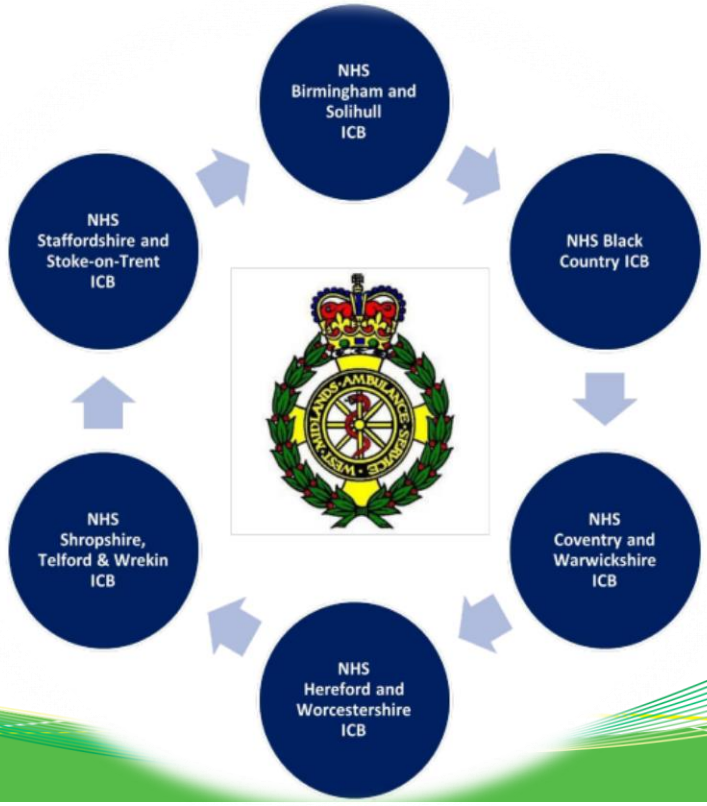
NHS
West Midlands
Ambulance Service
University NHS Foundation Trust

Quality Account 2023/24



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A Message from the Chairman

This year, I would like to concentrate my remarks on the work the Trust has been doing to support staff. In the last 12 months there have been two important reports published looking at the culture of ambulance services and to be honest, they make uncomfortable reading. In some respects, they came as no surprise as this is an area that we recognised needed considerable work some years ago. However, although we recognised this, the reports reaffirmed just how important this work is if we are to provide the support, compassion, and care that our staff need to be able to work to the highest standards, treating patients and saving lives.

As a Trust, we launched a new cultural statement at the beginning of 2023, which had been put together by staff after a series of workshops. However, we wanted to take that forward and see whether we were making progress, so last summer the Organisational Development Team also spoke to a wide range of staff to find out more about what individuals thought about our culture, retention themes and linked in other issues such as the staff survey and speaking up. As a result, a group of senior managers and directors reviewed in detail the anonymised responses and have created an action plan on how to take these comments forward. This includes looking at how the Board could be more accessible; improvements in internal communications; looking at ways managers could focus on providing more support to staff; and what more can be done to assist managers to enable them to provide that support. We intend to run a further review over the summer to see whether the work has been successful.

Allied to this work, the Trust has been investing heavily in our Freedom to Speak Up (FTSU) programme. We invited the National Guardian, Dr Jayne Chidgey-Clark, to come and speak to the Board where were able to brief her on the work that we were doing. One of the steps we have taken is to appoint a second FTSU Guardian, Lucy Butler, as well as increase the number of FTSU ambassadors on every site and highlight anonymised cases where we have been able to make a difference.

In March the Trust Board received an update highlighting a sharp rise in the number of concerns made through the FTSU process. I absolutely welcome the progress that has been made in relation to FTSU and it is pleasing to see the rise, as this demonstrates that staff have an increasing confidence in the process which is welcome. While we would always hope that staff don’t have a need to raise concerns, it is reassuring that they are confident to do so when such situations do arise.

Another area that has been an important step forward for the Trust was the launch of our sixth staff network. For some years we have had groups that support areas such as diversity and inclusion; LGBTQ staff; disability and carers; women; and staff with links to the military. Our sixth group is there to support external and internal students,

apprentices and other learners, of which we have around 1,000 at any one time working with us. The group has joint chairs, one a student at one of our partner universities and the other an internal student paramedic. I am confident that this group will bring real benefits to all of our learners.

As you will read in the Chief Executive's reports, our staff face challenges both at work from the likes of hospital handover delays, but also externally from rises in the cost of living. Over the last year we have invested heavily in trying to support staff to get through these difficult times. A tremendously successful part of that work has been the Health and Wellbeing Roadshows that have visited all of our sites. The events are supported by the Trust's Health and Wellbeing champions, Staff Advice and Liaison Service, Freedom to Speak Up Ambassadors and our union representatives. Colleagues can take part in fitness challenges and have the opportunity to take part in wellness checks, 30-minute menopause training courses as well as enjoying refreshments and time with each other.

We have an award-winning Staff Advice and Liaison Service (SALS) which offers peer to peer support to colleagues. Recently, the group welcomed 18 new advisors onto their team. They will join the on-call team that receives calls 24/7 and offers local support to staff members in their time of need. SALS also offers immediate post incident defusing in support of managers undertaking this role. They can also provide structured Social, Emotional, Educational Support meetings for staff involved as a group in a critical incident a few days later.

The Trust continues to train more staff as Mental Health First Aiders. The course, which has been undertaken by hundreds of staff, covers many topics including learning more about how to have the confidence to step in, reassure and support someone in a mental health crisis, gaining an in-depth understanding of mental health concerns and illnesses, developing skills such as non-judgmental listening and techniques for self-care which can be really important in a role such as this.

With a workforce that is over 50% female, many will understand periods are part of life. A few months ago, containers with free sanitary products were installed in all Trust female toilets.

Given how challenging the current situation is, the Trust is always looking for new ways to support staff. During the year, the Trust enhanced the chaplaincy team which now represents the Muslim and Sikh faiths alongside our Christian Chaplain. We hope to enhance the team further with representatives of both the Jewish and Hindu faiths soon. It doesn't matter which faith staff identify with or indeed if they have no faith, the team will be there to support them.

One of the highlights of my year is the annual awards ceremonies for both staff and volunteers. If ever there was a time to have your faith in humanity renewed, this is it. We continue to see hundreds of members of the public contact us each month to say ‘thank you’. Reading these messages is deeply humbling and is quite remarkable when you consider how tough the last two years have been for the Trust.

Thinking of staff, I wanted to highlight some tremendous news. As many of you will know, our staff kindly agree to appear on television so that the public can get an idea of what life is like in our service. Series 10 of 999: On the Frontline recently aired on Channel 4 and the viewing figures show that the programme is more popular than ever. In the final episode over 1,000,000 people watched the staff from Stoke, Stafford and Willenhall helping patients. Thank you to all of the staff who took part and the managers who helped get the programme on air.

I would like to finish by noting three changes to our Trust Board. After almost 40 years in the NHS, our Director of Nursing, Mark Docherty took a well-earned retirement. He has been replaced by Caron Eyre, who has over 30 years of experience in nursing. Caron has spent her entire career in the West Midlands working as an adult and children's nurse and a nurse tutor. She is also Chair of the Association of British Paediatric Nurses. I am passionate about patient safety, quality improvements and the benefits of a positive patient experience.

We also said goodbye to Non-Executive Director, Wendy Farrington-Chadd who has served on the Trust Board for seven years, most recently as Vice Chair and Chair of the Audit Committee. Wendy joined the service after becoming a patient! Wendy has made a remarkable contribution to the Trust, always taking a keen interest in staff and constantly reinforced the importance of doing the right thing for patients no matter how difficult it was. Wendy’s replacement is Suzanne Banks CBE. A career in nursing saw her retire from the role of Chief Nurse at Sherwood Forest Hospitals NHS Foundation Trust in 2019 following a career of 38 years. She currently works at a national level in the NHS supporting menopause care in the workplace and providing coaching and leadership development for senior nurses. I am sure you would agree that both appointments will ensure we continue to have a strong and patient focused Trust Board.

Finally, I would like to formally pay tribute to the work of our staff and volunteers; their efforts cannot be underestimated. Their dedication to saving lives and helping people in their hour of need is second to none and I thank each and every one of you for what you have done over the last 12 months.

Prof. Ian Cumming OBE
Chair, West Midlands Ambulance Service University NHS Foundation Trust

Chief Executive Review 2023-24

Each year when I come to write this review, I think I must come up with a new way to start. Simply saying that this last year has been the hardest of my near 40 years in the NHS doesn't seem sufficient to sum up what has been a truly challenged year. While we were able to bring in a balanced budget, it was only through taking some incredibly difficult decisions. Add to that the continued issue of hospital handover delays and it really was a tough one!

However, I want to start my review with two external reviews of our service. Last year we had two visits from the Care Quality Commission, who published their report in February. While we are disappointed that our rating dropped from 'Outstanding' to 'Good', we remain outstanding for being caring and the most successful ambulance service in the country. In addition, our Emergency Operations Centres (EOC) were rated outstanding, the only service in the country that has achieved that. A key theme of the report is the impact that hospital handover delays have on our service. Pleasingly, the report notes that we have been "*working hard to improve the culture, so people and staff could raise concerns without fear. WMAS had improved staff wellbeing and freedom to speak up guardian services. Also, staff understood the emotional impact the situation had on people's wellbeing and on those close to them, particularly when the service was experiencing delays. They were well trained and responded in a professional way to help people receive the care they needed.*"

As a result, the Trust has been given a Section 12 Notice which requires us to improve our response performance. Pretty much, whichever department our employees work in, handover delays will be having an impact on their role. It's not just the staff who face hours outside A&E Departments or control room staff left with hundreds of outstanding patients on their dispatch queue or increasingly angry callers. It is Vehicle Preparation Operatives who are being asked to prepare more vehicles more quickly than ever before; mechanics who have less time to service ambulances; HR advisors dealing with health and wellbeing issues; patient safety staff having to investigate more Serious Incidents.

