West Midlands Ambulance Service
University NHS Foundation Trust

AGENDA

TITLE OF MEETING: Extraordinary Meeting of the Board of Directors

Wednesday 28 February 2024 at 13:30 hours
To be held at Birmingham Newman University, Genners Lane, Barley Green B32 3NTor by electronic means through Microsoft Teams software and invitation will be sent upon request to the Trust Secretary – phil.higgins@wmas.nhs.uk.

Membership

Prof. I Cumming*****	Chair	Non Executive Director (Chairman)
Mr A C Marsh*****	CEO	Chief Executive Officer
Prof. A. Hopkins*	AH	Non Executive Director (Deputy Chair)
Ms C Beechey*	CB	Director of People
Mrs C Eyre*	CE	Director of Nursing
Mr M Fessal*	MF	Non Executive Director
Mr N Henry	Nhen	Paramedic Practice & Patient Safety Director
Mr N Hudson*	NHud	Director of Performance and Improvement
Mrs J Jasper*	JJ	Non Executive Director
Mr M Khan*	MK	Non Executive Director
Mr V Khashu	VK	Strategy & Engagement Director
Mrs N Kooner*	NK	Non Executive Director
Mr M MacGregor	MM	Communications Director
Ms K Rutter*	KR	Director of Finance
Dr R. Steyn*	RS	Interim Medical Director
Dr A Walker	AW	Medical Director

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

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

In attendance

Ms D. Scott	DJS	Interim Organisational Assurance Director
Ms R Farrington	RF	Staff Side Representative
Mr P. Higgins	PH	Governance Director & Trust Secretary

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

Item No	Description	Lead	Paper No	Timings
01	**Welcome, apologies and Chairman's matters**	Chairman	Verbal	13:30
02	**Declarations of Interest**			
	To enable declarations to be made, of any conflict of interest members may have in relation to any matters contained within the agenda for this meeting.	Chair	Verbal	
03	**CQC Inspection**			
	a. CQC Inspection Report and Ratings	CEO	Paper 01a	13:35
	b. CQC Action Plan	Interim Organisational Assurance Director	Paper 01b	13:45
	c. CQC Performance Improvement Action Plans	Director of Performance and Improvement	Paper 01c	13:50
04	**2024/25 Capital Plan**			
	To approve the 2024/2025 Capital Plan	Director of Finance	Paper 02	14:15
05	**Any Other Business** (Previously notified to the Trust Secretary)	Chair		
06	**Date and time of the next meeting: The next meeting will be on 29 MARCH 2024 from 09:00 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)

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 03 MONTH: FEBRUARY 2024 PAPER NUMBER: 01

Care Quality Commission (CQC) Report, ratings and WMAS Action Plans in relation to the Inspection.	
Sponsoring Director	Anthony Marsh – Chief Executive Officer
Author(s)/Presenter	Anthony Marsh – Chief Executive Officer Diane Scott – Interim Organisational Assurance Director Nathan Hudson – Performance and Improvement Director
Purpose	a. To receive the letter from the CQC along with the Inspection report including ratings and also the report on the actions WMAS plan to take. b. To update the Board on progress in implementing the actions arising in response to the report received from the CQC following its inspection between 15 – 17 August 2023, 3 - 5 October 2023. c. To seek Board approval for the WMAS CQC Performance Improvement Action Plan.
Previously Considered by	The WMAS Action Plan has previously been reviewed by: Executive Management Board: • 28/11/2023 - Actions from the unannounced inspection 15 - 17 August 2023. Board of Directors: • 29/11/2023 - Actions from the unannounced inspection 15 - 17 August 2023. Executive Management Board: • 23 January 2024 – Draft report - Inspection visit 15 - 17 August 2023, 3 - 5 October 2023 • 20 February 2024 – Final report - Inspection visit 15 - 17 August 2023, 3 - 5 October 2023
Report Approved By	Anthony Marsh – Chief Executive Officer

Executive Summary

- The Care Quality Commission (CQC) inspected 2 core services – EOC and Emergency and Urgent Care (or frontline emergency operations). The final report was published on 23 February 2024. (The letter and published report is attached as Appendix 01a)

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 03 MONTH: FEBRUARY 2024 PAPER NUMBER: 01

<table>
<tr><td colspan="2">

- The WMAS Action plan arising from the CQC report is attached for Board members to review (See Appendix 01b).
- The WMAS Performance Improvement Strategic Options and CQC Performance Improvement Action Plan are also attached (See Appendix 01c).

The actions from the unannounced inspection have been completed and confirmed closed by EMB on 23 January and the Board of Directors on 31 January 2024.
</td></tr>
<tr><td>Related Trust Objectives/ National Standards</td><td>SO1 - Safety, Quality and Excellence
SO2 – A great place to work
SO3 – planning and use of resources
SO4 – Innovation and Transformation
SO5 – collaboration and engagement</td></tr>
<tr><td>Risk and Assurance</td><td>This paper is for information and assurance on the immediate actions following the inspection of core services is provided for by the attached action plan developed in response to the initial feedback.</td></tr>
<tr><td>Legal implications/ regulatory requirements</td><td>The full inspection report has led to a change in the overall rating for the Trust, from Outstanding to Good.</td></tr>
<tr><td>Financial Implications</td><td>At this stage none, but any financial implications linked to responding to recommendations will need to be considered, in particular the MUST do improvement of:

The trust must ensure that national response time targets are met with a focus on the risks posed by the Category 2 calls (Regulation 12(1)).</td></tr>
<tr><td>Workforce & Training Implications</td><td>Aspects of organisational culture have been picked up via the core services inspection, particularly around the age demographic of the front-line workforce, follow up actions noted in the attached action plan.</td></tr>
<tr><td>Communications Issues</td><td>The report has been shared Executive Management Board members, the Board of Directors, the Council of Governors and the Integrated Care Board.</td></tr>
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WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 03 MONTH: FEBRUARY 2024 PAPER NUMBER: 01

Diversity & Inclusivity Implications	The CQC have provided feedback on working relationships, particularly between older and younger colleagues, this is set out in the initial feedback related to in core services and has linked actions contained within the attached action plan.
Quality Impact Assessment	Not applicable at this stage.
Data Quality	Evidence and updates are provided by the Lead for each action.

Action required:

a. To receive the letter from the CQC along with the Inspection report including ratings and also the template requiring a response on the action WMAS **must** take, attached as 01a.
b. To update the Board on progress in implementing the actions arising in response to the report received from the CQC following its inspection between 15 – 17 August 2023, 3 - 5 October 2023.; and to note that the action plan from the unannounced inspection between 15 to 17 August 2023 has been included at the end of Appendix 01b showing the completed status. Attached as 01b.
c. For the Board to review and decide on the options presented in the paper 'Performance Improvement Strategic Options & Actions'. Attached as 01c.
d. To receive and note the 'WMAS CQC Performance Improvement Action Plan'. Attached as 01c.

CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 03000 616161
Fax: 03000 616171
www.cqc.org.uk

Anthony Marsh
West Midlands Ambulance Service University NHS Foundation Trust
Unit 9
Waterfront Business Park, Dudley Road
Brierley Hill
West Midlands
DY5 1LX

13 February 2024

Your account number: RYA
Our reference: INS2-16436848591

Care Quality Commission
Health and Social Care Act 2008
Inspection report and report on the action you plan to take

Organisation name: West Midlands Ambulance Service University NHS Foundation Trust
Organisation ID: RYA

Dear Mr Marsh,

Following our recent inspection of West Midlands Ambulance Service University NHS Foundation Trust, we enclose a copy of our final report of the findings. This report includes our rating of the care provided. Please make this report readily available for people who use the service.

We reviewed your comments relating to any factual inaccuracies in the draft report and have made the changes outlined in the attached document. The changes made as a result of your comments relating to factual accuracy did impact on the ratings contained within the final report as follows:

- The rating for the Emergency Operations Centres under the key question of 'Effective' has been revised from Good to Outstanding. This revises the overall rating for Emergency Operations Centres from Good to Outstanding.
- The rating for Emergency and Urgent Care under the key question of 'Caring' has been revised from Good to Outstanding. This does not change the overall rating for this service, but does mean the trust is Outstanding overall for Caring.

We will publish this report on our website. When we have published this report you can see the contents and download a PDF version by clicking on this link.

https://www.cqc.org.uk/provider/RYA

As a result of the judgements made in our inspection, we have set actions we require the trust to take. These can be found at the back of the report.

Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, you must send us a written report of the action you are going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation we have identified you are in breach of.

If you have already sent us an action plan after this inspection about any of these actions, you do not need to include them in your action plan.

You must return the action plan to us no later than 28 days after receipt of this letter.

We would prefer you to send your report to us by email to: HSCA_Compliance@cqc.org.uk
If you are unable to do so, please post it to the address below. Please include our reference number INS2-16436845891 in any letter or email you send with the report.
You should inform us in writing when you have completed the actions in your plan. We will check to make sure that you have completed your actions and will report on our judgements.

Challenging the ratings
A ratings review involves checking whether or not CQC followed its process for making ratings decisions, as explained in the guidance published on our website. If you think that we have not followed the process you can request a review. You cannot ask for a review of ratings on the basis that you disagree with our judgements.

You must submit your request for review, using the online form, within 15 working days of the publication of your report. You must say in what way we have not followed the process, and which ratings you think have been affected.

Please use the following link to access the form:
http://www.cqc.org.uk/content/requesting-review-one-or-more-cqc-ratings

Please note that a ratings review does not involve a reconsideration of the evidence and ratings awarded, unless we find the process has not been followed. You can only request a review of ratings once after each inspection. Please note that requests for reviews of ratings can lead to ratings going down as well as up, or they can remain the same.

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC HSCA Compliance

Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

James Bullion
Interim Chief Inspector

Enc: Final report of inspection
Factual accuracy return with CQC responses

West Midlands Ambulance Service University NHS Foundation Trust

Inspection report

Unit 9
Waterfront Business Park, Dudley Road
Brierley Hill
DY5 1LX
Tel: 01384215555
www.wmas.nhs.uk

Date of inspection visit: 15 - 17 August 2023, 3-5 October 2023
Date of publication: N/A (DRAFT)

Ratings

Overall trust quality rating	**Good**
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

West Midlands Ambulance Service University NHS Foundation Trust serves a population of around 5.6 million people. It operates in an area covering 5,000m^2 in the counties of Shropshire, Staffordshire, Herefordshire, Worcestershire, and Warwickshire. This includes Coventry, Birmingham, and the Black Country conurbation.

The service provides a 999 emergency ambulance response from 15 operational hubs across the region with a fleet of around 460 ambulances. In partnership with 2 local mental health trusts, the ambulance service operates mental health triage cars to help patients in crisis. The trust has 2 emergency operations centres (EOCs) taking and managing around 4,000 999 calls each day. One EOC is at Brierley Hill, alongside trust headquarters, and the other at Tollgate in Staffordshire.

The trust also provides patient transport services (PTS) for non-medical emergencies and completes around a million trips each year for patients in Birmingham, the Black Country, Coventry and Warwickshire, Cheshire, and Wirral. The service operates around 350 PTS vehicles and coordinates activity from dedicated control rooms.

The trust contacts with and commissions with 5 air ambulances run by independent charitable trusts, operates a Hazardous Area Response Team (HART), works with voluntary organisations, such as BASICS doctors, and has a network of around 750 community first responders.

The service employs around 6,800 staff, which reduced from around 7,600 the previous year after changes in service delivery (including the 111-contract moving to a new provider).

We carried out this inspection, with the core services announced on the morning of that visit, as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust overall as outstanding.

On this inspection we covered the well-led key question for the trust overall which was announced to coincide with our inspection of the core services.

Our findings

We inspected 2 core services – EOC and Emergency and Urgent Care (or frontline emergency operations). We did not inspect Resilience (which includes the HART teams) or PTS on this occasion.

Use of resources

The use of resources was not inspected on this occasion.

Combined quality and resource

Combined quality and resources was not inspected on this occasion.

Outstanding practice

Trust wide

- West Midlands Ambulance Service University NHS Foundation Trust was awarded university status in 2018 for its substantial graduate recruitment and research activities with the 8 universities it worked with. In September 2023, the trust was validated as the first ambulance trust in the country to be permitted to train its own paramedic students. This would be done 'in-house' through an apprenticeship scheme towards a BSc (Hons) in paramedic practice.
- The trust had responded rapidly to reports on sexual safety at work from similar organisations picking up all recommended actions to protect its own staff and developed a charter well-publicised and recognised by staff.
- The trust had been a pilot site for the NHS clinical validation trial to increase the rate of remote clinical advice given to patients (hear and treat) and reduce ambulance dispositions. The clinical team operating in the emergency operations centres had risen from 25 to 152 clinical staff to date. This enabled the trust to be the best performer against hear and treat rates in England and divert ambulance crews to patients who needed them in attendance. The trust was treating on average around 18% of patients in this pathway which was around 5% higher than the England average across 2023.
- The trust had created a People Strategy which set out to support, develop, and retain a high performing, inclusive and diverse workforce that fostered a safe, healthy, and productive work experience. The People Strategy stated as one of its priorities how the trust would ensure all staff at Band seven or above held a leadership qualification, and an audit was completed every year to assess that outcome. At the last audit conducted in 2022, 79% (520 out of 659) staff at band seven and above held a leadership qualification.

Emergency and Urgent Care

- Information systems and the use of information technology were thoroughly embedded into the service with an almost complete removal of the use of paper and replacement with electronic forms on ambulances and in day-to-day work.
- The implementation of the logistics hub at Sandwell together with the associated systems which reflected industry best practice had resulted in a make ready provision that was not only efficient and effective but supported safety including in the management of medicines. This initiative was unique to West Midlands Ambulance Service University NHS Foundation Trust and was seen as a best practice model.
- The trust considered the environmental effects of its work, and all new programmes were assessed for their impact. The new build hubs were designed to minimise their carbon emissions through good design and heat pumps, solar panels and LED lighting were used extensively.

Our findings

- The trust had introduced of electric vehicles for emergency and patient transport ambulances, response cars, mental health and logistics vehicles. Their fleet strategy included the procurement of electric vehicles and deployment of electric vehicle infrastructure. They had introduced the first electric ambulance to the NHS which had completed 30,000 miles. The trust's design of emergency ambulance was together with an evidence base of costs and benefits resulted in the design being adapted for the national ambulance specification.
- Fleet and medical device asset management was well integrated and there was complete consistency and standardisation across the trust. All vehicles used for normal operations were less than 5 years old as were the medical devices.
- The trust's recruitment, career progression, retention and leadership approaches had resulted in a fully staffed establishment for the emergency and urgent care service. This meant that no agency or temporary staff were ever employed.

Emergency Operations Centre

- The trust had developed a web-based portal for community services to enable the clinical validation team to refer appropriate patients for community support when an ambulance was not required, but the patient needed some clinical intervention from local teams. This resulted in around 1,000 patients being referred to community care coordination centres each week and significantly relieving pressure on frontline ambulance services.
- In the period from April to December 2023, WMAS had responded to around 165,000 calls for other NHS ambulance services across England and a small number for Wales, Scotland and Northern Ireland. The trigger for WMAS staff to answer 999 calls for a number of other NHS ambulance services was when the call waiting times exceeded four minutes. This service provided significant reassurance to patients or callers to 999 who could otherwise be waiting well beyond NHS recognised call-answering times.

Areas for improvement

Areas the trust MUST improve

Emergency and Urgent Care

- The trust must ensure that national response time targets are met with a focus on the risks posed by the category 2 calls. Regulation 12(1)(2): Safe care and treatment

Areas the trust SHOULD improve

Trust wide

- The trust should consider re-evaluating the clinical strategy in order to show how the objectives around patient safety and clinical excellence will be achieved. It should show a clear pathway for paramedics to progress to a higher level with an emphasis on clinical professional development. The strategy should address how the organisation intends to respond to changing needs of a diverse and ageing population and how it will improve the community response.
- The trust should consider the work on culture and how it can demonstrate this is effective with measurable improvements in indicators, such as the NHS staff survey and Workforce Race Equality Standards. This includes:

Our findings

- Marked improvement in staff feeling safe to speak up and in line with those recommendations of the National Guardian's 2023 report. Providing assurance through actions and reports to the board that this is effectively recognised as a risk.
- Gaining assurance that the confidential nature of any staff concerns is protected.
- Improvements being seen in equality and diversity measures.
- Being assured all staff felt included in career progression opportunities.

- The trust should consider improving how it demonstrates and gains assurance that key measures of safety and performance are learned from when things go wrong. This includes serious incidents, complaints, and learning from death. The trust should move away from relying upon qualitative data as a measure of success and learning from these key indicators being paramount.
- The trust should think about how it can reduce the high volume of paperwork produced and provided to board, committees and members to ensure its focus and assurance is on key areas of risk, quality and safety. Committees of the board should provide sufficient assurance to reduce the over-reliance on provision of extensive board reports. The length of reports should also be reviewed to give a reasonable expectation of these being of actual value.
- The trust governors should be given the opportunity to fulfil their role of representing their communities and groups they speak for and delivering valuable insight of the experience of people and communities.
- The trust should consider how it reports staff vacancy metrics in board and other workforce papers so it presents the whole picture around workforce risks and safety.

Emergency and Urgent Care

- The trust should ensure that, for infection prevention and control reasons, uniform standards are consistently adhered to.
- The trust should ensure that pain assessments are completed for children.
- The trust should continue to work with partners to achieve national handover time targets.
- The trust should ensure that feedback to staff from incident reporting is consistently applied across the organisation.
- The trust should ensure that all staff are aware of the methods to speak up including the Freedom To Speak Up Guardian.

Is this organisation well-led?

Our rating of well-led went down. We rated it as good.

Our findings

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience and integrity to run the service. Most had worked in the ambulance service for many years and had come through to senior jobs from frontline roles, such as ambulance care assistants or starting as student paramedics. To balance that, a number of leaders had joined from other services, not all connected with healthcare, and bringing a wider or different perspective.

The senior executive team had a wide range of experience to support their specific roles and those we met demonstrated their enthusiasm, passion, extensive experience and knowledge. In terms of training and development, for example, the trust board had undertaken a session on safeguarding. The managers we met were insightful, articulate, experienced and committed to patients and their staff.

All the leaders we met demonstrated commitment to the organisation and its priorities, the staff and people and communities it served. However, in the 2022 NHS Staff Survey, when benchmarked against the other NHS ambulance services, West Midlands Ambulance Service University NHS Foundation Trust staff scored 5.9 out of 10 in the question about compassionate leadership. This was below (worse than) the average of 6.5 and had remained static since the previous year while other organisations had shown slight improvement.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Since the COVID-19 pandemic, and in a number of the months before that too, the performance of the service was under growing and significant pressure from demand and capacity in health and social care. This was not least mounting delays in handovers at emergency departments (resulting in extensive lost hours for crews) and in releasing crews and ambulances back into the community.

Adding to system capacity pressures from these delays were growing amounts of time needed to deal with an increasing deterioration in patient health including mental health in both adults and children. The service was contacted for help for patients due to long waits, perceived or real, for GP and other healthcare appointments. Hospitals were unable to discharge many often frail older patients with necessary ongoing care needs due to, among other things, capacity shortages in community, mental health, and social care facilities and teams. Simplistically, this was a key factor leading to extreme levels of handover delays at accident and emergency departments across England where they were unable to discharge patients to specialist care. This was at its most severe in December 2022 and around the 2022/23 wintertime.

The performance of the ambulance services across England deteriorated significantly in that time. West Midlands Ambulance Service University NHS Foundation Trust saw some of the worst performance results with ambulances stuck and queuing for many hours at the regions accident and emergency departments. Many thousands of hours were lost to handover delays and the standards for reaching patients needing an ambulance were no longer met.

The seriousness of this situation was recognised by the leadership and the various risks associated with it were at the highest levels on the corporate risk register. The performance, risks to patients and the wider community, and resulting anxiety and harm to morale for staff were all identified. Many of the senior leaders we spoke with talked about the problems and its effects at some length. There was understandable and notable frustration and anxiety with the limited ability to improve and influence the situation and a clear recognition of how this affected staff morale and wellbeing.

Our findings

The trust board assurance framework and risk register reviewed in August 2023, noted the situation had improved over the preceding months as winter abated, but not to pre-pandemic levels. It was agreed by the executive management board to maintain the risk as 'significant' and further reduction in the risk rating would not be made until pre-pandemic levels of performance were reached.

Most staff told us leaders were visible and approachable. This was an organisation with around 6,800 staff in a wide-range of different roles and spread over a wide geographical distance. All the staff we spoke with knew who their direct management team was and said they were mostly visible and approachable. They all knew the senior leadership team, and most had met with or attended meetings (online being a growing medium to reach staff, but also face-to-face) with senior executives. There were multiple initiatives for senior management to be visible and meet with frontline staff, and most staff we met felt this was successful.

Leaders supported staff to develop their skills and take on more senior roles. Since our last inspection, the trust had created a People Strategy which set out to "support, develop, and retain a high performing, inclusive and diverse workforce that fostered a safe, healthy, and productive work experience". The People Strategy stated as one of its priorities that the trust would ensure all staff at band seven or above held a leadership qualification. An audit was completed every year to assess that outcome. At the last audit conducted in 2022, 79% (520 out of 659) staff at band seven or above held a leadership qualification.

The trust pharmacist and the medicine safety officer ensured they were visible and approachable across the trust by visiting hubs to touch base with staff. There were clear senior leadership lines of communication and engagement for medicines across the trust.

A few staff we met said they did not always get the support they needed from their direct manager, but said there was always another manager they could approach in that case. The 2022 NHS Staff Survey supported this concern with 53% of staff saying their immediate manager cared about their concerns. This was 10% worse than the average score for NHS ambulance services. In the question of an immediate manager taking effective action to help with their problems, 53% of staff said this happened. This was 11% worse than the average score.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There was a strategic vision for the trust including safety, quality and sustainability. Staff in different senior roles said they and their teams had been able to influence and design their part of the strategy and vision. The trust's 5 strategic objectives were refreshed in the 2021/22 year and remained in current use. The underpinning objectives of the strategy were considered as 'active' within the trust and therefore, able to be refreshed and updated as needed and to address rising and falling risks or emerging areas of concern. The objectives of the strategy were linked through to the trust's governance, research, engagement and headline policies. We noted, for example, how they were linked with the patient engagement strategy, the communications and engagement strategy (objective 5: collaboration and engagement), and the quality and improvement strategy (objective 1: safety, quality and excellence; objective 4: innovation and transformation).

Our findings

The trust quality report stated how it was recognised that for the strategy to be delivered, there needed to be engagement and commitment to and from staff. To that end, the trust refreshed its values at much the same time as the strategy report, which were 'excellence, integrity, compassion, inclusivity and accountability'. These were decided and agreed through extensive engagement with staff.

The trust had underpinning actions and key performance indicators which supported the strategy. This included, for example, in accordance with strategy 1 and the commitment to provide the best care for all patients, the objective to have a paramedic on every ambulance. This had been achieved at almost 100%. There were lower-level objectives, as well including the improvement of information technology, clinical information sharing through electronic patient records, and being a paper-free organisation.

However, although parts of the clinical strategy were commendable, the document was not explicit on how it would meet the organisation's clear objectives of patient safety and clinical excellence. There was no clear explanation of how paramedics might progress through to the highest level of qualifications in the strategy, despite this being a clear direction for the trust. The section on population health management described an ageing and diverse population. However, there was no vision around how the trust was going to respond to this, and no reference to an improved community response. There were a number of initiatives and ideas in the organisation but these needed focus and leadership.

The trust pharmacist ensured medicine management was integrated into the trust's overall vision of the 'Right Care, Right Patient, Right Place at the Right Time' with a skilled workforce.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. There were some effective relationships with others evolving with the relatively new integrated care system boards (ICBs). The trust sat on the ICB as partner member in the Black Country ICS, but did not have direct influence with the other five ICBs at board level. However, the trust recognised the importance of partnership working, and five of the executive team were aligned with the six ICBs. This had been organised to place executives with certain portfolios into ICBs seen as outliers in those areas. However, this did not cut across professional relationships with, for example, directors of nursing still working together regionally.

Culture

Most but not all staff felt respected, supported and valued. All staff were focused on the needs of patients receiving care and the trust demonstrated the ways it worked to support wellbeing and mental health. Although some staff disagreed it was always working, the service demonstrated commitment to promote equality and diversity in daily work. There were many opportunities for career development, although not all staff felt included in career progression.

The service was endeavouring to support an open culture where patients, their families and staff could raise concerns without fear, although some staff told us they remained concerned about speaking up and raising concerns. Some of the issues relating to culture were not yet resolved and in some cases were deteriorating. This was not effectively reflected in the board assurance report or through other assurance mechanisms. Some senior management and those with trust oversight recognised our concerns and demonstrated commitment to proactive learning and developing while others still rejected these issues.

Those staff we met and talked with on our core service and well-led inspections felt supported, respected, valued and were positive and proud to work in the organisation. However, this was in contrast to an extent to some of the results of

Our findings

the 2022 NHS Staff Survey. The NHS staff survey benchmarked the West Midlands Ambulance Service University NHS Foundation Trust against the other 10 NHS ambulance services in England. The numbers of staff who responded in 2022 (the most recent survey conducted) was low at 39% against an average of 50%. It had fallen from the most recent peak in 2019 when 63% of staff responded. In context, response numbers from all NHS ambulance services fell in 2022. In questions relating to culture:

- The trust scored 6.4 out of 10 in the questions concerning being a compassionate and inclusive organisation. Although not seen as statistically significant, this was worse than the average of 6.7 and just above the worst result was 6.3.

- The trust scored 5.7 out of 10 in the questions concerning working as a team. This was worse than the average of 6.0 and just above the worst result of 5.5.

- The trust scored 5.6 out of 10 in the questions concerning staff engagement. This was worse than the average of 5.9 and just above the worst result of 5.4.

However, the trust scored 5.4 out of 10 in the questions concerning staff morale. This was better than the average of 5.2 out of 10.

The trust was open and transparent, and published many of the 841 free-text comments made by staff in the NHS 2022 Staff Survey in its May 2023 board papers. This was despite the sentiment from staff being mostly more negative than positive in free-text comments.

To respond to this, the trust provided staff with a range of tools and services to support their wellbeing and mental health. This included a multifaith chaplaincy team, maternity champions, financial advice, student support officers, and a range of wellbeing support. There was a 5-year strategy for wellbeing and the trust was in year 3. We met the staff running the wellbeing service and talked about the strategy and tools and services they provided or offered. There were health and wellbeing roadshows in 2023 at 25 of the hubs and staff bases with more planned until all 30 had been visited. As well as the lead for health and wellbeing, there were around 150 wellbeing champions. The trust had a testimonials page on its public wellbeing website pages so staff could see how the various services had worked for their colleagues. The website was open to the public as well as staff to provide guidance and advice www.wellbeing.wmas.nhs.uk. A number of wellbeing practical initiatives for staff had been rolled out including thermal cups, water bottles, massage chairs in the emergency operations centres, quiet rooms, and prayer rooms.

There were a range of networks for staff to join, including the ‘one’ network; pride network, women’s network; and the military network. Each had an executive sponsor. We met and talked with the staff who organised and participated in them. There was still work to do at the trust to provide the volunteers in these groups with good resources, managed time, and access to training and education. There was a SALS group – staff advice and liaison service with a 24-hour advice line. These were staff trained as advisors for their colleagues who could speak with them in confidence for support with issues affecting them. There were staff trained in suicide prevention, education and training; mental health first aiders; and staff trained as menopause champions.

The trust had trained mental health wellbeing practitioners and linked with a mental health charity which specialised in wellbeing conversations with staff. There was also a physiotherapy service for staff with clinics at a variety of locations and fast-track appointments.

Our findings

The trust's culture was centred on the needs and experience of people who used services. Three of the 5 strategic objectives were linked to patient care and experience. The other 2 talked about the environment for staff, and financial and performance efficiencies. All those staff we spoke with talked about the reason they worked in the ambulance service being the satisfaction which came from helping people every day. This remained uppermost for staff despite many of them also facing abuse and aggression from patients, relatives and members of the public – staff taking 999 calls as well as frontline crews.

Actions taken to address staff poor behaviour and performance had taken a new direction with the shift into focus of tackling misogyny and sexual safety in the organisation – and in the wider NHS ambulance service. The Association of Ambulance Chief Executives (AACE) released a report in early October 2023 which coincided with our inspection. https://aace.org.uk/reducing-misogyny-and-improving-sexual-safety-in-the-ambulance-service/. All ambulance services were required to implement recommendations and transform their culture to eradicate this harmful behaviour. Following reports about other similar organisations, West Midlands Ambulance Service University NHS Foundation Trust had picked up all the recommended actions. As a result, the trust were already implementing their strategy to combat this harm and had since also signed up to the NHS "Sexual safety in healthcare: Organisational charter" released in September 2023. Trusts were required to have implemented the charter, which required organisations to "commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce."

The trust launched its own internal charter in October 2022 and brought the subject into corporate induction and mandatory training. West Midlands Ambulance Service University NHS Foundation Trust had already taken action against staff exhibiting unacceptable or harmful behaviour or performance and a number had already been investigated, offered tailored support, and a number dismissed. Some staff we spoke with told us that "banter", which would have been tolerated in the past, was now feeling rightly uncomfortable and far less tolerated since the trust's campaign. A number of staff also mentioned the use of the term "misbehaving" being used when discussing this subject and how some had found this inappropriate language. The term was nevertheless used as a descriptor of this type of behaviour in a couple of our interviews.

Leaders and all staff we spoke with understood the importance of staff being able to raise concerns without fear of retribution, and the importance of appropriate learning and action being taken because of concerns raised. However, although the trust encouraged openness and honesty at all levels within the organisation, there remained around a third of staff (who responded to questions) who said they did not feel safe raising concerns. The NHS Staff Survey action plan provided to us and to the trust board did not address this and the board did not show effective challenge to this omission. The board assurance framework contained no reference to staff feeling fear and retribution from speaking up despite the national report and the organisation's staff survey.

The recent report published by the National Guardian's Office "Listening to workers: A speak up review of ambulance trusts in England (February 2023)" https://nationalguardian.org.uk/wp-content/uploads/2023/02/Listening-to-Workers-Speak-Up-Review-of-Ambulance-Trusts.pdf although discussing all NHS ambulance services, reported widespread serious concerns with staff feeling unsafe to speak up for fear of reprisals.

In the 2022 NHS Staff Survey:

- Only 63% of staff at West Midlands Ambulance Service University NHS Foundation Trust said they felt secure raising concerns about unsafe clinical practice. This was worse than the average for ambulance services of 66% and had fallen in the past 2 years.

Our findings

- Only 50% of staff felt confident the organisation would address their concerns. This was the same as the average. In 2020, 59% of staff said they felt safe to speak up about anything that concerned them. By 2020, this had fallen to 48% and below the average of 54%.

- Only 39% of staff felt the organisation would address their concerns if they spoke up – although this was the same as the national average for ambulance services.

We were concerned how the staff survey response action group had just 3 priorities and none of these related to the concerns around speaking up. The report to the trust board on the staff survey action plan from the July 2023 papers also did not highlight the concerns about speaking up and there was no obvious challenge. The report to the board covered mostly the, albeit important, recruitment of an additional speak up guardian to help with the growing workload. However, there was no mention of progress being made on the issues concerning staff and the reports of fear and retribution from speaking up. We were told the number of staff now using the speak up team's support had increased but this was not part of the assurance in the most recent board report.

The trust had appointed a second full-time 'freedom to speak up guardian' to join the team in September 2023. The trust had a large team of 44 'ambassadors' to support the guardian who worked across the organisation. Activity in terms of staff contact was increasing and was becoming broadly similar in comparison with other NHS ambulance trusts. The current theme for the guardian was behaviour and attitude of staff to one another. The guardian reported strong support from the board and the executive sponsor.

Some staff we spoke with expressed concerns for themselves and other colleagues about the confidentiality around speaking up. We heard a couple of examples where a confidential conversation was known about openly among peers and colleagues. A member of staff contacted us to say some private information about colleagues was discussed openly and too much discomfort in staff meeting areas.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. Most staff felt there were opportunities for development and training although some felt moves up through the career ladder in some roles or services were far less available where staff retention was strong.

Although we found there was a strong emphasis on the safety and wellbeing of staff, this did not reach some staff. A higher number than average for NHS ambulance services said they experienced harassment, bullying or abuse at work from colleagues. The 2022 NHS Staff Survey saw staff reporting they had experienced at least one incident in this category in the last year.

Experience of this from their managers was reported by 16.5% in the NHS Staff Survey (worse than average of 14%) and 18.5% from other colleagues (worse than average of 18%).

The trust was reported by its staff as 'improving' in terms of equality and diversity. The ability to work flexibly was also said to be improving and seems much more positively among managers. Staff said there had been a history of not dealing well with racism and there being use of inappropriate language and terminology. We were told there was now a better culture with education and support improving. However, not all staff agreed it was working and against the national benchmark, the trust's Workforce Race Equality Standard (WRES) report was poor. The latest WRES report

Our findings

(2021/22) reported a number of key indicators were significantly worse for staff from an ethnic minority background. Key indicators around experiencing harassment, bullying, and abuse (from both the public and other staff), equal opportunities, and discrimination, placed the trust in the worst 10% of NHS trusts in England. We acknowledge the low response rate to the survey from staff from ethnic minority groups.

However, sadly, of those staff who did respond (179 respondents were from an ethnic minority group), 54% said they experienced harassment, bullying or abuse from patients, relatives or members of the public in the last 12 months. This was the worst result for an NHS trust in England. Also, 51% of staff identifying as White experienced the same treatment from the public at times. In terms of experiencing this poor behaviour from colleagues, 40% of staff from ethnic minority groups reported this. Both of these indicators had increased significantly in the last 4 years, so this was not being successfully addressed.

The trust provided 2 WRES action plans. The version which was a submission to the national WRES team was rated throughout as green (we presume this meant all actions taken) but there was no indication to provide assurance the actions had led to any improvement or would be measured to determine that. The summary said it covered 4 key elements (then listed 5) and in the plan, only 3 were described. There was no mention of harassment and bullying. A second more detailed action plan was also provided which was more detailed, but again had no clear measures of success to judge its effectiveness.

A falling number of staff, including those with protected characteristics under the Equality Act, felt they were treated equitably. In 2019, 48% staff from ethnic minority groups felt there was equal opportunity for career progression or promotion. This was not significantly dissimilar to the response from White staff in that year. However, this key measure had deteriorated since then to just 35% of staff from ethnic minority groups reporting equitable treatment in 2022, against 46% of White staff. In 2019, West Midlands Ambulance Service University NHS Foundation Trust was much better than the national average in this measure, but since then, it has deteriorated each year while the national average has mostly improved.

It was not easy to unpick, but there were some comments made about age-related differences and antagonisms in the organisation and these becoming problematic. This was mentioned by staff across different grades and job roles and was acknowledged as an emerging theme by senior staff.

Governance

Leaders operated mostly effective governance structures throughout the service and with partner organisations. However, there was insufficient evidence of effective challenge and assurance to the board from non-executive directors, and community information being sought and provided by trust governors. There was also insufficient evidence about assurance of learning when things went wrong or people had cause to complain and some reports failed to extend beyond just statistical data to show quality care being provided or improving. There were no concerns around financial governance. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. However, minutes of meetings and reports tended to focus on the qualitative data around serious incidents, learning from death, and complaints and the learning was far less evident. For example, in the minutes of the health, safety, risk and environment board committee in May 2023, the focus around serious incidents and claims was on frequency and quantity (and timeliness of investigation) and not learning. Each division reported the

numbers of incidents and then the themes and trends. There were some narrative comments about changes made as a result of incidents or improvements seen, but this was of far lesser focus or did not happen. In the quality governance board committee in May 2023, complaints and serious incidents were mentioned in terms of numbers, but no discussion of learning or themes.

Furthermore, in, for example, the infection prevention and control annual report for 2022/23 there were some areas where performance had deteriorated. Incidents in the environment was one area which was up almost by 50% to 113 incidences that year. The report had no reassurance of how this was going to be learned from and improved. Most other areas were stable or had shown some improvement, but we did not learn how or why anything had improved and what positive changes had contributed to it. The safeguarding annual report was mostly concerned with stating numbers of referrals rather than demonstrating how effective the process had been in preventing or reporting abuse and/or harm to vulnerable people.

The duty of candour report to the board for May 2023 and the learning from death reports showed no learning from either of these subjects. They concentrated on numbers of open and closed cases and how many reviews had been completed. A number of senior staff told us this was a “learning organisation” and yet there was insufficient evidence to substantiate that statement in the information presented to the board.

There were effective governance structures for managing medicines within the trust with clear lines of escalation between committees. Governance arrangements around reporting medicine incidents had been tightened. Site audits and controlled drug audits ensured any incidents were picked up immediately. Staff knew how to report incidents and there was assurance that identified concerns were effectively communicated to the trust pharmacist. Any learning from medicine incidents with action plans were discussed at the senior clinical advisory group which was chaired by the medical director. Any clinical decisions were then reported to the professional standards group.

There were several hundred pages of reports provided to the membership for each trust board meeting (just under 400 in May 2023). This could be considered an excessive amount of information, some of which included copies of lengthy external reports and external presentations. The extent of the papers would not give board members sufficient time to read and digest these papers and determine what was critical to understand in order to provide challenge and assurance, particularly when all the reports were presented electronically and required reading on a screen.

There was a diverse and experienced team of non-executive directors from different commercial and NHS professional backgrounds. It was clear they were committed to both their role of holding the trust board to account, but also to chairing the sub-committees of the board. They were also involved with supporting transitional reviews for the board, such as responding to the sexual safety review. They felt they were able to effectively challenge and question areas of concern or risks. However, they agreed that most of the evidence for that challenge tended to sit within the board sub-committee sessions rather than be directly or explicitly demonstrated or reported in minutes of board meetings. We talked about how the minutes of board meetings showed limited challenge and holding of the board to account. We were told there had been a concerted effort to reduce the substantial reporting of board discussions through minutes and limit these to actions and decisions. We joined a trust board meeting on 25 October 2023 and observed a good level of challenge from the non-executive directors. On development for the group, the non-executive directors we met agreed there was an opportunity for development of their team in order to play a stronger role with effective challenge and assurance.

