat4
[redacted]	24:29:38	B31	NHS BIRMINGHAM AND SOLIHULL ICS	Fall Injuries Unknown	Cat4
[redacted]	22:33:56	WR8	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Medical	Cat4
[redacted]	20:19:17	WS15	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical	Cat4
[redacted]	20:14:50	WR3	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	Medical	Cat4
[redacted]	19:37:33	ST5	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Medical Minor	Cat4
[redacted]	19:18:07	B90	NHS BIRMINGHAM AND SOLIHULL ICS	Medical	Cat4
[redacted]	19:17:06	ST17	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	Trauma	Cat4

Patient Safety

Total Patient Safety Incidents		Year to date	
	Last reported month (Dec 23)	2022-23	2023-24
WMAS	579	4532	4409



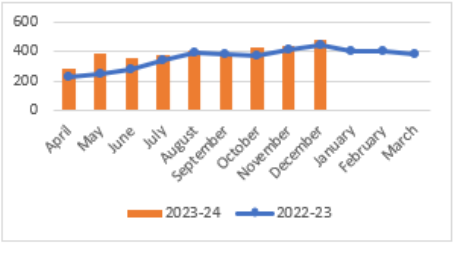
For the month of December, there were 579 patient safety incidents reported. This is a 15 % decrease on the same month last year.

E&U accounted for 60% of the total patient safety incidents.

PTS accounted for 14% of the total patient safety incidents.

EOC accounted for 26% of the total patient safety incidents.

No Harm Incidents		Year to date	
	Last reported month (Dec 23)	2022-23	2023-24
WMAS	481	3079	3527

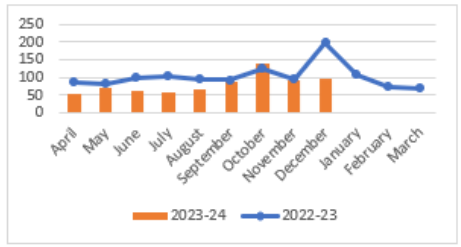


E&U accounted for 60% of the 'no harm' total patient safety incidents.

PTS accounted for 15% of the 'no harm' total patient safety incidents.

EOC accounted for 25% of the 'no harm' total patient safety incidents.

Harm Incidents		Year to date	
	Last reported month (Dec 23)	2022-23	2023-24
WMAS	98	966	719



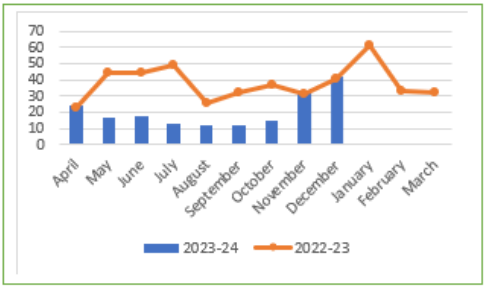
	Patient Harm		No Harm		
Area	Total	%	Total	%	Total
E&U	57	58%	288	60%	345
PTS	10	10%	73	15%	83
IEUC	31	32%	120	25%	151
Total	98	100%	481	100%	579

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.

Serious Incidents and Duty of Candour

Total number of serious incidents reported		Year to date	
	Last reported month (Dec 23)	2022-2023	2023-2024
WMAS	42	327	187

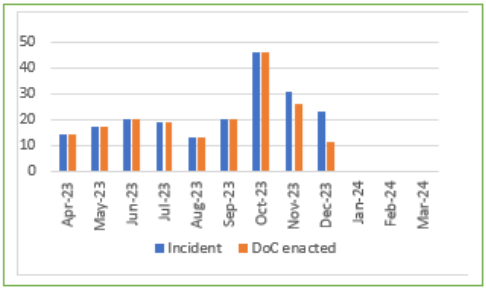


42 SI's were registered in December.
25 SI's were reviewed for closure.
The Lead ICB reviewed and closed 12.

The total so far for 2023/24 – 187 (96 solely related to delayed responses). There have been 199 recommendations completed that identifies learning for the Trust.

259 potential SIs have been reviewed since 01.04.23.

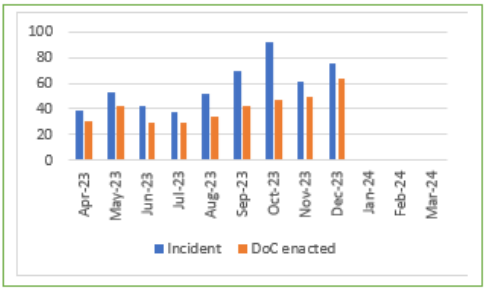
Moderate harm and above		Year to date	
	Last reported month (Dec 23)	Total number of incidents	Number of incidents being open completed
WMAS	23	203	186



Duty of Candour has been enacted in 47.6% of cases where moderate harm or above has been caused during so far December, this will increase.

The year-to-date figure is 91.6%

Low harm		Year to date	
	Last reported month (Dec 23)	Total number of incidents	Number of incidents being open completed
WMAS	75	521	367

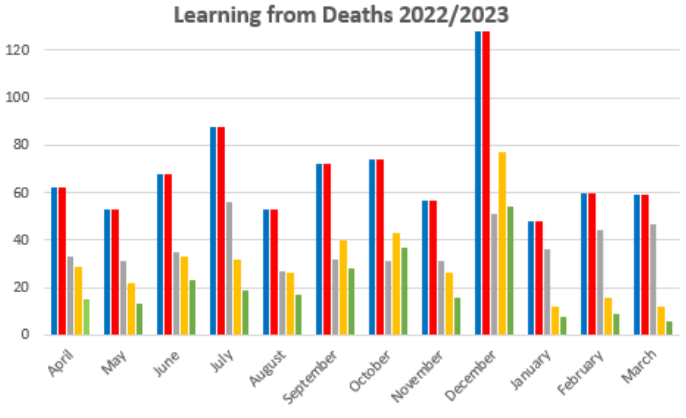


There have been 75 incidents where low harm has been caused to patients during December.

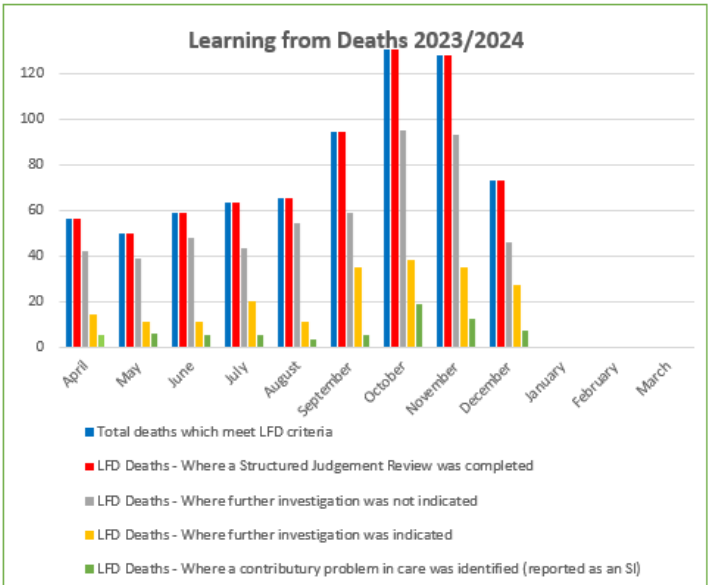
Out of these, evidence of 'Being Open' can currently be provided for 63 of the incidents (84.0%).

The year-to-date figure is 70.4%

Learning from Deaths



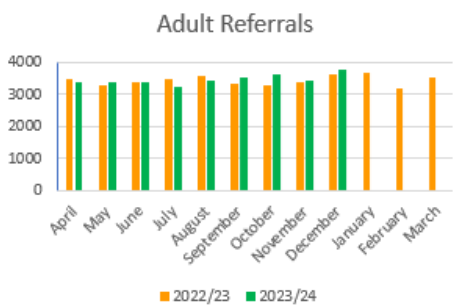
- The above is an overview of the 2022-2023 WMAS LFD reporting.
- In the 2022/2023 LFD reporting period: -
  - 844 deaths occurred which met LFD criteria for review.
  - 844 structured judgement reviews were completed.
  - 400 of the 844 deaths required further investigation following the structured 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 42.9% decrease in overall deaths meeting LFD criteria. (Note: due to demand and annual leave this figure is likely to increase significantly.)
  - 38.5% of cases required further investigation following a structured judgement review.
- During the current financial year, there have been 67 deaths investigated under the Serious Incident Framework following LFD review.
- Due to the nature of Learning from Deaths, the figures displayed are only correct on the date of the report being completed and are likely to increase.

Safeguarding

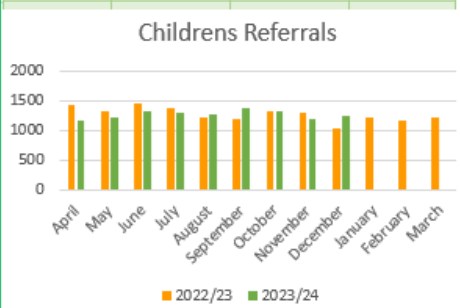
Total Adult Safeguarding Referrals		Year to date	
	Last reported month (Dec 23)	2022-2023	2023-2024
WMAS	3767	41175	31177



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 all other departments within the organisation. Comparison to previous years for the same period.

There is a 4.2% increase in the number of adult care/welfare and adult safeguarding referrals sent in December 2023 compared to the previous year.

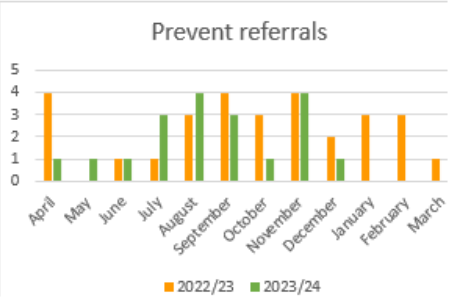
Total Child Safeguarding Referrals		Year to date	
	Last reported month (Dec 23)	2022-2023	2023-2024
WMAS	1244	15301	11393



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 period.

December 2023 saw an 20.4% increase in the number of referrals made compared to the same month last year.

Total PREVENT Referrals		Year to date	
	Last reported month (Dec 23)	2022-2023	2023-2024
WMAS	1	29	19

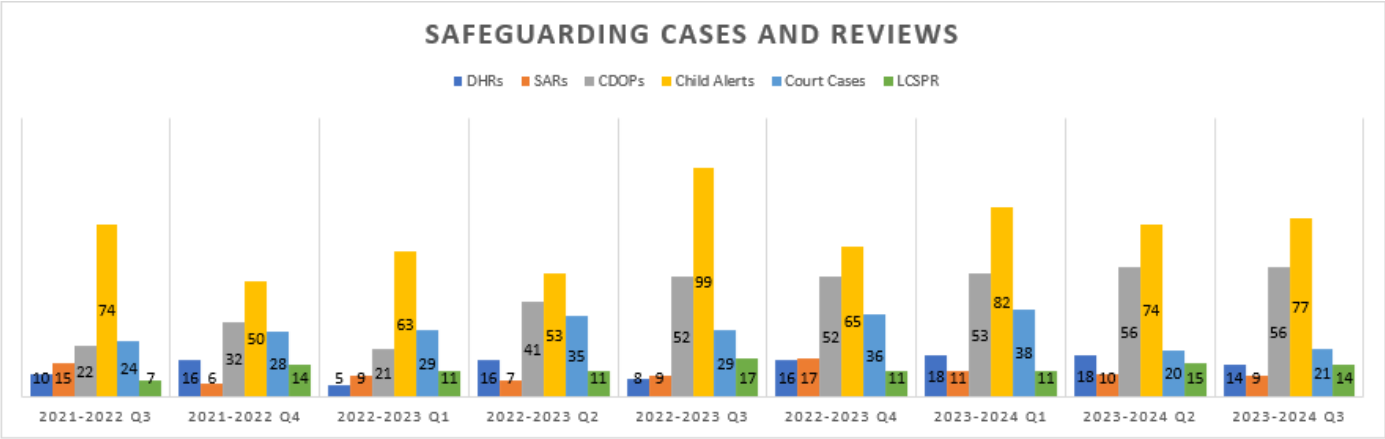


Prevent Referrals are made where there are concern an individual is being radicalised for extremism.

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 Q3 has risen by 6 against the same period last year with 14 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).

The number of SARs from Q3 against the same period last year has remained the same with 9 being received.

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.

There has been a decrease of 3 LCSPR's from Q3 against the same period last year.

CDOP's Child Death Overview Panel

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

In Q3 there has been an increase of 4 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 a decrease of 22 Child Alerts from Q3 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 a decrease of 8 court cases in Q3 against the same period last year.

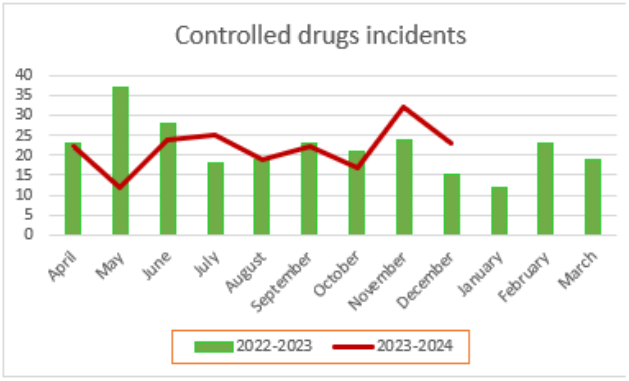
Medicines Management & Pharmacy

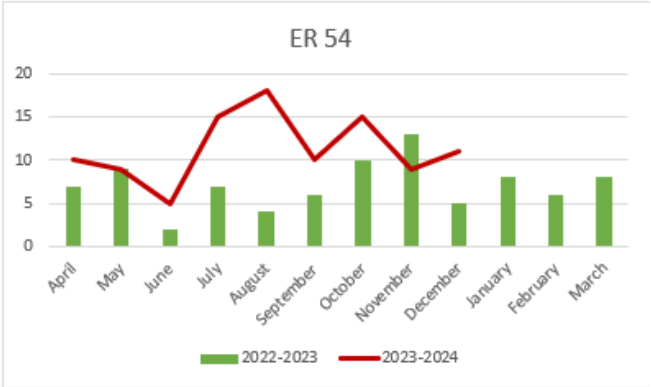
CONTROLLED DRUGS

Total Controlled Drugs Incidents (CDI's)		Year to date
Last reported month (Dec 23)	2022-2023 Apr - to date	2023-2024 YTD
23	208	196

MEDICINES ER54

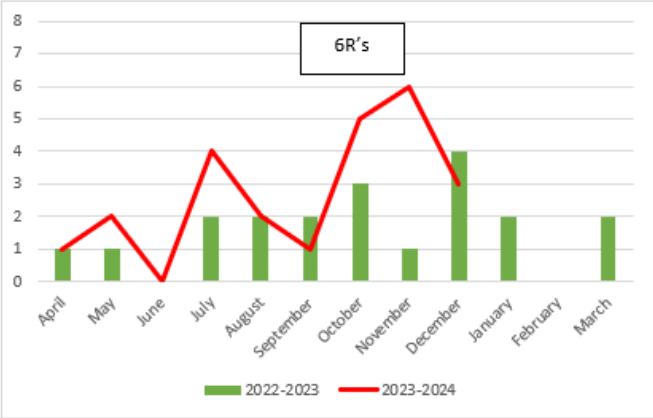
Total Medicines Management related ER54's		Year to date
Last reported month (Dec 23)	2022-2023 April - to date	2023-2024 YTD
11	63	102





Total Drug Errors, wrong route, wrong dose etc	Year to date	
Last reported month (Dec 23)	2022-2023 April - to date	2023-2024 YTD
3	16	24

MHRA Alerts	Year to date	
Last reported month (Dec 23)	2022-2023 April - to date	2023-2024 YTD
4	43	36

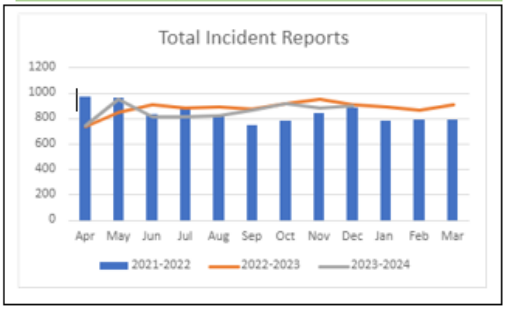


None of the medicines referenced within the alert were procured or distributed by WMAS.

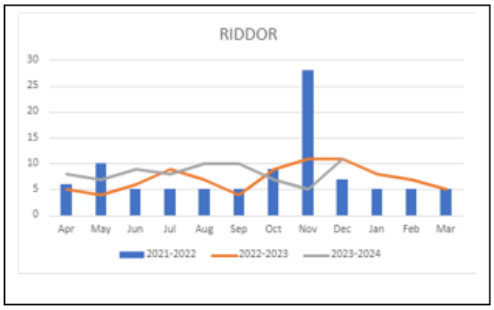
Actions (CAPA)			
	Last reported month (Dec 23)	2022-2023 April - to date	2023-2024 YTD
WMAS	0	0	0

Incident Reports

Total Incidents Reported		Year to date	
	Last reported month (Dec 23)	2022-2023 April –Mar	2023-2024 April-Dec
WMAS	906	10,645	7,531



RIDDOR		Year to date	
	Last reported month (Dec 23)	2022-2023 April - Mar	2023-2024 Apr-Dec
WMAS	11	86	65



Top 5 Incidents for Non-Patient Safety (December)

Trustwide Top 5 Types	Total
Violence / Aggression	186
Complaint	110
RTC	104
Injury	100
Communication	80

Trustwide Top 5 Categories	Total
V&A - Verbal - Intentional	88
Complaints – Other NHS	52
Manual Handling – Patient & Equipment	45
Equipment - Not Available or Suitable	41
Complaints - Non-NHS	36

Over 85,000 ER54's received since implementation.

Reporting continues with manager 24-hour acknowledgement, and this is reported to respective SMT's. The risk team continue to assist managers in investigation and completion of ER54's.

ER54 review continues to identify appropriate workstreams and inform certain actions for SMT's and the risk team. Work currently with the Patient Safety Team on improving reporting and management of equipment related issues, as well as another focus around non-frontline staff reporting and awareness.

Plans started to introduce a Human Factors faculty in 2024, which will aim to greater engage staff on improvements to the systems in place across the Trust to reduce risk and improve safety and efficiency – early ideas include dynamic risk assessment, personal accidents, communication and teamwork, bias, and cognitive HF/E.

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.

RIDDOR Regulations PIR received on 9th October by HSE – will be reviewed by Head of Risk and findings reported to HSREG.

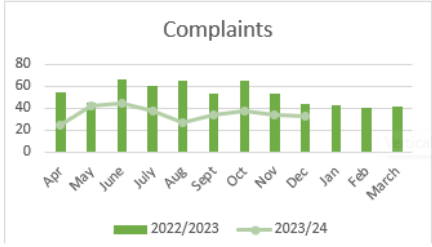
National Ambulance RIDDOR statistics show trends across all Trusts of slip, trip, and falls, carry chair, and struck by object incidents – work streams to be started. WMAS best performing Trust for reporting RIDDOR within timescales with 98%.

The Trust Top 5 incident categories for November –

1. V&A – Verbal - Intentional – Reviewed via Security.
2. Complaints – Other NHS – Majority relate to hospital delays.
3. Manual Handling – Patient and Equipment – All cases to be reviewed for specific concerns/trends.
4. Equipment – Not Available or Suitable – Work ongoing with Digital Make Ready, Logistics and Fleet.
5. Complaints – Non-NHS – Majority relate to Language Line – work ongoing.

Patient Experience

Formal Complaints	Last reported month (Dec 23)	Year to date 2022-23 Total	Year to date 2023-24 YTD
WMAS	32	506	313



Year to Date the Patient Experience Team has acknowledged 98.4% of its complaints within 3 working days. The Trust has responded to 96% of cases within 25 working days.

For the month of December, we saw 33 complaints received compared to 44 in December 2022 a decrease of 11. For the month of December, we saw 32 complaints received compared to 44 in December 2022 a decrease of 11. The main reason for a complaint was Response (12).

Of the cases closed to date: 4 Justified, 1 Part Justified, 4 Not Justified. Remaining cases are still under investigation and due for closure by 5 February 2024.

4 Information Requests were received in December 2023 by the Parliamentary Health Service Ombudsman (PHSO).

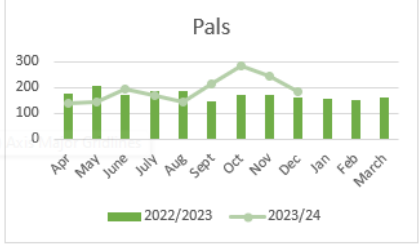
Month of December 2023: In December 2023, the Trust undertook:

168, 369 Emergency Calls, which equates to 1 Complaint for every 10,523 calls received.

87,746 Emergency Incidents, which equates to 1 Complaint for every 8,775 Incidents.

68,031 Non-Emergency Patient Journeys, which equates to 1 Complaint for every 9,719 Journeys.

Informal (PALS)	Last reported month (Dec 2023)	Year to date 2022-23 Total	Year to date 2023-24 YTD
WMAS	184	1581	1714



The Trust has seen a 14.4% increase in pals concerns from 160 in 2022 to 183 in 2023. The Trust has seen a 14.4% increase in pals concerns from 160 in 2022 to 184 in 2023.

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

43 Eligibility

42 Response

22 Loss & Damage

Of the Cases closed to date (month) –

18= *Justified,*
10= *Part Justified,*
56= *Not justified*

Compliments	Last reported month (Dec 23)	Year to date 2022-23 Total	Year to date 2023-24 YTD
WMAS	171	1978	1770

Compliments: December 2023: There have been 171 compliments received compared to 216 the previous year, a decrease of 45.

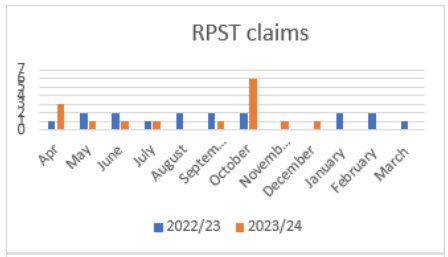
Friends and Family Test (YTD)
The FFT question is available on the Trust website: '**Thinking about the service provided by the patient transport service, overall how was your experience of our service?':**

Response (YTD)	Renal Survey	FFT Survey	PTS Survey
Very Good	27	17	38
Good	23	0	43
Neither Good or Poor	11	3	1
Poor	4	2	2
Very Poor	3	5	2
Don't Know	0	2	0
Total	**68**	**29**	**86**
Total PTS Journeys in December 68031 – 20 responses			

Discharge on Scene Results: 5 responses in December 2023

Claims and Coroners Cases

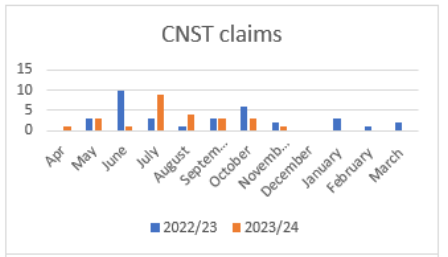
RPST (Risk Pooling Schemes for Trusts)	Last reported month Dec 23	Year to date 2022-23	Year to date 2023-24
WMAS	1	17	15



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 December 2023. This is an increase of 1 compared to the previous year.

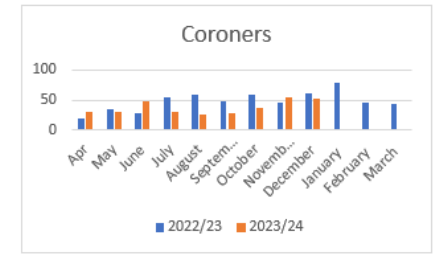
CNST (Clinical Negligence Scheme for Trusts)	Last reported month Dec 23	Year to date 2022-23	Year to date 2023-24
WMAS	0	34	26



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 0 CNST claim in December 2023. This is the same as the previous year.