As a result, the Trust Board has taken a decision to seek the support of each Integrated Care Board (ICB) to reduce handover delays at their respective hospitals and if they are unable to do so, then to find the mitigating cots to allow us to recruit additional paramedics to reach waiting patients before it is too late. Although a huge amount of work has been taking place to find solutions, the Notice now places additional pressure on the whole of the NHS to find a solution. During 2023-24, the Trust lost in excess of 250,000 hours of ambulance time; time that crews could have been treating patients, never mind the tens of thousands of additional calls that EOC staff have had to take from patients and their loved ones asking where their ambulance is.

We simply cannot carry on like this; we have to break the cycle. To do this, the Trust is proposing to recruit around an additional 300 Paramedics and increase the ambulance fleet by 20 during the coming year, over and above what had already been planned. Doing so will mitigate the delays in responding to patients and allow staff to finish on time. The Trust would not need any of the £20m if the ambulances could be released from hospital within required the timeframe. The figures are clear; when delays reduce our performance improves and we see fewer incidents of harm being reported for patients where we simply have not got there quickly enough. We must not allow handover delays to become the norm.

The other area where we have been inspected is in our Education and Training Department. The visit from Ofsted inspectors took place in February, with the regulator announcing that we had retained our 'Good' rating. Throughout the four-day inspection, inspectors interviewed a wide range of staff and were clearly impressed by what they found. I am extremely proud of the team for the incredible work they do every day, in training the next generation of paramedics.

Support for staff is a key part of the work of the Trust so I was delighted when we passed through the 50% mark for the number of operational staff who are now mentors. Courses have been running at five partner universities and all BSc student paramedics undertake mentorship training as part of their course. We know just how valued and important this role is during the training phase of the student paramedic course and beyond on an ongoing basis. As a University NHS Foundation Trust, learning is such a key part of what we do, so the fact that we have so many mentors is clearly fantastic news. Well done to you all.

While there are undoubtedly significant challenges facing the Trust, we are making good progress in other areas. As an organisation, we have had an ambition to have a paramedic on every vehicle for some years. As a Trust, we achieve that in over 99.5% of occasions. Having a paramedic attend means fewer patients end up going to A&E and more care can be given at the time. This was put into stark contrast by an independent investigation which found that in some services, around a third of Category 1 cases did not get a paramedic response to the patient. In comparison, 99.6% did in the West Midlands. Similarly, for Category 2 calls, one service sent a paramedic to only 64% of cases, compared to 98.7% in the West Midlands. While the value of paramedics is clear, I do not want to understate just how important our Community First Responders, Emergency Care Assistants, student paramedics and ambulance technicians are to the care of patients too. Having a blended workforce undoubtedly brings benefits to patients. We will continue to do everything possible to get a paramedic to every case because we firmly believe that it is the right thing to do.

One of the ways that we intend to do this is through a new partnership with Birmingham Newman University. Newman have 44% of their students from an ethnic minority background, and 40% of their students are mature learners. Expanding our reach and providing opportunities for these communities is something that is important for our workforce to become even more reflective of the community we serve. It's an exciting development that will offer many opportunities for people to join the paramedic profession, making this the seventh University the Trust has partnered with since 2018.

While we continue to make progress in the clinical care we provide, I did want to draw attention to one development, the introduction of five state-of-the-art maternity mannequins which can simulate a birth. Each one can be integrated with the Trust's Zoll X Series monitors which allows real-time monitoring of blood pressure and blood oxygen levels amongst other features. The mannequins are incredible pieces of equipment that will undoubtedly help improve the confidence and competency of our staff when attending obstetric emergencies. As well as the introduction of the mannequins, we have also introduced Maternity Champions on each of our hubs.

Patient Safety is another area where we have made significant strides over the last year. The Patient Safety Team has welcomed eight new Learning Leads who will enable the transition from the Serious Incident Framework (SIF) to the new Patient Safety Incident Response Framework (PSIRF). The new staff will allow us to focus more on staff, patient, and family engagement, be more proactive towards patient safety incidents and overall improve patient care.

Sadly, verbal and physical violence towards our staff remains all too common. All of our operational staff get conflict resolution training, there are CCTV cameras in the ambulance and staff now have access to body worn cameras too. Over the last year, we have seen the value of the cameras, particularly with a number of perpetrators pleading guilty as soon as they realised there was footage available. In addition, a report by the Association of Ambulance Chief Executives has shown that WMAS leads the way in the support provided to staff who are unfortunate enough to be involved in a violent attack. Even one attack is one too many, never mind the 7,600 that we had within the last six years. Sadly, the number rose again last year to 1,848 and ambulance staff remain twice as likely as the national average to be the recipient of violence while working. We will continue to do everything we can to help staff and bring perpetrators to justice.

This year, we were able to order 85 new ambulances. Sixty of them will replace vehicles that have reached five years old, but 25 will increase the fleet size which will ensure we have more resilience and mitigate situations such as hospital handover delays. The Trust continues to have the youngest and most efficient fleet in the country. The average age of our fleet is 2.24 years, compared to other services whose average was seven years, with the oldest ambulance in frontline operations 14 years old! Staff tell me regularly how

important it is that we have good quality vehicles that don't break down. We know that once a vehicle is past five years, it is far more likely to have issues that could make it unavailable for frontline operations. We want to make sure that staff always have the most modern, safest and least polluting ambulances as possible. It is the right thing for staff, for patients and the environment.

The Trust remains the only ambulance service that has electric vehicles in every service line, and we intend to increase the number of both emergency ambulances and officer response vehicle in the coming year. It is part of our commitment to reducing the carbon impact of the NHS. The Trust has invested heavily in reducing our footprint with modern buildings and the most efficient vehicles available. For the most recent period, we saw an 11.61% reduction on the previous year.

Thankfully we have not had to deal with a terrorist incident in the West Midlands for many years. However, in the times we live, it is something that we take extremely seriously. As a result, we continue to test our response to such incidents as often as possible. Recently we have undertaken exercises at locations as diverse as a football ground and a railway tunnel. We have also introduced a new way of dealing with mass casualty events, known as ten second triage and hot P1 loading which comes from learning from the Manchester Arena bombing. These exercises are a valuable opportunity to work alongside colleagues from other emergency services and partner agencies to test what we would do if ever the worst was to happen.

While physical injuries are always a risk, it is not just this area where the Trust has been investing heavily. Whether it is Malware, Phishing, Spoofing or a Trojan Horse, all present a real risk to the IT security of our Trust. We have all seen the impact cyber security breaches can have on businesses, so it is essential that we are all aware of the dangers and do all we can to reduce the risk. Running parallel to that, the IT and Digital team have been working behind the scenes to introduce security updates. A recent assessment by NHS England showed WMAS had the highest score of any NHS organisation with over 1000 devices. It follows a huge effort by the Information Management and Technology (IM&T) Department to update and upgrade computers within the organisation.

At the end of the day, saving lives is what we are here for. During the year we have launched two initiatives which aim to do just that. The Trust has started using the GoodSam app with more than 300 off duty staff signing up to respond to carry out 'hands only cardiopulmonary resuscitation (CPR)' until on-duty crews can get to the scene to take over. Currently, we are averaging around one activation a day and have already had two incidents during which a Return of Spontaneous Circulation (ROSC) was achieved, where a patient has started breathing for themselves again.

The second area is a groundbreaking campaign involving some of the country's top sports stars. The Trust has teamed up Rugby Football Union to create a video encouraging members of the public to learn CPR. The video was played to 80,000 fans on the big screens at Twickenham during the Gallagher Premiership Rugby Union final between Saracens and Sale. Now the team has created a second video with some of the top cricketers in the country with the video due to be shown before England matches and at all 18 county cricket grounds throughout the entirety of the season. I would like to thank Community First Responders (CFR) Steve Hart, Jon Essex, Simon Rhodes and Paul Telfer for their incredible contributions in making the video. Sadly, Paul passed away recently following a short illness and it is a great shame he was not there to see the reaction to his work.

I also want to pay tribute to Naomi Rees Issett and her inspirational work in and around the Rugby area. Tragically, her 18-year-old son, Jamie Rees, died after suffering cardiac arrest in the early hours of New Years Day 2022. Due to handover delays it took the Trust nearly half an hour to get there and a defib at a nearby school was locked up. Since then, Naomi has run a magnificent campaign to get more defibrillators in local communities. She initially tried to get 20, but recently unveiled the 150th! Naomi has twice spoken to our Board about what happened and the learning that has come from the incident.

The Trust continues to support another lifesaving campaign, the Daniel Baird Foundation. Daniel died after being stabbed just once in an attack in Birmingham. His mother Lynne, who received an MBE for her work, has been campaigning for life-saving bleed kits to be rolled out across Britain. The Trust helped Lynne to design the kits; there is one on each of our emergency hubs next to the defibrillator that is also available to the public should they be needed. In total, there are now over 15,000 deployed across England. A recent example reaffirmed just how important this work is. A young man was stabbed in Birmingham and our control room directed a member of the public to get a kit. In the end, specialist police officers deployed a kit they carry, but had they not been available, the kit was there and would have made the difference in the same way that the police one did.

Listening to stories of courage, bravery and heroism is always a real pleasure particularly when it involves our staff and volunteers. It was therefore particularly pleasing to host the Annual Awards ceremonies last summer. Awards included Long Service, Chief Officer Commendations, Student Paramedic of the Year, Mentor Awards, Apprenticeship Awards, Community Initiative and Partnership Awards; Community First Responder Long Service Awards and the CFR of the Year. To have the chance to recognise the extraordinary efforts of our staff, volunteers and members of the public is extremely important. We heard so many fantastic stories of people going above and beyond and all for the same reason: to provide the very best levels of care to our patients.

