Adult Social Care and Health Overview and Scrutiny Committee

Date: Wednesday 27 April 2022
Time: 10.00 am
Venue: Committee Room 2, Shire Hall

Membership
Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor Richard Baxter-Payne
Councillor John Cooke
Councillor Tracey Drew
Councillor Peter Eccleson
Councillor Marian Humphreys
Councillor Christopher Kettle
Councillor Jan Matecki
Councillor Chris Mills
Councillor Penny-Anne O'Donnell
Councillor Pamela Redford
Councillor Kate Rolfe
Councillor Sandra Smith
Councillor Mandy Tromans

Items on the agenda: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

(3) Chair's Announcements

(4) Minutes of previous meetings 5 - 28
To receive the Minutes of the meetings held on 10 and 16 February 2022.

2. Public Speaking

3. Questions to Portfolio Holders

Up to 30 minutes of the meeting is available for members of the Committee to put questions to the Portfolio Holder: Councillor Margaret Bell (Adult Social Care and Health) on any matters relevant to the remit of this Committee.

4. Questions to the NHS

Members of the Committee are invited to give notice of questions to NHS commissioners and service providers at least 10 working days before each meeting. A list of the questions and issues raised will be provided to members.

5. Quarter 3 Council Plan 2020-2025 Quarterly Progress Report (April 2021 to December 2021) 29 - 40

This report summarises the performance of the organisation at the Quarter 3 position, 1 April 2021 to 31 December 2021.

6. Update on NHS Dental Services

Dental services was added to the committee's work programme on 16 February. NHS England & Improvement will provide an update to the Committee.

7. West Midlands Ambulance Service (WMAS)

(1) WMAS - Performance Update

The Committee received an update from WMAS on 17 November 2021. This item will provide an update on performance.

(2) WMAS - Quality Account 41 - 124

West Midlands Ambulance Service has invited the Committee to consider and comment upon its annual Quality Account.

8. More than a Hospital – UHCW Organisational Plan 125 - 144

To consider the organisational plan of University Hospitals Coventry and Warwickshire, which is included in the document pack.

9. Work Programme 145 - 152

To review the Committee's work programme for 2021/22.

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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A member attending a meeting where a matter arises in which they have a disclosable pecuniary interest must (unless they have a dispensation):

- Declare the interest if they have not already registered it
- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests relevant to the agenda should be declared at the commencement of the meeting.

The public reports referred to are available on the Warwickshire Web https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

Public Speaking
Any member of the public who is resident or working in Warwickshire, or who is in receipt of services from the Council, may speak at the meeting for up to three minutes on any matter within the remit of the Committee. This can be in the form of a statement or a question. If you wish to speak please notify Democratic Services in writing at least two working days before the meeting. You should give your name and address and the subject upon which you wish to speak. Full details of the public speaking scheme are set out in the Council's Standing Orders.

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Adult Social Care and Health Overview and Scrutiny Committee

Thursday 10 February 2022

Minutes

Attendance

Committee Members
Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor John Cooke
Councillor Tracey Drew
Councillor Marian Humphreys
Councillor Christopher Kettle
Councillor Jan Matecki
Councillor Chris Mills
Councillor Kate Rolfe
Councillor Mandy Tromans

Officers
Shade Agboola, John Cole, Becky Hale, Nigel Minns and Paul Spencer.

Others in attendance
Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Councillors Jo Barker, Jerry Roodhouse and Izzi Seccombe OBE, Warwickshire County Council (WCC)
Chris Bain and Robin Verso, Healthwatch Warwickshire (HWW)
Danielle Oum and Phil Johns (Chair and Chief Executive (Designate), Warwickshire Integrated Care System (ICS))
Rose Uwins, Coventry and Warwickshire Clinical Commissioning Group (CCG).

1. General

(1) Apologies

Apologies for absence were received from Councillors Penny-Anne O'Donnell (WCC), Pam Redford (Warwick District Council) and Sandra Smith (North Warwickshire Borough Council).

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Chair's Announcements

None.

2. Public Speaking

None.

3. Questions to Portfolio Holders

Councillor Tracey Drew asked the following question to Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health:

The NHS has a positive public profile, but relatively scant public attention is paid to Social Care services. Yet as we know social care support and systems play a vital role in caring for residents both preventing admissions to and speeding up discharges from in-patient stays.

How can we, locally, raise the public profile of social care and its vital role?

Councillor Bell agreed, paying tribute to the commitment, dedication, and hard work of social care staff, both within WCC and from the provider market. She noted that they did not get the same recognition and national press as NHS colleagues.

In today's climate of a shortage of carers, their value was even more evident. To start to rectify this imbalance, that had become more acute during the pandemic, it would be helpful to plan some communications activity, to help local citizens understand their often understated role in supporting the most vulnerable.

This would fit in with the living well campaign from the marketing and communications team, to raise awareness of the support on offer to adults and older people. A key strand of the campaign would be raising the profile of social care and all the work taking place in the local authority and in partnership with health.

The Council could play its part in the national recruitment drive to attract people into this much needed and valued area of work. She agreed to work with the WCC communications team to raise the profile of social care accordingly.

Councillor Chris Mills asked the following question to Councillor Margaret Bell:

As we are generally an aging population, I understand there is a lack of placements and care packages which delay discharge from hospital. I know of one patient at the rehabilitation unit in Leamington who has been waiting over two months for a placement now, despite being fit for discharge.

How can we as a Council/ Committee help in this situation as I'm sure there are many cases like this one?

Councillor Bell responded that this was a very timely question and outlined contributing factors of capacity for both social care and NHS professionals. The system was under pressure and gaps were being identified. She had met with key officers recently to identify solutions. Many of the issues were systemic and required a joint approach. She remained passionate that care at home was best, where it was appropriate. However, at the moment a more pragmatic approach was needed, to get the most value from staff by gathering people together in appropriate settings, to ensure they received the care and therapy they required. An update had been provided at the Health and Wellbeing Board (HWBB) and she offered to circulate a briefing note to the committee with further information.

4. Integrated Care System

A presentation was provided to the Committee by Danielle Oum (Chair) and Phil Johns (Chef Executive Designate) of the Warwickshire Integrated Care System (ICS). Danielle Oum commenced the presentation which covered the following areas:

- The next steps for health and care in Coventry and Warwickshire
    - National move to bring health and care organisations together into an ICS
    - Legislative proposals by the Government for a new Health and Care Bill, building on recommendations in the NHS Long Term Plan
        - This would establish a statutory ICS in each ICS footprint
        - Continuing progress through parliament – currently at committee stage in the House of Lords
    - Already working closely together as a Health and Care Partnership – this was a development of what was believed best for Coventry and Warwickshire
    - The earliest this would become a statutory ICS was July 2022
- What is different about an Integrated Care System?
    - Break down the barriers between organisations
    - Join up health and care more effectively to make a difference to people's lives
- The aims of the ICS
    - Improve outcomes in population health and healthcare
    - Tackle inequalities in outcomes, experience and access
    - Enhance productivity and value for money
    - Help the NHS support broader social and economic development
- Our Vision – 'We will enable people across Coventry and Warwickshire to start well, live well and age well, promote independence, and put people at the heart of everything we do'. This was supported by five key strands around enabling everyone to keep well, working together to tackle underlying causes of illness, providing the best possible care, use of technology and valuing staff.
- Danielle also spoke of empowering citizens to be involved in influencing priorities, a shift of focus from treating ill people to move towards health prevention, in a collaborative way with key partners and communities. An aim to extend both life expectancy and healthy life expectancy, promoting ownership and involvement. Further points about being an 'anchor institution', employment links and the opportunity to work together with aligned objectives.

Phil Johns spoke to the following slides:

- System, Place and Neighbourhood – a graphic showing the three layers and areas of responsibility. A number of examples were provided to 'bring to life' the work that was taking place and show the vision in practice.
- For the 'system' an example of improving access to services through the elective accelerator programme, an increase in appointments and new ways of delivering care.
- In the Warwickshire North Place, an example of using technology to improve health and care through remote monitoring. This included care home staff monitoring residents and where changes were identified, reporting this to GPs for intervention. This pilot was being rolled out across Coventry and Warwickshire and for certain conditions in residents' homes.
- An example from the Rugby place was enabling everyone to keep well, working with communities to address local needs. Story Circles was an initiative for group discussions, building on communities and shared experiences / support. It built on the compassionate communities' approach and was targeted to young people with mental health and wellbeing challenges, including hospitalisation through self-harm. It provided a voice and support for young people in accessing services, also with the aim of more tailored support going forwards.
- In South Warwickshire, an example about development of the primary care networks. This aimed at providing the best possible joined-up care, through developing the role of care co-ordinators. An example of the focus on cancer services providing personalised, expert and ongoing contact and support for cancer patients. It focussed on the experience of the individual and their pathway of care.
- How the system could fit together. A complex flow chart showing the connectivity between the Integrated Care Partnership (ICP) and Board, the respective HWBBs for Coventry and Warwickshire, care collaboratives, Healthwatch organisations and health scrutiny committees, amongst other bodies.
- What's next
    - Ongoing work to establish the strategies and governance, in collaboration with the population and stakeholders
    - The current timeline was that the Integrated Care Board (ICB) and ICP will come into being on 1st July 2022 and the statutory powers would transfer from the CCG to the ICB

Questions and comments had been invited from all WCC members in advance of the meeting. The following areas were discussed:

- Councillor John Holland welcomed the arrangement of this additional meeting and the plans for integration. He had submitted questions in advance which he presented with additional context regarding the Joint Strategic Needs Assessment (JSNA), challenges for ambulance services, which needed more integration with A&E departments and hospital discharge delays associated with the need for care packages to be arranged. The first question concerned the criteria for success or failure of the ICS and how it would be assessed. One measure was an increase in life expectancy, but recently data showed this was reducing.
- Phil Johns acknowledged the current ambulance handover delays. Monitoring could take place to see if such delays reduced under the revised arrangements. Of more significance was avoiding the need for hospital admission. There were a number of clear metrics which could be monitored. The discharge process would be reviewed, whilst monitoring the process could show levels of success. Mr Johns spoke about the patient experience and gathering feedback to inform the design of services. There were some areas outside the

remit of the NHS such as carers pay levels. People were being encouraged to take up roles in the NHS and care as the workforce aspects were key. Danielle Oum added about the need to work together at all levels to agree shared priorities and success criteria. This would need to include the public priorities too. In the first year of the ICS, agreement of the priorities and how they would be achieved could be a success indicator.

- Councillor Holland referred to the structure chart in the presentation, speaking about the role of the HWBB. Phil Johns confirmed there would be a two-way relationship between the HWBB and ICP.
- Councillor Holland was aware of concerns raised by a campaign group that the ICS may be linked to privatisation of NHS services. He asked for clarification of the relationship of the ICS and the private and voluntary sectors. Mr Johns confirmed that the relationship remained unchanged where some services were bought from the private and independent sector to add capacity. Danielle Oum added that the voluntary sector an important role to play. This included providing the voice and needs of the community whilst some organisations also delivered services.
- Nigel Minns provided context on the proportion of patients in hospital who were receiving support associated with discharge arrangements. The 103 people included some who lived out of county, people who had Covid, or could not leave hospital for safeguarding reasons. Around two thirds of this number were awaiting a care package. This was estimated at three percent of those in hospital. There were other reasons why people who were medically fit to be discharged remained in hospital but they did not require WCC assistance with a care package. However, discharge arrangements remained a problem. He also reminded that the vast majority of care provision was delivered by the private, voluntary and community sectors. These relationships were important as was their involvement on the ICP.
- Becky Hale spoke about providers, inflation and costs of care. The inflationary awards would be notified to care providers in the next week. A fair cost of care exercise would be undertaken collaboratively across Coventry and Warwickshire, as part of the delivery of social care reforms. This was a positive move over the next year to ensure a sustainable care market and was critical for the NHS too. She mentioned the report to the January HWBB on the commissioned workforce strategy and the measures which were being progressed to support the social care workforce.
- Councillor Rolfe sought more information about the remote monitoring initiative, its success, how this was measured and plans for rollout across Warwickshire. Becky Hale confirmed this was a successful pilot which was implemented in the Warwickshire North area. It involved care homes for older people and those for people with learning disabilities. The pilot was now being expanded to Kenilworth and Warwick with Rugby to follow in the coming months. Data showed the positive impact in terms of reduced hospital admissions from care homes. People in their own homes could access the service and there were plans to expand to other cohorts who would benefit from remote monitoring. The service was undertaken through a clinical hub as part of the out of hospital arrangements. A presentation was planned for a future meeting of the HWBB.
- In response to a follow up question from Councillor Rolfe, Phil Johns explained how the remote monitoring worked, through scripted questions and looking at vital signs, with the person in the home submitting data into a system.
- Councillor Bell added that a comprehensive presentation had been requested to the HWBB on all the technology solutions being used both in care homes and in the community.
- Chris Bain welcomed open dialogue established with Danielle Oum and Phil Johns. He spoke about the elective accelerator programme and asked how this could be achieved given the workforce challenges.

- Chris Bain raised issues referred to Healthwatch as key priorities. The first was mental health services in the community, difficulty of access and the impact this had on patient outcomes. Next, access to NHS dentistry had been a longstanding issue. In some areas, there were no NHS dentists and from survey feedback, the position was worsening. Healthwatch would like to know how the population and especially younger people could access NHS dentists. General practice was a further area where complaints were received. The issues were getting access, the technology challenges and the absence of face-to-face appointments. Finally, discharge from acute settings and the experience of carers was raised. There were some challenges from 'seldom heard' groups. Chris Bain closed by focussing on the complexity of the system and how to ensure the patient voice was heard at all levels of the system.
- Danielle Oum said it was important to develop a strategic approach, referring to the people and community engagement strategy. This would set out the principles for all bodies to build in patient voice to key decision making. She outlined how HWW would be involved actively or as an observer at all key levels, whilst ensuring their independence was not compromised. There were plans for a voluntary and community alliance to enable sharing of intelligence, supporting engagement, influencing direction of travel and providing feedback. As the various layers were established, the principles around engagement would be embedded.
- Phil Johns responded to the points raised by HWW. The elective accelerator work would be dependent on existing people being willing to provide additional clinical sessions and revised ways of working through GPs to reduce demand on outpatient appointments and consultants. Use of artificial intelligence and maximising throughput in theatre were further points. Without growth in the workforce, it would be difficult to maintain the expected level of service. This may require greater use of the independent sector for elective surgery for the next two to three years. There would also be requirements to support neighbouring NHS systems which had larger waiting lists. The discharge of medically fit patients from hospital was a key aspect.
- Phil Johns spoke of the need to ensure GP access, the additional constraints about unmet need where patients were not presenting. It was a difficult task to address the waiting lists for elective procedures. Whilst funding was available, the need for additional staffing was the challenge.
- Mr Johns then acknowledged the impact of the pandemic on community mental health service demands. This had forced a focus on crisis cases, directing resources away from earlier interventions. There were no easy solutions, but a need to refocus on providing interventions at an earlier stage, possibly through accessing services from other organisations in the short term.
- Danielle Oum provided a comparison to the relative position elsewhere, where community services had been reduced to focus on inpatient care. There was an opportunity to get 'upstream' and provide care earlier. However, the next two to three years would be a challenge.
- On dentistry, an update had been provided to the January HWBB. Phil Johns confirmed that dentistry would transfer to the ICB in 2023. There would be a dialogue with NHS England as this approached, but he was not sufficiently informed at this stage to be able to respond to the points made. There may be opportunities for dentistry to link in with other services. It was expected that the local system would inherit a challenging position on dentistry.
- On GP access the CCG had invested to extend access to services. Phil Johns gave comparative data on the position in November 2019 to that in November 2021 on the number of GP appointments and of those, the number that were face-to-face. This showed

that more appointments were held in November 2021. The number of face-to- face appointments was increasing and nearly at the level of 2019. The demand for GP appointments was increasing. A further point that some people preferred remote appointments at different times to fit around other commitments, whilst many still preferred a face-to face appointment. Mr Johns praised GP doctors for the services provided during the pandemic, including the vaccination programme. Many went above and beyond, but there was high demand for services and expectations of the population. Endeavours were made with specific practices, where issues were identified, within the scope of the GP contract.

- Chris Bain confirmed that HWW was not seeking a return to the service provision prior to the pandemic, which had contributed to the problems identified. A survey by the Patients' Association indicated that delayed assessments and treatments were leading to a loss in patient confidence in the NHS. Such confidence was needed to have an impactful and effective preventative programme. There was a significant communication challenge to be addressed, as a matter of urgency.
- The Chair would be suggesting an item on dentistry for the committee's future work programme. This would provide a useful benchmark before the transfer of dentistry to the ICB.
- In response to a question from Councillor Matecki, Danielle Oum confirmed the national core responsibilities to be adopted by the 42 ICS's. Councillor Matecki commented that these measures should be happening anyway and not need stating. He welcomed a lot of the points made including 'places' taking ownership of their priorities. However, there was a need for staff and finance to deliver those priorities. He agreed with the aims for prevention both for residents and for organisations in finance terms. However, additional resources both staff and finance were required to achieve this transition. He asked if the additional money was available, as without it, progress could not be made. The identification of priorities at place level was welcomed and he advocated that once they had been achieved for that place, they be implemented across the whole area.
- Phil Johns agreed on the points about resourcing for the place priorities. There would be additional monies for the local system, with examples given of the types of targeted funding. However, clarity was awaited on the financial settlement. This funding was needed to enable investment in mental health services and GP services for example. At the same time, the system may need to achieve some savings. It would be useful to map the resource for health and care for this committee. He reiterated there was a clear commitment to devolve resource down to the place level.
- Councillor Golby spoke of a meeting recently about the use of digital services and preventative work in the North East and Cumbria. Reinstating preventative work post-Covid was a national issue.
- Councillor Roodhouse spoke of the benefits provided through the compassionate communities and story circles initiatives. He then referred to the complex local system shown in the presentation. Priorities agreed at the 'place' level would feed into the system but also have to align with many organisational, health and wellbeing and other strategies, all agreed in collaboration, with stakeholders and the public. He asked how a balance would be arrived at for funding decisions, especially if the top-down funding was not sufficient. He referred to the new white paper on integration and the key was pooling budgets. He referred to the current arrangements for the Better Care Fund, which comparatively was a much smaller element. Councillor Roodhouse spoke about the amalgamation of funds targeted to agreed priorities like prevention. This would take time, which wasn't available, and he sought views from both health and social care leads on this.

- Danielle Oum agreed that this was about a willingness to work differently. The final bill was awaited. There was acceptance that current arrangements did not meet what was required. Working together to achieve a balance was referenced. This was needed at the same time as achieving transformation, firefighting, efficiency and productivity. Achieving that balance would need a compromise.
- Phil Johns added that there should be a clear link through the various priorities and strategies. It was complex and system leaders would need to challenge themselves to work in a different way and collaboratively. He was an advocate for pooled resources and there was a need to understand the total resource available. Some funding had to be targeted, an example being the prevention agenda.
- Councillor Roodhouse explored how the pooled budgets could operate in practice to agree the allocation of funding across streams and respective contributions from partners. He also referred to the additional challenges posed by the 'fair cost of care'. Phil Johns responded that there was a lot of discussion needed before achieving the concept that Councillor Roodhouse had outlined. Other aspects, agencies and services needed to be included too.
- Councillor Humphries spoke of her experience from work in dementia services, about the need for coordination of different health disciplines and social care, sharing information to avoid duplication. Phil Johns confirmed that the work on integrated health and care records was a key strand of the new white paper. Work in the local system was ongoing but was by no means complete.
- The Chair agreed that a 'single view of the customer' shared by the NHS and social care would be a significant step forward. She also considered that people delivering services could be a key contributor to systemic changes. Danielle Oum confirmed that the engagement strategy would include those delivering services.
- Councillor Kettle asked how the new ICS arrangements would assist GPs in improving the health care offering, including for onward reference to other services. Phil Johns referred to 'shared care' of patients with multiple conditions. The ICS may be able to assist in a number of ways. The examples given were coordination of secondary care appointments with GPs, keeping patients informed of where they were on waiting lists, co-location of other services like physiotherapy at GP practices and making patient records available to the patient.
- Councillor Kettle asked how the ICS could assist with the effective allocation of developer contributions. He quoted an example where such funds had been lost due to a failure to reach agreement between the GP practice and CCG. Phil Johns agreed that on estates development and facilities, there was a great opportunity for partnership working. An offer to talk outside the meeting on the specific matter raised to ensure learning for the future. It was understood that there was a process in place for the allocation of funds from development for additional health facilities and a need to be aware of such developments in the near future. The Chair used an example of the expected population growth and need for additional GP services through developments in the Nuneaton and Bedworth area.
- Councillor Humphreys referred to the process and time taken to apply for care. This was not a role for the GPs to undertake and it was about allocation of appropriate staffing to undertake the role.
- A suggestion that this useful session could be extended to the wider Council membership. The meeting had been publicised to all members of Council and written questions invited from any member.
- Councillor Drew sought an assurance about how people could access care and other services.

- Councillor Seccombe felt there was value in an ongoing dialogue about the ICS between now and its commencement in July. She referred to spending on social care and there was a need for an equal partnership. She referred to the integration white paper and the good working relationships between health and care in Coventry and Warwickshire. Development of the white paper could be monitored alongside the ongoing discussions about the ICS. Danielle Oum agreed this white paper provided a great opportunity, also the importance of health and care working together and building on the work that was already happening.

The Chair thanked Danielle Oum and Phil Johns for their time, the presentation and responses to members' questions. It was perceived that everyone wanted the same outcomes for the best services for the area. Time would be needed to achieve the desired changes, and this would be assisted by an ongoing dialogue. The Committee would welcome a commitment to hold further meetings which Danielle Oum gave an assurance to do.

Resolved

That the Committee receives the presentation on the Warwickshire Integrated Care System.

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Councillor Clare Golby, Chair

The meeting rose at 11:50am

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Adult Social Care and Health Overview and Scrutiny Committee

Wednesday 16 February 2022

Minutes

Attendance

Committee Members
Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor John Cooke
Councillor Tracey Drew
Councillor Marian Humphreys
Councillor Jan Matecki
Councillor Chris Mills
Councillor Kate Rolfe
Councillor Mandy Tromans

Officers
Shade Agboola, John Cole, Becky Hale, Nigel Minns and Paul Spencer.

Others in attendance
Chris Bain, Healthwatch Warwickshire (HWW)
Councillor Jo Barker, Warwickshire County Council (WCC)
Rebecca Bartholomew, Coventry and Warwickshire Clinical Commissioning Group (CCG).
Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Katie Herbert, South Warwickshire Foundation Trust (SWFT) and WCC
Sam Owen, SWFT
John Dinnie, David Passingham, Verity Richardson, Amanda Holden and Paul Kelly (public)
David Lawrence, press

1. General

(1) Apologies

Apologies for absence had been received from Councillor Richard Baxter-Payne (Nuneaton and Bedworth Borough Council) and Councillor Sandra Smith (North Warwickshire Borough Council)

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Councillor Holland declared an interest as a governor of South Warwickshire Foundation

Trust. Councillor Barker, although not a member of the committee, declared an interest as a governor of South Warwickshire Foundation Trust and a member of the League of Friends for Ellen Badger Hospital.

(3) Chair's Announcements

None.

(4) Minutes of previous meetings

The minutes of the meeting held on 17 November 2021 were approved as a true record. As a matter arising it was noted that a response was still awaited to the question raised to West Midlands Ambulance Service regarding first responders. This would be pursued.

2. Public Speaking

Mr John Dinnie spoke to a circulated submission which is attached at Appendix A to the Minutes. This provided a position statement on behalf of Shipston-on-Stour Town Council in regard to the Ellen Badger Community Hospital and the review being undertaken by SWFT.

3. Questions to Portfolio Holders

Councillor John Holland submitted a question to Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health. He sought an update on the following motion approved at Council in December: "This Council requests that an invite be sent to the Chief Executive of the West Midlands Ambulance Service (WMAS) in order to consider how the ambulance service can be strengthened for the residents of Warwickshire and to agree an action plan".

Councillor Bell responded that she had requested to raise this matter at the next meeting of the Blue Light Collaboration Board on 9th March. Councillor Holland thanked her for the reply, reminding that WMAS was the only emergency service not based on the county's area and the need to maintain a focus on this matter. The chair agreed an ongoing dialogue was needed with WMAS.

4. Questions to the NHS

A question had been received from Councillor Mills concerning nursing. As this question had not been received in time to enable the preparation of a response at the meeting, it had been referred to the CCG for a written response, which would be circulated in due course.

5. Menopause Services

The Committee received a presentation from Dr Shade Agboola, Director of Public Health. The presentation covered the following areas:

- Background/context outlining the request from the Committee's Chair
    - There is a lack of visibility of the services provided. What services are provided across Warwickshire and are the services equitable across the whole County, or do they vary for each 'place'?

    - What are the access arrangements? Are services provided at times convenient for women who work?
    - Anecdotal feedback from a constituent told by her GP that she would not receive treatment until one year from her last menstrual cycle. When should services be available and how easy is it for women to get a referral? Does this vary for each GP/ area?
    - There is an education piece. Schools educate on puberty and many aspects of the reproductive cycle. Should this include reference to the menopause?
    - Are there triage arrangements to other services where required, such as CWPT for psychological impacts of the menopause?
    - What roles do Public Health provide in regard to menopause services?
- Why important
    - The menopause is caused by a change in the balance of the body's sex hormones, which occurs as women get older
    - It's a natural part of aging in women
    - It happens when the ovaries stop producing as much of the hormone oestrogen and no longer release an egg each month
    - Menopausal symptoms can begin months or even years before periods stop and last around 4 years after last period, although some women experience them for much longer
- Symptoms
    - Most women will experience menopausal symptoms. Some of these can be quite severe and have a significant impact on everyday activities
    - Common symptoms
- When to see a GP
    - Troubling symptoms or symptoms of menopause before 45 years of age
    - Can confirm if menopausal based on symptoms, but a blood test to measure hormone levels may be carried out in women under 45
- Treatments
    - hormone replacement therapy (HRT) – tablets, skin patches, gels and implants that relieve menopausal symptoms by replacing oestrogen
    - vaginal oestrogen creams, lubricants or moisturisers for vaginal dryness
    - cognitive behavioural therapy
    - eating a healthy, balanced diet and exercising regularly
    - Referral to menopause specialist if symptoms do not improve after trying treatment or if unable to take HRT
- What's available in Warwickshire?
- Menopause specialists
    - The British Menopause Society is a specialist society associated with the Royal College of Obstetricians and Gynaecologists https://thebms.org.uk/
    - British Menopause Society specialists are health care professionals that have been awarded additional qualifications.
    - All BMS specialists are encouraged to become menopause trainers
    - An online directory that provides a list of menopause specialists across the country
- Menopause specialists in Warwickshire
    - There are two specialists listed in the online directory available at https://thebms.org.uk/find-a-menopause-specialist/
    - They are both private providers
    - There is no NHS provision in the County

    - There are a number of specialists who provide NHS funded care in neighbouring Solihull, Birmingham and Coventry
- WCC menopause policy
    - Menopause guidance for managers published in 2018
    - Refers to a WCC menopause support group
    - Acknowledges impact menopause may have on work
- Next steps/discussion

The Chair reported her concerns on the findings, expressing that for some women the impact of menopause could be traumatic for years. She explained her research to date including anecdotal feedback received, the symptoms reported to her and those experienced personally. There was an absence of services which was not acceptable, and half of the population would go through the menopause. There was a need to agree actions to address the current position.

A lengthy debate followed with the following contributions and themes:

- Concern and astonishment at the lack of services provided.
- Some surgeries did have GP's who were skilled in addressing menopause problems. It was questioned if this was commonplace. In terms of specific provision, it was knowing when and how to access services such as gynaecology. The first point of contact was the GP.
- Reference to the private providers located in Leamington and Stratford. The cost of accessing their services was £180 for an appointment. This cost was not feasible for those in financial deprivation or unable to access the services.
- Accounts of the difficulties experienced by constituents with multiple challenges and the prescription of antidepressant medication instead of treating the menopause symptoms.
- The importance of raising this topic, which affected half the population. It had not previously been discussed adequately. There was a lot of discussion now via social media, with members of parliament and celebrities raising the profile of the menopause. A need to educate, also to take a holistic approach to treatment of this natural stage of a woman's life. Reference also to cultural aspects and the need for employers to be audited, to assess if they had menopause protocols in place.
- For some women, the menopause caused anxiety or other conditions impacting on heir careers.
- Many women may deal with the menopause in isolation. A need for services to be provided across the county and not be reliant on the two private providers in south Warwickshire. Having a specialist located at GP practices was suggested.
- A suggestion to form a task and finish group (TFG) to explore this in further detail at the conclusion of the current TFG on GP services. This could include mapping existing services and the pathways in place. A useful outcome from the TFG would be a report back to the Health and Wellbeing Board, especially detailing areas of good practice identified.
- The impact on the male population too in terms of relationships and supporting partners.
- Wider changes to health systems, including the new Integrated Care System (ICS), health inequalities and identification of priorities at the 'place' level. The menopause could be raised as a priority area.
- Rebecca Bartholomew of Coventry and Warwickshire CCG agreed there was an absence of specialists in Warwickshire, but there was medical knowledge. It would be useful to provide clearer information on GP practice websites of those doctors who had additional gynaecology qualifications. She agreed to take this point back to the CCG. Rebecca also spoke about access arrangements, the need for all employers to have bespoke policies to

support menopausal women and the employment difficulties experienced by some. Such policies did exist for maternity and should for menopause. A new initiative was a regional ambassador for women's health, as an expert by experience. It was perceived that there was a shift towards providing specialists for menopause amongst other areas.