Coroners Requests	Last reported month Dec 23	Year to date 2022-23	Year to date 2023-24
WMAS	52	578	336



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

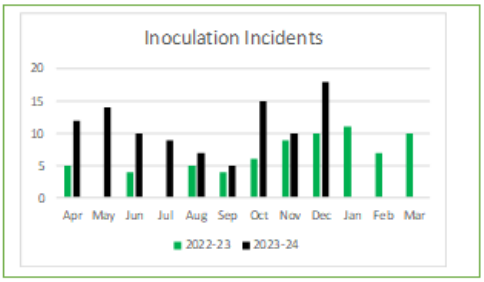
- Birmingham and Solihull
- Black Country
- Coventry
- Herefordshire
- Shropshire, Telford & Wrekin
- South Staffordshire
- Stoke on Trent & North Staffordshire
- Warwickshire
- Worcestershire

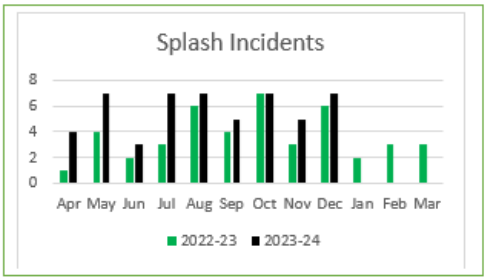
Infection Prevention and Control

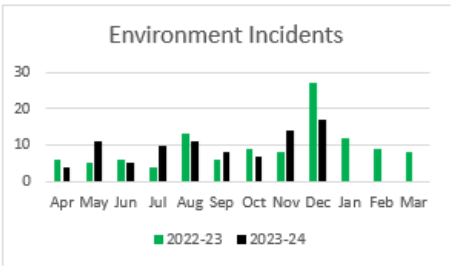
Inoculation Incidents		Year to date Comparison	
	Last reported month Dec 23	2022-23	2023-24 Apr-Dec
WMAS	18	71	100

Splash Incidents		Year to date Comparison	
	Last reported month Dec 23	2022-23	2023-24 Apr-Dec
WMAS	7	44	52

Environment Incidents		Year to date Comparison	
	Last reported month Dec 23	2022-23	2023-24 Apr-Dec
WMAS	17	113	87







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.

December 2023 saw 18 inoculation incidents reported. This is the highest reported incidence of this type of injury in the history of IPC reporting within the Trust. 8 incidents relate to used cannula devices, others include clean and used intramuscular needles, sharp objects, and a patient's own drug paraphernalia. One bloodborne virus exposure incident has been reported to HSRE as a RIDDOR.

Risk RAG = Red risk – 1 | Amber risk – 12 | Green Risk – 5

2023/24 Q3 has seen a significant rise in sharps related incidents. In response, the Trust have released dedicated articles in the weekly briefing to raise awareness amongst staff and have also launched a dedicated clinical notice for all clinical and operational staff.

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.

December 2023 saw 7 splash incidents reported. These involved blood and body fluids entering the eye/mouth of the treating clinician, the spittle of a patient entering the eyes/mouth of a treating clinician (violence and aggression).

Risk RAG = Red risk – 0 | Amber risk – 6 | Green Risk – 1

2023/24 Q3 has seen a significant rise in splash related incidents. In response, the Trust have released dedicated articles in the weekly briefing to raise awareness amongst staff.

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, Measles and Pertussis.

December 2023 saw 17 environment related incidents reported. This notable surge in incidence relates to a regional increase in exposure to measles. The IPC team continue to work closely with UKHSA. 2 staff members were also treated with prophylactic antibiotics following a confirmed exposure to bacterial meningitis.

Risk RAG = Red risk – 0 | Amber risk – 2 | Green Risk – 13

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.

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
- NASMeD meeting
- JRCALC Equality & Diversity Guideline Development meeting
- MERIT Clinical Operations Meeting
- ED Clinical Leads meeting
- Fortnightly Meeting with National Clinical Director for UEC
- Coventry and Warwick Integrated Urgent Care Delivery Group
- Coventry and Warwickshire Urgent and Emergency Delivery Board
- Professional and Minimum Standards of Care working group (patient handover delays)
- Clinical Policy and Competency Discussion and Review meeting
- MA/MERIT MI Plan review meeting
- Paramedic Independent Prescribers Controlled Drugs meeting
- Good Hope Hospital Site visit
- Shrewsbury and Telford Hubs/SaTH sites visit
- West Midlands CARETeam/WMAS meetings

Paramedic Practice and Patient Safety Director

- Health, Safety, Risk & Environment Group
- Professional Standards Group
- Serious Incident Recovery Group
- Senior Clinical Leads meeting
- 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

Executive Director of Nursing

- Day with paramedic colleagues at Warwick Hub.
- Update with Regional Chief Nurses
- Health, Safety, Risk & Environment Group
- QIGARD
- Planning meeting with KMPG re BAF and risk management audit
- Sign off complaint letters to ensure timely and compassionate responses.
- Senior Clinical Leads Meeting.

Dr Richard Steyn
Interim Medical Director

Caron Eyre
Executive Director of Nursing

Nick Henry
Paramedic Practice and
Patient Safety Director

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 13 MONTH: JANUARY 2024 PAPER NUMBER: 17

Service Delivery Report (EU, NEPTS, IEUC)	
Sponsoring Director	Director of Performance & Improvement
Author(s)/Presenter	Nathan Hudson, Director of Performance & Improvement
Purpose	This report provides an update from the Performance & Improvement Director on the current position of the three service areas: EU, NEPTS and IEUC.
Previously Considered by	Not Applicable
Report Approved By	Performance & Improvement Director

Emergency & Urgent

Risks to E&U Operations

1. Performance recovery going into winter for the government target of CAT 2 mean (30 min), as hospitals continue deteriorating, resourcing productivity has increased from last year.

2. Hospital Handover Delays following significant rise in delays November to December.

3. Potential delays in response and therefore calls stacking resulting in patient safety risks and serious incident rises.

Performance

Performance was extremely challenged in November and December 2023, following a significant rise in hospital handover delays. However, performance, particularly for Category 2 response, has seen an improvement since last year. Over the winter period, several actions were taken to increase staffing and therefore resourcing over this period. The CAT 2 mean performance finished at 44.18 min and the 90% at 100.48 min.

CAT 2 mean performance for quarter 3 2022 was 68 min and the 90% was at 164.55 min which does show improvement in performance compared to last year.

The government target for Category 2 mean of 30 min was achieved in July and August and therefore achieved for quarter 2, despite the significant challenges in September caused by handover delays.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 13 MONTH: JANUARY 2024 PAPER NUMBER: 17

Performance Quarter 3 (2023)

	Target		Month		QTD		YTD	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	8:22	14:39	8:21	14:38	8:14	14:29
Category 1 T	19:00	30:00	9:46	17:39	9:39	17:21	9:29	17:05
Category 2	18:00	40:00	46:22	105:35	44:18	100:48	35:33	79:46
Category 3	60:00	120:00	214:55	569:22	212:04	557:26	161:25	420:43
Category 4	-	180:00	251:31	604:51	241:45	592:31	189:02	490:02
HCP 2hr	-	-	233:55	625:06	238:50	610:34	226:34	597:59
HCP 4hr	-	-	253:34	553:51	283:54	638:19	326:19	807:13

Activity

Activity for all Incidents has increased during Quarter 3 compared to the previous year by just over 8,000 incidents.

	All Incidents			
	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
	Incident Count	Incident Count	Incident Count	Incident Count
Month	90,442	86,235	4,207	4.9%
QTD	265,625	257,332	8,293	3.2%
YTD	782,853	786,610	(3,757)	-0.5%

Absence Management in E&U Operations

YTD Sickness in E&U Operations has risen to 3.68% at the end of quarter 3, October 3.48%, November 4.03%, and December at 4.89% respectively, which has been challenging for the operational management team. The root cause of most increases in absence was an increase in homebased stress and anxiety, cough colds and flu and an increase in COVID cases were prevalent over this period.

Resourcing

We have seen a steady increase in resourcing in quarter 3 of this financial year, mainly based on some overtime increases, and new staff coming into the front-line operations in the form of student paramedics and graduate paramedics. The actions taken to increase the health care referral tier (HCRT) have increased the peak resourcing on days.

Quarter 1	Quarter 2	Quarter 3

23/24 Actual	April	May	June	July	August	Sept	Oct	November	December
	184.629	181.63	174.038	192.932	199.554	190.367	194.269	198.524	214.558

Operational Skill Mix (Paramedic on each Frontline DCA)

Skill Mix YTD remains 99.9%.

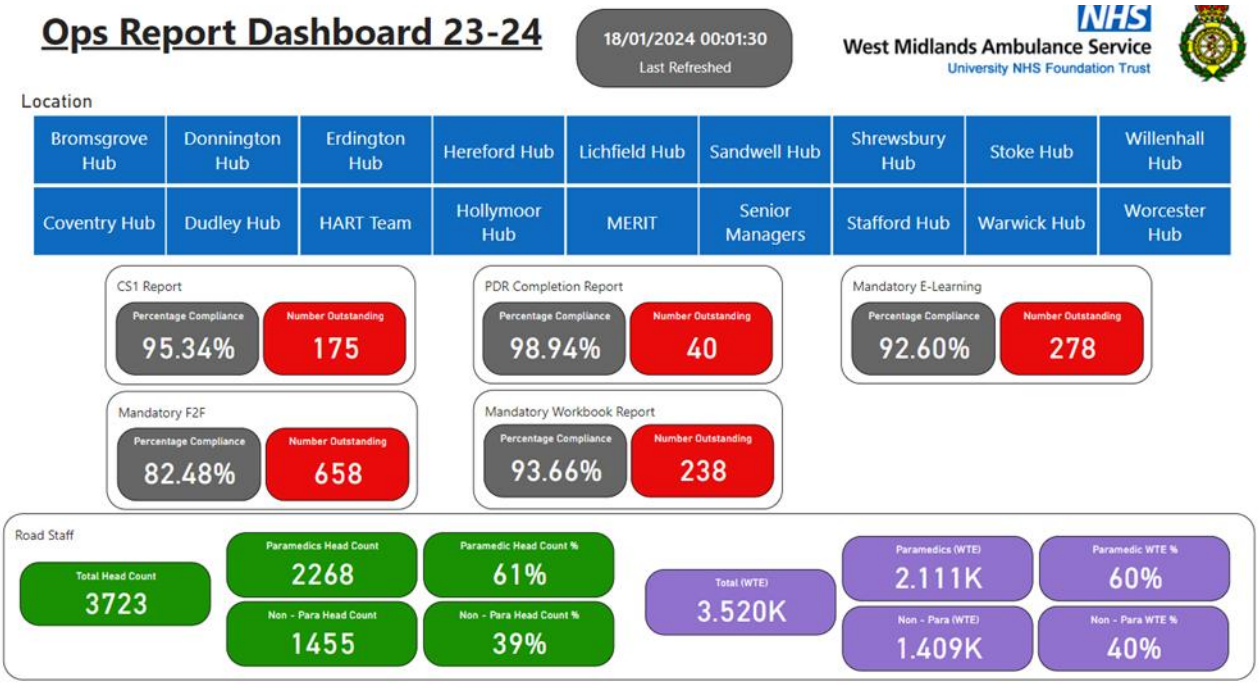
Hospital Handover Delays (YTD)

The trend of hospital handover delays matches the same trend seen in 2022, but the YTD data displayed below still demonstrates that at the end of Q3, EU Ops is experiencing a gradual increase in delays throughout Q3 and that the relief seen in November 2022's handover delays was not experienced this year – handover delays were a sustained pressure.

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 13 MONTH: JANUARY 2024 PAPER NUMBER: 17

Mandatory Training Compliance



Category 2 Performance Recovery

Actions

Dispatch

This workstream is focused on Category 2 responses & incidents, and a trial has commenced in Birmingham and Black Country sectors for the end of shift tasking plan. The data for this trial is being measured to review its efficiency.

Healthcare Referral Tier

Reintroduction of the HCRT tier to manage urgent referral activity, allowing frontline E&U paramedic crews to respond to category 2 patients in all sectors.

Operational Support Desk

The Operational Support Desk within EOC to monitor downtime and lost hours continues to monitor and promote effective crew resource management such as vehicle availability delays, recovery, and solo clinician management. The effectiveness of the desk in supporting our clinicians reduce lost hours and support timely response to patients is being monitored.

Recruitment

A workstream to review how we can increase the operational resourcing hours over the winter period with application for qualified graduate paramedics still open (160 starters in total) with 112 joining the trust before the start of January. Qualified paramedic and technician vacancies have been advertised and are open. Furthermore, Student Paramedic recruitment (in preparation for next year) has started with January, February and March courses open for recruitment.

NEPTS & Improvement Update

Risks

- Significant vacancies across PTS operations.
- Failure to achieve KPIs.
- Failed discharges having an impact on flow through the hospitals.
- Managers working operationally to meet the current demand.
- The wellbeing of staff working within PTS operations.
- Recruitment, specifically focused on fulfilment of the Coventry & Warwickshire Contract.

Performance

Overall, we failed to achieve 25 KPIs in December. There was a decrease in activity in December from November.

Workforce challenges continue to impact on the delivery of the KPI's. We are also supporting HCRT with 80 staff which will now move to frontline Technician courses.

We have struggled to meet the demand on the contracts given the shortfalls in staffing. This has led to an increase in outpatients being cancelled, activity caps being applied and delayed discharges, some of which have resulted in being bedded down within the hospital and being re-booked for the following day. We are still seeing an increase in higher mobility patients and, therefore, is impacting on our overall capacity. We are receiving daily escalations from the Acutes and ICBs due to the length of time it is taking to discharge patients and delays in general. They are advising that this is having a significant impact on the front door and flow.

Compliance

PDC's – 96.28% Complete
Mandatory Training – 70.79% Complete
Mandatory Workbooks – 87.11% Complete
Manager FTSU – 100% Complete
IP&C – 100% Compliant

Workforce

There were 104.90 operational vacancies at the commencement of December. This excludes the Coventry and Warwickshire additional discharge crews. We have 43.20 starters from now until February 2024 and 29.10 known leavers up until December 2023 which includes an additional 20 staff going to HCRT (15 PTS and 5 PTS Contracted HD).

We have factored in all of the new starters up until February and are left with 90.8 vacancies, however, with the Coventry and Warwickshire discharge crews we have 102.7 vacancies to fill.

IEUC

Activity and Performance

During December the Trust received 164,231 emergency calls, resulting in 84,794 incidents. The disparity between calls and incidents comes about because of two main factors:

- Supporting call answering for four other trusts which resulted in WMAS taking over 24,000 calls for other trusts.

- A duplicate call rate of 16.3% which equates to 26,798 calls.

Average hospital handover delay deteriorated to 53 minutes, which is over 10 minutes above the ICB trajectory for December. Lost hours due to hospital handover delay increased to 29,774 lost operational hours above 15 minutes. Lost hours present a significant challenge to the Trust, especially in responding to patients within a timely manner; this is evident in the overall deterioration in performance across most standards.

As stated above, the Trust has continued to support call answering for EMAS, SCAS, SECAMB and YAS, answering 23,592 emergency calls throughout December; an additional 834 calls were answered through IRP from England and devolved Trusts.

Incident Category Split

During December the incident category split for C1 and C2 incidents remained broadly similar, with a small increase in C1 incidents. A CAD change in early December has had an adverse effect on the reportable category of cases receiving clinical validation triage; this explains the activity shift in C3 and C5 incidents. Currently, December is reporting the category split pre-clinical validation. The Trust is working to resolve the issue with an update expected W/C 8 January.

Emergency incident activity increased to 84,794 incidents, the highest position this year.

999 Call Answering

The Trust has answered 164,231 emergency calls during December. In addition to the planned 10-15% call answer support arrangements with EMAS, the Trust also received waiting calls for SCAS, SECAMB and YAS at 00:02:00 (120 seconds) to answer patients promptly and reduce the national 2-minute delays.

The Trust received a duplicate call rate of 16.3%, resulting in 26,798 additional calls. Duplicate calls are predominately chasing an ambulance response or require further triage due to worsening symptoms. Despite the overall increased call activity, the Trust achieved a mean call answer of 0:04 seconds, with a 95th percentile of 0:28 seconds. Address match standard was achieved at 78.7%.

Year to Date	WMAS			
01/04/2023 to 31/12/2023	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
Year to end date	1,311,062	0:02	0:05	77.6%

Period Selected	WMAS			
01/04/2023 to 31/12/2023	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
Selected dates total	1,311,062	0:02	0:05	77.6%

By Month	WMAS			
	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
April 2023/2024	117,038	0:02	0:02	78.1%
May 2023/2024	126,449	0:02	0:02	77.8%
June 2023/2024	130,658	0:00	0:00	77.2%
July 2023/2024	134,582	0:00	0:00	77.4%
August 2023/2024	139,291	0:00	0:00	77.4%
September 2023/2024	164,990	0:02	0:16	76.5%
October 2023/2024	173,834	0:03	0:23	77.3%
November 2023/2024	159,989	0:02	0:06	78.2%
December 2023/2024	164,231	0:04	0:28	78.7%

Two-Minute Delays

During December the Trust experience an increase in 2-minute call answering delays, reporting 378 occurrences. This resulted from an overall increase in emergency calls received by the Trust and the continued support offered to other Ambulance Trusts.

The overall and consistent low number of 2-minute delays in comparison to other Trusts demonstrates the focus of the senior team to answer patients promptly, the review of rota outputs to ensure staffing resource aligns to demands and the calculated support to other ambulance Trusts.

Trust	April	May	June	July	August	Sept	October	November	December	Year to date
WMAS	0	8	4	0	4	148	264	211	378	1017
EMAS	181	66	592	212	141	814	2359	587	1857	6809
EOE	383	482	1133	957	1222	2210	2681	1982	1779	12829
LAS	5265	5180	9614	2645	2376	4836	2951	6152	11134	50153
NEAS	848	906	1264	943	1437	704	357	463	824	7746
NWAS	27	15	279	244	6	354	241	241	383	1790
SCAS	2972	3813	7624	10225	2575	564	1597	1306	2837	33513
SECAMB	2322	4432	9100	4665	5595	11619	4880	677	3477	46767
SWAST	49	455	477	77	58	1376	398	100	427	3417
YAS	1423	2214	4078	3640	2260	685	642	443	365	15750
Total	13470	17571	34165	23608	15674	23310	16370	12162	23461	179791

999 calls taken by WMAS for other areas

The Trust continues to support other ambulance Trusts, answering 24,426 emergency calls from outside the WMAS region during December. These numbers include the planned support provided to EMAS, SECAMB, SCAS and YAS as described above.

Trust	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
EEAS	35	44	32	64	122	166	135	143	128	869
EMAS	182	253	273	3,764	14,882	22,215	14,802	15,278	10,121	81,770
LAS	92	72	291	80	84	120	134	200	220	1,293
NEAS	25	23	22	33	27	37	29	31	30	257
NWAS	103	120	145	148	180	198	215	194	178	1,481
SCAS	511	1,027	202	233	1,517	7,966	9,448	5,658	7,213	33,775
SECAMB	41	55	180	61	78	248	1,888	2,856	3,917	9,324
SWAS	111	164	141	136	148	214	228	200	161	1,503
YAS	47	43	3,058	7,788	3,818	5,529	5,915	5,479	2,341	34,018
IOW	3	4		2	6	17	11	7	8	58
SAS	16	14	11	20	23	21	19	39	18	181
N.Ireland	8	11	13	15	21	13	16	19	9	125
Isle Man	1		1	1	1	1	2	1	1	9
WAST	87	96	97	85	106	118	120	89	81	879
Total	1,262	1,926	4,466	12,430	21,013	36,863	32,962	30,194	24,426	165,542

Clinical Validation

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 17.8% during December, consistent with previous months. When reviewing the outcome of those patients assessed by CVT clinicians, 59% received a H&T outcome and therefore were referred to alternative services for their ongoing care.

Only 14% of all triaged calls resulted in referral to ED, this is down from a YTD average of over 17%.

999 re-contacts within 48 hours

A review of the recontact rates for H&T patients during December demonstrated only 9.14% of patients required further 999 assessments within 48 hours, consistent with previous months.

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.

Month	Total EMR Incidents	Total EMR H&T	999 Recontacts	% Total EMR Activity	% EMR H&T
Apr-23	80,015	13,696	1,276	1.59%	9.32%
May-23	81,302	14,659	1,274	1.57%	8.69%
Jun-23	80,009	15,930	1,354	1.69%	8.50%
Jul-23	83,271	14,395	1,267	1.52%	8.80%
Aug-23	82,936	14,492	1,315	1.59%	9.07%
Sep-23	81,250	15,258	1,398	1.72%	9.16%
Oct-23	82,158	16,131	1,264	1.54%	7.84%
Nov-23	80,607	15,803	1,290	1.60%	8.16%
Dec-23	84,796	15,581	1,424	1.68%	9.14%
	736,344	135,945	11,862	1.61%	8.73%

Absence Management

There was a sharp increase in sickness absence for December with a disappointing 9.26% sickness for the month. The main reasons were cold and flu, mental health and gastro related issues. The difference seen in December compared to any time previously is that many staff were producing GP fit notes on their first day of sickness rather than self-certification for a 7-day period. This resulted in a longer period of absence with most notes being for a minimum of 14 days with very few staff returning to work before their fit note expired.

All absences during the festive period are being analysed and reviewed for patterns. If any are found, then escalation through the sickness management policy has or will be initiated.

General Update

PDCs are currently 98 completed. The only remaining staff to have a PDC are either on maternity leave, LTS or have recently returned and have their PDC scheduled.

Mandatory training is looking to be in a great position, and we will deliver compliance of 98.8% by the end of the year. There are 2 staff unable to complete due to health reasons preventing them from coming into the classroom environment. Both have completed their mandatory training workbooks.

Alternative duties staff have been redeployed into EOC to assist with contacting crews who are on scene with patients over 75 years of age and eligible for a conversation with the call

before you convey team. Anecdotally this is proving to be effective but a means of measuring the success of the whole call before you convey initiative are being developed so we can capture all contacts to the local call before you convey teams and understand the effectiveness to avoid ED conveyance.

Call answering support for other services has reduced. EMAS is currently at 15% and due to end at the end of the month, YAS and SECAMB are calls queuing for 2 minutes passed to WMAS by BT, whilst SCAS are calls predicted to be answered in 2 minutes or more and WMAS having call handlers (3 or more) available through IRP.