Not all of the responsibilities of the trust elected and representative governors were being delivered. The role was designed to receive important reports from the trust (which was largely done) but to also gather information from the public and disseminate information and concerns from local communities and staff represented by the governors. We

reviewed a number of sets of minutes form the recent meetings and found the content to be only information given to the governors about the trust. There was no mention of anything coming from the other direction and the invaluable sharing of community and public views. This was part of the trust's patient experience strategy for which no evidence of delivery was apparent. As with the trust board, the governors in their May 2023 meeting were provided with an extensive set of papers covering multiple internal reports which extended to 236 pages. This was a further example of excessive paperwork being shared with an expectation people were able to read and digest vast quantities of information and data.

The trust was revising policies and procedures in light of the new framework from NHS England issued in August 2023 around the Fit and Proper Persons Regulations (FPPR). At an extraordinary board meeting in September 2023, the director of people introduced new standards and advised of the immediate and future changes to be implemented by March 2024. The trust's recruitment manager was to work with the chair to ensure the new framework test was fully implemented. At the current time, the trust chair, although responsible for providing assurance around the fitness of those who fell within the jurisdiction of the FPPR, took assurance from papers to the board rather than provided the board with assurance. We were satisfied with the new arrangements that this would be addressed.

The trust had a strong track record of delivering its agreed financial plans and expected to do so again in 2023/24. The trust had set a target of improving its efficiency by £12 million, but staff told us it was likely to achieve only 40% of this plan by reducing its cost base. They expected to achieve the balance through one-off measures including the reduction of overtime and the management of vacancies. As an operational service, staff told us the trust needed additional funds to meet service costs and had given notice on some of its discretionary contracts where income received did not cover costs incurred.

The senior team took pride in the trust's ability to provide its service from up-to-date vehicles and premises. There was a 5-year replacement plan for vehicles; and there was no reported backlog maintenance. Staff told us they had invested in digital information systems to reduce waste and improve service responsiveness within the capital resources provided.

The trust was unusual in that detailed scrutiny of its revenue finances was carried out by the performance committee. Capital business cases above a certain level and approval of the capital programme were items reserved for the trust board. The trust's external auditors had given an unqualified opinion on the 2022-23 accounts. The internal audit team had given the trust substantial assurance about the operation of internal controls.

Staff were clear about their roles, responsibilities and accountability. The trust had a clear portfolio of responsibilities and roles for staff which stemmed from the executive officers down through the various directorates and responsibilities. There was a good working relationship with the unions and the staff-side representatives reported the trust compared well with other ambulance services in terms of consultations and negotiations. They reported no conflict during industrial action and the trust provided support where needed.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust had limited arrangements with third-party providers in terms of direct patient care and treatment. Unlike many other NHS ambulance services, it did not commission private providers to provide on-road services for emergency calls or patient transport. However, it did have commissioning arrangements with the local charitable trusts providing emergency air ambulance services. These relationships were well managed and working in a good collaborative partnership. We spoke with one of the air ambulance services shortly before our inspection and they reported excellent partnership working and cooperation.

Our findings

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, the assurance framework for the board was due for revision as it did not fulfil its purpose.

The organisation had assurance systems and performance issues were escalated through structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational, and financial processes and had systems to identify where action should be taken. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. However, the board assurance framework (BAF) in current use was being replaced with a proposal for a new much improved document coming before the October 2023 board meeting. The current document did not serve to provide the board with assurance, which was its purpose. It was overly detailed; undated with no indication of when the risk was added; some of the risks were more divisional than executive level; and some of the risks were linked but not connected in the document. There were no principal risks described against the strategic objectives and instead a list of 39 issues the trust was facing. This made it more akin to a corporate risk register than assurance framework. There was no reference to some of the areas of concern reported by staff in the past NHS staff surveys and Workforce Race Equality Survey in the strategic objective about the organisation being “a great place to work”. The risk to culture had been reduced despite there being little evidence to support how new and innovative programmes had been tested, embedded or seen to be working.

The new proposed BAF document (seen in draft and various stages of completion) appeared clearer in being more structured and linked to the mitigations within the operational risk registers. Mitigating actions and their timeline could be followed more easily. However, it remained undated and did not describe the trust’s appetite for risk.

The trust pharmacist had identified 7 key areas on the medicines risk register with clear action plans to mitigate any risks. The trust pharmacist assessed medicine risks on an annual basis to ensure they were fit for purpose. The main challenge affecting sustainability of the service was the provision and availability of some medicines due to ongoing national medicine shortages or manufacturers’ delays in the supply chain. This had been addressed with contingency planning with alternative medicines if needed.

There was alignment between recorded risks and what staff said was ‘on their worry list’. The risks to the performance of the ambulance service, which had been detrimentally affected by hospitals handover delays, deteriorating patient physical and mental acuity, and the effects on patient decision-making from critical overload on emergency and elective capacity in acute hospitals, were talked about by most of the staff we met. The minutes of the quality governance committee of the board from May 2023 discussed this at length with reporting around service improvement and changes to endeavour to play a part in the management of the extreme handover delays and consequent detriment to key performance indicators (such as response times).

Response to the pressures from growing demand and overloaded capacity in the system included the trust reducing its rate of conveyance to hospital from around 63% in 2015/16 to around 53% in 2023. This was done through a mixture of enhanced training for clinical staff and the establishment of the clinical validation team in the emergency operations

centre. This team of qualified paramedics, mental health professionals (being established), nurses, and doctors on call were able to support both dispatch teams and call assessors to provide the right resource for the patient. This might mean amending the automatic results of the clinical triage system, which had recognised limited scope in some cases, and applying more detailed clinical knowledge.

Alongside the reduction in conveyance to hospital, the 'hear and treat' rates had also exponentially increased with the intervention of the expanding clinical validation team. This service provided by clinicians in the emergency operation centre supported non-dispatch of an ambulance when determined as not needed; diversion to another more appropriate service; and/or clinical advice the patient could follow at home. West Midlands Ambulance Service piloted the NHS clinical validation trial for ambulance services in order to determine the safety and effectiveness of remote triage and decision-making by clinical staff talking with patients calling the service for help. The clinical validation team had grown over the past couple of years from 25 staff to 152 and was made up of paramedics, nurses, practitioners and mental health professionals. There were a number of clinicians with advanced practitioner skills including independent prescribing. This development had led to the hear and treat rate having risen from around 3% in 2019, when for the following two years the trust was below (worse than) the national average to a major reversal in mid-2021 to now up around 18% on average in 2023. This was generally around 5 to 8% above the England average for NHS ambulance services.

Mental health clinicians in the emergency operations centres and mental health response vehicles were providing the right response to patients. This was particularly where it was recognised that conveyance to an emergency department would likely have a poor outcome for the patient. There was a team who were supporting high intensity service users, linking with other health and social care providers.

With rising demand for both category 1 and 2 responses (the highest level of need) the trust had become an early adopter of the NHS England 'category 2 segmentation'. This involved a rapid clinical review by trained senior clinicians of patients categorised by the triage system as requiring a category 2 urgent response. The clinicians were then able to analyse the information in more detail to determine if an emergency ambulance being dispatched was the right response. This was for category 2 incidents in a predetermined and agreed code set which might mean the patient could receive an alternative response, or equally be upgraded to a category 1 response.

The trust had been the driving force in 'ambulance decision areas' being established in some local acute hospitals' emergency departments. This was a multidisciplinary approach, with Integrated Care System funding. It was set up to provide care and treatment to a distinct lower-risk group of patients by trained paramedics or ambulance care assistants in a discrete area adjacent usually to the emergency department. West Midlands Ambulance Service University NHS Foundation Trust provided the paramedics and care assistants, and the acute hospital provided the space and equipment. It represented a significant investment and new roles for staff working across both ambulance and acute services.

A local mental health trust had also agreed to participate in a 'call before you convey' protocol, so ambulance crews could seek advice from a mental health professional before taking the patient to hospital.

One area of significant concern for frontline staff was with late finishes to their shift. To address this, a memorandum of understanding had been signed with all the regions emergency departments that patients being held on ambulances where the member of staff was due to finish their shift, must be handed over within 30 minutes of the end of the shift.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Information and data was used to predict demand

fluctuations in both usual circumstances (such as across weekends, at night, or known busier days) and planned or unplanned major events (festivals, sporting events, and major incidents). Teams and leaders with different responsibilities in the service, including those responsible for emergency planning and major incidents, operational support, frontline services, and emergency operations centres, for example, worked closely together. This was to ensure there was continuity of service and risk mitigation in both business and usual and unplanned incidents. This was underpinned by regular training events, business continuity plans, major incident protocols, and multiagency large scalelarge-scale exercises.

There was a clear strategy and programme of work for managing the large fleet of vehicles and property. This demonstrated a strong focus on sustainability. The estates team had a clear programme of work and audit and worked with external professional organisations on maintenance of vehicles and property. Sustainability programmes had included delivery of electric-powered vehicles to be evaluated. This included emergency ambulances, response vehicles (cars) and patient transport ambulances. Trust buildings were fitted with solar panels where possible. All lighting was converted to LED and air-source heat pump systems were replacing gas boilers when due. There was a focus on sustainability in all decisions around equipment, technology, estates and working environments.

Risks around workforce competence, experience and skills were managed through training, performance reviews, support mechanisms and audits. The trust reported performance reviews (appraisals) and mandatory training from a reset of the compliance to zero at month one in any financial year, so across the year the results would increase as staff participated. As of August 2023, 83% of staff had completed their annual performance review. There were different elements to the mandatory training required for staff, but the trust reported in August 2023 compliance of between 43% and 75% in the different elements.

Risks in workforce metrics, such as staff vacancies, retention, sickness and performance were measured and reported. A number of senior staff told us the one thing they were most proud of were their staff and teams. We were told there were few vacancies, very low sickness rates, and low turnover. Some data confirmed this, but this might have been directorate-based rather than a trust-wide comment as not all data reflected this position. In a relatively unusual situation in the NHS, in recent months the trust had used no agency or bank staff. Staff turnover was slightly below the national average for NHS England, but slightly above that of other ambulance services together. Sickness absence was well below that of other NHS ambulance services at less than 5% (2023 national average 6.9%) and had remained at that level throughout 2023. Staff being enabled and supported to safely return to work following sickness was a high priority for the organisation. COVID-19 was now a small factor in sickness. The split between long and short-term sickness was similar at around 2% each. However, the vacancy rate was not reported in any of the board reports.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Data used was reliable, current, and credible. The NHS ambulance service relies extensively on live, precise and detailed information and data to be able to safely deliver its service. All systems used by West Midlands Ambulance Service University NHS Foundation Trust were electronic (computer-based), including the management of 999 calls, dispatch of ambulances, and recording patient information including by crews on the road. Staff told us these systems functioned well almost all the time, but there were back-up systems which were tried and tested in the event of, for example, major power failure.

Our findings

Information was used to measure improvement, not just provide assurance. The trust board integrated performance report showed trends and highlighted both improvements but also deterioration in key performance metrics.

Staff felt they had sufficient access to information and challenged it when necessary. There were clear service performance measures at divisional level. These were reported and monitored with effective arrangements to ensure the information used to manage and report on quality, safety, and performance was accurate. They included performance both in pre-hospital care, response times, and clinical outcomes, such as stroke performance and patients returning to spontaneous circulation following a cardiac arrest.

Information technology systems were used effectively to ensure medicines were monitored at all stages of the transfer of care of the patient. The use of the electronic patient record ensured all medicine records were recorded. Trends were assessed as well as undertaking audit trails for assurance in medicine use.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, were in line with legislation and data security standards. Computers and other systems were put through security checks each month as prevention against cyber attacks and there had been no incidents pertaining to network security. National guidance around cyber security and other security arrangements were followed.

Engagement

Leaders and staff had varying degrees of successful engagement with patients, staff, the public and local organisations to plan and manage services. However, the learning from people's complaints was not focused sufficiently on the themes and improvements, but on the numbers received and timely response. The trust collaborated with partner organisations to help improve services for patients and the community.

There was a strategy to engage with staff and stakeholders and for that purpose, a communications and engagement strategy for that audience. This strategy described a detailed and consistent approach to the multiple routes and channels for engagement, which were recognised to be growing and diversifying. It therefore, covered internal and external lines of communication, the online presence, and social media use. There were also measures of success, aims and objectives and the route for governance and assurance.

In what was a crowded field of organisations and people wanting to hear views and opinions, the trust endeavoured to link with members of the public to understand experiences and use this intelligence to support improvements. The patient experience strategy covered the aims and objectives of involving patients, relatives, carers and the public in shaping services. However, in what was not just a crowded field, but also under extremes of operational pressure, and limited people and resources, the trust was in the early stages of delivery of some of the aims. Some of the strategy, such as surveys and feedback forms, were still to be fully developed, fulfilled as intended, or shown as yet effective.

The use of compliments and complaints was a more direct source of information. We met with the patient experience manager and heard of the high level of activity in the trust to support people who made a complaint, and use the learning to improve service delivery. There was a well-supported and embedded team responding to complaints, but it was accepted that the rest of the aims and objectives to gather more direct feedback needed more resourcing and time. In terms of the vital importance of learning from complaints and concerns, the process was for each complaint to be fully investigated (we reviewed 5 recent complaints) and a response to be made to the complainant. However, in terms of providing the board with assurance the organisation was learning, in July 2023, the board received a short note

describing the number of complaints and nothing related to themes or learning. The trust's quality account concentrated more on numbers rather than what they were telling the trust it needed to learn from and improve. In the 5 complaints reviews shared with us, although most were related to ambulance delays, there was no particular evidence to show the trust had used the complaint as learning or would be making changes to services or practices as a result.

The trust had trained a number of staff as family liaison officers to work with bereaved families and this service was being widened to include the families of staff who died suddenly to provide support if requested.

The trust pharmacist ensured staff were aware of their role by visiting hubs as well as raising the profile of medicines at governance group meetings. They were also embedded within the procurement team and had a clear insight into purchasing medicines and ensuring legislation was followed and there was effective governance. The trust pharmacist also attended the ambulance pharmacist network meetings when possible to share and learn from other trusts.

There were improving but positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with key stakeholders about performance. The trust had an extensive geographical spread which covered 6 integrated care systems (ICSs). As reported above, one of these, the Black Country conurbation, was the coordinating commissioner for the ambulance service and worked closely with the trust. Other relationships with the ICSs were at different stages and the trust recognised different and tailored approaches were likely to be needed to have an effective and strategic role which worked for each. This was an area still evolving.

There were a number of major community initiatives undertaken in collaboration with local people and families. This included the Our Jay Foundation: the trust involvement with a family raising funds and campaigning for increasing the availability and awareness of defibrillators or to provide resuscitation training; the Half-time Campaign: the trust working with England rugby players to produce a video around signs of cardiac arrest and training in resuscitation; and the Daniel Baird Foundation: working closely with a family to raise funds for bleed-control kits and resuscitation training across the country. The locations for the bleed-control kits are part of the trust's dispatch system so members of the public can be directed to them while the ambulance in on the way. Many of the families who have worked with the trust to establish these campaigns have met and spoken with the trust board and at national events and received recognition for their work.

Collaborative relationships were maintained with other major partners, including the other emergency services, the local authorities, and the NHS. One example of valued partnership working was the work of the clinical validation team in having daily calls with system partners to look at current pressures and share information. In 2022, the trust played a central role in the planning and successful delivery of the 22nd Commonwealth Games and we acknowledge the years of planning and organisation in the aftermath of the COVID-19 pandemic. The trust had trained around 34,000 people in 2022 as part of the 'restart a heart' campaign. There were a team of volunteers and community first responders supported and valued by the trust.

Learning, continuous improvement and innovation

Staff described being committed to continually learning and improving services but reports where learning should be paramount did not demonstrate this effectively. However, there was continuous learning and innovation for staff and in clinical areas. The trust had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Our findings

Senior staff at the trust described the service as a "learning organisation". As further reported above, our review of learning through governance and assurance had provided insufficient evidence to show learning from the major performance indicators in healthcare. This included serious incidents, complaints, duty of candour and learning from death. There was a focus on numbers of these incidents, response times and performance, and not on the way these were used to improve the service and demonstrate learning.

Leaders aspired to continuous learning for their staff and innovation for their service. The trust had a head of organisational development committed to culture, leadership, learning and development. A programme of engaging leaders and engaging managers had been developed which included subjects, such as how to start and hold difficult conversations, coaching, and interview skills.

There had been extensive work in improving the personal development reviews (PDRs) and conversations with joined-up routes to development programme and resources for all staff. A handbook had been produced for reviewers to ensure consistency and meeting expectations of the organisation and staff. The PDR templates were a proactive mix of achievements, concerns, wellbeing, objectives and development. There was an interactive web-based learning portal with access to tools for development, education and training. This included tools for subjects, such as 'cultural competency' to give staff an opportunity to relook at their own worldview and improve their ability to understand, communicate with, and effectively interact with people across cultures. The head of development worked in partnership with NHS ambulance services, the integrated care systems, and other external partners locally and nationally.

There had been significant progress in innovation in areas, such as environmental sustainability. Included within this were achievements, such as reducing the weight of ambulances on the road; growing numbers of electric vehicles; all vehicles being under 5 years old; reduction in ageing estate.

The introduction of electronic patient group directions (PGDs) available as an app on the phones of paramedics and clinicians ensured they always had access to an up-to-date list of the trust's PGDs to safely treat patients.

The trust had developed a process with a number of the local Coroners to have access to certain information following the death of a patient where trust staff were present in the care and treatment. This was in order to look for learning and improvement in clinical care. Since March 2021 and up to February 2023, the trust had identified 37 cases of interest and had reviewed 18 of these, with the rest subject to procedural or legal matters. The investigating team found none of the cases highlighted any errors or omissions in care or treatment and decisions taken were clinically valid. The staff involved had found the exercise to be supporting and reassuring in terms of the actions they took.

West Midlands Ambulance Service University NHS Foundation Trust was awarded university status in 2018 for its substantial graduate recruitment and research activities with the 8 universities it worked with. In September 2023, the trust was validated as the first ambulance trust in the country to be permitted to train its own paramedic students. This would be done 'in-house' through an apprenticeship scheme towards a BSc (Hons) in paramedic practice.

The trust participated in appropriate research projects and recognised accreditation schemes. There had been involvement in research projects since 2010. Today this included, but was not limited to:

- SPEEDY – the specialist pre-hospital redirection for ischaemic stroke thrombectomy (study). This study was examining whether patients would have better access to thrombectomy through direct admission to a specialist centre rather than the nearest hospital.

Our findings

- PACKMaN – a study to determine if ketamine, a strong acting painkiller, was more effective and better for patients than the current go-to pain relief for paramedics, morphine.

- PARAMEDIC 3 – pre-hospital AI RAndomised trial of MEDIcation route in out-of-hospital cardiac arrest.

The trust submitted research to the National Institute for Health and Care Research and the PACKMaN and PARAMEDIC 3 trials had been submitted and accepted in recent months.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ➔➔ Feb 2024	Good ↓ Feb 2024	Outstanding ➔➔ Feb 2024	Good ↓ Feb 2024	Good ↓ Feb 2024	Good ↓ Feb 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Good ➔🡐 Feb 2024	Outstanding 🡅 Feb 2024	Good ➔🡐 Feb 2024	Good ➔🡐 Feb 2024	Outstanding ➔🡐 Feb 2024	Outstanding 🡅 Feb 2024
Resilience	Good Jan 2017	Outstanding Jan 2017	Not rated	Outstanding Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017
Patient transport services	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Emergency and urgent care	Good ➔🡐 Feb 2024	Requires Improvement 🡇🡇 Feb 2024	Outstanding ➔🡐 Feb 2024	Good 🡇 Feb 2024	Good 🡇 Feb 2024	Good 🡇 Feb 2024

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Emergency and urgent care

Good ↓

Is the service safe?

Good →←

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff received and kept up-to-date with their mandatory training. All staff to whom we spoke said they were given protected time to carry out their mandatory training and that mandatory training was obligatory for everyone. Many staff also commented positively on the quality of the training, and they could request help from the clinical team mentors (CTMs) if needed.

Hubs had 'virtual learning rooms' with computers on each hub should staff wish to use them although most used their work issued electronic tablets.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received mandatory training against an annual programme which comprised a mandatory digital workbook and a 2-day face to face training event.

The mandatory workbook was mapped to the 'Core Skills Training Framework (CSTF) and Care Certificate' and was made up of suitable modules. Staff completed the modules on their tablets, and this gave them flexibility as to where and when to carry out the work.

The day 1 syllabus of the face-to-face training was adjusted to meet current needs and as well as standing items included issues that needed addressing as a result of incidents, audits and developing clinical practice. The day 2 syllabus was an e-learning package and was again adjusted for current needs. For example, the current syllabus had been adjusted to take account of learning from serious incidents.

This training was supplemented with a yearly clinical supervision shift with a clinical team mentor.

The trust had just started a 5-year review of driving which comprised a 4-hour assessment including at least 1 hour on 'blue lights' training. Should staff fail the assessment there would be a requalification process.

There was additional mandated training for specific roles, such as clinical team mentors and those staff acting in a command role had two days of training that updated them on current threats and policies of both the trust and other agencies.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The mandatory workbook contained a suitable and comprehensive module on “awareness of mental health, dementia and learning difficulties” and the face-to-face training included an 'Oliver McGowan' training module.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers at all levels were informed when staff had booked and completed their training through a comprehensive dashboard that displayed data broken down by staff role, hubs and modules.

The trust required mandatory training to be completed by everyone within each financial year. This meant that the compliance rate started at 0% in April and the target was to be 100% by the end of March the following year. Completion rates for 2022/23 were 90% and for 2021/22 87%.

We saw "completion to date" data with graphed projections that demonstrated that the organisation was on a clear trajectory to meet its commitments for everyone to receive their training in the allotted time period. Staff and managers we spoke with confirmed that other than for staff absent from the workplace, training was always delivered. Training figures were often seen on noticeboards in the hubs to feedback to staff on the local performance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

We reviewed the organisation's safeguarding policies and procedures and found them appropriate. The trust had a comprehensive and suitable policy on disclosure and barring which reflected that many of their staff worked in an autonomous role and were often alone with patients.

The trust was introducing a revised safeguarding structure which was due to be completed in November 2023. This bolstered the organisation's safeguarding governance by modifying the roles and reporting for those staff with level 4 and 5 accountabilities and introducing additional staffing.

New staff were subject to a Disclosure and Barring Service (DBS) check on recruitment and figures for the last year demonstrated a 100% compliance rate. Risk assessments were carried out should staff commence work or training before an outcome was received. All staff were required to maintain registration with the DBS Update Service and rechecks were carried out when staff moved posts.

All staff received training specific for their role on how to recognise and report abuse. All staff received safeguarding training to level 1 as part of their induction. All clinical staff received level 3 safeguarding children training. Technicians received level 2 safeguarding adults training and paramedics level 3 safeguarding adults training. The trust required safeguarding update training to be completed by everyone within a financial year. This meant that the compliance rate started at 0% in April and the target was to be 100% by the end of March the following year. Completion dates for 2022/23 were 100% and the current year's figures demonstrated the trust was on target to achieve this in the current financial year.

Training was refreshed each year as part of the organisation's mandatory training programme and this included prevention of radicalisation. Senior managers told us that this training was adapted as necessary to reflect the changing nature of society and emerging risks to their patients.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. When we observed staff interacting with patients they explored their social circumstances and asked questions to ascertain whether they were vulnerable and or at risk of abuse or neglect.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ambulance crews were very confident and familiar with safeguarding processes and the raising of safeguarding referrals was a regular part of their job. Crews were, if asked, able to give examples of having made referrals as part of their work. These examples demonstrated good judgment and awareness of potential abuse or neglect.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, vehicles and the premises visibly clean.

The trust had an infection prevention and control (IPC) policy which was comprehensive and based on underlying legislation, guidance and specifications relevant to the services provided. This high-level document identified roles and responsibilities, an annual IPC programme and framework as well as lower-level procedures. These included the management of waste, hand hygiene, high consequence infectious diseases and personal protective equipment (PPE).

This suite of policies was brought together in an infection prevention and control manual. This was a recent innovation by the trust that provided a practical 'how to' guide and reference for staff to use in their day-to-day work with photographs, flowcharts and reference tables. The resources used in the guide were common across the trust being used in training and noticeboards which promoted a consistent approach to this topic.

The service generally performed well for cleanliness. The trust had an IPC plan for board assurance and the current version of this document showed most actions from the assessment as complete with some still ongoing. No action was identified as overdue.

The trust produced an annual infection prevention and control audit report. The most recent copy of this assessed the trust performance as “optimal” which was the highest of the 4 grades that the governance systems award. There was overlap between this and the board assurance document, and it was noted that where this was so, the issues that had been identified and the associated action plans agreed.

Within the framework, individual audits covered various topics such as hand hygiene and canulation.

Ambulances were visibly clean and had suitable furnishings which were visibly clean and well-maintained. All ambulances were fit for purpose and surfaces were generally visibly clean. However, some vehicles from the Warwick and Coventry hubs were noted as having some dusty surfaces in the saloon and particularly food crumbs in the cab. On one vehicle, we noted dried body fluid under the stretcher and this was drawn to the attention of a manager. The trust submitted data that showed that their own audit programme had identified some vehicle cleanliness concerns which had been addressed and that the number of spot checks had been increased from 20 to 60 per month on each hub.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Vehicles were cleaned daily as part of the 'make ready' process and subjected to a monthly deep clean. Records we saw demonstrated that this process was adhered to. Staff accommodation, replenishment and workshop areas were also kept clean to a suitable standard and records kept.

Staff followed infection control principles including the use of personal protective equipment. IPC requirements were clearly laid out in the trust’s infection prevention and control manual. Overall, crews were disciplined in their adherence to the trust’s IPC requirements.

The trust had clear policies for uniforms, as well as requirements for hand hygiene. Staff were required to be bare below the elbow when providing care, excepting where other health and safety considerations overrode this. Staff who we observed adhered to these principles and were diligent in the use of PPE to protect themselves and techniques to protect patients. Crews told us they could obtain replacement uniforms easily if they needed to.

However, we heard from ambulance staff that some crew wore jewellery in contravention of policy and a senior member of nursing staff at an acute hospital trust told us sometimes crew wore acrylic nails, as well as not always being bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We saw that crews cleaned the vehicle and equipment between patients using suitable wipes. Vehicles carried suitable cleaning materials including for spills and if a vehicle was significantly soiled it returned to a hub for mopping out.

Environment and equipment

The design, maintenance and use of facilities, premises, vehicles and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All ambulances were built and equipped to a standard specification. All vehicles were less than five years old as they were always disposed of at this age. When a new replacement vehicle was purchased, a whole suite of new medical devices and other equipment for it was purchased and the old equipment disposed of.

The numerous ambulance stations across the region had been replaced by 15 hubs. These were gradually being updated and the newer ones were purpose built with the trust's vision and strategy in mind and were built and equipped to a very high standard. Aside from garages and vehicle preparation areas there were staff rest and eating areas, training rooms, office accommodation, washing and changing facilities and workshops. They had suitable safety equipment, such as fire extinguishers, eyewash and first aid kits.

The new build hubs were designed to minimise their carbon emissions through good design and heat pumps, solar panels and LED lighting were used extensively and it considered the environmental impacts of all its projects.

The trust had trialled the use of electric vehicles for emergency and patient transport ambulances, response cars, mental health and logistics vehicles. As a result, their fleet strategy now included the procurement of electric vehicles and deployment of electric vehicle infrastructure.

All hubs were securely fenced with pedestrian and vehicle access controlled through secure entry and exit systems. Vehicles were fitted with GPS tracking devices, and they activated the hub gates automatically. Each hub underwent a yearly security assessment by the trust's security manager. The new hub at Sandwell had received a 'secured by design' award from West Midlands Police as it was designed to prevent crime and anti-social behaviour and the other newly constructed or upgraded hubs were expected to follow.

Staff carried out daily safety checks of specialist equipment. Ambulances were prepared by a 'make ready' function located at each of the hubs, and this was done once per day. Vehicle preparation operatives (VPOs) cleaned, checked, and stocked every vehicle to a common standard across the whole of the organisation. This was done in dedicated and specially designed preparation bays where the operatives had all the equipment and stocks to hand.

A standard operating procedure defined how the vehicle was to be prepared and adherence to this was subject to audit. This was managed using an electronic system and managers could monitor and manage the system through reports and electronic dashboards.

Should a change to the standard 'load list' be needed, for example as a result of learning from incidents or a manufacturer alert, the procedure could be modified, and the change rolled out overnight. If a vehicle was low for consumables the crew would go to a hub for a 'rolling restock', but only one of these was allowed between each full make ready restock.

Crews told us that vehicles were almost always presented to them in a suitable state to deploy with all equipment present and working and with all consumables stocked to the correct levels. Comments included, “VPO is excellent”, “always clean and equipped”.

The trust operated a logistics system that was unique among NHS ambulance providers where all consumables were distributed from a central warehouse to each hub once a week. This was effective and efficient and based on current best practice in the logistics industry. It resulted in stock levels that were sufficiently but not unnecessarily high, as well as ensuring that all stock was completely under control. As well as being cost efficient this meant that all equipment and consumables could be traced and recalled if necessary. As part of our inspection, we examined a sample of consumables in the stores, vehicle preparation areas and on ambulances. We did not find any consumable item that was damaged or out of date.

The service had suitable facilities to meet the needs of patients' families. If patients were conveyed to hospital, there was provision for relatives to travel if possible. Vehicles were equipped with suitable seats and belts to transport children if required although this was limited dependent on the numbers and ages.

The service had enough suitable equipment to help them to safely care for patients. Crews told us they had the equipment they needed to do their jobs and that vehicles were generally reliable. However, two crew members mentioned that spirometers were removed from vehicles as a response to the COVID-19 pandemic because their use was an aerosol generating procedure. They felt the risk was now low enough to reintroduce these.

Specialist equipment for normal operations was available as needed. For example, 15 vehicles were equipped with bariatric stretchers and 15 were equipped with four-wheel drive for use in rural locations and poor weather conditions.

Ambulances were maintained and repaired in the provider’s own well-equipped workshops by suitably trained staff. This included most warranty work which the manufacturer subcontracted back to the provider’s own workshops but not bodywork which was carried out by external companies. There was an electronic fleet management system which together with processes and procedures ensured that vehicles were safe and in a good state of repair. Managers told us this resulted in shorter downtime for vehicles and allowed them to prioritise work to the services’ own needs. Crews told us vehicles were in good condition and made no adverse comments when asked. Crews were able to review the maintenance history of their vehicles on the fleet management system through their tablets and be assured as to the safety of the ambulances.

As part of our inspection, we carried out a detailed review against a checklist of 9 ambulances. Other than minor concerns about cleaning we did not identify any concerns as to the safety and condition of the vehicles.

Medical devices were maintained under a hybrid system where some planned maintenance and repair was done inhouse and some by the manufacturer or other maintenance agency. The inhouse technicians were suitably qualified and experienced and worked from suitably equipped workshops.

There was an electronic asset management system that acted as both an inventory and held maintenance records. The trust was able to identify the location of every device and there were effective systems for ensuring that devices were returned to the workshop for their planned maintenance. All devices were labelled with a unique asset label and where appropriate a label indicating their next service date, beyond which they must not be used.

Equipment that was faulty or under repair was stored separately from that which was ready for use (both in the workshops and the preparation areas), and clearly labelled as such. This often included a chain to prevent staff from easily walking up to those storage areas.

As part of our inspection, we examined a sample of medical devices on ambulances. We did not find any device that was damaged, defective or in use past its labelled next service date.

There was a system in place where devices could be pulled back to the workshop for remedial work or checking either as a result of internal incidents or because of external alerts. This process was managed by the incident desk in the emergency operations centre (EOC). The trust subscribed to, and acted on, the relevant safety bulletins from manufacturers, the Medical and Healthcare Products Regulatory Agency and other NHS agencies.

Staff disposed of clinical waste safely. Waste was managed well with appropriate segregation of waste streams and disposal of the different categories of waste. The waste bins in hubs that we saw were always locked. Vehicles were provided with waste containers for sharps. These were generally used correctly, however on two vehicles they were more than three-quarters full. Laundry was separated into used and contaminated cages although at the Worcester hub we noted that a contaminated cage was adjacent to a cage of newly delivered clean laundry.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or reduced risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Each patient's condition was monitored using the National Early Warning Score (NEWS2) which was as recommended by guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). This uses a scoring system of observations and measurements to identify patients who may be deteriorating and to indicate their priority for treatment. This system was integrated into the trust's electronic patient record (EPR) system through crew's electronic tablets. It automatically calculated the NEWS2 score and suggested actions, such as carrying out a sepsis screen or administering oxygen or fluids. Crews spoke positively of this system with one telling us that it "allowed for most things". We observed that staff completed these assessments for each patient and reviewed them regularly. This completion was subject to audit by the trust and the electronic system required that certain assessments be completed. Crews told us that they could override these scores using their clinical judgement and escalate as they saw fit.

Patients subjected to delayed admission in ambulances outside of hospitals continued to be cared for and observed by ambulance crews. Staff at acute hospital trusts that we visited as part of this inspection told us that crews were good at escalating concerns amongst those patients. However, some crews told us it was sometimes difficult to get hospital staff to come out to see patients about whom they had concern.

Additional support was available to crews on request from their operations managers (OMs) who would attend. There were dispatch protocols to deploy additional crews to specific calls, such as for example, patients in cardiac arrest.

Crews could ask for advice from other paramedics such as clinical team mentors and there was always a critical care paramedic (CCP) available in the emergency operations centre to provide guidance.

On scene support was provided through a number of resources in addition to the operations managers. The trust's Medical Emergency Response Intervention Team (MERIT) vehicle was staffed by a doctor and CCP which could be deployed to a scene. We were told a car was to be put on the road shortly after our inspection crewed by an autonomous CCP. This was the start of a trust initiative to provide this service across the whole region.

Crews could also be supported by the Hazardous Areas Response Team (HART) which provided paramedics trained to work safely in dangerous environments and to work closely with other agencies including the fire and rescue services and the police. Several local charities also provided voluntary prehospital immediate care from professional clinical staff under the banner of the British Association for Emergency Care (BASICS). This provision is outside of the scope of this report.

Staff knew about and dealt with any specific risk issues. There were clinical guidelines for specific risks that were available to crews through their electronic tablets. These guidelines followed JRCALC requirements and were very clear as to how to deal with the presenting clinical picture. We looked in detail at an example of this in the trust's clinical guidelines for the management of sepsis. The document was comprehensive, appropriate and based on current best practice. We saw a recent audit report from April 2023 that demonstrated the trust had assurance care was being delivered to the required standard.

Staff shared key information to keep patients safe when handing over their care to others. When crews handed patients over to hospital care or another crew, they provided the necessary information. We observed several handovers from crews to hospital staff and these were carried out well. We spoke to several hospital staff, and they agreed that handovers were generally good.

Shift changes and handovers included all necessary key information to keep patients safe. The duty operations manager completed a shift report which was updated throughout the day. It provided an overview of staffing, risks, concerns and availability of resources. They used this to handover to the next shift.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe and very low vacancy rates. Senior managers told us, and we saw data to verify, that the service was fully staffed against its planned establishment.

Managers accurately calculated and reviewed the number and grade of ambulance crew needed for each shift in accordance with national guidance. The provider had a policy that crewing should aim for every emergency ambulance to be led by a paramedic. This was a strategic aspiration significantly beyond the national requirements and usual practice for other ambulance services. The provider also ensured that newly qualified paramedics were not assigned this lead role in the first 6 months after qualifying.

This was largely met through effective and robust management including the introduction of a new post of operational resource efficiency officer. There were some occasions, particularly for the Sandwell Hub, where ambulances were double crewed by technicians. However, this crewing of two technicians was itself beyond the requirements of national guidance.

We were told that the redeployment of staff to the large Sandwell Hub had resulted in a 50/50 split of paramedic/ technician establishment compared to the overall trust figure of 65/35. The trust was addressing this by developing their staff and many technicians were in the training pipeline to become paramedics at that hub.

Managers could adjust staffing levels daily according to the predicted needs of patients and the number of staff matched the planned numbers. Ambulance deployment was varied to match the predicted demand considering the time of day, day of the week and other factors that affected the demand on emergency ambulance services. While most staff preferred to work as established crews, the provider operated a 'relief shift' system whereby a pool of staff was available to be deployed wherever needed. This was not always popular with staff, but it did allow the service to always fill the rotas. We understood from managers that while rotas had always been staffed, the recent overtime ban had resulted in difficulty in doing this. However, overtime was now again authorised and the situation much better.

While the trust was always able to staff shifts, staff frequently complained that they were late finishing shifts. This was confirmed by the trust's own data that showed during the month of our inspection the staff only finished on time on 17% of shifts. The extra time worked was usually small, less than 15 minutes for 50% of staff and for 82% of shifts staff worked an extra 15 to 30 minutes. However, for around 5% of shifts staff worked over for around an hour. There were very few occasions, less than 1% when staff worked for more than 2 hours over their shift finish time. Staff told us this often affected their personal responsibilities around, for example, childcare and the work responsibilities of their partners.

Nearly all staff told us it was a problem and several staff told us it was the worst part of the job. One member of staff told us they had worked an additional 7.5 hours over their last 5 shifts and while they would be paid, they would rather have gone home. Managers told us it was something that caused concern and they tried to address it. Crews told us they knew their managers tried to support them with this and that hospital ambulance liaison officers (HALOs) often supported them at emergency departments. Senior managers told us there were agreements with the hospital departments that crews who had ended their shift must be handed over within 30 minutes, but this was not mentioned to us by crews.

Staff also told us that another concern was the inability to take meal breaks. This was partly because they could be dispatched to category 1 calls when making their way to a break, a situation we observed during our inspection, but mainly due to them caring for patients when queuing outside of emergency departments. Some staff said they no longer had any expectation of returning to base for their meals and brought them in cool bags to eat in the vehicle. The trust's data demonstrated that around 4% of breaks were not taken but there was wide variability between hubs. Staffordshire was particularly affected, with Stoke and Stafford hub- based crews missing 10 and 8 percent of breaks respectively.

The service had low turnover rates and low sickness rates in comparison with other NHS ambulance services.

By policy the provider made no use of bank and agency staff.

We saw figures that demonstrated the trust provided the 35 staff required to be trained for special operations including chemical biological nuclear radiation (CBNR) and marauding terrorist attack (MTA) incidents on each shift for 93% of the time. When there was a shortfall, it was below 30 staff for 2% of shifts and between 31 and 34 for 5% of the shifts.