- A need to start with GPs to ensure there were menopause specialists available. Discussion about the comparative provision elsewhere, there being such providers in Solihull, Coventry and Birmingham.
- Considering the education aspects and raising awareness of menopause to pupils at secondary schools. A need for this to be 'normalised'. Nigel Minns confirmed that that the curriculum did include the menopause.
- Accounts of poor support from GPs. A concern that HRT was not being prescribed due to suspected links to breast cancer, which had been disproven.
- Having specialist GPs for every subject was not feasible, but a 'go to' person located at each practice with capacity to provide information on a range of topics would be helpful.
- HWW found it surprising there was no specialist menopause provision in Warwickshire, unlike some adjacent areas and would look into this. HWW had undertaken work on care for women experiencing menopause. There were race, faith and cultural aspects which the TFG should take into account as part of its review. An offer from HWW to support the TFG and provide its evidence.
- There were mixed messages about not medicalising menopause, but then people were asked to see their GP. A need for clear messaging and consistent advice. Concerns that some women may self-prescribe.

The Chair asked the committee to think about next steps. There was support for the suggestion of a TFG at the conclusion of the current GP services TFG. She suggested that the scope included review of the comparative service position elsewhere and the quality of service provision. Additionally, she suggested a referral to the HWBB for consideration of this matter and that a letter be sent to the Secretary of State for Health and Social Care to seek a 'top down' focus. Further comments were submitted:

- The Secretary of State had announced that HRT would be available without prescription. Discussions were happening on menopause in government, so it was opportune to engage at this time. A need to ensure that Warwickshire got its fair allocation of resource to address the current inadequate provision.
- Comments on the potential risks of HRT being available over the counter, if suspected menopause symptoms were something else and it may not be a suitable medication for women with some other medical conditions.
- A member proposed to lobby her local MP on this topic and urged others to do likewise.
- It was requested that the TFG membership be drawn from the whole Council membership.

The Chair sought endorsement from the committee on the proposed way forward.

Resolved

1. That the Committee notes the presentation on menopause services.

2. That a task and finish group is formed to examine the issues above in greater detail, commencing after the conclusion of the current GP Services TFG.

3. That a letter is sent from the Chair of the Committee to the Secretary of State for Health and Social Care to seek a 'top down' focus; and

That menopause services are also referred to the Health and Wellbeing Board for further consideration.

6. Community Hospital Review

Katie Herbert introduced this item on behalf of South Warwickshire Foundation Trust (SWFT), to provide an overview of the purpose, scope and progress of its community hospital inpatient review. It presented findings of the initial patient, carer, stakeholder, and staff engagement as well as the future plan and indicative timeline for the review. There was a requirement to consult on substantial developments or variations in the provision of health services.

Sam Owen Head of Nursing for out of hospital at SWFT then took members through the detail of the report which covered the following areas:

Community Hospital Inpatient Provision
Background was provided on community hospitals and the facilities in the south of Warwickshire. Ellen Badger Hospital in Shipston on Stour had 16 inpatient beds and the Nicol Unit at Stratford Hospital had 19 inpatient beds. The bedded offer at the community hospitals was broadly split into two areas providing for acute discharge and admission prevention beds. There was currently no provision in the north of Warwickshire Rugby areas. Within those areas, patients' needs were met via a mix of primary care, community and acute provision.

The review of Discharge to Assess services
A system wide strategic review of discharge to assess (D2A) services was agreed by all local system partners in 2019. The report outlined this review which was now moving into its implementation phase. Recommendations within the review were to move towards a simplified, clear and fit for purpose D2A offer. Community hospitals formed part of that offer within south Warwickshire. A table within the report provided a breakdown of the different pathways available to patients at the point of discharge, including community hospital inpatient beds, which should account for no more than 4% of all discharges from acute hospital within the over 65's population.

Hospital Discharge Policy 2020
This was one of the central policy drivers for the D2A review, setting out the responsibilities of service providers. The report included an outline of the original guidance, the ambitions within the hospital discharge policy and its supporting guidance. This approach to 'Home First' stated that 'every effort should be made to follow home first principles, allowing people to recover, re-able, rehabilitate or die in their own home'.

The case for change
The community hospital review took place within the context of wider changes within both health and social care, the Integrated Care System (ICS), the development of out of hospital services, the wider availability of D2A services and the prevalence of preventative programmes. Community health/out of hospital services had developed and were able to support much higher levels of patient need with a focus on admission prevention and supported discharge. Therefore, community hospital provision should be reviewed within the context of this enhanced and broader community offer. Some patients went to community hospitals to die, but there were inpatient and

outpatient hospice facilities available. A multi-agency audit of patients using the community hospital inpatient facilities was undertaken in the spring of 2021 and the findings were reported.

Current utilisation, need and demand
Data was provided on the 923 admissions via this pathway, along with a typical patient profile, their home location, average length of stay and discharge destination.

Katie Herbert then spoke to the following sections of the report.

Engagement approach and findings
This included engagement with people who had or may use community hospital services, key stakeholders and groups who should be targeted. The approach to engagement was primarily to target those groups with personal experience of community hospital inpatient provision. Healthwatch Warwickshire (HWW) was commissioned to undertake the survey and independently to analyse the survey results. To gain further rich and in-depth insight 27 face-to-face patient interviews were conducted. Staff and wider stakeholders with an in-depth knowledge were also asked for their views.

The key themes from the patient surveys, patient interviews and staff and stakeholder surveys were summarise, together with quotes from those consulted and graphics to demonstrate the feedback from staff and professionals.

Ongoing engagement with key groups as well as the formation of a community panel would help to refine the key themes such as ‘increased therapy’ and what this should look like within the future community service.

The report outlined the equality impact assessment undertaken. A technical panel was formed to consider the long list of 14 proposals put forward from the public engagement and to consider these against a set of ‘hurdle criteria’ (patient safety & quality, workforce delivery, national/local direction and affordability), with a key aim of agreeing the viability of each proposal. From this, a table showed the proposals which had been deselected.

This was followed by the convening of a community panel to consider the remaining proposals. The groups represented in the panel were reported. It collectively agreed desirable criteria, which were represented visually in a word cloud. The outcome from this process was reported in a table showing the proposals and ranking the community panel preferences. This resulted in three proposals to be taken forward as part of the review for further exploration, as shown below:

1. Retain the Community Hospitals offer but change the type of services e.g.:
    - Diagnostics
    - Frailty Chair
    - A combination of the above or ‘other’ to be identified service offers alongside business as usual or reduced number of community beds.

2. Continue with some of the community hospital beds and invest in homebased alternatives such as package of care or therapy and/or a virtual ward in the community.

3. Retain the Community Hospital offer but change the location.

The report concluded with milestones, next steps and conclusions. Members of the Committee were invited to submit questions and comments:

- It was noted that there was no community hospital provision in the Warwickshire North or Rugby areas. A member viewed that this was irrelevant to this service review.
- Reference to the scope of this review and exclusion of some services currently delivered from these premises. Any services removed would impact elsewhere in the local system and a holistic approach should be taken. People valued these facilities and reference was made to the current challenges for acute services, notably in accident and emergency departments. In response, it was confirmed that the work on minor injuries was progressing, but not as part of this review. However, there were clear interdependencies.
- No details of comparative cost had been included in the report. There were questions around the efficiency of staff travelling to deliver care at homes rather than in a bespoke unit. Katie Herbert clarified that no decisions were required on the preferred option at this stage. Consent was being sought to explore further the three preferred options identified in the report. The costs and full details would be shown in the subsequent business case.
- A question why the option of increasing bed capacity had not been included as a measure of increasing efficiency and supporting the acute hospitals, looking at the whole system, rather than taking this review in isolation. Such an option to increase bed capacity had been considered but removed as it did not meet the hurdle criteria.
- There were interdependences between these services and the whole system approach through the ICS. Points about the drive towards 'home is best', the data showing that one third of patients at community hospitals could have been cared for at home and some wider benefits like retained mobility from care at home. Improving the community offer should reduce the requirement for hospital-based provision. This review focussed on making the best use of community hospital bed provision.
- There were demands on the acute hospital sector evidenced by ambulance waits at hospitals, the length of waits in the A&E departments, which in part was due to lack of inpatient bed capacity and also related to discharge delays. By providing step down care at community hospitals and at home it would ease these pressures.
- It was questioned if there were sufficient staff to provide care at home. There was a plan for workforce development to provide the service. Other aspects were admission avoidance, removing the emergency calls and transport to hospital with support and care at home. An acknowledgement that workforce was a major concern for both health and social care and there was a need to coordinate activity.
- The lack of community bed provision in the north of Warwickshire was raised. It was stated that there were different arrangements for step-down care in the north of the county and whilst it was not a community hospital, provision was made. This review concerned provision in south Warwickshire. Members replied that community bed provision in the north had been closed.
- Praise for the excellent services delivered at these community hospitals and a view that the services should not be changed. The data showed increasing usage of the facilities. The survey had been undertaken during the pandemic and may have produced different results at another time. The presumption that people wanted to receive care at home after a major incident was not always correct. The benefits of care by specialists in the community hospitals was stated. The costs of delivering services like physiotherapy at home would be significantly more. Whilst some minor adjustments may be beneficial, the service was working well.

- A suggestion for a similar review of provision in the north of the county.
- The service needs and priorities varied across each area. Services should be patient centred and in their best interests. They may prefer to recover at home, but this may not be advisable for some, especially those who lived alone. Reference to service integration and an outcome from the review could be the co-location of health and care staff at the community hospitals.
- Comment that 40% of patients using these centres came from Warwick and Leamington and perhaps the provision should be made between these locations.
- Katie Herbert clarified that only one of the proposals concerned reducing bed numbers with provision at home. Furthermore, the home provision included care and nursing homes. The other options retained the same bed numbers, looked at service enhancement and ensuring provision was located appropriately.
- Sam Owen gave details of the successful D2A pilot in the north of the County, which had been oversubscribed. This evidenced that such initiatives worked. For this consultation, she confirmed that the option of removing all bedded provision had been discounted. She touched on the NHS plan, the 'home first' principles and the additional service areas and workforce aspects which needed to be explored.
- A comment that this was not the time to reduce bedded provision, given the need to address service backlogs due to the pandemic and for other reasons. Reassurance was provided that the process would take time to complete before any changes were implemented. This review aimed to provide future sustainability and a range of issues would be weighed. This was early engagement in the process.
- A series of questions were submitted about the provision of respite care as part of this pathway and to complement the services provided at community hospitals. Respite services were provided in the county, but not as part of the community hospital remit. A parallel was drawn to the admission prevention services. The councillor clarified this was about complementing community hospitals, covering gaps between acute hospital discharge and returning to home. It was part of the discharge to assess process.
- Chris Bain spoke on behalf of HWW. There were anxieties between the proposals in this review and the accelerator programme, which sought to address the NHS backlog and to reduce waiting times. He referenced the HWW survey of carers. If they were consulted on the proposals, the feedback would differ from that reported. Carers were concerned about cover for patients if the carer became ill. Feedback from some people showed a view that services were still 'done to' them. Considerable work was required to ensure that this review met what HWW had heard from residents about the discharge provision and care at home required. The workforce issues were significant to ensure patients could be discharged to home safely. Reassurance was sought.
- Sam Owen spoke about the need to move away from current models of prescribed social care to provide services that met the person's needs. It was accepted that there were interdependencies between this review and many other areas. This review looked at different models of care, future proofing and addressing workforce aspects. There was a lot of work to do and approval was sought to do that work. Katie Herbert added that the engagement would continue with the aim of capturing richer feedback. This was the start of the engagement and future stages would seek feedback from those with lived experience of the community hospitals and those who may use them.
- Several members referenced the workforce issues and vacancies within the care system. Addressing this was essential to ensuring hospital discharge, especially for provision of care at home. It was a particular challenge for rural areas. The benefits of step-down care in a

hospital setting were emphasised, with reference to a successful example, helping a resident to continue living independently afterwards.

- Sam Owen emphasised this review concerned the SWFT out of hospital care offer before people returned to longer-term care. As context it related to 4% of discharges and did not just concern home care. Katie Herbert commented on the workforce issues, the aims of this review to plan for the future, sustain and provide different options. Also, there were opportunities for different ways of working, training and career pathways.
- Discussion about the options that had been deselected and those proposed for further consultation. Affordability and workforce issues had been quoted as the reason for not progressing some options. One of the current proposals was to relocate the current service provision, for which the affordability was challenged. Furthermore, there were concerns about reducing bed numbers which could be incremental and then make community hospital provision unviable or inefficient. 'Levelling up' services was also raised, with reference to the lower life expectancy in the north of Warwickshire where there were no community hospitals and this could be a contributor. The member urged retention of the community hospital beds.
- Councillor Bell, Portfolio Holder shared the NHS vision that home was best where possible. However, if that could not be delivered due to workforce capacity of both care staff and therapists, and especially in times of crisis, there needed to be another option. This could be to either increase or have flexibility to increase the bedded offer. A need to ensure that acute hospitals did not become 'clogged'. It was estimated that 4% of people discharged from acute care would need care in a bedded facility. She would like to see how many people that equated to across the whole county and that the review include both the Warwickshire North and Rugby areas. There was a need for realism that the vision could be delivered. The review was timely and was identifying key issues. She supported other speakers on the benefits of the current arrangements, notwithstanding that improvement could always be made. A need to ensure the best practice across all of Warwickshire.
- Several members supported the addition of an option to retain or increase the service provision at these locations. With an aging population this needed to be considered. It was not viewed that the relocation of the service was feasible and therefore this option should be withdrawn.
- Further reference to the workforce issues and the challenge for getting care at home, especially in rural areas. There was praise for the specialist role of carers. A need for good and consistent training, a career path and to make this an attractive career so there were sufficient staff numbers. The two existing centres would provide an excellent location for such training. Sam Owen responded on the joint work on blending the NHS and social care workforce. As a result of the pandemic, a lot of work had taken place and it was continuing. Further points that care was in itself a career and not necessarily a route into the NHS.
- On the option for reviewing the location, this was a choice of the panels in the earlier consultation stage. Reference to the rehabilitation centre at Campion, Royal Leamington Spa which provided a larger bed space to respond to surges in demand.
- The provision of training for carers, including college courses had been discussed previously by the Committee. There seemed to have been no progress with this. A personal reflection on the inadequate care provision at home when the visits were only for 15 minutes.
- Chris Bain spoke of the analysis undertaken of a 30 minute care visit. This showed that carers completed 43 tasks during such visits, which prevented adequate human contact. He then spoke about the time taken to complete such detailed reviews. Changes to services

impacted on people. The review needed to be completed efficiently, whilst not losing the things that currently worked well.

- Sam Owen provided information about the care certificate, which could help with career progression. It was viewed that the career pathway was now in a much better place than previously. Becky Hale echoed this, giving an outline of the joint health and social care funded learning and development partnership. This enhanced and delivered training across the whole workforce, working with external providers to support the care market. She reminded of the item considered on workforce at the January HWBB and the commitment to develop a strategy on supporting the commissioned workforce. It was confirmed that the former NVQ qualifications for care staff had been replaced by the care certificate. An offer to share more information about the training.

The Chair provided a summation and the Committee agreed that an additional proposal to retain or increase the service provision at these locations should be included in the options, especially in view of the aging population. The proposals submitted would be accepted for the next step of the review. She emphasised that this was the very beginning of the review, which would take time to complete.

As a separate recommendation the Chair proposed a review of the arrangements in the rest of the County be undertaken to provide parity of provision for the Warwickshire North and Rugby areas. Committee members signified support for this. Nigel Minns clarified that such a review would need to be led by the CCG and ICS. The Chair agreed, reminding of the CCG merger, which in turn would become the ICS in July. There was a need for parity and she reminded of the State of Warwickshire item considered at Council and the health findings for the north of the County.

Resolved

That the Committee:

1. Notes the scope and progress of the community hospital review in Warwickshire, including engagement feedback received to date.

2. Supports the planned approach to ensuring Warwickshire patients, carers and families are involved throughout the review process.

3. That South Warwickshire Foundation Trust be requested to include a further option in the rest of the consultation processes to retain or increase the service provision at the Ellen Badger Hospital and Nicol Unit at Stratford Hospital.

4. Requests the Coventry and Warwickshire Clinical Commissioning Group and the Integrated Care System to undertake a similar review of bedded stepdown care provision for the Warwickshire North and Rugby areas, to provide parity of service across the whole of Warwickshire.

7. Work Programme

The Committee reviewed its work programme. The following additional items were proposed:

- Dental services, suggested for the April agenda.

- Integrated Care System – an item at the end of 2022 to see how the new arrangements are embedding.
- An update from West Midlands Ambulance Service suggested for the April Committee.
- A workforce update on the success of the recruitment drive for additional carers. This could include aspects on the consistency and quality of training. It was suggested that members be signposted to the report to the January HWBB in the first instance.
- Delayed transfers of care. This was no longer an indicator which was monitored. An offer to provide information on the current indicators that were monitored through the Better Care Fund reports. A suggestion to look at this broadly to understand the reasons for delayed discharge, irrespective of whether this was due to an NHS or social care issue and how to reduce such delays. Members needed to understand the system and processes from 'end to end' to enable a holistic approach. A suggestion that the report include readmission rates too.
- A request for a presentation on Social Care.

It was suggested that the issues raised above be discussed further at the next meeting of the Chair and spokespeople.

Resolved

That the Committee notes its work programme and that the issues outlined above be discussed further at the next meeting between the Chair and Spokespeople.

……
Councillor Clare Golby, Chair

The meeting closed at 12:30pm

Appendix A

A position paper regarding the future of the Ellen Badger Community Hospital

This proposal draws on ideas generated by the Community Hospitals Association, The Parliamentary Inquiry into Rural Health and Care, the Wolfson prize winning "Planning and Designing the Hospital of the Future" and discussion with the Medical Centre Partners in Shipston.

Shipston has a growing population with a diverse character of older residents (some 30% of pensioner age) younger child rearing professionals and a disproportionate number of very young children in low-income households (17% of young children - twice the County average.)
The "Badger", established in 1896, had, only a few years ago, 36 inpatient beds, outpatient consulting rooms, a physiotherapy suite, an Xray service on demand, a scanner and ultrasound, it offered occupational therapy and a minor surgery and minor injuries unit.

We are encouraged to learn from local representatives of SWFT* that the inpatient facility will return as part of SWFT' second phase of the hospital site's redevelopment.
We assume this will include those services until recently provided in the Ellen Badger hospital together with future proofed facilities which enhance the local health care provision.

We believe they should be informed by the insights and experience derived from the international partners referenced in the Parliamentary Inquiry into rural health and care.

These should include community in-patient beds in a mix of single ensuite rooms and, if appropriate, a four bedded bay designed for acute admission prevention where secondary care in a DGH is not required. The preference of patients for privacy and respect for their personal dignity should be paramount and seek lessons from neighboring NHS facilities with experience of such provision.
Such beds would allow for assessment and observation, for respite care and rehabilitation following a period of inpatient treatment, for palliative care and care following minor episodes of trauma.
A small unit offering diagnosis, investigation, and treatment and, where possible, same day discharge with community nursing and care staff support would aim to minimize the incidence of hospital acquired infection.

We would expect to see an enhanced Outpatient Department to include Child and Adolescent Mental Health services, Speech Therapy, screening services to include mammography and aortic aneurisms, a minor surgery service together with a health promotion service with access to a Health and Wellbeing hub with facilities suitable for all age groups and their dependents.

As the sources quoted above point out Community Hospitals can be expected to enhance the local economy, training and employment opportunities, ecological priorities and minimize the shortfall in rural transport availability and access to otherwise distant health and care services.

*South Warwickshire NHS Foundation Trust

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Agenda Item 5

Adult Social Care & Health Overview & Scrutiny Committee

27th April 2022
Council Plan 2020-2025 Quarterly Progress Report:
Period under review: 1st April 2021 to 31st December 2021

Recommendation

That the Overview and Scrutiny Committee:

(i) Consider progress on the delivery of the Council Plan 2020 - 2025 for the period as contained in the report.

1. Introduction

1.1. The Council Plan Quarter 3 Performance Progress Report for the period 1st April 2021 to 31st December 2021 was considered and approved by Cabinet on 17th February 2022. The report provides an overview of progress of the key elements of the Council Plan, specifically in relation to performance against Key Business Measures (KBMs), strategic risks and workforce management. A separate Financial Monitoring report for the period covering both the revenue and capital budgets, reserves and delivery of the savings plan was presented and considered at the same Cabinet meeting.

1.2. This report draws on information extracted from both Cabinet reports to provide this Committee with information relevant to its remit.

1.3. Comprehensive performance reporting is now enabled through the following link to Power BI OSC 2021/22 Performance Report.

2.Council Plan 2020 - 2025: Strategic Context and Performance Commentary

2.1 The Council Plan 2020 – 2025 aims to achieve two high level Outcomes:

- **Warwickshire's communities and individuals are supported to be safe, healthy and independent**; and,
- **Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure**.

Delivery of the outcomes is supported by **WCC making the best use of its resources**.

Progress to achieve these outcomes is assessed against 54 KBMs.

Outcome	No. of KBMs	No. of KBMs available for reporting at Quarter 3
Warwickshire's communities and individuals are supported to be safe, healthy and independent	27	25
Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure	13	8
WCC making the best use of its resources	14	13

2.2 Some KBMs were suspended from reporting as inspection and reporting regimes were halted due to the Covid-19 pandemic. The following remains paused as data restrictions still apply:

- % of placements for adults in provision of Good or Outstanding quality as rated by Care Quality Commission.

Care Quality Commission (CQC) have advised that they are changing their inspection practice to be more intelligence led. They will only be visiting homes where there are concerns / significant intelligence and therefore ratings will potentially only decline.

2.3 Overall, the Council continues to maintain its robust performance across the board in the face of increased and changing demand, due to the ongoing and varying degree of impact of the Covid-19 pandemic resulting in significant changes in how services are delivered. Despite some restrictions being reintroduced Council Services are continuing to provide support to communities most in need but are now focusing more resource on their core work and less on specific Covid response, which is now being reflected in KBM performance.

2.4 Of the 54 KBMs, 12 are in the remit of this Overview and Scrutiny Committee and at Quarter 3, 11 KBMs are available for reporting as 1 is paused at this time, 73% (8) are On Track and 27% (3) are Not on Track. Table 1 below summarises KBM status at Quarter 3 by agreed Outcomes.

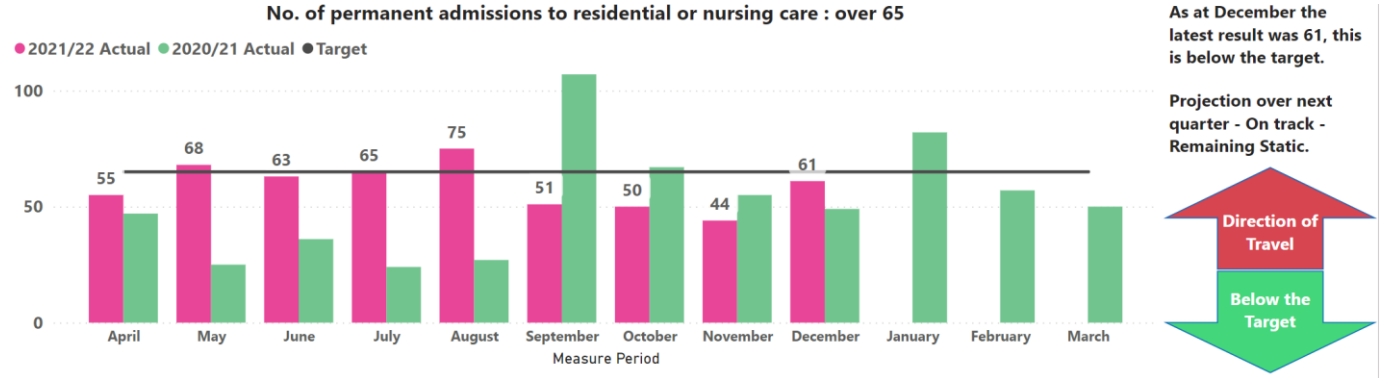
Outcome	Current Status	Number of measures
Warwickshire's communities and individuals are supported to be safe, healthy and independent	On Track	7
	Not on Track	3
	Not Applicable	1
Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure	On Track	1
	Not on Track	0
	Not Applicable	0
WCC making the best use of its resources	On Track	0
	Not on Track	0
	Not Applicable	0

Table 1

2.5 Of the 73% (8) KBMs which are On Track, there are 3 of note which are detailed in Table 2 below:

Warwickshire's communities and individuals are supported to be safe, healthy and independent

Number of permanent admissions to residential or nursing care: over 65



Current Performance:

The number of permanent admissions to residential and nursing care for customers over 65 is still below target.

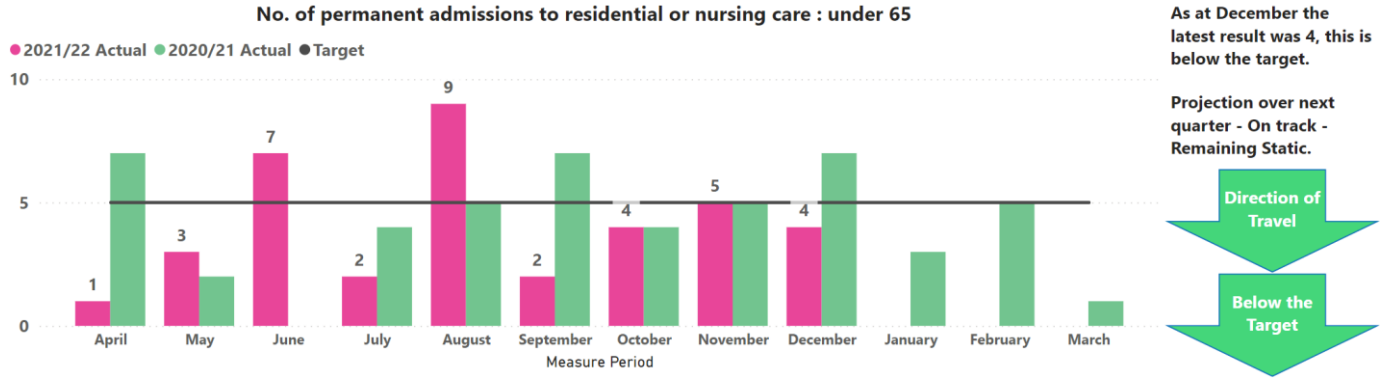
Improvement Activity:

Continue to monitor as the response to the pandemic changes. Direct Payments are being offered. Alternative care bridging arrangements are considered and utilised if available and Live in Care support is being commissioned to enable customers to remain at home and facilitate discharge.

Explanation of the projection trajectory: On Track – Remaining Static

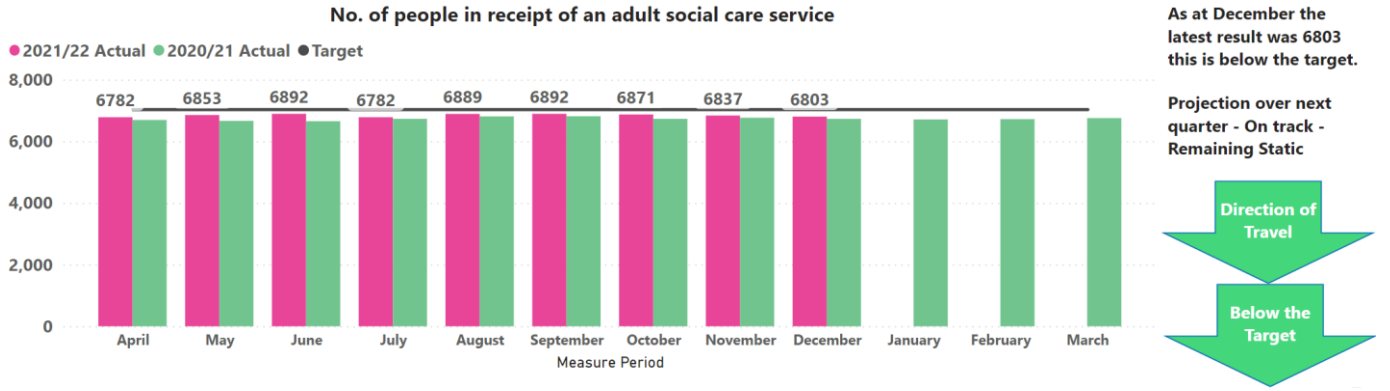
The possible reasons for the increase in December 2021 might be the pressure on hospitals and the need to discharge customers and the current domiciliary care market. Some customers are being discharged to residential and nursing beds as there is no domiciliary care in order to return home. Some customers are having to go into residential and nursing placements from the community as there is no domiciliary care for them to remain safely in the community. The trajectory is based on performance and trend.