Minutes of the meeting of the Quality Governance Committee held on 18 October 2023
The meeting was convened by electronic means through Microsoft Teams software

Present:

Alexandra Hopkins	(AH)	Non-Executive Director (Chair)
Mohammed Fessal	(MF)	Non-Executive Director
Dr Richard Steyn	(RS)	Interim Executive Medical Director
Caron Eyre	(CE)	Executive Director of Nursing
Nick Henry	(NVH)	Paramedic Practice & Patient Safety Director
Michelle Brotherton	(MB)	Non-Emergency Services Delivery & Improvement Director
Vivek Khashu	(VK)	Engagement & Strategy Director
Vickie Whorton	(VW)	Integrated Emergency & Urgent Care Clinical Commander
Stephen Thompson	(ST)	Staffside Representative

In attendance:

Diane Scott	(DJS)	Interim Organisational Assurance Director
Pippa Wall	(PW)	Head of Strategic Planning
Matthew Ward	(MW)	Consultant Paramedic – Head of Clinical Care
Graeme Jones	(GJ)	Head of Corporate Efficiencies
Richard Corrall	(RC)	Head of Clinical Practice – Mental Health
Matt Brown	(MWB)	Head of Risk
Leah Harris	(LH)	Patient Safety Specialist
Jenny Lumley-Holmes	(JLH)	Head of Clinical Audit
Andy Rosser	(AR)	Head of Research & Development

Secretariat:

Nicky Shaw	(NS)	PA to Interim Executive Medical Director

ITEM	Quality Governance Committee (QGC) Meeting 18 October 2023	ACTION
10/23/01	**Apologies and Introductions**	
	Apologies were received from JB, JW and CK. The meeting was quorate.	
10/23/02	**Minutes of previous meeting – 19 July 2023**	
	The minutes of the meeting held on 19 July 2023 were submitted.	
	Resolved:	
	That the minutes of the meeting held on 19 July 2023 be received and approved as a true and accurate record.	
10/23/03	**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 05/23/05.1: Executive Medical Director, Paramedic Practice & patient Safety Director and Interim Organisational Assurance & Clinical Director Integrated Quality Summary Report (Action Log Nos. 1 & 2) (Action No. 1) The Head of Clinical Practice – Mental Health was in attendance and would be providing an update on MH provision as an agenda item. QGC agreed to discharge this continued minute. (Action No. 2) AH said the action to raise the question to Board around the reduction in conveyance would be transferred to the Chairs Report which is used to capture those items that are urgent, usual or unexpected into a summary format and refer to the Board.	**Discharged** **AH**
	2. In relation to continued minute 05/23/05.2: Trust Board Reporting – Clinical Performance The Cardiac Arrest Report 2022-23 would be discussed as an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	3. In relation to continued minute 05/23/07.7: Clinical Audit Programme 6-Monthly Report The demonstration of the clinician dashboard was an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	4. In relation to continued minute 07/23/04.1: Learning Review Group (LRG) Chair's Report The presentation on the Patient Safety Incident Reporting Framework (PSIRF) had been shared as Appendix 1 to the action log. QGC agreed to discharge this continued minute.	**Discharged**
	5. In relation to continued minute 07/23/04.2: Health, Safety, Risk & Environment Group (HSREG) Chair's Report An update report on Datix had been circulated and will be discussed as an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	6. In relation to continued minute 07/23/04.3: Professional Standards Group (PSG) Chair's Report In relation with the action to update on the discussions taking place around improving ROSC performance, it was noted there is a Cardiac Arrest Strategy being developed. QGC agreed to discharge this continued minute.	**Discharged**
	7. In relation to continued minute 07/23/05.1: Interim Executive Director, Paramedic Practice & Patient Safety Director and Interim Organisational Assurance & Clinical Director Integrated Quality Summary Report At the last PSG meeting a business case for the introduction of MAD devices was approved which will allow Naloxone to be administered intranasally and should help to reduce the number of needle stick injuries. QGC agreed to discharge this continued minute. MF said this was good to hear but it would be good to know the nature of these incidents i.e. sometimes they might happen at the time of preparing or administering and sometimes they might happen after the event.	**Discharged**

	MF said there is a company that works with many Trusts who have a device which can help reduce both the clinical risk and clinical/environmental waste and was happy to provide details to NVH outside the meeting.	
	8. *In relation to continued minute 07/23/06.1: Board Assurance Framework (BAF)* MWB and NVH had discussed the risk relating to the delivery of clinical audits on 12 October 2023. A further meeting has taken place between NVH, RS and CE to look at process and system issues and the risk assessment needs to be updated. This action would remain on the log until the next meeting to ensure it has been completely closed down.	**NVH**
	9. *In relation to continued minute 07/23/07.1: Quarterly Review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones* The vacancy approval request form (VAR) for the sustainability lead role had been submitted to recruitment on 25 January 2023 with a response on 9 March 2023 that the Executive Management Board (EMB) had not discussed the vacancy. The same response was given on 22 March 2023 and then a recruitment freeze was imposed. QGC agreed to discharge this continued minute. AH highlighted this would be picked up later in PW's agenda item and thought it might be something we need to inform the Board for their awareness.	**Discharged**
	10. *In relation to continued minute 07/23/10: Any Other Business – Professional Standards Group (PSG) Terms of Reference* The PSG terms of reference had been updated to reflect the approval of an Operational Representative being added to the membership. QGC agreed to discharge this continued minute.	**Discharged**
	11. *In relation to continued minute 05/23/11: New or Increased Risk highlighted from the meeting* The new/increased risks highlighted at the meeting had been included in the Chair's Report. QGC agreed to discharge this continued minute. The risks being: 1. PTS staff vacancies (77). 2. PTS contracts performance and staff shortages. 3. Overtime restrictions – lack of communication why decision made, which areas are being targeted for overtime to resume and a plan going forward if need to occur again. 4. Issues with Language Line resulting increase in reporting ER54s. 5. Clinical Audit Team sickness and the impact on resources and workstream within the Trust. 6. Clinical Audits – findings and risks 7. NHS to NHS concerns and process. 8. Strikes – further impact across the whole system including hospital delays.	**Discharged**

	9. Sustainability management – delay in the VAR request being approved to recruit for a Sustainability Lead. 10. Increase of V&A incidents.	
10/23/04	**Chair's Reports from Working Groups**	
	4.1 Learning Review Group (LRG)	
	The Chair's Report from the meetings held on 20 September and 17 July 2023 and Action Logs of 17 July and 21 June 2023 had been submitted and noted. NVH noted the Patient Safety Incident Response Framework (PSIRF) presentation had been circulated as part of the action log and was happy to answer any questions from colleagues offline. The Chair's Reports submitted were 'as read' as LRG met on Monday (16th) and there are only 4 outstanding actions of which 1 is due January 2024. There is nothing significant to report from both meetings. There are going to be some deep dives undertaken into the increase of assaults on staff and increasing the usage of the body worn cameras to see what more we can do in this space to support staff. AH noted that this is something to flag up to the Board. NVH agreed suggesting the numbers might be due to an increase in staff reporting due to EOC working with staff to make sure incidents are reported and not being accepted as part of the job. Hospital handover delays have increased which EMB discussed and the risk assessment currently at 20 is being re-reviewed. In terms of lost hours, the trajectory is 26,000 for the end of this month, which is a significant rise, almost double from last month and rising again so that risk assessment is also being re-reviewed. MWB provided a brief update on the body worn cameras confirming the podcasts were being recorded which will include a staff member, someone from EOC, himself, CK and the Post-Qualification Manager and will be a round table exercise rather than a podcast. Training School are using the body worn cameras with new students to get them into the habit of going this every shift. It was noted more cameras are being worn and LRG discussed whether this is due to colder weather with more staff wearing jackets which it is easier to fit the camera on, this was also discussed at the OMT Meeting. It was highlighted CK is in regular meetings with Motorola to improve the data reporting. There are 2 cases going to prosecution before the end of the month where CK has said the body worn camera footage is key evidence in gaining prosecutions and the outcomes will be reported in the weekly brief. AH commented there is something around the culture and perhaps involving the student body might mean the uptake is better especially in the light of the worrying trends being seen and the significant increases, even if some of this is related to increased reporting, as the thought of staff having to face this is unacceptable and gave thanks to everyone for all the efforts being made to support staff.	

	Resolved:	
	That the Chair's Report from the meetings held on 20 September and 17 July 2023 and Action Logs of 17 July and 21 June 2023 be received and noted.	
	4.2 Health, Safety, Risk & Environment (HSRE)	
	The Chair's Report from the meetings held on 18 September and 24 July 2023 and the Action Logs of 24 July and 15 May 2023 had been circulated. CE noted the only outstanding action is a conversation between MD and the Head of Procurement and CE will speak to MD to confirm this has happened. In terms of risk, MWB said this was around the fire marshal training which used to be arranged by training school with an external provider. It came to light following an actual fire alarm activation at Sandwell Hub, and that this process had stopped because of COVID. Training school have now re-initiated the process and the Delivery Service Directors are collating the information for each of their areas in terms of coverage (i.e. 24-hour cover) and the number of staff to be trained. CE referred to the small pilot on stab vests which had been inconclusive and the plan to conduct a bigger pilot but what has been discussed is that for a variety of different reasons this did not happen and will be picked up at the next HSRE although CE will work out how this can be resurrected in between the planned meetings. Noted: Brief discussion around some of the regional hospitals re-introducing PPE and whether this would be a challenge for Operations/frontline staff. VK confirmed around half of hospitals have introduced the mandate for staff to wear masks on arrival into Emergency Departments. WMAS has a reasonable stock of face masks to supply to staff with a buffer stock of around 14 days' so there is no risk of running short. A clinical notice has been released with sets out to staff the expectations, basically enabling them to wear masks if they wish to wear them during normal business but they will be expected to wear them to support external bodies who are asking them to wear one. AH asked is there a means by in which if people are in a situation where they are very concerned there are clear routes to raise them, VK said no-one has raised any concerns other than around the inconsistency of the application from the hospitals which is something that has been flagged in terms of why some are doing it and some are not.	
	Resolved:	
	That the Chair's Report from the meeting held on 18 September and 24 July 2023 and the Action Logs of 24 July and 15 May 2023 be received and noted.	
	4.3 Professional Standards Group (PSG)	
	The Chair's Report from the meetings held on 25 September and 31 July 2023 and Action Logs of 31 July and 26 June 2023 had been received.	

	RS said the Chair's Reports were 'as read' noting most of the content provides assurance and there was nothing new to alert to QGC. One area to highlight is in relation to NICE issuing head injury guidance recommending 2 grams of tranexamic acid (TXA) being given to isolated head injuries. This has been discussed at length within WMAS and at the National Ambulance Service Medical Directors (NASMeD) Group who have recommended (the same as WMAS) to continue with a single gram being given by crews. It is felt it was too liable to inconsistencies in terms of whether it is an isolated head injury or not. The Enhanced Care teams, predominantly Doctors with additional skills, may choose to give 2 grams and they have to advise the receiving hospital, otherwise all the receiving hospitals we will be advised 1 gram of TXA has been given where appropriate and then it is up to the hospital to decide whether the second gram is given. RS re-iterated this action is in line with the NASMeD discussions and recommendations that is happening within other services elsewhere. MF welcomed a discussion around the 5-year strategy for cardiac arrest because this is more around the medium/long term and requested an update. Also, linked to this is the performance for post-resus management (being at 60%) and requested the data on where other services are, focussing on whether this a sector wide issue. It was agreed this would be picked up under the Clinical Performance agenda item. MF noted the positive improvement in clinical audits as re-audits have shown an upward trend. Also noted some audits show adequate or moderate assurance. AH re-iterated the importance of being focused on some of the assurance levels of the clinical audits noting the Falls discharged at scene is insufficient and that we are looking towards it being adequate or moderate assurance. A query raised around the ICBs learning disability and autism training proposal not being available until 2025 was raised. WMAS response was requested re this important issue. NVH advised that the Trust has decided to make sure the Oliver Macgowan training is available to staff now through the learning portal and as part of this year's training programme. ***Noted:*** this has gone really well and positive feedback has been received. Once the national training is available it will be delivered within the mandatory training programme along with the Oliver Macgowan online training. MF referred to the risk relating to Language Line which has been discussed at the People Committee and is included the PSG papers and as the key concerns are around delays in the interpreter joining the call and the non-auditability asked if there is any update since the last PSG meeting. MWB confirmed a risk assessment has been drafted and actions identified. VW stated there are over 220 languages supplied by Language Line to the NHS and had contacted her counterparts in other Trusts who are experiencing the same problems around a delay in the interpreter coming onto the call and the quality of the call. VW is liaising with the Telecommunications Manager to see the how many calls we are actually dealing with.	

	Work of this nature is done by other companies. A query was raised regarding standards of similar service providers and MF identified this as a significant risk when looking at inequalities and the importance of diversity and inclusion. Risk noted at QGC for so it can be discharged from the People Committee. VW was aware another Trust had utilised an alternative company but had reverted back to using Language Line. CE said Birmingham Women's & Children had done a lot of work around interpreter services and did move away from Language Line to another company who reportedly provided a good service but was unsure whether this is the Trust VW mentioned earlier. The important point to note is Language Line interpreters are trained around healthcare and not just being able to speak a particular language which gives some level of assurance. The Head of Patient Experience is meeting with a colleague at Birmingham Women's & Children and CE would pick this up and bring back via PSG as to whether the alternative solution is an option or not. AH said there is a sense of movement even though there is no resolution at this moment in time which is important to note.	
	Resolved:	
	a) That the Chair's Report from the meetings held on 25 September and 31 July 2023 and Action Logs of 31 July and 26 June 2023 be received and noted. b) That the Head of Patient Experience is meeting with a colleague at Birmingham Women's & Children and CE would pick this up and bring back via PSG as to whether the alternative solution is an option or not.	**CE**
10/23/05	**Care, Quality & Safety**	
	The following agenda items would be brought forward in the meeting to allow authors to present their items to leave the meeting early.	
	5.6 Update from Health Education England Lead on Non-Medical Prescribing & Advanced Clinical Practice	
	The Update from HEE Lead on Non-Medical Prescribing & Advanced Clinical Practice had been submitted. ***Noted:*** MW currently at a national conference on resuscitation decision making which links to guidelines around cardiac arrest management and the questions MF and others have in relation to cardiac arrest performance. Brief update on the work that is going on today nationally: *There are discussions on changing some of the termination of resuscitation guidelines*. ***Noted:*** advanced practice is developing well. There are 26 trainee advanced clinical practitioners (ACPs) and placements scope is being increased out to external providers to get a wealth of experience across primary and secondary care and also prescribing.	

	It was noted, 2 of the 26 ACPs are currently re-sitting their module because the leadership for that HEI changed and have changed the standards mid-final year for both of those trainee ACPs. MW has challenged because they should be assessed and governed on the programme they joined and not the programme with the new changes but after a second appeal being turned down, they are having to retake that third year to achieve the new standards which is being funded by the NHS England workforce and training directorate. We are currently in development of a non-medical prescribing independent prescribing support process with 2 of the very large out of hours providers within the West Midlands who are very keen to support the Trust. There are 12 independent non-medical prescribers working across the Trust, most are within the Clinical Validation Team (CVT) but there is an increase in numbers of independent prescribers within the MERIT Team which will further develop the critical care car which goes on line within quarter 4. There are 2 designated prescribing practitioners who can support that within the Trust as well as external support. MF noted interest in the development of a workforce plan/strategy approach although was unsure what the strategy is for ACPs and NMPs. MF fully supported this work as an opportunity and addresses a lot of the issues both in terms of workforce and development and retaining staff. It is also important re future direction in the NHS and WMAS over the next 5 to 10 years. MW thanked MF for their support and advised there is a draft strategy written which is going to form part of the clinical strategy. In terms of business opportunities, MW said we need to address what would be classed as the 'invisible' costs about the benefits of advanced clinical practice to the NHS, and in other areas, which could come back into WMAS to be able to develop and support more of our staff to provide excellence of clinical care to those patients. CE highlighted there needs to be a non-medical prescriber lead because this is a large piece of work to ensure continued train and safety. MW is currently the non-medical prescriber lead for the Trust in line with the policy, but highlighted as the number of practitioners increases this will need to be an independent post to ensure appropriate governance of non-medical prescribing. MF noted in other organisations, the non-medical prescriber lead is overseen by the Medical Director so this could be an option.	
	Resolved:	
	That the Update from HEE Lead on Non-Medical Prescribing & Advanced Clinical Practice be received and noted.	
	7.8 Research & Development Programme 6-monthly Report	
	The Research & Development Programme 6-monthly Report had been submitted. AR advised the Trust is supporting around 20 research studies this financial year.	

	The organisation has exceeded its annual target for research participants set by the Clinical Research Network and is now heading towards the 500-participant target which releases a small financial envelope from the Department of Health. The research and development programme is progressing well but the Paramedic 3 study had been delayed nationally as reported. There is a research strategy in draft format which is the first one as an organisation and RS, NVH and MF are all keen to be involved with that which is almost ready for internal/external review. MW & AR left the meeting.	
	Resolved:	
	That the contents of the Research & Development Programme 6-monthly Report be received and noted.	
	5.7 Datix Update Report	
	The Datix Update Report had been submitted. GJ said the paper was 'as read' and gave a brief overview of Datix in terms of its implementation and what it means for the organisation. The trust has introduced 2 modules; PolicyStat which helps manage our policies, procedures and clinical notices, and Claims which is a system that helps manage legal claims, clinical negligence claims, public liability and liability claims which both systems are working well. The emphasis on the claims module is about post claim learning and what can be learned from claims received. The next modules to go live are Safeguarding and Patient Experience. The Safeguarding module will enable clinicians to input safeguarding concerns onto their tablet at scene and that information will be sent direct to the relevant local authority. The second module is about PALS and processing and gathering information relating to concerns/compliments raised by patients or family members. The biggest benefit of Datix is it enables the consolidation of data in one place when a concern is raised i.e., emails, files, PRFs, which reduces the burden on our servers and data storage and ensures tracking and traceability of data. The largest module to be launched will be the Incidents module which replaces of the ER54. Datix, will support making the back of the system as straight forward to use but making sure all of the corporate areas have enough system complexity available to manage themes and trends, communications and produce meaningful reports regarding areas of concern. The aim is to build up themes and trends which are common throughout the organisation and make the activity as uniform as possible which might mean we pick up more subtle things not necessarily picked up on the legacy system. User videos have been produced which GJ was happy to share, the ones available at the moment relate to Legal and Claims, PolicyStat and Safeguarding but there is enough information in the videos to be able to understand how the system will behave in other environments.	

	Transfer to Datix is progressing in the right direction focussed on the key challenge of reporting and the organisation utilisation of reports. GJ confirmed WMAS has procured the ability to export the data from Datix to input into our existing data warehouse. We could report in the same way as in Orbit meaning less change for users albeit there might be changes in report names, but from a reporting perspective users would still be using their current kind of Orbit system to generate a report. The committee acknowledged this was important work and the biggest challenge will be implementation and training particularly for the Incidents module. MF noted he had worked with Datix at different organisations for over 10 years and thought the system is good. The main issue is around the incidents and assurance that the system will not be replacing any staff. DJS thanked GJ for his hard work which contributes to bringing all data together and improve the quality of data reporting. AH said further updates would be useful particularly as and when modules come on line together with feedback on what has been rolled out and what is being rolled out so QGC can understand where it is starting to have an impact. GJ was happy to arrange a sign-in onto the test system for anyone who wanted to have a look at the system and the work already done. GJ left the meeting and would schedule the next Datix update with NS to add to the Schedule of Business.	
	Resolved:	
	a) That the contents of the Datix Update Report be received and noted. b) That GJ would schedule the next Datix update with NS to add to the Schedule of Business.	**GJ/NS**
	5.8 Update on Mental Health Provision	
	RC said the mental health provision has been a significant piece of work over the last 2 years working with the Integrated Care Boards (ICB's) around a long-term plan and investment into improving the ambulance response to mental health. This has resulted in significant investment for this year and for moving forward across 4 distinct but inter-related areas, which include: • **Clinical validation team (CVT) mental health admissions** – 6.9 of 12.8 wte have been recruited into post. • **A mental health response vehicle programme** – 15 out of 16 staff have been recruited into post and there is work being done around policies and developing processes. The induction for these staff will commence in November with a 'go live' date anticipated as 4 December 2023. This pool of paramedic staff who will be for the most part working as the primary clinician and the Trust will be supporting them to upskill as specialist mental health paramedics through a new level 7 course currently out to tender. A 3-week induction will be delivered to support the initial upskilling and these specialist staff members will be working alongside student paramedics or technicians rotating to give them exposure, experience and the ability to work in that space and to develop knowledge to bring back into the wider organisation.	

	This will be supported in the control room through the mental health helpdesk to be established. • **Mental health clinical development officers linked to a mental health education programme** - 2 of 3 wte clinical development posts have been filled. This will support significant CPD delivery across the organisation particularly focusing on upskilling staff in the mental health core skills education training framework ensuring we have the correct skills within the organisation to meet the patient needs. This will also support the clinical supervision that runs across the mental health response vehicle function as well to give some insight and support there. • **A programme around high-intensity service use and being more efficient how we manage those patients to ensure that we are getting the right care and outcomes for them thus reducing their demand upon our service** - the high-intensity manager, admin support and 3 of 4 high use practitioners have been recruited. Work is ongoing around the governance ensuring the right policies, procedures and processes are in place. RC noted this is a significant cohort of patients, there are about 1,400 current high-intensity service users across a 12-month period. Circa 14,000 meet definitions, which amounts to around 20% of our overall demand in terms of call volumes throughout the year. Further work is being done to better understand the data regarding the inequalities ensuring that optimal care for the patient may need engagement with partners through collaboration working with patients so they get that care to meet those unmet or recognised needs in a better way and subsequently reduce the demand through 999. It was agreed an update on the mental health provision should be provided to QGC quarterly or annually (Especially in the light of the Police making the declaration they are not going to support the ambulance service in the same way they have done in the past by attending patients who are demonstrating acute episodes of mental health or mental illness) RC left the meeting.	
	Resolved:	
	a) That the verbal update on the mental health provision be received and noted. b) That the next update on the mental health provision to be scheduled and added to the Schedule of Business.	**NS**
	5.1 Paramedic Practice & Patient Safety Director, Executive Director of Nursing and Interim Executive Medical Director Integrated Quality Summary Report	
	The Paramedic Practice & Patient Safety Director, Executive Director of Nursing and Interim Executive Medical Director Integrated Quality Summary Report had been submitted.	

	NVH drew attention to an increase in hospital delays which will continue to be monitored the risk re-assessment planned. With the re-implementation of wearing face masks and increased COVID numbers, the hospitals face more challenges not just that it is winter as well. In terms of the NHS-to-NHS concerns, processes in place result in WMAS raising outgoing concerns to other NHS Trusts of which there are still over 200 open (some going back to 1 April 2023), so there are some significant delays which have been escalated at the monthly ICB quality meeting. A meeting has been scheduled with the Head of Patient Safety and one of the Leads to discuss next steps. PSIRF is a large piece of work and the 2 Patient Safety Specialists and Patient Safety Learning from Deaths Lead are in post. 8 Patient Safety Learning Leads have been appointed and had their induction and master classes from a number of people last week. They will be working within the serious incident framework and transitioning into PSIRF. The Black Country ICB are moving over to PSIRF from 1 November 2023 and will be collating everybody's plans and policies on 24 October 2023. NVH noted WMAS's policy is in draft only because it has not gone through the appropriate governance process to make it a Trust policy as yet. Serious incidents (SIs) are increasing and relate to the number of handover delays which is going to have an impact also; lost hours at hospital handover increase the likelihood there will be more patient stacking, more patients affected and potentially harmed due to those delays because there is no resource to send to them. Currently, response to ER54 reports is robust, there is nothing more than 3-months old and we are making sure everything is being delivered in that space to bring these numbers down, given the issues raised back in January. WE will continue reporting to this committee and Board to give that assurance. MF referred to the Care Quality Commission (CQC) concerns around electronic controlled drug registers. MF noted it might be worth the Trust's Controlled Drugs Accountable Officer (CDAO) or someone else attending the controlled drugs national sub-group as they are looking to put together a working group which MF will be a part of to look at electronic registers because of the concerns they do not meet the requirements. NVH said the Trust Pharmacist feeds into the national ambulance group and noted if attendance is required from the ambulance sector normally 1 representative attends and feeds back to the national group. MF noted safeguarding concerns for adults and children is fairly consistent, slightly rising year on year and he wanted to understand the current situation. NVH agreed to include more visibility on safeguarding going forward and the need to relook at what is being presented to QGC and to Board. MF asked if the Trust has a 'position of trust panel' where concerns about the professionalism of registered healthcare professionals within the organisation can be raised about their conduct and fitness to practice, and if there is a panel what is the governance arrangement. NVH said this would be picked up and managed through the allegations meetings where all relevant parties attend i.e. Clinical, HR, etc and these meetings happen	

	all the time and often at short notice to make sure these are managed in a 'live' fashion. CE noted trust allegations should not be discussed in committees due to maintenance of confidentiality, so the outcomes of the meetings NVH is describing is about professional practice or poor practice, etc. It was further noted, a position of trust is when there is a vulnerable person albeit it a child or adult and the allegation being made sometimes comes in from the local area designated officer as they are not about work and could be around what has happened externally to a member of staff and might be notified by an external agency (e.g. police) WMAS might only have part of that incident data. These meetings are held externally by local designated area officer and the Council so they are a little bit different to the internal allegation meetings. AH noted, whilst this is not this committee's business what has been raised is a really significant point around where the reporting will take place if it is falling between 2 committees. Further clarification is required. ST raised a quick observation around what NVH has mentioned which is relevant to QGC from a governance and assurance point of view because the group being talked about is not reflective in any policy ST was aware of whether that be disciplinary, investigation, safeguarding and is something we need to talk about in a relevant committee. AH will raise this issue on the Chair's Report to the Board from today as it is clearly something that is causing concern and we do need to be addressed.	
	Resolved:	
	a) That the contents of the Paramedic Practice & Patient Safety Director, Executive Director of Nursing and Interim Executive Medical Director Integrated Quality Summary Report be received and noted. b) That AH will raise this issue on the Chair's Report to the Board from today as it is clearly something that is causing concern and we do need to be addressed.	**AH**
	5.2 Trust Board Reporting – Clinical Performance	
	The Clinical Performance Report for August 2023 had been circulated. • Cardiac Arrest Annual Report 2022-2023 • Demonstration of Clinical Dashboard The clinical performance report would be taken 'as read' noting there were a couple of issues raised that need to be addressed, these being the 5-year strategy; to understand what is going to happen in the immediate term to resolve this. Also the post-resus management performance being data in both WMAS and the wider sector. JLH advised performance for post-ROSC on average is 68% noting nationally the top performer is 78%, and WMAS was eighth for the last reported month.	