Emergency and urgent care

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. All information was recorded on the trust's electronic patient record (EPR) system using the crew's individual electronic tablets. The only exception to this was electrocardiogram printouts as these were handed over to the receiving hospital. There were also paper documents that were completed when patients were discharged with advice. These were given to the patient but also recorded electronically.

The record system itself was closely integrated with the treatment protocols and pathways and together with the use of mandatory fields this promoted the keeping of accurate records.

The trust's EPR team carried out record audits and did teaching with staff as necessary. The trust's target for record completion was 100%. We saw sample figures that demonstrated that under circumstances where a patient record was required to be completed the rate was 98.8%. Examples of when a patient record would not be completed would be duplicate calls, no patient present at scene or another ambulance service had arrived first and logged the patient as theirs.

Staff had access to patient's emergency care summary (ECS) through their electronic tablets. ECS is a record of a patient's key safety information available to health professionals from their GP records.

If a patient was transferred to a new crew the record handover was seamless as the new crew could access the existing records.

Records were stored securely on the trust's EPR system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Processes and policies were in place which detailed how medicines should be managed. The trust had up to date 'patient group directions' which are written instructions for the administration of authorised medicines to a group of patients. This meant that medicines were administered to patients by staff with the legal authority to do so.

Formularies were regularly reviewed and updated. Clinical decision-support tools, containing useful clinical information and reflecting the best available evidence, were used alongside clinical experience and judgement. The service employed a pharmacist to provide advice, strategic direction and governance for the most effective use of medicines.

All staff who administered medicines had received appropriate competency-based training. We observed good practice during our inspection with crews checking prescribing decisions against protocols, discussing amongst themselves and cross checking before administration.

Emergency and urgent care

Staff managed all medicines safely. Medicines stocks were appropriately stored and managed in line with local standard operating procedures, including regular rotation of stock and checks to ensure medicines had not expired. When we sampled medicines stocks on hubs and vehicles we did not find any examples of them being out of date, damaged or being improperly stored. Similarly, where medicines needed to be stored in controlled temperatures, the fridge temperatures were diligently recorded without omissions.

Medicines storage on the hubs was robust with controlled access only by authorised staff to areas and cabinets through electronic passes and keys. CCTV was present in areas that stored controlled drugs (CDs). Medical gases were stored safely on hubs with usable and empty cylinders being separated and the appropriate warning signs were displayed.

There were effective systems for the issuing of medicines, including medical gases. Medicines kept on vehicles and at stations were all accounted for, with appropriate requisition documentation. Effective systems using tamper evident seals were in use, to ensure medicines were available when needed and fit for use. Regular checks were carried out by staff.

There was regular monitoring of the safe and secure management of medicines. For CDs, daily stock checks were undertaken. CDs were consistently signed for when taken out on vehicles and signed back in on return.

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the trust incident reporting policy. Staff told us they received updates about errors or incidents.

The overall management of medicines was enhanced by its integration with the trust's remarkable logistics system. This meant that medicines were delivered to the right place at the right time, stock was managed for rotation and all medicines were traceable meaning that faulty batches could be identified and retrieved.

Incidents

The service usually managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, there had been a breakdown in process resulting in some incidents not being properly investigated and some staff reported dissatisfaction with how they received feedback from incident investigations.

The trust had a suitable incident reporting policy which was due for review in October 2023. The trust used an 'in house' computer system to manage incidents but was planning to move to a commercial system.

In January 2023 the trust identified that there were a large number of incidents that had not been properly closed. The trust worked over the next three months to close these incidents, and a review of why this happened resulted in improved processes and procedures.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were investigated by operations managers and senior operations managers depending on the seriousness of the incident. All managers with an investigatory role were give suitable training. We saw that the trust visited all patients and relatives where there had been a delayed response to a patient having a STEMI, which is a serious type of heart attack.

If staff were under investigation, they were assigned a welfare officer to support them. One crew told us that incident investigations now felt “less like blame and more like learning”. Another member of staff told us it was a “supportive process but nevertheless still worrying”.

NHS ambulance services are required to review a sample of 20% of all patients that die in the care of, or immediately following care by the service. The trust, by policy, chose to review 100% of deaths to ascertain the standard of care provided and to identify both concerns and good practice. This was done using the Royal College of Physician’s Structured Judgement Review tool, adapted for the ambulance service.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff could report incidents using their electronic tablets. This promoted incident reporting as it meant they did not have to return to an office to do so.

Some staff told us they did not always report those incidents, such as inability to handover at emergency departments that happened frequently as nothing changed as a result. Managers told us they were aware of this and pushed for staff to do so as the organisation needed to understand the numbers of incidents.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff were able to articulate the duty of candour. One crew gave a recent example of their patient having been injured and what was done to apologise. Another crew showed us how they could access the policy on their electronic tablet and that it contained guidance as to what they should do. Trust data showed that for the previous year duty of candour had been correctly followed in 99.6% of 453 reported incidents. The shortfall was due to the incidents being stood down or there being police involvement where an apology would not be appropriate.

Not all staff received feedback from investigation of incidents. Operations managers told us that incident themes were discussed amongst them and learning cascaded down to crews. However, there was variability in crews' views as to whether they got feedback as a result of incident reporting. Some staff said they always got feedback from incidents they reported and others said they never did. Similarly, some staff said feedback was given in weekly briefings and others said there was no communication.

Managers shared learning with their staff about never events that happened elsewhere. The trust subscribed to, and acted on, the relevant safety bulletins from manufacturers, the Medical and Healthcare Products Regulatory Agency and other NHS agencies. This process was managed by the incident desk in the emergency operations centres.

There was evidence that changes had been made as a result of feedback. Crews and managers gave example of learning from incidents. We heard of 'skills and drills' sessions being carried out for teams when the investigation had uncovered problems with carrying out procedures. We also saw how each year’s mandatory training was modified to address training requirements uncovered by investigations.

We were told that the introduction of a new, cheaper medical device had caused a run of incident reports and that the trust had responded by returning to the original manufacturer.

Managers usually debriefed and supported staff after any serious incident. There was variability in what crews said about the support they got following traumatic incidents. Some crews from the Worcester hub said they did not always

get debriefs after a difficult job. Crew from Sandell told us that debriefs were good and that they would get them from their operations manager or medical emergency incident response team. They also said there were other resources available. A paramedic from the Coventry Hub said that debriefs used to be better when they were done on scene alongside fire and police colleagues.

We understood from conversations with senior managers the trust was developing and funding an approach to the forthcoming NHS Patient Safety Incident Response Framework (PSIRF) alongside the Black Country Integrated Care Board who were the local lead.

Is the service effective?

Requires Improvement ↓↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had comprehensive treatment protocols and policies which were based on Joint Royal Colleges Ambulance Liaison Committee and other organisations, such as the National Institute for Health and Care Excellence (NICE). They often incorporated guidance tools, such as flowcharts and tables to aid their implementation, as well as being integrated into the trust's electronic patient record system.

These documents were regularly reviewed and also in response to changing advice and learning from incidents and good practice. Crews were informed of changes through a system of “clinical notices” and any training or support was provided by the clinical team mentors.

Crews had access to all this material through their electronic tablets. Crews told us they were happy with the system and that it supported their clinical practice well.

We reviewed a sample of these polices and found them to be suitable. When we observed care our specialist advisors said good care and treatment was provided against these protocols on the calls we observed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff received suitable training and were able to discuss with the inspection team their approach to patients subject to the act.

Pain relief

Staff did not always assess and monitor patients to see if they were in pain, and did not always gave pain relief in a timely way. However, they supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff usually assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Crews used a recognised tool to assess pain and we saw this used appropriately on the calls we observed. The tool was suitable for adults, children and people with learning or communication difficulties. However, the most recent trust audit had identified deficiencies in the timely assessment and recording of children's pain as well as timely administration of painkillers which was therefore subject to improvement plans.

Patients usually received pain relief soon after it was identified they needed it or they requested it. Crew had pain relieving medicines always to hand. Where ambulances were stocked, for good reason, with low levels of controlled drugs the vehicle would be replenished through a rolling restock before being deployed again.

Staff prescribed, administered and recorded pain relief accurately. Medicines prescriptions and administration was recorded on the trust's electronic patient record system and subject to an audit programme.

Response times

The service did not meet agreed response times. However, they monitored and managed systems to provide as good a service as possible. They used the findings to make improvements.

It is recognised that all ambulance services are operating within an environment where they do not have control over certain external influences that greatly affect their ability to meet performance targets. Aside from the demand for the service from the public, at any time many ambulances are parked outside of emergency departments unable to transfer their patients to the hospital and this greatly reduces the numbers of ambulances that are available to respond to calls.

For WMAS, this situation has continued to get significantly worse and was identified, through its extreme risk level of 25 of the board assurance framework, as the greatest risk that the service had to deal with. For the financial year prior to our inspection, the service lost almost 400,000 hours of ambulance time due to handover delays which was over four times the number prior to the COVID-19 pandemic and more than twice that for the previous financial year. This situation was the underlying reason that this previously well performing provider no longer achieved many of the key performance targets. The trust provided evidence that were hospital trusts able to reduce handover delays to the levels required by NHS England it would itself likely be meeting its own targets. We saw further evidence of the trust engaging with those hospitals since our inspection.

This resulted in "call stacking", which are calls that cannot be responded to within key performance targets and subsequently created risk to those patients in the community that did not receive an appropriate ambulance response in a timely manner. The majority of incidents where harm was caused to patients were a result of ambulance delays.

There was also a culminative risk to staff welfare. Many staff told us the most distressing part of their job was sitting with a patient outside of emergency departments and hearing the emergency operations centres plead for an ambulance to attend category 1 calls.

The service was measured against national targets for Emergency and Urgent (E&U) care provision. These targets were "life threatening (category 1)", "emergency (category 2), "urgent (category 3)" and "non urgent (category 4)". The figures below were from the most recent financial year prior to our inspection, 2022/23.

For category 1 calls the 7-minute mean response time target was not met with 8 minutes and 24 seconds achieved. The 15 minutes 90th centile response time target was met at 14 minutes and 44 seconds, which meant that 9 out of every 10 calls were met in less than that time. Both these figures were around 7% worse than the previous year but the trust was often the highest performing ambulance trust for this category of call.

Emergency and urgent care

For category 2 calls the 18-minute mean response time target was not met with 48 minutes and 12 seconds achieved. The 40 minutes 90th centile response time target was not met at 110 minutes and 46 seconds. Both these figures were around 32% and 35% worse than the previous year respectively.

For category 3 calls the 120 minutes 90th centile response time target was not met at 189 minutes and 17 seconds. This figure was 41% better than the previous year and this was likely a result of the trust's "hear and treat" initiative.

For category 4 calls the 120 minutes 90th centile response time target was not met at 189 minutes and 17 seconds. This figure was 41% better than the previous year.

While only one of the standards was met, these figures were generally better than other NHS ambulance services. More recent figures that we saw indicated improvements were taking place.

A senior manager told us that failing patients through performance (meaning not getting to them on time) together with hospital delays was the trust's greatest risk. Throughout our inspection when we spoke to crew and managers at all levels there was a constant theme of working to improve this performance and mitigate the risks caused.

The trust had worked innovatively to deal with patients without having to take them to hospital and had a nationally low conveyance rate of 49%. This was achieved through initiatives, such as the use of alternative pathways supported by a clinical validation team, the introduction of a patient flow manager and a capacity cell working across the system The presence of paramedics on almost every ambulance meant that patients were more likely to be discharged at the scene. This released ambulances to be available but did not fully compensate for those lost because they were queuing at hospitals. This work was addressing the shortfall in reaching category 2 patients where it was recognised that harm was occurring.

The trust also worked to get ambulances back on the road through initiatives to deal with those waiting at emergency departments for handover. This included the use of 'ambulance decision areas' and 'hospital ambulance liaison officers' (HALOs) at hospitals, actions which had a demonstrable positive effect. However, HALO funding was through the Integrated Care Boards (ICBs) and following the cessation of money to relieve winter pressures the funding stopped. However, after lobbying from WMAS, some ICBs chose to continue the funding. The crews to whom we spoke were always positive about the presence of HALOs and several also noted the willingness of their operations managers to support them at emergency departments when needed. 'Operational efficiency officers' had been introduced to ensure that available resources were used in the best way possible, and overtime was available to increase the staffing resource. There were many examples of small changes to improve efficiency, such as doing staff appraisals while they were queuing at emergency departments and many staff told us they used this time to do their mandatory training.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements. However, outcomes for patients were variable in comparison with other ambulance providers.

The service participated in National Ambulance Clinical Audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Amongst others, in 2022/23 the trust participated in the care of ST elevation myocardial infarction (STEMI), care of stroke patients, care of patients following return of spontaneous circulation (ROSC) and sepsis audits. The trust also had a comprehensive local audit programme that covered drug administration, national ambulance indicators and local concerns identified through incidents.

Outcomes for patients were usually comparable with the other 11 NHS ambulance trusts but there was variability. For example, in recent audits we saw that WMAS was 1st in the country for delivery of the stroke care bundle, between 5th and 7th for delivery of the STEMI care bundle but 10th for the ROSC care bundle.

Managers and staff used the results to improve patients' care, treatment and outcomes. The outcomes of audits resulted in action plans. We saw, for example, completed actions to respond the care of stroke patients and management of STEMI audits. We saw through board minutes discussion of the clinical outcomes and action plans were produced to address issues. The trust identified deep underlying causes and had longer term plans under consideration. For example, the performance for ROSC was believed to be linked to the reducing number of cardiac arrest calls attended by individual crew members because effectiveness was linked not only to training but also to application of the skills. This was supported by dashboards which were available to clinicians to monitor the themes and trends of their individual cases.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff completed suitable training and assessments before they were deployed. Paramedics maintained their registration with the Health and Care Professions Council (HCPC). Staff were kept up to date through a comprehensive mandatory training programme and updates, training for which was supported by the clinical educators known as clinical team mentors (CTMs). Many staff told us the training they had was good and effective and that the trust made good use of its new training and education centre. We saw examples of innovative training practice including the use of skills trainers and simulators, including one for childbirth.

One paramedic told us they got lots of continuous professional development, another said that the CTM role was really valued by the crews. However, one crew member said that they did not get enough refresher training in infrequently used clinical skills.

Staff underwent annual clinical supervision shifts with their mentor and teaching was altered each year to account for changes to trust procedures and protocols. A crew member from the Sandwell Hub told us this was valuable experience.

Managers gave all new staff a full induction tailored to their role before they started work. This was done through a centralised training school which ensured staff new to the trust were able to work to the organisation's policies and procedures. All new staff were assigned a home hub and a mentor.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Each member of staff was expected to have an annual personal development conversation (PDC) with their line manager. This was in a prescribed format, stored electronically so the compliance rates could be monitored and managed. At the time of our inspection the compliance rate was 96%. Operations managers to whom we spoke were aware of the compliance rates for their staff and numbers were sometimes posted on noticeboards.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Many staff told us how they had been or were being supported to develop their skills

and knowledge and it was a common career path for paramedics to have progressed from the technician role. We spoke to a crew member who had recently become a technician from a patient transport role, and they were expecting at some stage to move on to be a paramedic and then an operations manager. Another crew told us that there were “very good development opportunities.”

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Notes were available to all crew through their electronic tablets. However, staff found it difficult to attend meetings because of the nature of the work. One crew member from the Lichfield Hub told us they had been there 12 months, were always invited to team meetings and always got to see the notes but had never managed to attend one.

Managers made sure staff received any specialist training for their role. Some staff had specialist or enhanced roles and they received specialist training. We saw figures showing that staff who had a 'special operations response team' (SORT) role received refresher training and that an additional 48 staff were programmed to qualify during the next year.

Managers identified poor staff performance promptly and supported staff to improve. We were made aware in our discussions with operations managers of staff with performance issues and that these were addressed.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and usually communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw ambulance crews working with other agencies including the fire and rescue service and the police.

Many staff spoke positively of working with other NHS staff including, for example the falls prevention team in Sandwell and we saw examples of crews pre-alerting emergency departments as to the condition of their patient. However, some told us of frustration as they believed that many hospital staff did not understand the impact queuing had on patients in the community.

Trust initiatives including ambulance decision areas were spoken of positively by ambulance crew and they were always positive about the role of the HALO and often expressed disappointment that they were no longer there in some areas.

One HALO to whom we spoke with told us “WMAS and the hospital need to understand each other better” and suggested that could be achieved by leaders doing shifts in each other’s services.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Crews were attentive to mental health problems being a factor or root cause in their patient’s illness and we saw this was covered in their assessments.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient’s health and provided advice for any individual needs to live a healthier lifestyle. As an example, we saw a crew who went to a patient with breathing problems. Aside from dealing with the acute illness they

asked about whether their home environment was damp and about how they kept healthy. When the patient said they had recently given up smoking they talked positively about this achievement and talked to the patient about how to not go back to smoking. This was done in a way as to not 'lecture' the patient as the conversation took place alongside their treatment, but was clearly deliberate on their part.

There was some material on vehicles that could be passed on to patients and relatives as part of the 'see and treat' discharge process.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. The service had appropriate policies in place in respect of consent and consent was part of the yearly mandatory training pack. On all the calls we attended we saw crews obtaining consent before carrying out tests or treatment including involving the patient in the decision to convey to hospital or not.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Capacity assessments and best interest decision making formed part of the yearly mandatory training pack. We spoke to some crews about this, and they demonstrated a good knowledge talking about passive, verbal and written consent, as well as the Mental Capacity Act 2005 and how to act in the best interests for an unconscious or uncommunicative patient.

We observed a crew dealing with a child with a significantly lowered level of consciousness and they effectively carried out treatment in the child's best interests with the involvement of a parent.

Staff clearly recorded consent in the patients' records. Consent formed part of the electronic patient record system's mandatory recording.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Initial and refresher training for ambulance crew covered these topics.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding.

Emergency and urgent care

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy, and took account of their individual needs. While the dignity of patients required to queue in ambulances outside of emergency departments could not always be ensured they were treated with great compassion by the crews looking after them.

Staff were discreet and responsive when caring for patients. When we observed crews interacting with patients, they took every effort to do this on the ambulance and making sure the doors of the saloon were closed. We observed a male crew member withdraw from the ambulance while a female colleague attached electrocardiogram leads to a female patient. While crews expressed concern about the toileting needs of patients when queuing outside of emergency departments, as they were not trained to provide personal care, and some male crew members said they were sometimes uncomfortable supporting female patients with this, this represented their insight into the needs of their patients.

The trust had developed systems to support crews looking after for patients outside of hospitals so that they could care to the best of their ability. This included ensuring management support was onsite to deal with difficulties and trying to ensure crews at the end of their shifts were relieved as soon as practicable.

Staff took time to interact with patients and those close to them in a respectful and considerate way. When we observed crews caring for patients the interactions were very caring and reassuring to both patients and those with them. We saw staff being patient with patients who walked slowly or had difficulty understanding what they were being told.

Several staff members made use of humour to put patients at ease particularly when they were distressed to be queuing outside of emergency departments. They often demonstrated considerable empathy and adapted their conversation to the individual patient.

Patients said staff treated them well and with kindness. We spoke to some patients about their experiences, and all spoke of the service positively. One patient said they had used the service before, and they were “absolutely excellent – never had a bad one”. Another patient said that another ambulance had been out to them recently, but they hadn’t needed to go to hospital. The crew had made sure they were OK and had prepared them a meal before they left.

Staff followed policy to keep patient care and treatment confidential. All patient records were stored on the trust’s Electronic Patient Record system and accessed through the crew’s secure electronic tablets.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. Staff understood and respected the personal, cultural and social needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. On 2 of the calls we observed, a cardiac arrest and a road traffic collision, the Operations Manager supported the crews by taking the lead in supporting the relatives of the patients. This meant the crews were able to give effective care without being distracted.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. If a patient died, crews supported relatives and made sure they could spend time with their loved one before they were transported to the mortuary. They gave practical advice including leaflets on what to do next.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Crews told us they were aware of how distressed patients and their relatives could become when queuing to access emergency departments and we observed them making efforts to reassure them as well as keeping in touch with the emergency department.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. When we observed calls, we saw that crews communicated effectively and modified their approach to each patient.

Staff talked to patients in a way they could understand, using communication aids where necessary. When we attended a call to a child who had become unwell in the street the staff involved both the child and their parent about the decision to go to hospital. Ambulances carried communication cards to support working with patients who might have learning difficulties or did not speak English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Each ambulance had a poster explaining how people could give feedback on the service and this was also on any printed material that was handed out.

The trust carried out various patient surveys of which we saw some examples and the results were overwhelmingly positive with scores higher than 85% in respect of the consideration, empathy shown to and communication with patients.

Is the service responsive?

Good  

Our rating of responsive went down. We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that aimed to meet the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service had and used business intelligence data to predict the resources required considering the time of day, day of the week and other factors. Factors that affected the demand included the density of population and effectiveness of the road network as well as the location of hospitals. Ambulances and crews were deployed to best meet this predicted demand and were redeployed in response to changing circumstances.

During every shift there was a tactical conference call involving the duty manager for each hub and twice a week there was command call for each area.

For each hub the duty operations manager completed a shift report which was updated throughout the day. It provided an overview of staffing, risks, concerns and availability of resources. They used this to handover to the next shift.

The service relieved pressure on other departments when they could treat patients in a day. The service had a 'see and treat' approach to patients who could be treated and discharged by crew at the scene without conveyance to hospital. This reduced the workload of other NHS services.

The trust had worked innovatively to treat patients without having to take them to hospital and had a nationally low conveyance rate of 49%. This was achieved through initiatives, such as the use of alternative pathways supported by a clinical validation team and the presence of paramedics on almost every ambulance meant that patients were more likely to be discharged at the scene. This released those ambulances to be available for other calls.

Staff could not always access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. While the service had systems to help care for patients in need of additional support or specialist intervention those partner agencies which provided these were not always able to do so. Several crews expressed concern that the police service was pulling away from attending calls where mental health rather than criminality was the underlying issue and said this worried them as to their safety and the care of these patients. They also expressed the view that the police were less likely to attend with them to addresses with 'red markers' and they felt under pressure to go in anyway without police support.

Senior managers were aware of these concerns and told us that they were assessing the impact through discussions with the local police forces alongside the Association of Ambulance Chief Executives (AACE) and the National Police Chiefs Council. They were expecting impact information from another ambulance service already affected by this and the matter was a discussion item for the next board.

They were also aware of crew concerns about police support and said that this was due to stretched police resources. Body worn cameras were now available for staff alongside the CCTV installed to monitor the interior and exterior of ambulances. Some staff told us the camera was rarely used but was a helpful “next step” option to deescalate a situation and gave examples of how it had changed people’s behaviour. Senior managers told us that the introduction of stab vests was also being given consideration. All staff received conflict resolution training with a yearly update, and all staff had an emergency button on their radio to request police support.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. The service made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Where these documents existed at the instigation of other providers crews would make use of them.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Crews had

access to a language line facility to act as interpreters. They told us that the service was generally good, but for less common languages an interpreter might not be immediately available, and this meant that relatives were sometimes used as interpreters. Staff knew that this was not good practice, but they were aware of the specific risks of doing so and it was done in the context of needing to provide urgent or emergency care.

Staff had access to communication aids to help patients become partners in their care and treatment. Vehicles carried a visual aid book with materials to help communicate with patients with special needs. However, two crews we spoke to were not aware of this. Crews would always try to accommodate carers for people with special needs when conveying to hospital.

Access and flow

People could not sometimes access the service when they needed it, in line with national standards, and did not always receive the right care in a timely way. However, this situation was largely outside of the control of the provider.

Handover Delays

It is recognised that all ambulance services are operating within an environment where they do not have control over certain external influences that greatly affect their ability to meet performance targets. At any time many ambulances are parked outside of emergency departments unable to transfer their patients to the hospital.

For WMAS this situation has continued to get significantly worse and was identified as the greatest risk that the service had to deal with. For the financial year prior to our inspection, the service lost almost 400,000 hours of ambulance time due to handover delays, which was over 4 times the number prior to the COVID-19 pandemic and more than twice that for the previous financial year.

Handover start time is defined as the time the ambulance arrives at the emergency department, with the end time defined as the time the patient is handed over to the care of the department staff. National ambulance standards indicate handover should take place within 15 minutes, with none taking more than 30 minutes.

We asked for and were provided with details of handover delays for a period during the month of our inspection. The utility of this data was reliant on the quality of the recording, and we noted that the trust recorded data for 95% of handovers which was high in comparison to other ambulance providers.

The data, which covered 20 type 1 emergency departments over a 3-week period, showed a degree of variability which was to be expected given the different sizes, catchment areas, activity and hosted specialisms of the departments. Overall, the data described the significant handover delays that all staff talked to us about and correlated well with CQC's own knowledge of where delays were worse.

The mean percentage of patients handed over in under 30 minutes across the whole region was 72%. However, this represents a wide spread with around 90% of patients being handed over within this time at some sites and less than 50% at others. Around 17% of patients were handed over in the next hour but this meant that around 11% of patients spent more than an hour in an ambulance waiting to be handed over. This was approximately 2,400 of the 20,500 patients taken to hospital by WMAS during the period.

Seven hundred and sixty-seven patients waited between 2 and 4 hours, 151 between 4 and 6 hours and 38 patients waited for more than 6 hours to be handed over.

Despite the care and attention given to these patients by the ambulance crews, the patients were not yet in the right place for effective care. Any definitive hospital diagnosis or treatment they needed was delayed. Patients were at risk of injury from pressure sores and if they became suddenly unwell they might not receive the correct treatment quickly enough. Their privacy and dignity was compromised; they could not go to the toilet easily and they did not have ready access to food and drink. They, and their carers and relatives, were often distressed. Crews told us that they worried that in trying to keep their patients safe and meet the expectations of the emergency department staff they might work beyond their scope of practice.

We were told that this issue was the greatest risk that the trust identified and so it was a constant focus of management and board attention. The trust had introduced various as described earlier in this report.

A member of staff from one acute hospital trust said the loss of their hospital ambulance liaison officer was a real blow and added to workload.

Crews with patients subject to handover delays often found themselves in situations where they had not had meal breaks or they were at the end of their shifts. Where possible operations managers relieved this situation through 'cohorting'. This term is used variably across the NHS, but WMAS use it to describe when a crew needing a break or coming to the end of their shift is relieved by the dispatch of another crew to the hospital site. We were given data that showed variability across the hospital locations but this, as expected, correlated to some extent with the number of handover delays for that site. For the 2-week period the data applied to there were just under 500 occasions when cohorting occurred. Processes had been introduced to support this activity and as part of our inspection we reviewed, and found appropriate, the relevant standard operating procedures.

Aside from the effect on patients, both at hospital and waiting in the community, the resultant inefficiency of the service and the demoralisation of staff, a significant amount of the trust's management, planning and information resources were given over to dealing with this day-to-day crisis.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. There was information displayed on ambulances telling patients how they could share their experience of the service, including making a complaint. This could be done by FREEPOST, email, telephone, through the trust website or by accessing through a QR code. There was also information about feedback on discharge sheets given to patients.

This information was also on the trust's website which directed patients to support from the organisation's own 'patient advice and liaison service' (PALS) as well as several advocacy groups across the region. There was also accurate information about the role of the Parliamentary and Health Services Ombudsman and the CQC. Staff understood the policy on complaints and knew how to support patients to make them.

Managers investigated complaints and identified themes. Complaints were dealt with by operations managers and senior operations managers (SOM) on the hubs. A SOM told us that they dealt with 2 or 3 a week. For the financial year prior to our inspection the trust responded to 99.5% of complaints within the required 3 days of receipt and all complaints received a final resolution letter within the required 6 months.

Emergency and urgent care

Information that the trust placed on its website demonstrated detailed themes to complaints and whether or not the conclusion was that the complaint was upheld. The 3 key themes identified were response time, staff conduct and the loss of or damage to property.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. Several staff told us they thought the organisation took complaints seriously and could give examples of having been briefed about learning from complaints. As well as any local action needed the trust had, a learning review group which reviewed upheld complaints and actioned any learning or changes across the region.

Is the service well-led?

Good  

Our rating of well-led went down. We rated it as good.

Leadership

Most leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.

The service had an effective leadership structure with clear structures, defined roles, and lines of reporting and accountability.

Leaders at all levels in the service had the skills and abilities to manage the service. This was achieved through training and professional development and most of the operational managers had “come through the ranks” in the service. All operational managers were paramedics and maintained their professional registration and credibility by doing clinical shifts.

Most staff were supportive and complimentary of their leaders and the way they were managed. In our private conversations with crews, they were overwhelmingly positive saying they felt supported both in terms of leadership, but also in practical ways like being present at difficult calls and coming to emergency departments when handover delays were occurring.

Some crews felt differently, and this appeared to be in relation to specific managers. While some of the concerns we heard were current, others were historic and when we explored further often found the issue had been addressed. One theme we frequently heard was a perception of 'favouritism' and people being treated differently. In turn managers told us that dealing with interpersonal relationships between crew members was one of the challenges of the job.

Emergency and urgent care

As well as their line management responsibilities, managers' day to day focus was very much on the stresses that the service was under and delivering against the trust's priorities. When we spoke with managers, they were very clear and consistent at all levels as to what the organisation wanted them to do and how it wanted them to achieve it. Operations managers were also consistent in their answers as to what the key risks were, and this correlated well with what senior leaders told us and the risks we saw recorded in documentation.

Staff generally told us that operational managers were approachable, and some were very complimentary and gave examples of them being there for them individually and the rest of the team. Similarly, senior operations managers (SOMs) said that senior managers including the executive team were supportive. However, some crews told us they did not see their operations manager (OM) as approachable or available and again this seemed linked to specific individuals. We understood that previous concerns about the lack of management presence and support had been addressed by ensuring that, within the needs of the service, there was usually an operational manager present at a hub for crew to speak with.

A consistent theme in our discussions with staff was how they were encouraged and supported to develop their skills and progress to more senior clinical and managerial roles. We heard many examples of how staff had been given access to training, including financial support to get degree qualifications. There were established progression pathways through the organisation. Only one member of staff specifically said that there was not opportunity for progression in the organisation.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a strategic vision, developed with internal and external stakeholders, that was articulated in their document 'Trust Strategy 2021 – 2026 Trust us to Care'. This recognised that the organisation's pathway, while successful in achieving current aims, risked not having the necessary workforce capacity, a suitable clinical model of care to deal with ageing and long term and chronic conditions, and to work effectively with the integrated care systems.

This resulted in five strategic objectives to focus on safety, quality and excellence; be a great place to work; to effectively plan and use resources; to innovate and transform and pro-actively engage and collaborate. Each objective was broken down further to define success criteria.

In examining these criteria, we recognised elements that we had seen and staff had talked to us about during our inspection. Examples included the development of clinical outcomes, increasing the representation of ethnic minority staff, carbon reduction initiatives, such as low carbon buildings and the implementation of electric vehicles.

Culture

Most but not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Although some staff disagreed it was always working, the service demonstrated commitment to promote equality and diversity in daily work. There were many opportunities for career development. The service was endeavouring to support an open culture where patients, their families and staff could raise concerns without fear, although some staff told us they remained concerned about speaking up and raising concerns. Some of the issues relating to culture were not yet resolved, however, plans were in place to address these.

Emergency and urgent care

Most staff we met and talked with on inspection felt supported, respected, valued and were positive and proud to work in the organisation. Staff's concerns were very much focussed on patient care and most told us how hard it was to sit at emergency departments listening to calls going unanswered. Many were enthusiastic about their job, their local team and the organisation as a whole. However, this was to some extent in contrast to the results of the 2022 NHS Staff Survey.

The trust had a low response rate of 39% against a national average of 50% and results were worse than other trusts for being a compassionate organisation, teamworking and staff engagement. However, staff morale was higher.

The trust was open and transparent and published many of the 841 free-text comments made by staff in the NHS 2022 Staff Survey in its May 2023 board papers. This was despite the sentiment from staff being mostly more negative than positive in those free-text comments. This approach was noted in our discussions with OMs and SOMs who, rather than direct our attention away from problems, placed them before us with minimal prompting.

The trust provided staff with a range of tools and services to support their wellbeing and mental health. This included a multifaith chaplaincy team, maternity champions, financial advice, student support officers, and a range of wellbeing support. There was a 5-year strategy for wellbeing and the trust was in year 3. Most staff spoke positively about this support in the conversations we had with them, and many gave some examples of having received mental health support, help getting back to work after injury and debrief following traumatic incidents. However, there were some staff who told us about having not been supported locally in this way.

Staff's concerns were very much focused on patient care and most told us how hard it was to sit at emergency departments listening to calls going unanswered.

One group of staff who spoke of feeling unsupported were student paramedics on placement from university. While we spoke to very few currently in study, several qualified paramedics contrasted their current positive experiences as an employee with their previous and recent experience as a student. They felt WMAS students were given preference over those on university placement. In contrast those student paramedics in trust employment transitioning from the technician role did not report poor experiences, instead they were overwhelmingly positive about their training and opportunities.

Staff also described a cultural gap between younger and older staff. Staff, including some operations managers told us they needed a different style of management, that they were sometimes less self-reliant and resilient.

The trust was reported by its staff in the staff survey as 'improving' in terms of equality and diversity. Staff said there had been a history of not dealing well with racism and there being use of inappropriate language and terminology. We were told there was now a better culture with education and support improving. However, not all staff agreed it was working and against the national benchmark, the trust's Workforce Race Equality Standard (WRES) report was poor. The latest WRES report (2021/22) reported that several key indicators were significantly worse for staff from an ethnic minority background. Key indicators around experiencing harassment, bullying, and abuse (from both the public and other staff), equal opportunities, and discrimination, placed the trust in the worst 10% of NHS trusts in England. We acknowledge the low response rate to the survey from staff from ethnic minority groups. During our inspection some staff gave us specific examples. One told us that as a student they were subject to racist comments by a patient which were not challenged by the rest of their crew. Another described that despite being well supported to progress in the organisation, they always felt they had to do better than other staff.

Many staff told us how they had been or were being supported to develop their skills and knowledge and it was a common career path for paramedics to have progressed from the technician role. We spoke to a crew member who had recently become a technician from a patient transport role and they were expecting at some stage to move on to be a paramedic and then an operations manager. Another crew told us that there were "very good development opportunities."

Leaders and all staff we spoke with understood the importance of staff being able to raise concerns without fear of retribution, and the importance of appropriate learning and action being taken because of concerns raised. However, although the trust encouraged openness and honesty at all levels within the organisation, there remained around a third of staff (who responded to questions) who said they did not feel safe raising concerns. When we spoke to staff on inspection specifically about the freedom to speak up guardian there was considerable variability in their response. Two paramedics from the Warwick Hub described the role well and 1 from the Stoke Hub said they were aware of them, and it was mentioned in every hub update. A Sandwell based crew said they had "no idea" of the role and thought that was the "role of union reps" while a crew member from Bromsgrove said there was apathy about the role as "they are in cahoots with management".

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure with defined roles and responsibilities and the structures were well understood by staff at all levels in the organisation. The practical implementation of systems and processes was generally consistent across the organisation with little variability in evidence.

The governance structure was supported by several sub committees including the quality governance committee, the performance committee, the people committee, the audit committee, the remuneration and nomination committee, and the trustee committee. There were also a number of groups who reported to the various committees. For example, the immediate care governance group and the clinical audit and research group reported to the professional standards group.

The patient experience group reported monthly to the learning review group (LRG) and the professional standards group which focused on themes and trends. The LRG reported to the quality governance committee and reported any issues relating to assurance, as well as risks identified, and key points for escalation. The trust board received monthly data on formal complaints and concerns through the trust information pack.

Shared governance arrangements with other NHS ambulance services were managed through national arrangements, such as the Joint Emergency Services Interoperability Program, the National Ambulance Resilience Unit and other mechanisms.

For local partnerships we saw that suitable service level agreements were established for the two helicopter emergency medical services and regular quality and performance meetings took place. The trust's medical director chaired the intermediate care governance group which oversaw all the enhanced and critical care services. This included the various groups that delivered a BASICS service.

Community first responders were subject to a volunteer agreement which defined their roles, responsibilities, and scope of practice. Regular meetings took place chaired by the responsible WMAS director.

Policies and procedures were regularly reviewed and updated.

The service had regular management meetings at each management level including for all staff on a hub. These meetings covered governance, performance, and risk management. The meetings had a set agenda and we saw example copies of the notes that demonstrated that they took place and the relevant topics were discussed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust had a risk management system that was well embedded across the emergency and urgent care service. Assurance systems and performance issues were escalated through structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational, and financial processes and had systems to identify where action should be taken. Impact on quality and sustainability was assessed and monitored.

We spoke to crews and operations managers about their concerns they were consistent in describing handover delays which impacted the welfare of their patients and response times but also crew morale and the maintenance of their skills. Some were also worried about the proposed withdrawal of police attendance to mental health related incidents.

When we spoke to senior managers, they were conversant with these risks and were able to articulate the issues in more detail and context and to explain the proposed responses. When we asked for the trust's documentation of risk, we noted the topics and the action plans discussed appeared on these risk registers.

The trust had matured and tested plans to cope with unexpected events as expected of an NHS ambulance service. However, this element of service provision sits within the separate resilience core service and was outside the scope of this inspection.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Data used was reliable, current, and credible. The NHS ambulance service relies extensively on live, precise and detailed information and data to be able to safely deliver its service. Almost all systems used by WMAS were computer-based, including the management of 999 calls, dispatch of ambulances, and recording patient information including by crews on the road. Staff told us these systems functioned well almost all the time, but there were back-up systems which were tried and tested in the event of, for example, major power failure.

Each member of staff had their own electronic tablet through which they could access the various systems they needed to use. We saw crews constantly entering information so as to record the results of assessments and the treatments given as well as using them as a reference guide. Almost everything the crews needed to do in their day-to-day work including checking which vehicle they were assigned to and its readiness state, making incident reports, looking at the notes of a meeting or reading clinical updates was done through these devices. Where paper was used, for example on noticeboards or information sheets these were almost always supplemented by QR codes so staff could access additional information through the use of the tablet's camera.

