West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Meeting of the Board of Directors

Wednesday 26 October 2022 at 10.30 hours
Millennium Point or through Microsoft Teams software.

Membership

Prof. I Cumming*	Chair	Non Executive Director (Chairman)
Prof. A C Marsh*	CEO	Chief Executive Officer
Ms W Farrington Chadd*	WFC	Non Executive Director (Deputy Chair)
Prof. L Bayliss-Pratt*	LBP	Non Executive Director
Ms C Beechey	CB	People Director
Ms M Brotherton	MB	Non-Emergency Services Operations Delivery & Improvement Director
Mr J Brown	JB	Integrated Emergency & Urgent Care & Performance Director
Mr M Docherty*	MD	Director of Nursing and Clinical Commissioning
Mr M Fessal*	MF	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
Mr P Jarvis*	PJ	Interim Director of Finance
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	DS	Organisational Assurance Director
Ms K Freeman	KF	Private Secretary – Office of the Chief Executive
Mrs R Godfrey	RG	Chair Womens Network
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms R Farrington	RF	Staff Side Representative

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

Item No	Description		Lead	Paper No/ Comments
01	**Welcome, apologies and Chairman's matters**		Chairman	Verbal
02	**Women's Network Board Update**			
	To receive a report from the Chair of the Network, Ms Rebecca Godfrey, Chair of the Women's Network.		Rebecca Godfrey	Verbal
03	**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
04	**Any Questions from the Public relating to matters to be discussed at this Board of Directors meeting.**		Chair	Verbal
05	**Board Minutes**			
05A	To agree the Minutes of the meetings of the Board of Directors held on the following dates: a) 27 July 2022 b) Extraordinary meeting on 28 September 2022		Chair	Paper 01a Paper 01b
05B	Board Log and any matters arising from both sets of Minutes not on the Agenda		Organisational Assurance Director	Paper 02
06	**Chief Executive Officers Update Reports**			
06a	To receive the report of the Chief Executive Officer.		CEO	Paper 03a
	Action	a) To receive and note the contents of the paper seeking clarification where necessary. b) To confirm the action taken in relation to the NHSE Core Standards.		
06b	Executive Scorecard relating to Trust performance for the month of September 2022		Strategy & Engagement Director	Paper 03b
	Action	To receive the Executive Scorecard		
06c	Scorecard on Trust performance at an ICS level		Strategy & Engagement Director	Paper 03c
	Action	To receive and comment on this new scorecard		
06d	Covid Update		Strategy & Engagement Director	Paper 03d
	Action	To receive the Covid update report for June 2022 and the Covid monthly trend for the period March 2020 to September 2022.		
06d	EPRR Update		CEO/James Williams	Paper 03e
	Action	The Board are requested to note all the attached papers in relation to EPRR update		

Item No	Description		Lead	Paper No/ Comments
		for the organisation, fully complaint status for annual core standards and deep dive submission relating to 'Evacuation & Shelter'		
06e	Commonwealth Games – Feedback.		CEO/James Williams	Paper 03f
	Action	To receive feedback on the work of staff at the Commonwealth Games. The Board are asked to note the report, evidencing a hugely successful deployment for WMAS in supporting the games. The report provides an oversight of the key actions taken, resourcing and response statistics along with feedback following completion.		
07	**Report of the Director of Finance**			
07a	A financial update from the Interim Director of Finance		Interim Director of Finance	Paper 04a
	Action	To receive the Month 6 Financial Update		
07b	IFRS 16 – Accounting for Leases		Interim Director of Finance	Paper 04b
	Action	To receive a presentation on the impact of IFRS 16. The Board are requested to review and comment on further actions if required.		
07c	Financial Strategy		Interim Director of Finance	Paper 04c
	Action	To receive for comment on the draft Financial Strategy		
08	**Quality Reports**			
08a	Executive Medical Director & Executive Nurse Director Quality Summary Report		Director of Nursing and Clinical Commissioning & The Medical Director.	Paper 05a
	Action	1. Note the integrated quality report to the Board. 2. Receive the report. 3. Gain assurance on the quality agenda and the robustness of our quality governance processes. 4. Note the significant harm being caused as the result of long patient handover delays and resultant actions. 5. To receive Stanley's Story		
08b	Board Assurance Framework & Significant Risks		Director of Nursing and Clinical Commissioning	Paper 05b
	Action	To receive and review the Board Assurance Framework & Significant Risks.		

Item No	Description		Lead	Paper No/ Comments
09	**Operations Update**			
09a	a) Non-Emergency Services Operations Delivery & Improvement Director Update b) Cohorting - Ambulance Decision Area		Non-Emergency Services Operations Delivery & Improvement Director	Paper 06a Paper 06b
	Action	a) To receive and note Non-Emergency Services Operations Delivery & Improvement Director Update b) To receive and note Cohorting - Ambulance Decision Area the update		
09b	Integrated Emergency & Urgent Care & Performance Director Update		Integrated Emergency & Urgent Care Performance Director	Paper 06c
	Action	To receive and note the update		
09c	Emergency Services Operations Delivery Director Update		Emergency Services Operations Delivery Director	Paper 06d
	Action	To receive and note the update		
10	**Report of the Strategy & Engagement Director**			
10a	Corporate Strategy Review		Strategy & Engagement Director	Paper 07a
	To receive a report from the Strategy & Engagement Director. The Board are requested to provide feedback in advance of November strategy day session			
10b	Freedom to Speak Up Bi-annual Report		Strategy & Engagement Director	Paper 07b
	Action	To receive the Bi Annual Report		
10c	ICS and WMAS Hub Engagement		Strategy & Engagement Director	Paper 07c
	Action	To receive and approve the internal Board/ Hub link and ICB link.		
11	**Governance**			
	a. To confirm and approve the Committee structure and Board Committee Terms of Reference b. To receive a report setting out the contents of the draft NHSE published Code of Governance which aims to update the current Code of Governance to reflect the following changes that will affect the Trust, inter alia: • the legal establishment of integrated care systems (ICSs) under the Health and Care Act 2022 • the evolving NHS System Oversight Framework, under which trusts will be treated		Chairman/ Governance Director and Trust Secretary	Paper 08

Item No	Description		Lead	Paper No/ Comments
	similarly regardless of their constitution as a trust or foundation trust.			
	Action	a) To receive and note the report b) To approve the Terms of Reference of the Executive Management Board c) To confirm the Committee structure and Board Committee Terms of Reference		
12	**Board Committee Meeting Minutes**			
	Action	a) Performance Committee – To receive the Minutes of the extraordinary meeting held on 14 June 2022 b) Quality Governance Committee – To receive the Minutes of the meeting held on 20 July 2022 c) People Committee – To receive the Minutes of the meeting held on 23 May 2022.	Respective Chairs of Committee	Paper 09a Paper 09b Paper 09c
13	**New or Increased Risks Arising from the Meeting**			
14	**Board of Directors Schedule of Business**			
	To receive the Schedule of Business and Development Sessions		Trust Secretary	Paper 10
	Action	To review and note the Board Schedule of Business		
15	**Any Other Business** (previously notified to the Trust Secretary)		Chair	
16	**Review of Guiding Principles**		Trust Secretary	Circulated by email for response
17	**Date and time of the next meeting:** **The next meeting will be on** **Wednesday 25 January 2023 at 10:00 hours**		Chair	

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

Minutes of the Meeting of the Board of Directors held on 27 July 2022, at 1030 hours, via Microsoft Teams

Present:		
Prof I Cumming*	Chair	Non-Executive Director (Chairman)
Mr A C Marsh*	CEO	Chief Executive Officer
Mrs W. Farrington Chadd* (Via Microsoft Teams)	WFC	Non-Executive Director (Deputy Chair)
Ms. Bayliss Pratt*	LBP	Non-Executive Director
Ms. C. Beechey	CB	People Director
Mrs M Brotherton	MB	Non-Emergency Services Ops Delivery Director/Asst. Chief Officer
Mr M Docherty*	MD	Director of Nursing & Clinical Commissioning
Mr M. Fessal*	MF	Non-Executive Director
Mr N. Hudson	NH	Emergency Services Operations Delivery 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 (Via Microsoft Teams)	MM	Communications Director
Mrs K Rutter*	KR	Interim Director of Finance
Dr A Walker*	AW	Medical Director
* Denotes a voting member appointed pursuant to the Constitution of the West Midlands Ambulance Service NHS Foundation Trust		
In attendance:		
Ms N. Rees		For the patient story item only
Ms D Scott	DS	Organisational Assurance Director
Mr T Yeaman	TY	Head of Legal Governance
Mr M Ward	MW	Head Of Clinical Care
Mr P. Higgins	PH	Governance Director & Trust Secretary
Ms R Farrington	RF	Staff Side Representatives

07/22/01	**Patient Experience – "Jamie's Story"**	
	The Chairman welcomed Naomi Rees and her partner to the meeting. The Director of Nursing stated that after his initial meeting with Naomi and Jamie's family he had sought their permission to use "Jamie's Story" in presentations on the impact of patient handover delays and the result of delays in getting to patients. Jamie's story was used at a Care Quality Commission (CQ) Led event Chaired by Sir Robert Francis QC in	

	London. In a response from the Chief Executive to Naomi he made the offer for Naomi to come to the Board to present the story of the loss of her son. Naomi's son Jamie was an 18 year old who was socialising on New Year's Eve into New Year's Day 2021/22. Approximately 2.00 am he became unwell and whilst outside the venue he put himself on the floor and subsequently went into cardiac arrest. The initial call to the Trust was at 2.16am and the 999 call was made by a friend. The WMAS call handler sought clarity from the caller and quickly identified it was a peri-arrest that quickly became a full cardiac arrest. The call handler then provided advice on resuscitation. The Board was advised that the Police arrived after approximately 12 minutes but did not have a defibrillator on the vehicle. Although the Trust had put out extra vehicles given the New Year occasion, 17 of the vehicles were queuing outside Acute Hospital. The nearest defibrillator was locked in a school. It was 17 minutes after the 999 call was made before an Ambulance arrived at scene, by which time police had given Jamie two shocks from a police Automated External Defibrillator (AED). A Return Of Spontaneous Circulation (ROSC was achieved and Jamie was taken to University of Coventry and Warwickshire Hospital (UHCW) where he survived for 4 days before his life support was discontinued with his family by his side. Naomi stated that she had been campaigning for the Rugby Clinical Assessment Service (CAS) site near to where they lived to be reopened as an operational site and handed a petition containing 10,300 names to the CEO at the meeting. In addition, Naomi had been campaigning and fundraising for more defibrillators to be made accessible for the public to use and was raising funds for 20 Defibrillators to be installed and be publicly accessible by the first anniversary of Jamie's death. In addition, given that the closest defibrillator that night was locked away to protect it from possible vandalism; Naomi had also been campaigning for appropriate sentencing for anyone convicted of vandalizing a defibrillator. In addition, it was also recognized that there was a need for increased CPR training within the community. This is already part of the national curriculum. It was noted that the Police vehicle did not have a defibrillator available, and it was suggested that there could be a campaign to place defibrillators on all public vehicles. Naomi indicated that she is meeting with the Police on this matter.	

	The Chairman concluded by thanking Naomi for attending the meeting today and sharing Jamie's story and the work that she is doing in his memory. The Chief Executive also thanked Naomi for attending and stated that those persons involved in providing care to Jamie would be invited to the WMAS Awards Ceremony to receive a Chief Officer's commendation. That subject to the Trust receiving a copy of the letter sent to the family from the Ministry of Justice confirming the position, a press release will be issued advising the public that vandalism or theft of a defibrillator, will upon conviction be treated in the same way a criminal prosecution for vandalism of an Ambulance vehicle and may be subject to a custodial sentence, and that a notice be attached to all Trust owned buildings to which a defibrillator is available for public use. In terms of the commitment of the family to raise funds for the procurement and installation of 20 defibrillators and making them available for use in an emergency to the community of Rugby by the first anniversary of Jamie's death, the Trust has committed to providing the defibrillators if the family fall short of their target Naomi and her husband thanked the Board for listening and then left the meeting. In addition, given that the closest defibrillator that night was locked away to protect it from possible vandalism; Naomi had also been campaigning for appropriate sentencing for anyone convicted of vandalising a defibrillator. In addition, Jamie's story highlighted that there was a need for increased CPR training within the community. The CEO advised the Board that this is already part of the national curriculum in schools so the foundations were in place. It was noted that the Police vehicle did not have a defibrillator available, and it was suggested that there could be a campaign to place defibrillators on all public vehicles. Naomi indicated that she is meeting with the Police on this matter. The Chairman concluded by thanking Naomi for attending the meeting today and sharing Jamie's story and the work that she is doing in his memory. The Chief Executive also thanked Naomi for attending and stated that those persons involved in providing care to Jamie would be invited to the WMAS Awards Ceremony to receive a Chief Officers commendation.	

	That subject to the Trust receiving a copy of the letter sent to the family from the Ministry of Justice confirming the position, a press release will be issued advising the public that vandalism or theft of a defibrillator, will upon conviction be treated in the same way a criminal prosecution for vandalism of an Ambulance vehicle and may be subject to a custodial sentence, and that a notice be attached to all Trust owned buildings to which a defibrillator is available for public use. In terms of the commitment of the family to raise funds for the procurement and installation of 20 defibrillators and making them available for use in an emergency to the community of Rugby by the first anniversary of Jamie's death, the Trust has committed to providing the defibrillators if the family fall short of their target Naomi and her husband thanked the Board for listening and hoped that learning would come out of Jamie's story for everyone involved, they then left the meeting	
07/22/02	**Chairman's Introductions, Apologies and Announcements**	
	An apology was received from Mr J. Brown The Chairman welcomed everyone to the meeting and given the number of meetings that day including a meeting of the Council of Governors and the Annual Meeting of the Trust he asked members to recognise that the reports had been circulated and read by members, so any presentations should be brief and highlight the key issues for the Board.	
07/22/03	**Declarations of Interest**	
	No Director declared any conflict of interest in relation to any matter on the agenda for this meeting. Vivek Khashu advised the Board that he had been nominated as a Non-voting member of the Black Country Integrated Care Board representing WMAS as a provider organisation. He had made the appropriate declaration in the register of Directors' interests. The Chairman reminded directors to review and update their respective entries in the appropriate registers, as these were open to public scrutiny for reasons of transparency and probity. Reena Farrington as the staff side representative that attended Board Meetings for reasons of probity and transparency declared her interest in Agenda Item 10c "*Trade Union Facility Time Regulations".*	

07/22/04	**Questions from the Public**	
	The Chairman indicated that an email had been received on 25 July 2022 from Terry Lawless, a volunteer Car Driver and posed the following question to the Board of Directors seeking an increase to the current mileage rate of 45p a mile to reflect the current fuel price? It was recognized by the Trust that its voluntary car drivers are valued, and do an excellent job and that it had lost drivers as the payments for fuel had not risen in line with fuel costs. It was indicated that with fuel cost was around £2.00 per litre, any increase would still offer best value as opposed to use of taxis as an alternative. In response to the question received, the CEO submitted a report to the meeting that had been submitted to Executive Management Board (EMB) the previous day that proposed an increase in mileage reimbursement rates for Voluntary Car Drivers. The paper had recommended EMB approval for an increased rate of mileage reimbursement for voluntary car drivers to 56p per mile which would bring these drivers in line with the rates paid to WMAS staff and Community First Responders. The cost (based on values paid in the 21-22 financial year) would be an additional c£100k. These costs were expected to be met by a reduction in the use of taxis and will be monitored throughout the year. It was emphasized that that this increased rate may have an impact on individual taxation liabilities. The EMB had approved the increase and the CEO requested the Board to ratify the decision of the EMB in the light of the question received.	
	Resolved:	
	That the question received on behalf of the Trust's Voluntary Car Drivers be noted and that the decision of EMB to approve an increase in the rate of 56p per mile being paid to voluntary car drivers claims with effect from 1st April 2022, with funding being met by a reduction in the use of taxis be ratified.	
07/22/05	**Board Minutes**	
	To agree the Minutes of the meeting of the Board of Directors held on	

	25 May 2022.	
	Resolved:	
	That subject to a typo on page 12 being corrected the Minutes of the meeting of the Board of Directors held 25 May 2022 be approved as a correct record.	
07/22/06	**Board Minute Log**	
	The Board Log that contains the schedule of matters upon which the Board have asked for further action or information to be submitted. Matters on this log can only be deleted through resolution of the Board. (For the avoidance of doubt unless specified below all matters contained on the Board log will remain on the log until the Board resolves that the matter can be discharged).	
	Minute 05/22/23 - **Report of the Communications Director** That the Communications Strategy be brought to the Board later in the year. It was reported that the Communications Strategy forms part of a broader Communications & Engagement Strategy which is due to be reviewed in September 2023. It was therefore agreed that this item could be discharged from the action log on the grounds that the Communications and Engagement Strategy is included in the Board's schedule of Business.	
07/22/07	**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. **Commonwealth Games Planning** The Chief Executive also took the opportunity of updating the Board on the planning for the Commonwealth Games which was due to open in Birmingham the following day. He indicated that there had been detailed planning including undertaking exercises to test planning. He said staff were already working with the organisers and athletes at the venue and in the competitor's village. The new Hub would be used temporarily, as it was not yet complete. The Chairman advised the Board that he had joined the CEO on a visit to the new Hub to see for himself the preparations and he was reassured that the preparations and planning had been exceptional. He could not	

	identify any risks that had not been mitigated. He therefore asked the CEO to convey the thanks of the Board to the event planners.	
	Resolved:	
	a. That the contents of the report, and the update on the planning for the Commonwealth Games be noted. b. That the CEO be requested to convey the thanks of the Board to the planners in recognition of all their hard work in this matter.	
07/22/08	**Executive Scorecard relating to Performance for the Month of June 2022**	
	The Executive Scorecard of KPIs for the month of June 2022 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 is circulated with the agenda for the meeting and contains Trust wide performance data and information and is circulated separately to the agenda papers for this meeting.	
	Resolved:	
	That the Executive Scorecard be received and noted.	
07/22/09	**Covid Update**	
	A report of the Strategy and Engagement Director was submitted. It was indicated that staff will be encouraged to have a “booster” vaccination on top of the Flu vaccination as part of the Winter contingency planning.	
	Resolved:	
	To receive the Covid update report for June 2022 and the Covid monthly trend for the period March 2020 to June 2022	
07/22/10	**Business Continuity Policy**	
	The Trust’s Business Continuity Policy was submitted. This paper informs the Board on an updated version of the Trust’s Business Continuity Policy following minor changes required by Internal	

	Audit. The EMB meeting held the previous day had approved the content of the Policy as revised and recommended the Board of Directors to ratify the Policy now submitted.	
	Resolved:	
	That the revised Business Continuity Policy as submitted and approved by EMB be ratified.	
07/22/11	**Financial update**	
	A report of the Interim Director of Finance was submitted. The report provided the Board with an update to the Budget approved by the Board in March and following the final plan submission to NHS England In June 2022 The Interim Director of Finance briefed the Board on the current financial position for the Trust within the context of the revised system following the legal establishment of the ICBs in the region. The Interim Director of Finance stated that following an NHSEI challenge of the ICS initial planned deficit of £48m, system partners agreed a set of actions to enable a balanced system plan to be submitted in June 2022. This being the final plan submission for the financial year 2022/23. A risk share agreement between Integrated Care System (ICS) partner organisations was in operation last year (2021/22) and is again this year (2022/23). Under the terms of the risk share, all organisations within the ICS agree to work collectively to achieve financial balance. For 2022/23 this included incorporating funding adjustments within the June 22 plan submission i.e., moving money between ICS organisations to enable each to achieve a balanced plan. The impact of risk share driven funding adjustments on WMAS was a transfer of £7.537m from the Trust to other organisations within the ICS. The majority of this arose because of a NHSE instruction to organisations to remove all post quarter 1 Covid expenditure from Trust plan submissions. The value of this adjustment being £7m, which reflected the Trust Covid expenditure submissions made during 2021/22. This NHSEI mandated change to the WMAS plan created a surplus, which the ICS redistributed. The Trust challenged this on the basis that it's reported Covid spend included £4.8m of the costs relating to NHS111 surge cell and that this expenditure would not reduce as a consequence of changes in Covid measures. This risk was acknowledged by the incoming Integrated Care Board (ICB) Director of Finance, but agreement could not be reached on	

	a plan adjustment to remove this from the resource transfers, prior to resubmission of the ICS plan in June 2022. The plan remains at breakeven, but to achieve this the FIP/CIP will increase to £13.1m. The Board noted, during discussion on the impact of fuel cost increases in future years, the current impact of the cost of living increases such as domestic fuel costs for staff. In response the People Director indicated that the Trust were putting out communications on the support that staff can seek to assist with the cost of living increases, this included working with a high street bank. It was suggested that a briefing note on the proposed pay award should be circulated to Board members. It was reported that the national team were looking at the impact of handover delays to mitigate the impact on patient care.	
	Resolved:	
	a. That the Trust's plan submissions as part of the Black Country and West Birmingham ICS be received and noted. b. That approval be given to the adjustments to the initial March budget to reflect the balanced budget represented in the final plan and detailed in the report submitted.	
07/22/12	**The 5-Year Capital Expenditure Programme**	
	A report of the interim Director of Finance was submitted. The update provided a refresh of potential capital commitments over the next five years (2022/23 to 2026/27). The paper considered the following matters: - • Anticipated availability of capital funding over the life of the plan • Impact of Integrated Care System (ICS) based capital control totals • Planned expenditure for Fleet, Information Technology, general Estates costs and Premises upgrade/replacements. • Additional capital financing resource that would be required over and above the available / anticipated sources, to enable the Trust to fully fund the planned expenditure. • The impact of IFRS16 is covered in brief, but the absence of NHS guidance on if/how capital limits (CDEL) will be adjusted to reflect the change in accounting policy, prevents any meaningful assessment of long-term implications.	

	• The paper briefly considers the impact of changes in technology in respect of E-Ambulances etc., The likely cost of such technologies. Further work is required to refine these assumptions. Recent changes with the formal establishment of the Integrated Care Boards meant that the operational capital funding allocation process are such that Trusts no longer receive direct allocations of capital funding. Instead, a single allocation is made to the host ICB for the whole of the system. In addition to changes in allocation arrangements, capital resource availability in aggregate has fallen for the Trust's host ICB in 2022/23 compared to 202122 and is expected to remain at similar levels for the next two years. Operational capital funding levels used in the paper submitted are as confirmed by NHSEI for 2022/23 and as advised by NHSEI for planning purposes for 2023/24 and 2024/25, though these are subject to change. For 2025/26 and 2026/27, the 2024/25 figure has been used as a working assumption. Looking forward ICBs will prioritise capital allocations so as to deliver system priorities, aligned to their long-term strategic plans. Though nominally hosted by Black Country ICS, WMAS provides services to five other ICSs. A key task for the Trust will thus be ensuring full participation and engagement in the development of urgent and emergency care transformation programmes to demonstrate system value and so secure capital resource	
	Resolved:	
	a. That the level of anticipated operational capital plus other known funding streams is not sufficient to enable the Trust to proceed with all the proposals set out in this initial review/update of the 5-year programme as detailed in the report submitted be noted. b. That expenditure plans for Double crewed vehicles are based on existing diesel technologies and on achieving improvements in these through weight reduction. This is due to a lack of available practical alternatives at this time; and the costs of moving to zero emission technologies is currently estimated to be c £10m higher than existing diesel vehicles be noted.	

	c. That the need to identify and explore options to close the gap between capital expenditure proposals and capital funding noted and in particular it was noted that this should include: • Full engagement with the host ICS and potentially other ICSs served by the Trust, to secure support for Trust capital spending priorities re allocation amongst system partners of operational capital spending limits • Implement an internal review and prioritisation process for capital proposals applying defined prioritisation criteria • Review the Trust's asset "lives" replacement policies to assess the best balance between affordability and asset reliability in light of restricted capital funding. • Pursue additional national funding allocations where available, to alleviate pressures on operational capital funding e.g., IM&T/Digital programmes. • Consider a lease model where appropriate - subject to as yet unavailable NHSEI guidance re impact of the application of the IFRS16 accounting standard to capital control totals.	
07/22/13	**Debtors**	
	A report of the interim Director of Finance was submitted requesting Board approval for "write off" aged debtors following agreement at the meeting of EMB in May 2022 and the meeting of the Audit Committee in July 2022. The Board was advised that there were a number of aged balances included in the receivables (Debtors) balances. The interim Director of Finance stated that it is good practice to review these balances regularly and assess the likelihood of settlement. Any balances deemed to be irrecoverable should be written off so as not to inflate the Trust's asset value. The list of accounts which have no identifiable recovery have been proposed to be written off with the majority being offset against a bad debt provision made in the 2021-22 accounts. Presenting the report, the Interim Director of Finance indicated that a robust review of outstanding debts has been undertaken and some of them are quite old. The majority have been through a debt collection agency who did not recover any monies. The Audit Committee as part of its review of the report requested assurances regarding the systems in place to recover payroll debt and asked for Internal Audit's perspective on this matter and requested a report on the payroll debt recovery systems and process element to its next meeting.	

	Resolved:	
	That for the reasons set out in the report submitted, approval be given to "write off" the debts set out in the report now submitted.	
07/22/14	**Cost Improvement Plan – Update**	
	A report of the Interim Director of Finance was submitted. To note the current delivery against identified CIP target, and next steps. The Board reviewed the current position in relation to the Financial Improvement Plan (FIP) (formerly Cost Improvement Planning). It was noted that there was a risk to delivery of these given the pressures placed on E&U budget due to the payment of overtime caused by the handover delays and maintaining quality and minimizing risks to patient care. In future the development of the FIP programme required detailed planning to include the impact of fuel costs, and this should form part of the EMB financial planning for next year's budget. This should include Quality Impact Assessments.	
	Resolved:	
	a. That the contents of the report be received and noted. b. That the development of the Financial Improvement Plan as part of the overall Trust planning process be developed in line with NHSE planning timelines. c. That the Senior Efficiency Group, which reports into EMB: - develops a Financial Improvement (CIP) programme that is more proactive and operates over a medium-term time horizon - monitor the delivery of in year targets, taking action where needed	
07/22/15	**Quality Report**	
	A joint report from the Director of Nursing and the Medical Director was Clinical Directors to give the Committee assurance on the clinical quality agenda. It is an integrated report that has been developed to provide a single reporting mechanism to the Committee on all clinical quality issues. The report highlighted the following specific areas that the Board need to be sighted on: • Patient handover delays continue to result in significant patient harm and the impact of these delays resulting in long patient waiting times also causes harm, including death.	

	• As a result of long delays, the number of serious incidents involving serious harm or death is increasing every month The Chairman referred to the number of compliments received and felt that this should be amplified to enable staff to celebrate success. As working on a System basis is now enshrined within legislation, we want to ensure we can play our part in helping the newly established Integrated Care Boards to develop and prosper over the coming months and years, the Chief Executive and the Chairman have agreed to meet each of ICB Chairs and CEOs across our region. Dr Walker indicated that she had met with the Medical Director for the ICB.	
	Resolved:	
	That the content of the integrated quality report be noted, in particular the significant harm being caused as the result of long patient handover delays which is reflected in the Board Assurance Framework.	
07/22/16	**National Review into the murders of Arthur Labinjo-Hughes and Start Hobson**	
	A report of the Director of Nursing & Clinical Commissioning The report outlined the learning from two recent child deaths, namely Arthur Labinjo-Hughes and Star Hobson. WMAS was not involved in either of these cases, except a call to Arthur when he was in cardiac arrest. The report takes the learning from these two sad cases and identifies an action plan for WMAS to implement as a result of the learning from these two cases. Much of the learning centres around assuring ourselves of safeguarding processes and taking opportunity to strengthen these processes and our resources dedicated to safeguarding. In presenting the report the Director of Nursing and Clinical Commissioning indicated that the report did not criticize this Trust and was submitted purely for assurance that the Trust will use the findings to develop its own learning.	
	Resolved:	
	a) The Board is asked to receive and note the report, and in particular to note that WMAS has reviewed the report and identified an appropriate action plan.	

	b) That the action identified be supported and that the Board receive regular updates on the implementation of the action plan and the wider learning.	
07/22/17	**Board Assurance Framework (BAF)** & **Extraordinary Meeting of the Performance committee (update report)**	
	A report of the Director of Nursing & Clinical Commissioning was submitted that presented the Board Assurance Framework for review and approval. The Director of Nursing & Clinical Commissioning informed the Board that the report should only include risks rated 12 and above. The Trust's main risk remains the hospital handover delays. There are also an increasing number of serious incidents but many of these relate to the delays. In addition, a report of the Strategy and Engagement Director was submitted on the extraordinary meeting of the Performance Committee held in June 2022 which was convened by its Chairman in response to the significant downturn in response time performance and the risk this has created for patients. After reviewing the BAF the Board had asked the Performance Committee to formally review the reasons for the downturn and to set out a plan of actions which could be taken in response. An extraordinary performance committee was held in June 2022, it received a briefing covering possible drivers for the decline in response time performance and the actions the Trust has taken to date to mitigate the performance downturn and risk. The committee was also briefed on a forecast on how 'long' this challenge will persist and finally, actions the Trust could take to improve performance and reduce risk and harm to patients. The report presented the briefing pack which was discussed at the committee. It also set out the actions which are and can be taken to reduce the risk to patients, these have already been discussed via performance committee and Executive Management Board (EMB)	
	Resolved:	
	a) To receive and approve the Board Assurance Framework & Significant Risks, recognising noting that the principal Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents remains at 25, despite mitigations being put in place by the Trust. b) To receive the report on the matters discussed at the Extraordinary Meeting of the Performance Committee and that	

	subject to detailed operational review, the list of actions as set out in the appendix to the briefing be endorsed.	
07/22/18	**Paramedic Advanced Practice and Non-Medical Prescribing**	
	A report of the Medical Director and also Matthew Ward, Consultant Paramedic – Head of Clinical Care. Matthew Ward was in attendance and made a PowerPoint presentation to the Board on the salient matters contained in the Board. The purpose of the report and presentation was to inform the Board of the development of Advanced Clinical Practitioners within the Trust and the Non-Medical Prescribing action plan. The development of Advanced Clinical Practitioners within the Trust has increased the scope and ability of professionals to assess and treat patients remotely, being able to call on their developed advanced practice academic, clinical knowledge and to undertake remote electronic prescribing when indicated. The Non-Medical Prescribing action plan has been enacted following a review of non-medical prescribing within the Trust in order to further improve the governance and development of non-medical prescribers. A copy of the slides used in the preparation were circulated to the Board as part of the agenda. There then followed a question and answer session to clarify elements of the presentation: Q. Why 3 years' experience before prescribing? A. It is important that paramedics have exposure to a wide range of patients and conditions and to embed their post graduate experience and fundamental skills before developing into specialist and advanced practitioners. Thank you to HEE for their significant support in developing our advanced clinical practitioners. Q. What are the benefits of paramedics being prescribers and how is it operationalised? A. Enabling advanced paramedics to prescribe allows the trust to definitely manage a larger range of conditions without putting additional pressures on primary and secondary care services improving patient experience and clinical effectiveness. Q. Where are the non-medical prescribers practicing and will Electronic Prescribing be utilised?	

	A. There are currently 44 clinical practitioners and they mainly work in the IEUC, they utilise electronic prescribing to undertake remote assessment and prescribing. Q. Has the Trust Pharmacist been advising on this development? A. Yes the Trust IEUC Pharmacy Leads are fully involved and engaged. The Chairman thanked Dr Walker and Matt Ward for the presentation and the felt that this was an exciting development. He further suggested that the Mohammed Fessal could be involved given his background and experience. Resolved	
	That the report and presentation be received and noted	
	Operational Performance Update	
07/22/19	**Non-Emergency Services Operations Delivery & Improvement Director Update – Michelle Brotherton**	
	The report of the Non-Emergency Services Operations (NEPTS) Delivery & Improvement Director was submitted. The content of the report was an update on the pressures facing the NEPTS service at this time and how the risks to patient care and quality are being mitigated. The report also contained key indicators in relation to management and operational performance, and the impact of handover delays on the non-emergency operations.	
	Resolved:	
	That the contents of the report be received and noted.	
07/22/20	**Quality Improvement Update**	
	A report of the Non-Emergency Services Operations Delivery & Improvement Director was submitted The report covered the following areas: 1. Update on the proposed National Improvement Faculty 2. Quality Improvement Strategy 3. Update on Training in Quality Improvement 4. Feedback on specific Quality Improvement projects	
	Resolved	

	That the report be received and noted	
07/22/21	**Integrated Emergency & Urgent Care & Performance Director**	
	The report of the Integrated Emergency & Urgent Care & Performance Director was submitted providing an update showing key indicators.	
	Resolved:	
	That the report be received and noted	
07/22/22	**Emergency Services Operations Delivery Director Update**	
	The report of the Emergency Services Operations Delivery Director was submitted. The Chairman indicated that he had as part of his visits to engage with staff had spent the day with the Hazardous Area Response Team (HART). He found the visit fascinating and helpful given his role as the Nominated NED required under the NHS England Emergency Preparedness, Resilience and Response Framework. He asked Nathan to convey his thanks to the staff.	
	Resolved:	
	That the report be received and noted	
	Reports of the People Director	
07/22/23	**Education and Training Student Paramedic Programme Delivery Update**	
	The report of the People Director was submitted. This paper summarised the current education development provision of our Trust employed Student Paramedics. The report provided an overview and detail of the current and future programme delivery models of Trust employed Student Paramedic education to ensure that the Trust have a solution to paramedic workforce challenges by focusing on growing our own Paramedics of the future	
	Resolved:	
	That the report be received and noted	
07/22/24	**Staff Survey Update**	

	A report of the People Director was submitted. The paper submitted provided the Board of Directors with assurance that action plans are in place and being progressed for the 2021 NHS Staff Survey. The Board was advised that the National Staff Survey 2021 results had been discussed at: EMB: the Staff Survey Response Action Group; senior management team meetings, and with staff side representative. Three high impact actions were agreed and are reflected in the Trust-wide Action Plan. Local Action Plans (LAPs) have also been established.	
	Resolved:	
	That the Report be received and noted.	
07/22/25	**Trade Union Facility Time Regulations for publishing**	
	A report of the People Director was submitted. Reena Farrington as the staff side representative that attended Board Meetings declared her interest in this matter. The Chairman noted the interest and indicated that her comments would be welcomed. 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 data in relation to their usage and spend on trade union facility time. There is a requirement for the Board to receive the Public Sector Facility Time Report for 2022. to publish the data on the Trust's public-facing website by 31 July 2022.	
	Resolved:	
	a) That the content of the report be noted b) That approval be given to publish Public Sector Facility Time Report for 2022 on the Trust's website by 31st July 2022 and to also submit it to the relevant regulator.	
07/22/26	**Professional Registration and Medical Revalidation Assurance**	
	A report of the People Director was submitted.	

	To provide an update and assurance regarding the professional registration and medical revalidation processes within the Trust. This report therefore provided assurance that all appropriate checks are in place for all Doctors engaged in work with the Trust. This assurance exercise will be repeated on an annual basis with any issues arising by exception escalated to the Executive Medical Director and People Director.	
	Resolved:	
	That the contents of the report be received and noted	
	Report of the Strategy & Engagement Director	
07/22/27	**ICS Level Scorecard**	
	A report of Strategy and Engagement Director was submitted. Following on from the refresh of the "executive scorecard" a draft ICS level scorecard was presented to the Board, to enable it to have a view on key deliverables and outcomes for patients on an ICS level footprint. The principle behind the draft scorecard presented to the BoD is to breakdown our executive scorecard onto an ICS level where possible / appropriate. For example, it doesn't include our financial position on an ICS level, but does include things like lost hours to handover delays and our response times. The draft scorecard submitted was presented to the Board for feedback, whilst it is in development, some aspects included within the draft contain real data, others not so, the charts clearly articulate which is applicable. Our host ICS, the Black Country ICS has also requested a copy of a ICS level scorecard to assess their own performance, and that of other ICSs.	
	Resolved:	
	a) That the contents of the ICS level Scorecard be received and noted. b) That members of the Board refer any comments or observations to the Strategy and Engagement Director c) That the Score card "go live" and be published as part of the agenda for the next ordinary meeting of the Board.	

07/22/28	**NHS Systems Oversight Framework 2022/23**	
	A report of Strategy and Engagement Director was submitted. To update the Board of Directors on the new Single Oversight Framework (SOF) for Integrated Care Boards (ICBs) and NHS Trusts. The framework was published in June 2022, and from 1 July 2022 Integrated Care Boards (ICBs) were established with the statutory function of arranging health services for their population, they are responsible for performance and oversight of NHS services within their ICS, or in the case of WMAS, the Black Country ICB taking a lead role on behalf all six ICBs in the West Midlands. It was indicated that 2022/23 will be a year of transition as ICBs are formally established and new collaborative arrangements are developed at system level. Over the course of 2022/23 NHS England will consult on a long-term model of oversight for system-led care. The 2022/23 Single Oversight Framework reinforces system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan.	
	Resolved:	
	That the contents of the report be received and noted.	
07/22/29	**Board Committee Meeting Minutes** a) Performance Committee – To receive the Minutes of the meeting held on 26 April 2022 b) People Committee – To receive the Minutes of the meeting held on 28 February 2022 c) 1. Audit Committee – To receive the Minutes of the meeting held on 23 May 2022 2. To receive the Annual Report of the Audit Committee and to note the contents. d) Quality Governance Committee – To receive the Minutes of the meeting held on 18 May 2022 Mushtaq Khan, Chairman of the Performance Committee, referred to the Extraordinary Meeting of the Performance Committee held on 14 June 2022 which focused on response times and handover delays at hospitals and their effects on staff and patients and to devise a plan of action. The meeting had been referenced and a report submitted earlier in the meeting. Mushtaq indicated that as recognised by the Board that this a system wide issue and not something that can be addressed solely by the Trust.	

	The Minutes of the meeting of the 14 June will be submitted to Board when approved as an accurate record at the next meeting of the Performance Committee, however he indicated that he wanted to report verbally to the Board pending the minutes being submitted.	
	Resolved:	
	a) Performance Committee – To receive the Minutes of the meeting held on 26 April 2022 b) People Committee – To receive the Minutes of the meeting held on 28 February 2022 c) 1. Audit Committee – To receive the Minutes of the meeting held on 23 May 2022 2. To receive and note the Annual Report of the Audit Committee d) Quality Governance Committee – To receive the Minutes of the meeting held on 18 May 2022	
07/22/30	**Any Other Business**	
	As the Voluntary Car Driver Mileage Reimbursement Rates report was considered and determined in response to the question to the received earlier in the meeting, there was no other Business to be considered.	
07/22/31	**New or Increased Risks**	
	The principal Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents remains at 25, despite mitigations being put in place by the Trust. These are monitored at each meeting through the BAF. The level of anticipated operational capital plus other known funding streams is not sufficient to enable the Trust to proceed with all the proposals set out in this initial review/update of the 5-year programme as detailed in the report submitted be noted. The impact of risk share driven funding adjustments on WMAS was a transfer of £7.537m from the Trust to other organisations within the ICS. The majority of this arose as a consequence of a NHSE instruction to organisations to remove all post quarter 1 Covid expenditure from Trust plan submissions. The value of this adjustment being £7m, which reflected the Trust Covid expenditure submissions made during 2021/22. This NHSEI mandated change to the WMAS plan created a surplus, which the ICS redistributed. The plan for the Trust remains at breakeven, but to achieve this the FIP/CIP will increase to £13.1m.	

07/22/32	**Board of Directors Schedule of Business**	
	The Schedule of Business was submitted.	
	Resolved:	
	That the Board Schedule of Business be received and noted.	
07/22/33	**The Date of the next meeting**	
	Wednesday 26 October 2022	
	The Chairman brought proceedings to a close and thanked members for their attendance.	

Paper 01b

Minutes of the Meeting of the Extra Ordinary Board of Directors
held on 28 September 2022, at 0930 hours, via Microsoft Teams

Present:		
Prof I Cumming*	Chairman	Non-Executive Director (Chairman)
Prof A C Marsh*	CEO	Chief Executive Officer
Mrs W Farrington-Chadd*	WFC	Non-Executive Director (Deputy Chair)
Ms L Bayliss -Pratt*	LBP	Non-Executive Director
Ms C Beechey	CB	People Director
Mrs M Brotherton	MB	Non-Emergency services Operations Delivery & Improvement Director
Mr J Brown	JB	Integrated Emergency & Urgent Care & Performance Director
Mr M Docherty*	MD	Director of Nursing & Clinical Commissioning
Mr M Fessal*	MF	Non-Executive Director
Mr N Hudson	NH	Emergency Services Operations Delivery Director
Mr P Jarvis*	PJ	Interim Director of Finance
Mr M Khan*	MK	Non-Executive Director
Mr V Khashu	VK	Strategy & Engagement Director
Mr M MacGregor	MM	Communications 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:		
Mr P Higgins	PH	Governance Director & Trust Secretary
Ms K. Freeman	KF	Private Secretary – Office of the Chief Executive
Ms R Farrington	MF	Staff Side Representative
Ms D Scott	DJS	Interim Organisational Assurance Director
Mr N Henry	NHen	Head of Ops Information & Planning (part of meeting)

09/22/01	**Chairman's Introductions, Apologies and Announcements**	
	Apologies for absence received from Narinder Kooner and Dr Alison Walker. The Chairman advised the Board of Directors that from 1 October 2022 the Board will be joined by the new Non-Executive Director Julie Jasper.	
09/22/02	**Declarations of Interest**	
	There were no declarations of interest.	

09/22/03	**Confirmation of Action Taken – Bank Holiday for the State Funeral of HM Queen Elizabeth II**	
	The Trust Secretary wrote to the members of the Board on 13 September 2022 stating that HM Government had declared that Monday 19 September 2022 was to be a Bank Holiday for the State Funeral of HM Queen Elizabeth II. Given the circumstances it was proposed that the Trust will honour the contractual terms and enhancements described in the relevant terms and conditions for all staff who are required to work on Monday 19 September. This is in line with advice received from NHS Employers. The detailed costings associated with this decision was shared and also clarity was provided in relation to how the Bank Holiday leave would be applied to operational staff. For the purposes of good governance, members of the Board of Directors were requested to indicate their support for the proposal to honour the contractual terms and enhancements described in the relevant terms and conditions for all staff who are required to work on Monday 19 September 2022. In addition, the Board and the Remuneration and Nominations Committee were requested to approve all staff being allocated 7.5 hours in their leave entitlement, to either take the day as leave on Monday 19th September, or to have available to take at an alternative time if required to work. Members of the Board sought clarity on the proposals and that the Trust was only paying bank holiday rates where it is necessary. The Board was provided with the assurance that payments will be made strictly in accordance with contractual terms, conditions and entitlements based on hours worked. No objections were received and the Board are now requested, for the purposes of transparency to approve the action taken by means of email due to urgency.	
	Resolved:	
	That the Board of Directors approved the action taken.	
09/22/04	**Diversity & Inclusion Annual Report**	
	The People Director gave an update and informed the Board that last year the Diversity & Annual Report was included within the Trust's overall Annual Report. This year the report has been produced separately. 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]. This report provides information about the work we are doing and what we have achieved over the previous year including information and progress on projects such as: Equality Delivery System2 report and grading, The Workforce Race Equality Standard	

(WRES) The Disability Workforce Equality Standard (DWES) and the Gender Pay Gap data and action plans. The People Director explained that the report is submitted today for approval to publish on the Trust's website.

Mr Khan said this was a helpful document, but he would like more time to consider the report and its contents. Mr Khan was not happy with the report being presented without discussing it as he has some questions. Mr Khan asked why ethnicity equal pay is not part of the plan. The Chief Executive Officer (CEO) asked if today's papers had been to the Diversity & Inclusion Steering Group, the People Committee and all the various Networks. Mr Fessal confirmed these points had been raised at the People Committee and discussion was required around ethnicity equal pay. The Chairman advised the Board that he and Mr Fessal had discussed this and were arranging an EDI session for the Board. As Mr Fessal is not at the November Board Meeting the EDI session has been arranged for January 2023. The Chairman asked if there was a timeline to get these documents published. The People Director confirmed that the Annual Report is required as soon as possible and the WRES and WDES Reports require publishing on the Trust's website by 31 October 2022.

The People Director explained that the other ideas and initiatives were added from the D&I Steering Group. The data is from a national set of metrics which the Trust has no influence on or can change. The ethnicity pay gap report is a manual process and will take some time to pull the data together. This information is being worked on ready for the next People Committee. Detailed discussions around the Gender Pay Gap and Ethnicity Pay Gap are scheduled for the people Committee in November and then for Board. Mr Khan said he was frustrated as this was exactly the conversation the Board had a year ago. The People Director apologised as the first time she had picked up on this was at the Board Away day in Coventry. Mr Khan said he would be happy to attend the People Committee to help with this item but that it needs to be within a short timeframe.

After discussion it was agreed that an Extraordinary Meeting of the People Committee would take place in October. Mr Khan and the CEO would attend this meeting. The draft Ethnicity Pay Gap report & content would be submitted to this meeting. The People Committee would also agree the content for the Board Session in January.

Nick Henry joined the meeting.
After discission the Board of Directors delegated authority to the People Committee to review and approve the following:

- D&I Annual Report 21/22
- WRES Annual report & Action Plan 22/23

	• WDES Annual Report & Action Plan 22/23 These documents would then be ratified at the Board of Directors Meting at the end of October.	
	Resolved:	
	That the Board of Directors received the Diversity & Inclusion Annual Report. That the Board of Directors delegated authority to the People Committee to review and approve the D&I Annual Report 21/22. That the document would then be ratified at the Board of Directors Meeting at the end of October.	
09/22/05	**WRES Annual Report 2022 & Action Plan 2022/23**	
	That the Board of Directors delegated authority to the People Committee to review and approve the WRES Annual Report & Action Plan.	
	Resolved:	
	That these documents would then be ratified at the Board of Directors Meeting at the end of October.	
09/22/06	**WDES Annual Report 2022 & Action Plan 2022/23**	
	That the Board of Directors delegated authority to the People Committee to review and approve WDES Annual Report & Action Plan.	
	Resolved:	
	That these documents would then be ratified at the Board of Directors Meeting at the end of October.	
09/22/07	**Winter Plan**	
	The CEO informed the EMB that this Winter Plan sets out the Strategic overview of the arrangements for the Trust for the coming Winter Period for 2022/23. The Trust has many years of experience of developing its robust planning arrangements for the Winter period and this captures learning from last Easter/Winter, plus the NHS England winter priorities. The CEO was confident this plan would serve the Trust well this Winter. Mr Henry confirmed this plan does mirror the NHS Plan and also includes the cohorting work. Mr Khan noted this was a very comprehensive and detailed plan with lots of data and action points. Mr	

	Khan asked how we though as a Trust we will cope this winter. The CEO said this was dependent on a number of things: • Weather last year no snow. This year it's unknown. • Covid & Flu – the extent to how this affects the Trust. We need to maximise the covid and flu vaccinations. • Impact on families – cost of living - food /heating. This is all outside of our control. The CEO confirmed the Trust will do everything it can to protect our staff and save lives. The Strategy & Engagement Director informed the Board that there is a Winter Plan and assurance process in place with Acute Trusts. Mrs Bayliss-Pratt asked if the Trust would be recruiting volunteers. The CEO confirmed the Trust already has CFRs and Volunteer Car Drivers but does not have any plans to recruit other volunteers.	
	Resolved:	
	That the Board of Directors approved the Winter Plan.	
09/22/08	**The Date and time of the next meeting**	
	The next meeting will be on Wednesday 26 October 2022 at 10:00 hours	
	There being no other business for this meeting the Chairman brought proceedings to a close and thanked members for their attendance.	

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
05/22/24	**Governance & Terms of Reference Review** That the five themes relating to the Governance model would be brought back to a future Board Briefing Meeting for further discussion.	**PH**	**October 2022**	Included within the papers for this meeting
07/22/01	**Patient Experience** a. That those persons involved in providing care to Jamie be invited to the WMAS Awards Ceremony to receive a Chief Officers commendation. b. That subject to the Trust receiving a copy of the letter sent to the family from the Ministry of Justice confirming the position, a press release be issued advising the public that vandalism or theft of a defibrillator, will upon conviction be treated in the same way a criminal prosecution for vandalism of an Ambulance vehicle and may be subject to a custodial sentence, and that a notice be attached to all Trust owned buildings to which a defibrillator is available for public use. c. In terms of the commitment of the family to raise funds for the procurement and installation of 20 defibrillators and making them available for use in an emergency to the community of Rugby by the first anniversary of Jamie's death, the Trust has committed to providing the defibrillators if the family fall short of their target.	**a. CB** **b. MM** **c. NH**		a. Those whose details we have will be invited to the Awards Ceremony b. The Trust has now received the Ministry of Justice letter and it makes it clear that investigation of theft and vandalism and then sentencing is dependent on circumstances of each case. c. The Trust has already worked with St John ambulance to donate two defibs to the campaign and will liaise with Naomi towards the end of the year to establish if she needs any further support.

Minute Reference	Notes and Any Actions Required	Action by	Timescale	Progress/Evidence
09/22/04	**Diversity & Inclusion Annual Report** Board of Directors delegated authority to the People Committee to review and approve the following: • D&I Annual Report 21/22 • WRES Annual report & Action Plan 22/23 • WDES Annual Report & Action Plan 22/23 These documents would then be ratified at the Board of Directors Meeting at the end of October.	**CB**	**October 2022**	An extraordinary Meeting of the People Committee was convened on 19 October 2022 at which the D&I annual report, The WRES and WDES reports and associated actions plans were all approved for publication. The Chairman of the People Committee will provide assurance to the Board on the content of the reports submitted to People Committee.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 06a MONTH: October 2022 PAPER NUMBER: 03a

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. Increase the Geofence Radius of Automated External Defibrillators
2. NHS England Core Standards
3. CEO Meetings – 18 July to 14 October 2022

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: 06a MONTH: October 2022 PAPER NUMBER: 03a

Action required

The Board of Directors is asked to:

- Receive and note the contents of the paper seeking clarification where necessary.
- To confirm the action taken in relation to the NHSE Core Standards.

1. Increase the Geofence Radius of Automated External Defibrillators (AEDs)

The Executive Management Board (EMB) received a paper in August 2022 about making a change to the current setting of AED radius for the Computer Aided Despatch (CAD) from 200 meters to 500 meters. This request for this change comes following a couple of incidents of cardiac arrest where an AED was just over the 200-meter radius away from the patient and the guardians have queried why their AED had not been responded. In reviewing the Trusts radius against other ambulance services, it has identified that there is now only West Midlands Ambulance Service (WMAS) and London Ambulance Service that still have a radius of 200 meters, where most other ambulance services in the UK have a radius set at 500 meters. There has been a timely request to the Trust Board from a community team that provide AEDs in Droitwich to increase the radius to all their AEDs, to enable their town to have greater coverage. This move should only improve access to AEDs to patients in cardiac arrest and it may increase the survival rates to out of hospital cardiac arrest. The EMB approved the recommendation to increase the geofence radius to 500 meters. This will be continually monitored.

2. NHS England (NHSE) Core Standards

The NHSE Core standards for 2022/23 was submitted on 14 September 2022. An initial assurance session was successfully held with NHSE Midlands with no changes required. The document and evidence were reviewed by the Senior Command Team and then approved by the Accountable Emergency Officer prior to submission. A request from NHSE Midlands Emergency Preparedness, Resilience & Response Team was received on 15 September 2022 for a further submission to the annual core standards. No evidence was required at this time completion of the work sheet only. The submission date was 27 September 2022. The review has been undertaken and the submission completed with the CEO approval.

3. Chief Executive Officer Meetings – 18 July to 14 October 2022

Staff

- Regional Partnership Forum
- Katie Tustin Funeral

- Freedom to Speak Up (FTSU) Ambassador Development Session
- Adam Aston & Sarah Bessant – Staff Governors
- Managers Meeting
- NEDs Meeting
- Serious Incidents Team
- Eileen Cox, Governor
- Financial Accounts Team
- All Staff Briefing
- FTSU Quarterly Meeting
- Council of Governors
- Staff Side Representative
- EMB Planning Day
- Staff Governors

National Meetings

- NHS England – UEC Ambulance Workstream Stakeholder Group
- NHS England - Covid 999 Cell Key Actions
- Pete Bramwell, NHS England
- NHS England – National Thursday Meeting
- NHS England – Covid Inquiry 999 Recap
- Natalie Mullen, CQC
- NHS England – Joint Ambulance Improvement Programme Board
- Secretary of State for Health
- Association of Ambulance Chief Executives – Ambulance Chief Executives Group
- Association of Ambulance Chief Executives – Ambulance Board Meeting
- Daren Mochrie, Association of Ambulance Chief Executives
- NHS England – WS2 Strategy Sub-Group Meeting
- Amanda Pritchard, NHS England – Winter Capacity Event
- NHS England – Cat 2 Improvement Meeting
- Ambulance Leadership Forum
- NHS England - UEC Check In
- NHS England – Cat 2 Validation
- NHS England – IRP Implementation Board
- National Memorial Service
- NHS England – C2 Next Steps
- DHSC Reserve Ambulance Service
- Marc Thomas, NHS England
- NHS England – Falls Meeting
- NHS England – NACC / Handover Meeting
- NHS England – Roundtable – Our Plan for Patients

- Emergency Call Prioritisation Advisory Group
- NHS England – C2 Follow Up meeting
- NHS England - 999 Ambulance Check In
- Secretary of State / NHS England Meeting
- National Ambulance Resilience Unit Steering Group
- NHS England – Ambulance Improvement & Implementation Board
- Martin Flaherty, Association of Ambulance Chief Executives
- Claire Joss, NHS England

Regional Meetings

- Phil Loach, Chief Fire Officer, West Midlands Fire Service
- Theo Clarke MP
- NHS Charities Together / The Ambulance Service Charity
- Jason Evans NHS Black Country & West Birmingham
- Professor Jackie Dunn, Newman University
- Professor Ian Campbell, Interim Vice Chancellor, Wolverhampton University
- Sarah Jane Marsh, CEO, Birmingham Women's & Children's Hospital

Professor Anthony C. Marsh
Chief Executive Officer
October 2022

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Executive Performance Dashboard
September 2022

Activity and Performance

Measure	Month	YTD	Monthly Trend
Category 1 - Mean Target 7 mins	08:20	08:12	
Category 1 - 90th Target 15 mins	14:38	14:25	
Category 1 T - Mean Target 19 mins	09:49	09:32	
Category 1 T - 90th Target 30 mins	17:12	17:03	
Category 2 - Mean Target 18 mins	45:05	47:20	
Category 2 - 90th Target 40 mins	102:51	109:38	
Category 3 - Mean Target 60 mins	197:03	194:40	
Category 3 - 90th Target 120 mins	545:28	534:56	

Measure	Month	YTD	Monthly Trend
Category 4 - Mean Target 180 mins	188:35	223:21	
Category 4 - 90th	487:37	602:49	
HCP 2hr - 90th	531:42	539:00	
HCP 4hr - 90th	751:58	758:33	
Call Answer (999 only) 95th	00:22	00:22	
Number of 2 min call delays	23	173	
Number of Handovers >60 minutes (all depts, including cohorts)	8324	50742	
% of Handovers < 30 mins (all depts, including cohorts) Target 95%	72.1%	72.8%	
% of Handovers < 15 mins (all depts, including cohorts) Target 65%	60.8%	61.4%	

111

Measure	Month	YTD	Monthly Trend
Call Answer - 95th Target <= 120 seconds	297	357	
Call Answer - Avg (mm:ss) Target <= 20 secs	55	59	
% of Calls Abandoned Target <= 3%	2.3%	2.4%	

Measure	Month	YTD	Monthly Trend
% of Calls Assessed by a Clinician Target >= 50%	45.7%	44.8%	
Proportion of Call Backs by a Clinician (P1 within 20 mins)	28.1%	23.8%	

Workforce

Measure	Month	YTD	Monthly Trend
Sickness (Target - top quartile of all Amb Services)	4.8%	5.4%	
Appraisals (YTD)	91.0%	91.0%	
Mandatory Training E&U (YTD)	48.5%	48.5%	

Measure	Month	YTD	Monthly Trend
Mandatory Training PTS (YTD)	53.3%	53.3%	
Number of Freedom to Speak up Enquiries	0	9	

Clinical Quality & Safety

Measure	Month	YTD	Monthly Trend
Total Incident Forms	876	5143	
No. of RIDDORS	4	33	
No. of Verbal Assaults	94	646	
No. of Physical Assaults	57	309	
Complaints	57	354	
PALS	156	1108	
Compliments	250	1341	

Measure	Month	YTD	Monthly Trend
Patient Safety (Total)	404	2433	
Patient Safety Harm	66	540	
Being Open (low harm only)	25	163	
Duty of Candour (moderate harm and above)	9	149	
Serious Incidents	32	218	
Claims	5	30	

Financial

Measure	Month	YTD	Monthly Trend
EBITDA £million (Plan £25.02m)	1.52	10.26	
Delivery of CIP Programme £million (Target £9.7M)	0.54	4.59	
Capital Expenditure £million (2022/23 £13.03m)	0.31	6.28	

Measure	Month	YTD	Monthly Trend
Better Payment Practice Code	89.4%	89.4%	
Overtime Spend	0	0	

Clinical Quality & Safety

Measure	Aug-22	YTD	Monthly Trend
Return of Spontaneous Circulation At Hospital (Comp)	42.86%	44.64%	
Cardiac Arrest Survival to discharge (Comp)	11.11%	12.89%	
Post ROSC Care Bundle	Not required in month	74.31%	

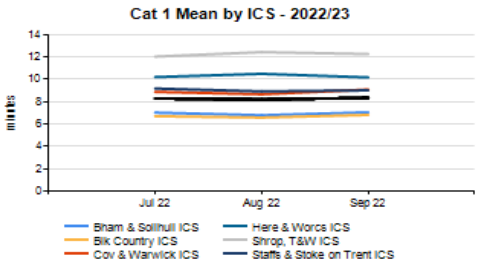
Measure	Aug-22	YTD	Monthly Trend
STEMI Care Bundle	72.49%	75.37%	
Stroke Diagnostic Bundle	89.94%	93.57%	
Sepsis Care Bundle	Not required in month	90.18%	

PTS

Measure	Aug-22	YTD	Monthly Trend
Achieved KPIs	68	68	

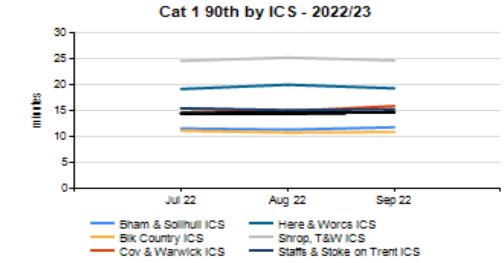
Measure	Aug-22	YTD	Monthly Trend
Failed KPIs	1	1	

Executive ICS Scorecard
September 2022
(YTD from July 2022)



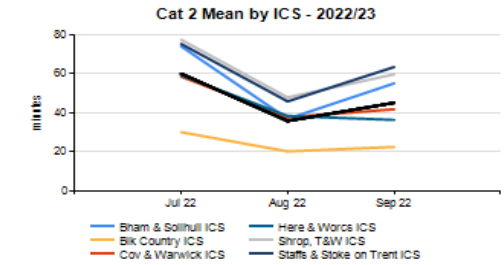
Priority	ICS	MTD	QTD	YTD
Cat 1 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	7:02	6:57	6:57
	NHS BLACK COUNTRY ICS	6:48	6:42	6:42
	NHS COVENTRY AND WARWICKSHIRE ICS	9:04	8:52	8:52
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	10:10	10:17	10:17
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	12:15	12:13	12:13
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	9:01	9:02	9:02
	WMAS	8:20	8:16	8:16

-------- WMAS



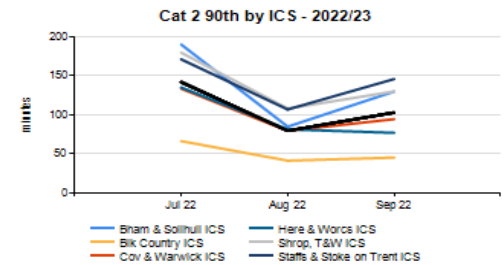
Priority	ICS	MTD	QTD	YTD
Cat 1 90th	NHS BIRMINGHAM AND SOLIHULL ICS	11:45	11:30	11:30
	NHS BLACK COUNTRY ICS	10:51	10:55	10:55
	NHS COVENTRY AND WARWICKSHIRE ICS	15:49	15:27	15:27
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	19:14	19:22	19:22
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	24:35	24:37	24:37
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	15:13	15:14	15:14
	WMAS	14:38	14:29	14:29

-------- WMAS



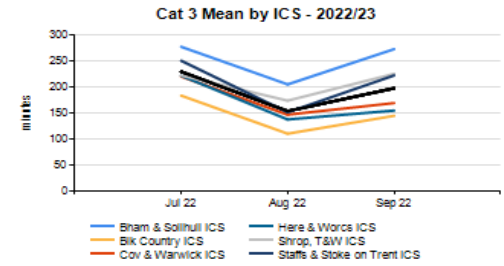
Priority	ICS	MTD	QTD	YTD
Cat 2 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	55:01	55:24	55:24
	NHS BLACK COUNTRY ICS	22:31	24:29	24:29
	NHS COVENTRY AND WARWICKSHIRE ICS	41:48	46:19	46:19
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	36:21	44:57	44:57
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	59:39	62:01	62:01
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	63:22	61:38	61:38
	WMAS	45:05	47:14	47:14

-------- WMAS



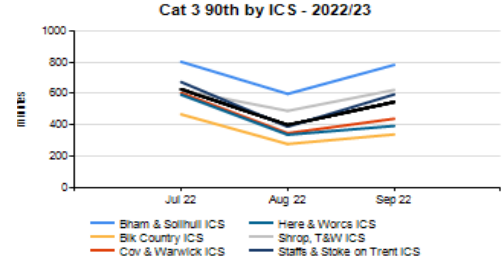
Priority	ICS	MTD	QTD	YTD
Cat 2 90th	NHS BIRMINGHAM AND SOLIHULL ICS	129:36	133:46	133:46
	NHS BLACK COUNTRY ICS	45:14	51:58	51:58
	NHS COVENTRY AND WARWICKSHIRE ICS	94:22	102:26	102:26
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	76:56	97:33	97:33
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	129:44	139:04	139:04
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	145:37	143:58	143:58
	WMAS	102:51	108:36	108:36

-------- WMAS



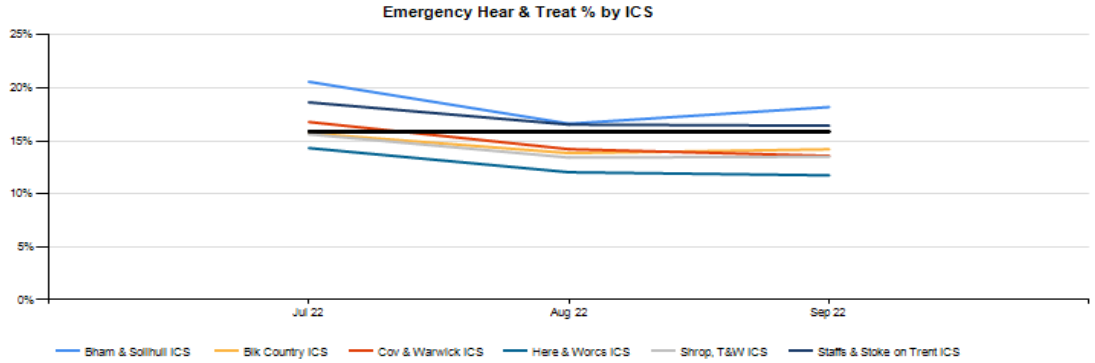
Priority	ICS	MTD	QTD	YTD
Cat 3 Mean	NHS BIRMINGHAM AND SOLIHULL ICS	272:01	246:28	246:28
	NHS BLACK COUNTRY ICS	144:07	143:41	143:41
	NHS COVENTRY AND WARWICKSHIRE ICS	168:37	176:07	176:07
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	154:13	168:43	168:43
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	224:38	204:44	204:44
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	221:35	202:38	202:38
	WMAS	197:03	190:07	190:07

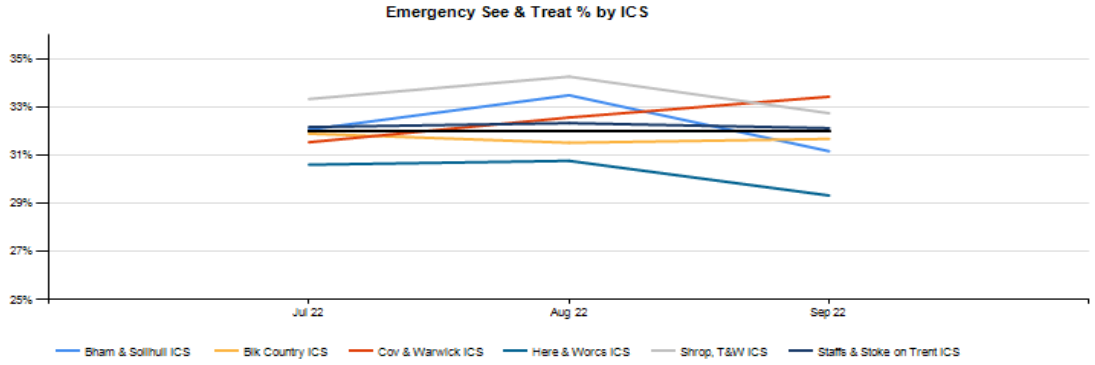
-------- WMAS

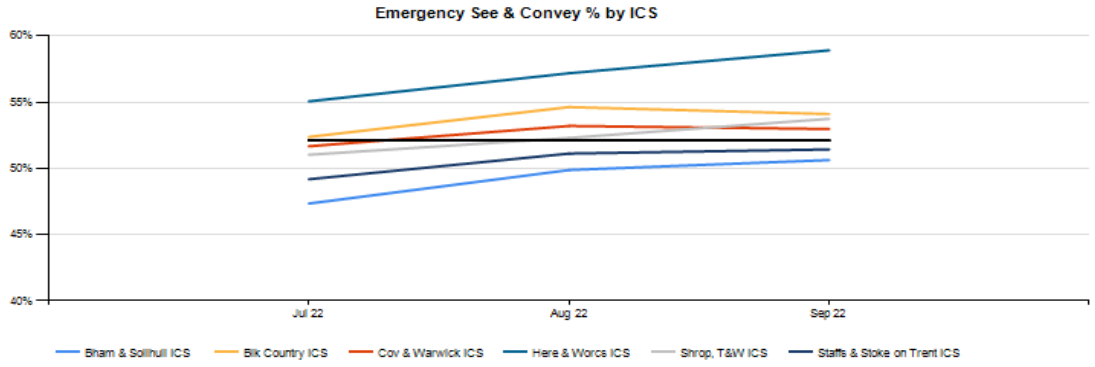


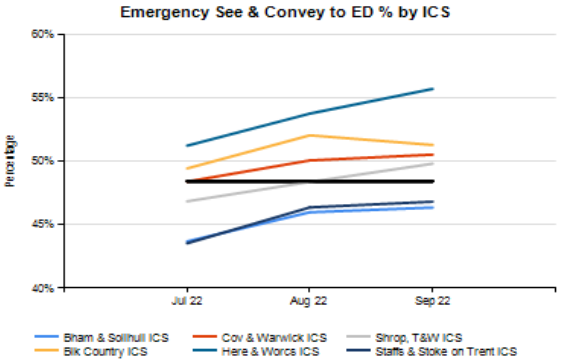
Priority	ICS	MTD	QTD	YTD
Cat 3 90th	NHS BIRMINGHAM AND SOLIHULL ICS	781:51	725:41	725:41
	NHS BLACK COUNTRY ICS	338:58	358:16	358:16
	NHS COVENTRY AND WARWICKSHIRE ICS	438:52	455:05	455:05
	NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	393:29	443:18	443:18
	NHS SHROPSHIRE, TELFORD AND WREKIN ICS	622:23	579:11	579:11
	NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	593:32	537:49	537:49
	WMAS	545:28	518:55	518:55

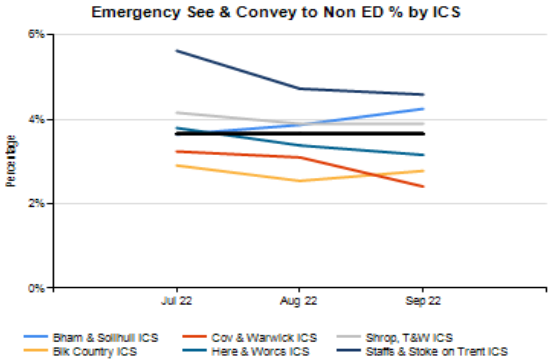
-------- WMAS


Emergency Hear & Treat % by ICS
25%
20%
15%
10%
5%
0%
Jul 22
Aug 22
Sep 22
Bham & Solihull ICS
Blk Country ICS
Cov & Warwick ICS
Here & Worcs ICS
Shrop, T&W ICS
Staffs & Stoke on Trent ICS

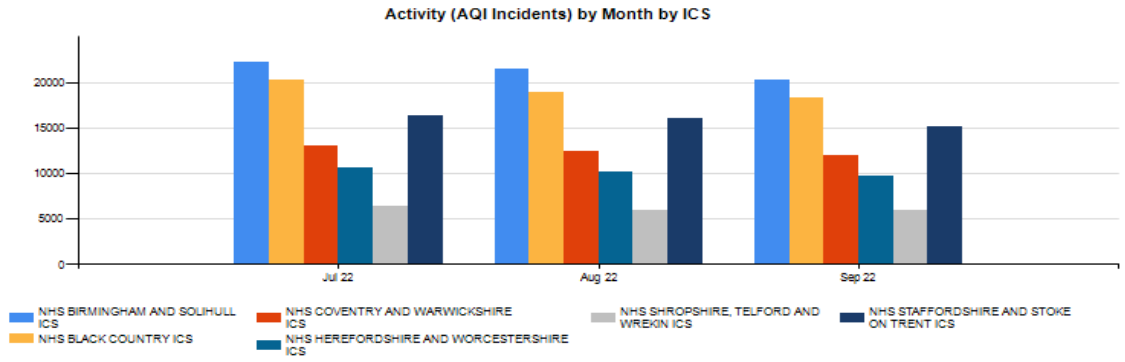

Emergency See & Treat % by ICS
35%
33%
31%
29%
27%
25%
Jul 22
Aug 22
Sep 22
Bham & Solihull ICS
Blk Country ICS
Cov & Warwick ICS
Here & Worcs ICS
Shrop, T&W ICS
Staffs & Stoke on Trent ICS

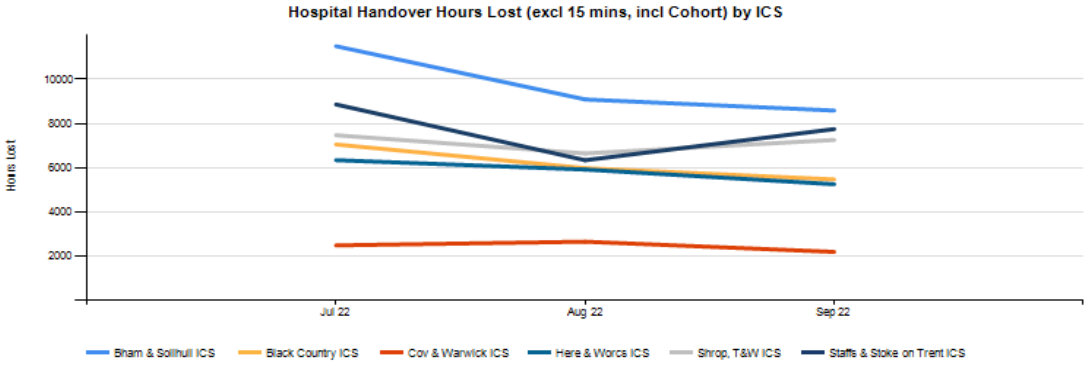

Emergency See & Convey % by ICS
60%
55%
50%
45%
40%
Jul 22
Aug 22
Sep 22
Bham & Solihull ICS
Blk Country ICS
Cov & Warwick ICS
Here & Worcs ICS
Shrop, T&W ICS
Staffs & Stoke on Trent ICS


Emergency See & Convey to ED % by ICS
Percentage
60%
55%
50%
45%
40%
Jul 22
Aug 22
Sep 22
Bham & Solihull ICS
Blk Country ICS
Cov & Warwick ICS
Here & Worcs ICS
Shrop, T&W ICS
Staffs & Stoke on Trent ICS


Emergency See & Convey to Non ED % by ICS
Percentage
6%
4%
2%
0%
Jul 22
Aug 22
Sep 22
Bham & Solihull ICS
Blk Country ICS
Cov & Warwick ICS
Here & Worcs ICS
Shrop, T&W ICS
Staffs & Stoke on Trent ICS

Executive ICS Scorecard
September 2022
(YTD from July 2022)





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 BOARD OF DIRECTORS

AGENDA ITEM: 06d MONTH: October 2022 PAPER NUMBER: 03d

Title	**Covid Monthly report**			
Sponsoring Director	Strategy and Engagement Director			
Author(s)/Presenter	Strategy and Engagement Director			
Purpose	To provide the monthly covid update to the Board of Directors and to request consideration to a transition in reporting.			
Previously Considered by	EMB			
Action Required from Committee/Group	Approval	x	Information	

Summary

The monthly covid report has been running for over two years (March 2020), essentially since the covid-pandemic began. The two years have covered a tumultuous period for the country, the NHS and WMAS, however, two years on, all are now having to live with covid and manage its continued existence.

Essentially covid has become part of our "business as usual" in terms of how we operate as a Trust, as an employer and a care provider. On this basis it is proposed that we move this report to a quarterly update going forwards.

The Trust is currently making preparations for the national covid enquiry, which recently started meeting. It is recommended the board receives updates from the covid enquiry planning group by exception. The group is chaired by Tony Yeoman, with the support of the Organisational Assurance Director, the Covid Incident Director and other key colleagues from across the organisation.

Related Trust Objectives/ National Standards	SO1 "Safety Quality and Excellence"
Risk and Assurance	Key covid indicators should as staff abstractions and cost still captured through normal reporting mechanisms
Legal implications/ regulatory requirements	The paper advocates for a move to reporting upon preparation for the covid enquiry (by exception) rather than continuing the current monthly covid report

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 06d MONTH: October 2022 PAPER NUMBER: 03d

Financial Planning	NA
Workforce Implications	NA
Communications Issues	NA
Equality and Diversity Implications	No equality and diversity implications are identified
Quality Impact Assessment	NA
Data Quality	Removing the monthly report will reduce the burden of internal reporting.

Action required by the Committee/Group

- To receive the recommendation to move the monthly covid report to a quarterly update
- In addition to moving the covid report to a quarterly update, EMB and the Board of Directors receive updates from the covid enquiry group by exception.

West Midlands Ambulance Service
University NHS Foundation Trust

Monthly COVID-19 Sitrep

01/09/2022 – 30/09/2022

Report Created 05/10/2022

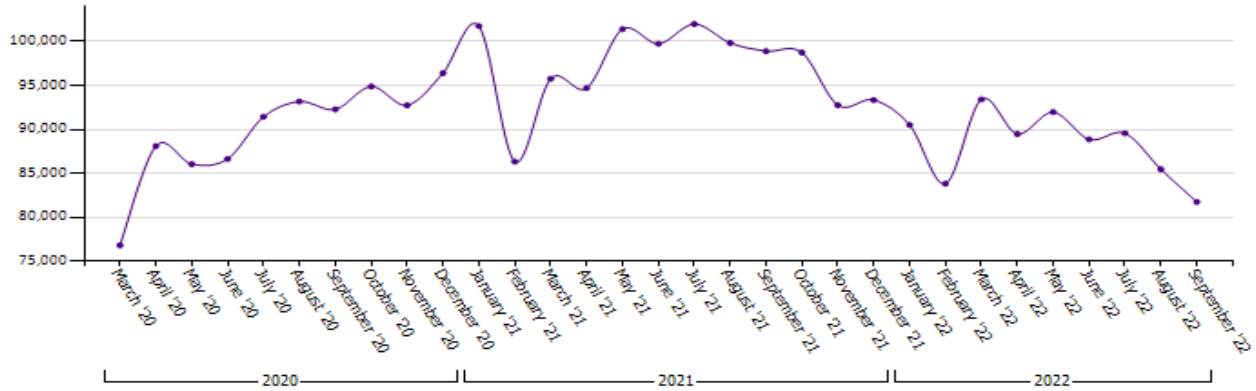
Welcome to the COVID-19 Monthly Report, produced by the Tactical Incident Command Team.

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.