Number of permanent admissions to residential or nursing care: under 65



Current Performance:

Overall admissions is below trajectory and continue to meet service aims to reduce the number of people under 65 who are living in residential care
Improvement Activity: To continue to consider and offer alternatives to residential care: either specialised housing with care or supported living.
Explanation of the projection trajectory: On Track – Remaining Static Alternatives to residential care in the form of specialised housing or supported living to continue to be offered.
No. of people in receipt of an adult social care service



Current Performance: The numbers of people receiving support is remaining stable and is within the expected range.
Improvement Activity: Not required.
Explanation of the projection trajectory: On Track – Remaining Static The number of people receiving support is expected to remain stable in the short to medium term.

Table 2

2.6 At Quarter 3 position, the 17% (3) measures reporting as Not on Track do not require escalating in this report, however, the associated commentary and improvement activity for all reporting measures is available as part of the OSC 2021/22 Performance Report.

2.7 Table 3 below illustrates the considered forecast performance projection over the forthcoming reporting period.

	On Track			Not on Track			Not Applicable
	Improving	Remaining Static	Declining	Improving	Remaining Static	Declining	
Warwickshire's communities and individuals are supported to be safe, healthy and independent	0	7	0	0	3	0	0
Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure	0	1	0	0	0	0	0
WCC making the best use of its resources	0	0	0	0	0	0	0

Table 4

It is forecast that over the next period of Quarter 4 2021/22, 8 KBMs will remain static with a status of On Track.

All 3 of the KBMs that are Not on Track, are projected to remain static over the forthcoming period:

- No. of people with a learning disability or autism in an inpatient unit commissioned by the Clinical Commissioning Groups (CCG) - there has already been a discharge at the start of Quarter 4, so there are currently 11 CCG inpatients for Warwickshire. There are two additional inpatients who are likely to be discharged during Quarter 4. The final actual number of inpatients at the end of Quarter 4 will depend on the effectiveness of the admission avoidance activities described above and the impact of Covid-19, but is likely to be around the Warwickshire target of 10 or slightly above;
- No. of People assisted to live independently through provision of Social Care equipment - Quarter 4 is likely to be consistent with previous Quarters in the face of the challenges set out above further exacerbated due to winter pressures and Covid-19 variants . Commissioners and practitioners will continue to work with the provider, ensuring risks are mitigated and managed; and,
- % of successful completions as a proportion of all in treatment (Opiates, Non Opiates, Alcohol and Alcohol & Non Opiates).

2.8 The Pandemic continues to impact on a proportion of these measures leading to delays in programmes of activity and both additional and frequently changing service demands. Improvement activity is in place to improve performance across all measures, and this is under constant review to ensure it is robust. Full context on all measures is provided in the Power BI report

2.9 The Council is developing a new performance management framework alongside the Council Plan refresh, which aims to provide a sharpened focus on performance and trajectory and will better support delivery of the Organisation's new priorities as outlined in the refreshed Council Plan. A Members Working Group (MWG) has been supporting the development of the new Framework and Cabinet will receive a full report, including the recommendations from the MWG and the full proposed Performance Management Framework, in March.

3. Financial Commentary

3.1. Revenue Budget

The Council has set the following performance threshold in relation to revenue spend as zero overspend and no more than a 2% underspend. The following Table X shows the forecast position for the Services concerned.

Service Area	Approved Budget	Service Forecast	(Under) /Over spend	Variation as a % of budget	Change from Q2 forecast	Represented by:				Remaining service variance as a % of budget	Remaining Service Change from Q2 forecast
						Investment Funds	Impact on Earmarked Reserves	Covid Impact	Remaining Service Variance		
	£m	£m	**£m**	**%**	£m	£m	£m	£m	£m	**%**	£m
Adult Social Care	159.399	163.086	**3.687**	**2.31%**	0.042	(0.023)	0	3.590	0.120	**0.08%**	0.165
Strategic Commissioner for People	35.767	41.347	**5.580**	**15.60%**	1.615	(0.264)	(1.454)	7.898	(0.600)	**(1.68%)**	(0.085)
Total	**195.166**	**204.433**	**9.267**	**4.75%**	**1.657**	(0.287)	**(1.454)**	**11.488**	**(0.480)**	**(1.60%)**	**0.080**

3.1.1. **Adult Social Care** reported a forecast overspend of £3.687m including £3.590m Covid pressures at the end of Quarter 3. The Covid related pressures are:

- £3.490m Enhanced hospital discharge activity which is funded from the Covid Hospital Discharge Grant.
- £0.100m Financial support to providers funded from Covid grant income.

After taking account of the impact of Covid of Investment Funds, a minor £0.023m in year underspend on an investment funded project, there is an underlying service overspend of £0.120m, which represents an increase in expenditure of £0.165m since Q2.

3.1.2. **Strategic Commissioner for People** reported a forecast overspend of £5.580m including £7.898m of Covid pressures at the end of Quarter 3.

The impact of Covid-19 on the forecasts amounts to £7.898m and at a high level relates to:

- £6.902m Covid related activity funded from the Contain Outbreak Management Fund
- £0.958m Covid related activity funded from the Test and Trace Grant
- £0.038m Covid related staffing costs funded from other Covid income.

Investment funded Creative Health and Tackling Family Poverty projects have been delayed due to covid and approval processes, leading to the in year underspend of £0.264m, funding will be required in future years.

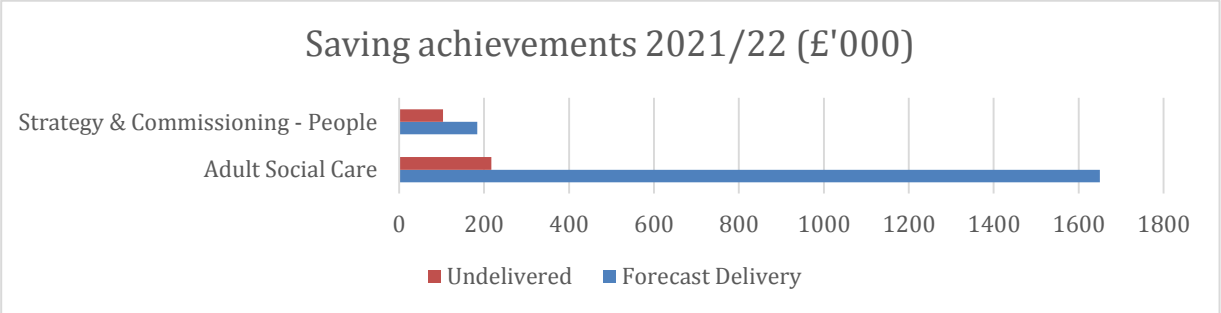
The forecast to transfer of £1.454m expected into earmark reserves primarily relates to a £0.927m underspend on Domestic Abuse Safe Accommodation which is funded from the MHCLG grant for the new statutory duty, service is continuing to progress market testing and

service scoping. There is £0.223m representing income from the Community Discharge and Integrated Commissioning for Learning Disabilities and Autism, spending plans are developed.

After taking account of Covid costs of £7.898m; the underspend of £0.264m on investment funded projects and a net transfer to earmarked reserves of £1.454m, there is a remaining service underspend of £0.600m, which represents a marginal decrease in costs of £0.085 since Q2.

3.2. Delivery of the Savings Plan

3.2.1. The savings targets and forecast outturn for the Services are shown below:



3.2.2. **Adult Social Care** saving target of £1.867m and consists of 6 schemes of which 5 forecast to be achieved with £217k shortfall relating to one saving plan. The shortfall is planned to be mitigated by underspends in the wider service area.

3.2.3. **Strategic Commissioning for People** saving target of £0.287m is expected to fully deliver two out of three saving plans for the year, with £103k shortfall on the savings plan to review services purchased from third parties. The shortfall is planned to be mitigated by underspends in the wider service area.

3.3. Capital Programme

3.3.1. The table below shows the approved capital budget for the Services, new schemes and any delay into future years.

Service	Approved 2021-22 capital programme	New projects in year	Budget Reprofile	Net over / underspend	Total capital programme	Delays	Forecast In year capital spend	Delays %
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Adult Social Care	313	0	0	0	313	0	313	0%
Strategic Commissioning & Public Health	5,295	0	0	0	5,295	0	5,295	0%

The current economic situation, both nationally and internationally post Covid-19, is likely to have an impact on the delivery of the capital programme in the short to medium term. Inflation, material shortages and supply chain issues are creating uncertainty and a challenging delivery environment.

4. Risk Management

4.1 Strategic risks were updated and assessed by Corporate Board in January 2022. Those strategic risks that align to the Committee's remit and Council Plan priority areas are reported at in the Appendix, along with mitigation strategies and an indication of the direction of travel for each risk.

4.2 Strategic areas of risk that are assessed as high (red rating) or with increasing levels of residual risk due to a challenging external environment include:

- The risk that inequalities, which were compounded by the Pandemic across a range of social, economic, education and well-being indicators, are sustained with cost-of-living increases, despite targeted catch up activity in schools, social care, community health & well-being and support for businesses.
- Risks associated with continued uncertainty about key policy, economic and funding forecasts affecting our underlying financial planning assumptions in the medium and longer term.

4.3 All Q3 service risk registers were updated by Assistant Directors and service risk owners in January. The highest rated risks and movements in risk levels are then reported to respective Directorate Leadership Teams for senior leader oversight and assurance on mitigation actions. Directorate level risk reporting will continue to evolve in 2022/23, making use of Power BI to report aggregated risk and provide a facility to drill down to risk register information. There are cross cutting strategic risk themes identified from service risk registers which also impact on Adult Social Care and Public Health, most significantly;

- The sustained risk of inflationary pressures alongside sustained levels of high demand for services, putting pressure on direct costs, service budgets, service continuity and affordability; and
- Workforce resilience and impact on service capacity and individual well-being, particularly in customer contact roles.

5. Supporting Papers

A copy of the full report and supporting documents that went to Cabinet on the 17th February is available via the committee system.

6. Environmental Implications

None specific to this report.

7. Background Papers

None

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Appendix A

1. Strategic Risk Update, Corporate Board 17 January 2022 – Q3 Risks for reporting to ASCH OSC

For each strategic risk, a **residual risk score is applied, using a consistent risk assessment matrix [(impact x likelihood) + impact]**. The positive impact of existing control and mitigation measures is also considered.

Priority Areas and Risk Appetite	Risk	Mitigation Approach	Lead Directorate	Residual Risk Scores Corporate Board assessment			
				Feb 2021	Oct 2021	January 2022	Direction of Travel
Best Lives Risk Appetite: Community safety and well being, Safeguarding. (Minimalist)	04.Risk of continuing Covid transmission and infections as a result of new covid variants and a possible surge as Covid-related restrictions are eased, resulting in adverse impacts on health & well-being, including mental health.	Campaigns and public communications to support County based vaccination programme. PH Covid Outbreak Management plan	People	12	8	12	→
	05.Risk of Post Pandemic widening of social and health inequalities and inability to catch up, compounded by challenges in healthcare catch up and cost of living increases, e.g., increased waiting lists for treatments and the emergence of long covid, resulting in worsening outcomes for our communities.	Community Powered Warwickshire Programme. Levelling Up initiatives. People Strategy & Commissioning Plans 2020-22 – Health, Well Being and Self Care, Integrated and Targeted Support.		16	16	16	→
	07: Risk of failings in the protection of vulnerable adults in our communities and the potential for legal and reputational damage to the Council.	Adult Social Care service plans; Service development and assurance frameworks including case file reviews and learning.		10	10	10	→
	08: Risk of continued and increasing levels of disruption to care markets and impacts on the supply of core provision and cost pressures from inflation, demand and legislative changes.	Integrated Commissioning approach provides some flexibility to respond to pressure points. Market viability framework; market intelligence and engagement will inform market analysis and future plans (fee levels, provider support).		12	12	16	↑
	14. Risk of continued uncertainty about key policy, economic and funding forecasts; impacting on financial planning assumptions and our ability to address the ongoing structural gap in available resources to deliver Council Plan priorities and respond effectively to unplanned events.	MTFS update process includes scenario planning and sensitivity analysis of assumptions. Shorter term volatility is managed through reserves and availability of unallocated funds. An Integrated Planning approach allows refreshed Council priorities to inform resource planning and allocation decisions, including scaling back or withdrawing from activity.	Resources	16	20	16	→

Priority Areas and Risk Appetite	Risk	Mitigation Approach	Lead Directorate	Residual Risk Scores Corporate Board assessment			
				Feb 2021	Oct 2021	January 2022	Direction of Travel
RISKS ADDED Q3	17.The risk of sustained inflationary pressures and cost of living increases putting pressure on staff costs, recruitment and retention and impacting on service resilience, service continuity and affordability as well as social, health and economic inequality.	Risk 2,5 and 14 Mitigation approach				12	↑

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Agenda Item 7(2)

Quality Account 2021-22

Trust us to care.

Contents

Please note that information regarding each area of the Trust as described in the Quality Account will be available on the Trust website

Part 1

Introduction

Foreword from the Chairman

Statement currently being finalised

Professor Ian Cumming

Chairman

Statement on Quality from the Chief Executive

Statement currently being finalised

Anthony Marsh
Chief Executive Officer

Statement on Quality from the Medical Director and Executive Nurse

Statement currently being finalised

Dr Alison Walker
Medical Director

Mark Docherty
Director of Nursing and Clinical Commissioning / Executive Nurse

Healthier Futures Partnership
Statement from the Independent Chair

This year we have once again seen real strength in the health and care services locally. Despite providing hospital care for over 8,500 people affected by COVID-19, NHS services have continued to provide other emergency and routine care and treatment. There have been over 7.4 million primary care appointments, over 18,000 babies born, more than 1,200 urgent heart surgeries, over 2,400 hip/knee operations and around 700,000 mental health contacts. Our partners in West Midlands Ambulance Service have responded to over 650,000 999 and 111 calls. Many services have had to adjust the way that they have worked to respond to demands and to keep staff and patients safe. I recognise how hard some of these changes have been for those using services, but they have been necessary in these unprecedented times, and they have ensured we have been able to be there for those most at need, when they need us most.

Health and care services have been working tirelessly to keep people safe in their own homes, promoting independence, supporting rehabilitation, and preventing emergency admissions by wrapping care around people as close to home as possible. These efforts have not only protected those who have been receiving this excellent care but also protected services from becoming overwhelmed, thus protecting others who need them too. We have over 300 care homes in the Black Country and West Birmingham and many more carers visiting people at home. My thanks go to all of those working in care for their fantastic work.

Our thriving community and voluntary sector have continued to work tirelessly to provide essential companionship and support to communities to remain strong throughout the pandemic. All four community and voluntary sector councils have come together to form an alliance which will provide resilience to their offer of support and allow them to grow stronger over the coming years.

With over 2.5 million doses delivered since December 2020, perhaps the greatest example of our partnership working has been our vaccination programme. We have opened over 100 vaccination sites, ranging from GP surgeries and pharmacies, to community halls, places of worship and of course some of our larger centres. There have been over 70 volunteers helping these sites to work well and many, many more clinical leaders, vaccinators, administrative staff and others supporting the roll-out. Recognising the hesitancy and some areas of low uptake, this year we have adopted a grass roots level of engagement. Community COVID-19 Champions have worked with local authority, voluntary and community groups and NHS staff to reach communities and take a targeted approach to getting the right information to people who need it. This network of trusted voices has undoubtedly made a difference and it is a model which has been highlighted in several national reports as best practice. I am pleased to see that through partnership working we are seeing those hesitant continuing to come forward and get the lifesaving vaccine.

Another highlight for me this year has been the collective work of our people board. The collective expertise of health and care leaders in this space has resulted in over 600 international nurses joining our system, many apprentice opportunities being created across all our partner organisations, many training opportunities, awareness sessions to support those with protected characteristics, a raft of health and wellbeing support for our workforce and events put on that celebrate those working so hard on the frontline, including a really successful event to mark Black History Month. This is an area which will continue to gather momentum over the coming year as we combine efforts to make the Black Country the best place to work.

This last year has affected us all in many ways and we have seen the far-reaching terrible impact of COVID-19 on local people and communities. There is however a positive that we should take from the fact that this pandemic has bought public health issues to the forefront and the positive impact we can have when we work better together. Across the Black Country and West Birmingham, we have some the country's most deprived neighbourhoods, some of the worst health outcomes and poorer than average life expectancy. It is no coincidence that we have seen a bigger impact than many areas from COVID-19 but it is something which we indisputably need to work together to address. This pandemic has focused our partnerships attention on the inequalities that exist for some of our communities such as those who are black, Asian and minority ethnic. As we focus on restoring services we are looking to ensure that we create a system which is weighted to support those most vulnerable, improves access and reduces these inequalities. We are committed to working with partners and communities to create an environment in which local people can live healthier lives and to make a concerted effort to reach out to those with poorer access to improve health outcomes and reduce the inequality gap.

Throughout the last 12 months, much like the previous year, the strong relationships across our partnership have ensured we have been in the best position to tackle the COVID-19 pandemic. It is true though that our partnership is only as great as the people within it, and despite the most tumultuous of years those working across health and care have dug deep to keep services going and to protect those most vulnerable. On behalf of our partnership I want to recognise the strength, the compassion, commitment and determination of our people and say thank you to each and every one of you for all you have done, and continue to do.

Looking to the future, we have made good progress towards establishing the future Integrated Care Board (ICB) and our new Integrated Care Partnership (ICP) ready for the Health and Care Bill to be enacted in July 2022. These changes will also see the movement of West Birmingham Place to the Birmingham and Solihull Integrated Care System. Our commitment is to work with colleagues in Bsol to make that transition a smooth one and for their to be minimal disruption for the people in West Birmingham. I am delighted to say that we have recruited new Board Members for the ICB, these new appointments, with their strong personal motivations and experiences, will bring different ideas, perspectives, and backgrounds to create a

stronger and more creative environment, forge ever stronger partnerships across our area, and deliver a healthier future in the Black Country.

Our strength comes from the relationships we have with each other, and this will continue to grow as our system builds new partnerships and collaboratives. Together we exist to benefit local people, and through our continued collaboration, I am confident we can deliver truly integrated health and care services of which everyone in the Black Country can be justifiably proud.

Jonathan Fellows
Independent Chair
Black Country and West Birmingham Healthier Futures Partnership

Introduction

At West Midlands Ambulance Service University NHS Foundation Trust, we place quality at the very centre of everything that we do. We work closely with partners in other emergency services, different sections of the NHS and community groups. These include working strategically with those that commission and plan local health services, which are the Sustainability and Transformation Partnerships as they transition towards Integrated Care Systems, and on a day-to-day basis with hospitals, Primary Care Networks, mental health and other specialist health and social care workers. We recognise that each care provider plays a vital role in responding to the day-to-day health needs of our population.

Having refreshed our strategy last year, we remain committed to our vision, as this continues to reflect our overall purpose:

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

Put simply, patients are central to all that we do. This means a relentless focus on the safety and experience of patients during our care and ensuring the best clinical outcomes are achieved. Our strategic objectives provide an alignment of the Vision with carefully determined priority areas of work.

We continue to promote our values which represent the professionalism, courtesy and respect that are demonstrated daily by every member of the Trust.

Values

World Class Service
Patient Centred
Dignity and Respect for All
Skilled Workforce
Teamwork
Effective Communication
Environmental Sustainability

We understand that to continue to improve quality, it is essential that our patients and staff are fully engaged with our plans and aspirations. Whilst our values were considered as part of the recent strategy refresh, there will be a much wider review in the coming year. All staff will be encouraged to participate, to ensure our values for the future continue to represent the behaviours that we all stand for and expect or each other.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status, is the highest level of "Outstanding". WMAS has no conditions attached to its registration.

The Trust has been registered with the Care Quality Commission without conditions since 2010. WMAS has not participated in any special reviews or investigations by the Care Quality Commission during 2019/20 and CQC has not taken enforcement action against West Midlands Ambulance Service during 2019/20.

During 2019/2020 the Trust updated its regulated activity following the acquisition of NHS111 and the Clinical Assessment Service. The Trust was inspected by the CQC in 2019. The final report, available from www.cqc.org.uk, confirms the Trust maintained its overall rating of Outstanding.

Care Quality Commission

West Midlands Ambulance Service University NHS Foundation Trust

Inspection report

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

Date of inspection visit: 24 Apr to 26 Apr 2019
Date of publication: 22/08/2019

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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

We regularly engage with the CQC and ensure that any information relating to our service which may be of use in system wide assessments is available and discussed where appropriate. Any actions identified through these discussions are completed promptly and kept under regular review.

Part 2

Priorities for Improvement 2022/23

We have assessed our progress against the agreed priorities for 2021/22 and have confirmed those that need to continue to ensure a high-quality service is maintained and continues to improve. In deciding our quality priorities for 2022/23 for improving patient experience, patient safety and clinical quality, we have reviewed outputs from discussions with stakeholders, engagement events, surveys, compliments, complaints and incident reporting. We regularly review all information available to us to identify trends and themes, this helps us to identify causes and priorities for improvement. We confirm the following have been identified:

Maternity

WMAS remains committed to supporting the delivery of high-quality care for women during pregnancy, childbirth and the postnatal period, taking into account changing clinical guidelines, best practice and recommendations. Our work plan in maternity care was a key priority in 2021/22, and we plan to continue this priority in 2022/23.

Mental Health

WMAS recognises a significant proportion of patients requiring urgent or emergency care have mental health needs and is committed to ensuring equity in the delivery of mental health care at the point of need through the provision of high-quality, evidence-based care. Following the appointment of a Head of Clinical Practice for Mental Health, the Trust will be developing and implementing a work plan as part of our Quality Account.

Integrated Emergency and Urgent Care Clinical Governance

Achievement of the Trust's vision relies on the efficiency and expertise at the point of initial call, regardless of the number dialed. The ability to quickly and accurately assess patient needs and identify the best response is key to achieving the best patient outcome. The Trust recognises the significant challenges it has faced during the last two years and is committed to delivering the best service to the patients it serves. By focussing upon our clinical governance arrangements, our plans will be focussed upon safety and assurance in all that we do.

Utilisation of Alternative Pathways

Delivering the Trust's Vision requires WMAS to not only always provide an effective emergency service to those who need it, but also to create the appropriate links into other services too, for example Urgent Community Response (UCR) to those patients who do not have immediately life and limb threatening illness and injury – the right response, to the right patients at the right time. Urgent Community Response is a national programme of work, being rolled out in 2021/22 and 2022/23, developing a community-based response to urgent patient needs.

Developing Our Role in Improving Public Health

WMAS provides a major gateway into the NHS for patients of all ages, and from all clinical groups. Through liaison with both patients and other healthcare providers, WMAS has both a responsibility and an opportunity to support and improve public health. Without action, all NHS services, including the ambulance service, will continue to see a rise in demand because of the wider impacts of the COVID-19 pandemic. NHS England has cited within national policies that action is needed to tackle inequalities as an integral part of Reset & Recovery planning.

Our Services

The Trust serves a population of 5.6 million who live in Shropshire, Herefordshire, Worcestershire, Coventry and Warwickshire, Staffordshire and the Birmingham and Black Country conurbation. The West Midlands sits in the heart of England, covering an area of over 5,000 square miles, over 80% of which is rural landscape.

The Trust has a budget of approximately £400 million per annum. It employs more than 7,500 staff and operates from 15 Operational Hubs together with other bases across the region. In total the Trust uses over 1000 vehicles to support front line operations including ambulances, minimal response cars, non-emergency ambulances and specialist resources such as Mental Health, Critical Care, HART and helicopters.

There are two Integrated Urgent and Emergency Operations Centres, located at Tollgate in Stafford and Brierley Hill in Dudley. Approximately 8,000 calls are received each day from both 999 and 111. These calls are handled by our dual trained call assessors and clinicians, providing the opportunity to deliver the optimum level of response to each patient, regardless of number dialled.

During 2021/22, West Midlands Ambulance Service University NHS Foundation Trust provided the following core services:

1. **Emergency and Urgent (E&U)**
   This is the best-known part of the Trust which deals with the emergency and urgent patients. Initially, the Emergency Operations Centres (EOC) answers and assesses 999 calls. EOC will then send the most appropriate ambulance crew or responder to the patient or reroute the call to a Clinical Support Desk staffed by experienced paramedics who will be able to clinically assess and give appropriate advice. Where necessary, patients will be taken by ambulance to an Accident and Emergency Department or other NHS facility such as a Walk-in Centre or Minor Injuries Unit for further assessment and treatment. Alternatively, they can refer the patient to their GP. The EOC incorporates the Strategic Capacity Cell (SCC), a specialist function with regional oversight to support the operational crews to provide the best possible outcome for patients. The staff in the SCC are able to assess the status of emergency departments throughout the region and influence the onward care for patients by facilitating the intelligent conveyance to the most appropriate destination when the most local hospital is operating at capacity.

2. **Non-Emergency Patient Transport Services (NEPTS)**
   In many respects, this part of the organisation deals with some of the most seriously and chronically ill patients. They transfer and transport patients for reasons such as hospital appointments, transfer between care sites, routine admissions and discharges and transport for continuing treatments such as renal dialysis. The Non – Emergency Patient Transport Service has its own dedicated control rooms to deal with the 1,000,000 patient journeys it undertakes annually, crews are trained as patient carers. The Trust has contracts in Birmingham, Coventry & Warwickshire, Cheshire, Walsall, Dudley and Wolverhampton. The Trust retained some existing contract through recent tender activities and has been awarded a new contract in Sandwell.

3. NHS111

In November 2019, the Trust commenced the provision of the NHS 111 service throughout the West Midlands (excluding Staffordshire). Through this service, the Trust handles more than 1,000,000 calls from patients who require advice or support in determining the best course of treatment for their presenting medical condition. These are mostly patients who do not consider themselves to require an emergency ambulance, however all calls are triaged and categorised according to the patient's clinical need, with the following outcomes:

- Calls transferred to 999 service for ambulance response 10.9 per cent
- Advice to attend Emergency Department Referrals 12.1 per cent
- Referral to Primary Care or other Service 60.0 per cent
- Referral to other service 5.3 per cent
- Self-care advice 11.7 per cent

4. **Emergency Preparedness:**

The Trust has significantly invested into Emergency Preparedness, and it remains one of the top operational priorities for the organisation. Incidents such as Grenfell and the Manchester arena bombings have highlighted the importance of Ambulance Services being prepared to deal with significant and major incidents. The Trust has been rated fully compliant in the 2021 NHS England audit of the Hazardous Area Response Team (HART) and the 2021 Emergency Preparedness Response and Recovery (EPRR) annual Core standards process. The organisation evidenced a robust set of documentation to NARU Key Lines of Enquiry in February 2022 further supporting the assurance process. The resilience team continues to ensure the Trust's plans remain current, robust and reflect any learning outcomes obtained from both local and national incidents in line with Joint Emergency Services Interoperability Principles (JESIP).

Enhancement of both HART and The Tactical Incident Commander (TIC) teams supports continuous development and improvement of our service following a key theme of the organisation. This year the Trust has moved all its commanders to electronic recording of evidence ensuring competency is in line with National Occupational Standards (NOS). Aligning values as a department with the Trust's strategy on fleet and equipment plus local investment and national influencing will ensure our specialist operations staff are provided with the very best vehicles and equipment available to ensure that should the worst happen in the West Midlands our staff are able to respond accordingly and provide world class care. Emergency Preparedness Managers will continue to focus on providing appropriate care and event management for public and private contract holders ensuring the public remain safe and well when attending events such as festivals, parades and concerts etc. The Trust has ensured that multi-agency working and engagement occurs throughout the organisation and especially within the Emergency Preparedness department. Training and exercising wherever possible includes partner agencies. Each Local Resilience Forum within the region of the Trust is served by a nominated Strategic Commander, and relevant information gained from these forums are shared internally.

Midlands Air Ambulance

In 2021 Midlands Air Ambulance Charity (MAAC) informed the Trust of their intention to seek independent CQC registration, in the same manner that the Air Ambulance Service (TAAS) currently operate. The Trust maintains a strong relationship with both organisations and has supported MAAC in gaining registration. From 1st April 2022,

WMAS will retain the MERIT Commissioned service, staffing the MERIT vehicle and regional trauma desk, both on a 24 hour basis. The Trust continue to work closely with a range of British Association of Immediate Care Schemes (BASICS) who provide the Trust with volunteer clinical staff providing enhanced care to our most seriously ill and injured patients whilst offering invaluable training opportunities to our prehospital clinicians.

Commonwealth Games

The 2022 Commonwealth Games is to be held in Birmingham commencing in July, the Trust has implemented a dedicated planning team which is working closely with the games' organising committee, external stakeholders and blue light partners to plan and prepare to deliver a safe and secure games. The planning team will produce a set project planning documentation as part of the assurance process which will reviewed both internally and externally. WMAS will second circa 400 staff from frontline operations to support games delivery, all will receive familiarisation training and commanders will undertake testing and exercising linked to their assigned venue. A number of logistical decisions have been taken to enable games time mobilisation ensuring any patients requiring medical assistance from the Trust receive world class care at this prestigious event. The robust ongoing recruitment process will ensure the organisation is able to maintain business as usual responses alongside the significant assets being directed to Commonwealth Games. The Trust will undertake a number of external assurance exercises and reviews to ensure the Trust's readiness for the event is complete.