With flags flying, tea flowing, bunting waving and cupcakes aplenty, there was no doubt WMAS staff got stuck in to celebrating the coronation of King Charles III. We were very fortunate to have several members of staff attend events in London, representing the Trust in various capacities. One was at Westminster Abbey for the service; two staff joined 20 other ambulance staff to represent the ambulance service as part of the 200 Uniformed Civilian Services, who street lined the processional route. Four staff attended Coronation Garden Parties at Buckingham Palace as well.

May I finish by saying how enormously proud I am of each of our staff and volunteers; please accept my enormous thanks and pass on my personal thanks to your family members that have loved and supported you to enable you to give your best every day, saving lives across the West Midlands. While the future is clearly uncertain, I am confident that our Trust is as prepared as any to take on whatever comes our way over the next 12 months. I firmly believe that the public of the West Midlands should be justifiably proud of the team that protects them.

Anthony C. Marsh
Chief Executive Officer

Part 1

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 the Integrated Care Systems as they plan local health services, and on a day-to-day basis with hospitals, Primary Care Networks, mental health and other specialist health and social care providers. We recognise that each organisation plays a vital role in responding to the day-to-day health needs of our population.

Our strategy, which has been reviewed over the course of the last twelve months remains focused on 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 understand that to continue to improve quality, it is essential that our patients and staff are fully engaged with our plans and aspirations. Our values, which were launched in March 2023, Are kept at the core of our work, helping us to improve the organisation, improve the quality of services for our patients and strengthen the support that we provide to all our staff.

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) and has been rated as 'Good' following its inspections in August and October 2023. This follows the rating of 'Outstanding' from the previous two inspections. The resulting report was published on 23rd February 2024. The following provides an overview of the ratings of the Trust as a whole:

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

The individual services which are registered with the CQC carry the following ratings from the CQC's focused inspections:

Rating for ambulance services

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

Key to tables

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

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 2024/25

We have assessed our progress against the agreed priorities for 2023/24 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 2024/25 for improving patient experience, patient safety and clinical quality, we have reviewed outputs from discussions with stakeholders throughout the year, 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:

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 investment realised in 23/24 from Integrated Care Boards to 'Improve the Ambulance Response to Mental Health' as part of the NHS Long Term Plan, WMAS will continue to establish and embed new mental health service delivery through:

- the delivery of mental health nurses within the emergency operations centre
- provision of mental health response vehicles (where commissioned by the ICB)
- provision of clinical support to manage patients with complex needs presenting as high intensity service users to the Trust supporting educational opportunities for all WMAS staff in respect of mental health education to support and improve patient care delivery.

To determine the success of our work towards this priority, we will:

- Monitor Emergency Operations Centre (EOC) Mental Health Nurse activity and clinical outcomes in respect of alternative care pathway use
- Monitor Mental Health Response Vehicle (MHRV) activity – including Emergency Department conveyance metrics and Section136 activity.
- Enrol Senior Mental Health Practitioners (SMHPs) on L7 education pathway
- Reduce High Intensity Service User (HISU) demand and increased availability of appropriate care plan documents for HISU patients
- Deliver mental health educational opportunities and pre/post learning staff feedback

Patient Experience

Our patients represent all ages, all backgrounds and all health conditions, and we understand the importance of learning from their experiences as we plan future service improvements. Gaining feedback can be a challenge due to the short time they are with us, we currently utilise surveys, complaints, compliments, Patient Advice and Liaison Service (PALS), reported incidents and risks to provide a comprehensive overview of the experience of our patients. However, we plan to improve engagement to improve shared learning. In addition to the existing arrangements, we will set up a Patient Advisory Committee, where patients, carers

and Foundation Trust members will share experience to allow the Trust to learn and influence change. These meetings will be undertaken once per quarter (online initially, with consideration to face to face annually.
The degree of success of our work on this priority will be determined by:

- an increase in the source of feedback
- implementation of our new Patient Advisory Committee once per quarter
- increase in the learning outcomes which may influence service delivery and training for staff

Patient Safety Incident Response Framework (PSIRF)
WMAS, as part of the Integrated Care Board / System has a statutory requirement, in 2024, to transition from the Serious Incident Framework (SIF) to the Patient Safety Incident Response Framework (PSIRF). In order to achieve this transition, in 2023, significant WMAS investment has occurred to support patient safety and the delivery of PSIRF.

We plan to implement and thereafter deliver on the 4 principal aims of PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents NHS Providers
- Supportive oversight focused on strengthening response system functioning and improvement

The success of our work on this priority will be determined by comparing, each of the 4 aims of PSIRF to the individual responses commenced:

- Surveys and focused groups of those that are involved in patient safety incidents.
- Audit of previous data to determine if complaints and concerns have reduced.
- Compare patient response types under PSIRF in comparison to SIF
- Effectiveness of actions implemented under PSIRF by analysing quantitative data (clinical records and incident management systems) and qualitative data (training feedback and staff surveys)

Ambulance Handover Delays
Hospital Handover Delays remain a significant and increasing problem. However, WMAS CQC report, published on 23 February 2024, served a Regulation 12 notice in relation to operational performance standards. In order to maximise operational resourcing to respond to patients in the community a Performance Improvement Plan has been created, which includes a review of all Paramedic secondments and schemes. As part of this plan, we will:

- Follow a structured exit plan for the removal of ADA facilities across UHB as the temporary agreement comes to an end, requirement for UHB to maintain independence in managing ambulance handovers, returning Paramedics to substantive positions for frontline duties.
- Review the region's Hospital Ambulance Liaison Officer (HALO) cover. This will entail ensuring that all HALO positions are delivering optimal support, develop an enhanced HALO model to support Emergency Departments in streaming and supporting crews in accessing alternative pathways for patients where appropriate.
- Undertake an independent capacity review with our partners
- Work with stakeholders to reduce handover delays, and where not possible, consider increasing the staffing establishment to mitigate delays

The success of our plans in this area will be determined by:

- A reduction in over 15 minute Hospital Handovers across the Region, this can only be achieved by a system wide approach.
- Greater engagement with acutes/ICBs and NHS England
- Shared learning across sites including what works well, how initiatives have been implemented, lessons learned etc.

We are and will continue to engage with the ICBs on key components of the improvement plan, especially around workforce and ambulance handover delays.

Our Services

With a budget of approximately £400 million, 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 service provides a 999-emergency ambulance response from 15 operational hubs across the region with a fleet of around 460 ambulances. In partnership with 2 local mental health trusts, the ambulance service operates mental health triage cars to help patients in crisis. The trust has 2 emergency operations centres (EOCs) taking and managing around 4,000 999 calls each day, amounting to approximately 1.7 million during the year with a mean answer time of 2 seconds. One EOC is at Brierley Hill, alongside trust headquarters, and the other at Tollgate in Staffordshire.

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

The Trust contracts with 5 air ambulances run by independent charitable Trusts, operates a Hazardous Area Response Team (HART), works with voluntary organisations, such as BASICS doctors, and has a network of around 750 Community First Responders.

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

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 2023/24 to support Non – Emergency Patient Transport Services. Sub-contractors are subjected to a robust governance review before they are utilised.

The income generated by the relevant health services reviewed in 2023/24 represents 99.75% of the total income generated from the provision of health services by the Trust for 2023/24. More detail relating to the financial position of the Trust is available in the Trust's 2023/24 Annual Report.

Performance - Emergency and Urgent Service

The Trust is measured nationally against **operational standards for Emergency and Urgent**

- ***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.)*
  - 30 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 2022-2023 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

- *Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period.*
- *The mean, median and 90th centile time from the call for help until hospital arrival for confirmed stroke patients*
- *The mean, median and 90th centile time from the arrival at hospital to scan for patients who receive a CT scan*
- *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 2023-2024 and the following actions are intended to improve the quality of healthcare provided for patients:

- AQI Newsletter
- Videos on how to record AQIs on EPR
- Clinical Times edition 42
- Clinical AQI Guidance
- AQI Posters displayed on Hub screens
- Quality Improvement Paramedic appointed for 1 year secondment. CPD Events facilitated by QI Paramedic

Drug Administration Clinical Audits	Administration of Morphine Audit
	Adrenaline Administration
	Naloxone Administration
	Activated Charcoal
	Co-amoxiclav administration
Locally Identified Concerns	Management of Paediatric Pain
	Maternity Management
	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 discharged at scene
	Blood Ketone Audit
	Management of Sepsis Audit
	Asthma in Children
	Mental Capacity Act Audit
	Management of Overdose
	Post Intubation Documentation Audit

Participation in Research

During 2023/24, 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, as 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 2023/24 period to participate in research approved by the Health Research Authority and a Research Ethics Committee was 1090, of which 733 were added into the National Institute of Health Research Portfolio. During this period, the Trust participated in 17 research studies meeting these criteria, of which 9 studies were categorised as National Institute of Health Research Portfolio eligible.

The following research studies have continued during 2023/24

Epidemiology and Outcomes from Out of Hospital Cardiac Arrest Outcomes (OHCAO)

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.

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.

PIONEER

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.

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.

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

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.

Specialist Pre-hospital redirection for ischaemic stroke thrombectomy (SPEEDY)

Stroke is a common medical emergency and time critical treatments reduce the chance of disability or death. Approximately 1 in 10 patients are suitable for an emergency operation to remove blood clots blocking large arteries in the brain (known as 'thrombectomy') which greatly improves their chances of recovery. However, this operation is only available at specialist regional hospitals and unless patients live nearby, they are first admitted to their local hospital and must be transferred for the treatment. This research project will now test the impact of this new pathway by conducting a multicentre cluster randomised controlled trial, that will transport patients directly to a specialist centre.