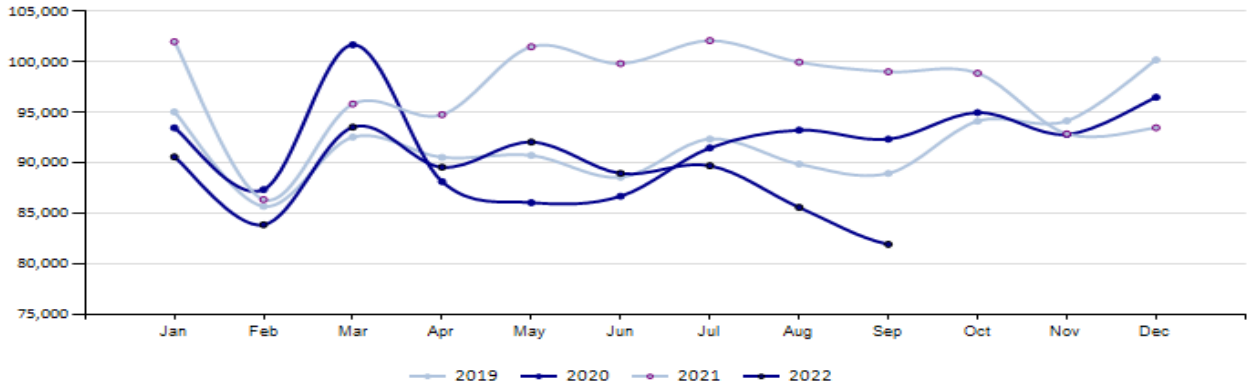
Data captured in this report has been taken from ORBIT report 1120 (unless otherwise stated), which provides information monthly.

Trust us to care.

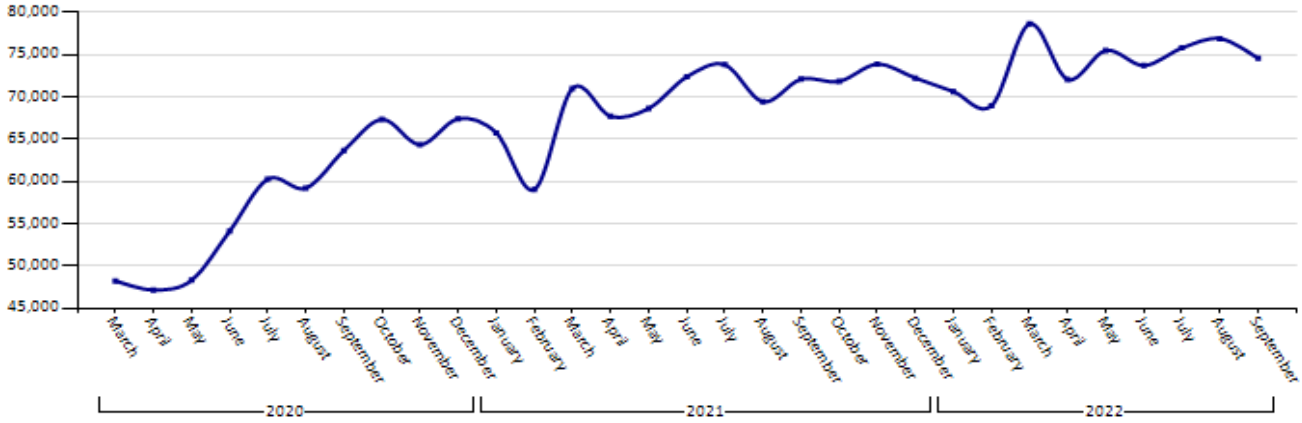
Monthly 999 Incident Activity



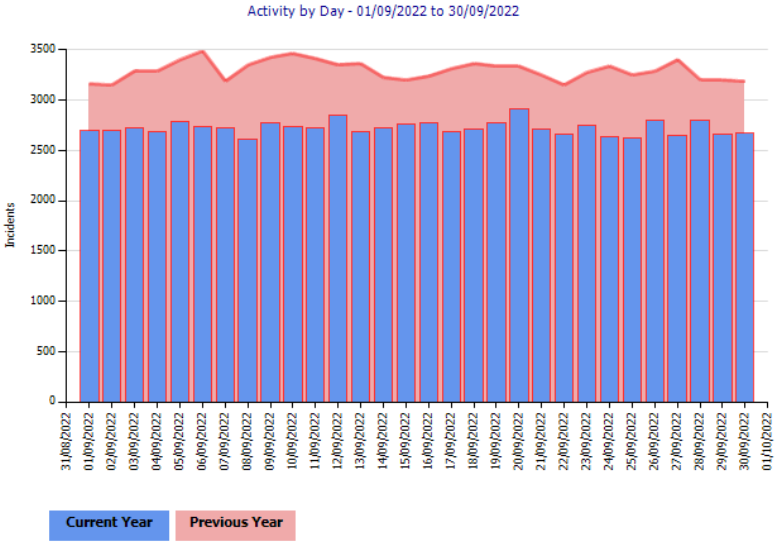
Monthly Emergency & Urgent Incidents Compared to Previous Years



Patient Transport Service Activity



E&U Incidents Compared to Previous Year (01/09/2022 to 30/09/2022, ORBIT 29 / 71 / 144)



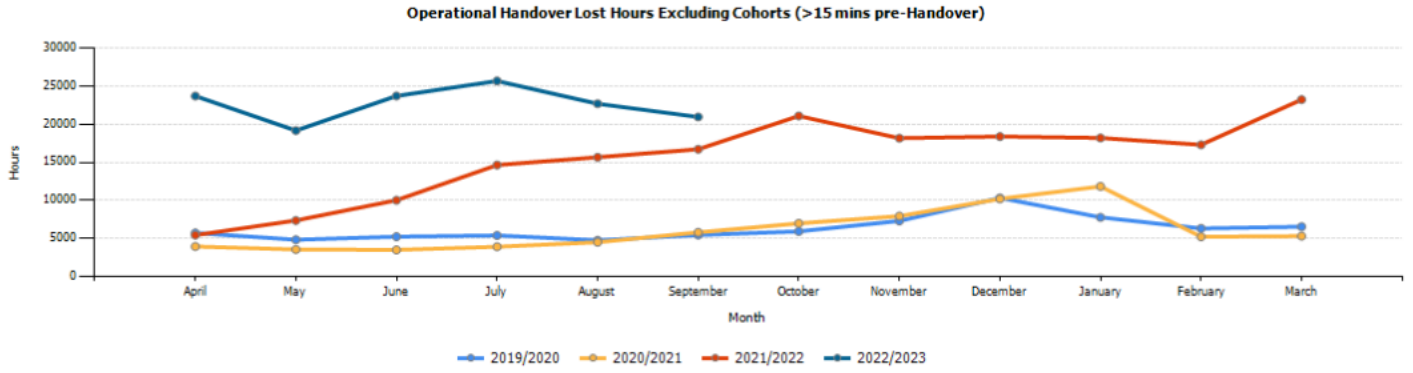
For clarity, an 'Incident' encompasses all 'See & Treat', 'See & Convey' and 'Hear & Treat' figures, it is classed as a call being opened and then closed following the appropriate disposition.

Daily E&U activity during September totalled 81,966 compared to August's total of 85,620 (4.5% decrease). This is a 20.8% decrease from September 2021, which saw 99,022 incidents. The 30th September 2022 now ranks 18th in the top 20 busiest days in the last 10 years (5644 calls). The busiest day remains the 19th of July 2021, which saw a total of 6420 calls. The 27th September saw the biggest variance in comparison to the same day last year (22.3% decrease in incidents)

Hospital Handover Lost Hours - >15mins Pre-Handover (ORBIT 17 / 1214)

	2021/2022												2022/2023					
Destination	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Alexandra	31:38:18	64:46:51	99:21:10	242:27:30	320:08:34	259:00:20	348:59:38	400:33:34	232:59:20	295:35:14	149:43:30	458:28:04	478:19:45	493:56:27	827:37:23	744:58:56	817:37:33	632:20:25
Birmingham Childrens	40:16:26	59:53:52	74:52:49	71:38:36	59:32:19	83:27:19	102:52:10	85:01:19	86:41:16	123:38:03	81:36:40	92:34:59	76:26:44	79:24:33	88:22:16	90:32:54	48:32:04	65:18:00
Burton	88:03:42	131:33:49	94:59:03	157:21:15	137:36:04	184:05:38	285:38:42	300:13:58	331:27:53	306:48:53	270:20:19	427:01:05	674:40:59	485:57:11	630:06:54	676:23:35	676:14:40	530:02:37
City (Birmingham)	85:10:55	84:02:12	158:43:37	258:28:31	196:16:04	252:16:13	301:16:32	349:00:27	283:26:29	251:51:38	197:45:12	291:21:10	260:14:21	237:47:20	335:58:56	278:50:01	287:39:02	298:17:35
County Hospital (Stafford)	33:00:13	48:16:37	58:59:18	56:38:33	61:17:27	96:21:35	78:14:55	100:40:58	146:13:46	174:14:09	83:57:44	172:43:17	122:43:58	125:48:50	84:31:19	100:40:34	108:46:57	146:00:43
George Elliot	93:11:34	87:56:29	92:34:13	104:51:44	99:54:10	98:39:28	147:17:21	156:51:20	228:46:06	215:28:36	154:36:27	285:55:54	261:14:39	204:54:33	214:20:26	326:59:14	263:21:36	183:51:29
Good Hope	299:18:25	626:25:26	859:41:11	972:42:18	1132:06:10	1186:43:22	1772:00:36	1454:16:03	1234:49:33	1116:36:32	1274:50:13	1702:41:14	1689:38:17	1220:21:40	1911:11:01	1753:07:50	1552:38:53	1405:29:47
Heartlands	567:52:16	824:33:38	1373:03:41	2069:34:43	2293:27:31	1951:29:11	2873:37:16	2352:50:33	2163:41:22	2102:52:29	1979:41:42	2391:45:59	2141:37:29	2008:33:04	2535:07:26	2679:56:25	2068:10:13	2013:57:48
Hereford County	127:32:11	142:57:40	198:34:26	240:54:56	330:49:51	293:07:26	562:24:57	226:07:33	413:04:17	371:48:56	345:19:13	673:28:45	349:23:20	182:56:38	297:11:06	463:16:51	449:39:01	297:21:05
New Cross	226:54:52	371:00:10	589:05:53	882:36:34	1176:51:02	1383:44:36	1671:09:55	1072:38:37	1294:19:53	872:02:06	893:35:51	1319:15:29	1040:21:05	926:49:34	1032:31:45	1474:06:21	1433:47:25	1193:48:28
New Queen Elizabeth Hosp	624:02:54	726:39:07	963:38:03	1576:57:49	1819:47:08	1630:28:15	1839:35:13	1451:15:26	1221:08:53	1460:59:00	1430:11:58	1872:57:56	1995:16:21	1470:31:39	1757:51:44	1851:49:21	1472:41:17	1396:24:14
Princess Royal	232:08:12	327:47:01	440:41:03	851:18:03	515:16:35	768:16:25	1290:11:28	1241:22:42	1165:19:07	1098:58:01	1191:13:10	1437:45:31	1616:04:40	1202:30:35	1590:44:25	1693:09:30	1541:38:54	1456:51:11
Royal Shrewsbury	456:44:54	539:27:58	880:17:44	1202:39:40	1249:27:06	1375:21:10	1281:12:55	1310:56:43	1162:58:30	1213:17:24	957:12:26	1391:05:02	1415:39:25	1273:51:42	1352:22:12	1783:24:42	1492:16:09	1590:29:56
Royal Stoke Univ Hosp	659:38:48	859:18:43	986:33:39	1559:44:21	1954:31:45	1810:53:10	2805:30:13	2514:26:44	2948:48:04	3036:43:10	2921:06:29	3925:28:25	4119:26:30	2346:59:33	3872:49:44	4283:43:10	2832:34:10	3743:40:15
Russells Hall	277:49:29	559:17:21	646:03:25	795:14:02	620:11:55	1314:02:02	1429:59:39	930:20:47	1124:40:52	899:13:51	976:19:56	1186:04:00	1292:38:50	1177:46:22	867:31:34	1252:31:59	1317:26:00	1129:44:55
Sandwell	273:14:26	224:35:15	257:53:17	434:38:46	351:35:22	635:03:04	689:08:44	553:33:22	671:43:13	534:12:39	574:56:33	831:53:22	673:38:02	806:46:16	718:14:35	623:49:49	513:20:46	510:00:26
Solihull	00:24:54		00:09:56	01:17:48	01:14:49	00:09:48		00:41:40	00:25:49	00:46:15		00:17:01	00:27:00	00:36:50	00:27:26	00:13:21	01:10:13	01:01:34
St Cross	01:23:59	00:20:52	00:15:16	01:41:39	01:08:36	00:14:16	00:28:04	01:53:56	01:01:15	01:32:23	00:01:51	01:53:26	04:41:00	00:17:20	01:10:28	02:31:24	01:18:01	01:28:27
Uni Hospital Cov & War	577:03:45	636:35:28	799:25:41	806:26:54	668:44:05	1112:14:01	776:16:40	912:14:28	805:30:02	990:09:19	919:18:18	1066:49:06	1444:57:40	1215:23:53	1418:45:47	1478:22:26	1805:46:30	1491:46:55
Walsall Manor	124:26:35	121:55:19	154:38:45	190:15:37	201:03:12	272:14:10	253:43:41	195:53:43	200:27:22	194:26:42	189:04:04	226:35:08	254:58:15	258:39:29	307:32:01	299:29:17	313:31:01	212:29:37
Warwick	237:54:47	244:51:18	287:01:42	340:24:37	455:52:42	442:34:14	718:00:33	547:08:06	364:50:02	350:57:43	351:22:32	463:36:34	492:39:53	406:29:03	476:29:00	487:37:04	390:28:08	402:38:32
Worcestershire Royal	359:48:35	664:25:44	992:20:28	1818:06:06	2010:00:05	1562:27:16	1859:28:05	2006:26:05	2305:10:35	2585:39:01	2358:02:11	3015:56:57	3269:11:27	3038:29:11	3394:05:12	3343:08:08	3298:15:16	2251:49:07
Overall	5417:40:10	7346:40:50	10008:54:20	14636:03:02	15656:52:32	16712:52:59	21087:07:17	18164:28:04	18387:33:39	18197:52:04	17300:16:19	23235:38:24	23704:49:40	19164:51:43	23715:02:40	25688:42:52	22689:53:49	20954:53:06

The above table highlights the significant increase in hospital handover delays currently experienced by WMAS conveying patients to hospitals in the West Midlands. When comparing September 2021 (16712:52:59) to September 2022 (20954:53:06), there has been a significant increase in hours lost (circa. 25% increase). The graph below provides a visual representation when comparing the current delays experienced to those from April 2019 onwards. The table at the bottom of the page outlines the Hospital activity during September 2022 (ORBIT 17), highlighting that 73.8% of Arrival to Handover times were out of target (15min target)



Average Time Periods upto 15 mins | 15-30 mins | 30 mins +

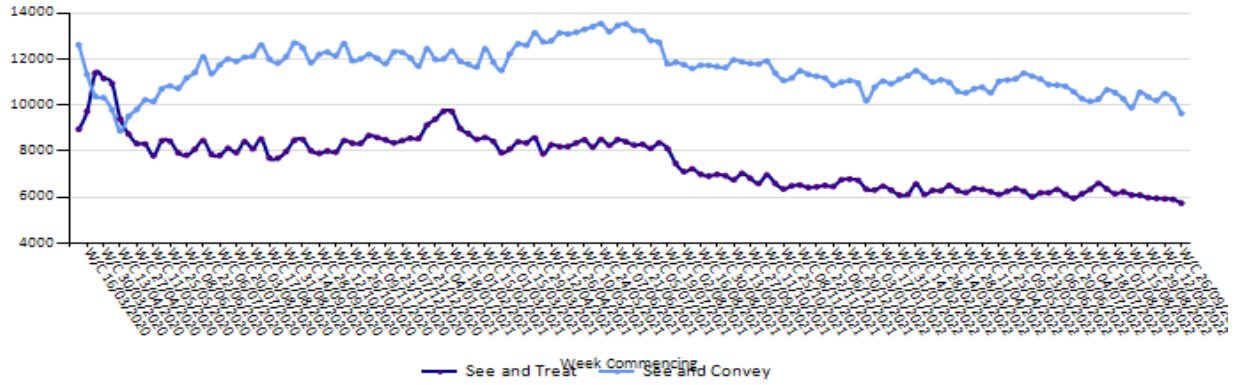
		Conveyed To ED			All Departments		Handover Time Recorded		*Arrival To Handover (15min target)					**Handover To Clear (15min target)			Arrival To Clear (turnaround) (30min target)						
		Grand	Handover Time Recorded						in target		out of target		avg; time	out of target		avg; time	in target		out of target		avg; time	max; time	Total Over 1hr
Acute Trust Name	Hospital Conveyed To	Total	Total	%	Total	Forecast	Total	%	Total	%	Total	%	h:m:s	Total	%	h:m:s	Total	%	Total	%	h:m:s	h:m:s	Total
Birmingham Childrens	Birmingham Childrens	510	447	87.6%	592	914	482	81.4%	353	59.6%	239	40.4%	0:18:34	261	44.1%	0:19:28	367	62.0%	225	38.0%	0:30:31	1:41:59	18
Dudley Group Of Hospitals	Russells Hall	2,730	2,605	95.4%	2891	3899	2713	93.8%	601	20.8%	2290	79.2%	1:03:00	1352	46.8%	0:22:17	662	22.9%	2229	77.1%	1:20:04	9:43:06	576
Heartlands Foundation	Good Hope	1,879	1,677	89.2%	2093	3046	1845	88.2%	368	17.6%	1725	82.4%	1:18:55	936	44.7%	0:24:28	457	21.8%	1636	78.2%	1:33:30	9:39:52	639
	Heartlands	2,597	2,285	88.0%	3053	4581	2648	86.7%	474	15.5%	2579	84.5%	1:29:14	1374	45.0%	0:27:06	626	20.5%	2427	79.5%	1:43:48	10:57:53	853
	Solihull	n/a	n/a	n/a	3	274	0	0.0%	0	0.0%	3	100.0%	0:35:31	3	100.0%	0:35:31	1	33.3%	2	66.7%	0:35:31	0:42:40	0
The Royal Wolverhampton	New Cross	3,072	2,851	92.8%	3411	4611	3039	89.1%	1178	34.5%	2233	65.5%	0:47:21	1545	45.3%	0:21:37	1194	35.0%	2217	65.0%	1:01:49	11:51:18	631
Sandwell & West Birmingham	City (Birmingham)	2,080	2,021	97.2%	2240	2775	2106	94.0%	1216	54.3%	1024	45.7%	0:21:28	902	40.3%	0:16:39	1151	51.4%	1089	48.6%	0:35:58	4:34:43	135
	Sandwell	2,149	2,036	94.7%	2266	2820	2102	92.8%	667	29.4%	1599	70.6%	0:35:09	1016	44.8%	0:19:31	714	31.5%	1552	68.5%	0:50:21	7:28:42	262
University Hospital Birmingham	New Queen Elizabeth Hosp	3,048	2,794	91.7%	3311	4501	2884	87.1%	570	17.2%	2741	82.8%	0:53:55	1328	40.1%	0:19:56	820	24.8%	2491	75.2%	1:07:04	11:47:55	676
Walsall Hospital	Walsall Manor	2,647	2,610	98.6%	2723	3489	2641	97.0%	1341	49.2%	1382	50.8%	0:17:52	1075	39.5%	0:16:05	1309	48.1%	1414	51.9%	0:32:51	2:12:28	95
Hereford	Hereford County	1,440	1,291	89.7%	1453	2004	1296	89.2%	641	44.1%	812	55.9%	0:26:18	586	40.3%	0:17:18	674	46.4%	779	53.6%	0:38:52	5:06:12	152
Shrewsbury & Telford	Princess Royal	1,512	1,113	73.6%	1639	2263	1149	70.1%	146	8.9%	1492	91.0%	1:48:18	966	58.9%	0:40:26	224	13.7%	1415	86.3%	2:01:20	11:54:30	707
	Royal Shrewsbury	1,209	739	61.1%	1302	1804	775	59.5%	97	7.5%	1204	92.5%	3:06:52	813	62.4%	0:59:23	168	12.9%	1134	87.1%	3:17:53	11:54:32	675
Worcester Hospitals	Alexandra	1,622	1,533	94.5%	1648	2175	1548	93.9%	770	46.7%	878	53.3%	0:39:23	643	39.0%	0:17:42	754	45.8%	894	54.2%	0:53:23	7:12:02	353
	Worcestershire Royal	2,324	1,758	75.6%	2578	3235	1849	71.7%	673	26.1%	1905	73.9%	1:45:31	1452	56.3%	0:44:59	737	28.6%	1841	71.4%	1:58:34	11:47:20	902
George Elliot	George Elliot	1,123	1,087	96.8%	1160	1518	1112	95.9%	249	21.5%	911	78.5%	0:24:07	417	35.9%	0:14:41	361	31.1%	799	68.9%	0:37:29	2:29:21	74
University Coventry & Warwick	St Cross	n/a	n/a	n/a	7	11	0	0.0%	0	0.0%	7	100.0%	0:27:38	7	100.0%	0:27:38	5	71.4%	2	28.6%	0:27:38	0:34:33	0
	Uni Hospital Cov & War	3,268	2,896	88.6%	3582	4973	3093	86.3%	539	15.0%	3043	85.0%	0:41:39	1513	42.2%	0:18:48	888	24.8%	2694	75.2%	0:54:05	7:16:22	711
South Warwickshire	Warwick	1,619	1,565	96.7%	1663	2127	1593	95.8%	273	16.4%	1390	83.6%	0:29:46	780	46.9%	0:16:44	394	23.7%	1269	76.3%	0:44:48	5:37:13	219
Burton Foundation	Burton	994	865	87.0%	1134	1421	983	86.7%	141	12.4%	993	87.6%	0:46:20	485	42.8%	0:19:56	216	19.0%	918	81.0%	0:58:59	7:00:00	302
Univ Hosp North Mids	County Hospital (Stafford)	846	807	95.4%	887	1100	847	95.5%	394	44.4%	493	55.6%	0:28:34	325	36.6%	0:16:26	417	47.0%	470	53.0%	0:42:35	7:31:35	87
	Royal Stoke Univ Hosp	3,268	2,482	75.9%	3687	5643	2726	73.9%	662	18.0%	3025	82.0%	2:03:59	2100	57.0%	0:42:49	768	20.8%	2919	79.2%	2:17:58	11:43:28	1520
	WMAS Hospital Summary	39937	35,462	88.8%	43323	59183	37431	86.4%	11353	11353	31968	73.8%		19879	45.9%		12907	29.8%	30416	70.2%			9587

Response Status (30/09/2022)

The month of September remained a significant challenge nationally, as extreme pressures linked to demand and hospital delays continued. There have been prolonged periods of Surge 2, 3 & 4 which were managed effectively in line with the Trust's Surge Demand Management Plan. Below is a snapshot of the National REAP summary, taken from information produced by the National Ambulance Co-ordination Centre (NACC) on the 30th September, highlighting the continued pressures across the country.

Trust	REAP	SURGE
EEAST	4	4
EMAS	3	4
LAS	4	4
NEAS	3	3
NWAS	3	4
SCAS	3	4
SECAmb	3	4
SWAST	4	3
WMAS	4	4
YAS	3	4
WAST	3	4
SAS	4	N/A
IoW	3	N/A

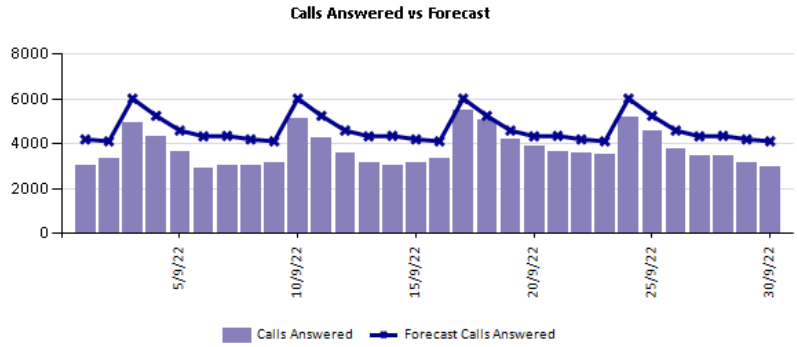
Conveyances & Non-Conveyances (16/03/2020 – 30/09/2022 ORBIT 58)



Note:
1: Data is based upon Incident Volume and not Patient Volume.
2: Volumes shown are all conveyances with or without a known hospital code/name.

CCG	Total Incidents	Hear & Treat		See & Convey		See & Treat	
		Total	As % of total incidents	Total	As % of total incidents	Total	As % of total incidents
NHS BIRMINGHAM AND SOLIHULL ICS	19,500	3,529	18.1%	9,885	50.7%	6,086	31.2%
NHS BLACK COUNTRY ICS	17,573	2,489	14.2%	9,513	54.1%	5,571	31.7%
NHS COVENTRY AND WARWICKSHIRE ICS	11,357	1,542	13.6%	6,017	53.0%	3,798	33.4%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	9,353	1,090	11.7%	5,516	59.0%	2,747	29.4%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	5,762	773	13.4%	3,100	53.8%	1,889	32.8%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	14,423	2,368	16.4%	7,420	51.4%	4,635	32.1%
CCG Total	77,968	11,791	15.1%	41,451	53.2%	24,726	31.7%

Daily 111 Calls Answered vs Forecast (01/08/2022 – 31/08/2022, ORBIT 1014)

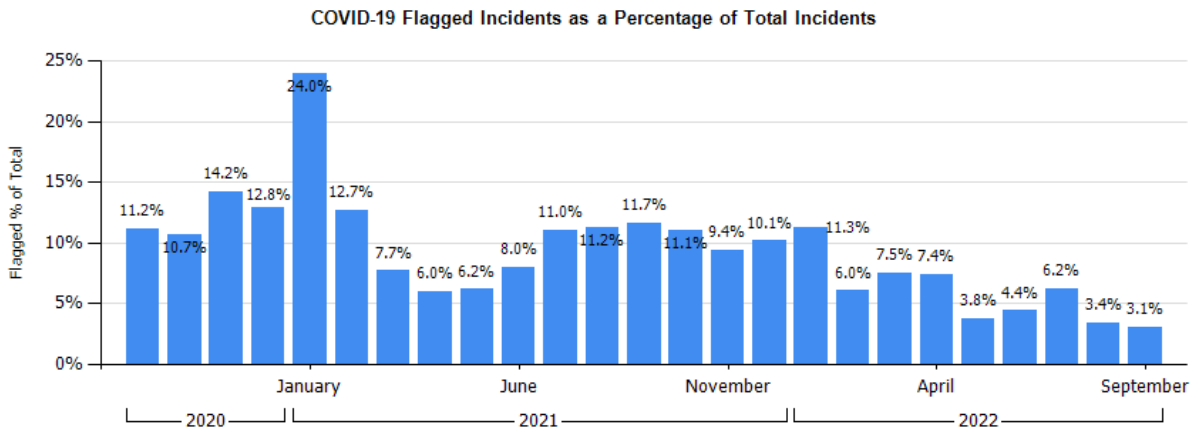


The graph above shows the Daily 111 Calls Answered for the month of September, with call answering remaining fairly consistent with forecasted patterns. The 17th September saw the most calls answered, totalling 5489, despite this being 8.96% below WMAS forecast. Whilst WMAS is forecasting a level of demand it is important to note the forecast and actuals continue to be signifcantly in excess of what was planned for with our commisioners when taking the service on, by as much as 40%

COVID-19 Incidents 01/09/2020 to 30/09/2022 (ORBIT 1090)

The information below is taken from ORBIT 1090 and includes all cases flagged in the CAD as 'Coronavirus'

Incidents	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Total
All Incidents	82175	96032	93019	97419	90790	87351	96823	89798	102105	89164	89933	85806	82175	96032	93019	97419	90790	87351	96823	89798	102105	89164	89933	85806	82175	2283005
Cases flagged in CAD	9173	10255	13227	12513	21770	11067	7443	5393	6288	7114	9899	9642	9580	10635	8712	9882	10214	5283	7284	6629	3840	3934	5584	2938	2527	210826
Flagged % of Total	11.2%	10.7%	14.2%	12.8%	24.0%	12.7%	7.7%	6.0%	6.2%	8.0%	11.0%	11.2%	11.7%	11.1%	9.4%	10.1%	11.3%	6.0%	7.5%	7.4%	3.8%	4.4%	6.2%	3.4%	3.1%	9.2%

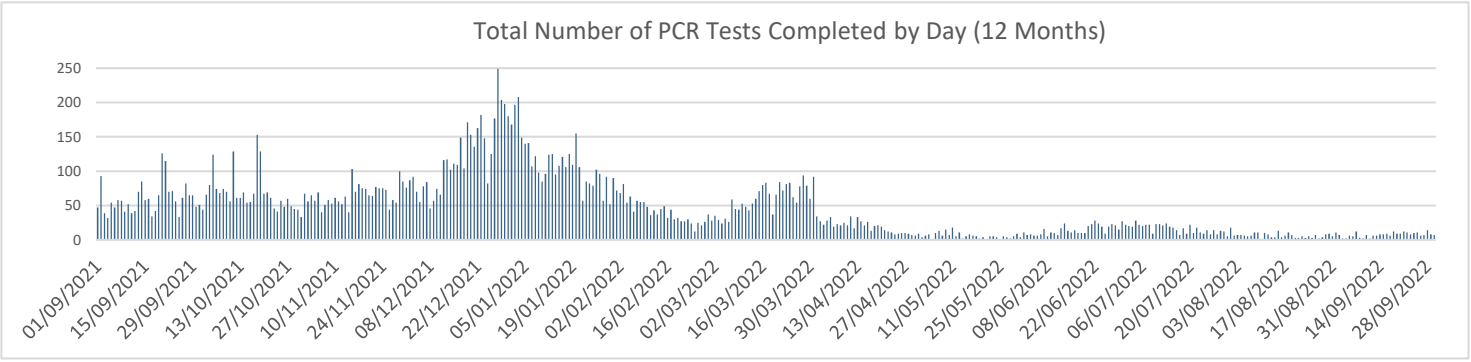


Over the last 12 months, the number of COVID related cases that the Trust repsonded to matches the trend seen throughout the UK with regards to the number of COVID cases reported. September saw a 0.1% decrease from August in the percentage of calls flagged as 'Coronavirus' within the CAD (2527 from 82,175). Whilst the numbers of COVID like presentations continune to decrease in comparison to previous months, our hospitals still have a static number of COVID inpatients, some being actively treated for COVID, others diagnosed incidently whilst being treated for other conditions.

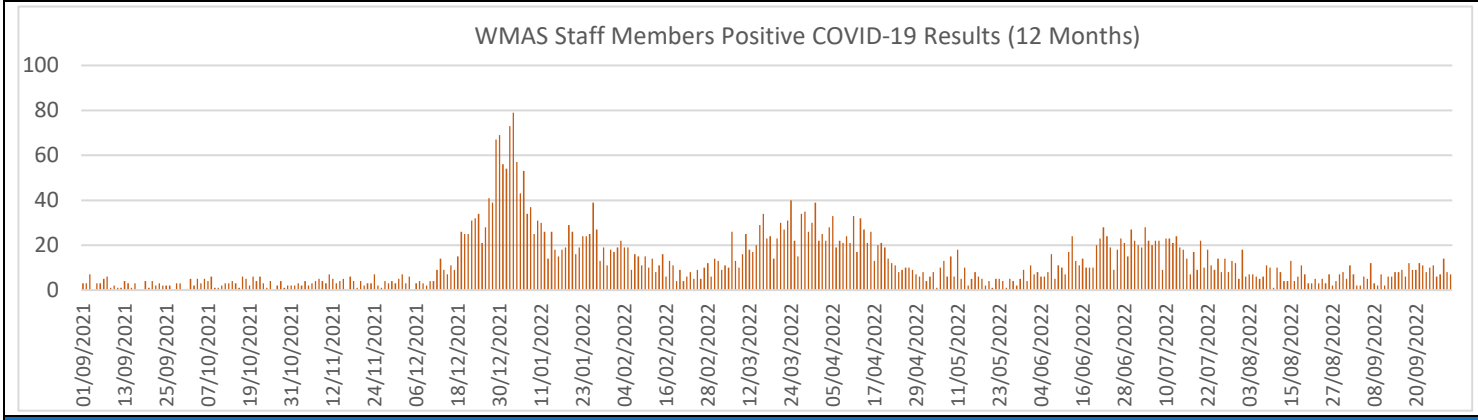
Staff Sickness Breakdown (Strategic Daily Sitrep 30/09/2022)

	EOC & Perf	111	A&E	PTS	Other	WMAS Staff Total	WMAS in Hospital	WMAS in ICU / HDU
COVID Abstraction	3	12	28	1	0	44	0	0
COVID Shielding	0	0	0	0	0	0		
COVID Test & Trace	0	0	0	0	0	0		
COVID Sickness	4	9	8	6	3	30		
Normal Sickness	40	80	145	59	13	337		
TOTAL	47	101	181	66	16	441		

Staff Swabbing (PCR) Summary (01/09/2021 – 30/09/2022)



Staff Positive COVID-19 Cases (01/09/2021 – 30/09/2022)



Staff Testing Summary (August 2022)

September saw a 14.5% increase in WMAS staff contracting COVID-19 in comparison to August, obviosuly there is some concern about the winter, particualrly when we consider the volume of cases that was experienced last December and this January. There has not been any new changes to how COVID-19 in managed in the workplace, however further change could happened in the coming months. LFD Tests continue to be available for NHS staff and despite weekly testing no longer being a requirment staff are being encoraged to test if they feel unwell or have any type of symptom. Masks continue to be universally adopted in clinical settings and there are no plans to reverse this, as a Trust we are prepared for re-introducing measures in the heiracy of controls should they become nessesary.

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Staff Positive 2020	0	0	0	357	80	12	7	4	63	146	219	303
Staff Positive 2021	537	97	13	1	6	25	120	156	72	96	103	609
Staff Positive 2022	942	323	684	562	187	430	503	199	226			

Summary of Testing by Provider (01/03/2020 to 31/08/2022)

	Total Offered	Total	Positive	Negative	Awaiting	Invalid	DNA
Wolverhampton Drive-In	1,606	1,282	300	938	0	10	34
Better2Know Home Test	190	190	65	125	0	0	0
Edgbaston	240	188	75	108	0	1	4
WMAS Community Test	16,402	16,402	2,738	13,235	0	271	157
WMAS Test to Release	4,960	4,960	287	4,437	0	115	121
WMAS LFT PCR	2,295	2,295	1,842	450	0	2	1
Asymptomatic Test	2,757	2,757	36	2,696	0	13	12
Self-arranged Test	5,272	5,272	1,839	3,245	0	133	55
City & Sandwell	180	106	25	81	0	0	0
Unconfirmed + LFT	0	2,222	2,221	1	0	0	0
WMAS LAMP Test	0	552	35	516	0	0	1

Summary of Testing Results (01/03/2020 to 30/09/2022)

(YTD)	Swabs Offered	Swabs Sent	Positive	Negative	Awaiting	Invalid	DNA
Count	33,902	36,226	9,463	25,832	2	545	385
% of Swabs Sent		100%	26.1%	71.3%	0.0%	1.5%	1.1%

Test Results by NHS Ethnic Categories (01/03/2020 to 30/08/2022)

* Exclude DNA, Invalid and Wait	Total	Positive	% Positive	Negative	% Negative
Total of all Tests*	35,190	8,964	26.1%	25,339	74.3%
Non BAME Total*	24,043	6,246	26.6%	17,222	73.9%
BAME Total*	2,942	791	27.7%	2,064	72.9%
Unknown and Not Stated	8,205	1,927	24.1%	6,053	75.9%

NHS Foundry Reported PPE Stock Levels – Ops / PTS / Anchor Brook (IPC PPE Audit 29/09/22)

	Item	Anchor Brook (Push stock only)	A/E Hubs Fleet Tracker	PTS IPC PPE Stock Levels	Quarantined (Ops)	HART Base (extra)	Total Stock Today
NHS FOUNDRY	Body Bags	366	135				501
	Face Mask IIR (Ear Loops) (Excl. Sensitive Alternatives)	89,100	39,900	63,910			192,910
	Face Mask IIR (Ties)	4,000					4,000
	Gloves (L) - Non-Sterile Nitrile (6N) Standard Cuff	222,900	56,500	16,200			295,600
	Gloves (M) - Non-Sterile Nitrile (6N) Standard Cuff	297,600	39,600	22,900			360,100
	Gloves (S) - Non-Sterile Nitrile (6N) Standard Cuff	64,400	34,800	16,300			115,500
	Gloves (XL) - Non-Sterile Nitrile (6N) Standard Cuff	8,700	40,800	15,600			65,100
	Gloves (XS) - Non-Sterile Nitrile (6N) Standard Cuff	23,600	24,900	14,800			63,300
	Hand Hygiene Alcohol Gel - 151-500ml DESK PUMP	308	142	347			797
	Hand Hygiene Alcohol Gel - 50-150ml TOTTLES	1,600	1,305	960			3,865

PPE Mutual Aid Summary

Below is the summary for the Mutual Aid provided to Trusts from 1st October 2021 – 30th September 2022. A detailed list of items allocated to other Trusts through Mutual Aid is held in the Tactical Command Cell and is updated regularly.

Date	Product Code	Product Description	Quantity	Order number	Trust Allocated to	Date
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	14395	n/a	Combined - Shrewsbury, Aston, Stoke, Bedworth and Bromsgrove	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	2995	n/a	Combined - Shrewsbury, Aston, Stoke, Bedworth and Bromsgrove	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1995	n/a	Combined - Shrewsbury, Aston, Stoke, Bedworth and Bromsgrove	06.10.21
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	1	n/a	Shrewsbury SY3 8XQ	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	1	n/a	Shrewsbury SY3 8XQ	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1	n/a	Shrewsbury SY3 8XQ	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	1	n/a	Aston B7 5TE	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1	n/a	Aston B7 5TE	06.10.21
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	1	n/a	Aston B7 5TE	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	1	n/a	Stoke ST6 4JH	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1	n/a	Stoke ST6 4JH	06.10.21
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	1	n/a	Stoke ST6 4JH	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	1	n/a	Bedworth CV12 8NF	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1	n/a	Bedworth CV12 8NF	06.10.21
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	1	n/a	Bedworth CV12 8NF	06.10.21
Oct-21	n/a	PROSUM Hypodermic Needle 21g (vaccinations)	1	n/a	Bromsgrove	06.10.21
Oct-21	n/a	PROSUM Syringe with Needle 1ml luer slip 23g	1	n/a	Bromsgrove	06.10.21
Oct-21	n/a	Safew ay 2ml Syringe (Vaccinations)	1	n/a	Bromsgrove	06.10.21
Aug-21	n/a	Lateral Flow Test Kit	135	n/a	University Hospitals Birmingham NHS Foundation Trust- QE	31.08.21
Jul-21	n/a	Tympanic covers	21120	Various	Black Country Partnership NHS Foundation Trust	06.07.21
Jul-21	n/a	Tympanic Genius	2	Various	Black Country Partnership NHS Foundation Trust	06.07.21
Jul-21	n/a	Moisturiser	348	Various	Walsall Healthcare NHS Trust	06.07.21
Jul-21	n/a	Moisturiser	192	Various	Birmingaham & Solihull Mental	06.07.21
Jul-21	n/a	PRPH Centurion Filter	382	Various	Auction	09.07.21
Jul-21	n/a	Gentlew ash 1ltr	450	Various	Kettering Hospital	12.07.21
Jul-21	n/a	Hand Sanitiser	450	Various	Kettering Hospital	12.07.21
Jul-21	n/a	Moisturiser	60	Various	Kettering Hospital	12.07.21
Jul-21	n/a	Hand Sanitiser	450	Various	Stoke Hospital (University Hospitals of North Midlands NHS	14.07.21
Jul-21	n/a	Tympanic cover 303030 for Genius Inf a Red Cardinal	1	Various	Stoke Hospital (University Hospitals of North Midlands NHS Trust)	14.07.21
Jul-21	n/a	Generic Coverall Type 3B	20	Various	Stoke Hospital (University Hospitals of North Midlands NHS	14.07.21
Jul-21	n/a	Special Wear Coverall M	25	Various	Stoke Hospital (University Hospitals of North Midlands NHS	14.07.21
Jul-21	n/a	Generic Supertouch Coverall XXL	20	Various	Stoke Hospital (University Hospitals of North Midlands NHS Trust)	14.07.21
Jul-21	n/a	Disposable Aprons	100	Various	Stoke Hospital (University Hospitals of North Midlands NHS	14.07.21
Jul-21	n/a	Chloriclean Tablets	1box of 200	Various	Stoke Hospital (University Hospitals of North Midlands NHS	14.07.21

General Notes & Commentary (September 2022)

1. The national covid enquiry “module 2” opened in September, which focuses on Governement decision making, between January 2020 and February 2022.
2. Following the reduction in PPE use on the back of PPE guidance changes, the burn rate (so the volume we use each week) has been adjusted downwards for the purpsoes of forward ordering. This will ensure WMAS doesn’t develop an unecessary level of stock holding.
3. Approximately 13k type IIR ear looped face masks from the NHS England push remain in quarantine, at the request of NHSE, we are yet to receive guidance on next steps.
4. The WMAS covid enquiry group continues to meet, deveoping our internal preparations should evidence be required to be submitted from us as an individual trust.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 06e MONTH: October 2022 PAPER NUMBER: 03e

EPRR Update	
Sponsoring Director	Chief Executive Officer
Author(s)/Presenter	James Williams – Head of Emergency Planning
Purpose	The associated reports are to provide the board with an overview of EPRR activity over the last 6 months and assurance regarding the organisation's annual submission against core standards. Note deep dive submission relating to 'Evacuation & shelter' which does not form part of the core standard submission rating
Previously Considered by	Core standards submission is an annual process, WMAS undertook a NARU KLoE review in February 2022 which further supported this assurance process.
Report Approved By	Core Standards reviewed at EMB and submission approved by the Accountable Emergency Officer (AEO) which is the Chief Executive.

Executive Summary

A structured process was undertaken to assure the core standards submission was met. A one-week extension to the submission date was agreed with NHSE regional colleagues due to the timeframe of receiving the data and submission date falling within Commonwealth Games deployment. Input was taken from HART Manager and reviewed by Craig Cooke/James Williams, the Strategic Command team and EMB prior to Chief Executive approval as the AEO. The organisations EPRR update highlights the significant amount of work being undertaken to ensure the organisation is able to submit a fully compliant status to core standards with confidence.

Related Trust Objectives/ National Standards	Papers Provide assurance that the organisation is compliant with regards to NHSE Core standards which are based upon the NHS EPRR Framework
Risk and Assurance	No specific risks related to the reports, NHSE EPRR colleagues are reviewing the organisations submission and have requested further pieces of evidence to support the Core standards statement. These have been submitted and awaiting final rating return.
Legal implications/ regulatory requirements	Core standards are directly linked to the NHS EPRR National framework, which all NHS organisation are required to maintain standards to meet the framework.
Financial Implications	No specific costs related to EPRR update and Core standards submission

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 06e MONTH: October 2022 PAPER NUMBER: 03e

Training & Workforce Implications	None specifically related to the update.
Communications Issues	None
Diversity & Inclusivity Implications	None
Quality Impact Assessment	Not required
Data Quality	James Williams – Head of Emergency Planning

Action required

The Board are requested to note all the attached papers. In relation to EPRR update for the organisation, fully complaint status for annual core standards and deep dive submission relating to 'Evacuation & Shelter'

Emergency Preparedness, Resilience & Response (EPRR) Update (1st April 2022 – 1st October 2022) to EMB – 4th October 2022

Updated from September 2022

The purpose of the paper is to provide an overview to the committee of the EPRR workstreams over the last quarter. With this being the primary paper submitted to EMB any feedback regarding presentation of data or further detail requirements would be greatly received.

Staff Overview (TIC / EPM)

Name	Role
Keith Nevitt	Emergency Preparedness Manager – Birmingham & Black Country / Lead NILO
Rob Stevens	Emergency Preparedness Manager – West Mercia & Shropshire / NILO
David Levesley	Emergency Preparedness Manager – Staffordshire, Coventry & Warwickshire / NILO
John Woodhall	Lead Tactical Incident Commander
Cameron McVittie	Tactical Incident Commander
Tim Atherton	Tactical Incident Commander
Liz Astbury	Tactical Incident Commander
Carl Cooper	Tactical Incident Commander
Greig Smith	Tactical Incident Commander
Jim Pitt	Tactical Incident Commander
Joanna Hardwick	Tactical Incident Commander
Aidan Brown	Tactical Incident Commander (Seconded to Senior Support Commander to CEO)
Alex Walker	Tactical Incident Commander

Name	Role	Return Date
Ray Earl	Seconded Emergency Preparedness Manager	31/10/22
Dan Marino	Seconded Tactical Incident Commander	31/10/22
Martyn Scott	Seconded Tactical Incident Commander	01/01/23
John Bragginton	Seconded Tactical Incident Commander	27/09/22
Deb Hudson	Seconded Tactical Incident Commander	02/10/22
Natalka Greenwood	Seconded Tactical Command Cell Support Officer	26/10/22
Cameron Bowden	Seconded Tactical Command Cell Support Officer	26/10/22
Ben Hand	Seconded Tactical Command Cell Support Officer	26/10/22
Kirsty Morris	Seconded Tactical Command Cell Support Officer	26/10/22
Rhys Jones	Seconded Tactical Command Cell Support Officer	26/10/22

Intentionally left blank

Current EP Plans

Plans under review are highlighted in yellow, updated draft versions will be submitted to EMB for approval prior to release.

WMAS PLAN REVIEWS V.35 - Update 11/09/22							
PLAN	EPM	LAST REVIEWED	CURRENT PLAN NUMBER	REVIEW DATE	Complete By	Comments	RAG Status
Major Incident Plan	DL	May-22	V14	Oct-24	DL	V14 published 27.05.22	
MTA Plan	DL	Apr-22	V7.4	Oct-24	DL	Published 20.04.22 JESIP compliant	
MTA JOPS		Dec-20	Edition 2			Owned by JESIP-live **note old graphics**	
CBRNHAZMAT Plan	RS	Mar-22	V11.3	Mar-24	RS	V11.3 published 01.03.22	
Mutual Aid Plan	DL	Jul-22	V8.0	Jul-23	AB	Final 8.0 released 26/07/22 JESIP compliant	
Casualty Regulation plan	SR	May-22	V.15	May-24	SR	Live - Under review In prep for V15 estimated release end of May 2021 - SR confirms	
RAMP Plan	KN	Aug-21	V5.8	Aug-23	KN	Final V5.7 released 06/05/21 JESIP compliant	
Fuel Plan	KN	Nov-21	V7.4	Nov-22	KN	Published 01.12.21 with JESIP updates	
Resource Escalation Action Plan (REAP)	DL	Nov-21	V 5.1	Oct-23	JW	Published 01.12.21 with JESIP updates	
Adverse Weather Plan	RS	Nov-21	V9.5	Sep-23	RS	Published 01.12.21 with JESIP updates	
Business Continuity Plan - EP	SR	Aug-21	V.8	May-24	SR	Complete - Updated for 2021/22 with Shane Roberts Agreed EMB	
Pandemic Influenza Plan	DL	Nov-21	V6.1	Nov-23	DL	Published V6.1 29.11.21	
WMAS Protected Persons Visit (Operation Consort)	RS	Nov-21	V1.1	Dec-22	RS	Published 01.12.21 with Trauma tool updates	
C3 Deployment	KN	Sep-22	V1.1	Sep-23	KN	Final V1.0 live JESIP compliant	
ECS Deployment	KN	Dec-21	V9.0	Dec-23	KN	Live 01.12.21 JESIP compliant	
Operation Whittle	KN	Apr-21	V4.2	Apr-23	KN	Final V4.2 released 06/05/21 JESIP compliant	
Strategic Control Plan	RS	Sep-19	V4.5	Apr-20	RS	Removed and archived as now part of Tactical Cell Arrangements	
Tactical Cell plan	RS	Sep-19	V1.0	Aug-21	RS	Removed and archived as now part of Tactical Cell Arrangements	
NACC Plan	AB	Jul-22	V4.4	Jul-23	GF	Published 27.07.22 owned by NARU	
Tactical Command Cell Arrangements	JPW	Aug-22	V4.0	Aug-23	JPW	Reviewed, in draft, awaiting move to new Sandwell hub for release	
Response to Public safety & Public Order Incidents	KN	Dec-21	V1.1	Dec-22	JW	Published 01.12.21 with JESIP updates	
High Consequence Infectious Diseases	GJ	May-21	126 V.3	May-23	GJ	Removed and archived now part of Pandemic plan	
Resilience Direct Procedure	RS	Dec-21	V1.1	Dec-22	RS	Published 01.12.21 with JESIP updates	
Operation Bridge	JW	Jul-22	V2.0	Jul-24	JW	Published 02.07.22 with JESIP updates	
Special Operations Vehicle list (SOVA)	JW	May-22	V23.0	Sep-23	JW	V23.0 Published 27.05.22	
STADIA PLANS	EPM	LAST REVIEWED	CURRENT NUMBER	REVIEW DATE		Comments	
Wasps and Coventry City FC Conops	DL	Aug-22	V4.3	Jun-23		Published 11.08.22 with JESIP updates	
Alexander Stadium Birmingham Plan	KN	Jun-21	V5.1	Jun-22		On hold as current builing site in prep for CWG - remove/archive plan for now	
Aston Villa FC Stadium Plan	RE	Aug-22	V8.6	Jun-23		Published 11.08.22 with JESIP updates	
Birmingham City FC Stadium Plan	RE	Aug-22	V8.3	Jun-23		Published 11.08.22 with JESIP updates	
Warwickshire Cricket (Edgbaston) Stadium Plan	KN	Jul-22	V8.3	Jun-23		Published 13.07.22 with JESIP updates	
West Bromwich Albion FC Stadium Plan	RE	Aug-22	V8.3	Jun-23		Published 11.08.22 with JESIP updates	
Wolverhampton Wanderers FC Stadium Plan	RE	Aug-22	V8.3	Jun-23		Published 11.08.22 with JESIP updates	
Walsall Town FC Stadium Plan	RE	Aug-22	V8.3	Jun-23		Published 11.08.22 with JESIP updates	
Stoke City FC Stadium Plan	DL	Aug-22	V5.5	Jun-23		Published 11.08.22 with JESIP updates	
Shrewsbury Town FC Stadium Plan	RS	Aug-22	V4.0	Jun-23		Published 12.08.22 with JESIP updates	
Worcester Warriors RFC Stadium Plan	RS	Aug-22	V8.0	Jun-23		Published 12.08.22 with JESIP updates	
Uttoxeter race course	DL	Aug-22	V1.2	Jun-23		Published 11.08.22 with JESIP updates	
Burton Albion FC Stadium Plan	DL	Aug-22	V1.0	Jun-23		Published 11.08.22 with JESIP updates	
Port Vale FC Staduim Plan	DL	Aug-22	V1.6	Jun-23		Published 11.08.22 with JESIP updates	

David Levesley (DL), Keith Nevitt (KN), Robert Stevens (RS) Shane Roberts (SR) Keith Prior (KP) Graham Finnigan (GS) Graeme Jones (GJ) Ed Middleton (EM) Aidan Brown (AB) Ray Earl (RE)

Plans for approval

- Tactical Command Cell Arrangements V4.0
- WMAS Protected Persons Visit V2.0
- WMAS Op Bridge V3.0
- WMAS Response to Public Order and Public Safety Incidents V1.3

NHSE Core Standards Submission

NHSE Core Standards for 22-23 was submitted on the 14th September 2022. An initial assurance session was successfully held with Jason Evans (NHSE Mids), with no changes required. The document and evidence were reviewed by the Senior Command Team and then approved by the Accountable Emergency Officer prior to submission. Papers submitted to EMB for reporting purposes

NHSE Core Standards (Interoperable Capabilities)

A request from NHSE Midlands EPRR team was received on 15.09.22 for a further submission to the annual core standards. No evidence required at this time, completion of the work sheet only. Submission date of 27.09.22. The review has been undertaken a submission completed with the AEO/CEO approval. Work sheet submitted to EMB.

Interoperability Capabilities / NARU KLoE Submission

This was completed in February 2022 – There were 4 Amber ratings out of 164 contractual standards, which have all been actioned and resolved. This has been reported to EMB and subsequently Trust Board.

EPRRG / EPRRDG

James Williams forms part of EPRRG committee which meets quarterly, all meetings and actions are recorded. EPRRG reports into NDOG (Chair – Jim Richardson-EMAS)

Rob Stevens forms part of the EPPRDG committee, team also meets quarterly, meetings and actions are recorded. EPPRDG reports to EPRRG. (Chair – Clare Langshaw- WAS). Rob Stevens provides a back brief to James Williams.

CBRN Audits – Acute Sites

This year's assurance process has begun, a meeting with all acute leads completed Friday 23rd September. Following the meeting self-assessment forms have been sent to acute leads for completion and return. Site visits are being arranged by WMAS EPM's to review Acute CBRN capabilities, (this requires erection of CBRN facilities and witnessed fully functioning kit and staff). Reports are then produced by WMAS EPM's prior to collation and submission to NHSE Midlands EPRR team. This process was undertaken last year and was seen as good practise following a review with NHSE EPRR team. Completion date planned for 20.12.22

ISU Fleet Map – 4 Hub Model
The current ISU Asset map (18.3) will be updated upon completion of the new operational Sandwell Hub. This has seen the ISUs move to a 4-site model, improving the accessibility to mass casualty resources in higher risk areas. ISU's are situated in each of the regions LRF conurbations ensuring WMAS has suitable capability across the whole of our footprint.

The following ISU annual audits are due for review as follows and plans are in place to maintain compliancy:

- ISU B – REVIEW SEP22
- ISU D – REVIEW OCT22
- ISU E – REVIEW OCT22
- ISU M – REVIEW COMPLETED MAY22 FOR CWG
    - Out of Date Stock replacement requirement Jan 2023
- EP7000 – REVIEW COMPLETED MAY22 FOR CWG

Command Courses completed:

- NARU COURSES (OPS) – 29 completed (8 planned)
- NARU COURSES (TAC) – 6 completed (6 planned)
- MAGIC – 4 completed (6 planned)
- CBRN TAC – 4 completed
- L5 MFWI – 5 planned (October 2022)
- RPS – 18 planned (November 2022)
- NILO – 4 completed (1 planned)
- AIRWAVE TAC ADVISOR – 1 planned (September 2022)

- COMMAND UPDATES
  - Commanders completed an initial Major incident & ISU refresher update in June 2022, in preparation for the B2022 Commonwealth Games, total commanders attended - 298
  - Mandatory Command Updates commenced on the 6th September 2022 (running until 13th October 2022) and will see all Trust Commanders complete the annual update with the following objectives:
    - Review of underpinning knowledge with regards to WMAS Policies, Plans & Procedures
    - Major Incident structure
    - WMAS Major Incident Exercise review and learning
    - Overview of WMAS Specialist capabilities
    - WMAS Operations review and learning
    - Walkthrough Major Incident
    - JESIP, CPD, CWG review
  - 326 commanders registered for course at present.

- **JESIP**

  All active commanders within WMAS have received JESIP training which is in date, these are recorded in the c2 overview spreadsheet which is reviewed on a quarterly basis. Since April 2022 WMAS have been part of five JESIP courses where WMAS commanders have been present to form the multi-agency attendance to validate the course.
  - June x2 courses within West Midlands (CWG focus)
  - July x1 course in West Midlands and x1 course in Warwickshire
  - September x1 course in Warwickshire

C2 Competencies / CPD Logs

Reviews of the Trust's Commanders CPD logs are ongoing with peer support sought through the Tactical Incident Command Team. All command logs were reviewed for NARU KLoE submission in February this year. A review was undertaken prior to CWG deployment where a focus detailed in CWG commanders.

Commander Competency Database

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

No. of Commanders in Database	226	Commander JESIP Compliance			100%
Strategic Commanders	6				
Tactical Commanders	31	Deployable (On-Call Tac + OM)	71	Non-Deployable (TIC + PTS / EOC Tac)	24
Tactical Command Qualified OMs	52				
Operational Managers (Substantive)	74				
Operational Managers (Development - Signed Off)	64				
Operational Managers (Development TBC)	25				
Operational Command Qualified OMs (NARU)	145				
National Inter-Agency Liaison Officers	20	Operational	7	Additionally Qualified	13
Tactical Airwave Advisors	3				
Trained Radiation Protection Supervisors	17				
Water Incident Managers	14				
Loggists	24				

Airborne Data Link – Update Required

The ADL was implemented in February 2022. Currently the trust has 2 operational devices, 1 on the tactical Incident Command RRV and the other is stowed in EP7000, the Command Vehicle. A 6-month review is currently ongoing which aims to review the effectiveness of it's inception and recommendations moving forwards.

SAG / Events / Ops Orders

Month	Event
April	N/A
May	Great Birmingham Run Half Marathon & 10k Royal Sutton Fun Run Robbie Williams PVFC Operation Blueside 2 Coventry City of Culture Hand Over Event Diamond League Athletics Alexander Stadium
June	Rammstein CBS Arena Cosford Air Show Boyzlife Concert Worcester Racecourse
July	Wireless Music Festival NEC
August	Godiva Coventry
September	Madness Concert Wolverhampton Racecourse Pride Birmingham Operation Blueside 4 Operation Bridge Operation Wavero & Operation Founder
October	Op Pelkin

EPM's are fully embedded in all SAG meetings related to events occurring in the region, Ops orders are produced then reviewed by James Williams prior to wider distribution of the senior command team for comment. The on call Strategic commander then provides approval of the document for release.

LRF / LHRP / Other External Engagement

There are five LHRP groups within the region, James Williams attends meetings on behalf of WMAS on a quarterly basis. Minutes and actions are recorded. Any pertinent updates are fed into the organisation via OMT updates. LHRP groups will fall under new ICB groups moving forwards. Next meetings planned for December 2022.

LHRP's

- Arden
- Hereford & Worcester
- Midlands region
- Shropshire
- Staffordshire

ICB's

(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
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

Regional / Local Prepare & Protect Boards

Lead NILO Keith Nevitt represents WMAS on the RPPB providing a direct link to CTU and operations. Communications and engagement have been vastly improved over the last two years with regular training and links with CTPOR within our region. Previously accessibility to Trust IT has been challenged when working in a STRAP environment. Following engagement Operational NILO's now have connectivity and reach back into the organisation from a secure environment.

JOPS 2 Meeting

Tuesday 13th September 2022 saw a second region review of JOPS 2 (MTA) assurance with Police and Fire colleagues within the West Midlands. Attended by James Williams. Overall, some positive joint working and implementation of lessons identified by all partners from multi agency exercises. A focus on training of non-specialist responders became a theme of the meeting which the region MTA working group will take on as an action. (Carl Cooper- TIC, chairs this regional group)

TIC / EPM / NILO Meetings

Meetings with all groups occur approximately every six weeks, minutes and actions are recorded for assurance. All meetings are chaired by James Williams. Meetings in July/August were postponed due to significant CWG activity.

Next TIC meeting – 10th November 2022
Next EPM/NILO meeting – 11th October 2022

OMT Monthly Papers

A monthly update is provided to OMT providing oversight of EPRR activity along with relevant papers for awareness. Updates affirm Monthly activity, incidents of note, training and exercising, Staff welfare (sickness, mandatory training, absences, secondments), events, updated plans and kit changes. A CWG update which will now cease following debrief submission.

Testing & Exercising

An extensive exercise program has been undertaken in preparation for Commonwealth Games. All exercises produced a set of robust arrangements, delivery ConOps and debriefs which captured lessons identified. This in turn allowed WMAS to update plans and implement resolutions to enhance a response if required.

Month	Type of scenario	Exercise name	TTX / Live	Notes
April	CCS / CLP	Ex SILVERSTONE	Live play	Ex involving patients into CCS/CCP and loaded onto DCA
May	CBRN	Ex PLUTONION	Live play	Live CBRN exercise
May - June	MI Update Days	Commander Training	TTX	All OM's, DOMS's and Tac's to attend update, ISU vehicles for show / tell
June	MTA	Ex AMBER	Live play	National EX at Winterbourne Gunner (WBG)
June	MTA	Ex KNOT	TTX	Multi agency TTX incl. LRF / Civil Contingencies Unit players.
June	MTA	Ex MONUMENT	Live play	Warwickshire college C Cooper / D Levesley planning
June	CBRN	CAPEX22	Demo day	National update at WBG, WMAS HART / SORT support

Month	Type of scenario	Exercise name	TTX / Live	Notes
September	EOC/FCP	Ex Impertior	Live play	Ex involving patients into CCS/CCP and loaded onto DCA
October	MTA	SF assurance	Live play	4 dates throughout Month across region. Hereford, Bham, Solihull, Staffs
November	TBC	TBC	Live play	Based at Potteries shopping centre, planning meeting 4th October 2022
November	Fire	TBC	Live play	Worcester Cathedral

Ongoing Equipment Review

- **X-TRACT –** procured and delivered to trust 14.09.22 – rollout workstream complete by cop 29.09.22
- **EPD –** Update paper submitted to EMB for review and approval
- **DUODOTE –** paper submitted to EMB as update on procurement, RA produced in preparation for short life extension of current stock and drugs expire end of September 2022.
- **TABARDS –** due for delivery 1st week in October 2022
- **Replacement Ballistic PPE –** Received into organisation 23.0.22 – switch out program in place

CWG Update

Following a successful WMAS deployment during the B2022 Commonwealth Games, the Planning Team are currently completing the debrief process, which will encompass staff and commander feedback and a comprehensive lessons learned document, detailing the recommendations and legacy information from the Games. A post games analysis confirming patient interaction has already been submitted to EMB.

A post games power point presentation has been produced for updating the Council of Governors and Trust board on the successes of Commonwealth games deployment. Both will be presented in October 2022.

Forward Look

- NHSE Interoperable capabilities evidence request due 11th October 2022
- Winter Event Calendar
- Testing & Exercising Schedule (continuous)
- Command Updates
- M Vehicle Load List Review & Restock (significant funding)
- ADL Review
- Stadia Plans Review
- Access to National Countermeasures (local agreements)
- Command Courses
- EPRR Policy Statement Update
- TIC annual review
- JESIP updates next year for circa 70% of WMAS commanders (one day every 3 years)
- Manchester Arena Inquiry recommendations

Event Forward Look

Month	Event
October	Operation PELKIN
November	Frankfurt Christmas Markets
December	World Cup

James Williams
Head of Emergency Planning
28.09.2022

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
HART						
Domain: Capability						
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y	WMAS HART exceeds these requrements with the move to 10 per team in August 2022. Team is complaint with national NARU standards and the PROCLUS portal holds the data sheets and evidence of training records for all specialist elements.	Fully Compliant
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y	100% coverage past 12/12. Evidence via daily Manning reports and internal Global Rostering System Further evidence noted via the daily NARU Special Ops report produced from Proclus	Fully Compliant
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	WMAS HART maintain their competances through an audited process to ensure compliance of each HART operative. All staff records are on the PROCLUS system.	Fully Compliant
Domain: Human Resources						
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y	HART Training week is encompassed within the HART roster, and is never cancelled / resources diverted. PROCLUS evidences compliance. Training plans are completed as further evidence.	Fully Compliant
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y	HART resources are only cancelled / diverted from Training week in the event of a critical incident or due to a dynamic operational requirement. Otherwise, resources complete their protected training hours every 7 weeks, as evidenced o nthe PROCLUS online portal. Training plans are also completed as further evidence	Fully Compliant
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y	Operative training records are recorded on the PROCLUS system. Daily shift reports contain detail of any trainnig completed on shift, which are completed as part of the handover process between teams. In addition, all HART staff complete all WMAS Clinical Mandatory training (annual) - recorded on WMAS Training Records The only adjustments made to training schedules this year related to CWG deployment where training was moved from the current delivery plan. No training was cancelled and NARU were fully sighted as part of CWG assurance.	Fully Compliant
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y	All HART team members are State Registered Paramedics	Fully Compliant
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y	WMAS runs at 10 per team, 100% compliance with 6 on shift at any given time. Evidence via internal rostering system, daily manning reports and daily NARU Specialist Ops report..	Fully Compliant
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y	All complete initial PCA assesments to the national standard, with records available evidencing completion. Records are mainatined locally and all PCA's are completed off operational shifts on a 21 week rolling roster, this allowing a 3 week buffer for short term sickness or failure of PCA.	Fully Compliant
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	All complete ongoing PCA assesments to the national standard, with records available evidencing completion. Records are mainatined locally and all PCA's are completed off operational shifts on a 21 week rolling roster, this allowing a 3 week buffer for short term sickness or failure of PCA	Fully Compliant
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	All complete ongoing PCA assesments to the national standard, with records available evidencing completion. Records are mainatined locally. Staff are managed, in co-operation with Human Resources, where standards are not met. Records of such are mainatined locally.	Fully Compliant
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y	All WMAS Commanders attend the National Ambulance Resilience Unit (NARU) to complete the national specification for their respective command tier. In addition to this, WMAS holds annual command updates for commanders from all levels, informed by lessons learned from response learning and exercise debriefing. HART deployment is covered by the update curriculum and evidenced on the lesson plans.	Fully Compliant
Domain: Administration						
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y	Reviewed and updated in August 2021, WMAS maintains a local deployment policy (v16.1) which is set for review in Augsut 2023.	Fully Compliant
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y	The deployment of HART resources is overseen by the Incident Command Desk (ICD) and the Tactical Command Cell (TCC) withinn the Emergency Operations Centre (EOC). Information regarding deployment criteria and overwatch is provided in the document.	Fully Compliant
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y	Processes are embedded within the HART Deployment Polcy (v16.1). WMAS ensures that a safe system of work is always available through the increase in the whole time equivalenets to 10 operatives per team, mitigating against such shortfalls. In the unforseen event of any shortfalls, the NARU on-call officer and the National Ambulance Co-ordination Centre (NACC) would be contacted without delay.	Fully Compliant
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y	WMAS HART Resourcing is recorded 4 times daily on the PROCLUS Online portal. The Duty Team Leader (TL) confirms the resourcing for the Duty Team and Trianing Team at 0700 and 1900. This information is also provided to the Senior Command Team (Incl. the CEO) and On Duty Commanders for situational awareness.	Fully Compliant
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y	WMAS Business Intelligience Unit (BIU) have created internal reporting dashboards (ORBIT), which are date adjustable to provide information on HART Assigned Incidents (749) and HART RRV Emergency Activity (756). These reports are reviewed annually for audit purposes.	Fully Compliant
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	WMAS HART has internal risk assesments based upon risks identified nationally and locally. All recorded in the Trust's Local Risk Register	Fully Compliant
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Identified and recorded on PROCLUS via 'LID' page (Lessons Identified). WMAS also maintains an internal response learning function, whereby commanders and HART Team Leaders complete a comprehensive debrief document which highlights learning opportunities. Such learning is used to inform Commander training and changes to Trust Response Plans	Fully Compliant
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Identified and recorded on PROCLUS via 'LID' page (Lessons Identified) or PROCLUS Safety Alert System. Local records also held for assurance and accountability	Fully Compliant
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y	Chief Executive Officer / Tactical Command Cell / Head of Emergency Planning / HART Manager / HART Training Manager and HART Team leaders (24/7 on-duty) all receive the Safety Alerts. These are reviewed and actioned by the Duty HART Team Leader. Local records also held for assurance and accountability	Fully Compliant
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y	The WMAS HART Manager is a member of the National Operations Group, whereby change requests are revived. These processes are in place within the organisation	Fully Compliant
Domain: Response time standards						
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y	Reviewed and updated in August 2021, WMAS maintains a local deployment policy (v16.1) which contains the protocols required to ensure timely HART release (within 15 minutes of the call being received).	Fully Compliant
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y	Deployment criteria is detailed in the deployment policy (v16.1). WMAS mitigates against the rare circumstance of the minimum deployment 96 operatives) by havin 10 operatoves allocated to each team. Reviewed by NARU as part of annual audit process	Fully Compliant
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y	The HART is situated close to our strategic site of interest - Birmingham City Centre, with a circa 10-12 minute response time. The Tactical Command Cell maintains oversight of ongoing incidents and have the capability to liaise directly with the HART TL with regards to the release of resources to cases requirnig HART capabilities and the safy systems of work required.	Fully Compliant
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y	This is explicit in the HART deployment policy (v16.1). All HART Operatives are aware of the obligations, with the Trust Mutual Aid vehicle and HART welfare vehicle in a constant state of readiness for no notice deployments. Detail of this is also included in the WMAS Mutual Aid Plan (v7 July 2022).	Fully Compliant
Domain: Logistics						
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y	Annual Capital Planning through the internal Capital Control Group sets priorities and approved by the Trust Board - including the 5yrs asset replacement plan. The WMAS HART Manager completes a monthly finance review to ensure appropriate replacement schemes are maintained.	Fully Compliant
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	All core equipment is maintained and purchased via approved national suppliers. All HART equipment is in line with National NARU data sheets found on the PROCLUS online portal. A local review is undertaken annually to verify all WMAS kit is in line with EDS and levels of equipment held meet the required standards.	Fully Compliant

H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y	All core equipment is maintained and purchased via approved national suppliers. All HART equipment is in line with National NARU data sheets found on the PROCLUS online portal.	Fully Compliant
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y	All HART fleet is aligned with the National specifications. Due to being purchased before the natioanl specification, the WMAS Polaris was converted in March 2022 to meet the national spec. The Polaris carrier is currently on long term loan from NARU to maintain compliance and interoperability. WMAS' new Polaris carrier is currently on order - expected delivery Q4 2022.	Fully Compliant
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y	All core equipment is maintained and purchased via approved national suppliers. All HART equipment is in line with National NARU data sheets found on the PROCLUS online portal. Equipment is recorded locally on an asset management system	Fully Compliant
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Available on the PROCLUS online portal and also locally on WMAS Asset Management Register (Fleet Tracker and Capital Asset Management).	Fully Compliant
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y	WMAS has a derogation place with NARU as it cannot currently meet the specficaiton at the currrent base. WMAS has planned and invested consdierable capital to create a new compliant HART opearing base - the building is now complete and transfer of services across to the new facility is taking place Sept / Oct 2022.	Fully Compliant
MTFA						
Domain: Capability						
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y	WMAS exceeds the requirement daily, evidenced by the Live ORBIT report dashboard (502 - Gold dashboard). This details how many SORT staff (dual trained MTA & CBRN) are currently on duty.	Fully Compliant
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y	Robust training plans remain in place and exceeds the requred standard. HART competencies and SORT staff records are recorded as required.	Fully Compliant
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y	Detailed in the NARU core training objectives / JESIP / JOPS 2 MTA	Fully Compliant
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	Detailed in the WMAS MTA Plan v7.4 May 2022	Fully Compliant
Domain: Human Resources						
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y	WMAS exceed this requirement daily - Live ORBIT dashboard (502) details how many Dual Trained SORT staff are on duty 24/7	Fully Compliant
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y	SORT staff are required to complete the Physical Competency Assessment (PCA) before completing the SORT training. This is in place and records held locally. Annual PCA for all SORT staff has commenced under the SORT enhancement programme	Fully Compliant
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y	All completed in line with the SORT enhancement programme.	Fully Compliant
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y	All recorded internally within SORT training records	Fully Compliant
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y	All WMAS Commanders attend the National Ambulance Resilience Unit (NARU) to complete the national specification for their respective command tier. In addition to this, WMAS holds annual command updates for commanders from all levels, informed by lessons learned from response learning and exercise debriefing. HART deployment is covered by the update curriculum and evidenced on the lesson plans.	Fully Compliant
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y	WMAS continue to meet with FRS colleagues at the regional MTA working group (quarterly). In addition, training and exercising is completed alongside external partners from the FRS	Fully Compliant
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y	All WMAS Commanders attend the National Ambulance Resilience Unit (NARU) to complete the national specification for their respective command tier. In addition to this, WMAS holds annual command updates for commanders from all levels, informed by lessons learned from response learning and exercise debriefing. HART deployment is covered by the update curriculum and evidenced on the lesson plans. WMAS Strategic Commanders undertake the same annual internal training alongside maximum exposure to nationally available courses and annual exercise participation. Evidence via commander training record worksheet. All frontlne staff receive familiarisation via mandatory clinical updates annually.	Fully Compliant
Domain: Administration						
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	WMAS MTA plan version 7.4 May 2022 reflecting current national requirements detailed in the JOPS 2 document	Fully Compliant
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	WMAS MTA plan version 7.4 May 2022 reflecting current national requirements detailed in the JOPS 2 document. WMAS maintained a Recall to Duty mechanism through an automated Everbridge system, which is tested on weekly basis (commanders) monthly basis (SORT staff). Staff on duty can easily be identified through the Computer Aided Dispatch (CAD) system for deployment qhere required	Fully Compliant
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y	WMAS are aware of the required processes which are managed through the PROCLUS online portal. This is overseen by the HART manaher, with no submissions to date	Fully Compliant
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y	WMAS Business Intelligience Unit (BIU) have created internal reporting dashboards (ORBIT), which are date adjustable to provide information on HART Assigned Incidents (749) and HART RRV Emergency Activity (756). These reports are reviewed annually for audit purposes.	Fully Compliant
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y	Processes are embedded within the HART Deployment Polcy (v16.1). WMAS ensures that a safe system of work is always available through the increase in the whole time equivalenets to 10 operatives per team, mitigating against such shortfalls. In the unforseen event of any shortfalls, the NARU on-call officer and the National Ambulance Co-ordination Centre (NACC) would be contacted without delay.	Fully Compliant
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y	WMAS SORT Resourcing is recorded 2 times daily on the PROCLUS Online portal. The Duty HART Team Leader (TL) confirms the resourcing for the Trust at 0700 and 1900. If HART are tasked to an incident, the Tactical Command Cell (TCC) completes the update. This information is available 24/7 through the live ORBIT dashboard (502).	Fully Compliant
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	Local processes are implemented and are recorded on the local risk register Commanders and HART staff complete regular high profile site visits, reviewing elements such as access, layout, footprint and egress considerations. These are recorded within daily shift logs and within local records	Fully Compliant
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Identified and recorded on PROCLUS via 'LID' page (Lessons Identified). WMAS also maintains an internal response learning function, whereby commanders and HART Team Leaders complete a comprehensive debrief document which highlights learning opportunities. Such learning is used to inform Commander training and changes to Trust Response Plans. Externa multi-agency learning that is identified is submitted to the Joint Organisational Learning (JOL) portal	Fully Compliant
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Identified and recorded on PROCLUS via 'LID' page (Lessons Identified) or PROCLUS Safety Alert System.	Fully Compliant
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y	Chief Executive Officer / Tactical Command Cell / Head of Emergency Planning / HART Manager / HART Training Manager and HART Team leaders (24/7 on-duty) all receive the Safety Alerts. These are reviewed and actioned by the Duty HART Team Leader	Fully Compliant
Domain: Response time standards						
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y	The HART is situated close to our strategic site of interest - Birmingham City Centre, with a circa 10-12 minute response time. The Tactical Command Cell maintains oversight of ongoing incidents and have the capability to liaise directly with the Incident Command Desk (ICD) to ensure that the appropriately trained staff are responded as soon as they are required. WMAS exceeds the national framework requirements on a daily basis.	Fully Compliant
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y	Plans are detailed in the WMAS MTA plan version 7.4 May 2022 and HART deployment Policy V.16.1 This is managed by the Incident Command Desk (ICD) in EOC	Fully Compliant
Domain: Logistics						
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y	WMAS exceeds requirement on PPE availability. This is recorded via WMAS internal asset management register. Equipment is stowed on Incident Support Unit (ISU) 'B' vehicles, strategically placed within the region for rapid response to model response sites. Special Operations Vehicle Asset Register V23 May 2022 / ISU Asset Map v 18.3 August 2022	Fully Compliant
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y	All core equipment is maintained and purchased via approved national suppliers. All MTA equipment is in line with National NARU data sheets found on the PROCLUS online portal.	Fully Compliant
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y	All core equipment is maintained and purchased via approved national suppliers. All MTA equipment is in line with National NARU data sheets found on the PROCLUS online portal. Equipment is recorded locally on an asset management system	Fully Compliant
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y	Annual Capital Planning through the internal Capital Control Group sets priorities and approved by the Trust Board - including the 5yrs asset replacement plan. Further Ballistic vest updates are currently in progress due for completion end of November 2022. Revenue scheme in place to uphold compliancy (within Budget setting - approved by EMB)	Fully Compliant