The West Midlands Ambulance Service University NHS Foundation Trust has reviewed all the data available to them on the quality of care for these four relevant health services.

The Trust is supported by a network of volunteers. Around 400 people from all walks of life give up their time to be community first responders (CFRs). CFRs are always backed up by the Ambulance Service but there is no doubt that their early intervention has saved the lives of many people in our communities. WMAS is also assisted by voluntary organisations such as BASICS doctors, water-based Rescue Teams and 4x4 organisations.

The Trust does not sub-contract to private or voluntary ambulance services for provision of its E&U services.

To ensure excellent business continuity in support of major incidents the Trust has agreements in place to request support from other NHS Ambulance Services.

The Trust has utilised the services of private providers during 2021/22 to support Non – Emergency Patient Transport Services. particularly during the introduction of new contracts and to facilitate social distancing and safe working practices throughout the pandemic. Sub-contractors are subjected to a robust governance review before they are utilised.

The income generated by the relevant health services reviewed in 2021/22 represents 99.66% of the total income generated from the provision of health services by the Trust for 2021/22. More detail relating to the financial position of the Trust is available in the Trust's 2020/21 Annual Report.

Performance - Emergency and Urgent Service

The Trust is measured nationally against **operational standards for the Emergency and Urgent Service**. Due to its participation in the national Ambulance Response Programme and early implementation of the recommendations, the Trust has been measured against the new national standards since September 2017.

These standards are:

Category 1
Calls from people with life-threatening illnesses or injuries

- 7 Minutes mean response time
- 15 Minutes 90th centile response time

Category 2
Serious Condition that requires rapid assessment (Serious Injury, Stroke, Sepsis, major burns etc.)

- 18 minutes mean response time
- 40 minutes 90th centile response time

Category 3
Urgent but not life threatening (e.g., pain control, non-emergency pregnancy)

- 120 minutes 90th centile response time

Category 4
Not urgent but require a face-to-face assessment.

- 180 minutes 90th centile response time

Ambulance Quality Indicators

National Audits

Ambulance Services are not included in the formal National Clinical Audit programme, however, during 2020-2021 the Trust participated in the following National Ambulance Clinical Quality Indicators Audits:

1. **Care of ST Elevation Myocardial Infarction (STEMI)**
   This is a type of heart attack that can be diagnosed in the pre-hospital environment. Patients diagnosed with this condition are often taken directly to specialist centres that can undertake Primary Percutaneous Coronary Intervention (PPCI).

   Audit Element

   Percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period.

   In patients diagnosed with STEMI it is important to get them to a Primary Percutaneous Coronary Intervention (PPCI) centre as quickly as possible - MINAP records the time that the PPCI balloon is inflated by the hospital.

   Audit Element

   The Trust measures 999 Call to catheter insertion by the mean and 90th percentile.

2. **Care of Stroke Patients**

   A stroke is a brain attack. It happens when the blood supply to part of your brain is cut off. Blood carries essential nutrients and oxygen to your brain. Without blood your brain cells can be damaged or die. A stroke can affect the way your body works as well as how you think, feel, and communicate.

   Audit Element

   1. *Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period.*
   2. *The mean, median and 90th centile time from the call for help until hospital arrival for confirmed stroke patients*
   3. *The mean, median and 90th centile time from the arrival at hospital to scan for patients who receive a CT scan*
   4. *The mean, median and 90th centile time from the arrival at hospital to thrombolysis for patients who receive treatment*

Face – can they smile or does one side droop? Arms – Can they lift both arms or is one weak? Speech – is their speech slurred/muddled? Time to call 999.

3. **Care of Patients in Cardiac Arrest**
   In patients who suffer an out of hospital cardiac arrest the delivery of early access, early CPR, early defibrillation and early advanced cardiac life support is vital to reduce the

proportion of patients who die from out of hospital cardiac arrest. The Trust provides data to the Out of Hospital Cardiac Arrest Outcomes Registry.

Audit Element

Percentage of patients with out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital and patients that survive to hospital discharge and a care bundle for treatment given post return of spontaneous circulation.

4. Sepsis

Sepsis is a serious complication of an infection. Without quick treatment, *sepsis* can lead to multiple organ failure and death.

Audit Element

Percentage of patients where observations were assessed, oxygen administered where appropriate, fluids administration was commenced and recorded, and a Hospital pre-alert was recorded.

The reports of the National AQIs were reviewed by the Trust in 2020-2021 and the following actions are intended to improve the quality of healthcare provided for patients:

- Communications including compliance with indicators through the Trust “Weekly Briefing” and “Clinical Times”
- Awareness campaign to reduce 999 on scene times.
- Development and review of individual staff performance from the Electronic Patient Record.

Local Audits

The below details the local clinical audit programme and two examples of clinical audits that were completed during 2021-2022:

Drug Administration
PGD Administration
Administration of Morphine Audit
Administration of Adrenaline 1:1000
Administration of Naloxone
Pre Hospital Thrombolysis
Administration of Activated Charcoal
Administration of Co-amoxiclav
Administration of Salbutamol MDI

Current NICE Clinical Audits
Management of Deliberate Self Harm Patients
Locally Identified Concerns
Management of Paediatric Pain
Management of Head Injury
Maternity Management
Post Intubation Documentation Audit
Post-partum haemorrhage (PPH) management
Falls >=65 discharged at scene
Non traumatic chest pain >=18 years discharged at scene
Head Injury discharged at scene discharged at scene
Feverish Illness in children (<16, Temp>=37.8) discharged at scene
Post RSI Sedation audit
Deliberate Self Harm

National Ambulance Indicators
Cardiac Arrest - Return of Spontaneous Circulation (Overall)
Cardiac Arrest - Return of Spontaneous Circulation (Comparator)
Cardiac Arrest - Survival to discharge (Overall)
Cardiac Arrest - Survival to discharge (Comparator)
Post-ROSC Care Bundle
STEMI Care Bundle
Stroke Care Bundle
Sepsis Care Bundle
Further information on National Indicators: EPR AQI Guidance

Participation in Research

During 2021/22, the Trust has continued to expand the opportunities for staff and patients to be involved in pre-hospital research, making huge steps forward in forging academic and research relationships in collaboration with local universities, culminating in West Midlands Ambulance Service becoming a University Ambulance Service.

The Trust continues to acknowledge that research active Trusts are associated with improved patient outcomes. During the year, the Trust has continued to develop strong partnerships with NHS Trusts and universities from across the UK. Key to the success of research delivery within the Trust are the excellent relationships built with the West Midlands Clinical Research Network, who help us to ensure that all research undertaken by the Trust is ethical, and complies with the highest standards of research governance, to safeguard our patients and colleagues.

The number of participants that were recruited during the 2021/22 period to participate in research approved by the Health Research Authority and a Research Ethics Committee was 987. During this period the Trust participated in 16 research studies meeting these criteria, of which 15 studies were categorised as National Institute of Health Research Portfolio eligible.

The following research studies have continued during 2020/21

Epidemiology and Outcomes from Out of Hospital Cardiac Arrest Outcomes

Survival from cardiac arrest differs around the country. This project aims to establish the reasons behind these differences in outcome. It takes a standardised approach to collecting information about Out of Hospital Cardiac Arrest and for finding out if a resuscitation attempt was successful. The project will use statistics to explain the reasons why survival rates vary between region. It is sponsored by Warwick University and funded by the Resuscitation Council (UK) and British Heart Foundation.

Golden Hour (Brain Biomarkers after Trauma)

Traumatic Brain Injury is a major cause of illness, disability and death and disproportionally affects otherwise young and healthy individuals. Biomarkers are any characteristic which may be used to gain insight into the person either when normal or following injury or disease. The study will look at biomarkers taken from blood, from fluid in the brain tissue and from new types of brain scans and investigate whether any biomarkers can give us insight into new treatments. West Midlands Ambulance Service and Midlands Air Ambulance are working with the University of Birmingham to support this study. This study is currently paused by the University of Birmingham, due to the COVID-19 pandemic.

Resuscitation with Pre-Hospital Blood Products (RePHILL)

WMAS and Midlands Air Ambulance are working with University Hospitals Birmingham to investigate whether giving blood products (red blood cells and freeze-dried plasma) to badly injured adult patients, before reaching hospital improves their clinical condition and survival. Patients with major bleeding are currently given clear fluids but military and civilian research suggests that survival could increase if hospital patients receive blood products instead.

Major Trauma Triage Tool Study (MATTS)

MATTS will carefully study existing triage tools used in England and world-wide. We will also use data already collected by ambulance services and the English national major trauma database (the Trauma Audit and Research Network, TARN) to investigate what factors are important for detecting serious injury at the scene of the incident. Additionally, the study will develop a computer model that simulates the costs and outcomes of using different triage tools. Together, we will take this information to a group of experts and ask them to develop a new triage tool. Participating ambulance services will then test the experts' triage tool, together with other existing tools, to see how they perform.

Strategies to Manage Emergency Ambulance Telephone Callers with Sustained High Needs (Using Linked Data)

To evaluate effectiveness, safety and efficiency of case management approaches to the care of people who frequently call the emergency ambulance service; and gain understanding of barriers and facilitators to implementation. For high 999 service users: What are the demographics, case mix and patterns of use? What are the costs and effects of case management across the emergency care system? What are the facilitators and barriers to implementation?

PIONEER is the Health Data Research Hub for Acute Care, led by the University of Birmingham and University Hospitals Birmingham NHS Foundation Trust, in partnership with West Midlands Ambulance Service, the University of Warwick, and Insignia Medical Systems. Acute care is the provision of unplanned medical care; from out of hours primary care, ambulance assessment, emergency medicine, surgery and intensive care. Demand for acute health services are currently unsustainable for our national healthcare resource. Despite this, there has been less innovation in acute care than in many others health sectors, in part due to siloed information about patients with acute illnesses. The PIONEER Hub collects and curates acute care data from across the health economy, including primary, secondary, social care, and ambulance data. PIONEER uses this data to provide accurate, real-time data for capacity planning and service innovation support learning healthcare systems including better use of current/novel investigations, treatments and pathways map innovation needed.

Accuracy, impact, and cost-effectiveness of prehospital clinical early warning scores for adults with suspected sepsis (PHEWS)

The study will test early warning scores for sepsis, collect data from a large group of people who are brought to hospital by ambulance and might have sepsis. We will determine whether patients actually have sepsis and whether they needed urgent treatment. We will determine how accurately the early warning scores identified people with and without sepsis that needed urgent treatment. We will then use mathematical modelling to compare different early warning scores in terms of improving survival and effects on organisation of the emergency department and the costs of providing care. This will allow us to identify the best early warning score for the NHS.

Community First Responders' role in the current and future rural health and care workforce

Community First Responders (CFRs) are trained members of the public, lay people or off-duty healthcare staff who volunteer to provide first aid. They help ambulance services to provide emergency care for people at home or in public places. CFRs are vital in isolated rural areas. CFRs are broadly perceived to be positive, but we need evidence on how they

contribute to rural health services and how they improve care for rural communities. We aim to develop recommendations for rural CFRs, by exploring their contribution to rural care and exploring the potential for CFRs to provide new services.

COPE-West Midlands: The contribution of occupational exposures to risk of COVID-19 and approaches to control among healthcare workers (COPE-WM)

Healthcare workers have higher risk of getting coronavirus (COVID-19 disease). Contact with infected patients, the type of work and measures such as use of masks affect their risk. However, factors outside the workplace are also important. For example, being older, from minority ethnic groups, some health conditions and home circumstances increase risk. We don't know how these aspects compare with workplace risks, or which work exposures are most risky. We will invite about 5000 staff with different job-roles and departments from three large West Midlands NHS Trusts to join our study. We will compare workplace exposures and other characteristics amongst those who had positive with those who had negative tests. Our findings will help us to better understand the risk of infection among healthcare workers and to develop guidelines to reduce risk.

What TRIage model is safest and most effective for the Management of 999 callers with suspected COVID-19? A linked outcome study

To evaluate models used to triage and manage emergency ambulance service care for patients with suspected COVID- 19 who call 999 in England, Wales and Scotland. The study's objectives are to categorise models of triage used in emergency ambulance services during the 2020 COVID-19 pandemic and to compare processes and outcomes of care between models identified using linked anonymised data.

The following research studies have commenced during 2021/22

Paramedic Analgesia Comparing Ketamine and MorphiNe in trauma (PACKMaN)

The PACKMaN study aims to find out if ketamine is better than morphine at reducing pain in adults with severe pain due to traumatic injury. Pain from severe trauma has been reported as being poorly treated and NHS Paramedics have a limited formulary of medicines to treat severe pain. Current practice might suggest that patients with severe pain following trauma may receive Morphine, which can be slow to reach peak effect and has a number of associated side effects. Ketamine may be an ideal prehospital drug due to it being a safe option and quick to take effect.

Impact of pre-alerts on patients, ambulance service and ED staff

When a patient is seriously ill, ambulance staff may call the Emergency Department (ED) to let them know the patient is on their way. This is known as a 'pre-alert' and can help the ED to free up a trolley space or bed and get specialist staff ready to treat the patient as soon as they arrive. If used correctly, pre-alerts can help to provide better care, earlier access to time-critical treatment and improved outcomes for patients. However, if used too often, or for the wrong patients, then the ED staff may not be able to respond properly and may stop taking them seriously. This has important risks for patient safety. This study will explore how pre-alerts are being used and how there use can be improved.

A mixed-methods study of female ambulance staff experiences of the menopause transition (CESSATION)

The aims of this study are to identify current menopause guidance, policies and support offered by United Kingdom (UK) ambulance services; understand work and personal impacts of the menopause on female ambulance staff and their managers; and identify service developments that may best support female ambulance staff during this life phase. From the study findings, potential menopause service developments and interventions will be identified for female ambulance staff and service managers, and there will be improved menopause transition awareness across all UK ambulance services. Further research activities will be needed to explore the impact of any new interventions on staff health and wellbeing.

Experiences of staff providing telephone CPR instruction

This study aims to improve outcomes of patients who suffer out of hospital cardiac arrest, by applying behavioural science to enhance telephone assistance and increase rates of bystander cardiopulmonary resuscitation.

Prehospital feedback in the United Kingdom: A realist evaluation of current practice using a multiple-case study design (PRE-FEED REAL)

Prehospital feedback is increasingly receiving attention from clinicians, managers and researchers. The effectiveness of feedback in changing professional behaviour and improving clinical performance is strongly evidenced across a range of healthcare settings, but this has not yet been replicated within the prehospital context. Without a firmer evidence base, development in practice relies on isolated initiatives with no clear intervention model or evaluative framework. The aim of this study is to understand how UK ambulance services are currently meeting the challenge of providing prehospital feedback and develop an evidence-based theory of how prehospital feedback interventions work.

Pre-hospitAl RAndomised trial of MEDICation route in out-of-hospital cardiac arrest (PARAMEDIC3)

PARAMEDIC3 Medication Route in Cardiac Arrest

Each year over 30,000 people's hearts suddenly stop beating in communities around the UK (a condition known as cardiac arrest). Unless the heart is restarted quickly, the brain will become permanently damaged, and the person will die. Injecting drugs such as adrenaline through a vein is very effective at restarting the heart. Current guidelines advise paramedics to inject drugs into a vein. However, a new, faster way of giving drugs is to put a small needle into an arm or leg bone. This allows drugs to be injected directly into the rich blood supply found in the bone marrow. Some research studies suggest this may be as good, if not better, than injecting drugs into the vein. Other studies suggest it may be less effective. None of the existing research is good enough to help paramedics decide how best to treat people with cardiac arrest. Both of these approaches are already currently used in NHS practice. In this trial, we will test these two ways of giving drugs (into the vein or into the bone) to work out which is most effective at improving survival in people that have a cardiac arrest.

Sustainability

Over the last 10 years, the NHS has taken notable steps to reduce its impact on climate change. As the biggest employer in this country, there is more that the NHS can do. Action must not only cut NHS emissions, currently equivalent to 4% of England's total carbon footprint, but also build adaptive capacity and resilience into the way care is provided.

WMAS have led the way in the ambulance service implementing a large amount of change to our operation which has led to significant reductions in our direct and indirect carbon footprint, including:

- Implementing the Make Ready Model – reducing the estate portfolio by Commissioning new build sites compliant with the exacting requirements in the BREEAM standards.
- Changing our lighting on sites to LED lighting reducing a significant amount of electricity usage
- Delivering a fleet replacement programme with no front-line operational vehicles over 5 years old – WMAS now operate the most modern ambulance fleet in the country which are compliant to the latest euro emission standards.

West Midlands Ambulance Service University NHS Foundation Trust is committed to the ongoing protection of the environment through the development of a sustainable strategy. Sustainability is often defined as meeting the needs of today without compromising the needs of tomorrow.

A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage.

The Trust's Green Plan sets out the Trust's commitment to ensure governance and management arrangements are in place to deliver both the Trust's statutory responsibilities for sustainability and to achieve the target set by the NHS of reducing its carbon footprint set out in "Delivering a Net ZERO National Health Service (published October 2020).

To summarise our programme of work and key achievements to date:

- **Estates**
  Since 2011, the Trust has engaged in a significant programme of activity to manage and reduce our carbon footprint, mitigate our impact on air pollution which has allowed the Trust to achieve a 14.2% reduction in CO^2 in electricity at one of our major Hubs in 2021.

- **Fleet**
  Progress towards delivering a Net Zero NHS includes a series of achievements including the newest ambulance fleet in the country, with all vehicles less being than five years old and achieving continued weight savings.

  A range of electric vehicles in use including the country's first fully electric double crewed ambulance, a range of operational managers' and support cars and PTS vehicles

Looking to the future, we aim to reduce our carbon emissions by 25 per cent by 2025, with an 80 percent reduction by 2032, and net zero by 2040. This is supported by a delivery plan with the following components:

- Estates – to include renewable energy, LED lighting, use of smart meters, water saving devices, intelligent heating systems and other sustainable initiatives
- Transport – zero emission vehicles and electric charging points, reduced business miles and cycle to work schemes
- Waste Management – Introduction of recycling at all sites following successful trial at Erdington Hub, which resulted in the equivalent of the following carbon savings:

- Reducing single use plastics – working alongside our cleaning contract provider to build a comparison over the next 12 months regarding our usage prior to the switch over to PVA and post PVA to show the plastic saving across the Trust.

Data Quality

West Midlands Ambulance Service will be taking the following actions to assure and improve data quality for the clinical indicators while the Clinical Audit Department completes the data collection and reports. The patient group is identified using standard queries based on the Electronic Patient Record. These clinical records are then audited manually by the Clinical Audit Team using set guidance. The data is also clinically validated and then analysed following an office procedure that is available to the Clinical Audit Team and is held on the central Clinical Audit Team's drive. The process is summarised as:

- For the clinical indicators, the Clinical Audit Team completes the data collection and reports.
- The Patient Report Forms/Electronic Patient Records are audited manually by the Clinical Audit Team.
- A process for the completion of the indicators is held within the Clinical Audit Department on the central Teams site.
- A Clinician then reviews the data collected by the Clinical Audit Team.
- The data is then analysed, and reports generated following a standard office procedure. A second person within the Clinical Audit Team checks for any anomalies in the data.
- The results are checked for trends and consistency against the previous month's data.
- The Clinical Indicators are reported through the Trust Clinical Performance Scorecard.

The reports are then shared via the Trust governance structure to the Board, of Directors, Commissioners and Service Delivery meetings.

NHS Number and General Medical Practice Code Validity
The Trust was not required to and therefore did not submit records during 2021/22 to the Secondary Uses service for inclusion in the Hospital Episode Statistics to be included in the latest published data.

Data Security and Protection Toolkit
The Trust continues to work on the NHS Data Security and Protection Toolkit (DSPT) for 2021-22 (version 4). The baseline deadline was extended by NHSE from the 28 February 2022 to the 4 March 2022. This was to provide specific assurance following advice to NHS organisation from the Cyber Associates Network. The Trust completed its baseline assessment.

The process for assurance of the DSPT was reviewed by internal audit and was reported to the Trust's Audit Committee as 'optimal' on the 14 March 2022, the highest possible assurance. The submission of the DSPT is 30 June 2022. The Trust will receive regular reports on the progress of DSPT through the Health Safety Risk & Environmental Group, Quality Governance Committee, Executive Management Board and Trust Board. The Trust's Head of Governance and Security reports the DSPT through to the Executive Director of Nursing & Clinical Commissioning, and is responsible for management of the DSPT.

Clinical Coding Error Rate
West Midlands Ambulance Service was not subject to the Payment by Results clinical coding audit during 2021/2022 by the Audit Commission.

NICE Guidance
The Trust monitors NICE guidance to ensure relevance to the services we provide is identified. These are reported and reviewed at Professional Standards Group (PSG).

Learning from Deaths

In March 2017, the National Quality Board (NQB) produced a framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. At the time of publication, the applicability of the NQB Framework and how it would be applied within the ambulance services was unclear, however, from February 2018 it became a contractual obligation that implementation would commence from 1st April 2018. In July 2019, with an implementation date of January 2020, the National Guidance for Ambulance Trusts on Learning from Deaths was published that gave further clarity on how the Learning from Deaths Framework should be applied. WMAS have implemented all the requirements specified within The Learning from Deaths Framework and additionally have employed a full time Patient Safety Officer to ensure it is successfully imbedded into the learning culture of WMAS.

During the 2021/22 reporting year, the total number of deaths that occurred, while in WMAS care, was 771. This aggregate figure represents quarterly totals of:

- 158 in quarter one
- 194 in quarter two
- 222 in quarter three
- 197 in quarter four

During the 2021/22 reporting year, 560 case record reviews and 184 investigations were conducted. WMAS, although not stipulated within the National Guidance for Ambulance Trusts, have adopted the approach that where deaths have occurred while in WMAS care, all will receive a case record review. Therefore, the number of case record reviews that have been conducted will be identical to the number of deaths that have occurred while in WMAS care. This aggregate figure represents quarterly totals of:

- 158 case record reviews and 43 investigations in quarter one
- 194 case record reviews and 74 investigations in quarter two
- 222 case record reviews and 11 investigations in quarter three
- 197 case record reviews and 67 investigations in quarter four

During the 2021/22 reporting year, upon initial case record review or investigation, 77 of the 771 deaths or 9.98% were considered more likely than not to have been due to problems in the care provided to the patient. This number and percentage have been estimated as a result of each case meeting the threshold for investigation under the Serious Incident Framework, which may ultimately determine that there were no problems in the care that was provided. The aggregate figure and percentage represent quarterly totals of:

- 19 deaths or 2.49% in quarter one
- 29 deaths or 3.80% in quarter two
- 0 deaths or 0% in quarter three (patient records in this quarter were not available for review following a change of electronic system. All reporting was reinstated for quarter 4 onwards.
- 29 deaths or 3.76% in quarter four

Please note that all figures highlighted above will be updated in time for the final Quality Account to be published.

All deaths where it was considered more likely than not to have been due to problems in the care WMAS provided to the patient are managed and reported under the Serious Incident Framework. The purpose of a Serious Incident process is to identify the root cause and furthermore to establish what lessons can be learnt to prevent reoccurrence. To ensure learning occurs from the Serious Incident investigation process; actions plans are formulated, and these are instigated and monitored by the WMAS Learning Review Group.

In the previous 2020-2021 Quality Account reporting period, the following information was published that remains correct:

37 of the 891 deaths or 4.15% were considered, upon initial case record review or investigation, more likely than not to have been due to problems in the care provided to the patient.

Performance Against Quality Indicators

To ensure patients of the West Midlands receive quality care from their Ambulance Service a set of national Ambulance Quality Indicators have been set. This helps set our policies and guidelines and develop our organisational culture that places quality at the top of the Trust agenda. The following details the figures for each and highlights the national mean percentage and position of WMAS against other Trusts.

Operational Performance

Ambulance Services nationally have again struggled to meet both national performance targets and efficiency targets in 2020/21 but West Midlands Ambulance Service University NHS Foundation Trust has continued to perform well, consistently exceeded the national average in all measures as shown in the following table:

Category	Performance Standard	Achievement	National Average (to be published by mid April 2022)
Category 1	7 Minutes mean response time	7 mins 50 seconds	
	15 Minutes 90th centile response time	13 minutes 46 seconds	
Category 2	18 minutes mean response time	32 minutes 53 seconds	
	40 minutes 90th centile response time	72 minutes 52 seconds	
Category 3	120 minutes 90th centile response time	331 minutes 48 seconds	
Category 4	180 minutes 90th centile response time	384 minutes 38 seconds	

We continue to work with our Commissioners and other providers such as acute hospital colleagues to ensure improvements in the provision of healthcare for the people of the West Midlands. WMAS continues to employ the highest paramedic skill mix in the country with a paramedic present in virtually all crews attending patients every day.

WMAS considers that this data is as described for the following reasons: it has been cross checked with Trust database systems and is consistent with national benchmarking and has been audited by external auditors.

Ambulance Quality Indicators

1. **Care of ST Elevation Myocardial Infarction (STEMI)**
   Percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction (type of heart attack) who received an appropriate care bundle from the trust during the reporting period.
2. **Care of Stroke Patients**
   Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.
3. **Care of Patients in Cardiac Arrest**
   In patients who suffer an out of hospital cardiac arrest the delivery of early access, early CPR, early defibrillation and early advanced cardiac life support is vital to reduce the proportion of patients who die from cardiac arrest.
4. **Sepsis**
   Sepsis is a serious complication of an infection. Without quick treatment, *sepsis* can lead to multiple organ failure and death.

STEMI (ST- elevation myocardial infarction)
This is a type of heart attack. It is important that these patients receive:

- Aspirin - this is important as it can help reduce blood clots forming.
- GTN – this is a drug that increases blood flow through the blood vessels within the heart. (Improving the oxygen supply to the heart muscle and also reducing pain).
- Pain scores – so that we can assess whether the pain killers given have reduced the pain.
- Morphine – a strong pain killer which would usually be the drug of choice for heart attack patients.
- Analgesia – Sometimes if morphine cannot be given Entonox, a type of gas often given in childbirth, is used.

The Care Bundle requires each patient to receive each of the above. In addition to the care bundle the Trust measures 999 Call to catheter insertion by the mean and 90th percentile.

Stroke Care Bundle
A stroke care bundle includes early recognition of onset of stroke symptoms and application of the care bundle. The Stroke Care Bundle requires each patient to receive each of the detailed interventions below:

- FAST assessment - A FAST test consists of three assessments; has the patient got Facial weakness, or Arm weakness or is their Speech slurred.
- Blood glucose - In order to rule out the presence of hypoglycaemia patients suspected of having suffered a stroke should have their blood glucose measured
- Blood pressure measurement documented - Raised blood pressure is associated with increased risk of stroke so patients suspected of having suffered a stroke should have their blood pressure assessed.

In addition to the care bundle the Trust measures 999 Call to Hospital, 999 call to CT Scan and Arrival to Hospital to Thrombolysis by the mean, median and 90th percentile.

Cardiac Arrest

A cardiac arrest happens when your heart stops pumping blood around your body. If someone suddenly collapses, is not breathing normally and is unresponsive, they are in cardiac arrest. The AQI includes:

- Number of cardiac arrests
- ROSC (return of spontaneous circulation) on arrival at Hospital
- Survival to discharge from hospital
- Post Resuscitation care bundle

ROSC and Survival to discharge from hospital are reported within two different groups as follows:

- Overall Group
  - Resuscitation has commenced in cardiac arrest patients
- Comparator Group
  - Resuscitation has commenced in cardiac arrest patients AND
  - The initial rhythm that is recorded is VF / VT i.e., the rhythm is shockable AND
  - The cardiac arrest has been witnessed by a bystander AND
  - The reason for the cardiac arrest is of cardiac origin i.e., it is not a drowning or trauma cause.

  In this element, we would expect a higher performance than the first group.

Post Resuscitation Care Bundle

- 12 lead ECG taken post-ROSC
- Blood glucose recorded?
- End-tidal CO2 recorded?
- Oxygen administered?
- Blood pressure recorded?
- Fluids administration commenced?

Care bundles include a collection of interventions that when applied together can help to improve the outcome for the patient.

Sepsis

Sepsis is a serious complication of an infection. Without quick treatment, *sepsis* can lead to multiple organ failure and death.

- Observations assessed?
- Oxygen administered where appropriate?
- Fluids administration commenced?
- Administration of fluids recorded
- Hospital pre-alert recorded?