	There is a national benchmarking day soon focusing on the fluids standard which is one of the standards WMAS drop in. Therefore, not only will there be focus on the fluid standard but internally around how we can report it better on EPR so these are a couple of actions being done about post-resus. It was noted that managing stroke and STEMI have both recovered in performance; WMAS was tenth for stroke and are now first nationally and much has done by the Quality Improvement Paramedic re: putting on numerous CPD events, disseminating information, reminder notification screens on EPR as a reminder for staff, also videos, AQI newsletter, etc which is thought to have contributed to performance recovery. There is a new AQI which is 'Falls over 65 discharged at scene' and this data will be included in the next month's clinical performance report. NVH noted there is focus on where we are preforming less well and action plans for improvement are in place. This is built into our training needs analysis for the mandatory training for the next year. JLH sits on the national group making sure the AQIs meet with what is going on so there is a balance and some of the AQIs are reliant on other people's data. The hospital cardiac arrest report 2022-23 had been included with the QGC papers and contains an interactive link to the data which JLH could demonstrate but was aware of time constraints. The other action is to give a demonstration on the clinician data analytic dashboard and again JLH was happy to give a quick run though if there was enough time or to take off-line and do individual sessions with committee members. It was agreed it would be of value for the committee to have a demonstration of the clinician dashboard at the beginning of the January meeting.	
	Resolved:	
	a) That the contents of the Clinical Performance Indicator Report for May 2023 be received and noted. b) That there will be a demonstration of the clinician dashboard at the beginning of the January meeting.	**JLH**
	5.3 Clinical Supervision Plan	
	The Clinical Supervision Plan had been received. The report was 'as read' noting some work being conducted relooking at the delivery of clinical supervision and standardising it across the organisation. All of the elements captured in the report are on track. ***Noted:*** Work is being undertaken to develop the clinical supervision plan for next year taking account of staff feedback.	
	Resolved:	
	That the contents of the Clinical Supervision Plan be received and noted.	
	5.4 Quarterly Exception Report on the Quality Account Priorities	
	The Quarterly Exception Report on the Quality Account Priorities had been submitted.	

	PW stated everything is on track with nothing further.	
	Resolved:	
	That the contents of the Quarterly Exception Report on the Quality Account Priorities be received and noted.	
	5.5 Update to the published Quality Account re: Freedom to Speak Up	
	The Update to the published Quality Account re: Freedom to Speak Up had been submitted. VK advised a complaint had been received from a member of the public regarding the Quality Account specifically on the Freedom to Speak Up (FTSU) section highlighting the omission of any detail or reference to the 'NHS England review of concerns' which was undertaken in the organisation. It was noted this is a confidential review and only certain members of the organisation i.e. members of remuneration committee and Non-Executive Directors had seen that report. Following advice from various stakeholders and legal services, the Trust had decided to issue an update to the FTSU section which has been sent to all of the recipients of the Quality Account which refers to the review having taken place and a brief narrative about what it did not include i.e. patient safety or patient outcomes and not too much detail on what it did include because we are not permitted to. The update includes some of the things undertaken in response to the review and committing to refer to it in next year's Quality Account which will be consulted on in spring of next year. VK said the Board are due the 6-monthly update on FTSU next week and this matter will be included in that paper but wanted to appraise QGC members of the update that has been issued in response to a complaint.	
	Resolved:	
	That the contents of the Update to the published Quality Account re: Freedom to Speak Up be received and noted.	
10/23/06	**Risk**	
	6.1 Board Assurance Framework (BAF)	
	The Board Assurance Framework (BAF) had been received. MWB said the paper is 'as read' noting an update on the actions which are progressing daily. There is another meeting tomorrow with the Good Governance Institute and the new BAF will be presented to the Board next week. Accompanying the report is the high risk 20 and above review which is being undertaken monthly by RS, CE, NVH with support from MWB to provide greater assurance that these are being reviewed regularly by the 3 Quality Directors rather than solely by the risk owner (who may have a level of subjectivity) as they can bring more objective evidence and data to the table. A BAF 'frequently asked questions' document has been released and will be going to Board next week.	

	Resolved:	
	That the contents of the Board Assurance Framework be received and noted.	
10/23/07	**Governance/Compliance and Regulation**	
	7.1 Review and Approval of the Annual Strategies Operational Objectives & Milestones	
	PW said in terms of the review of strategies, some were due for review and approval by September, with the Trust Wide Strategy going through the review process by the Board and due for completion next month. Therefore, for those strategies due to be updated by September a short delay is noted. EMB discussed this yesterday and agreed those strategies needing to be updated will be undertaken and any further update from the Board discussion in November will also be incorporated.	
	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.	
	7.2 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. PW said the updates for quarter 2 had been collated for those strategies aligned to QGC of which most are 'on-track'. No update had been received against the sustainability strategy therefore going back to the questions raised around recruiting to the sustainability lead role, PW advised this was around G4S as there was an admin role sent through to recruitment back in January who have confirmed it was put on hold some time ago which was the last update to QGC. Once the update against the sustainability strategy is received PW will update the report and circulate via email. VK informed an update paper is being presented at next week's Board outlining a consolidated view on all the strategies. EMB have discussed there are circa 20 strategies in the organisation and the possibility of consolidating a number i.e. finance and commissioning resulting in fewer strategies overall.	
	Resolved:	
	a) 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. b) That once the update against the sustainability strategy is received PW will update the report and circulate via email.	**PW**
	7.3 Learning from Deaths Quarter 2 Report	
	The Learning from Deaths Quarter 2 Report had been circulated. LH advised the report is 'as read' with the highlights being:	

	• 227 deaths in our care, all of which have received a review under SJR within 40 days of the case being identified. • 71 (31.2%) required further investigation of which 19 are currently being investigated under the serious incident framework. • Due to the pressures within the non-clinical auditing team providing support to EMAS, there has been a slight delay in processing the September data. • Pages 12 – 14 shows learning across all 4 phases and all actions are completed.	
	Resolved:	
	That the contents of the Learning from Deaths Quarter 2 Report be received and noted.	
	7.4 Security Management Report	
	The Security Management Report had been circulated.	
	7.5 Violence Prevention Reduction Standard (VPRS) Action Plan Quarter 1 Report	
	The Violence Prevention Reduction Standard (VPRS) Action Plan Quarter 1 Report had been submitted.	
	7.6 Data Sharing & Protection Toolkit (DSPT) Report	
	The Data Sharing & Protection Toolkit (DSPT) Report had been received. In CK's absence, agenda items 7.4, 7.5 and 7.6 were taken 'as read'. AH asked if anyone had any questions to send them through to NS and copy in committee members, who will obtain a response back from CK. It was noted all of these documents had been submitted to HSRE.	
	Resolved:	
	a) That the contents of the Security Management Report, Violence Prevention & Reduction Standards (VPRS) Action Plan Quarter 1 Report and the Data Sharing & Protection Toolkit (DS&PT) Report be received and noted. b) That if anyone had any questions to raise on the Security Management Report, Violence Prevention & Reduction Standards (VPRS) Action Plan Quarter 1 Report and the Data Sharing & Protection Toolkit (DS&PT) Report to send these through to NS and copy in committee members, who will obtain a response from CK.	**ALL/NS**
	7.7 Clinical Audit Programme 6-monthly Report	
	The Clinical Audit Programme 6-monthly Report had been submitted. JLH advised the report shows the progress of the clinical audit programme into 3 areas; locally identified concerns whether that is from patient safety, learning review or clinical audits, drug administration and any national audits. It shows any concerns about the standards and what mitigating actions are being done along with a breakdown of the assurance levels each audit is providing, noting there has been a big focus to improve assurance levels over the last 18 months.	

	MF noted it was very concerning that the overarching picture shows 'inadequate' in most of the self-reporting audits locally and acknowledged all the work being done to improve the assurance levels. In terms of awareness, it was queried if staff see this data, as this would enable staff to see the scale of the issue. JLH stated the outcomes of the clinical audits are promoted but more from a Trust view perspective. Work has been undertaken with individual clinicians on developing the clinician dashboard mentioned earlier. It was noted that clinicians realised documentation of events could be improved. It is the aim to require individual clinicians to use the dashboard as a reflective CPD piece not only for the national AQIs but for the airway checklist, cannulation log, etc and all the clinical audits to review individual performance against the Trust/hub data. It was noted that an offer of support with training was proposed. It was noted that the auditing of the clinical audits particularly Naloxone protocol (specifically in relation to the line referring to 'onward care of the patient is clinically appropriate') and the ACMG recommendation (accepted by the Government as best practice) is for all ambulance trusts that discharge a patient on-scene, Naloxone is provided as a supply. Therefore, audits should be audited against not only the standards that in the main come from JRCALC or NICE but also from different sources including best practice.. JLH noted with Naloxone administration, all of the safety netting is fully documented and what we do for all the clinical audits is to use the evidence-based standards from whatever guidance that would be. Obviously if the Trust has not adopted something from JRCALC guidance, we would not expect staff to do that, but if it is in the JRCALC or NICE guidance we look at that standard regardless of whether we provide training or information on it and we have the community groups externally to be able to safeguard those patients.	
	Resolved:	
	That the contents of the Clinical Audit Programme 6-monthly Report be received and noted.	
10/23/08	**Documents for Approval/Discussion**	
	None presented.	
10/23/09	**Schedule of Business**	
	The Schedule of Business had been received. AH wanted to review the schedule of business to ensure that the reporting falls organically in the way things are managed in the service so we can be sure where we have had late or missing papers the schedule has gone awry a little so is it time to re-look at it again. As the new Chair of QGC, AH had not yet got a sense of the flow, and it might be the flow is perfect but if not was keen to have any views from any committee members or contributors today as well so we can be sure the schedule of business is as correct as it can be. As part of the review, we will re-look at the number and frequency of meeting but no decision will be made without participants having their view.	
	Resolved:	

	a) That the Schedule of Business be received and noted. b) That the Schedule of Business is reviewed and any comments are directed back to AH and NS.	**ALL**
10/23/10	**Any Other Urgent Business**	
	• **High Risk Review** - CE said as consequence of BAF work need to relook at the high-risk report and as Clinical Directors and anybody else who would like to help to have a quick look at the high-risks monthly to make sure WMAS is 'comparing like with like' and when new ones come in the organisation we will have a better understanding of them. • **Allegations meetings –** NVH confirmed there is a policy that covers off the allegations meetings in terms of safeguarding, sexual safety and those type of things to provide assurance and will pick this up with ST outside of the meeting to confirm exactly what the other issue was being referred to.	**NVH/ST**
10/23/11	**New or Increased Risks highlighted from the meeting**	
	The following new/increased risks were highlighted at the meeting. 1. Increase in hospital handover delays and lost hours at hospital. 2. Increase in assaults on staff. 3. Concerns raised around Language Line i.e. delay in interpreters joining calls, non-auditability of calls and over 220 languages to provide. 4. Clinical audits several showing 'insufficient' assurance. 5. Post-ROSC performance 6. Increase in safeguarding reports AH thanked colleagues for their contribution and level of debate and apologised to JLH for having to defer the clinician dashboard demonstration to the next meeting. There being no further business, the Chair declared the meeting closed at 14.00 pm.	
10/23/12	**Date and Time of the next meeting**	
	Wednesday 24 January 2024 at 11.00 am via Microsoft TEAMS	

These minutes were agreed as an accurate record on Monday 24 January 2024.

West Midlands Ambulance Service
University NHS Foundation Trust

Minutes of the People Committee
held on Monday 4th September 2023 at 1300 hours
via Microsoft Teams

Members:

Mohammed Fessal (Chair)	MF
Narinder Kooner	NK
Carla Beechey	CB
Lucy Mackcracken	LM
Michelle Brotherton	MB
Nathan Hudson	NH
Karen Rutter	KR
Jeremy Brown	JB

Invited:

Diane Scott	DJS
Julie Jasper	JJ
Paul Tolley	PT
Barbara Kozlowska	BK
Usha Ramnatsing	UR
Mohammed Ramzan	MR
Reena Farrington	RF
Pete Green	PG
Stephen Thompson	ST
Simon Day	SD
Louise Jones	LJ
Jason Kirkham	JK
Stephanie Simister	SS
Dawn John (Secretariat)	DEJ

ITEM	Meeting held on 4th September 2023	ACTION
09/23/01	**Welcome:** The Chair thanked everyone present for attending.	
	Apologies / Did not attend: Jeremy Brown, Simon Day, Julie Jasper, Steve Thompson. It is noted that Jason Kirkham is deputising for Steve Thompson. Louise Jones and Stephanie Simister are from the People Directorate and attending for their observation and development purposes.	
09/23/02	**Minutes of the last meeting of the People Committee held on 22nd May 2023:**	

	The minutes from the meeting on 22nd May 2023 were submitted and agreed as an accurate record.	
09/23/03	**Actions arising:**	
	1. Resources and Staffing required for full delivery of the EDI agenda. Benchmark report from all Ambulance Trusts. CB has discovered that many trusts combine their HWB and EDI teams' resource: A full report is embedded in the action log. An intern has now been appointed to support the team. There is a national proposal to protect the time of Network Chairs for attendance at meetings. The networks feedback into Diversity & Inclusion: Steering and Advisory Group. Each network has a designated secretariat, HR buddy and Executive Director assigned to support. We will review after 6 months to see how this is progressing.	**Carla Beechey**
	2. Listening Centre average waiting time of 13 days: The update is provided in today's action log. Triage is in depth and identifies needs around shift patterns, locations and specialty needed e.g., bereavement, eating disorders. Before reaching the Listening Centre service, each referral is assessed by our Mental Wellbeing Practitioner team.	**Lucy Mackcracken**
	It was advised and noted that we will resume the use of the Board Papers App for the papers for People Committee meetings. Papers will also be distributed via email with the SharePoint link inserted.	
09/23/04	**NHS EDI Improvement Plan**	
	Carla Beechey presented this item and referred to documents 4 to 4b. The action plan has come from NHS England EDI plan for all organisations. All actions are long term and not imminent. They have been discussed at EMB. Organisationally this should not wholly sit in the workforce agenda, it is an organisation approach and responsibility and therefore Diane Scott will monitor and progress the plan for the Trust. It is here at People Committee for oversight and assurance. We are comfortable with the progress at the moment. The Chair asked CB to clarify the background of this plan. CB explained that it has come from the national workstreams and forms one overarching NHSE/I plan to evidence meeting all of their duties. The group discussed international recruitment, as part of the plan up to 2025. CB explained that we do not do this as it has to be proven from a visa perspective that you cannot recruit domestically within the UK and at present this is not the case for the Trust.	

	NK added that it would be useful to triangulate this plan with all of our other action plans i.e. domestic abuse and recognition of the impact and how we support staff in terms of attendance and impact from home. LM stated that the domestic abuse policy is referenced, together with the support and approach we take. RF concurred that management are very supportive of staff in such situations. Staff are supported to return to work safely.	
	Resolved: a) That the contents of items 4 to 4b are received and noted.	
09/23/05	**EDS3 2022 – 2023 Report and Findings**	
	Papers are presented as read and relate to EDS3 version for 2022. We had agreed with ICB to do joint evidence gathering but it has been almost impossible to get all organisations on board. The report lays out the areas we are good at and the areas to develop. By the end of this financial year, we will have formulated an action plan. The group discussed how decisions are made around which area to focus on i.e. procurement. The Black Country ICB direct us to identify two areas to focus on to compare, contrast and make improvements. Collectively we have decided on PALS this year to buddy up with other trusts, examine evidence and provide positive critique. The Chair directed a question to Nathan Hudson around 'Language Line' which had been discussed in QGC as there have been delays in connecting to this service. There is a legal obligation to provide understanding in any language. The group acknowledged that this is being addressed by Vickie Whorton at QGC and is not our field of expertise for People Committee. However, the Chair raised this as risk. NK added that we do not collect the ethnicity of our service users or people with disabilities.	
	Resolved: b) That the contents of item 5 and 5a are received and noted.	
09/23/06	**London Fire Brigade and Police Services Review updates:**	
	Carla Beechey has previously presented these action plans and reports to People Committee and they are here today to close down as all actions have been agreed and completed. The Chair raised the concerns around sexual safety and safeguarding. CB replied that there will be a separate sexual safety and wellbeing working group set up for oversight of this work but will also formally report to this Committee.	

	Resolved: a) That the contents of item 6 to 6b are received and noted.	
09/23/07	**Public Sector Facility Time Publications Regulations**	
	The Trade Union (Facility Time Publication Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public sector employers, including NHS Trusts, to report annually a range of date in relation to their usage and pend on trade union facility time. This has now been completed by the Trust. We have seen an increase in trade union activity, which was expected in light of the industrial action around the pay award. A safe service was maintained for the public. Our representatives sit on national groups which means that our voice is being heard at those meetings, which is of great value. Only 0.05% of the pay bill is spent in this area. CB has tried to obtain benchmarking against other trusts but only 1 of the other 9 services have published their data so far. She will take to the national HR directors to try and get this information, which will be shared with EMB and People Committee if available. .	
	Resolved: a) That the contents of items 7 and 7a are received and noted.	
09/23/08	**Workforce Key Performance Indicators dashboard and analysis: April, May, June and July 2023**	
	April May, June and July KPIs were presented today as read. Ellie Huddleston has done a great job in updating the format and content of the KPI's for this financial year having taken into account requests and feedback from this committee. Key Points: Bank staff have reduced with only 41 remaining within MERIT service. Overtime has been reduced and focused on front line resources. Turnover has been benchmarked against other trusts. Retention Steering Group looking at data. Sickness is at 4,3%, which is a good position. Mental health and MSK remain the main reasons for absence. Appraisals are in a strong position and all on track. BME headcount numbers have reduced as a result of the NHS 111 exit. The group discussed vacancies and recruitment. It is acknowledged that all vacancies are considered and if approved from EMB, bt the Chief Executive, the Finance Director and People Director. ICB review and scrutinise to ensure they are business critical roles.	

	After the recent recruitment freeze, it is pleasing that this is unlocked and a full cohort of students commence on 14th August. The Chair raised the question of staff with secondary employment. Staff may be struggling financially and some requests have not been supported. He asked how many secondary employment requests are we getting? LM confirmed that the data is contained within the report i.e., 41 requests over 12 months, of which 37 approved, 3 denied and 1 withdrawn. The Chair raised the issue first heard at QGC around clinical supervision and 1:1s not being consistent. NH replied that all of the managers go through the process with Organisational Development, so they know how to conduct the conversations. It is certainly a challenge on the larger hubs to ensure good conversations and they need to be more meaningful. We are therefore looking at joining the PDCs with the clinical team mentor and CS1 days which will hopefully pay dividends going forward. The Chair expressed that it was refreshing to hear so much work and triangulation was being undertaken in this area. NH will update at the next People Committee. **Action: Nathan Hudson** BK added that the PDRs and now called PDCs (Professional and Development Conversations). There is a disparate picture across the trust which will depend on 3 key things – the time, skill of the manager and will of the participant. All reviewers have a development session and some need to improve in confidence. UR noted that the staff survey results from staff, show that the quality of appraisals has increased by 2%.	**Nathan Hudson**
	Resolved: b) That the contents of item 8 to 8c are received and noted.	
09/23/09	**Organisational Development Report:**	
	Barbara Kozlowska presented her papers with the following key updates: We have stopped using the term 'talent management'. We develop people with potential through the PDC (Professional and Development Conversation) process. We currently have 650 staff identified as high or emerging potential. We take part in exercises and provide evidence and timescales. We have influenced ICBs to use the 'developing potential' terminology. There were previously two main envelopes of funding from Health Education England, Workforce Development Funding (WDF) and	

	CPD Funding. The WDF pot has been reduced by 80% which now goes to the ICB directly rather than provider leve. ICB have small pots of funding and decide how that is spent. We are looking at how we can get the most value from the remaining CPD funding available. Usha Ramnatsing is doing a great job with our Finance teams. We spent £17k on NHS Elect membership from October 2022 and promoted the opportunities for staff to access online courses and webinars in their own time and at their own pace. Take up was low so it is unlikely that the subscription will be renewed this October. Retention work continues, targeting different areas and job roles and staff at the top of their pay band. Career and development conversations are taking place. UR emailed individuals directly. Winningtemp comments are given to locality leads, anonymised for this committee. The Culture Review went to EMB last month. This month we are holding an designated exec session to look at the results and what we actions we take going forward. The Chair commented that he liked the staff retention career conversations and the exploration of motivation, especially around bands 5 and 6. He would welcome this back at People Committee to see how these conversations have gone. BK explained that there are lots of career development conversations taking place, not just within this context. NK noted that on page 9 staff retention – there is a line suggesting that BME staff feel there is a lack of support and it would be useful to understand more about this. CB replied that this was part of the WRES data – a specific question so that a conversation could be held to find out why people feel this way or believe there is a lack of progression. BK added that every year more and more toolkits and frameworks are out there. Last year we had a whole pathways framework, with routes to other roles and names of who to speak to. Some of the negative feedback might be assumptions from staff talking between themselves or saying they cannot do a second job. It would be interesting to find out. NK asked what are the barriers in working towards our EDI agenda? UR responded that there is a pulse survey in the Weekly Briefing this week. We have completed all of the actions on our Trust wide action plan and need to know what impact this is having on staff. A discussion followed and alternate views exchanged. Engaging Leaders evaluation improves year on year. BK is delighted with the high average scores at the University side. The Chair asked how the time out for delegates is arranged. BK explained that this is left to local management to facilitate. The	

	programme is well supported and managers release staff or swop shifts. Staff also attend on their day off. Thanks go to Nathan Hudson for his help in advising Oms of these arrangements. The Chair expressed an idea to bring the Senior Tranche Members to this meeting to share their experience of the courses and give us a flavour of what is happening. BK feels it will be difficult to persuade the individuals to come to a committee. It was agreed that they may feel more comfortable here than at Board. BK will ask people. Day in the Life: The Trust Chairman has completed 5 visits in Q1 and another 17 since then. The whole process is undergoing a refresh to make it leaner and clearer. The Chair welcomed this paper as a separate document, as presented today. BK added that not all of the Directors respond to her monthly emails on Development and DITL visits undertaken. Some PAs respond on behalf of their Directors but all Executives need to respond in some way. The Chair totally agrees and feels that every hub visit he makes give him as much assurance as coming to People Committee. This will be taken to EMB and then Board. Thanks were expressed to BK for all her work on this.	
	Resolved: a) That the contents of item 9 to 9b are received and noted.	
09/23/10	**Education and Training Update:**	
	Paul Tolley presented his paper with the salient points as follows: We currently deliver a practical based AAP driving course for around 53% of the hours. The transfer of simulation area equipment from Brierley Hill to Sandwell hub included the household living areas, the extrication cars and the hospital beds. The road layout and aircraft for confined working have not been transferred. Interactive quiz development AAP course is reviewed over 6 months – second of our new ones. Two anatomage tables have been purchased. Hugely valuable piece of equipment to us. 6 high fidelity Maternity manikins are in use – one has gone to air operations. Driving simulator – Lander simulations to develop a bespoke platform to reduce carbon footprint and maintenance costs. Opportunity to explore things we cannot change in the live arena i.e., change in weather conditions etc. Wide spread use of simulation now.	