Emergency and urgent care

There were clear service performance measures at divisional level. These were reported and monitored with effective arrangements to ensure the information used to manage and report on quality, safety, and performance was accurate. They included performance in pre-hospital care, response times, and clinical outcomes, such as stroke performance and patients returning to spontaneous circulation following a cardiac arrest.

Information technology systems were used effectively to ensure medicines were monitored at all stages of the transfer of care of the patient. The use of the electronic patient record ensured all medicine records were recorded. Trends were assessed, as well as undertaking audit trails for assurance in medicine use.

There were arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems. National guidance around cyber security and other security arrangements were followed. There were arrangements to ensure data or notifications were submitted to external bodies as required.

The trust was one of only two ambulance trusts NHS England accredited as part of its Global Digital Exemplar programme.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There was a strategy to engage with staff and stakeholders. This strategy described a detailed and consistent approach to the multiple routes and channels for engagement, which were recognised to be growing and diversifying.

The trust endeavoured to link with members of the public to understand experiences and use this intelligence to support improvements. The patient experience strategy covered the aims and objectives of involving patients, relatives, carers and the public in shaping services but was early in implementation.

The trust had trained a number of staff as family liaison officers to work with bereaved families and this service was being widened to include the families of staff who died suddenly to provide support if requested.

The trust pharmacist ensured staff were aware of their role by visiting hubs, as well as raising the profile of medicines at governance group meetings.

There were improving but positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population.

Collaborative relationships were maintained with other major partners, including the other emergency services, the local authorities, and the NHS. One example of valued partnership working was the work of the clinical validation team in having daily calls with system partners to look at current pressures and share information. The trust had trained around 34,000 people in 2022 as part of the ‘restart a heart’ campaign. There were a team of volunteers and community first responders supported and valued by the trust.

The service used patient feedback forms which asked patients or carers about the quality of the service and any additional comments they would like to make. The trust had a dedicated feedback and engagement telephone line, which had an answerphone facility out of hours to enable messages to be left and a call back made the next working day.

Emergency and urgent care

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders aspired to continuous learning for their staff and innovation for their service. The trust had a head of organisational development committed to culture, leadership, learning and development. A programme of engaging leaders and engaging managers had been developed which included subjects, such as how to start and hold difficult conversations, coaching, and interview skills. There was a small team dedicated to research and development.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement methods and skills were available and used across the organisation, with staff empowered to lead and deliver change. Programmes were managed under formal project management methodologies.

Several staff told us of research and development activities that they had been involved in such as the Paramedic Analgesia Comparing Ketamine and Morphine in trauma (PACHMaN) trial and the SPEEDY trial for specialist pre-hospital redirection for ischaemic stroke thrombectomy.

The trust was trialling its successful 'Hear and Treat' methodology for category 3 calls, where they offer advice and do not send a response for category 2 calls. This was reported as working and was reducing conveyance.

Emergency operations centre (EOC)

Outstanding ☆ ↑

Is the service safe?

Good ● →←

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Most staff received and kept up to date with their mandatory training. The service had effective systems in place to monitor staff's compliance with mandatory training known as 'Decider training'. Staff received mandatory training in safe systems, practices, and processes.

Staff training rates were high across the emergency operations centres. The call-taking duty managers, performance supervisors and administrators all achieved 100% mandatory training compliance. At the time of the inspection, call assessor supervisors achieved 81%, call assessors 92% and the dispatch teams 80%, against a trust target of 100%. However, these figures were for the year to date, and since the inspection the trust provided data to show that completion rates were on track to achieve 99.4% compliance by the year end.

All staff we spoke with received and kept up to date with their mandatory online 'training workbook' which consisted of the more generalised elements of the mandatory training required. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us if they fell behind with their mandatory training, managers would receive notification of this and would speak to them.

Mandatory training was also monitored by the training department and the senior management team. Information regarding compliance was reported at every senior management team meeting. Once staff finished their online mandatory training they were issued with a certificate of completion. Managers covered mandatory training as part of staff annual appraisal. The mandatory training was comprehensive and met the needs of patients and staff. Staff spoke positively of the mandatory training programme.

Training was delivered as a mixture of face-to-face training and online completion by staff. Training modules included effective communication, health and safety, safeguarding adults, children and preventing radicalisation, information governance, health and safety, awareness of mental health, conflict resolution, dementia, equality and diversity, and disability training.

Duty of Candour (DoC) was part of the service's mandatory training for staff. The service had a DoC policy which staff were aware of and their responsibility to be open and honest with those who used the service.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Emergency operations centre (EOC)

Staff received training specific for their role on how to recognise and report abuse. Staff told us they followed the safeguarding guidelines and had attended safeguarding training, which was part of their annual mandatory training requirement.

There were effective systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. Safeguarding was delivered in line with the intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018.

Non-clinical staff were trained to level 2 safeguarding adults and clinicians were trained to level 3. The safeguarding leads were trained to level 5. Data showed staff achieved 100% compliance with safeguarding adults and children training level 1 and 2 with the call assessors achieving 98%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service worked with other agencies to support patients and protect them from neglect and abuse, such as the local safeguarding team. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

All staff we spoke with had a good understanding of what constituted harassment and discrimination and the actions they would need to take if they suspected a patient required safeguarding.

Equality and diversity were promoted within and beyond the organisation. Staff including those with particular protected characteristics under the Equality Act, told us they were treated equitably. There were cooperative, supportive, and appreciative relationships among staff and teams worked collaboratively to share responsibility and resolve conflict quickly and constructively.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff we spoke with were aware of what to report and how to make a safeguarding referral when required. Staff were knowledgeable about the processes for recognising and referring a safeguarding concern. During our inspection, a member of staff showed us an example of a safeguarding referral they had made, and how they liaised with the relevant safeguarding authority to ensure the person was safe.

The safeguarding policies were easily accessible in electronic form as the trust were in the process of going paperless. The policy outlined what safeguarding was, its importance and provided definitions to the different types of abuse. The policy also covered staff responsibilities about raising safeguarding concerns and the procedure by which to report these.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

All operations centres were set out and maintained in a way that created a suitable working environment for staff. The EOCs were visibly clean, tidy, and well maintained. There was no government recommendation for specific COVID-19 testing process at the time of our inspection. However, this risk was locally managed with staff through the West Midlands Ambulance Service University NHS Foundation Trust health and safety policy.

Emergency operations centre (EOC)

Environmental audits were regularly carried out and action plans for improvement developed and shared. We observed reports of 3 audits carried out during June and July 2023. Workstations were well spaced and there was furniture which could be adapted to suit individual needs of staff. For example, there were desks and chairs that could be adjusted and extra-large display screens to enhance the view of information displayed.

The trust had a Display Screen Equipment (DSE) Policy to ensure that workstations conformed to the Health and Safety DSE regulations 1992 as amended in 2002 to ensure the safety of all users and compliance with the law. DSE regulations were being met, all staff had completed a workstation safety assessment in the last 12 months, and a general risk assessment was completed. Staff safety matters bulletins provided topical updates and reminders for example, in one we saw an article on Spotlight On...DSE.

We saw several items of equipment purchased specially for some members of staff because of the assessments, such as specialist chairs and desks. In addition to this the arrangements within EOC staff were supported with a special break agreement approved in consultation with staff side representatives and management. This incorporated the required natural refreshment breaks into allotted periods away from DSE operation into 4 set periods within the 12-hour shift or equivalent.

The operations centres had a recent upgrade to the communication systems as part of the national Ambulance Radio Programme. A control room solution was introduced which provided enhanced communication, using voice and data methods with the aim of providing greater resilience to the service. Staff were apprehensive of the new system before its introduction but had noticed the improvements immediately. For example, staff told us communications links were quicker and easier to use and it provided an enhanced major incident capacity which made working with other ambulance services, as well as police and fire services, much easier.

There was a rolling programme to replace all information technology hardware every 3 years with maintenance schedules in place and up to date. There was a system for staff to report equipment failure, the trust information technology team managed any repairs and maintenance to computers and monitors. EOC staff had access to up to date satellite navigations systems which were updated monthly.

Every 4 weeks the computer aided dispatch (CAD) system was upgraded to ensure security and critical updates were completed. The service alternated between live sites to facilitate preventative testing of the resilience every month, ensuring that if one site was to fail, the other site was in the position to take over.

During any addition of new software to the CAD a rigorous testing schedule was followed to ensure all core functions of the CAD were maintained and not inadvertently impacted by the changes. We were shown evidence of this from the most recent update to introduce Good Sam responder integration. There were no recorded CAD outages during the reference period of April 2022 to April 2023.

Staff we spoke with explained the CAD received regular development updates to support the integrated urgent and emergency care (IUEC) team, this benefited patients and improved patient safety. For example, a recent development request to the CAD was provided following a serious incident recommendation by the enhanced care ‘trauma desk’ clinicians. The upgrade had automated the population of an SMS text alert to medics, releasing the trauma desk clinician to task specialist assets, provide support and ultimately promote a timely response to patients.

Emergency operations centre (EOC)

There was a business continuity plan to mitigate any system wide failure. Building expansion was available at both sites to increase the number of call handlers to help support other services across the country. Both operations centres kept emergency equipment for use in the immediate vicinity, we checked the emergency bag in the Brierley Hill and Stafford operations centres and found all medicines and consumables within their expiry date.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. Call handling staff used the NHS Pathways system when taking initial calls. The NHS Pathways system gave call handlers categories to enable them to prioritise callers due to the nature of their emergency or redirect callers to alternative services. For example, a category 1 call for life threating illness or injuries would need an immediate emergency dispatch for an ambulance to arrive on scene within 15 minutes 90% of the time. A category 3 call would require an emergency ambulance to be dispatched or a clinical call back within 60 minutes. Call handlers also advised callers how to locate and access community-based defibrillators to help in urgent health emergencies.

Staff could see their own and other EOC's call handling times and staff availability to take calls displayed on IT screens placed around the EOCs. Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident.

Following the initial call being prioritised by the call handlers, the dispatch call team then identified the most appropriate resource to dispatch to the emergency within the correct time frames. Call handling staff could liaise with the call handling team leader or duty manager for additional advice on responding to a caller.

Staff knew about and dealt with any specific risk issues. The service had a patient 'stack', which was a list of patients in call order, waiting until an available resource could be allocated. Call priority changed at varying points during the stacking process and risks were assessed as more information was obtained from the caller during welfare calls. There was no specific desk or team to look at high volume or frequent contact service users, but we were advised the service was planning to introduce this.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. We observed that call staff could refer patients to other services which included GP's services, police, social services, community matrons, mental health teams and district nurses. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff had a good understanding of how to support patients experiencing a mental health crisis and this included staying on the line with people who were threatening suicide. We observed that EOC staff were patient with elderly callers and patients who were confused or anxious. Staff also told us they had undergone mental health training, as part of their mandatory training requirements.

Data showed all staff received awareness training regarding mental health and suicide, through a combination of external courses delivered by members of the training team who were qualified mental health first aid and suicide first aid instructors. The training was part of mandatory training. Pathways also provided 'hot topics' and 'toolkits' regarding mental health.

Emergency operations centre (EOC)

During our inspection, we observed face to face classroom training on mental health first aid (MHFA). This was undertaken by 2 qualified teachers. The staff were awarded protected time to attend the training. All staff completed a half day mental health first aid course as part of their mandatory training. The service also provided a 2 day MHFA course which accredits the staff to be a mental health first aider.

We found there was not a specific mental health desk within EOC, however, the service employed mental health nurses who worked as part of the clinical validation team at Navigation Point and who would take up any calls that were categorised as potential suicide or confirmed patients with mental health needs. The mental health nurses could see the GP notes but not any mental health notes from the local NHS trust.

Staff shared key information to keep patients safe when handing over their care to others. EOC duty managers conducted comprehensive verbal and written handovers between control rooms including all necessary key information to keep patients and staff safe.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency, and locum staff a full induction.

There were systems to review historical data which enabled the forecasting of staffing levels and skill mix. The trust's Business Intelligence Unit (BIU) provided a dynamic emergency call forecast, embedded into key resourcing and activity reports. The call forecast was embedded into live reports displayed across the IEUC and was reviewed manually, as required.

A predefined model, built into the trust's analysis server compiled an emergency call forecast based upon 'week of year', 'day of week' for the last 4 years and adjusts for trends during the last 12 weeks. This ensured sudden uncharacteristic surges in demand, such as a significant incident did not result in an increased activity forecast. For long-term strategic planning, the trust used a yearly 4.5% emergency activity increase.

Staffing levels for all staff groups were reviewed annually. The IEUC directorate was at or over establishment in all functional roles, with an active recruitment programme for the clinical validation team to ensure the establishment was maintained to deal with increased activity that was forecast to arise during the winter period.

Emergency call forecasting enabled the trust to predict incident categorisations based upon the previous 12 months of activity. This ensured the incident category forecast reflected seasonal changes, such as an increase in category 2 incidents through respiratory illness during winter.

The dispatch function within the EOC was split into divisions according to the number of resources being managed in each area rather than the activity. The senior management team within the IEUC could increase staffing levels within dispatch during periods of increased demand, such as planned events and adverse weather scenarios. An example of this was the provision of the Commonwealth Games, where a separate command cell was enacted to manage the emergency activity and resources separately.

The trust did not operate a staff 'bank'. However, there were relief rotas that allowed flexibility to increase the resourcing levels when planning for increased demand such as bank holidays and festive periods. In addition to relief, the trust had

a development programme to ensure resilience in all IEUC functional roles. This provided additional fully trained staff to cover on-day absence and increase the routine staffing levels, as required. For example, during an on-day requirement or planned resilience would be a call assessor (development dispatcher) moving to cover a dispatch position, a controller covering a duty manager and a dispatcher covering the incident command desk.

All new starters were placed on a relief rota by default unless prior arrangements were agreed at interview. Staff told us they have the option to join a range of rota patterns, which will affiliate them with a team and follow the shifts of their colleagues. Some staff preferred to stay on relief due to the increased flexibility. All relief staff had a nominated line-manager and were affiliated to a team.

The EOC's worked as one virtual call centre, the telephony system distributed incoming calls across both centres determined by the number of staffs on shift at the time in each centre. Due to increased demand in telephony nationally WMAS were assisting several NHS ambulance providers with initial call handling.

Resourcing Escalatory Action Plan (REAP) was embedded in the day to day running of the service. We saw information displayed in the operations centres informing staff of the REAP level. REAP is a national indicator of the pressure in ambulance services across the UK, which triggers specific actions when the trust is operating at significant and sustained levels of increased activity. For example, REAP level 1 is normal service and REAP level 4 in severe pressure. Staff we spoke with were familiar with the REAP levels and the actions they needed to take when the REAP level changed this could be using amended scripts or informing patients that the ambulance might be longer than usual.

Staff turnover rates were reported on a month by month basis and were monitored in order to understand increased periods of attrition. For example, higher rates of staff turnover were noted during the period April 2022 and March 2023 as a result of changes in the provision of the NHS111 service and staff employed during the Covid pandemic whose chosen career path was not in health.

Sickness rates were also noted to have increased in line with staff turnover rates during staffing changes in the NHS 111 service. The year April to March 2023 sickness rate was 8.83%. However, these levels were then reduced post March 2023 to an average figure of 7.1%.

The IEUC directorate did not use any agency or locum staffing services. The IEUC workforce establishment comprised solely of contracted, directly employed staff, with no zero-hours contracts. Flexible working arrangements supported both full and part time contracts.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff used computerised systems for recording patient details and the category of response. The NHS Pathways system prioritised the caller's symptoms and the calls were then transferred to the dispatch queue. Call handlers had to complete all the information fields before the system allowed them to progress to the next question. This meant that records were safe, accurate and complete.

All emergency and urgent calls were triaged utilising NHS Pathways triage and following full triage to an end disposition was reached and a category/response assigned to the call. Each disposition with NHS Pathways was matched to a category of call which had response times, this was all embedded within the system settings of the CAD to ensure that following an NHS Pathways triage that the disposition reached matches the correct category of call.

Emergency operations centre (EOC)

Senior manager told us they carried out record audits called Pathways, Evaluation, Training Session (PETS). Each month staff undertaking telephone triage had 3 audits completed to see if they were compliant in the provision of undertaking telephone consultations and giving advice in line with current guidelines. The pass mark for the audit was 86%.

As part of routine PETS audit the call auditors looked at every aspect of the call. For example, the patient record, advice given, accuracy of information and avoidance of jargon. Identified any areas for improvement.

Patient records were shared electronically across ambulance staff delivering care and treatment. All EOC staff could access the patient record and review the information and the record could be transferred electronically to road staff. Some patients had 'special notes' attached to their electronic records, and we saw staff checking special notes for any relevant information to aid the assessment care and treatment of the patient. Special notes were used for a variety of reasons for example to inform visiting ambulance crews of any access issues or to inform EOC staff of a care plan that may be in place for a patient allowing a direct transfer and admittance to hospital. Staff told us that on the whole special notes were helpful and meaningful.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Within the system staff had access to other clinical pathways for patients to be seen at the right time and place when an ambulance was not dispatched. For example, bookings could be made at local GP surgeries and treatment centres if this was a more appropriate method of providing treatment.

Very little confidential waste was produced in the EOC. Confidential waste bins were strategically placed around the call centre and emptied regularly.

Medicines

Staff gave advice on medicines in line with national guidance.

Call handlers asked patients if they were taking any medicines or pain control medicines as part of their initial assessment. They advised patients to use medicines they had been prescribed for specific conditions and how to take simple analgesia in line with NHS Pathways guidance.

Call handlers would not give any other advice about medicines or prescribe medicines. If a patient needed advice about prescribed medicines, they were referred to their GP or other services, such as their local pharmacy.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy and knew what incidents to report and how to report them. The policy set out clear expectations on staff roles and responsibilities, including sharing lessons learned and using outcomes from incidents to improve quality within the service.

Emergency operations centre (EOC)

The trust used an electronic reporting system which all grades of staff had access to. Training in incident management was provided at induction and during regular trust training sessions. Managers were provided with training in the use of incident reporting software prior to being granted access.

The CAD system allowed staff in different areas to contact each other through a messaging system. This meant that staff could deliver urgent messages to each other regardless of which EOC they were based in, about incidents without having to leave their workstations or make a phone call.

During 2022 and 2023, several training and learning resources had been created in response to learning from incidents and trends identified including via audit, a newsletter was sent to staff outlining the trends and themes and learning that had been put in place.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. There was an incident reporting policy and a serious and moderate harm incident policy incorporating both Duty of Candour and never events. The Duty of Candour policy requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide support to that person. The policy contained suitable references to regulations and highlighted the steps that needed to be undertaken following a serious incident. Senior staff understood Duty of Candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong and the requirement to be open and transparent.

Staff reported incidents through the trust's electronic reporting system. Staff understood their responsibilities to raise concerns and to record safety incidents, concerns, and near misses. Guidance was available to control room staff to enable them to recognise when incidents required the hazardous area response team (HART) medical emergency response incident team (MERIT) Air Ambulance or other escalation.

Data showed that from the period April 2022 to April 2023 the combined EOCs declared 313 serious incidents, in all of the serious incidents, Duty of Candour was discharged by the trust.

Data showed that there were no never events for the period April 2022 to April 2023.

Managers shared learning with their staff about never events that happened elsewhere. Managers investigated incidents and shared lessons learned with the whole team, the wider service and partner organisations. Serious incident reviews identified the root cause of the incident and where appropriate set out action plans to address any areas of shortfall within the service as well as recognising any areas of good practice which had been followed. Incident reporting methods were consistent, and staff received feedback about incidents.

Is the service effective?

Outstanding ☆ ↑

Our rating of effective improved. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Emergency operations centre (EOC)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Emergency operations centre (EOC) call handling staff used the Pathways system to assess and prioritise emergency calls. Managers we spoke with told us the system was regularly updated including changes to national guidance, protocols and procedures relating to the management of emergency medical conditions. The service had a dedicated IT team who worked with Pathways staff to regularly update the system. The service was using the most up-to-date version of Pathways at the time of our inspection.

NHS Pathways operated on a number of questions by way of a diagnosis of exclusion which means the medical conditions which are identified are done so on a set of triage questions. It is an evidence based triage system designed by NHS clinicians for 999-call triage and other services, such as GP out of hours. NHS Pathways was integrated with a Directory of Services (DOS), which was a list of local health care providers, and services that allowed EOC staff to refer patients to more appropriate services.

For example, on every call we listened in to, when the call handler took a call the first thing they would say was “Ambulance service, is the patient breathing?”. Dependent on if the patient was breathing or not, the next set of questions would guide the call handler to ask the relevant questions to ascertain the medical condition the caller was ringing about.

Call handlers told us they underwent an 8 week training programme on the clinical content and telephone use before they were allowed to answer calls. The training included at least 60 hours of classroom tuition, assessments and at least 6 weeks of supervised use. Routine clinical audits were also performed with direct feedback given to the call handler.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service employed mental health clinicians in the EOC. The clinicians specialising in mental health were part of the clinical validation team to pick up any calls identified, for example, as potential suicide or confirmed patients with a mental health illness. The mental health clinicians supported patients to seek alternative care pathways where an ambulance dispatch was not the right response. The clinical validation team could also see GP notes about patients and use past clinical history to support decisions. The trust's 'high intensity service user' team also worked with patients and partners to provide more coordinated support for patients with mental health problems leading to frequent contact with the ambulance service.

Call answering times

The service was the best in the country for rapid answering of calls from patients dialling 999. The call answering times were significantly better than the national average for NHS ambulance services with most patients waiting just a few seconds for a response. The trust also responded by answering many thousands of calls made to other NHS ambulance services that were unable to answer quickly due to high demand or capacity.

The two emergency operations centres at West Midlands Ambulance Service answered 999 calls on average in just a few seconds - and was the best in the country at rapid answering when compared with the other NHS ambulance trusts. Since April 2021 to December 2023, the service took over 3.5 million calls from people calling 999. This was around 13% of national 999 calls which amounted to around 28 million in England in the period. As explained below, calls to WMAS included some calls taken for other ambulance services, but were predominantly for the West Midlands. There were, on average, just under 110,000 calls each month to the service which ranged widely from 76,861 to 141,165 in those 33 months. The service was significantly below (better than) the England average in all those months with a mean average call answering time of 3.6 seconds. This was against the England mean average of 22.2 seconds.

Emergency operations centre (EOC)

The 99th centile average response time in the period April 2021 to December 2023 was 40.4 seconds. This was significantly better than the England average of 178.4 seconds. The 99th centile response time refers to the response time that is slower than 99% of all requests. For example, if there are 100 calls made to the trust, the 99th centile response time would be the response time for the 99th slowest request. This is also known as the 'tail end' of the response time distribution.

Call answering performance was also measured by the number of calls taking more than two minutes to answer. In the period from April 2022 to December 2023 there were just under 180,000 calls made to England ambulance services taking more than two minutes. Of these, only 1,017 (under 1%) were taken by WMAS.

Alongside taking calls for the population of the West Midlands, the trust was on call-response standby for other NHS ambulance services when the demand for call answering hit certain thresholds. The trigger for WMAS staff to answer 999 calls for a number of other NHS ambulance services was when the call waiting times generally exceeded around four minutes. At that point, WMAS staff would take the call where they were able and triage emergency calls in line with WMAS protocols. Some critical calls would be routed immediately to WMAS if they were not answered almost immediately by the corresponding ambulance service. The result of the call, such as the dispatch of an ambulance required, would be then handed back to the local ambulance service to organise. In the period from April to December 2023, WMAS had responded to around 165,000 calls for other NHS ambulance services across England and a small number for Wales, Scotland and Northern Ireland. There were also some arrangements agreed through memoranda of understanding for WMAS to answer a bulk of calls for another ambulance service when that other service was stretched with resources or might be launching new technology.

Patient outcomes

The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Recontact rates were low and audits of call quality showed good compliance with clinical standards and patient outcomes.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The service participated in relevant national clinical audits around outcomes. The service collected and monitored information for patients and produced monthly board and performance reports which monitored outcomes.

One key indicator of good outcomes for patients was the patient recontact rate. This was where patients who received a 'hear and treat' outcome (so were given clinical advice over the phone) went on to recontact 999 within 48 hours of their original call. The concern for the service was if the triage system and clinical advice was not providing effective care or outcomes through the hear and treat pathway. The recontact rate was a measure of how it was working. The trust provided a series of data from April 2022 to March 2023 which showed just under 1.7% of patients on average had cause to recontact 999 with 48 hours of their first call. and receiving a hear and treat service. The trust audit noted how some of these calls were due to the failure in the patient referral pathway where the patient recontacted the trust to ask for further advice or an alternative option. This result was not comparable to any nationally published data but was recognised in the context of recontact rates as being low and giving patients a good outcome.

The outcomes monitored included staff listening into a randomly generated sample of calls for purposes of audit and qualilty management. Audit data was used to make improvements within the service and provide additional training and support to staff who did not meet the required performance standards within the call handling process, for example call handling times, professionalism on calls.

Emergency operations centre (EOC)

Managers shared and made sure staff understood information from the audits. Staff received feedback on audit activity shared by email and followed up with managers meeting individually with staff to provide feedback. Improvement was checked and monitored and staff who achieved high compliance during call audits received awards to recognise their compliance and their impact on patient safety.

The licence the trust has with the triage system, NHS Pathways, sets a level of compliance with call answering standards of 86%. However, the service had set its own internal target for staff at 95% compliance with standards. The service had also adopted the 'gold standard' for auditing the quality of call handling. This was a higher standard of auditing including 'live' audits. Live audits were introduced following feedback from staff who felt the retrospective audits were sometimes misinterpreted. Live audits enabled audit staff to provide immediate feedback to the call assessors and clinicians, which included both constructive feedback but also praise where deserved. This has been well received by staff and met the NHS Pathways 'gold standard' for audit performance.

Regular audits were carried out for all staff in line with standards and there was a clearly defined process to manage performance and support staff if they failed to meet any of them. The trust audit schedule took place on a monthly basis, as call auditing is a licence requirement for any organisation that uses NHS Pathways. Clinical audits had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

The trust worked with peers to measure effectiveness of care and treatment and evaluate pathways. To that end it particiapted in meetings with the national heads of emergency operations centres, was part of the national clinical coding group, the NHS Pathways user group and sat on the integrated care board quality governance group.

Managers and staff used the results to improve patients' outcomes. Following a review of complaints and incident reporting, it was identified by the trust that additional support was required for the management of emergency calls to obtain an access code for community defibrillators. In response to the incident reporting, a defibrillator workshop and an operational notice was issued to assist the call assessors and supervisors. An operational notice was a notice to inform staff about important safety and operations developments. They address factual situations or circumstances that all operational should be made aware of and take into consideration to ensure operational safety.

During our inspection, the trust were in the process of implementing a patient survey to specifically target patients who had received a clinical triage after contacting 999. This was undertaken to enable the trust to gain specific patient feedback of their experience and highlight any difficulties or concerns during the patient journey. The trust were in the process of using the information to form part of the patient experience report, to be presented through the professional standards group and the quality governance committee for senior review. The survey had been actively promoted through the trust's social media outlets.

Managers used information from the audits to improve care and treatment. The service monitored, and met, agreed response times so that they could facilitate good outcomes for patients. They used the findings to make improvements. For example, the trust monitored effectiveness of care and treatment both at an individual and at an organisational level.

Monthly continual quality improvement (CQI) audit summaries and quarterly trend analysis were presented through the EOC senior management team meetings with reports submitted to the clinical audit and research programme board.

Completed audits were then shared with the individual call assessor or clinician with recommendations to ensure appropriate learning. Audits were discussed and reviewed during regular one to one session with the staff members line manager. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

EOC staff who used NHS Pathways received a comprehensive training package. This included a 2-week initial training session and then an 8-week period of supervision using the system with a mentor. There was ongoing training for NHS Pathways consisting of regular version updates and training in relation to issues identified by the NHS Pathways User Group.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. All staff attended the trust induction programme. In addition to mandatory training bespoke training packages had been developed for EOC staff. Training was role specific, for example the emergency medical dispatchers attended an 8-week training programme. Once the initial training course was completed staff were assigned a buddy/mentor, until they felt confident and were competent to work unsupervised. New staff had a probation review with their line manager at 3, 6 and 9 months to check their progress.

Managers identified training needs for their staff and gave them the time and opportunity to develop their skills and knowledge as appraisals and one to ones had not been completed for all staff. We were given examples of good communication and encouragement from managers regarding training and support.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and gain support to develop their skills and knowledge. Staff told us they received regular meaningful appraisals. Appraisal rates for all EOCs was 98.3%. for the period March 2022 to April 2023.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers supported clinical staff to develop through regular, constructive clinical supervision of their work. Clinical staff we spoke with told us they had to access additional support and supervision should they require it. Managers made sure staff received any specialist training for their role.

A new mental health first aid training package had been added to the mandatory training programme for all staff to attend. Most staff we spoke with told us that callers with mental health problems were the most challenging and they needed more training to be able to safely manage these patients. Posters and information cards had been developed to inform staff about learning disability, the Mental Health Act, and the Mental Capacity Act code of practice.

During one to one and audit feedback meetings, staff were always offered support and directed to additional learning aids that were available, these included continued, professional development that was available on the trust learning portal or via NHS Pathways hot topic. For example, breathing, blood loss and questioning skills. If there were no improvements, then supervisors would escalate to the training team for additional training and support.

Managers identified poor staff performance promptly and supported staff to improve. NHS Pathways audit (Pathways, Evaluation, Training Session) is based around a set of 8 core competencies which are essential for effective triage using the NHS Pathways System. For example, case reason, time to code and address match performance. Audit outcomes

were provided to all staff within EOC. Once an audit had been undertaken this was automatically emailed to the member of staff and also included their line manager to assist with feedback and overall monitor their staff and audit compliance. Staff who did not achieve the required standard of 86% were supported and processed through the NHS Pathways audit tier system.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. There was a trust-developed referral system for effectively and safely diverting patients to community services for care and treatment when they did not need emergency services.

Staff worked across health care disciplines and with other agencies when required to care for patients. Effective and positive multidisciplinary working was clearly evident. All necessary staff, including those in different teams and services, were involved in assessing, planning, and delivering people's care and treatment. Staff told us they had effective communication with other services and teams of individuals they worked with.

The service worked with other organisations and professionals to ensure the safety of patients. The service had contracts with other NHS providers and attended regular meetings with these organisations. There were clear processes for dealing with other emergency services and agencies. We observed an incidence where EOC hazardous response team (HART) and medical emergency response incident team (MERIT) worked well with the fire service and the police to manage an appropriate response to a complex emergency.

Staff worked with the local authority and NHS organisations when raising safeguarding concerns about patients. Staff liaised with the local emergency departments and hospital wards about specific patients' care. When they conveyed an acutely unwell patient to an emergency department or hospital ward, they alerted the hospital to this situation.

In 2021, with the introduction of the clinical validation team, the trust recognised there was a significant gap in the ability to divert patients to community services with any efficiency. When this procedure was reviewed, it was found only around 9% of community services had the capability to accept any electronic patient referral from the ambulance service. Almost all other community services were email based which gave rise to concerns not least about breaches in patient-data security and the inefficiency of the system. In response, the trust developed an 'integrated referral portal' based on an internet platform and issued services with a login and password to allow limited and authorised access to proposed patient onward referrals. This system also allowed users to have a live 'chat' with a member of the ambulance service if further information was needed. The portal system provided the community team with the details of the caller and the clinical consultation. An example of a patient who might be passed to the team was a patient categorised as a non-injury faller and in need of community support, but not an ambulance. The system enabled the community team to accept the patient or reject the request. If the patient was rejected, a reason was required, and they were then returned to the ambulance service 'call stack' for internal action. The system had enabled the ambulance service to divert over 1,000 patients every week into care coordination centres. It was regularly reviewed against opportunities to expand the criteria particularly to avoid rejections, but also to test that patient outcomes were safe and effective.

Staff we spoke with during our inspection knew the service had access to a language line and translation services. We were advised that interpreters were used when required to assist callers for whom English was not their first language.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us there were a wide range of issues that meant certain people who used the service frequently were alwerted by patient records which recorded the reasons for the frequent calls. The service had an up-to-date frequent user policy. The high intensity

service user (HISU) policy which staff were knowledgeable about, gave a number of different definitions of what was classified as a high intensity service user. For example, an individual who had made more than 5 emergency calls within any 1 month period, or an individual who had made more than 12 emergency calls to the service within any 3 month period. The policy also included a section on identifying vexatious callers and what action to follow. All information in the policy was in line with national standards. Data on the monthly number of HISU calls for the period April 2022 to April 2023, showed that in May 2022 the lowest number of HISU calls were 13.9% of all calls rising to 19.6% in December 2022. For the month of April 2023, the number was 14% of all calls received in the EOC.

Staff followed set processes for welfare or return calls to frequent callers based on the caller's clinical condition and ongoing needs. All staff we spoke with knew the frequent caller procedure and how to escalate any changes in the caller's condition or unusual patterns in their calling behaviour. During our inspection, we listened into a call from a frequent user. We noted the call handler dealt with the frequent caller in a calm and professional manner.

However, at the time of our inspection, the service did not have a working relationship with GP practices involved in the management and care planning for frequent callers, but advised the inspectors, they were in the process of developing one.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service 'special note' facility within the clinical assessment software was used appropriately. We saw examples of notes which gave details on pre-planned care pathways for patients. For example, direct access to cardiology wards for patients with cardiac disease and direct access to respiratory wards for patients with chronic obstructive pulmonary disease.

Staff told us they had access to some patient's information held by their GP through other electronic systems. This meant they could review a patient past medical history and recent GP attendances to aid their decision about advice for the patient. We observed staff liaising with other healthcare professionals involved in the care of a patient to make sure they shared up to date information about the patient. For example, we saw a call handler supervisors speak with social services concerning the implementation of a pendant alarm for a patient.

Staff signposted patients for mental health assessments when they showed signs of mental ill health or depression. The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

A variety of care pathways were in place including those described in patients 'special notes. Dispatch staff were aware of the correct pathway for specific patients such as major trauma, critical care patients and maternity. This meant that patients were transported to hospitals which could meet their need.

Callers could speak to the clinical validation team for advice and guidance on their condition. EOC staff had access to an online directory of specialist health care services and could signpost callers to other local services for ongoing care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent.

Emergency operations centre (EOC)

The service had an up to date policy for staff to follow in relation to mental capacity and consent. Staff gained consent from callers for their care and treatment and recognised when patients could not give consent. For example, call handlers may take an emergency call where the caller was unable to complete the call due to an injury or suspected cardiac event. In these cases, staff made decisions in the patient's best interest and followed the NHS Pathways guidance to manage the emergency. In some cases where the calls were very complicated, they were escalated to the supervisor to action.

Staff could describe and knew how to access the service Mental Capacity Act policy on the services intranet and guidance was also available on staff notice boards and pocket guides around the EOC.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We noted when listening into calls that staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff were aware of the challenging experiences faced by unwell patients and responded flexibly and in a professional way to these, where needed.

Staff ensured patients and their relatives understood what they were being told and kept communication open and easy to understand throughout all the calls we listened to. Data from the 2022/23 Emergency and Urgent Care Online Patient Survey, showed that 74.2% of the 155 people who responded to the survey, felt the call taker gave advice in a reassuring manner.

Staff followed policy to keep patient care and treatment confidential. Staff understood the principles of patient confidentiality and knew that personal details should not be shared with unauthorised persons. Staff were professional and discreet when sharing patient information with supervisors and colleagues. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

People who called the service received clear, timely information and support. There were arrangements and systems to support staff to respond to people with specific health care needs, such as end of life care and those who had mental health needs including training, awareness seminars and bulletins.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff described how they would communicate with a caller whose condition was deteriorating. We observed that staff were alert and responsive to the distressing impact of such situations and how they would communicate in a clear and sensitive manner to provide comfort and reassurance.

Emergency operations centre (EOC)

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. During our inspection, we listened into a total of 41 calls from the combined emergency operations centres. In all cases staff were polite and respectful, even when on one occasion we listened into, they were verbally challenged by a member of the public for delays in the service.

Staff supported patients who became distressed and helped them maintain their privacy and dignity. We saw staff were considerate of patients' privacy and dignity at all times, continually showing kindness and caring, especially when callers were upset and distressed. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

We observed and heard numerous examples of EOC staff providing emotional support to patients, relatives, and members of the public phoning on their behalf. For example, one person rang to say their baby had suffered a significant head injury. The caller was clearly very distressed. The call handler spoke with them in a very empathetic way, saying a few times "I know this is upsetting for you, but I do need to take the details". The call handler then asked if there was anyone else who could speak to them. The call handler put on the phone their parent, who was able to answer the questions in a calmer manner. At the end of the call, the call handler checked to see if the original caller was OK, due to the distress they had undergone.

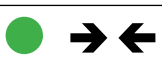
Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. The EOC used the SMS emergency text service for callers who were hard of hearing. For callers who were visually impaired, they were incorporated into the NHS Pathways triage tool as required. There was also the 999 British Sign Language, Emergency Video relay service for call handlers to use.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service undertook an annual Emergency and Urgent Online Patient Survey. Data from the 2022/23 Emergency and Urgent Care Online Patient Survey, showed that 78.7% of the 155 people who responded to the survey felt the call taker listened to all of the details, 86.5% of people felt like they were treated with privacy, dignity, and respect and 82.5% of people would recommend the service to their friends and family.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Emergency operations centre (EOC)

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service effectively planned and delivered services based on patient needs. Services were planned to take into account the different needs of the type of incidents and patients they responded to. For example, on the West Midlands Ambulance Service University NHS Foundation Trust (WMAS) website they had a video explaining to people what a defibrillator was and how to use it.

Patients had access to timely care and critical care treatment. Effective procedures were in place to respond and learn from complaints. The service monitored compliance against key performance indicators to continue to drive improvements in patient outcomes.

There were clear protocols for deploying specialist response teams, such as the hazardous area response team (HART) and medical emergency response incident team (MERIT). Computer aided dispatch (CAD) staff demonstrated a good understanding of the protocols.

The service analysed data to use as intelligence to plan their response to public events. They also reviewed the localities that generated the highest number of calls, from this information the service was able to forecast the number of call handlers and other staff required. The service held regular calls with the police to look at resource, discuss resilience and any issues likely to affect the operation of the service. The police would also share details of any large events or increased risks in the area, for example any threats from terrorism, large congregations of people or major events.

Facilities and premises were appropriate for the services being delivered. The EOC facilities and premises were appropriate for the services that were provided. The bases were large and clean with appropriate resources and amenities.