Optimising Implementation of Ischaemic Stroke Thrombectomy (OPTIMIST): exploring NHS professional views about the emergency stroke pathway (OPTIMIST)

This study will use qualitative focus group discussions and/or individual interviews to collect and report professional views at two important time points during the SPEEDY study research programme. Up to 36 professionals will be invited to take part at time point 1 (qualitative study 1) and 16 professionals at time point 2 (qualitative study 2). Professionals invited to give their views will be from a number of different roles and based in several regions across England.

Co-producing an Ambulance Trust national fatigue risk management system for improved Staff and Patient Safety (CATNAPS)

Ambulance services are trying out different ways of working to help staff feel less tired at work and safer on scene, but these actions are often piecemeal, and we don't know whether they are making care and working environments safer. We have brought together a team of patients, staff with lived experience, fatigue experts, ambulance service researchers and managers, international expertise, and companies currently working with ambulance services on fatigue management. We aim to develop a new approach to fatigue management for the UK ambulance sector that meets the needs of staff and operations and is most likely to improve

patient and staff safety. Our recommendations will include learnings from the COVID-19 pandemic.

Prehospital resuscitation decisions (PROTECTeD)

Despite the best efforts of ambulance staff less than one in 10 people who suffer an Out of Hospital Cardiac Arrest survive. This means that ambulance staff often have to make the difficult decision of when to stop resuscitation. he old guidelines no longer correctly guide paramedics when to stop treatment or when to carry on. This means that treatment may be stopped too soon in some patients. In other patients, the guidelines suggest to move the patient to hospital despite the fact they have no chance of surviving. The knock-on effects of this are journeys which put ambulance staff and other road users at risk of injury. Patients are separated from their families and taken to a busy hospital. At the hospital, it is difficult for staff to allow the family to spend quiet time with the patient. Hospitals also become overcrowded which can affect other patients. This research will develop new guidelines based on the most up to date information available.

The following research studies have commenced during 2023/24

Occupational stress risk assessment: Association of Ambulance Chief Executives (AACE) Ambulance Trust Control Rooms

The principal goal of the project is to explore the root causes influencing occupational stress and subsequent impacts on mental wellbeing amongst staff within the specific area of control rooms in ambulance services. The project aims to examine the range of occupational factors currently influencing work-induced strain, develop a bespoke survey tool including the identified factors, and develop recommendations based on the findings to help alleviating levels of work strain. Scientific literature has identified the most common source of stress risks across occupations.

An evaluation of the South Warwickshire Frailty Admission Avoidance in the Community Pathway: a mixed methods study (E-WRAP)

This study aims to conduct a formative evaluation of South Warwickshire's Frailty Admission Avoidance pathway in order to establish the progress of the care model and suggest ways in which its development and implementation model can be improved.

The paraHEALTH study: Cardiovascular disease on the frontline

This research aims to estimate cardiovascular risk amongst ambulance personnel through screening, whilst exploring the associated occupational risk factors and identify high risk groups for targeting appropriate interventions. CV events amongst ambulance personnel will also be measured where relevant. This data could then lead to justifying further research into effective, realistic and cost-effective interventions for both treatment and prevention of CVD within UK ambulance services.

Risk of Adverse Outcomes after a Suspected Seizure (RADOSS)
RADOSS seeks to ultimately generate a risk prediction tool that will allow ambulance crews to generate a personalised estimate of that individual's risk of death/recontact with the urgent and emergency care system within 3 days and the likelihood of their attendance at ED satisfying the definition of an AA if conveyed.

The experiences of Paramedics in a UK ambulance service attending victims of domestic violence and abuse: A narrative inquiry
Narrative enquiry of stories from Paramedics about their experiences responding to domestic violence case. To make visible the complexity and challenges paramedics encounter in their clinical practice.

What are the barriers to health promotion advice delivered by staff working in urgent care and emergency departments? – promotED study
The aim of this study is to determine whether and how health promotion activities are undertaken by paramedics and Emergency Department nurses and investigate ways of overcoming potential barriers. To investigate the views of staff and patients on health promotion activities in urgent and emergency care. To explore potential barriers and facilitators for health promotion activities in urgent and emergency care.

Paramedic delivery of end-of-life care (ParAid Study): a mixed methods evaluation of service provision and professional practice
To evaluate different models of paramedic delivered end-of-life service provision. To conduct a large-scale online survey throughout England to evaluate paramedics' current practices, factors influencing their professional contribution and the potential for the paramedic workforce to improve end-of-life care (Phase 1). To characterise and evaluate models of service delivery (including innovative models) via mixed methods case studies of practice (Phases 1 + 2). To conceptualise decision-making and risk management by paramedics on scene using vignette methodology within interviews (Phase 2). To hold an expert consultation workshop to consider findings and generate paramedic service delivery recommendations to support end-of-life care (Phase 3)

Sustainability

The NHS continues to take 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 Building Research Establishment Environmental Assessment Method (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).

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.

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 reduction in $C0^2$ year on year as shown below:

- **2021-2022 -** Energy reduced by 6.37% from the previous year; transport reduced by 5.29% from the previous year
- **2022-2023 -** Energy reduced by 13.68% from the previous year; transport reduced by 8.64% from the previous year

Fleet

Our commitment to delivering the emission reduction targets set out by NHSE remains on track, during the past twelve months we have introduced 6 x fully electric ambulances and 2 x rapid response cars along with charging infrastructure to support. Our lease car policy has also been updated so only fully electric vehicles can be ordered for staff covering the necessary business related mileage to be eligible.

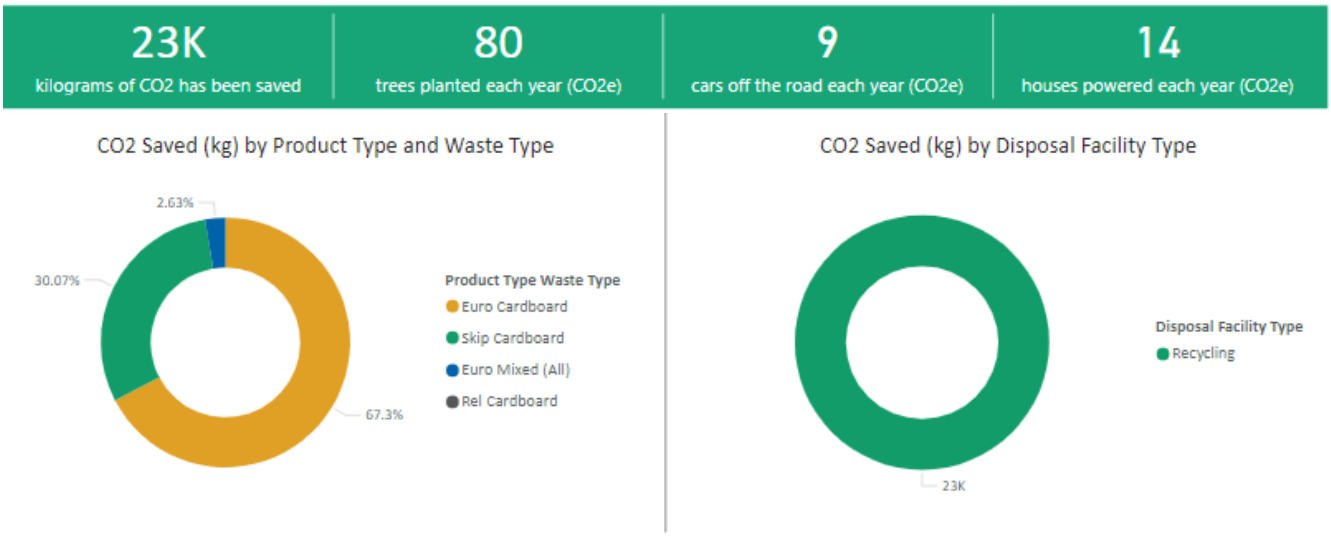
Year on year the emissions from transport related activities reduced from 5.29% for 2021/22 to 8.64% for 2022/23. We are currently reviewing our position on front line emergency ambulances looking to introduce a further three fully electric assets later this year. All WMAS ICE vehicles remain compliant with the latest Euro 6 emission standard.

Estates

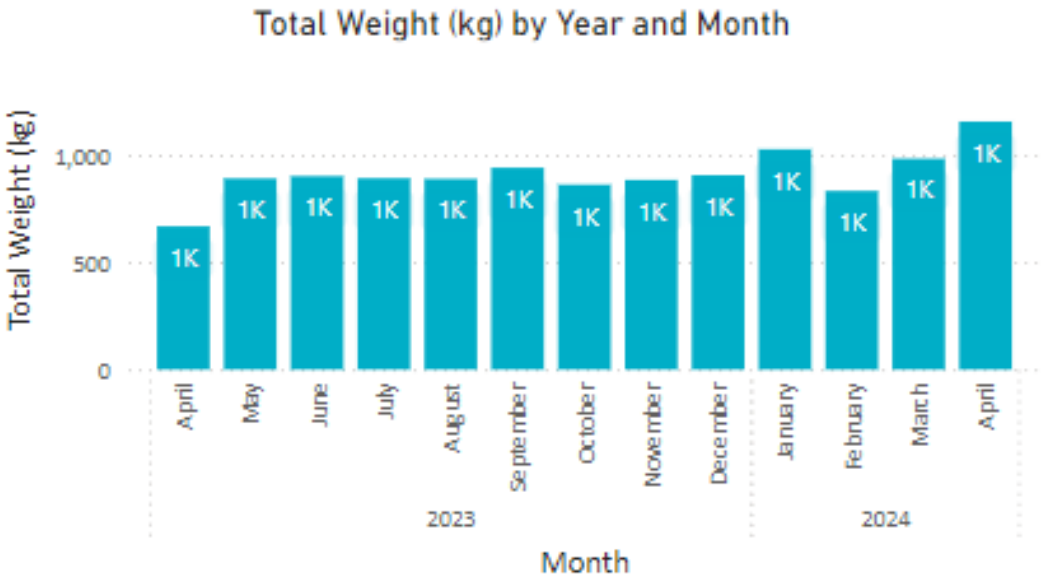
In October 22, we opened our new facility in Sandwell Birmingham, this site is our most environmentally friendly to date, conforming to BREEAM Excellent standards, the building has a 96kw PV on the roof. We have also installed 20 electric vehicle chargers which are available for staff/visitors to use.