M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Details are recorded on the WMAS Internal asset management register & Special Operations Vehicle Asset Register V23 May 2022	Fully Compliant
CBRN **Domain: Capability**						
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y	Initial Operational Response (IOR) is covered on staff mandatory trianing IOR / STEPs123+ / PRPS / Specialist Operational Response (SOR) forms part of Commander / SORT training and subsequent refersher courses 5 x ISU Decontamination (D) units within Trust all annaully serviced by GRS Trust holds Duo Dote countermeasures on all frontline vehicles SOR forms part of HART / SORT competenices All Tactical Incident commanders and NILO's trained to CBRN tactical command level	Fully Compliant
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y	All CBRN capabilities are in line with National capability Matrices for CBRN, ratified by NARU annually	Fully Compliant
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y	Twice yearly refresher SORT training Supported by the dedicated Trust SORT manager and CBRN & HAZMAT Plan v11.3 / MI plan v14. SORT enhancement programme has been commenced which has seen training enahncement to 7 days annually	Fully Compliant
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y	EPM / NILO / TIC on call 24/7 and all have reach back capability through the National CBRN Centre and PHE. The Trust also has a cadre of Radiation Protection Supervisors (RPS) who have completed the required training	Fully Compliant
Domain: Human resources						
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y	All WMAS Commanders attend the National Ambulance Resilience Unit (NARU) to complete the national specification for their respective command tier. In addition to this, WMAS holds annual command updates for commanders from all levels, informed by lessons learned from response learning and exercise debriefing. HART deployment is covered by the update curriculum and evidenced on the lesson plans.	Fully Compliant
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y	Encompassed within the Trust HAZMAT & CBRN plan v11.3	Fully Compliant
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y	Staff identified through CAD records as SORT or HART operative. Individual ARP handheld Radios tracked within CAD. Inner cordon working recorded by the Entry Control Officer as detailed in the Trust HAZMAT & CBRN plan v11.3 Time inside PPE is recorded, as well as exposure time to contaminants. Staff have access post-incident to occupational health (OH). All actions ratified by NARU	Fully Compliant
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y	WMAS exceed this requirement daily - Live ORBIT dashboard (502) details how many Dual Trained SORT staff are on duty 24/7	Fully Compliant
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y	Anthony Carswell - Resilience & SORT Training Manager	Fully Compliant
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y	Implemented and evidenced through HART staff training records, which details who is trained to CBRN Instructor status	Fully Compliant
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y	Training aligns with the National Standards, evidence via the PROCLUS online portal Further evidenced through SORT training delivery material.	Fully Compliant
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y	WMAS no longer uses FFP3 as a mask and utilises 3M powered respiratory hoods (PRPH). All frontline staff have personal issue hoods.	Fully Compliant
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y	IOR training is delivered as part of staff's initial and ongoing mandatory training. Regular articles within the Trustwide Weekly Briefing (WB) and also the Monthly Command and Control Newsletter. Further evidenced through the information freely available to staff on the WMAS Virtual Learning Environment (VLE)	Fully Compliant
Domain: administration						
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y	The Trust has a dedicated HAZMAT & CBRN Plan v11.3 This plan is accessible to staff and managers through the intranet and Teams application	Fully Compliant
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y	WMAS HAZMAT & CBRN Plan v11.3 reflecting current national requirements. WMAS maintains a Recall to Duty mechanism through an automated Everbridge system, which is tested on weekly basis (commanders) monthly basis (SORT staff). Staff on duty can easily be identified through the Computer Aided Dispatch (CAD) system for deployment qhere required	Fully Compliant
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y	Information is held on LRF community risk registers and EPM's maintain continuous engagement with with LRF partners. Trust specialist assets complete Key site visits to maintain awareness of dynamic risks and changes to sites	Fully Compliant
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y	Yes - WMAS HAZMAT & CBRN plan V.11.3 and MI Plan V14 are aligned to national standards.	Fully Compliant
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y	Yes - WMAS HAZMAT & CBRN plan V.11.3 and MI Plan V14 are aligned to national standards.	Fully Compliant
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y	Yes - WMAS HAZMAT & CBRN plan V.11.3 and MI Plan V14 are aligned to national standards. Access can be gained through the NILO function or the on-call NARU officer, details of which can be found through the 24/7 on-call dashboard	Fully Compliant
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y	Yes - WMAS HAZMAT & CBRN Plan v11.3	Fully Compliant
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y	Yes - WMAS HAZMAT & CBRN Plan v11.3	Fully Compliant
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y	Yes - Aligned to National SOP's and recorded on WMAS local risk register	Fully Compliant
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y	Risk assesments are included in multi agency COMAH plans. In addition, the LRF community risk assesments contain further detail, which EPMs / NILOs have access to via Resilience Direct.	Fully Compliant
Domain: Response time standards						
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y	Yes - SORT Automated Everbridge recall to duty (regularly tetsed) / On duty SORT staff indicated on CAD (and correct levels moniored on live Dashboard) ISU asset register indicates Strategically placed decontamination vehicles across the region which are located appropriately according to high risk site locations	Fully Compliant
Domain: logistics						
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	All equipment is maintained and purchased via approved national suppliers. All equipment is in line with National NARU data sheets found on the PROCLUS online portal.	Fully Compliant
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y	All equipment is maintained and purchased via approved national suppliers. All equipment is in line with National NARU data sheets found on the PROCLUS online portal.	Fully Compliant
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y	Annual Servicing of equipment occurs through GRS Evidenced through sign off documents to demonstrate compliance Respirex manage CBRN Suits and CBRN body bags as per National contract	Fully Compliant
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y	Annual Servicing of equipment occurs through GRS and documentation is evidenced upon completion. Advice and guidance available is gained through GRS with regards to a preventative programme of maintenance.	Fully Compliant
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Managed locally via WMAS Asset management register	Fully Compliant
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y	WMAS Asset Management register and appropriate service records. Replacement programme in place to maintain National PRPS suit requirement.	Fully Compliant
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y	WMAS currently hold 278 PRPS suits, which have recently been procured through the replacement plan and are live for use	Fully Compliant
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y	Anthony Carswell - SORT & Resilience Training Manager (responsible) James Williams - Head of Emergency Planning (accountable)	Fully Compliant
Mass Casualty Vehicles **Domain: Administration**						Fully Compliant Fully Compliant
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y	Yes - Both located indoors at Bromsgrove Hub, shorlined in a state of readiness	Fully Compliant
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y	Yes - Weekly runs completed and recorded on WMAS Fleet Tracker	Fully Compliant
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y	ISU Deployment is overseen by the Tactical Command Cell within the Emergency Operations Centre, with guidance on deployment detailed within the Tactical Cell Arrangements (v3.9) and the Trust major Incident Plan (v14)	Fully Compliant
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y	In place on all M ISUs (x8) with a rolling annual service contract via Medical Gas Solutions (MGS).	Fully Compliant

Domain: NHS England Mass Casualties Concept of Operations						
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* .	Y	Supporting Evidence: - Mass Casualty arrangements are embedded within Trust response plans (Major Incident Plan v14.0 / MTA Plan v7.4 / Hazmat & CBRN Plan v11.3) The Trust maintains its Major Incident / Mass Casualty assets in a state of readiness, checked weekly recorded on WMAS Fleet Tracker - Major Incident Vehicle Asset Map (v18.3 - Aug 2022) - Special Operations Response Team (SORT) operatives receive training twice yearly which is now moving to the National SORT Enhancement Programme (NARU KLoE 2022) - Casualty Regulation & Capability Chart (v15.0) was updated in May 2022 - 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	Fully Compliant
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y	Yes, WMAS hosts NARU and the NACC. Escalation in process emdedded into repsonse plans and on call NARU forms part of WMAS on call roster. These plans were tested, exercised and updated before the B2022 Commonwealth Games	Fully Compliant
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y	Communication with receiving facilities is co-ordinated through the Strategic Capacity Cell (SCC), which is a 24/7 function within EOC. Action cards are embedded within plans to assist with delivery. This is detailed within the Trust Major Incident Plan (v14), The Casualty Regulation Plan (v15). The Mass Casualty Implementation System (MCIS) is being introduced over the next 12 months, as it is currently in testing phase.	Fully Compliant
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y	Regional Casualty regulation plan v15 - Updated May 2022	Fully Compliant
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y	4 x ISU E vehicles in a state of readiness, located around the region and are loaded with the required equipment. The Special Operations Asset Register confirms equipment held and the ISU Asset Map v18.3 confirms the holding positions within the regional footprint.	Fully Compliant
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y	This is detailed in the Major Incident Plan v14 and can also be facilitated through the internal on-call system, where there is access to the NILO network whereby outreach to other organisations is completed	Fully Compliant
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y	This falls under current busiess as usual operations, and is supported by: REAP plan v5.1 Nov 2021 Surge management plan V2.4 July 2021 Mutual Aid plan v8 Aug 2022, which details access to extra resources as required	Fully Compliant
Command and control **Domain: General**						
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y	Plans are aligned to the current NHS England EPRR Framework and wider NHS command and control arrangements along with current NARU Command and Control guidance	Fully Compliant
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y	All WMAS Commanders attend the National Ambulance Resilience Unit (NARU) to complete the national specification for their respective command tier. In addition to this, WMAS holds annual command updates for commanders from all levels, informed by lessons learned from response learning and exercise debriefing. HART deployment is covered by the update curriculum and evidenced on the lesson plans. Commanders maintain competencies set out in the national frameworks / guidance and also keep ongoing records of CPD, showing compliance with National Occupational Standards for their level of command	Fully Compliant
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y	Stated in MI plan v14. The WMAS on call roster displayed within EOC identifes the contact details for the on-call NARU officer. The Tactical Command Cell are also located close to the National Ambulance Co-ordination Centre (NACC), which is hosted by WMAS. Embedded within the NACC plans is immediate notification to NARU in the event of a major incident.	Fully Compliant
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y	The WMAS Chief Executive Officer maintains the AEO role and is also the National Strategic Advisor to Ambulance Services. All planning documents are maintained and under continuous review to ensure they are up to date, effective and fit for purpose, following excerises or lesssons learned. Annual Training and Competencies for Commanders is undertaken and monitored through an annual Personal Development Review process. All plans are agreed by Trust Board and EPRR standards are reported to the Board for assuarnce.	Fully Compliant
Domain: Human resource						Fully Compliant
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y	WMAS has clear chain of command as part of internal structure WMAS also has robust mutli-displinary on call arragement including 24/7 on call teams In addition the Trust has a 24/7 Tactical incident Commander (TICs) on duty who is trained to be the subject matter expert for the Trust at a Tactical level. There are 2 TICs on duty at any one time, with one operational and also one within the EOC environment to provide off-scene co-ordination and ensure plans are being enacted as required	Fully Compliant
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y	The Trust has a list of pre-determined attendance protocols, which are embedded into Incident Command Desk procedures. This ensures that incidents are resourced with an appropriate and proportionate response, depending on the incident type. Additional resouece is available through the on-call and recall to duty mechanims, should it be required. The Trust Major Incident Plan details the resources allocated to a major incident.	Fully Compliant
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	All substantive command positions follow the appropriate WMAS / NHS recruitment processes. Commanders developing from Paramedic roles are exposed to a robust selection process, which progresses to encompass assessments, ongoing mentorship and preceptership from senior commanders, training and a sign off process which documents all stages of development. It also provides commanders with an opportunity to reflect and agree an ongoing development plan, to maintain some autonomy over their learning. The Trust maintains a position of nil vacancies in these roles and has development plans for future backfill.	Fully Compliant
C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y	Forms part of contract of employment under a defined job description Annual Training to ensure continuous competence is maintained and this is affirmed within Commanders' Personal Development Review (Annual)	Fully Compliant
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y	All Commanders have equipment including PPE, Command Valise and Command tabard with interchangeable functional role slides. which indicates the role undertaken at an incident. They also have access to all relevent Plans and Documents relevant to the Commanders actions.	Fully Compliant
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y	Communication systems include: Airwave / Mobile Phone / Airbox Command Application / HART Associated Technology Incl. Drone / Airborne Data Link / Personal issue iPads. The Trust continuously reviews communications arrangements and trials / implements new solutions where appropriate	Fully Compliant
Domain: Decision making						
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y	Training that Commanders complete contains detail of managing risk, using the ERICPD heirarchy of risk. This is delivered at NARU courses and reinforced during annual internal commander update training	Fully Compliant
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y	All WMAS plans have the JESIP principles embedded to ensure a joint approach to incident management. Commanders complete JESIP commander courses which are valid for 3 years, then they complete refresher trainnig. Commanders have access to the JESIP app on work issues devices. JESIP is also covered in during all internal command update courses	Fully Compliant
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y	Legal and professional obligations are discussed during NARU Command courses and also during WMAS internal annual command training days. Commanders have access to documents detailing these requirements and also senior commanders who provide peer support to ensure compliance with legal requirements	Fully Compliant
Domain: Record keeping						
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y	Detailed in the Trust Major Incident plan v14 - Contract in place with provider for central, secure archiving	Fully Compliant
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y	Commanders can log decisions through the CAD system, relaying decisions by voice for recording by operatives within the Emergency Operations Centre. They also utiloise Trust issue pocket books and Trust approved Inicident log books v10	Fully Compliant
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y	All officers receive loggist training as part of NARU command courses. WMAS have a cadre of administration and call taker staff trained as loggists (25) These staff are identified and activated through the Everbridge recall to duty programme. Further detail is contained within the Major Incident Plan v14	Fully Compliant
Domain: Lessons identified						
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y	WMAS has an incident response learning channel within microsoft teams, which is accessible to all commanders within the organisation. Immediate hot debriefs are completed at scene with staff and multi-agency commanders. Incidents are then reviewed and more detailed debriefing takes place to identify learning, which informs future practice, training and updates to response plans. Learning for the ambulance sector is shared on the PROCLUS online platform, which is accessible to the wider NHS ambulance services. Multi-agency learning that is identified is shared through the Joint Organisational Learning platform. Full details of its use is found in the Trust Resilience Direct procedure.	Fully Compliant
Domain: Competence						
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	All Strategic Commaners are MAGIC and CBRNe Strategic trained. All Strageic Commanders undertake regular On-Call Commitments as part of the 24/7 On-Call Team and Duty Director shifts within EOC - managing a wide range of Strategic Risks and Trust Responses to Incidents in the annual cycle of work. All Strateic Commanders have undertaken either a exercise or live deployment in the past 2 years.	Fully Compliant
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y	All Strategic Commanders are MAGIC trained within last 3 years and maintain CPD logs to show compliance with the National Occupational Standards	Fully Compliant

C20	C2	Tactical commander competence - National Occupational Standards	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	All Tactical Commanders are NARU Tactical Level trained and also receive annual command refresher training. Record of competencies against NOS recorded on personal CPD log. Monitored as part of annual PDR process for competencies.	Fully Compliant
C21	C2	Tactical commander competence - nationally recognised course	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a suffficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	All Tactical Commanders are NARU Tactical Level trained and also receive annual command refresher training. Record of competencies against NOS recorded on personal CPD log. Monitored as part of annual PDR process for competencies.	Fully Compliant
C22	C2	Operational commander competence - National Occupational Standards	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	All Operational Commanders are NARU Operational Level trained and also receive annual command refresher training. Record of competencies against NOS recorded on personal CPD log. Monitored as part of annual PDR process for competencies.	Fully Compliant
C23	C2	Operational commander competence - nationally recognised course	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a suffficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	All Operational Commanders are NARU Operational Level trained and also receive annual command refresher training. Record of competencies against NOS recorded on personal CPD log. Monitored as part of annual PDR process for competencies.	Fully Compliant
C24	C2	Commanders - maintenance of CPD	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y	All Commander CPD is recorded electronically and stored centrally. This allows continuous senior commander review and discussion in the commander annual personal development review.	Fully Compliant
C25	C2	Commanders - exercise attendance	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y	Commanders maintain their CPD log to demonstrate where they have taken part in exercises. A centrally held command database also documents the last time commanders took part in a planned exercise. The annual command updates contain live play exercises in addition to commanders having a wide range of opportunities to exercise with multi-agency partners	Fully Compliant
C26	C2	Training and CDP - suspension of non-compliant commanders	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y	All Commander competencies are recorded electronically and stored centrally. This allows continuous senior commander review and discussion in the commander annual personal development review to ensure compliance	Fully Compliant
C27	C2	Assessment of commander competence and CDP evidence	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y	All Commander competencies are recorded electronically and stored centrally. This allows continuous senior commander review and discussion with line managers in the commander annual personal development review to ensure compliance	Fully Compliant
C28	C2	NILO / Tactical Advisor - training	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y	7 Operational NILOS in place all have gone through the national trainng course, additional required vetting and courses. This is evidenced via commanders training record and personal CPD Logs to demonstrate ongoing competence	Fully Compliant
C29	C2	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y	All NILO competencies are recorded electronically and stored centrally. This allows continuous senior commander review and discussion in the NILO annual personal development review to ensure compliance. All NILO training and exercising is in line with required National Ambulance NILO standards.	Fully Compliant
C30	C2	Loggist - training	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y	The loggists available to WMAS have completed an internal course which provides them with the requirements of the role. This is recorded on the central command database and loggists complete ongoing CPD to demonstrate compliance	Fully Compliant
C31	C2	Loggist - CPD	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	The loggists available to WMAS have completed an internal course which provides them with the requirements of the role. This is recorded on the central command database and loggists complete ongoing CPD to demonstrate compliance	Fully Compliant
C32	C2	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y	All three roles are availabe through the WMAS On-Call function and also the 24/7 MERIT Services. All attend NARU operaitonal and Tactical Courses as a base level course, in addition to the WMAS annual refresher. The WMAS Medical Director assures their ongoing Medical Competencies annually.	Fully Compliant
C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y	All attend the WMAS annual command updates which contains a live exercise. MAs also attend live mulit-agency exercises, records of this are stored centrally	Fully Compliant
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y	All WMAS Commanders have completed a JESIP commanders course and complete a refresher every 3 years. JESIP is embedded within all WMAS annual comamnders update to demonstrate ongoing compliance	Fully Compliant
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y	Control Commanders and Incident Command Desk Operators attend NARU Ops / Tac command courses and also attend WMAS annual commanders update, with communication plans tested to ensure familiarity with trust response plans	Fully Compliant
C36	C2	Responders awareness of NARU major incident action cards	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y	WMAS does not use the NARU actions cards but bases WMAS specific action cards on the core functions described in the NARU cards, with enhanced local detail. All commanders have access to Proclus where NARU MI action cards are available for viewing. First person on scene commanders upon their arrival. All command vehicles have a full set of WMAS action cards. The WMAS MI plan is available electronically which all commanders have access to.	Fully Compliant
JESIP Domain: Embedding doctrine						
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y	All current repsonse plans are aligned with JESIP principles/doctrine and forms part of command training.	Fully Compliant
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y	All current repsonse plans are aligned with JESIP principles/doctrine and forms part of command training.	Fully Compliant
J3	JESIP	Five JESIP principles for joint working	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y	All current repsonse plans are aligned with JESIP principles/doctrine and forms part of command training. The JESIP Principles are embedded into daily practice	Fully Compliant
J4	JESIP	Use of METHANE	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y	All current repsonse plans are aligned with JESIP principles/doctrine and forms part of command training. The use of the METHANE pneumonic is embedded into daily practice	Fully Compliant
J5	JESIP	Joint Decision Model - advocate use of	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y	All current repsonse plans are aligned with JESIP principles/doctrine and forms part of command training. The use of the JDM is embedded into daily practice	Fully Compliant
J6	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y	All plans have a maximium review length of 2 years or post signficant incident / exercise learning.	Fully Compliant
J7	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y	Commanders have access to a command valise which contains all the key documents required for their respective level of command. In addition to this, further detail is available electronically through Teams Apps, the JESIP App and this is reinforced during annual command updates	Fully Compliant
Domain: Training						
J8	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y	Covered annually on mandatory clinical training and further CPD is available through the Trust Virtual Learning Envirnoment	Fully Compliant
J9	JESIP	Awareness of JESIP - control room staff	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y	Covered annually on mandatory clinical training and further CPD is available through the Trust Virtual Learning Envirnoment	Fully Compliant
J10	JESIP	Awareness of JESIP - Commanders and Control Room managers / supervisors	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y	Commanders and Control Room Managers / Supervisors all attend Nationally recognised courses at NARU. They all complete JESIP training and then complete multi-agency exercising which is recorded centrally. This forms part of the annual personal development review process to ensure compliance with national requirements	Fully Compliant
J11	JESIP	Training records - staff requiring training	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y	All records of completed JESIP training are stored centrally to ensure Trust compliance	Fully Compliant
J12	JESIP	Command function - interoperability command course	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y	All WMAS Commanders have completed a JESIP commanders course and complete a refresher every 3 years. JESIP is embedded within all WMAS annual comamnders update to demonstrate ongoing compliance	Fully Compliant
J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y	Covered on WMAS annual Command update day and within the clinical annual mandatory update course, with records held centrally of completion	Fully Compliant

J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y	All WMAS Commanders have completed a JESIP commanders course and complete a refresher every 3 years. JESIP is embedded within all WMAS annual comamnders update to demonstrate ongoing compliance	Fully Compliant
J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y	All Trust exercises promote multi-agency participation, with external engagement taking place during the planning phase through to debriefing. JESIP principles are applied throughout, ensuring that exercises robustly test organisation's response plans and commanders from all 3 tiers of command	Fully Compliant
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y	JESIP forms part of all Operational and control room staff induction training when joining the Trust.	Fully Compliant
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y	Covered annually on mandatory clinical training and further CPD is available through the Trust Virtual Learning Envirnoment. The Trust ensures that the latest versions of documents are available through the Trust intranet	Fully Compliant
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y	Trust currently has 3 trainers identified, who are Emergency Preparedness Managers / NILOs and cascade knowledge of JESIP to delegates	Fully Compliant
Domain: Assurance						
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y	Ongoing 6 monthly through self-assessment JESIP returns to demonstrate compliance	Fully Compliant
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y	Covered on initial and annual clinical update training with associated records held centrally within WMAS training department. The JESIP principles and in particular the METHANE messagde form part of normal BAU responses to all incidents, to ensure familiarity and ensure best practice. Senior commanders review incident responses and ensure that these principles are constantly applied, with appropriate lessons learned implemeted where required	Fully Compliant
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y	WMAS took part in 13 live multi-agency exercises in the build up to the B2022 Commonwealth Games, to ensure that plans were robust, up to date and fit for purpose. These took place alongside external partners and have all had subsequent debriefs and lessons learned reviewed.	Fully Compliant
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y	Commanders all receive an annual personal development review, whereby a review of commander's competence is undertaken. Commanders across the 3 tiers have access to peer and specialist support to ensure compliance with national occupational standards, which informs action plans with mentors where appropriate	Fully Compliant
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y	WMAS ensures that Ops Orders are created for all exercises and that umpires have a good understanding and awareness of their roles. Each are afforded with a template document to complete during the exercise which ensures that good practice and opportunities to improve are captured, which forms part of the exercise debrief process	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	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: 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)	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 September 2021 and updated in September 2022. Submitted evidence includes the current WMAS EPRR Policy Statement v1.4	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 (Public Board) WMAS Annual Report & Accounts (21-22) Specialist subject (B2022 Commonwealth Games) presentation to Board (Paper I) & Council of Govenors (Paper J) with reference to planning and delivery. Attached as evidence	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 workprogramme 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 EPRR Policy Statement). This is supported by monthly reporting to the Operational Management Team (OMT), which links directly to EMB (May & June 2022 Reports submitted as evidence)	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 outlines which indivuduals are responsible for fulfilling EPRR functions Organisational Chart - EPRR resource discussed at EMB level and with CEO before final presentstion to the Board April 2021 - NARU / NHSE audits, structures reguarly reviewed - Updated organisational structures shared at EMB and Board - Continued commitment to Commander Training and Exercise regime to ensure constant state of learning and review is undertaken.	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 which identifies both good practice and learning opportunities. This involves utilising 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: - National and Internal Learning Review Group Process - WMAS Debrief & Learning Process (v3.0) - All WMAS EPRR Policies are reviewed for effectiveness and revised following learning from planned exercises or live deployment	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 - 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	The WMAS EPRR Policy Statement contains a link to the WMAS Local Risk Register. - NHSE / NARU National Risk Register - with planned mitigation in response arrangements - LRF sub group risk membership - Internal WMAS ER54 incident reporting system in place - EPPR risks recorded and on the Trusts risk register	Fully compliant				
Domain 3 - Duty to maintain Plans											

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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders 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 - 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 Changes to plans are recorded within the document control, which is located at the beginning of each Trust Plan / Procedure / Policy Major Incident Plan Changes submitted as evidence Casualty Regulation plan submitted as evidence Regional Strategic Resilience Forum Agenda (chaired by WMAS) during B2022 CWG	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) 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 - CBRN Plan v11.3 - Tactical Cell Arrangements v3.9	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 (v9.5) which covers all aspects of Adverse Weather	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.	Supporting Documents: - Management of Infectious Diseases Procedure (v5.0) - High Consequence Infectious Diseases Procedure (v3.0) - Infection Prevention & Control Policy (v9.0)	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) 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. This plan has recently been updated and will be reviewed later this year with likely further updates folloiwng the review of the COVID-19 pandemic	Fully compliant				
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: 100 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. 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 Ongoing work is underway to update the countermeasures available to the Trust and is due for completion Q3 2023. This work is alongside the Dudley Group NHS Foundation Trust, to ensure compliance with the NHS Mids EPRR Countermeasures distribution guidance. Currently awaiting national guidance on how countermeasures will be distributed to Trusts	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
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 / MTA Plan v7.4 / Hazmat & CBRN Plan v11.3) The Trust maintains its Major Incident / Mass Casualty assets in a state of readiness, checked weekly recorded on WMAS Fleet Tracker - Major Incident Vehicle Asset Map (v18.3 - Aug 2022) - Special Operations Response Team (SORT) operatives receive training twice yearly which is now moving to the National SORT Enhancement Programme (NARU KLoE 2022) - Casualty Regulation & Capability Chart (v15.0) was updated in May 2022 - 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	Fully compliant				
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 OP RAINBOW - This relates to the repatriation of Ukrainian children with illnesses to the UK	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 (v6.0), 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	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 (v1.1) - 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), 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, where excess fatality management is delivered as part of the course objectives	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 Screenshot of Everbridge Testing provided as evidence	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, which are continually monitored to affirm assurance. Further evidenced with CPD Logs from the Tactical & Strategic Level	Fully compliant				
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. Staff 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 Lesson Plan Commander CPD Portfolio	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
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 exercisign takes place within the organisation to ensure response plans are fit for purpose and in line with current threats, methodologies and intelligience. An enhanced exercise programme was completed in the build up to the B2022 Commonwealth Games All exercises have had debriefing documents completed which identify good practice and lessons learned for implementation into such plans. EX Debriefs provided EX Schedule from CWG Pres	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 Commander CPD Portfolios Mandatory Update Certificate	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 C2 Command Database for exercise attendance Command Training Lesson Plan Online Training (incl. JESIP - All Staff) Clinical Update Certificate (All Staff)	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 v3.9	Fully compliant				
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	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	Business Continuity Policy v8.0 Each operational site has it's own dedicated BC Plan which contains information of escalation processes Example of Hub BC Plan	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 The Trust has a cadre of trained loggists that are accessaed through the Everbridge Recall to Duty System. The Tactical Command Cell will perform this task where appripriate and detail the availability of trained personnel Loggists are sought for Major incident exercises to ensure they are afforded testing and exercising. They were also utilised during the recent Birmingham 2022 Commonwealth Games to good effect within the CWG Command Cell. 10 Trained Loggists on duty at the time of the everbeidge recall to duty - screenshot provided as evidence of those staff 'clocked in' 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 - Evidence provided of app user guide	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
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 SitRep template INCL MAIC ION Example App User Guide	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.	On call Press Officer is available 24/7 to co-ordinate any communications reqests. Incidents of significance are passed to the press team through the Emergency operations Centre (EOC), via a dedicated messaging system. 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	Fully compliant				
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. 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 Escalations from the Strategic Capacity Cell (SCC) within EOC ensures that rdceving hospitals and also NHSE are aware of patient acutiy and demand. They also escalate any incidents of note to NHSE 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 (SOP attached) WMAS Communications and Engagement Strategy v2 Oct 2021 AACE guidance to social media WMAS Social and Digital Policy V2.2 May 2021 LRF multi agency press policies (Staffs uploaded as an example) 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	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 (24/7) in conjunction with the Trust press office and On-Call Press Officer (24/7) All commanders have acces to Resilience Direct (SOP attached) WMAS Communications and Engagement Strategy v2 Oct 2021 AACE guidance to social media WMAS Social and Digital Policy V2.2 May 2021 LRF multi agency press policies (Staffs uploaded as an example) 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	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	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	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 - WMAS Mutual Aid plan V8, which is aligned with the National Mutual Aid plan (exercised, tested and updated in preparation for the B2022 CWG) - NACC Plan - Coordinated through the Tactical Command Cell which is operaitonal 24/7 - Recall to duty of staff managed by Everbridge system	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	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
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. Further supported by: - Representation at any SCG or TCG conviened WMAS represented by appropiate level Trust Officers - Use of Resilience Direct (WMAS RD procedure v1.1) - EOC utilisie the ESICTRL Airwave Talkgroup to share critical situational awareness messages between all Blue light servcies in our region - 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											
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 v8 WMAS have a dedicated BC lead - Shane Roberts. He provides regular updates to OMT and EMB which report into the board (quarterly).	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 V8 Aug 2021 - Each operational site has its own specific BC plan including exercising process - Regular review of BC Plan Compliance at EMB and onward reproting 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.	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 v8, relating to the BIA for the organisation	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 v8	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 V8 Aug 2021 Post Exercise / Learning Report all submitted to reflect lessons learned Cyber Exercise as Evidence	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 Assurances provided through internal audit and subsequent report to the internal audit committee and EMB WMAS Data Protection Policy v2 July 2022 WMAS Data Quality Policy V7 Dec 2020 WMAS Cyber Mitigation & Reporting May 2022	Fully compliant				
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 v8	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 programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within	Action to be taken	Lead	Timescale	Comments
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 quartely and shared with EMB via OMT. Reported to the Board Annually	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 Internal review of BC plans when activated - with learning and revised planning WMAS BC Policy v8 Aug 2021	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 V1 Apr 2022	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 OVERLORD CAD Entries provided 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	Fully compliant				

Ref	Domain	Standard	Deep Dive question	Further information	NHS Ambulance Service Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) =	Action to be taken	Lead	Timescale	Comments
Deep Dive - Evacuation and Shelter											
Domain: Evacuation and Shelter											
DD1	**Evacuation and Shelter**	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	There is no specific requirement with regards to evacuation and shelter when considering WMAS actvity. Requirement to ensure continuation of critical services is captured within Business Continuity arrangements, and WMAS is able to maneouvre staff between operational sites should there be a critical failure of any infrastructure (as per 2.2 within the NHS in England guidance document) Despite this, Ambulance services have a role in assisting evacuating organisations if necessary. Such incidents are dynamic and are supported by Trust reponse plans, such as the Major Incident Plan v14. Assistance provided will be appropriate and proportoinate to the incidents requirements, and will be throught the following Trust functions: • Strategic Capacity Cell (SCC) is a 24/7 function within the Emergency Operations Centre, that maintains commnuicaiton with key external partners within the NHS. This function would be responsible for co-ordinating any external requests to assist with the movement of patients requirng evacuation from another external trust sites, or redirecting ambulances to other organisations • WMAS on-call system provides 24/7 acess to PTS Management who are able to assist with the above process as required • This on-call function also has the ability to call upon strategic or tactical level commanders who have the ability to mobilise to any co-ordination group established around the region • The Duty NILO provides the origanisation with strong links into the wider LA and LRF with regards to transport and shelter • The Duty Director (Strategic Level) is present within the EOC from 0800-2000 daily (incl. weekends), who join any system calls required. We currently provide circa 50% of the PTS provisions within the region, therefore WMAS are heavily embedded within this system In the event of a mass evacuation from a partner location, WMAS have the capability to enact a recall to duty through the everbridge system, as well as the national mutual aid plan, which would enhance the resouces required to manage the incident	Fully compliant				
DD2	**Evacuation and Shelter**	**Activation**	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	The duty or on-call strategic commander has the authority to implement and mobilise WMAS resources to meet the requirements of any incident requiring the evacuation of a Trust site. These critical decisions will be made in conjunction with the CEO	Fully compliant				
DD3	**Evacuation and Shelter**	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	WMAS has an array of tactical plans and resources to provide support to any incident. These can be dynamically mobilised in line with such pland and on-call arrangements, for example Major Incident Declaration / Mutual Aid Request / Patient Transport mobilisation / Intelligient conveyance / Casualty Regulation / SCG or TCG Activation / LA Engagement. Evidence of this would include Operation PITTING (AUG 2021), which relates to the repatriation of regugees to the UK from Afghanistan	Fully compliant				
DD4	**Evacuation and Shelter**	**Activation**	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	As per the WMAS Major Incident Plan v14 - SMART triage is utilised by the trust to proivide Triage SORT / Sieve The SCC provide co-ordination with regards to the regulation plan, ensuring the correct dispotition as per the patient's triage category	Fully compliant				
DD5	**Evacuation and Shelter**	**Patient movement**	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	All frontline staff are trained in lifting and handling and movement of patients utilisng the correct equipment	Fully compliant				
DD6	**Evacuation and Shelter**	**Patient transportation**	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	All frontline staff receive the appropriate driver training and are competent with regards to moving patients between locations	Fully compliant				
DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	The organisation uses an electronic patient record form (EPR) and the computer aided dispatch (CAD) system to ensure that resources can be tracked apporpriately and affirm patient dispositions. In the event of a major incident, casualty regulation applies and allows appropriate dispersal of patients to the required destinations	Fully compliant				
DD8	**Evacuation and Shelter**	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.				Not applicable				

DD9	**Evacuation and Shelter**	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	There is no specific requirement with regards to evacuation and shelter when considering WMAS activity. Requirement to ensure continuation of critical services is captured within Business Continuity arrangements, and WMAS is able to maneouvre staff between operational sites should there be a critical failure of any infrastructure (as per 2.2 within the NHS in England guidance document) Despite this, Ambulance services have a role in assisting evacuating organisations if necessary. Such incidents are dynamic and are supported by Trust reponse plans, such as the Major Incident Plan v14. Assistance provided will be appropriate and proportoinate to the incidents requirements, and will be throught the following Trust functions: • Strategic Capacity Cell (SCC) is a 24/7 function within the Emergency Operations Centre, that maintains commnuicaiton with key external partners within the NHS. This function would be responsible for co-ordinating any external requests to assist with the movement of patients requirng evacuation from another external trust sites, or redirecting ambulances to other organisations • WMAS on-call system provides 24/7 acess to PTS Management who are able to assist with the above process as required • This on-call function also has the ability to call upon strategic or tactical level commanders who have the ability to mobilise to any co-ordination group established around the region • The Duty NILO provides the origanisation with strong links into the wider LA and LRF with regards to transport and shelter • The Duty Director (Strategic Level) is present within the EOC from 0800-2000 daily (incl. weekends), who join any system calls required. We currently provide circa 50% of the PTS provisions within the region, therefore WMAS are heavily embedded within this system In the event of a mass evacuation from a partner location, WMAS have the capability to enact a recall to duty through the everbridge system, as well as the national mutual aid plan, which would enhance the resouces required to manage the incident	Fully compliant				
DD10	**Evacuation and Shelter**	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	WMAS has an array of tactical plans and resources to provide support to any incident. These can be dynamically mobilised in line with such plans and on-call arrangements, for example Major Incident Declaration / Mutual Aid Request / Patient Transport mobilisation / Intelligient conveyance / Casualty Regulation / SCG or TCG Activation / LA Engagement. This is supprted by the more recent Operation RAINBOW, whereby WMAS worked closely with partner organisations to ensure the safe repatriation of Ukrainian children suffering from critical illnesses.	Fully compliant				
DD11	**Evacuation and Shelter**	**Communications-Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	On call Press Officer is available 24/7 to co-ordinate any communications requests. Incidents of significance are passed to the press team through the Emergency operations Centre (EOC), via a dedicated messaging system. 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. Specific incident communications plans are embedded within the Trust's Major Incident Plan v14. There are multiple plans in the event of a multi-sited incident The Press Officer Action Card contains actions including contact with external partners to activate existing health messages and formulate and communicate public health information Escalations from the Strategic Capacity Cell (SCC) within EOC ensures that rdceving hospitals and also NHSE are aware of patient acutiy and demand. They also escalate any incidents of note to NHSE for situational awareness and the potential for media interest 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 All commanders have access to the Resilience Direct site	Fully compliant				
DD12	**Evacuation and Shelter**	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Evidence of the Trusts compliance with the relevant equality guidance is captured in the Trust's Conveyance Policy, highlighting how WMAS will treat everyone with courtesy and consideration as we recognise, acknowledge and value difference across all people and their backgrounds.	Fully compliant				
DD13	**Evacuation and Shelter**	**Exercising**	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	All WMAS response plans are regularly reviews, tested, exercised and updated as per Core Standard 29. Specifically related to evacuation and shelter: Op RAINBOW was mobilised and executed within 48hours. Evidence is provided by the Ops plan and subsequent ops plan template which is for use in similar circustances	Fully compliant				

West Midlands Ambulance Service
University NHS Foundation Trust

EPRR Policy statement

Version 1.4 September 2022

Version	Version 1.4 September 2022
Ratified By	Operational Management Team
Date Ratified	
Lead Author	Emergency Preparedness Manager
Responsible Officer	James Williams – Head of Emergency Preparedness
Date for Review	
Intended Audience	West Midlands Ambulance Service Staff
Protective Marking	OFFICIAL
Supporting Documentation and Drivers	Civil Contingencies Act 2004 NHS Act 2006 Health and Social Act 2012 NHS EPRR Framework 2015 NARU Quality Assurance Framework V1.0 National Security Risk Assessment (NRSA) 2019
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

Contents

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)

EPRR Governance

WMAS will be responsible for the delivering the 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 – (Major Incident Response)
- Training
- Partnerships and exercising
- Occupational Health/Human Resources

WMAS will be responsible for delivery and risk mitigation balanced against the current NHS EPRR framework 2015. WMAS has a robust Management structure allowing the organisation to discharge its duties as follows:

Named Accountable Emergency Officer (AEO)
Dr. 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 Planning
James Williams oversees the day-to-day duties of WMAS Emergency planning Managers (x3)

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

Named accountable Director to HART
Nathan Hudson, Emergency Services Operations Delivery Director.

Under command of HART Director sits

- HART Manager – Edward Middleton
- HART Training Manager – Nicholas Pavard
- Specialist Operations Response Team (SORT) Manager – Anthony Carswell.

WMAS AEO reports to Executive Management Board (EMB) 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.

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.

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 duties as a WMAS command function
- HART – Maintain 100% tactical capability in line with National capability Matrices for HART
- 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.

Risk Assessments

WMAS holds a local comprehensive risk register which encompasses risks focused on the region 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

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 Emergency Planning.

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

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 Gold 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 Gold Commander cadre. The TCGs and working groups are predominantly serviced by the locality EPMs indicated above.

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.

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 Operational Management Team (OMT) monthly meetings, regular updated to the Executive Management Board (EMB) and onward reporting to the Board of Directors.

EPRR Programme delivery

- Maintain response plans and policies
- Training – JESIP/Command competency/SORT/IOR
- HART – as per National specification (National Ambulance Resilience Unit 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 principles.
- 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)

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.

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

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 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
- Full internal and external debrief, alongside multi-agency partners, relating to the Birmingham 2022 Commonwealth Games

- 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

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 06f MONTH: October 2022 PAPER NUMBER: 03f

Commonwealth Games Update	
Sponsoring Director	Chief Executive Officer Officer
Author(s)/Presenter	James Williams – Head of Emergency Planning
Purpose	The Commonwealth Games report provides an update of key actions, statistics and feedback post games which took place during the summer.
Previously Considered by	Commonwealth Games planning reported monthly to EMB along with briefings to the Board & CoG. The senior command team also undertook two Strategic briefing sessions for assurance following independent assurance from National Ambulance Resilience Unit (NARU) and Association of Ambulance Chief Executives (AACE)
Report Approved By	Post Games review approved for release by the Chief Executive.

Executive Summary

Commonwealth Games report provides a snippet overview of the success of games deployment, There is a full debrief document in final draft which will be forwarded to the committee following attendance at EMB in November 2022.

Related Trust Objectives/ National Standards	Papers Provide assurance that the organisation is compliant with regards to NHSE Core standards which are based upon the NHS EPRR Framework
Risk and Assurance	No specific risks related to the reports, NHSE EPRR colleagues are reviewing the organisations submission and have requested further pieces of evidence to support the Core standards statement. These have been submitted and awaiting final rating return.
Legal implications/ regulatory requirements	Core standards are directly linked to the NHS EPRR National framework, which all NHS organisation are required to maintain standards to meet the framework.
Financial Implications	Commonwealth Games budget currently in final review ensuring all costs captured, on track to complete within budget range and achieving CiP
Training & Workforce Implications	None specifically related to the update.
Communications Issues	None

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 06f MONTH: October 2022 PAPER NUMBER: 03f

Diversity & Inclusivity Implications	None
Quality Impact Assessment	Not required
Data Quality	James Williams – Head of Emergency Planning

Action required

Post Games report, the Board are asked to note the report, evidencing a hugely successful deployment for WMAS in supporting the games. The report provides an oversight of the key actions taken, resourcing and response statistics along with feedback following completion.

West Midlands Ambulance Service University NHS Foundation Trust

Birmingham 2022 Commonwealth Games

West Midlands Ambulance Service University NHS Foundation Trust

Post Games Review – Council of Governors & Trust Board (Public)

Games Overview

- 28th July – 8th August
- 11 successful days of sport
- More medal events for women than men for the first time in Commonwealth Games history
- Fully integrated para-sport programme
- Arts & Culture programme continues into Winter 2022 with various exhibitions, displays and events

WMAS Key Dates

- **30th September 2017**
  - Bid submitted to Commonwealth Games Federation
- **31st March 2021**
  - Dedicated planning commences
- **9th July 2022**
  - CWG Deployment Centre Access
- **18th July 2022**
  - QBR entered the West Midlands / MACC Support began
- **22nd July 2022**
  - CWG CC Operational / Medical Support began
- **28th July 2022**
  - Opening Ceremony at Alexander Stadium
- **8th August 2022**
  - Closing Ceremony at Alexander Stadium
- **10th August 2022**
  - Medical Support Ends
- **13th August 2022**
  - Recovery Completed

Planning Approach

Planning → Assurance → Mobilisation → Delivery

- Considerations:
  - Ongoing COVID-19 Pandemic
  - Whole Time Equivalent Workforce Requirements
  - Business as Usual Activity
  - Hospital Handover Delays
  - Significant Multi-Agency & External Stakeholder engagement

The Planning Team

- Dedicated planning commenced March 2021
  - Tactical support seconded to the team in February 2022
    - Operational support seconded to the team in April 2022
      - Administration / EOC / Logistical Support added in May 2022

Craig Cooke

James Williams

Cameron McVittie

Keith Nevitt

Edd Davis

Tim Atherton

Deployment Centre

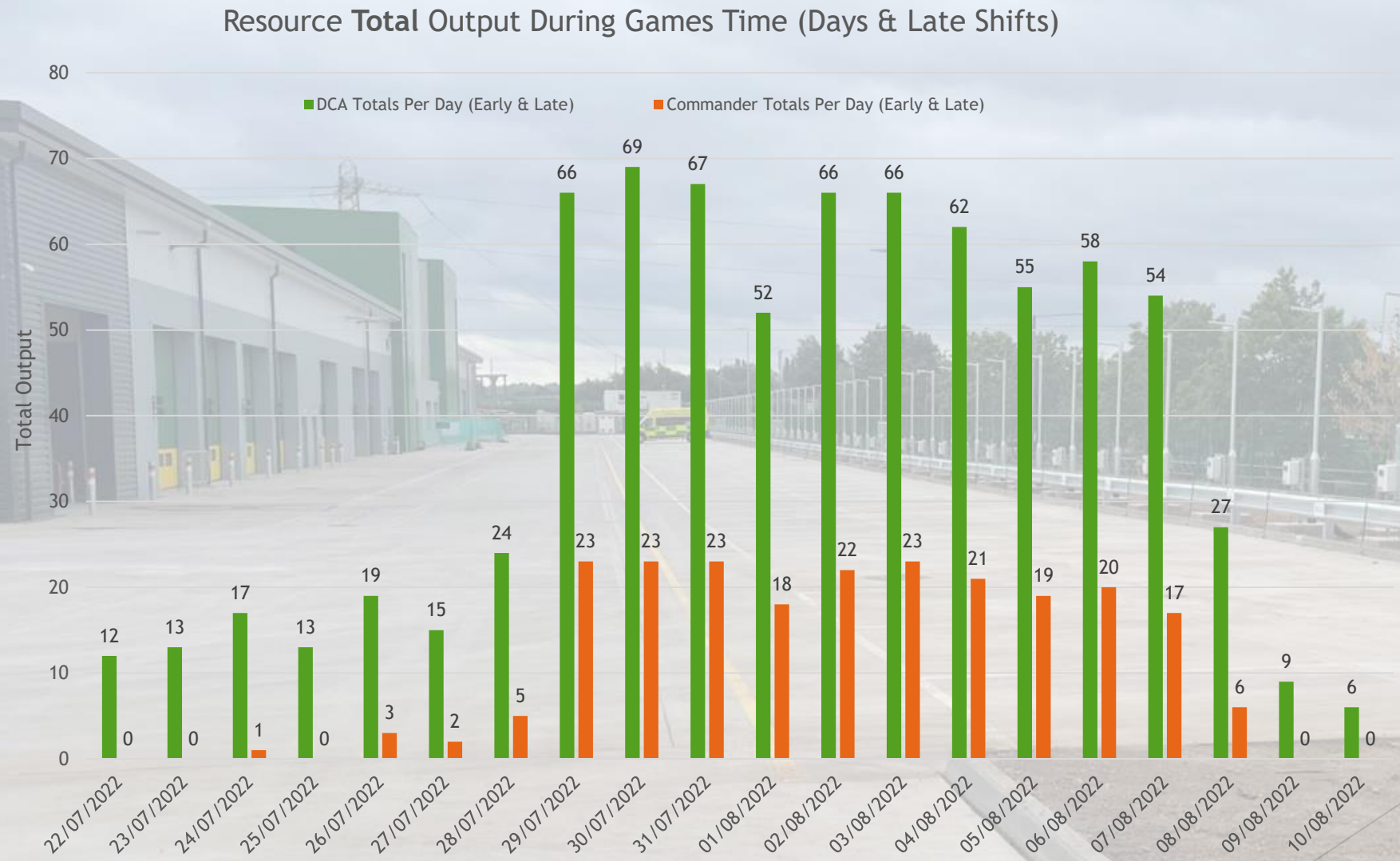
- Access granted to the CWG Planning Team on the 9th July 2022
- Requirement for transformation input to ensure CWG readiness
- Locked down in accordance with the Vendor Certification Scheme (VCS) on the 21st July 2022
- Home to CWG Operations:
  - Staff Processes
  - Fleet & Workshops
  - Logistics
  - IT & Comms

Fleet

- 60 new Ambulances
  - Fleet replacement programme
- 27 new Rapid Response Vehicles (X3 & X5)
- 4x4 Specialist capability vehicles utilised from BAU to support greenfield venues (Cannock Chase / Sutton Park)
- NARU loan vehicles to facilitate additional HART assets & Polaris capability
- No mechanical VOR during the Games period
- Workshop support including an on-call facility 24/7
- Accredited team to provide mechanical support within the CWG Venues

Operational Delivery

- Over 23,000 hours resourced across the organisation
- 1664 operational shifts
  - 770 Ambulance (DCA) Shifts
  - 62 Incident Support Unit (ISU M) Shifts
- Venue Commanders at all CWG Venues
  - 225 Commander Shifts
- HART
  - 2 Full Teams Daily (24/7)
- Multi-Agency Specialist Assessment Team
  - 2x HART Operatives, 3x Teams Daily (0700/0900/1200)
- Deployment outside of core rostering, maintaining BAU response & in line with the Working Time Directive (WTD)
  - 0.29% of shifts filled by BAU staff due to short notice vacancy (5 shifts)
- No mutual aid requested


Resource **Total** Output During Games Time (Days & Late Shifts)
DCA Totals Per Day (Early & Late)
Commander Totals Per Day (Early & Late)
Total Output
80
70
60
50
40
30
20
10
0
12 0
13 0
17 1
13 0
19 3
15 2
24 5
66 23
69 23
67 23
52 18
66 22
66 23
62 21
55 19
58 20
54 17
27 6
9 0
6 0
22/07/2022
23/07/2022
24/07/2022
25/07/2022
26/07/2022
27/07/2022
28/07/2022
29/07/2022
30/07/2022
31/07/2022
01/08/2022
02/08/2022
03/08/2022
04/08/2022
05/08/2022
06/08/2022
07/08/2022
08/08/2022
09/08/2022
10/08/2022

Patient Activity

Activity Summary

Cases Attended	168
Conveyed from Games Venues	71
Conveyed from Zone X	13*
Discharged on scene	84
MASAT (All teams)	3
HART – EP040 CWG Cases	1
HART – EP050 CWG Cases	0

Glasgow 2014 vs Birmingham 2022

Cases breakdown	Incident Count SAS	Incident Count WMAS	Conveyed SAS	Conveyed WMAS
Athlete	25	26	14	15
Spectator	48	71	14	34
Other Accredited (Incl. Workforce)	35	47	8	21
Unknown	54	24	24	1
Total	**162**	**168**	**60 (37%)**	**71 (42%)**

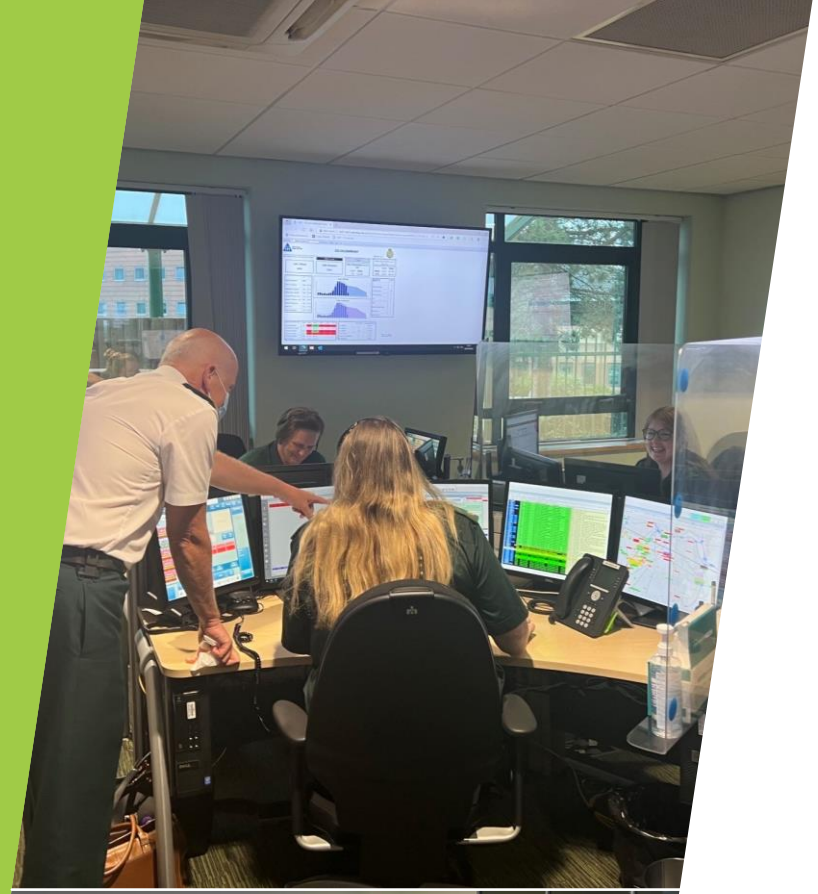
*13 conveyances by BAU crews from incidents within Zone X, following initial assessment by dedicated Games venue assets

Patient Information (Games Venue Only)

Cases breakdown	Incident Count	Conveyed
Athlete	26	15
Spectator	71	34
Other Accredited (Incl. Workforce)	47	21
Unknown	24	1
Total	**168**	**71 (42%)**

London Ambulance Service (Lee Valley Velodrome Activity Only)

LAS Cases breakdown	Incident Count	Conveyed
Athlete	10	6
Spectator	0	0
Other Accredited (Incl. Workforce)	2	0
Unknown	0	0
Total	**12**	**6**



CWG Command Cell

- Located in the Strategic Briefing Room (SBR), within Regional HQ
  - 22nd July - 10th August
  - 0600-0000
  - Out of Hours – Athlete's Village Resources managed by Tactical Command Cell
- Dedicated oversight of all Games assets
- Streamlined communications relating to CWG
- Direct link to the Multi-Agency Command Centre (MACC)
- Linked well with BAU through smooth information flow

Press & Communications

- Daily Updates sent to all Trust staff
- Venue visits to engage with staff
- Social media Updates
- CWG Staff Communication Teams Updates
- Promoting WMAS at the CWG

Challenges

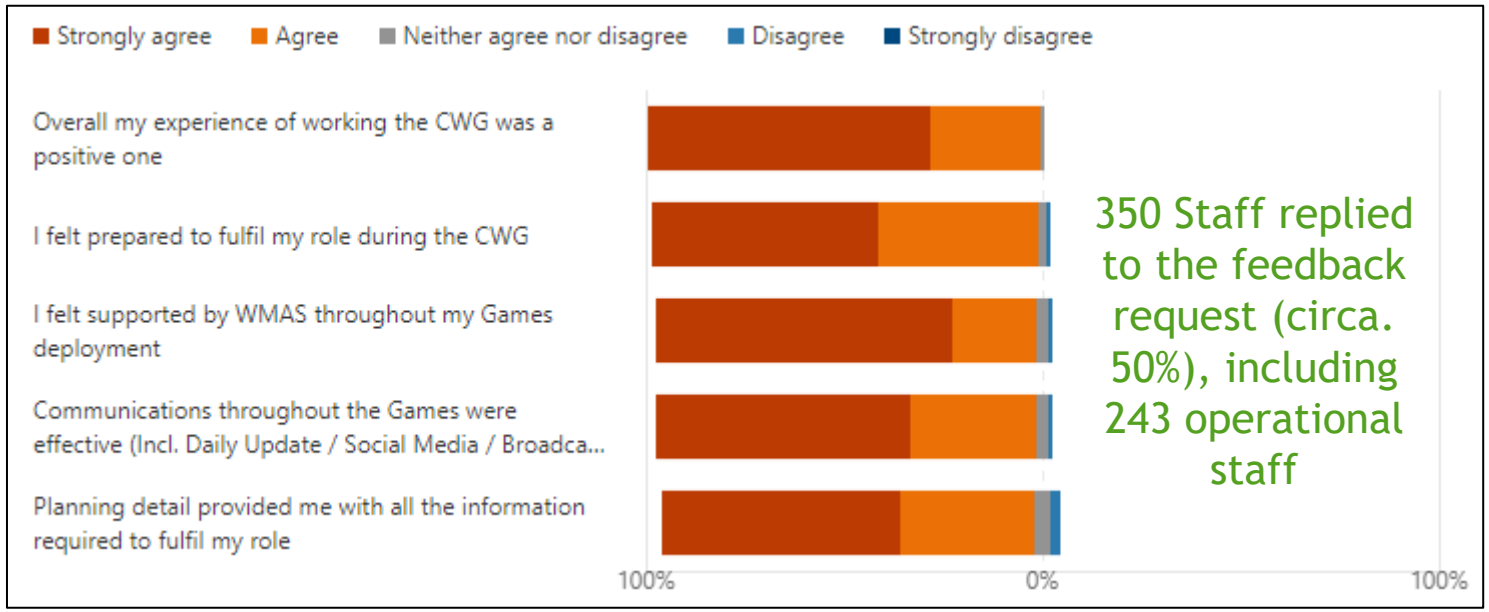
- Vehicle Screening Area (VSA) challenges
  - Delays to venue access for resources
  - Inconsistencies in agreed process with West Midlands Police
- Dynamic resourcing changes to scoping to meet CWG requirements
- Statutory Category 1 Responder responsibilities vs Contract Agreement
- Organising Committee (OC) Medical Resourcing shortfalls
- Identification of OC Volunteer Clinical Skillset
- Delays in Security Risk Assessment (SRA) process, relating to Accreditation

Staff Feedback

"...a true honour to work at the games representing the trust working alongside others from other agencies demonstrating JESIP by working together on such an amazing event. Big thanks to all the planning team"

"I think the organisation was brilliant, deployment centre worked fantastic, on site organisation worked great"

"Well organised and arranged. Enough staff at venues overall. Great communication with staff. Well done. Thoroughly enjoyed it"



350 Staff replied to the feedback request (circa. 50%), including 243 operational staff

"Congratulations to everyone involved for ensuring a safe and secure event, it has been a pleasure working with you all and our other emergency service colleagues"

"Really enjoyed being part of something so large and pivotal for the West Midlands. Thank you for the opportunity"

"I Had a really good time working at the CWG deployment hub it was a good change from my normal VPO role"

"...it has been one of my proudest moments working for the Trust in the last 28yrs. The whole event and WMAS element has been superb, thank you"

Summary

- Supported the delivery of a Safe, Secure & Successful Games
- A significant boost to staff morale
- High quality, fit for purpose and robust plans implemented
- Showcased the organisation's capabilities & innovation on the Global stage
- Legacy benefits implemented into core & event operations to further enhance resilience arrangements

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 07a MONTH: October 22 PAPER NUMBER: 04a

Finance Report at Month 6 (September 22)	
Sponsoring Director	Interim Director of Finance
Author(s)/Presenter	Interim Director of Finance
Purpose	Provides an update on performance against key financial targets at month 6
Previously Considered by	n/a
Report Approved By	Interim Director of Finance

Executive Summary

- The year-to-date income & expenditure position is a £1.381m deficit
- The forecast remains breakeven but is under review. A financial recovery plan will be drawn up if the forecast review indicates a deficit out-turn is likely.
- The FIP/CIP programme is ahead of target by £0.8m and a full-year shortfall of £3.0m.
- The Trust capital programme is on target
- The cash position is strong
- Better payments performance is below the 95% target
- The financial position of the Black Country ICS at month 6 is a deficit of £42m. NHSE will require a recovery plan.

Related Trust Objectives/ National Standards	Achieve financial duties in respect of revenue and capital resource limits
Risk and Assurance	
Legal implications/ regulatory requirements	None
Financial Implications	Financial performance update against key targets
Workforce & Training Implications	N/A
Communications Issues	N/A
Diversity & Inclusivity Implications	N/A
Quality Impact Assessment	N/A

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 07a MONTH: October 22 PAPER NUMBER: 04a

Data Quality	N/A
Action required • Note the contents of the report.	

Financial Report - Month 6, September 22

Headlines

Revenue surplus/(deficit)	£m
Year-to-date	(£1.38m)
Reported Forecast	£0.0m
Revenue surplus/(deficit) risk	£m
Forecast risk – estimated likely case	(£5.9m)
FIP achieved against plan	£m
Year-to-date	£0.8m
Forecast	(£3.0m)
Capital programme	£m
Forecast variance to plan	£0.0m
Cash balance	
Balance at end of month	£44.0m
Public sector payment target	%
Year-to-date	89.4%

- Forecast remains at break-even
- Financial risks total £5.9m*
- Mitigations identified so far to offset the risk total £3.9m*
- Mitigations include a contribution of £1.8m from new service initiatives
- Further mitigations of £2m are thus required to ensure break-even

**Most likely case scenario*

Income and expenditure

Year-to-date bottom line deficit

At the end of September 22, the Trust had a year-to-date deficit of £1.38m.

Variance against NHSE plan

The Trusts base plan submitted to NHSE at the end of the 2022/23 planning cycle, was for a year-to-date surplus of £2.6m by the end of month 6. The actual position at M6 is a deficit of £1.38m, so there was an adverse variance against the NHSE plan of £4m.

Variance against internal plan

Since the NHSE plan was submitted the Trust has revised budgets, especially for the CIPs.

Both the original NHSE plan* and the internal revised plan* show end of year breakeven, but there are differences between the two plans due to: -

a) Offsetting changes in income / expenditure assumptions

b) Differences in plan phasing assumptions i.e., timing receipts, payments, and CIP delivery

Against the revised plan there is a year-to-date deficit of £2.2m comprising: -

- The Trust is ahead of its income plan by £2.5m
- The Trust is overspent against expenditure budgets by £4.7m

The key factors that are creating financial pressures are: -

- NHS111 contract cessation
- Underachievement of overtime reduction FIP
- Underfunding of PTS Contracts

**Note the operation of the 'two plans' is not a new phenomenon, but a continuation of the approach used by the Trust in previous years. The nature of the planning process precludes elimination of this issue entirely, but actions will be taken in future years to minimise the differences between NHSE and internal plans and to make reporting of the remaining differences much clearer.*

Forecast

The Trust forecast for the financial year remains breakeven but there are a number of risks that must be carefully managed to ensure this is achieved.

Divisional Forecast Review Meetings

The forecast position is currently under review by the Senior Finance Managers to reassess the end of year projections in detail

Once the review is complete, meetings will be arranged with the Divisional Directors to jointly review the forecast and to identify actions that can be taken to mitigate financial pressures.

Financial risks

Though the forecast at month 6 remains at break-even, several significant risks have been identified that require mitigation.

The most likely case risks total £5.9m, against which £3.9m mitigations have been identified so far leaving a balance of £2m further mitigations to be found.

Summary of risks, plus details of mitigations identified so far

RISK REPORTED TO ICS AT MONTH 6		**(1,635)**	**(5,946)**	**(7,827)**
Further Potential (Risk)/Mitigations				
BSOL discharge crews		85	85	85
Pay award		238	238	238
BC ICB Income		700	350	
New Service Initatives (see table below)		1,811	1,811	1,811
Increased balance sheet flexibility		3,800	1,500	0
CURRENT RISK ADJUSTED POSITION		**4,999**	**(1,962)**	**(5,693)**
Further Mitigations to be identified		1,612	1,962	0
TARGET POSITION		**6,611**	**0**	**(5,693)**

- Mitigations include a financial contribution of £1.8m from new service initiatives (see next section)

See Appendix A for breakdown of risks in full

Contributions from new service initiatives

An assessment of additional income from new service initiatives is shown below, together with an assessment of the additional costs of delivering them.

Service initiatives	Starts	Ends	2022/23			2023/24		
			Income	Costs	Contribution	Income	Costs	Contribution
			£000s	£000s	£000s	£000s	£000s	£000s
Coohorting - BSOL	Oct-22	Sep-23	2,055	1,179	876	2,055	1,769	286
Coohorting - Shropshire	tbc				0			0
Coohorting - Staffs.	tbc				0			0
LAS 999s	Sep-22	Oct-22	310		310			0
National 999	Nov-22	Oct-23	2,083	1,458	625	2,917	2,041	876
C2 early adopter site	tbc				0			0
111 Agency/overtime	tbc				0			0
(excess costs of retaining post Oct 22)					0			0
					0			0
Totals			4,448	2,637	1,811	4,972	3,810	1,162

Within 2022/23: -

- Additional income from the initiatives is estimated to be £4.4m
- Additional costs of delivery of the initiatives are estimated to be £2.6m.
- The net contribution from the initiatives is thus £1.8m

Commissioner confirmation is required on whether a number of initiatives will be supported. These are included in the table as 'TBC'

Income

Income was £2.5m above plan

This comprises a surplus of £2.4m against HEE/NHSE. This is largely increased training income.

ICB income was increased in month 6 for the impact of the increased costs of the pay award of 1.66%.

Income (by organisation) Sep-22	This Month			Year to date		
	Budget	Actual	+ / (-)	Budget	Actual	+ / (-)
	£000s	£000s	£000s	£000s	£000s	£000s
ICBs	35,671	36,116	444	191,318	191,370	52
FT's Trusts	392	539	148	1,761	1,972	211
NHS England	1,315	2,193	878	1,754	2,930	1,176
HEE/ESFA	332	290	(43)	1,278	2,378	1,100
Other	807	1,589	(783)	6,259	6,277	18
Misc	1	2	1	1	2	1
Totals	**36,905**	**37,551**	**646**	**202,371**	**204,930**	**2,559**

See Appendix B for detail of income by commissioner / source

Expenditure

Expenditure budgets were £4.7m overspent, comprising £2.2m pay overspend and £2.3m non pay overspend and £0.1m loss on disposal.

The pay overspend was primarily due to E&U overtime costs, partially offset by 111 vacancies

Causes of the non-pay overspend are multifactorial, though vehicle related expenses were the main contributor. There have been significant price pressures on tyres and spares. There is also a significant overspend on the use of taxis.

Pay budgets have been increased for the pay award, which was paid, including backpay, in September.

The announced reduction in Employers National Insurance Contributions will be clawed back by NHSE from Contract payments in November and so there will be a further adjustment to budgets at this time.

A detailed breakdown of the current and year to date positions for both Pay and Non pay are in the tables below.

Pay Costs Sep-22	This Month			Year to date		
	Budget £000s	Actual £000s	+ / (-) £000s	Budget £000s	Actual £000s	+ / (-) £000s
111 & EOC	6,395	4,907	1,488	34,511	30,514	3,997
BI, IT, CR	294	258	36	1,626	1,492	134
Budget Reserves	(1,483)	0	(1,483)	(1,483)	0	(1,483)
Commercial	4,337	4,462	(125)	18,696	17,569	1,127
Corporate Depts.	1,054	926	127	5,609	5,544	65
Estates & Fleet	405	289	116	2,146	1,832	315
E&U	16,065	17,649	(1,584)	93,818	100,247	(6,430)
Surplus / (deficit)	27,067	28,491	(1,425)	154,923	157,197	(2,274)

- 111 underspend due to significant number of vacancies
- E&U overspend is mainly related to overtime costs

Non-pay Costs Sep-22	This Month			Year to date		
	Budget £000s	Actual £000s	+ / (-) £000s	Budget £000s	Actual £000s	+ / (-) £000s
111 & EOC	170	168	2	1,020	994	26
BI, IT, CR	625	588	37	3,750	3,656	94
Budget Reserves	(737)	606	(1,343)	(3,985)	(2,691)	(1,295)
Commercial	1,195	1,583	(388)	7,159	8,586	(1,427)
Corporate Depts.	1,072	1,181	(109)	7,597	7,954	(356)
Estates & Fleet	1,341	1,422	(80)	6,937	7,208	(271)
E&U	1,695	1,989	(294)	12,786	12,035	751
Depreciation	1,958	1,943	15	11,358	11,261	97
Surplus / (deficit)	7,319	9,479	(2,160)	46,621	49,003	(2,382)

- The Commercial overspend relates to taxi costs
- Budget Reserves relate to unallocated CIP and release of balance sheet flexibilities

Pay Expenditure	This Month			Year to Date		
	Budget £000s	Actuals £000s	+ / (-) £000s	Budget £000s	Actuals £000s	+ / (-) £000s
Chairman & Non Execs	12	10	1	74	69	5
Executives	86	66	20	548	526	21
Directors & Senior Manager	904	1,093	(189)	5,915	6,471	(556)
Medical Staff	274	181	93	1,724	1,255	470
Nursing	1,715	1,308	407	9,773	7,992	1,782
Sci Tech & Ther	226	124	102	1,277	773	504
Ambulance Managers	1,203	1,186	17	6,895	6,810	85
Ecp / Paramedic	10,020	11,276	(1,256)	57,909	60,840	(2,930)
Technicians	2,969	3,142	(174)	15,940	17,829	(1,889)
Trainee Technicians	628	1,610	(981)	9,284	8,054	1,231
Eca / Other Operational	117	92	24	613	369	244
Pts Operational	3,874	3,285	590	15,947	16,005	(58)
Control Managers	936	763	172	5,243	4,758	485
Control Assistants	2,960	2,648	313	16,194	16,037	157
Support Staff	591	614	(24)	2,992	3,080	(88)
Admin & Clerical	886	751	134	4,854	4,390	464
Other Non Clinical	282	211	71	1,572	1,295	277
Apprenticeship Levy	91	130	(39)	570	644	(74)
Reserves	(706)	0	(706)	(2,402)	0	(2,402)
Total Pay	**27,067**	**28,491**	**(1,425)**	**154,923**	**157,197**	**(2,274)**

Non Pay Expenditure	This Month			Year to Date		
	Budget £000s	Actuals £000s	+ / (-) £000s	Budget £000s	Actuals £000s	+ / (-) £000s
Amortisation	28	39	(12)	166	246	(80)
Audit Fees	7	7	0	42	42	0
Clincial Supplies	532	637	(105)	3,922	3,986	(65)
Clinical Negligence	298	298	0	1,785	1,785	0
Depreciation Owned	1,522	1,443	79	9,133	8,307	826
Depreciation Rou Assets	408	461	(53)	2,376	2,708	(332)
Dividends Payable	85	72	13	509	509	0
Drugs	92	114	(22)	546	563	(17)
Establishment	719	625	95	2,850	3,763	(913)
External Consultants	7	21	(15)	40	133	(93)
Fuel	873	764	109	5,133	4,880	253
Interest Payable	33	16	17	199	99	100
Non Clincial Supplies	232	372	(141)	1,580	1,905	(326)
Other	86	150	(64)	563	846	(282)
Premises	495	1,389	(893)	5,075	5,507	(432)
Rates	109	97	12	605	568	37
Training Expenses	(17)	304	(321)	120	234	(114)
Unwinding Of Discount	2	2	(0)	10	10	(0)
Vehicle Insurance	173	214	(42)	1,036	1,177	(141)
Vehicle Leasing	509	295	215	3,962	2,843	1,119
Vehicle Maintenance	1,128	2,162	(1,034)	6,968	8,891	(1,923)
Total Non Pay	**7,319**	**9,479**	**(2,160)**	**46,621**	**49,003**	**(2,382)**

Financial Improvement Programme

Year to date, the Trust delivered £4.5m savings against a plan of £3.7m. The over delivery is largely due to the increased level of vacancies in 111, offsetting the shortfall on the overtime reductions.

Full year, the program shortfall is currently forecast to be £3.0m. The shortfall is due to the failure to deliver the E&U overtime CIP.

FIP By Division Sep-22	This Month			Year to date			Full Year			
	Plan £000s	Actual £000s	+ / (-) £000s	Plan £000s	Actual £000s	+ / (-) £000s	Target £000s	Plan £000s	FYF £000s	+ / (-) £000s
E&U	836	721	(115)	2,317	721	(1,596)	6,427	6,427	774	(5,654)
111 / EOC	99	646	548	592	2,787	2,195	1,184	1,184	3,166	1,982
Commercial Services	15	15	(0)	293	293	(0)	1,173	1,173	1,383	210
Estates, Facilities & Fleet	22	31	9	132	124	(8)	258	258	249	(9)
BI IMT & CFR	17	16	(1)	102	99	(3)	203	203	192	(11)
Corporate Departments	58	210	152	280	570	290	474	474	891	417
Totals	1,047	1,639	592	3,716	4,594	878	9,719	9,719	6,655	(3,064)

Capital

Non-lease capital

Capital funding for the year is expected to be £13.75m comprising £13.0m operational capital and £724k additional allocation for DCAs.

The additional allocation was subject to a business case submitted earlier in the year per an NHSE request. Confirmation of this additional allocation has not yet been received however and is being chased.

Capital expenditure is in line with plan year to date and is forecast to be £13.75m.

Should the additional DCA funding not be issued, expenditure plans will be reviewed to ensure the Trust's capital expenditure limit is not breached.

Capital Summary Sep-22	This Month			Year to date			Ful Year		
	Plan	Actual	+ / (-)	Plan	Actual	+ / (-)	Plan	FYF	+ / (-)
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Capital Funding									
Operational allocation	1,086	1,086	0	5,428	5,428	0	13,026	13,026	0
Additional alloc. DCAs (TBC)	60	60	0	302	302	0	724	724	0
Total capital funding	1,146	1,146	0	5,730	5,730	0	13,750	13,750	0
Capital Expenditure									
Fleet	0	77	(77)	5,877	5,916	(39)	11,812	11,812	0
Information technology	0	(102)	102	105	12	93	955	955	0
Estates	15	14	1	115	36	79	618	618	0
Clinical equipment	20	0	20	20	11	9	130	130	0
Contingency	0	0	0	0	0	0	235	235	0
Total capital expenditure	35	(11)	46	6,117	5,975	142	13,750	13,750	0
Net under / (over) spend	1,111	1,157	46	(387)	(245)	142	0	0	0

Lease capital

From April 22 the reporting of leased asset costs is subject to the IFRS16 accounting standard. This requires that the non-interest charge component of a lease costs to be treated as capital expenditure. This is called the 'Right-of-use' cost.

At month 6, the Trust's Right-of-use cost remained within the level included within the NHSE financial plan submission. Further details/breakdowns of lease related expenditure will be included in future reports.

An IFRS 16 (Accounting for Leases) transition return is due by the end of October 2022. IFRS 16 is effective from 1/4/22 and this is known as the transition date (the date the new standard comes into effect).

The return requires disclosures at this date. This requires us to provide a reconciliation of the operating lease commitments at 31/3/22 (under the old standard) to the lease liabilities under IFRS 16 at 1/4/22.

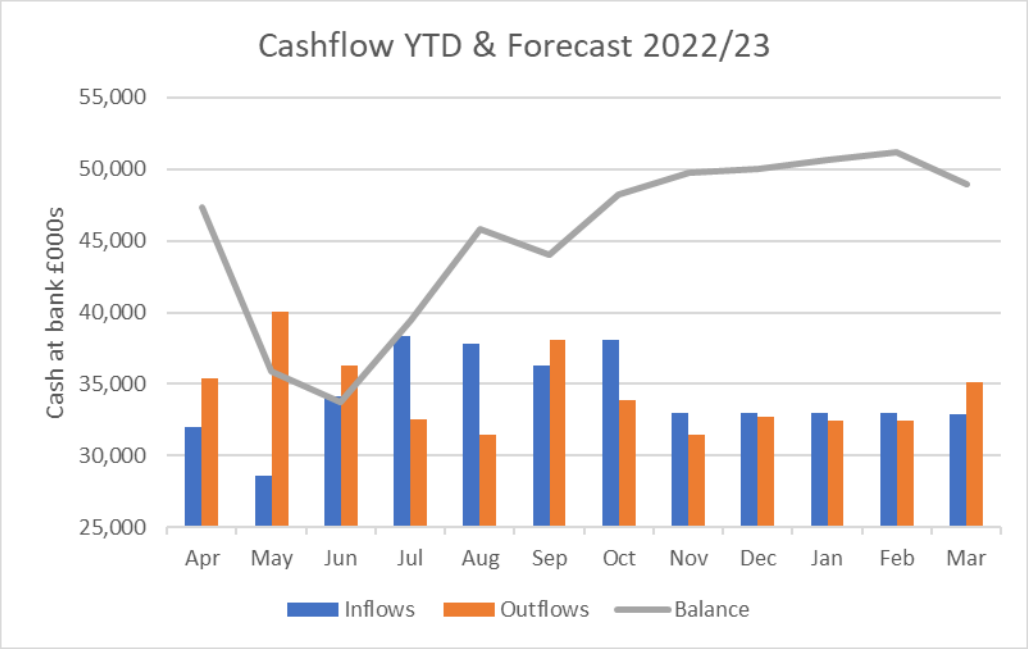
A further reconciliation between the lease liability and Right of Use asset on transition at 1/4/22 is also required, however this should just be any prepayments on leases.

The second part of the return requires information regarding any leases where we act as a lessor to other government accounting bodies. However, this does not apply to WMAS.

Cash

The cash balance at 30.9.22 was £44m and is currently forecast to be £48.9m by year end.

The high level of cash balance is due to retained surpluses from previous financial years and depreciation charges (a non-cash expense) being greater than the level of investment in asset replacement i.e., capital expenditure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inflows	31,973	28,630	34,143	38,332	37,770	36,278	38,098	33,005	33,005	33,005	32,973	32,901
Outflows	35,429	40,085	36,265	32,572	31,464	38,079	33,894	31,474	32,683	32,452	32,401	35,122
Balance	47,317	35,862	33,740	39,500	45,806	44,005	48,209	49,740	50,062	50,615	51,187	48,966

Better payments practice code

The public sector Better Payment Practice Code (BPPC) says that at least 95% of invoices received must be paid by the Trust within 30 days of receipt. The Trust must also pay 95% by £'s value within 30 days of receipt.

BPPC Performance	Year to date	
All invoices	**Number**	**£000s**
Invoices paid	14,943	99,538
Target to pay (95%)	14,196	94,562
Actually paid	13,352	93,952
Percentage achieved	**89.4%**	**94.4%**

- Performance has deteriorated slightly from the last reported figures of 91.7% due to the finance system loss in August.

Statement of financial position (Balance Sheet)

Statement of Financial Position	2021/22	2022/23		
	Outturn £000s	Last month £000s	Sep-22 £000s	Forecast £000s
Non-current assets				
Intangible	1,609	1,304	1,264	1,278
Tangible non-lease	82,654	81,863	80,729	85,178
Tangible lease (note 1)	0	21,811	21,628	45,429
Debtors	728	728	728	728
Subtotal	84,991	105,706	104,349	132,613
Current assets				
Stock	2,811	2,083	2,633	2,811
Debtors (NHS)	3,136	8,160	11,380	6,611
Debtors (Non-NHS)	13,396	11,017	9,067	13,837
Other				
Bank	50,763	45,796	43,995	48,956
Cash	10	10	10	10
Subtotal	70,116	67,066	67,085	72,225
Current liabilities				
Trade creditors (capital)	1,102	3	3	1,261
Trade creditors (non-capital)	53,768	53,063	52,561	55,862
Lease creditor (IFRS16)	0	4,586	4,462	7,168
Provisions	10,089	10,001	9,972	10,088
Deferred income	0	147	84	0
Subtotal	64,959	67,800	67,082	74,379
Net current assets	5,157	(734)	3	(2,154)
Non-current liabilities				
Borrowings (lease creditor)		15,691	15,497	40,311
Provisions	1,962	1,945	1,939	1,962
Subtotal	1,962	17,636	17,436	42,273
Net Assets	88,186	87,336	86,916	88,186
Financed by				
PDC	43,812	43,812	43,812	43,812
Revaluation reserve	9,665	9,665	9,665	9,665
I&E reserve	29,314	28,464	28,044	29,314
Other reserve	5,395	5,395	5,395	5,395
Financed by	88,186	87,336	86,916	88,186

Balance sheet items are consistent to the prior month and forecast except for IFRS 16 leased assets and lease creditors. These are below the year end forecast due to the Sandwell project lease not yet completed as at the end of September.