The trust planned and delivered services to meet the needs of local people, with good organisation and distribution of staff and a wide variety of vehicles. Services delivered took account of the needs of patients and callers. Managers we spoke with said they had meetings with key stakeholders within the local health care economy, for example the clinical commissioning groups, integrated care system and primary medical services to discuss demand and access to services.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff reported they had access to emergency mental health services within the community. For example, the out of hours emergency duty social work team for people who were having an emergency mental health crisis. The service had systems to help care for patients in need of additional support or specialist intervention.

The EOC call handlers used the SMS emergency text service, for those callers who were hard of hearing.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Emergency operations centre (EOC)

Managers we spoke with said they had meetings with key stakeholders within the local health care economy, for example the integrated care boards and primary medical services to discuss demand and access to services. WMAS had contracts with 7 different integrated care boards. The service had regular contract meetings with the integrated care boards to discuss performance issues and where improvements could be made.

The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the provider. For example, there were alerts about people being on the end of life pathway and frequent callers. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Call handlers told us they had specific mandatory training in meeting the needs of patients living with mental health problems, such as learning disabilities or dementia.

We noted that staff demonstrated an awareness of these needs during calls and followed the appropriate processes to ensure callers received the necessary care to meet their needs. Call handling staff could add special notes to the patient record to guide ambulance staff to any additional needs the patient may have, for example how to access their building or informing relatives about the patient's condition.

The patient experience team where possible would engage with community groups, such as Healthwatch. Healthwatch are an independent national champion for people using health and social care services. This allowed the local community to have their views heard about future care.

We observed staff speaking with callers with mental health illnesses and interacting with them in a way that met their individual need. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had been trained in conflict resolution which was part of their mandatory training as a way of equipping them to deal with violent or aggressive callers. During our inspection, we listened into a call where the person calling became verbally aggressive and raised their voice to the call handler. The call handler remained polite and calm and utilised the skills taught in the conflict resolution training. The service had 'caution markers' which could be placed against the names of callers who were threatening and or abusive.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service used interpreters to assist callers for whom English was not their first language. Interpreters were accessed using 'Language Line' and joined the call so a three-way conversation could take place. This enabled information to be gathered for the NHS Pathway assessment.

Callers who could not speak, for example if it was unsafe to do so, were able to text 999 and communicate with the call handlers by text message. Staff had access to communication aids to help patients become partners in their care and treatment. The EOCs met individual needs including using a variety of communication tools for callers, having processes for frequent callers and silent calls and providing welfare calls to patients who had waited longer than target time for resource.

The service worked closely with the police to look at resources, discuss resilience and any issues likely to affect the operation of the service.

Access and flow

People could access the service when they needed it, in line with national standards, and received the right care in a timely way.

Emergency operations centre (EOC)

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The trust had in-depth systems to monitor access and flow and make changes when necessary. All staff had access to live performance data and managers could monitor the status of calls and redeploy resources in line with escalation plans.

Managers monitored waiting times. However, patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets due to prolonged delays at some of the local acute hospital's emergency departments. This reduced the capacity of front-line staff to respond to emergencies, because ambulance staff needed to stay with their patients to deliver care and support them until they were handed over to hospital staff. This was a continued issue affecting capacity and flow for the service however, the senior management were in regular contact with the hospitals to discuss how they could work together to reduce pressures.

During our inspection, we noted patients waiting long periods in the stack. The stack was when staff took details of the call and triaged the patient. Each call was listed in the stack known as a 'call stack' which was monitored by the duty manager to identify any emergencies that may need a response from the critical care team. We saw there were long waits for category 2 calls due to the significant delays at hospitals for the handover of patients. This meant ambulance crews could not be released back on to the road to respond to calls.

Hazardous area response teams (HART) staff and vehicles were not used for patient transport, which meant that hospital turnaround times, or issues in the wider healthcare economy did not affect them.

During our inspection staff told us that when dispatched to an incident within The Home Office Model Response Strategy guidelines, which are Home Office guidelines that sets out recommended times to dispatch HART teams to specific incidents. The team had always met the required response times of 15 and 45 minutes.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Effective procedures were in place to respond and learn from complaints. People who used the service were aware of how to make a complaint or raise a concern. Information on how to make a complaint or raise concerns was available on the trust website.

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. Call handlers could also escalate complaints as soon as they were received to the duty manager. Data showed for the period April 2022 to April 2023, 98.9% of all complaints were dealt and closed by the patient experience team in under 25 days. This was in line with the timescales set out in the complaints policy.

At the time of our inspection, there were 15 open complaints. A total of 16 complaints had been received by the service between 12 July and 9 August 2023, equating to 93.8% that were open. All 15 were open and within the agreed response timeframe.

Data showed the trust had referred 8 cases where information was requested by the Parliamentary and Health Service Ombudsman (PHSO) between 1 June 2022 and 30 June 2023 of which the following, 4 did not meet the investigation threshold by the PHSO. One where there were no concerns found by the PHSO and the complaint was closed. One case was investigated by PHSO and was found to be part justified, the service was required to write to the complainant which had been completed, and 2 which remained under investigation by the PHSO.

Emergency operations centre (EOC)

Staff understood the policy on complaints and knew how to handle them. The complaints policy and procedures were in line with recognised guidance. Staff we spoke with knew the service had a complaints policy and how to access this and guide callers towards the complaints process. Staff told us they would refer callers to the supervisor or duty manager if an immediate response was required or if they were received any verbal abuse or threats.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Themes regarding calls would also be identified during the call audits processes and details from call audits were shared with staff. These included complaints regarding the quality of the call, the accuracy of information shared or waiting times for ambulances, which was a common theme of complaints to the service.

Is the service well-led?

Outstanding ☆ ➔➔

Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had a leadership structure with clearly defined roles and responsibilities at all levels. The chief executive officer (CEO) led the service and reported to a board of trustees. All staff we spoke with told us the CEO was very visible, highly committed to the services aims and mission, approachable to all and that they had spent time with people in all roles across the service in order to understand their needs and promote the services mission.

Leaders at all levels understood the challenges to good quality care in their service. They told us these included the timeliness of tasking, management capacity for expanding the service, developing dashboards and databases, and improving patient follow up. There were comprehensive and successful leadership strategies to ensure and sustain delivery and to develop the desired culture.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Leaders supported staff to develop their skills and take on more senior roles. Managers and staff, we spoke with described local senior leaders as very supportive and willing to go the extra mile to deliver the services. For example, staff we spoke with told us managers were receptive to requests for reasonable work adjustments which complied with occupational health guidance and were very responsive to specialised requests, such as bereavement leave.

The service was focused on achieving response time performance targets. There was clearly a high standard of leadership at the service, with strong leadership from the chief executive officer. All the executive directors were well engaged and appeared to interact with each other appropriately. Leaders of all levels within the service had the right skills and abilities to run a service providing quality and sustainable care.

Emergency operations centre (EOC)

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The strategy called "Trust us to care Leadership – 2021-2026", which included the West Midlands Ambulance Service University NHS Foundation Trust Five-Year Strategy Document". The vision and strategy focused on a specific vision, as well as values, strategic objectives, and priorities. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. There was a systematic and integrated approach to monitoring, reviewing, and providing evidence of progress against the strategy and plans

The strategy was developed after reviewing national guidelines and involved both internal and external stakeholders and was closely aligned to partners. Data showed the trust currently had 16 enabling strategies aligned to the five strategic objectives within the overarching organisational strategy. The strategy supported objectives and plans that were challenging and innovative, while remaining achievable. The strategy was refreshed and re-launched on all mediums including a popular streaming channel in March 2023.

Both managers and staff we spoke with knew the services values and the behaviours expected of them and that the service aimed to provide outstanding care to patients and support for all staff.

The vision and strategy were focused on patient care and the sustainability of services which were aligned to local plans within the wider health economy. Staff we spoke with were aware of the vision and strategic plan and leaders had clear objectives and job roles designed to ensure the plan was implemented and reviewed. The service had a systematic and integrated approach to monitoring, reviewing, and providing evidence of progress against the strategy and plans. This was overseen by the trustees and progress reviewed within the clinical governance structures. The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. There was a systematic and integrated approach to monitoring, reviewing, and providing evidence of progress against the strategy and plans.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had an exceptionally positive shared purpose and strive to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act.

The culture within the organisation was overwhelmingly supportive and positive. There was a genuine culture of wanting to provide the best care for patients and desire to improve services. Staff from the most senior, to the most junior posts were passionate about the service provided

Staff described an extremely positive working culture where they felt valued and supported. Staff also consistently spoke positively about the flexibility the work allowed them and how proud they were to work for the service.

Emergency operations centre (EOC)

The service worked with commissioners to plan for future demand but only undertook work they had capacity for taking into account the number of vehicles and staff they had.

Staff spoke of a culture where they were actively encouraged to report incidents. They also said they could raise concerns without fear of retribution. Since our last inspection, the trust had created a dedicated Staff Survey Response Action Group, which created a trust-wide action plan and local action plans built through "Listening into Action" staff conversations. Staff told us that conversations and focus groups were held regularly, where they would be consulted on the values, behaviour, and culture statement.

There was also a staff suggestion scheme called "All Ideas Matter" (AIM) which enabled staff to make suggestions which were then considered by the relevant managers. Outcomes were reported to People Committee and promoted in the Weekly Briefing.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure across the EOCs with defined roles and responsibilities. Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

Leaders proactively reviewed and operated an effective governance process throughout the service. A systematic approach was taken to working with other organisations to improve care outcomes.

The EOC governance structure was supported by several sub committees including the quality governance committee, the performance committee, the people committee, the audit committee, the remuneration and nomination committee, and the trustee committee. There were also a number of groups who reported to the various committees. For example, the immediate care governance group and the clinical audit and research group reported to the professional standards group.

The patient experience group reported monthly to the learning review group (LRG) and the professional standards group which focused on themes and trends. The LRG reported to the quality governance committee and reported any issues relating to assurance as well as risks identified, and key points for escalation. The trust board received monthly data on formal complaints and concerns through the trust information pack.

Policies and procedures were regularly reviewed and updated. Polices we looked at had clear processes reflecting current practices. This meant performance could be measured against the relevant policy. The service had monthly management meetings. This meeting covered governance, performance, and risk management. The meetings had a set agenda and were minuted.

Staff were clear about their roles and understood what they were accountable for. Every standard operating procedure we reviewed detailed responsibilities of staff in varying roles. All the policies we reviewed were in date, current and ratified. There was also evidence of regular updates to standard operating procedures and any changes were effectively communicated to staff. All staff we spoke with understood their role and could tell us what their responsibilities were including the responsibilities of each committee and meeting.

Emergency operations centre (EOC)

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was as demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensured staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

There were established and understood arrangements to identify, understand, monitor and address current and future risks. There was a systematic programme of clinical and internal audit and this was used to monitor quality and identify where action should be taken.

The EOC had a dedicated risk register that reflected current risks within the service. Risks included but were not limited to, increased stacking during times of high demand, the clinical validation of category 2 999 call impacting on patient safety and performance and risk of call handlers not staying online with the callers. All risks had dedicated owners, risk and effect, control measures and risk ratings.

The risk register for the EOC was a standing agenda item. Risks were escalated from front line services to the performance committee for consideration and action. We reviewed the risk register after our inspection. There were 28 current open and ongoing risks. It contained information on when the risk was raised, the date of review, category of risk, the risk score which was rated, and who owned the risk and any mitigation of risk. We saw it was reviewed and updated at the monthly management meeting. At this meeting risks were identified and discussed, and a plan made to eliminate or reduce them.

The service had detailed business continuity plans and emergency response plans. Staff knew where to find these policies and knew their role in each of these plans.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Managers understood performance targets including quality, data from audits, dispatch operations, and finances. Information was shared across the service to key committees and oversight groups to provide assurances on the quality, risk, and performance within the service.

Quality assurance processes were embedded to review how information was stored and shared when handling calls and dispatching resources. IT systems were integrated and secure, to prevent unauthorised access of information.

Staff could find the data they needed, in easily accessible format to understand performance, make decisions and improvements. The information systems were integrated and secure, including those where patient records and KPI details were recorded. The service had secure electronic systems with security safeguards including individual usernames and passwords for each member of staff. The physical security of the base was secure, only people with security access could enter the building out of office hours and all visitors' identities were carefully confirmed before allowing their entry, and ID badges provided. The electronic patient record system enabled staff to manage and share the information that was needed to deliver effective care treatment and support, and was coordinated to provide real-time information across services, and support care for people who use services.

Emergency operations centre (EOC)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had three freedom to speak up guardians and 45 freedom to speak up ambassadors for staff to speak with. Freedom to speak up guardians support workers to raise issues without fear of negative consequences. They also help their organisations identify and address barriers to speaking up. Due to the nature of freedom to speak up, the confidentiality of the information from staff is both fundamental and essential. Staff told us that they felt confident to speak to up should they feel the need to. The freedom to speak up guardian's office sent out a quarterly newsletter called “Your voice matters”. The guardian we interviewed during our inspection said they had regular quarterly meetings with ambassadors to discuss themes and trends and any other relevant issues. An executive was also invited to attend these meetings.

The service used patient feedback forms which asked patients or carers about the quality of the service and any additional comments they would like to make. The trust had dedicated feedback and engagement telephone line, which had an answerphone facility out of hours to enable messages to be left and a call back made the next working day.

In 2022, the trust was the medical provider for the Commonwealth Games. The integrated urgent and emergency care clinical assessment team (IUEC) provided a specific command centre for the duration of Games. A project team consisting of IEUC leaders was generated and formed part of the Trust Commonwealth Games Planning Team.

The service used a range of patient engagement methods with patients and communities covered by the EOC including face-to-face public engagement events, school and education visits with children and young people. Community group educational visits, talks and presentations for community groups, patient story discovery interviews (filmed and shown at the services board or for staff training), links with community and patient network groups and specific patient groups such as adults with learning disabilities, carers support groups, and young patients.

The trust provided a counselling and support service for staff who require support following attendance at traumatic or upsetting calls. Staff within the trust had a number of methods that were available to engage and learn, as well as having access to management, they could use for example. All EOC`s had monthly meetings for different staff skill mixes to be updated on a variety of issues current at the time and to/ask questions.

Meetings with staff groups comprised of the following:

- Duty managers
- Call supervisors
- Controllers/dispatchers
- Call assessors

The individual groups discussed and updated on relevant current issues to that group, gaining current information and resolving any details that may have been misunderstood or missed.

The trust used a weekly briefing email as the fundamental way to communicate with staff. The weekly briefing provided an opportunity for senior leaders to communicate with staff and for staff to promote activities in their areas.

Emergency operations centre (EOC)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was an embedded and systematic approach to improvement across the organisation. The service was committed to ongoing development, improvement, and sustainability. There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement methods and skills were available and used across the organisation, with staff empowered to lead and deliver change.

Managers told us they were keen to grow and improve the service. They discussed a number of areas where they were aiming to improve which included developing the recently appointed high-volume service user lead to develop and manage frequent callers.

'Good Sam' had just been introduced by the trust. Good Sam was an app designed for emergency services, which allowed colleagues and members of the public to instantly share their location, as well as what they were seen at the scene of an incident via the camera on their mobile phone.

Due to COVID-19, the service had streamlined their delivery model and introduced the clinical validation team, who at the time of our inspection were treating 18% of activity through "hear and treat". Hear and treat is remote clinical decision making by qualified staff and it applies when a person does not require an ambulance, but a clinician is able to provide treatment and advice over the phone. Hear and treat is used in the scenario 999 calls and successfully completed without despatching an ambulance vehicle response. The person calling may receive advice on how to care for themselves or where they might go to receive assistance.

The service had 5 staff networks across the trust. ONE Network: This was the name for Black and Minority Ethnic (BME) support group for all staff who identified from this background including associates who were supportive of the aims of this network. The Proud Network was the Lesbian, Gay, Bisexual & Trans Network. The network supported any staff who identified as being LGBT+ or those who considered themselves to be supportive allies. The Women's Network aimed to ensure that staff who identified as women, and advocates of women, felt supported, as well as providing support and inspiration to others. The group was an opportunity to learn from each other and network. The Disability, Carers and Advocates Network (DCA) aimed to promote a disability positive environment for all staff who were disabled and provided mutual support for staff with disabilities which were hidden or apparent, and also those who had carer responsibilities. The Trust Armed Forces Network was an open to all, and not just limited to those who serve or had served in the Forces. It encouraged anyone who wanted to be involved, whether they had friends or family in the military, parents, grandparents, or children who had served or just an interest in the armed forces and coming together as a network.

Each network and the chair worked towards supporting staff and giving them opportunities to develop their skills, find a sense of work collective and give them a voice within the organisation. The co-chair of the One Network told us as well supporting BME staff, they also visited communities where there was a high population of BME residents, as well as attending trust board meetings.

Report on actions you plan to take to meet Health and Social Care Act 2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RYA
Our reference	INS2-16436848591
Location name	West Midlands Ambulance Service University NHS Foundation Trust

Regulated activity	**Regulation**
Treatment of disease, disorder or injury	**Regulation 12** **Safe care and treatment**
	How the regulation was not being met:
	The trust must ensure that national response time targets are met with a focus on the risks posed by the Category 2 calls. (Regulation 12(1))

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Who is responsible for the action?	
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
Who is responsible?	
What resources (if any) are needed to implement the change(s) and are these resources available?	

Date actions will be completed:	

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	
Position(s):	
Date:	

Appendix 01b

West Midlands Ambulance Service University NHS Foundation Trust
CQC Inspection report – Date of Inspection visits 15-17 August 2023 and 3-5 October 2023

The Care Quality Commission (CQC) inspected 2 core services – EOC and Emergency and Urgent Care (or frontline emergency operations).
The CQC did not inspect Resilience (which includes the HART teams) or PTS on this occasion.
The 'Use of resources' and 'Combined quality and resources' were not inspected on this occasion.

*Following the Unannounced inspection visit between 15-17 August 2023 a separate action plan was created and commenced on 18/08/23, which is shown below this action plan and is now complete.

ACTION PLAN

No	Areas for improvement Report published – 23/02/2024. The key pages of the report noting the area for improvement are shown in brackets.	Leads	Action/s required	Comments	By Date	RAG Rating
Areas the trust MUST improve:						
Emergency and Urgent Care						
1	The trust must ensure that national response time targets are met with a focus on the risks posed by the Category 2 calls. Regulation 12(1)(2): Safe care and treatment (Page 36)	**NH**	The CEO has arranged an operational performance review meetings with each of the service line assistant chiefs. A specific performance improvement action plan will be presented to the Board of Directors on 28 February 2024.	The performance improvement action plan will be presented to the Board of Directors on 28/02/2024. Performance Improvement Plan: Copy of Performance Improvement Action P	**April 2024**	

Areas the trust <u>SHOULD</u> improve:						
Trust wide						
2	The trust should consider re-evaluating the clinical strategy in order to show how the objectives around patient safety and clinical excellence will be achieved. (Page 7)	**Nhen AW RS**	The clinical strategy should be explicit on how the Trust can meet the organisation's clear objectives of patient safety and clinical excellence.	The Clinical Strategy was approved by the Board of Directors on 29/11/2023 - Item 05a, paper 03. The strategy is a working document, and the objectives to achieve are under review. The inclusion of PSIRF, SEIPS and management of themes & trends in next version.	**March 2024**	
2.1	It should show a clear pathway for paramedics to progress to a higher level with an emphasis on clinical professional development.	**CB**	There should be an explanation of how Paramedics might progress through to the highest level of qualification in the strategy.	CCP on Merit cars etc. Undergraduate diploma Paramedics all have the option to top up to BSc. Advanced Clinical Practitioner roles available in CVT. Operating and funding model doesn't allow for advanced clinical roles in operations. Career Development Pathway in place Career Development Pathways Final 230523.ppsx PDCs and Continuous Personal and Professional Development (CPPD) Framework in place.	**March 2024**	

				Viewing Continuous Personal and Professional Development (CPPD) Framework (policystat.com)		
2.2	The strategy should address how the organisation intends to respond to changing needs of a diverse and ageing population and how it will improve the community response.	**Nhen AW RS KMc**	The clinical strategy should show how the Trust will respond to the health management of an aging and diverse population and show how it will improve community response. The number of initiatives and ideas already within the organisation require focus and leadership.	The strategy is a working document, and the objectives to achieve are under review. There is an update to expand the population health and community response elements.	**March 2024**	
3	The trust should consider the work on culture and how it can demonstrate this is effective with measurable improvements in indicators, such as the NHS staff survey and Workforce Race Equality Standards. This includes: (Pages 8, 10, 47, 72)	**CB**		Culture review completed and recommendations agreed at EMB 24th January 2024. Gender Pay Gap 2023 had reduced and therefore improved. WRES and WDES action plans in place. Staff Survey action plans for all areas and trust wide to be implemented for 2023 results. Member of the NHSE People Promise Exemplar Programme – Retention. Recruitment for People Promise Manager underway.	**March 2024**	

				Anti Racism and Equality Charter to be launched this month and associated roll out training. Staff Engagement Report produced annually triangulating data from NHS SS, Winningtemp, HR KPIs, operational KPIs, compliments/complaints/mental health sickness and absence/FTSU/NSS.		
3.1	Marked improvement in staff feeling safe to speak up and in line with those recommendations of the National Guardian's 2023 report. Providing assurance through actions and reports to the board that this is effectively recognised as a risk. (Page 10)	**VK** **PW**		Quarter 3 demonstrated a significant increase in staff raising FTSU concerns, more so through the confidential / open route rather than the anonymous form. The actions taken to date are delivering real results, it now needs maintenance and on-going engagement etc as we go forward. The National Ambulance Network meet regularly, and discussions are ongoing around reporting and detailed sub-categories in relation to new NGO guidance to allow consistent benchmarking but still meet local requirements. The current FTSU risk on risk register recognises the need to regularly review our processes to assure staff and the Board members.	**March 2024**	

3.2	Gaining assurance that the confidential nature of any staff concerns is protected. (Page 11)	**CB** **VK** **PW**		HR letters have a standard paragraph where we inform an individual of an investigation and/or are suspended of the need for confidentiality and any breach of this may result in disciplinary action within itself. Also now included in the dignity at work templates. Whilst we can give assurances from a manager perspective information is only shared with appropriate parties, we can't control who individuals may to choose to share information with, either from a complainant or accused perspective. Case reviews to be undertaken that have been through the investigation/disciplinary process to examine the process as a whole from all parties' perspective and identify learning and improvements – which may include elements of confidentiality. The February FTSU newsletter reminds staff of the reasons the anonymous form should not be the primary source of raising a concern. People who speak up through FTSU are provided with a	**March 2024**	

				confidentiality statement which they are asked to acknowledge. Confidentiality Statement:  Confidentiality Statement.msg		
3.3	Improvements being seen in equality and diversity measures. (Pages 8, 47)	**CB**		Gender Pay Gap reduced. WRES and WDES action plans in place. Anti Racism and Equality Charter to be launched this month and associated roll out training. WRES and WDES 2023 metrics to be produced to review if improvements have taken place.	**March 2024**	
3.4	Being assured all staff felt included in career progression opportunities. (Page 8)	**CB**		PDC Reviewers Sessions (and refreshers); Reviewees' Handbook; On-line frameworks and resources for career development/conversations; developing potential process and development centres; specific groups have targeted promotion; CPPD Framework; many 121 career coaching sessions take place each year – currently YTD 84 Staff survey question re appraisal.	**March 2024**	

4	The trust should consider improving how it demonstrates and gains assurance that key measures of safety and performance are learned from when things go wrong. This includes serious incidents, complaints, and learning from death. The trust should move away from relying upon qualitative data as a measure of success and learning from these key indicators being paramount. (Pages 8, 10, 12, 13, 18, 19, 34, 48)	**CE NHen**	A section to demonstrate learning from events and incidents should be incorporated into each report to provide assurance, and improvement where data shows deterioration.	Patient experience and complaints reports will now evidence learning on modified charts. This includes Learning from Deaths (LFD). The Board of Directors will have the opportunity to discuss the revisions at the Board Development session in April 2024, with revised reports available from the Board meeting in May 2024.	**May 2024**	
5	The trust should think about how it can reduce the high volume of paperwork produced and provided to board, committees and members to ensure its focus and assurance is on key areas of risk, quality and safety. Committees of the board should provide sufficient assurance to reduce the over-reliance on provision of extensive board reports. The length of reports should also be reviewed to give a reasonable expectation of these being of actual value. (Page 14)	**ACM PH**	Use actions taken from the recommendations of GGI Well Led and report to avoid duplication.	We recognise that the Board and committees receive high volume of paperwork, as the Trust has a culture of openness and transparency. The Good Governance Institute (GGI) who carried the well led review and in 2023 have been requested to undertake a review of committee terms of reference and good practice in terms of papers submitted to Board and committees to reduce duplication and paper flow. The Standing Financial Instructions (SFI'S) have been reviewed and approved at the BoD in January 2024, following review at the Audit committee for assurance purposes. This will contribute to a reduction in papers to the Board, as a result of an increase in the amount that can	**March 2024**	

				be now signed off by the CEO under the advice of the DoF. This is an increase in delegation from £250,000 to a Million pounds. The EMB are trialling storing documents into a library section, which is noted on the agenda and is available for members upon request. Consideration will be given to using the Good Governance Institute (GGI) to provide some coaching to Directors on the content of their reports.		
6	The trust governors should be given the opportunity to fulfil their role of representing their communities and groups they speak for and delivering valuable insight of the experience of people and communities. (Pages 12, 13)	**IC** **SW**	Ensure the responsibilities of the trust elected and representative governors are clear and being delivered, and community information being sought and provided.	Examples of the roles given to trust governors is attached below: Governor Engagement Example	**March 2024**	
7	The trust should consider how it reports staff vacancy metrics in board and other workforce papers so it presents the whole picture around workforce risks and safety. (Page 17)	**CB**	Consider enhancing the current workforce reports to include the staff vacancy metrics.	WMAS doesn't hold vacancies. Recruitment plan and update already in People Committee papers / reports. Establishment v's budget in workforce KPI's. E&U Workforce plan v's actual to be included in monthly KPI's.	**March 2024**	

Emergency and Urgent Care						
8	The trust should ensure that, for Infection Prevention and Control reasons, uniform standards are consistently adhered to. (Page 27)	**CE** **KMc**	The Trust IP&C and uniform policies should be reinforced and monitored to ensure consistent adherence to all sections e.g. bare below the elbows and finger nail compliance.	Requirements for BBE (including wrist jewellery and fingernails) is monitored through the hand hygiene audit requirements, with each Hub undertaking x20 audits per month, supervised by CTMs. Compliance is captured and reported as per IPC Incident and Audit Framework to HSREG. A checklist of IPC, Uniform and Code of Conduct requirements has been shared with E&U/PTS SOMs to reinforce the standards required to achieve compliance with Trust policy – see attached.  Personal Appearance Uniform Standards.m  Personal Appearance Uniform Standards.m	**March 2024**	
9	The trust should ensure that pain assessments are completed for children. (Page 35)	**AW/RS** **Nhen** **JW** **PB**	Ensure the timely assessment and recording of children's pain as well as timely administration of painkillers by WMAS clinicians, with re-audit to ensure learning. WMAS has a paramedic on every ambulance, pain score assessments should be undertaken for every patient, this	The EPR system uses a system called the Wong-Baker Scale, we also incorporate a 0 –10 standard which can be asked, but for children the attending clinician can use the pictures to easily identify a child level of pain. This can be recorded at any time and multiple times each with a time stamp during the patients	**March 2024**	

			may be a lack of recording on the EPR? Consideration should be given to amending the EPR?	journey with WMAS, therefore the system does provide this information to aid the clinician. An education reminder surrounding pain scoring especially in Children was reissued in the Clinical Times in January 2024. Clinical Times issue 51.pdf (sharepoint.com) A paper is due to EMB in March 2024 showing an action plan for each audit. A further paper will be added including any further options (if applicable) for amendments to EPRR to assist in the capture of clinical interventions and diagnostics.		
10	The trust should continue to work with partners to achieve national handover time targets. (Pages 6, 15, 36, 44 - 49)	**AW/RS Nhen MB**	Regular meetings, communication and data sharing with partners to take place to work together to achieve the national targets.	Evidence of letters sent to CMO and CNOs of Acutes re handover delays:  Hospital Handover Delay Meetings Matri: Engagement list, daily weekly meetings:	**March 2024**	

				SCC Engagement Diary (002).docx		
11	The trust should ensure that feedback to staff from incident reporting is consistently applied across the organisation. (Pages 18, 33, 34)	**CE Nhen MB NH**	Ensure the process for feeding back to staff following a review or investigation into an incident is allocated to an appropriate individual to undertake as part of the process.	Staff incident FAQ list: Incident Reporting FAQ.docx Information on all ER54's is available to staff currently and during SI process's, staff attend RCA's to capture learning, and redacted reports are available to all staff as published on Treble 9.	**March 2024**	
12	The trust should ensure that all staff are aware of the methods to speak up including the Freedom To Speak Up Guardian. (Pages 10, 11, 48)	**VK PW**	Ensure all staff are aware of the Trust FTSU arrangements, purpose and methods available to speak up.	Reminders of the routes available to raise concerns are included in regular articles, newsletters, staff meetings / inductions. FTSU month in October 2023 included a promotional event on every Hub / site. This will be continued in October 2024, in addition to support staff wellbeing road shows and other staff networks throughout the year. The FTSU Guardians attend student inductions with all universities and deliver a presentation to every cohort to raise their awareness of the process of FTSU and their key contacts.	**March 2024**	

				Student Power point presentation:  Student induction December 2023.pptx  Freedom to Speak Up Onboarding Pack V4.p		

Leads		
ACM	Anthony Marsh	Chief Executive Officer
IC	Ian Cumming	Chair
NH	Nathan Hudson	Director of Performance Improvement Delivery
AW	Alison Walker	Medical Director
RS	Richard Styne	Interim Medical Director
CB	Carla Beechey	Director of People
VK	Vivek Khashu	Strategy & Engagement Director /FTSU Executive
PW	Pippa Wall	FTSU Guardian
CE	Caron Eyre	Director of Nursing
NHen	Nick Henry	Paramedic Practice & Patient Safety Director
PH	Phil Higgins	Governance Director & Trust Secretary
KMc	Karl McGilligan	Head of Public Health & IPC
MB	Michelle Brotherton	Non-Emergency Services Ops Delivery Director
JW	Jason Wiles	Consultant Paramedic for Emergency Care
SW	Suzie Wheaton	Governor & Membership Engagement Officer
PB	Paul Baker	Project Manager

RAG Rating legend	
	No comment received from the Lead
Green	Action complete
Amber	Action commenced, but not complete (Ongoing)
Red	Action not commenced

CQC Action Plan in Response to the Unannounced CQC Inspection 15 to 17 August 2023

Issue 1	**E&U Operations -** On 15 August 2023, the CQC found 4 ambulances at the Warwick hub that were visibly dirty after going through the 'make ready' system.					
	Action taken	**Evidence**	**Lead**	**Update**	**Comp' Date**	**RAG**
1.1	**<u>Immediate action</u>** All vehicles put through make ready system, with additional clean undertaken in the cab and saloon.	All available DCA fleet put through full make ready process, with full clean of cab and saloon.	DS	Spreadsheet of audit details is attached.  CQC Action - Vehicle Cleaning Make Ready	21/08/23	
1.2	**<u>Governance (Policies, Procedures and Notices)</u>** Clinical and Make Ready notice to share information produced/updated to inform Vehicle Preparation Operatives (VPO's) when an ambulance vehicle enters the make ready process, the areas must be encompassed: No change to practice for frontline operational staff.	Make Ready – Notice (MR/100)  MR-100 Notice Vehicle Cleanliness.pd MR-100 Notice published on 18/08/23. Reminding staff of the Ambulance Cleaning Requirements (Including Sharps Management). Make Ready Clean have been reinforced to VPO's. The process, areas associated with the cleaning of ambulance vehicles is underpinned through the delivery of education and training and can be found within documented procedures.	KMc	KM to update Cleaning Schedule Procedure for next Health, Safety, Risk and Environment Group (HSREG) on 18 September 2023 to reflect Make Ready requirements. Enforced spot checks to be undertaken by senior management team. With immediate effect 60 cleaning audits per month on each Hub, completed by Managers. E&U Vehicle Cleaning Schedule updated via PolicyStat, sent to Health, Safety, Risk and Environment Group (HSREG) 18 September 2023 to reflect Make Ready requirements.	18/08/23	

		The cleaning regime has been reiterated for Make Ready, Deep Clean, In-between Patient Cleans and the frequency. Operations Managers (OMs) are required to continue to undertake randomised qualitative vehicle cleanliness audits of ambulance vehicles that exit the make ready system, and report findings via Auditr. This as per the IPC Incident and Audit Framework.				
Issue 2	**E&U Operations -** On 16 August 2023, the CQC found that sharps bins at the Coventry hub were over ¾ full.					
	Action taken	**Evidence**	**Lead**	**Update**		**RAG**
2.1	**<u>Immediate action</u>** On identifying issue with sharps box, it was removed from the vehicle immediately and replaced with a new one.	Completed in the presence of the CQC inspector.	DS	Complete		
2.2	**<u>Audit</u>** Audit of DCAs/Fleet undertaken and submitted.	CQC Action - DCA Sharps Audit Aug 23	KMc	The need to undertake Spot checks have been reinforced with Operational Managers via the Daily OM Conference Call as instructed by the Operational Support Services Director. This was further reinforced within MR/100 attached. MR-100 Notice Vehicle Cleanliness.pd	18/08/23	
2.3	**<u>Collaboration and Engagement</u>**	Via MS Teams 18/08/23 @ 13:00	KMc	KM met with DS on the 18/08/23 and arranged a subsequent meeting in person	07/09/23	

	Head of Public Health and IPC has met with SOM (18/08/23) to gain assurance of local process, quality checks and audits undertaken. KM & NP to engage with staff during site visits to ensure key messages have been received at operational level.			at site, scheduled for the 07/09/23 (see action 2.4)		
2.4	**<u>Site Visits</u>** Site visits scheduled at C&W between SOMs, Head of Public Health and IPC (September).	Visits scheduled with C&W SOMs, Head of Public Health and IPC, Compliance Lead, Head of Corporate Efficiencies.	KMc	Site visit scheduled 07/09/23 with findings to be reported to Performance and Improvement Director and Director of Nursing. KMc has visited both sites in CW and therefore this action was complete. Coventry was fine minor issues which was resolved on the day, however there were some actions for Warwick which are not vehicle based, but directly related to the make ready area. KMc is going back to Warwick on the 20th of September to ensure the actions are complete. KMc revisited Warwick Hub 20/9/23 11:00 – 13:00 to re-measure compliance with Trust IPC requirements. There is a notable increase in compliance across the Hub, Make Ready area and vehicle cleanliness with positive feedback delivered to the local teams. Performance and	20/09/23	

				Improvement Director appraised of findings.		
2.5	**Governance (Policies, Procedures and Notices)** Clinical and Make Ready notices to share information produced/updated to inform the step-change for VPOs that sharps containers must be replaced when no ½ full. No change to practice for frontline operational staff.	• Clinical Notice – Ops (CN/508)  CN - 508 Clinical Waste Management.p Clinical Notice – Ops (CN/508) in place and republished on 18/08/23. The Notice reiterates the safe control of clinical waste and associated sharps. It is imperative to ensure the safety of staff and reduce the risk of infection to others. By being aware of the steps listed in the Notice, staff will help protect themselves and their colleagues whilst at work. Further information is available in the Clinical Waste Management Policy.	KMc	KM to update Cleaning Schedule Procedure for next HSREG (18 Sept) to reflect Make Ready requirements. To be reiterated in the Weekly Briefing. E&U Vehicle Cleaning Schedule Procedure updated via PolicyStat and submitted to HSREG (18 Sept), to reflect Make Ready requirements. Article sent to Press to be reiterated in the Weekly Briefing on 19/08/23.	19/08/23	
2.6	**IPC Incident and Audit Framework** Across all sites, Operations Managers to measure compliance with clinical waste and sharps management within their submission of qualitative vehicle cleanliness audits per month, submitted via Auditr and reported to HSREG and to SMT members within the IPC	 E&U IPC Report - 2023-24 Q1.pdf	KMc	Details of compliance/non-compliance with sharps management will be captured and reported within the scope of this document and reported within the E&U/PTS IPC Incident and Audit Report.	18/09/23	

	Incident and Audit report. In agreement with the Executive Office, this has been increased from 20 to 60 until further instruction.					
2.7	**Communications** Key messages relating to compliance with sharps management (container capacity, labelling, disposal) will be shared and reinforced through a dedicated campaign over the next quarter via the Weekly Brief.	Discussed with MM and articles to be released weekly to promote compliance.	KMc	Explore additional signage on hubs to instil practice into everyday behaviours.  Waste and Sharps Management.msg Linked to 2.5 above.	19/08/23	
2.8	**Communications** Region wide audit of both saloon and BLS sharps boxes undertaken, any approaching ¾ full replaced for new. In addition, checked that all sharps' boxes have a WMAS sticker.	Spreadsheet of audit details.	DS	 CQC Action - DCA Sharps Audit Aug 23 (Spreadsheet of audit details.	21/08/23	
2.9	**Communications** Head of Public Health and IPC to develop a programme of campaigns, so the subject features various times throughout the year to maintain momentum.	Draft plan of communications campaign to be developed.	KMc	IPC targeted briefings to be released, as per IPC Communications attachment. Programme of key messages produced, to be shared regularly within the Weekly Briefing. IPC Communications.pdf	11/09/23	
	E&U Operations -					

Issue 3	Staff reported at each hub the CQC visited, tension between younger and older crew members. Examples stemmed from different communication styles, and the route trainee paramedics were qualifying through (i.e., there was a disparity between university and apprenticeship trainee paramedics).					
	Action taken	**Evidence**	**Lead**	**Update**		**RAG**
3.1	Stories (using videos) to be developed and promoted from graduates/SPs/IHCD highlighting the differences that should be celebrated and that give our crews strength and the ability to deal well with a broad spectrum of jobs – eg the older/IHCD have lots of experience – clinically and also in communicating with service users; graduates have the latest clinical research; SPs get to know the organisation from the inside straight away.	Individuals to be identified.	CB	HR Managers to raise for volunteers at E&U SMT. 3 volunteers identified (SP, IHCD) and linked in with comms to progress production of their bio and video. Additional volunteers needed from all workforce / career routes asap – grads outstanding. Recruitment Manager requested to identify any potential volunteers through recruitment engagement events that colleagues attend. 2 future employees currently in the recruitment process being approached. JA from Press and Communications Department is working on creating the videos to share on social media, which should be available to share on social media channels by December 2023. 21/12/23 - the videos have been produced and the first one went out last weekend, the next one is going out tomorrow, and will continue to run roughly each week, ending up with five in total.	31/12/23	
3.2	Valuing Difference workshop / training to be developed and delivered	Training content in development.	LM	Training package being developed collaboratively with relevant stakeholders including networks.	14/11/23	

	alongside Racism Charter launch.			Working group meeting 15th September, aim to have training materials completed by end of September. The charter, poster and training materials will then be presented to EMB to approve prior to roll out. Then the launch can commence at the end of October, this being subject to EMB approval. This is an agenda item for EMB on 14/11/23. 14/11/23 – agenda item 4e - EMB members reviewed the contents of the report and approved the launch of the charter, poster and training package across the Trust.		
3.3	Engage with network chairs to encourage discussion about generational difference at their scheduled network meetings.	HR manager network chair buddy advised to schedule into agendas.	CB	Discussion scheduled into DISAG. Network Chair meeting taking place 26th September with CEO – to be raised for discussion there also. Networks to work collectively on producing an educational awareness piece on how the use of terminology and language (specific to their protected characteristics) has changed over time and therefore generations will have different experiences and awareness. A final draft of the Inclusive Language Guide document (shown below) has been produced and is going to DISAG for sign off on 16/01/24.	30/12/23	

				It will then be added to the EDI section of the intranet and referenced in the E&I charter training. Inclusive Language final draft.pptx		
3.4	All task and finish working groups and meeting membership to have a balanced generational stakeholder input.	To discuss at EMB.	NH/ ALL / EMB	Raised and discussed at EMB on 5th September for action moving forward.	05/09/23	
3.5	Job profiling by age to be undertaken to identify any roles / staff groups that are underrepresented from specific generations to inform recruitment activity.		CB	Report produced. Item and report placed on agenda of DISAG 4th October for further discussion. No specific job role or staff group identified as disproportionately represented.	04/10/23	

Lead Initials	**Lead Name**	**Job Title**
DS	Dan Swain	Senior Operations Manager – Coventry Hub
KMc	Karl McGilligan	Head of Public Health and Infection Prevention & Control
CB	Carla Beechey	People Director
NH	Nathan Hudson	Emergency Services Operations Delivery Director
LM	Lucy Mackcracken	Head of Human Resources
EMB	Executive Management Board	

RAG Rating legend	
	No comment received from the Lead
Green	Action complete
Amber	Action commenced, but not complete (Ongoing)
Red	Action not commenced

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 03 MONTH: February 2024 PAPER NUMBER: 01c

Performance Improvement Strategic Options & Action Plan	
Sponsoring Director	Nathan Hudson
Author(s)/Presenter	Director of Performance & Improvement
Purpose	Strategic options to be considered by Board of Directors for restoring operational performance standards, as per the requirement set out by the CQC.
Previously Considered by	EMB
Report Approved By	Director of Performance & Improvement

Executive Summary

The CQC report requires the Trust to restore performance against nationally agreed operational response standards. 5 options are set out below for determination by the Board of Directors.