Waste Management

Increasing recycling at all sites has been very successful over the last two years across the Trust, which resulted in the equivalent of the following carbon savings:



Additional cardboard recycling was introduced at all sites in March 2023, whereby cages were placed at each site, and are then returned to the Sandwell Hub to be placed into the cardboard compactor which generates an income for the Trust, which is £110.00 per tonne. The graph below shows the success of this within the last 12 months of it being in place, which is equal to 11.8 tonnes of waste collected.



Working alongside our cleaning provider, they are now using PVA products, which are environmentally friendly cleaning products which come in water soluble sachets. Data from March 2022 – March 2023 shows we have had plastic savings of 1,625.12kg, which is a C02e saving of 2,194.84kg across the Trust. The image below demonstrates the savings:

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 2023/24 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 2023-24 (version 6). The Trust completed and published its baselines assessment as required by the 29 February 2023.

The process for assurance of the DSPT was previously reviewed by internal audit and was reported to the Trust's Audit Committee as 'optimal', the highest possible assurance. The same process is being followed for version 6, the submission of which is required by 30 June 2024. 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, Safety and Security reports the DSPT through to the Director of Finance.

Clinical Coding Error Rate

West Midlands Ambulance Service was not subject to the Payment by Results clinical coding audit during 2023/2024 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 Learning from Deaths Lead to ensure it is successfully imbedded into the learning culture of WMAS.

For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures.

NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

The Learning from Deaths Lead identifies cases where a death has occurred in our care (from the point of 999 call to the point we leave/discharge the patient. Cases are then reviewed using the Structured Judgement Review (SJR) methodology. During the 2023/24 reporting year, the total number of deaths that occurred, while in WMAS care, was 1191. This aggregate figure represents quarterly totals of:

- 195 in quarter one
- 240 in quarter two
- 429 in quarter three
- 327 in quarter four

During the 2023/24 reporting year, 1191 case record reviews and 336 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:

- 195 case record reviews and 49 investigations in quarter one
- 240 case record reviews and 76 investigations in quarter two
- 429 case record reviews and 127 investigations in quarter three
- 327 case record reviews and 84 investigations in quarter four

During the 2023/24 reporting year, upon initial case record review or investigation, 163 of the 1191 deaths or 13.68% 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:

- 21 deaths or 1.76% in quarter one
- 27 deaths or 2.26% in quarter two
- 75 deaths or 6.29% in quarter three
- 40 deaths or 3.35% in quarter four *(figure correct at point of submission).*

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. Moving forward, the Trust is implementing the Patient Safety Incident Response Framework (PSIRF), which will be replacing the Serious Incident Framework and is discussed on page 73, Patient Safety.

In the previous 2022-2023 quality account reporting period the following information was published “262 of the 844 deaths or 31.04% were considered more likely than not to have been due to problems in the care provided to the patient”. This can now be confirmed as 268 of the 942 deaths or 28.45% were considered more likely than not to have been due to problems in the care provided to the patient. This is as a result of Serious Incident Investigations being raised subsequently to the publication of the 2022-2023 Quality Account.

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 national performance targets throughout 2023/24, however West Midlands Ambulance Service works hard to prioritise the most clinically vulnerable patients to maintain patient safety and has continued to achieve faster responses than the national average for the most acutely unwell of our patient groups. The extensive delays experienced are directly attributable to the sustained extreme pressure within some of our major hospitals.

Category	Performance Standard	Achievement	National Average
Category 1	7 Minutes mean response time	8 Minutes 15 Seconds	8 Minutes 27 Seconds
	15 Minutes 90th centile response time	14 Minutes 30 Seconds	15 Minutes 02 Seconds
Category 2	30 minutes mean response time	36 Minutes 03 Seconds	36 Minutes 23 Seconds
	40 minutes 90th centile response time	80 Minutes 48 Seconds	78 Minutes 15 Seconds
Category 3	120 minutes 90th centile response time	428 Minutes 59 Seconds	296 Minutes 55 Seconds
Category 4	180 minutes 90th centile response time	502 Minutes 20 Seconds	359 Minutes 45 Seconds

Performance by ICS	Category 1		Category 2		Category 3	Category 4
01/04/2023 to 31/03/2024	**Mean**	**90th**	**Mean**	**90th**	**90th**	**90th**
Birmingham and Solihull ICS	6:59	11:39	37:56	88:43	598:44	744:22
Black Country ICS	6:38	10:56	22:51	48:37	348:38	423:07
Coventry and Warwickshire ICS	8:57	15:44	37:57	79:42	368:48	393:49
Herefordshire and Worcestershire ICS	10:41	20:12	40:11	88:17	400:23	464:35
Shropshire, Telford and Wrekin ICS	11:29	23:34	47:47	106:17	423:37	442:04
Staffordshire And Stoke On Trent ICS	8:57	15:22	40:47	90:58	414:07	502:17

Alongside our response standards, we are measured on the time in which emergency calls are answered. On this measure, WMAS remains the best in the country having taken no fewer than 1.78 million emergency calls in the year yet accounted for less than one percent of the over 2 minute call delays across the country. Included in our calls were 210,979 from other services.

Clinical validation of Category 3 and 4 emergencies remains a key function to support the overall emergency demand and to ensure patients receive an appropriate response. The Trust achieved a hear and treat rate of 16.3% during March, consistent with previous months. When reviewing the outcome of Category 3 and 4 patients assessed by a Clinical Validation Team clinician, 56.6% received a Hear and Treat outcome and therefore were referred to alternative services for their ongoing care.

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. This includes the 'Call before you convey' Programme. Launched in December 2023 to further support patients accessing appropriate healthcare. This initiative provides a collaboratively, and consistent regional approach for ambulance clinicians to access acute and community teams for a joint clinical discussion to support the right care for our patients. The programme is successfully supporting a continued reduction of conveyance to Emergency Departments and is also positively supporting our ambitions for our mental health patients.

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

- **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.
- **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.
- **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.
- **Sepsis Sepsis** is a serious complication of an infection. Without quick treatment, *sepsis* can lead to multiple organ failure and death. The National Sepsis care bundle was replaced with an Older Adults discharged at scene AQI which was piloted during 2023-2024 and will become a formal AQI during 2024.

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.
- Glyceryl Trinitrate (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:

- Face, Arm, Speech Test (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 hypoglycemia 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 Ventricular Fibrillation (VF) / Ventricular Tachycardia (VT) i.e., the rhythm is shockable AND
- The cardiac arrest has been witnessed by a bystander AND
- The reason for 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

Percentages based on April 2023-February 2024 data

Mean (YTD)							
Ambulance Quality Indicators	WMAS (20-21)	WMAS (21-22)	WMAS (22-23)	WMAS (23-24)	Last National Average	Highest	Lowest
STEMI Care Bundle	95.56%	86.80%	77.45%	95.97%	78.86%	98.09%	94.01%
Stroke Care Bundle	99.20%	98.67%	87.15%	99.44%	97.70%	99.70%	98.84%
Cardiac Arrest - ROSC At Hospital (Overall Group)	25.12%	25.92%	26.56%	25.54%	29.63%	30.50%	18.89%
Cardiac Arrest - ROSC At Hospital (Comparator)	44.34%	44.08%	46.17%	47.40%	35.29%	35.29%	63.41%
Cardiac Arrest - Survival to Hospital Discharge (Overall)***	8.15%	8.42%	6.85%	6.50%	10.01%	6.01%	8.10%
Cardiac Arrest - Survival to Hospital Discharge (Comparator)	22.26%	25.93%	24.20%	25.00%	30.75%	35.00%	20.40%
Post Resuscitation	69.68%	66.90%	68.72%	65.67%	76.18%	69.12%	59.82%

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 of working for their NHS organisations. It provides essential information to employers and national stakeholders about improvements required in the NHS. Since 2021 the survey questionnaire has been re-developed to align with the People Promise in the 2020/21 People Plan. In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes.

People Promise Elements	Sub-Scores
We are compassionate and inclusive	Compassionate culture Compassionate leadership Diversity and equality Inclusion
We are recognised and rewarded	No sub-score
We each have a voice that counts	Autonomy and control Raising concerns
We are safe and healthy	Health and safety climate Burnout Negative experiences
We are always learning	Development Appraisals
We work flexibly	Support for work-life balance Flexible working
We are a team	Team working Line management
Themes	**Sub-Scores**
Staff engagement	Motivation Involvement Advocacy
Morale	Thinking about leaving Work pressure Stressors

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. For example, the Burnout sub-score, a higher score (closer to 10) means a lower proportion of staff are experiencing burnout from their work. These scores are created by scoring questions linked to these areas of experience and grouping these results together. WMAS results are benchmarked against the Ambulance Trusts benchmarking group average, the best scoring organisation and the worst scoring organisation.

The 2023 NHS Staff Survey fieldwork was open for 10 weeks at WMAS, from 20th September to 24th November 2023. It was administered by Picker Europe Ltd and was conducted as a census. For the last seven years WMAS has been running the survey electronically for ease of access to all staff. A unique link to the survey questionnaire is sent by email to each individual staff. The completed questionnaire is then submitted securely and anonymously to the contractor for processing.