Black Country ICS

ICS financial position at month 6

ICSs are required to prepare a system financial performance report bringing together performance of each provider organisation within the ICS and of the ICB.

Year-to-date, the ICS reported a financial deficit of £42m at month 6, a £34.6m deficit to plan.

This significant adverse position is subject to NHSE scrutiny, and it is expected that the ICS will remain under scrutiny and will be required to develop a financial recovery plan.

The ICS forecast at month 6 remained breakeven. A review of forecast assumptions is underway.

The deficit is concentrated within the Acute and Community Trust sector. Affected organisations have/are developing Financial Recovery Plans.

Updates on Finance Directorate activities

Successful catchup post Cyber Attack

I'm including my thanks this month the members of the fiancé team who worked extremely hard to catchup on work such as invoice payments, that arose as a consequence of the recent cyber-attack. Thank-you

Finance Department Accreditation – Level 1 achieved!

The One NHS Finance Towards Excellence Accreditation process is designed to allow the Finance Leadership Council to give due recognition to organisations that have the very best finance skills development culture and practices in place.

There are three levels of accreditation, each designed to reflect the continuous development of the finance function and recognise the highest standards of financial competence and commitment to skills development.

WMAS finance function have just received confirmation of their Level 1 accreditation which is the first step for recognition of the work the team do.

In order for the team to have achieved this, we have demonstrated we are meeting target levels of good finance staff development practice as described in both national and local strategies and action plans.

This includes ensuring that our finance staff are up to date with latest finance guidance both locally and nationally and are widely supporting the wider trust with finance development.

Over the next 12 months WMAS finance team will be working on embedding the Level 1 standards before looking to build on this and working towards Level 2 accreditation.

A further 2 years will be required to achieve level 3.

Levels 2 and 3 entail wider participation and cultural embedding of good practice across the Trust in respect of financial matters.

Appendices

APPENDIX A – Risks & Mitigations

Forecast		Best Case £000s	Likely Case £000s	Worst Case £000s
Current Forecast		**0**	**0**	**0**
RISKS				
Cessation of 111 contract (assume this includes Pressure Funding)	Income	(1,758)	(1,758)	(1,758)
Her & Wor - SDF Funding	Income	(1,039)	(1,039)	(1,039)
Loss of PTS social distancing income - BSOL	Income		(450)	(1,850)
Loss of PTS social distancing income - CW	Income		(54)	(35)
Cost of Pay award above 2%	Pay	(238)	(238)	(238)
Overtime CIP unachieved	Pay		(1,000)	(1,000)
Additional Overtime	Pay		(1,500)	(1,500)
Taxi CIP unachieved	Non Pay		(600)	(600)
Other Non Pay CIPs unachieved	Non Pay		(207)	(207)
Total Risks		(3,035)	(6,846)	(8,227)
MITIGATIONS				
Cohorting Trial reduces overtime	Pay	1,000	500	
Balance Sheet Flexibility	Non Pay	400	400	400
Total Mitigations		1,400	900	400
Net (Risk)/Mitigation		(1,635)	(5,946)	(7,827)
RISK REPORTED TO ICS AT MONTH 6		**(1,635)**	**(5,946)**	**(7,827)**
Further Potential (Risk)/Mitigations				
BSOL discharge crews		85	85	85
Pay award		238	238	238
BC ICB Income		700	350	
New Service Initatives (see table below)		1,811	1,811	1,811
Increased balance sheet flexibility		3,800	1,500	0
CURRENT RISK ADJUSTED POSITION		**4,999**	**(1,962)**	**(5,693)**
Further Mitigations to be identified		1,612	1,962	0
TARGET POSITION		**6,611**	**0**	**(5,693)**

APPENDIX B – Income Details

Income by service / type

Income (by category) Sep-22	This Month			Year to date		
	Budget £000s	Actual £000s	+ / (-) £000s	Budget £000s	Actual £000s	+ / (-) £000s
111 Income	3,748	1,511	(2,237)	22,152	19,915	(2,237)
Commercial Services	3,812	3,066	(746)	21,981	21,260	(720)
Communications	0	0	0	0	10	10
E&U Income	28,618	32,098	3,480	153,804	156,819	3,015
Finance	81	144	62	481	662	181
Fleet Management	0	1	1	0	11	11
It Service Delivery	9	14	5	56	85	29
Logistics	0	0	0	0	1	1
Other Items Income	50	143	93	300	635	335
Pay Recharges	194	337	143	1,086	1,142	56
R&D Income	107	0	(107)	202	180	(22)
Training Income	285	238	(47)	2,308	4,209	1,901
Totals	**36,905**	**37,551**	**646**	**202,371**	**204,930**	**2,559**

Income by commissioner / source

Income (by organisation) Sep-22	This Month			Year to date		
	Budget £000s	Actual £000s	+ / (-) £000s	Budget £000s	Actual £000s	+ / (-) £000s
CCG's / ICBs						
Nhs Birmingham & Solihull ICB	7,023	7,023	(0)	39,255	39,255	0
Nhs Black Country ICB	12,160	12,559	399	60,574	60,958	384
Nhs Cheshire & Merseyside ICB	852	852	1	4,725	4,726	1
Nhs Coventry And Warks ICB	4,346	4,376	29	24,112	24,176	64
Nhs Hereford & Worcester ICB	4,061	4,055	(6)	22,578	22,139	(439)
Nhs Shropshire Telford ICB	2,515	2,515	(0)	13,953	13,953	(0)
Nhs Staffordshire ICB	4,703	4,703	(0)	26,087	26,087	0
Other ICB's	11	33		34	77	
Sub total	35,671	36,116	423	191,318	191,370	9
FT's/Trusts						
Birmingham & Solihull Mental H	25	25	0	151	152	0
Black Country Healthcare Nhs F	32	(38)	(70)	194	124	(69)
Midlands Partnership Nhs Ft	50	51	1	302	306	4
University Hosp Birmingham Ft	27	27	0	161	161	0
NHS England	1,315	2,193	878	1,754	2,930	1,176
Other FT/Trusts	257	474	217	953	1,229	276
Sub total	1,706	2,732	1,026	3,515	4,902	1,387
Other						
HEE/ESFA	332	290	(43)	1,278	2,378	1,100
Other	(805)	(1,587)	(783)	6,260	6,280	19
Sub total	(472)	(1,297)	(825)	7,538	8,658	1,120
Totals	**36,905**	**37,551**	**624**	**202,371**	**204,930**	**2,559**

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD Of DIRECTORS

AGENDA ITEM: 07b MONTH: OCTOBER 2022 PAPER NUMBER: 04b

IFRS 16	
Sponsoring Director	Interim Director of Finance
Author(s)/Presenter	Paul Jarvis Interim Director of Finance Ian Geddes Chief Financial Accountant
Purpose	This paper is to brief Directors on the key points of IFRS 16 (Accounting for Leases) and guidance received from NHS England
Previously Considered by	Reference to IFRS 16 has been made in various finance led documents.
Report Approved By	Paul Jarvis Interim Director of Finance

Executive Summary

This paper provides Directors with the key points relating to IFRS 16 (Accounting for Leases), an update on the guidance received and the current plan/work undertaken.

Related Trust Objectives/ National Standards	Achieve Quality and Excellence
Risk and Assurance	None Identified
Legal implications/ regulatory requirements	As per NHS providers guidance, the Trust will be required to meet financial year end requirements regarding the standard and other submissions required leading up to adoption of the standard.
Financial Implications	There will be an impact on the statement of Financial position (SOFP) and statement of comprehensive income statement in the 2022/23 year end accounts. This will involve leases being capitalised onto the SOFP that were previously shown as operating expenditure.
Training & Workforce Implications	Training of relevant staff to enable a thorough understanding of the standard throughout the organisation.
Communications Issues	N/A
Diversity & Inclusivity Implications	None Identified
Quality Impact Assessment	N/A

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD Of DIRECTORS

AGENDA ITEM: 07b MONTH: OCTOBER 2022 PAPER NUMBER: 04b

Data Quality	Produced in line with the NHS Foundation Trust Annual reporting Manual (NHS England) and IFRS 16 standard.
Action required	
The board are requested to review the briefing and comment on further actions if required.	

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Introduction

IFRS 16 – Accounting for Leases

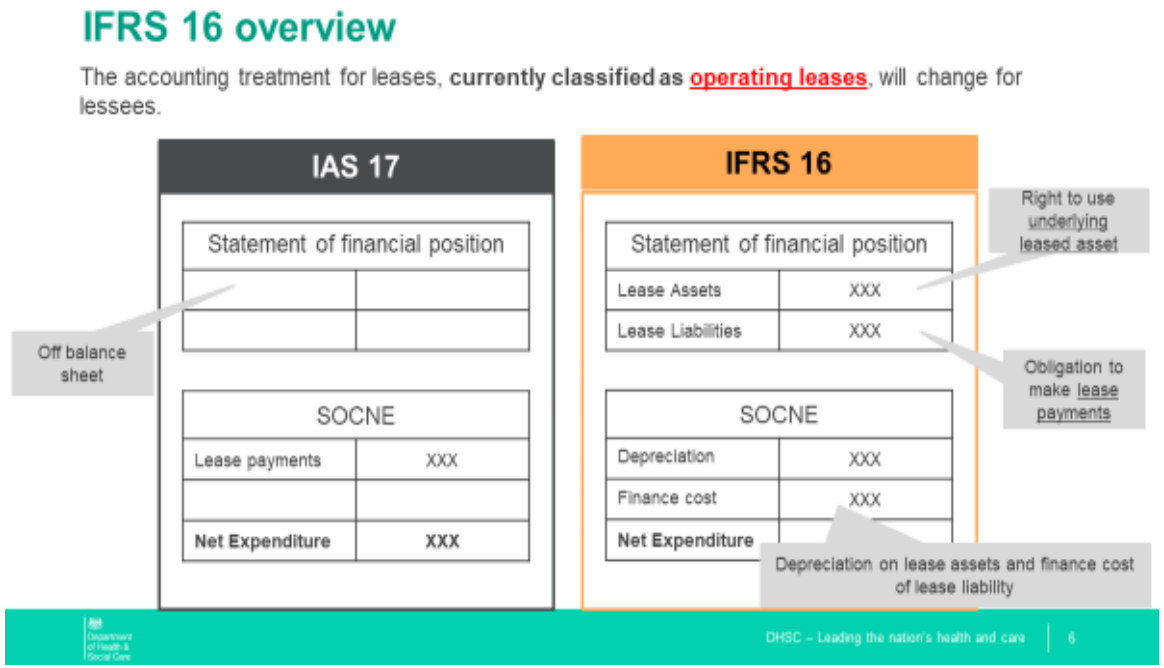
West Midlands Ambulance Service
University NHS Foundation Trust

Background

- IFRS 16 applies to the NHS from 1 April 2022, for the 2022/23 financial year ie 31/3/23
- Transition adjustments will be made on 1 April 2022
- New accounting standard covering leases
- A single accounting model bringing almost all leases ‘on balance sheet’
- Recognise a right of use asset and lease liability

Impact

West Midlands Ambulance Service
University NHS Foundation Trust



Previously operating lease costs were expensed to the income and expenditure account. Under IFRS 16, there will still be a cost to the income and expenditure account, but this will now show as depreciation and interest

Transition arrangements

West Midlands Ambulance Service
University NHS Foundation Trust

- Upon transition to IFRS 16 on 1/4/22 the Trust recognise an asset and corresponding liability.
- For leases previously classified as operating leases:

Recognise a **lease liability**

Derived by:
- measuring the lease liability at the present value of the **remaining lease payments discounting at a rate provided nationally.**

Recognise a **right-of-use asset**

By taking:
- the amount **equal to the lease liability; and**
- adjusting by the amount of any prepaid or accrued lease payments relating to that lease.

Current situation and progress

West Midlands Ambulance Service
University NHS Foundation Trust

- Significant work has been undertaken in order to provide transition figures and to identify operating leases affected.
- A software package and finance spreadsheets have been produced which details IFRS 16 leases and the relevant calculations.
- Disclosure was produced for the 2022 year end accounts for transition figures
- A return is due at the end of October 2022 to collect an update for the transition figures

Updated guidance October 2022

West Midlands Ambulance Service
University NHS Foundation Trust

- Updated guidance was distributed in early October containing more details on the impact of IFRS 16.
- The IFRS 16 implementation CDEL budget cover will be managed nationally by providing an uplift on CDEL to cover the incremental impact of IFRS 16. This means any new IFRS 16 leases in 22/23 that would have been classified as operating leases previously will be covered by national funding.
- At present there is still no confirmation on how new leases after 22/23 will be managed .

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 07c MONTH: OCT 22 PAPER NUMBER: 04c

Financial Strategy	
Sponsoring Director	Paul Jarvis, Interim Director of Finance
Author(s)/Presenter	Paul Jarvis, Interim Director of Finance
Purpose	Update to the Trust Finance Strategy
Previously Considered by	None
Report Approved By	Paul Jarvis, Interim Director of Finance

Executive Summary

This document provides an update to the Financial Strategy previously approved by the Trust in 2019.

Key external and internal strategic drivers were considered, and the resulting analysis informed a series of adaptations to the Trust's Financial Strategy to enable the Trust to achieve its financial objectives within the current strategic context.

An action plan is included, setting out the specific activities that will be executed to implement the Strategy, along with timescales for their completion.

Related Trust Objectives/ National Standards	Effective planning and use of resources
Risk and Assurance	Not applicable
Legal implications/ regulatory requirements	Not applicable
Financial Implications	Supports achievement of Trust financial objectives
Workforce & Training Implications	Not applicable
Communications Issues	Not applicable

Diversity & Inclusivity Implications	Not applicable
Quality Impact Assessment	Not applicable
Data Quality	Not applicable
Action required To consider and comment on the draft strategy	

West Midlands Ambulance Service
NHS Foundation Trust

FINANCE STRATEGY
Nov 2022 – Mar 2024

DATE APPROVED:
APPROVED BY:
IMPLEMENTION DATE:
REVIEW DATE:
LEAD DIRECTOR: Director of Finance
IMPACT ASSESSMENT STATEMENT:
Document Reference Number:

Trust us to care.

Contents

Executive Summary

This document provides an update to the Financial Strategy previously approved by the Trust in 2019.

Key external and internal strategic drivers were considered, and the resulting analysis informed a series of adaptations to the Trust's Financial Strategy to enable the Trust to achieve its financial objectives within the current strategic context.

Following this, an action plan was developed, setting out the specific activities that will be executed to implement the Strategy, along with timescales for their completion.

Due to the high level of uncertainty and instability within the operating environment, such as unprecedented inflationary pressures, the time horizon for this iteration of the Finance Strategy is short. It runs from the November 2022 through to March 2024.

Though the Strategy's is timeframe is short, many of the actions are designed to deliver long-term benefits.

A further revision to the Finance Strategy will be undertaken during 2023/24.

The principal strategic adaptations included in this Strategy document are: -

- → Secure additional funding for E&U services on basis of a level investment required to deliver clearly defined/agreed operational performance targets, within the context of current NHS operating conditions i.e., long handover times.
- → Ensure that commercial services are only maintained where they are able to generate positive financial contributions. Work with commissioners to this end.
- → Work collaboratively with host ICS to secure revenue resources for Trust cost pressures / business cases across the regional footprint, and to ensure Trust capital planning priorities are clear to ICSs well in advance, and are supported
- → Implement service portfolio growth and/or cost reduction measures to compensate for cessation of the NHS111 contract.
- → Move the focus of efficiency/productivity planning from short term to medium/long term, supported by medium term financial planning.
- → Improve Trust Board and EMB financial reporting, with special regard to transparent reporting of financial risk / mitigation, run-rate performance, reliable forecasting, and the underlying recurrent financial position.
- → Significantly increase the application and efficacy of cost control measures and financial performance management in respect of key cost drivers, including overtime expenditure and use of taxis.

Introduction

The Financial Strategy was last updated and approved in 2019. Since then, several changes have occurred within the operating environment that require different approaches to be taken to ensure financial sustainability and to underpin effective operational performance. Two changes in particular have significant implications for the Trust, block funding, and ICSs.

Prior to 2020/21, funding via a tariff based mechanism ensured that investment in service capacity kept pace with demand. Strong operational performance followed. Since then, funding has moved onto block arrangements which have transferred the financial risk of increased service demand from Commissioners to the Trust.

A second change is the implementation of the Integrated Care System model. This moves the focus from individual organisational performance to collective system performance. Provider autonomy diminishes within this context.

For a regional service provider, hosted within a single ICS but servicing six ICSs, this creates complexity in respect to governance arrangements in matters such as securing funding for business developments across a regional footprint.

A further factor is that senior finance leadership within the Trust has undergone a lengthy period of instability. This has delayed progress in responding to the external strategic drivers. This lost ground must now be made up.

This Strategy focuses on these and other strategic drivers, setting out the changes in approach that are required to adapt to them. An accompanying action plan is included which identifies the specific activities required to deliver key objectives, and their execution timescales.

Due to the high level of uncertainty and instability within the operating environment, such as unprecedented inflationary pressures, the time horizon for the Strategy is short, running from the November 2022 through to March 2024.

Though the time-line focus is short-term, many of the actions will deliver long-term benefit.

A further revision to the Strategy will be undertaken during 2023/24.

Trust Financial Objectives

The Financial Strategy is a key supportive enabler of the Trust's Strategic plan to deliver high quality healthcare for patients (Appendix 1)

Trust Financial Objectives

1. Operate a financially sustainable business model
2. Achieve NHS financial targets
3. Demonstrate effective use of resources
4. Deliver value for money for patients and public
5. Conduct business within a robust financial governance framework

Finance Strategy on a page

Trust 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	

Financial Strategy			
Objectives		**Key areas**	**Outcomes**
Achieve a financially sustainable business model	Identify and maintain total clarity on the underlying financial position and develop a sustainable financial plan Secure commissioner support for plan together with funding commitments, within context of an ICS led, block-based funding model.	Financial sustainability	Financially stable organisation Working in partnership with ICSs
Deliver effective financial planning to aid the Trust in navigating a challenging period financially and operationally	Extend the focus of planning from short-term finance focused budgeting to medium term integrated activity, capacity, and financial planning	Financial planning and financial management	Trust Board fully sighted on where the Trust is now, where it needs to be, and how it will get there
Embed an efficiency development programme to deliver short, medium, and long term benefits	Implement a structure and Strategy to improve productivity/efficiency via an ongoing programme of work, within the context of challenging financial environment	Financial efficiency and productivity	Productivity improvement as a routine, business as usual activity
Deliver a value adding and customer focused finance support service to the Trust	Build finance team capacity, capability, and responsiveness to the needs of Trust managers and staff. Raise finance service standards though national accreditation. Engage service users through listening exercises and other means to help align the services provided with the needs of internal customers and other stakeholders	Financial skills and capabilities Responsive to service users' needs	Nationally accredited finance team Close partnership working with service users
Maintain a firm foundation of strong and effective financial governance principles and practices	Strengthen content and application of financial governance mechanisms to ensure the Trust delivers value for money services for patients and public.	Financial assurance	Deliver value for money services

Risks

Risk management is a key component of enhancing patient care and is, therefore, central to the Trust's Financial 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 Finance Strategy are captured within the Trust's 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 with the Regulatory Body Standards and Quality Indicators

The associated risk assessments for these significant risks are influenced by clinical, operational, and quality risks, which are reviewed on a regular basis through the Trust committee structure.

The Finance Department continues to monitor its governance and risk management processes against the detailed key objectives.

Strategic Drivers

The Trust's last Financial Strategy was approved in 2019. This document builds on the strengths of that document, adapting it as required to address the key changes and challenges within the Trust's operating environment.

External factors

- → Tariff based funding replaced by block-based allocations
- → Introduction of Integrated Care Boards and Integrated Care Systems
- → Impact of the Covid Pandemic on productivity
- → Reductions in non-recurrent Covid support allocations
- → Inflation and other economic factors
- → Restrictions on capital funding and impact of lease accounting under IFRS16
- → Climate change and the green agenda

Internal factors

- → Cessation of NHS111 services and impact on the Trust's revenue and cost base
- → Reliance on overtime to maintain frontline E&U service capacity
- → Investing in Trust strategic priorities within a revenue and capital constrained system

Factor - changes to the NHS funding framework

The Issue

In the Spring of 2020, the Covid-19 pandemic took hold in the UK and world-wide.

The tariff-based NHS funding regime was suspended and replaced by simplified block funding arrangements.

- ✦ The link between activity growth and increased funding is thus no longer automatic
- ✦ Reimbursements for hospital handover delays have ceased
- ✦ A “Covid” block funding allocation was distributed to support pandemic responses

Impact on the Trust

- → Loss of a financially sustainable funding model
- → No longer able to invest in increased capacity as activity rises
- → Loss of productivity due to handover delays, but with no financial reimbursement to mitigate this, or to fund the resulting increase in overtime expenditure
- → Significant deterioration in operational performance
- → Reliance on non-recurrent Covid block funding that is now being removed

Strategic response

- ✓ Refocus funding Strategy from an activity/tariff driven model to a cost recovery model via clearly articulated arguments in support of increases in contract blocks to address service pressures.
- ✓ Make strong arguments for additional funding for well publicised service pressures by building clear, well-reasoned and well-articulated cases e.g., handover delays.
- ✓ Demonstrate effective financial management and cost efficiency to commissioners to support/substantiate the Trust’s claims for additional funding.
- ✓ Increase the scale/scope of service productivity and efficiency programme through the development of short, medium, and long term, efficiencies to aid financial sustainability.
- ✓ Increase the rigour and effectiveness of cost control policies and activities.
- ✓ Ensure all services deliver an acceptable financial margin to contribute towards Trust running costs.
- ✓ Negotiate commercial tariff based contracts where this is possible e.g., PTS.

Factor - Integrated Care Systems

The Issue

Changes in national policy have resulted in the following:

- ✦ A reduction in emphasis on competition and plurality of provision as the means by which improvements in healthcare are achieved.
- ✦ Focus on local co-operation and collaboration within geographically based Integrated Care Systems (ICSs) led by an Integrated Care Board to deliver change.
- ✦ De-emphasised organisational autonomy in favour of collective responsibility within an ICS.

Impact on the Trust

- → The Trust serves six ICSs but is hosted by Black Country ICS.
- → Operational capital is no longer directly allocated to the Trust but is a system resource subject to system prioritisation.
- → Distribution of growth uplifts and other revenue allocations are subject to system prioritisation.
- → There is increasing system oversight, scrutiny, and governance of the Trust's performance and decision making.

Strategic response

- ✓ Ensure Trust capital priorities are clear and shared with ICS partners at the earliest opportunity to gain their support within system prioritisation processes.
- ✓ Ensure host ICS prioritisation processes for sharing operational capital take full account of the Trust's Regional footprint.
- ✓ Engage with ICSs in furtherance of shared aims and objectives.
- ✓ Seek host ICB support and assistance in progressing Trust resource bids with non-host ICSs.
- ✓ Where possible, seek to secure ring-fencing of Ambulance Trust capital and revenue resources via dialogue at national level and by negotiation locally.
- ✓ Liaise with other Ambulance Trusts to identify best practice approaches for securing resources within an ICS context.

Factor – The Pandemic

The Issue

Though the worst aspects of the pandemic have subsided, the following issues remain

- ✦ Backlog of elective care, cancer treatment and increased emergency pressures.
- ✦ Strained hospital bed capacity compounded by social care provision challenges.
- ✦ Potential for a resurgence in Covid infections, especially during the winter months.

Impact on the Trust

- → Unprecedented levels of hospital handover delays leading to deteriorating operational performance, service productivity, and driving up operating costs.
- → Ongoing requirement to maintain social distancing measures for Covid positive patients creates cost pressures within PTS.
- → A Covid resurgence would increase pressures on Trust services, lengthen hospital delays and increase staff sickness absence.

Strategic response

- ✓ For E&U services, make the case for funding based on the realistic costs of delivery under current operating conditions and at current levels of productivity.

  Calculate these costs for two scenarios

  i. Maintaining existing operational performance

  ii. Improving / restoring operational performance

- ✓ For PTS services make the case for funding on the basis of actual social distancing protocols and implement tight control / monitoring of taxi usage.

Factor – Inflation and other economic factors

The Issues

- ✦ The UK economy is experiencing high levels of price inflation with energy markets especially affected.
- ✦ Supply chain disruption due to global factors.
- ✦ Government taxation and expenditure policy changes have increased borrowing costs.
- ✦ Labour markets affected by reduction in European economic migrants post Brexit.

Impact on the Trust

- → Increased pressures on public finances may lead to health sector funding cuts reducing growth funding available to the Trust.
- → Higher pay cost inflation reduces the balance of funding available for other activities.
- → Price increases rather than reductions are now the norm when undertaking procurement exercises.

Strategic responses

- ✓ Increase the scale of procurement through partnership / consortia.
- ✓ Increase emphasis on achieving efficiency benefits through productivity rather than price gains.
- ✓ Mitigate pay cost pressures and skills shortages through automation and non-core outsourcing where appropriate.
- ✓ Increase level of grip and control on costs by reviewing cost control policy content and the mechanisms sued to ensure compliance.

Factor - NHS111 service contract cessation

The Issues

- During 2022 recruitment challenges impacted adversely on the Trust's NHS111 service performance and necessitated that notice be given on the contract.
- High vacancy levels, though unfavourable from a service delivery standpoint, were offsetting other pay cost overspends in the Trust such as E&U overtime.
- Service funding had supported investment in duel-trained call-handling personnel and clinical staff, retention of these staff within other Trust services thus becomes a cost pressure.
- Premises and infrastructure costs of Navigation point were funded via the 111 contracts.

Financial consequences

Loss of financial contribution from the 111 service contract creates financial pressures in respect of: -

- → Underspends against vacant posts no longer contributing to pay cost position.
- → Costs pressure re those staff retained via a transfer into other services within the Trust.
- → The financial contribution from the 111 contract toward support department and overhead costs has ceased.

Strategic response

There are two potential approaches, a growth Strategy, and a cost reduction Strategy. Both can be applied in combination.

Growth

- ✓ Utilise surplus capacity released from 111 services to increase the scale of other existing services provided by the Trust e.g., expand 999 call handling services beyond the West Midlands footprint i.e., market development strategies.
- ✓ Seek to grow Commercial Services where this is economically advantageous.
- ✓ Seek commissioner support to develop new services not currently provided by the Trust e.g., cohorting service i.e., service development strategies.

Cost Reduction

- ✓ Conduct a review of staffing and non-staffing resources directly linked to the 111 contract and downscale these.
- ✓ Review impact on workload demands of all support / overhead services and adjust as accordingly.
- ✓ Conduct a review of estate capacity requirements. Conduct a financial appraisal to assess the most financially advantageous (or least disadvantageous) options for divesting in surplus estate.

Factor – Reliance on overtime to maintain E&U capacity

The Issues

- ✦ Ongoing recruitment / retention challenges place heavy reliance on overtime spending to maintain frontline staffing capacity.
- ✦ Unprecedented levels of hospital handover delays have reduced operational productivity, exacerbating the need to utilise overtime to support staffing rotas.

Financial consequences

→ Overtime costs are creating a significant and growing cost pressure for the Trust.

Strategic Response

Work collaboratively with operational leads to: -

- ✓ Review the effectiveness of current rostering systems.
- ✓ Implement and maintain tighter controls on approval of overtime.
- ✓ Set hub-level targets based on staffing rotas.
- ✓ Monitor relative financial performance of hubs against targets.
- ✓ Provide training and guidance to support effective budgetary control.

FINANCIAL STRATEGY
Guiding Principles

The following principles establish a framework within which the action plans required to deliver the Strategy are developed.

Principle 1

Operate within a framework of robust financial governance

- Ensure all business developments and service changes are carefully evaluated within the framework set out within the PwC consolidated action plan and accompanying business case approvals process.
- Apply best practice financial governance, financial management and financial reporting methodologies to: -
  - → Ensure the Trust Board receives accurate, timely and comprehensive financial information to inform decisions and support Trust aims.
  - → Facilitate the Audit Committee in exercising oversight and scrutiny.
  - → Support effective managerial control of resources within the Trust.
  - → Provide assurance to external oversight bodies demonstrating strong and effective financial grip and control.
- Operate an effective system of internal audit.

Outcomes

- ✓ Demonstrate effective/efficient use of resources and value for money.
- ✓ External stakeholders are assured of good governance and financial efficiency.
- ✓ Single oversight framework requirements are met.
- ✓ Audit recommendations are implemented promptly.

Principle 2

Prioritise actions to achieve & maintain a financially stable and sustainable service model

→ Develop and implement a financial sustainability / financial recovery plan to achieve recurrent financial balance.

a) Undertake a comprehensive and critical review of the Trust's cost base to inform cost reduction, efficiency, and productivity programmes.

b) Evaluate service line profitability to inform contracting negotiations and tendering opportunities.

c) Conduct a detailed examination of the efficiency with which premises and other capital assets are utilised to inform the Estates Strategy.

d) Establish structures and processes to implement and embed medium term financial planning and medium-long term efficiency programme development.

e) Secure additional resources through service changes, developments, and bidding for tender opportunities.

f) Secure a non-recurrent financial support package as required.

→ Increase organisational focus on cost control measures to support financial sustainability within a block funded financial framework.

→ Actively engage with key stakeholders to ensure parties are informed of and support, the Trust's actions re financial position and plans.

Outcomes

✓ Achieve recurrent financial balance within a timeframe to be determined as an outcome of the planning process.

✓ Financial stability as measured by the income and expenditure account, cash holdings and Use of Resources risk rating.

Principle 3

Secure resources to enable service objectives to be achieved

- Engage proactively with host ICS and other ICSs served by the Trust to secure sufficient capital and revenue resources to enable the Trust to deliver high quality and high performing services for patients.
- Build capacity re monitoring/managing income and contracts and capacity to respond to service tenders.
- Engage nationally and locally re securing changes to revenue and capital funding mechanisms that currently operate within the host-ICS model.
- Re-establish commercial contracting / tariff arrangements for PTS and other commercial services where possible.
- Increase the Trust's income base by seeking to expand services such as PTS and 999 call handling, where these can demonstrably deliver a positive financial contribution to the Trust and where there is alignment with Trust Strategy and core operational competencies.

Outcomes

- ✓ Partnership working with external bodies able to support the Trust to secure its strategic and operational objectives but flexed to accommodate regional service requirements.
- ✓ Commercial based PTS contracts re-established or fully funded blocks.
- ✓ Increased capacity to manage contract income and respond to tenders leading to increased income base.

Principle 4

Apply best practice approaches in financial planning, financial management and financial control activities

- → Implement the Healthcare Financial Management Association's toolkit/techniques to financial planning, management, and control. This methodology is now an NHSE requirement for organisations.
- → Engage with finance / procurement networks within and beyond the ambulance sector to share ideas and identify best practice approaches.
- → Operate an effective delegated budgetary control and financial performance management process at Trust and Divisional level.
- → Provide effective and customer focused support services to the Trust e.g., financial management, procurement, payroll etc.

Outcomes

- ✓ Deliver an agreed budget which meets the service delivery needs of the Trust.
- ✓ Establish and achieve annual financial improvement programme targets as required and achieve year on year productivity gains.
- ✓ Support delivery of the Trust's capital programme.
- ✓ Ensure Trust finances are effectively managed, properly accounted for, and that Value for Money is achieved.
- ✓ Financial planning and management embedded into the Trust's structures, processes, and culture.
- ✓ Five-year Capital Strategy which aligns with the Trust's service vision for that period.
- ✓ Devolved financial management to the lowest level possible across the Trust.
- ✓ Assurance that the Board and managers have a level of financial knowledge and the financial tools appropriate to their needs.

Delivery Action Plans

The remainder of this document sets out the activities that will operationalise the Strategy.

Objective 1 – Establish a clear plan to achieve a financially sustainable position

Financial sustainability defined

Financial sustainability concerns the Trust's medium-long term financial health.

This objective is intimately linked to financial planning activities and objectives but has been separately identified as an objective in its own write due to its critical importance.

The Trust Board and EMB must be fully sighted at all times on delivery against this objective.

The focus is on the **underlying financial position** after excluding the effects of non-recurrent factors.

The underlying position the reported financial position less: -

- Non-recurrent income.
- Non-recurrent expenditure.
- Savings / efficiencies delivered non-recurrently.

Measuring financial sustainability

To be financial sustainable, the Trust must: -

- ✓ Deliver a year on year underlying recurrent surplus.
- ✓ Have adequate cash holdings to maintain and meet its obligations e.g., paying suppliers within contracted timescales.
- ✓ Have the financial capacity to withstand a certain level of unplanned financial pressures i.e., a financial contingency e.g., by developing a 1% planning reserve.
- ✓ Be able to generate sufficient year on year efficiencies to meet NHS planning requirements.
- ✓ Be able to maintain adequate levels of operational and support service capacity to deliver patient care services at an appropriate level of quality and performance whilst maintaining a financially stable position.
- ✓ Have and effective financial risk management process in place to identify risks and to mitigate them.

Financial recovery

Where the Trust is unable to deliver its financial targets, it must develop and implement a financial recovery plan.

A financial recovery plan (FRP) must move the Trust into recurrent financial balance within a timescale that is both realistic and acceptable to the Trust Board, NHS England, the host Integrated Care System and other key stakeholders.

No	Actions	Timescales	Lead
1	Establish best, worst, and most likely financial outturn for 2022/23 and advise EMB, Board and ICS.	Oct 22	TE
2	Calculate and verify the Trust's underlying financial position.	Nov 22	TE
3	Engage with ICS CFOs re WMAS financial pressures and agree funding approach for 2023/24.	Jan 23	PJ
4	Build a medium term financial sustainability plan and secure stakeholder support for actions and timescales of delivery. ▪ EMB ▪ Trust Board ▪ ICSs ▪ NHS England	Dec 22	TE
5	▪ Secure financial support for interim period of financial recovery.	Ongoing	PJ

Objective 2 – Deliver capital and revenue plans including an annual budget and a medium term financial plan that meets the delivery needs of the Trust

	Action	Timescale	Lead
1.	<u>Governing policies and processes</u> ▪ Apply NHS guidance & policies and adhere to ICS governance requirements, control totals and other specified targets. ▪ Where practically deliverable, plans will incorporate a financial contingency / reserve. ▪ Financial planning, budgeting and CIP development will follow a defined process and timetable aligned to Trust oversight and approval deadlines e.g., Trust Board approval. ▪ Monthly progress updates will ensure Board, EMB, and Committees remain fully apprised of progress on the planning agenda. ▪ Plans will be fully risk assessed utilising as appropriate, scenario and sensitivity analysis, ensuring that risk-register and Board assurance framework are updated where required. ▪ There will be clear communication and guidance for all participants to deliver an integrated process, aligning key financial and non-financial assumptions e.g., workforce, operational, capital, digital, efficiency, quality, environmental sustainability. ▪ Financial planning and budgeting activities will be supported by transparent and consistently applied policies for resource allocation prioritisation decisions e.g., cost pressures. ▪ Budgeted staffing levels will align with workforce plans and the budgeted establishment will provide the in-year control mechanism in respect of approval to appoint into vacancies. ▪ Planning assumptions will be clearly stated and captured via templates to provide an audit trail / sign-off. For budgeting, these will include statements of key non-financial metrics such as overtime assumptions. ▪ Planning will be a transparent and collaborative process with relevant stakeholder engagement and sign-off e.g., budget holders.	Nov 22 to Jan 23	DDoF

	▪ Capital planning will be supported by a policy framework to inform and assist in the capital allocation decision-making including assessment, prioritisation, and approval. Plans will fully reflect revenue implications of capital expenditure. ▪ Plans will be fully compliant with Trust financial governance processes as set out in Standing Financial Instructions and Scheme of Delegation. ▪ Financial plans and budgets will be reviewed during the financial year with material changes reported to the Board and where required, approved by the Board.		
2.	<u>Medium term financial planning</u> Prepare and maintain a rolling five-year medium-term activity, capacity, and financial model which will inform, and be informed by, Trust Strategy. The model will be updated on a regular basis during each financial year, to always provide the Trust with a clear view of the medium term financial position.	Nov 22 to Feb 23 then ongoing updates	DDoF
3.	<u>Annual budget and in-year budget changes</u> Prepare an annual income and expenditure budget in line with the national and local financial and commissioning parameters. ▪ Set a budget with a bottom line surplus each year that meets the Control Total required by NHSE / ICS. ▪ Set a budget that ensures the Trust is in financial balance each year. ▪ Achieve at least a risk rating of 2 on all of the risk metrics assessed as part of the Use of Resources risk rating. ▪ Maintain budget reconciliations including a clear audit trail from Board approved start-point and all in-year approved budget changes / virements. ▪ Budget records will at all times differentiate between recurrent and non-recurrent income and expenditure to enable the Trust to report on underlying recurrent position. ▪ Budgets changes will be approved by budget holder and finance manager to reflect in-year changes such as approved developments.	Nov 22 to Jan 23	HoFM

4.	Multi-year capital programme Prepare and maintain a rolling five-year capital plan for replacement of business as usual assets for approval by the Trust Board.	Nov 22 – Dec 22	DoF
5.	Annual capital budget Prepare an annual capital plan aligned to Trust Strategy and which is affordable within capital resource allocations, for approval by the Trust Board.	Nov-Dec 22	DoF
6.	Cash planning Cash plans will be prepared that reconcile with the timing of income and expenditure to ensure that the organisation maintains the appropriate cash balances, manages prompt supplier payments, and identifies possible shortfalls in good time to take necessary action.	Nov 22 to Jan 23	Chief FinAcc

Objective 3 – Establish and embed an efficiency/productivity development process that meets the short, medium, and long term financial improvement targets for the Trust

	Actions	Time-scale	Lead
1.	<u>Governing policies and processes</u> ▪ Efficiency planning will take place in tandem with Trust annual budgeting and medium-term financial planning timetables. ▪ Efficiency planning will entail both top-down and bottom-up approaches. ➢ A top-down approach will focus on Trust-wide / cross-cutting initiatives and will align with the medium-term Efficiency Strategy. ➢ A bottom-up approach will empower staff to identify areas that they regard as poor value for money, utilising their detailed knowledge of services and will result in greater ownership of solutions. ▪ Efficiency plans will align/support ICS initiatives where relevant. ▪ Efficiency planning will be led / coordinated by the Senior Efficiency Group, reporting to EMB. ▪ All schemes will require a project initiation document (PIDs. PIDs must include defined mechanism / metrics for measuring scheme delivery. ▪ Scheme credibility/deliverability will be fully risk assessed. ▪ Schemes must be 'owned' by the relevant clinical and non-clinical lead managers. ▪ All schemes will be subject to QIA and EIA prior to approval to proceed. ▪ Where large / complex schemes are approved, a project/programme methodology will support their development, implementation, and delivery monitoring. ▪ The timing of delivery and the nature of a schemes as either recurrent or non-recurrent will be clearly established. ▪ Recognising that schemes may not deliver fully as planned, scheme development will include identification of additional schemes, over and above the planning requirement, to provide a planning contingency. ▪ In-year monitoring / performance management of efficiency programme delivery will be led by the Senior	Nov-Dec 22	DoF

	Efficiency Group with escalation to EMB where support is required to deliver . ▪ Should it not be possible to identify fully the efficiency planning requirement, the value of unidentified efficiency will be monitored closely and fully reported so that the risk is clearly understood by the Board.		
2.	<u>Establish structure to deliver medium/long term programme</u> Establish structures and processes to develop and deliver a rolling productivity, efficiency, and cost reduction programme with a remit to: - ▪ Develop and implement internal initiatives to improve productivity/efficiency. ▪ Evaluate and apply insights from externally developed productivity improvement initiatives such as Carter efficiency review and Model Ambulance, where applicable to WMAS. ▪ Adopt and/or develop suitable benchmarking / performance metrics to assess productivity/efficiency relative to other Ambulance Services and/or measure improvements over time.	Nov 22 Ongoing Ongoing Ongoing	DoF
3.	<u>Establish annual (upcoming year) delivery process</u> Support the setting, implementation, and monitoring of achievement of the annual cost improvement programme.	Nov 22	DoF
4.	<u>Ensure alignment of finance and quality processes</u> Work with Director colleagues to ensure that the annual cost improvements identified are tested and reviewed for their potential and actual impact on clinical quality.	Ongoing	DoF
5.	<u>Ensure Value for Money through active procurement processes</u> ▪ Review Procurement Strategy and Policy annually to take account of legislative changes. ▪ Contracts to be in place for all significant or high risk non pay areas of expenditure.	Ongoing	Head of Procure-ment

Objective 4 – Build finance team capacity, capability, and effectiveness to deliver 'customer focused' services to the Trust and its stakeholders.

	Actions	Timescale	Lead
1.	<u>Building finance team capacity, capability, and customer service focus</u>		
	Ensure the Trust Finance Directorate has the capacity and capability to deliver an effective and value-adding service to the Trust, whilst operating in an efficient and cost effective manner. Determined via: -	Ongoing	DoF
	<u>Staffing capacity and capability</u>		
	▪ Carry out a periodic review of staffing structures to maintain alignment with changes in organisational structure/priorities where these occur.	Nov 2023	DoF
	▪ Establish a department succession plan.	Dec 2022	DoF
	▪ Ensure that the Finance Department is adequately staffed with appropriately qualified people and continue to support training for Professional Qualifications and CPD.	Ongoing	DoF
	▪ Conduct periodic assessment/reviews of staffing levels, skills/qualifications, processes, and IT systems relative to similar organisations (where information is available) or via assessment against Healthcare Financial Management guidelines.	Nov 2023	DoF
	▪ Apply the Trust staff appraisal process ensuring adequate provision for staff development objectives.	Mar 2023	DoF
	▪ Develop and monitor internal training and CPD plan.	Ongoing	Finance Training lead
	▪ Further develop the Senior Finance Directorate Team to build on shared goals and objectives and collective team successes.	Ongoing	DoF
	<u>Internal 'customer' feedback</u>		
	▪ Conduct periodic surveys which will be used to obtain feedback from budget holders and other staff groups to assess the effectiveness of the Finance Directorate's support offered to them.	Nov 22 Apr 23 Sep 23	DDoF

	▪ Hold periodic 'listening' sessions to discuss the effectiveness of the finance service from the service users' perspective. ▪ Apply feedback / lessons learnt to adapt the service to better serve its users. <u>External Accreditation</u> Achieve accreditation under the NHS Finance Academy's Future Focused Finance programme to support the development of best practice culture, processes, and skills and to raise the profile of the organisation nationally. ▪ Level 1 accreditation – good practice ▪ Level 2 accreditation – high level performance ▪ Level 3 accreditation – leading edge	Achieved Nov 22 Nov 23 Nov 25	 DoF DoF
2.	<u>Finance team support functions</u> *Financial management* ▪ Provision of a comprehensive financial management service to support budgetary control, financial planning, reporting and business case development that delivers best practice services. *Financial services* ▪ Provision of an effective debtors, creditors and financial accounting service including guidance on VAT matters. *Payroll and pensions* ▪ Provision of a comprehensive Payroll and Pensions Service. *Procurement and supplies* ▪ Provision of a comprehensive procurement and supplies service in accordance with the Procurement and Supplies Service Strategy.	Ongoing Ongoing Ongoing Ongoing	HoFM Chief FinAc Head of Payroll Services Head of Procurement

3.	<u>Reporting</u> ▪ A clear month-end timetable will be in place to ensure NHSE, ICS, Trust Board / Committees receive accurate financial reports within required timescales. ▪ Budget managers will receive their budget reports in a timely manner to enable them to review and correct for any errors and omissions, before they are used to review financial performance. ▪ Financial reporting will assess performance at budget-manager, directorate, divisional and Trust-wide levels. ▪ Financial reporting will be accompanied by forecasts and run-rate analysis and will clearly identify recurrent / non-recurrent factors. ▪ Where forecast changes would result in the Trust deviating from its agreed control total trajectory, this change must be approved by the Director of Finance. ▪ Changes in forecast levels of income and expenditure will be reflected in balance sheet and cashflow forecasts.	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	DDoF HoFM HoFM HoFM HoFM Chief FinAcc
4.	<u>Managing income</u> ▪ Ensure clear agreements / contracts are in place. ▪ Ensure income receipts are in line with agreed values. ▪ Promptly follow up on and resolve discrepancies / disputes.	Ongoing	HoFM
5.	<u>Managing Expenditure</u> ▪ Budget managers will receive appropriate training to enable them to discharge their responsibilities and they will be supported by an assigned Financial Management team. ▪ Budget managers will be given clear guidance on what actions they need to take to manage any overspends and will be made aware that they are expected to manage within in their resource allocation. ▪ Key variances will be identified, and their nature understood with remedial action plans developed and followed up on. ▪ Action plans to redress overspends will require impact assessment in respect to their downside risks, with	Ongoing Ongoing Ongoing Ongoing	HoFM HoFM HoFM HoFM

	especial regard to potential impact on clinical service quality. ▪ Review expenditure controls for each cost category to assess effectiveness. Update controls as required to tighten controls.	Nov-Dec 22	DDoF
6.	<u>Managing Debtors</u> ▪ Apply appropriate credit checks to non-NHS debtors. ▪ Recover all debts within payment terms. ▪ Minimise invoicing errors and other issues that delay debt recovery. ▪ Operate an effective debt management / debt recovery process. ▪ Minimise bad debts.	Ongoing	Chief FinAcc
7.	<u>Managing Stock / Inventory</u> ▪ Monitor and control investment in stock to maintain at optimal levels. ▪ Minimise stock losses and write-offs.	Ongoing	Head of Procure-ment
8.	<u>Managing creditors</u> ▪ Pay creditors promptly within contractual payment terms. ▪ Deliver Public Sector Payment Policy target.	Ongoing	Chief FinAcc
9.	<u>Managing capital assets</u> ▪ Ensure assets are correctly valued in the accounts with an agreed annual valuation method between quinquennial revaluations. ▪ Maintain capital accounting and reporting processes including the annual census of assets held.	Ongoing	Chief FinAcc
10.	<u>Managing service-line financial contributions and service costing</u> ▪ Production of detailed costing information to support decision-making in the Trust and to meet NHSI and DH requirements. ▪ Development of Patient Level Costing (PLICS) in line with the national timetable (Road Map Partner). ▪ Develop service contribution analysis and service pricing models.	Ongoing	HoFM

Objective 5 – Build upon / enhance the financial governance arrangements within the Trust

Overarching policies

- Financial governance arrangements are defined within the Trust standing orders, standing financial instructions, scheme of delegation and associated governance documentation.
- Governance documents will be supported by relevant and up-to-date policies and procedures to direct / control staff activities to ensure efficient and effective use of Trust resources.
- These documents will be kept up to date, with any changes being formally approved.
- Financial governance documents will be readily available to all staff and Board members via the Trust intranet.
- All staff will receive training/guidance in the interpretation and application of the financial governance documents, with regard to executing the duties of their roles in accordance with the documents.
- Financial assurance will follow the principles of: -
  - First-line assurance – line-manager level controls.
  - Second-line assurance – management oversight via EMB, Committees and Board.
  - Third-line assurance – internal and external audit.

Principles with respect to Board / Committee reporting

The content and style of financial reporting to Board and Committees will be periodically reviewed and revised to ensure it remains relevant, is comprehensive, and fully meets the requirements of those charged with governance.

Changes in style/content of reports will be informed by good practice and will require Board approval.

Reports will be: -

- Accurate, timely, and relevant to its users' requirements.
- Clear, jargon free, and use graphical representations where these aid understanding.
- Forward focused and action orientated.
- Supported by activity, workforce, and other non-financial metrics where appropriate.
- Comprehensive and include analysis of risks and opportunities.
- Include written commentary designed to provide insight and prioritise the Board's decisions.

Other matters

Financial staff have training that is focused on the development of future skills, as well as current competencies.

Financial governance requirements included in new starter packs/ on-boarding processes.

	Actions	Timescale	Lead
	<u>Governance documents</u> Maintain up-to-date standing financial instruction documents and make available via intranet. Provide training / guidance in application of documents. Ensure systems are in place to monitor compliance.	Ongoing	DoF
	<u>Board / Committee Reporting</u> Support the cycle of reporting to Board and Committees, ensuring that those charged with governance are fully apprised of: - ▪ Performance against NHS financial duties and targets. ▪ Performance against Financial Improvement targets ▪ Actions to address underperformance. ▪ Financial risks and potential mitigations including contract performance risks. ▪ The underlying, recurrent income and expenditure position of the Trust i.e., excluding non-recurrent in-year income and expenditure. ▪ Effective management of Trust assets / liabilities. ▪ The medium term financial position of the Trust. ▪ Regulatory and legislative matters pertaining to Trust financial matters e.g., impact of changes in financial reporting standards.	Ongoing	DoF
	<u>Annual Accounts</u> Production of the Annual Accounts in line with the required national timetable.	Per NHS accounts timetable	Chief FinAcc
	<u>Annual Report</u> Production of the Annual Report in line with the required national timetable.	Per NHS timetable	DoF
	<u>Accounting systems</u> Maintain financial accounting processes and ensure the integrity and full application of the general ledger and feeder systems. Ensure business continuity plans are robust and enable essential financial processes to be maintained in the event of cyber-attack or other event that incapacitates the Trust's accounting systems.	Ongoing	DoF

	<u>Financial risk management</u> Review/apply process whereby the Trust methodically addresses the financial risks attached to its activities with especial regard to: - ▪ Failure to achieve Operational Performance Standards. ▪ Failure to manage Finances appropriately. ▪ Failure to comply with the Regulatory Body Standards and Quality Indicators. Review financial risks and mitigations monthly and report to EMB/Board.	Ongoing	DoF
	<u>Business cases and business developments</u> Fully implement PwC defined base case approvals process All business cases and/or unfunded service changes / cost pressures must follow the above process including: - ▪ Completion of relevant financial and non-financial templates. ▪ Submission to the relevant group/board for review and approval. In the first instance this must be the Capital and Revenue Investment Group.	Nov 22 and ongoing	DoF

Appendix 1 Trust Strategic Framework

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08a MONTH: OCTOBER 2022 PAPER NUMBER: 05a

Executive Medical Director & Executive Nurse Director Quality Summary Report	
Sponsoring Director	Mark Docherty, Executive Director of Nursing and Clinical Commissioning.
Author(s)/ Presenter	Mark Docherty, Executive Director of Nursing and Clinical Commissioning. Dr Alison Walker Executive Medical Director
Purpose	The report is presented to the Board 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	Quality Governance Committee 19 October 2022
Report Approved By	Mark Docherty, Director of Nursing and Clinical Commissioning.

Executive Summary

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

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

- Patient handover delays continue to result in significant patient harm and the impact of these delays resulting in long patient waiting times also causes harm, including death.
- As a result of long delays, the number of serious incidents involving serious harm or death remains significant

Related Trust Objectives/ National Standards	Supports the monitoring against our strategic objective to achieve quality and excellence.
Risk and Assurance	The report is presented as a document that gives Board assurance and highlights areas of clinical risk.
Legal implications/ regulatory requirements	The report highlights the areas where we have a statutory duty to report.
Financial Implications	There are no direct financial implications raised in this report. Patient handover delays are creating a financial pressure for WMAS, estimated at around £44m.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 08a MONTH: OCTOBER 2022 PAPER NUMBER: 05a

Workforce Implications	None in the context of this report.
Communications Issues	The contents of this report are not confidential and have been provided to multiple people inside and outside the organisation. Much of the information is in the public domain.
Diversity & Inclusivity Implications	The report will highlight any diversity and inclusion issues as or if they arise.
Quality Impact Assessment	The report will highlight any quality impact assessments as they arise.
Data Quality	The data used in the report has been provided and quality assured ahead of publication in Board papers. Data has been sourced from the WMAS portal ORBIT and from the WMAS contract monitoring report and monthly AIF report

Action required

The Board is asked to:

1. Note the integrated quality report to the Board.
2. Receive the report.
3. Gain assurance on the quality agenda and the robustness of our quality governance processes.
4. Note the significant harm being caused as the result of long patient handover delays and resultant actions.

Introduction – Quality Report from Medical Director and Nurse Director

On an ongoing basis, in addition to regular Trust meetings alongside patient care and patient safety, our main focus has continued to be the patient and staff safety and staff wellbeing issues related to Hospital Handover Delays which result in long waiting times for patients wating for an ambulance response.

Our Patient Story at the July Board meeting was Jamie's Story presented by Jamie's Mum, Naomi. Jamie was 18 years old when he presented with cardiac arrest which was a Category 1 call. The first WMAS vehicle was on scene in 17 minutes and a further 2 mins was taken to don PPE. The crew managed to get a return of spontaneous circulation (ROSC) and Jamie was taken to UHCW where he sadly died four days later.

Jamie's story was presented at the Ambulance Leadership Forum in September 2022 and a recording of this is being presented as the Patient Story. We also present a complimentary patient story which is summarised in the papers.

Patient Handover Delays

The issue of patient handover delays shows little sign of improvement and the impact of this means we are keeping patients waiting for very long periods for an ambulance response. As a consequence, there is an increase in the numbers of serious incidents being reported and investigated.

The lost hours for the year to date has plateaued across August and September, but early indicators for October suggest a worsening position.

Integrated Care Systems (ICS) are undertaking work to support WMAS and reduce long patient delays examples of which include:

- Investment of over £4m by the Birmingham and Solihull ICS to operationalise a cohorting project in each of the main hospitals. This reduces ambulance delays and enhances the role of the Paramedic in the patient flow through emergency care pathways.
- Proactive work by the Community Rapid Intervention Service in Staffordshire and Stoke on Trent, providing a service in the Emergency operations Centre to proactively take patients who have been assessed, direct into a community service and preventing long waits for patients

The impact of the lost hours due to handover delays continues to worsen, and as a result of this the Board the risk identified in the Board Assurance Framework (BAF) continues to be rated as a 25.

The impact of handover delays is patients waiting longer than necessary for an emergency ambulance response and patients waiting in Category 1 (rarely) or Category 2 (regularly) stacks where there is no ambulance immediately available to respond. This means that patients who are immediately time critical medical emergencies do not get the response they need and may suffer significant harm or death. The risk rating of 'incident stacking' also remains at a 25.

Support and Communication with Staff

We continue to support staff who are working remotely. We have twice weekly staff briefings to ensure that staff physical and mental health and wellbeing is considered and addressed. Provision of a corporate credit card enables us to quickly address, and staff equipment needs to enable safe and effective remote working.

All staff in the team have the option of working in one of our corporate buildings as we also recognise that not everybody wants or is able to work remotely.

Body Worn Cameras

A paper will be considered by EMB on 18 October 2022.

The National Ambulance Violence Prevention and Reduction Operational Lead from the Association of Ambulance Chief Executives will be soon setting up a Body Worn Camera (Video) working group to look at the wider system applications of the cameras. There will be engagement with our staff side colleagues on a national basis, and the necessary governance arrangements will be put into place to ensure the safe and efficient use of the footage from the Body Worn Camera system.

Stab Proof Vests

A verbal update will be given to the Board following consideration at the Executive Management Board on 18 October 2022.

Serious Incident Investigation Work

Die to the number of serious incidents (SIs) increasing in part due to delays resulting from lost hours of handovers, there has been a significant pressure on the team that lead the investigations and people responsible for implementing the agreed actions.

Work is ongoing to ensure that investigations do not exceed the agreed timeframes and the information below summarises the position as of 18 October 2022:

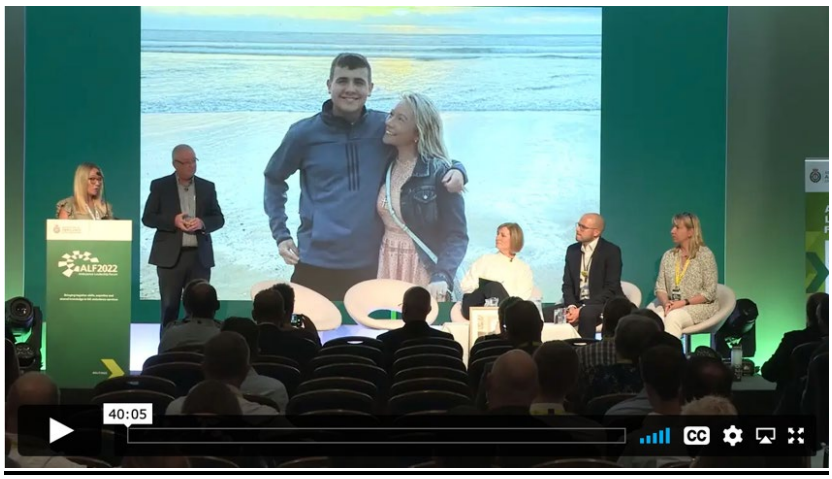
Recommendations 2020-2023 (LRG)		%
Total Recommendations	1440	100.0%
Recommendations Complete	1009	70.1%
Recommendations Due	90	6.3%
Recommendations Overdue	341	23.7%
Total	**1440**	**100.0%**

Overdue Recommendations by Business Area Total		
A&E	18	5.2%
Patient Transport Services	3	0.9%
IEUC	186	53.8%
Workforce & Organisational Development	0	0.0%
Education and Training	2	0.6%
Clinical & Commissioning	118	34.1%
Strategic Operations	5	1.4%
Specialist Care	0	0.0%
Logistics	3	0.9%
Service Delivery	0	0.0%
Emergency Preparedness	0	0.0%
Operational Information & Planning + CFR	6	1.7%
Executive Office (Inc Press Med Dir & Strat & Eng)	5	1.4%
Misc	0	0.0%
Total	**346**	**100.0%**

- 341 Overdue
- 303 Closed in past 11 days (upto 18 October 2022)
- 10 Working days left to close 341 before the target date of 31 October 2022
- Daily Target Remains 35 per day

Patient Story – Jamie's Story

Jamie's Story was presented to the Trust Board Meeting on 27 July 2022. Jamie's story was presented at the National Ambulance Leadership Forum on 7th September 2022 and the link to that event video is shown below (follow the link and go to the video, where Jamie's story starts at 1:30 mins into the session start



https://aace.org.uk/ambulance-leadership-forum-2022-presentations/

Patient Story – Stanley's Story

I just wanted to send a quick email to thank the wonderful 2 paramedics who were called out to my very poorly 3 year old boy at around 8.30 on 14thOctober, my little boy was found unresponsive in the morning which led to Roger Davies and Dylan McAteer being sent to us they arrived extremely quickly (less than 4 minutes I believe) and were so quick at making decisions to go straight to hospital in the ambulance he started to have a seizure which was absolutely frightening but Dylan who was in the back with us was really caring and kept me calm throughout until we got to hospital. I strongly believe that they saved my little boy's life that day by acting so sufficiently and done everything they could to make him better, it takes a very special person to be able to do the job you guys do every single day and I wanted them to receive some recognition for the service we received it went above and beyond, they even came back to visit Stanley later in the afternoon when they were back at Good Hope Hospital A&E to see how we all were and to chat with us about it. That meant the absolute world to me and my husband at the time because we felt like they really understood what we'd been through that morning and took the time out of their busy day to check in on us it really made us feel like they cared so much about us all. They have shown us that the NHS is absolutely precious to us all and these two men are a credit to WMAS and the NHS. I can't find the words to thank them enough and I'd love to get a little gift as a way of a thank you if that is at all possible?

Patient Handover Times

Year to date from 01/04/2022 to 30/09/2022

Lead ICS & Destination Hospital		total (pre AIF + AIF)	Pre AIF			AIF			AIF - Over 60:00 mins breakdown																				
			0-30:00 mins	30:01-45:00 mins	total	45:01-60:00 mins	Over 60:00 mins	total	1-2 hrs	2-3 hrs	3-4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9-10 hrs	10-11 hrs	11-12 hrs	12-13 hrs	13-14 hrs	14-15 hrs	15-16 hrs	16-17 hrs	17-18 hrs	18-19 hrs	19-20 hrs	20-21 hrs	21-22 hrs	22-23 hrs	23-24 hrs	over 24 hrs
BIRMINGHAM AND SOLIHULL ICS	Birmingham Childrens	2,912	2,816	77	2,893	15	4	19	1																						
	City (Birmingham)	12,804	11,710	428	12,138	180	486	666	41	17	8																				
	Good Hope	10,846	5,365	977	6,342	546	3,958	4,504	258	142	96	82	44	17	16	11	6	7	2	1											
	Heartlands	15,713	7,588	1,867	9,455	849	5,409	6,258	316	135	82	56	66	49	45	33	14	10	4		1	1	1	2	1	1					
	New Queen Elizabeth Hosp	18,066	11,492	2,309	13,801	823	3,442	4,265	211	114	85	54	41	29	19	12	10	3	2	1											
	Solihull																														
BLACK COUNTRY ICS	New Cross	19,187	13,871	1,388	15,259	786	3,142	3,928	237	90	58	46	41	27	10	3															
	Russells Hall	17,402	10,438	1,858	12,296	727	4,379	5,106	329	192	121	86	38	19	10	4		2													
	Sandwell	13,126	9,486	1,457	10,943	525	1,658	2,183	122	59	41	20	9	5	1			1													
	Walsall Manor	17,037	15,438	1,061	16,499	299	239	538	27	6																					
COVENTRY AND WARWICKSHIRE ICS	George Elliot	7,176	5,386	1,111	6,497	466	213	679	38	12		2																			
	St Cross																														
	Uni Hospital Cov & War	18,734	11,926	2,959	14,885	1,043	2,806	3,849	294	127	53	11	2	2	1	1															
	Warwick	9,859	7,322	1,113	8,435	457	967	1,424	143	34	13	1																			
HEREFORDSHIRE AND WORCESTERSHIRE ICS	Alexandra	10,414	7,361	767	8,128	511	1,775	2,286	140	39	19	8	3	5	1																
	Hereford County	8,262	6,808	578	7,386	243	633	876	72	15	8	2																			
	Worcestershire Royal	11,325	5,144	762	5,906	523	4,896	5,419	201	126	97	83	69	42	44	29	27	31	25	16	8	6	2	2	1						
SHROPSHIRE, TELFORD AND WREKIN ICS	Princess Royal	8,019	3,644	921	4,565	500	2,954	3,454	145	74	56	50	31	41	28	16	14	10	10	8	8	6	4	4	1	2	1				1
	Royal Shrewsbury	6,614	2,040	843	2,883	456	3,275	3,731	152	70	52	38	31	21	17	10	18	13	7	4	2				2						
STAFFORDSHIRE AND STOKE ON TRENT ICS	Burton	5,470	3,275	559	3,834	344	1,292	1,636	110	75	26	14	1	3																	
	County Hospital (Stafford)	4,767	4,078	258	4,336	141	290	431	35	6	3																				
	Royal Stoke Univ Hosp	16,332	7,675	1,591	9,266	732	6,334	7,066	220	127	121	70	82	43	36	24	25	9	12	15	6	4	6	1	1	2					
	Hospital Total	234,065	152,863	22,884	175,747	10,166	48,152	58,318	18,506	9,340	6,151	4,287	3,006	1,950	1,483	1,021	771	516	381	260	156	110	68	56	35	26	10	9	3	4	3	

September 2022

Lead ICS & Destination Hospital		total (pre AIF + AIF)	Pre AIF			AIF			AIF - Over 60:00 mins breakdown																				
			0-30:00 mins	30:01-45:00 mins	total	45:01-60:00 mins	Over 60:00 mins	total	1-2 hrs	2-3 hrs	3-4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9-10 hrs	10-11 hrs	11-12 hrs	12-13 hrs	13-14 hrs	14-15 hrs	15-16 hrs	16-17 hrs	17-18 hrs	18-19 hrs	19-20 hrs	20-21 hrs	21-22 hrs	22-23 hrs	23-24 hrs	over 24 hrs
BIRMINGHAM AND SOLIHULL ICS	Birmingham Childrens	447	428	16	444	2	1	3	1																						
	City (Birmingham)	2,027	1,826	77	1,903	22	102	124	58	26	15	3																			
	Good Hope	1,770	902	177	1,079	94	597	691	205	132	94	66	30	20	17	16	9	5	1	2											
	Heartlands	2,441	1,166	320	1,486	137	818	955	253	156	121	94	62	45	28	24	17	7	7	4											
	New Queen Elizabeth Hosp	2,860	1,770	417	2,187	130	543	673	256	90	65	45	29	18	14	7	6	5	2	3	3										
	Solihull																														
BLACK COUNTRY ICS	New Cross	2,925	2,118	231	2,349	115	461	576	207	96	40	33	24	17	19	12	4	4	2	1		1	1								
	Russells Hall	2,678	1,610	294	1,904	109	665	774	238	185	102	56	31	16	11	5	6	5	2	3	2				1	2					
	Sandwell	2,081	1,562	248	1,810	76	195	271	91	40	25	16	10	8	2		2	1													
	Walsall Manor	2,612	2,430	118	2,548	41	23	64	23																						
COVENTRY AND WARWICKSHIRE ICS	George Elliot	1,090	872	150	1,022	49	19	68	17	2																					
	St Cross																														
	Uni Hospital Cov & War	2,959	1,847	483	2,330	145	484	629	265	133	65	12	7	1	1																
	Warwick	1,576	1,217	158	1,375	59	142	201	112	19	6	4	1																		
HEREFORDSHIRE AND WORCESTERSHIRE ICS	Alexandra	1,579	1,115	102	1,217	82	280	362	163	67	18	22	7	2	1																
	Hereford County	1,299	1,090	76	1,166	34	99	133	72	16	8	2	1																		
	Worcestershire Royal	2,071	1,084	147	1,231	59	781	840	231	131	91	89	63	38	36	25	16	19	16	8	4	6	2		3	3					
SHROPSHIRE, TELFORD AND WREKIN ICS	Princess Royal	1,288	488	186	674	98	516	614	194	79	54	41	41	35	17	13	9	6	12	6	4	2		1			2				
	Royal Shrewsbury	1,035	255	111	366	55	614	669	102	89	74	63	54	51	25	33	25	11	21	25	9	7	3	7	3	6	2	2	1	1	
STAFFORDSHIRE AND STOKE ON TRENT ICS	Burton	883	538	94	632	63	188	251	121	42	18	2	3	1		1															
	County Hospital (Stafford)	824	683	34	717	31	76	107	49	14	3	5	1	1	2	1															
	Royal Stoke Univ Hosp	2,834	1,114	220	1,334	131	1,369	1,500	326	228	203	176	145	98	55	44	49	17	18	10											
	Hospital Total	37,279	24,115	3,659	27,774	1,532	7,973	9,505	2,984	1,545	1,002	729	509	351	228	181	143	80	81	62	22	16	6	8	7	11	4	2	1	1	

Table – Time lost due to handover delays exceeding 15 minutes (conveying resource)

	2020/2021			2021/2022									2022/2023							
Hospital	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Alexandra	99:59:37	36:13:03	29:50:44	31:38:18	64:46:51	99:21:10	242:27:30	320:08:34	259:00:20	348:59:38	400:33:34	232:59:20	295:35:14	149:43:30	458:28:04	478:19:45	493:56:27	827:37:23	744:58:56	817:37:33	632:20:25
Birmingham Childrens	45:11:46	47:38:15	68:07:35	40:16:26	59:53:52	74:52:49	71:38:36	59:32:19	83:27:19	102:52:10	85:01:19	86:41:16	123:38:03	81:36:40	92:34:59	76:26:44	79:24:33	88:22:16	90:32:54	48:32:04	65:18:00
Burton	115:24:00	83:45:15	140:58:47	88:03:42	131:33:49	94:59:03	157:21:15	137:36:04	184:05:38	285:38:42	300:13:58	331:27:53	306:48:53	270:20:19	427:01:05	674:40:59	485:57:11	630:06:54	676:23:35	676:14:40	530:02:37
City (Birmingham)	409:12:08	95:39:35	73:41:30	85:10:55	84:02:12	158:43:37	258:28:31	196:16:04	252:16:13	301:16:32	349:00:27	283:26:29	251:51:38	197:45:12	291:21:10	260:14:21	237:47:20	335:58:56	278:50:01	287:39:02	298:17:35
County Hospital (Stafford)	34:19:09	36:37:41	24:09:20	33:00:13	48:16:37	58:59:18	56:38:33	61:17:27	96:21:35	78:14:55	100:40:58	146:13:46	174:14:09	83:57:44	172:43:17	122:43:58	125:48:50	84:31:19	100:40:34	108:46:57	146:00:43
George Elliot	199:10:35	131:09:42	97:43:04	93:11:34	87:56:29	92:34:13	104:51:44	99:54:10	98:39:28	147:17:21	156:51:20	228:46:06	215:28:36	154:36:27	285:55:54	261:14:39	204:54:33	214:20:26	326:59:14	263:21:36	183:51:29
Good Hope	723:04:09	203:51:28	267:37:16	299:18:25	626:25:26	859:41:11	972:42:18	1132:06:10	1186:43:22	1772:00:36	1454:16:03	1234:49:33	1116:36:32	1274:50:13	1702:41:14	1689:38:17	1220:21:40	1911:11:01	1753:07:50	1552:38:53	1405:29:47
Heartlands	1217:47:17	556:11:27	641:52:18	567:52:16	824:33:38	1373:03:41	2069:34:43	2293:27:31	1951:29:11	2873:37:16	2352:50:33	2163:41:22	2102:52:29	1979:41:42	2391:45:59	2141:37:29	2008:33:04	2535:07:26	2679:56:25	2068:10:13	2013:57:48
Hereford County	144:09:41	86:08:28	110:53:00	127:32:11	142:57:40	198:34:26	240:54:56	330:49:51	293:07:26	562:24:57	226:07:33	413:04:17	371:48:56	345:19:13	673:28:45	349:23:20	182:56:38	297:11:06	463:16:51	449:39:01	297:21:05
New Cross	1295:33:56	203:32:17	250:50:53	226:54:52	371:00:10	589:05:53	882:36:34	1176:51:02	1383:44:36	1671:09:55	1072:38:37	1294:19:53	872:02:06	893:35:51	1319:15:29	1040:21:05	926:49:34	1032:31:45	1474:06:21	1433:47:25	1193:48:28
New Queen Elizabeth Hosp	1347:04:10	545:59:31	590:21:30	624:02:54	726:39:07	963:38:03	1576:57:49	1819:47:08	1630:28:15	1839:35:13	1451:15:26	1221:08:53	1460:59:00	1430:11:58	1872:57:56	1995:46:21	1470:31:39	1757:51:44	1851:49:21	1472:41:17	1396:24:14
Princess Royal	679:51:43	348:53:56	245:24:44	232:08:12	327:47:01	440:41:03	851:18:03	515:16:35	768:16:25	1290:11:28	1241:22:42	1165:19:07	1098:58:01	1191:13:10	1437:45:31	1646:04:40	1202:30:35	1590:44:25	1693:09:30	1544:38:54	1456:51:11
Royal Shrewsbury	465:18:51	402:27:10	360:45:49	456:44:54	539:27:58	880:17:44	1202:39:40	1249:27:06	1375:21:10	1281:12:55	1310:56:43	1162:58:30	1213:17:24	957:12:26	1391:05:02	1415:39:25	1273:51:42	1352:22:12	1783:24:42	1492:16:09	1590:29:56
Royal Stoke Univ Hosp	803:54:39	452:45:08	605:43:12	659:38:48	859:18:43	986:33:39	1559:44:21	1954:31:45	1810:53:10	2805:30:13	2514:26:44	2948:48:04	3036:43:10	2921:06:29	3925:28:25	4119:26:30	2346:59:33	3872:49:44	4283:43:10	2832:34:10	3743:40:15
Russells Hall	1409:00:39	286:09:00	276:45:49	277:49:29	559:17:21	646:03:25	795:14:02	620:11:55	1314:02:02	1429:59:39	930:20:47	1124:40:52	899:13:51	976:19:56	1186:04:00	1292:38:50	1177:46:22	867:31:34	1252:31:59	1317:26:00	1129:44:55
Sandwell	760:37:53	290:32:45	319:43:26	273:14:26	224:35:15	257:53:17	434:38:46	351:35:22	635:03:04	689:08:44	553:33:22	671:43:13	534:12:39	574:56:33	831:53:22	673:38:02	806:46:16	718:14:35	623:49:49	513:20:46	510:00:26
Solihull	03:48:44	01:42:07	01:10:01	00:24:54		00:09:56	01:17:48	01:14:49	00:09:48		00:41:40	00:25:49	00:46:15		00:17:01	00:27:00	00:36:50	00:27:26	00:13:21	01:10:13	01:01:34
St Cross	03:23:05	03:09:59	02:11:50	01:23:59	00:20:52	00:15:16	01:44:39	01:08:36	00:14:16	00:28:04	01:53:56	01:01:15	01:32:23	00:01:51	01:53:26	04:41:00	00:17:20	01:10:28	02:31:24	01:18:01	01:28:27
Uni Hospital Cov & War	1093:51:57	651:23:51	537:40:22	577:03:45	636:35:28	799:25:41	806:26:54	668:44:05	1112:14:01	776:16:40	912:14:28	805:30:02	990:09:19	919:18:18	1066:49:06	1444:57:40	1215:23:53	1418:45:47	1478:22:26	1805:46:30	1491:46:55
Walsall Manor	245:21:40	120:21:20	110:35:29	124:26:35	121:55:19	154:38:45	190:15:37	201:03:12	272:14:10	253:43:41	195:53:43	200:27:22	194:26:42	189:04:04	226:35:08	254:58:15	258:39:29	307:32:01	299:29:17	313:31:01	212:29:37
Warwick	228:13:06	170:32:45	174:40:37	237:54:47	244:51:18	287:01:42	340:24:37	455:52:42	442:34:14	718:00:33	547:08:06	364:50:02	350:57:43	351:22:32	463:36:34	492:39:53	406:29:03	476:29:00	487:37:04	390:28:08	402:38:32
Worcestershire Royal	497:54:20	449:58:35	360:27:07	359:48:35	664:25:44	992:20:28	1818:06:06	2010:00:05	1562:27:16	1859:28:05	2006:26:05	2305:10:35	2585:39:01	2358:02:11	3015:56:57	3269:11:27	3038:29:11	3394:05:12	3343:08:08	3298:15:16	2251:49:07
Total	11822:13:05	5204:43:18	5291:14:23	5417:40:10	7346:40:50	10008:54:20	14636:03:02	15656:52:32	16712:52:59	21087:07:17	18164:28:04	18387:33:39	18197:52:04	17300:16:19	23235:38:24	23704:49:40	19164:51:43	23715:02:40	25688:42:52	22689:53:49	20954:53:06

Table – Time lost due to handover delays exceeding 15 minutes (cohorting resource)