Year-to-date Clinical Performance AQI's

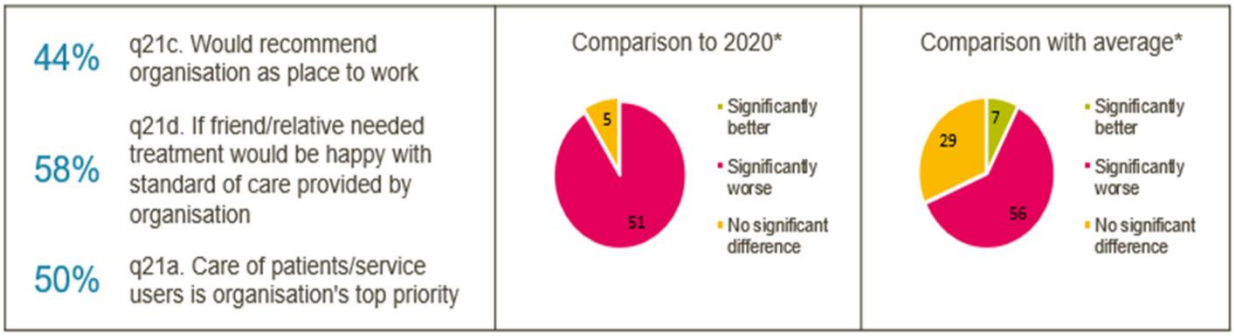
Mean (YTD)										
Ambulance Quality Indicators	**WMAS (15-16)**	**WMAS (16-17)**	**WMAS (17-18)**	**WMAS (18-19)**	**WMAS (19-20)**	**WMAS (20-21)**	**WMAS (21-22)**	**Last National Average**	**Highest**	**Lowest**
STEMI Care Bundle	77.99%	81.17%	81.01%	95.97%	97.14%	95.56%	86.80%	76.09%	96.88%	64.85%
Stroke Care Bundle	98.19%	97.36%	95.19%	98.98%	98.66%	99.20%	98.67%	97.91%	99.77%	96.86%
Cardiac Arrest - ROSC At Hospital (Overall Group)	30.17%	29.49%	29.26%	32.31%	32.61%	25.12%	25.92%	26.00%	30.84%	21.84%
Cardiac Arrest - ROSC At Hospital (Comparator)	50.61%	45.60%	51.91%	54.93%	53.98%	44.34%	44.08%	46.16%	31.25%	59.09%
Cardiac Arrest - Survival to Hospital Discharge (Overall Group) ***	8.66%	8.94%	9.08%	11.56%	10.16%	8.15%	8.42%	9.22%	11.99%	5.30%
Cardiac Arrest - Survival to Hospital Discharge (Comparator Group) ***	24.69%	26.39%	30.43%	32.61%	27.80%	22.26%	25.93%	26.21%	50.00%	16.28%
Sepsis Care Bundle					83.62%	84.96%	88.95%	83.02%	90.16%	87.86%
Post Resuscitation					69.33%	69.68%	66.90%	76.89%	74.04%	60.75%
	* The Trust is permitted to re-submit nationally reported clinical data to NHS England twice a year. This is to allow for data to be accessed from hospitals for outcome data and to ensure a continual validation of data can be completed. The figures in the above table are therefore subject to change. ** Due to changes in the reporting of national Ambulance Clinical Quality Indicators, not all AQIs will be reported monthly. Future figures will be reported as per the new National AQI Timetable. *** Survival to discharge data is reported at 30 days. At time of compiling report 30-day period had not passed therefore ytd figures may not be completely accurate.									

Clinical Data Notes

- *STEMI, Stroke, Cardiac Overall, Cardiac Comparator, Survival Overall, Survival Comparator **YTD** is based on April 2021 to February 2022.*
- *POST ROSC YTD is currently based on 4 Submissions of April 2021, July 2021, October 2021, January 2022.*
- *Sepsis YTD is currently based on 3 submissions of June 2021, September 2021 and December 2021.*

What our Staff Say

The National NHS Staff Survey is one of the largest workforce surveys in the world and has been conducted since 2003. It is a survey that asks NHS staff in England about their experiences for working for their NHS organisations. It provides essential information to employers and national stakeholders about improvements required in the NHS. At West Midlands Ambulance Service this survey took place in the third quarter from 20th September to 26th November 2021. The survey was conducted by Picker Europe Ltd and once again the Board of Directors took the decision to run a census. The survey was conducted electronically for accessibility and to maintain confidentiality and anonymity. 6884 staff were eligible to take part in the 2021 staff survey and 3028 staff returned a completed survey compared to 3724 in 2020. The response rate for WMAS is 44% compared to 56% in the 2020 survey. The average response rate for all Ambulance Trusts is 57% and across the NHS is 48%.



An overview of the 2021 staff survey results reported by our contractor is shown below.

The first chart in the image above shows the number of questions that are better, worse or with no significant difference compared to the organisation's results in 2020. It is to be noted that some questions could not be compared as they were recently added in the 2021 survey, or some questions were changed during the redevelopment of the questionnaire. The second chart shows the number of questions that are better, worse or with no significant difference compared to other Ambulance Trusts in the 2021 survey.

From 2021 the NHS Staff Survey has been re-developed to align with the People Promise in the 2020/21 People Plan. Changes to the questionnaire were made following consultation with various participating organisations (including WMAS) and reviews led by the Staff Experience and Engagement team at NHS England and NHS Improvement, with the support of the Staff Survey Advisory Group, the Survey Coordination Centre, and academic experts. Reporting of staff survey results is based around the seven People Promise elements along with measures on Staff Engagement and Morale.

People Promise element	Sub-scores
Promise 1: *We are compassionate and inclusive*	P1.1: Compassionate culture P1.2: Compassionate leadership P1.3: Diversity and equality P1.4: Inclusion
Promise 2: *We are recognised and rewarded*	[No sub scores]
Promise 3: *We each have a voice that counts*	P3.1: Autonomy and control P3.2: Raising concerns

People Promise element	Sub-scores
Promise 4: *We are safe and healthy*	P4:1 Health and safety climate P4:2 Burnout P4:3 Negative experiences
Promise 5: *We are always learning*	P5.1: Development P5.2: Appraisals
Promise 6: *We work flexibly*	P6.1: Support for work-life balance P6.2: Flexible working
Promise 7: *We are a team*	P7.1: Team working P7.2: Line management
Measure	**Sub-scores***
Staff Engagement	E.1: Motivation E.2: Involvement E.3: Advocacy
Morale	M.1: Thinking about leaving M.2: Work pressure M.3: Stressors (HSE index)

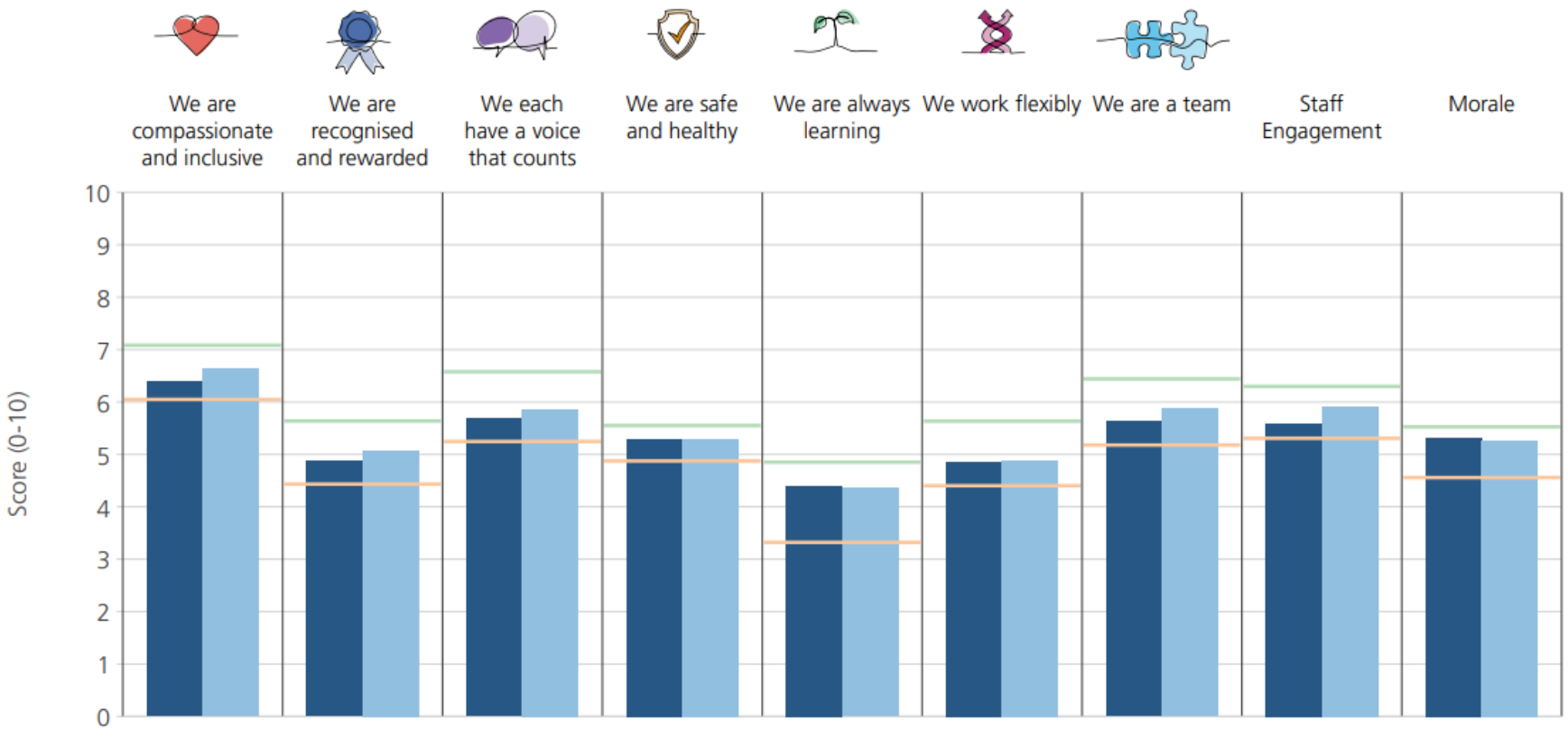
The theme scores that were being reported in previous years, has ceased from 2021. The table below presents the results of significance testing conducted on the theme scores calculated in both 2020 and 2021. Note that results for the People Promise elements are not available for 2020. The table details the organisation's theme scores for both years and the number of responses each of these are based on. The final column contains the outcome of the significance testing:(🡅) indicates that the 2021 score is significantly higher than last year's, whereas (🡇) indicates that the 2021 score is significantly lower. When there is no comparable data from the past survey, you will see N/A.

People Promise elements	2020 score	2020 respondents	2021 score	2021 respondents	Statistically significant change?
We are compassionate and inclusive			**6.4**	2910	N/A
We are recognised and rewarded			**4.9**	2985	N/A
We each have a voice that counts			**5.7**	2866	N/A
We are safe and healthy			**5.3**	2906	N/A
We are always learning			**4.4**	2740	N/A
We work flexibly			**4.9**	2968	N/A
We are a team			**5.6**	2928	N/A
Themes	**2020 score**	**2020 respondents**	**2021 score**	**2021 respondents**	**Statistically significant change?**
Staff Engagement	**6.3**	3678	**5.6**	2992	🡇
Morale	**6.2**	3651	**5.3**	2980	🡇

The new summary reports are shown below. People Promise elements and theme scores are calculated on key questions from the survey. For most elements/themes, this includes a series of sub-score categories as well. The maximum possible score is 10 (all respondents answer most positively) and the lowest possible score is 0 (all respondents answer most negatively).

Section	Description	Organisation Score
People Promise element 1: We are compassionate and inclusive	Compassionate culture sub-score	6.2
	Compassionate leadership sub-score	5.7
	Diversity and equality sub-score	7.3
	Inclusion sub-score	6.0
	We are compassionate and inclusive score	6.3
People Promise element 2: We are recognised and rewarded	We are recognised and rewarded score	4.8
People Promise element 3: We each have a voice that counts	Autonomy and control sub-score	5.5
	Raising concerns sub-score	5.8
	We each have a voice that counts score	5.6
People Promise element 4: We are safe and healthy	Health and safety climate sub-score	5.0
	Burnout sub-score	4.0
	Negative experiences sub-score	6.7
	We are safe and healthy score	5.3
People Promise element 5: We are always learning	Development sub-score	5.6
	Appraisals sub-score	2.9
	We are always learning score	4.2
People Promise element 6: We work flexibly	Support for work-life balance sub-score	4.8
	Flexible working sub-score	4.7
	We work flexibly score	4.8
People Promise element 7: We are a team	Team working sub-score	5.8
	Line management sub-score	5.3
	We are a team score	5.5
Theme: Staff Engagement	Motivation sub-score	6.0
	Involvement sub-score	4.9
	Advocacy sub-score	5.7
	Staff Engagement Score	5.5
Theme: Morale	Thinking about leaving sub-score	5.5
	Work pressure sub-score	5.0
	Stressors (HSE index) sub-score	5.3
	Morale score	5.3

This chart shows the organisation's score for each of the People Promise elements and compares it with the benchmark group (all Ambulance Trusts in England), average, best and worst scores.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.1	5.6	6.6	5.6	4.9	5.6	6.4	6.3	5.5
Your org	6.4	4.9	5.7	5.3	4.4	4.9	5.6	5.6	5.3
Average	6.6	5.1	5.9	5.3	4.4	4.9	5.9	5.9	5.3
Worst	6.0	4.4	5.2	4.9	3.3	4.4	5.2	5.3	4.6
Responses	2,910	2,985	2,866	2,906	2,740	2,968	2,928	2,992	2,980

Top WMAS scores compared to 2020

The most improved score compared to 2020 is:

Trust 2021	Trust 2020	Most improved scores
78%	76%	R13d. Last experience of physical violence was reported

The Top 5 WMAS scores recorded against the Picker Average are:

Trust Average	Picker Average	Top 5 scores VS Picker Average
87%	68%	R19a. Received appraisal in the last 12 months
62%	52%	R3h. Have adequate materials, supplies and equipment to do my work
63%	71%	R3i. Enough staff at organisation to do my job properly
60%	67%	R10c. Don't work additional unpaid hours per week for this organisation, over and above contracted hours
78%	73%	R13d. Last experience of physical violence reported

Bottom Scores compared to 2020

The most declined scores within WMAS compared to 2020 are:

Trust 2021	Trust 2020	Most declined scores
30%	54%	R3i. Enough staff at organisation to do my job properly
44%	63%	R21c. Would recommend organisation as place to work
58%	75%	R21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
50%	65%	R22c. I am not planning on leaving this organisation
36%	50%	R22a. I don't often think about leaving this organisation

The Bottom 5 WMAS scores against the Picker Average are:

Trust Average	Picker Average	Bottom 5 scores vs Picker Average
45%	63%	R11e. Not felt pressure from manager to come to work when not feeling well enough
48%	58%	R28b. Disability: organisation made adequate adjustments to enable me to carry out my work
50%	59%	R21a. Care of patients/service users is organisation's top priority
47%	56%	R9d. Immediate manager takes a positive interest in my health & well-being
48%	57%	R9e. Immediate manager values my work

Staff Engagement

	2017	2018	2019	2020	2021
Best	6.4	6.5	6.6	6.7	6.3
Your org	6.1	6.3	6.3	6.3	5.6
Average	6.1	6.2	6.3	6.3	5.9
Worst	5.5	5.7	5.8	5.8	5.3
Responses	2,277	2,990	3,374	3,678	2,992

Morale

	2018	2019	2020	2021
Best	5.9	6.0	6.2	5.5
Your org	5.9	6.0	6.2	5.3
Average	5.5	5.5	5.7	5.3
Worst	4.7	4.9	5.1	4.6
Responses	2,967	3,357	3,651	2,980

Workforce Race Equality Standard

a) Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

	2017	2018	2019	2020	2021
White: Your org	51.0%	48.4%	49.1%	48.6%	51.3%
BME: Your org	43.5%	37.7%	37.9%	45.2%	49.1%
White: Average	49.7%	46.5%	45.8%	43.5%	44.1%
BME: Average	39.4%	37.8%	41.2%	44.3%	39.4%
White: Responses	2,022	2,666	3,030	3,127	2,539
BME: Responses	108	183	198	325	222

Average calculated as the median for the benchmark group

b) Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	2017	2018	2019	2020	2021
White: Your org	29.7%	29.2%	25.5%	23.9%	26.8%
BME: Your org	39.6%	31.3%	24.9%	26.5%	35.0%
White: Average	27.5%	27.1%	25.5%	24.1%	23.8%
BME: Average	32.0%	31.0%	26.2%	31.1%	29.5%
White: Responses	2,022	2,657	3,025	3,123	2,538
BME: Responses	106	182	197	325	223

Average calculated as the median for the benchmark group

c) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

	2017	2018	2019	2020	2021
White: Your org	49.6%	48.9%	51.9%	51.3%	44.7%
BME: Your org	34.3%	36.6%	47.7%	40.5%	36.6%
White: Average	49.3%	48.9%	51.2%	51.3%	47.7%
BME: Average	33.2%	36.7%	34.6%	39.5%	40.2%
White: Responses	2,016	2,660	3,035	3,162	2,580
BME: Responses	108	183	199	328	224

Average calculated as the median for the benchmark group

d) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months

	2017	2018	2019	2020	2021
White: Your org	10.7%	10.0%	8.8%	8.6%	11.4%
BME: Your org	22.7%	17.9%	15.8%	20.7%	22.6%
White: Average	10.3%	10.0%	8.8%	8.6%	10.0%
BME: Average	18.3%	17.7%	15.8%	16.7%	15.8%
White: Responses	2,031	2,661	3,009	3,158	2,577
BME: Responses	110	184	196	329	226

Average calculated as the median for the benchmark group

Workforce Disability Equality Standard

a) Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	52.3%	55.0%	52.5%	59.8%
Staff without a LTC or illness: Your org	46.9%	46.9%	46.8%	48.0%
Staff with a LTC or illness: Average	52.3%	52.5%	47.5%	51.2%
Staff without a LTC or illness: Average	45.8%	44.9%	42.1%	41.6%
Staff with a LTC or illness: Responses	526	671	771	737
Staff without a LTC or illness: Responses	2,296	2,606	2,722	2,061

Average calculated as the median for the benchmark group

b) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	31.0%	24.8%	25.3%	28.8%
Staff without a LTC or illness: Your org	16.6%	13.3%	11.7%	14.0%
Staff with a LTC or illness: Average	28.4%	23.2%	22.1%	19.2%
Staff without a LTC or illness: Average	13.8%	13.3%	11.2%	11.1%
Staff with a LTC or illness: Responses	523	666	767	730
Staff without a LTC or illness: Responses	2,277	2,596	2,711	2,041

Average calculated as the median for the benchmark group

c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	24.7%	25.1%	23.1%	27.6%
Staff without a LTC or illness: Your org	16.3%	14.5%	13.5%	15.3%
Staff with a LTC or illness: Average	26.5%	25.9%	23.1%	23.9%
Staff without a LTC or illness: Average	16.3%	15.7%	14.7%	15.3%
Staff with a LTC or illness: Responses	522	665	771	728
Staff without a LTC or illness: Responses	2,276	2,601	2,713	2,039

Average calculated as the median for the benchmark group

d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	46.2%	46.4%	46.2%	43.5%
Staff without a LTC or illness: Your org	44.0%	47.1%	48.5%	49.1%
Staff with a LTC or illness: Average	40.4%	44.6%	46.2%	46.4%
Staff without a LTC or illness: Average	40.6%	41.2%	45.6%	45.3%
Staff with a LTC or illness: Responses	305	392	444	480
Staff without a LTC or illness: Responses	1,094	1,266	1,250	1,033

Average calculated as the median for the benchmark group

e) Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	41.4%	48.5%	45.7%	35.8%
Staff without a LTC or illness: Your org	49.2%	52.0%	51.3%	46.5%
Staff with a LTC or illness: Average	41.8%	45.3%	45.3%	39.4%
Staff without a LTC or illness: Average	49.3%	52.0%	52.0%	49.3%
Staff with a LTC or illness: Responses	529	670	775	744
Staff without a LTC or illness: Responses	2,288	2,610	2,753	2,099

Average calculated as the median for the benchmark group

f) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	61.3%	58.2%	54.6%	64.6%
Staff without a LTC or illness: Your org	50.5%	44.3%	44.9%	50.5%
Staff with a LTC or illness: Average	45.3%	41.6%	38.3%	39.2%
Staff without a LTC or illness: Average	33.1%	32.3%	30.8%	29.3%
Staff with a LTC or illness: Responses	429	531	582	615
Staff without a LTC or illness: Responses	1,363	1,566	1,371	1,230

Average calculated as the median for the benchmark group

g) Percentage of staff satisfied with the extent to which their organisation values their work

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	27.6%	26.7%	28.3%	16.9%
Staff without a LTC or illness: Your org	36.0%	39.9%	38.1%	26.5%
Staff with a LTC or illness: Average	25.3%	27.8%	29.1%	20.8%
Staff without a LTC or illness: Average	36.0%	38.9%	37.9%	29.3%
Staff with a LTC or illness: Responses	525	670	775	745
Staff without a LTC or illness: Responses	2,290	2,611	2,762	2,105

Average calculated as the median for the benchmark group

h) Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work

	2018	201
Staff with a LTC or illness: Your org	60.6%	56.4
Staff with a LTC or illness: Average	60.3%	58.8
Staff with a LTC or illness: Responses	292	36

Average calculated as the median for the benchmark group

i) Staff engagement score (0-10)

	2018	2019	2020	2021
Organisation average	6.2	6.3	6.3	5.5
Staff with a LTC or illness: Your org	5.7	5.8	5.8	4.9
Staff without a LTC or illness: Your org	6.3	6.4	6.4	5.7
Staff with a LTC or illness: Average	5.7	5.9	6.1	5.5
Staff without a LTC or illness: Average	6.4	6.4	6.4	6.1
Organisation Responses	2,990	3,374	3,678	2,992
Staff with a LTC or illness: Responses	529	671	778	747
Staff without a LTC or illness: Responses	2,300	2,616	2,765	2,106

Average calculated as the median for the benchmark group

Equality and Diversity

Diversity and Inclusion

The Trust has its core Diversity and Inclusion running through all business streams of the Trust. Over the last year there have been a range of themes and workstreams where work has continued to advance the equality and inclusion agenda. These themes are:

- EDS2-Better Health Outcomes for All
- WRES Workforce Race Equality Standard
- Recruitment – implementation of the NHS 6 Point action plan
- Public Sector Equality Duty
- Specific Duties
- Equality Objectives
- Diversity & Inclusion Steering Group
- Staff networks
- National Ambulance Diversity Group [NADG]
- National LGBT Group
- WDES Workforce Disability Equality Standard
- Gender Pay Gap

Equality Delivery System 2 (EDS2)

The main purpose of the Equality Delivery System 2 (EDS2) is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. Using the NHS Equality Delivery System 2 provides a way for the organisation to show how it is performing doing against the four goals.

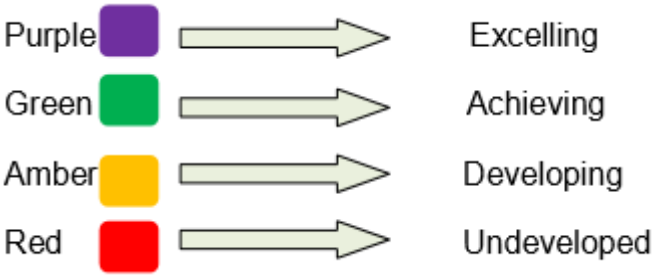
1.	Better health outcomes
2.	Improved patient access and experience
3.	A representative and supported workforce
4.	Inclusive leadership

In 2020/21, WMAS undertook assessment of goal 3, moving away from previous years where all the goals were assessed. A similar path has been followed for 2021/22. Due to organisational and system pressures because of Covid 19, it was appropriate that all resources were concentrated on dealing with the pandemic. For 2021/22 it was agreed by the Executive Management Board (EMB) that the organisation would concentrate on one goal, that being goal 1: Better Health Outcomes for All. There are several benefits with this approach as follow:

1) Assessments are not rushed, and a more qualitative and in-depth analysis takes place which results in actions to improve the service.
2) Assessors are not over-burdened with information and assessments are not rushed.
3) Setting realistic goals and action plans which lead to transformational change
4) Making EDS2 work as a tool to effect organisational change, as it was originally intended, as opposed to a tick box exercise.

Having gathered the evidence, an internal process assessment and grading took place, results of which are featured in the report which will be published on the WMAS Equality and Inclusion internet page.

There are four grades in the EDS2 framework which can be given as follows:



What did we do?
It was agreed that procurement would be the service area where evidence would be gathered and subsequent EDS2 assessment would take place and grading undertaken for 2021/2022. It has been acknowledged that the past year has been challenging for all the NHS in responding to the COVD-19 pandemic and in that regard WMAS, like all ambulance services, has had a unique challenge due to the nature of the service, in dealing with the pandemic and responding to the ever-increasing demand and pressures as a result.

Procurement, contracting, and subsequent monitoring is an essential tool, if used effectively, in gaining assurance that providers are meeting their obligations under the Equality Act 2010, both as an employer and service provider. The head and deputy head of purchasing and contracts have actively agreed for their service to be addressed and provided evidence in the form of procurement overarching governance documents, NHS Terms and Conditions for Supply of Goods (contract version), and PQQ questions and technical guidance including the Equality and modern slavery act questionnaire. Having gathered the evidence, an internal process assessment and grading took place.

Analysis and grading
Call for evidence went out to the procurement team in respect of the current position of the service in respect of equality, inclusion and diversity in the business of the service. Senior management of the procurement team were appraised of the EDS framework and an analysis took place of the evidence that was provided. As the planning of the EDS assessment and grading had taken place in the midst and peak of the pandemic when restrictions were still in place, the actual assessment was one which was undertaken internally with the proviso that the grading process would be open to external scrutiny if requested. The report and assessment would also be made available to various network chairs and the document would be live and changes suggested would be incorporated as appropriate. The assessment team went through the evidence, and it was observed that there were areas which had equality embedded within the policy:

After assessing and analysing the evidence, the panel decided collectively that the service was at a developing stage as more work needed to be done to assure the procurement and contracts team that equality and inclusion considerations were embedded within the processes of the service. The evidence also found that certain elements of the service were on the border of achieving with one area classed as under-developed. It was therefore decided, after much deliberation and discussion that the service would be graded as **Developing**. It was also acknowledged that with an effective action plan and through further advice, support and guidance from the Diversity and Inclusion lead, the service could move from **Developing** to **Achieving** within 12 months, provided the elements within the action plan were delivered.

It should also be noted that the EDS3, a revised and much leaner framework is due to replace EDS2 in 2023. WMAS will adopt this as per instructions from NHSEI. For now, not all outcomes within EDS2 are relevant to the Ambulance service so a more practical approach was undertaken in the application of the framework for this assessment.

Workforce Race Equality Standard (WRES)

The aim of the Workforce Race Equality Standard (WRES) is designed to improve workplace experiences and employment opportunities for Black and Minority Ethnicity (BME) people in the National Health Service (NHS). It also applies to BME people who want to work in the NHS. The Trust supports and promotes the WRES, encouraging BME staff to reach their full potential through equality of opportunity. The Trust aims to recruit a workforce that is diverse and representative of our communities. The WRES is a tool to identify gaps between BME & White staff experiences in the workplace. These are measured through a set of Metrics. The metrics are published annually in conjunction with an Action plan. The data and action plan was published in 2021 and progress has been made against those actions and monitored by the Diversity, and Inclusion Steering Group.

Recruitment

The Trust makes every effort to recruit a workforce that is representative of the communities we serve. The Trust has a Positive Action statement on all job adverts encouraging applications from people with disabilities and BME backgrounds. A diverse workforce research tells us provides better patient care, to compliment the WRES the Trust is keen to encourage BME applicants particularly for the role of Paramedic. To achieve this, aim the Trust has enhanced its recruitment programme by the following:

- Employing a Recruitment Engagement Officer with emphasis on encouraging BME applicants.
- Marketing materials have been developed using staff BME role models i.e., pop up stands that can be used for events.
- Literature is reflective of the diversity of the Trust.

- Staff who are involved in the recruitment process must undergo training involving;
    - Value Based Recruitment
    - Equality & Diversity
    - Equality Act 2010 and the law
    - Unconscious Bias
    - Interview skills
    - Co-mentoring for BME staff
- The Trust now has a more modern recruitment web site to attract potential applicants.
- The Recruitment department offers support for BME applicants through the pre-assessment programme.
- All BME applicants are monitored from the point of application to being successful at assessment.

2021 has been challenging just like 2020 in respect of using diverse methods of recruitment like going out into the communities and attending events. For 2022 and beyond, with the lifting of restrictions and through a risk analysis, it is envisaged that the recruitment team will venture out into the communities the Trust serves, in order to attract the best and diverse staff

Public Sector Equality Duties (PSED)

The Equality Duty is supported by specific duties (Public-Sector Equality Duty (section 149 of the Act), which came into force on 10 September 2011. The specific duties require public bodies to annually publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives. Public bodies must in the exercise of its functions, have due regard in the need to;

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Through the adoption of the NHSE&I mandated standards such as the; Equality Delivery System (EDS); Workforce Race Equality Standard (WRES); Accessible Information Standard (AIS); and Workforce Disability Equality Standard (WDES), WMAS is able to demonstrate how it is meeting the three aims of the equality duty.

Specific Duties

The Specific Duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty; and to set themselves specific, measurable equality objectives and to publish information about their performance on equality, so that the public can hold them to account. The Specific Duties require the Trust to:

- Publish information to show compliance with the Equality Duty at least annually
- Set and publish equality objectives at least every four years

The Trust publishes this information annually on the website.

Equality Objectives

The Trust is required under the "Specific Duties" to prepare and publish equality objectives which help to further the aims of our Equality Duty. The objectives must be published every four years and this year WMAS has continued to deliver on the Equality Objectives. A full report on progress on the Equality Objectives will be included in the annual PSED report in 2022.