	The Chair expressed a wish to come and visit the new training facilities at some point. Chair asked for assurance from this committee that we can give support on simulation training in a timely manner. PT assured that this week we have HCPC validation to move education forward. We can influence university partners and the practitioners have had the opportunity to move forward under our own timescales. The Chair thanked PT for his contribution. The Chair asked about the completion of portfolios for newly qualified paramedics. Would ETOs pick up overtime to take home to complete? PT explained that overtime is always ad hoc. People may take the odd portfolio home and perhaps work for an hour or so. The Chair asked how often Ofsted, Ofqual inspect and when? PT responded that they only have to give two days' notice. We are currently rated 'good' and due for a visit from Ofsted. For us it is always about being prepared and we never lower the bar.	
	Resolved: a) That the contents of item 10 are received and noted.	
09/23/11	**Equality, Diversity and Inclusion Progress Report:**	
	Mohammed Ramzan presented papers 11 to 11j with the following salient points: The WRES and WDES action plans from last year are here to close down with the agreement of the members. Approval is sought for the 2023 - 2024 action plans, which will progress to Board for approval and ratification then be published by the end of October. The EDI report will go to Diversity & Inclusion: Steering and Advisory Group. The annual report is to also be ratified by the Board before publication. CB asked the members to note that a different approach to data presented in WRES and WDES action plans has been taken this year, with all stakeholders meeting together with network chairs and D&I: SAG. She thanked everyone for their feedback. There have been much more measurable objectives with desired outcomes, although some crossover with WRES, WDES and protected characteristics. A discussion followed and it was stated that we are way behind representing the people we serve. A structured approach will be best	

	to fill the gap however there is concern that the targets are not getting us there fast enough. We have held successful events in recruitment and a celebration of South Asian heritage (covered by the BBC Asian network) however, this does not always translate into figures and the recent recruitment freeze impacted progress. CB referred to the Masters in Research programme into why people from a BME background aren't joining the Paramedic profession and why some people are not staying. The Chair acknowledged that as we progress in this area, it will have a snowball effect on BME staff, with higher visibility and family members working within the Trust. NK reminded the committee that she would prefer to see numbers, rather than percentages on reports. CB confirmed that both numbers and percentages are reported in the KPIs. The ONE Network is leading on the Black History month. We are collating assessments for EDS3 2023 to 2024 over the next two months. There is a men's health event in Coventry with other blue light services in attendance. The Chair stated that an ethnicity pay gap action plan would be welcome at this committee in the future. CB responded that this is incorporated in the WRES action plan and metrics, with a specific metric around pay. The Chair would still prefer to see this is an individual way and some thought will be given to this for the future.	
	Resolved: a) That the contents of item 11 to 11j are received and noted.	
09/23/12	**People Report:**	
	Lucy Mackcracken presented her papers 12 to 12l with the following key points: The grievance and disciplinary paper allows us to see any themes or trends. The four policies listed are all ratified. Some extensions have been agreed for paternity and 3 months in order to include the enhanced provisions for baby loss. 3 productive sessions were held with Policy Group for the Sickness Policy, which will go to RPF in October. HCPC renewal process – 100% compliant. Thanks to everyone for their hard work in getting this over the line. With regard to Policy Group, we are refreshing the terms of reference with the Values Framework to test that each policy works within our values.	

	Resolved: a) That the contents of items 12 to 12l are received and noted.	
09/23/13	**Recruitment Report:**	
	Recruitment: There has been a successful student paramedic intake. However, two factors have limited the impact on our ability to increase our BME recruitment for this year; People are already within our system or are pre-selected by Universities. IT have supported us with the issues around the Careers website. NHS technical requirements have now been resolved. The time frame sits within another directorate, so we are awaiting a date.	
	Resolved: a) That the contents of items 13 to 13b are received and noted.	
09/23/14	**Health and Wellbeing Report:**	
	We have concluded the HWB roadshows for the Spring and Summer with thanks to everyone involved. We are now in the process of analysing the data form the surveys undertaken. The HWB teams also supported the Asian Network event. The Chair noted the good work happening in HWB, which is working very well for the organisation. There are new chaplains in different faiths and the networks are supported so well done to all involved.	
	Resolved: a) That the contents of items 14 and 14a are received and noted.	
09/23/15	**Risks Identified:** EDI: We do not represent the people we serve. Language Line not available to patients and risks associated with 3rd party information to continue through QGC **Staff experiencing moral injury resulting in sickness performance issues:** CB explained that this assessment is here as tabled and to confirm the amalgamation of many risk assessments covering the same topic. The Chair said that moral injury is very subjective, and self-determined. How do we categorise it? LM answered that with QWELL and the HWB Practitioners, data is triangulated and fed into this risk assessment.	

	CB added that it is not for us to define if an individual had suffered moral injury. Risks remain around the workforce numbers previously reported.	
09/23/16	**Schedule of Business 2023 – 2024:**	
	Taken as read.	
	Resolved: a) That the contents of item 17 are received and noted.	
09/23/17	**Any Other Urgent Business:**	
1	Sexual Safety: Concerns have been raised around the students on placement with us. Actions have been put into place by the Trust to focus on this area and the safety of students in general. A student safety and wellbeing group, chaired by a NED, will be set up with the terms of reference presented at people committee for us to consider and agree. Sexual Safety will be monitored at People Committee with support from EMB. NK noted that the letter from the Chief Executive to students did not contain a clear link on where students could go to raise issues. CB responded that the correspondence does advise on who to contact and a QR code is also provided at induction which details this info. Education & Training and Pippa Wall also cover this and explain different avenues for support during the welcome induction. Sexual Safety and Wellbeing will come to People Committee as an agenda item. **Action: Carla Beechey** We are also meeting with the University HEI leads to work in partnership in our support to students.	**CB**
09/23/18	**Dates of Future Meetings 2023 to 2024:**	
	Via Microsoft Teams unless otherwise notified: **2023 – 2024:** ~~Monday 22nd May at 1000 hours~~ ~~Monday 4th September at 1300 hours~~ Monday 20th November at 1000 hours Monday 26th February at 1000 hours **PLEASE CHECK THESE MEETINGS ARE IN YOUR DIARIES**	

Close:	The Chair thanked everyone for their input and closed the meeting at 1615 hours.	

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS MEETING

AGENDA ITEM 14c MONTH January 2024 PAPER NUMBER 23

Committee	**People Committee**
Chair	Mohammed Fessal
Executive Director	Carla Beechey
Meeting Date(s)	20th November 2023
Matters of concern or key risks to escalate	Student placement numbers to be discussed at Board in November following NHSE confirming no current concerns around students undertaking placements at WMAS. SSWG work has highlighted historic issues with student inductions, clinical updates, weekly briefings and access to buildings(ID cards). Staff survey with 1 week to go shows return rate lower than last year, the lowest across the sector. There has been financial incentives, time given for completion, as well as Staff Survey Review Action Group engagement. Questions on whether it is being actively pushed by managers. Management capacity concerns – Followed from a conversation on PDCs e.g. a manager can have up to 90 PDCs to complete; a single OM at hub finding it difficult to support ad hoc conversations or RTWs. This may partly explain some of the negative responses in the staff survey around management relationships. Agreement a wider discussion on management capacity to support staff is needed.
Major actions commissioned/ work underway	Clinical supervision & general PDC review – NH to present paper in February 2024. Sexual Safety & Wellbeing Group (SSWG) established – 1 meeting held to date, and formal report to be presented to this Committee going forward. Student Network Chair and Vice Chair to be appointed in December.
Positive assurances to provide	SSWG and Student Network established. Positive actions in new organisational policies to support those undergoing fertility treatment and loss of child. Neonatal Care Bill

	going through Parliament which should further enable us to support our staff. Organisation at the forefront of simulation training, though it has faced equipment and capital restrictions delays.
Decisions made	Approval of previous committee meeting minutes Policies approved: Supporting Attendance for Work Policy Occupational Health Clearance & BBV Policy Maternity Policy Maternity Support-Paternity Leave Policy Flexible Working Policy
Chair's comments on the effectiveness of the meeting	Good discussions at committee. Some members did need to leave early.
Any other key points for escalation to the Board	Day in the Life question for Board: Are we happy for feedback to be shared with the People Committee (relevant for other committees too)?

Minutes of the Audit Committee meeting held on 18 July 2023, 10am, CR1, WMAS HQ, Millennium Point, Brierley Hill and via Teams

Present:

Julie Jasper	JJ	Non-Executive Director - Chair
Wendy Farrington-Chadd	WFC	Non-Executive Director – via Teams
Karen Rutter	KR	Director of Finance
Phil Higgins	PH	Trust Board Secretary and Governance Director
Julie Hill	JH	Local Counter Fraud Specialist
Jamie Phillips	JP	Local Counter Fraud Specialist
Diane Scott	DJS	Organisational Assurance Director – via Teams
Zoe Picken	ZP	Internal Audit
Mandy Kalea	MK	Head of Claims (part of mtg)
Carla Beechey	CB	People Director (part of mtg) - via Teams
Mark Docherty	MD	Director of Nursing (part of mtg) - via Teams
Donna Stevenson	DS	EA to Director of Finance
Kristi Deakin	KD	Business Administration Apprentice, Finance (observing)

ITEM	Audit Committee Meeting 18 July 2023	ACTION
07/23/01	**Declaration of Interests** There were no Interests declared from the members of the Committee.	
07/23/02	**Welcome and Apologies**	
	Apologies were received from Mushtaq Khan, Narinder Kooner, Matt Brown and Andy Cardoza.	
07/23/03	**Minutes of the Last Meeting (6 June 2023)**	
	Resolved: The minutes of the meeting held on 6 June 2023 were agreed as an accurate record.	
07/23/04	**Matters Arising from the last meeting and Action Log**	
	Action Log • Risk paper – Risks will be included in the GGI review and action plan. • Policy Group Terms of Reference – these will be reviewed as part of the GGI action plan and will be submitted to EMB. • Timesheets manual intervention – KR said approvals via this route occur occasionally and is via email, rather than paper based. • All other Actions were completed and closed.	
	Resolved: a) The Action Log was received and noted by the Committee.	

07/23/05	**Claims and Coroners Report**	
	MK presented the report to the Committee and said the Trust has received 11 claims so far this year. Last year during 2022-23, 34 CNST claims were received and 17 staff claims. 10 claims were closed and no damages were paid on 6 of these. 109 requests have been received from coroners so far this year and this is an increase compared to the same time last year. An additional paper has been included to provide Audit Committee with some further analysis on claims. The report provides a summary of WMAS' NHS Resolution Scorecards and Benchmarking data compared to other ambulance services. MK also said that there were no trends identified. The Benchmarking report was noted by the Committee. KR said that NHS Resolution are paid a calculated sum per annum by WMAS for litigation cover. WFC queried the scorecard and benchmarking report and asked if this had been to the Board. PH said there is a continued minute for Tony Yeaman to progress this item. PH will send the paper to WFC that was submitted to the Board.	
	Resolved: a) The Claims and Coroners Report was received and noted by the Committee. b) PH to send paper to WFC.	**PH**
07/23/06	**External Audit Report**	
	KPMG were not present at the meeting. WFC said she was disappointed that External Audit had not attended the meeting. KR reported that the Annual Report and Accounts have been laid before Parliament and that KPMG did not have any items to report plus they also had a conflict with this meeting, but KR and JJ have arranged to see them separately.	
07/23/07	**Board Assurance Framework (BAF)**	
	MB was not in attendance to present the BAF. JJ asked if anyone had any comments to forward these to JJ or MB. JJ said as part of the GGI Well Led review the BAF has been reviewed and a development session is being held with GGI to move this forward. Therefore, the BAF will be updated and revised going forward. MD said that some of the risks will be removed from the BAF when it is reviewed (e.g. industrial action). Other risks may be added, i.e. financial pressures, reduction in overtime and gaps in rotas.	

	PH pointed out the importance of attendance at the Audit Committee to present papers as it is a Statutory Committee of the Board. JJ will include this in her report to the Board.	**JJ**
	Resolved: a) The BAF was received and noted by the Committee. b) JJ to include attendance at Audit Committee in her report to the Board.	**JJ**
07/23/08	**Internal Audit Update**	
	Internal Audit Progress Report, including revised Internal Audit Plan for 23-24. ZP said three reports have been finalised since the last meeting; • ***General Ledger*** - Substantial assurance given - 2 minor actions noted which are being addressed by the Finance Department. • ***Payroll*** – Substantial assurance given – some of the actions are repeated and have not been addressed in year, these are only minor actions including updating policy wording and ZP would chase up these outstanding actions. • ***Risk Management and Assurance Framework*** – Requires Improvement. ZP pointed out that this area has received the same Requires Improvement assurance for the last four years. Hopefully the BAF will be reviewed and refreshed this year following the GGI review. ZP said this will be moved forward as best as possible. WFC commented on the report and said that the management and operation of risk is a concern, plus the ongoing lack of assurance. JJ also said that the ongoing "requires improvement" assurance is a cause for concern. WFC said that any actions put in place must address the issues raised. ZP said she would work with MB as best as she can to move this forward. ***Looking Ahead*** - Three reviews are ongoing and these will be submitted to the next meeting in November. ***Internal Audit Plan 2023-24*** – ZP said that after discussions with KR and JJ the plan for this year was reviewed and as a result the number of days have been reduced to 200 days in order to make the plan leaner and more focused. ZP has included all the changes in the revised plan and asked that this is approved. ZP said that it is intended to deliver the revised plan this year within the resource capability. KR said the plan will be reviewed on an ongoing basis. ***Follow Up*** - Overdue actions – 19 actions from audit recommendations are overdue and ZP should be able to clear these with the relevant leads.	
	Resolved: a) The Committee received and approved the revised Internal Audit Workplan 2023-24. KR to submit to EMB for information. b) The Committee received and noted the Progress Report.	**KR**

	c) The Committee received and noted the Full Internal Audit Reports.	
07/23/09	**LCFS Progress Report**	
	JJ reported that this would be Julie Hill's last Audit Committee as she will be retiring at the end of August. JJ thanked Julie on behalf of the Committee for her support and all her hard work with the Trust in the area of Counter Fraud. WFC echoed these comments. Jamie Phillips was welcomed to the meeting and JH said he would be taking over Julie's role from September and will be attending future Audit Committee meetings. **Progress Report** • JH said there had been no new referrals since the last meeting. • One fraud alert has been received and relates to a growing trend in fraud for people working elsewhere. A training forum will be held in August to address this issue. KR said that a message via the Ops team regarding adherence to the working time directive would be useful. JP said he would provide feedback from the training session. JH confirmed that it is a requirement for employees to declare all secondary employment and obtain approval for this from their line managers. • Fraud Survey – JH said it was disappointing that only 29 replies had been received to the fraud survey. The link to the survey would be re-issued via the weekly briefing and within the next newsletter from Counter Fraud to try and encourage more responses. Feedback from the survey will help the LCFS to target which areas of the Trust need additional awareness/training sessions. • The CFA has released details relating to two national Local Proactive Exercises relating to Procurement Fraud. The two reviews will focus on due diligence and contract management and these will be included in the LCFS workplan.	
	Resolved: a) The Committee reviewed and noted the LCFS Progress Report.	
06/23/10	**Payroll Debt**	
	• KR presented a brief report to the meeting on the level of payroll related debtors as at 30 June 2023. The information is to monitor the level of debt and manage any actions that need to be taken. The paper is for information only. • KR said the overdue debts are followed up by the financial accounts team with most focus on the over 90 days debts. • There are issues with leavers and these are being worked through with the Ops team and GRS team so that staff do not leave owing a large number of hours. • JJ raised concern over the repayment schedules that were previously in place. JJ requested that assurance is provided regarding the	

	processes that have been put in place through management controls and recovery processes in order for the debt to be brought down to an acceptable level. • WFC also expressed concern over the level of debt and the current processes when staff leave the Trust.	
	Resolved: a) The Payroll Debt report was received and noted by the Committee. b) The payroll debt report is included on the Schedule of Business for updates to the Committee, twice per year.	
07/23/11	**Audit Committee Self-Assessment**	
	The Self-Assessment was undertaken during the meeting. The following items were noted:- • There has been inquoracy on two occasions due to remote attendance and hybrid and remote working is under review. • There is always healthy debate. • Membership – o It was suggested that the meeting is extended to all NEDs as part of the membership. o Designated Vice Chair required as it was noted that there is no Vice Chair for the meeting. o The Committee membership has defined roles and appropriate qualifications in its membership as laid out in the TofR. • The Action Log is reviewed at each meeting and all actions are followed up. • The Committee is well supported administratively. Completed Self-Assessment to be forwarded to PH.	
	Resolved: a) The Self-assessment to be forwarded to PH.	**DMS**
07/23/12	**Report from the People Director regarding Band 8d and 9 and overtime**	
	CB presented the report to the meeting which details overtime payments during 2021-22 and 2022-23 for Band 8d and 9 managers. CB said that during these periods the overseeing of operations by Directors outside of normal working hours during Covid, the Commonwealth Games, and Industrial action had had an impact on the claims made. These overtime arrangements have ceased since February 2023, however, it should be noted that there will still be an on-call element that will continue to be paid. CB confirmed the authorisation process and said that claims were not submitted via GRS and were authorised by the CEO or relevant Director. KR pointed out that the 2022-23 figures include the Commonwealth Games which was externally funded which would have offset some of the overtime payments costs.	

	CB confirmed that normally, under AfC, duties for band 8a and above would be managed without overtime. This report will be brought back to Audit Committee yearly.	
	Resolved: b) Report received and noted.	
07/12/13	**Reportable Items**	
	KR outlined the report to the meeting which includes :- **Stock Disposals –** KR said that all disposals should be out of date before disposal, e.g. unused vaccines. The disposal forms and process is being managed by K Deakin, Finance Business Admin Apprentice. The prescription only medicine disposals are dealt with via a different process. **Losses** – one bag reported as stolen from the back seat of a car. There was no loss of data. **Ex Gratia Payments** – noted. **Credit Notes over £1k** – noted. **Waivers** – 7 waivers noted. JJ said it is important that SFIs are adhered to.	
	Resolved: a) Report received and noted by the Committee.	
07/23/14	**Review of the Annual Report of the Audit Committee 2022-23**	
	The draft report has been reviewed by WFC and JJ. JJ said that the report may include more detail than required. WFC said that the Council of Governors find this report very helpful.	
	Resolved: a) The Report was approved by the Committee and will be forwarded to the Council of Governors and the Board of Directors.	**DMS**
07/23/15	**Review of the Chief Executive's credit card transactions**	
	JJ said this report was referred to the Audit Committee from the Remuneration Committee to maintain transparency and propriety, and is available on request. PH said there was no cause for concern with the content of the report or the transactions. The CFA has received a copy of the report and any reply from the CFA will be reported back to the Audit Committee. PH said this will be noted in the Action Log from the Remuneration Committee meeting that this paper has been forwarded to Audit Committee.	**PH**
	Resolved: • The Report was received and noted by the Committee.	

	• PH to note in Remuneration Committee Action Log.	**PH**
07/23/16	**Any Matters reported to the Chair from other Committees.**	
	No items reported to the Chair of Audit Committee from any other meetings, other than those included on the agenda.	
07/23/17	**Any New Risks Identified**	
	PH noted the following: • Attendance at Audit Committee meeting. • BAF and Risks – giving sufficient assurance. • Payroll debt – strengthening operational processes prior to any debts being incurred. DJS pointed out the following: • BAF – increasing risk around financial pressures. This could be an emerging risk.	
	Resolved: a) Above risks to be flagged to Head of Risk.	**DMS**
07/23/18	**Schedule of Business**	
	Schedule of Business received and noted. This may be subject to recommendations in the future made by the GGI.	
07/23/19	**Any Other Urgent Business**	
	• ***Stock Management (Follow Up) Internal Audit Report*** **from 2022/23** – typo in 'background' paragraph of full report, stated that original report had an overall assurance opinion of 'requires improvement' but should have stated 'insufficient' – picked up as report shared as part of the COVID-19 public inquiry. ZP to attach addendum to report and share with PH. • ***Business Case review action plan*** – KR said that as part of the FTSU action plan an update on this is to be brought back to the Audit Committee. This is the same update that went to the Board briefing in July stating that all the business case process changes have been implemented and embedded the lessons learnt, therefore, did not require re-submission to this meeting. DJS will articulate the action around the Archus review in the action plan as it was agreed not to take this review forward due to the cost.	**ZP** **DJS**
	Resolved: • Stock Management report – addendum to be provided for Report. • DJS to update action re Archus review.	**ZP** **DJS**
07/23/20	**Dates of Future Meetings**	
	• 7 November 2023, 10am, CR1, MP • 25 January 2024, 10am, CR1, MP • 12 March 2024, 10am, CR1, MP.	

07/23/21	**Meeting of the Audit Committee in the absence of Officers of the Trust**	
	This meeting was held with Internal Audit attendees separately.	

The meeting closed at 1200 hours.

Action Points – Audit Committee 18 July 2023

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
07/23/05	NHSR Benchmarking and Scorecard report to be forwarded to WFC	**PH**		
07/23/07	Attendance at Audit Committee to be included in Chair's report to the Board	**JJ**		
07/23/08	KR to submit revised Internal Audit Workplan 2023-24 to EMB for information.	**KR**	Complete	
07/23/11	Completed Self-Assessment to be forwarded to PH	**DMS**	Complete	*Sent to PH on 18 July 2023.*
07/23/14	Annual Report of the Audit Committee to be forwarded to CofG and Board.	**DMS**	Complete	
07/23/15	PH to include referral of report to Audit Committee in Remuneration Committee Action Log	**PH**		
07/23/17	Potential/emerging risks to be forwarded to MB.	**DMS**	Complete	*Actioned 19.7.23.*
07/23/19	ZP to attach addendum to report and share with PH.	**ZP**	Complete	*Actioned.*
07/23/19	DJS to update action re Archus review.	**DJS**		

Date of next meeting:
7 November 2023, 10am, CR1, Millennium Point

Minutes of the Audit Committee meeting held on 7 November 2023, 10am, CR1, WMAS HQ, Millennium Point, Brierley Hill and via Teams

Present:

Julie Jasper	JJ	Non-Executive Director - Chair
Narinder Kooner	NK	Non-Executive Director
Karen Rutter	KR	Director of Finance
Diane Scott	DJS	Organisational Assurance Director
Zoe Picken	ZP	Internal Audit
Matt Brown	MB	Head of Risk
Muhammad Khan	MK	Bishop Fleming External Auditors
Alex Wallings	AW	Bishop Fleming External Auditors

Minutes from this meeting were produced from a recording.

ITEM	Audit Committee Meeting 7 November 2023	ACTION
11/23/01	**Declaration of Interests** There were no interests declared from the members of the Committee.	
11/23/02	**Welcome and Apologies**	
	Apologies were received from Mushtaq Khan, Wendy Farrington-Chadd, Philip Higgins and Jamie Phillips. The committee welcomed MK and AW to the meeting. Tributes were paid to Wendy for her contribution as past audit chair.	
11/23/03	**Minutes of the Last Meeting (18 July 2023)**	
	Resolved: The minutes of the meeting held on 18 July 2023 were agreed as an accurate record.	
11/23/04	**Matters Arising from the last meeting and Action Log**	
	Action Log All of the items on the action log were discharged with no outstanding issues carried forward. **Payroll Debt** An update was given by the Director of Finance, and it was agreed that the Finance and Performance committee will be responsible for monitoring this issue going forward.	
	Resolved:	

	a) The Action Log was received and noted by the Committee.	
11/23/05	**External Audit – KMPG Formal letter of Resignation**	
	The letter of resignation from external auditors KPMG was received and acknowledged by the committee and thanks, on behalf of the Audit Committee and Board were paid for their services as external auditors.	
	Resolved: a) The committee accepted the letter of resignation.	
11/23/06	**Board Assurance Framework (BAF) and Risk Register**	
	BAF review - JJ said that a review of the BAF identified it may not be fit for purpose and confirmed paper 4.0 went to Board on 25 October 2023. JJ said that all risks in the new framework were approved by the Board of Directors and reflected an accurate status of risks at that time. **BAF refocus** - JJ and MB are working with the GGI to refocus the BAF and add to the richness of data on which the board can gain greater assurance. JJ said that they are moving in the right direction. NK suggested capturing the risk development impact from the actions, i.e. has the action impacted positively to reduce the risk or has the risk increased etc. **Reporting to Board** - MB said the BAF is reported quarterly to Board and shows a clear risk score i.e. whether the risk has increased/decreased. MB said it is the responsibility of the Committees who manage those risks to discuss what actions are working to reduce the risk and to advise Board of suitable actions. MB said the Board will then decide where to focus their attention across the Trust within the overall 7 risks, where factors such as the risk tolerance, risk appetite and level of residual risk are considered. JJ said more ownership of the BAF is needed and that gaps in controls need to be picked up to ensure the BAF is suitably presented to Board with all relevant information, and clearly outlining the risk journey. **Revised BAF action plan** – MB said that Governance and updating the Trusts appetite statement are a focus. JJ said improvement in the recording of the BAF and reviewing risks and how they are presented at Committees is a focus. This is to ensure it is rolled out effectively to other Committees.	
	Resolved: a) The BAF and its revised format was received and noted by the Committee. b) Risk development impact to be noted on the BAF.	**MB**

11/23/07	**Internal Audit Progress Report, including revised Internal Audit Plan for 23-24**	

ZP outlined the Internal Audit Progress Report and stated there had been 4 audits finalized since the last Committee in July. ZP stated the outcome of those audits were as follows:

Cost Improvement Programme – ZP said an advisory review took place in Dec 2021 to compare our processes in place against HFMA best practice guidance. 18 recommendations were received – all were accepted and to be incorporated into last year's CIP. ZP said the recommendations are being followed up on a rolling basis and that a complete follow-up report of the review was done. The outcome of the audit report was the following:

- 18 recommendations received – 15 now closed.
- 6 recommendations - accepted and implemented.
- 9 recommendations - superseded (no changes to be made).
- 3 actions outstanding – new dates/following up as normal.