	2020/2021			2021/2022									2022/2023								
Hospital	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Alexandra	04:47:04	00:22:32			03:11:21	05:56:41	36:33:49	19:09:16	17:56:57	45:35:42	43:45:16	14:33:19	40:11:06	09:37:10	46:34:29	66:18:11	62:38:44	129:11:26	110:07:19	108:00:22	102:17:41
Burton	01:20:04		03:46:42	00:57:04	03:42:59	01:02:55	03:30:28	02:36:54	15:19:42	23:49:58	23:49:47	27:36:22	23:59:11	18:46:28	25:09:58	78:36:17	42:26:18	57:51:38	69:10:17	70:30:28	69:39:59
City (Birmingham)	42:33:45	04:37:47	00:42:08	01:31:06	00:42:49	06:03:32	17:59:22	12:34:28	29:55:50	28:24:06	42:27:37	36:40:06	23:45:50	48:09:12	42:55:51	08:14:16	25:06:09	48:58:09	23:00:09	32:21:10	39:39:50
County Hospital (Stafford)	00:44:06			00:31:13			01:22:28	00:22:29	17:41:18	05:27:50	09:33:22	08:25:57	27:34:25	07:39:04	20:03:40	14:44:08	11:12:42	03:12:24	28:42:08	72:45:53	79:12:03
George Elliot			00:26:08	00:06:20		00:37:56		00:37:20	00:11:46	02:24:11		05:48:39	03:01:20	02:59:58	16:43:18	17:03:53	00:25:24	03:12:24	23:53:06	15:18:00	03:37:35
Good Hope	73:46:38	06:05:05	13:52:07	26:17:56	62:31:18	69:13:02	122:44:30	249:27:05	373:59:20	557:46:29	712:59:07	681:24:46	696:02:17	834:33:16	1153:56:54	928:37:07	568:26:03	1143:48:53	1465:33:26	1173:04:58	893:11:56
Heartlands	544:32:03	31:24:57	68:53:33	78:07:07	99:08:25	220:50:49	714:29:43	991:55:07	1294:38:55	1897:38:29	1975:37:30	1657:41:33	1721:34:09	1923:23:48	2088:24:57	1663:11:49	1591:40:29	2186:02:04	2563:48:24	2167:44:00	1893:55:08
Hereford County	03:59:40	00:28:22	02:48:12	00:43:07	01:32:17	01:02:35	06:21:06	14:30:19	16:06:31	49:47:58	07:24:41	86:20:23	47:02:13	22:52:20	77:05:40	09:45:03	08:40:54	16:46:48	34:34:32	31:43:58	19:25:08
New Cross	299:10:50	35:20:12	77:07:42	61:38:06	126:31:50	246:17:20	454:25:42	816:56:50	1058:45:05	829:49:00	535:41:45	341:38:08	293:00:57	234:43:49	725:30:53	918:45:25	471:30:23	649:01:16	1396:50:47	797:54:06	788:24:22
New Queen Elizabeth Hosp	128:38:09	15:25:35	26:30:57	45:33:22	28:21:44	90:16:11	415:44:13	1047:12:06	1139:36:05	1303:22:17	777:29:48	715:02:35	321:53:54	471:45:27	425:29:36	572:46:44	372:43:43	714:47:18	863:22:21	577:13:58	827:40:41
Princess Royal	78:51:12	05:23:21	14:14:42	09:08:38	14:38:29	25:47:46	84:37:57	61:36:06	169:26:14	423:32:45	571:19:21	836:56:02	588:12:12	695:37:03	744:00:18	1530:03:09	676:42:41	1320:48:44	1830:02:15	1578:30:47	1264:06:29
Royal Shrewsbury	56:08:29	15:22:34	10:38:55	21:41:37	33:55:20	68:50:22	175:01:01	405:16:49	682:34:19	1114:19:19	1051:43:09	874:14:35	1691:05:40	1518:50:07	1733:43:02	850:51:17	838:36:55	1623:32:03	2113:24:34	2007:32:48	2753:52:02
Royal Stoke Univ Hosp	27:43:29	07:43:18	01:41:44	02:06:47	09:19:54	21:39:56	90:30:25	145:41:46	170:01:05	403:48:19	433:23:48	553:08:13	764:04:33	560:03:07	795:49:06	2456:55:06	1379:18:52	3477:14:36	3532:00:47	2418:52:45	3201:04:59
Russells Hall	186:25:36	14:33:07	07:51:08	14:12:42	23:42:32	58:17:07	111:22:04	66:13:55	426:04:51	609:25:14	375:43:57	461:54:53	388:46:23	476:36:43	756:55:01	1331:14:08	1483:19:03	1120:14:37	1657:18:08	1452:32:32	1378:57:19
Sandwell	68:31:09	09:08:00	11:25:04	11:17:22	00:15:53	04:58:05	46:56:18	12:34:43	51:40:12	84:53:21	61:25:35	126:06:44	99:38:51	93:01:11	261:46:12	264:00:16	248:40:12	307:41:08	381:10:37	269:03:39	312:56:03
Uni Hospital Cov & War	41:32:11	15:53:43	01:50:05	02:17:54	04:19:44	13:59:00	13:40:05	18:29:22	73:28:44	33:24:26	61:11:33	22:05:16	90:44:08	59:21:45	80:52:02	164:03:06	123:20:24	148:19:27	170:30:15	214:22:10	156:59:40
Walsall Manor	02:09:24			00:00:00			01:35:26	01:08:51	31:15:56	05:37:20	05:27:19	00:36:00	01:11:15	00:49:47	03:09:58	08:30:40	12:09:00	49:29:55	35:40:30	05:24:28	00:24:51
Warwick	04:32:55	02:47:42	01:45:41	10:42:34	03:54:47	04:08:26	05:35:33	30:23:50	30:34:17	110:13:54	61:27:44	22:53:01	34:36:33	35:47:37	53:20:04	51:36:28	48:59:27	104:02:23	44:37:17	35:21:32	18:46:25
Worcestershire Royal	52:21:58	53:58:04	26:44:55	27:42:08	43:22:08	115:51:20	246:57:13	413:37:19	305:50:13	309:05:33	481:41:06	624:01:10	753:40:39	670:34:09	1046:23:43	1319:31:52	1309:37:18	1554:12:24	1712:35:34	1189:44:37	1990:58:24
Total	1617:48:42	218:34:19	270:19:43	314:35:03	459:11:30	954:53:03	2549:27:23	4310:24:35	5905:07:20	7838:26:11	7232:12:25	7097:08:04	7611:35:56	7685:12:01	10097:54:42	12254:48:55	9277:19:39	14658:27:37	18056:22:26	14218:02:11	15795:10:35

Graph – Time lost due to handover delays exceeding 15 minutes and cohorting for the last 4 financial years

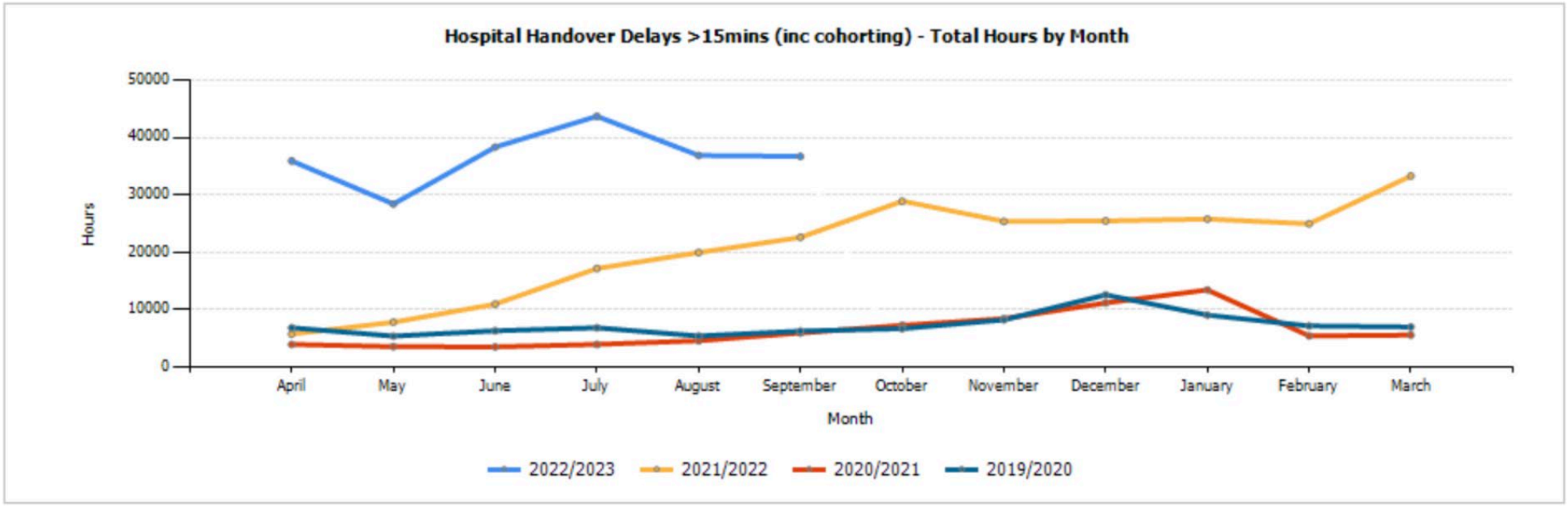
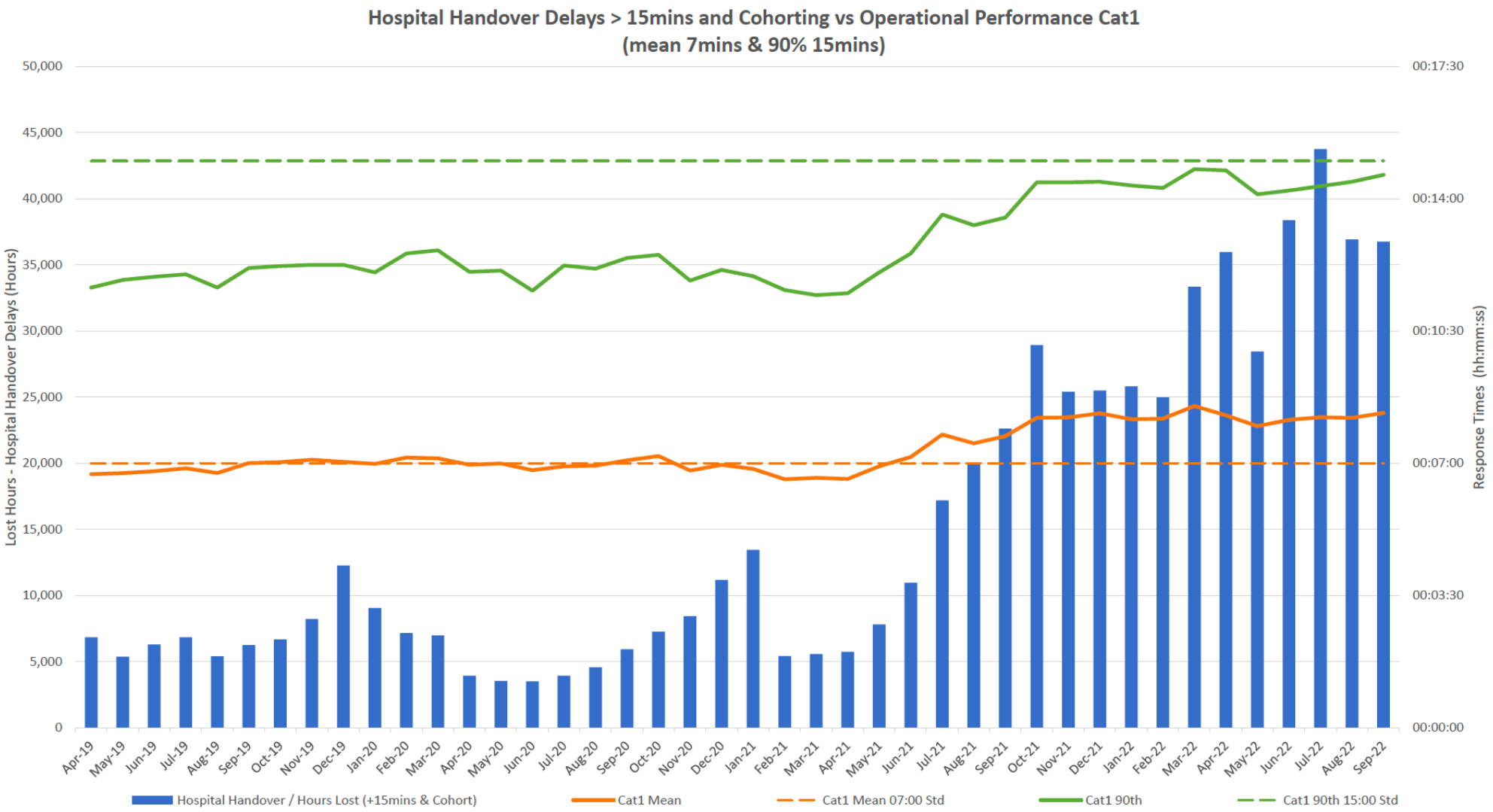


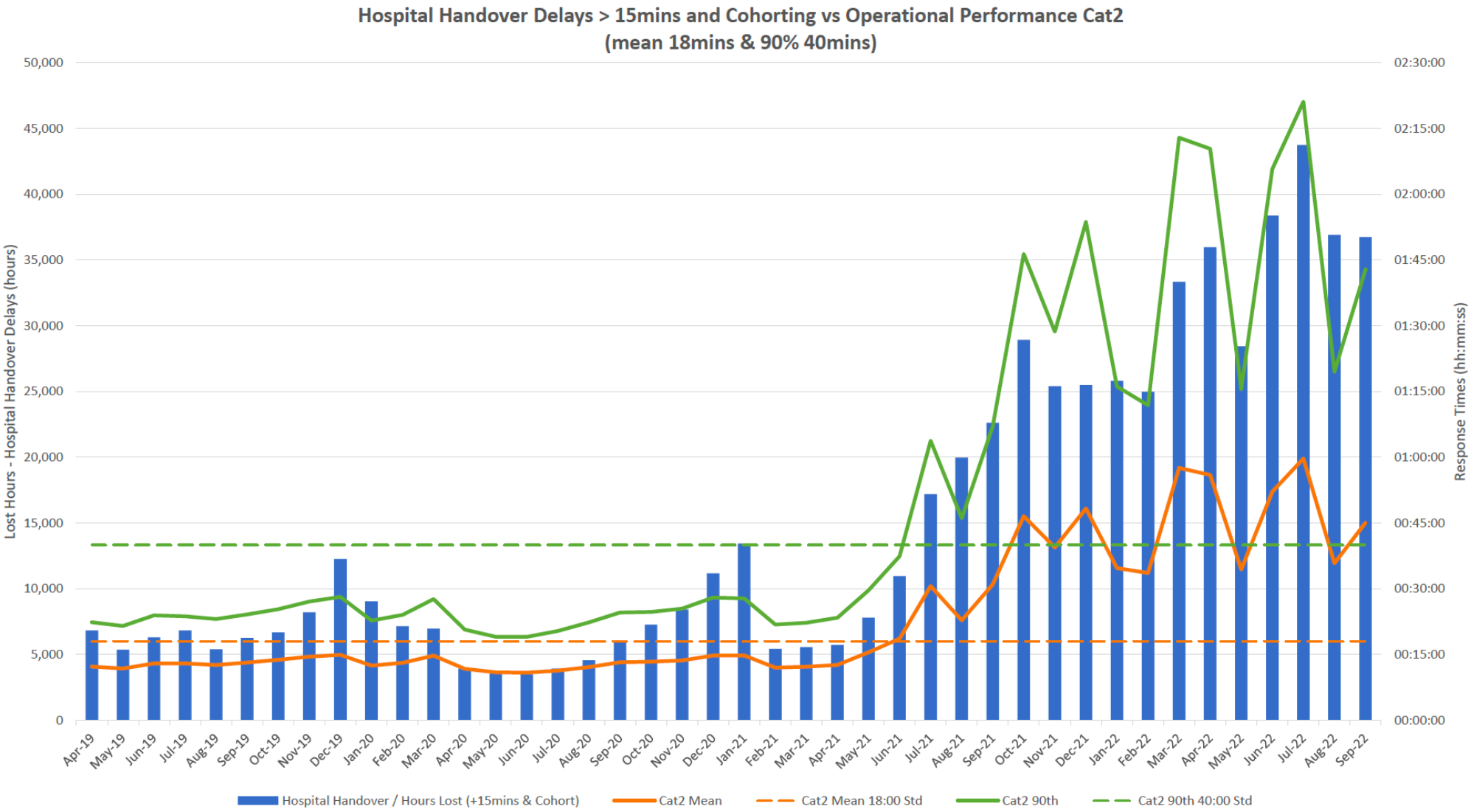
Table – Time lost due to handover delays exceeding 15 minutes and cohorting for the last 4 financial years

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/2020	6834	5376	6302	6834	5397	6258	6677	8214	12577	9047	7151	6972
2020/2021	3930	3535	3504	3927	4564	5927	7269	8427	11174	13440	5423	5561
2021/2022	5732	7805	10963	17185	19967	22618	28925	25396	25484	25809	24985	33333
2022/2023	35959	28442	38373	43745	36907	36750						

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 is at the highest level ever within WMAS with some areas (Birmingham) achieving a level of non-conveyance to ED of 54.7% year to date.

Year to Date (to end September 2022) 2022/23

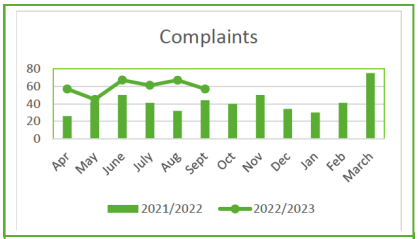
Year To Date			Hear & Treat		See & Treat		See & Convey		Conveyed To ED		Conveyed To Non ED	
ICS	Call Volume	AQI Incident Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total	Total	% Total
NHS BIRMINGHAM AND SOLIHULL ICS	103,636	61,776	11,410	18.5%	19,939	32.3%	30,427	49.3%	28,010	45.3%	2417	3.9%
NHS BLACK COUNTRY ICS	75,565	55,169	8,062	14.6%	17,496	31.7%	29,611	53.7%	28,094	50.9%	1517	2.7%
NHS COVENTRY AND WARWICKSHIRE ICS	52,569	35,581	5,307	14.9%	11,560	32.5%	18,714	52.6%	17,671	49.7%	1043	2.9%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	44,099	29,236	3,718	12.7%	8,849	30.3%	16,669	57.0%	15,658	53.6%	1011	3.5%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	26,817	17,689	2,510	14.2%	5,919	33.5%	9,260	52.3%	8,554	48.4%	706	4.0%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	71,824	45,379	7,817	17.2%	14,620	32.2%	22,942	50.6%	20,676	45.6%	2266	5.0%
ICS Total	374,510	244,830	38,824	15.9%	78,383	32.0%	127,623	52.1%	118,663	48.5%	8,960	3.7%

September 2022

September 2022			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	32,882	19,501	3,530	18.1%	6,086	31.2%	9,885	50.7%	9,055	46.4%	830	4.3%
NHS BLACK COUNTRY ICS	23,726	17,573	2,489	14.2%	5,571	31.7%	9,513	54.1%	9,024	51.4%	489	2.8%
NHS COVENTRY AND WARWICKSHIRE ICS	16,440	11,357	1,542	13.6%	3,798	33.4%	6,017	53.0%	5,743	50.6%	274	2.4%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICS	13,553	9,354	1,091	11.7%	2,747	29.4%	5,516	59.0%	5,220	55.8%	296	3.2%
NHS SHROPSHIRE, TELFORD AND WREKIN ICS	8,706	5,762	773	13.4%	1,889	32.8%	3,100	53.8%	2,875	49.9%	225	3.9%
NHS STAFFORDSHIRE AND STOKE ON TRENT ICS	22,666	14,423	2,368	16.4%	4,635	32.1%	7,420	51.4%	6,758	46.9%	662	4.6%
ICS Total	117,973	77,970	11,793	15.1%	24,726	31.7%	41,451	53.2%	38,675	49.6%	2,776	3.6%

Patient Experience

Formal Complaints	Last reported month (Sept 2022)	Year to date 2021-22 Total	Year to date 2022-23 YTD
WMAS	57	235	354



Year to Date the Patient Experience Team has acknowledged 98.9% of its complaints within 3 working days. The Trust has responded to 100% of cases within 25 working days

For the month of September, we saw 57 complaints received compared to 44 in September 2021 an increase of 13.

The main reason for a complaint was Call Management = 14

Of the cases closed to date:

7 Justified, 11 Part Justified, 12 Not Justified. 27 Cases are still under investigation. Cases open need to be closed by 4 November 2022.

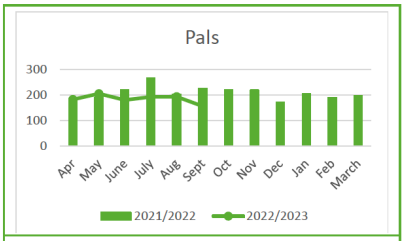
Month of September 2022: Month of September 2022:
126,143 Emergency Calls, which equates to 1 Complaint for every 6,307 calls received.

81,117 Emergency Incidents, which equates to 1 Complaint for every 4,771 Incidents.

74, 603 Non-Emergency Patient Journeys, which equates to 1 Complaint for every 11,964 Journeys.

113,003 IUC Calls answered which equated to 1 complaint for every 20,301 calls received

Informal (PALS)	Last reported month (Sept 2022)	Year to date 2021-22 Total	Year to date 2022-23 YTD
WMAS	156	1291	1108



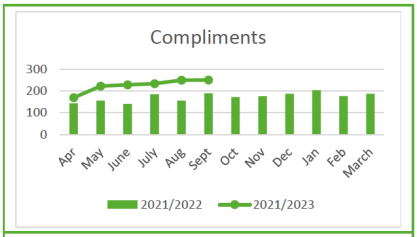
The main reason for an informal concern being raised was as follows:

Response 34
Attitude & Conduct 28
Clinical 20

Of the Cases closed to date (month) –

37= *Justified,*
14 = *Part Justified,*
43= *Not justified*

Compliments	Last reported month (Sept 2022)	Year to date 2021-22 Total	Year to date 2022-23 YTD
WMAS	250	970	1351



Compliments: September 2022: There have been 250 compliments received compared to 189 the previous year an increase of 61 (32.3%)

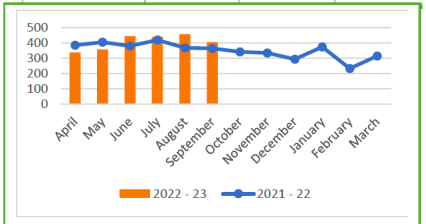
Friends and Family Test (YTD)
The FFT question is available on the Trust website: '**Thinking about the service provided by the patient transport service, overall how was your experience of our service?':**

Response	FFT Survey	PTS Survey	Small Survey
Very Good	11	23	6
Good	16	27	3
Neither Good nor Poor	0	1	0
Poor	0	0	0
Very Poor	1	0	0
Don't Know	0	0	0
Total	**28**	**51**	**9**

Discharge on Scene Results: 2 response in September 2022

Patient Safety

Total Patient Safety Incidents	Last reported month (Sept 22)	Year to date 2021-22	Year to date 2022-23
WMAS	404	2315	2433



For the month of September, there were 431 patient safety incidents reported. This is a 11% (41) increase on the same month for last year.

Service Delivery (E&U & EOC) had 291 patient safety incidents which accounts for 72% of the total. The main themes are:

- Incidents relating to delayed ambulance responses.
- Injuries caused during manual handling.

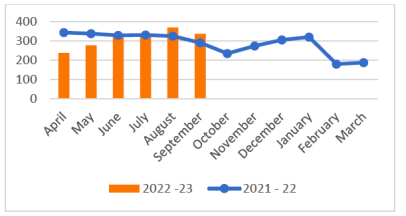
PTS had 100 patient safety incidents which accounts for 25% of the total reported. The main themes are:

- Avoidable injuries and skin tears.

IUC/111 had 13 patient safety incidents which accounts for 3% of the total reported. The main themes are:

- Ambulance delays and categorisation queries.

No Harm Incidents	Last reported month (Sept 22)	Year to date 2021-22	Year to date 2022-23
WMAS	338	1672	1964



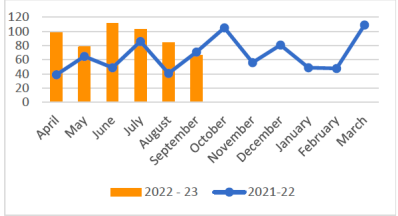
For the month of September, there were 338 no harm incidents.

Service Delivery accounts for 70% (237) of the total of no harm patient safety incidents.

PTS accounts for 26% (89) of the total of no harm patient safety incidents.

IUC/111 accounts for 4% (12) of the total of no harm patient safety incidents.

Harm Incidents	Last reported month (Sept 22)	Year to date 2021-22	Year to date 2022-23
WMAS	66	351	540



Harm	Sept 2022	%
Service Delivery	54	82%
PTS	11	17%
IUC / 111	1	2%
Total	66	100%

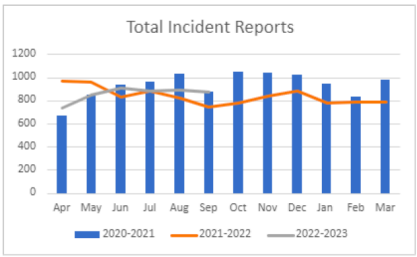
The top trend for low harm incidents, relates to harm caused due to avoidable injuries caused to patients. E.G., skin tears during moving and handling, injury due to collision/contact with an object and ECG dot removal.

The top trends for severe harm incidents, relate to delayed ambulance responses.

Service Delivery accounts for 82%, PTS 17% & IUC/111 2% of the total of patient harm incidents.

Incident Reports

Total Incidents Reported		Year to date	
	Last reported month (Sep 22)	2021-2022 April –Mar	2022-2023 April – Sep
WMAS	876	10,080	5,191



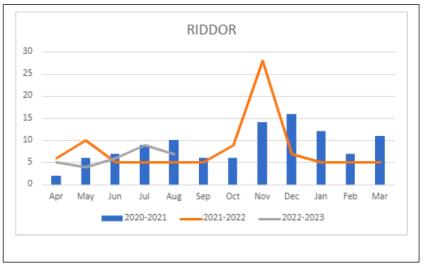
Over 65,000 ER54's received since implementation

Safety Culture Pulse Survey released, action plan created and tabled at HSREG. Follow up survey released with questions to Staff who showed an interest in further questions and support. Actions include a series of FAQ's for all Staff – Incident Reporting FAQ to be released Oct/Nov 2022

Risk Intranet site build planned to be live by October 2022

Organisational Learning Paper reviewed at HSREG, QGC and EMB and further paper on its implementation sent to Directors to review.

RIDDOR		Year to date	
	Last reported month (Sep 22)	2021-2022 April - Mar	2022-2023 Apr – Sep
WMAS	4	95	35



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.

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

Top 5 Incidents for Non-Patient Safety (Sep)

WMAS Top 5 Types	Total
Violence / Aggression	173
Equipment	112
RTC	98
Complaint	90
Injury	52

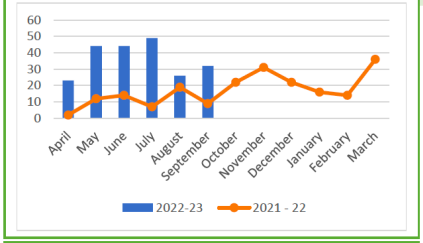
WMAS Top 5 Categories	Total
V&A - Verbal - Intentional	63
Equipment - Failure	56
Near Miss	46
V&A - Physical - Intentional	36
Equipment - Damage	35

The Trust Top 5 incident categories for September –

1. V&A – Verbal - Intentional – Reviewed via Security
2. Equipment – Failure – Continuing trend of BWC failures – Security aware
3. Near Miss – Reviewed via Security
4. V&A – Physical – Intentional – Reviewed via Security
5. Equipment – Damage – Numerous pieces of equipment, specific trend concerning Trust issue iPad/EPR

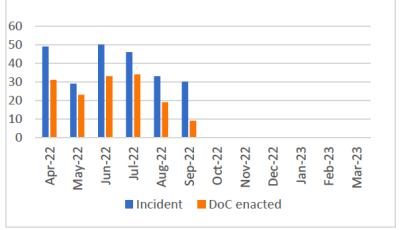
Serious Incidents and Duty of Candour

Total number of serious incidents reported		Year to date	
	Last reported month (Sept 22)	2021-2022	2022-2023
WMAS	32	63	218



- There are currently 84 investigations sitting with WMAS.
- 0 SI's are currently over the time frame.
- 49 SI's were submitted for review during September, these have now been reviewed, and closure requested to the commissioners.
- The CCG reviewed and closed 43 during September.
- Serious Incident Review Groups continued during September.
- 26 SI's registered in August.
- 32 SI's were registered in September.
- The total so far for 2022/23 is 218 (90 being solely due to delayed responses. Clinical themes: management of choking, management of cardiac arrest, inappropriate discharge)
- For the same period during 2021/22 there were 63 SI's reported (246% increase).
- 258 potential SIs have been reviewed since 01.04.22 (as of 10th October).
- 7 cases currently sit in the potential SI files. 0 awaiting director response. 2 need registering on StEIS as SI's. 3 awaiting review. 2 awaiting more information (call audits).
- Discussions are taking place with the CCG to attempt to streamline the process of the thematic reviews further. This is with the aim to obtain maximum efficiency whilst still adhering to the Serious Incident Framework 2015.
- A business case has been submitted to EMB for an additional 10 Investigating Officers.

Moderate harm and above		Year to date
	Last reported month (Sept 22)	2022-2023
WMAS	30	237

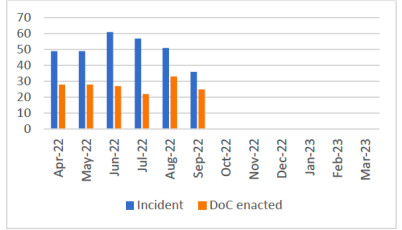


Duty of Candour has been enacted in 30.0% of cases where moderate harm or above has been caused during September. Delays in completion of DoC are because at the time of reporting, NoK (Next of Kin) details are not always known.

Multiple reporting of the same incident also reduces the compliance.

The year-to-date figure is 62.9%

Low harm		Year to date	
	Last reported month (Sept 22)	Total number of incidents	Number of incidents being open completed
WMAS	36	303	163

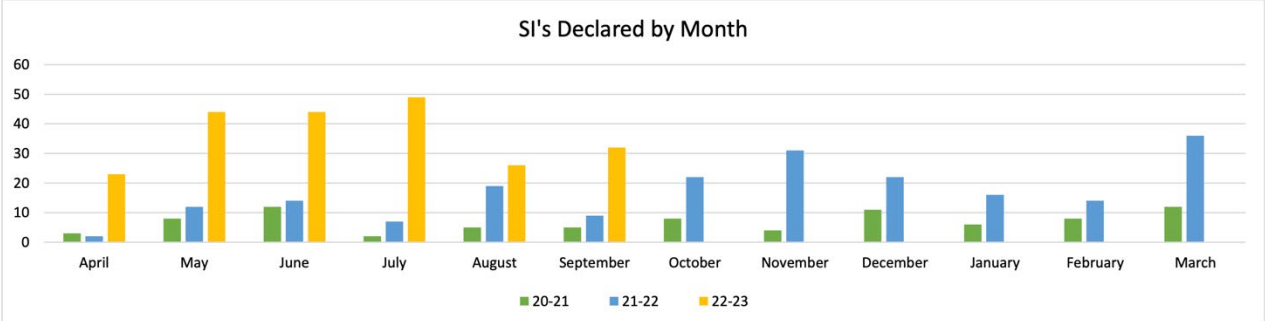


There have been 36 incidents where low harm has been caused to a patient.

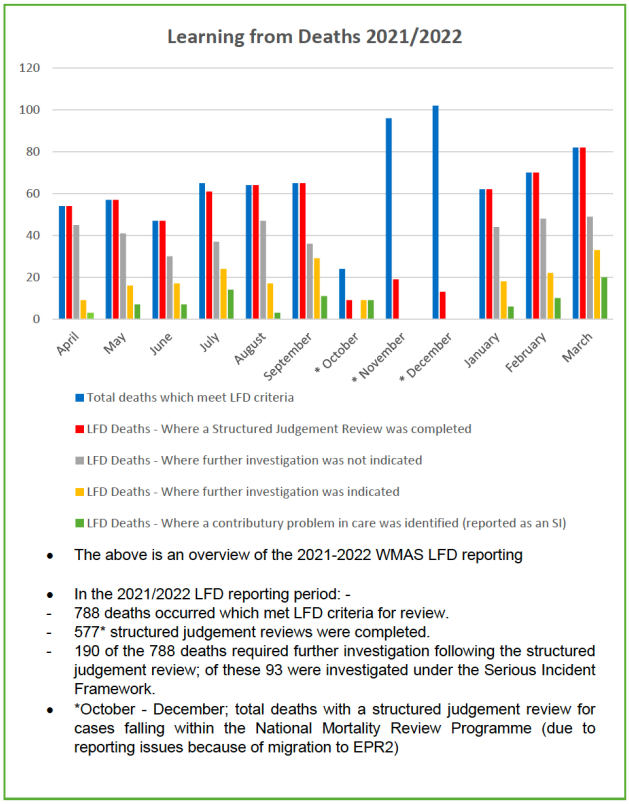
Out of these, evidence of 'Being Open' can be provided for 25 of the incidents (69.4%).

The year-to-date figure is 53.8%

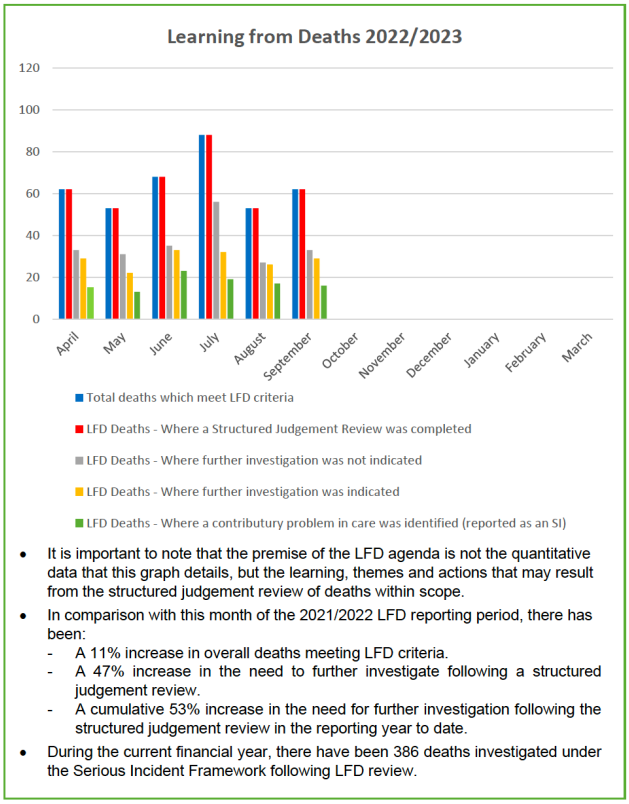
Serious Incidents Registered by Month



Learning from Deaths



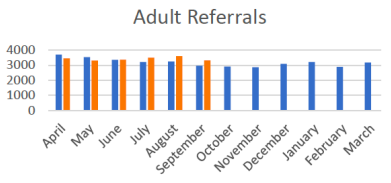
- The above is an overview of the 2021-2022 WMAS LFD reporting
- In the 2021/2022 LFD reporting period: -
  - 788 deaths occurred which met LFD criteria for review.
  - 577* structured judgement reviews were completed.
  - 190 of the 788 deaths required further investigation following the structured judgement review; of these 93 were investigated under the Serious Incident Framework.
- *October - December; total deaths with a structured judgement review for cases falling within the National Mortality Review Programme (due to reporting issues because of migration to EPR2)



- 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 2021/2022 LFD reporting period, there has been:
  - A 11% increase in overall deaths meeting LFD criteria.
  - A 47% increase in the need to further investigate following a structured judgement review.
  - A cumulative 53% increase in the need for further investigation following the structured judgement review in the reporting year to date.
- During the current financial year, there have been 386 deaths investigated under the Serious Incident Framework following LFD review.

Safeguarding

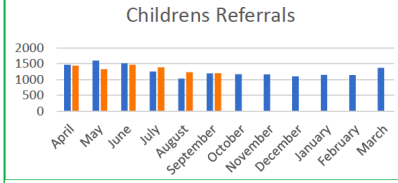
Total Adult Safeguarding Referrals	Last reported month (Sept 22)	Year to date 2021-2022	Year to date 2022-2023
WMAS	3315	38048	20496



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

There is a 12.6% increase in the number of adult care/welfare and adult safeguarding referrals sent in September 2022 compared to the previous year. There is work underway to reduce the number of referrals across the board, with education to staff relating to an enhanced understanding of the criteria for a safeguarding referral, and specifically the distinction between a true protection referral and one highlighting a care and or welfare concern. The change of reporting from the Commercial Call Centre to the Emergency Operations Centre has increased the number of safeguarding referrals.

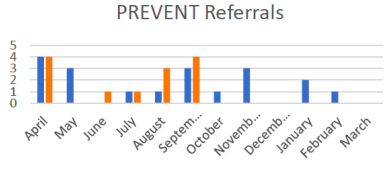
Total Child Safeguarding Referrals	Last reported month (Sept 22)	Year to date 2021-2022	Year to date 2022-2023
WMAS	1199	15105	8043



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

September 2022 saw a 0.9% increase in the number of referrals made compared to the same month last year. Work is continuing from the actions identified in May's report.

Total PREVENT Referrals	Last reported month (Sept 22)	Year to date 2021-2022	Year to date 2022-2023
WMAS	4	19	13

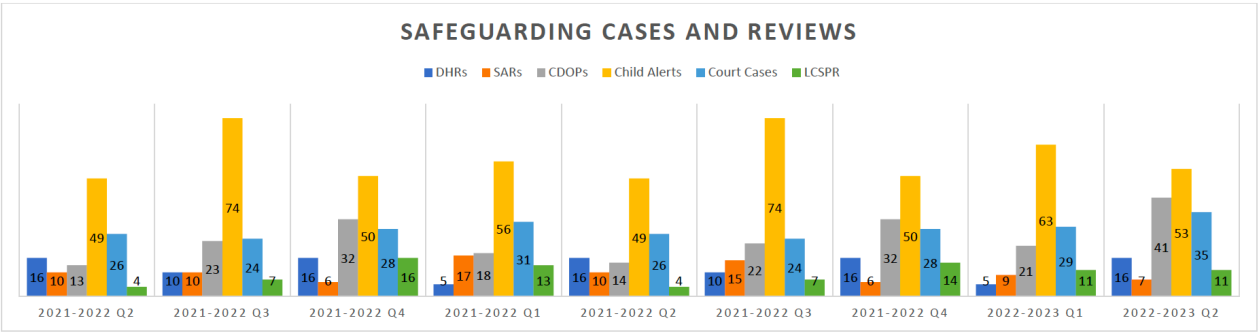


Prevent Referrals are made where there are concern an individual is being radicalised for extremism.

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.

There has been no change in the number of DHRs in Q2 against the same period last year with 16 being received.

SAR's - Safeguarding Adult Review

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

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

There has been a decrease of 3 SARs from Q2 against the same period last year.

LCSPR's – Local Child Safeguarding Practice Reviews

Is defined in Working Together 2015 as when:

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

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

WMAS have received 11 LCSPR's in Q2 2022/2023.

There has been a increase of 7 LCSPR 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 Q2 there has been an increase of 28 CDOPs against the same period last year.

Child Alerts – Internal WMAS named case

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

There has been an increase of 4 Child Alerts from Q2 against the same period last year.

Court Cases

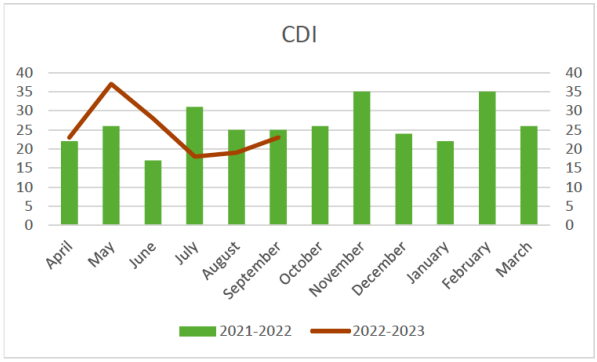
Court cases the safeguarding team can be involved with include court proceedings for child protection, abuse and or neglect.

There has been a increase of 9 court cases in Q2 against the same period last year.

Medicines Management & Pharmacy

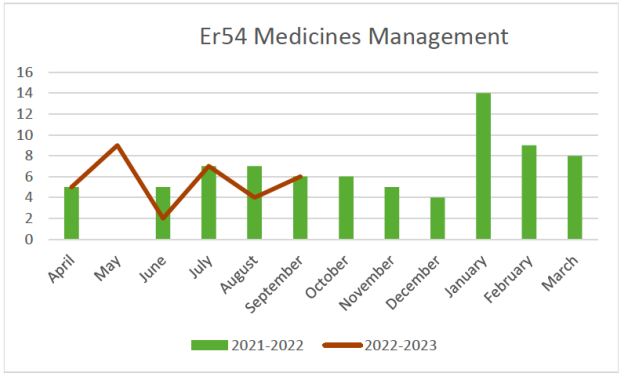
CONTROLLED DRUGS

Total Controlled Drugs Incidents (CDI's)		Year to date
Last reported month *Sept* 22)	2021-2022 April- to date	2022-2023 YTD
23	146	148



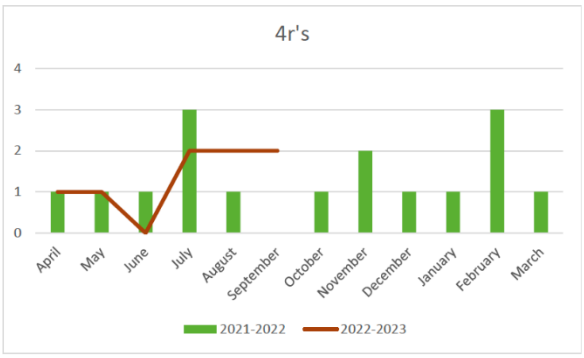
MEDICINES ER54

Total Medicines Management related ER54's		Year to date
Last reported month (*Sept* 22)	2021-2022 Apr- to date	2022-2023 YTD
6	30	33



Total Drug Errors, wrong route, wrong dose etc		Year to date
Last reported month *Sept* 22)	2021-2022 April- to date	2022-2023 YTD
2	7	8

Paracetamol given less than 4 hours apart



MHRA Alerts

MHRA Alerts		Year to date
Last reported month (*Sept* 22)	2021-2022 April- to date	2022-2023 YTD
3	15	28

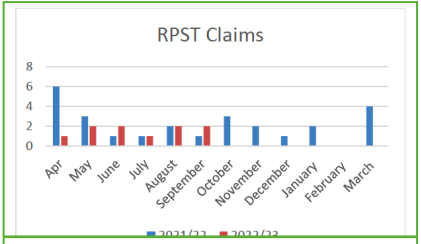
None of the medicines referenced within the alert were procured or distributed by WMAS.

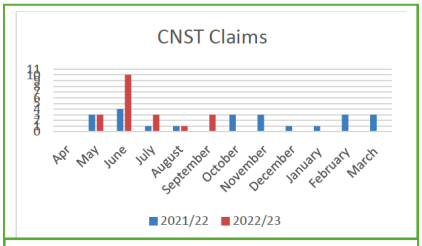
Claims and Coroners Cases

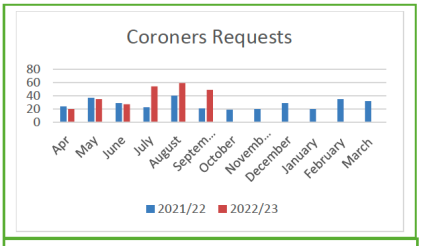
RPST (Risk Pooling Schemes for Trusts)	Last reported month September 22	Year to date 2021-22	Year to date 2022-23
WMAS	2	26	10

CNST (Clinical Negligence Scheme for Trusts)	Last reported month September 22	Year to date 2021-22	Year to date 2022-23
WMAS	3	23	20

Coroners Requests	Last reported month September 22	Year to date 2021-22	Year to date 2022-23
WMAS	49	329	244







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 2 RPST claims in September 2022. This is 1 more than compared to the previous year.

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

- The Trust has received 1 CNST claim in August 2022. This is the 3 more than compared to the previous year.

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

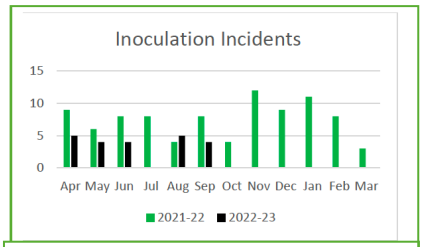
- Birmingham and Solihull
- Black Country
- Coventry
- Herefordshire
- Shropshire, Telford & Wrekin
- South Staffordshire
- Stoke on Trent & North Staffordshire
- Warwickshire
- Worcestershire

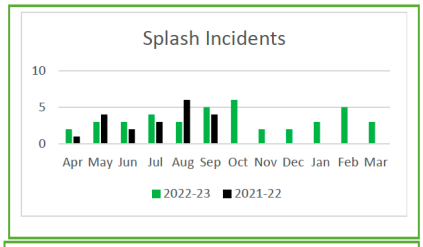
Infection Prevention and Control

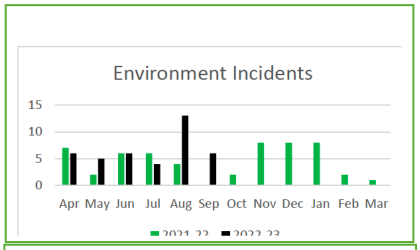
Inoculation Incidents	Last reported month Sept 22	Year to date Comparison 2021-22	Year to date Comparison 2022-23 Sept
WMAS	4	90	22

Splash Incidents	Last reported month Sept 22	Year to date Comparison 2021-22	Year to date Comparison 2022-23 Sept
WMAS	4	41	20

Environment Incidents	Last reported month Sept 22	Year to date Comparison 2021-22	Year to date Comparison 2022-23 Sept
WMAS	6	54	40







Inoculation Incident Key Performance Indicator:
By the end of 2022/23 all inoculation incidents shall be reported and managed through the incident reporting system with results reported through the Health Safety Risk & Environment Group.

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

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

Aug 2022 saw 4 inoculation incidents reported.

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

Splash Incident Key Performance Indicator:
By the end of 2022/23 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.

Sept 2022 saw 4 splash incidents reported.

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

Environment Incident Key Performance Indicator:
By the end of 2022/23 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.

Sept 2022 saw 5 environment related incidents reported.

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

Additional Information of Clinical Director's Activity

Over the last 2 months our focus has remained reducing the risks to patients most importantly for those people in our communities waiting for emergency ambulances while there are ongoing issues with over a thousand hours lost in ambulance response times on many days. 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. We have had a particular focus on community and SDEC (same day emergency care access). We have continued to work across the national and regional systems by contributing to joint meetings on patient flow, reducing hospital handover delays and improving the responses to our patients.

Despite this work the number of serious incidents related to ambulances unable to respond while held outside hospitals continues to rise. Our focus now is on wider system engagement particularly with the new Integrated Care Boards which took over from the CCGs on 01 July 2022 and their Clinical Director leads.

Medical Director

Regional

- Attended multiple meetings to discuss patient safety and hospital handover delays
- Attended regional Emergency Department clinical director's meetings
- Completed clinical ambulance shifts with crews and several Director "days in the life"
- Led the first Clinical Team Mentor online meeting for WMAS

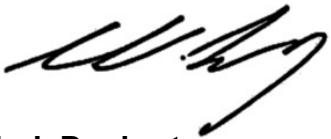
National

- Attended national ambulance service medical directors' meeting and national ambulance service research group meetings.
- Attended Ambulance Leadership Forum
- Attended AACE Women in Leadership Event
- Led the publication of the JRCALC "Bundle 9" clinical guidelines and related national video
- Examiner for the Faculty of Prehospital Care, Royal College of Surgeons of Edinburgh
- Contributed to national ambulance research trial management and trial steering groups
- National ambulance services medical directors lead on:
    - The national reducing medical greenhouse gases group
    - Royal College of Emergency Medicine Prehospital Emergency Medicine contributor, position paper on reducing nitrous oxide use
- Royal College of Emergency Medicine Annual Scientific Conference Poster presentation: "Put on hold – the impact of ambulance handover delays on Emergency Departments and Hospitals"

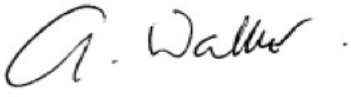
Nurse Director

- Presented on Patient safety and patient experiences at the Ambulance Leadership Forum
- Meeting with Staffordshire Local Medical Committee to discuss ambulance response times
- Revalidation sessions with staff who are qualified nurses as well as Paramedics
- Meeting with Health Education England to discuss maternity training
- Regular meetings with the Emergency Care Intensive Support Team and NHS England to discuss emergency care pathways
- Serious Incident Recovery meetings
- Regular meetings with the Clinical Team
- 1:1 meeting with the Regional Chief Nurse
- Meeting with Regional Chief Nurses to discuss impact of patient harm caused by handover delays
- 1:1 meetings with Walsall Hospital Chief Nurse
- Regular 1:1 meetings with team members
- SIRO meetings
- Meeting with complainant at Burton Hospital
- Regular attendance at the Quality, Infection, Governance and Risk Directors (QIGARD) meeting hosted by the Association of Ambulance Chief Executives
- Regional Chief Nurse Updates
- Attendance at the Shrewsbury and Telford Hospitals Safety Oversight Group
- Regular monthly meetings with the NHSE team to discuss the broad urgent and emergency care agenda and system pressures
- Participation in weekly COO/MD/DN briefings by NHSE
- Meeting with senior executive team of Winncare to discuss use of iStumble and Mangar Elk to avoid ambulance response for falls in care homes
- Judging of the National Air Ambulance Awards 2022
- WMAS cohorting project meetings

- **Medical and Nurse Directors Jointly**
- Supported Serious Incident review process improvements and reviews
- Meeting with new ICB CMO lead
- Meetings with NHSE regionally and nationally



Mark Docherty
Executive Director of Nursing and Clinical Commissioning



Dr Alison Walker
Executive Medical Director

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 08b MONTH: October 2022 PAPER NUMBER: 05b

BOARD ASSURANCE FRAMEWORK & SIGNIFICANT RISKS	
Sponsoring Director	Executive Director of Nursing and Clinical Commissioning
Author(s)/Presenter	Executive Director of Nursing and Clinical Commissioning and Head of Risk
Purpose	The Board Assurance framework has been revised into a new format considering Auditor's recommendations. The Committee is asked to note the risks and the actions and mitigations to control and reduce those risks
Previously Considered by	EMB
Report Approved By	Director of Quality and Clinical Commissioning

Executive Summary

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

After discussion with Web Development, it has been decided to explore using DATIX to house the BAF, rather than SharePoint. This will form part of a wider piece of work around using DATIX to house the Risk Register also, given that the Trust's Risk Management processes have now "outgrown" the use of an Excel format.

This will form part of a DATIX update at future committees

Changes to the BAF since the last Board review are;

Strategic Objective 1 –

PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents
EOC-003 - Clinical validation for Cat 3 and Cat 4 incidents

Strategic Objective 2 –

No changes to Risks

Strategic Objective 3 –

No changes to Risks

Strategic Objective 4 –

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

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

Strategic Objective 5 –

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

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.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 08b MONTH: October 2022 PAPER NUMBER: 05b

Quality Impact Assessment	This is addressed, where appropriate in the risks identified and mitigating actions.
Data Quality	The information in the BAF is sourced from the WMAS Risk Register

Action required

The Board is asked to review, discuss and agree the changes to the BAF

West Midlands Ambulance Service University NHS Foundation Trust Board Assurance Framework

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

Strategic Objective	1: Safety, Quality and Excellence

Principal Risks	Risk Title	Current Risk Score With Controls and Assurances in Place (Consequence x Likelihood)	Mitigated Risk Score After Applying all Mitigating Actions (Consequence x Likelihood)	Target Risk score *(if deemed appropriate upon Board review)*
	SR-1 - Failure to achieve Operational Performance Standards	5x4=20	5x3=15	5x2=10
	PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times	5x5=25	5x4=20	5x3=15
	HS-012 - Risk of staff suffering serious injury because of stab / ballistic weapons	5x3=15	5x2=10	5x2=10
	EP-027 – Risks associated with Terrorist Threats	5x3=15	5x2=10	5x2=10
	ORG-003 – Failure to complete SI investigations within timescales	4x4=16	4x3=12	4x2=8
	IPC-032 PTS Staff at risk of conveyance of suspected infectious Patients including COVID-19	4x3=12	4x2=8	4x2=8
	IPC-035 -Risks associated with bird/vermin droppings on Trust sites	4X4=16	4X3=12	4X1=4
	EOC – 016 - Stacking of incidents at times of high demand	5x5=25	5x4 = 20	5x3=15
	IPC-002 - Regulatory concerns due to non-compliance with Clinical Waste Management	4X3=12	4X2-8	4X1=4
	ORG-093 - Utilisation of surge contingency as a result of COVID-19 and increased demand, and its impact on 2021/22 resourcing, training, finance and ultimately	5x3=15	5x2=10	5x1=5

Lead Committee	Quality Governance Committee
Last Reviewed	September

Reviewed Risks

PS-074 - Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents

EOC-003 - Clinical validation for Cat 3 and Cat 4 incidents

	performance and potential patient delays and harm				
	EOC-003 - Clinical validation for Cat 3 and Cat 4 incidents	4x4=16	4x3=12	4x2=8	
	EOC-021 - Risks associated with the management of 111 Clinical Queue resulting in extensive delay, patient harm, increased stress and performance concerns	5X3=15	5X2=10	5X1=5	
	EOC-022 - Clinical validation for Cat 2 999 Calls impacting patient safety and performance	5X4=20	5X3=15	5X2=10	
	EOC-023 - Failed clinical contacts within IEUC resulting in delay to adequate treatment, patient deterioration, non-compliance with policy and potential litigation/complaints	5X3 = 15	5X2=10	5X2=10	
	EOC-027 - Consideration for Category 2 IEUC Closing Instructions impacting patient safety, performance, and staff wellbeing.	5X4=20	5X4=20	5X3=15	
	ORG-029 - Risk of failure of Corporate IT or IT Telecommunications System due to Cyber Terrorism	4X4=16	4X3=12	4X2=8	
	ORG-056 - Continuity of Business in the result of the East conflict and worldwide shortages of materials and supplies. Resulting in the inability to source, increase in costs and the impact on patient care and meeting regulatory requirements.	4X3=12	4X2=8	4X2=8	
	ORG-102 - Patients held on the back of an Ambulance awaiting hospital handover for prolonged periods resulting in harm and potential litigation and adverse publicity	5X3=20	5X2=10	5X1=5	
	ORG-116 - Risks associated with undertaking Resus training online	4X3=12	4X3=12	4X2=8	
	ORG-125 - Inability to procure supplies, medicines and Clinical consumables resulting in out-of-date items, patient harm and possible litigation	4X3=12	4X2=8	4X2=8	
	ORG-126 - Failure to contact patient once clinical audit has identified inappropriate advice,	4X5=20	4X4=16	4X3=12	

	resulting in patient harm, claims, adverse publicity, financial consequence and possible regulatory concerns					
	HARTOD11 - Marauding Terrorist Attack Deployment	5x4=20	5x2=10	5x2=10		
	HARTODNB1 – CBRN Attack Deployment	5x4=20	4x2=8	4x2=8		

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

Strategic Objective	2: A great place to work for all	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*	**Lead Committee**	People Committee
Principal Risks						**Last Reviewed**	June 2022 (EMB)
						Reviewed Risk	

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

Strategic Objective	3: Effective planning and use of resources	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*	**Lead Committee**	Performance Committee
Principal Risk		**SR-2** The Trust fails to meet its financial duties	4X3 = 12	4X3=12	4X2=8	**Last Reviewed**	July 2022 (Performance Committee)
		FI-009 - Patient activity varies at a rate that cannot be contained within the Trust's cost base	3X4=12	3X4=12	3X4=12		
		FI-020 - The change in planning and commissioning of services on a national basis, particularly with reference to STPs, could destabilise the Trust's current business model.	4X4=16	4x3=12	4x3=12		
		FI-022 - Implementation of the IFRS 16 standard for leasing of assets	3X4=12	3X3=9	3X3=9		

	FI-026 - The new nationally agreed pay award is not fully funded for the Trust	5X4 = 20	5X3=15	5X3=15	

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

Strategic Objective	4: Innovation and Transformation	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*
Principal Risk		**ORG-088 -** Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)	4x3 =12	4x2 = 8	4x1 = 4
		ORG-083 - Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.	4x3 = 12	4x2 = 8	4x1 = 4
		ORG-087 – Proposed changes to Urgent and Emergency Care Quality and Access Standards will result in new set of measurement metrics	4X3=12	4X2=8	4X1=4
		ORG-016 - End of Life IT Systems	4X4=16	4X3=12	4X2=8

Lead Committee	Quality Governance Committee
Last Reviewed	May 2022 – HSREG and QGC
Reviewed Risks	Awaiting update on whether ORG-088 and ORG-083 are still required

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

Strategic Objective	5: Collaboration and Engagement	**Risk Description** *What might happen if the risk materialises*	**Current Risk Score** With Controls and Assurances in Place (Consequence x Likelihood)	**Mitigated Risk Score** After Applying all Mitigating Actions (Consequence x Likelihood)	**Target Risk score** *(if deemed appropriate upon Board review)*
Principal Risk		**ORG-084** - The opportunity for "collective accountability" on performance could be helpful in addressing issues - how this would work though is ill defined	4x3 = 12	4x2 = 8	4x2 = 8

Lead Committee	People Committee
Last Reviewed	May 2022 (HSREG and QGC)
Reviewed Risks	Awaiting update on whether ORG-084 is still required

	ORG-087 - Proposed changes to Urgent and Emergency Care Quality and Access Standards	5X3 = 15	5X2 = 10	5X2 = 10		

Appendices

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

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
PS-074 -	Risks associated with extensive Hospital Breaches, Delays and Turnaround times resulting in patient delay and harm, lack of resources to respond and serious incidents	Many hospitals have started improvement plans with a number adopting the Bristol North Pilot. WMAS are working Collaboratory with UHB on a cohorting pilot, where staff will be recruited into cohort roles and will enable the release of crews to respond to outstanding call in the community. The cohort Paramedics will be taught new skills by UHB and the pt journey will start as soon as they are handed over into the cohort space, thus reducing the time spent in ED as their diagnostic and treatment will start in this area and not waiting for transfer into the ED department. The aim of the cohort pilot is to eliminate handover delays at UHB. Halo cover remains strong across the region with the seconded halo cover continuing on a month-by-month basis	Hospital Handover delays continues to be our biggest risk however we have seen a slight reduction in August from 43758 hours in July to 36904 in August.	As per RA	Identify and agree any actions	Continue to monitor
EOC-003 -	Clinical validation for Cat 3 and Cat 4 incidents	Reviewed and actions extended due to impact of ongoing recruitment and TUPE of 111 staff as result of the release of the existing contract to DHE in October 2022. Assessment to be reviewed in 3 months' time once contract has moved over and all CVT staff are in post.	In terms of CVT performance, although has been a slight reduction in percentage of hear and treat, it is not significant and around the 1% mark. It is hoped that once substantive posts are in place, productivity will increase due to greater ownership and understanding of the role.	As per RA and associated actions	Identify and agree any actions	Continue to monitor

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

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	*Mitigating Actions*	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*

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

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*

Strategic Objective 4 : Innovation and Transformation
Lead Director: Mark Docherty

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls or Assurance*
ORG-082	Devolution of resources to place and PCN level, for example around transformation funds and how the ambulance trusts engage (220 PCNs across the Midlands region)	None given – still awaiting update	Awaiting update from Senior Finance Team			N/A
ORG-083	Investment in digital capability for ambulance services often benefit from a regional approach, however again devolution of monies to individual ICS may challenge us.	None given – still awaiting update	To be discussed and drafted with Executive Director of Strategic and Digital Integration			N/A

Strategic Objective 5 : Collaboration and Engagement
Lead Director: Carla Beechey

	Risk Description *What might happen if the risk materialises*	**Assurance** ***Evidence that the controls are effectively implemented***	**Gaps in Assurance**	**Mitigating Actions**	**Board Review – Tolerance and Appetite**	**Action Required (with timescale to complete)** *Gaps in Controls*

						or Assurance
ORG-084	The opportunity for “collective accountability” on performance could be helpful in addressing issues - how this would work though is ill defined	None given – still awaiting update	Awaiting update			N/A

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

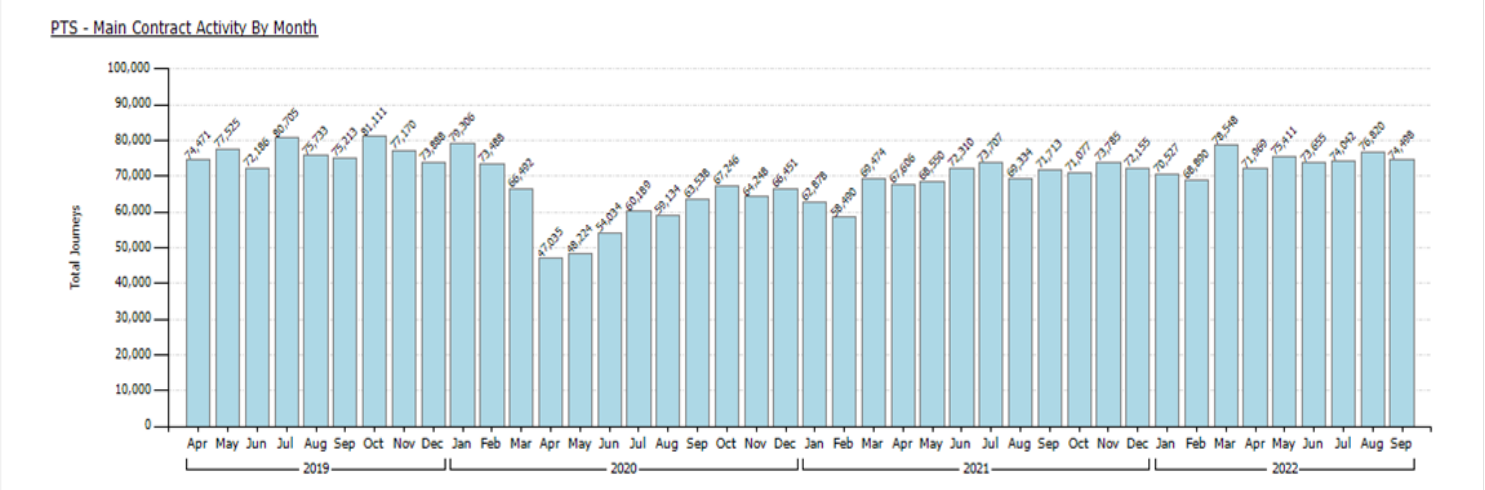
AGENDA ITEM: 09a MONTH: OCTOBER 2022 PAPER NUMBER: 06a

Non-Emergency Services Operations Delivery & Improvement Director	
Sponsoring Director	Non-Emergency Services Operations Delivery & Improvement Director
Author & Presenter	Non-Emergency Services Operations Delivery & Improvement Director
Purpose	The report is presented to the Board to give the Board an update on the pressures facing the NEPTS service at this time and how the risks to patient care and quality are being mitigated.
Previously Considered by	This is a new and developing report structure in the light of the changes to the agenda approved by the Board.
Report Approved By	Non-Emergency Services Operations Delivery & Improvement Director

Performance

During the month of September, we achieved all KPI's across all contracts with the exception of Coventry and Warwickshire where we failed one. We failed Planned outwards – collect < 60 mins of request, 94% achieved out of 95% target. We have seen a small improvement on the KPI within the month.

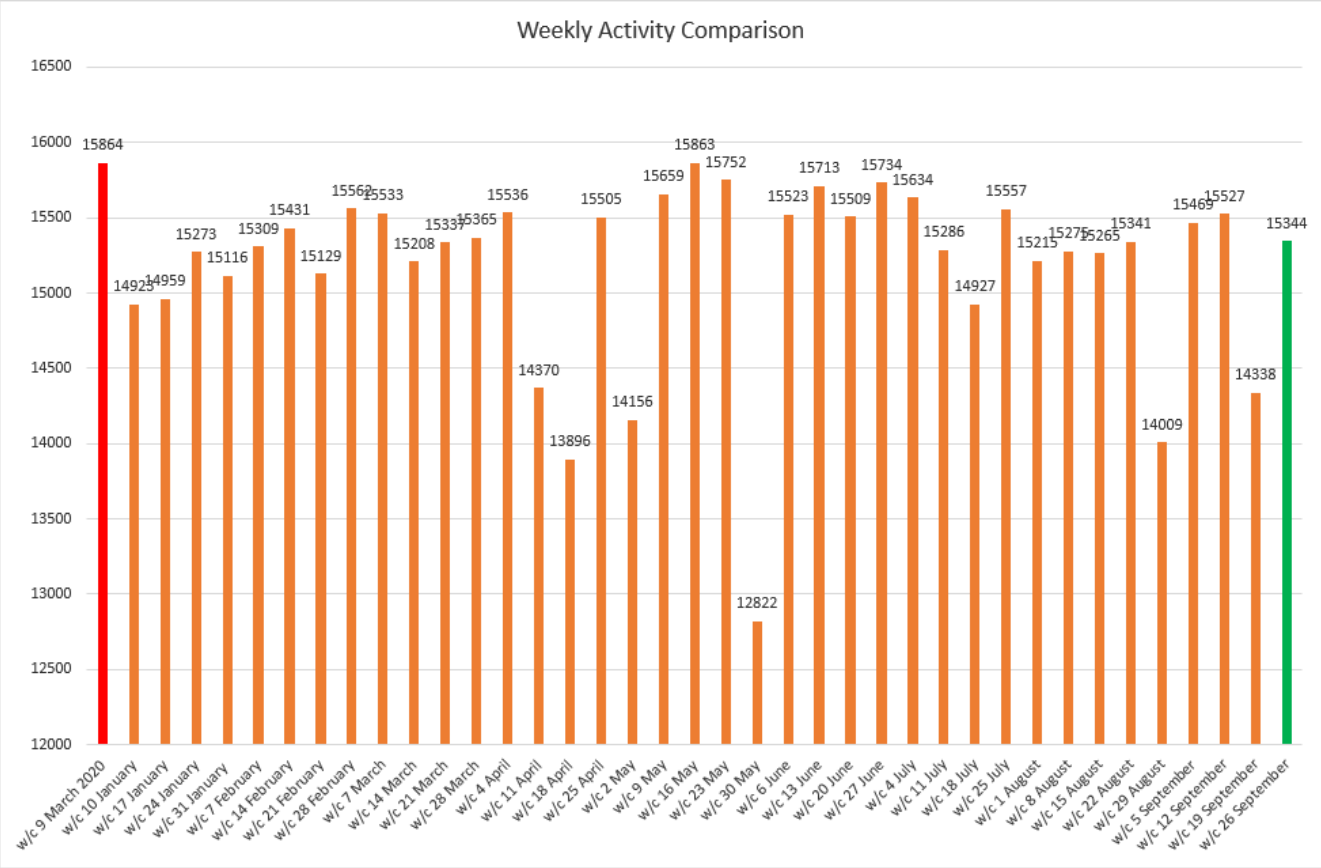
There was a slight decrease in overall activity in the month, however we have seen an increase in higher mobility patients and 'must travel alone', due to an increase in respiratory infections.



WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: OCTOBER 2022 PAPER NUMBER: 06a



The PTS Team continue to be focused on resourcing all Hospital Discharges as a priority and ensuring these patients are collected in a timely manner, to assist with hospital in-patient flow. We continue to work closely with Acute's on their discharge planning, however we still have 95% of discharges booked on the day.

Contract update

Discussions continue with commissioners regarding funding for 2022/23, with resolution expected during October. Commissioners of contracts that expire in Spring 2024 have been encouraged to make early decision on retendering / extension to account for extended lead times in procuring fleet and estate.

PDR's – 98.17% completed to date. Remaining PDR's are staff currently on LTS and Maternity Staff and will be completed on their return to work.

Mandatory Training – PTS are currently 47.41% complete with all staff booked onto the training.

Mandatory Workbooks – 95.00% complete.

Michelle Brotherton
Non-Emergency Services Operations Delivery & Improvement Director / ACAO
October 2022

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: OCTOBER 2022 PAPER NUMBER: 06b

Cohort Update – Ambulance Decision Area (ADA)

Introduction

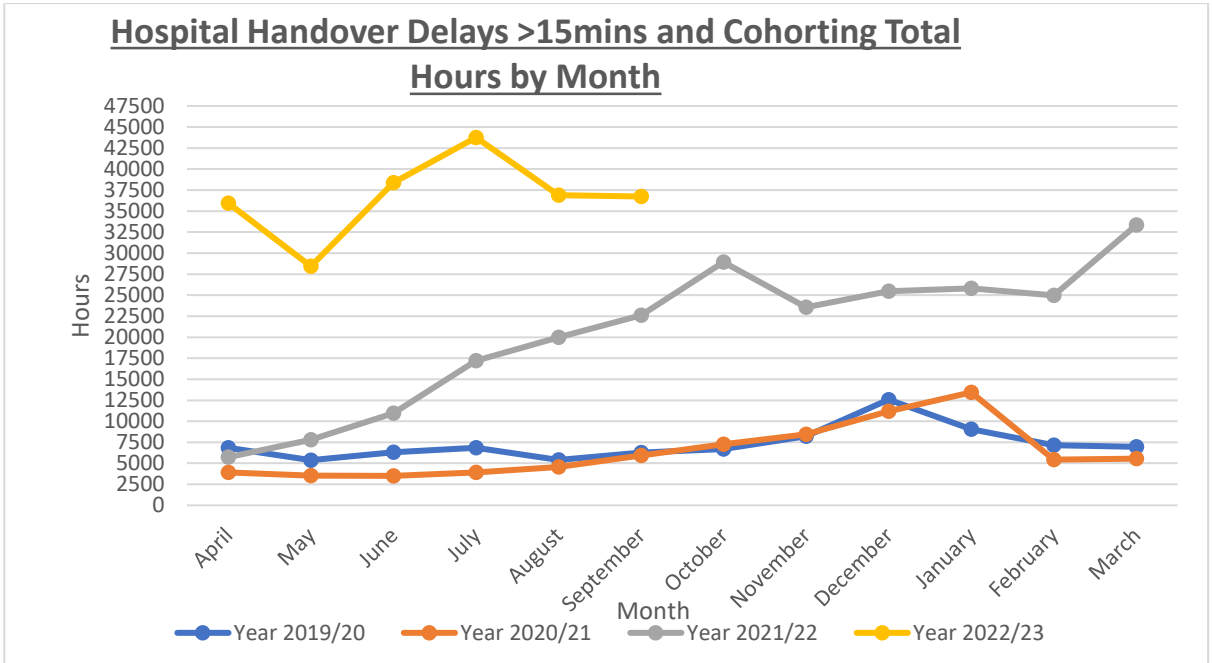
In October 2021, the Board agreed to increase the risk level of risks associated with Ambulance Handover Delays and risks associated with increased patients waiting for an ambulance response in the community to a risk rating of 25.

The Director of Non-Emergency Services Delivery and Operations Director was asked to manage the Hospital Ambulance Liaison Officer's (HALO's) and Strategic Capacity Cell (SCC). This would streamline the SCC who manage the delays and escalations of the hospitals with the HALO's who are working on the Acute sites under the same management. The post of Head of Patient Flow (HoPF) was then created with the SCC and HALO's reporting to that post as well as engagement with Acutes, CCG's and NHSE/I.

Current Position September 2022

Handover delays over 15 minutes including Cohorts

		April	May	June	July	August	September	October	November	December	January	February	March
Year	2019/20	6835	5376	6302	6835	5397	6259	6678	8214	12577	9048	7152	6973
	2020/21	3931	3536	3505	3928	4565	5927	7270	8428	11174	13440	5423	5562
	2021/22	5732	7806	10964	17186	19967	22615	28925	23550	25484	25806	24984	33333
	2022/23	35957	28435	38372	43758	36904	36749						



During the month of September there was a slight improvement in handover delays. In total we lost 36,749 hours (over 15-minutes) and including Cohorts.

We have seen a significant increase at some Acutes, Royal Shrewsbury, Worcester Royal and Stoke in particular. We are currently working with these Acutes to reduce handovers.

There is national focus on the worse Acute Trusts with the longest handover delays. In the West Midlands Region we have Worcestershire Royal, Shropshire and Telford Hospitals (RSH and PRH), University Hospitals Birmingham group (UHB) and Stoke.

WMAS in response to the handover delays has supported Acute Trusts and the wider systems with a number of initiatives to date to try and improve the situation in the benefit of patient care and patient safety. However, it is unfortunate to report that the delays continue to deteriorate and impacting significantly on WMAS ability to get to patients in a timely manner in the community.

As part of collaborative/system working we are progressing a model whereby WMAS support the Acutes with workforce in dedicated cohort areas.

We are now also in a strong position where we can evidence the improvements experienced following the collaborative working with BSOL and UHB.

UHB Group

We have been working with UHB and BSOL in setting up the 'Ambulance Decision Area Project'. We have been meeting regularly in order to progress the various workstreams including writing job descriptions, training programmes, governance, sharing agreements, SOP's and medicine management. The paramedics have undertaken 5 days training at UHB, which includes extended clinical skills, request for imaging, rapid access triage and the use of all of their IT and diagnostic equipment. The Ambulance Health Care Assistants training is two weeks at WMAS Academy, followed by a further three days training at UHB.

We saw the first cohort of 13 paramedics go live on Monday 27th September 2022 across the Queen Elizabeth and Heartlands. The first tranche of AHCA's commenced training on 3rd October with the next tranche commencing w/c 17th October.

The table below is a time line on the UHB Ambulance Decision Area project.

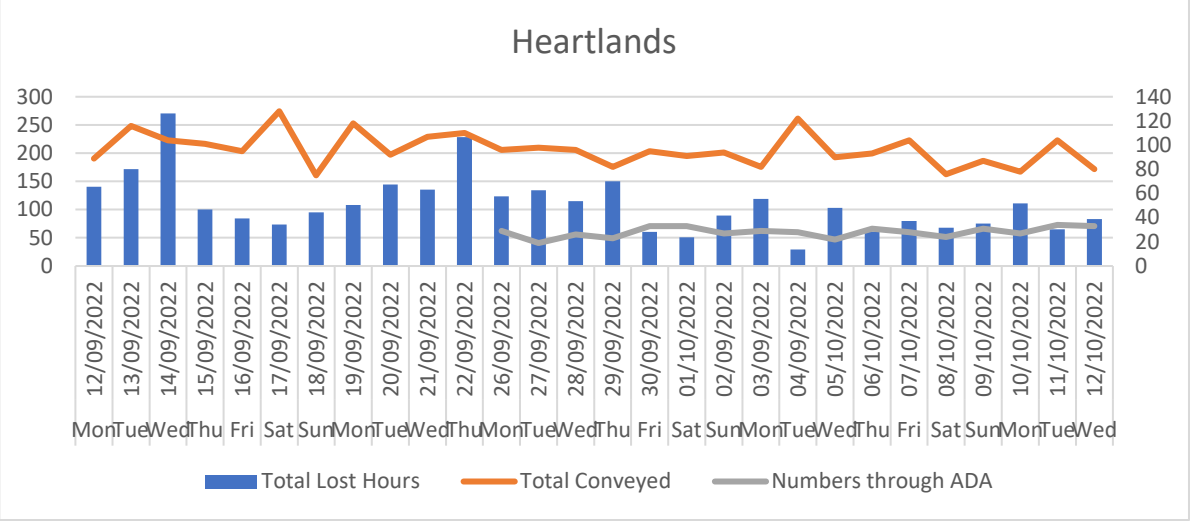
Date	Action
20/09/22	1st Tranche Paramedics undertake 5 Days UHB Training – 13 Paramedics
27/09/22	1st Tranche Paramedics Operational at QE & Heartlands Go live
3/10/22	1st Tranche AHCA 2 Week Training at WMAS Academy – 9 x ACHA
10/10/2022	2nd Tranche Paramedics Undertake 5 Day UHB Training – 11 Paramedics
17/10/22	1st Tranche AHCA commence 3 Day UHB Training

17/10/22	2nd Tranche Paramedics Operational at QE Heartlands & GHH
17/10/22	2nd Tranche AHCA Commence 2 Week Training at WMAS Academy – 18 ACHA
24/10/22	1st Trance AHCA Operational at QE, Heartlands & GHH
31/10/22	2nds Tranche AHCA Commence 3 Day UHB Training
7/11/22	2nd Tranche AHCA Operational at QE, Heartlands and GHH

To date we have recruited 24 Band 7 Paramedics and further interviews have taken place with 6 more paramedics securing a position resulting in a further 6 Paramedics being required to fulfil the request.

We had appointed 36 Band 3 AHCA staff however we have had people drop out or simply not turn up for their training resulting in a further requirement to recruit 9 more for the band 3 role.

The following outlines the offload data for each of the sites following the implementation of the Ambulance Decision Area all be it not fully functioning due to staffing levels; however, we can see that there has been a significant improvement in Ambulance Handover Delays with further improvement expected as the areas become better staffed.

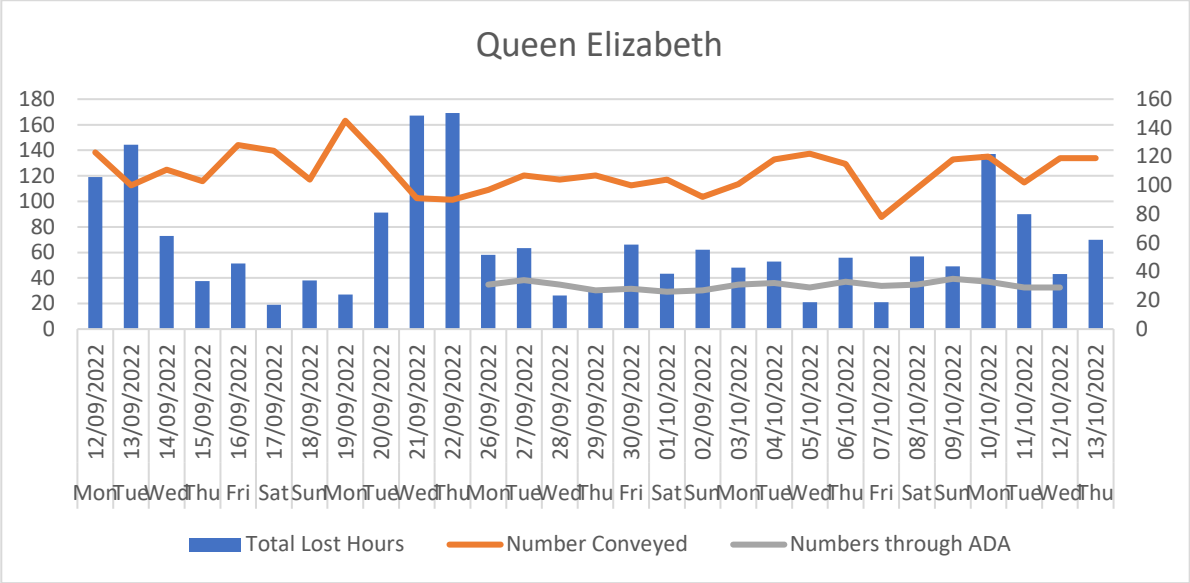


Heartlands have seen a promising improvement in their Handover delays since the implementation of the Ambulance Decision Areas coupled with the implementation of the Bristol North project which they introduced 4/09/22. Handover delays have been significantly lower than neighbouring Acutes and the conveyance rate indicates that WMAS are not Intelligently Conveying as many patients away from the site, so delays have reduced yet conveyance is increasing this indicates the work that has been undergone at this site.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09a MONTH: OCTOBER 2022 PAPER NUMBER: 06b



Queen Elizabeth has also seen improvements in their delays with also an increase in conveyance with added multiple trauma cases. QE has also seen an increase in Covid admissions, which has caused some concerns.