Equality Objectives 2020-2024
Objective 1 Equality Standards Our commitment to meeting the Equality Standards set by NHS England will be demonstrated by the implementation and monitoring of the following standards: • Workforce Race Equality Standard • Accessible Information Standard • Equality Delivery System 2 • Workforce Disability Equality Standard • Gender Pay Gap Reporting **We will do this by:** • Implementing and strengthening our approach to the NHS Equality Delivery System 2 (EDS2) • Continuing to develop our response to the Workforce Race and Disability • Equality Standards (WRES) (WDES) • Investigate the experiences/satisfaction of staff through further surveys and focus groups • Keep invigorating and supporting the staff equality networks to ensure they are aligned with our strategic equality objectives
Objective 2 Reflective and diverse workforce We will enhance our approach to recruitment, selection and promotion to positively attract, retain and support the progression of diverse staff across the Trust **We will do this by:** Target local and diverse communities in recruitment campaigns • Review our people policies to ensure that there is appropriate fairness • Support managers and teams to be inclusive • Work closely with external partners and providers (e.g., university paramedic programmes) to ensure diversity among the student group, and appropriate course content • Ensure the recruitment and selection training programme informs recruiting staff and managers of their legal duties under the Equality Act 2010
Objective 3 Civility Respect Ensure all our Board leaders, senior managers, staff, contractors, visitors and the wider community are aware of

the effects of their behaviour on others and are equipped to challenge and report inappropriate behaviour when they experience or witness it **We will do this by:** • Develop and deliver an internal communication campaign on civility and respect in the workplace Develop a system where all cases of bullying or harassment are clearly recorded as such, and monitored to identify any trends or patterns across the Trust • Capture good practice from our partners and peers to improve our diversity and Inclusion performance, e.g., working collaboratively with the NHS Employers' National Ambulance Diversity Forum and Regional Diversity Groups
Objective 4 Supportive Environment Ensure our leadership is committed to creating an environment that promotes and values equality and diversity and this is embedded in all we do **We will do this by**: • Delivering diversity and inclusion training to all members of the Board of Directors and Council of Governor's • Ensuring all our leaders have specific diversity & inclusion objectives in their annual objectives with performance discussed during their appraisals • Board and Committee reports include an equality impact analysis

Diversity and Inclusion Steering Group

The Trust supports a "Diversity & Inclusion Steering Group" with representation from a diverse range of staff from across the Trust who are representative of the various roles and departments within the organization. This group is chaired by the CEO. The Diversity & Inclusion Steering Group meets every three months to consult and drive the Diversity & Inclusion agenda forward.

Staff Groups

- **Proud @ WMAS Network:**

  This network is for Lesbian, Gay, Bisexual & Transgendered staff and is supported by "Straight Ally's" which is a concept developed by Stonewall. The Network is represented at Pride marches and the Trust is a member of the Ambulance Sector National LGBT group. The Network provides support for all LGBT staff and raises issues at national level were appropriate.
- **The BME Network**

  The BME Network is expanding. Progress has been made by developing Terms of Reference and electing a new committee. The Network has been actively engaged in a culture change programme as part of the implementation plan for the WRES.
- **A Disability and Carers Network** was launched in July 2020 and supported the recommendations for action in the WDES.
- **A Women's Network** was launched in 2021 to support the Gender Pay Gap Action plan. The Trust ran a Springboard Women's Development Programme in 2019, a second cohort in 2020 and a third cohort is currently underway in 2021.
- **National Ambulance Diversity Group (NADG** The Trust is represented on the national group and attends the meetings regularly. It is a forum of shared knowledge and expertise which drives the Diversity & Inclusion agenda at a national level.
- **Military Network.** The Military network was formed to recognize staff who are serving reservists, veterans, cadet instructors and families of serving personnel. The Trusts celebrates various military events and WMAS achieved the employer Gold Award in 2019 by the Defence Employer Recognition Scheme.

Workforce Disability Equality Standard (WDES)

The NHS Equality and Diversity Council has recommended that a Workforce Disability Equality Standard (WDES) should be mandated via the NHS Standard Contract in England from April 2019. NHS England has launched this. This has now been implemented and published by the Trust. An action plan has been developed which is being monitored by the Diversity and Inclusion steering group.

Gender Pay Gap

Since 2017 there has been a statutory requirement for all organisations with 250 or more employees to report annually on their gender pay gap.

West Midlands Ambulance Service NHS University Foundation Trust is covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 that came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require the relevant organisations to publish their gender pay gap data annually, including:

- mean and median gender pay gaps;
- the mean and median gender bonus gaps;
- the proportion of men and women who received bonuses; and
- the proportions of male and female employees in each pay quartile.

The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings, while equal pay is about men and women being paid the same for the same work.

There is a requirement to publish the data on the Trust's public-facing website by 31 March 2022

A full gender pay report and key data analysis, that highlights the key variations for different occupational groups, and the actions that will be taken to improve these findings has been published. An action plan has been developed to address the gaps progress against those actions is being monitored by the Diversity and Inclusion Steering group.

Health and Wellbeing

National Wellbeing Framework
In January 2022 a new NHS National Wellbeing Framework was launched. This is very different from the previous framework with a diverse range of sections;

- Framework Dashboard
- Personal Health & Wellbeing
- Relationships
- Fulfilment at Work
- Environment
- Managers & Leaders
- Data Insights
- Professional Wellbeing Support

Phase 1 was to complete the first section the outcomes are automatically measured which provides a basis for the Trust action plan. This needs to be in place by October 2022. Other new frameworks have been developed which also need to link into the National HWB Framework the below all relate to Mental Health & Suicide

- Ambulance Self Audit AACE
- AACE Assessment Matrix
- Mental Health at Work Commitment [Trust signed up 2022]
- Preventing Suicide in Ambulance Sector Local Improvement Plans WMAS
- Mental Health & Suicide Strategy WMAS [Under Development]
- Mental Health Continuum AACE [released 10th March]

Health & Wellbeing Champions
Over the last 12 months the opportunities for training & development for Champions has been excellent. NHSI & NHS England have developed two sets of training each one to run over a six-month period. Champions could choose which suited their needs best
The courses have been advertised to all of our Champions which now totals 112 in number. In addition, further in house development opportunities HWB Champions have had are;

- Menopause Advocates
- To be able to complete Health Checks
- Suicide Lite awareness course
- Mental Health First Aiders course

Weight Management
Slimming World continues to be extremely popular with an additional 150 sets of vouchers plus 30 online vouchers having been used. After lockdown many staff found that they had put weight on and had not ate healthily, so wanted to kickstart their efforts.
All vouchers have now been used and an additional 100 have been purchased through NHSI/NHS England funding. Although the NHS Programmes are also advertised and offered our staff prefer Slimming World and in particular the group sessions.

Physical Activities

Physical activity programmes are frequently advertised in the Weekly Brief from discounts to apps.

- Doing it right is an NHS platform that was designed in conjunction with the Royal Wolverhampton NHS. This programme covers cardiovascular workouts, Pilates, Yoga, Gentle exercise and salsa dance type programmes that children can join in with. Its totally free and has been nationally acclaimed.
- Be Military Fit a new NHS platform offering a mixture of not only exercise but nutrient, hydration and sleep. Last week Bear Grylls hosted a session and over 600 NHS staff took part. This new platform has a limited life span currently a survey is underway to see if its worth continued funding.
- NHS Fitness Studio Exercise this offers different types of exercise for all levels of fitness. It also offers variety in terms of what's available.
- Walsall MBC offer a 15% discount to all WMAS staff which is regularly advertised and covers all of their centres.

Mental Health First Aid Courses

Currently all Trust MHFA trainers have had to reapply to get their licences back and must complete an online course and exam which they have to pass to be reinstated. This was due to the fact that courses haven't been delivered over the last two years due to demand on WMAS. An extension has been requested due to technical issues at MHFA, this has been granted until 1st April to allow everyone to complete the 4 hour programme.

The MHFA are not running any new instructors' programmes until January 2023 as they are reviewing the two-day programme. In the interim due to unexpected funding BlackCountry Health care are going to deliver 6 courses in May & June at very reduced costs. The dates are as follows.

1. Thur 19th – Fri 20th May
2. Mon 23rd – Tues 24th May
3. Thur 26th – Fri 27th May
4. Tues 7th – Wed 8th June
5. Wed 15th – Thur 16th June
6. Tues 28th – Wed 29th June

Each course can hold 16 participants and priority will be given firstly to those courses that were cancelled at the last minute so there are 96 places available. The venue is likely to be Alamein House TA Centre in Dudley.

Suicide First Aid Courses

WMAS is the first ambulance service in the country to use National Centre for Suicide Prevention, Education and Trainings (NCSPET). The Trust has funded 13 instructors' places. The course was run from 14-18 March and involved a four-day course followed by individual delivery of the "Suicide Lite" course [awareness course] which will be assessed online. A module also has to be submitted to the City and Guilds governing body, as it's a recognised qualification at that level. The first set of courses were delivered on the 18th March face to face on a reduced numbers basis. This allowed 24 staff to participate. The course is nationally recognised and certificated and will be recorded on OLM. Once qualified the SFA Instructors will also be able to deliver the one-day course which is "Suicide First Aiders" whereby

participants will be issued with the lanyard
similar to the MH First Aiders. The aim will be that the Suicide Lite is delivered first and then staff can move on to become Suicide First Aiders if they want. This will allow the instructors to fulfil their NCSPET requirements as instructors. The courses will commence in April to allow the instructors to be assessed whilst delivering the course online. The expectation is that all instructors will be fully qualified by the beginning of May. Online courses will be advertised to targeted audiences to enable the assessments in the first instance and then will be opened up to all across the Trust. To date 6 courses have been delivered with further dates in April so far 40 staff have participated with excellent feedback.

SALS

SALS Adviser numbers had been dropping due to staff retiring etc A brand new cohort is due to start their training in April 2022 which will provide an additional 29 Advisers. This will take the total up to 63 Advisers providing a 24/7 service. The new SALS Advisors will be mentored to start with and will pick up additional training for the role.

Menopause

The Trust invested in 24 staff being trained to be Menopause trainers. The training had been placed on hold due to demand on resources. The first course delivered was to the HR team last week. Worcester will be delivering their first course 21st March. Dates will be sent out for staff to participate and their attendance will be recorded on OLM in the very near future.

Family Liaison Officers

The next course will take place 28&29 April 2022 due to many FLO's having retired or moved on. The course will accommodate 17 staff and is currently full. This will also become a Trust resource for our own staff who die suddenly to provide support for their families should it be requested. The training programme has been developed and Cruse are providing a tailored made bereavement programme funded by NHSI/NHS England.

NHSI Funding

All ambulance services received funding in December 2021 for HWB with the emphasis that it needed to be spent or allocated by 31st March 2022. The bids had to achieve the objectives set by NHSI. To date the following initiatives have been undertaken;

- Slimming World Vouchers x 2 batches to cope with demand
- Suicide First Aid Instructors course 13 new instructors
- New Health & Wellbeing web site
- 2 full sets of Health Check equipment.
- Gym equipment 3 bikes, two rowing machines, two pop up mini marques all have arrived.
- MHFA courses x 6 May /June this will allow 96 staff to attend

- Marketing goods for the roadshow.
- Renewal of Instructors MHFA Licences.
- Family Liaison Officers Course to incorporate the staff element.28/29 April
- 2 x Health Check Equipment to allow for more members of staff to have a health check the Trust now has 3 full sets.

Mental Health

The Mental Wellbeing Practitioners have seen a steady increase in patients. One member of the team has left and this has obviously had an impact.

An initiative that is being worked on is a new charity lead initiative called 'Just B' which provides support to staff as part of the pandemic support response, with the following points:

- Charity is part of the Royal Foundation. Very proactive on Mental Health.
- Just B offers to contact members of staff by phone for a 20 minute conversation with a trained volunteer, to see if staff need any extra assistance.
- Staff can opt out in advance.
- Conversation is to identify how each staff member is doing, their resilience and coping strategies. If staff are identified as needing support, they can have and additional session with the charity to go through support options – information will be given on internal Trust support and external support available.
- Designed to be a proactive service.
- Anonymous data and dashboard are provided to the Trust, with an overview of how staff are feeling. Follows all relevant data protection and initiative is fully funded. Data collected is basic demographics: age, gender, work role. No names and doesn't identify specific roles if that would make the individual identifiable.
- A pilot of the scheme was undertaken at EMAS to positive feedback.
- Volunteers are trained the same as the Samaritans and that this is a proactive information sharing service not counselling. The script is very much on listening and giving people time to be heard on how they are feeling.
- Scheme is for 12 months.

Dog Visits

The Trust have had a variety of dog visits from Police dogs to Chihuahuas. Strict criteria are adhered to and this always goes down well with staff and normally raises morale. At present we are looking for a more formalised approach across the Trust.

Physiotherapy

The Trust has tried to recruit our own Physiotherapists unfortunately applicants were not at the standard we required. The Physiotherapy service is currently being provided by our Occupational Health Provider "Team Prevent" which is working well. They are able to provide clinics across the Trust at a variety of locations.

Flu Vaccination

The Trust achieved a 75% flu vaccination rate. Although this is lower than the previous year its possibly due to the fact that staff were being encouraged to be Covid vaccinated as a priority.

Participation

The Trust is also involved with the following groups etc;

- National Ambulance Wellbeing Forum
- ICS Trailblazer Group [National Framework]
- Step into Health Group [Military national]
- HWB team leader Toolkit Designer group [Leadership Academy]

Freedom to Speak Up

West Midlands Ambulance University NHS Foundation Trust (The Trust) is committed to ensuring that staff have the confidence to raise concerns and to know that they will be taken seriously and investigated. At work, it is reasonable that staff may have concerns from time to time, which normally can be resolved easily and informally. However, when staff have serious concerns about unlawful conduct, financial/professional malpractice, or risk to patients/others it can be daunting to speak up about this. Therefore, the Freedom to Speak up (Whistleblowing) policy aims to give staff the assurance that concerns will be listened to and to outline a fair and easy process for staff to raise concerns at work. In order to deliver high quality patient care and protect the interests of patients, staff and the organisation, the Trust aims to encourage a culture of openness and transparency, in which members of staff feel comfortable about raising legitimate concerns. It is hoped that by providing clear procedures and channels for staff to raise concerns, issues can be addressed at the earliest opportunity, in the most appropriate way, so that positive steps can be taken to resolve them and reduce future risk.

FTSU Guardian

Until 1 March 2022, the Trust's current guardian was Barbara Kozlowska, Head of Organisational Development. The role has since been taken up by Pippa Wall, Head of Strategic Planning. The Guardian is a member of the West Midlands Guardian Network, and the National Ambulance Network (NAN), ensuring that good practice is followed and shared.

FTSU Ambassadors

There are currently 41 trained ambassadors around the region. They receive 2 half-days' training each year as part of their mandatory updates. In 2021/2022 a series of development sessions were planned by the Guardian but regrettably did not take place due to surge levels. However bi-monthly drop-in sessions were held for updates, and for discussion of case studies, ensuring the ambassadors knowledge is current. A poster showing *ambassadors*' photographs and locations is displayed in each area.

Governance

There are number of ways in which assurance is provided for FTSU:

- Quarterly returns to National FTSU Guardian's Office
- Quarterly reports to WMAS Learning Review Group, and bi-annual reports to the People Committee, Executive Management Board and Board of Directors
- FTSU NHS Improvement Self-assessment conducted in 2018/19 and reviewed annually at Board of Directors Strategy days, last reviewed April 2021
- Training is in place for all staff at all levels as per the National Guardian's Office guidelines.

Promotion

A poster with details of the FTSU Guardian, Executive (ED) and Non-Executive (NED) leads is on display in all areas.

A SharePoint site has been established, accessed through the Trust's E-Nav Moodle site and intranet - Treble 9.

STAND UP SPEAK OUT

How Staff May Speak Up

The many ways in which staff are able to speak up are outlined in the Freedom to Speak Up (Whistleblowing) Policy which was updated September 2019. The policy includes flow-charts to determine how concerns can be raised and how they are dealt with.

Concerns Raised 2021/22

FTSU Ambassadors addressed 174 approaches from staff wishing to obtain information about FTSU in quarters 1 – 3 (Q4 being collected), to discuss informally a concern or to seek advice on how best to deal with their issue. The main themes arising were:

1. Middle management
2. Bullying and harassment

Eleven formal concerns have been raised and investigated year-to-date, and all but one are closed.

The focus of the Trust's actions is to ensure that our managers have the confidence, skills and knowledge to welcome and deal with concerns as and when they arise, so that staff feel positive in raising any concerns with them. There are several routes available within the Trust, by which staff can raise concerns. FTSU therefore adds to these well-established reporting arrangements

Coronavirus (COVID 19) Progress and Priorities

The Covid-19 pandemic has been hugely challenging for the Trust and the wider NHS. This is in the main due to a combination of variations in demand, staff sickness and abstractions, and hospital handover delays. The three peak waves of Covid saw the Trust under perhaps the most pressure it has ever experienced. The pandemic leaves a legacy of challenge for the NHS, which it will be heavily focussed on in the coming years.

A specific COVID risk register has been developed which has identified several risk assessments related to new risks as a result of the pandemic. These are linked to various directorates and processes across the Trust including Operations, Integrated Emergency and Urgent Care, Patient Transport Services, Human Resources, Infection Prevention and Control and their impact on the whole organisation. These have been regularly reviewed throughout the pandemic when any changes have occurred with national guidance and practices. Where risks increased/decreased based on incident reporting, impact on staff and resourcing through test and trace and COVID Secure and other factors which influence the risk. The Risk Assessments are all supported via a robust approach to safety notices, action cards and guidance. These are frequently and accurately updated to reflect the current stance to ensure that all staff are kept up to date and able to undertake their job safely. This approach has meant that the safety of our Staff and Patients has continued to remain paramount throughout the pandemic whilst the Trust still provided a world class service and adhered to its vision, values and strategic objectives.

Part 3
Review of Performance against 2020-21 Priorities

Our priorities for 2021-22 were based upon the following overarching priorities:

Cardiac Arrest Management

There are three elements that are reported for Cardiac Arrest:

- Return of Spontaneous Circulation (ROSC) at hospital
- Survival to discharge post resuscitation
- A care bundle for treatment given post Return of Spontaneous Circulation (ROSC) is achieved on scene following a non-traumatic cardiac arrest. The care bundle includes a 12 lead ECG, Blood Glucose, End-tidal C02, Oxygen administered, Blood pressure and fluids administered

Whilst still delivering very safe and highly effective patient care, reports from the last year have shown a reduction in performance.

Maternity

WMAS remains committed to supporting the delivery of high-quality care for women during pregnancy, childbirth and the postnatal period, taking into account changing clinical guidelines, best practice and recommendations.

Reduction in the Volume of Patient Harm Incidents During Transportation (PTS)

Any incidents or near misses which occur during the care and transportation of patients are reported and investigated. Actions are implemented which may require a change of practice or further training for staff to reduce the likelihood of a similar incident occurring again. We included this priority in our Quality Account for 2020/21 and have monitored the trends throughout the year. The year-to-date comparison with the previous year demonstrates a slight reduction in both harm and no harm incidents, however the latest reporting period (Quarter 3) represented an increase compared to the same period in the previous year. With regard to Serious Incidents, these numbers are always very low, and there is a notable decrease in these numbers this year

Learning from our Patients' Feedback

The new Family and Friends Test (FFT) national guidance is now in place. The Trust is keen to maximise responses and learning from patients and plans to implement some short surveys at the end of calls from patients:

111 Following the introduction of "Think 111 First", we would like to gain a better understanding of the experience of patients during and after the call; and determine whether the outcome achieved met the patients' needs. The Trust is required to report twice per year based upon a mandatory set of questions. These questions will be included, along with other locally agreed questions, in an online survey. The survey will be introduced through a recorded message at the end of the patient's initial call (there may be a need to tailor the message to specific types or categories of call). The specific arrangements and timing for the survey will be confirmed during Quarter 1. This will include a decision as to whether it is possible to implement a short telephone-based survey, with an onward link to the website for patients who are happy to complete the full survey; or whether the message at the end of the call is purely a recorded announcement for the full online survey.

PTS Due to the regularity of calls from some of our patients (renal for example), it has been decided to implement a telephone survey for one week per quarter. This will provide trends as the year progresses, and the ability to select each survey week to ensure that, as far as possible, different patients are included in each survey. In quarter 1, a test week will be established to ensure that the survey runs smoothly and generates sufficient responses. This will provide assurance of the technical process, the responses and the reporting arrangements. Following this, a survey week will be identified during each quarter to ensure sufficient time for inclusion in the Quarterly Quality Account report. Any responses to the online survey will be collated and reported alongside the telephone survey results. In line with the rules on social distancing, we will consider our options for carrying out targeted surveys by post / email or using discharge / renal coordinators

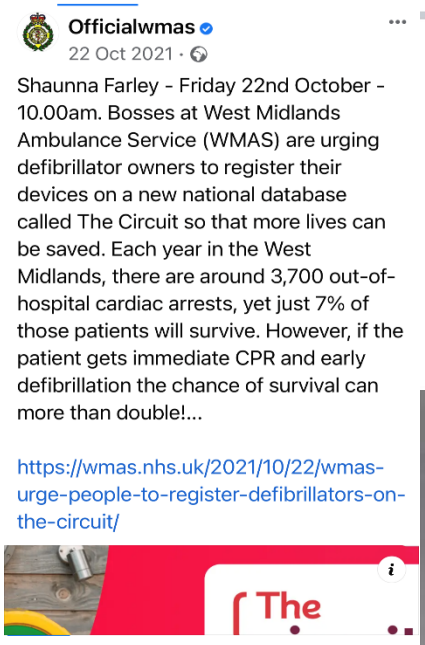
Throughout 2021-22, our progress towards each of the above priorities was reported through the governance committee structure. Our achievements are summarised as:

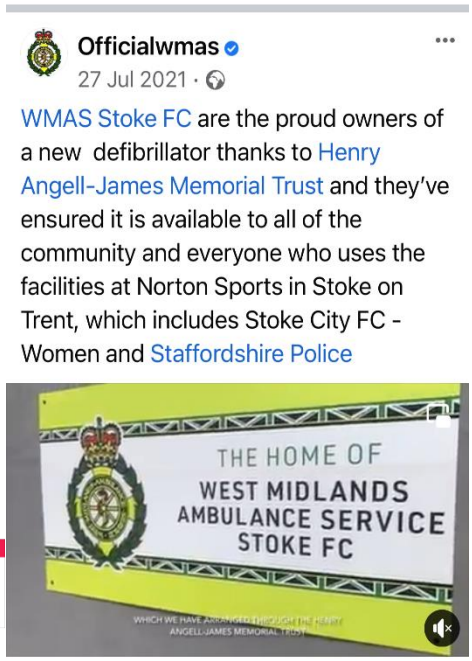
Cardiac Arrest Management	
Patient Safety	**Measurement** • Review and ensure completion of actions/recommendations arising from serious incidents • Conduct a review of all serious incidents relating to the management of cardiac arrest to identify strategic themes and make recommendations • Improved training and support for clinicians attending patients requiring cardiopulmonary resuscitation
Summary of Achievement ➢ The Trust has a very thorough and successful investigation process for all serious incidents, with direct input from senior clinicians. Monthly reporting and recommendations logs remain in place for all serious incidents. ➢ Cardiac Arrest Management was incorporated into the training plan for 2021/22. Courses completed by the end of December 2021 (PTS workforce figures used for % at 30/9/21) were: - 1732 (48.65%) E&U staff completed Statutory and Mandatory face to face training - 2314 (65.00%) E&U staff completed Statutory and Mandatory Workbook - 876 (86.22%) PTS Staff completed Statutory and Mandatory face to face training - 939 (92.42%) PTS Staff completed Statutory and Mandatory Workbook	
Clinical Effectiveness	**Measurement** • Improvement in the national quality indicator for Return of Spontaneous Circulation (ROSC) through implementation of actions to improve patient safety in cardiac arrest management • Increase public awareness of the importance of CPR and early defibrillation in the chain of survival • National post ROSC Care AQI – include audit figures to demonstrate improvement to above national average
Summary of Achievement ➢ National Ambulance Quality Indicator performance shows: o A 0.8% increase on overall ROSC at hospital over the year o A 0.27% increase on overall discharge to survival– this is the ultimate aim to have a person leave hospital after their cardiac arrest. o A 2.8% decrease in post resuscitation over the year ➢ The Trust has completed the following to further improve cardiac arrest management: o Quality improvement programmes o Mandatory education sessions on the management of cardiac arrest o Cardiac arrest checklists o Regular messages are shared on social media in relation to the importance of CPR and early defibrillation. A sample of recent messages are shown on the next page. o The Trust has consistently achieved above 68% for the care bundle in post ROSC management: o Mandatory education sessions on the management of cardiac arrest and post ROSC care o Post ROSC checklist	
Patient Experience	**Measurement** • Learning from experience and excellence • Disseminating best practice
Summary of Achievement Following thorough investigation, all incidents are discussed at our Learning Review Group, which is attended by a core group of clinicians from across the Trust. This ensures an open and	

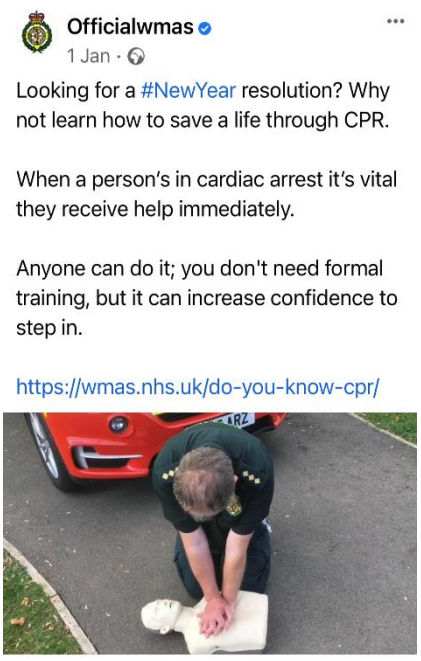
transparent process to enable key learning points are highlighted and that recommendations are agreed and acted upon.

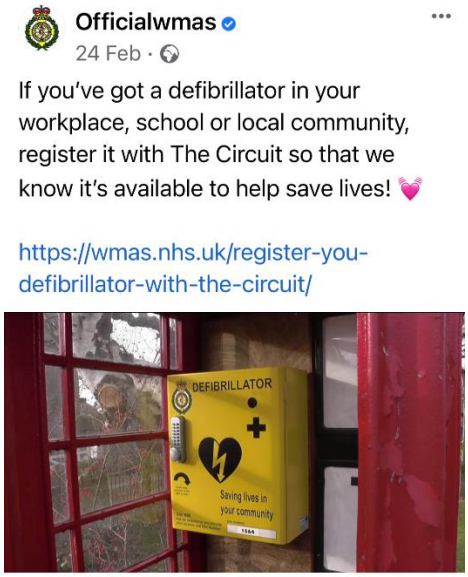
Progress Towards Target Outcome:	**Current Status**
The target was to reduce the number of serious Incidents relating to the management of cardiac arrest. This was to be achieved through all of the measures described above, to ensure robust governance, training and public awareness.	

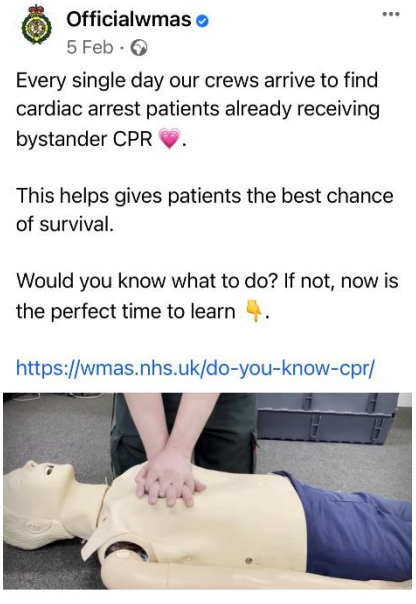
Sample of social media messaging to promote CPR and early defibrillation:











West Midlands Ambulance Service
University NHS Foundation Trust

Maternity	
Patient Safety	**Measurement** Development of processes to ensure strong governance arrangements, sharing of information and that lessons learned are responded to and embedded in Trust practices
Summary of Achievement - All maternity Serious Incidents are shared with local maternity networks - Successful implementation of red pre-alert phone at trial maternity units - Board level champion for maternity services - Regular articles published for staff regarding maternity audit results -	
Clinical Effectiveness	**Measurement** Enhanced arrangements for staff training and sharing of information
Summary of Achievement - Transwarmer and cuddle pocket video launched - New maternity clinical care procedure - Virtual Training session “Born Too Soon” and collaborative training event with Birmingham Womens Hospital - Maternity placements for qualified ambulance clinicians with local Trusts - Triangulation of information from complaints, serious incidents and other events to develop trends and themes - Development of maternity champions at each hub	
Patient Experience	Measurement Improved methods of receiving feedback from patients in relation to maternity services
Summary of Achievement - Dissemination of survey for maternity services - Planned work for Quarter 4 - launch of maternity services page on WMAS website to include information on what to expect when calling 999 for pregnancy or childbirth and links to online maternity survey once complete	
Progress Towards Target Outcome: Supporting the delivery of high-quality care for women during pregnancy, childbirth and the postnatal period, taking into account changing clinical guidelines, best practice and recommendations.	**Current Status**

West Midlands Ambulance Service
University NHS Foundation Trust

Safe Transportation of Patients (PTS)

Patient Safety	Measurement • Maintain incident reporting and learning from these incidents with a planned reduction in the number of 'harm' incidents and the level of harm.