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

Relevant Trust Value	Excellence	☒	Integrity	☒
	Compassion	☒	Inclusivity	☐
	Accountability	☒		
Risk and Assurance	There are some risks associated with the options: 1. Not complying with the 'regulation 12' notice to improve national response time targets. 2. Financial implications associated in option 5. 3. Risk of collaborations and relationship internally and externally in option 3. 4. Risk of ICBs not providing for extra funding to restore performance. 5. There is a risk of patient harm if no action is taken.			

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

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Legal implications/ regulatory requirements	The CQC has imposed regulatory requirement on the Trust.
Financial Implications	Potential financial deficit implications depending on the option chosen.
Workforce & Training Implications	There is a need to recruit and train an additional 327 Paramedics.
Communications Issues	Directors will need to follow up with the ICB and NHS England to inform them of the option determined by the Board. Our plans will also need to be communicated to our staff.
Diversity & Inclusivity Implications	There are no Diversity & Inclusion issues arising from this report.
Quality Impact Assessment	Some options within this report include the cessation of some roles such as the Ambulance Decision Areas, and seconded HALO's etc, to increase the operational DCA hours on the road.
Data Quality	There are no specific data quality matters arising from this report.
Action required. The Board of Directors are required to make a decision on the options presented within this paper, after determining which option will best support the restoration of operational performance standards.	

Background

The Trust consistently achieved national response time targets for many years. Response time performance has deteriorated over the last two years with substantial increases in lost hours due to handover delays at hospital; there is a direct correlation between the number and length of delays and poor performance (Appendix 1). The Trust has recognised the risk from hospital handover delays as the highest BAF risk score possible (25) for some time.

Following an inspection in 2023 by the Care Quality Commission (CQC), they have imposed a regulation 12 requirement on the Trust. This states 'The Trust must ensure that national response time targets are met with a focus on the risks posed by the Category 2 calls'.

The CQC report clearly highlights those patients in the community awaiting an ambulance response are the responsibility of the Trust, regardless of hospital handover delays. NHS England policy is clear that as soon as an ambulance arrives at hospital, the patient is the responsibility of the hospital (Appendix 2). A consequence of the significant increase in hospital handover delays is that the Trust has been looking after patients on the back of ambulances for whom we don't have responsibility for, at the detriment to patients waiting for an ambulance in the community that we do have responsibility for. This has in some cases resulted in harm coming to patients in the community.

In order to meet the regulation 12 requirement, it is clear this situation can no longer continue.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

AGENDA ITEM: 03 MONTH: February 2024 PAPER NUMBER: 01c

During 2023/24 the Trust will lose a total of nearly 250,000 hours due to hospital handover delays over 15 minutes, an average of 21,000 hours every month. The cost of these lost hours to the Trust is circa £16 million per annum. This is at the detriment to patients in the community, particularly category 2 patients whereby increased harm and deaths take place due to long waits for an ambulance response.

The wider impacts of hospital handover delays on the Trust are significant:

- The Trust regularly sees several hundred calls stacking with no resource to send.
- Call takers have to deal with duplicate calls and frustrated callers ringing back seeking an estimated time of arrival for a response.
- Dispatchers experience patient's conditions worsening due to long delays for an ambulance response but are helpless to assist them as there is no resource to send.
- A marked increase in the workload of the patient safety team due to the number of Serious Incidents resulting from the delays.
- The emotional impact on our staff dealing with patients and their family members who can be angry at the delay, particularly where their loved one has come to harm as a result of the delay
- The health and wellbeing of front-line staff is impacted by repeated late finishes, missed meal breaks and the resultant low morale.
- All of the above issues are clearly visible in the results of the 2023 NHS staff survey results.

Despite reduced conveyance rates to emergency departments, hear and treat rates significantly higher than the national average through the implementation of systems such as the Clinical Validation Team and additional recurring funding from NHS England to improve Category 2 performance, lost hours continue to increase and performance remains challenged.

	England	**WMAS**
Hear & Treat rate	10%	18%
Patients conveyed to ED	52%	49%

*YTD figures

A range of supporting information including letters from NHS England highlighting the risks and actions required to improve hospital handover delays are included (Appendix 3,4,5).

The Trust is required to submit our action plan to the CQC evidencing how we will meet the regulation 12 requirement by **the 12th March 2024.**

Options

In response to the regulatory requirement to improve performance, the Board is presented with 5 options.

Option 1

Do nothing.

Option 2

The Integrated Care Boards and hospitals collectively eradicate hospital handover delays over 15 minutes and facilitate a timely handover of patients into their care in order to allow ambulance crews to respond to patients in the community which will restore performance.

Option 3

The Trust invokes the immediate handover protocol of patients when there is a Category 2 incident outstanding within the Trust with no ambulance available to be assigned. This would involve staff leaving patients at the hospital immediately even if there is nowhere for them to go in A&E

Option 4

The Trust requires approximately £20 million to recruit and train 336 paramedics and 20 additional emergency ambulances to achieve the performance targets. The methodology to support the requirements are presented at Appendix 6. This funding would be requested recurrently in full by the ICB.

This option would not reduce hospital handover delays, but by increasing the number of ambulance crews on the road, we can subsequently achieve performance and therefore comply with the regulatory requirements the Trust is required to meet.

Option 5

If the discussions with the ICB fail to secure the funding, the Trust invests approximately £20 million to recruit and train 336 paramedics and 20 additional emergency ambulances that are required to achieve the performance targets. This would result in the Trust meeting the Regulation 12 notice, achieving performance targets, but having a deficit of circa £20 million.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

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Recommendations

Should hospital handover delays improve, the Trust can review financial commitments throughout the year within student paramedic recruitment or overtime availability based on the reduced requirement for additional investment.

Option 1 recommendation

It is recommended that the Board **rejects option 1**. The Trust are required to achieve the CQC regulation 12 notice. There is no confidence that performance will improve without action.

Option 2 recommendation

It is recommended that the Board **support the ongoing discussions with option 2.** However, most acute trusts were not facilitating timely patient handovers pre-pandemic therefore, it is unlikely the required level of performance improvement will be achieved.

Option 3 recommendation

It is recommended that the Board **rejects option 3.** There are significant logistical challenges inherent with this option and the reputational harm that could be caused because of this process becoming part of business-as-usual responses to Category 2 emergencies. There are existing policies which do support the immediate handover of patients where this can be facilitated however their affect is limited.

It is unlikely that all paramedics would support or follow this process when undertaken because of concerns related to their HCPC registration and moral concerns of leaving certain patients within an acute trust outside of the normal handover process.

Leaving patients at acute trusts to respond to Category 2 emergencies within the community also provides a logistical challenge of not having any beds, trolleys, or stretchers to offload patients onto.

This option would have a significant impact on the collaborative working undertaken between hospital staff and other relationships between Trust partners and is likely to cause some reputational harm by leaving patients at hospital to respond to a community emergency call.

Option 4 recommendation

It is recommended that the Board **accepts option 4.**

Option 5 recommendation

It is recommended that the Board **accepts option 5 only if option 4 is unsuccessful** in delivering the required finances from the ICBs for the Trust to meet its regulation 12 requirements.

Further recommendation

NHS England have also recently produced a document awaiting WMAS sign off regarding 'improving ambulance patient flow' (Appendix 7). We do not believe that this will improve the position or reduce patient harm and therefore **we recommend the Board does not approve 'signing' this document**, and undertakes further engagement with NHS England on suitable policy for ambulance handovers to restore performance and reduce harm.

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO THE BOARD OF DIRECTORS

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Appendices

Appendix 1 – WMAS hospital handover delays and performance (Attached)

Appendix 2 – NHSE policy detailing the duty of care for a patient (Attached)

Appendix 3 – NHSE Letter supporting ambulance handover (Attached) (Attached)

Appendix 4 – NHS letter on UEC tiering and improvement support (Attached)

Appendix 5 – Ambulance handover letter 2017 (Attached)

Appendix 6 – Calculations of required investment to meet regulatory requirements

The total amount required to achieve performance is £20 million pounds. This is the combination of £16.35 million in pay costs (Table 2) with a further £ 3.5 million for fleet increases required for the increase in staffing numbers.

Table 1 - Shows the total resourcing hours produced for the year at 2,368,153 with the lost crew hours recorded on average at 20,430 hours per month, which equates to 10.4% of lost produced operational hours to hospital delays.

	DCA hours produced	Hospital handover lost hours
April 23	184,573	9,781
May 23	181,610	11,889
June 23	174,042	11,199
July 23	192,906	14,461
August 23	199,576	14,626
September 23	190,386	21,032
October 23	194,269	26,722
November 23	198,524	26,738
December 23	214,558	29,785
January 24	220,237	34,933
February 24*	202,041	22,000
March 24*	215,431	22,000
Total	**2,368,153**	**245,166**
Average	**197,346**	**20,430**

*Predicted

Table 2 - Highlights the calculations which equates to 327 WTEs required in accordance with the lost hours at hospital (Table 1). The cost of this is £16.35 million pounds.

Average crew lost hours per months (handover delays)	Converted to average staff lost hours per month (handover delays)	Calculation	Required to cover handover delays	Accounting for abstractions (circa 30%) not available to operations	Required to be available to operations to cover handover delays	Calculation	Cost
20,430	40,860	40,860 hours / 4.33 weeks in a month / 37.5 hours average worked per week	= 251 WTE	= 76 WTE	= 327 WTE	327 X average £50k per WTE	£16.35 million

Fleet costs

A fully equipped DCA costs circa £174k (chassis, conversion and medical devices including vat)

£3.5m would secure 20 additional DCA's.

Operating cost for a new year 1 DCA is £17,400 (maintenance & tyres per vehicle including VAT) plus £2,000 insurance, therefore 20 x additional new DCAs would require an annual revenue budget of approximately £388k.

We have the option to retain owned DCA's being replaced in April and May.

20 x retained DCA's would require an annual operating revenue budget of approximately £544k

Appendix 7 – Improving ambulance flow DRAFT for approval (Attached)

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST
TERMS OF REFERENCE

Operational Oversight Delivery Programme Board	
1.	**Purpose**
	Following an inspection in 2023 by the Care Quality Commission (CQC), they have imposed a regulation 12 requirement on the Trust. This states 'The Trust must ensure that national response time targets are met with a focus on the risks posed by the Category 2 calls'. The purpose of the Operational Oversight Delivery Programme Board is to provide comprehensive focus on the operational performance of West Midlands Ambulance Service University NHS Foundation Trust (WMAS), and improve the performance of the Category 2 calls, therefore providing a safer service to its patients and the public it serves. The Operational Oversight Delivery Programme Board Group will be a Task and Finish Group and as such it will be a time limited group set up as an action sub-group of the Performance Committee, with the aim of delivering the specified objectives. Once the specified area of work has been completed, or a need for a longer-term amendment to the Trust committee structure has been identified the Operational Oversight Delivery Programme Board Group will be disbanded. The outcomes and progress of the Operational Oversight Delivery Programme Board will be fed back into the Performance Committee meetings, with the Executive Management Board having oversight and management of delivering its operational objectives. The Operational Oversight Delivery Programme Board will oversee and ensure the delivery of the operational performance improvement plan as agreed by the Board of Directors. The Operational Oversight Delivery Programme Board is responsible for implementation and delivery of specific objectives and workstreams that are aligned to the overall objectives within the related Trust strategies.
2.	**Objectives**
2.1	Identify and prioritise actions and activities with a clear focus on achieving operational performance.
2.2	Provide operational leadership and guidance to the Trust.
2.3	Ensure all stakeholders are kept informed of progress against delivery, including the Integrated Care Board (ICB), NHS England and our staff.
2.4	Provide assurance to the Board of Directors and its Committees' that the Trust is fulfilling its legislative and regulatory requirements relating to its operational performance standards.
2.5	Meet the Trust strategic objectives: SO1 – Safety Quality and Excellence SO2 – A great place to work for all SO3 - Effective Planning and Use of Resources SO4 - Innovation and Transformation SO5 – Collaboration and Engagement

3.	**Membership**
	• Chief Executive Officer (Chair) • Chief of Staff & Head of Enhanced Care (Vice-Chair) • Director of Performance and Improvement • Director of People • Non-Emergency Operations Services Delivery Director • IEUC and Performance Director • Head of Emergency Preparedness, Resilience and Response • Operational Support Services Director • Director of Finance will also be invited where required.
3.1	Members are expected to attend the meetings.
4.	**Key Documents for this Steering Group**
4.1	Trust Strategic Plan
4.2	West Midlands Ambulance Service University NHS Foundation Trust CQC Inspection report – Date of Inspection visits 15-17 August 2023 and 3-5 October 2023
4.3	NHSE policy detailing the duty of care for a patient & any other associated NHSE ambulance performance and hospital handover policy.
4.4	National Operational Data Set Reports
4.5	NHS Staff Survey Report
4.6	Trust Vision & Values
4.7	NHS Constitution
4.8	Operational Strategy
5.	**Accountability**
5.1	The Operational Oversight Delivery Programme Board is accountable to the Performance Committee.
6.	**Responsibility**
6.1	The Operational Oversight Delivery Programme Board is responsible to the Performance Committee and the Executive Management Board.
7.	**Reporting Arrangements**
7.1	The agreed minutes and an update on the work of the Operational Oversight Delivery Programme Board will be provided to the Performance Committee and the Executive Management Board, with updates to the Board of Directors through the Chair's report.
8.	**Administration**
8.1	Secretarial support for the steering group is provided from within the group.
8.2	Agenda and papers will be distributed 3 working days before each meeting. The action points will be available for group members within 3 working days of the meeting.

8.3	Members will ensure provision of agenda items, papers and update commentary on action points at least 3 working days prior to each meeting.
8.4	Papers tabled will be at the discretion of the Chair.
9.	**Quorum**
9.1	The quorum necessary for the transaction of business shall be 3 members, of which one must be the Chair or Vice-Chair. Deputies will not count towards the quorum.
10.	**Meeting Frequency**
10.1	The Operational Oversight Delivery Programme Board will meet fortnightly in the first instance, with a review within the first 6 months of the meeting.
10.2	Extraordinary meetings may be arranged with the agreement of the Chair
11.	**Review of Terms of Reference**
11.1	The Operational Oversight Delivery Programme Board will review the terms of reference within 6 months of agreement, and then annually thereafter.
11.2	The Chair will ensure the Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

12.	**Standard Agenda Items**	
Standard agenda items must include key operational deliverables, action plan risks and issues log:		
12.1	Performance Improvement Plan	Review of progress against the Trust operational performance improvement plan, agreed timescales and completion of actions.
12.2	Recruitment	Provide an update on E&U recruitment
12.3	Fleet	Provide an update on E&U fleet
12.4	WMAS Data / information	Update on number of operational performance and key performance indicators, including hospital handover delays and related KPI's, and Category 2 trajectory.
12.5	National Data Set	Regular updates on other ambulance services data performance.
12.6	Risk Log	Update group on any risk in delivering actions or objectives of the Operational Oversight Delivery Programme Board.
12.7	Schedule of Updates	Agenda items for future meetings

These Terms of Reference were reviewed and agreed at the [Title] on [insert date].

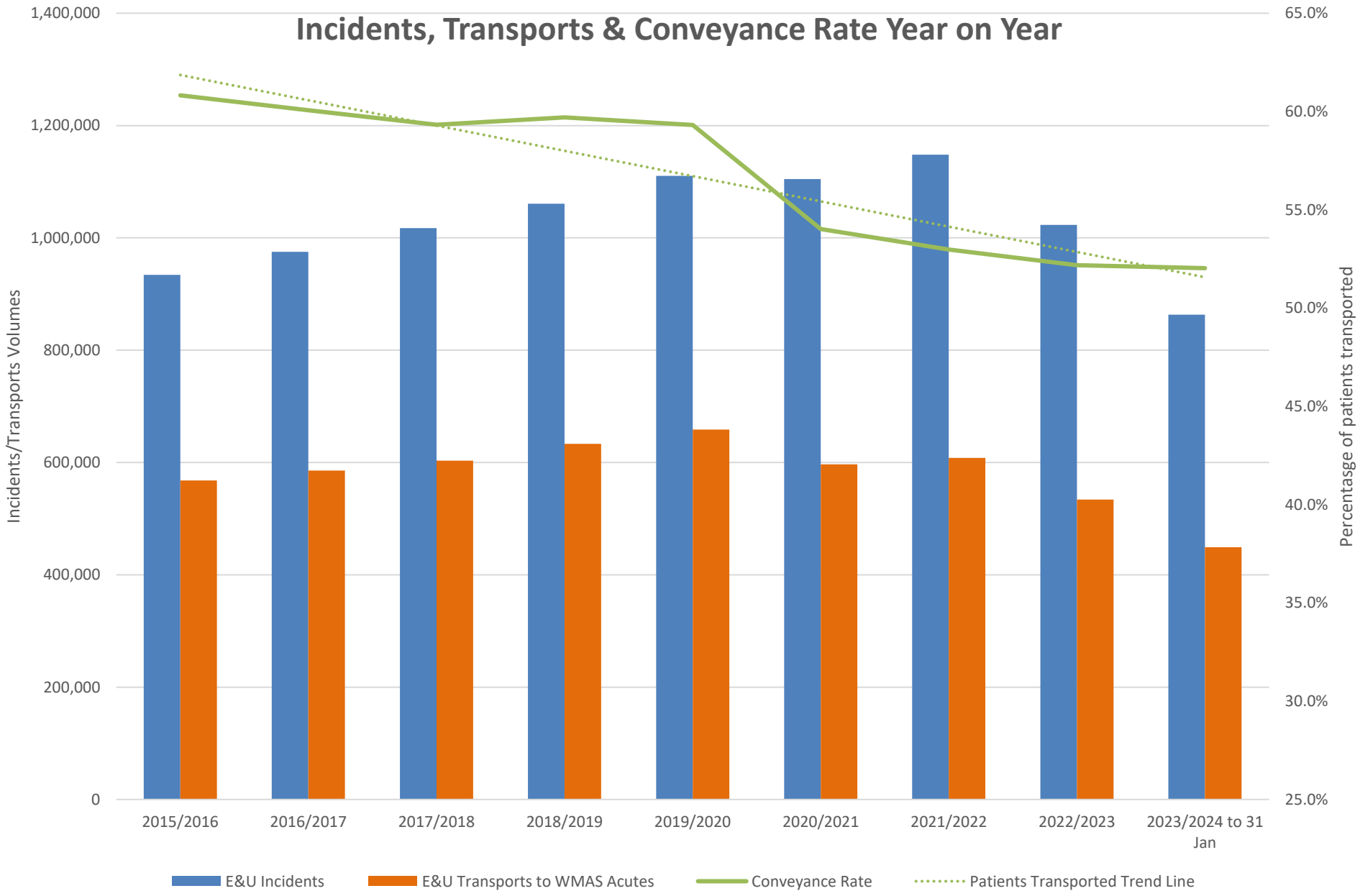
And approved by the Operational Oversight Delivery Programme Board on: …….

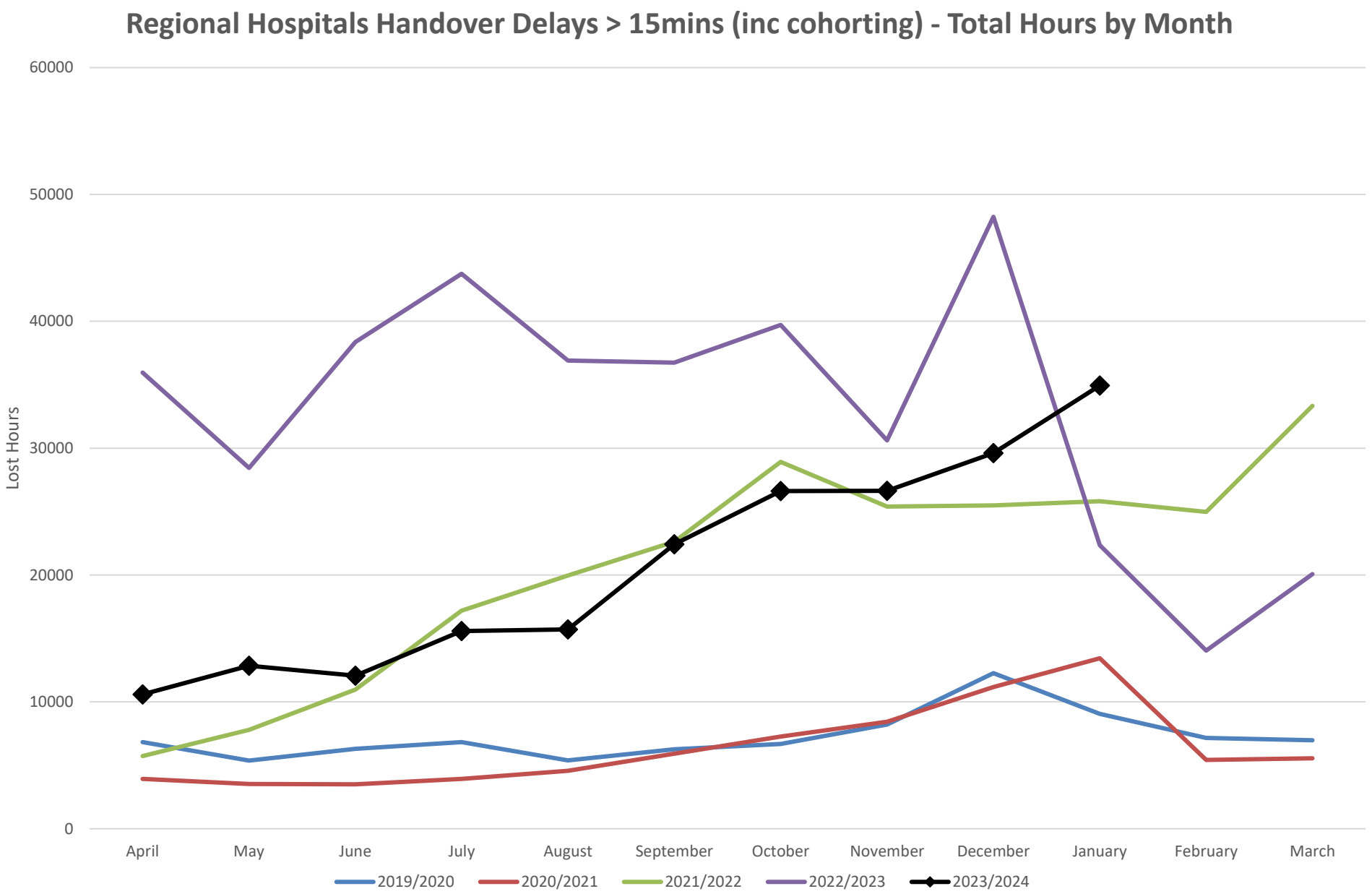
West Midlands Ambulance Service
University NHS Foundation Trust

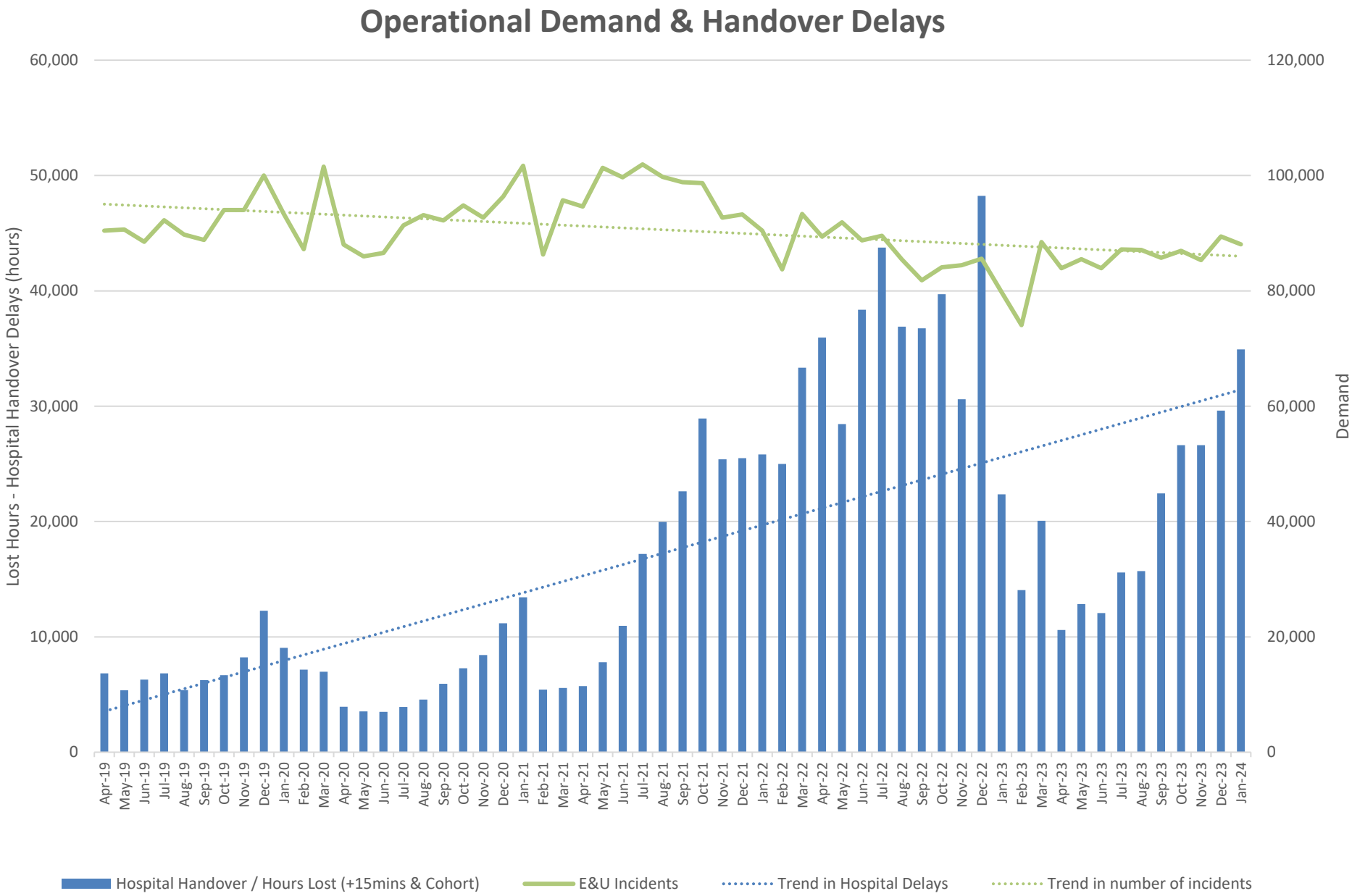
WMASRegional Demand,HospitalDelays &Performance

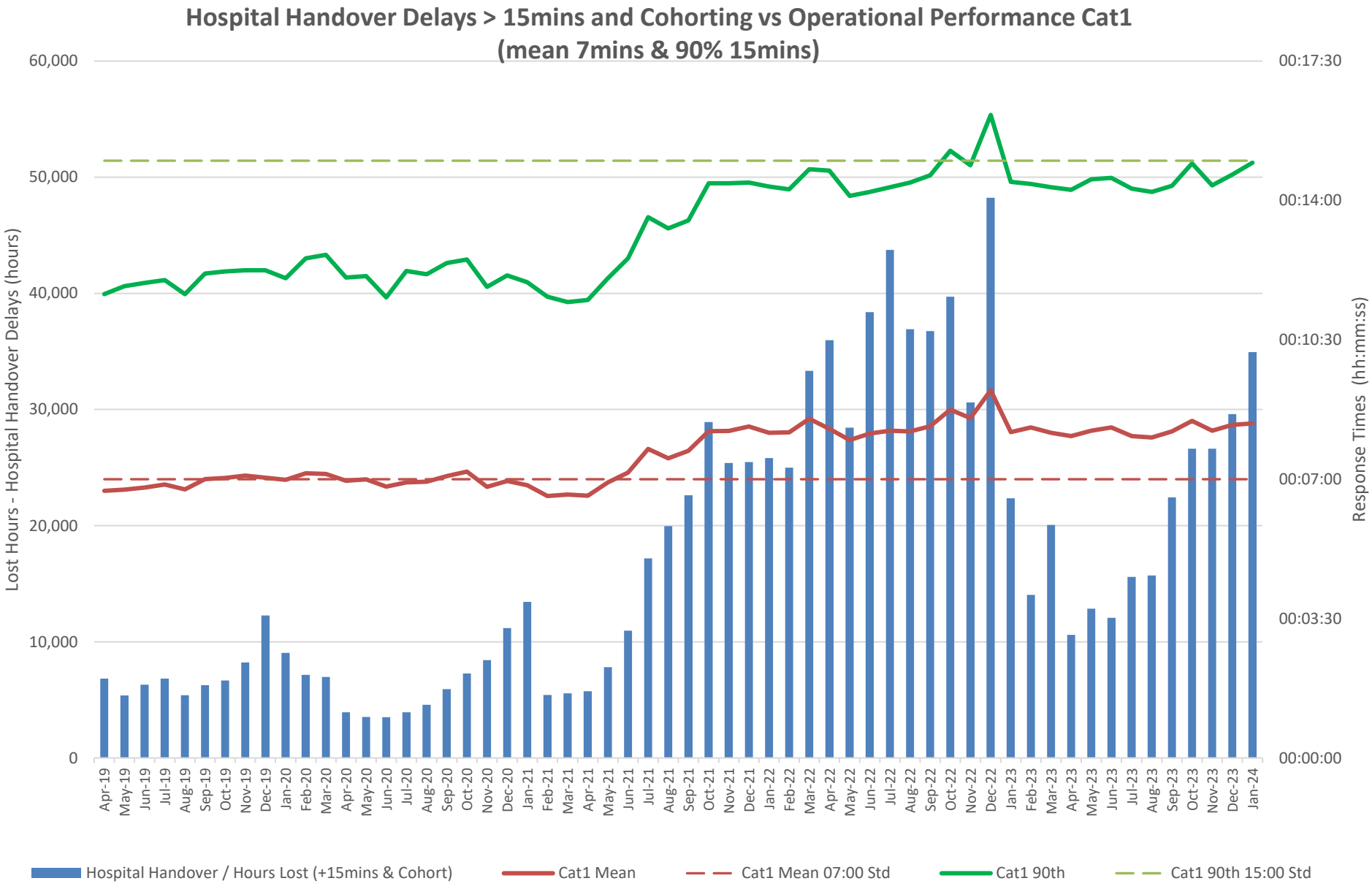
January 2024

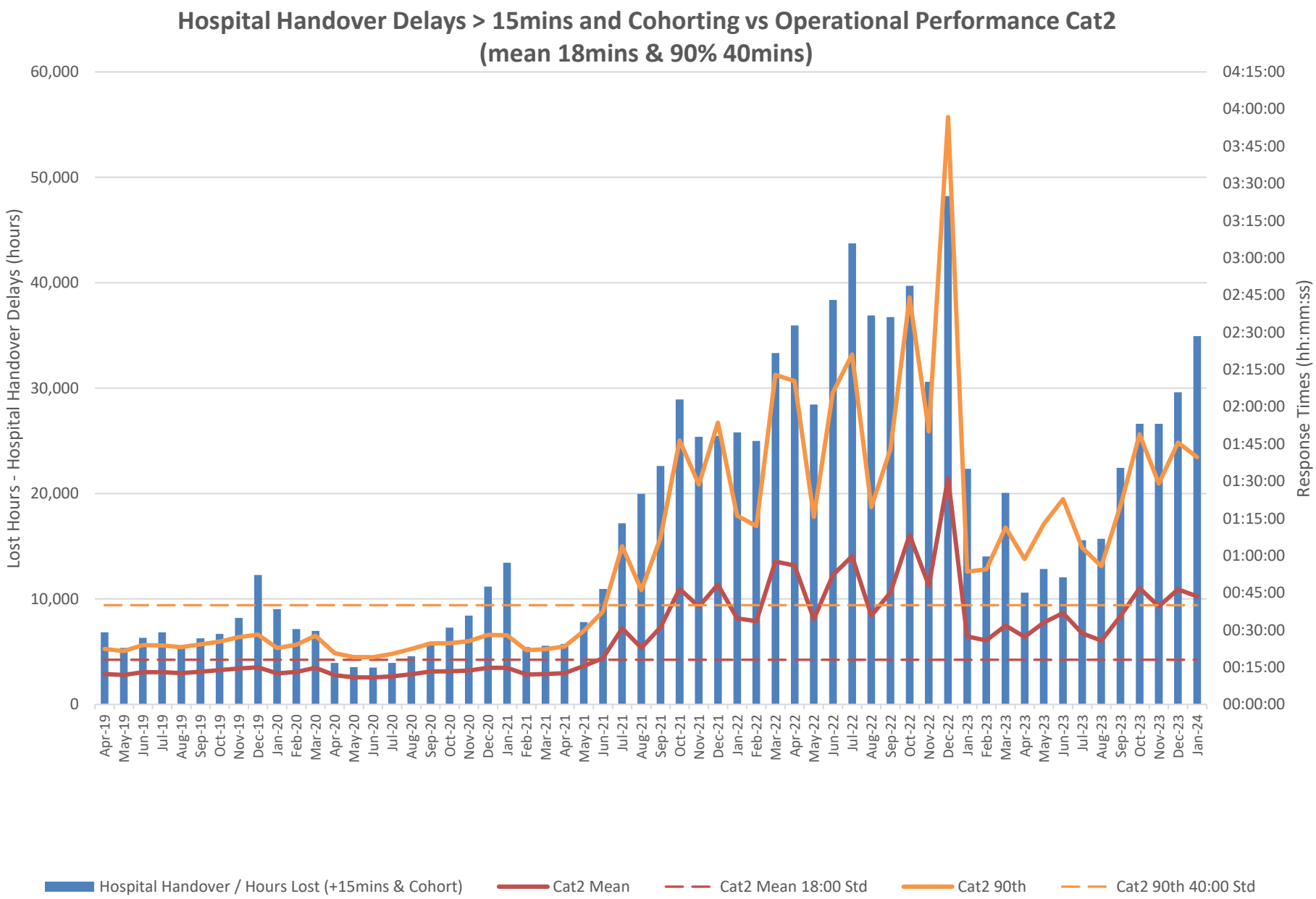
Trust us to care.