Following the implementation of the Ambulance Decision Area at UHB, WMAS have been approached by a number of Integrated Care Systems who have also requested that we support them on similar projects. Over the last couple of months we have had various conversations and requests, however we have only had confirmation from Shropshire and Worcester on Friday 15th October that they would like to progress with the UHB model. We will now work with the Trusts to set up the same model as we have across UHB.

Michelle Brotherton
Non-Emergency Services Operations Delivery & Improvement Director / ACAO
October 2022

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

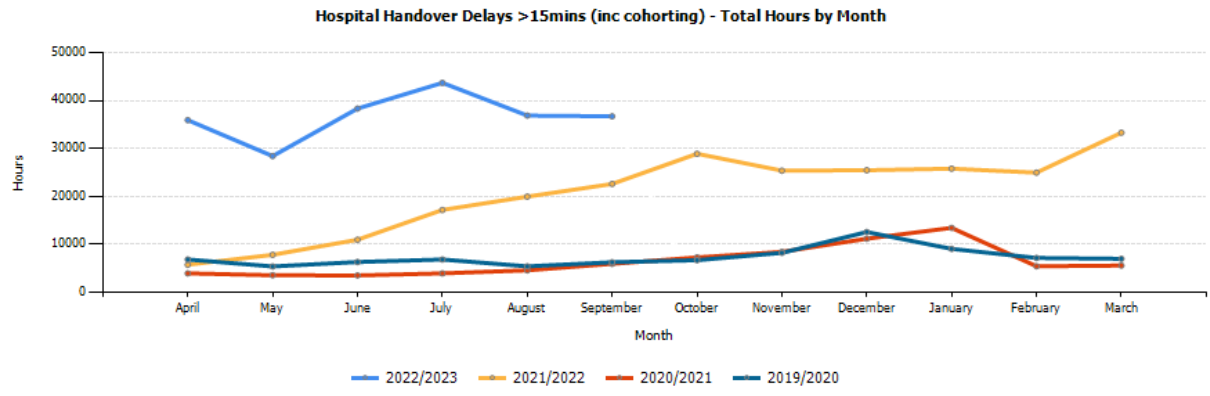
AGENDA ITEM: 09b MONTH: OCTOBER 2022 PAPER NUMBER: 06c

IEUC Director Update
September 2022

Contents

1. Activity and Performance

During September 2022, the Trust received 122,227 emergency calls, resulting in 77,970 incidents. Despite engagement and continued support, delays in hospital turnaround continue to increase and present a significant challenge to performance. During September there has been a reduction in lost hours, most likely resulting from the continued reduction in activity. Overall delays remain at the highest level experienced over the previous four years. Handover delays have resulted in 36,750 lost hours after 15 mins, reducing from 36,907 during August.



WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09b MONTH: OCTOBER 2022 PAPER NUMBER: 06c

Performance remained challenged across all but Category 1 targets. Category 1 performance improved significantly, from a mean at 08:12 minutes during August to 03:17. The mean position for category 2 incidents has remains challenged increasing from 35:54 minutes in August to 44:29.

	Target		MTD			QTD			YTD		
Priority	Mean	90%	Incs	Mean	90%	Incs	Mean	90%	Incs	Mean	90%
Category 1	7:00	15:00	1	3:17	3:17	1	3:17	3:17	58264	8:12	14:25
Category 1 T	19:00	30:00	5838	9:02	16:06	18079	8:59	15:59	36419	8:52	15:49
Category 2	18:00	40:00	42987	44:29	101:39	134273	47:09	108:10	275646	47:19	109:27
Category 3	60:00	120:00	12852	203:41	548:12	40244	200:49	532:03	80912	202:54	545:35
Category 4	-	180:00	552	201:51	487:51	1535	217:36	585:29	3209	233:14	614:31
HCP 2hr	-	-	1452	194:09	498:39	4645	206:17	541:33	9497	208:30	545:09
HCP 4hr	-	-	1404	274:09	708:45	4570	275:13	762:44	9119	289:29	755:55
			Calls	Mean	95%	Calls	Mean	95%	Calls	Mean	95%
Call Answer (999 only)			28	0:08	0:28	28	0:08	0:28	615058	0:05	0:22

2. Category Breakdown

Emergency activity categorisation has seen a small increase to the most acute category 1 and 2 incidents, and a relative reduction in category 3 incidents. Category 5 (H&T) remains a key focus to improve, with the CVT workforce now substantiated.

	Category 1		Category 2		Category 3		Category 4		Category 5		Total
	Inc.	%	Inc.	%	Inc.	%	Inc.	%	Inc.	%	Inc.
Apr-22	9,742	11.4%	47,243	55.3%	14,109	16.5%	646	0.8%	13,742	16.1%	**85,482**
May-22	9,520	10.9%	47,919	54.7%	16,758	19.1%	719	0.8%	12,665	14.5%	**87,581**
Jun-22	9,885	11.6%	46,806	55.2%	14,557	17.2%	580	0.7%	13,025	15.4%	**84,853**
Jul-22	10,742	12.5%	47,273	55.2%	13,759	16.1%	505	0.6%	13,327	15.6%	**85,606**
Aug-22	9,004	11.1%	44,389	54.6%	16,288	20.0%	640	0.8%	10,931	13.5%	**81,252**
Sep-22	9,373	12.0%	43,172	55.4%	14,150	18.1%	659	0.8%	10,616	13.6%	**77,970**
Oct-22											
Nov-22											
Dec-22											
Jan-23											
Feb-23											
Mar-23											
YTD	58,266	11.6%	276,802	55.1%	89,621	17.8%	3,749	0.7%	74,306	14.8%	**502,744**

3. 999 Call answering

The Trust has answered 122,227 emergency calls throughout September, with activity increasing slightly from August. The Trust remains in a strong position with a mean call answer of 0:05 seconds and 95 percentiles at 0:22 seconds. This is reflected in the low number of 2-minute delays reported below, in comparison to other English ambulance Trusts.

Increased response times during peak demand and turnover delays continue to be a significant contributor to call volumes, receiving 18.3% duplicate calls during September, a small increase from 17.2% during August.

Year to Date	WMAS			
01/04/2022 to 30/09/2022	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
Year to end date	**783,523**	**0:05**	**0:22**	**78.7 %**

Period Selected	WMAS			
01/04/2022 to 30/09/2022	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
Selected dates total	**783,523**	**0:05**	**0:22**	**78.7 %**

By Month	WMAS			
	Emergency Calls	Call Answer Mean (999 lines only)	Call Answer 95th (999 lines only)	Address Match % under 60 secs
April 2022/2023	**135,356**	**0:03**	**0:13**	**79.2 %**
May 2022/2023	**127,418**	**0:02**	**0:02**	**79.6 %**
June 2022/2023	**134,548**	**0:05**	**0:25**	**79.8 %**
July 2022/2023	**142,659**	**0:08**	**0:36**	**78.8 %**
August 2022/2023	**121,315**	**0:04**	**0:18**	**77.4 %**
September 2022/2023	**122,227**	**0:05**	**0:22**	**77.4 %**

4. 2-minute delays

During September the Trust reported 23, 2-minute delays answering emergency 999 calls. This remains significantly lower than any other English ambulance Trust, with the closest reporting 282 during the same period.

Trust	April	May	June	July	August	Sept	Year To date
WMAS	**8**	**5**	**33**	**77**	**27**	**23**	**173**
[redacted]	6008	8589	10752	11622	3691	5149	**45811**
	445	445	408	579	652	282	**2811**
	4481	6051	10274	14498	10111	11544	**56959**
	1019	715	849	1703	2641	3164	**10091**
	4557	5091	6845	11400	7323	6119	**41335**
	6713	2949	7913	9817	6601	5526	**39519**
	3391	2162	3123	6686	5466	7426	**28254**
	6181	3982	6053	7913	7012	5468	**36609**
	4304	845	2481	6518	6155	6911	**27214**
Total	**37107**	**30834**	**48731**	**70813**	**49679**	**51612**	**288776**

5. 999 calls taken for other Ambulance Services

The Trust continues to support other ambulance Trusts, answering 3,798 emergency calls during September. The Trusts has agreed to provide additional call answering support to London Ambulance Service during October. This is expected to impact upon emergency call answer performance and 2-minutes delays however, will significantly benefit patients in the capital.

Trust	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
EEAS	108	132	184	144	123	120							811
EMAS	311	287	316	355	345	282							1,896
LAS	197	218	426	1,412	824	2,144							5,221
NEAS	43	35	28	48	41	31							226
NWAS	204	280	325	450	306	231							1,796
SCAS	140	125	128	144	110	86							733
SECAMB	66	100	78	214	161	220							839
SWAS	535	326	528	800	629	449							3,267
YAS	74	96	80	115	79	62							506
IOW	0	0	0	64	51	32							147
SAS	15	17	9	12	9	10							72
WAST	104	85	120	135	107	131							682
Total	1,797	1,701	2,222	3,893	2,785	3,798	0	0	0	0	0	0	16,196

6. 111 Call Answering

The Trust answered 113,003 NHS111 calls during September, the lowest activity seen this financial year.

Call answer performance has been impacted by attrition, cessation of recruitment and an increase in sickness following the decision to exit the NHS111 contract. The mean call answer and 95th percentile performance was not achieved during September, at 00:00:55 and 00:04:57 respectively; 3% of calls were abandoned.

Year to Date	Calls Answered	Answered in 60 %	Abandoned % (post IVR, target <3%)	Mean (all calls answered, target 00:00:20)	95th Centile (all calls answered, target 00:02:00)
1st April to 30/09/2022	801782	81.1%	3.0%	00:00:59	00:05:57

Selected Period	Calls Answered	Answered in 60 %	Abandoned % (post IVR, target <3%)	Mean (all calls answered, target 00:00:20)	95th Centile (all calls answered, target 00:02:00)
01/04/2022 - 30/09/2022 Totals	801782	81.1%	3.0%	00:00:59	00:05:57

May be part months, depending on date selections

Selected from: 01/04/2022 To: 30/09/2022

Month	Calls Answered	Answered in 60 %	Abandoned % (post IVR, target <3%)	Mean (all calls answered, target 00:00:20)	95th Centile (all calls answered, target 00:02:00)
2022 - April	141846	65.2%	6.7%	00:02:29	00:13:07
2022 - May	134660	96.9%	0.3%	00:00:05	00:00:25
2022 - June	146045	82.3%	2.2%	00:00:43	00:04:41
2022 - July	145043	73.5%	3.9%	00:01:13	00:06:21
2022 - August	121185	92.1%	1.0%	00:00:19	00:01:55
2022 - September	113003	78.4%	3.0%	00:00:55	00:04:57
Total	801782	81.1%	3.0%	00:00:59	00:05:57

As a comparison this is the National 111 call answering and clinical interaction data for September. West Midlands 111 data is submitted by the Black Country ICB.

Provider	A01 - Calls Offered	A03 - Calls Answered	KPI 1 - Abandoned Calls (<3%)	KPI x - Answered with 60s (%)	KPI 2 - Mean Call Answer (<20s)	C01 - Triaged Calls	D01 - Assessed by Clinician	KPI 4 - Clinical Input (>50%)	KPI 5a - 20 Min Call Backs (>90%)
Black Country ICB	**120,720**	**113,003**	**3.03%**	**78.39%**	**55**	**103,685**	**47,394**	**45.71%**	**28.12%**

NHSE Geography	A01 - Calls Offered	A03 - Calls Answered	KPI 1 - Abandoned Calls (<3%)	KPI x - Answered with 60s (%)	KPI 2 - Mean Call Answer (<20s)	C01 - Triaged Calls	D01 - Assessed by Clinician	KPI 4 - Clinical Input (>50%)	KPI 5a - 20 Min Call Backs (>90%)
	1,961	1,678	14.39%	55.36%	247	1,442	610	42.30%	60.29%
East of England	177,495	155,976	7.14%	64.26%	183	129,580	72,065	55.61%	51.55%
London	232,498	210,035	9.46%	57.74%	171	134,249	63,277	47.13%	39.48%
Midlands	290,145	250,735	2.95%	78.52%	53	122,129	55,315	45.29%	30.05%
North East and Yorkshire	223,585	194,165	11.48%	56.41%	381	71,427	26,367	36.91%	40.89%
North West	164,890	144,474	5.38%	67.22%	120	130,775	37,041	28.32%	37.08%
South East	240,793	202,691	12.67%	45.55%	286	95,093	47,887	50.36%	44.29%
South West	129,055	107,105	11.60%	63.08%	198	75,051	43,774	58.33%	54.92%
Total	**1,460,422**	**1,266,859**	**8.57%**	**62.03%**	**196**	**759,746**	**346,336**	**45.59%**	**43.55%**

7. Clinical Validation

Clinical validation of category 3 & 4 emergencies remains a key function to support the overall demand upon the Trust and to ensure patients receive an appropriate response. The Trust hear and treat (H&T) rate increased to 14.7% during September, from 14.1% in August.

A review of recontact rates for hear and treat patients demonstrates only 11.1% of patient required further 999 assessment within 48 hours during September; this is consistent with previous months. Of those re-contacts, only 39.6% of patients were conveyed to an emergency department.

999 Recontacts within 48 hours from calls validated

	Total Emg Incidents	Total Emg H&T	Recontacts	% of Total Emg Activity	% of Emg H&T
Apr 22	85483	15678	1159	1.4%	7.4%
May 22	87581	14201	1429	1.6%	10.1%
Jun 22	84853	14850	1450	1.7%	9.8%
Jul 22	85609	14947	1491	1.7%	10.0%
Aug 22	81252	12085	1298	1.6%	10.7%
Sep 22	78024	11847	1311	1.7%	11.1%
Total	**502802**	**83608**	**8138**	**1.6%**	**9.7%**

Selective C2 validation remains in place daily, with a CVT clinician based daily within EOC dispatch.

8. Clinical Validation Outcomes

Outcome of CVT Triaged Calls	Apr-22		May-22		Jun-22		Jul-22		Aug-22		Sep-22		YTD Total	
Cat 1 response	14	0.1%	11	0.1%	24	0.2%	11	0.1%	13	0.1%	11	0.1%	84	0.1%
Cat 2 Response	1,286	8.2%	1,373	8.8%	1,590	10.5%	1,512	10.2%	1,363	10.1%	1,506	11.4%	8,630	9.8%
Cat 3 Response	3,745	23.9%	4,567	29.2%	3,624	24.0%	3,518	23.8%	4,086	30.2%	3,844	29.2%	23,384	26.6%
Cat 4 Response	6	0.0%	1	0.0%	4	0.0%	5	0.0%	3	0.0%	5	0.0%	24	0.0%
Contact Dental	16	0.1%	26	0.2%	35	0.2%	20	0.1%	11	0.1%	13	0.1%	121	0.1%
Contact Pharmacist	10	0.1%	20	0.1%	11	0.1%	10	0.1%	3	0.0%	7	0.1%	61	0.1%
COVID	84	0.5%	37	0.2%	53	0.4%	70	0.5%	31	0.2%	38	0.3%	313	0.4%
Other Referrals	289	1.8%	266	1.7%	223	1.5%	208	1.4%	186	1.4%	148	1.1%	1,320	1.5%
Primary Care	3,321	21.2%	3,174	20.3%	2,961	19.6%	3,170	21.4%	2,644	19.5%	2,544	19.3%	17,814	20.3%
Refer to SDEC	127	0.8%	118	0.8%	112	0.7%	78	0.5%	73	0.5%	49	0.4%	557	0.6%
Refer to Social Services	6	0.0%	4	0.0%	10	0.1%	6	0.0%	4	0.0%	4	0.0%	34	0.0%
Refer to Treatment Centre (ED)	2,990	19.1%	2,878	18.4%	2,987	19.8%	2,608	17.6%	2,243	16.6%	2,099	15.9%	15,805	18.0%
Self Care	3,603	23.0%	3,030	19.4%	3,340	22.2%	3,483	23.5%	2,815	20.8%	2,830	21.5%	19,101	21.7%
Speak to Community Nurse	146	0.9%	112	0.7%	85	0.6%	87	0.6%	65	0.5%	65	0.5%	560	0.6%
Speak to Midwife	12	0.1%	12	0.1%	15	0.1%	7	0.0%	9	0.1%	6	0.0%	61	0.1%
Total	**15,655**		**15,629**		**15,074**		**14,793**		**13,549**		**13,169**		**87,869**	**100%**

Priority	Total Incidents	Dispatch Criteria	Incidents Triaged	% Triaged
Category 1	9412	9412	67	
Category 2	43393	43393	1668	
Category 3	14718	9603	5115	35%
Category 4	692	415	277	40%
Category 5	10935	-	7059	100%
HCP	2921	-	123	-
Total	**82071**		**14311**	

Trust Outcome	%
Hear & Treat	14.6%
See & Treat	31.1%
See & Convey	54.3%

Summary	Total	%
Total Cat 3 and 4 Incidents (based on initial priority)	**19814**	-
Total Calls Triaged (initial priority cat 3/4/5)	**13169**	66.5%
Outcome - Ambulance Response	**5494**	41.7%
Outcome - Alternative Pathway / Non Response	**7675**	58.3%

Outcome of Triaged Calls	Total	%
H&T / Alternative Pathway	**7598**	58%
See & Treat	**2116**	16%
See & Convey	**3301**	25%
Calls Closed	**154**	1%
Total	**13169**	100%

Priority Group	Hear & Treat	See & Treat	See & Convey
Category 1	0.0%	37.7%	62.3%
Category 2	0.2%	33.1%	66.7%
Category 3	8.4%	45.9%	45.7%
Category 4	15.5%	45.7%	38.8%
Category 5	98.4%	0.9%	0.7%
Total	**14.6%**	**31.1%**	**54.3%**

Priority Group	Transport - ED	Transport - Non ED
Category 1	57.1%	5.2%
Category 2	62.1%	4.6%
Category 3	43.8%	1.9%
Category 4	36.4%	2.4%
Category 5	0.6%	0.0%
Total	**49.7%**	**4.6%**

9. NHS 111 Clinical Performance

Clinical call-back performance remained stable during September, with 28.1% of priority one patients contacted within 20 minutes. There is also an increase in performance for priority two patient, with 49.6% receiving a call back between 20-60 minutes. It is acknowledged there is work to do to reach the required standards, and continual review of individual clinician productivity remains a key focus.

Clinical performance does have parity with the overall national positions, with some KPIs exceeding the national average.

Several factors impact upon performance, with recruitment and retention of clinicians and productivity remaining the key challenges. The volume of patient requiring a P1 20-minute call back remains high as newly trained call assessors consolidate their knowledge and gain confidence to probe. As a forward view with the confirmation that WMAS will continue to deliver the 111 provision until March 2023 the performance is likely to be impacted by the clinical attrition which has already increased significantly following the announcement to exit the NHS111 contract.

The clinical input KPI remains stable, with 45.7% of patients receiving a clinical assessment along the IUC pathway against the system target of 50%.

Regionally Reported Figure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD
Abandoned calls (%)	6.7%	0.3%	2.2%	3.9%	1.0%	3.0%							3.0%
Avg Speed to Answer (seconds)	149	6	43	74	19	55.09							59
95th centile call answer time	787	25	281	381	115	297							TBC
Amb Validation (within 30 mins)	18.2%	30.6%	21.9%	13.4%	32.3%	29.9%							24.0%
ETC Validation	15.0%	15.0%	17.2%	24.2%	24.4%	25.6%							20.0%
DOS: no alternative to ED	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%							0.1%
First DOS Service Type selected	63.8%	63.1%	63.4%	63.2%	62.8%	62.6%							63.2%
Proportion Of Calls where caller was booked into UTC	13.4%	13.7%	13.1%	13.6%	4.6%	10.6%							11.8%

111 only (Part of a Regional Figure)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD
Clinical Input	44.2%	44.0%	44.4%	45.8%	44.9%	45.7%							44.8%
20 Min Call Backs	20.4%	30.0%	22.3%	14.7%	28.3%	28.1%							23.8%
Over 20 Min Calls Backs	28.2%	50.4%	36.1%	29.7%	45.4%	49.6%							39.1%
Self Care following Clinical Input	8.6%	9.4%	9.2%	9.2%	9.2%	8.9%							9.1%
Booked into GP Practice or Hub	37.6%	43.3%	42.9%	43.3%	45.3%	42.6%							42.4%
Booked into IUC Treatment Centre of Home Visit	1.8%	2.1%	2.0%	2.0%	0.4%	0.4%							1.5%
Type 1 or 2 ED Booking	19.0%	22.0%	22.0%	20.7%	22.0%	20.1%							21.0%
SDEC Booking	1.3%	0.0%	1.5%	0.0%	0.0%	0.0%							0.6%
Booked with any Service	13.8%	16.2%	15.7%	15.7%	14.7%	14.5%							15.1%

*Amb. Validation: Initial C3 & 4 Ambulance Cases Validated **Within 30mins**

10. Establishment

721.82 WTE (901 heads) call assessors are currently in post, as of the 7 October 2022; 30 are currently in the classroom completing their NHS Pathways course. This is against a funded establishment of 706 Call assessors. At peak earlier this year we were actually over-established by 80 call assessors to account for the training and attrition. The current staffing levels do suggest that 111 and possibly 999 call answering performance will be more difficult to achieve consistently.

NHS111 Clinical establishment is 128.39 WTE, a shortfall of 105.61 WTE against a budget of 234 WTE. NHS111 Clinicians successful in their substantive CVT applications are now being moved to CVT validation. In order to compensate for the staff moving over the 111 Cat 3& 4 validation requirements will be transferred into CVT. This means that 111 validation (Cat 3 & 4) will be done by the validation team and not 111. Just working through the reporting side of this to ensure the activity is captured appropriately.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09b MONTH: OCTOBER 2022 PAPER NUMBER: 06c

Clinical Validation Team (CVT) substantive establishment, including the Navigators, CSD and the old legacy SCC paramedics is 131.9 WTE (152 heads). In addition, there are 22.62 WTE (26 heads) clinicians seconded from other roles to continue supporting clinical validation.

Leavers

During September there were 25.02 WTE (31 heads) call assessor leavers and 8.99 WTE (12 heads) clinicians. Staff reducing their hours upon completion or their Pathways training, flexible working applications and robust sickness management continues to reduce the overall establishment.

Abstractions

There are 26.47 WTE (33 heads) call assessors and 9.49 WTE (13 heads) clinicians currently on maternity leave or a career break.

Call Assessor Establishment

Trained Position	Heads	WTE	Budget	Diff.
999 Trained Only	150	123.5	300	
111 Trained Only	242	176.42	406	
Dual Trained	479	391.9		
In Training (999)	30	30		
Total	**901**	**721.82**	**706**	**15.82**
Able to take a 999 call (* Inc. TRG)	659	545.4	75.56%	
Able to take a 111 call	721	568.32	78.73%	

111 Clinical Establishment.

Clinical Role	Heads	WTE	Budget	Diff.
Pharmacist	32	14.96	24	-9.04
Mental Health Nurse	5	3.80	20	-16.20
General Practitioner	9	6.47	15	-8.53
Dental Nurse	17	14.09	15	-0.91
Clinical Supervisor	10	9.15	15	-5.85
Clinical Advisor	72	57.36	90	-32.64
Advanced Practitioner	29	22.54	55	-32.46
	174	**128.39**	**234**	**-105.61**

Clinical Validation Team Establishment

Substantive Role	Heads	WTE	Budget	Diff.
CVT Navigator	5	5.00	5	0.00
CVT Advanced Practitioner (Substantive)	147	126.90	130	-3.10
CVT Advanced Practitioner (Seconded)	26	22.62	0	22.62
	178	**154.52**	**135**	**19.52**

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09b MONTH: OCTOBER 2022 PAPER NUMBER: 06c

11. Sickness

Accepting there is still work to do to achieve the 4% target, sickness has further improved throughout September to 6.51%. NHS111 remains the main contributary factor, with call assessor sickness being the significant challenge. Robust sickness management is reflected in the high call assessor attrition during September, with 31 staff exiting the Trust in total.

Mental health presents as a key theme for sickness, especially with the younger workforce demographic. Regular sickness management and welfare meetings are in place to support staff, with signposting and engagement from the Trust's health and wellbeing services. Most often, such issues result from personal situations and home environments opposed to work related stress and anxiety.

Absence Timeline Detail	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD
217 111 Integrated Urgent Care	6.43%	6.17%	6.66%	8.35%	9.67%	8.07%							7.45%
217 Emergency Operations Centre	5.39%	5.17%	5.84%	6.42%	5.58%	5.42%							5.65%
217 Integrated Emergency & Urgent Care Total	5.96%	5.71%	6.29%	7.33%	7.42%	6.51%							6.54%

12. Recruitment & Training

Recruitment has re-commenced with a focus on 111 Call assessors and clinical advisors. We have recruitment days planned for 22nd and 29th October 2022.

In total we have 324 new staff signed off and working independently in 999 and a further 69 that are trained to 111. Call assessors initially trained on 111 have all been given course dates to complete their '111 to 999' conversion courses.

In the classroom we have 35 staff in total, comprising of 22 call assessors, 1 Clinical advisor, 1 Clinical Navigator and 9 CVT clinicians.

CM1 Week 1	1 Clinical Advisor, 5 Call Assessors & 9 CVT Clinicians
CM1 Week 2	12 Call Assessors & 1 Clinical Navigator
Clinical Course	1 Advanced Nurse Practitioner
CAD System Training	7 Call Assessors

Future courses planned with the number of new starters shown below, these have now been extended until 7th November 2022.

Date	Location	Call assessors	Clinical advisors	CAS
10th October	NP	5	5 CVT	
17th October	NP	2	6 CVT	
24th October	NP	2	3 CVT	
31st October	NP		3 CVT	
7th November	NP		4 CVT	
21st November	NP			

28th November	NP			
5th December	NP			
12th December	NP			

13. Risks

- Attrition. Call taking staff continue to leave the Trust, some as a result of the TUPE decision to exit 111 with staff choosing to join DHU early, others don't like the thought of only taking 999 calls and another group of call takers have left the Trust citing pressures of the job dealing with duplicate calls and the increased level of frustration, often abuse aimed at them. Clinical staff are also leaving at a much larger rate than we have seen previously which means added pressures on those that remain.

- Sickness has increased and the themes are stress and anxiety, some of which is attributed to high demand pressures, duplicate calls and TUPE. All efforts to manage this are being put in place with staff leaving the Trust with poor sickness on the increase.

- Recruitment is not as fruitful as we have previously seen so the call taking numbers are likely to decrease below the required establishment level before we get into December. Of the recent advert placed for clinical positions only 4 nurses have applied.

- The clinical queue in 111 is likely to grow, I am pushing the ICB hard to take some responsibility for this given their request for WMAS to continue in the 111 delivery past the date originally agreed.

- Staff survey is unlikely to yield positive views. Staff are feeling the strain of high call demand, long deployment delays and reduced ambulance availability due to the significant hospital handover delays and general staffing pressures we are seeing across the NHS.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

Emergency Services Operations Delivery Director Report	
Sponsoring Director	Emergency Services Operations Delivery Director
Author(s)/Presenter	Nathan Hudson, Emergency Services Operations Delivery Director
Purpose	This report provides an update from the Emergency Services Operations Delivery Director and covers the year to date position up to and including September 2022
Previously Considered by	Not applicable
Report Approved By	Emergency Services Operations Delivery Director

This report covers the second quarter of 2022

Overview

Board members will have received key information at various updates in the period since the last meeting. These included detailed updates on performance challenges and hospital delays which are still causing significant delays in responses to patients, creating significant clinical risks. Although this report repeats some of the detail that has already been provided to the board, it is intended to provide an update on operational performance in the second quarter of 2022/23 and a general update from E&U Operations.

In addition to that risk to patients caused by hospital delays, our staff are really starting to suffer too; attending patients' hours after they have called is challenging and there are some examples of where some staff have become over-whelmed and upset. Conversations indicate that staff are frustrated at sitting outside of hospital, which is decaying their skills, restricting the development of students, and resulting in staff actively exploring other employment. There is a risk that performance challenges could be exacerbated should more staff find alternative roles, or their well-being is affected to the point of creating sickness absence.

Performance

Hospital turnaround issues have significantly contributed to our ability to respond, as the deterioration of the hospital situation continually impacts on productivity, patinet safety and morale of staff and managers. Escalations has continued with the regional and national NHSE/I teams.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

	Target		Month		QTD		YTD	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	8:20	14:38	8:16	14:29	8:12	14:25
Category 1 T	19:00	30:00	9:49	17:12	9:43	17:16	9:32	17:03
Category 2	18:00	40:00	45:05	102:51	47:14	108:36	47:20	109:38
Category 3	60:00	120:00	197:03	545:28	190:07	518:55	194:40	534:56
Category 4	-	180:00	188:35	487:37	208:54	576:36	223:21	602:49
HCP 2hr	-	-	197:30	531:42	203:37	540:57	205:11	539:00
HCP 4hr	-	-	283:52	751:58	276:17	772:06	289:28	758:33

MTD	Target		Arden		Birmingham		Black Country		Hereford and Worcester		Shropshire		Staffordshire	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	9:04	15:49	7:02	11:45	6:48	10:51	10:10	19:14	12:15	24:35	9:01	15:13
Category 1 T	19:00	30:00	11:46	17:14	7:48	13:11	7:28	11:48	12:09	22:28	15:11	29:01	10:55	18:32
Category 2	18:00	40:00	41:48	94:22	55:01	129:36	22:31	45:14	36:21	76:56	59:39	129:44	63:22	145:37
Category 3	60:00	120:00	168:37	438:52	272:01	781:51	144:07	338:58	154:13	393:29	224:38	622:23	221:35	593:32
Category 4	-	180:00	174:48	431:37	233:24	765:33	206:53	482:57	125:12	315:11	222:51	556:04	180:53	461:50
HCP 2hr	-	-	163:40	393:16	248:51	679:44	152:15	302:09	134:43	342:36	272:05	742:23	211:15	589:48
HCP 4hr	-	-	258:42	723:36	282:03	662:57	304:37	802:23	261:57	593:02	356:15	921:13	284:24	794:44

QTD	Target		Arden		Birmingham		Black Country		Hereford and Worcester		Shropshire		Staffordshire	
Priority	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%	Mean	90%
Category 1	7:00	15:00	8:52	15:27	6:57	11:30	6:42	10:55	10:17	19:22	12:13	24:37	9:02	15:14
Category 1 T	19:00	30:00	10:48	17:42	7:48	12:53	7:29	12:18	12:24	23:00	14:55	28:52	10:59	19:01
Category 2	18:00	40:00	46:19	102:26	55:24	133:46	24:29	51:58	44:57	97:33	62:01	139:04	61:38	143:58
Category 3	60:00	120:00	176:07	455:05	246:28	725:41	143:41	358:16	168:43	443:18	204:44	579:11	202:38	537:49
Category 4	-	180:00	173:14	426:40	269:00	768:48	215:01	593:30	183:19	443:26	228:24	613:33	198:40	494:46
HCP 2hr	-	-	189:44	492:01	233:18	654:04	155:59	378:25	176:10	429:03	294:40	876:31	204:54	555:24
HCP 4hr	-	-	260:47	768:01	262:06	584:54	269:52	679:34	295:24	805:08	378:35	961:29	279:20	851:09

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

Activity

Compared to last year, demand continues to reduce and is on a downward trend.

Incident Demand

	All Incidents			
	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
	Incident Count	Incident Count	Incident Count	Incident Count
Month	82,170	99,190	(17,020)	-17.2 %
QTD	257,909	301,775	(43,866)	-14.5 %
YTD	529,167	599,537	(70,370)	-11.7 %

	Emergency Incidents			
	Current Year	Previous Year	Variation from Previous Year	% Variation from Previous Year
	Incident Count	Incident Count	Incident Count	Incident Count
Month	79,042	94,699	(15,657)	-16.5 %
QTD	247,975	287,138	(39,163)	-13.6 %
YTD	509,119	567,708	(58,589)	-10.3 %

Operational Absenteeism Management

Sickness absence for the year is currently 4.47%. There is an improving picture with September recorded 3.8%. Staff reporting they are too unwell to work because of Covid is currently 1.08%.

Resourcing

The largest variant for resourcing is caused by our students going to university. Resourcing in September was challenged because of this, with output being 199,773hrs. Students begin to return in October which see a higher output of 213,000hrs. Outport this October is the highest it has been in any October.

Skill mix

Skill Mix remains strong and has improved with September seeing 99.5% of ambulances crewed by a Paramedic.

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Bromsgrove Hub	99.6%	96.7%	96.8%	96.5%	99.2%	98.8%
Coventry Hub	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%
Donnington Hub	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%
Dudley Hub	93.6%	93.3%	94.4%	96.3%	97.7%	99.4%
Erdington Hub	97.9%	97.6%	97.9%	98.2%	97.3%	99.6%
Hereford Hub	99.8%	98.9%	100.0%	100.0%	100.0%	100.0%
Hollymoor Hub	97.6%	97.8%	97.9%	99.8%	100.0%	100.0%
Lichfield Hub	99.2%	100.0%	99.8%	99.8%	100.0%	100.0%
Sandwell Hub	95.6%	92.3%	93.6%	95.6%	91.7%	97.1%
Shrewsbury Hub	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stafford Hub	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Stoke Hub	99.8%	100.0%	99.9%	99.7%	100.0%	100.0%
Warwick Hub	98.9%	99.8%	100.0%	100.0%	100.0%	100.0%
Willenhall Hub	94.6%	96.9%	100.0%	100.0%	100.0%	99.7%
Worcester Hub	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total	97.8%	97.6%	98.2%	98.8%	98.7%	99.5%

Workforce

The workforce Numbers by WTE and September will be lower. We now see the same staffing numbers as in 2021.

Operational Workforce																	
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Staff in Post FTE	3403.64	3424.74	3412.87	3450.46	3424.91	3405.7	3492.75	3470.78	3423.33	3448.31	3473.15	3470.03	3439.13	3435.1	3402.57	3407.57	3404.77

Attrition

	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09
Leavers Headcount	28	26	36	23	30	29
Leavers FTE	24.97	24.10	31.69	18.81	27.02	27.35
Turnover Rate (Headcount)	0.77%	0.71%	0.99%	0.63%	0.82%	0.80%
Turnover Rate (FTE)	0.72%	0.70%	0.92%	0.54%	0.78%	0.79%
Leavers (12m)	332	344	367	361	362	367
Leavers FTE (12m)	289.85	301.60	322.45	315.39	320.13	327.79
Turnover Rate (12m)	9.17%	9.52%	10.14%	9.98%	10.04%	10.03%
Turnover Rate FTE (12m)	8.43%	8.80%	9.39%	9.19%	9.37%	9.44%

Hospital delays over 15 min

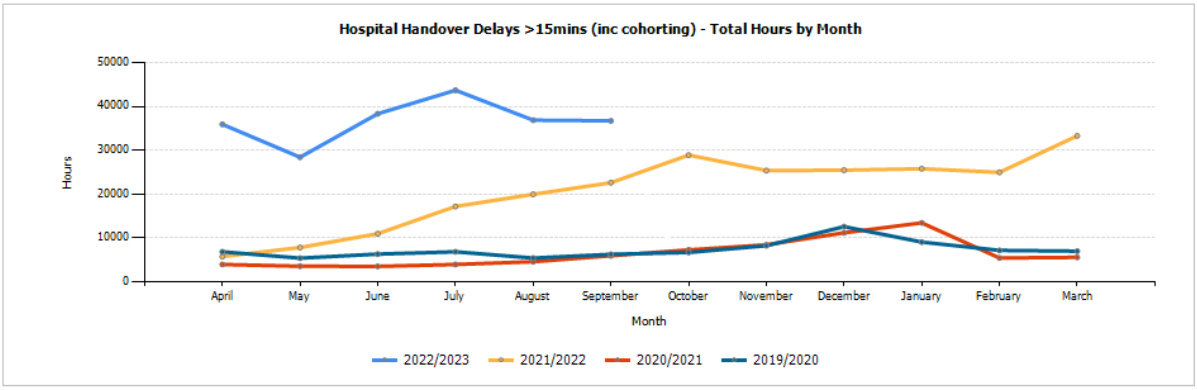
As mentioned hospital delays continue. This quarter having 117,402hrs lost. This is having significant impact on patients, staff and performance.

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

Summary for All Hospitals - Total Lost Operational Hours (rounding to whole hours will occur)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/2020	6834	5376	6302	6834	5397	6258	6677	8214	12577	9047	7151	6972
2020/2021	3930	3535	3504	3927	4564	5927	7269	8427	11174	13440	5423	5561
2021/2022	5732	7805	10963	17185	19967	22618	28925	25396	25484	25809	24985	33333
2022/2023	35959	28442	38373	43745	36907	36750						



Compliance

ALS Training	40% Complete
PDRs	96 %
Online training	69%
CRT	51.72%
MWB	82.48%
CS1 days	85.23%

Late finishes

In addition to reporting late finishes for September, please find a comparison to September 2019. There has been nearly double the amount of crews, that have finished late up to the 3-4hour indicator.

In 2019 nearly 30 % of crews finished on time. In 2022 it is now only 16%. In 2019, 850 crews finished between 1-2 hours late, whereas for 2022, that has increased to 1450. Most commonly, crews from Shropshire, Worcester and the Black Country are the worst affected.

Deep Cleans

All operational vehicles were deep cleaned within the required timeframe. Those that were overdue/late were as a result of being off the road and being repaired/serviced (VOR).

Hub	*DCA/Vehicle Count*	*DCA/Vehicle Clean Count*	*Current Compliance*	*Vehicle(s) Overdue*
Bromsgrove	**33**	**28**	**100.00%**	**0**
Coventry	**45**	**46**	**97.87%**	**1 1 x RRV VOR 1 Day**
Donnington	**16**	**18**	**100.00%**	**0**
Dudley	**53**	**69**	**100.00%**	**0**
Erdington	**48**	**58**	**100.00%**	**0**
Hereford	**16**	**16**	**94.12%**	**1 1 x VOR 8 Days**
Hollymoor	**53**	**59**	**98.21%**	**1 1 x VOR 46 Days**
Lichfield	**20**	**20**	**95.24%**	**1 1 @ LD**
Sandwell	**35**	**43**	**97.67%**	**1 1 x VOR 15 Days**
Shrewsbury	**22**	**24**	**100.00%**	**0**
Stafford	**26**	**26**	**96.55%**	**1**
Stoke	**39**	**43**	**100.00%**	**0**
Warwick	**20**	**22**	**100.00%**	**0**
Willenhall	**44**	**50**	**100.00%**	**0**
Worcester	**26**	**25**	**93.10%**	**2 2 x Worcester**
Air	**1**	**0**	**0.00%**	**5199 Overdue**
HART	**21**	**27**	**100.00%**	**0**

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

General Update

1. As articulated at EMB, more staff being recruited and abstracted from front line operations for the 'cohorting paramedic' role will mean reduced resource capacity. Overtime is fully open and will be continually pushed.
2. There is great work going on in Ops, resulting in positive feedback from the staff and CTMs, with regards to the face-to-face ALS training. Marc Cutler is project managing this. 40% of staff have completed this training already and we aim to have this complete by the end of January.
3. I have a post pandemic action plan ongoing as previously mentioned.
4. A current review of bariatric stretchers and deployment is underway because of the effect hospital delays have on this.
5. I have commissioned a review of NQP hours and the support by Hub.
6. We have increased the pace of reducing owed hours significantly for this year.
7. We have completed a review of staff who have not yet completed safeguarding training. 68 staff were identified, and they have all been booked in for completion; this will be 100% complete. Those 68 in the main have returned from maternity leave or LTS. We also identified a gap where NQP's needed to undertake the additional training, from when this was initially rolled out and they had only completed the shorter Technician Safeguarding module. This has now been resolved. The route cause was a lack of follow up from training school, following successful completion of training and registration of becoming an NQP.
8. All sites have returned to using books to document stock control for POMS.
9. There is a reverse mentoring paper and action plan
10. We are currently developing an OM mandatory training day which includes, EDI, Sexual harassment awareness, mental health training and compassionate leadership.
11. Investigation training continues.
12. There has been a focus on ensuring any near miss or incident is reported over the past few months.
13. We continue to drive digital progression with the creation and development of apps.
14. VPO, OM and station meetings continuing.
15. Dates for my Visits around the region are in the weekly briefing.
16. FTSU on all sites now.
17. There are no current issues regarding HART.

18. Sandwell Hub will relocate to the new Oldbury sight in the first week in November following half term.

RISKS

The below risks are not listed in any order. Many of the risks would reduce or not exist at all if hospital delays are reduced.

1. Hospital delays.
2. Performance.
3. Clinical safety.
4. The continued loss of front-line staff.
5. Staff survey will be challenged again this year because of the environment staff are working.
6. Industrial Ballot.
7. COVID.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

National reporting for September 2022

Response Times **Ambulance Quality Indicators: Systems Indicators[1]**
September 2022

Code	Ambulance Service	Count of Incidents	Response times: Total (hours)	Response times: Mean (hour: min:sec)	Response times: 90th centile (hour:min:sec)
Category 1		A8	A24	A25	A26
	England	**69,458**	**10,790**	**9:19**	**16:38**
		7,853	1,192	9:07	16:27
		8,562	1,543	10:49	20:07
		132	23	10:40	17:48
		7,508	904	7:14	12:16
		3,094	388	7:31	13:19
		8,385	1,218	8:43	14:51
		3,327	538	9:42	17:16
		4,430	699	9:28	17:20
		9,528	1,772	11:10	20:31
	West Midlands	9,373	1,302	8:20	14:38
		7,266	1,211	10:00	17:31

Category 1T	A9	A27	A28	A29
England	**45,304**	**9,208**	**12:12**	**22:37**
	5,058	1,420	16:51	37:58
	5,614	1,330	14:13	25:19
	84	18	13:03	20:52
	5,259	1,064	12:08	21:06
	2,016	283	8:25	14:59
	5,578	1,037	11:09	19:16
	2,109	393	11:11	19:57
	2,865	548	11:28	21:05
	5,658	1,197	12:42	23:54
West Midlands	5,843	956	9:49	17:12
	5,220	962	11:04	19:30

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 09c MONTH: October 2022 PAPER NUMBER: 06d

Category 2	A10	A30	A31	A32
England	**345,642**	**276,426**	**47:59**	**1:45:45**
	33,766	29,865	53:04	2:00:50
	35,787	44,253	1:14:12	2:47:37
	1,165	558	28:46	59:59
	36,841	24,919	40:35	1:32:42
	20,915	14,205	40:45	1:23:30
	47,288	30,135	38:14	1:24:21
	25,166	15,761	37:35	1:18:17
	31,784	20,544	38:47	1:19:08
	34,650	39,782	1:08:53	2:25:47
West Midlands	43,106	32,393	45:05	1:42:51
	35,174	24,010	40:57	1:33:23

Category 3	A11	A33	A34	A35
England	**107,603**	**291,376**	**2:42:28**	**6:51:31**
	7,606	21,288	2:47:56	7:06:28
	7,860	28,705	3:39:07	9:10:49
	747	865	1:09:30	2:39:26
	12,281	20,172	1:38:33	4:09:12
	5,517	12,776	2:18:56	5:45:44
	14,167	42,788	3:01:13	7:08:06
	11,458	30,383	2:39:06	6:18:04
	13,428	40,509	3:01:00	7:17:45
	11,971	33,981	2:50:19	8:00:40
West Midlands	12,971	42,599	3:17:03	9:05:28
	9,597	17,310	1:48:13	4:22:07

Category 4	A12	A36	A37	A38
England	**4,176**	**13,402**	**3:12:34**	**7:48:12**
	131	436	3:19:50	8:28:20
	242	756	3:07:34	13:10:06
	52	62	1:11:55	2:57:45
	636	2,204	3:27:55	7:15:12
	403	884	2:11:41	5:22:48
	888	3,180	3:34:53	7:32:39
	607	1,854	3:03:15	7:30:11
	356	1,493	4:11:33	10:07:35
	138	467	3:22:56	9:44:58
West Midlands	557	1,751	3:08:35	8:07:37
	166	315	1:53:49	3:45:30

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10a MONTH: OCTOBER 2022 PAPER NUMBER: 07a

Organisational Strategy review and next steps	
Sponsoring Director	Vivek Khashu – Strategy and Engagement Director
Author(s)/Presenter	Vivek Khashu – Strategy and Engagement Director
Purpose	To brief the board on the plan to review the organisational strategy at the November 2022 Board strategy day, including providing information now, in advance of the session to aid discussion. In briefing the board, to also seek any feedback in advance of the November session itself.
Previously Considered by	April 2021 – Trust Board May 2021 – Trust Board
Report Approved By	Vivek Khashu – Strategy and Engagement Director

Executive Summary

WMAS approved it's five year organisational strategy in May 2021, it is time to reflect on our current strategy and priorities, the progress we have made, the current and future strategic context and determine any changes that may be required.

This paper will set out:

- The current strategy on a page and the context WMAS signed it off in.
- The measures of success agreed as part of the current five-year strategy
- The strategic context now facing WMAS, by strategic objective.
- A framework for the discussion in November, including what will be ruled in and ruled out for discussion and why.

Related Trust Objectives/ National Standards	SO1 – Safety, Quality and Excellence SO2 – A great place to work SO3 – Effective planning and use of resources SO4 – Innovation and Technology SO5 – Collaboration and Engagement

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10a MONTH: OCTOBER 2022 PAPER NUMBER: 07a

Risk and Assurance	This paper will cover the major strategic risks WMAS currently manages.
Legal implications/ regulatory requirements	No legal advice has been sought as part of the preparing this paper.
Financial Implications	The current and future financial context will be addressed
Workforce & Training Implications	The current and future workforce context will be addressed
Communications Issues	Updates to the strategy will need to be communicated both internally to staff and to key external stakeholders, such as our host Integrated Care Board
Diversity & Inclusivity Implications	The current and future context with regard to quality, diversity and inclusion will be addressed.
Quality Impact Assessment	NA
Data Quality	NA

Action required

1. For the board to receive this briefing
2. For members of the board to provide feedback in advance of November strategy day session

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10a MONTH: OCTOBER 2022 PAPER NUMBER: 07a

Introduction

WMAS signed off its five year strategy in May 2021, it was the culmination of a considerable amount of internal and external engagement involving multiple stakeholders and groups. At the time of signing it off, the context was very different to the one we face now and are likely to face in the medium term, in May 2021 WMAS:

1. Delivering all its response times standards
2. Staff were living with low inflation and interest rates
3. The previous year had 84 serious incidents
4. Staff survey reflecting the prior year had improved
5. Was delivering 111 as part of an integrated Urgent and Emergency Care offering
6. Were able to recruit to a stable level attrition of paramedics and expected growth
7. Had a changing demographic of workforce, with a left shift in the age profile
8. In a block contract, but with covid financial support in place supporting the Trust, understanding things could get more difficult though, with no certainty of a return to Payment by Results
9. Research work previously disrupted due to covid, beginning to resume
10. Retained Segmentation level one in the NHSE/I oversight framework
11. Launched its emerging green fleet of electric vehicles
12. Progressing as a “Global Digital Exemplar”
13. Maintained a paramedic on every vehicle, each vehicle being no more than five years of age
14. No organisational risks recorded on our Board Assurance Framework greater than 20

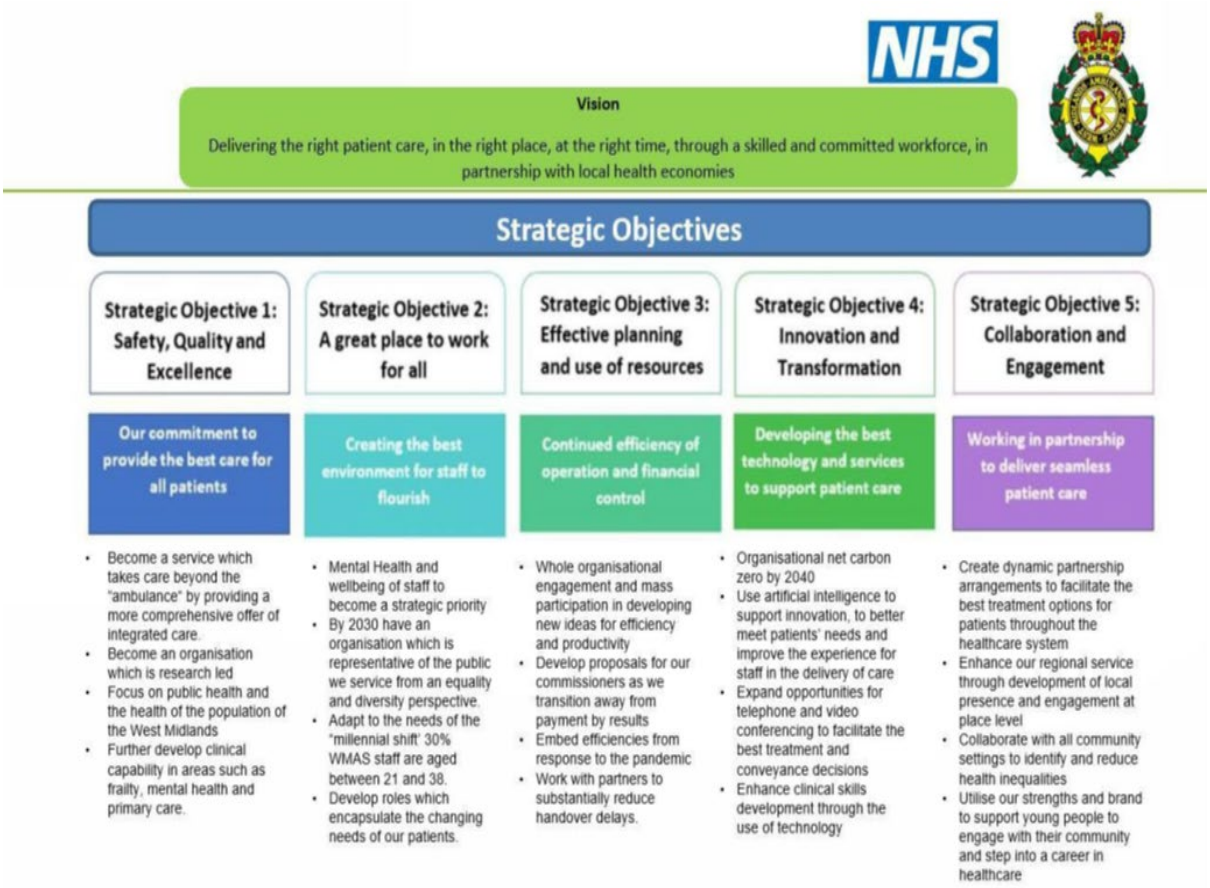
The above context framed much of the discussion when designing our strategy, the “strategy on page” is noted below

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10a MONTH: OCTOBER 2022 PAPER NUMBER: 07a

WMAS Strategy on page



In refreshing the organisation strategy, a balance must be struck between not starting from 'scratch' versus being able to consider changes which need to be responded to. We will use our existing strategy as a basis to inform discussion.

The review of organisational values is being led by the People Director, therefore that workstream will not need to be duplicated here.

It is proposed that the vision and strategic objectives remain the same, however that we do reflect upon them with regard to change, and if change is required, it is considered.

The main focus of the review in November should be 'sifting' the current and future strategic context and drivers for change through the existing strategic objectives and where required updating our priorities accordingly. In addition to this, the Board of Directors will also need to review our "success criteria" for the existing strategy, to understand where progress has been made, where it has not and why, and what if any need updating.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10a MONTH: OCTOBER 2022 PAPER NUMBER: 07a

What did we set out as our success criteria by strategic objective for our current organisational strategy?

Objective 1 – Safety Quality and Excellence

• Retain CQC rating of Outstanding, but improve from 'Good' to 'Outstanding' for the domain of "Safe"

• Continually deliver upon national access standards across all services

• Improve clinical outcomes through changing clinical practice, driven by research and development

• Improve the outcomes for patients from a public and population health perspective, with greater integration of services, sharing of public health data with partners and embedding different roles within WMAS, which can meet the needs of patients

Objective 2 – A great place to work

• Improve staff survey results year on year

• Improve performance on Workforce Race Equality Standard gender pay gap and workforce disability equality standards.

• Increase the representation of ethnic minority colleagues at all levels with the organisation, 10.7% of the WMAS workforce is from an ethnic minority background, c17% of the West Midlands population identifies as coming from an ethnic minority group.

• Retain our staff for longer, with roles which attract and retain new and existing colleagues which are aligned to the need of our patients and the aspirations of our staff.

Objective 3 – Effective planning and use of resources.

• WMAS continues to deliver a balanced budget each year, by continually improving our efficiency and reducing lost clinical time.

• We co-design with partners the emerging commissioning model for our service, as the NHS moves to Integrated Care Systems.

• Lessons are learned from the pandemic, which have supported efficiency, such as remote working, use of technology and reduce building use.

• Our staff feel engaged in our investment decisions, our financial performance and ideas for efficiency and productivity.

Objective 4 – innovation and transformation

• We deliver on the NHS ambition of an 80% reduction in carbon emissions by 2028-2030 and move to carbon neutral by 2040.

• We provide the technological capability to our front line so clinical teams can connect remotely the services our patients require, from interpreting to specialist advice.

• We can measure how much activity automated technology can now take up, eg through chat bot use in 111 as an example

Objective 5 - Collaboration and Engagement

• That we continue to appropriately improve upon non conveyance rates to Emergency Departments, through better co-ordination of services between primary, secondary and community base services

• That we continue to provide regional services such as 111 and patient transport, beyond our statutory 999 responsibilities

• That we build our relationships at 'place level' through our regional ambulance hubs

• That we contribute to reducing health inequalities and social value

• Where possible, we support new workforce models which require collaboration across organisations and sectors.

T**he Strategic context one year on when sifted through our five strategic objectives**

The table below summarises the current strategic context when sifted through our five strategic objectives.

It is not an exhaustive list, but a range of external and internal issues, risks and challenges which the board should consider (amongst others that may arise in discussion) as part of reviewing our current set of strategic priorities.

Safety, Quality and Excellence	**A Great place to work**	**Effective Planning and Use of Resources**	**Innovation and Transformation**	**Collaboration and Engagement**
Operational delivery very different, missing the majority of	Staff survey results have deteriorated	Payment by Results model gone, therefore no assured	Constraints in capital likely to threaten investment in green / climate	Stakeholder engagement survey 2 shows progress on "what are

our response time targets		income against activity growth	improvement and technology – what do we prioritise?	WMAS like to work with"
BAF risk of 25 x2 for one year now, Serious Incident numbers are rising sharply, we are also receiving more complaints (and compliments) – SIs not all about poor response times	50% of 999 workforce has been with WMAS for <5 years, we are loosing increasing numbers of our most experienced clinicians	No direct re-imbursement for lost hours – if in place for 2022/23 would equate to c£50m	Roll out of Ipads completed, what tech led benefits can we achieve?	Escalation of UEC crisis into national media did cause relationship damage in some quarters (praise in others)
Care integration Vs Board decision on 111. Considerable progress on integration of alternative care pathways	Attrition is rising (c15 paramedics were leaving per month last year, now c25) – losing senior clinicians into advanced practice in other sectors High attrition in IUEC	Capital tied into the ICS position, competing against priorities for other trusts. Implications for our plans on estates, fleet and tech investment	Opportunities for AI to reduce current workload across all areas of the organisation?	Evolving, positive approach to ICB engagement
Clinical experience reducing through demographic shift in workforce + reduce on the job clinical	Clinical model remains the same but are the needs of our patients changing?	Britain heading towards austerity, which will again affect the NHS in addition to our staff facing a cost of living crisis	Currently very low levels of backlog maintenance, maintaining this increasingly challenged,	Visibility and engagement with our own staff

contacts – triangulating in growth of SIs relating to clinical practice			linked to capital availability.	
Research / public health and reducing health inequalities – an NHS priority, now not a Government one	Hybrid working arrangements with other providers growing providing new opportunities	Revenue growth will clearly constrain whilst we experience pressure to deliver more		Regulation changing, accountability through the Integrated Care Board first, Oversight Framework also being updated WMAS moved to Segmentation level 2 due to response time challenges on the back of handover delays.
Strong relationships with Higher Education and linked Research bodies	For the first time can no longer recruit to meet attrition and growth in activity for the first time	Productivity is a major challenge, from seeing 6-8 patients per ambulance shift, now down to c2-3 and c25% of calls now being duplicate 'where is my ambulance' type calls.		
	2022/23 a year which will likely see industrial action	Delivering successive years of cost		

		improvement becoming harder		

The plan for November Board Strategy Session

The outline below is a proposed way to review the current organisational strategy:

1. Reflection on the year just gone, our current strategy and the criteria we agreed we would use to measure success
2. Review the drivers for change, by strategic objective and assess to what extent do these effect our organisational vision and strategic objectives?
3. In reviewing the drivers for change underneath each strategic objective, assess which of our current strategic priorities need to change to reflect current and emerging risks and opportunities, objective by objective.
4. Based on discussion, updated organisational strategy to be brought back to the board for approval, communication both externally and internally on the updated approach.

Conclusion and recommendations to the Board

The paper sets out much of detail the board will require to make a judgement on changes to our strategic priorities in the coming 12-36 months, in sharing it in advance of November, it is hoped it will inform the required debate in advance of the session itself.

The Board are asked to:

1. Note the content of the briefing
2. Provide feedback on the proposal in advance of Novembers session so it can be considered for the development session.

Vivek Khashu

Strategy and Engagement Director

October 2022

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10b MONTH: OCTOBER 2022 PAPER NUMBER: 07b

Freedom to Speak Up	
Sponsoring Director	Strategy and Engagement Director
Author(s)/Presenter	Head of Strategic Planning / FTSU Guardian / Strategy and Engagement Director
Purpose	Information
Previously Considered by	Learning Review Group Quality Governance Committee
Report Approved By	Head of Strategic Planning / FTSU Guardian Strategy and Engagement Director

Executive Summary

The attached paper provides assurance to the Board of Directors that FTSU is being progressed appropriately and effectively in the Trust through the work and activities of the Guardian supported by the Executive Director (ED) and Non-Executive Director (NED) FTSU Leads, and Ambassadors. Reporting arrangements are detailed.

Related Trust Objectives/ National Standards	Safety, Quality ad Excellence; A great place to work for all.
Risk and Assurance	The report to Learning Review Group and Quality Governance Committee includes an overview of every concern received, without divulging any characteristic that might identify an individual. This provides the opportunity to triangulate information and to examine trends and themes for mitigation of risk and added assurance.
Legal implications/ regulatory requirements	The Care Quality Commission inspects the Trust's FTSU arrangements and interviews the Guardian and Board members under the Well Led domain. The National Guardian's Office provides best practice guidance and offers support to both Guardians and staff who wish to speak up.
Financial Implications	A small amount of time is required for FTSU Ambassadors to be released for development.
Workforce Implications	The Guardian does not have any administrative assistance to support this role. Additionally, this role is carried out alongside a substantive role. This arrangement will be regularly reviewed to limit the risk that the National Guardian's Office expectations or the substantive role cannot be fully delivered.

Communications Issues	The Trust's "paperless" policy has been expanded to include all noticeboards. This impacts on the ability of the Guardian and the FTSU Ambassadors to effectively promote FTSU. The posters are currently being updated and will be streamed to the television screens on all Trust sites. The Guardian and Ambassadors will be discussing other ideas and opportunities to promote the service.
Diversity & Inclusivity Implications	There are no identified Equality and Diversity implications.
Quality Impact Assessment	Not required at this time.
Data Quality	Data is collated locally and saved on Trust SharePoint, which meets the requirements of the National Guardian's Office. The data is available to the Guardian and to the Executive Lead. To ensure quality of responses and reports, and also provide resilience in case of absence, each FTSU concern is discussed in detail (confidentially) between the Guardian and Executive Lead.
Action required	
The Board of Directors is asked to note the report.	

NHS
West Midlands
Ambulance Service
University NHS Foundation Trust

Freedom to Speak Up

REPORT TO THE BOARD OF DIRECTORS OCTOBER 2022

PIPPA WALL - HEAD OF STRATEGIC PLANNING AND FTSU GUARDIAN
VIVEK KHASHU – STRATEGY AND ENGAGEMENT DIRECTOR

Freedom to speak up

Contents

Introduction

This report provides assurance that policy, processes, activity and reporting are fit for purpose, regularly reviewed and that progress is being made.

FTSU Guardian

The current Guardian, Pippa Wall, Head of Strategic Planning (the author), has been in post since 1 March 2022.

The Guardian is a member of the West Midlands Guardian Network, and the National Ambulance Network (NAN), ensuring that good practice is followed and shared.

FTSU Ambassadors

Currently there are 36 ambassadors, a decrease of 4 since July covering the region, however, a promotional campaign is currently underway, and a further 18 people have expressed an interest and are being progressed through the governance and induction process.

Once these are complete, there will be at least one Ambassador on every one of the Trust's sites. Once these applications have been administered, the diversity of the Ambassador team will be refreshed and reported through this report in January. Up until July, Ambassadors from minatory ethnic backgrounds reflected 22% of the total group.

The Guardian is keeping in touch with ambassadors regularly to ensure they are supported. All Ambassadors were invited to an informal meeting on 20 July, which was also attended by the Chief Executive and Chairman. As part of Speak Up Month, all Ambassadors will be invited to one of two pizza evenings at the end of the month. This will also serve as a welcome evening for our new Ambassadors.

All Ambassadors will be requested to complete the National Guardian's Office online Training programme Speak Up, Listen Up, Follow Up. This will be requested to be completed by March 2023, prior to roll out to the rest of the Trust as part of the new year's mandatory training requirement.

Policy

The Raising Concerns (Whistleblowing) Policy was created in accordance with the National Guardian's Office (NGO) standard, and was approved in August 2017. The policy has since been reviewed regularly. In 2022, the NGO has published a new national policy with the expectations that Trusts will adopt this policy. A draft has been completed and shared with Executive Management Board, Board of Directors and Executive Partnership Group. The document will be finalised and shared with Policy Group members on 3 November 2022.

Vision and Strategy

A Vision and Strategy were agreed by the Board of Directors in September 2018 and reviewed at the Board Strategy Day on 26th February 2020 and was again reviewed on 28th April 2021. The strategy is currently under review according to the new national policy. The document is currently in draft form and will be finalised and submitted for approval and implementation once the Policy has been approved by Policy Group.

Promotion

Freedom to Speak Up

The Freedom to Speak up (Whistleblowing) policy aims to give staff the assurance that concerns will be listened to and to outline a fair and easy process for staff to raise concerns at work.

Freedom to Speak Up

FTSU SharePoint Site

Reporting Arrangements

1. National Guardian's Office

Quarterly reports are submitted detailing numbers and types of concerns raised, and feedback received.

2. Board of Directors

Bi-annual reports providing assurance and detailing trends, numbers and types of concerns raised.

3. Executive Management Board

Bi-annual reports providing assurance, and detailing trends, numbers, locations/areas and types of concerns raised, and feedback received. Recommendations will be made for action. This report is the most detailed provided and should therefore be treated as confidential.

4. People Committee

Bi-annual reports providing assurance, and detailing trends, numbers, and types of concerns raised and feedback received.

5. Learning Review Group

Quarterly report providing detail of trends, numbers and types of concerns raised, feedback received, and making recommendations for learning.

6. Care Quality Commission (CQC)

FTSU is part of the CQC Well Led Domain and the Guardian will be interviewed at inspections. CQC may also request access to data.

7. NHS Improvement (NHSI) Board Review Tool

NHSI work jointly with the CQC in monitoring FTSU. On 2nd May 2018 NHSI wrote to CEOs with details of a guide they had published outlining their expectations of Boards about FTSU.

Part of this was a self-review that all Boards were expected to complete. WMAS Board finalised this self-review on 26th September 2018, and has reviewed the document periodically since.

The document is now due for review and will form part of the Board's Strategy discussion in November.

National Guardian Office Speak Up Review

There is an ongoing speak up review of the Ambulance Sector. The National Guardian's Office collected information from every Trust as part of phase 1 of the review. Phase 2 is now underway, which comprised:

Focus groups:

- All workers Bands 2 – 5
- All workers bands 6 – 7
- All ethnic minority workers
- All workers

Interviews

- One to One with Executive Lead,
- One to One with Non Executive Lead
- One to One with FTSU Guardian
- Joint with Executive Lead and FTSU Guardian

The final report is expected by December 2022, following which a full report will be presented and an action plan developed accordingly.

Speak Up Month

October is Speak Up Month. The NGO has created the following themes for this year's campaigns:

- Week 1 - Speak Up for Safety
- Week 2 - Speak Up for Civility
- Week 3 - Speak Up for Inclusion
- Week 4 - Speak Up for Everyone

The Chief Executive recorded a video to launch the campaign and an article is being published in each week's staff briefings throughout the month, to coincide with these themes. Due to time and resources being limited, along with the operational pressures facing the Trust, other promotional activities have been limited this year. Further ideas will be generated in advance of next year's campaign.

WMAS Concerns Raised April to September 2022

Nine concerns were raised during this period. One was not applicable to FTSU, but is recorded for transparency. Two were submitted as separate concerns, but related to the same issue, site and individual. A summary of these cases is as follows:

Ref	Nature of Concern	Service Area	Actions Taken	Resolution / Status	Status
22-074	Recruitment	E&U	Passed to Operations Director, who reviewed and responded	No change in outcome, but situation has been explained in full. Case to be closed	Closed
22-075	Staff welfare	E&U	Several attempts made to discuss in more detail, but no responses received. Out of concern for member of staff, discussion in confidence with HR.	Further response sent to staff member.	Closed
22-076	Behaviour / Culture	E&U	Communication with relevant senior manager, who reviewed historical events, and discussed with staff member.	Plan of action agreed. Discussed with staff member who was happy to close.	Closed
22-077	Staff supervision	PTS	Options discussed for progressing concerns discussed with Ambassador who in turn, discussed with staff member.	Agreed to close for now and will re-open should they wish to continue.	Closed
22-078	Culture / Leadership	E&U	Issues and processes pertaining to the individual discussed. Discussion with People Director who provided significant update on historical processes and outcomes.	Agreed that there was nothing further to answer, however further communication has been received by the Non Executive Director.	Open
22-079	CQC have received a concern from an anonymous whistle blower concerning culture and excessive hours at a hub	E&U	Whilst not raised as an FTSU concern to WMAS by the CQC. An investigation will be carried out and FTSU concerns at the hub will not be dealt with in isolation to this.	Not applicable to FTSU.	Closed

22-080	Safeguarding concern for family of member of staff	IEUC	Advice taken from Head of Safeguarding, confirming that member of staff should raise concerns directly through local authority's online portal, advice and support offered to the ambassador who raised the query and also directly to the colleague concerned.	Staff member advised of process	Closed
22-081	Concerns about management culture at a one of the Trust's sites	PTS	Senior Manager has been actively supporting and coaching the named Manager. Plan currently being developed with OD	Support provided to manager in question	Open
22-082	Concerns about management culture at one of the Trust's sties	PTS	Senior Manager has been actively supporting and coaching the named Manager. Plan currently being developed with OD	Support provided to manager in question	Open

Feedback Received

The following anonymised feedback has been received this week, in relation to an open concern. This concern was received in October, and is therefore not included in the above. This will form part of the next quarterly uipdate.

From:
Sent: 17 October 2022 08:10
To: Vivek Khashu <vivek.khashu@wmas.nhs.uk>; Pippa Wall <pippa.wall@wmas.nhs.uk>
Cc:
Subject: Re: FTSU 22-084 Record of Concern
Sensitivity: Confidential

Good morning,
Sorry for the delay in reply, I was away over the weekend. Just wanted to thank you all for the support and thank you for keeping me updated on what is happening.

Vivek, thank you for the birthday wishes and thank you for taking my concern seriously and helping it reach the correct people.

Without the three of you my concerns would not have been heard so thank you all very much, have a good week 🙂

Further planned developments

The next bi-annual report will include a breakdown concerns by ethnicity, gender and age, this will be subject to those raising concerns giving permission and also in the context of a relatively low numbers of colleagues speaking out coming through. This is to further support the triangulation of FTSU concerns with things like the staff survey and WRES data.

The Triumvirate of Lisa Bayliss-Pratt, Non Executive Lead, Pippa Wall as Guardian and Vivek Khashu as Executive Lead are also in the process of reviewing the reporting arrangements going forwards. Any changes to the established arrangements will be brought back to the relevant sub committees of the Board and the Board of Directors itself.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10c MONTH: October 2022 PAPER NUMBER: 07c

ICS and WMAS Hub Engagement by WMAS Directors

Sponsoring Director	Vivek Khashu – Strategy and Engagement Director
Author(s)/Presenter	Vivek Khashu – Strategy and Engagement Director
Purpose	To update the Board on the status of engagement arrangements with Integrated Care Systems (ICSs), AE Delivery Boards (AEDBs) and our sites / hubs considering changes to the membership of the Board of Directors.
Previously Considered by	EMB and Board in 2020/21 EMB May 2022 EMB October 2022
Report Approved By	Vivek Khashu – Strategy and Engagement Director

Executive Summary

WMAS covers six Integrated Care Systems, a greater number of A&E Delivery Boards and a larger still number of sites, all requiring engagement and input from WMAS senior leadership team.

This paper sets out the current arrangements which have previously been agreed, it also sets out proposed updated arrangements following changes to our own leadership team.

It should be noted there are regional professional forums to, for example the regional HR Directors network and the Regional Directors of Finance Network, these arrangements do not cut across such arrangements.

Engagement across systems and with our own team has never been more important, visibility both internally and externally with our partners and of course our own staff is of paramount importance.

Related Trust Objectives/ National Standards	SO5 – “collaboration and engagement”
Risk and Assurance	This paper sets out how this Board will engage with our system partners and through the Hub Links with our staff.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10c MONTH: October 2022 PAPER NUMBER: 07c

Legal implications/ regulatory requirements	No legal advice has been sought as part of the preparing this paper.
Financial Implications	NA
Workforce & Training Implications	N/A
Communications Issues	Updates to internal or external engagement arrangements in terms of the people who are doing it from WMAS perspective will require communicating out to our Hubs.
Diversity & Inclusivity Implications	NA
Quality Impact Assessment	NA
Data Quality	NA

Action required

1. Board to approve the set of ICS and AE Delivery Board links
2. Board to receive update on nominated Director hub buddy links

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 10c MONTH: October 2022 PAPER NUMBER: 07c

Introduction

System level governance and architecture changed considerably from July 2022 onwards, with the go live of Integrated Care Boards (ICB) forming within ICSs, our own senior leadership team within WMAS has changed to, with a new Non Executive Joining the WMAS Board in October 2022 and a new Acting Director of Finance.

Furthermore, with the resumption of 'normal' working arrangements, it is also time to re-affirm the Director buddy arrangements in place for our Hubs.

2.0 Summary

Since May 2022, WMAS has been working with 6 ICSs, within those ICSs are several sub committees which fall out of them, the agreed arrangements are noted in the table below.

ICS	WMAS Link Director	A&E Delivery Boards requiring attendance	Senior operational support link
Stoke and Staffs	Mark Docherty	• Staffordshire	Nathan Hudson
Coventry and Warks	Pippa Wall	• Cov and Warks	Craig Cooke
Black Country	Vivek Khashu	• Dudley • Walsall • Wolves • Sandwell and West Birmingham	Jeremy Brown
Bham and Solihull	Vivek Khashu	• Bham and Solihull	None required
Shropshire	Mark Doherty	• Shropshire	Nick Henry
Herefordshire and Worcestershire	Vivek Khashu	• Worcestershire • Herefordshire	Michelle Brotherton

Whilst formally recognised, in reality there has not been a need to call upon the "operational support links in any meaningful way. However, a degree of matrix support has been required, for example involving the Director of Nursing in changes to clinical pathways, or the IUEC Director on integration of community colleagues within the Clinical Validation Team :

Guiding Principles behind the changes made in 2020 and updates in 2022 are still recommended going forwards:

- WMAS Director of Nursing and Clinical Commissioning should be focussed towards the systems which we believe to be in greatest distress on Urgency and Emergency Care, hence the allocation of Shropshire and Staffordshire ICSs and A&E delivery boards.

- Strategy and Engagement Director has a key role in developing relationships and is also responsible for feeding back to the Board on developments within systems, so taking on several ICSs supports that responsibility. The Strategy and Engagement team will lead the relationships with four of our six systems, with the remaining two being looked after by the Director of Nursing and Clinical Commissioning, which will further support the ability to maintain a 'consolidated view'
- The Strategy and Engagement Director has taken the Black Country and Herefordshire and Worcestershire ICSs as they have the greatest number of A&E Delivery Boards, a key forum of engagement which ideally benefits from in-person engagement.
- Senior Operational links are 'greyed out', as they are not called upon.
- It is recommended that Pippa Wall remains the lead for C&W ICS, Pippa has a long-standing relationship with that system spanning years, it also poses the least patient safety risk to WMAS out of all six, the Director of Nursing and Clinical Commissioning has also agreed to support Pippa in her work in that system, should any be required.
- An annual review of these arrangements should be undertaken (or more frequently if required), so the right level of engagement, especially around patient safety concerns or risks can be maintained, should the current position change.

In addition to our links with ICSs and AEDBs, the Board of Directors has already approved the table set out below, which highlights which Directors and Non-Executives will buddy with which hub sites

The currently agreed links are set out below

<table>
<tr><th>No</th><th>Site</th><th>Director</th><th>Non Executive Director</th></tr>
<tr><td></td><td colspan="3">Staffordshire</td></tr>
<tr><td>1</td><td>Stoke</td><td rowspan="3">Stoke – Mark Docherty
Stafford and Lichfield – Jeremy Brown</td><td rowspan="3">Wendy Farrington-Chadd</td></tr>
<tr><td>2</td><td>Stafford</td></tr>
<tr><td>3</td><td>Lichfield</td></tr>
<tr><td>4</td><td colspan="3">West Mercia</td></tr>
<tr><td>5</td><td>Worcester</td><td rowspan="5">Worcester, Bromsgrove and Hereford – Michelle Brotherton

Shrewsbury and Donnington – Mark Docherty</td><td rowspan="5">Mushtaq Khan</td></tr>
<tr><td>6</td><td>Bromsgrove</td></tr>
<tr><td>7</td><td>Hereford</td></tr>
<tr><td>8</td><td>Shrewsbury</td></tr>
<tr><td>9</td><td>Donnington</td></tr>
<tr><td>10</td><td colspan="3">Coventry & Warwickshire</td></tr>
<tr><td>11</td><td>Coventry</td><td rowspan="4">Craig Cooke</td><td rowspan="4">Lisa Bayliss Pratt</td></tr>
<tr><td>12</td><td>Warwick</td></tr>
<tr><td>13</td><td>Coventry PTS</td></tr>
<tr><td>14</td><td>Warwick PTS</td></tr>
<tr><td>15</td><td colspan="3">Birmingham</td></tr>
</table>

16	Erdington	Vivek Khashu	Narinder Kooner
17	Hollymoor		
18	Birmingham PTS		
19	Black Country		
20	Dudley	Nathan Hudson	Mohammed Fessal
21	Willenhall		
22	West Bromwich		
23	Black Country PTS		
24	Other sites		
11	Cheshire PTS IUEC and MP Academy Anchor Brook (until move to Oldbury Hub)	Carla Beechey	Chairman

However, with changes to the Board of Directors, a small number of updates are proposed, they are set out in the table below

No	Site	Director	Non Executive Director
	Staffordshire		
25	Stoke	Jeremy Brown	Julie Jasper
26	Stafford		
27	Lichfield		
28	**West Mercia**		
29	Worcester	Worcester, Bromsgrove and Hereford – Michelle Brotherton Shrewsbury and Donnington – Paul Jarvis	Mushtaq Khan
30	Bromsgrove		
31	Hereford		
32	Shrewsbury		
33	Donnington		
34	Coventry & Warwickshire		
35	Coventry	Mark Docherty	Lisa Bayliss Pratt
36	Warwick		
37	Coventry PTS		
38	Warwick PTS		
39	Birmingham		
40	Erdington	Vivek Khashu	Narinder Kooner
41	Hollymoor		
42	Birmingham PTS		
43	Black Country		
44	Dudley	Nathan Hudson	Mohammed Fessal
45	Willenhall		
46	West Bromwich		
47	Black Country PTS		

48	Other sites		
11	Cheshire PTS IUEC and MP Academy Oldbury	Cheshire PTS and Oldbury - Carla Beechey MP and IUEC - Murray MacGregor	Ian Cumming Wendy Farrington-Chadd

What to do with feedback following visits?

Directors may well receive feedback on the visits, concerns and indeed areas of good practice or recognition. Directors picking up feedback should share it with the relevant Director based on the location of the feedback, also with the Trust Secretary. The Trust Secretary will liaise with the Communications team.

Where follow up action is required, the Director who has been notified by the 'Hub Buddy' must ensure feedback is provided to those offering the feedback and with the Trust secretary also informed to.