Summary of Achievement

The Trust has continued to promote the need to report any incidents that occur whilst patients are in our care.

Following an increase in reported incidents during 202/21, we have continued to monitor the trend of incidents during 2021/22. The increase was due, in part due to the crews being reminded of the importance of reporting, along with the challenges that all staff have faced since the start of the pandemic.

At the time of reporting, (December 2021), there had been an increase in incidents where harm had occurred from 89 in 2020/21 to 104 in 2021/22 (an overall rise of 16.9%). It is important to note that the volume of incidents remains extremely low in comparison to overall activity, which has continued to rise steeply as the NHS has restored elective activity in the latter stages of the pandemic. The total journeys carried out by the PTS service in the same period was 530,141 in 2020/21, which rose to 640,551 in 2021/22, representing a rise of 20.8%.

	Harm Incidents	Total Journeys	Number of Journeys per Harm Incident
Q1 2020/21	32	149585	4675
Q2 2020/21	30	182860	6095
Q3 2020/21	27	197696	7322
Q4 2020/21	TBC	TBC	TBC
YTD	**89**	**530141**	**5957**

	Harm Incidents	Total Journeys	Number of Journeys per Harm Incident
Q1 2021/22	41	208697	5090
Q2 2021/22	39	214789	5507
Q3 2021/22	24	217065	9044
Q4 2021/22	TBC	TBC	TBC
YTD	**104**	**640551**	**6159**

During the course of the year, where any harm was reported, all but three (95%) were reported as low harm. One incident has been investigated under our Serious Investigation procedure, in comparison to three in the previous year.

We will continue to learn from any incidents that do occur, ensuring that staff training is updated to reflect any new trends in practice or skills.

Progress Towards Target Outcome:	**Current Status**
The Trust planned to continue to learn from incidents and to educate staff when particular trends emerge, with the target of reducing the trend of incidents of all severity. The overall volume of incidents has risen slightly but to a lesser degree than the rise in overall incidents, resulting in a proportionate reduction for the year to date.	

West Midlands Ambulance Service
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Learning from Patients' Feedback

Patient Experience	Measurement - **111 -** Introduce survey at the end of the telephone call. This will provide a link to an online survey which will include a simple set of questions to meet both national and local quality improvement requirements - **PTS -** Introduce survey at the end of the telephone call, during one survey week each quarter. There will be advice to progress to a more detailed online survey which will run concurrently. - Consider opportunities to carry out further targeted surveys through our Discharge or Renal Coordinators

Summary of Achievement

During quarter 1, the development of the telephony system was taking place, however, as we have never utilised technology in this way, a technical issue was encountered with the database connection.

During Quarter 2, the post-call survey was tested on the IT Support Desk for approximately 1 month, and results were successfully logged. For the 111 survey, the required questions were to be confirmed in order that the survey could be established. The questions for the PTS survey were agreed, and following successful testing, implementation in a live manner was agreed for one of the Trust's contracts.

During quarter 3, A technical issue has developed with the post call survey (affecting both PTS and 111). This is currently being investigated by the supplier, and the expected date for resolution has not yet been confirmed.

- Quarter 1 - 47 responses received to date via our 111 online survey
- Quarter 2 - 20 forms of feedback relating to the Non Emergency Patient Transport Service (FFT Survey, Small Patient Survey and PTS Survey)
- Quarter 3 - 2 responses received in Quarter 3 via our 111 online survey with 49 response YTD. 14 forms of feedback relating to the Non-Emergency Patient Transport Service (FFT Survey, Small Patient Survey and PTS Survey) in quarter 3

Progress Towards Target Outcome:	**Current Status**
The overall intention was to increase response and subsequent learning from patient surveys. Despite our best intentions and efforts to establish the post-call surveys, this has not been possible during this year, however the technology and design work is in place, and once the issue has been fixed, we will continue to ensure that the surveys are in place during the coming financial year.	

Service-based Annual Reports 2021/22

Whilst the above tables represent the overall progress in relation to the quality priorities that were established for 2021/22, the following reports are available on our website which contain further details of the work in each of these corporate and clinical departments.

- Controlled Drugs and Medicines Management
- Infection Prevention & Control
- Better Births
- Patient Experience
- Safeguarding (including Prevent)
- Making Every Contact Count
- Emergency Preparedness
- Equality, Diversity & Inclusion
- Security and Physical Assaults
- Health, Safety and Risk
- Patient Safety
- Clinical Audit and Research

The Annual Report in respect of the Data Security and Prevention Toolkit will be available later in the year, in conjunction with the national guidance for 2021/22.

Patient Safety

Reporting, monitoring, taking action and learning from patient safety incidents is a key responsibility of any NHS provider. At WMAS, we actively encourage all our staff to report patient safety incidents so that we can learn when things go wrong and make improvements.

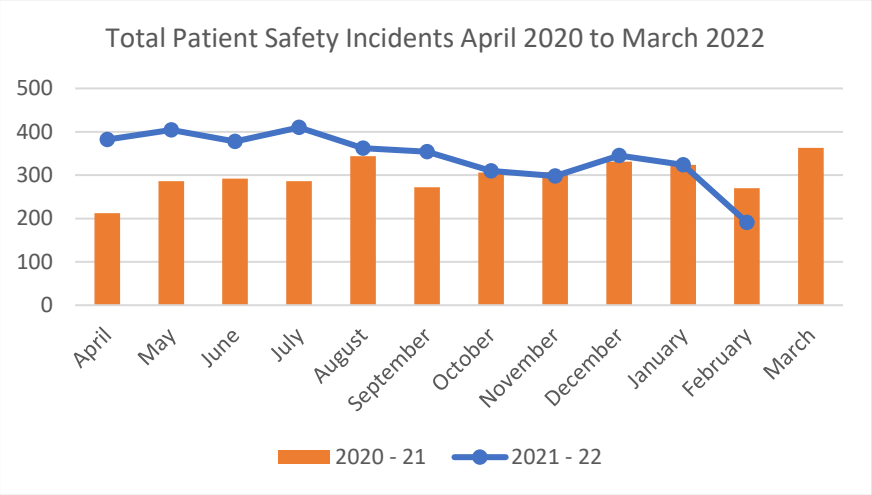
A positive safety culture is indicated by high overall incident reporting with few serious incidents which we continue to achieve. Encouraging staff to report near misses allows us the opportunity to learn lessons before harm occurs.

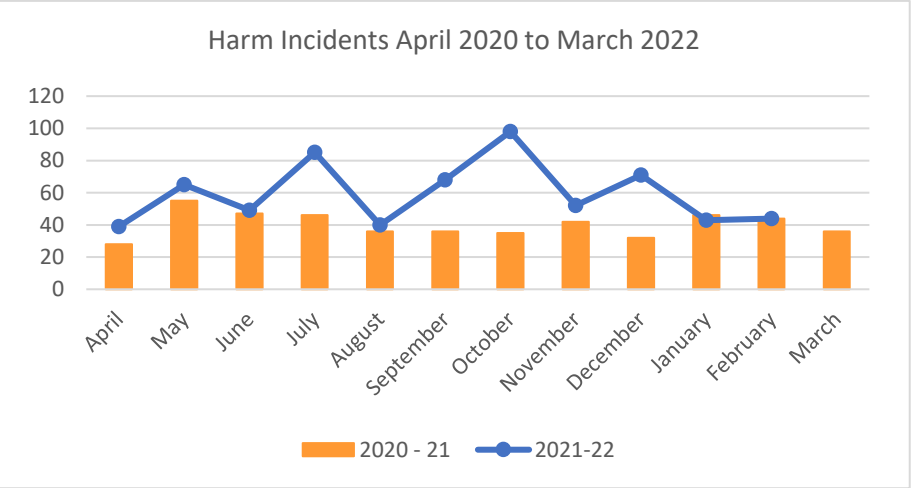
Analysis of all incidents takes place and is supported by triangulation with other information such as complaints, claims, coroners' inquiries, clinical audit findings and safeguarding cases. These are discussed monthly at the Learning Review Group (LRG). The meeting is chaired by the Director of Clinical Commissioning and Service Development and attended by clinicians from across the organisation. Themes and trends are reported quarterly to the Quality Governance Committee and the Trust Board of Directors.

Total Number of Patient Safety Incidents reported by Month

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Harm	39	55	49	85	40	68	98	52	71	43	44		644
No Harm	343	339	329	325	322	286	212	245	271	278	147		3097
Total	382	394	378	410	362	354	310	297	342	321	191		3741

The total number of incidents reported during 2021-22 (to the end of February) have increased from the previous year by 19.7% (from 3,125 to 3,741). This includes complaints and NHS to NHS concerns as well as staff reporting through the internal electronic reporting system. There were fluctuations corresponding to the various stages of national lockdown and local restrictions as the pandemic progressed. Patient harm events (644) accounted for 17.2% of all incidents reported during 2021/22. Commentary to be updated once March figures are finalised.





Themes (Patient Safety/Patient Experience/Clinical Audit)

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

The top trends for severe harm incidents, relate to delayed ambulance responses, which directly correlate to the increased hospital handover delays.

Serious Incidents

All serious incidents are investigated using Root Cause Analysis methodology to determine failures in systems and processes. This methodology is used to steer away from blaming individuals, to ensure the organisation learns from mistakes and that systems are reinforced to create a robustness that prevents future reoccurrence.

Between April 2021 and February 2022, the Trust registered 172 cases as serious incidents, compared to 72 in the previous year. To be updated when March figures are available, with rationale relating to the increased cases. The proportion of serious incidents is consistent with activity and has remained so for the last four years. Following investigations into serious incidents the Trust identified the following key trends and themes in relation to the discharge of patients on scene, for patients with the conditions;

- Sepsis
- STEMI / NSTEMI
- Stroke

Additionally, root cause analyses have identified a common theme, which is related to Crew Resource Management and communication.

The Trust has not had cause to report any Never Event incidents.

Top Patient Safety Risks

- Missing equipment/drugs and/or out of date drugs on vehicles that have been through the make ready system.
- Incidents when transferring/moving patients during transport.
- Failure to interpret clinical findings and act on appropriately.
- Administration of medicines – wrong route and inappropriate dosage.

Duty of Candour

The Trust promotes a culture of openness ('just' culture) to ensure it is open and honest when things go wrong, and a patient is harmed. Being open is enacted in all incidents where harm is caused no matter the severity to ensure this culture is carried out.

NHS providers registered with the Care Quality Commission (CQC) are required to comply with a new statutory Duty of Candour, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 Duty of Candour which relates to patient harm events considered to have caused moderate harm or above. This regulation requires a more formal process of ensuring that incidents are investigated at an appropriate level and that being open and honest with the patient and/or their families is completed.

The introduction of a Patient Safety section of the Trust website supports the Trust Duty of Candour requirements and allows greater openness and sharing about when things have gone wrong and what the Trust has learnt and is doing to put things right and improve.

The Trust Duty of Candour/Being Open policy is available via the Trust website or directly from the Freedom of Information Officer.

The policy details the arrangements the Trust has in place for staff and managers and the Trust Learning Review Reports published on the Trust Website and presented to the Board of Directors each quarter identifies compliance with our statutory duties.

Safeguarding 2021/22 update to be added before final publication

In 2020/2021 West Midlands Ambulance Service has continued to ensure the safeguarding of vulnerable persons remains a priority within the organisation and the trust is committed to ensuring all persons are protected at all times through embedded policies, procedures, education and literature. All staff within WMAS are educated to report safeguarding concerns to the single point of access Safeguarding Referral Line. This enhanced training and promotion of the need to make referrals, coupled with the overall rise in calls to both 111 and 999 contribute to an annual increase in referrals.

Safeguarding Referral Numbers

	Adults		Children	
	Referrals	% Variance from Previous Year	Referrals	% Variance from Previous Year
2016/2017	21386		4534	
2017/2018	21130	-1.2%	4756	4.9%
2018/2019	23206	9.8%	5631	18.4%
2019/2020	31639	36.3%	9232	63.9%
2020/2021	39926	26.2%	14082	52.5%

Currently there are 27 Safeguarding Boards across the West Midlands and engagement continues to develop with WMAS, in addition to contribution to Child Death Overview Panels, Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Case Reviews, Social Care and Prevent panels and networks.

The Safeguarding Manager is the Prevent lead for the trust and ensures compliance with contractual obligations through reporting via Unify2 to NHS England. In addition, close links have been established with NHS England and Police to ensure Prevent is a key priority within our safeguarding agenda.

The Trust is committed to ensuring all Paramedics are trained to level 3 in Safeguarding, which will refresh and enhance the knowledge of our staff in respect of best practice and current legislation.

Patient Experience

The key themes for Patient Advice and Liaison Service (PALS) and formal complaints relate to:

- **Timeliness of 999 ambulance and Patient Transport Service Vehicles** - there is a delay or perceived delay in the arrival of a 999 ambulance or response vehicle, or there is a delay in the arrival of a Non-Emergency Ambulance to take a patient to and from their routine appointment.
- **Professional Conduct** - that the patient or their representative feels that the attitude or conduct of the attending ambulance staff, or call taker was not to the standard that they would expect.
- **Loss/Damaged**- the patient or their representative feels that they have lost personal belongings whilst in our care.

Complaints

Complaints are an important source of information about patients' views regarding the quality of services and care provided by the Trust. All staff are encouraged to respond to complaints and concerns raised by patients and relatives in an effective, timely, and compassionate way.

The Trust has received 505 complaints raised so far (1 Apr- 29 Mar) compared to 350 2020/21. The main reason relates to clinical timeless (response) raised.
Breakdown of Complaints by Service Type YTD:

	2020/21	2021-2022	% Variance 20/21 – 21/22
EOC	35	176	402.9
EU	248	215	15.3
PTS	34	54	58.8
Air Ambulance	0	0	0
Other	1	12	1,100
IUC	32	48	50
Total	**350**	**505**	**44.3**

Upheld Complaints

The table below indicates that of the 505 complaints, 123 were upheld & 89 part upheld. If a complaint is upheld or part upheld, learning will be noted and actioned locally and will also be reported to the Learning Review Group for regional learning to be identified and taken forward as appropriate.

National Reason	Justified	Part Justified	Not Justified	TBC	Total
Attitude and Conduct	7	14	22	12	**55**
Call Management	8	9	21	16	**54**
Clinical	13	29	79	25	**146**
Eligibility	0	1	3	0	**4**
Info Request	2	2	17	5	**26**
Lost/Damaged	1	0	1	0	**2**
Other	0	0	1	4	**5**
Out of Hours	1	0	0	0	**1**
Patient Safety	3	2	2	3	**10**
Response	87	28	30	44	**189**
Safeguarding	1	4	5	2	**12**
WMAS	**123**	**89**	**181**	**111**	**505**

Patient Advice and Liaison Service (PALS) Concerns (data 1 Apr – 29 Mar)

This year has seen an increase in concerns with 2482 concerns raised in 2021/22 compared to 2109 in 2020/21. The main reason for a concern be raised is 'timeliness (response).

Learning from complaints / PALS

You said	We did
IUC why was a call back not received on the number requested	the number was noted but not available through the computer aided dispatch system. Learning has been identified and this requires both a technical and training solution, the responsible leads have been made aware for a case study and case review
PTS a concern that staff were allegedly not wearing masks	An article in the Trust Weekly Briefing went out to all staff to remind them of their responsibility
Patients that use the Non Emergency Patient Transport who don't have a timely pick up or require a specific vehicle	Notes added to the computer system
Patients mobility incorrectly booked by an external source	On review of the system the external booking office did not have the ability to select the mobility type, the system was updated

Ombudsman Requests
The majority of complaints were resolved through local resolution and therefore did not proceed to an independent review with the Parliamentary and Health Service Ombudsman. During 2021/22 – 14 independent reviews were carried out, (1 case was part upheld), compared to 3 independent reviews in 2020/21.

Patient Feedback / Surveys
The Trust received 132 completed surveys via our website, relating to the Patient Transport Service. The table below outlines the response by survey type.

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

Response (YTD)	Small Survey	FFT Survey	PTS Survey
Very Good	19	29	10
Good	2	56	1
Neither Good or Poor	1	4	1
Poor	0	0	0
Very Poor	1	1	3
Don't Know	0	4	0
Total	**23**	**94**	**15**

Discharge on Scene Survey:

8 responses were received relating to patients who have been discharge to the location the 999 call was made.

Emergency Patient Survey:

104 responses received in 2021/22

Compliments
The Trust has received 1883 compliments in 2021/22 compared to 1834 in 2020/21. It is pleasing to note that the Trust has seen an increase in positive feedback.

Governance
Patient Experience reports monthly to the Learning Review Group (LRG) which focuses on 'trend and theme' reports. The LRG reports to the Quality Governance Committee and reports any issues relating to assurance; any risks identified; and key points for escalation. The Trust Board receive monthly data on formal complaints and concerns through the Trust Information Pack.

Single Oversight Framework

This Framework was introduced by NHS Improvement in 2016 as a model for overseeing and supporting healthcare providers in a consistent way. The objective is to help providers to attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding', meet NHS constitution standards and manage their resources effectively, working alongside their local partners. This is done by collating information relating to achievement of the following key themes:

Theme	Aim
Quality of Care	To continuously improve care quality, helping to create the safest, highest quality health and care service
Finance and Use of Resources	For the provider sector to balance its finances and improve its productivity
Operational Performance	To maintain and improve performance against core standards
Strategic Change	To ensure every area has a clinically, operationally and financially sustainable pattern of care
Leadership and improvement capability (well-led)	To build provider leadership and improvement capability to deliver sustainable services

Since maintaining its overall rating of Segmentation 1, since the SOF was introduced, WMAS has recently been rated within segmentation 2, due to the significantly increased operational pressures and the impact on response times. The Trust is working closely with the Care Quality Commission and local integrated care systems to jointly address the factors that are affecting patient care throughout the system.

Category	Performance Standard	Achievement April 2021 to March 2022
Category 1	7 Minutes mean response time	7 mins 50 seconds
	15 Minutes 90th centile response time	13 minutes 46 seconds
Category 2	18 minutes mean response time	32 minutes 53 seconds
	40 minutes 90th centile response time	72 minutes 52 seconds
Category 3	120 minutes 90th centile response time	331 minutes 48 seconds
Category 4	180 minutes 90th centile response time	384 minutes 38 seconds

West Midlands Ambulance Service
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Listening to feedback

Each year our commissioners and stakeholders provide feedback in relation to the content of the Quality Account. We received many very positive comments in response to the 2021/22 report, a selection of which are listed below:

To be added to final version

Additionally, we would like to provide responses to some of the other comments that were fed back to us in response to the draft report for 2020/21:

To be added to final version

West Midlands Ambulance Service
University NHS Foundation Trust

Annex 1 Statements from External Stakeholders

Commissioners
Local Healthwatch Organisations
Overview and Scrutiny Committees

West Midlands Ambulance Service
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Statement from the Lead Commissioning Group

To be added to final version

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Statement from Local Healthwatch Organisations

To be added to final version

Statement from the Council of Governors

To be added to final version

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Annex 2 - Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2021 to March 2022
  - papers relating to quality reported to the Board over the period April 2021 to March 2022
  - feedback from commissioners dated xxxxx
  - feedback from governors dated xxxx
  - feedback from local Healthwatch organisations dated xxxxx
  - feedback from Overview and Scrutiny Committee dated from xxxx
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxx.
  - the [latest] national staff survey published
  - the Head of Internal Audit's annual opinion of the Trust's control environment. This was discussed and agreed at the Trust's Audit Committee in May 2021, attended by Internal and External Auditors.
  - CQC inspection report dated 22/08/2019
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the board

Professor Ian Cumming
Chairman
Date: xxxxxx

Professor Anthony Marsh
Chief Executive
Date: xxxxx

Annex 3: The External Audit Limited Assurance Report

National guidance has been updated for 2021/22 Quality Account as follows:

There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.

WMAS' Audit Committee is an established sub committee of the Board of Directors, which is attended by the Trust's external auditors. Each year, the Quality Account is presented to this committee for review. This process will take place as part of the review and approval process prior to publication.

Annex 4: Glossary of Terms

Glossary of Terms

Abbreviation	Full Description
A&E	Accident and Emergency
AFA	Ambulance Fleet Assistant
ARP	Ambulance Response Programme
AQI	Ambulance Quality Indicators
BASICs	British Association of Immediate Care Doctors
CCGs	Clinical Commission Groups
CFR	Community First Responder
CPO	Community Paramedic Officer
CPR	Cardio Pulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
COVID-19	Coronavirus Pandemic
CSD	Clinical Support Desk
DCA	Double Crewed Ambulance
E&U	Emergency & Urgent
EMB	Executive Management Board
EOC	Emergency Operations Centre
FAST	Face, Arm, Speech Test
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Area Response Team
HCAI	Healthcare Acquired Infections
HCRT	Healthcare Referral Team
IGT	Information Governance Toolkit
IM&T	Information Management and Technology
IPC	Infection Prevention and Control
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
KPIs	Key Performance Indicators
MERIT	Medical Emergency Response Incident Team
MINAP	Myocardial Infarction Audit Project
NED	Non-Executive Director
NHSP	National Health Service Pathways
NICE	National Institute for Health and Clinical Excellence
NRLS	National Reporting & Learning System
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PDR	Personal Development Review
PRF	Patient Report Form
NEPTS	Non – Emergency Patient Transport Service
QIA	Quality Impact Assessment
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROSC	Return of Spontaneous Circulation
RRV	Rapid Response Vehicle
SI	Serious Incident
SOF	Single Oversight Framework
STEMI	ST Elevation Myocardial Infarction
STP	Sustainability and Transformational Partnerships
VAS	Voluntary Aid Services
WMAS	West Midlands Ambulance Service University NHS Foundation Trust
YTD	Year to Date

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Further Information

Further information and action plans on all projects can be obtained by contacting the lead clinician named on the project.

Further information on performance for local areas is available as an Information Request from our Freedom of Information Officer or from the leads for the individual projects.

Progress reports will be available within the Trust Board papers every three months with the end of year progress being given in the Quality Report to be published in June.

If you require a copy in another language, or in a format such as large print, Braille or audio tape, please call West Midlands Ambulance Service on 01384 215 555 or write to:

West Midlands Ambulance Service University NHS Foundation Trust
Ambulance Headquarters
Millennium Point
Waterfront Business Park
Brierley Hill
West Midlands
DY5 1LX

You can also find out more information by visiting our website: **www.wmas.nhs.uk**

If you have any comments, feedback or complaints about the service you have received from the Trust, please contact the **Patient Advice and Liaison Service (PALS)** in the first instance; **01384 246370.**








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University Hospitals
Coventry and Warwickshire
NHS Trust

Your views are invited to shape our organisational strategy for 2022-2030

More than a hospital

More than a hospital – thank you

We've been on an incredible journey over the last few years and achieved so much together in delivering great healthcare. As a Trust our five year partnership with Virginia Mason Institute and the establishment of our improvement system (UHCWi) have given us the tools and techniques to bring about change and deliver improvements to the quality of the care we provide for our patients. The commitment by our staff to provide excellent care was very visible for all to see during 2020/21.

Covid – a springboard for transformation

Responding to the Covid pandemic showed us all the benefits of working in partnership for the people of Coventry and Warwickshire. We were united in the battle against Covid with individuals, communities and businesses - all helping us to make a difference, however big or small.

Reflecting on the impact that Covid had on us as individuals, our families and on those people who are vulnerable, there has never been a better time for us to ensure that we place more emphasis on keeping people fit and healthy. Many people have fed back to us the life changing impact living through the pandemic has had and their promise to take this opportunity to make long lasting lifestyle improvements.

We need to continue to help build and strengthen resilience within our communities and be more proactive in reaching out and ensuring people can access the services they need. We recognise that we cannot achieve this on our own and are working hard with our partners to create more joined up services to support the health and well-being of our population.

Healthcare is changing

The new Health and Care bill published on 6 July 2021 set out key changes to reform the delivery and organisation of health services in England. The ambition is to not only provide healthcare, but to work together with a strong local focus and fundamentally improve the health and well-being of local people. In the near future, we will be increasingly connected to all the health and care organisations in our local area, collaborating more closely to deliver joined up care for our local communities. These new ways of working will be supported by evolving governance, finance and commissioning structures with regulatory oversight from NHS England and Improvement at a system level.

This transition to care that is more proactive, preventative and centred around individuals' needs presents our Trust with significant challenges and opportunities. Effective collaboration with partners, particularly primary and social care, is vital to overcoming these challenges and delivering the best care for our patients.

Next steps – building better health together

Our draft organisational strategy 2022-2030 sets out the next part of our journey for University Hospitals Coventry and Warwickshire NHS Trust. Every one of us has an important part to play in this and we really would like to hear your thoughts and feedback as well as give you the chance to shape the way we deliver this. Please take your time to view our survey and video **(see details on the back page of this document)** and let us have your views to help us deliver a better future together. We will share the findings and publish our strategy in April 2022.

Dame Stella Manzie DBE
Chair

Professor Andy Hardy
Chief Executive Officer

1 Rooted in our communities

Leader in healthcare

Our last organisational strategy stated the vision for our organisation to be a "national and international leader in healthcare." It recognised how passionate we are about improving the quality of our care for our patients and being the best we can be. That goal of being the best we can be, continues. However, we want to add to it.

Rooted in our communities

Good health requires more than a hospital or the services within it. It requires access to good housing, exercise, a healthy diet, meaningful employment and a feeling of belonging and support.

By effectively utilising our considerable resources and influence we can be a major contributor to the good health and well-being of our local population. That is why our new vision reflects the new world we are in **"to be a national and international leader in healthcare rooted in our communities".**

For example, as one of the biggest employers in Coventry and Warwickshire, more than 80% of our staff live in the area with their families relying on us as an employer we can really make a difference in strengthening the future health of our population now and for future generations.

Collectively we all have a crucial part to play as both employees and residents in actively contributing to supporting the good health and well-being of the people of Coventry and Warwickshire.

Ensuring that local integration and being the best is in all we do

Our organisational strategy proposes three interconnected purposes or focus areas for UHCW for the next eight years - **local integrated care; research innovation and training, and being a regional centre of excellence.** In other words we wish to deliver the best care possible for our patients, delivered in a more seamless and integrated way with our health and care partners. Our staff are trained with the latest knowledge and research and they will always strive for the best outcomes for our patients. To help us to deliver the vision and the three purposes, we will have strategies which support quality of care, our people, digital technology and sustainability as we move into the future.

Patient Story

What integrated care will look like

Raj is a 55 year old teacher. Five years ago he had chemotherapy for cancer. He recovered and went back to work.

He has been feeling breathless and fatigued for about six months. It's really affecting his work.

Raj goes to his GP. His symptoms are not telling a clear story but his GP can use the GP data system to link his symptoms to his previous chemotherapy and help make a diagnosis of potential Heart Failure.

Raj's GP books blood tests and an echocardiogram at the local Community Diagnostic Centre.

Raj's results come back and show that he is in Heart Failure. Raj's GP links to the specialist Heart Failure team via the virtual advice and guidance system to discuss his care and organise a review.

Raj does not need to go to the hospital but can go to the community clinic to see the specialist team who explain his diagnosis and plan. He is offered cardiac rehabilitation and psychological support and is linked into the patient support group.

His diagnosis, management plan and personal goals are documented in the shared electronic record which is accessible by Raj, his GP and specialist team. Raj knows that he can speak to his GP, specialist team or peers at the support group if he has concerns about his condition.

If his symptoms deteriorate he can access the specialist team directly or via his GP.

...Raj has lived with Heart Failure now for ten years. He is still working. There have been times when things deteriorated but he was able to quickly get help. He has never been admitted to hospital for care.

He now leads the patient support group and has used his teaching skills to co-design the education programme for patients with low literacy skills.