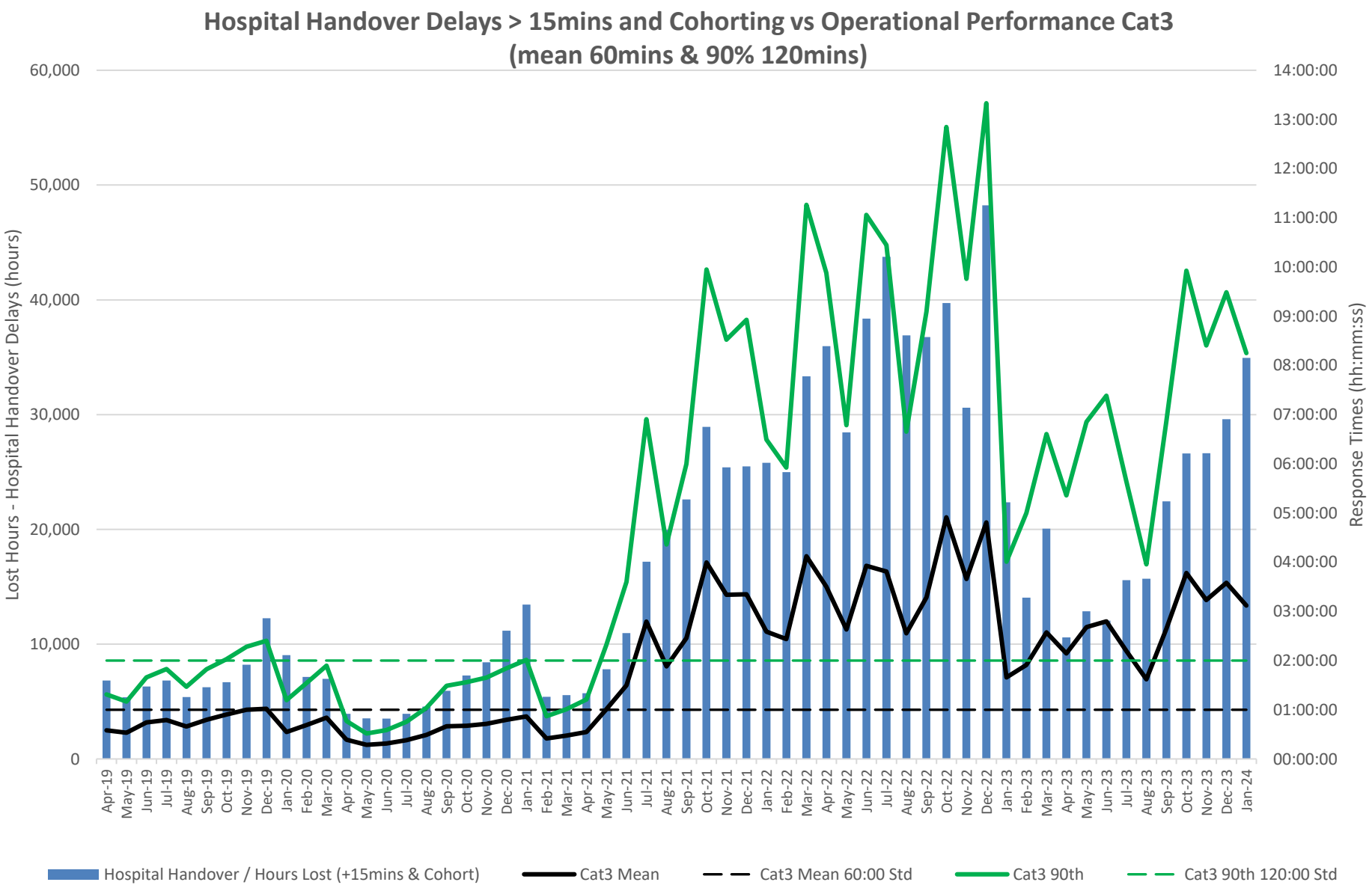












NHS England

Managing Ambulance Conveyances to Hospital

Midlands Region

Managing Ambulance Conveyances to Hospital Policy

Version number & Status	**V3.0 Final**
First published:	22/06/2020
Date updated:	05/12/2022
Next review date:	05/12/2024 *In line with the Corporate Policy this should be no more that 2 years since the policy was last updated.*
Policy prepared by:	Ambulance Lead - Midlands Region
Policy Owner:	Urgent and Emergency Care Board – Midlands Region
Policy approved by and Date:	*[Please refer to the Policy on Internal Corporate Policies for details on approving minor and major changes to policies. Any queries please contact nhsei.ara@nhs.net]*
Brief summary of changes since previous version:	Updates Task and Finish Group – 22.11.22 included • Removal of out-of-date terminology and processes • Details added to Intelligence Conveyance Section • Included information on discussions around end of shift handover for ambulance crews • Simplification of appendices due to duplication • Update on escalation process

Contents

1. Purpose

National Health Service (NHS) Ambulance Services have a finite amount of resources at their disposal to respond to 999 calls. Failure to respond to 999 calls in a timely manner is a significant patient safety risk to which the Ambulance Service is held to account. Delays in ambulances attending patients in the community cause harm and death. A widely acknowledged contributing factor associated with resources not being available is delays at hospital. It is essential that risks to patient safety are mitigated by adopting a proactive and reactive response to any handover delays.

Patients arriving at hospital by ambulance are at increased risk of harm if there are delays in their transfer of care, however there is a greater significant risk for those patients waiting in the community if ambulances are delayed at hospitals. Patients in ambulances and in hospital, even when busy, have clinicians near to hand. Patients who have rung 999 have no clinicians with them, little to no clinical oversight, no assessment, no diagnosis, and no treatment. As a result, these patients represent the most vulnerable in terms of risk of harm.

The purpose of the policy is a proactive approach to managing hospital conveyances through active monitoring in Ambulance Services Emergency Operations Centre (EOC) to operate a strategic conveyancing model. In the event of delays at hospital being encountered and no resources available for Ambulance Services to respond to life threatening 999 calls, then a rapid handover process can be undertaken. The rapid handover process should be used in conjunction with system escalation process where it is possible to do so.

2. Scope

Managing ambulance handover delays encapsulates escalation actions to be taken when handover delays are being experienced following the Regional Framework for Escalation (Appendix 1), along with a proactive approach to prevent them occurring using Strategic/Intelligent Conveyancing Process (Appendix 2).

The proactive monitoring of hospital conveyances across the region will enable early intervention to prevent an individual hospital site being overwhelmed with a high volume of conveyances during a certain timeframe. It is acknowledged there will be certain periods of time where the region will be experiencing globally high conveyance rates, or the distance to convey to an alternative site not being a feasible option along with certain hospitals offering specialist services e.g., hyperactive stroke management, vascular or major trauma. It is also acknowledged that the Ambulance Service has been given a key role in being the trusted assessor in managing conveyance risk across the region. This is a difficult role with extremely complex and changing factors.

A Full Divert Protocol (Appendix 3) should be followed in the event of failure to deliver business as usual service delivery regardless of the cause. Other forms of 'lesser' divert can be considered which are also referred to.

In the event of 999 calls not having ambulance resources available to respond to them the Releasing Ambulance Operational Resource (Immediate Handover) Framework (appendix 4) outlines a process for a rapid release of ambulance resources that are delayed at hospital. A joint risk assessment that is clinically focused should be undertaken between Ambulance Service Strategic Commanders and wider System Executives. It is widely accepted that delays of over 60 minutes can result in time-critical lifesaving treatment and assessments being missed. Delays cause harm and death. In the event of a handover delay exceeding 90 minutes, NHS England Midlands Regional Framework for Escalation should be followed, (Appendix 1).

In the event of a delay of the clinical handover from the Ambulance Service to the receiving department either Acute hospital provider or any other community-based provider e.g., Urgent Treatment Centre, the Professional Standards of Care relating to Hospital Handover Delays should be adopted (Appendix 5). These standards ensure patients are seen by a senior decision making thus reducing the risk of harm or death.

3. Roles and Responsibilities

All system partners contribute toward managing ambulance conveyances.

4. Impact Assessments

Equality and Health Inequality Analysis

As part of the development of this policy. It is impact on equality has been analysed and no detrimental effect identified. However, it is noted that Emergency Departments, staff, and their patients may be impacted in the event of an immediate handover being enacted which would further crowd an ED (Emergency Department). It is clearly the responsibility of the acute Trust and the system to avoid crowding and to have well developed and well tested plans which deal with crowding. The most vulnerable patient is that of the undiagnosed emergency in the community and, for this policy, takes priority. Systems should ensure they have well developed policy which compliments this policy to ensure health inequalities are minimised at the hospital.

5. Definitions:

Full Divert

A Full Divert is defined as movement of ambulance borne activity away from a hospital site under pressure to the next nearest/appropriate Emergency Department - with receiving Trusts agreement. This does not include hospitals that are part of the same Trust (but this can be negotiated with an Ambulance Service). In the event of a service delivery failure triggering the implementation of business continuity plans, the process for requesting a Full Divert should be followed.

Strategic/Intelligent Conveyancing

Strategic/Intelligent conveyancing is defined as the process by which Ambulance Services make dynamic real time decisions on the destination to convey patients to. This is dependent on the current demands within the region. This will be based on current ambulance handover times; number of conveyances inbound to ED along with prehospital 999 activity along with incidents of note e.g., multi casualty incidents. The Ambulance Service is the trusted assessor for this process and is afforded the ability to make any decision which balances risk across the region and releases ambulances quicker to respond to vulnerable patients waiting in the community. It is accepted that this a complex process and therefore challenges will also be complex around accessing patient history, discharging into community and social care and financial support. Systems are encouraged to maintain communication and learning with the Ambulance Service as they enact this. This tool is used across the NHS every day.

The aim of Strategic/Intelligent conveyancing is to convey patients to hospitals where there is less pressure for a defined period of time to prevent surges in conveyances to a particular site. It is good practice for the Ambulance Service to inform services if patients are being conveyed to them. This also includes neighbouring ambulance trusts when a strategic/intelligent conveyance is into an acute trust outside of ambulance trust boundary. The Ambulance Service does not need to seek permission to enact strategic conveyance. Further, a system or Trust cannot request or enact strategic conveyance – this would instead require a formal discussion with surrounding partners to request and agree a formal divert arrangement. Unless there is a clinical requirement to travel further. i.e., major trauma, PPCI, Strokes etc. Transfer patient to next nearest acute trust.

Patients who require conveyance that have been discharged from hospital in the last 24 hours, and present with same condition/complaints. In the first instance, should return to the hospital they were an in-patient at (unless the presenting condition requires specialist care due to deterioration).

Patients who have existing open access to Acute sites should continue to be conveyed to that site unless the presenting condition of the patient means they need to be transported to more specialist care facilities PPCI, Stroke, or Major Trauma.

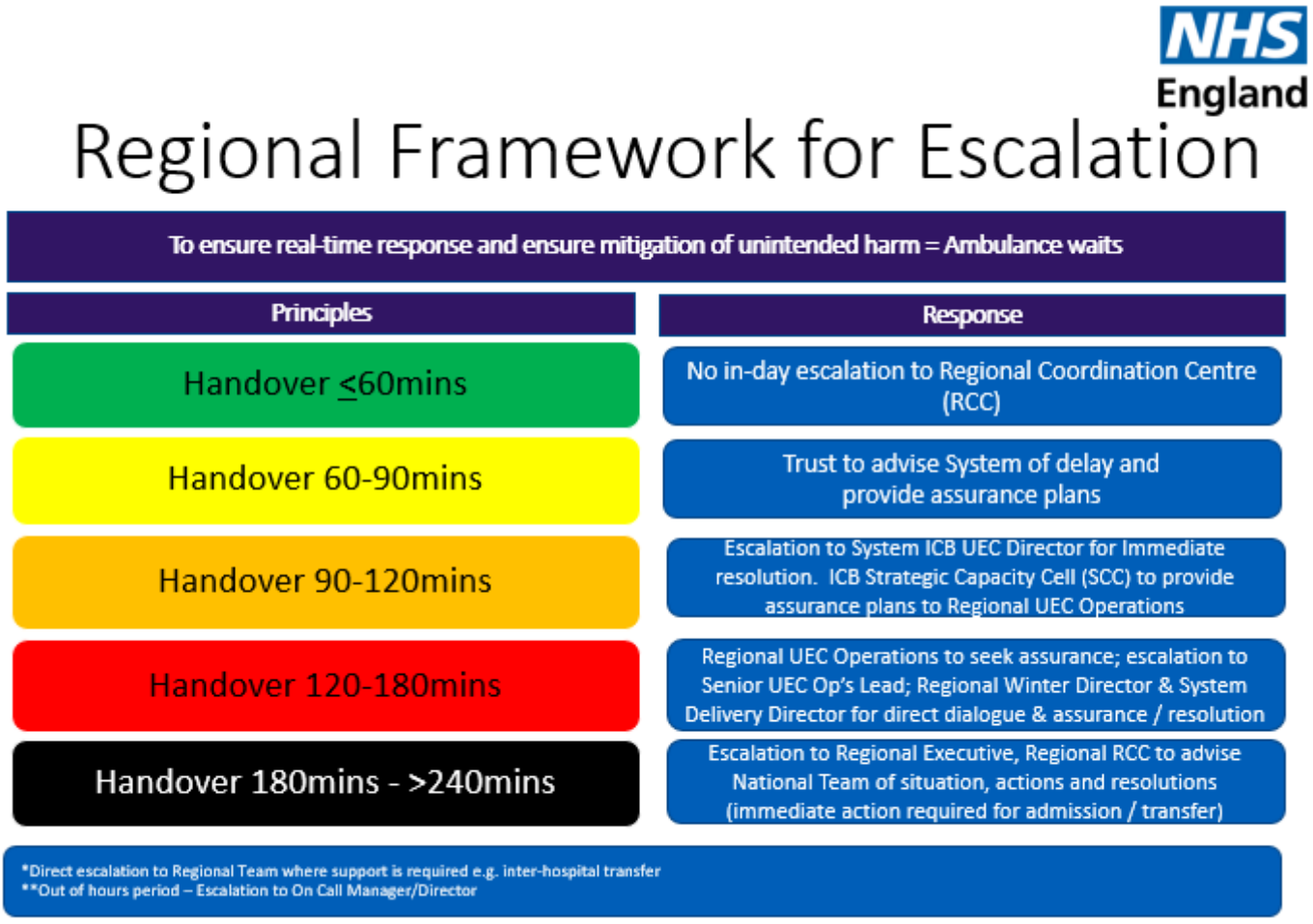
Immediate Handover

Ambulance Services are responsible for the maintenance of safety in the community. It is the responsibility of the acute provider and wider system to maintain care and safety at the acute sites. After a formal assessment by the Strategic Commander on behalf of the ambulance Trust, the Ambulance Service may be required to instigate an immediate handover at any stage to release crews to attend Category 1 and Category 2 patients who are at high risk of lifelong harm or death. This process is in place to protect patients with life threatening / life changing illnesses or injuries in the community and to prevent avoidable death and harm.

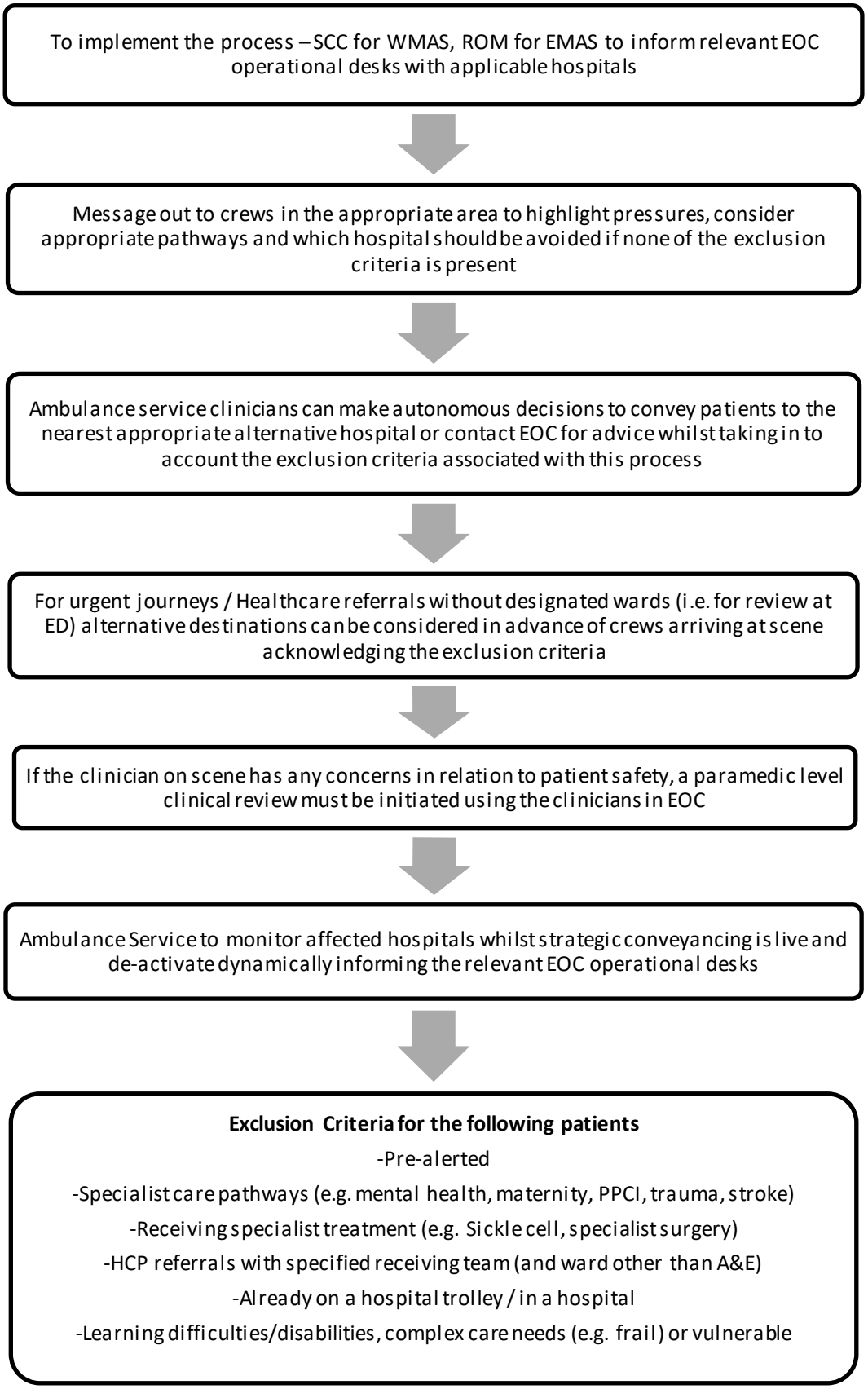
For ambulance crews at the end of their operational shift time, discussions between ambulance strategic commander and acute site should take place to instigate an immediate handover where practical and safe to do so.

Appendix 1: Regional Framework for Escalation

All ICB UEC leads join daily 10:00 hours Regional Command Centre (RCC) System Escalation Call to provide system pressures/actions including ambulance delay position. Midlands Region UEC monitor all >120-minute delays throughout the day and contact ICB's for update and actions.

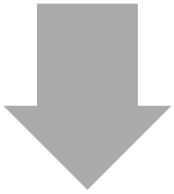


Appendix 2: Strategic/Intelligent Conveyancing Process



Appendix 3: Full Divert Protocol

The Requesting Acute Trust Director (On-Call OOH) must contact SCM for WMAS, ROM for EMAS to explore if a full divert (all ambulance conveyance) is required or strategic/intelligent conveyances (partial ambulance conveyance) will support relief of their situation. The requesting Acute Trust Director may like to consider hosting an All Acute Trusts Conference Call to explore and communicate their challenges. Other organisations will need to agree to a divert.



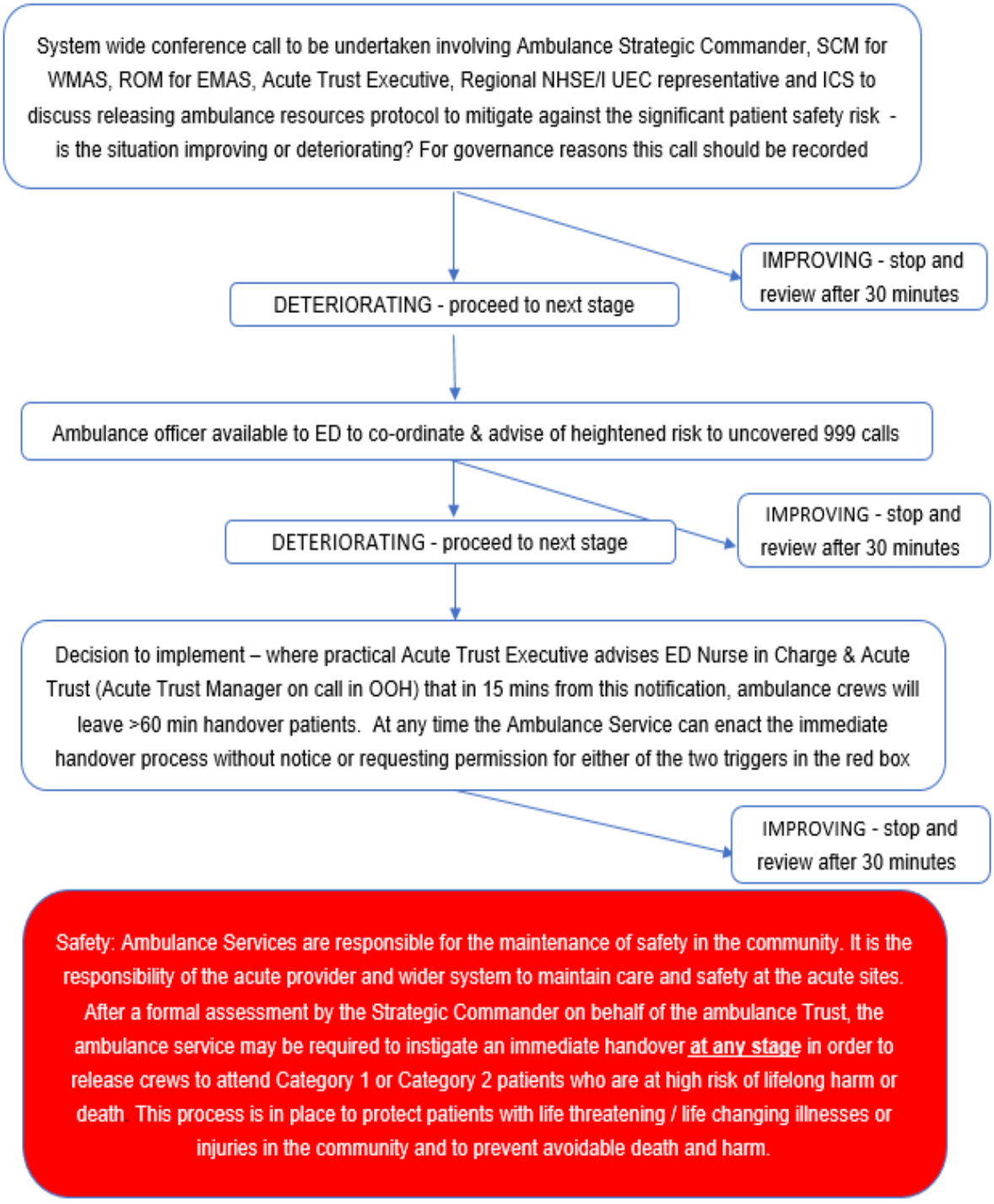
Once the full divert has been agreed to be supported by the SCM for WMAS, ROM for EMAS the Acute Trust Director (On-call OOH) must contact any potential receiving hospitals to request assistance to receive diverted ambulance conveyance activity. The Acute Trust Director must contact SCM for WMAS, ROM for EMAS to advise on outcome of request along with ICS (on call OOH)

Ambulance Services – Notification of the divert must be communicated to the ambulance crews (hospital diverting away from, hospital accepting diverted patients, agreed time frame, who to contact in EOC for clinical advice) in line with local policy. Adopting adherence to the exclusion criteria for the strategic conveyancing protocol unless the divert request is as a result of significant disruption to deliver business as usual e.g. fire, loss of diagnostics. Please note this is should be assessed on an individual basis for each divert requested. The request must come from an Executive from the organisation requesting the Divert. In the event of the divert effecting neighbouring Ambulance Services - Inform neighbouring Ambulance Trusts of Divert details and inform neighbouring Ambulance Trusts if the Divert is changed.

Acute Executive Director – Demonstrate a clear, robust actionable de-escalation plan to enable the hospital to be in a position to receive patients who are conveyed by ambulance. Regularly review the requirement to continue the divert during the designated timeframe and inform SCM for WMAS, ROM for EMAS, receiving Trust Director(s) (On-Call OOH) and ICS if the divert needs to be changed / terminated

Receiving Acute Trust Director (On Call OOH) - Ensure staff are briefed of the divert arrangement along with ensuring sufficient additional resources are provided to support additional patients. Maintain close liaison with the requesting Acute Executive Director to review impact of the Divert.

Appendix 4: Releasing Ambulance Operational Resource (Immediate Handover)



Appendix 5: Professional standards of care relating to patient hospital handover delays.

Professional Standards of Care for Patients Waiting in Ambulances

1. No patient should **ever** be kept waiting in an ambulance.
2. Delays cause harm. As such every delay should be escalated and acted upon immediately.
3. Any Trust or system having routine patient delays needs to act immediately.
4. It is equally unacceptable that patients are put at risk from lapses in IPC standards of care in Emergency Departments or to experience sub-optimal care in an inappropriate non-clinical area in ED

Core Principles if a delay occurs on any shift:

No patient should ever be held on an ambulance outside of a hospital. This practice is unsafe and causes harm.

The duty of care for a patient formally transfers from the ambulance service to the receiving hospital trust on arrival.

Ambulance services have a duty to safely convey patients as well as to attend patients in the community; they do not have a duty to wait and can enact immediate handovers if they must in order to maintain safety in the community.

Delays occur when departments are crowded – this is a Trust issue to resolve

i) Crowded departments are a Trust issue which need to be immediately resolved by the department and Trust
ii) Strict escalation occurs to ensure department leads, operations and executive (Chief Nurse, Medical Director and Chief Operating Officer in hours and on call executive out of hours) are ALWAYS aware of patients being delayed in ambulances. These leaders have a direct responsibility to ensure patients do not come to harm.
iii) Where delays are occurring which ED cannot resolve, a Trust should have a Full Capacity Protocol that immediately creates space in ED. No system should create a mitigation plan that rests with ED. Delays are a Trust and system problem which require an immediate Trust and System resolution.
iv) Any Trust who routinely delay patients being brought into the hospital should, with system executive, enact an extra-ordinary meeting to immediate enact plans for change.
v) Any patient who deteriorates/comes to harm who was delayed in an ambulance **must be** formally reported via DATIX for clinical investigation and executive review to ensure the delay didn't contribute to patient harm.

All events of actual harm **must be** reported on STEIS (incident reported system) by one of the providers following a collaborative discussion. In the event of any disagreement all events should be escalated to the CCG and NHS England / Improvement Quality team by both providers.

1

Minimum Care Safety Standards

These standards are mandated to ensure safety and risk mitigation is optimised at all times. Further basic care standards can be found in the NaSMed Standards.

1. All patients should be **booked in immediately** on arrival regardless of handover delays
2. Every patient should have an **initial assessment** by a competent Trust clinician **within 15 minutes of arrival** regardless of whether they are in the department or waiting outside it
3. The initial assessment must ALWAYS be performed **next to the patient**, NEVER by phone or via a handover.
4. After the initial assessment, **further assessments** by a competent Trust clinician should be performed after any deterioration and at least **every 30 minutes**. This will enable the receiving department's clinical leaders to consciously balance risk and maintain patient safety.
5. If a patient's condition deteriorates, the ambulance crew should escalate this immediately to the department they are waiting at AND to their own service. The receiving Trust is directly responsible for the care and safety of this deteriorating patient.
6. Patients held in ambulances should have **regular observations (and NEWS2)** performed by the ambulance crew **every 30 minutes** as a minimum.
7. Ambulance crews should document any and all actions, clinical interventions & communication performed by either themselves or by the acute provider until they leave
8. If a patient is delayed in the back of an ambulance they should be physically reviewed by a Hospital Trust **senior decision maker no later than 30 minutes** of arrival and this should be documented in the patient's hospital notes.

2

Appendix 2

To: Chief Executive Officers - all Integrated Care Boards
All Acute NHS Trusts and all Type 3 Providers (NHS and Private Providers)

cc. Chief Executives - all NHS Provider Trusts
Ambulance Services: Chief Executives
Chief Operating Officers
Medical Directors / Chief Medical Officers
Chief Nurses / Chief Nursing Officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

25 January 2024

Dear colleague,

Thank you for your ongoing work to support front line teams and deliver high quality urgent and emergency care for patients. We are very aware that the winter period has been particularly pressurised and exacerbated by several rounds of industrial action; and would like to thank you and your teams for their outstanding leadership throughout.

We are now almost halfway through delivering the two-Year Urgent and Emergency Care Recovery Plan, published in January 2023, and centred around two key deliverables for 2023/2024.

- Patients being seen more quickly in Emergency Departments (EDs): with the ambition to improve to 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

Significant progress has already been made, with four-hour performance better in every month this year compared to the same month last year; and category two ambulance response times in December significantly improved in comparison to last year.

However, there is more to do to ensure that the NHS delivers in full on these key public commitments by March 2024, and that plans to achieve these standards are implemented in full, as set out in the operational planning reset which took place in November 2023.

The **UEC Recovery Plan** establishes a programme of transformative improvement across the entire urgent and emergency care pathway and this work should continue at pace. In addition, and in the immediate term, it is also essential that every ED operates as effectively as possible to achieve planned performance levels this year, even with the current constraints many are experiencing.

Given this, we are writing today to ask that as a priority, Trusts review their own internal systems and processes to support their ED teams, ensuring as a priority that the initiatives described at Appendix A are in place.

We are aware that the best performing trusts and systems follow these approaches routinely, but a reminder that these priorities are (evidenced) ways in which consistent application delivers results. They are also the areas that we will place a particular focus on in terms of our oversight and support offers, which will include:

- **Access and instructions to optimise Getting it Right First Time (GIRFT) UEC data**, supporting identification of opportunities at system level related to the five initiatives set out above. These resources can be accessed through the Summary Emergency Department Indicator Table (SEDIT). If you have not already registered to the OKTA/Insight platform, please register at https://apps.model.nhs.uk/register. Once registered, login to your account using this link https://apps.model.nhs.uk/products. Scroll down to the bottom of the "Insight" home page and then press the button to "*request access*" to the SEDIT. Alternatively, please try this link SEDIT: Launch - Tableau Server (england.nhs.uk) which is bespoke for SEDIT access.

- **National Workshops (multiple locations).** NHS England national and regional teams will be running a series of workshops to expand on the five initiatives, including case studies supporting rapid implementation. Attendance is for an executive sponsor and a representative of the UEC pathway delivery triumvirate (operations, medicine, nursing). The sessions will also provide space for providers to discuss their plans,

constraints and support needed, whilst learning from one another. A summary of the events are set out at Appendix B below.

- **Virtual drop-in sessions.** NHS England will facilitate support and connection between colleagues as challenges are worked on together. This will include access to subject matter experts.

- **Improvement support pack.** The support pack at Appendix C includes resources and materials to assist with delivery of the initiatives outlined in this letter. A series of UEC improvement guides have also been designed for providers and systems to consider embedding as good practice to reduce handover delays. Resources include key principles for ED leaders to help create a positive culture and enable change.

  In addition to the support offer, we as a **Midlands Region** will continue to work closely with all systems and providers to ensure improved access for patients across the UEC pathway. The Midlands regional team will;

  - Maintain a performance focus on delivery of 4 hour and Cat 2 trajectories through a planned oversight meeting. Tier 1 systems [Shropshire, Telford and Wrekin (Shrewsbury and Telford Hospitals)] will be coordinated by National and regional colleagues, Tier 2 [Hereford and Worcester (Worcester hospital), Staffordshire and Stoke-on-Trent (University hospital North Midlands), Lincolnshire (United hospitals Lincoln & Boston), Northamptonshire (Northampton and Kettering hospitals)] will be led by the region (Regional Director and Regional Chief Operating Officer) and Tier 3 (Coventry and Warwickshire, Black Country, Birmingham and Solihull, Joined Up Care Derbyshire, Nottingham and Nottinghamshire, Leicester, Leicestershire and Rutland) will be coordinated by the regional team and systems. These interactions will oversee delivery, identify exceptions and agree recovery actions with systems and providers where required.

  - Continue to work with ICBs and providers to share good practice aligning support offers

  We would like to thank you in advance for your ongoing focus on delivering improved access for patients across the UEC pathway.

Finally, colleagues are reminded that providers with a Type 1 Emergency Department who can achieve better performance in the second half of the year are still able to access a share of a £150 million capital fund in 2024/25 to be used for local improvement projects

We hope this provides a clear way forward for the remainder of 2023/24, however should you have any further questions on the details included in this letter, or any of the individual components, please contact your NHS England Regional Performance and Improvement Director in the first instance.

We would like to thank you in advance for your ongoing support. We will be in touch in due course, with regard to next steps for your system and organisations.

Yours sincerely,

Sarah-Jane Marsh
National Director of iUEC
and Deputy Chief Operating Officer
NHS England

Dale Bywater
Regional Director – Midlands
NHS England

Appendix A: Five Priority ED Improvement Initiatives:

1. **Streaming and redirection:** A competently trained member of clinical staff should perform an initial assessment within 15 minutes of a patients arrival and be able to stream and redirect appropriate patients to an alternative service in line with the CQC Patient First framework. This is a tool providing practical solutions for all ED leaders to support good, efficient, and safe patient care. Planning for discharge from hospital services also should start at the point of initial assessment in ED.

2. **Rapid assessment and treatment (RAT)**: RAT is the most intensive form of initial assessment and incorporates both streaming and triage. A competently trained member of clinical staff should perform a rapid assessment within 60 minutes of a patients arrival to ED to reduce delay and support immediate referral where appropriate, and / or the initiation of required diagnostics and first line treatment. Where a specialty opinion is required, this must be available in a timely way.

3. **Maximising the use of Urgent Treatment Centres (UTCs**): All UTCs should be compliant with UTC standards and principles and where possible co-located with EDs and open for 24 hours a day. UTCs that are not co-located should be open for a minimum of 12 hours per day 7 days a week.

4. **Improving ambulance handovers:** EDs should ensure prompt assessment by a trained clinician as part of the ambulance handover process and perform regular care rounds which include fit to sit assessments. There should be adequate seated and cubicle capacity to meet the needs of patients, and executive oversight of the ambulance handover position must be in place, with timely escalation and associated actions to resolve delays. There is now clear evidence that timely handover is a whole hospital leadership issue and it must be approached as such. Planning to safely reduce avoidable conveyance: aims to support ambulance services, systems, and commissioners to safely reduce the number of patients conveyed to EDs. Leaders should familiarise themselves with the objectives and deliverables set out in the guidance and test where there is potential to go further.

5. **Reducing time in department:** We know that having too many patients in an ED is a serious risk to patient safety. Again, regular executive and senior clinical lead oversight is imperative so that all patients approaching the maximum waiting times are highlighted for escalation. It is also crucial that Same Day Emergency Care (SDEC), acute frailty services and other ambulatory capacity is not used for bedded care otherwise it is not possible to maintain flow. Use of ambulatory facilities also enhances the opportunity to discharge patients either to their usual place of residence or to a specialty bed.

Appendix B: ED Improvement Workshops in February 2024 (further details to follow)

1. Title: **ED Improvement Workshop**

2. What is it?

- Four events will be hosted, focussing on ED performance improvement.
- Events have been grouped by NHS region.
- Please attend the event for your region.
- If you are unable to attend on the preferred date, please consider attending one of the other sessions.

3. Dates, Times, and Venues:

A. For colleagues based in the **Midlands**:

- **Date: 20th February** from 0900-1700.
- **Venue TBC**

B. For colleagues based in **London and East of England:**

- **Date: 27th February** from 0900-1700:
- **Venue:** Mary Ward House (27th), 5-7 Tavistock Place, London, WC1H 9SN

C. For colleagues based in the **South East and South West:**

- **Date: 28th February** from 0900-1700.
- **Venue:** Ambassador Bloomsbury, 12 Upper Woburn Place, Bloomsbury, London, C1H 0HX

D. For colleagues based in the **North East and Yorkshire and North West:**

- **Date: 29th February** from 0900-1700.
- **Venue:** Metropolitan Hotel, King Street, Leeds, Yorkshire, LS1 2HQ

4. Registration:

A **link to register** will be provided, along with the agenda and event details in our follow-up communications. The registration link includes venue, location, timings, dietary and access requests.

5. Who should attend?

- NHS Providers: one executive sponsor and one member of the UEC Pathway triumvirate.
- ICB's: Ideally the accountable individual/s for delivery of the 4 Hour Standard.
- Regional UEC leads
- ECIST regional and national leads
- GIRFT leads
- National UEC leads

Appendix C: Improvement Tool / Resources

Intervention area	Metric Focus	Tools or products in existence that will directly help a trust to focus on what to do to improve in this area in 4-6 weeks. *"How" not "why".*
Streaming & Redirection & Initial Assessment	Time to initial assessment % patients streamed 100% 4HS Type 3	• Maturity Index – streaming Maturity Index – redirection How to do a missed opportunity audit • ECIST Emergency department crowding and patient delays improvement guide • Effective Streaming presentation Case studies from Highest Performing on HHO delays • Case studies - Streaming and redirection
Senior Decision Maker & RAT (stationary and roving)	Seen within 60 minutes Time in Department admitted Time in Department non-admitted	• Case studies from Highest Performing on HHO delays. • Case studies - seen within 60 minutes interventions. • Pre-hospital Navigation and Access – Improvement Guide • ECIST criteria to admit audit tool and podcast • ECIST Emergency department crowding and patient delays improvement guide
Maximising the use of UTCs	>% patients attending Type 3 <% patients attending Type 1	• Maturity Indices: collocated UTC or equivalent (link below) Case studies from UTC programme • Co-located ECIST emergency department crowding and patient delays improvement guide
Improving Ambulance Handovers & Direct Access	>% ambulance handover 15 mins <% ambulance handover 30 mins	• Maturity Index - Ambulance Receiving Area AtED audit Futures resource on Direct Access & SPoA Pre-hospital • Navigation and Access, Fit to Sit – Improvement Guide Case studies from Highest Performing on HHO delays • Case studies - Ambulance receiving models
Reducing Time in Department - 12 hours & IPS & Escalation	<time in department for non admitted <time in department for admitted	• Maturity Index - operational comms and escalation • Maturity Index - Site management • Case studies from Highest Performing on HHO delays • Case studies - Operations, Leadership and Escalation • RCEM Best practise guide Nov 21-ECIST emergency department crowding and delays improvement guide

If you would like access to any of the documents described above, please contact us at england.universalsupportoffer@nhs.net

Appendix 4

To:
- Ambulance Trust Chief Executives

cc.
- NHS England Regional Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 January 2024

Dear colleagues

Re: UEC Tiering and Improvement Support

Following the publication of the delivery plan for recovering urgent and emergency care in January 2023, we wrote to you in May 2023, identifying that your Trust had been allocated into one of three tiers, determining the level of improvement and oversight required to achieve your contribution to the key ambitions. Allocation into tiers was regionally led, based on local insight and performance, and evidenced by data.