Recommendation

- For the Board to approve the set of ICS and AE Delivery Board links
- For the Board to receive the updated Director hub buddy links and approve

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11 MONTH October 2022 PAPER NUMBER 08

Title	**Governance**
Sponsoring Director	The Chairman
Author	Governance Director and Trust Secretary
Purpose	1. To remind the Board of the five themes relating to the Governance model approved by the Board. 2. To review and approve the Committee Structure and to review and approve the Board Committees Terms of Reference as attached, including EMB Terms of Reference. 3. To receive an update on the proposed NHSE Code of Governance and the implications for the Trust and proposed changes to the Constitution. 4. To note that that the NHSE have commenced a consultation on changes to the NHS Provider licence that correlates to the changes to the Code of Governance.
Previously Considered by	Governance review and review of committees previously approved: Board of Directors – July 2020/October 2020 Board of Directors – October 2021 Board of Directors – May 2022 Current review by Committees: Executive Management Board -19 April 2022 & 18 October 2022 Trustee Committee - 30 March 2022 Remuneration & Nominations Committee -6 April 2022 Audit Committee -14 March 2022 People Committee - 28 February 2022 Performance Committee - 22 February 2022 & 26 April 2022 Quality Governance Committee - 18 May 2022 & 20 October Capital & Revenue Investment Advisory Group (CRIAG) - Approved by EMB on 22 March 2022
Report approved by:	The Chairman / Interim Organisational Assurance Director

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11 MONTH October 2022 PAPER NUMBER 08

Summary
The attached report is in four parts.

1. Governance Model

   When I took on the role of Chairman on 1 April 2020 I asked the Board to agree a governance model that is based around five key themes. These were established following my initial discussions with colleagues on amongst other things the governance of the Trust. As you are aware the Council of Governors have agreed to appoint me as Chairman for a further four years from 1 April 2023 it is, therefore timely to remind ourselves of the themes which are set out in the attached report.

2. Committee Structure and Terms of Reference

   The Committee structure is attached for your review and approval. It is now timely to review the Terms of Reference the Board Committees and the Executive Management Board. The Terms of Reference have been reviewed in the light of the review of Business Case review and also the content of the Assurance Map developed by the internal audit. Rather than present documents with tracked changes which can be difficult to read the amendments/changes to the Terms of Reference have been documented within the report.

3. Draft NHSE Code of Governance

   A draft Code of governance for NHS providers was issued by NHS England (NHSE) on 27 May 2022. The new code will replace the NHS Foundation Trust Code of Governance which was last updated in 2014. For the first time the code will apply to all trusts i.e. both NHS Trusts and NHS Foundation Trusts. The draft Code does not make enormous changes, and the report provides an overview of the content of the code and its requirements, with a focus on what's new or different, and includes brief summaries of its general provisions. It is proposed that the Constitution is reviewed and varied in line with the revised Code of Governance.

4. To note the proposed amendments to the NHS Provider Licence Conditions that promote systems wide working and also promoting the NHS Triple aim of:
   - Improving the patient experience of care (including quality and satisfaction)
   - Improving the health of populations;
   - Reducing the per capita cost of health care

Related Trust Objectives/ National Standards	The Board has the key role of formulating strategy and then holding the Trust to account for delivery of the strategy. In formulating its strategy the Board should seek the views of the Council of Governors who in turn should engage with its stakeholders namely the public, staff and key partners This paper clarifies the role of the Board and its committees in undertaking the above duties.
Risk and Assurance	The Trust are required to remain compliant with its licence and CQC registration and a strong governance model is crucial to retaining our Licence and Registration.
Legal implications/regulatory requirements	Legal advice has not been sought in relation to any matters within this report.
Financial implications	Financial Governance forms part of the Terms of Reference of the Performance Committee and the Audit Committee.
Workforce & Training Implications	Workforce are invited to attend meetings of the Board of Directors and its committees. The establishment of the People Committee has further strengthened this area in terms of governance. .
Communications Issues	The salient matters considered at meetings of the Board of Directors and the Council of Governors are disseminated if appropriate within the Trust through the Weekly Brief. Members of the public and the press are welcome to attend public Board and Council meetings. The meeting dates and the papers for the public meeting are available on the Trust website.
Equality and Diversity Implications	Equity, Diversity and Inclusivity and the Trusts duties under the Public Sector Equality Duty are included within the Terms of Reference for the Board and its Committees.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11 MONTH October 2022 PAPER NUMBER 08

Quality Impact Assessment	Not applicable in relation to the content of this report
Data Quality	The documents referred to in this report are held by the Trust Secretary.

Recommendation:

1. To note the content of this report.

2. To confirm the five themes that underpins the Trust governance model pending review in line with the revised Code of Governance.

3. To approve the Committee structure attached. (Appendix 1)

4. To approve the Terms of Reference for the:
    1. The Executive Management Board (Appendix 2)
    2. The Audit Committee (Appendix 3)
    3. The Remuneration & Nomination Committee (Appendix 4)
    4. The Performance Committee (Appendix 5)
    5. The Quality Governance Committee (Appendix 6)
    6. The People Committee (Appendix 7)
    7. The Trustee Committee (Appendix 8)

5. To receive the report on the draft Code of Governance and to agree that when the final version of the Code of Governance is published to receive a further report on the proposed variations to the Trusts Constitution and appropriate Terms of Reference to maintain compliance.

6. To note the NHSE consultation on changes to the NHS Provider Licence Conditions

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM 11 MONTH October 2022 PAPER NUMBER 08

Governance around five key themes

1. The Board at its meeting in July 2020 approved a governance model that is based around five key themes. These were:

    a. Strategy - The strategic direction of the organisation has to be owned and agreed by the board as a whole and that formulating strategy is therefore a whole-board activity.
    b. Streamlining - The time spent in Board and Committee meetings needs to have better focus so that it can be more productive with our time.
    c. Structure of Committees - In terms of developing a more streamlined approach to the governance of the Trust as previously stated, it is appropriate for the Board to at least annually review its Committees and governance. The structure should maintain appropriate governance and assurance but not be overly bureaucratic. The Committee structure is attached for review by the Board.
    d. Succession (and resilience) - We have some exceptionally talented people in WMAS. Which provides us with an opportunity to develop our 'talent pipeline' so that ideally we have at least one credible candidate in-house for every senior job that becomes available. This should be a key role for the people committee to give some thought to how we can strengthen our talent planning across the organisation and how non-executives could add value in this area.
    e. Stakeholder engagement – WMAS has a reasonable track record in engaging with key stakeholders; this will be a good base to respond to the changing health care system and structure. In this changing landscape we will need to develop even stronger relationships. The draft Code of Governance includes the requirement for boards of directors to assess the trust's "***contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships***" as part of its assessment of its performance. In addition, as a University Trust we should also continue to develop strategic alliances where these can help in our objective to remain a world leading provider.

The Board is requested to review these key themes.

2. The revised Committee Structure and Terms of Reference

Attached as Appendix 1 is the committee structure, and the Board is requested to approve the content of the structure including the Chairman and Deputy Chairman lists. The Terms of Reference for each of the Board Committees and EMB are attached as Appendix 2 to 8 and for approval. The Terms of Reference have been revised where appropriate in line with the developing work with PwC on the

Business Case Development and also the Assurance Map developed by Internal Audit, and review by the Interim Organisational Assurance Director.

3. Revised NHSE Code of Governance

A draft Code of governance for NHS providers was issued by NHS England (NHSE) on 27 May 2022. The new code when published will replace the NHS Foundation trust code of governance which was last updated in 2014. For the first time, the code will apply to all trusts i.e. both NHS Trusts and NHS Foundation Trusts. The new Code is not a complete rewrite of the current code. It is recognising the changing environment within which provider trusts operate. Overall, the Draft Code of Governance tends to see a greater blending of the governance of NHS Trusts and NHS Foundation Trusts by contributing to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships. It is therefore, when finally published that the Constitution and the Terms of Reference of the Board of Directors will need to be varied in line with the revised Code of Governance. The Interim Organisational Assurance Director and also the Trust Secretary will bring the varied Constitution and Terms of Reference where required to a meeting of the Board when the final version of the Code is published.

The summary below sets out the five sections which the code describes as the principles of good governance and the provisions (based on the principles). Boards of Director and Councils of Governor must ensure that that they are meeting the governance requirements as set out in the 2006 Act as amended by the 2012 Act and our provider licence. If the obligations in the Code are not mandatory, then comply or explain applies. This requires the Trust to set out in the Annual Report if it has departed from the Code with an “explanation”.

The proposed modifications to the Provider Licence upon which the NHSE are currently consulting aim to further promote and support system working and patient-centred care, in line with national policy expectations and NHS objectives, in other words a common duty across the system. A summary of the proposed changes to the Provider Licence are set out later in this report.

The Draft Code of Governance is broken down into the following sections:

Section A: Board leadership and purpose

The principles are updated to align with current NHS policy. They stress the importance of an effective, diverse and entrepreneurial board which sets the trust’s vision, values and strategy. It should do so with regard to the triple aim duty of better health and wellbeing for everyone, better quality services, and the sustainable use of resources. **There is now also specific reference to the trust’s role in reducing health inequalities, assessing and**

monitoring culture, and investing in, rewarding and promoting the wellbeing of its workforce.

Section B: Division of responsibilities

The section notes the need for clear division between the leadership of the board and executive leadership of the trust's operations. The board's collective responsibility for the performance of the trust and infrastructure and resources needed to function is specified, along with the role of the non-executives and their need for sufficient time to meet their board responsibilities. The Board is collectively responsible for the performance of the Trust.

Section C: Composition, succession and evaluation

There is a new requirement for the board to have published plans for succession in place and will also be required to publish "**how the board and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher" and consideration of diversity is now included within the annual board evaluation**.

The code also strengthens the fit and proper persons requirement from "abide by Care Quality Commission (CQC) guidance" **to "have a policy for ensuring compliance"**.

In foundation trusts any extension of the chair's term beyond nine years should be agreed with NHSE.

Annual reporting on the work of the Remuneration and Nominations Committee includes the new provision to describe the trust's policy on diversity and inclusion including in relation to disability, reference to indicator nine of the NHS Workforce Race Equality Standard, and the gender balance of senior management and their direct reports. **Directors or governors involved in recruitment should receive training in equality, diversity and inclusion, including unconscious bias.**

For foundation trusts, the inclusion of the expectation to involve NHSE in advertising for director positions and on selection panels. It is stated that it is best practice to that on panels for both executive and non executive appointments there should be a representative of NHSE "and/or" a representative from a relevant ICB. If external recruitment consultancies are used instead, they should be identified in the annual report along with any connection they have with the trust or its directors.

There is new provision for trusts to set a lower threshold for a council of governors' vote to remove a governor from the council and the code describes the limited circumstances in which NHSE may act to remove a governor. In addition, "**foundation trust governors should be provided with information on ICS plans,**

decisions and delivery that directly affect the organisation and its patients". This provision will require amendment of the Constitution.

Section D: Audit, risk and internal control

This section sets out the principles around having independent and effective internal and external audit functions, and procedures for managing risk and determining long-term risk appetite. The Audit Committee should have a membership of at least three Non Executive Directors, but now **smaller trusts are now able to establish an audit committee of only two non-executives (the code does not define a small Trust.) The code extends the maximum external auditor contractual period for foundation trusts to ten years,** though it still recognises that audit services should usually be refreshed more frequently, and the requirement to include the value of external audit services in a trust's annual report has been removed.

The Chairman, Deputy Chairman nor the Senior Independent Director should not be Chair of the Audit Committee.

Section E: Remuneration

Section E covers suitable remuneration, pay, and benefit arrangements, including performance related pay and the role, responsibilities and composition of remuneration committees.

The principles now refer trusts to NHSE's pay frameworks for very senior managers and, for NHS trusts, Guidance on senior appointments in NHS trusts. The code states trusts should await notification and instruction from NHSE before implementing any cost of living increases and it now sets expectations for all trusts around adhering to the Chair and non-executive director remuneration structure. Executive director bonuses and incentives are now limited "to the lower of £17,500 or 10% of basic salary". Indeed the Code recommends that the Remuneration and Nominations Committee should link a proportion of executive directors remuneration to corporate and individual performance.

Director-level severance payments should be discussed with NHSE regional directors at the earliest opportunity.

Schedule A: Disclosure of corporate governance arrangements

The disclosures pull together the provisions from the commentary above, setting out the provisions that trusts should comply with or explain how alternative arrangements comply. The disclosures are broken down into sections depending on what trusts should do:

- provide a supporting explanation of compliance or explain non-compliance in the annual report

- "basic" comply or explain – where trusts are welcome but not required to provide statements of compliance but should explain where they have deviated from the code (most provisions fall into this category)
- provide information to the governors or make information available to members (FTs only).
- make information publicly available.

Appendices

A: The role of the trust secretary

The appointment/removal of a company secretary is now a matter for the whole board instead of the chair and chief executive

B: Council of governors and the role of the nominated lead governor

The role and responsibilities of councils in law does not change with the new act, and so there is very little to note here for foundation trusts save:

The description of councils of governors' duty to represent the interests of the "public at large" is fleshed out: "this includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS."

A new suggestion that the council may look at the nature of the trust's "collaboration with system partners" as an indicator of organisational performance

A clarification of the council's role in relation to approving significant transactions, mergers and acquisitions so that **"to withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken."** This was always the intention of their role in this.

Conclusions

Overall the Code of Governance as revised tends to see a greater blending of the governance of the NHS Trust and NHS Foundation Trusts to underpin collaborative working across the system.

Although the changes proposed are minimal in relation to the current Code of Governance, the changes proposed will require a review our Constitution and appropriate Terms of Reference when the Code is published. This will be done by the Interim Organisational Assurance Director and the Governance Director and Trust Secretary with a report to the next meeting of the Board of Directors setting out proposed changes to the Constitution and Terms of Reference to comply with the Code of Governance.

It is also proposed that given the duty to represent the population of the local system of which the trust is part and the whole population of England served by the wider NHS it is proposed that the Public Constituency which was based on the system in

place when we were authorised as a Foundation Trust should be varied to align with the ICBs in the region. The views of the Board of Directors are requested.

4. Proposed changes to the Provider Licence Conditions:

NHSE are currently consulting on changes to the provider licence condition to give effect to the duty on NHS service providers to collaborate. The proposed modifications to the Provider Licence include:

- New co-operation condition – outlining expectations on NHS trusts, FTs and NHS Controlled Providers on system working and co-operation to deliver core system objectives, which as stated above is a key aim of the Draft Code of Governance.
- New Triple Aim condition – reflecting expectations for NHS trusts, FTs and NHS Controlled Providers to collaborate in meeting the Triple Aim and health inequalities in their work. The Triple Aim is:
    - Improving the patient experience of care (including quality and satisfaction)
    - Improving the health of populations;
    - Reducing the per capita cost of health care
- New digital requirements – reflecting digital obligations to share information (subject to commercial considerations) through a new condition and an amendment to existing information governance condition.
- Amended Integrated Care condition – reframing the condition to encourage providers to actively participate in service integration and reduce inequalities.
- Amended Patient Choice condition – expanding the condition to reflect the importance of personalised care.
- Removing the Competition condition – reflecting the shift in healthcare priorities from competition to collaboration, and the removal of NHS England's statutory duty in relation to competition oversight.
- NHS England will continue to use reasonable evidence from disclosures made by the NHS foundation trust to determine whether intervention is required in compliance with the current Foundation Trust Licence Condition 4: Governance. The Board is reminded that each year it currently signs off on disclosures in terms of compliance with the NHS foundation trust licence. This includes the disclosures in the corporate governance statement, this should be based on the evidence presented such as the Going Concern statement and the Annual Governance statement. The proposed revised licence condition will if Implemented remove this requirement on the Board to self-certify via certificate and to produce a Corporate Governance Statement (FT4) each year. The effect of the latter change would mean FTs no longer report on future risks around compliance with governance standards. Assessments of past compliance with governance standards instead being solely captured

via the annual reporting processes as part of the Annual Governance Statement. This will reduce duplication in terms of reporting

Recommendations

1. To note the content of this report.
2. To confirm the five themes that underpins the Trust governance model pending review in line with the revised Code of Governance.
3. To approve the Committee structure attached. (Appendix 1)
4. To approve the Terms of Reference for the:

- The Executive Management Board (Appendix 2)
- The Audit Committee (Appendix 3)
- The Remuneration & Nomination Committee (Appendix 4)
- The Performance Committee (Appendix 5)
- The Quality Governance Committee (Appendix 6)
- The People Committee (appendix 7)

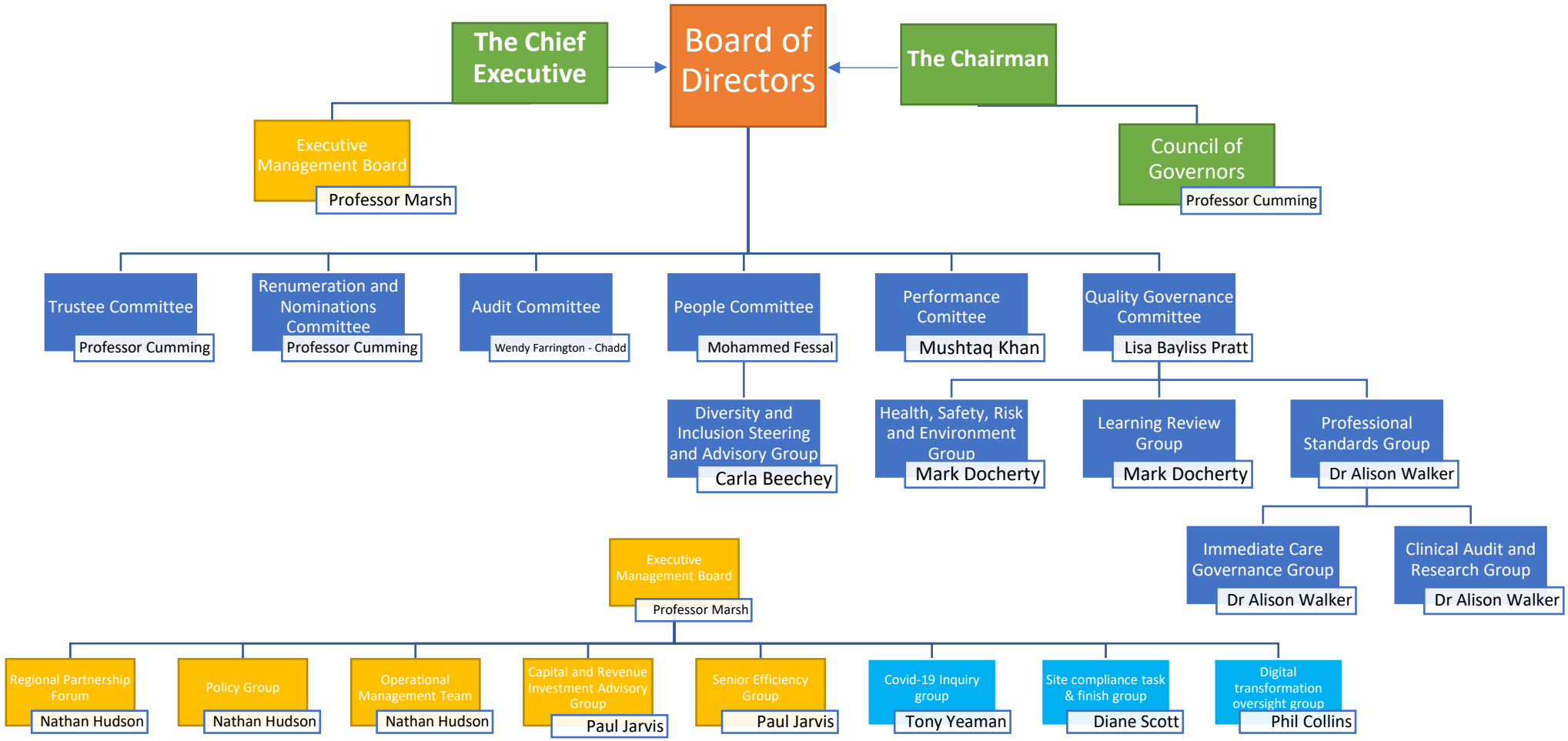
5. To receive the report on the draft Code of Governance and to agree that when the final version of the Code of Governance is published to receive a further report on the proposed variations to the Trusts Constitution and appropriate Terms of Reference to maintain compliance.

6. To note the NHSE consultation on changes to the NHS Provider Licence Conditions

Professor Ian Cumming OBE MSc FIBMS CSci FRCGP(hon)

Chairman - West Midlands Ambulance Service NHS University Trust

(October 2022)



Trust Committee structure v1.6 October 22

Committee	Chair	Deputy Chair	Secretarial support provided by
Executive Management Board	Professor Marsh	TBC	Karen Freeman
Council of Governors	Professor Cumming	Wendy Farrington-Chad	Suzie Wheaton
Trustee Committee	Professor Cumming	Wendy Farrington-Chad	Philip Higgins
Renumeration and Nominations Committee	Professor Cumming	Wendy Farrington-Chad	Philip Higgins
Audit Committee	Wendy Farrington-Chad	NED TBC	Donna Stevenson
People Committee	Mohammed Fessal	Lisa Bayliss Pratt	Dawn John
Performance Committee	Mushtaq Khan	Narinder Kooner	Donna Stevenson
Quality Governance Committee	Lisa Bayliss Pratt	Mohammed Fessal	Nicky Shaw
Diversity and Inclusion Steering and Advisory Group	Carla Beechey	Mohammed Ramzan	Dawn John
Health, Safety, Risk and Environment Group	Mark Docherty	Matt Brown	Nicky Shaw
Learning Review Group	Mark Docherty	Dr Alison Walker	Nicky Shaw
Professional Standards Group	Dr Alison Walker	Craig Cooke	Nicky Shaw
Immediate Care Governance Group	Dr Alison Walker	Aidan Brown	Nicky Shaw
Clinical Audit and Research Group	Dr Alison Walker	Andrew Rosser	Nicky Shaw
Regional Partnership Forum	Nathan Hudson	Carla Beechey	Dawn John
Policy Group	Nathan Hudson	Nick Henry	Aimee Dicken
Operational Management Team	Nathan Hudson	Michelle Brotherton	Sharon Hooper
Capital and Revenue Investment and Advisory Group	Paul Jarvis	TBC	Donna Stevenson
Senior Efficiency Group	Paul Jarvis	TBC	Donna Stevenson
Covid 19 Inquiry task & finish group	Tony Yeaman	TBC	TBC

WMAS Site compliance task and finish group	Diane Scott	Nick Pavard	TBC
Digital transformation oversight group	Phil Collins	Nick Henry	TBC

Key

Group	Colour
Board committee	
Executive committee	
Task & finish group	

Appendix 2

Terms of Reference for the Executive Management Board (Amendments in red font)

Contents

1 Role and Purpose

The Executive Management Board (EMB) is constituted by West Midlands Ambulance Service University NHS Foundation Trust (WMAS) Board of Directors (BoD), subject to amendment at future BoD meetings. It supports the BoD in shaping the culture, setting the direction and holding to account. EMB is required to comply with all extant WMAS standing orders and standing financial instructions and has no delegated powers other than those embodied in these Terms of Reference. Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained within the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.

EMB is authorised to consider all matters within its Terms of Reference and to seek any information it requires from any member of staff to discharge its responsibilities and all staff are required to cooperate with any request for information it requires.

As the executive arm of the BoD, it is responsible for the management of West Midlands Ambulance Service University NHS Foundation Trust and is the senior executive decision making body of the organisation.

The Chair of EMB will provide, as a scheduled item of business, written feedback for discussion at each confidential ordinary meeting of the BoD on an ‘assurance, exception and escalation’ basis for all business enacted at the most recent EMB meetings.

2 Membership

EMB shall comprise:
The Chief Executive Officer (Chair)
Communications Director
Emergency Services Operations Delivery Director
Director of Finance
Director of Nursing & Clinical Commissioning
Governance Director & Trust Secretary

Head of Emergency Planning (and Commonwealth Games Planning)
Head of Operational Information & Planning
Integrated Emergency & Urgent Care & Performance Director
Medical Director,
Non-Emergency Services Operations Delivery & Improvement Director
Operational Support Services Director
People Director
Strategy & Engagement Director

The proposed attendance of any other person must be notified to and agreed with the Chair of EMB in advance of the meeting. If the Chair is unable to attend a meeting, then a Chair will be nominated by the CEO for that meeting only.

Fully briefed deputies of sufficient seniority, understanding and authority to participate fully in the meeting may be required to attend in circumstances where non-attendance is unavoidable. Other members of staff may be requested to attend meetings.

A quorum will be four members to include the Chair or his nominated deputy.

3 Accountability

EMB is accountable to the WMAS Board of Directors. It will support the BoD in promoting the values of WMAS, support a positive culture throughout WMAS and adopt behaviours that exemplify the corporate culture, ensuring that constructive challenge is made as appropriate. EMB will develop proposals or priorities, business continuity and sustainability, risk mitigation, values and standards and lead the development of strategy. It will also ensure that relevant KPIs, milestones and timescales are developed as necessary and monitored for achievement and delivery.

4 Review arrangements

These terms of reference will be reviewed by EMB on an annual basis. The EMB Chair will ensure terms of reference are amended in light of any major changes in committee or Trust governance arrangements/requirements. EMB will self-assess its performance in accordance with WMAS BoD established protocols, including an annual performance report to the BoD.

5 Working methodology

The Chair of EMB is responsible for the setting of the meeting agenda, the effective running of EMB, sound leadership, ensuring that EMB works effectively and takes full account of key issues facing WMAS, ensuring timely delivery of BoD approved strategies, plans, policies and procedures.

The Private Secretary to the Chief Executive will be the secretary to EMB and will provide administrative support and advice. Duties will include agreement of agenda and required attendees with the Chair, together with the collation and timely distribution of associated documentation (5 days in advance) for the meeting, the taking of minutes by the Chief Executive's secretariat and the recording of action

plans of matters arising (ordinarily available to EMB members within three working days following each meeting) and maintenance of annual/forward cycles of business. Papers may only be tabled on an exceptional basis, and with the agreement of the Chair.

EMB meetings will be held not less than once per month, with additional meetings where necessary for the due discharge of its remit.

The timing of meetings will be as necessary to ensure the timely discharge of business by the WMAS BoD. Additional meetings may be arranged with the agreement of the Chair or on the instruction of the BoD.

EMB will direct, manage and hold to account the executive, in meeting agreed goals and objectives, satisfy itself on the integrity of financial, clinical, operational performance and other information provided, satisfy itself that financial, operational, clinical and quality performance, business cases and change management plans, controls and systems of risk management and mitigation are sound and applied with due diligence. Maintaining compliance with the terms of the Trust's licence and CQC registration

It will ensure adequate information is provided on a timely basis, with any areas of concern highlighted, and appropriate remedial/development plans provided in a suitable format to monitor the reporting of progress, performance and service sustainability.

The Chair of EMB will ensure that any sensitive, contentious, exceptional or urgent items are escalated as appropriate immediately following the meeting.

The business and input materials for each meeting will be planned and structured to facilitate the completion of scheduled business in a time span not exceeding three hours. For each scheduled item of business a planned time allowance will be agreed in advance with the Chair of EMB.

6 Duties and interrelationships

The principal duties of EMB are to receive and consider reports on matters material to the Trust detailing, in particular, information and action with respect to:

i. human resource matters
ii. operational performance
iii. patient experience, clinical quality and safety, including infection
iv. prevention and control
v. financial performance
vi. the identification and management of risk
vii. matters pertaining to the reputation of the Trust;
viii. strategic development

In particular:

Strategy

1) Deliver the objectives set out in the Trust strategic and business plans.
2) Develop and endorse Trust strategies and plans prior to Board approval

3) To receive and review appropriate analysis, assurance and option appraisal regarding strategic business development opportunities for submission to the board
4) Identify business development opportunities and ensure that these are explored to establish their relevance and fit with the Trust's overarching strategy.
5) To construct the Board's Strategy and Development sessions, ensuring that strategy agendas are compliant with Trust and regulatory requirements.
6) Organise and oversee periodic reviews of the Trust's overarching statements relating to vision and strategic objectives.

Governance

1) Maintain the Regulators conditions of licence and Registration as an NHS Healthcare Provider
2) Ensure risks are managed in accordance with the Risk Management Strategy to include:
    - Monitoring of 12 high and above risks and escalation of significant risks to the Board of Directors
    - Maintenance and updating of the Board Assurance Framework to ensure that it is contemporaneous
    - Any new risks or regrading to risks to the organisation
3) Review of any incidents or claims that could pose any adverse reputational risk, and/or significant unplanned costs.
4) Approving relevant policies on behalf of the Board
5) To facilitate a programme of engagement with other providers, and stakeholders as appropriate including (but not restricted to) Integrated Care Boards and Integrated Care Partnerships, local authorities, other emergency services, charities and educational establishments.
6) To review Freedom to Speak Up action plan and quarterly reports.
7) Quarterly review of Communications, media and Engagement including an annual review by the Board of Directors, but by exception the Chairman of EMB will report to the Board of Directors via his regular report.

Financial

1) Ensure delivery against the Board of Directors approved Capital and Revenue financial plans including the delivery of a Quality Impact assessed and also Equality Impact Assessed (EIA) Cost Improvement Programme (CIP).
2) Review & approve, as appropriate, all capital and revenue business cases in accordance with the Trust's Standing Financial Instructions (SFIs) and NHSEI Guidance Documents for capital and revenue schemes.
3) Agree 'significant' business cases prior to sharing with Resource Committee for escalation to the Board of Directors
4) Regular review of Commercial Contracted Services provided by the Trust.

Appendix 2

Operational

1) Advise the Trust on matters relating to the specification, procurement and use of clinical equipment for the West Midlands Ambulance Service University NHS Foundation Trust
2) Maintain Trust performance (operational, clinical & financial) against nationally set targets
3) To receive regular updates on Emergency Preparedness, Resilience and Response
4) To receive regular reports by exception from OMT in relation to the operational support service function including Estates, Fleet, Make Ready, Stores and Information Management Technology (IMT), this not an exclusive list.

People

1) Receive progress against the Action Plan developed arising from the Staff Survey results

Clinical & Quality

1) Ensure that actions required to embed the Clinical and Quality strategies are successfully completed
2) To make key decisions to improve patient care, safety and operational responses
3) Ensure that immediate care schemes are compliant with the requirements of Quality Governance as outlined in the CQC Essential Standards of Quality and Safety

Audit and Regulation

1) Maintain the Regulators conditions of licence and Registration as an NHS Healthcare Provider.
2) Ensure that an annual clinical audit programme and R&D programme is in place that they are completed to plan, that learning is identified and ownership of subsequent actions have been accepted and monitored to completion.
3) To receive, review and agree the annual internal Audit plan for submission to the Audit Committee
4) Ensure adherence to legislation and appropriate guidance relevant to the business of the Trust including Health & Safety, Equality, Information Governance & IM&T including the SIRO and Caldicott obligations, Employment, Road Safety, medicines management etc.
5) Ensure that Care Provision of the West Midlands Ambulance Service University NHS Foundation Trust is safe and compliant with the requirements of Care Quality Commission (CQC), Home Office, Medicines and Healthcare Regulatory Authority (MHRA) Guidance and current National and International Clinical Standards and any other relevant regulations, guidance and standards.

6) To gain assurance through OMT that the Trust's Business Continuity Plans are compliant and that the Chair of EMB report to the Board of Directors for the purpose of reassurance

In event of any ambiguity or concern regarding the role of EMB, its sustainability or relevance in light of any changing circumstance/anticipated/emerging issue or of its interrelationship with any other committee or working group of WMAS, this should be referred to the next BOD meeting for clarification and resolution.

7	**Delegated authority**

EMB delegated authority is as set out in WMAS Standing Financial Instructions.

8	**Key input documents**

- Trust Strategies and Plans
- Risk Register and Board Assurance Framework
- Financial Plans and Budgets
- The latest CQC Provider Report
- Appropriate Business Cases
- SIRO and Caldicott Report

9	**Inward reporting arrangements**

- Regional Partnership Forum
- Capital and Revenue Investment Advisory Group
- Operational Management Team
- Senior Efficiency Group
- Policy Group
- At times the EMB may approve additional task and finish Groups, which will be time limited to undertake a specific work stream.

The approved minutes of the above groups will be submitted to the next appropriate meeting of EMB. The Chair of each sub group, and also all members of the EMB on Board pillar committees/Groups e.g. Professional Standards Group to provide EMB with a short summary highlighting pertinent key issues and assurances after each meeting of the relevant Committee/Group.

In line with the agreed EMB schedule of business members will provide more detailed reports aligned with their portfolio responsibilities.

EMB Approval Date:

Board Approval Date:

Terms of reference of the Audit Committee

Contents

Appendices

1 Role and purpose

The NHS Act 2006 (Schedule 7) (As amended) requires the Board of Directors to have in place a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate

This Committee is therefore constituted as a standing committee of the Trust's Board of Directors ('the Board') pursuant to Schedule 7 of the NHS Act 2006. The Committees constitution and terms are as set out below, subject to amendment at future Board meetings. The Committee supports the Board in shaping the culture, setting the direction and holding to account. It is required to comply with all extant standing orders and standing financial instructions and has no delegated powers other than those embodied in these Terms of Reference. Hence the term Chair will apply to the Chair of the Committee, and members is to be read as a member of the Committee.

The Committee is authorised to investigate all matters within its Terms of Reference and to seek any information it requires from any member of staff to discharge its responsibilities and all staff are required to cooperate with any request for information required by the Committee.

The Committee has primary responsibility for monitoring and reviewing the system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. For these aspects, the Committee shall ensure that appropriate standards are set and compliance with them monitored on a timely basis, for all areas that fall within the duties of the Committee.

The Chair will provide, as a scheduled item of business, written feedback for discussion at each public meeting of the Board of Directors on an 'assurance, exception and escalation' basis for all business scheduled for the most recent meeting of the Committee. The feedback report will be supported by approved minutes of meetings of the Committee.

2 Membership

The Committee shall comprise of four non-executive directors, excluding the Trust Chair, and at least one of whom will have recent and relevant financial experience. The Chair of the Audit Committee must hold an appropriate professional accountancy qualification.

Other attendees should include the Director of Finance or nominated deputy, Internal Audit representation, External Audit representation, Local Counter Fraud representation. Other members of staff may be required to attend meetings where their area of responsibility is under consideration. The Chair and CEO to attend by invitation of the Committee, and that the CEO attend annually to present the Annual Governance Statement.

A quorum will be two non-executive members. The Chair may not hold the Chairmanship of the Performance or Quality Committees at the same time.

Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.

Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.

3 Accountability

The Committee is directly accountable to the Board and will promote the values of WMAS, support a positive culture and adopt behaviours that exemplify the corporate culture, ensuring that constructive challenge is made as appropriate.

4 Review arrangements

These Terms of Reference will be reviewed by the Committee on an annual basis. The Trust Chair will ensure all terms of reference are amended in light of any major changes in committee or Trust governance arrangements/requirements.

The Committee will self-assess its performance in accordance with Board approved protocols, including an annual performance report to the Board.

5 Working methodology

Meetings of the Committee will be held at least on a quarterly basis, with additional meetings where necessary for the due discharge of the remit of the Committee. The timing of meetings will be as necessary to ensure the timely discharge of business by the Board. Additional meetings may be arranged with the agreement of the Chair or on the instruction of the Board. In addition, the External Auditor or Head of Internal Audit may request a meeting if they consider necessary.

The Chair is responsible for the setting of the meeting agenda, the effective running of the Committee, sound leadership, ensuring that the Committee works effectively and takes full account of important issues facing the organisation, ensuring compliance with Board approved strategies and procedures.

The PA to the Director of Finance will be the secretary to the Committee and will provide administrative support and advice. Duties will include agreement of agenda and required attendees with the Chair, together with the collation and timely distribution of associated documentation (7 days in advance) for the meeting, the drafting of minutes (which must be circulated to members of the Committee within 10 working days of the meeting) and the recording of action plans of matters arising and maintenance of annual/forward schedules of business.

Papers may only be tabled on an exceptional basis, and with the agreement of the Chair. The business and input materials for each meeting will be planned and structured to facilitate the completion of scheduled business in a time span not exceeding three hours. For each scheduled item of business a planned time allowance will be agreed with the Chair.

The Committee may allocate work streams, where appropriate, based on a 'task and finish' principle and, where appropriate, through the Director of Finance, obtain external expert advice as required to provide assurance to the Board.

The Committee will scrutinise and satisfy itself that the system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), is sound, applied with due diligence and supports the achievement of the organisation's objectives.

The Committee will ensure adequate information is provided on a timely basis, with any areas of concern highlighted, and appropriate remedial/development plans provided in a suitable format to monitor the reporting of progress, performance and service sustainability.

The Chair will ensure that any sensitive, contentious, exceptional or urgent items are escalated to the CEO and Trust Chairman immediately following the meeting.

6 Duties and interrelationships

The objectives and principal duties of the Committee are as follows:

1) Review the adequacy and effectiveness of all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
2) Review the adequacy and effectiveness of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
3) Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance
4) Review the annual report, quality account, and financial statements before submission to the Board and Council of Governors
5) Review the Scheme of Delegation and matters reserved to the Board
6) Examine the circumstances of any significant departure from the requirements the Standing Financial Instructions, the Constitution, Codes of Conduct and standards of business conduct and determine whether the departure is a failing an overruling or a suspension

7) Review the register of sealing, in particular the values of any contract or agreement
8) Annual review of the Committee's Terms of Reference and effectiveness, with a performance report to the Board
9) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
10) Review the adequacy and effectiveness of the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
11) Approve the content of the Data Security and Protection Toolkit
12) Review the adequacy and effectiveness of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service
13) Seek to ensure that there is an effective internal audit function that meets appropriate professionally recognised standards and provides appropriate independent assurance to this Committee, the Chief Executive and the Board
14) Approve the internal audit strategy and programme
15) Consider the findings of internal audit investigations and management responses and the implications and then monitor progress on the implementation of recommendations
16) The Committee will be required to ratify the appointment, and to be consulted on the removal of, the Head of Audit and Assurance.
17) Oversee the market testing exercise for the appointment of an external auditor as appropriate and based on the outcome make a recommendation to the Council of Governors with respect to the appointment of the auditor
18) Make recommendations to the Council of Governors in respect of the appointment or reappointment and removal of an external auditors and related fees as applicable (if the recommendation of this committee is not adopted by the Council of Governors this shall be included in the annual report, along with the reasons that the recommendation was not adopted
19) Discuss with the external auditor before the audit commences, the nature and scope of the audit
20) Receive the work and findings of the external auditors and consider the implications and the management responses to their work
21) Satisfy itself on the assurance that can be gained from the clinical audit function
22) Satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work
23) Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board
24) Review on behalf of the Board the operation of and any proposed changes to the Standing Financial Instructions, the Constitution, Codes of Conduct and standards of business conduct; including the maintenance of registers
25) Examine any other matter referred to this Committee by the Chief Executive, Committee or Board and to initiate an investigation as determined by this Committee.
26) Approve appropriate policies and strategies
27) Prior to the commencement of the year, review the draft BAF and the proposed significant risks to the delivery of strategic objectives and advise the Board of any omissions or updates in content or format required before final Board approval
28) Request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control

29) Receive regular reports from Pillar Committee Chairs upon the key risks to the delivery of organisational objectives and priorities and any identified gaps in internal control and governance processes

In event of any ambiguity or concern regarding the role of the Committee, its sustainability or relevance in light of any changing circumstance/anticipated/ emerging issue or of its interrelationship with any other committee or working group of the Trust, this should be referred to the next Board meeting for clarification and resolution.

7	**Delegated authority**

Currently, there is no delegated authority for this Committee.

8	**Key input documents**

- Trust Financial Statements and Annual Report
- Annual Quality Account
- Annual Governance Statement
- Internal Audit Statement
- External Audit Annual Report
- Risk Register
- Board Assurance Framework
- Internal Audit Strategy and Operational Plan
- External Audit Plan
- Internal Audit and External Audit Reports

9	**Inward reporting arrangements**

- Executive Management Board for progress on items within the remit of the Committee.
- Reports by other Pillar Committee chairs

Appendix 4

The Terms of Reference of the Remuneration and Nominations Committee

Contents

1 Role and purpose

The NHS Act 2006 (Schedule 7) (As amended) requires the Board of Directors to have in place:

- A committee consisting of the chair, the Chief Executive and the other non-executive directors to appoint or remove the executive directors.
- A committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors

This Committee is therefore constituted as a standing committee of the Trust's Board of Directors ('the Board') pursuant to Schedule 7 of the NHS Act 2006. The Committees constitution and terms are as set out below, subject to amendment at future Board meetings. The Committee supports the Board in shaping the culture, setting the direction and holding to account. It is required to comply with all extant standing orders and standing financial instructions and has no delegated powers other than those embodied in these Terms of Reference. Hence the term Chair will apply to the Chair of the Committee, and members is to be read as a member of the Committee.

The Committee is authorised to investigate all matters within its Terms of Reference and to seek any information it requires from any member of staff to discharge its responsibilities and all staff are required to cooperate with any request for information required by the committee.

The Committee has authority for agreeing the policy in accordance with regulation in relation to:

- setting remuneration for all executive directors and senior managers including pension rights and any compensation payments
- determining the terms of the appoint or removal of the executive directors.
- reviewing and maintaining a Board level and senior management succession plan having regard to the NHS Workforce Equality Standard or other obligation or agreed best practice.
- providing appropriate governance in the event of redundancy or mutually agreed resignation scheme (MARS).

- agree the annual objectives for the Chief Executive Officer and review performance against these each year.
- reviewing the skills matrix of the Board and also reviewing annually the CQC fundamental standards obligations relating to the Fit and Proper Person requirements for directors of the Trust and others that are performing the functions of, or functions equivalent or similar to the functions of a director

2 Membership

The Committee shall be Chaired by the Chair / Deputy Chair of the Board of Directors with the Non-Executive Directors of the Board of Directors as members, unless the Committee is determining the appointment or removal of the executive directors (other than the Chief Executive) in which case the Chief Executive will sit as a voting member of the Committee.

The Chief Executive Officer or nominated deputy will normally be required to attend as appropriate. The People Director may be requested to be in attendance to provide professional advice.

The Chair of the Committee will determine the exact attendance at each meeting, to be notified to individuals and members in advance.

A quorum will be three non-executive members, one of whom will be the Chair or Deputy Chair of the Board.

3 Accountability

The Committee is directly accountable to the Board and will promote the values of WMAS, support a positive culture and adopt behaviours that exemplify the corporate culture, ensuring that constructive challenge is made as appropriate.

The minutes of the Committee shall be formally recorded and circulated to the Trust Chair and all Non-Executive Directors, the Chief Executive and the People Director .

The Chair of the Committee will present to the Board of Directors a short summary highlighting any key issues from the most recent meeting of the Committee whilst being mindful of the sensitive nature of some of the committee's discussions.

The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action.

The Trust's Annual Report shall include a statement by the Committee on the Trust's remuneration policy for directors.

4 Review arrangements

These Terms of Reference will be reviewed by the Committee on an annual basis, but can only be amended by resolution of the Board. The Trust Chair will ensure all terms of reference are amended in light of any major changes in committee or Trust governance arrangements/requirements. The Committee will self-assess its performance in

accordance with WMAS Board approved protocols, including an annual performance report to the Board.

5 Working methodology

Meetings of the Committee shall be held as necessary but not less than twice a year and at such other times as the Chair shall determine.

The meetings of the Committee will be convened by the Chair to determine matters that fall within these Terms of Reference.

The Chairman is responsible for the setting of the meeting agenda, the effective running of the Committee, sound leadership, ensuring that the Committee works effectively and takes full account of relevant issues facing the organisation, ensuring compliance with Board approved strategies and procedures. The Trust Secretary will be the secretary to the Committee and will provide administrative support. Duties will include agreement of agenda's and required attendees with the Chairman, together with the collation and timely distribution of associated documentation (7 days in advance) for the meeting, the taking of minutes and the recording of action plans of matters arising and maintenance of annual/forward cycles of business. Papers may only be tabled on an exceptional basis, and with the agreement of the Chairman.

The Committee will ensure adequate information is provided on a timely basis, with any areas of concern highlighted, and appropriate remedial/development plans provided in a suitable format to monitor the reporting of progress, performance and service sustainability.
.

Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained within the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.

6 Duties and interrelationships

The duties of the Committee are:

1) Regularly review the structure, size, and composition of the Board of Directors, including skills, knowledge, experience and diversity to ensure sufficient capacity and capability to lead the organisation
2) Obtain external legal, remuneration or other independent professional advice if considered necessary.
3) Undertake an annual review of the Committees' Terms of Reference and effectiveness, and report to the Board
4) For the purpose of providing appropriate governance to approve any proposed redundancy or mutually agreed resignation scheme (MARS)
5) Consider, determine and then monitor succession planning for the members of the Board and also senior management positions within the Trust taking into account the challenges and opportunities facing the Trust and the skills and expertise

needed on the Board in the future (and where appropriate make recommendations to the Council of Governors in relation to the NED membership of the Board.)

6) Review the Fit and Proper Person Test Annual Assurance Statement
7) When a vacancy is identified that is within the remit of this Committee, evaluate the balance of skills knowledge and experience on the Board , and its diversity having regard to the NHS Workforce Standard in relation to Board membership; or any other obligation or guidance issued from time to time; and in the light of that evaluation prepare a description of the role and capabilities required for the particular appointment using either open advertising or the use of a recruitment consultant to facilitate the search for a suitable candidate from a wide range of backgrounds and consider candidates on merit against objective criteria
8) When making an appointment the Committee must adhere to the Trusts policy in respect of selection procedures and in particular in respect of equality and diversity i.e. to ensure that any member forming part of a selection panel must have received appropriate training in respect of equality and diversity.
9) When necessary, identify and appoint a candidate for approval by the Council of Governors to fill the position of Chief Executive
10) Establish and keep under review a remuneration policy in respect of Board directors
11) In accordance with relevant laws and regulations and also Trust policies decide and keep under review the terms and conditions of the Trust's executive directors and Chief Executive Officer; and other directors as determined by the Chief Executive and Chair including:
    - Salary, including any performance related pay or bonus
    - Provisions for other benefits including pensions and cars.
    - Allowances
    - Payable expenses
    - Compensation payments

12) When brought to its attention, to consider any matter relating to the continuance in office of any Board Executive Director , including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law, their service contract, and in compliance with the Trust's own redundancy policy
13) Approve the annual objectives of the Chief Executive prior to the commencement of the year
14) Receive a report from the Chair of the Committee on the mid and end of year review of performance in meeting the objectives, prior to determination of the CEO remuneration package for that year
15) Advise the Board of any new or material changes in the profile of risks which relate to the remit of this committee

In event of any ambiguity or concern regarding the role of the Committee, its sustainability or relevance in light of any changing circumstance/anticipated/ emerging issue or of its interrelationship with any other committee or working group of WMAS, this should be referred to the next Board meeting for clarification and resolution.

7	Delegated authority

To determine and agree the Trust's strategy in relation to the remuneration, allowances and terms of service of the Chief Executive Officer and with the Chief Executive Officer the Committee will determine the remuneration, allowances and terms of service of the Executive Directors and any other senior managers that the Chair and Chief Executive shall determine.

The Committee shall agree on behalf of the Board individual remuneration, allowances and terms of service arrangements for the Chief Executive and Executive Directors.

The Committee shall also agree on behalf of the Board arrangements for the termination of employment and other contractual terms giving due regard to employment law and Treasury Guidance in determining remuneration packages.

8	Key input documents

- Change Management Agreement
- Disciplinary Policy and Procedure
- Equal Opportunity Policy
- Trust Charter of Expectations
- Board director and senior manager succession policy
- Monitors Code of Governance
- The Trust's Constitution

9	Inward reporting arrangements

- The Committee has no sub-committee responsibilities.

Approved by the Committee at its meeting on 6 April 2022

Approved by the Board of Directors:

Appendix 5

Performance Committee – Terms of Reference

1	**Role and Purpose** **(Trust Strategic Objectives:** **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)**

The Performance Committee (the Committee) is constituted as a standing committee of the Board of Directors. The Committee is a Non-Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Board.

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is responsible for providing information and making recommendations to the Board of Directors on financial Investment and operational performance issues and for providing assurance that these are being managed.

The approved Minutes of the Committee meeting will be submitted to the next appropriate meeting of the Board of Directors.

2	**Membership**

Three Non-Executive Directors of which one will be the Chairman appointed by the Board.

other members include:
Director of Finance
Non-Emergency Services Operations Delivery & Improvement Director
Integrated Emergency & Urgent Care & Performance Director
Emergency Services Operations Delivery Director
Operational Assurance Director

Other members/attendees may be co-opted or requested to attend as considered appropriate.

Quorum

Pursuant to paragraph 4.18 of the Standing Orders of the Board of Directors of the Constitution no business shall be transacted at a meeting unless at least one-third of the whole number of the Directors is present, including at least one Director and one Non-Executive Director. For the avoidance of doubt an “acting Director” as defined in the Constitution shall count towards the quorum.

All Board members outside the core membership have an open invitation to attend any meeting if he/she wishes to do so.

3 Accountability

The Committee is accountable solely to the Board of Directors.

4 Review arrangements

These terms of reference will be reviewed on an annual basis. The Chair will ensure terms of reference are amended in light of any major changes in legislation and Trust governance arrangements/requirements.

5 Working methodology

The Committee will have an annual schedule of business which is a dynamic document and is developed and maintained by the Committee Chairman and Lead Directors with reference to the schedule of business of the Board of Directors. The Trust's business is always conducted by employees and an executive team led by the Chief Executive Officer (CEO) with oversight from the Board.

The Committee will meet on at least five occasions a year.

Meetings of the Committee are either ordinary which are scheduled as part of the Annual Cycle of Business or are extraordinary meetings which are convened for specific matters at the sole discretion of the Chairman.

All papers for meetings must be finalised and distributed at least five days prior to the meeting of the Committee. Late papers will only be accepted at the discretion of the Chair.

The production of high quality, concise papers (with appendices - if really necessary) is crucial for effective decision making, and these should be produced and circulated on time, and read in advance of the meeting by all board members.

Reports should:

- have the standard coversheet
- be concise and to the point as a general rule no report should be more than six pages in length including the coversheet
- have the appropriate control boxes completed.
- be cross referenced to the financial plan agreed by the Board
- contribute to the successful outcome of the Trust strategic plan

As a general rule the business of the meeting should be concluded within no more than 3 hours.

For procedural details see the Standing Orders for the practice and procedure of the Board of Directors and for the avoidance of doubt the Standing Orders of the Board of Directors do apply to its Committees (Annex 7 of the Constitution). (Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained within the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.)

The Committee will be supported administratively by the PA to the Director of Finance whose duties in this respect will include:

- Agreement of the agenda with the Chairman of the Committee
- collation and distribution of papers at least five working days before each meeting.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Providing support to the Chairman and members as required

6 Duties and interrelationships

The specific responsibilities of the Committee are to:

1. Review the integrated performance of the Trust
2. Provide overview and scrutiny in any other areas of financial and operational performance referred to the Committee by the Board.
3. Review the Trust's performance against its annual financial and operational plan. Ensuring the robustness, credibility and quality of financial management, performance and planning information is reviewed and triangulated by the Committee and any corrective mitigations are in place
4. Assurance and overview of the Trusts delivery against the annual and longer term financial improvement and efficiency programme
5. Ensure the financial plan is designed, developed, delivered, managed and monitored within the Trusts management framework
6. Ensure the financial and operational plan is developed to appropriately supports the Trust's strategic objectives and its long-term sustainability
7. Review the performance indicators relevant to the remit of the Committee
8. Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate
9. Provide the Board of Directors with advice and support on the development and delivery of the following strategies:
    a. Finance Strategy
    b. Operational strategy
    c. Capital and investment strategy
    d. Estates strategy
    e. Commercial strategy
    f. Digital strategy
10. Assurance of business investment opportunities, Capital, and revenue investment schemes are in accordance with the Trusts' strategic plan.
11. To review business cases both revenue and capital that are greater than £250k in value, or those business cases that are submitted at the discretion of the CEO or EMB based on their consideration of the risk to the Trust, for review and scrutiny prior to approval by the Board of Directors.
12. Monitor the performance of the Trust's physical assets including estates, IT, fleet and that the Trust's resources and assets are being used effectively and efficiently
13. Review proposals for acquisition, disposal, change of use of land/buildings
14. Undertake any other responsibilities as delegated by the Board of Directors. Accountability and Reporting arrangements
15. Request for independent external support where it is deemed necessary to ensure appropriate overview, scrutiny and assurance

The Committee shall be directly accountable to the Board of Directors and shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any financial or operational aspect.
The Chair will report any specific issues on the risk register to the Audit Committee.

The minutes of the Committee meetings shall be formally recorded and the approved minutes submitted to the next meeting of the Board following the production of the minutes.

The Terms of Reference of the committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

The Committee shall be directly accountable to the Board of Directors and shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any financial or operational aspect.

The Chair will report any specific issues on the risk register to the Audit Committee.

The minutes of the Committee meetings shall be formally recorded and the approved minutes submitted to the next meeting of the Board following the production of the minutes.

The Terms of Reference of the committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

7 Delegated authority

None.

8 Key input documents

- The Constitution
- Standing Financial Instructions
- Trust Strategies and Plans
- Risk Register and Board Assurance Framework
- Financial Plans and Budgets
- Appropriate Business Cases

9 Inward reporting arrangements

The Committee has no established sub-committees but it will receive information and assurances from the following:

Integrated performance reviews
Executive meeting with directorate teams to focus on performance, activity demand, capacity available, spend against budget, delivery of CIP, forecast workforce rostering/capacity and management of overtime

Capital and Revenue Investment Advisory Group
Changes required to the prioritisation process of capital and revenue projects

Long term Planning and investment cases
- Due diligence process to ensure investment requests have been appropriately reviewed and signed off by all prior to EMB approval. Including adequate option appraisals
- To support long term planning – demand, workforce, finance

Approved by the Performance Committee on : 26 April 2022

Approved by The Board : May 2022

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE 2022-23
QUALITY GOVERNANCE COMMITTEE

Appendix 6

Contents – All proposed changes are in red font	
	1. Role and purpose 2. Membership 3. Accountability 4. Review arrangements 5. Working methodology 6. Duties and interrelationships 7. Delegated authority 8. Key input documents 9. Inward reporting arrangements
1	**Role and purpose** **Strategic Objectives:** • **SO1 – Safety Quality and Excellence (our commitment to provide the best care for patients)** • **SO5 – Collaboration and Engagement (Working in partnership to deliver seamless patient care)**

The Committee is constituted as a standing committee of the Trust's Board of Directors ('the Board') and its constitution & terms are as set out below, subject to amendment at future Board meetings. The Committee supports the Board in shaping the culture, setting the direction and holding to account. It is required to comply with all extant standing orders and standing financial instructions and has no delegated powers other than those embodied in these Terms of Reference. Hence the term Chair will apply to the Chair of the Committee, and members is to be read as a member of the Committee. The Committee is authorised to investigate all matters within its Terms of Reference and to seek any information it requires from any member of staff to discharge its responsibilities and all staff are required to cooperate with any request for information required by the Committee.

The purpose of the Quality Governance Committee is to provide the Trust Board with an objective and independent review of quality, to support the delivery of safety and excellence in patient care. This remit includes a focus on six key dimensions:

- Patient Safety – avoiding harm from care that is intended to help people.
- Clinical Effectiveness – providing services based on evidence and which produce a clear benefit.
- The experience of the patient – establishing a partnership between practitioners and service users to ensure care respects their needs and preferences.
- Timeliness of care – ensuring care is delivered in a timeframe that reduces harmful delays.
- Efficiency – avoiding waste and maximizing the positive impacts of available resources.
- Equitable – providing care that does not vary in quality because of a service users' characteristics.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE 2022-23
QUALITY GOVERNANCE COMMITTEE

Appendix 6

The Committee will enable the Trust Board to obtain assurance that high standards of care are provided, and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety, high quality patient care across all Trust departments
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidence based clinical practice
- Ensure that the Trust is aligned to the statutory and regulatory requirements relating to quality and safety
- Ensure effective supervision and education and training of the workforce
- Protect the health and safety of Trust employees
- Ensure effective information governance across the Trust's functions.

2 Membership

- 2 Non Executive Directors, one of which will be appointed as Chair and one will be appointed as Deputy
- Executive Director of Nursing and Clinical Commissioning
- Executive Medical Director
- Lead Paramedic for Urgent and Emergency Care
- Clinical Governance Lead for 111
- Non-Emergency Services Delivery & Improvement Director
- Staffside Representatives

The Chief Executive should attend meetings of the Committee at least once a year otherwise at his sole discretion or when invited by the Chair of the Committee.

Fully briefed deputies of sufficient seniority, understanding and authority to participate fully in the meeting are to attend in circumstances where non-attendance is unavoidable. Other members of staff may be expected to attend meetings where areas of performance, risk or strategy are their responsibility.

A quorum will be three members and must include one non-executive member and either the Executive Director of Nursing & Clinical Commissioning or Executive Medical Director. The Chairman may not be the Chairman of the Audit Committee at the same time.

3 Accountability

The Committee is directly accountable to the Board and will promote the values of WMAS, support a positive culture, and adopt behaviours that exemplify the corporate culture, ensuring that constructive challenge is made as appropriate.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE 2022-23
QUALITY GOVERNANCE COMMITTEE

Appendix 6

4	Review arrangements

These Terms of Reference will be reviewed by the Committee on an annual basis. The Trust Chair will ensure all committee terms of reference are amended in light of any major changes in committee or Trust governance arrangements/requirements.

The Committee will self-assess its performance in accordance with Board approved protocols, including an annual performance report to the Board.

5	Working methodology

A minimum of 5 meetings will be held each year, with additional meetings where necessary for the due discharge of the remit of the Committee. The timing of monthly meetings will be as necessary to ensure the timely discharge of business by the Board and additional meetings may be arranged with the agreement of the Chair or on the instruction of the Board.

The Chair is responsible for the setting of the meeting agenda, the effective running of the Committee, sound leadership, ensuring that the Committee works effectively and takes full account of important issues facing WMAS, ensuring compliance with Trust approved strategies and procedures.

The PA to the Executive Director of Nursing & Clinical Commissioning and Executive Medical Director will be the secretary to the Committee and will provide administrative support and advice. Duties will include agreement of agenda's and required attendees with the Chair, together with the collation and timely distribution of associated documentation (7 days in advance) for the meeting, the taking of minutes and the recording of action plans of matters arising and maintenance of annual/forward cycles of business. The minutes will be circulated within 10 working days after the meeting.

Papers may only be tabled on an exceptional basis, and with the agreement of the Chair. The business and input materials for each meeting will be planned and structured to facilitate the completion of scheduled business in a time span not exceeding three hours. For each scheduled item of business, a planned time allowance will be agreed with the Chair.

The Committee will scrutinise the performance of the executive in meeting agreed goals and objectives, satisfy itself on the integrity of clinical, quality and other information provided, satisfy itself that clinical and quality performance aspects of business cases and change plans, controls and systems of risk management and mitigation are sound and applied with due diligence.

The Committee will ensure adequate information is provided on a timely basis, with any areas of concern highlighted, and appropriate remedial/development plans provided in a suitable format to monitor the reporting of progress, performance and service sustainability.

The Chair will ensure that any sensitive, contentious, exceptional or urgent items are escalated to the CEO and Trust Chair immediately following the meeting.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE 2022-23
QUALITY GOVERNANCE COMMITTEE

Appendix 6

6	Duties and interrelationships

Review of Clinical and Quality related strategies

- The Committee has primary responsibility for the compilation and delivery of the Quality Account and associated Annual Reports.
- Receive and review the recommendations from Executive Management Board (EMB) and recommend to the Board approval of all clinical and quality related strategies (Clinical, Quality and Stakeholder Engagement), and to regularly monitor achievement of the associated strategic priority objectives and milestones.

Review of Compliance/Clinical and Quality
To receive and regularly review recommendations on all contractual and regulatory compliance in respect of clinically and quality governance standards and duties.

Compliance with Information Governance specifically related to patient data
To receive and review the recommendations in relation to compliance with all relevant information governance legislation and guidance including Caldicott Guidelines and SIRO report Data Protection Act with respect to the use of clinical data and patient identifiable information**.**

Monitor performance against the Quality Account
Monitor performance against the Quality Account and annual priority objectives ensuring a continual drive for quality improvement.

Make recommendations to the Board on the content of the Quality Account
To receive and review the recommendations of EMB in relation to the Trust's Quality Account before submission to the Board.

Monitoring Quality & Clinical KPIs
To receive and regularly review recommendations on the performance against relevant quality and clinical KPI's and seek assurance that adverse variances are acted upon to meet all defined standards and targets.

Learning from Incidents, Deaths and Complaints

- Receive and review the report from the Learning Review Group and make appropriate recommendations to the Board in relation to Quality.
- Proposed: To receive the Coroners and Claims report.
- Receive and review incident themes and complaint themes and trends from the results of patient surveys, PALS, Staff Surveys and seek assurance from the Executive Director of Nursing & Clinical Commissioning that appropriate action is being taken to address any risks to quality.

Quality of Safeguarding
Seek assurance from the Executive Director of Nursing & Clinical Commissioning that appropriate processes are in place that safeguard adults and children.

Clinical Audit & Research and Development

- Within the remit of the Committee, and as deemed appropriate by the Committee, make recommendations to the EMB and Audit Committee for topics/issues to be

considered for inclusion in the annual internal audit programme also Clinical Audit Programme and the Research and Development programme.

- To receive and monitor at least quarterly the annual clinical audit programme and R&D programme.

Maternity Services

To monitor the provision of maternity services and review progress against the maternity action plan and reports (including Ockenden Report).

Stock & Equipment

To have an oversight of current stock level shortages and the obsolete stock and equipment that come within the remit of this committee, ant to recommend its disposal in compliance with Standing Financial Instructions relevant at the time.

References from EMB

Regularly review EMB business reports of key issues and assurances referred by, or within the remit of, the Committee.

Quality Impact Assessments/CIP

Review and receive assurance from the EMB on the rigour of CIP and material service change Quality Impact Assessments, making appropriate recommendations, and escalate any concerns to the Board patient safety so that it can assure the Board that risk is being managed according to organisational policies and procedures.

Quality, Safety & Risk

- The Committee is responsible for the escalation of significant Quality and Safety risks from the Risk Register to the Board and has specific responsibility for the management of the Trusts Clinical risk register.
- Review the recommendations of any relevant external or internal reports and monitor effective and timely implementation of associated action plans.
- The Committee is responsible for setting their appetite and tolerance (as per the Trust risk Appetite Statement) for levels of risk which pertain to their Strategic Objective. Any actions which are identified to reduce the relevant risks need to be logged, assigned, monitored appropriately and escalated to the BAF if relevant.

Strategy and Quality (BAF)

To receive and review the recommendations from EMB on any material changes in the profile of resource related risks which relate to the strategic objectives included in the BAF.

Oversight of Sub Groups

- Approve the Terms of Reference of Reporting Groups and review annually and assess effectiveness.
- Ensure through its Health, Safety, Risk & Environment Group the effective prevention and control of Healthcare Associated Infection (HCAI) for the organisation.

- To agree the Terms of Reference and Annual work programme for the Health, Safety, Risk & Environment Group and receive appropriate recommendations from the Group.
- Receive and review reports from:
  - Learning Review Group;
  - Health, Safety, Risk & Environment Group; and make appropriate recommendations to the Board in relation to Quality.

External/Internal reports relevant to the Committee

At the sole discretion of the Committee's Chair, to review the recommendations of any relevant external or internal reports and monitor effective and timely implementation of associated action plans.

Review of its Terms of Reference
Annual review of the Committees' Terms of Reference and effectiveness, with a performance report to the Board.

7	**Delegated authority**

Currently there is no delegated authority for this Committee.

8	**Key input documents**

- Clinical Strategy
- Quality Strategy
- Communication & Engagement Strategy
- Security Strategy
- Risk Management Strategy
- Sustainability Strategy
- Quality Account including Annual Reports
- Strategic and Annual Plans and relevant supporting priority objectives and KPIs
- Monthly Integrated performance report (IPR) - relevant elements
- CIP and service change Quality Impact Assessments
- Relevant risk register extracts (12+ risks)
- CQUIN
- Clinical Audit Programme
- Research & Development Programme
- Maternity Action Plan & Reports (including Ockenden Report, etc)
- Reports on low stock (of concern), and obsolete and disposal of stock and equipment.

9	**Inward reporting arrangements**

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

TERMS OF REFERENCE 2022-23
QUALITY GOVERNANCE COMMITTEE

Appendix 6

- Health, Safety, Risk & Environment (HSRE) Group
- Learning Review Group (LRG)
- Professional Standards Group (PSG) - the following report into PSG:
  - Immediate Care Governance Group (ICGG)
  - Clinical Audit & Research Programme Group (CARPG)
  - Medicines Management Group (MMG)
- Executive Management Board (EMB) for progress on items within the remit of the Committee
- Other ad hoc Task & Finish work streams/groups

These current Terms of Reference were agreed at the Quality Governance Committee meeting on 18 May 2022 and approved at the Board of Directors meeting on 25 May 2022.

Appendix 7

The People Committee - Terms of Reference

1	**Role and Purpose** **(Trust Strategic Objective:** **SO2 – A great place to work for all (Creating the best environment for all staff to flourish)**

The People Committee ('the Committee') is formally established as a Committee of the Board of Directors of West Midlands Ambulance Service University NHS Foundation Trust. Its constitution and terms of reference are subject to amendment by the Board.

The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee will adhere to and be cognisant of the Trust values at all times.

The purpose of the Committee is to provide assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, diversity and inclusion.

The Committee will assure the Board of the achievement of the objectives set out in the NHS People Plan and the Trust's People Plan and ensures alignment of work with the STP/ICS Workforce Strategy.

The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

The committee will promote local level responsibility and accountability.

2	**Membership**

The Committee shall consist of the following members:

Membership
3 Non-Executive Directors (to include the NED Wellbeing Guardian)
People Director
Non-Emergency Services Operations Delivery Director
Emergency Services Operations Delivery Director
Director of Finance or a representative
Integrated Emergency and Urgent Care Director
Trade Unions Representatives x 3 total (Unison, Unite and GMB)
Other members/attendees may be co-opted or requested to attend as considered appropriate.

One of the Non-Executive Directors shall act as Committee Chair. In their absence, one of the other Non-Executive Directors present shall be nominated and appointed as acting Chair for the meeting.

The quorum necessary for the transaction of business shall be 3 members, of which one Non-Executive Directors and one Director must be present. Deputies will not count towards the quorum

3 Accountability

The approved Minutes of the Committee meeting will be submitted to the next appropriate meeting of the Board of Directors.

4 Review arrangements

The Committee's Terms of Reference shall be reviewed on an annual basis and approved by the Board of Directors.

5 Working methodology

The Committee will have an annual schedule of business which is a dynamic document and is developed and maintained by the Chairman and Lead Director with reference to the schedule of business of the Board of Directors. The Trust's business is always conducted by employees and an executive team led by the Chief Executive Officer (CEO) with oversight from the Board.

Meetings of the Committee are either ordinary which are scheduled as part of the Annual Cycle of Business or are extraordinary meetings which are convened for specific matters at the sole discretion of the Chair.

All papers will normally be submitted for review by the Chair and lead Director at least two weeks prior to the Committee meeting. All papers for meetings must be finalised and distributed at least five days prior to the meeting of the Committee. Late papers will normally only be accepted in exceptional circumstances and will only remain on the agenda for the Committee meeting at the express permission of the Chair in consultation with the lead director.

The production of high quality, concise papers (with appendices - if really necessary) is crucial for effective decision making, and these should be produced and circulated on time, and read in advance of the meeting by all committee members.

Reports should:

- have the standard coversheet
- be concise and to the point as a general rule no report should be more than six pages in length including the coversheet
- have the appropriate control boxes completed.
- be cross referenced to the financial plan agreed by the Board
- contribute to the successful outcome of the Trust strategic plan

For procedural details see the Standing Orders for the practice and procedure of the

Board of Directors and for the avoidance of doubt the Standing Orders of the Board of Directors do apply to its Committees (Annex 7 of the Constitution). (Pursuant to paragraph 6.1.3 of the Standing Orders of the Board of Directors as contained within the Constitution, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees 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 also as the context permits.)

Meetings will normally be held on the following basis:

- Meetings will be held bi-monthly (every two months).
- Items for the agenda should be sent to the Committee Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under 'any other business'.
- The agenda will be issued by email to the Committee members and attendees, five days prior to the meeting date, together with the action schedule and other associated papers.

A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

The Committee shall be supported by the PA to the People Director whose duties in this respect will include:

In consultation with the Committee Chair and People Director develop and maintain the reporting schedule to the Committee.

Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.

Taking the minutes and keeping a record of matters arising and issues to be carried forward.

Advising the group of scheduled agenda items.

Agreeing the action schedule with the Chair and ensuring circulation.

Maintaining a record of attendance.

6	Duties and interrelationships

Review of National Guidance

- Review national workforce guidance and strategies, for example the NHS People Plan, and their applicability to the Trust.
- Monitoring and review of the Trust's People Plan as part of strategy
- Consider and recommend to the Board, the Trust's overarching People Plan and associated activity/implementation plan(s) to support Trust forward strategy.

- Obtain assurance and monitor delivery of the People Plan through the associated activity/implementation plan.

Monitoring relevant KPIs

- Consider and recommend to the Board the key people and workforce performance metrics and targets for the Trust.
- Receive regular reports to gain assurance that these targets are being achieved and to request and receive exception reports where this is not the case.

Review risks to delivery of relevant Strategic priorities and Risk

Review and provide assurance on those elements of the Board Assurance Framework identified as the responsibility of the Committee, seeking where necessary further action/assurance.

Review workforce related risks identified on the Corporate Risk Register and seek assurance in relation to risk mitigation and future activity/plans.

The Committee is responsible for setting their appetite and tolerance (as per the Trust risk Appetite Statement) for levels of risk which pertain to their Strategic Objective. Any actions which are identified to reduce the relevant risks need to be logged, assigned, monitored appropriately and escalated to the BAF if relevant.

Review workforce metrics

Review workforce related elements of the Performance Scorecard and provide assurance on the adequacy of the Trust's performance against operational workforce metrics.

Strategic reviews

Conduct reviews and analysis of strategic people and workforce issues at national and local level and, if required, agree the Trust's response.

Confidential reporting

Provide assurance to the Audit Committee and Board that that arrangements are in place to allow staff to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently.

Staff Communications

Seek assurance on the adequacy and effectiveness of staff communication and levels of staff engagement

Any other matter referred to the Committee

Seek assurance on any additional matter referred to the Committee from the Board.

D&I

To receive and review the Equality, Diversity & Inclusion Strategies and annual implementation plans, arising out of analysis of the WDES, WRES, Gender Pay Gap and EDS2 information and data.

Training & Development

To oversee and seek assurance on the development and delivery of the Trust's education and training strategy through the development of clinical and non clinical skills in new and innovative ways.

7	Delegated authority

The Committee is authorised by the Board to investigate any activity within its terms of reference.

The Committee is accountable to the Board and any changes to these terms of reference must be approved by the Board of Directors.

The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

The Committee is authorised by the Board to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board

8 Key input documents

- The Constitution
- Standing Financial Instructions
- NHS People Plan
- People Strategy
- STP/ICS Workforce Strategy
- Risk Register and Board Assurance Framework
- Financial Plans and Budgets
- Appropriate Business Cases
- Equality, Diversity & Inclusion Strategies and annual implementation plans
- NHS Staff Survey
- Trust Strategic Plan

9 Inward reporting arrangements

A briefing from those Groups reporting up to the People Committee detailing items for escalation and key risks (as applicable) will be received by the Committee along with exception reports as agreed.

- Diversity and Inclusion: Steering and Advisory Group

Approved by the People Committee on 28 February 2022

Approved by the Board of Directors in May 2022

Appendix 8

Terms of Reference - The Trustee Committee

Contents

Appendices

1 Role and purpose

The Committee is constituted as a standing committee of the Trust's Board of Directors ('the Board') and its constitution and terms are as set out below, subject to amendment at future Board meetings. The Committee supports the Board in shaping the culture, setting the direction and holding to account. The Committee is required to comply with all extant standing orders and standing financial instructions & has no delegated powers other than those embodied in these Terms of Reference. Hence the term Chair will apply to the Chair of the Committee, and members is to be read as a member of the Committee

The Committee supports the Board in the management of West Midlands Ambulance Service NHS Foundation Trust's charitable funds. These funds are held on trust – a trust is created when funds are accepted by a trustee to be held and used for the benefit of a beneficiary. In the case of WMAS these funds are managed by corporate trustees – i.e. the NHS corporate body and therefore the Trust's Board acts on behalf of the corporate trustee in the administration of the charitable funds. These Terms of Reference therefore set down how the corporate trustee undertakes that administration through the operation of the Corporate Trustee Committee. Trustees have a duty to ensure compliance, a duty of prudence, and a duty of care – which are detailed below.

The funds covered here are designated charitable in line with the Charities Acts 1993 and 2006. The funds exist to provide public benefit, are for defined charitable purposes in line with the 2006 Act, and are used solely to further the objectives of the funds.

The charity is registered with the Charity Commission under the name: West Midlands Ambulance Service NHS Trust General Charity, registration number 1058359. The charity is not responsible for the administration of any subsidiary charities.

The committee is required to comply with all extant WMAS standing orders and standing financial instructions and has no delegated powers other than those embodied in these Terms of Reference.

The Committee is authorised to investigate all matters within its Terms of Reference and to seek any information it requires from any member of staff to discharge its responsibilities

and all staff are required to cooperate with any request for information required by the committee.

The Committee is authorised to:

- Investigate any activity within its Terms of Reference
- To seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee
- Obtain outside legal or other independent professional advice
- Secure the attendance/participation of outsiders with relevant experience and expertise.

The approved minutes of the Committee will formally be submitted to the Board and the Audit Committee for information.

2 Membership

Membership is restricted to the 'directing body' of the West Midlands Ambulance Service NHS Foundation Trust – i.e., the Board of Directors

Where required legal and financial advice will be made available on an 'in attendance' basis.

A Staff elected Governor will be invited to attend the meeting as an observer.

A quorum will be at least four members of WMAS NHSFT Board – to include the Chairman, the Chief Executive, and the Director of Finance.

3 Accountability

The Trust board as corporate trustee is accountable to the Charity Commission for its actions and decisions.

4 Review arrangements

These terms of reference will be reviewed by the Committee on an annual basis. The Trust Chairman will ensure all terms of reference are amended in light of any major changes in committee or Trust governance arrangements/requirements. The Committee will self-assess its performance in accordance with WMAS Board approved protocols, including an annual performance report to the Board.

5 Working methodology

Meetings of the Committee shall be held as necessary, but not less than twice a year, and will be convened by the Chair to address and determine matters that fall within these Terms of Reference.

Ad-hoc meetings may be called at the discretion of the Chair and in accordance with Standing Orders and Standing Financial Instructions of the Trust as they apply to formally established Committees. As such, members of this Committee may requisition a meeting in writing in line with Standing Orders, Section 3.

The Chair is responsible for the setting of the meeting agenda, the effective running of the Committee, sound leadership, ensuring that the Committee works effectively and takes full account of important issues facing the organisation, ensuring compliance with Board approved strategies and procedures.

The Committee will be supported administratively by the Trust Secretary who will:-

- Agree the agenda with the Chair (and attendees) and collate papers
- Ensure minutes are taken and keep a record of matters arising and issues to be carried forward
- Liaise with the Director of Finance and team to ensure that all supporting papers are produced and distributed one week in advance of meetings.

The business and input materials for each meeting will be planned and structured to facilitate the completion of scheduled business in a time span not exceeding three hours. For each scheduled item of business a planned time allowance will be agreed with the Chair.

6 Duties and interrelationships

The principal duties of the Committee are:

1) Ensure that funds within the Trust's registered charity are managed in accordance with relevant legislation, regulations and specific trust deeds where applicable.
2) Ensure that donations and investment income or losses are attributed to individual funds appropriately.
3) Ensure the sources of income and the terms on which donations are received are acceptable to the Trustees (and to consider how to manage terms which are not considered acceptable).
4) Review the annual accounts relating to charitable funds.
5) Annual review of the Committees' Terms of Reference and effectiveness, with a performance report to the Board
6) Ensure that any donation made to the charity by a third party falls to the trusteeship of the board and is accounted for separately from West Midlands Ambulance Service NHS Foundation Trust's exchequer funds.
7) Ensure that individual fund objectives and spending plans are in keeping with the objectives, spending criteria and priorities set by donors
8) Obtain spending proposals for all individual funds and approve if and when appropriate (The Chief Executive or Director of Finance in consultation with a Staff Governor can agree requests of less than £1,000. All other requests should be agreed by a majority of the trustees.
9) Ensure that all funds are correctly allocated as restricted, unrestricted or designated, and accounted for accordingly.
10) Recommend an investment advisor to the Trustees following appropriate tendering procedures and regularly monitor and review their performance.
11) Establish, monitor, and manage an investment policy for charitable funds, and ensuing that sufficient funds are kept readily available to meet planned requirements.
12) Ensure that West Midlands Ambulance Service NHS Foundation Trust's Standing Financial Instructions and the Scheme of Delegation are appropriately interpreted and applied to charitable funds.
13) Ensure (through the Director of Finance) that there is an appropriate system of control over charitable income and expenditure, and that there are robust governance arrangements in place.
14) Receive and discuss all audit reports on charitable funds and recommend action to the Trustees.
15) Respond to requests from the Board of Trustees for review or investigation on matters relating to charitable funds.

16) In event of any ambiguity or concern regarding the role of the Committee, its sustainability or relevance in light of any changing circumstance/anticipated/ emerging issue or of its interrelationship with any other committee or working group of WMAS, this should be referred to the next Board meeting for clarification and resolution.

7	Delegated authority

To ensure, on behalf of the Board of Directors, that funds within the Trusts registered charity are appropriately managed in accordance with relevant legislation, regulations and specific trust deeds where applicable.