ZP said the 3 outstanding recommendations relate to this year's CIP. KR said it is sensible and practical to base the recommendations for this year as opposed to looking back to last year. KR said changes have been made to the way plans are put together and monitored as well as how meetings are established to review them. ZP said the programme has evolved since the review and that positive changes have been made.

Data Security Protection toolkit – Substantial Assurance.
Version 5 of the toolkit was submitted by the Trust in June. ZP said it was a substantial Internal Audit opinion overall and stated there were two further opinions mandated by NHS Digital. ZP outlined the reports:

- Self-assessment confidence level – high.
- Overall risk rating (against the National Data Guardian standards) – moderate.

ZP said the overall risk rating is based on a 4-tier scale on which we scored positively. ZP said following a review of the evidence submitted by the Trust, data security controls were found to be in place but stated that one area relating to IT protection scored slightly lower. ZP said that action is being taken by Chris Kerr to address this for the toolkit that will be submitted next year.

ZP said there are 2 medium and 13 low priority actions which will be followed up and reviewed before the interim toolkit submission in February 2024.

Working time regulations – Optimal Assurance.

There were 4 areas of focus:

	• Rest breaks/meal breaks • Daily rest periods (11 hours in each 24hr period) • Weekly rest periods • Average weekly hours (over a 17-week reference period) ZP said the Trust is taking a proactive approach in addressing all elements of the working time regulations and encourages compliance through use of Trust policies and procedures. ZP said there is also ongoing monitoring through Nathan Hudson [The Director of Performance and Improvement]. ZP stated there is optimal assurance overall and no recommendations have been agreed to further enhance controls. JJ pointed out concerns about secondary employment controls and whether this was being monitored or if assurance could be given. ZP said this was within limitations of the current scope but was aware it had been highlighted. ZP said this could be audited or investigated by counter fraud in the future if more assurance is needed.	
	Serious Incidents – **Substantial Assurance.** ZP highlighted the following from the report: • **New Framework** - Working towards a new framework (published in August 2022 replacing the old framework that has been used since 2015). ZP said the Trust is behind on the 12-month transition period but expects this should be complete by December 2023. ZP stated that no recommendations have been made in relation to this and that individual action plans are in place. • **Serious Incident Review Group** – The new Serious Incident Review Group is now in place. ZP said there will need to be formal Terms of Reference agreed for it to become part of the overall Governance structure. Nick Henry has agreed to complete this action by January 2024. JJ pointed out that NH has been including the progress of the new framework in his report to the Board. **Other Internal Audit issues** – ZP said there are two reports from last year whereby the fieldwork commenced but were not included in the Head of Internal Audit opinion: ➢ **Learning from staff feedback review** ➢ **Health and Safety** KR and JJ agreed not to pursue these 2 assignments at this point in time.	

	Follow up of actions – ZP reported on 3 overdue actions. ZP said that a full update from Pippa Wall will be provided before the end of December regarding the two reports that relate to the cost improvement programme. Awaiting an update from Chris Kerr re the Information Governance action. JJ asked for the summary overview on individual assignments to be reintroduced to ensure audit committee members have a view on the cumulative position that will inform the head of internal audit opinion. **Internal Audit provision update –** KR provided an update on the provision of internal audit services going forward and outlined the following: • Internal Audit history/structural changes • KPMG 2023/24 audit cover proposal JJ said that KPMG will be contracted to deliver the Head of Audit opinion and the 2023/24 plan.	
	Resolved: a) The Committee received and noted the Progress Report. b) The Committee received and noted the full Internal Audit Reports. c) ZP to contact CK for an update on the IG action. d) ZP to provide a summary of individual audit assignments as a tracking mechanism for the developing Head of Internal Audit Opinion.	**ZP** **ZP**
11/23/08	**LCFS Progress Report**	
	KR gave an update and outlined the referral process to the Committee as follows: • A referral is received by Counter Fraud and an initial report is produced and discussed with KR who can then provide onward approval to investigate the matter. The committee noted the following update: • A higher rate of referrals at present. • 4 referrals have been closed. • 4 open referrals. • Secondary employment allegations - KR said these two referrals are in relation to employees who are working a secondary job whilst off sick. • Timesheet fraud allegation. • Vehicles being used for personal use. KR said that these investigations are ongoing. JJ asked for the status of the referral i.e. closed/open to be visible on the report going forward. NK	

	said it would also be useful to note the date that the referral was reported and the date it was closed to provide a visual timeline of the investigation. JJ suggested publishing guidance in a December issue of the weekly brief reminding staff of the WMAS policy on receiving gifts and hospitality.	
	Resolved: a) The Committee reviewed and noted the LCFS Progress Report. b) Status of referrals to be recorded in the LCFS Report going forward. c) Date the referral was made and date the referral was closed to be recorded in the LCFS Report going forward. d) Refer staff in the December weekly brief of the WMAS Gifts and Hospitality policy.	**JP** **JP** **JP**
11/23/09	**Any matters reported to the Chair from other Committees**	
	There were no additional items from any other meetings reported to the Chair of Audit Committee other than those included on the agenda.	
11/23/10	**Update to the Scheme of Delegation**	
	KR informed the Committee that this paper had already been presented to the Board on 25/10/2023. However, for good governance, the paper will be brought back to the Audit Committee for noting and to highlight the review of the Scheme of Delegation. KR said the proposal is to split the Scheme of Delegation into various areas to make it more robust and clearer. KR explained that the Chief Executive's approval limit is relatively low, which increases the workload for approvals of contracts and procurements. KR stated that this should be operational but isn't currently reflected in the Scheme of Delegation. KR said that the amended Scheme of Delegation proposal will be presented to EMB in December and then to the January Audit Committee followed by final approval by the Board of Directors. The Committee agreed to this process.	
	Resolved: a) The Scheme of Delegation was reviewed and accepted by the Committee. b) The amended Scheme of Delegation proposal will go to the January Audit Committee for review and approval.	**KR**
11/23/11	**Reportable Items - Confidential**	
	KR outlined the reportable items that have been approved since the last Committee. **Single Tender Waivers** – NK queried the £93k spend on coronation coins due to NEDs previously rejecting this proposal for the use of charitable funds. KR said that this was an instruction and believed the distribution of the coins was scaled back. NK requested more information surrounding this. NK queried value for money and why the contract	

	values differ for similar delivery of services. KR said that all contracts go through lengthy procurement processes and value for money tests. JJ stated that budget holders who have not gone through the correct procurement process should explain to the Audit Committee why this is the case. JJ queried the PTS taxi waivers. KR said there were no robust agreements in place and confirmed that they were put onto a contract prior to running a proper tender process for the provision of taxi services. KR said that further details surrounding waivers can be requested by the Committee but said that it might not be appropriate to bring to Audit Committee due to the confidential nature of the information. JJ asked for procurement comments to be included on the waivers for assurance purposes. **Credit Notes over £1k** – JJ queried the high value credit notes that relate to NHSE. KR said the invoices have been raised to regional NHSE and that the contract is now with the Shropshire ICB.	
	Resolved: a) The reportable items were received and noted by the Committee. b) KR to provide more background information relating to the spend on coronation coins. c) Procurement comments to be recorded on waivers.	**KR** **KR**
11/23/12	**Appointment of External Auditors**	
	The Chair of the Audit Committee, the Director of Finance, 2 members of the Council of Governors and members of the Procurement Team formed the interview panel that recommended to the Council of Governors the appointment of Bishop Fleming as the External Auditors. JJ said the Council of Governors, who are responsible for the appointment of the External Auditors, unanimously supported this appointment and the fee arrangements. Bishop Fleming representatives Alex Walling and Muhammad Khan introduced themselves to the Committee and outlined their experience in the Public Sector including an overview of their external audit approach for WMAS.	
	Resolved: a) Verbal update was received regarding the appointment of BF as External Auditors.	
11/23/13	**Any New Risk Identified**	
	No new risks were identified by the Committee.	
	Resolved: a) Noted.	
01/23/14	**Schedule of Business**	
	JJ reported that the PWC consolidated action plan had been through various iterations and processes including monitoring by NHSE. JJ	

	reported that the plan was last received at the July Audit Committee and that an update will be given at the January meeting. Schedule of Business received and noted.	
07/23/15	**Dates of Future Meetings**	
	• 25 January 2024, 10am, CR1, MP • 12 March 2024, 10am, CR1, MP • 4 June 2024, 10am, CR1, MP	

The meeting closed at 1130 hours.

Action Points – Audit Committee 7 November 2023

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
11/23/06	Risk development impact to be noted on the BAF.	**MB/JJ**		
11/23/07	ZP to contact CK for an update on the IG action.	**ZP**		
11/23/07	ZP to provide a summary of individual audit assignments as a tracking mechanism for the developing Head of Internal Audit Opinion.	**ZP**		
11/23/08	Status of referrals to be recorded in the LCFS Report going forward.	**JP**		
11/23/08	Date the referral was made and date the referral was closed to be recorded in the LCFS Report going forward.	**JP**		
11/23/08	Refer staff in the December weekly brief of the WMAS Gifts and Hospitality policy.	**JP**		
11/23/09	The amended Scheme of Delegation proposal to go to the January Audit Committee for review and approval	**KR**		
11/23/11	KR to provide more background information relating to the spend on coronation coins.	**KR**		
11/23/11	Procurement comments to be recorded on waivers.	**KR**		

Date of next meeting:

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS MEETING

AGENDA ITEM 14d ii MONTH JANUARY 2024 PAPER NUMBER 25

Committee	**Audit Committee**
Chair	Julie Jasper, Non-Executive Director
Executive Director	Karen Rutter - Director of Finance
Meeting Date(s)	7 November 2023
Matters of concern or key risks to escalate.	• Resignation of Wendy Farrington-Chadd resulting in dilution of financial expertise amongst the NED's. • Number of waivers that should have been subject to tender
Major actions commissioned/ work underway.	• Internal Audit provision for delivery of HOIA opinion • Internal Audit history/ structural changes
Positive assurances to provide.	Internal Audit Reports • Optimal Assurance – Working time regulations. • Substantial Assurance – Serious Incidents and Data Security Protection toolkit BAF – Good progress made. Revised version will be presented to Board for approval in November.
Decisions made	• Approval of Audit Committee minutes 18/7 • External Auditors appointment – following the procurement process. The Chair reported the unanimous decision by the Council of Governors to appoint Bishop Flemming as External Auditors for WMAS.
Chair's comments on the effectiveness of the meeting.	The meeting was quorate. Good discussions and debate. Good meeting with the new External Auditors both within the meeting and in the private session with NEDs Wendy Farrington -Chadd – Tributes were paid to Wendy for her contribution to the Audit Committee in her capacity of past chair.
Any other key points for escalation to the Board.	• Board members to note the formal letter of resignation from KPMG as our External Auditors from 23/24 onwards, having discharged all their statutory duties as External Auditors for the 22/23 Annual Accounts. .

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS MEETING

AGENDA ITEM 14d ii MONTH JANUARY 2023 PAPER NUMBER 25b

Committee	**Audit Committee**
Chair	Julie Jasper, Non-Executive Director
Executive Director	Karen Rutter - Director of Finance
Meeting Date(s)	24 January 2024
Matters of concern or key risks to escalate	• Resignation of Wendy Farrington-Chadd, resulting in the dilution of financial expertise amongst NED's. • The number of waivers continues to remain a concern.
Major actions commissioned/ work underway	• KPMG have been engaged to deliver the Head of Internal Audit Opinion for 23/24 (A statutory requirement). • KPMG have been engaged to provide WMAS Internal Audit services for 24/25. (KPMG have been engaged via a direct award on a compliant procurement framework)
Positive assurances to provide	The revised BAF was presented and discussed. Committee members and both sets of Auditors acknowledged the improvements made to the BAF, which will be presented to the Board for assurance at the January 31 meeting.
Decisions made	• Approved Audit Committee minutes of 7 November. • Recommended to the Board the approval of the revised Scheme of Delegation. • Approved the revised Internal Audit Plan. • Approved the letting of a tender for Internal Audit services beyond 24/25. • Approval of the KPMG Internal Audit Charter.
Chair's comments on the effectiveness of the meeting	The meeting was quorate. There was good discussion and engagement between Audit committee members and attendees. There was a good dialogue between both sets of Auditors and the Audit Committee members in the private session.
Any other key points for escalation to the Board	None other than detailed above.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 15 MONTH: JANUARY 2024 PAPER NUMBER: 26

Board of Directors Schedule of Business	
Sponsoring Directors	Chairman
Author	Governance Director & Trust Secretary
Purpose	The Board are requested to review the contents of the attached Schedule of Business for the Board of Directors and approve the schedule of business for the year ahead.
Previously Considered by	The Board Schedule of Business is submitted to each ordinary meeting of the Board of Directors for review and approval.
Report Approved By	Schedule of Business is approved by EMB

Executive Summary

The workplan of the Board is attached, this schedule does not preclude the Board from considering any other issue it wishes or to vary the schedule if required.

It is now subject to formal review by EMB prior to submission to the Board of Directors. It is a dynamic document that is subject to review by EMB. The schedule of Business should reflect the changing environment within which the Board operates and should also be a reminder to colleagues to enable the timely preparation of reports.

The schedule of meetings of the Board has now been varied so that there is not such a large gap in the cycle of meetings between the October Board and the January Board meeting. The schedule attached has been varied as follows:

- The September meeting will now be an ordinary meeting.
- The October meeting will now be a Board Briefing meeting
- The November meeting will now be an ordinary meeting of the Board.
- No meeting is scheduled in December
- The January meeting will be an ordinary meeting.

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

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

Action required

a) The Board is requested to review the contents of the attached Schedule of Business for the Board of Directors and approve the schedule of business for the year ahead.
b) To note the variation in the cycle of meetings.

	Board Schedule of Business		Lead	31/01/24	28/02/24 Board Briefing	29/03/24	26/04/24 Board Briefing	29/05/24	26/06/24 Board Briefing	31/07/24	Aug 24	25/09/24	30/10/24 Board Briefing	27/11/2024	29/01/25 Board Briefing	26/02/25	26/03/25 Board Briefing
Standing Items				✓								✓		✓			
Apologies			Chair	✓		✓		✓		✓		✓		✓		✓	
Declarations of Interest			Chair	✓		✓		✓		✓		✓		✓		✓	
Minutes of Previous Meetings			Chair	✓		✓		✓		✓		✓		✓		✓	
Board Action Log			Chair	✓		✓		✓		✓		✓		✓		✓	
CEO report			ACM	✓		✓		✓		✓		✓		✓		✓	
Risks arising from meetings			All	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Care Quality and Safety																	
Annual reports	Patient Experience Report	Report through QGC	CEO/JW					✓		✓							
	EDI Annual Report+B11:P11	Report through PC	CB							✓							
	Safeguarding Report	Report through QGC	CE					✓		✓							
	Infection, Prevention and Control Report	Report through QGC	CE					✓		✓							
	Patient Safefy, Duty of Candour and Serious Incidents Report	Report through QGC	Nhen					✓		✓							
	Research and Development Report	Report through QGC	NHen					✓		✓							
	Medicinces Management Report	Report through QGC	Nhen					✓		✓							
	Accountable Officer for Controlled Drugs Report	Report through QGC	Nhen					✓									
	Annual staff survey report	Report through PC	CB			✓										✓	
	Physical and Verbal Assaults to Staff Report	Report through QGC	KR					✓									
	Better Births Annual Report	Report through QGC	CE					✓									
	Annual Report on Health and Safety, including fire safety	Report through QGC	CE					✓									
	Making Every Contact Count Annual Report	Report through QGC	NHen					✓									
	Medicines Management Annual Report	Report through QGC	Nhen					✓									
	Controlled Drugs Annual Report	Report through QGC	Nhen					✓									
	Emergency Preparedness Annual Report	Report through EMB	CEO/JWms					✓									
	Security Management Annual Report	Report through QGC	KR					✓									
	Learning from Deaths Annual Report	Report through QGC	NHen					✓									
	Freedom to Speak Up Bi-annual Report	Report through QGC	VK/PW			✓										✓	
Quality Impact Assessment Report (and also any Equality Impact Assessment) Relating to CIP		Report through QGC	KR/Nhen			✓										✓	
Governance																	
Annual Governance Statement as part of the Annual Report		Through Audit Committee	KR					✓									
Annual Budget (including capital programme and CIP programme) - Draft			KR		✓										✓		
Annual Budget (including capital programme and CIP programme) - Final			KR			✓										✓	
Review Board Assurance Framework and Significant Risks			CE/MaBr	✓		✓		✓		✓		✓		✓		✓	
Annual Review of Risk Appetite Statement		Through Audit Committee	CE		✓	✓									✓	✓	
Review of Register of Seals		Confidential	PH					✓				✓					
Reports and Minutes from Commitee Meetings	Audit Committee		JJ	✓		✓		✓		✓		✓		✓		✓	
	Annual Report of Audit Committee		JJ							✓							
	Performance Committee		MK	✓		✓		✓		✓		✓		✓		✓	
	Quality Governance Committee		AH	✓		✓		✓		✓		✓		✓		✓	
	People Committee		MF	✓		✓		✓		✓		✓		✓		✓	
	Remuneration and Nominations Committee		IC			✓		✓		✓						✓	
Review of Terms of Reference to Committees of the Board			PH			✓										✓	
attendance			PH				✓										✓
Review of Goverance structure of the Trust			ABr/PH			✓										✓	
Staff Survey Action Plan Quarterly Review		Report through PC	CB			✓				✓						✓	
Procurement Workplan		Report through AC	KR			✓										✓	
Executive Scorecard			Nhud	✓		✓		✓				✓		✓		✓	
NHS Resolution Annual Scorecard		Through EMB & Audit Committee	TY/Mka			✓										✓	
Update on NARU - KP to attend			KP					✓									
Serious Incidents report		Included in Quality Report to Board	DoN/Nhen	✓		✓		✓		✓		✓		✓		✓	
Claims & Coroners Report			TY/MK			✓		✓		✓						✓	
Communications Report & Data Pack (Quarterley update)		To be reported through EMB Rep	MM	✓				✓		✓		✓		✓			
Communications Report & Data Pack (Annual update)			MM					✓									
EPRR Update			JW/CEO	✓		✓		✓		✓		✓		✓		✓	
Trust Information Pack																	
Regular performance KPI based exception reports covering:				✓		✓		✓		✓		✓		✓		✓	
Finance including CIPS and Capital Programme			KR/DS	✓		✓		✓		✓		✓		✓		✓	

Governance & Security Indicators		KR/CK	✓		✓		✓		✓		✓		✓		✓	
Patient Safety (Meds Management, Safeguarding, SI's, Incident reporting)		CENhen/A	✓		✓		✓		✓		✓		✓		✓	
Nursing & Clinical Indicators		CE/AW	✓		✓		✓		✓		✓		✓		✓	
Operational Key Perforamnce Indicators		Nhuds	✓		✓		✓		✓		✓		✓		✓	
Workforce Indicators		CB	✓		✓		✓		✓		✓		✓		✓	
Strategy & Engagement																
People Strategy	Report through EMB/ People Committee - review Sep 26	CB														
Operational Strategy	Report through EMB/ Performance Committee	NHuds														
Clinical Strategy	Report through EMB/QGC	CE/NHen														
Cardiac Arrest Strategy	Report through EMB/QGC	CE/NHen														
Quality Strategy	Report through EMB/QGC	CE/NHen														
Volunteer Strategy	Report through EMB/QGC	VK														
Stakeholder Engagement Strategy	Report through EMB/QGC	VK/MM														
Commissioning Strategy	Report through EMB/Performance Committee	KR														
Communications & Engagement Strategy	Report through EMB	VK									✓					
Commercial Services Stragegy	Report through EMB/Performance Committee	MB														
Operating Model	Report through EMB	NHuds									✓					
Estate Strategy	Report through EMB/Performance Committee	KR														
Risk Management Strategy	Report through EMB/QGC/PC	CE/MBr														
Fleet Strategy	Report through EMB/PC	KR														
Research Strategy	Report through EMB/QGC	NHen										✓				
Operating Plan (NHSI Submission)	Report through EMB	VK			✓										✓	
Finance Strategy	Reort through EMB/Perf Ctte	KR									✓					
IT Strategy	Report through EMB/Perf Ctte	KR														
Procurement Strategy	Report through EMB/Perf Ctte	KR														
Sustainability Strategy (ICB Green Plan)	Report through EMB/Perf Ctte	KR														
HWB Strategy	Report through EMB/ People Committee - review Apr 25	CB														
EDI Strategy	Report through EMB/ People Committee - review Jul 25	CB														
Security Management Strategy (Oct 2024)	Report through EMB	CK														
Strategic Plan	Report through EMB	VK						✓			✓					
Regulatory, Guidance or Contractural																
Annual Audit Letter ISA 260	Through Audit Committee	Auditors					✓									
Annual report and accounts	Through Audit Committee	KR					✓									
FTSU Strategy and Self-Assessment and Board Development Session		VK/PW									✓					
Quality Account Approval	Through QGC	PW/VK					✓									
Review of Register of Interests - Directors	Through Audit Committee	PH					✓				✓					
Data Security and Protection Toolkit (March - review, June - submission)		KR/CK			✓			✓							✓	
Patient Safety Incident Response Framework (PSIRF)		NHen														
GDPR/Data Protection Officer Report	Forms part of Trust Information Pack	KR/CK	✓		✓		✓				✓		✓		✓	
Learning From Deaths Report	Included in NHen/CE report	CE/NHen	✓		✓		✓		✓		✓		✓		✓	
Workforce Race Equality Standard data report for publishing	Report through PC	CB							✓							
Workforce Disability Equality Standard data report for publishing	Report through PC	CB							✓							
Gender Pay Gap data report for publishing	Report through PC	CB			✓										✓	
Trade Union Facility Time Regulations report for publishing	Report through PC	CB						✓								
Professional Registration and Medical Revalidation Assurance	Report through PC	CB					✓		✓							
Annual Meeting of Members - Agenda Approval		PH					✓									
Board Development																
Safeguarding and Prevent	Nhen	Chair						✓								
General Data Protection Regulation (GDPR)/Cyber Security	KR	Chair						✓								
Directors role in Inclusion and Diversity	CB	Chair														
WRES Updates and Training	CB	Chair						✓								
Patient Safety, Duty of Candour and Serious Incidents	NHen	Chair														
Research Development	NHen	Chair				✓		✓								✓
NHS Patient Safety Syllabus Training (level 1+ Online Training)	Carla Beechey	Chair														
Downside Scenerio Planning	Karen Rutter	Chair														
Miscellaneous Items																
Winter Plan	OMT/EMB/Board/CoG	JWms									✓					
Festive Plan	OMT/EMB/Board	JWms											✓			
Pandemic Plan		NHen	✓										✓			
Quality Improvement Update		Nhuds							✓							

Going Concern Review		KR			✓										✓	
Review of SFI's		KR							✓							
Refresh on SFI's delegations and investment decision making		KR														
Integrated Emergency & Urgent Care Director Annual Update to Board		JB					✓									
Non Emergency Operations Delvery Director Annual Update to Board		MB														
NARU Annual Update		KP							✓							
Key:	CEO - Chief Executive Officer															
	CB - Carla Beechey															

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 16a MONTH: JANUARY 2024 PAPER NUMBER: 27

Freedom To Speak Up Report and Action Plans	
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 associated documents that have been developed in response to the National Guardian's Office Speak Up Review of the Ambulance Sector and recent the joint review with NHS England.
Previously Considered by	The documents incorporate updates following those previously created in line with guidance from NHS England
Report Approved By	Strategy and Engagement Director

Executive Summary

The paper includes:

- Guardian Report covering the period April 2023 to December 2023
- Appendix 1 Action Plan produced in response to National Guardian's Office Speak Up Review of the Ambulance Sector
- Appendix 2 Action Plan produced in response to review and support from NHS England

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 comprise the Trust's response to the recommendations by the two national organisations, thereby reducing risk and building assurance that the service provided to staff is compliant with best practice and incorporates further development to continue to emulate best practice			
Legal implications/ regulatory requirements	The Trust's arrangements for Freedom To Speak Up forms 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	None included in this paper.			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 16a MONTH: JANUARY 2024 PAPER NUMBER: 27

Workforce & Training Implications	The FTSU arrangements are built upon the expanding network of Ambassadors, who require time for development sessions (half a day per 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 delivered.
Communications Issues	A communications plan is in place and is regularly updated.
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 - we regularly provide an update on the age, 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 Health and Wellbeing 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 consider the Guardian report and note the following updates:

- The recommendations of the National Guardian's Office and NHS England and the associated action plans, updated versions of which are included for information
- Confirmation that the Reflection and Planning Tool has been completed and approved by the Board of Directors, thus meeting nationally determined requirements, and that the agreed actions will form the basis of our FTSU Strategy during 2024/25
- Ongoing discussion and development of metrics to analyse in a more in-depth way, the cases that are reported through throughout the Trust
- Our continuing work to expand FTSU Ambassador representation and our plans to work more closely with other staff networks

Freedom To Speak Up Report to Board of Directors January 2024

Contents

Purpose of Report

This report provides assurance that policy, processes, activity and reporting are fit for purpose, regularly reviewed and that progress is being made according to national guidance.