Within the plan two key targets were set for 23/24:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

In December 2023, a review was undertaken of the approach to supporting ambulance trusts that were initially allocated to Tier 1 and 2. The review concluded that there has been good progress made in areas such as resourcing, use of clinicians in the control room and care coordination. In addition, the involvement of ambulance services in the systems placed in tier 1 and 2 for UEC performance, working alongside other system colleagues, has led to improvements.

Whilst this improvement was marked, there is still further progress required to improve Category 2 response times and we expect ambulance services to contribute to the development and innovation of system plans, especially where patients are experiencing longer ambulance response times. In practice, this will mean ambulance services joining system discussions, particularly where they are in Tier 1 and 2 for urgent and emergency care. In order to allow for this focus, we have decided to pause the tiering of ambulance services with immediate effect, meaning tiering status has now been removed from the South West, East Midlands and East of England ambulance services.

There are, of course, still areas for operational improvement across ambulance service footprints that are in control of the ambulance services alone, and we are considering options for how to facilitate this. For example, an ambulance trust collaborative to identify good practice and reduce unwarranted variation. If you have any thoughts on how we might best take these forwards please share them via Marc Thomas, Director for Out of Hospital UEC at Marc.Thomas1@nhs.net.

We know you remain focused on delivering the ambitions outlined in the delivery plan for recovering urgent and emergency care and we look forward to supporting you in achieving these goals in the most effective way.

Yours sincerely

Sarah-Jane Marsh
National Director of iUEC and Deputy Chief Operating Officer.

NHS England
Medical Directorate
5th Floor (5W52)
Quarry House
Quarry Hill
Leeds LS2 7UE

Gateway Reference: 07388

To: Trust Chief Executives
CCG Accountable Officers
Local A&E Delivery Board Chairs

15th November 2017

Re: Addressing ambulance handover delays

Delays in handover of patients from ambulance services to Emergency Departments (ED) result in:

- increased risk to patients on site due to delays in diagnosis and treatment;
- increased risk in the community because fewer ambulances are available to respond;
- the ability to respond to a serious or major incident being seriously compromised; and
- reduced ambulance response performance due to time wasted queuing.

Ambulance handover delays can be a symptom of system-wide issues, a mismatch of capacity and demand and inadequacy of patient flow. As such, handover delays must be recognised as a system wide responsibility. All organisations must co-operate to ensure effective working at the interfaces of healthcare organisations.

Last winter (2016-17) saw record numbers of delayed hospital handovers across the NHS. It is therefore timely to restate the expectation that delayed ambulance handovers should not occur. In renewing our focus on this issue, it will become a sentinel indicator for both winter monitoring and on an ongoing basis

The attached guidance '**Addressing ambulance handover delays: Actions for Local A&E Delivery Boards**' sets out the main points from recent guidance documents, and separates them into actions to be embedded as part of normal working practice, and actions to be taken should ambulances begin to queue. This summary is not exhaustive and Local Delivery Boards should refer to more detailed guidance from NHS Improvement and the Royal College of Emergency Medicine as referenced.

There are 4 key principles that local systems should note:

- The patients in the urgent care pathway who are at highest risk of preventable harm are those for whom a high priority 999 emergency call has been received, but no ambulance resource is available for dispatch.

- Acute Trusts must always accept handover of patients within 15 minutes of an ambulance arriving at the ED or other urgent admission facility (e.g. medical/surgical

assessment units, ambulatory care etc.).

- Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is inappropriate.

- The patient is the responsibility of the ED from the moment that the ambulance arrives outside the ED department, regardless of the exact location of the patient.

We expect that all local A&E Delivery Boards should therefore ensure that all measures to reduce the impact of handover delays are embedded in normal practice; and Regional Directors will want to be reassured that appropriate measures are a fundamental component of local winter escalation plans. In the development of these plans, lead ambulance commissioners should be fully engaged, and provide a link between A&E Delivery Boards, STPs, CCGs and Regional Leads.

Yours sincerely,

Professor Keith Willett, FRCS, FRCS(Ed), CBE
Director for Acute Care, NHS England

Professor Jonathan Benger**,** MD FRCS DA DCH DipIMC FCEM.
National Clinical Director for Urgent Care, NHS England.

Pauline Philip
National Director of Urgent and Emergency Care

Addressing ambulance handover delays: Actions for Local A&E Delivery Boards

A. Actions to be taken now, and embedded as part of normal working practice to reduce the likelihood of delays

To reduce the likelihood and impact of ambulance handover delays, Local A&E Delivery Boards should ensure that:

Acute Trusts and Ambulance Trusts

1. Must appoint a senior lead, directly accountable to the Trust Board, to oversee the development and implementation of clinical handover protocols for acute departments. These protocols should have a focus on patient safety and hence the need to minimise delays to assessment and treatment.

2. Must avoid the use of ambulance trolleys and ambulance staff to queue patients in a corridor or other areas of the ED or Admissions Unit, including Ambulance Triage areas where these are used. Patients should be transferred to a hospital trolley on arrival and hospital staff allocated to provide safe care to these patients.

3. Must avoid the use of ambulance trolleys for patients who are 'fit to sit', and should move them to a chair if appropriate. This can expedite investigations and facilitates discharge assessments. Such an approach assists greatly the use of ambulatory care pathways and reduces the demand on trolley/cubicle spaces. Hospital staff including handover staff, and ambulance staff should be made aware of the fit to sit guidance and a clinical champion appointed to see that this is being implemented.

4. Must book patients onto the Hospital PAS or ED PAS system when the patient first arrives in the department.

5. Must ensure that handover standards are applied consistently where patients are transferred directly to admissions units and other clinical departments.

6. Must have an agreed protocol for the timely escalation of handover delays with established warning and trigger responses. This should include a clear policy to manage waiting ambulances safely with regular risk assessments and required actions in order to deliver a safe waiting environment for patients.

7. At no time should a patient be kept in an Ambulance outside a hospital.

Commissioners:

8. Must facilitate ambulance services and acute hospitals working together and with partner organisations at STP level to agree effective escalation procedures and interventions for periods of high demand, and agree trigger and response mechanisms. HAS screen information may be a useful source

for local monitoring and escalation.

9. Should ensure that they fully understand where high demand increases are being generated from, and take appropriate action to assist in reducing demand growth, for example high 111 referral rates to 999, high volume frequent users and other sources of demand resulting from alternative access to services.

10. Must ensure ambulance services have in place regional capacity management systems to be enacted when queues develop. These should provide information to hospitals and ambulances services to know capacity in real-time and include processes for diverting patients at times of significant pressure. This allows clinicians and managers to make better informed decisions about patient care and use of alternative care pathways.

11. Should improve general practice input to care homes to reduce unnecessary conveyance and implement care home navigators as a matter of urgency. These should be provided 24/7 or over extended hours wherever possible.

12. Must ensure that there are a wide range of referral options within the community that 999 and the Clinical Assessment Service (CAS) supporting NHS 111 can use as an alternative to the ED. This could include frailty services, ambulatory emergency care services, falls services and urgent treatment services. These should be provided 24/7 or over extended hours wherever possible.

GP practices:

13. Must ensure prompt telephone access for ambulance crews to make contact with a patient's own GP surgery before deciding whether to convey, as access to advance care and end-of-life plans, advice or urgent GP review may avoid the need for conveyance and hospital attendance/admission or enable direct referral to the medical or surgical take teams.

14. Should take measures to avoid referred patients arriving in surges as a result of all domiciliary visits, and thus conveyance requests, taking place after morning surgeries. This severely inhibits the ability of ambulance services to convey these patients in a timely manner and practices should have plans in place to run visits throughout the morning, as opposed to batching them.

15. CCGs and GPs should work together with the CCG being responsible for overseeing the daily schedule of GP visits from all surgeries to ensure that large numbers of Ambulances do not arrive together.

Community Services:

16. Should have rapid response teams to see patients in their own homes. Best practice is for teams to reach patients within 60 minutes of a request, and never longer than two hours.

Ambulance services:

17. Should implement electronic patient handovers. These must be available to ED staff within 15 minutes of arrival.

18. Must share predicted activity levels with Acute Trusts on an hourly and daily basis to trigger effective escalation when demand increases.
19. Must put in place measures to enable safe reduction of conveyance to the ED, as set out in the 2017-19 CQUIN.

B. Actions to be taken when ambulances are predicted to queue or are queuing

Ambulance trusts:

1. Should escalate all handovers exceeding one hour to the on-call executive director of the responsible acute hospital trust and CCG director on-call.

2. Should consider the range of vehicles in their fleet to convey patients to the emergency department, but only where it is safe and appropriate to do so.

3. Reassess clinically appropriate alternative options to emergency department transfer.

Acute trusts:

4. Must enact an handover escalation protocol where time to handover is exceeding 30 mins. This should include contacting the on-call Hospital Director so that immediate action can be taken to release ambulance resources. Where time to handover is exceeding 60 minutes, the on-call CCG Director and on-call NHSE Director must be contacted and those individuals should put in place whole system local escalation processes to release ambulance resources. Over winter the regional winter on-call Director should also be informed 24/7.

5. Must not place restrictions on ambulances in order to limit or regulate access to the emergency department or the handover of patients arriving by ambulance.

6. Should report ambulance handover delays at site-wide bed meetings in order to ensure that there is a whole system response when required.

7. Must ensure that all patients handed over from the ambulance service are managed in a clinical setting that reflects their acuity as assessed by prompt triage. This action is often referred to as ‘cohorting’. Cohorting should occur after assessment to ensure departments are fully aware of the acuity and needs of each patient and any attendant risks.

a. Areas used for cohorting must have appropriate equipment and facilities to maintain patients' privacy, dignity and safety at all times.

b. All cohorted patients must receive regular review and be subject to an ED safety checklist.

c. Escalation plans should include how the extra nursing staff required for any cohort area will be met. Ambulance staff (or managers) must not be used to look after cohorted patients.

8. Must put in place a clear process for reporting significant clinical concerns by staff and carers.

9. Must ensure that where normal processes are delayed the effects of such delays are mitigated by pre-emptive interventions (where appropriate) and investigations such as blood tests, ECGs, X-rays and CT scanning.

10. Must raise an SI for all incidents where a handover greater than 60 minutes has occurred.

Emergency Department staff:

11. Should assess the 'pre-alert' information provided by paramedics regarding acute severe injury or illness patients so they can anticipate resource utilisation.

12. Should undertake regular reviews whenever at or near full capacity. A serious handover problem is sufficient reason for escalation of the issue to senior managers and executive officers.

13. Ensure prompt referral for in-patient care as soon as it becomes clear that admission will be necessary.

References:

- *Zero Tolerance. Making Ambulance delays a thing of the past*. NHS Confederation in association with the Association of Ambulance Chief Executives. 2012.
- http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Zero_tolerance061212.pdf
- Reducing patient handover delays from ambulances to hospitals, DH 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/126787/Ambulance-handover-delays-19062012-gw-17718.pdf.pdf
- Tackling Emergency Department Crowding, RCEM 2015 www.rcem.ac.uk/docs/College%20Guidelines/5z23.%20ED%20crowding%20overview%20and%20toolkit%20(Dec%202015).pdf
- Quick guide: clinical input into care homes, NHS England 2016 http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf
- Patient Flow Guidance, NHS I, 2017 https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/
- 2017/19 CQUIN https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/
- Ambulance handover: tactical advice to hospitals and ambulance services, NHS I 2017
- https://improvement.nhs.uk/uploads/documents/ECIP_Reducing_Ambulance_Handover_Delays_March_2017.pdf
- Fit to Sit, NHSI, 2017 https://improvement.nhs.uk/resources/are-your-patients-fit-sit

NHS England

Appendix 7

Improving Ambulance flow outside Emergency Departments

Rapid handovers

This document covers the key information around the process of rapid handovers at Acute Trust sites across the Midlands Region.

The requirement for a rapid handover occurs when there is an imbalance of risk between the Acute Emergency Department and the unsighted patients awaiting an Ambulance 999 response in the community

There is an expectation that Ambulance providers, Acute Trusts and ICB's will work within their systems to ensure that patient safety is maintained as a priority and that consideration is also given to the pressures being experienced at Trust/site levels such as ongoing critical incidents before initiating any rapid handovers.

This process is overseen by Ambulance service providers when the risk in the community is substantial and should not be used as a business-as-usual policy.

Criteria to initiate rapid handovers at Emergency Departments.

To initiate rapid handovers, trigger 1 should be met along with 1 other trigger:

1. No handover completed within a 45 min period (excluding alerts and paediatrics)
2. Between 5-15 Ambulances being held at the Acute trust site depending on site. See appendix 1 and 2 for more information.
3. Ambulance Trust holding >60 Category 2 calls within the East/West regions of midlands.
4. Longest waiting category 2 call in the region >40 minutes per system.
5. Patient being held on the back of an Ambulance or cohorted by an ambulance resource excluding HALO's for more for more than 6 hrs.
6. In the event of a major incident standby/declared for the ambulance service there is an expectation that all ambulances held will commence the immediate handover process to enable a response to the incident.

Rapid handovers at Emergency Departments

Request handover of 2-4 Ambulances to support patient care in the community and C2 performance.

Rapid handover:

1. Instigated by Ambulance Service ROM/SCM
2. Clear methods of communication should be sustained throughout process to ensure risk is spread across system- Hospital Ambulance Liaisons Officers should be included in these conversations.
3. Call ED via Site manager/CSM and a clinical conversation held to understand joint risks.
4. Ambulance service ROM/SCM and HALO on site should work with Acute trust to identify appropriate patients to be offloaded.
5. Once agreed advise that rapid handovers will be taking place due to following reasons (no handover seen within a 45 min period and 1 other of the rapid handover trigger points).
6. Any requirement for more than 4 rapid handovers per hour will require ICB/Trust executive sign off.
7. Normal procedures will continue for any C1 immediate off loads.

Rapid handovers at Emergency Departments for Ambulance services

Escalation process:

1. Escalate to CSM/site manager the requirement for rapid handovers after clinical conversation has taken place.
2. Escalate to Acute Trust site manager (if above fails)
3. Escalate to Acute Trust exec on call (if above fails)
4. Ambulance service should be liaising with System Command Centres or on-call managers throughout this process for system oversight and to enable ICB clinical officers to have oversight of system risk to help make an informed decision based on patient safety.
5. Escalate to ICB on call if step 1,2 or 3 does not resolve the issue.
6. If handover still does not take place, log accordingly
7. Escalating for response to the NHSE UEC Operations Lead within working hours for oversight of region. Out of hours the 1st on call for NHSE should be escalated too for a response.
8. Once maximum rapid handovers (4 patients) have been conducted at an Acute Trust a reset time of 1 hr is required to allow the site to manage the patients and ensure that safety of the site is being balanced along with safety of the community.

Clear communication between ambulance service and Acute trust is required to ensure safety of all patients in the system are taken into consideration.

Please note the rapid handover process does not replace normal handover procedures and should only be initiated at times of immense pressure when all else has failed to protect the unsighted risk to patients in the community.

Liaise with System Command Centres or on-call managers throughout this process for system oversight and to enable ICB clinical officers to have oversight of system risk to help make an informed decision based on patient safety.

Clinical discussion of the current or emerging situation to take place.

Ambulance Service escalates to CSM/ Site Manager requesting Rapid Handovers.

Rapid Handovers Confirmed

Rapid Handovers Declined

Escalate to Acute Trust/ICB Exec (On Call)

Rapid Handovers Confirmed

Rapid Handovers Declined

Handovers take place

Escalate to NHS UEC Ops Lead or First on Call

Once maximum rapid handovers (4 patients) have been conducted at an Acute Trust a reset time of 1 hr is required to allow the site to manage the patients and ensure that safety of the site is being balanced along with safety of the community.

Clear communication between ambulance service and Acute trust is required to ensure safety of all patients in the system are taken into consideration.
Please note the rapid handover process does not replace normal handover procedures and should only be initiated at times of immense pressure when all else has failed to protect the unsighted risk to patients in the community.

Appendix 1

WMAS weighting per site:

Tier	Number of delayed resources on site	Site
One	5	County, George Elliot, SWFT, Walsall Manor, Hereford, Burton
Two	7	RSH, PRH, RHH, Sandwell, AGH, GHH, City, Worcester
Three	10	New Cross, Heartlands, QE
Four	15	Stoke, UHCW

Appendix 2

EMAS weighting per sites:

Tier	Number of delayed resources on site	Site
One	5	CRH, Burton (including WMAS crews)
Two	7	RDH, ULHT (combined) NGH, KGH
Three	10	LRI, NUH

Signature page ICB chief operating officers/delivery officers:

- Birmingham and Solihull-
- Black Country-
- Coventry and Warwickshire-
- Derby and Derbyshire-
- Hereford and Worcestershire-
- Leicester, Leicestershire and Rutland-
- Lincolnshire-
- Northamptonshire-
- Nottingham and Nottinghamshire-
- Shropshire, Telford and Wrekin-
- Staffordshire and Stoke-on-Trent-

Signature page Ambulance Service Director of Operations:

East Midlands Ambulance Service-

West Midlands Ambulance Service-

Thank You

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Action No	Action	Funding	Achievement Date	Responsible	Operational Hours	Supporting Files	Performance Gains in Min	Progress and Actions - 16th FEBRUARY 2024	Progress and Actions - DATE TO BE CONFIRMED	RAG Status
1	Establish an Operational oversight board		Mar-24	CEO	N/a	To follow	Oversight of achieving targets.	This group will be established, reportig into EMB and the Performance Committee. Terms of Reference and membership will be drafted, and it is proposed to meet fortnightly.		
2	Identify the number of staff required to compensate for hospital delays and update the 2024/25 Recruitment Plan reflecting that number.	Yet to be agreed by the Trust Board	Mar-24	Nathan Hudson,	On average, 20,403 hours a month are lost to hospital delays. To compensate for this, 327 WTE clinicians are required in addition to the current workforce planning strategy.	Action 1 - Recruitment	Cat 2 mean performance 20 min _	**16th February 2024** Each cohort of 42 places will provide an additional 1,260 operational resourcing hours each week to operations, working on 1 WTE = 30 hrs (after average abstraction rate). SP Cohort 1 - Operational 2nd September 2024 - 42 Places SP Cohort 2 - Operational 28th September 2024 - 42 Places SP Cohort 3 - Operational 23rd December 2024 - 42 Places SP Cohort 4 - Operational 27th January 2025 - 42 Places SP Cohort 5 - Operational 24th February 2025 - 42 Places **Total: Currently planned for 210 Student Paramedics within the 2024/25 financial year.** Grad Para 1 - Operational 28th October 2024 - 42 Places Grad Para 2 - Operational 25th November 2024 - 42 Places Grad Para 3 - Operational 24th February 2025 - 42 Places Grad Para 4 - Operational 24th March 2025 - 42 Places **Total: Currently planned for 168 Cohort Paramedics within the 2024/25 financial year.** Internal AAP 1 - Operational 26th October 2024 - 42 Places Internal AAP 2 - Operational 25th November 2024 - 42 Places **Total: Currently planned for 84 AAPs (Tech Courses) to be operational within the 2024/25 financial year.**		
3	Review the following deployment criteria for HART resources to maximise efficiency.: - Team Leaders - The Minimum Attendances at specific incidents - Dispatch Requirements for HART Crews within BAU	No funding implications	To be agreed	Jeremy Brown, James Williams	This will provide an additional 2-3 HART RRVs (dependent on staff on duty) per shift, for responding to any operational business as usual cases. Their aim being to discharge as many patients on scene as possible, preventing the requirement for a DCA to attend. This provides an additional 22.5hrs of operational resourcing for each shift; 50 additional hours of operational resourcing every 24 hours; 350hrs of additional resourcing each week, compared to the current output.	Action 2 - HART Deployment		**16th February 2024** It is recognised that the trusts Hazardous Area Response Team (HART) currently provides a response model to specialist operations or to deployments within the scope of deployment for the HART Team. Following a strategic review of the resourcing, HART could provide additional support to E&U Operations outside of specialist taskings. The below proposed response model has been produced. If approved, this response model will be reviewed again in 2025 when the HART RRV's are due for decommissioning. HART are required to respond to HART taskings within 15 minutes of the being identified, therefore the Team Leader vehicle and the Recce vehicle will remain on station ready to respond to these incidents. All other on duty assets will be dispatched to any category of call with the aim of discharging the patient on scene, along with supporting the Bariatric & Operational Support Vehicles in preventing the need for double crewed ambulances to attend. Duty assets excluding the HART TL and the Recce vehicle will still be dispatched to category 1 calls (auto dispatch) and other emergencies whereby Paramedic intervention is required. This should be BAU no matter of REAP or surge status. The HART RRVs will be deployed and respond within the Birmingham sector, instead of the Black Country sector. The Birmingham sectors dispatch desks will work collaboratively with HART RRVs to identify cases that patients are likely to be discharged at scene.		
4	Reduce the number of resources sent per incident (RPI).	No funding implications	To be agreed	Jeremy Brown	Whilst WMAS already achieves a low number of RPI, further focus will maximise the availability of the resources on duty.	Action 3 - RPI		**16th February 2024** By reducing the number of resources per incident, and by selecting which resource type attends certain cases (safeguarding double crewed ambulances for Category 2 incidents), we aim to improve operational performance by committing emergency double crewed ambulances to incidents with patients that are likely to require conveyance. To reduce the Resources Per Incident, the below recommendations are made to improve the efficiency of our resources: •Change to Operational Manager deployments as outlined below, ensuring that they are HUB based for impactful workforce support. •Reduction in Operations Manager deployments in the role of Operational Commanders, utilising the TCCC where appropriate, reducing the requirment of commanders to attend scene, dependent on the information and intelligence gathered. •Ambulances are not to be deployed to any cases unless an actual patient is identified. •Operational crews are not to complete Patient Report Forms upon attendance at cases where no patients are present or identified (for example, a non-injury RTC or a No Sign of Incident case). •We are currently also reviewing whether repositioning the seating within the EOC to a pod-based layout would be effective, to support decision making on the number of crews that are sent to an incident (such as a Cardiac Arrest).		
5	Review the Dispatch Protocols for incidents which have no patients reported.	No funding implications	To be agreed	Jeremy Brown, James Williams	Maximise the availability of resources on duty by reducing unnecessary attendance			To apply a no send policy to incidents with no patients. This will be monitored by incident command.		
6	Review the OM Dispatch Protocols to increase the availability, and therefore capacity of managers, to manage the Hub.	No funding implications	To be agreed	Jeremy Brown, Nathan Hudson	This recommendation does not provide any direct additional operational resourcing hours, but will maximise the availability of resources either on duty, or planned to be on duty. It creates capacity for frontline managers to robustly manage abstractions such as sickness, and supports the timely booking on of crews during peak change-over. A dashboard is being designed for each OM to review their own Hub's Live Performance in relation to On Scene Times, Mobilisation Times etc, to improve their ability to manage, monitor and improve their Hub's performance.	Action 5 - OM Deployment		**16th February 2024** To ensure our operational workforce are well managed, abstractions are significantly reduced, and that local Hub level performance is as efficiently managed as possible; the deployment criteria for the Operations Managers has been reviewed as outlined below. •Operations Managers are removed from Automatic Category 1 Allocations •Operations Managers are deployed by the Category 1 Desk to Confirmed Cardiac Arrests with CPR in Progress, with the closest responding resource over 15 minutes away from the incident location (and with the OM showing within an 8-minute response). Operations Managers will continue to be deployed immediately, as operational commanders to the below incident types: •Major Incident standby/declared. •MTA/CBRN incident •Explosion •Full emergency BHX/aircraft incidents •Fire PDA •ICE incidents •Corrosive substance attack •Confirmed Firearms incident. •Trust vehicle RTC with injuries reported. •Significant RTC with multiple serious injuries suspected or confirmed. •RAMP flights •Paediatric Cardiac arrest / SCIP completion required. •Any incident requested to attend by TCCC.		
7	Review the role and duties of the HALO	Potential funding implications	To be agreed	Michelle Brotherton	There is potential for HALO's to increase the availability of operational crews on duty, by monitoring and managing crews whilst at hospital.	Action 6 - HALO	Linked to action 9	Substantively employed HALOs with a permanent contract of employment will continue, however all other secondments etc will end on 31st March 2024 and return to operational duties.		
8	Review of the Ambulance Decision Areas Provision	Potential funding implications	To be agreed	Michelle Brotherton	Ensure the duties of WMAS staff provide the maximum contribution to responding to patients as quickly as possible.	Action 7 - ADA		All ADAs will cease on 31st March. The Paramedics will return to their substantive operational role. The PTS staff will return to their operational role. Any other staff will also return to their substantive role. All of the AHCAs will be met with to either return them to their substantive roles, or offer permanent contracts in other roles, including on PTS operations, PTS control, EOC, VPO, Technician & Paramedic patways.		
9	Meet establishment template for PTS recruitment	To be confirmed by Michelle Brotherton.	To be agreed	Michelle Brotherton		Action 8 - PTS Recruitment		**16th February 2024** A report from Michelle Brotherton on the overview of current NEPTS vacancies can be found in the action plan folder. PTS recruitment is progressing at pace, and will be supplemented by staff on secondment returning to PTS operations by 31st March.		
10	Review the patient flow procedures and initiatives at all Acute Trusts to identify best practice and improve hospital turnaround times	No funding implications	To be agreed	Michelle Brotherton	Reducing the hospital turnaround time will maximise the availability of operational crews.		15 min Cat 2 mean performance _	There is a requirement for hospital handovers to improve for 24/25 for sustained improvement in performance, Work will continue with ICBs, throughout the course of the year with a focus on freeing up resourcing. A separate action plan is required which will be inputted into this action.		
11	Review the availability of fleet and the efficiency of current Make Ready Processes	To be confirmed by Nathan Hudson	To be agreed	Nathan Hudson	There is potential to increase the availability of fleet by creating more efficient processes in the Make Ready Operation, reducing the time crews wait for a vehicle at the start of their shift.	Action 10 - Fleet	2 min on Cat 2 mean Performance _	**16th February 2024** As of 14th February 2024, there are 453 Emergency DCA Ambulances owned by the trust. This can be further broken down to: •16 4x4 Mercedes Ambulances •15 Bariatric Ambulances •422 Standard Emergency Ambulances. There are a further 25 Emergency Ambulance vehicles due for delivery into E&U Operations by the end of March 2024. These vehicles are profiled for late crews, 1100 onwards, to help achieve Category 2 Performance. Coventry - 4 Erdington - 4 Hereford - 1 Hollymoor - 4 Stoke - 5 Tollgate - 1 Warwick - 1 Willenhall - 4 Worcester - 1 A workstream is currently underway to review how we can make the Make Ready process more efficient, whilst balancing the requirements for ambulances to be fully stocked on deployment each shift. This review is looking at a Rapid Restock model, where operational resources during the day are restocked when they return for meal break, to reduce the lost hours between day to night shifts. This workstream is underway to look at what hours this could return to operational resourcing. Make readies could be done at break times and reduce the number required to make ready of a night time. An extra 20 ambulances have been requested at a cost of £3.5 million pounds.		
12	Review the Alternative Duties Roles and Processes	No funding implications	To be agreed	Nathan Hudson	Explore opportunities for staff on alternative duties to support frontline operations more, with the aim of reducing lost hours and maximising the availability of resources to respond to patients.	Action 11 - Alternative Duties		**16th February 2024** There are currently 25 staff on general alternative duties and 46 staff on maternity alternate duties. A review is currently underway to identify what work activities would be safe for those staff members to undertake which focuses on reducing lost hours or improving operational response and performance, instead of administrative type duties, as an example. This will be assessed and managed on a process where key decisions relating to the individual are considered.		
13	Review Secondments for those staff not working in Operations, with the aim of returning those staff to operational duties.	To be confirmed by Nathan Hudson	To be agreed	Nathan Hudson	Summary – Secondment Hours Returned to EU Operations WEEKLY Cohort Paramedics – 828 Hours (27.6 WTE) Research Paramedics – 150 Hours OSD – 150 Hours Patient Safety – 120 Hours HALO – 480 Hours Other – 165 Hours Total – 2,055 Hours Weekly	Action 12 - Secondments		**16th February 2024** The below data summarises which members of clinical staff are currently working away from E&U Operations, on secondments around the trust. When calculating what operational hours are likely to be returned to frontline duties from 1 x WTE employed 37.5 hours a week, it is likely that 30 hours of operational duties will be returned each week per person. This is calculated on the current abstraction data (training, sickness etc) seeing on average 7.5hours lost per person per week. All secondmnets will end on 31st March unless agreed by the Director lead and CEO to continue.		
14	Reduce Operational Abstractions	No funding implications		Nathan Hudson	Maximise the availability of planned and on duty resources.			This will be monitored by the SOM and the Director of Performance Improvement. There is caution around the perception that not authorising time off means staff will turn up for shift. Losing staff to sickness for long periods of time, moral and the staff survey can be impacted without offering flexibility, and the ability to support our staff compassionately. One mangers compassion may be seen by another manager as weakness, however to ensure we keep the staff on board this will be monitored on a case by case basis with an overview from the director.		
15	Review Operational Resource Desk Function within EOC	No funding implications	March 31st	Nathan Hudson	5 staff returning to operations, resulting in approx. 187 of additional operational hours.			The aim is to withdraw this function from EOC. Staff will return to there current lines at the end of March. There are a number of reasons for this and although the operational lost hours has reduced with this function by 6,000 a month, the aim is that the changes we are making to the OM deployment,monitoring of downtime will return to the OM's on Hubs. Down time and resource management functions are being developed for each hub by the BI team for implementation March onwards.		
16	Review and analyse operational data	No funding implications	February 16th		Up to date intelligence is required to ensure efficient planning. This needs to be regularly reviewed to highlight any changes, so that operational output can be 'tweaked' to meet the new demand profiles and highlight any inefficiency			Analysis has been completed and the Activity in each County has been reviewed for CAT 2 performance improvement, in turn this has shown there is an activity imbalance, between the hours of 0900-1200 each day whereby there isnt enigh resources to meat the activity. Any source of new vehicles and staff will target these areas to prevent the stacking of patients which will improve CAT 2 performance, reduce the impact on meal break and hospital delays.		

WEST MIDLANDS AMBULANCE SERVICE UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 04 MEETING: February 2024 PAPER NUMBER: 02

2024-25 Capital Plan – for approval	
Sponsoring Director	Karen Rutter, Director of Finance
Author(s)/Presenter	Paul Jarvis, Deputy Director of Finance Karen Rutter, Director of Finance
Purpose	To propose a 24-25 capital plan for approval
Previously Considered by	EMB 20.02.24 Performance Committee 27.02.24
Report Approved By	Karen Rutter, Director of Finance

Executive Summary

The Black Country ICB has confirmed that operational capital funding will be top sliced to accommodate a mental health trust development. (see table below)

As a consequence of this decision, the Trust's capital funding for 2024/25 is now **£12.246m**

2024-25 Allocation of System Operational Capital				
	Top Slice	Core	Central	TOTAL
Trust	£000's	£000's	£000's	£000's
Dudley Group NHS Foundation Trust		6,170		6,170
Royal Wolverhampton NHS Trust		17,273		17,273
Walsall Healthcare NHS Trust		7,472		7,472
Black Country Healthcare NHS Foundation Trust	13,755	6,049		19,804
Sandwell & West Birmingham Hospitals NHS Trust		16,502		16,502
West Midlands Ambulance Service NHS FT		11,310	936	12,246
Dudley Integrated Healthcare NHS Trust		202		202
Total	13,755	64,978	936	79,669

Capital programme 2024/25

The total programme cost for 2024/25 is £26.741m. This includes the cost of maintaining the 5-year lifecycle for response vehicles and of replacing/upgrading elements of the HART fleet in line with national contractual requirements.

Capital programme 2024/25	
Fleet	24,382
IT	1,200
Estates	818
Contingency	341
Total	26,741

Funding the programme

In order to deliver the programme within available resources the Trust will utilise leasing as the financing mechanism for replacing DCAs.

The table below breaks down the programme into purchase and leasing components.

Capital programme 2024/25			
Expenditure	Buy	Lease	Total
Fleet	9,887	14,495	24,382
IT	1,200	0	1,200
Estates	818	0	818
Contingency	341	0	341
Total	12,246	14,495	26,741

The programme thus comprises: -

- Capital purchases £12.246m which is in line with capital resource funding
- Leasing solutions £14.495m for which funding arrangements are described below

Lease funding (IFRS16) in 2024/25

Since the adoption by the NHS of IFRS16, most leases have to be accounted for in a similar way to capital purchases.

A restriction on the amount of leasing that systems are permitted to undertake will apply for 2024/25. NHSE has confirmed this, but systems have yet to be notified of their allocation for this element.

It is understood that NHSE will assess the regional impact based on initial planning returns and use these to determine whether there is enough resource available to cover proposed commitments.

As part of the month 10 financial reporting data collection, NHSE requested, and were provided with, estimates of Trust's leasing requirements for next year. WMAS provided a return that reflects the anticipated replacement per the proposed lease programme.

At this stage, the ICB has advised that providers should ensure they accurately state their leasing impact assessment in their plans, as any additions or errors at a later date will need to be covered from their core allocation.

Key points

- A system limit will be set on leasing commitments and the ICS will be required to prioritise this in a similar fashion to capital expenditure
- Providers are required to accurately assess their lease commitments and include these within their draft 2024/25 planning returns
- The level of leasing expenditure limits is yet to be determined and is thus a risk given the Trust's proposed £14.495m leasing requirement
- The timing of notification of lease funding limits for 2024/25 remains uncertain and may not become known until the end of this financial year or beyond.

Details of the programme are at the end of this header document.

Related Trust Objectives/ National Standards	To deliver against strategic objectives. Maintain compliance with SFIs.
Risk and Assurance	. Expenditure will be committed on behalf of the Trust
Legal implications/ regulatory requirements	N/a
Financial Implications	Spend must be in line with available capital funding and it must be demonstrated that value for money can be achieved.
Workforce & Training Implications	Not directly applicable.
Communications Issues	Not directly applicable.

WEST MIDLANDS AMBULANCE SERVICE
UNIVERSITY NHS FOUNDATION TRUST

REPORT TO BOARD OF DIRECTORS

AGENDA ITEM: 04 MEETING: February 2024 PAPER NUMBER: 02

Diversity & Inclusivity Implications	The Trust obligations are set out in the Public Sector Equality Duty and the Equalities Act 2010. This paper is not directly affected by these regulations.
Quality Impact Assessment	Not directly applicable within the context of this paper.
Data Quality	All data and background documentation are held by finance and Fleet.

Action required

The Board are asked to:

- **Approve** the 24-25 capital plan as detailed in this paper
- **Note** that leasing component may be subject to later revision when lease resource limits are made available to systems and lease prioritisation by systems has been completed.

Appendix A – Capital purchase and leasing programme 2024/25

Capital purchase and leasing 2024/25						
Line items	Purchase		Lease		Total	
	Number	£000	Number	£000	Number	£000
Fleet						
DCA Conversion deferred 23/24		2,613				2,613
Subtotal		2,613		0		2,613
DCA 4x4						
Chassis	15	1,440		0	15	1,440
Conversion	15	1,530		0	15	1,530
Defibs					0	0
Other equipment	15	362			15	362
Subtotal		3,332		0		3,332
DCA E FORD						
Chassis			3	194	3	194
Conversion			3	450	3	450
Defibs					0	0
Other equipment	3	147			3	147
EV charger	1	66			1	66
Subtotal		213		644		857
DCA FIAT						
Chassis			55	2,097	55	2,097
Conversion			55	5,148	55	5,148
Defibs					0	0
Other equipment	55	1,364			55	1,364
Subtotal		1,364		7,245		7,245
DCA MAN						
Chassis	26			1,560	26	1,560
Conversion	26			2,444	26	2,444
Defibs					0	0
Other equipment	26	634			26	634
Subtotal		634		4,004		4,004
HART 4x4 Light						
Chassis	1	29			1	29
Conversion	1	76			1	76
Defib	1	18			1	18
Other equipment	1	6			1	6
Subtotal		129		0		129
HART Crew Carrier						
Chassis	1	62			1	62
Conversion	1	112			1	112
Subtotal		174		0		174
HART Crew Carrier PO Issued	1	47			1	47
Subtotal		47		0		47
HART Logistic Support						
Chassis	1	52			1	52
Conversion	1	62			1	62
Subtotal		114		0		114

Line items	Purchase		Lease		Total	
HART Response						
Chassis	1	58			1	58
Conversion	1	206			1	206
Defib	1	18			1	18
Other equipment	1	7			1	7
Subtotal		289		0		282
HART Response PO Issued	4	338			4	338
Subtotal		338		0		338
HART Welfare						
Chassis	1	94			1	94
Conversion	1	205			1	205
Subtotal		299		0		299
DISTRIBUTION						
Chassis			2	108	2	108
Conversion			2	156	2	156
Subtotal		0		264		264
FLEET						
Chassis	1	96			1	96
Conversion	1	144			1	144
Subtotal		240		0		240
MERIT Vehicles						
Chassis	1	53			1	53
Conversion	1	28			1	28
Defib	1	18			1	18
Other equipment	1	2			1	2
Subtotal		101		0		99
Other vehicles						
Cars			10	198	10	198
Major incident vehicles			2	346	2	346
DCAs			13	1,794	13	1,794
					0	0
Subtotal		0		2,338		2,338
Total - Fleet		9,887		14,495		24,382
IM&T						
General Computer Hardware		100				100
Critical Server Hardware		780				780
TG/MP/NP WAN		200				200
Paper free		120				120
Total - IM&T		1,200		0		1,200

Line items	Purchase		Lease		Total	
Estates (general)						
Sustainability - Hereford		188				188
Unit 2 UPS - 150K		150				150
Worcester roof - 100k		100				100
VPO Heater/BMS links		100				100
Bird Ingress measures		100				100
Various site upgrades		150				150
Building infrastructure		30				30
Premises lease remeasurements				TBC		
Total - Estates		818		0		818
Contingency						
General contingency		341		0		341
Total - Contingency		341		0		0
Grand Total		12,246		14,495		26,741