8	Key input documents

- Income and expenditure reports
- Performance of funds
- Annual accounts
- Investment proposals

9	Inward reporting arrangements

- The Committee has no sub-committee responsibilities.

Approved by the Trustee at a meeting of the Trustee Committee in March 2022

West Midlands Ambulance Service
University NHS Foundation Trust

Minutes of the Extraordinary Performance Committee held on 14 June 2022, 9am, via Microsoft Teams

Present:

MK	Mushtaq Khan, Non-Executive Director (Chair)
NH	Nathan Hudson, Emergency Services Operations Delivery Director
CC	Craig Cooke, Operations Support Services Director
KR	Karen Rutter, Interim Director of Finance
ACM	Anthony Marsh, CEO
JB	Jeremy Brown, Integrated Emergency and Urgent Care and Performance Director (part of mtg)
MB	Michelle Brotherton, Non-Emergency Services Operations Delivery and Improvement Director
AW	Alison Walker, Medical Director
VK	Vivek Khashu, Strategy and Engagement Director
DJS	Diane Scott, Interim Organisational Assurance Director
DMS	Donna Stevenson, EA to Director of Finance (Minutes)

	Meeting held on 14 June 2022	ACTION
06/22/01	**Welcome and Apologies**	
	Apologies were received from Narinder Kooner, Mark Docherty, Wendy Farrington-Chadd and Matt Brown. MK outlined the reason and objectives for this extraordinary committee meeting which will focus on response times and handover delays at hospitals and their effects on staff and patients and to devise a plan of action. MK outlined the main agenda item of the meeting. VK said he would also cover some of the diagnoses at (2) in his presentation under items (5) and (6).	
06/22/02	**Minutes of the Meeting of the Performance Committee held on 16 April 2022 and Matters Arising**	
	Resolved: The minutes of the Performance Committee meeting held on 16 April 2022 were agreed. **Matters Arising - Costing for lost hours/overtime costings -** KR and NH to work with MD to provide these costings and overtime breakdown. KR said she will include the reasons for staff taking overtime as well. It was agreed that this information will be compiled by the end of June, but if not definitely for the next meeting in July. NH said it would be beneficial to include the financial impact of other aspects of the abstractions (e.g. 11 hour break rule), as well as hospital delays, and this will be reflected in the data.	

	Resolved: KR and NH to work with MD to provide data detailed above.	**KR/NH /MD**
06/22/03	**Main Agenda Item:-**	
	1. Performance	
	NH presented the performance report to the Committee. May activity is down (by 10% compared to same time last year). This is due to a number of reasons; this includes the public confidence in the service which may have contributed to this as members of the public are possibly preferring to make their own way into hospitals. Performance is still red in all categories apart from 90% on Cat 1 and Cat 1 Transports. Some areas are performing better than others. Cat 1 in BBC is being achieved, on mean and 90th percentile. Cat 2/3 has seen some performance changes in Black Country it is 20.53% on the mean and 24.52% on the 90th. This is due to better hospital performance by ICB areas. Shropshire and Staffordshire areas have seen a deterioration in performance (University Hospital N Midlands in particular). The only area that is different is Arden as activity is higher but there are not big delays at University Hospital C&W. JB pointed out that the issue is movement as the Trust is seeing activity starting to build due to patients waiting for ambulances. Patients are also re-ringing 999 to chase the response. Therefore, there is very little movement of patients. Diversion from low priority patients to higher priority patients is also taking place due to deterioration of patients waiting for ambulances. JB said he can share the latest data regarding the increase in Cat 1 and 2 calls and will send out today. VK said the wait for ambulances information/patient deterioration can be made available as the data is there to back it up. ***Hospitals delays*** – NH said the Trust lost 28,000 hours from delays at hospitals during May. This is a 270% increase (over 30 minutes) compared to May 2021, which is a significant number of hours. ***Covid*** - There has also been a rise in Covid cases which will put the Service under extreme pressure, due to staff sickness as well as demand. NH said Mark Docherty's comments regarding the Service being under too much pressure in August is understandable from the data that is available. ***Sickness*** overall for E&U Ops improved from 6.37% in April to 4.15% in May with the YTD position is 5.27%. These figures includes Covid. ***Resourcing hours*** – NH said in May 2019 190,000 hours and June 2019 180,000 hours were outputted, in May 2022 - 213,000 hours and in June 212,000 hours were resourced. NH pointed out that he is using 2019	

figures to give a comparison rather than 2020 and 2021 due to the pandemic and the resourcing initiatives that were in place for that period.

Abstraction Types by reason – NH presented a report regarding the difference between 2019 and 2022 and these abstractions have been examined and RAG rated. The following abstractions for the quarter 1 period for both years were highlighted:

- 11 hour breaks due to delays at hospital.
- Annual leave remains stable.
- Bank holiday leave in 2022 has increased.
- Staff support in 2019 was 900 hours and this has increased to 1,700 in 2022.
- Maternity leave has also increased due to the baby boom in 2021.

The system is being managed well and is not showing any major variables to pre-pandemic.

Downtime is an area to note as this has increased by over 50% compared to 2019. This is due to a number of reasons and the following were pointed out:

- Basic level C1 responders.
- Covid Cleaning
- Crews travelling with Crews.
- Crew behaviour.
- Solo responses increase
- Solos responding to Cat 1 calls.

NH said there is a definite correlation with the overall abstractions from the daily output relating to Covid and hospital delays.

JB said there has been an increase to 11% for cat 1 calls and 55% for cat 2 calls (a rise of approx. 6% over the last 12 months). October 2021 saw significant increase in pressure in hospital handover delays. JB said some Cat 2 patients are having to wait, sometimes over 100 patients waiting 3-4 hours.

3. Prognosis for the next 3, 6, 12 months and 2 years

NH shared the regional slide regarding hospital delays showing Cat 3 mean and Cat 3 90th percentile targets, this shows an improvement in May 2022, but the Trust cannot predict future hospital delays. Overall, Cat 3 performance has improved in line with the reduction in the hospital delays. It would also improve the downtime experienced by the Trust.

Hospital performance/delays – MK asked if there was any indication of an improvement in hospital handovers. JB and NH said there is no sign that there will be a significant improvement, and this will continue to have

	an impact on the Ambulance Service. JB said in June so far there has been an increased number of hospital delays with no sign of this changing. VK said he had met with NHSE and have challenged each of the ICBs to come up with a recovery plan to reduce the delays, lost hours etc. As this is a medium to long term problem a longer-term strategy will be required to resolve it. **4. What are the Risks to patients? Has it been quantified?** AW outlined to the Committee the risks to patient safety and said that as hospital handover delays continue to increase, the CWG lasting 11 days will be a particular challenge and risk to the Trust. ***Serious Incidents*** (SI's) – AW said these are on the increase, in 2020-21, 84 total were received in the year and these used to be reviewed at the Learning Review Group. However, in 2021-22 the Learning Review Group were unable to review the SI's due to the increase in numbers to 204. From April to May 2022, 77 SI's so far have been received, 38 of which were due to delayed responses. Overall compared to the first two months of last year this is a 453% increase in SIs and within that an 189% increase in non-delay SIs, which relate to either the care given or another reason other than ambulance delay. **Risks –** • Non conveyance with non-referral – non traumatic chest pain – 40% of these people left on scene will have had acute coronary syndromes. • Cardiac Arrest management. • Choking Management. • Inappropriate clinical discharge on scene (Sepsis and Acute coronary syndromes). AW said some clinical staff are now seeing 0-1 patients per shift, compared to 6-8 patients per shift before and this is almost all due to waiting at hospitals and providing health care assistance whilst waiting. There will also be a knock-on effect as the newly qualified paramedics are not getting the experience required to become a paramedic then a CTM two years later. This will be a long-term problem from the increasing situation over the last 2 years. Risks to our patients are: • Delays to emergency care • Delays to definitive care	

	• Delays to admission – it has been found that those patients who were waiting beyond 6-8 hours from ED arrival to admission for every 82 patients there was one extra death. AW said that even though there has been "zero tolerance" letters from NHSE/I since 2017 regarding delays there has been no improvement. AW also mentioned the use of "corridor care" but said even if this is re-introduced this will have a short term effect only. There is a serious need for adequate social care for patients, to enable them to be discharged from hospital. AW said the Trust must focus on patient safety whilst they are in our care whether this is on scene or in hospital queues.	
	2. Diagnoses and 5. Impact on staff and reputation of WMAS	
	VK and MB have been working on the impacts and VK gave a slide to the presentation to the Committee. The main items noted are as follows: • The Trust needs to focus attention on resolving the route cause and the longer-term approach. • Demand increase affecting the handover delay problem. • Sickness – WMAS has the lowest sickness recorded compared to other ambulance services. • Lost hours – deteriorated dramatically since same time last year. • Cat, Cat 2, Cat 3 response times, which mirror the lost hours. • Hospitals – long length of stay (LLoS) patients. Time to treatment in ED's mirrors LLoS, due to availability of beds. • Failure Demand – in April 2021 duplicate 999 calls stood at 8.9% compared to 25.9% in March 2022. • Patient and Staff harm –preventing future deaths report that was published states that hospital delays are a contributory factor to deaths. Staff morale is low, lates shifts, violence and aggression from patients. • Adverse media attention. • Staff attrition is increasing (c. 27 staff per month). VK also outlined the actions have been taken so far to manage the risk. • The Clinical Validation Team has made a huge difference, JB pointed out that the CVT was only put in place to help with the hospital delays. CVT team attract B7 clinician posts, but there has been higher attrition in the EOC. AW said clinicians are attracted to B7 roles as there is advanced practice skills (e.g. Prescribing) which appeals to them, but there are also Trust requirements (legal and regulatory) in terms of the senior clinical capacity to support the clinicians in these roles. There	

	is also recruitment of paramedics elsewhere in the NHS which is desirable due to their career progression, but is likely to have an ongoing impact on the Trust. • CAD Portal. • PTS – should not lose sight of PTS performance which is excellent in supporting patient flow. • Rapid Handover protocol – is not rapid enough. • Intelligent conveyance – is not a solution. • Staff wellbeing, mental health and support is in place but can be expanded further. ACM summed up his thoughts regarding the future regarding hospital handover delays and said this is a national problem for ambulance services and is concerned about the effect on staff and patients. ACM said he has been attending regular national meetings to establish what can be done regionally and nationally. ACM stressed that WMAS has a very strong operational model in place.	
	6. Plan of Action	
	VK outlined the further initiatives that have been recognised, including: People: • Recruitment of complementary skills into the Trust e.g. Nurses into CVT. • Senior clinical leadership role - to be based at Hubs. • Reward/recognize teams/individuals and partners • Additional HALO funding. • Work on culture and behaviour. Performance: • Cat 3 and 4 patients to be pushed through to alternative pathways – UCR. • Handover interface – change pathways to reduce lost hours. • E&U careflow agreements from CQC and NHSE not being put in place. • Peer review s to take place locally to consider implementing a model. Safety: • CFR schemes to be considered by WMFS • Safety Culture Survey – to be launched to our staff soon. • Companions with patients to be re-instigated. • ICB risk register to be reviewed to ensure it reflects handover delays, plus sharing of Sis with ICBs. • Work more closely with Healthwatch.	

	VK said these actions have been suggested by himself and MB and said he would welcome any other suggestions from colleagues to be included.	
06/22/04	**Summary**	
	MK summarised the conclusions from the meeting and said it would be helpful if all colleagues could review actions and initiatives and contribute. NH said the Acute Trusts need to be involved and the impact on patients by perhaps hosting ICB risk summits with each acute with WMAS attending also to describe the risks the Trust is facing. Also invite the CQC. AW said EDs' attendances and delays to admission are the highest on record. The number of SI's here are also increasing. AW said some hospitals are considering using corridor care again. She also said the risk ownership should be moved from WMAS to the organisations that are ultimately responsible. AW also pointed out that more funding for social care would be beneficial. The recommendations made in VK's slides to be reviewed. It was stressed there is a need to work in collaboration with Acute Trusts is key to reducing handover delays. VK said it had been a good debate and agreed to devise an action plan, along with colleagues, with recommendations going forward. To be presented to the next Board meeting in July. VK to share with Committee members before presentation to the Board. MK thanked everyone for attending and for the presentations made at today's meeting.	
	Resolved: a) VK to circulate any proposed actions plans to colleagues. b) VK to share the report with the Committee members for any input/observations before sharing/presenting to the board. c) Presentation to be made to the Board in July.	**VK** **VK** **VK**
06/22/05	**Any Other Urgent Business**	
	There was no other business.	
06/22/06	**Dates and times of Future Meetings 2022-23**	
	• 28 July 2022 • 27 October 2022 • 23 January 2023 • 23 February 2023	**All**

	• 25 April 2023 • 25 July 2023 • 24 October 2023 The meeting closed at 1100 hours.	

West Midlands Ambulance Service
University NHS Foundation Trust

Performance Committee - July 2022

Action Points from Meeting held on 26 April 2022

	Minute	Details	To be actioned by	Complete	Evidence
1.	04/22/04	Breakdown of Overtime to be brought to the next meeting.	**KR/NH**	✓	**Complete. It was agreed that further work is required on the details behind the overtime – PJ and NH to provide to October meeting.**
2.	04/22/06	JB to raise recruitment promotion at fairs/schools/colleges at People Committee.	**JB**	✓	**Complete.**
3.	04/22/08	Self-assessment circulated for comment. Terms of Reference circulated for final approval.	**DS** **DS**	✓ ✓	**Both documents circulated, no comments received, forwarded to PH on 5.5.22 for Board Meeting in May**
4.	04/22/09	KR to report back to the next meeting re the progress of the Capital and Revenue Investment Advisory Group and its key purpose.	**KR**	✓	**The Group meets regularly and business cases are presented to the meeting for either onward approval at EMB or returned to owner for more information. The minutes are forwarded to Performance Committee for information.**
5.	04/22/12	JB to share IEUC deep dive presentation via email DS to place on the agenda for the next meeting.	**JB** **DS**	✓	**Complete and on agenda - but this is not now necessary to be discussed.**

Action Points from Extraordinary Meeting held on 14 June 2022

	Minute	Details	To be actioned by	Complete	Evidence
1.	04/22/04 06/22/02	Breakdown of Overtime to be brought to the next meeting.	**KR/NH**	✓	**Complete – as 04/22/02 above.**
2.	06/22/04	Handover delays : VK to circulate any proposed actions plans to colleagues. VK to share the report with the Committee members for any input/observations before sharing/presenting to the board. Presentation to be made to the Board in July.	**VK**	✓	**Complete**

Minutes of the meeting of the Quality Governance Committee held on 20 July 2022
In view of the current National Emergency and the guidance on maintaining social distancing the meeting was convened by electronic means through Microsoft Teams software

Present:

Lisa Bayliss-Pratt	(LBP)	Non-Executive Director (Chair)
Mohammed Fessal	(MF)	Non-Executive Director (Vice Chair)
Dr Alison Walker	(AW)	Executive Medical Director
Mark Docherty	(MD)	Executive Director of Nursing & Clinical Commissioning
Vivek Khashu	(VK)	Engagement & Strategy Director
Jason Wiles	(JW)	Consultant Paramedic for Emergency Care
Nick Henry	(NVH)	Head of Operational Information & Planning
Vickie Whorton	(VW)	IEUC Clinical Commander
Cynthia Clayton	(CCN)	IEUC Clinical Governance Lead
Stephen Thompson	(ST)	Staffside Representative

In attendance:

Diane Scott	(DJS)	Organisational Assurance Director
Pippa Wall	(PW)	Head of Strategic Planning
Chris Kerr	(CK)	Head of Governance & Security

Secretariat:

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

ITEM	Quality Governance Committee (QGC) Meeting 20 July 2022	ACTION
07/22/01	**Apologies and Introductions**	
	Apologies were received from Craig Cooke, Operational Support Services Director, Jeremy Brown, Integrated Emergency & Urgent Care Director, Matt Brown, Head of Risk and Jenny Lumley-Holmes, Head of Clinical Audit. The meeting was quorate.	
07/22/02	**Minutes of previous meeting – 18 May 2022**	
	The minutes of the meeting held on 21 March 2022 were submitted. The question was raised whether the Non-Emergency Services Delivery & Improvement Director should be part of the QGC member. MD supported this suggestion as they are the Lead for PTS and on a wider response for patient handover delays and quality improvement. AW said there is a need to review the membership in terms of the changes in the Director portfolios and members of the Board of Directors. DJS as QGC is a pillar committee of the Board, the terms of reference were submitted to the last public Board meeting noting the changes made relating to the internal audit mapping. The terms of reference can be taken back to the Executive Management Board to ensure the membership is correct and make any recommendations who should be on the membership of QGC. If there are any changes made, these can be documented in the Chair's Report to the Board of Directors.	

	Resolved:	
	a) That the minutes of the meeting held on 21 March 2022 be received and approved as a true and accurate record. b) That the terms of reference are reviewed by the Executive Management Board to ensure the membership is correct.	**DJS**
07/22/03	**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 05/22/04.3: Quality Account & Departmental Annual Reports (Acton Log Nos. 1 & 2) (Action No. 1) No further comments/amendments had been received against the annual reports, therefore, QGC agreed to discharge this continued minute. (Action No. 2) The Quality Account and Departmental Annual Reports were approved by the Board of Directors meeting on 25 May 2022. QGC agreed to discharge this continued minute.	**Discharged** **Discharged**
	2. In relation to continued minute 05/22/04.4: Clinical Supervision Plan The Clinical Supervision Plan will be discussed as an agenda item, therefore, QGC agreed to discharge this continued minute.	**Discharged**
	3. In relation to continued minute 05/22/06.1: Review of Terms of Reference & Committee Self-Assessment The approved terms of reference and the completed committee self-assessment had been circulated as appendices to the minutes. QGC agreed to discharge this continued minute.	**Discharged**
	4. In relation to continued minute 05/22/06.2: 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 will be discussed as an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	5. In relation to continued minute 05/22/06.8: Measuring Organisational Learning Report The measuring organisational learning report will be discussed as an agenda item. QGC agreed to discharge this continued minute.	**Discharged**
	6. In relation to continued minute 05/22/07.1: Equality Impact Assessment (Action Log Nos. 7 & 8) (Action No. 7) CB had confirmed the Equality Impact Assessment training sessions have been delivered to the relevant policy leads, etc. QGC agreed to discharge this continued minute.	**Discharged**

	(Action No. 8) CB had advised due to other workstreams/timescales it was not possible to encompass the Quality Impact Assessment Training within the Equality Impact Training as the delivery was prioritised due to the revised paperwork/documentation being 'live'. QGC agreed to discharge this continued minute.	**Discharged**
07/22/04	**Chair's Reports from Working Groups**	
	4.1 Learning Review Group (LRG)	
	The Chair's Report from the meetings held on 15 June and 16 May 2022 and Action Logs of 16 May and 20 April 2022 had been submitted. AW informed the salient points to note from the Chair's Report of 15 June is there are 3 themes emerging from the serious incidents relating to cardiac arrest management around the lack of use of cardiac arrest checklist, team leading and choking. It was noted there have been 5 choking incidents reported in 1 month. Other themes are discharging patients on-scene with Acute Coronary Syndrome (ACS) or sepsis and this is also being seen as a concern in the internal clinical audits for discharge on-scene. The focus of the Chair's Report of 16 May is on cardiac arrest management and the serious incident workload for the patient safety team. AW felt it was important to note following escalation from herself and MD, the Trust is reinstating the face-to-face cardiac arrest management training and this will include the management of choking.	
	Resolved:	
	That the Chair's Report from the meetings held on 15 June and 16 May 2022 and Action Logs of 16 May and 20 April 2022 be received and noted.	
	4.2 Health, Safety, Risk & Environment (HSRE)	
	The Chair's Report from the meeting held on 4 July 2022 and Action Log of 9 May 2022 had been received. MD said contents of the Chair's Report and Action Log were 'as read' noting the committee had already spoken about the biggest concerns for the Trust. The report details the Top 5 trends and themes which you would expect will increase in workload due to the impact of the hospital handover delays, for example, there has been an increase in complaints and an increase in the number of violence and aggression incidents and there is a significant level of aggression aimed at our control staff which is detrimental on their health and wellbeing. Some of the newer control staff seem to be more accepting of this as being normal and part of the job but it is not acceptable and staff are being encouraged to report more through the ER54 system. The DSPT self-assessment audit has been submitted and the internal audit report shows substantial assurance.	

	With regards to Datix, the Trust is behind implementing this system but it is more complex than anticipated and if there is 1 learning point this would be not to implement a new system during a global pandemic. MD said the Trust is changing to a cloud based system and it is anticipated this will go live from 1 October and once implemented will provide more rich data in the overall systems. MF referred to the Top 5 trends and themes, in particular controlled drugs incidents asking if the increase in incidents relates to theft or losses as MF sits on the controlled drugs action group which has found more controlled drugs themes have been picked up over the pandemic period therefore if the increase was in relation to that this would be a concern in terms of our staff. MD confirmed there has been no increase in theft it is down to processes at a couple of Hubs which have been tightened up and there is CCTV in the areas to controlled drug storage areas which are accessed by a swipe card. Some of the increase in controlled drugs incident relate to Misoprostol which is not a controlled drug but it is treated like one by WMAS and these incidents are detailed separately within the reports. ST referred to the new electronic controlled drugs system which was being trialled at Coventry asking if there had been any improvement. MD was aware there had been a problem with the audits and the trial had been paused but assumed everything was back on track as the trial has now gone live again at Coventry.	
	Resolved:	
	That the Chair's Report from the meeting held on 9 May and 24 March 2022 and Action Log of 24 March and 20 January 2022 be received and noted.	
	4.3 Professional Standards Group (PSG)	
	The Chair's Report from the meetings held on 27 June and 30 May 2022 and Action Logs of 30 May and 3 May 2022 had been submitted. AW stated the salient points to be taken from the report are: • ***Clinical Performance*** – particularly for Stroke and STEMI and the report will discussed later in the meeting. • ***Clinical Audit Summaries*** - 14 out of the 15 audits conducted provided insufficient assurance of the clinical care being provided across the Trust. 1 audit was moderate assurance, relating to post-intubation noting this skill has been withdrawn from the standard paramedic skill set and is only used by the enhanced care platform. Further audits have been conducted, all showing insufficient assurance and this will be the main focus at the extra ordinary Board or Executive Management Board as there are themes emerging around non-conveyance including head injuries, Sepsis, non-traumatic chest pain, ACS and the other audits included administration of adrenaline, naloxone management, post-partem haemorrhage management, etc.	

	AW highlighted the concerns raised around the Student Paramedics having less clinical experience over the last 2 years which is one of the more significant impacts because of the hospital handover delays as students can only spend time with 1 patient per shift which is becoming a daily occurrence when previously students would be seeing 4-6 patients per shift. Therefore, if they are seeing less patients this means they have less clinical experience and the Trust is doing a review of clinical placements offered by the Universities which they would have had 2 years ago because in 2 years-time these students will be eligible to become Clinical Team Mentors (CTMs) who will be less experienced than previously. AW had spoken with some of the Newly Qualified Paramedics (NQPs) who are expressing concerns about the support they have in order to make clinical decisions, and experience of the students and being responsible for other student paramedics. It was noted that NQPs are being asked to make the same decisions around non-traumatic chest pain as a Band 7 or 8 advanced practitioners working in A&E (and without specialist tests) therefore the Trust is asking them to do a lot and they need that extra support. The process has now started around talking about some ways to provide support and needs to be a conversation with the Integrated Care Systems and Boards, as it is not down to WMAS it is around the failure of the health and social care system which means our staff are seeing less patients than everyone else and looking after patients outside hospitals who are the responsibility of the Acute Trusts. As a consequence, there is an increase in serious incidents regarding NQPs such as never having seen a patient have a cardiac arrest or a patient under 65 have a MI therefore they are unable to make the right decisions if they have not seen these patients in their clinical experience previously. This is why we need to take action and the ICSs need to support us as this is a system failure across the whole of the NHS and our patient are a higher risk than other areas. ST agreed with AW's comments as there used to be an education committee and when students did their training, they did a 6 month preceptorship which provided the benefits of a good education and follow ups. Previously when this started the trust had ECPs and each Hub had a ECP facilitator like for like, who may have done extra education to facilitate on the CTM1 day but this standalone status was taken away and then we had Clinical Supervisors who provided the clinical support to the people they were supposed to because they had better knowledge and qualifications than others had and this will happen again moving forward. Whatever needs to be done needs to be hard hitting, honest and maintain the integrity of this committee as the increasing number of serious incidents around ambulance response delays is concerning together with the ever decreasing competence not just for students but frontline staff in general as they are not getting the same numbers of day to day patient contacts. Previously they would see around 8 patients/shift with varying conditions, now it is only around 4 which is demoralising for staff as they know it is happening and are nursing patients more rather than providing emergency care for them. ST suggested when things have eased to use a shift day to catch up on what they need to do in the training rooms with	

	the CTMs to bring them back up to speed as much as possible. MF raised we are talking about issues that are linked to serious incidents, our skills knowledge and competency which all goes back to the insufficient assurance of the clinical audits which are raising concerns. For the last few years, there have been concerns around the number of serious incidents which are continuing to increase over the last few months and it would be helpful as it is not clear to differentiate in the data those that are more system based and those that are more in our own gift to be resolved, for example, we have spoken about using the cardiac arrest checklist and we need to focus our energy on what we can change, as there have been positive findings and there are lots of things that we can do. MF said this was the best robust clinical audit programme he had seen and gave congratulations to those involved. MD confirmed in terms of non-conveyance WMAS do not push clinicians in non-conveyance; we encourage appropriate conveyance and audits that have been undertaken support the fact that we do not have high levels of conveyance of patients to EDs that are inappropriate based on the services that are available to avoid an ED attendance. MF sought more clarification around the child frequent callers, AW replied the Trust had started to do a piece of work on frequent callers which falls under the remit of the Head of Clinical Practice (Mental Health) who does not have the resources or capacity to keep on top of the workload because compared to other organisations where they may have between 6-8 staff to do this. Before moving to a block contract the Trust was paid for every call received and this was when the organisation got to every patient within the response times agreed, until June last year. There is now a financial and a patient-centred rationale to manage these patients in a different way. The block contract takes the patient safety and patient centred approach and these patients health and social care needs but do not have an emergency care need therefore the management of these patients lies with their normal health providers. If these patients have rang so many times during the year, then they will need to be flagged with the Integrated Care Systems who should hold a multi-team disciplinary meeting where WMAS would have some input but these are not overall primarily our patients as they are only in our care for a short time. The children frequent caller information forms part of the safeguarding reviews and nationally there is a move to look at the number of children calling 999 and from the report there are some surprising outputs as 1 child was calling frequently but not for an emergency call requirement. MF suggested it might be useful to have an insight into frequent callers at a future date in terms of what is being done for those repeat callers to help reduce the number of calls and the intensity of work. Those that are not urgent calls, are they getting help in the system so that we know we are doing everything we can and how we can work better with external partners. JW stated the Head of Clinical Practice for Mental Health is picking up high volume service users but only those at the highest level and does not	

	have the capacity to do anything else. It was noted there currently is no national standard for child frequent callers, only for adults. This is a safeguarding function and the reason for this is that the pilot undertaken by a couple of other ambulance services had identified around 70% of child frequent callers are either children in need or at risk. It is about having the assurance we are doing everything we can to make sure these children get the right help at the right time and this is something that the Trust had not previously looked at in detail before and needs to start doing this but there is no resource or capacity to do so. AW stated with high volume service users in the past the Trust was working and leading on a project but as there is a system issue and they default to the 999 system, WMAS should not be leading on this. In one area there is a member of the public who calls 4-5 times a day with chest pain as they know if they say this they will get a CAT2 response and staff have their views as these callers are well known and the Trust still goes out to them because one day they may be having an ACS and if they are not responded to may die, and then the organisation will have a serious incident. So we do need to look into this but at the end of the day it will be a Trust and commissioning decision on resources. WMAS do not currently have an effective system and other services have significant teams and when looking at this in other organisations it is mainly based in the IEUC system with clinical input working with stakeholders and GPs so there is more of a joint multi-team disciplinary approach. MF said from the point on resource, this is important and how do we take this to the board. LBP said the Trust is doing the Level 3 Safeguarding training but did not know how much of a big issues this is and whether this is covered by the Safeguarding training. MF said repeat callers are a performance issue and we cannot quantify how much of an issue this was in the past system as if these patients are pushed out to GP's without appropriate review systems, they may get forgotten about. In a new way of working with the ICS's there needs to be more emphasis on why we should be doing this as WMAS and staff are going to be pressurised by taking calls, sending out the same ambulance crew, therefore this is a good reason to flag for discussion. LBP said from an executive point of view, it would come down how much of a problem is this in relation to the other problems and which is a priority. MD said having worked in commissioning demand management is the responsibility of the CCGs and the Trust has done schemes in the past through CQUIN and was unsure whether this had any impact on the number of high volume service users as it depends on the definition i.e. more than 3 times a day this still equates to hundreds of calls a year and the risk of a block contract is that the organisation will be expected to do more than its core work without having any funding. If there was a robust system for managing high volume service users, we would be able to provide the information on high volume service users to Managers and ICSs and MD felt this warrants a debate at executive level in terms of what this means to the organisation as a business as these patients come to WMAS because we answer the telephone and talk to	

	them and are filling the gap other systems cannot fill. These are patients who do have needs, it is just our service is not the best service for those needs to be met and it is not our issue to fully sort but we are in the system that needs to be sorted. ST raised the Trust used to have a dedicated team which was predominately run by a clinical supervisor and alternate duties staff but the biggest frustration was the outcomes for these patients. If we go down this route, there are fewer staff and what outcome can we deliver or who is going to deliver it and then how are we going to resource it therefore the organisation has to make a decision, as we cannot keep putting extra work like this on the clinical or safeguarding teams. This is specialist work and there needs to be the resource to do this and not putting pressure on the teams we already have or bringing in staff to assist them, we need to look at finances and there are financial challenges going forward but there needs to be some give in the system and perhaps recruit 10 less paramedics in the system to resource this work. AW had been involved previously in setting up a frequent caller system which had 5-6 staff and was commissioned separately and information was shared with the CCGs (now ICBs) as it is their responsibility for managing these patients within the CCG now ICS systems and this needs to be looked at as we can try to manage some of these high volume service users for the benefit of the Trust. AW said in summary there needs to be an executive level discussion to ascertain the size of the issue initially, to look at the national definition and to discuss how this will be worked into the system with the CCGs and ICS's and the consideration of extra resources. All of this information will be presented through an options paper to the Executive Management Board as it will involve financial implications and funding for a decision to be made. MD agreed this was a way forward as these patients are not easily sorted and the Trust can spend hundreds of hours but there is never any change. AW added if we can manage 50% through other systems this should ease some of the pressure. VK said it does take considerable resource and the Trust used to take the "top 10" high volume service users by the ambulance service which could be 276 call outs in a year for some patients, there is usually an impact for a period of time and some of these patients slip off the list but there is always another group to be added. In terms of the social value and responsibility, as nothing is happening for these patients, we do try and make a difference but because it requires multi-disciplinary teams and approaches with different sectors, we did the best we could with the team that we had and this issue lends itself to public health and work with the ICS's. AW referred to complex acute chronic patients who are risky patients in EDs, and there is not anyone below a Band 8 making a decision about discharging these patients, therefore, 1 proposal is to do a pilot of live streaming for clinical senior support for NQPs so they have the option to ask someone to look at the patient with them and support them in terms of decision making. This will be an 'excuse me can I ask you?' system	

	and depending on this goes, we may look at rolling it out beyond NQPs. Another option is 'no decision in isolation' as every day there is a patient taken to hospital who does not require immediate emergency intervention and this would be a system where the crew would telephone a single point of contact at an Acute Trust who has access to care systems and outpatient systems and will be able to support some of the decision of paramedics which are entered into the system and book outpatient appointments. The Trust is looking at human factor elements which are triggers as it has been seen in a number of serious incidents there has been a conversation with the patient around how long the hospital handover will be and this may be subconsciously influencing the decision making of a clinician particularly if there is a 6 hour hospital handover delay and the crew have 1 hour left on shift and this could prevent them from not getting back home to pick up their child or look after a relative with dementia for example. One of the areas that needs review is non-conveyance decision-making through shift periods and there are concerns around adverse decisions being made by the patients and human factors affecting staff. In terms of risk, over the last 2 months there has been over a 300% increase in serious incidents compared to last year, with there being 204 already reported and if this continuing it could be over 600 for this year. The AACE report predicted 400 reported based on an audit conducted in January 2021 around patient harm due to hospital handover delays. The primary harm is when there is no ambulance to be sent out to sick patients within the community and these patients then die. The secondary harm is the impact of these delays on call takers and responding clinicians where they are being shouted at by patients and their families concerned about delays and ambulances are outside EDs for hours with no definitive care being offered by the hospital. There are direct and indirect links to the hospital handover delays as when you look at the non-traumatic chest pain audit, 40% of patients may have ACS but it is difficult to know and this is being escalated nationally as no other ambulance trusts have looked at this in detail because how do you communicate that risk to the patient or the GP once it is recognised through clinical audit. We also need to look at and have the capacity of making a clinical assessment and process where both the patient and GP are aware we have a concern after the patient was managed on scene and this is extremely complex and needs a process. The salient risks identified are: • ***Stroke Performance*** – concerns around the recovery of the Stroke performance and this is being constantly monitored. • ***Alternate Duty Paramedics (new)*** – concerns were raised around alternate duty paramedics who were supporting the clinical audit team that have been moved across to support the serious incidents investigations which are out of time and the impact this will have on the audit team who are struggling to have sufficient staff to conduct the audit they are being asked to do.	

	It was noted verbal reports have been received advising some alternative duties paramedics are finding doing the serious investigation reviews quite upsetting and making them unwell therefore because of their inexperience they are not being asked to undertake more than 2 investigations and some no longer do SI reviews. There is a paper going back to the Executive Management Board around the capacity for serious incident reviews and the ongoing concern around the clinical audit programme. • ***Clinical Placements (Non-Ambulance) for BSc Student Paramedics (new)*** – concerns raised about the lack of assurance around standardisation of their student placements across the region. Each of the universities were contacted to provide information in terms of whether clinical placements are taking place and what is being offered. It was noted 1 university did not provide a response and this is being escalated internally. This issue also being escalated nationally. • ***Newly Qualified Paramedics (NQPs) Portfolio Completion (new)*** – the issue has been raised around NQPs progressing through Gateway 6 to Band 6 before submitting their portfolio and this is being picked up by the People Committee. AW raised there had been a serious incident involving a NQP who had not completed the sign off of all the relevant PGDs before starting their clinical practice and we cannot have NQPs out on the frontline who have not signed off all the PGDs.	
	Resolved:	
	That the Chair's Report from the meetings held on 27 June and 30 May 2022 and Action Logs of 30 May and 3 May 2022 be received and noted.	
07/22/05	**Care, Quality & Safety**	
	5.1 Executive Medical Director & Executive Nurse Director Quality Summary Report	
	The Executive Medical Director & Executive Nurse Director Quality Summary Report had been submitted. MD gave a brief outline of the report which included the SIRO report which had not been reported before. The biggest concerns are patient hospital handover delays and stacking of incidents. MD stated last Monday (11 July 2022) the organisation was stacking 748 patients at one point which is the highest it has gone to noting that pre-COVID if the number of patients waiting went above 20-30 the Trust would be sending staff out responding who would not normally respond. This figure is twice as many compared to the rostered ambulances of 350 ambulance and approximately 500 patients waited through the night until the next morning to receive an ambulance response. MD stated what is concerning is the number of patients waiting over 10 hours and pages 4-5 shows the year to date figure being 631 patients and June is the worse month so far for the majority of 10 hour waits noting that actually some of these reached 15 or more hours. It was highlighted	

	not all hospitals have long waits and these mainly relate to Worcester Royal Hospital, UHB, Princess Royal Hospital and Royal Stoke Hospital. MD said there has been a change in reporting lost hours as we have added in the cohorting time as well as it is not just about looking after the patients outside hospitals but the number of lost hours cohorting patients inside the hospitals and these numbers are going up significantly and are outlined on pages 6-7. In previous years, the number of hours lost per month would be a couple of hundred but for June 1500 was just for the cohorting resource. It was noted June had been the worse month for handover and cohorting delays with 40,000 hours lost and looking into July at the point this report was written this is heading towards 48,000 and if it keeps the same trajectory in August we could be looking at 58,000 meaning 30% of our resources will be lost. The expediential graph on page 9 shows this going up every month and MD had predicted that the service would fail to meet any of its targets mid-August although some have said it has failed already as recently 34.7% of the total resource was lost and we did not hit any targets. Page 10 shows details of the hospital handover delays and correlating all the factors in the performance targets, shows the impact on CAT1 performance which needs to be hit at any cost even noting we are regularly failing the mean average and on occasion the 90th percentile. As a consequence this means patients that need to go to hospital are delayed and one patient was not transported in time to have mechanical thrombectomy for a stroke. MD said if patients take themselves to A&E that is categorised as non-conveyance as there is no filtering mechanism to take out more than half (52%) of the work into non-conveyed or routed into any other services. There had been an increase in complaints and patient safety incidents and MD is presenting some of the comments from patients at the Board of Directors next week. Compliments have increased which shows patients appear to be more accommodating during these challenging times. Violence and aggression incidents have decreased but when you look back in comparison to the previous year we are not back to where we were pre-COVID so this figure is much higher than we would want it to be. There has been an internal audit on violence prevention and reduction which has come back as providing optimal assurance which is positive to note. In terms of Learning from Deaths, the Trust is still reviewing every single death and not a sample size like other services. With regards to Freedom of Information requests, what we are finding is that journalists are coming through this route to obtain information as a request had been received about all the letters that had been written to NHS England highlighted hospital handover delays and the concern is that some of the letters/emails might not all be written in the context of freedom of information therefore by just not saying anything means they are finding ways to obtain the information.	

	MD had met with a group of cardiologists around the impact of hospital handover delays on inter-hospital transfers and getting patient late in their presentation and there had been good discussions around alternative options for these patients. MD had met with the MPs in Shropshire which was useful as they are taking an interest in hospital handover delays and want to do everything they can to be supportive. MD had attended a CQC event in London where they are interested in the patient stories relating to hospital handover delays and 2 were WMAS stories were presented and 1 of those being presented at the Board of Directors next week is Jamie's story and his parents will be in attendance. AW advised herself and MD, as one of the man actions from the thematic reviews of hospital handover delays, is to re-escalate these concerns and they will continue to do this particularly when the service lost 2,000 hours in 1 day of ambulance response time. Numerous regional meetings have been attended regarding this and patient safety concerns clearly communicated. AW said she attends the regional emergency department lead clinicians meeting and our messaging is consistent across us and EDs. They understand any changes we make are related to patient safety. Last Friday there had been an Executive Management Board conversation risk to CAT2 patients as there had been a number of cases where patients had died because there was no ambulance resource available to send to them and a family had asked why the organisation had not said anything to them as they were told we were arranging help but not for several hours. A Healthwatch comment had also been made about being honest with the public advising there is no ambulance resource to send at the moment and this may be several hours but once available we will arrange help. As an NHS Trust and clinicians, we have to be honest and tell patients or families if there is no ambulance immediately available. AW said she had also triggered an emergency NASMeD discussion as we had taken this step and there was a heat wave coming and NHSE were aware of the risks. This had also triggered 2 calls in relation to the heat waves and the additional clinical risks, escalated to top of NHSE. AW had joined an international call with British Columbia experts who had a heat wave last summer who shared learning from that that she had not been aware of as JRCALC chair. This included shared information about the risks for people with serious MH conditions of dying, the risks for those over 65, those with multiple co-morbidities. Overall, there had been an excess 714 deaths, many were related to people being in doors in the evening or 24 hours, when they could be cooler outdoors in the shade. There had been a number of reasons to do something urgently and she had led drafting extreme heat guidance supplementary to JRCALC which had been shared across the UK before the heatwave. The Trust is reviewing the thematic review investigation recommendations and as mentioned previously these are being escalated through regional and national systems and we have asked regionally what they would like	

	us to do to help. In one case in the South West, an Acute Trust lead had a stroke and had to be taken to hospital by car as he husband thought there would not be an ambulance available. We have had a similar case where a man was crossing a road and was knocked down and taken to hospital by his family in a car with serious injuries which then needed emergency ambulance transfer to a MTC. This case has been reported through a TRID. If the Public believe they will not get an ambulance they will take people to hospital themselves and they are already doing this for CAT3 and CAT4 calls which has increased the number of patients at the ED door. If the hospital does manage to release some of the paramedics they do not always bring the next patient back into ED as we do manage patients outs in the community. LBP said we talk about all of the things we are doing and implementing actions resulting in improvement is key, but the question is, should there be a 10 point plan that every system should have and is managed by the Secretary of State for Health. In terms of assurance on the ongoing communication of the risks across our regional leads, AW and MD had given a presentation to the Regional Medical Directors, Nurse Directors and Patient Safety leads, which can be shared with the committee, whereby she went through the risks, mitigating actions and MD included 3 patient stories. ST said previously the Trust was stacking CAT3 and CAT4 calls and now CAT2 calls are stacking which backs up MD's comments how badly things are moving towards August around hospital handover delays and obviously there is potentially room for even more delays based on the announcement on the NHS pay award, as there have already been lots of comments in the media and more nursing/paramedic staff will be lost as they are moving to private based providers. Now we know what the issues are and there are a lack of resources, and we may have further problems going forwards as the Unions have been asked to ballot members asking them what they want to do. VK said there is work being dong with the ICB and CEO's of the most challenged systems and there are weekly conversations taking place around improvements and a letter was released last Friday.	
	Resolved:	
	That the contents of the Executive Medical Director & Executive Nurse Director Quality Summary Report be received and noted.	
	5.2 Patient Stories	
	MD presented 3 patient stories (John, Jamie and Arif) to committee members noting that Jamie's story is being presented to the Board of Directors next week and Jamie's parents will be in attendance. The outcomes of these patients were discussed which could have been avoidable deaths or harm if resources had been available earlier.	
	Resolved:	

	That the details of the 3 patient stories be received and noted.	
	5.3 Trust Board Reporting – Clinical Performance	
	The Clinical Performance Report for May 2022 had been received. AW stated the high-level message to note for QGC, is the concerns discussed at Professional Standards Group around Stroke performance which were originally due to the changes to the EPR2 system but there are additional ongoing concerns around this. Performance for STEMI is currently stable and for Cardiac Arrest there has been a positive increase in survival to discharge. AW noted the requirement for the standard PPE Level 3 option for cardiac arrest has been moved to a Level 2 requirement with the option to move to Level 3 after ventilation has started.	
	With regards to performance for Sepsis, it was noted the Trust is consistently achieving above 81%.	
	Resolved:	
	That the contents of the Clinical Performance Indicator Report for May 2022 be received and noted.	
	5.4 Quarterly Exception Report on the Priorities of the Quality Account	
	PW provided a verbal update on the workplans for the 5 quality account priorities that had been agreed for next year as follows: • **Maternity** – the maternity action plan has been agreed but due to the serious incident work which the Clinical Manager – Maternity Lead has been involved with, the focus has been restricted to the education and training part of that. AW and JW have received this submission and are happy with where we are and acknowledge more work needs to be completed. • **Mental Health** – an update had been provided by the Head of Clinical Practice for Mental Health who is starting afresh and reflecting on the workplan the workstreams in terms of training and development. • **Integrated Emergency & Urgent Care Clinical Governance** – PW gave thanks to CCN and IEUC colleagues for the updates and has had some time with JB going through the updates noting there will be some movement on the planned work as everything has started. AW had spoken with JB in terms of a further review from IEUC perspective and will provide PW with an updated plan for the next meeting. • **Utilisation of Alternative Pathways** – this is a piece of collaborative working in partnership with all our partner services, ICBs and so on and will move in the direct which each of the systems are moving in. There are some good examples i.e. Stafford CRIS service and initiatives in SWIFT. Warwickshire are doing fortnightly training with our staff, so they are aware of the services used for alternative pathways, CAD portal being made available around the system, etc. There are a variety of themes in progress which will continue to evolve. • **Developing our role in improving Public Health** – a WMAS public	

	health group has been established under the leadership of AW with some expertise and it is important to have good contacts to start to network and link in with relevant agencies including in public health and university links. All workstreams are on track.	
	Resolved:	
	That the discussion on the Quarterly Exception Report on the Priorities of the Quality Account be received and noted.	
	5.5 Clinical Supervision Plan	
	The Clinical Supervision Plans for 2021-22 and 2022-23 had been submitted. NVH said the key point is that the supervision plan for last year is being presented as a completed report noting the high performing outcomes. In terms of this year's plan, clinical supervision had continued through the current pressures and working through the pandemic because if the organisation stopped everything it would not start anything up again, therefore, the decision was made to continue to deliver clinical supervision throughout the year. It was noted mandatory training was paused for the Commonwealth Games and almost all of August but this is being delivered again. NVH said what needs to be added is the classroom assessment around ALS and this will be reported once it has been identified how this data will be captured in the report. The figures are per the report noting CRT is currently at 47% and the training has been spread out and the classroom numbers halved to maintain delivery and will run up to the end of the financial year therefore the uptake will be seen as slower because we have reduced the numbers and it is only a half day release for staff. There is some work that needs to be drafted to meet the national clinical supervision model and this is around clinical supervision being captured as CPD on a quarterly basis and NVH is exploring the option of a face to face clinical training each quarter and is working through a model in Operations noting this will be easier to do in IEUC. In the operational phase there will be a need to increase the number of Clinical Team Mentors (CTMs) in the system to deliver that work and we are working through what can we do and looking at learning from colleagues around the country on how they deliver that. The Trust does deliver a lot in Quarter 1, 2, 3 and 4 so NVH said there will be a need to schedule training going forward so that we plan for minimal impact on operation staff which we have done before and it has worked successfully. LBP said it was good to see the Trust in a good place and the delivery of clinical supervision is an important thing to do.	
	Resolved:	
	That the contents of the Clinical Supervision Plans for 2021-22 and 2022-23 be received and noted.	

	5.6 Violence Prevention & Reduction Quarter 1 Report	
	The Violence Prevention & Reduction Quarter 1 Report had been received. CK stated the report was 'as read' noting it had previously been presented at the HSRE and LRG. Overall the report is showing a slight decrease in physical and verbal assaults which algins with the number of ER54s received being down in the first quarter. There is a detailed breakdown of physical, verbal, security and near miss incidents for each of the Hubs, PTS and IEUC areas. The body worn cameras have been rolled out and the report captures the number of activations. In terms of them being used as a preventative measure, it was noted physical assaults have reduced by 9%, verbal by 7% and overall there has been a 11% reduction in reporting. The action plan has been included for assurance which is based on the framework from NHS England who are using this to drive prevention and reduction in violence. There are 57 indicators for the violence prevention and reduction standard and the action plan will be reviewed regularly. Internal audit have conducted an audit and have stated optimal assurance has been provided. MF referred to the data broken down by Hub asking if this is proportional to the size of the Hub and if not what is there to learn. CK said the information provided in the report is the same which is distributed to the Senior Operation Managers (SOMs) and the Emergency Services Delivery Director as lead is trying to give the SOMs that information to give them the best idea of their size compared to other Hubs and to drive them to spot any issues/concerns straight away for example if Warwick is higher compared to Coventry then it drives both sides to reporting not just those with high levels but those with low who might be underreporting. AW highlighted the reason for the reduction in reporting might be because crews are not seeing the same number of patients per shift or another indication is the aggression phase where a family who have lost a member of their family or a patient has been stuck outside a hospital for 9 hours and are aware it is not our fault but might have a verbal outburst and then calm down which is an understandable reaction to a terrible event. CK said WMAS have rolled out the body worn cameras well and make them available to staff as there are 350 vehicles with 2 crews members on each vehicle so there is a gap in terms of usage and the Trust is trying to understand why there is a gap so that we can determine whether they are making a difference or reducing the likelihood of an assault. There is ongoing work with staffside and staff on this as we are still in a learning stage. LBP suggested next time having more of a discussion around the body worn camera usage rate and an update in terms of the cultural aspect for example are the elderly scared of the camera, do younger people become more agitated because of it.	

	Resolved:	
	That the contents of the Violence Prevention & Reduction Quarter 1 Report be received and noted.	
	5.7 Integrated Emergency & Urgent Care (IEUC) Update Report on Clinical Audits	
	The Integrated Emergency & Urgent Care (IEUC) Update Report on Clinical Audits and CAT2 Trial Report had been submitted. **CAT2 Trial Report** VW outlined the contents of the report advising from 25 March following the successful implementation of clinical validation of CAT 3 and CAT 4 calls the Trust commenced clinical validation of CAT2 999 calls. The total number of calls triaged as an initial CAT2 priority was 8,618 (5.1%) of these 4935 (57.3%) had an outcome of an ambulance response and 3,683 (42.7%) had an outcome where an alternative pathway was utilised or non-response. In total 4258 (49%) had a CAT2 response. At the time of producing the report, VW did not have the recontact details but provided a verbal update since April this year. AW said approximately 2.5% of 999 'hear and treat' are requiring an emergency ambulance and 97.5% have not, spread across all categories of calls. AW said it was fantastic to receive this information and it needs to be reported through to Board as part of the IEUC performance standards. **Integrated Emergency & Urgent Care (IEUC) Update Report on Clinical Audits** CCN gave a brief overview of the report which is looking at the calls taken and audited from clinician and includes the numbers for call assessors audit against the NHS Pathway standards. Compared to previously, and because of demand and pressures the audits have not been as robust in terms of numbers but we are making some improvements. For the month of June, a total of 2,141 audits were completed by IEUC and the themes identified were over-probing, for senior clinicians the effective utilisation of the audit tool PaCC's and identification of red flags. With regards to 111 Pathways Clinical audits, these have been broken down into clinical skill sets i.e. clinical advisors, nursing and paramedics. 416 audits were required but only 108 completed and this is due to long term sickness and under establishment for 111 pathway clinical auditors and IEUC have been using other auditors who are not full time and are creating a new job description to attract auditors to the post as a Band 6. Compliance is 93% and the average audit score was 95% which provides some assurance for this staff group. The outcomes of the other audits are as follows: • ***Pharmacists*** – 73 audits required and 84 completed equating to 87%. Compliance is 92% of which the average audit score was 95% and where audit are not compliant feedback is given via the audit leads or line manager so they are aware and learning is taking place. • ***Dental Nurses*** – 51 audits required and 61 completed. Audit	

	compliance is 97% of which the average audit score was 94%. Overall these are high numbers which is encouraging. • ***GPs*** – 146 audits required and completed. 4 failed the audit but this number is still quite good. • ***Advanced Clinical Practitioner*** – 113 audit required and 137 completed. 1 failed the audit and compliance was 99%. • ***Clinical Validation Team*** – 360 required only 294 were completed which is 82%. 19 failed the audit and feedback have been given to those concerned. • ***Mental Health*** – 38 required and completed which is 100%. All audits passed with an average audit score of 95%. CCN acknowledged there is work to be done increasing the number particularly for the clinical advisor group and a job description had been released to attract more auditors to backfill and use for other audits to enable us to catch up and be where we need to be. This is a strong position in terms of the standard and provides some assurance for those audits that have been completed.	
	Resolved:	
	That the contents of the Integrated Emergency & Urgent Care (IEUC) Update Report on Clinical Audits be received and noted.	
07/22/06	**Risk**	
	6.1 Board Assurance Framework (BAF) The Board Assurance Framework (BAF) had been circulated. In MWB's absence, the BAF was taken 'as read' based on there will be a full discussion on the BAF at the Board of Directors meeting next week. MD noted the 2 significant risks of 25 relating to the hospital handover delays and the stacking of incident remain unchanged.	
	Resolved:	
	That the Board Assurance Framework be received and noted.	
07/22/07	**Governance/Compliance and Regulation**	
	7.1 Quarterly Review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones The Quarterly review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones had not been submitted. PW apologies for not submitted the report advising it had been a challenge to complete with the pressures everyone is under but gave thanks to colleagues for their contribution. A copy of the report was displayed on the screen and PW was working on using the same template for the reporting of the strategies as for the quality account priorities and as this was the first time using this template it had taken a couple of attempts to get it fully populated in terms of the themes and measures being as smart as they should be and measurable.	

	The overarching message to the committee is that the Trust is on track with most things as it can be given the pressures it is currently under. MF said the strategies linked to this committee are supposed to be linked to the overarching strategies of the organisation highlighting for example the digital strategy is linked to the performance committee but there is not purely around performance as there is also an element of quality and confidentiality. PW replied that there a need to look at the alignment and some of the strategies are being reviewed shortly. VK said there was a paper presented to Board which showed the family tree of the organisational structure and there are 18 underling strategies and we need to ensure this reflects properly the alignment and cross over to committees. It was agreed that VK and PW would work with DJS to ensure the alignments of the strategies are correct.	
	Resolved:	
	a) That the discussion on the Quarterly review of the delivery of clinical and quality related Strategic and Operational priority objectives and milestones be received and noted. b) That VK and PW would work with DJS to ensure the alignments of the strategies are correct to each committee.	**VK/PW/ DJS**
	7.2 Serious Incident Report	
	The Serious Incident Report for June 2022 had been received. MD stated there had been a lot of discussion around serious incidents, therefore, the report is 'as read' and provides a more detailed breakdown of the 111 incidents reported from April to June 2022. MF highlighted the report talks about recruiting 10 investigation officers and this that still the plan for the long term or is this an interim solution. In response MD stated the board report proposes 10 additional investigators which was correct at that time, but the difficulty will be if the number of serious incidents keep rising then it will still be difficult to manage the workload going forward. The proposal has gone through the Executive Management Board and the Capital Group and will be coming to Board for the next step of approval.	
	Resolved:	
	That the contents of the Serious Incident Report be received and noted.	
	7.3 Data Sharing & Protection Toolkit (DSPT) Report	
	The Data Sharing & Protection Toolkit (DSPT) Report had been circulated. CK advised the report was 'as read' highlighting this is a framework that protects our data, staff and patient data. It was pleasing to report version 4 had been submitted and evidence had been provided against all 109 mandatory lines. It was noted 5 extra non-mandatory lines have been reviewed compared to those in version 3.	

	Internal audit have conducted a review of the DSPT and given substantial assurance which is important to note because this is a self-assessment. The DRAFT audit report has been received at Audit Committee and the Board of Directors on 29 June 2022. The key points are version 5 was released as few days ago and there is a bigger proportion around the IT cyber security element. The training based on the PDR completion rate which is 95% has moved over to mandatory version for version 5.	
	Resolved:	
	That the contents of the Data Sharing & Protection Toolkit (DS&PT) Report be received and noted.	
	7.4 Learning from Deaths Quarter 4 Report	
	The Learning from Deaths Quarter 4 Report had been received. LBP requested this item is deferred to the next meeting.	
	Resolved:	
	That the Learning from Deaths Quarter 4 Report be deferred to the next meeting.	**MD**
	7.5 Measuring Organisational Learning Report	
	The Measuring Organisational Learning Report had been received. LBP requested this item is deferred to the next meeting.	
	Resolved:	
	That the Measuring Organisational Learning Report is deferred to the next meeting.	**MWB**
07/22/08	**Documents for Approval/Discussion**	
	None presented.	
07/22/09	**Schedule of Business**	
	The Schedule of Business had been received.	
	Resolved:	
	That the Schedule of Business be received and noted.	
07/22/10	**Any Other Urgent Business**	
	None raised.	
07/22/11	**New or Increased Risks highlighted from the meeting**	
	The following risks were highlighted at the meeting: • ***Clinical Competency*** – raised through LRG and serious incidents and being escalated through the appropriate channels. • ***High volume service users*** – funding support. Options papers to be presented to the Executive Management Board. • ***Handover delays*** – lost hours, patient safety, experience and quality. Patient waits in the community, etc. Being escalated continually regionally and nationally.	

	• ***Alternate duties staff*** - being used for serious investigations and issues with moving forward with clinical audits and some staff struggling with dealing with the nature of serious incidents. • ***Clinical Audits*** - 15/16 internal clinical audits showing as insufficient assurance. Escalation to Executive Management Board. There being no further business, the Chair declared the meeting closed at 13.00 pm.	
07/22/12	**Date and Time of the next meeting**	
	Wednesday 19 October 2022 at 10.00 am via Microsoft TEAMS	

These minutes were agreed as an accurate record on Wednesday 19 October 2022

West Midlands Ambulance Service
University NHS Foundation Trust

Minutes and Actions of the People Committee held on Monday 23rd May 2022 at 1300 hours via Microsoft Teams

Members:

Mohammed Fessal (Chair)	MF
Narinder Kooner	NK
Lisa Bayliss-Pratt	LBP
Carla Beechey	CB
Lucy Mackcracken	LM
Michelle Brotherton	MB
Nathan Hudson	NH
Karen Rutter	KR
Jeremy Brown	JB

In attendance:

Diane Scott	DJS
Paul Tolley	PT
Barbara Kozlowska	BK
Mohammed Ramzan	MR
Matt Brown	MB
Reena Farrington	RF
Stephen Thompson	ST
Simon Day	SD
Damian Dixon	DD
Dawn John	DEJ

ITEM	Meeting held on 23rd May 2022	ACTION
05/22/01	**Welcome:** The Chair thanked everyone present for attending.	
	Apologies: Lisa Bayliss- Pratt, Diane Scott and Michelle Brotherton. Please note that Narinder Kooner will leave the meeting at 1500 hours.	
05/22/02	**Minutes of the last meeting of the People Committee 28th February 2022:**	
	The minutes from the meeting on 28th February 2022 were submitted and agreed as an accurate record.	

05/22/03	**Actions arising:**	
	1. National Diversity group measure / analysis. Action ongoing for MF. 2. Recruitment and Retention. Action Complete. JB will take to Quality Governance Committee meetings. 3. Workforce Risks: Action complete. Matt Brown is present today to highlight the main red and amber risks.	
05/22/04	**Matt Brown – Workforce Risks Overview**	
	Matt Brown kindly attended today to review the Workforce risks with member of the People Committee. A discussion took place around crossover of risks presented to multiple committees, i.e. People Committee, QGC and RPF. If we are to have a report update on a particular risk, we need a subject matter expert. There are regular updates at RPF, where multi directorates attend. John Kelly would be invited to RPF to present an update if needed. The Chair enquired at what point would a risk be archived? Matt Brown advised that only when there is a removal of equipment, process or other positive change would a risk be archived. Subsequently, if a matter arises again, a risk can be brought out of archive. The Chair thanked Matt Brown for his overview today.	
	Resolved: a) That the contents of item 4 are received and noted.	
05/22/05	**Wellbeing Guardian Action Plan:**	
	CB presented item 5 with an oversight of requirement for the Wellbeing role. Narinder Kooner and Maria Watson link in with each other and update the People Committee with a report. MF has had general involvement as a non-executive in 'Day in The Life' (DITL) and recently spent some time with the Call Assessors, which was incredibly informative. Barbara Kozlowska sends out DITL paperwork for completion and return every month for ongoing development records.	
	Resolved: a) That the contents of item 5 are received and noted.	
05/22/06	**EDS2 Update 2021/2022**	
	MR presented item 6 with the following key points: • Contents of assessment and grading gone to publication.	

	• EDS2 highlights good areas and those needing further development. Progress is monitored quarterly. • EDS3 is on the horizon and will be launched next year. Assistance has been sought from colleagues and it has come to the fore that procurement is an area for further work. We have a new Head of Procurement in the Trust who will be able to review with fresh eyes with a new and enlarged team.	
	Resolved: a) That the contents of item 6 are received and noted.	
05/22/07	**Leavers Analysis:**	
	Lucy Mackcracken presented item 7 – Leavers Analysis with the following salient points: • Annual analysis of leavers from 1st April 2021 to 31st March 2022. 978 leavers from the Trust compared to 611 in the period from 1st April 2020 to 31st March 2021. This includes all leavers including dismissals, TUPE transfers and voluntary resignations. • Just under 10% of leavers complete exit interviews. There is an app to encourage uptake and to gain more intelligence on why staff leave. • There is a predetermined 'reason for leaving' list of options on ESR. There is a higher turnover of staff within IEUC i.e. when a call assessor starts the training but does not complete it. Not a neat option available for that. A discussion followed. NK expressed the need to understand information on staff leaving for health reasons, incompatible working relationships and lack of learning opportunities. Annual reviews could be held with staff members to identify patterns and gain feedback. CB responded that the PDR process is triangulated to exit interview i.e. if a member of staff can no longer do shifts or there is difficulty in work / life balance. Staffside added that discussions have been held at QGC around a lack of progression opportunities from a clinical point of view. Paramedics have left the Trust to go into Primary Care. In 2008 we looked at Advanced Paramedics but this did not gain momentum and staff can feel that they have reached a 'dead end' with progressions only offered at high end e.g. Masters. With the current health economy, there are lots of alternative opportunities. The group agreed that it would be interesting to correlate long serving staff with banding and pay grades.	

	NH stated that we are on a bit of a backfoot with the hours we can offer. Working night shifts can have an impact on health and wellbeing for some staff. We can upskill staff as ACPs and then they leave to work for PCNs or other careers outside of the organisation. NH feels that recruitment is key in offering opportunities for band 6. Staffside acknowledged the really difficult situation of losing our staff to Primary Care, for which there is no easy solution. NH added that we are keeping up with the recruitment element and offering more opportunities. Staffside noted the attrition from IEUC and linked it with taking on a younger workforce than ever before. There are a high number of aggressive calls to deal with and staff can get the same salary at supermarkets so leave. The Chair noted that 150 of the leavers had over 10 year service, therefore we are losing valuable experience. CB responded that career patterns have changed. People want to weave in and out and have asked to come back. People want more of a fluid career. The Chair praised the work put into this report and the quality of the data. Time continues to be protected for PDRs to allow for meaningful conversations around development, aspirations, training and encouragement. Staffside confirm that these are better than they were at the start of the pandemic. Conversations are logged. The challenge is the organisation's ability to meet the aspirations of staff. The PDR quality audit is presented to People Committee annually. Organisational Development also carries out interviews to gain feedback.	
	Resolved: a) That the contents of items 7 are received and noted.	
05/22/08	**Workforce Key Performance Indicators dashboard and analysis:** February 2022 Workforce Diversity Profile 2019-20 and 2021-22	
	The February, March and April 2022 reports were accepted as read.	

	• The number of university students on bank staff has reduced as many have joined the Trust as full time employees and Graduate paramedics. • Agency spend is zero. • We ended March 2022 with sickness at 5.2%. Without Covid, we are within our target of below 4%. Covid numbers are decreasing. The main areas of concern are mental health issues. Extra resources are in place with an extra Mental Wellbeing Practitioner and resilience training for staff planned once funding is confirmed. • The Gender Pay Gap reports will continue to be presented at People Committee along with WRES and WDES. • Ethnicity Pay Gap will be discussed at the D&I: SAG. The group discussed the challenges of handover delays, sickness levels and staff recruitment. JB explained that we work with staff through issues, exploring working patterns to assist work / life balance. As a 24/7 organisation we are unique in demand profile and we make the rotas clear from a recruitment point of view and support some flexibility. We have needed to take on candidates with minimal requirements and sometimes staff are young with no life experience. We can offer a range of rotas but have to meet the needs of our patients too. The group went on to discuss the hybrid working model for corporate staff. Staff have the choice to come in when needed, following conversations with local managers. It is acknowledged that there are no concerns in this area. Staffside raised the point that given the age demographics and life experience of new call assessor candidates, could we have a mock set up added to the recruitment process, which demonstrates some of the aggressive and abusive calls they are likely to encounter. JB agreed that this was a good idea and would take forward as an action for this Committee. **Action: Jeremy Brown**	**JB**
	Resolved: a) That the contents of item 8 are received and noted.	
05/22/09	**People / Workforce Report:** • **HR Casework** • **ET Report** • **Recruitment Activity and Progress Reports** • **Health and Wellbeing Report** • **Medical Revalidation Annual Assurance Report** • **Professional Referrals Annual Assurance Report**	

	• **Policies and Procedure update / Policies for Ratification:**
	  ○ Domestic Leave
	  ○ Resolutions (Grievance)
	  ○ Adoption
	  ○ Dignity at Work	

	Lucy Mackcracken presented item 9. With regard to the Annual Assurance section, there are systems in place within the Trust for Professional Referrals. Over the past 12 months there have been 11 referrals to HCPC. Professional Revalidation and Appraisal: 60 Doctors are engaged within the Trust. We have assurance that we have checked their data. One Doctor within MERIT is on military deployment. We have just had an internal audit for professional qualification of nurses and paramedics professional qualifications for which we were awarded 'Optimal' so very pleased with that result. General Workforce: There has been an increase in Employment Tribunals. Specific action is in place for recruitment. The July cohort is almost full and a recent event at The Copthorne was well attended. The policies listed above are here for final ratification following Policy Group and RPF. The Chair particularly noted the excellence of the Domestic Leave / Time Off policy, which he felt was simple to read and demonstrated the important focus on the wellbeing of staff. The Health and Wellbeing Report for quarter 4 captures all of the work in this area. Mental Wellbeing Practitioners triage staff and make the most appropriate onward referral. The average wait time is 12 days. QWELL continues to be used effectively by staff. NH added that our Mental Wellbeing Practitioners are supporting managers and staff well. Resilience training is key. SALS advisors are also critical in helping with new and difficult social pressures. The Trust continues to train staff to support our patients. NK noted that it was good to see that men are coming forward for help and support, which has not always been the case. It is positive that the systems in place are working well.	
	Resolved: a) That the contents of item 9 are received and noted.	
05/22/10	**Equality, Diversity and Inclusion Progress Report:** ○ WRES Action Plan 2021	

	○ WDES Action Plan 2021 ○ Gender Pay Gap Action Plan 2021	
	Mohammed Ramzan presented his papers for item 10. Work continues on the WRES action plan. This is shared with Organisational Development for their input. We are looking at improvement in equal opportunities in non-clinical roles and career progression. We have performed really well in the clinical and medical areas with proportional representation. We will be looking at March 2022 data, which is not available as yet. Detailed discussion can then be held in D&I: SAG and CB extended an invitation to the Chair and NK to attend. Discussion followed on the pathway of the actions plans via EMB and Board, prior to being published. NK asked if we can have these reports showing numbers of BAME staff, rather than percentages, which would help give a clearer picture. MR to share the action plans as soon as they are available: **Acton: Mohammed Ramzan**	**MR**
	Resolved: a) That the contents of item 10 are received and noted.	
05/22/11	**Education and Training Update:**	
	Paul Tolley presented item 11. Education packages and programmes are offered from Level 2 to Level 7 with core training standards agreed by the Board. We develop our programmes against the funding schemes. We are adopting a process to report wellbeing, primarily led by our students. University engagement continues with three partner universities, Wolverhampton, BCU and Staffs. There is wide ranging engagement, fully compliant with HCPC. We continue to develop our internal level 6 / BSc apprenticeship programme. There are 18 apprenticeships being delivered, including those offered in post, sometimes offered as development through an agreed partner. All opportunities are listed on Trust sites and NHS Jobs.	
	At 1500 hours Narinder Kooner, Nathan Hudson, Jeremy Brown, Mohammed Ramzan, Matt Brown and Simon Day left the meeting.	

	Resolved: a) That the contents of item 11 are received and noted.	
05/22/12	**OD Dashboard; Development and Engagement:** OD Annual Report	
	Barbara Kozlowska presented the Organisational Development Annual Report, which is promoted widely in the Trust Weekly Brief so that staff know what is on offer. The Chief Executive has asked BK and CB to run a session on refreshing vision, values and behaviours during the June Board Strategy and Development Day.	
	Resolved: a) That the contents of item 12 are received and noted.	
05/22/13	**Schedule of Business 2021 – 2022:**	
	Taken as read.	
	Resolved: a) That the contents of item 14 are received and noted.	
05/22/14	**Any Other Urgent Business:**	
	There being no further business, the meeting closed at 1530 hours. The Chair thanked everyone for their input in evolving the People Committee into an opportunity for in depth discussion and focus.	
05/22/15	**Dates of Future Meetings 2022 to 2023:**	
	Via Microsoft Teams unless otherwise notified: ~~Monday 23rd May - 1300 hours~~ Monday 22nd August – 1000 hours Monday 28th November – 1300 hours Monday 27th February – 1000 hours **PLEASE CHECK THESE MEETINGS ARE IN YOUR DIARIES**	
Close:	The meeting closed at 1615 hours.	

Action Points – People Committee 23rd May 2022

Minute	Details	To be actioned by	Complete/ Incomplete	Evidence
02/22/05	CB asked if the National Diversity Group have a measure/analysis? Where do we measure nationally in Ambulance sector? **ACTION MR to bring this information to the next meeting in August.**	**MR**	**Ongoing**	Nationally AACE don't benchmark all the Ambulance sector on things like WRES or DWES, however regional comparison is available between Trusts. This is a Trust v Trust comparison and the Trusts are not in the Ambulance sector.
02/22/08	Staffside raised the point that given the age demographics and life experience of new call assessor candidates, could we have a mock set up added to the recruitment process, which demonstrates some of the aggressive and abusive calls they are likely to encounter. JB agreed that this was a good idea and would take forward as an action for this Committee. **Action: Jeremy Brown**	**JB**		
05/22/10	Discussion followed on the pathway of the actions plans via EMB and Board, prior to being published. NK asked if we can have these reports showing numbers of BAME staff, rather than percentages, which would help give a clearer picture. MR to share the action plans as soon as they are available: **Acton: Mohammed Ramzan**	**MR**		The WRES data will be shared alongside the action plans so that numbers are seen alongside the percentages.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 14 MONTH: OCTOBER 2022 PAPER NUMBER: 10

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

Executive Summary

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

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

The schedule of business aligns with the Assurance Map recently produced by the Internal Audit and presented to the Audit Committee and EMB. The Schedule will be kept under review.

Related Trust Objectives/ National Standards	All Trust Objectives
Risk and Assurance	The Code of Governance states that it is the Chair's responsibility for ensuring that directors (and governors) receive accurate and timely and clear information that is appropriate for their respective duties The Chair should ensure that the Board receives timely and considered papers, this schedule is a means of establishing specific standards in the preparation of the board papers. Without a robust schedule of business The Board would function inadequately without appropriate and timely information.

Legal implications/ regulatory requirements	The schedule as aimed at ensuring compliance with all regulatory requirements
Financial Implications	The schedule of business should be influenced by the Trust's financial and strategic planning and also compliance regimes to which the Trust is subject.
Workforce Implications	Workforce matters, such as the Staff Survey are included in the schedule of Business.
Communications Issues	Dates of Board of Directors meetings are advertised on the website and key partners are advised of the dates.
Diversity & Inclusivity Implications	Equality Impact Assessment complies: Equality Impact Assessment is not applicable and will be undertaken in relation to projects and programmes.
Quality Impact Assessment	Not applicable for this report
Data Quality	The schedule is influenced by the reporting and planning requirements of the Trust.
Action required The Board of Directors are requested to review the contents of the schedule attached and if appropriate approve the schedule of business for the year ahead.	

	Board Schedule of Business		Lead	26/10/22	30/11/22 Board Briefing	Dec 22	25/01/23	22/02/23 Board Briefing	29/03/23	26/04/23 Board Briefing	31/05/23	28/06/23 Board Briefing	26/07/23	Aug 23	27/09/23 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	MD								✓		✓		
	EDI Annual Report	Report through PC	MR										✓		
	Safeguarding Report	Report through QGC	MD								✓		✓		
	Infection, Prevention and Control Report	Report through QGC	MD								✓		✓		
	Patient Safefy, Duty of Candour and Serious Incidents Report	Report through QGC	MD								✓		✓		
	Research and Development Report	Report through QGC	CC								✓		✓		
	Medicinces Management Report	Report through QGC	MD								✓		✓		
	Accountable Officer for Controlled Drugs Report	Report through QGC	MD								✓		✓		
	Annual staff survey report	Report through PC	CB						✓				✓		
	Physical and Verbal Assaults to Staff Report	Report through QGC	CC/JK								✓		✓		
	Better Births Annual Report	Report through QGC	MD								✓		✓		
	Annual Report on Health and Safety, including fire safety	Report through QGC	MD/MB								✓		✓		
	Making Every Contact Count Annual Report										✓				
	Medicines Management Annual Report										✓				
	Controlled Drugs Annual Report										✓				
	Emergency Preparedness Annual Report										✓				
	Security Management Annual Report										✓				
	Learning from Deaths Annual Report										✓				
	Freedom to Speak Up Bi-annual Report		MD	✓					✓						
Quality Impact Assessment Report (and also any Equality Impact Assessment) Relating to CIP			KR/PW						✓						
Governance															
Annual Governance Statement as part of the Annual Report		Confidential	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			MD/MB	✓			✓		✓		✓		✓		
Annual Review of Risk Appetite Statement			MD/MB				✓								
Review of Register of Seals		Confidential	PH	✓							✓				
Minutes from Commitee Meetings	Audit Committee		WFC	✓			✓		✓		✓		✓		
	Annual Report of Audit Committee		WFC										✓		
	Performance Committee		MK	✓			✓		✓		✓		✓		
	Quality Governance Committee		LBP	✓			✓		✓		✓		✓		
	People Committee		MF	✓			✓		✓		✓		✓		
	Remuneration and Nominations Committee		IC	✓			✓		✓		✓		✓		
Review of Terms of Reference to Committees of the Board			PH						✓						
Annual Review of Self Assessement of Committees of the Board and their membership			PH							✓					
Review of Goverance structure of the Trust			PH						✓						
Staff Survey Action Plan Quarterly Review		Report through PC	CB	✓					✓				✓		
Staff Survey Action Plan Annual Outcome Report		Report through PC	CB								✓				
Procurement Workplan		Report through AC	KR												
Review Leases due to IFRS16										✓					
Executive Scorecard (Review Feb, Approve March)			VK					✓	✓						
Update on the implementation of the PWC recommendation					✓										
NHS Resolution Annual Scorecard		Confidential	MD						✓						

Update on NARU - KP to attend		KP								✓				
Serious Incidents report	Included in MD/AW report	MD/ST	✓			✓		✓		✓		✓		
Claims & Coroners Report	Confidential	MD/MK	✓			✓		✓				✓		
Communications Report & Data Pack (Quarterley update)	To be reported through EMB Repo	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	✓			✓		✓		✓		✓		
Governance & Security Indicators		CK	✓			✓		✓		✓		✓		
Nursing & Clinical Indicators		MD	✓			✓		✓		✓		✓		
Operational Key Perforamnce Indicators		CC	✓			✓		✓		✓		✓		
Workforce Indicators		CB	✓			✓		✓		✓		✓		
Strategy & Engagement														
People Strategy		CB	✓											
Operational Strategy		CC												
Clinical Strategy		MD												
Quality Strategy		MD												
Stakeholder Engagement Strategy		VK/MM												
Commissioning Strategy		MD												
Communications & Engagement Strategy		VK												✓
Commercial Services Stragegy		MB												
Operating Model		CC												✓
HART, Academy, West Brom Estate Strategy		CC												✓
FTSU Strategy and Self-Assessment and Board Development Session		VK												✓
Risk Management Strategy		MD												
Fleet Strategy		CC												
Research Strategy		CC												
Commissioning Intentions		MD	✓											
Operating Plan (NHSI Submission)		VK				✓		✓						
Finance Strategy		KR												
IT Strategy		MD/CC												
Procurement Strategy		KR												
Sustainability Strategy		CC												
HWB Strategy		CB												
EDI Strategy		CB												
Security Management Strategy (Oct 2024)		CK	✓											
5 Year Strategic Plan		VK									✓			
Regulatory, Guidance or Contractural														
Annual Audit Letter ISA 260	Confidential	Auditors								✓				
Annual report and accounts	Confidential	KR								✓				
Quality Account Approval		PW/VK								✓				
Review of Register of Interests - Directors		PH								✓				
Data Security and Protection Toolkit (March - review, June - submission)		CC/CK						✓			✓			
GDPR/Data Protection Officer Report	Forms part of Trust Information Pack	CC/CK												
Learning From Deaths Report	Included in MD/AW report	MD/ST	✓			✓				✓		✓		
Workforce Race Equality Standard data report for publishing		CB	✓									✓		
Workforce Disability Equality Standard data report for publishing		CB										✓		
Gender Pay Gap data report for publishing		CB				✓		✓						
Trade Union Facility Time Regulations report for publishing		CB									✓			
Professional Registration and Medical Revalidation Assurance		CB										✓		
Licence Conditions		PH								✓				
Annual Meeting of Members - Agenda Approval		PH								✓				
Board Developments														

Safeguarding and Prevent		Nicola Albutt	Chair									✓				
General Data Protection Regulation (GDPR)		Chris Kerr	Chair		✓							✓				
Directors role in Inclusion and Diversity		Mohammed Ramzan	Chair													
WRES Updates and Training		Mohammed Ramzan	Chair									✓				
Patient Safety, Duty of Candour and Serious Incidents		Simon Taylor	Chair													
Research Development		Andy Rosser	Chair		✓							✓				
NHS Patient Safety Syllabus Training (level 1+ Online Training)		Carla Beechey	Chair							✓						
Downside Scenerio Planning		Mark Docherty/Karen Rutter	Chair					✓								
Miscellaneous Items																
Winter Plan			CC													
Festive Plan			CC		✓											
Quality Improvement Update			VK										✓			
Going Concern Review			KR						✓							
Review of SFI's			KR										✓			
Refresh on SFI's delegations and investment decision making			KR													✓