6746 staff were invited to take part in the 2023 staff survey and 2661 staff returned a completed survey compared to 2768 in 2022. There was a decrease in the number of BAME staff responding to the survey on this occasion. 147 BAME staff returned the questionnaire in 2023, compared to 179 in the 2022 staff survey. The overall response rate for WMAS is 40% compared to 39% in the 2022 survey. WMAS has the lowest response rate out of the 10 Ambulance Trusts in England. *(Note: Your Org= WMAS, compared to highest and lowest response rate for Ambulance Trusts and the average response rates for Ambulance Trusts).*

	2019	2020	2021	2022	2023
Your org	63.39%	56.13%	43.99%	38.88%	39.69%
Highest	71.48%	73.43%	67.10%	62.02%	68.40%
Average	50.20%	56.13%	56.78%	49.66%	51.81%
Lowest	41.38%	36.89%	34.11%	33.00%	39.69%
Responses	3375	3724	3028	2768	2661

The average response rate for all Ambulance Trusts (including Isle of Wight) is 52% compared to 50% in 2022.

The following actions were taken before and during the survey to encourage staff to take part and share their views:

- Announcements through the weekly briefing prior to the survey launch
- Publication of “You said, We did” poster and information about how the staff survey results is used in the Trust.
- 15 minutes protected paid time was offered to all staff to complete the survey questionnaire.
- Localities organised walk in sessions at different sites to answer any questions from staff and encourage them to complete the survey.
- Staff were encouraged to complete the survey on their iPads while waiting for their flu jabs
- Staff survey pull up banners were displayed at different Trust events such as health and wellbeing, FTSU, Culture Day, to raise awareness about the staff survey.
- Weekly results from Picker Europe were posted on the information screens at all locations and in the Weekly Briefing to provide clarity and show progress.
- Posters and information about confidentiality were shared with staff at all sites.
- Weekly emails were sent to managers to remind them to keep encouraging their staff to complete their survey questionnaire.
- A banner was featured on the intranet home page as a constant reminder for staff to complete their survey.
- All email signatures were assigned a staff survey tag.

- Prize incentives were offered to encourage staff participation. Thirty lifestyle vouchers worth £50 each were allocated to participants in the survey, following three draws carried out by Picker. The winners remained anonymous to the Trust, but they were given the opportunity to share their identity and experience if they wanted to.
- Videos and articles of winners of the prize draws who came forward, were published on Treble 9 and weekly briefing.

Results of the 2023 Staff Survey

Overall, there is a significant improvement in the positive responses compared to 2022 results. A total of 118 questions were asked in the 2023 survey, of these, 113 can be compared to 2022 and 100 can be positively scored. However, when compared to other Ambulance Trusts, WMAS scored significantly worse. The highest number of positive responses were received from the Administrative and Clerical(82%), Nursing and Midwifery(76%) and Students(54%) staff groups. The lowest number of positive responses were received from Allied Health Professionals, Additional Clinical Services and Estates and Ancillary staff groups.

Top 5 Scores

The table below shows the top 5 scores for WMAS compared to the average score for Ambulance Trusts that used Picker as their contractor.

Top 5 scores vs Organisation Average	WMAS	Picker Average
q23a. Received appraisal in the past 12 months	92%	76%
q3h. Have adequate materials, supplies and equipment to do my work	67%	58%
q13d. Last experience of physical violence reported	82%	76%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	67%	61%
q3i. Enough staff at organisation to do my job properly	35%	29%

Most Improved Scores

The following are the areas where WMAS has scored better than 2022.

Most improved scores	WMAS 2023	WMAS 2022
q7b. Team members often meet to discuss the team's effectiveness	32%	24%
q4c. Satisfied with level of pay	28%	21%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	60%	53%
q6c. Achieve a good balance between work and home life	43%	37%
q5c. Relationships at work are unstrained	40%	35%

Bottom 5 scores

The table below shows the bottom 5 scores for WMAS when compared to other Ambulance Trusts that used Picker as their contractor.

Bottom 5 scores vs Picker Average	WMAS	Picker Average
q11e. Not felt pressure from manager to come to work when not feeling well enough	54%	69%
q6d. Can approach immediate manager to talk openly about flexible working	50%	61%
q9d. Immediate manager takes a positive interest in my health & well-being	53%	63%
q9b. Immediate manager gives clear feedback on my work	46%	56%
q25a. Care of patients/service users is organisation's top priority	52%	61%

Most Declined Scores

The following are areas where WMAS scores have most deteriorated compared to 2022.

Most declined scores	WMAS 2023	WMAS 2022
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	46%	49%
q14c. Not experienced harassment, bullying or abuse from other colleagues	79%	81%
q3b. Feel trusted to do my job	78%	79%
q14b. Not experienced harassment, bullying or abuse from managers	82%	83%
q5b. Have a choice in deciding how to do my work	38%	39%

Advocacy Results

A significant improvement was noted for the advocacy questions as shown below.

	2023	2022
q25c. Would recommend organisation as a place to work	44%	42%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	55%	51%
q25a. Care of patients/service users is organisation's top priority	52%	52%

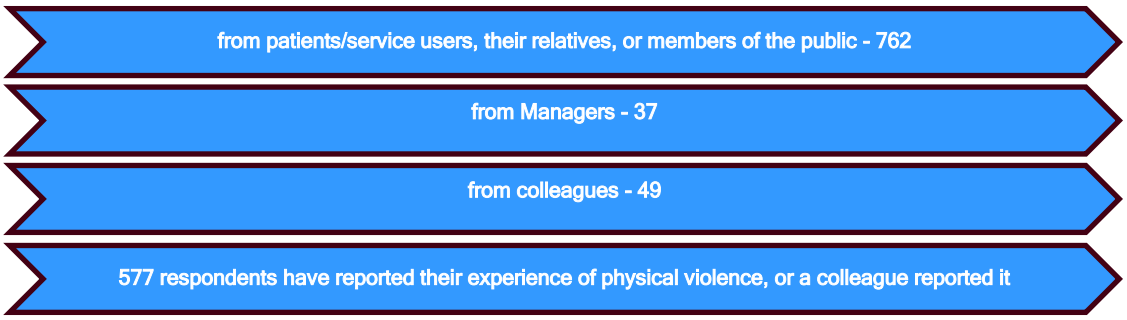
Experience of Unwanted Behaviour of Sexual Nature

For the first time in 2023 two additional questions were included in the staff survey questionnaire relating to unwanted behaviour of a sexual nature. The table below shows the positive responses for the questions.

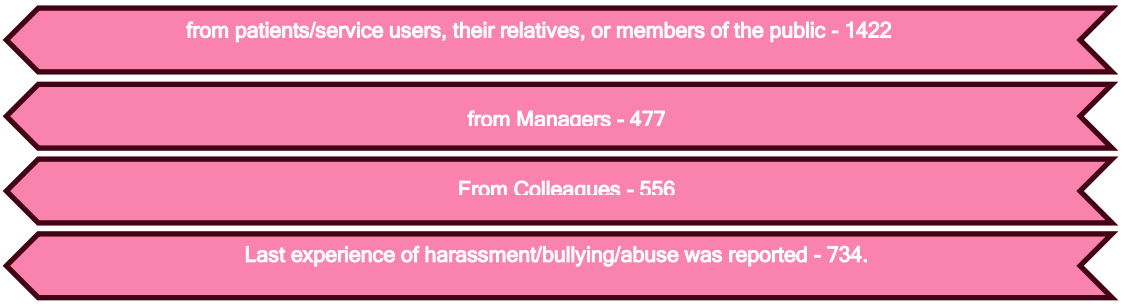
		Picker Average 2023	WMAS 2023
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	77.3%	74.5%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	91.4%	91.5%

Experience of physical violence and bullying and harassment

762 respondents (35%) have said that they have experienced physical violence from members of the public. 37 respondents (1%) said that they have experienced physical violence from Managers. 49 respondents (2%) said that they have experienced physical violence from colleagues. 577 respondents (73%) said that themselves or a colleague reported the experiences of physical violence.

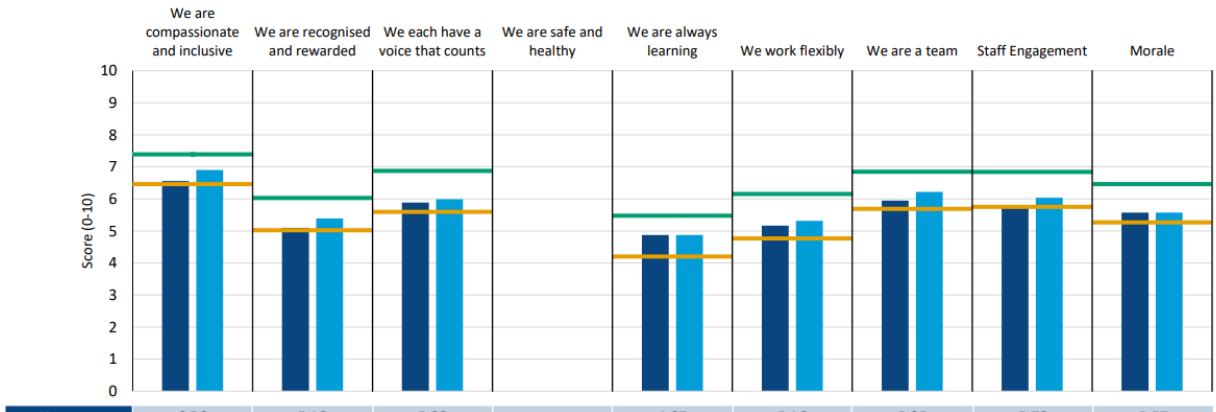


1422 respondents (53%) reported that they have experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public. 477 respondents (19%) said that they have experienced harassment, bullying or abuse from managers and 556 (22%) reported that they experienced bullying and harassment from colleagues. 734 respondents (45%) reported their experience of bullying and harassment.