2 A vision for health

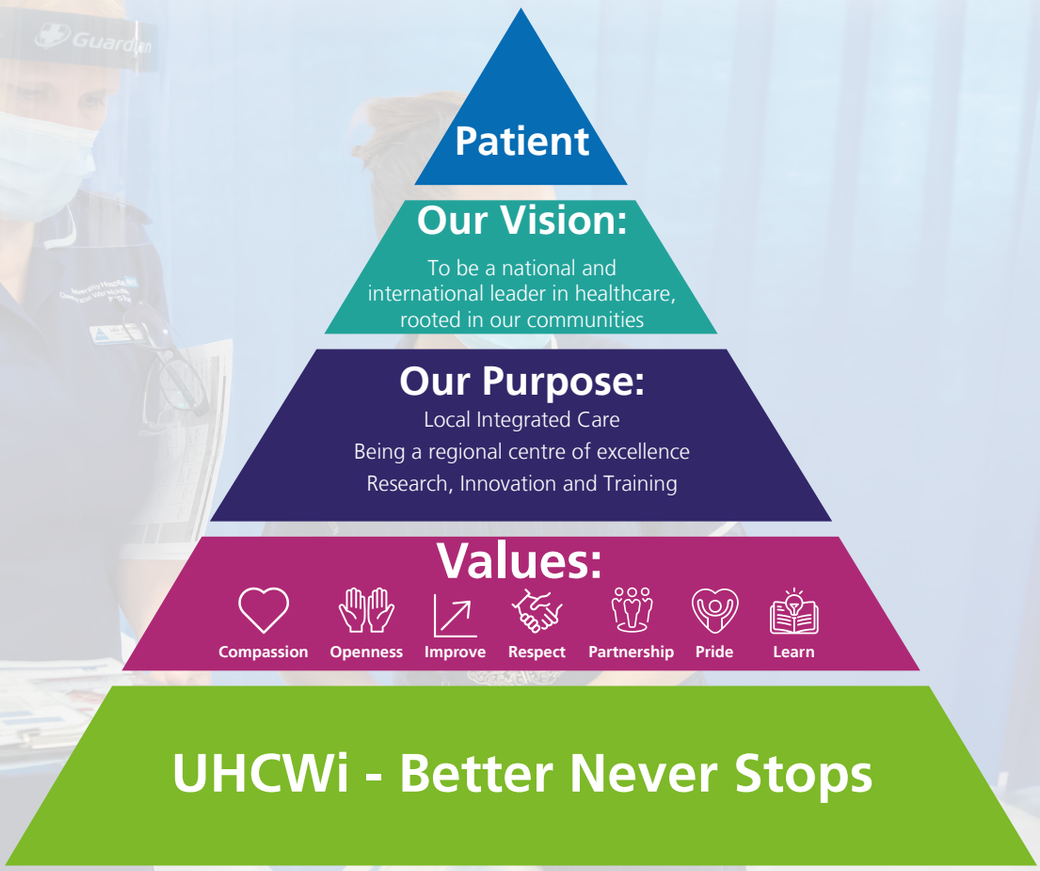
Transforming and improving health for Coventry and Warwickshire requires compassionate and collaborative **leadership**. For UHCW, leadership means supporting those around us to achieve and recognising our partners' strengths so we can all excel. Above all, it means leading the delivery of outstanding, joined up care for our communities.

The diagram below summarises our leadership approach with the patient first in all that we do and how everything we do connects to care for our patients. Our vision captures our ambition to deliver world-leading care for our communities, and our three purposes set out how we will achieve this.

We lead by living our values in every interaction with our patients, people, and partners. We will invest in other enablers to improve care quality, treatment outcomes, and the experience of patients and their families.

Our commitment to improvement through the use of our UHCWi methodology continues to drive us forward as an organisation as we know "better never stops".

Fig. 2.1 Our strategic triangle




ADVANCED CLINICAL PRACTITIONER
University Hospitals Coventry and Warwickshire NHS Trust
NHS
Sunita Mahay
Lead Advance Clinical Practitioner

3 Our vision, purpose, and values

Our Vision

To be a national and international leader in healthcare, rooted in our communities

For UHCW, being a national and international leader means **delivering the best care for our communities.** It means **being exceptional in everything we do** – from providing proactive, joined up support for local people to delivering specialised services for those with the most complex health conditions. It means creating the best experiences and opportunities for our staff, and being a supportive and collaborative partner. Above all, in the changing health and care landscape we aim to be an **outstanding partner in local care**, with our regional work enabling us to improve care quality and outcomes for everyone.

Our Purpose

Our overarching purpose is to deliver the best possible care for our local communities. We will achieve our vision through our **three interconnected purposes** enabling us to continually improve local care.

Our Values

Our values reflect the culture we want to create. Developed by our staff, our seven core values guide what we do daily to achieve what we envision. Wherever we work within our organisation, we commit to uphold these values as we work together to deliver world-class care:

Compassion
We treat everyone with courtesy and compassion.

Partnership
We work in partnership to deliver and improve the services we provide for our patients.

Respect
We treat everyone with respect and dignity.

Improve
We are open to change and seek to innovate to improve what we do.

Learn
We see education, research, and innovation as central to improvement.

Openness
We act with openness, honesty and integrity in all we do.

Pride
We take pride in all we do and aspire to do.

4 So what does this actually mean for us?

Our purpose is evolving. Putting patients first remains at the heart of what we do. Integrating services around patients and communities is both a national and local priority and our role will move beyond providing care for people who are acutely unwell.

As our integrated care system matures and is formalised in July 2022, we have a **leading role to play in the gradual and sustained transformation of local health and care services.** This transition to care that is **proactive, preventative and joined up around people** presents our Trust with some challenges and more opportunities. Effective collaboration with partners, inside and outside the health service is vital to overcoming these challenges and delivering the best care for our patients whilst supporting the health and well-being of our staff. To do this well, we will need to work across traditional organisational boundaries and in different ways.

We deliver specialised and acute services to broader populations at a regional and national level, which helps us to improve the quality of care, outcomes, and experience that we deliver for all patients. We are also one of the largest teaching hospitals in the country, and engage in cutting-edge research and innovation that helps us improve everything we do and contribute to the wider health and care system.

Our three refreshed purposes will be used to engage our people, partners, and communities in the new direction we are taking as an organisation. These purposes will determine how our Trust spends its time and focuses its resources and efforts.

Staff stories

Abeesh Panicker, Cardiology Research Nurse has been able to be supported through iCAhRE™ – Interdisciplinary Clinical Academic health Research Excellence programme which supports our staff to be the research leaders of the future.

"Going forward my aim is to continue my journey towards a PhD. I am grateful to UHCW and Coventry University for supporting me to complete this programme to the best of my ability and National Institute for Health Research (NIHR) for their help throughout. Research not only improves patient outcomes and identifies new treatments, but is also a rewarding clinical and academic career which is an option open to all staff within the NHS."

Born in India, **Consultant Smruta Shanbhag** joined UHCW as our Gynaecological Cancer consultant from Glasgow in 2019 where she had been a Consultant for 10 years. She chose to become the lead for Gynaecological cancer as well as Lead for Gynaecology, as Smruta believes that change is driven by clinicians and non-clinicians working together for world class patient care. Her passion for quality care for her patients and pushing boundaries was seen first hand on BBC Hospital where she continually sought out any options or treatments that might help her patient Natasha.

"I've been so impressed with the commitment towards our Trust values, especially those of openness and honesty with patients and colleagues. We feel like a family that strive to work toward a common and higher goal of world class patient care across all services. This is a great place to build a medical career and working as part of a fantastic team of supportive and innovative professionals"

Juliet Starkey joined UHCW in June 1999 as a band two waiting list clerk working part time in her local hospital in Rugby. Twenty-plus years later and continuous progress has seen her become the Group Director of Operations for Trauma and Neuro. Her roles along the way have included Orthopaedic Theatre Scheduler, Administration Manager, Ops and Performance Manager and General Manager at Hospital of St Cross, Rugby. Support from the Trust has allowed Juliet to complete the Leading Together programme and an Institute of Line Management course. She is also currently undertaking a Masters of Business Administration. She says they have helped her to develop compassionate leadership and an appreciation for developing the teams she manages.

"I have benefitted from a succession of managers who have supported me in fulfilling my potential,"

4.1 Local integrated care

Our most fundamental purpose is to care for our communities. UHCW is committed to playing an active role in helping people to live happier, healthier lives, as well as providing care for those who are acutely unwell. UHCW will work closely with health and care partners to provide proactive, joined up care to local people – delivered with world-leading quality. A vital part of this will be tackling health inequalities, addressing underlying health factors and reducing variation in our services.

Focus areas	Actions
Integration. Integration puts people rather than organisations at the centre of care. This helps improve the quality of care, outcomes and makes the best use of resources. We will support health and care organisations across our system to deliver joined up services for our communities.	**To integrate care, we will:** • Work with healthcare partners and form multidisciplinary teams to make joint leadership decisions. • Work together to plan how we improve services and share information collaboratively.
Population health. We will work together with partners to design and deliver services that prevent ill health, improve patient outcomes and well-being. We are focused on proactive care, and prevention approaches that make a difference to individuals and the population as a whole.	**To improve the health of our population, we will:** • Facilitate data sharing and analysis to develop a clear picture of our population's health needs. • Work with partners to change what we do, to support the health needs of local people better. • Develop a strategy for how we can best utilise our Hospital of St Cross, Rugby site for more health and well-being.
Health inequalities. Good health is affected by wider factors such as housing, access to education and employment. With partners, we will take action to address these and ensure our services are accessible to everyone. We will tailor health and care services to meet the needs of deprived communities.	**To overcome health inequalities, we will:** • Work with partners whose roles influence local people's health for example in housing and education. • Look at how we could change services to ensure patients get consistently good quality services which overcome inequalities.

What we want to achieve	Patient experience
For our patients: • Local people should live longer, healthier lives, supported by effective, joined up services. • Improve outcomes by timely support in areas such as diabetes, cancer, smoking and obesity. **For our people** • A sustainable workforce equipped to provide the best care. • Opportunities to work across other organisations, strengthen relationships and gain new skills. • More satisfaction from delivering holistic, joined up care that helps patients to stay well. **For our organisation:** • Leading collaborative work with our partners in integration, population health and health inequality. • Embedding multi-disciplinary teams across services and areas.	**Our patients will:** ✓ Experience responsive and proactive services: where we can to reduce the number of patients getting ill. ✓ Have timely access to the right care, in the right place, at the right time. ✓ Experience holistic care and support that considers their emotional and well-being needs. ✓ Have the confidence that wherever care is provided, people will understand and meet their social, emotional, and health needs. ✓ Only need to tell their story once, because our local health and care services are joined up seamlessly around patient needs.

4.2 Regional centre of excellence

Providing regional acute and specialised services is vital for improving care quality and outcomes for a broader patient population. To do this successfully, we need an evidence-based understanding of which services we can offer to patients at a regional level based on excellent treatment outcomes and strong operational performance. We also need to further develop strategic partnerships with other regional acute providers so we can work together to meet the health needs of a broader population across our region.

Focus areas	Actions
Develop our strengths. We deliver a number of regional specialist services that we are proud of and wish to build on. To make strategic decisions about which services we deliver for our region in the future, we need to establish clear evidence for evidence for our resources related to the ability to achieve outstanding outcomes. to achieve outstanding outcomes.	**To develop our strengths, we will:** • Analyse our patient outcomes and operational performance for high performing specialties, and benchmark against other NHS trusts to help us deliver the best outcomes for patients. • We will model the demand and identify gaps to meet the needs of patients to inform our developing services for the future, wherever they need to be. • Collaborate with regional partners to embed hub and spoke models for selected specialties.
Meet a broader population's needs. UHCW is in a unique position to serve multiple geographies at system and regional level. By understanding the needs across these areas and through partnerships, we have the potential to deliver even more specialised care across the Midlands.	**To meet a broader population's needs, we will:** • Conduct analysis to understand which populations depend on our services. • Establish regional agreements that set out which services each organisation will lead on. • Collaborate closely with primary care networks to streamline referrals.

What we want to achieve	Patient experience
For our patients: • Local and regional patients will have consistently excellent health outcomes. • Patients with highly complex conditions will achieve the best possible outcomes from treatment. **For our people we will provide opportunities:** • To develop in specialised areas and build a career with us and our partners. • To work with regional partners and different communities of patients. **For our organisation:** • Attract and retain the best talent to build a culture of excellence. • Improved productivity and operational performance. • Be a regional leader that recognises partners'. strengths and learns from them, to support our service improvement.	**Our patients will have:** ✓ Timely access to the best specialised treatment. ✓ Seamless, joined up services that maintain excellent communication with their closest health and care organisations. ✓ More appropriate choice in where and how they receive care, including in community outpatient settings close to their homes and virtually where appropriate. ✓ Dedicated support for families and visitors. ✓ Interactions and processes that are clear, straightforward, and instil confidence in our ability to deliver excellent care.

4.3 Research, innovation and training

We are one of the country's largest teaching hospitals and are committed to developing the next generation of health and care professionals. Our strategic partnerships with University of Warwick and Coventry University enable us to have the best research and teaching environments to support our staff. We are involved in cutting-edge research and innovation in areas such as reproductive health and human metabolism, and collaborate closely with the National Institute for Health Research (NIHR) to deliver this. We want to encourage everyone at UHCW to be involved in teaching and research at scale and in a way that makes sense for them and contributes directly to improving patient outcomes.

Focus areas	Actions
Expand our educational reach. Alongside our core teaching activities for students and trainees, we will play a greater role in training health and care professionals in all settings. We will enhance our learning offer to students, and invest in providing this education to a wider audience abroad.	**To increase our educational reach, we will:** • Continue to train medical undergraduates and postgraduates, nursing students and Allied Health and care professionals in all care settings. • Strengthen partnerships with local universities in Coventry and Warwick and international institutes (e.g. Skills Training Institute India). • Invest in digital virtual learning.
Develop a learning health system. A learning health system continuously analyses data which is collected as part of routine care to monitor outcomes, identify improvements in care, and implement changes. Our UHCWi improvement methodology enables us to do this through embedding a culture of continuous learning and improvement. We will use this approach to help us drive innovation forward in our organisation, and across our local system.	**To develop a learning health system, we will:** • Continue to embed our UHCWi methodology and share learning from this across our system. • Provide ongoing learning opportunities for all our people, focused on using data to generate evidence-based improvements.
Broaden and develop research areas. Much of our current research is in clinical areas connected to our strongest specialties and through our pioneering Centre for Care Excellence (CCE). Our CCE will help us champion clinical academic careers and leadership development in nursing and Allied Health Professions. We will continue to advance in this, while broadening our research to include areas such as quality improvement, innovation, and organisational design.	**To broaden and develop research areas, we will:** • Promote research excellence for all staff. • Develop institutes of excellence, in line with our emerging R&D strategy. • Become a Biomedical Research Centre (BRC). • Increase awareness by publishing papers, attending conferences, and applying for awards.

What we want to achieve	Patient experience
For our patients: • Improved care quality and better treatment outcomes. **For our people:** • Continuous learning, development, and leadership opportunities for all. • Opportunities to innovate and experiment in a supportive environment. • Increased satisfaction from delivering successful, cutting-edge treatments for patients. **For our organisation:** • Strong national and international reputation for teaching, research, and innovation. • Increased ability to attract students and professionals in all health and care disciplines. • Greater ability to attract investment for continued research and innovation.	**Our patients will benefit from:** ✓ Access to clinical trials and experimental treatments that may not be available elsewhere. ✓ Continual improvement in the quality of services and care experiences. ✓ Care from highly motivated professionals who strive to deliver the best treatment. ✓ Digital and technological innovations that will streamline care interactions. ✓ Feeling involved in every aspect of what we do, and know that their voice influences our services and the way we deliver care. ✓ Additional education resources.

5 Enablers

Our ability to deliver outstanding care is dependent on how we **improve quality, support our people, invest in digital technology and data insights, and promote a sustainable future.** These cross-cutting enabling strategies relate to our three interconnected purposes of local integrated care, being a regional centre of excellence and research, training and innovation.

5.1 Quality

The primary purpose of the NHS, and everyone working within it, is to provide a high quality service, free at the point of delivery to everyone who needs it. As such, achieving high quality care is the foundation to everything we do. However, achieving this standard is not an easy task; quality is a moving target. Continuous improvement in quality means that what is considered an acceptable quality today may not be acceptable next year. Our Quality Strategy therefore outlines a journey towards providing exceptional, safe, clinically effective care experienced in a way our patients wish. To meet these ambitions we will focus on a number of key themes:

Embedding a culture of Continuous Quality Improvement: Utilising the UHCW improvement system (UHCWi being a system of tools and techniques based on Lean principles and continuous improvement), we will continue to focus on a culture within UHCW that enables clinicians to work at their best. This requires them to systematically learn, measure and monitor quality at all levels (within and outside of the hospital setting), whilst having capacity for innovation and improvement.

Making a real difference to clinical outcomes for our population - Our long term aim is to achieve the best and most equitable clinical outcomes for the population we serve. This will require us to not only focus on how we improve the quality of our core services, but think beyond our hospital walls and require us to explore the quality of care at a pathway level across acute, community and primary care settings.

Improve the experience of patients and their families who use our services: To ensure that patients continue to be right at the heart of all we do, we need to build upon and spread what our patients and carers value. To achieve our commitment to deliver exceptional care, we will involve and use the experiences of our patients, carers and other advocates to shape the provision of our services.

5.2 Our People

Our people define UHCW and are vital to the care we deliver and the outcomes we achieve for patients. Our Organisational Development, Workforce & Innovation Strategy is to be redeveloped and will include a People Strategy – to **transform our culture, and make UHCW a great place to work**.

We have focused on two areas:

- **People** – supporting staff at every step of their journey to reach their potential and deliver the best patient care. This involves enabling continuous learning, development and progression, flexible working, and proactively supporting their health and well-being. We are a values - based organisation, committed to attracting and retaining the best people who reflect our communities.
- **Culture** - creating an environment where staff feel empowered and supported to make decisions and deliver change. This involves embedding a culture of coaching, learning and inclusivity where equality and diversity (including of skills, knowledge and experience) are celebrated. It is underpinned by our UHCWi improvement system.

As we deliver, we will focus on supporting our people in the following ways:

Local integrated care	Regional centre of excellence	Research, innovation and training
✔ Explore flexible workforce models, including shared roles and cross-organisational multidisciplinary teams. ✔ Help increase people's skills, e.g. in population health analytics.	✔ Support health and care professionals to deepen their expertise in our regional services. ✔ Empower people to build relationships at a regional level.	✔ Embed teaching and learning opportunities for all our staff. ✔ Recruit nationally and internationally to support UHCW's long term sustainability.

5.3 Digital

Digital technology and advancements in the way we use data to help us plan services more effectively, will inform how we deliver healthcare in the future.

Our Digital Strategy sets out five principles for transforming the way we enable and deliver care, notably focussing on:

- **Patients:** Patient led care through Digital Empowerment
- **Population health:** Digitally supporting Integrated Care and Population Health across the system
- **Staff:** Provide outstanding experience for all staff using digital technology
- **Quality:** Enhance Patient care through an integrated Electronic Patient Record solution
- **Value:** Drive standardised efficient processes through the use of innovative technology including Artificial Intelligence (AI) and automation

Local integrated care	Regional centre of excellence	Research, innovation and training
✓ Implement an integrated Electronic Patient Record (potentially system wide) that allows seamless access to patient health information for all clinicians. ✓ Enable integrated digital pathways with full secure data sharing between clinicians and social care. ✓ Enable patients to take control of their own healthcare with digital access to their records, remote monitoring and self-care tools. ✓ Minimise inequalities by supporting our population to optimize digital and health literacy.	✓ Improve the way information flows for more specialist services. ✓ Use technology to support relationships with regional acute and primary care providers for data sharing. ✓ Deliver solutions that enable care closer to people's home. ✓ Support our people to deliver care remotely where appropriate. ✓ Optimise the ICT infrastructure to maximise effectiveness of digital solutions and staff workflows.	✓ Maximise and improve the use of technology to deliver benefits and standards of care and patient outcomes. ✓ Use technology to expand our educational reach, for example streaming robotic surgery to students across the world. ✓ Maximise use of data and AI to enable world leading research. ✓ Invest in innovative technology and systems to be a leader in healthcare. ✓ Enhance our staff experience by investing in digital skills.

We will be investing in an outstanding, secure and resilient infrastructure (including cyber security), and processes that are easy for staff and patients.

5.4 A Sustainable Future - clinical, environmental, and financial

Building a sustainable future for our Trust involves a holistic consideration of clinical, environmental, and financial factors. We are a major 'anchor' organisation, part of the long term fabric of Coventry and Warwickshire. We must play a positive and sustainable contribution to the local economy as well as influencing the health and well-being of individuals and communities.

Our 2018 Finance Strategy sets out how we are prioritising reducing costs by removing unnecessary processes and maximising value in service delivery. This will also include a clear plan to address future capital investment needs for responsive services that offer the best outcomes for patients. As we move to being part of a formalised integrated care system, we will consider **financial sustainability on a wider scale** – NHS England and Improvement will assess the combined financial performance of health and care organisations in Coventry and Warwickshire. We will need to consider environmental sustainability at both organisational and system levels. Building on our membership of the Coventry and Warwickshire Anchor Alliance, we will continue our joint work around minimising the impact we have. We will ensure we achieve our net zero carbon commitment by 2045 as we develop our refreshed strategy. We will also consider how our ambitions can contribute to **clinical sustainability**:

Local integrated care	Regional centre of excellence	Research, innovation and training
✓ Focus on collaboration, integrating services, and proactively managing the health of our communities will help us be more clinically sustainable. ✓ Optimise the skill mix across our people by innovative approaches e.g. role substitution and skills enhancement.	✓ Collaborate with partners to organise certain services at a regional level will contribute to our clinical sustainability. More specialised services require a critical mass of patients and health and care professionals to be viable, and are best delivered across a wider geography.	✓ Train the next generation of health and care professions. ✓ Focusing on critical research areas mean we are contributing to the local and national sustainability of health services.

6 Your Views

Thank you for reading our draft organisational strategy for 2022-30. We hope you like what you have heard and we encourage you to let us know your views to help inform our work. This is our future together.

We have a quick online survey that allow you to offer your feedback. This should take no more than five minutes to complete. Additional information is also available in our special video outlining why we are so much more than a hospital.

Take our survey

View our video

Please complete the survey by **Friday 18 March 2022.** We will publish our final strategy in April 2022 including a summary of feedback we have received.

If you have any queries about this strategy please email **Strategy@uhcw.nhs.uk**

Agenda Item 9

Adult Social Care and Health Overview and Scrutiny Committee
27 April 2022

Work Programme

1. Recommendation(s)

1.1 That the Committee considers and approves its work programme.

2. Work Programme

The updated work programme was discussed by the committee's Chair and spokespeople at a meeting on 31 March. The outcome from that discussion is attached at Appendix A to this report.

A copy of the work programme will be submitted to each meeting for members to review and update, suggesting new topics and reprioritising the programme.

3. Forward Plan of the Cabinet

The Cabinet and Portfolio Holder decisions relevant to the remit of this Committee are provided for the committee to consider as potential areas for pre-decision scrutiny. Members are encouraged to seek updates on decisions too. The Portfolio Holder, Councillor Bell has been invited to the meeting to answer questions from the Committee.

Date	Report
16 June 2022	Coventry and Warwickshire's Living Well with Dementia Strategy (2022-2027)

4. Forward Plan of Warwickshire District and Borough Councils

This section of the report details the areas being considered by district and borough councils at their scrutiny / committee meetings that are relevant to health and wellbeing. The information available is listed below. Further updates will be sought and co-opted members are invited to expand on these or other areas of planned activity.

North Warwickshire Borough Council (NWBC)	
	In North Warwickshire, the meeting structure is operated through a series of boards with reports to the Community and Environment Board. There is a Health and Wellbeing Working Party and a Warwickshire North Health and Wellbeing Partnership (covering both North Warwickshire and Nuneaton and Bedworth). From the NWBC website, the Board met on 14 March. On this occasion there were no items related to health. The Working Party met on 15 February with the agenda including the Health and Wellbeing Action Plan and Dementia Strategy.
Nuneaton and Bedworth Borough Council (NBBC)	
	The NBBC Housing, Environment and Health OS Panel met on 7 April. The agenda included a progress report on the County Health and Wellbeing Strategy and addressing teenage conception in Nuneaton and Bedworth.
Rugby Borough Council – Overview and Scrutiny Committee	
	The Borough Council (BC) has a single overview and scrutiny committee with the use of task groups. From the Rugby BC website, the last meeting was held on 28 March 2022 and a further meeting is scheduled for 18 July. Looking at the work programmes, there is a future item carried over from 2020/21 on health and wellbeing, with a date to be scheduled.
Stratford-upon-Avon District Council – Overview and Scrutiny Committee	
	The Council's Overview and Scrutiny Committee met on 6 April and has a further meeting scheduled for 20 May. From examination of these agendas, there was an item in April on the HEART Shared Service. There is a future item listed (date to be confirmed) for an update on health recovery (COVID) from Coventry and Warwickshire Clinical Commissioning Group.
Warwick District Council – Overview and Scrutiny Committee	
	The Overview and Scrutiny Committee met on 8 March and 12 April 2022 and will meet again on 24 May 2022. The committee's work programme in April included a call in of a report going to Cabinet on the HEART Shared Service update, including the implementation of the new IT system.

4.0 Task and Finish Groups (TFGs)

4.1 The current TFG is focussed on GP services. Two meetings have been held to date. The next stages are to undertake a site visit to a health centre and the one selected is at Hastings House in Wellesbourne. The next TFG meeting on 25th May will consider the available 'baseline' information. A further TFG has been scheduled to consider menopause services.

5.0 Briefing Notes

5.1 The work programme at Appendix A lists the briefing notes requested and circulated to the committee. Members may wish to raise questions and to suggest areas for future scrutiny activity, having considered those briefing notes.

6.0 Financial Implications

6.1 None arising directly from this report.

7.0 Environmental Implications

7.1 None arising directly from this report.

Appendices

1. Appendix A Work Programme

Background Papers

None

	Name	Contact Information
Report Author	Paul Spencer	01926 418615 paulspencer@warwickshire.gov.uk
Assistant Director	Sarah Duxbury	Assistant Director of Governance and Policy
Strategic Director	Rob Powell	Strategic Director for Resources
Portfolio Holder	n/a	

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillor Clare Golby

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Adult Social Care and Health Overview and Scrutiny Committee
Work Programme 2021/22

Date of meeting	Item	Report detail
27 April 2022	Quarter 3 Council Plan 2020-2025 Quarterly Progress Report	This report summarises the performance of the organisation at the Quarter 3 position, 1 April 2021 to 31 December 2021.
27 April 2022	An update on NHS Dental Services	A report was submitted to the Health and Wellbeing Board on 12 January 2022. Dental services was added to the committee's work programme on 16 February. NHS England and Improvement will provide an update to the Committee. As background, here is a link to the report to the HWBB in January.
27 April 2022	More than a hospital – UHCW Organisational Plan	To consider the organisational plan of University Hospitals Coventry and Warwickshire.
27 April 2022	An update from West Midlands Ambulance Service (WMAS)	The Committee received an update from WMAS on 17 November 2021. Here is a link to the meeting documents as background. The Committee has requested a performance update and WMAS will also speak on its Quality Account.
22 June 2022	'Approach to Levelling Up'	This is a standard item for all overview and scrutiny committees in June, ahead of the consideration of this matter by Cabinet in July.
Dates to be confirmed	Integrated Care System - Update	An update to the committee on the commencement of the ICS and the progress made in implementing the revised arrangements. The suggested timing for the item is the end of 2022.
	Workforce Update - the Care Market	A report was submitted to the Health and Wellbeing Board on 12th January 2022 and the topic was added to this committee's work programme on 16th February. A workforce update on the success of the recruitment drive for additional carers. This could include aspects on the consistency and quality of training. Here is a link to the

		report to the January HWBB.
	Delayed Transfers of Care	Added to the committee's work programme on 16th February. A suggestion to look at this topic broadly, to understand the reasons for delayed discharge, irrespective of whether this is due to an NHS or social care issue and how to reduce such delays. Members would like to understand the system and processes from 'end to end' to enable a holistic approach. A suggestion that the report include readmission rates too.
	Presentation on Social Care	This was added to the committee's work programme on 16th February at the request of Councillor Drew. Further detail is awaited on the areas to be covered by the presentation. There is a suggestion for a briefing session from Pete Sidgwick, which may be a useful mechanism for some aspects.

BRIEFING SESSIONS PRIOR TO THE COMMITTEE

Date	Title	Description
TBC	Duties Under the Care Act	Suggested by Pete Sidgwick at the Chair and Spokesperson meeting on 7 June 2021, to provide a briefing for the committee on the Council's duties under the Care Act.

BRIEFING NOTES

Date Requested	Date Received	Title of Briefing	Organisation/Officer responsible
7 June 2021	28 June and 29 July	An offer from Healthwatch to provide briefing papers on its role (circulated 28 June) and the carers' survey of lived experiences during the pandemic (circulated 29 July).	Chris Bain, Healthwatch Warwickshire
7 June 2021		Minor Injuries Unit – Stratford. This unit at Stratford Hospital is currently closed. A request for information on when it will reopen.	Rose Uwins, Coventry and Warwickshire CCG
29 September 2021	25 October 2021	Follow up briefing on dementia services, with data on young onset/ early onset dementia and Admiral Nurses.	Claire Taylor, WCC Commissioning
	22 December 2022	Council Plan 2020-2025 Quarter 2 Progress Report. This report summarises the performance of the organisation at the Quarter 2 position, 1 April 2021 to 30 September 2021. Due to a timing issue, it was agreed to circulate the report to members as a briefing between meetings.	Performance, Planning and Quality, together with relevant services in the People Directorate

TASK AND FINISH GROUPS

ITEM AND LEAD OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	FURTHER INFORMATION
GP Services – Revisit	A task and finish group (TFG) took place in 2017/18. The committee agreed to undertake a further TFG.	TBC	Two meetings have been held. A site visit is planned and the next meeting will consider the available 'baseline' information..
Menopause Services	This was agreed on 16th February, following the consideration of a presentation on menopause services.	TBC	This review will be commenced after completion of the above GP Services review. It has also been referred to the Health and Wellbeing Board.

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