Governance Arrangements

In accordance with guidance, WMAS has adopted the new national policy, and has also generated an Improvement Strategy and a separate Procedure, which are available on PolicyStat. Each of these documents will be regularly reviewed and refreshed as needed.

The case activity and promotional work within FTSU are captured within summary reports which are presented routinely to:

- Learning Review Group – this is where Heads of Service present activity reports in respect of incident reports, investigations, complaints and risks. This provides the ideal opportunity for triangulation where FTSU reporting correlates with other activity
- Quality Governance Committee – a sub-committee of the Board of Directors been presented and effectively scrutinised.
- People Committee - a sub-committee of the Board of Directors focussing on all matters relating to employment, which provides assurance to the Board that reports have been presented and effectively scrutinised.
- Executive Management Board – an overview of activity and discussions at assurance committees prior to reporting to Board of Directors
- Board of Directors – a high level overview of recent activity and planned work, following discussion at assurance committees
- Council of Governors

Each quarter, all cases are discussed (anonymously) with the Executive and Non-Executive Leads, to ensure a thorough understanding of all concerns and the response to each. A summary of cases is also discussed with the Chief Executive and Chairman each quarter to support accountability and a thorough understanding of trends and themes.

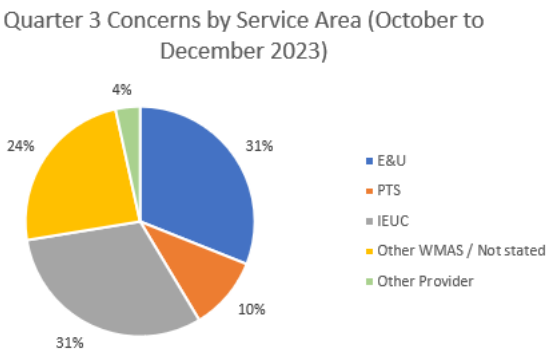
Assessment of Individual Cases April to December 2023

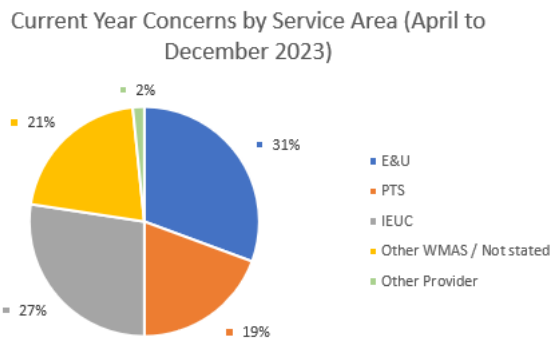
In total 62 concerns have been raised year to date, compared to 17 in the same period during the previous year. In Quarter 3 for 2023/24, 29 concerns were received, whereas 33 concerns were received for the previous 2 quarters of the current year. During Quarter 3 in the previous year, 8 concerns were raised. The increase in concerns raised can partly be attributed to Freedom to Speak Up Month in October, where considerable promotion of FTSU was done.

The concerns raised year to date are about the following service areas:

- Emergency and Urgent = **19 (30.6%)** of which Q1 = 3, Q2 = 7, Q3 = 9
- Patient Transport Services = **12 (19.4%)** of which Q1 = 4, Q2 = 5, Q3 = 3
- Integrated Emergency and Urgent Care = **17 (27.4%)** of which Q1 = 3, Q2 = 5, Q3 = 9
- Other / Not stated = **13 (21.0%)** of which Q1 = 4, Q2 = 2, Q3 = 7
- Other provider = **1 (1.6%)** which was reported in Q3

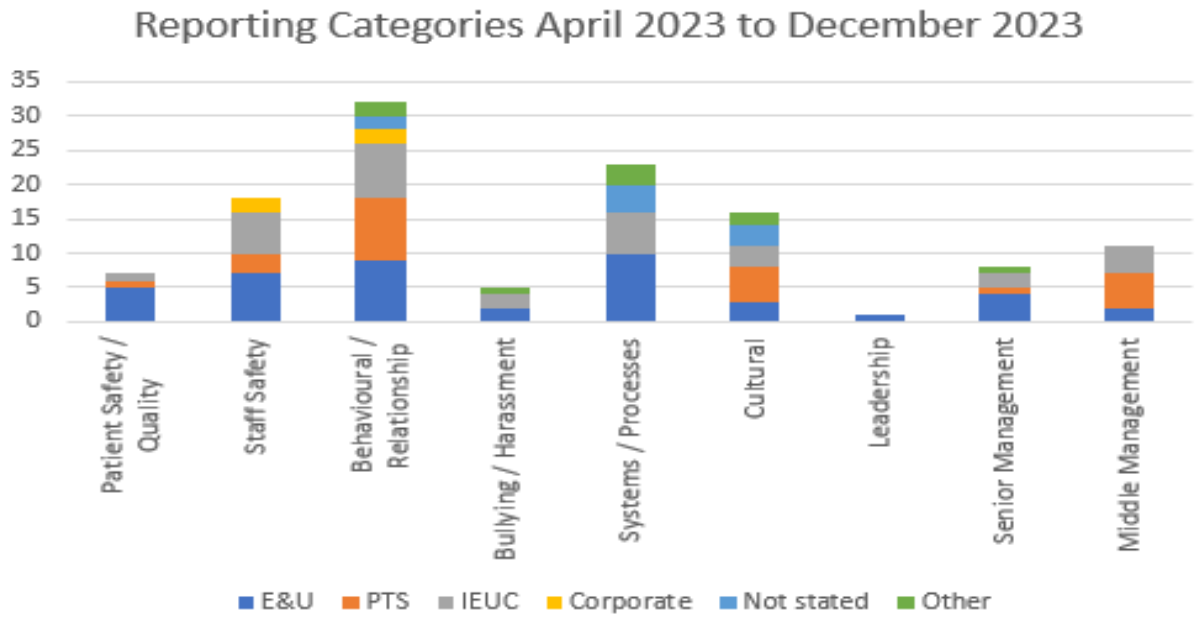
One of the cases was reported by someone external to the Trust, but relates to E&U and therefore has been included in the E&U numbers. Some concerns have been raised within the Trust about other areas, these are counted in the service areas to which they relate, regardless of who raised them.





Reporting categories of concerns raised 2023/24 by Service Area:

	E&U	PTS	IEUC	Corporate	Not stated	Other	Total YTD
Patient Safety / Quality	5	1	1	0	0	0	7
Staff Safety	7	3	6	2	0	0	18
Behavioural / Relationship	9	9	8	2	2	2	32
Bullying / Harassment	2	0	2	0	0	1	5
Systems / Processes	10	0	6	0	4	3	23
Cultural	3	5	3	0	3	2	16
Middle Management	2	5	4	0	0	0	11
Senior Management	4	1	2	0	0	1	8
Leadership	1	0	0	0	0	0	1



We have seen an increase in the number of Staff Safety concerns raised over the three quarters of this reporting year. Q1 saw 2 concerns, Q2 saw 6, rising to 10 concerns in Q3. This is a subjective reporting area and also takes into account the perception of the member of staff raising it. Three of the cases were also recorded under the categories of bullying/harassment and/or behavioural/relationships.

Analysis of Trends and Themes in Respect of Location from which the Issue was Raised

This is intended to identify the locations from where concerns were raised. This will not always balance with the figures reported above, which focus on the areas that the concerns were about.

Of the cases raised from within Emergency and Urgent Cases during the year:

- 5 were raised by staff at one hub. These were all unrelated issues, at least one of which related to Trust-wide processes rather than an issue experienced at the hub itself.
- One of the hubs had 4 concerns reported, two of which concerned other locations or services.
- In the last two financial years, there are only 4 hubs where no concerns have been raised at all. This suggests that we do not have any significant hot spots, nor do we have many clear quiet spots.

	E&U			
	Raised by Location			
	2020/21	2021/22	2022/23	2023/24
Hub 1	1	1	1	1
Hub 2			1	
Hub 3				
Hub 4			1	1
Hub 5				1
Hub 6		1	1	
Hub 7				3
Hub 8				
Hub 9			1	5
Hub 10				1
Hub 11			1	
Hub 12			3	1
Hub 13			1	3
Hub 14				4
Hub 15				
Not stated / Anon E&U		2	3	4

	PTS			
	2020/21	2021/22	2022/23	2023/24
Hub 1		1		
Hub 2				
Hub 3				
Hub 4				
Hub 5				
Hub 6				
Hub 7				
Hub 8			2	2
Hub 9			1	
Hub 10				4
Hub 11				1
Hub 12			1	
Hub 13			3	
Hub 14				
Hub 15			1	2
Hub 16	1			2
Anon PTS		1	1	1

Of the 12 Patient Transport Services cases during the year:

- 4 were related to one site, mostly relating to similar issues. This has been addressed by Senior Management.
- Three sites each had two concerns raised, generally about to unrelated matters.
- Several sites have not had any concerns raised at all during the last 18 months

9 concerns have been raised in the first three quarters of the reporting year relating to other departments, compared to three in the previous full financial year and four in the year before. This indicates that awareness and confidence in FTSU has grown through more regular promotional exercises.

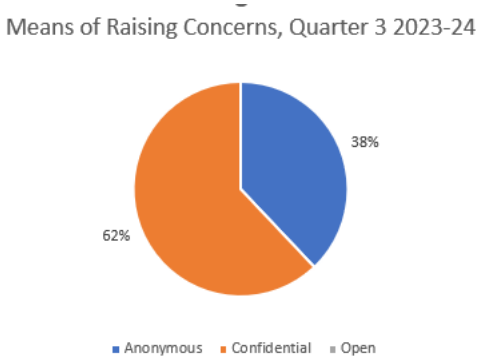
Other Departments				
	2020/21	2021/22	2022/23	2023/24
Tollgate / MP / NP IEUC				16
Other WMAS (including all corporate departments, Headquarters and support functions)		4	3	9
Other Provider		1	1	1
Anonymous site and service				4

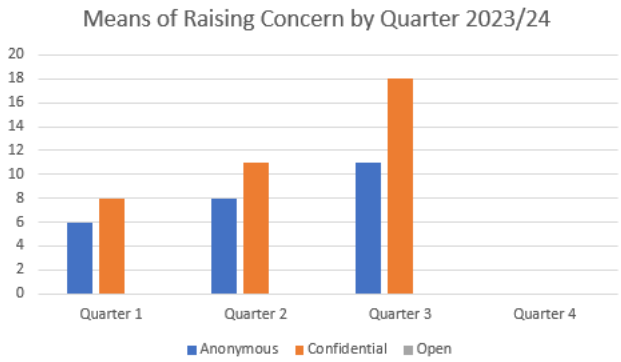
Anonymous Concerns

25 of the 62 concerns (38%) during the first 3 quarters were raised anonymously. During quarter 1, 6 anonymous concerns were received, following by 8 in quarter 2 and 11 in quarter 3. The percentage of anonymous concerns remained steady during the first 2 quarters at 43% and 42%, respectively and reduced to 38% for quarter 3. During quarter 3, 3 of the 11 anonymous concerns did not state which service area of the Trust they worked in.

In order that all at WMAS feel safe to speak up and have the opportunity to speak up anonymously, we have been working on improving access to the anonymous route.

It is important that we monitor the trends in anonymous concerns, including the type of concerns that are raised in this way, as this is a good measure of whether staff are using the best means of speaking out, or are fearful of being identified. Indications are that the use of the anonymous route at WMAS is slightly higher than elsewhere, though it is pleasing to note that in the last quarter, those reported confidentially have risen at a greater rate than those raised anonymously. We will continue our work to improve the culture throughout the organisation to provide assurance that concerns will be taken seriously and treated sensitively.





Year on Year Comparison

The volume of reported cases continues to increase each year, and since Q3 2022/23 it is increasing every quarter. In quarter 3 this year we saw a significant increase in the number of concerns raised. This was not altogether surprising as Freedom to Speak Up Month in October ran during this reporting period, and FTSU was heavily promoted across the Trust. The quarter saw the number of concerns rise from 19 in the previous quarter to 29. The same quarter for the previous year recorded 8 concerns. Whilst the volume of anonymous concerns has risen along with those raised confidentially, the proportion of anonymous compared to confidential has maintained a slight decrease through the three quarters of 2023/24 reducing from 43% in Quarter 1 to 38% in Quarter 3.

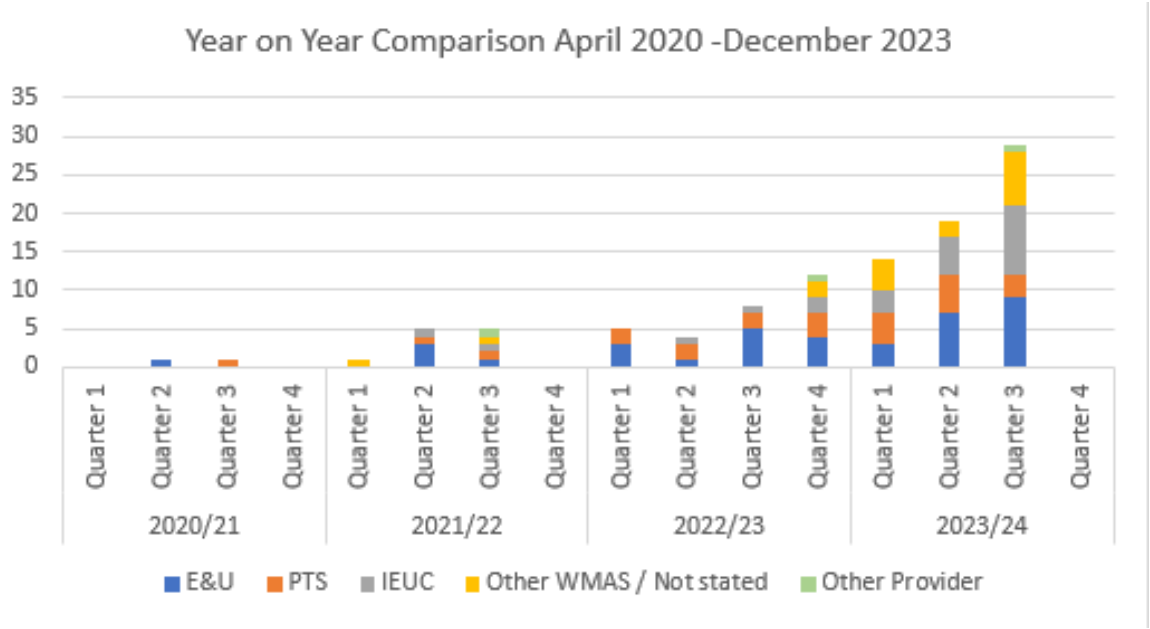
The continued input by the Trust to raise awareness of FTSU is likely to be an influencing factor in rising numbers of staff speaking up.

Staff are encouraged to speak to their line managers in the first instance, if appropriate, about any concerns, and the Trust also has many internal routes for staff to use to speak up.

We are currently reviewing routes for staff to report incidents and concerns and beginning to build criteria in relation to inclusion and exclusion of other metrics for correlation.

The input made by the Trust over this time to raise awareness of FTSU is likely to be encouraging staff to make contact, however, there are many other routes for staff to use if they feel they need to discuss matters of concern, these include:

- Line manager(s)
- Human Resources Team
- Union Representative
- Staff Advice and Liaison Advisor(s)
- Health and Wellbeing Champion(s)
- Staff Network(s)
- Direct contact with Executive or Non-Executive Directors



In order to effectively triangulate the information relating to reported cases, it is also important to understand the trends of other activity and performance metrics, including:

- Sickness absence
- Resolution Requests (Grievances)
- Attrition
- Complaints
- Compliments
- Incident Report Forms
- Leadership Development activity

Our Executive Scorecard compares our FTSU Concerns to some of these metrics. We also have an annual Staff Engagement report which incorporates FTSU in comparison with other methods of engaging with staff. We continue to further develop our reporting capabilities through discussion with other key departments, and we plan to continue to review the best method of comparison across all metrics for ongoing trend analysis to understand common themes at a greater depth. This will help us to fully understand matters that are being reported through FTSU and, importantly, those that are not. There will be a particular focus on cases relating to patient or staff safety, and correlation will be analysed across all metrics.

Detriment

During the first half of 2023-24, 2 concerns were identified with a form of detriment following raising concerns. These concerns were not raised through the FTSU route, however we feel it is important to identify such behaviour and support staff as much as possible regardless of their chosen route. Despite the rise in overall concerns, there were no reports of detriment during Quarter 3. We continue to provide assurance to people who step forward to raise a concern that their concern will be handled with sensitivity and will only be progressed with their agreement. Furthermore, we are promoting the work of the staff networks and demonstrating the need to approach difficult conversations in the right way, and to ensure respect and dignity at work for colleagues.

WMAS is keen to understand what further processes and levels of protection can be implemented to shield staff who raise concerns in the future. In addition to mandating the NGO FTSU training for all staff, these actions will include a review of material issued to staff in relation to civility, respect and dignity at work, and conversations with managers to ensure that they know what to look out for within their teams.

Promotion

Following a busy time promoting our service during Speak Up Month, we are following up on some of the work that arose during the month.

In December the Freedom to Speak Up Guardians were invited to participate in the induction of new student paramedics from Birmingham City University who will be undertaking their placements with the Trust. In January, we were included in the induction for student paramedics from Keele University. Further dates with the other universities are planned.

In July, we produced our first Newsletter “Your Voice Matters”. Our second publication was November 2023, which focussed on our Speak Up Month activities. Our third newsletter will be produced at the end of January 2024, which will highlight some of the key trends during the year, some success stories and begin to identify some of our planned events for 2024.

We will soon be planning a series of visits to our sites and joint work with other staff networks. The details of these will be included in future reports.

Ambassadors

We continue to attract ambassadors and during December we inducted 4 new Ambassadors to FTSU. They have all been asked to provide a photograph and a personal statement so that this can be uploaded as part of their electronic poster to be displayed on the site where they are based, along with the details of the corporate FTSU Team. A further 15 staff have expressed an interest in becoming Ambassadors and these applications will be progressed during January and February.

We are planning to hold service specific events to meet with the FTSU Ambassadors. A date has been set at the end of January to meet with the Ambassadors from within PTS to discuss local themes and trends, with further dates to be confirmed for both E&U and IEUC.

Finally, we are planning a joint staff network development day for Champions and Ambassadors of all networks. This is due to take place on National Staff Network Day, 8th May 2024.

Training

Having mandated the National Guardian's Office training packages and embedded the content within our Learning Portal, we have tracked completion by staff across the organisation according to the following requirements:

- All staff – required to complete "Speak Up" training as part of their Statutory and Mandatory Workbook
- Band 7 – 8B required to complete "Listen Up"
- Band 8C and above required to complete "Follow Up"

Completion of the Statutory and Mandatory workbook is completed by our Education and Training Team, the completion rate is reported through the People Directorate. The following represents the compliance rates of staff within Bands 7 and upwards completing FTUS modules:

	Band 7 – 8B	**Band 8C and Above**
Total Staff	493	45
Completed Speak Up In FTSU Module	424	27
Completed Speak Up in Workbook but not FTSU Module	57	18
% Speak Up Completion	97.6% of Total 100% excl maternity and LTS	100%
Completed Listen Up	481	45
% Listen Up Completion	97.6% of Total 100% excl maternity and LTS	100%
Completed Follow Up	39	45
% Follow Up Completion	Not required	100%

Please note that percentages are based upon workforce numbers in April 2023, so will have changed slightly. Some of those who have completed may not have been part of the workforce count in April.

National Guardians Office Review of the Ambulance Sector

We have an action plan in relation to the review which was published in February 2023 and again in October 2023. A copy of our action plan is attached at Appendix 1.

NHS England Guidance and Support

Further to some direct engagement with NHS England earlier in the year, the Trust has been working on an agreed action plan. This plan has been updated and is attached at Appendix 2. The actions will be fully delivered by March 2024.

Reflection and Planning Tool

Following publication of NHS England's Reflection and Planning Tool, the first version of this was published and presented to Board of Directors in March 2023. This was updated and presented to Board of Directors in October 2023, fully achieving the requirements set out by the National Guardian's Office. The actions identified will form part of the FTSU Strategy work plan during 2024/25 and will be reviewed on a quarterly basis along with our other enabling strategies.

NHS England review into the management of concerns by WMAS

Last year NHS England commissioned an independent review into our Trust based on some concerns that were expressed to them. It looked at how they were managed and our response to them; the review was not about patient care or patient safety; neither was it about 'Freedom To Speak Up' (FTSU) alone, but it was included as part of the process.

The review made a set of recommendations which was overseen by the Board of Directors, with support from NHS England and our host Integrated Care Board; the CQC were also sighted on this review, and the action plan has been fully signed off as complete.

Our Quality Account for 2023/24 will include an overview of this review in respect of FTSU.