2023/24

People Promise Elements and Themes: Scores Overview



	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
Your org	6.56	5.10	5.89	-	4.87	5.16	5.95	5.79	5.57
Best result	7.39	6.03	6.87	-	5.47	6.15	6.85	6.84	6.46
Average result	6.90	5.39	5.99	-	4.87	5.32	6.22	6.03	5.57
Worst result	6.46	5.02	5.60	-	4.20	4.77	5.69	5.75	5.27
Responses	2658	2651	2648	-	2462	2646	2658	2660	2659

(Note: Your Org= WMAS, the scores show the best, worst and average results among all Ambulance Trusts).

It is to be noted that the scores for "We are safe and healthy" have not been reported this year due to a data quality issue that was identified close to the publication date. A statement from the National Staff Survey Coordination Centre (NSSCC) explains that there is a higher-than-expected rate of missing data for Q13a-d in the survey. The initial investigation shows that the rates of missing data are higher for a specific group of respondents: those accessing Picker's online survey from an iPhone. It appears that there has been an issue with how this question appeared on screen for some – but not all – iPhone users. The precise cause of this issue is still under investigation. The NSSCC has provided reassurance that no other staff accessing the survey by any other means were impacted; nor have any other questions been impacted by this issue. The NSSCC has stated that for most organisations, the impact of this is likely to be limited – but the risk increases in direct proportion to the level of missing data associated with phone responses. The NSSCC therefore recommends treating the existing results for Q13a-d with caution, particularly if the rate of potentially affected responses is high (e.g. above 10%). It is estimated that approximately 17% (444 responses) of all respondents at WMAS may not have provided an answer to Q13a-d because of this issue. The NSSCC and NHS England are reviewing options on how to present results impacted by this issue. They are aiming to produce results at an organisational and aggregated level at the earliest opportunity, and they will provide a direct update on this as soon as possible.

The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023 for WMAS.

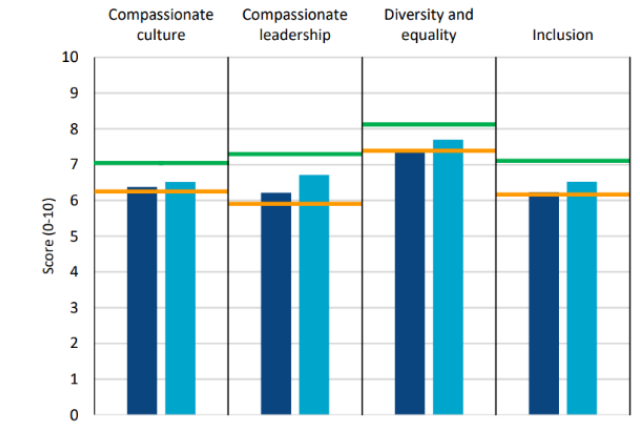
People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.39	2764	6.56	2658	Significantly higher
We are recognised and rewarded	4.80	2762	5.10	2651	Significantly higher
We each have a voice that counts	5.76	2756	5.89	2648	Significantly higher
We are safe and healthy	5.38	2759	-	-	-
We are always learning	4.64	2638	4.87	2462	Significantly higher
We work flexibly	4.74	2758	5.16	2646	Significantly higher
We are a team	5.71	2761	5.95	2658	Significantly higher
Themes					
Staff Engagement	5.62	2767	5.79	2660	Significantly higher
Morale	5.37	2766	5.57	2659	Significantly higher

WMAS People Promise results compared to other Ambulance Trusts

Rank by response rate	Trust	Trust Response rates 2023	"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"
1	London Ambulance Service	68.4%	6.9	5.4	6.1	4.5	5.0	5.6	6.5	6.1	5.5
2	South East Coast Ambulance Service	59.6%	6.7	5.3	5.8	4.4	4.7	5.2	6.2	5.9	5.6
3	South Western Ambulance Service	55.5%	6.8	5.2	5.9	4.3	4.9	5	6	6.0	5.4
4	North East Ambulance Service	53.0%	6.6	5.0	5.6	4.7	4.6	4.8	5.8	5.8	5.4
5	South Central Ambulance Service	52.3%	7.0	5.5	6.0	4.5	5.0	5.3	6.5	6.0	5.4
6	East of England Ambulance Service	51.8%	6.5	5.0	5.6	4.3	4.2	5.5	5.7	5.8	5.3
7	Yorkshire Ambulance Service	50.5%	7.0	5.4	6.1	4.5	5.1	5.5	6.3	6.2	5.7
8	Isle of Wight Ambulance Service	48.7%	7.4	6.0	6.9	5.1	5.5	6.2	6.9	6.8	6.5
9	North West Ambulance Service	47.9%	6.9	5.5	6.0	4.6	5.1	5.2	6.2	6.2	5.7
10	East Midlands Ambulance Service	43.1%	6.9	5.5	6.1	4.5	4.8	5.6	6.2	6.2	5.6
11	West Midlands Ambulance Service	39.7%	6.6	5.1	5.9	4.3	4.9	5.2	5.9	5.8	5.6

We are compassionate and inclusive

WMAS overall score for this element is below average when compared with other Ambulance Trusts for the last three years. Although the WMAS overall score for this element is below average compared to other Ambulance Trusts for this element, the internal improvement over the last three years, is very significant; showing that we are moving in the right direction.



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.37	6.21	7.41	6.23
Best result	7.05	7.29	8.12	7.10
Average result	6.51	6.71	7.70	6.52
Worst result	6.25	5.90	7.39	6.16
Responses	2656	2658	2657	2655

Compassionate culture

	2021	2022	2023
Your org	6.24	6.17	6.37
Best result	6.77	6.92	7.05
Average result	6.44	6.35	6.51
Worst result	5.94	5.77	6.25
Responses	2875	2760	2656

Compassionate Leadership

	2021	2022	2023
Your org	5.91	5.94	6.21
Best result	6.93	6.99	7.29
Average result	6.32	6.52	6.71
Worst result	5.50	5.77	5.90
Responses	2930	2762	2658

Diversity and Equality

	2021	2022	2023
Your org	7.37	7.39	7.41
Best result	8.17	7.89	8.12
Average result	7.55	7.58	7.70
Worst result	6.97	7.03	7.39
Responses	2910	2763	2657

Inclusion

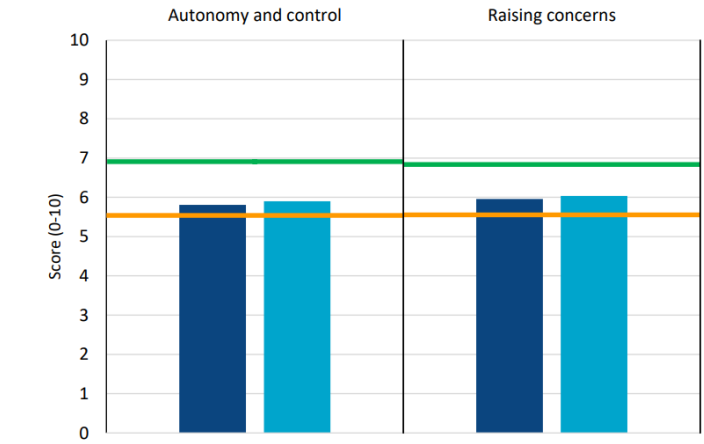
	2021	2022	2023
Your org	6.09	6.07	6.23
Best result	6.74	6.69	7.10
Average result	6.42	6.45	6.52
Worst result	5.83	6.07	6.16
Responses	2936	2760	2655

We are recognised and rewarded

There are no sub scores for this element. Whilst the internal results are very positive; WMAS scores are significantly below average when compared to other Ambulance Trusts.

	2021	**2022**	**2023**
WMAS	4.89	4.80	5.10
Best Result	5.66	5.61	6.03
Average Result	5.09	5.07	5.39
Worst Result	4.45	4.69	5.02
Responses	2985	2762	2651

We have a voice that counts



	Autonomy and control	Raising concerns
Your org	5.81	5.96
Best result	6.91	6.84
Average result	5.90	6.03
Worst result	5.54	5.55
Responses	2660	2648

Autonomy and Control

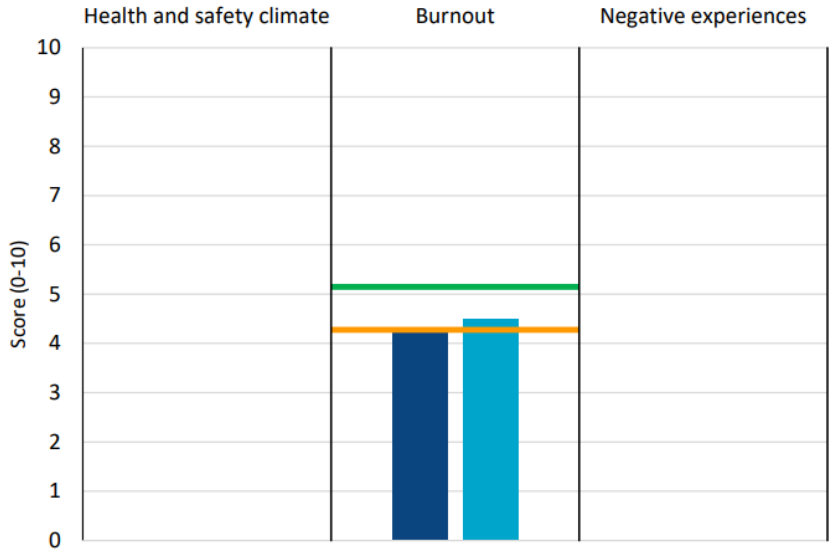
	2021	2022	2023
Your org	5.55	5.67	5.81
Best result	6.41	6.72	6.91
Average result	5.81	5.78	5.90
Worst result	5.25	5.52	5.54
Responses	2992	2767	2660

Raising Concerns

	2021	2022	2023
Your org	5.83	5.85	5.96
Best result	6.72	6.86	6.84
Average result	5.99	5.90	6.03
Worst result	5.27	5.29	5.55
Responses	2866	2757	2648

We are safe and healthy

Some positive results were observed for this element, especially in the reporting of physical violence and bullying and harassment. It is noteworthy that quite a lot of time and effort has been invested into promoting safety around speaking up and raising concerns.