Recommendations

The Board of Directors is requested to note the contents of this report, ask questions and note the actions that are in development, particularly in relation to:

- The recommendations of the National Guardian's Office and NHS England and the associated action plans, updated versions of which are included for information
- Confirmation that the Reflection and Planning Tool has been completed and approved by the Board of Directors, thus meeting nationally determined requirements, and that the agreed actions will form the basis of our FTSU Strategy during 2024/25
- Ongoing discussion and development of metrics to analyse in a more in-depth way, the cases that are reported through throughout the Trust
- Our continuing work to expand FTSU Ambassador representation and our plans to work more closely with other staff networks

Rec No.	Recommendation	Lead	Action	Update	By Date	RAG
1	**Recommendation 1: Review broader cultural matters in ambulance trusts** **This recommendation calls for an independent cultural review, bringing together the work of NHS England, the Association of Ambulance Chief Executives (AACE), the Care Quality Commission and partner organisations with Ministerial oversight.**					
1.1	The cultural review should consider management and leadership behaviours and focus on worker wellbeing, as well as: • The effectiveness of governance/leadership structures, particularly considering the complex geographical footprint of ambulance trusts. • Models/expressions of leadership, including 'command and control'. • Defensiveness and 'just' culture. • Arrangements for appointments, including fair and open recruitment and values-based recruitment. • Operational and workforce pressures. • Bullying and harassment including sexual harassment. • Discrimination, particularly on the grounds of ethnicity, gender and gender identity, sexual orientation and disability. • Bringing together other blue light services and the military to share learning and good practice to facilitate effective speaking up cultures in similar operating environments. An action plan to be agreed following the cultural review, with specific actions for delivery and organisations assigned to make improvements.	Department of Health and Social Care and NHS England to carry out a review. WMAS to provide assurance	•			
2	**Recommendation 2: Make speaking up in ambulance trusts business as usual**					
2.1	Mandate training on speaking up - in line with guidance from the National Guardian's Office - for all their workers, including volunteers, bank and agency staff, as well as senior leaders and board members.	PW	Publish training plan: • Discuss at SMTs • Send to Board members • Send to all Managers Band 7 and above • Send to Governors • Confirm requirements with Staffside • Send to CFR groups	E&U 28/3/23; PTS 20/4/23; EOC 1/6/2023 Discussed at Board Develoment Session February 2023 All required to complete by end of April. Compliance report circulated to key Directors. Discussed at Council of Governors and training requirements circulated Requirements confirmed through EMB and Board meetings Attended Regional CFR Forum 6/3/23. Training requirements issued	Table 2 for completion by 30/4/2023 Table 1 for completion by 31/3/2024	

2.2	Ambulance trust leadership (including managers, senior leaders and board members) to fully engage with Freedom to Speak Up, evidenced by board members undertaking development sessions, delivered by the National Guardian's Office, with a view to role model effective speaking up, including purposefully providing and seeking feedback in the carrying out of their leadership roles.	Board PW / VK	Development session with NGO and NHSE to be planned Actions and outcomes from development session to be captured for further development sessions with managers	Completed 10/5/2023. Follow up meeting to be planned May 2024 Initial meeting on 9th June with VK, PW and AB. Action plans updated. Various meetings attended including SMTs, LPFs, DISAG and other team meetings.	 ~~01/06/2023~~ 31/10/2023	
		PW PW / LJ PW / CB / Chairs	Develop a quarterly newsletter to be published in the Weekly Briefing to promote work within the Trust to improve FTSU, confidentially highlight success stories and to highlight trends and updates from the NGO Continue to include FTSU in onboarding, mandatory training, Engaging Managers and Engaging Leaders Regularly meet with network chairs, SMTs and staffside reps to consider how we can further remove barriers and proactively offer support to all staff	First publication of Your Voice Matters circulated in Weekly Briefing 27/07/2023. Issue 2 published November 2023. Issue 3 January / February 2024 Onboarding Complete. EM and EL to be updated as further content becomes available DISAG Attended October 2023 Collaborative staff conversation hosted by network chairs took place as part of Speak Up Month Joint development day to be held early 2024 with all Ambassador and Champion networks	~~01/06/2023~~ 31/07/2023 Jun-23	

2.3	Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and Freedom to Speak Up guardians across ambulance trusts through regular communications. Trust leadership teams should identify the professional groups/areas within the trust that need support in implementing Freedom to Speak up by diagnosing root causes and putting in place a support mechanisms for managers and workers to feel psychologically safe when speaking up and reduce detriment	PW / BK	Further triangulation of information from around the Trust to identify trends	Initial triangulation included in Quarter 4 report. This report will be updated by OD Team annually. Work to be carried out BI Team. This will evolve as the year progresses. Brief update included in Quarter 1 report, completion date changed to March to allow for full development of reporting. Currently reviewing routes for staff to report incidents and beginning to build criteria in relation to inclusion and exclusion of other metrics for correlation. Draft report will be ready by the end of January with a plan to build into ORBIT for April 2024	~~01/07/2023~~ 31/03/2024	
		PW / BK/ CB	Consider further requirements for support from OD Team and Mental Health Practitioners	OD Team to support development needs of Ambassadors. To be planned throughout the remainder of 2023/24 Mental Health Practitioners supported Ambassadors at September meeting to support the "Removing Barriers" theme for Speak Up Month	31/03/24 15/09/23	
2.4	Ambulance Trust Boards to annually evaluate the effectiveness of speaking up arrangements; including effectiveness of facilitating all workers, including those from groups facing barriers to speaking up, being able to speak up about all types of issues and action being taken in response to speaking up. Trust boards will report on this evaluation publicly in their annual reports.	PW / VK	Update Schedule of Business for Board and EMB	Schedule of business updated for all committees	31/12/2023	
		PW	Update annual FTSU report	Initial update made in Quarter 4 report and Annual Report. Further updates developed throughout 2023/24 to be incorporated into Annual Report March 2024. The only ongoing piece of work relates to triangulation of data.	31/03/2024	
			Working with NHS England on the development of board development sessions.			

2.5	The National Guardian's Office commits to the following:	NGO	Working with partners including NHS England and the Care Quality Commission, to publicise a how-to-guide on effective metrics to evaluate speaking up culture and arrangements Working with the Care Quality Commission, NHS England and others to promote the impact of effective speaking up culture and arrangements Working with partners, including NHS England, NHS Providers, NHS Employers, and the Association of Ambulance Chief Executives, to facilitate networking and the sharing of good practice, innovation, policy and research in the field of speaking up among non-executive directors, including those on the boards of ambulance trusts.			
3	**Recommendation 3: Effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts**					
3.1	Ensure workers' voices are effectively captured and reflected in regulators' decisions when reviewing their frameworks and treated with parity to those of patients' voice.	CQC and NHSE				
3.2	Implement mandatory and regular training on speaking up - in line with guidance from the National Guardian's Office - for all workers (including senior leaders) involved in the regulation, inspection, and improvement support of ambulance trusts.	CQC and NHSE				
3.3	Make assessment of the speaking up culture and arrangements a cornerstone of their regulatory and oversight frameworks, recognising that the safety of patients and the public - as well as the sustainability of the health service - depends on workers' ability to speak up and for regulators to listen and follow up when they do.	CQC and NHSE				
3.4	The Care Quality Commission to continue to improve their inspection methodology around the rigorous assessment of speak up culture and psychological safety.	CQC and NHSE				
3.5	Communication and partnership working among national bodies to share information about speaking up culture and arrangements.	CQC and NHSE				
3.6	Support training for NHS England and the Care Quality Commission workers on speaking up.	NGO				
3.7	Leading the collaboration with partners including the Department of Health and Social Care, the Care Quality Commission and NHS England.	NGO				

3.8	Working with NHS England and the Care Quality Commission to strengthen their approach to addressing detriment.	NGO				

4	**Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers**					
4.1	Meaningfully invest in the Freedom to Speak Up Guardian role. In discussion with their Freedom to Speak Up Guardian(s), leaders should identify the time and resources needed to meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions and board plans for implementing Freedom to Speak Up roles should be clear on resource implications and set realistic timescales.	ACM / VK / PW	Options paper for increasing resources to be reviewed by EMB and Board of Directors	Business Case to be reviewed at EMB on 30/5/2023 Business Case approved, Post appointed to. New Guardian in post from 18/9/023	21/03/2023 29/03/23 30/05/23	
4.2	The National Guardian's Office suggests that as a minimum, the equivalent to three full-time workers is needed to carry out the reactive and proactive parts of the Freedom to Speak Up Guardian role in ambulance trusts. This is because of the characteristics of ambulance trusts, including their complex geographical footprint, and broader cultural and operational issues. The National Guardian's Office and NHS England will support, review and challenge the rationale arrived at by ambulance trusts about how much time is allocated to the role.	ACM / VK / PW		As 4.1	21/03/2023 29/03/23 30/05/23	
4.3	The recruitment process used for the appointment of Freedom to Speak Up guardians must be fair, open and transparent and comply with current good practice in recruitment and equality, diversity, inclusion and belonging principles. This will help ensure that people appointed have the confidence of, and are representative of, the workers they support.	VK / CB		Process is in place and will be utilised for any future recruitment	Ongoing	
4.4	Create (if not already in place), maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up. Consideration to the organisation's size, geographical footprint and the nature of their work should be given to ensure support for workers, especially those facing barriers to speaking up.	PW	Network in place, with some new applicants to be processed through the induction phase. Consideration being given to updating application paperwork to match that used by other networks.	Additional expressions of interest received. Inductions planned for the summer were completed, and a further group of new Ambassadros will be receive inductions in December and January. Applicants will be asked to complete form used for other Champion networks. Annual Declaration form has been updated to improve governance arrangements	30/06/2023	

4.5	Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s). This support should reflect the challenges of the role and ensure the need for confidentiality. There should also be periodic check-ins with Freedom to Speak Up Guardian(s) about the effectiveness of this support.	All ambulance Trusts	This is ongoing through regular dialogue with both Exec and Non Exec leads, along with the Chairman and CEO		Ongoing	
4.6	Support ambulance trusts and NHS England in determining the amount of time and resources needed	NGO				
4.7	Review the feedback we received about the support the National Guardian's Office provides Freedom to Speak Up guardians, including review of the universal job description for Freedom to Speak Up guardians.	NGO				
4.8	Publicising guidance to assist in the calculation time and resources needed to carry out the role.	NGO				

Lead

Initial	**Name**	**Position**
VK	Vivek Khashu	Strategy and Engagement Director
PW	Pippa Wall	Head of Strategic Planning / Freedom To Speak Up Guardian
ACM	Anthony Marsh	Chief Executive Officer
CB	Carla Beechey	People Director
BK	Barbara Kozlowska	Head of Organisational Development
LJ	Louise Jones	Recruitment Manager

Committee / Group

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

Rec No.	Recommendation	Lead	Action	Update	By Date	RAG
1	**Help managers understand their roles, responsibilities and accountability for FTSU**					
1.1	A starting point will be to mandate that all managers watch all training modules created by the NGO.	PW	Issue requirement to all Managers, attend SMTs and publish in Weekly Briefing	Instructions issued to all groups of managers and staff. Compliance report to be circulated	17/03/2023	
1.2	To really embed the changes the trust should consider developing wrap around resources to support managers to respond well to speaking up. The Trust should ensure that these resources include guidance on how to look into and resolve issues locally.	ACM / PW / VK	Options for increased resource compiled and scheduled for Exec Management Board review	Vacancy for Guardian approved and advertised. Post appointed to and new Guardian in post from 18/9/2023	30/09/2023	
2	**Advice: Expand the resource dedicated to FTSU**					
2.1	We would recommend the Trust consider increasing their resource with at least one standalone FTSU Guardian with ringfenced hours	PW / VK	Options for increased resource compiled and scheduled for Exec Management Board review	NGO Action plan 4.1 and 4.2 - expectation of 3 FTE Business Case to be reviewed at EMB on 30/5/2023 Vacancy for Guardian approved and advertised. Interviews to be held w/c 31/7/2023	28/02/2023 30/05/2023 19/07/2023	
2.2	Any Guardian should be recruited via an external and open recruitment process as this helps to instil trust in the role	LJ	Continue to utilise Trust's recruitment process for any positions that need to be fulled	NGO Action plan 4.3 Vacancy advertised internally in first instance to utilise expertise within the Trust and to allow for progression	19/07/2023	
2.3	The Trust could consider a model with the current Guardian taking on a leadership role with FTSU and a dedicated Guardian working operationally	PW / VK	Options as per 2.1	NGO Action plan 4.1 and 4.2 - expectation of 3 FTE Business Case to be reviewed at EMB on 30/5/2023 Vacancy for Guardian approved and advertised. Interviews to be held w/c 31/7/2023 New Guardian appointed following interview 3/8/23	28/02/2023 30/05/2023 19/07/2023 03/8/23	

2.4	Consider allocating greater ringfenced time for Champions which offers greater support to the Guardian (other trusts have offered up to a day per month)	ACM	Options as per 2.1 To be reviewed and discussed with Ambassadors on 22/3/2023	NGO Action plan 4.1 and 4.2 - expectation of 3 FTE Business Case reviewed at EMB on 30/5/2023 Business Case Agreed and post appointed to New Guardian Commenced 18/9/2023 Item discussed at EMB to confirm requirement for Ambassadors to be released from duty to attend meetings	28/02/2023 30/05/2023 31/07/23 3/10/2023	
		PW		Further recruitment of Ambassadors to continue through August and September	30/09/2023	
2.5	Champions can then support with comms and engagement action plan	PW / Ambassadors	Lucy Butler appointed as Guardian. Additional resource will be available to support recruitment and development of Ambassadors and ongoing communication	New Guardian appointed Increased communication and involvement of Ambassadors in all communications. Meeting to be planned Speptember and Speak Up month activities to be planned for October	31/03/2024	
3	**Advice: Develop triangulation and use this to inform planning, actions and strategy (NHSE to support)**					
3.1	Consider what your triangulated data may be telling you (see p18/19 of guide for suggestions of what data to include and for qu estions to consider)	PW	Use WinningTemp report and staff engagement report presented to People Committee to develop triangulation	First version of Board Report to be based upon these reports for the current financial year. Pulse surveys in WinningTemp to be made available from September 2023	31/03/2023 31/12/2023	
				Initial triangulation completed based upon historical data trends in the Staff Engagement Report. This will be refreshed annually. More regular triangulation is presented to each Board meeting through the Executive Scorecard.	30/06/2023	
			Triangulation findings to be refreshed, expanded and regularly incorporated in to FTSU Reports	Discussions continue with regard to the best approach to further develop triangulation reports to incorporate other data metrics. To allow this work to be fully achieved, the target date has been extended as this work will form part of our work plan into 2024/25.	30/09/2024	

3.2	Where hotspots (or quiet spots) emerge, how will you plan to capture views in those areas? (Guardian listening events/surveys/ Exec or non exec visits/targeted/ comms/cultural reviews)	PW / VK	Consider how best to engage with staff in both hot and quiet spots. Communication Plan to be updated accordingly The Hub Buddy arrangements for execs and non execs contributes to this area to	Concerns by hub now being reported to assist with identification of hot / quiet spots. Following trends in concerns, some targeted work has been carried out at identified locations. This approach will continue as necessary. Whilst this action had initially been extended to account for planned work with the BI Team to develop enhanced triangulation of data to inform future targeted improvement plans, our regular discussion with the leads of key hot / quiet spots does not depend upon this analytical work, and is therefore marked as complete. Our approach to meeting with Ambassadors and Service Leads in January 2024 reflects our approach to discuss hot and quiet spots in greater depth.	31/03/2023 ~~30/09/23~~ 31/03/24	
3.3	Does your Guardian need specialist analyst support to interpret data (some organisations have dedicated analyst/BI support to aid with this)	PW / BK / TRB	Review report as per 3.1 and consider what support BIU could provide	Plan developed in collaboaration with Head of BI Team. Initial report to be manually drafted with data sources identified prior to development of routine report in ORBIT. This work will continue as part of our work plan in 2024/25	~~30/06/2023~~ ~~30/09/23~~ ~~31/03/24~~ 30/09/2024	
3.4	Consider a dedicated FTSU steering group (national team can offer ToR) to drive the triangulation and resulting action plans		Appropriateness of such a group to be discussed. The current arrangments for reporting at Learning Review Group, People Committee and Quality Governance Committee provides the basis for wide engagement and triangulation with other factors and action plans.	No current plans to develop thnis committee		
3.5	Some Trusts have developed a dashboard which has all the worker and safety metrics included. This gives an 'at a glance' over view of where hotspots and themes may be occurring. This is usually shared at People committees and discussed in detail there.	PW / BK / TRB	Review report as per 3.1 and consider what support BIU could provide	Plan developed in collaboaration with Head of BI Team. Initial report to be manually drafted with data sources identified prior to development of routine report in ORBIT	~~30/06/2023~~ ~~30/09/23~~ ~~31/03/24~~ 30/09/2024	
4	**Advice: Develop the FTSU Guardian report to board and provide Board with some training on how to spot the 'red flags'**					

4.1	NHSE have a template which can be used to develop the reports NHSE/NGO guidance gives outline of what to include	PW	Develop Guardian Report based upon template provided by NHSE and utilising triangulation data in 3.1	This will be a develomental milestone, with initial triangulation based upon Staff Engagement Report and Winningtemp report (completed by planned timescale of 31/03/2023). Further triangulation to be developed throughout 2024/25	~~31/03/2023~~ ~~31/03/2024~~ 30/09/2024	
4.2	Use the report to analyse the data over time, is action leading to improvement using success measures?	PW	Include some historic data in the Annual Report for 2023. Other time-series based sussess measures will develop over time	Reports through 2023/24 to build on 2022/23	31/03/2023 and ongoing	
4.3	Add soft intelligence to the report, does this fill in any gaps or create a wider picture?	PW / VK	Consider what soft intelligence could be included in the Annual Report and develop on an ongoing basis	Feedback now being included in report. Other soft intelligence will be included as available, e.g. feedback from SMTs, Health and Wellbeing Roadshows, patient safety, patient experience, staff surveys, HR processes	~~31/03/2023~~ 31/03/2024 and ongoing	
4.4	Are there repeated issues being raised with no improvement? Or are there areas where very few people speak up about known trust wide issues or the numbers speaking up are high?	PW		This needs to be a longer term action, to be reviewed once triangulation trends emerge	31/03/2024	
4.5	Outline the current barriers. What is being done to break these down?	PW	Meet with chairs of all staff networks and D&I Lead to identify known barriers; and consider how to identify unknown barriers	Information regarding Barriers received from NHSE. This will be reviewed and discussed when meeting with network leads Targeted events taking place through October 2023 to support Speak Up Month. This includes Staff Conversation hosted by Staff Network Chairs	~~31/05/2023~~ 31/10/2023	
4.6	What lessons have been learned from FTSU issues?	PW	To be identified in Annual FTSU Report	This was not included in the Annual Report, but will be developed as part of Quarterly Updates from June 2023. First Quarterly Newsletter published July 2023. Second edition October 2023 will incorporate lessons identified to date	~~31/03/2023~~ 30/09/2023	
4.7	Can the information be drilled down further to departments? This would give a greater overall picture of themes within areas as these are often different within the same organisation (microcultures)	TBC	TBC	Only relevant if triangulation highlights more complex picture. The current FTSU numbers do not allow such drill downs	TBC	

4.8	NEDs may need support on what to look for and challenge	JCC / AB / VK / PW / AH	To be discussed during NHSE and NGO Session with Board	Planned NGO / NHSE training session of the board stood down by the NGO with a days notice - to be re planned during discussion 17/3/23 (changed to 10/05/2023) (Link to NGO Action Plan 2.2) A good discussion was held during Board session and good engagement from NEDs. Further development to be discussed with AH and IC	10/05/2023	
5	**Advice: Develop a communications plan which shares positive outcomes from speaking up**					
5.1	It is important that senior leaders are aware that there is often a difference between their vision of the culture and what is happening on the ground. To begin to change the internal narrative around speaking up, you need to not only share messages about the importance of speaking up, how to speak up and assurances it is safe to do so. You also need to show that this is the case by using positive outcomes.	PW / VK	Develop quarterly FTSU Newsletter. Consider how to utilise input from both senior leaders and staff	NGO Action Plan 2.3 First newsletter published 27/07/23	~~30/06/2023~~ 31/10/2023	
5.2	Sometimes Trusts worry unnecessarily about breaking confidentiality when doing this but this should not be a barrier. Cases and issues can easily be anonymised, or you can use amalgamated details of a few cases, which illustrate how issues have been resolved. We have seen this done in alternative ways at one trust an animation was created which was shared on the intranet as well as on social media. It told the anonymised story of a worker who had spoken up from the start to the outcome. The animation had high numbers of views and the Guardian found increased people speaking up after viewing. They referenced the animation on contact with the Guardian as giving them the courage to speak up.	PW	Incorporate into Annual FTSU Report and quarterly newsletter	NGO Action Plan 2.3 This did not form part of the Annual Report but will be commenced from the first Quarterly newsletter at the beginning of July 2023 The first newsletter was an introduction to FTSU and incorporated some high level features. This included an overview of key themes and subject areas, but did not on this occasion include any specific anonymised cases. Further consideration will be given to this for future articles.	~~31/03/2023~~ 31/07/2023	
5.3	The Guardian should also consider visiting a number of different sites on a rolling programme, particularly focusing on areas highlighted from an assessment of barriers or via triangulation or hotspot data, to raise awareness of their role and discuss in person some of the positive outcomes from speaking up (this wou ld likely need additional Guardian resource).	PW / VK	This was planned as a joint initiative with Head of D&I. However, it needs to be co-ordinated with SOM / OMs and Ambassadors at each site to be worthwhile. To be included in Communications Plan Plans to include FTSU in wellbeing roadshows throughout the summer. Visited Tollgate on 16/1/23 Wellbeing day at Hereford 8/3/23	NGO Action Plan 4.2 Ambassadors are attending Health and Wellbeing Roadshows as they are avaialble	Ongoing	
6	**Advice: Analyse and understand the barriers people encounter to speaking up**					

6.1	The Trust could use current survey data or undertake a survey to understand barriers fully. NHSE undertook a similar exercise which we can share which included focussed interviews with volunteers, focus groups and social media conversations.	PW	NHSE to share survey report to use as a baseline		03/03/2023	
		PW	Plan WMAS Survey witih BK and RM, to build on triangulation report and develop joint plan to understand barriers	WinningTemp Pulse Surveys can't be started until September 2023, therefore this work will be planned for September / October. Meeting with BK scheduled for 31/8/23	~~31/03/2023~~ 31/10/2023	
6.2	The Guardian should at the very least be linking in with staff networks and analysing the trust speaking up data to look for hot spots where staff either don't report at all or they report in higher numbers, as this may indicate some barriers in their areas . This linking in should start to highlight what the specific barriers may be in those areas, so the organisation can then take appropriate steps to address them.	PW	Presented to chairs of staff networks previously. Now need to set up quarterly meetings with chair of each network	Scheduled to attend DISAG Meeting 04/10/23 Collaboarative approach including joint staff network conversation to which all staff were invited. Following this, an invitation for staff to request a confidential discussion with network chairs, or FTSU Guardians Joint champion development day planned for early 2024	31/03/2023	
7	**Advice: Revisit the national guidance around FTSU**					
7.1	The most recent policy makes it clear that most speaking up happens within regular conversations with line managers. However, there may be occasions where this is not the preferred option and it is important that the policy makes other options clear, ensures workers knows they are available and acceptable.	PW	Regular communications via Weekly Briefing, Ambassadors and other channels to remind staff of options available to them	Policy updated according to new national policy	31/03/2023	
7.2	In order to change the narrative around speaking up, it is important that the Trust is seen as welcoming speaking up, however that happens, that managers welcome it and overcome any internal defence mechanisms they may face where workers bypass them and that it becomes something that happens as business as us ual (NB: it may be worth managers undertaking some self reflection when this occurs to understand why workers felt unable to approach them).	BK / PW / CB	Opportunities for further staff development to be explored and implemented	Discussed at SMTs and will continue to be discussed To be discussed with BK (scheduled for 31/08/23) to establish if any further support can be provided via Engaging Leaders / Engaging Managers Continuing work in respect of vital conversations and coaching sessions to be continued There is evidence that Managers throughout the Trust are taking FTSU seriously and are responding promptly and appropriately when concerns are raised.	31/03/2024	
	Within the Board reports there seems to be some delineation between	PW	Speak to AB to see what further improvements can be made to avoid delineation	All matters raised with the Guardian are documented within the FTSU reports.	17/03/2023	

7.3	Within the Board reports there seems to be some delineation between what is or isn't a FTSU matter, this was also mentioned in the review. Some issues are recorded as conversations. However the National Guardian's Office is clear that ' Speaking up is about anything that gets in the way of doing a great job ' and so everything brought to the Guardian should be recorded and reported. This can help show themes in areas over time. For example, if you see a number of reports over a 12 month period from one area, where workers are having to speak to the Guardian about either a minor or major issue, this should cause reflection and further question . It may show a poor speaking up culture in that department, or an ongoing safety issue which isn't being addressed. Not recording and reporting on these issues means the Trust may be missing vital intelligence about themes which can build a picture over time.	PW and Ambassadors	A form has been developed for Ambassadors to record their ad hoc conversations as they happen, and will aid gathering of information, and support us to build a picture of the level of interest in FTSU, along with those considering speaking up compared to those that actually do. This form should be tested before implementation	To be tested with a few Ambassadors and discussed at meeting on 22/3/2023 before launch in April Form has been tested but not fully implemented. It will be further tested towards the end of Quarter 1 and used fully form Quarter 2 Form has not yet been implemented for Ambassador use. This is expected to be implemented from Quarter 4.	~~31/03/2023~~ ~~30/06/2023~~ ~~30/09/2023~~ ~~31/12/2023~~ 30/03/2024	

Lead

Initial	Name	Position
VK	Vivek Khashu	Strategy and Engagement Director
PW	Pippa Wall	Head of Strategic Planning / Freedom To Speak Up Guardian
LJ	Louise Jones	Head of Recruitment
BK	Barbarak Kozlowska	Head of OD
RM	Ramzan Mohammed	Head of Diversity and Inclusion
AH	Alex Hopkins	Non Executive Director
LB	Lucy Butler	Freedom To Speak Up Guardian

Committee / Group

RAG Rating legend	
Green	Action complete
Amber	Action commenced, but not complete (Ongoing)
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	Action not due to have commenced