Your org	-	4.28	-
Best result	-	5.15	-
Average result	-	4.49	-
Worst result	-	4.28	-
Responses	-	2657	-

(Note: 2023 results for "We are safe and healthy" have not been reported due to an issue with the data)

Health and safety climate

	2021	2022	2023
Your org	5.07	5.25	
Best result	5.07	5.25	
Average result	4.71	4.93	
Worst result	4.26	4.55	
Responses	2990	2767	

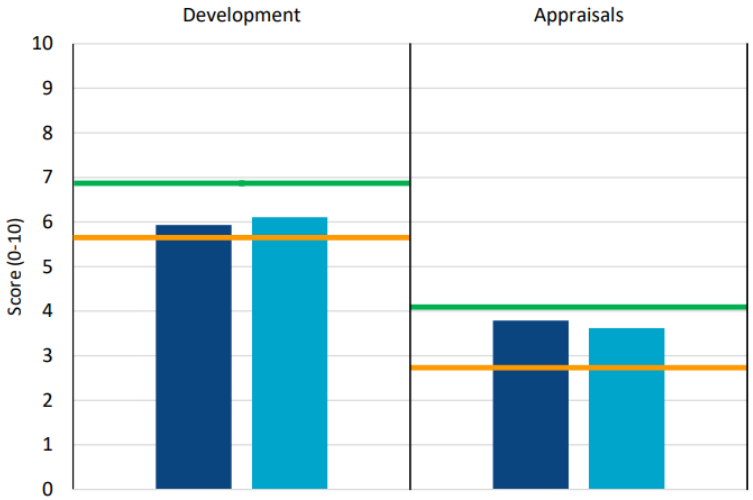
Burnout

	2021	2022	2023
Your org	4.03	4.06	4.28
Best result	4.63	4.77	5.15
Average result	4.16	4.22	4.49
Worst result	3.73	3.88	4.28
Responses	2918	2765	2657

Negative experiences

	2021	2022	2023
Your org	6.80	6.84	
Best result	7.42	7.25	
Average result	6.90	7.04	
Worst result	6.61	6.62	
Responses	2908	2762	

We are always learning



	Development	Appraisals
Your org	5.93	3.79
Best result	6.87	4.09
Average result	6.11	3.62
Worst result	5.65	2.73
Responses	2644	2462

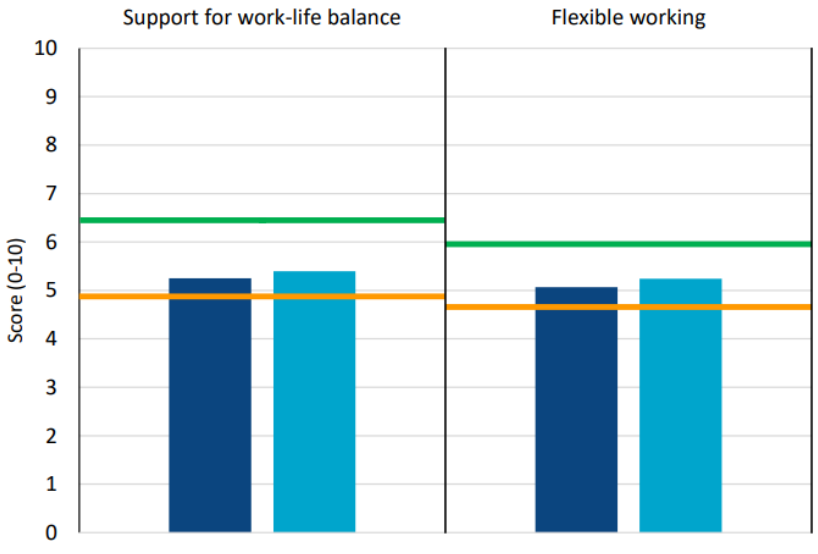
Development

	2021	2022	2023
Your org	5.73	5.83	5.93
Best result	6.17	6.54	6.87
Average result	5.84	5.91	6.11
Worst result	4.97	5.16	5.65
Responses	2896	2763	2644

Appraisals

	2021	2022	2023
Your org	3.09	3.43	3.79
Best result	3.62	3.78	4.09
Average result	2.80	3.29	3.62
Worst result	1.72	2.16	2.73
Responses	2750	2642	2462

We work flexibly



	Support for work-life balance	Flexible working
Your org	5.25	5.07
Best result	6.45	5.95
Average result	5.40	5.24
Worst result	4.88	4.66
Responses	2658	2647

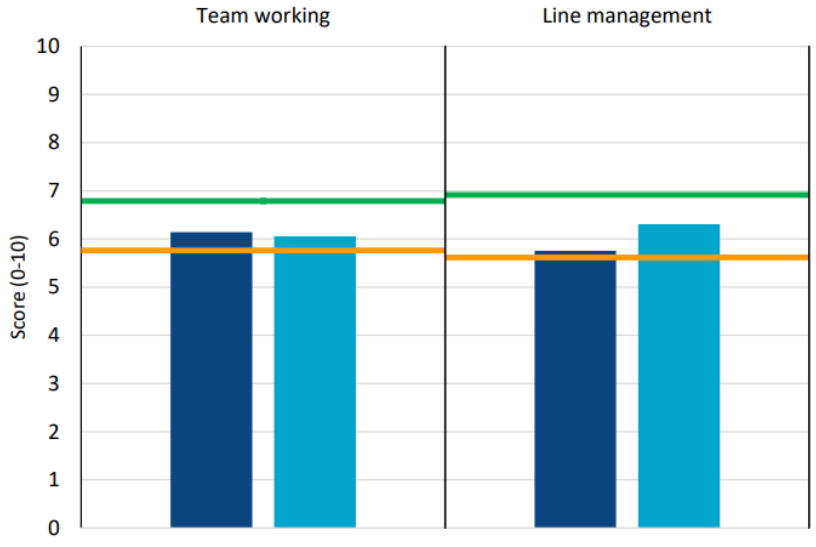
Support for work life balance

	2021	2022	2023
Your org	4.90	4.82	5.25
Best result	5.77	6.06	6.45
Average result	5.01	5.12	5.40
Worst result	4.54	4.73	4.88
Responses	2973	2764	2658

Flexible working

	2021	2022	2023
Your org	4.88	4.66	5.07
Best result	5.53	5.87	5.95
Average result	4.88	4.95	5.24
Worst result	4.25	4.40	4.66
Responses	2980	2760	2647

We are a team



	Team working	Line management
Your org	6.14	5.75
Best result	6.79	6.92
Average result	6.06	6.30
Worst result	5.76	5.62
Responses	2658	2659

Team working

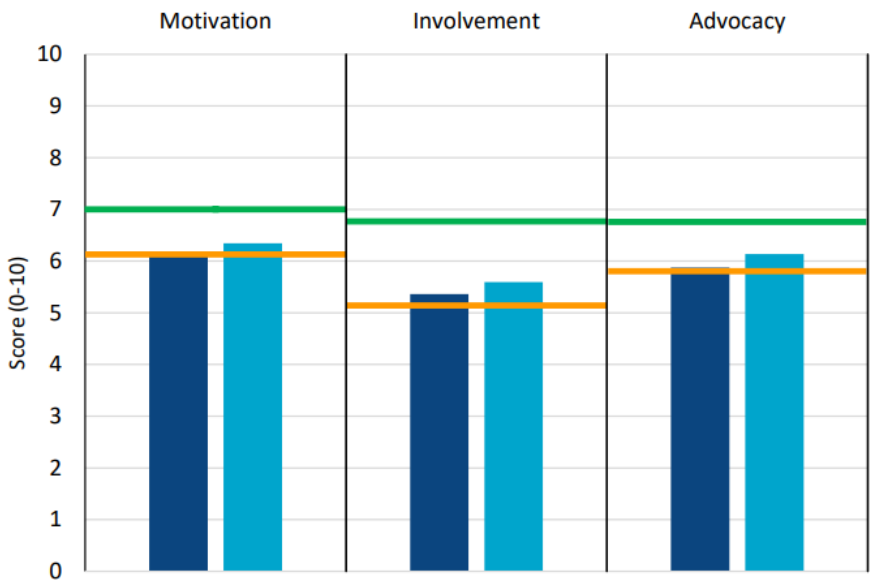
	2021	2022	2023
Your org	5.87	5.92	6.14
Best result	6.26	6.48	6.79
Average result	5.91	5.95	6.06
Worst result	5.40	5.62	5.76
Responses	2953	2765	2658

Line management

	2021	2022	2023
Your org	5.43	5.50	5.75
Best result	6.62	6.60	6.92
Average result	5.95	6.16	6.30
Worst result	5.00	5.43	5.62
Responses	2932	2762	2659

Staff Engagement

The staff engagement score is calculated on 9 key questions in the staff survey relating to Advocacy, Motivation, and Involvement. The maximum possible score is 10 (all respondents answer most positively) and the lowest possible score is 0 (all respondents answer most negatively). A considerable improvement is noted in the positive responses over the last three years. Overall, Central Functions sector has returned the most positive responses in the survey. The staff in this group generally work in 'real' teams with one line manager in most cases. Central Functions staff are also mostly non-patient facing.



	Motivation	Involvement	Advocacy
Your org	6.13	5.36	5.87
Best result	7.00	6.77	6.76
Average result	6.34	5.59	6.13
Worst result	6.13	5.14	5.80
Responses	2651	2660	2656

Motivation

	2019	2020	2021	2022	2023
Your org	6.71	6.69	6.00	5.97	6.13
Best result	6.85	7.07	6.50	6.74	7.00
Average result	6.71	6.74	6.13	6.22	6.34
Worst result	6.39	6.42	5.84	5.86	6.13
Responses	3363	3709	3023	2757	2651

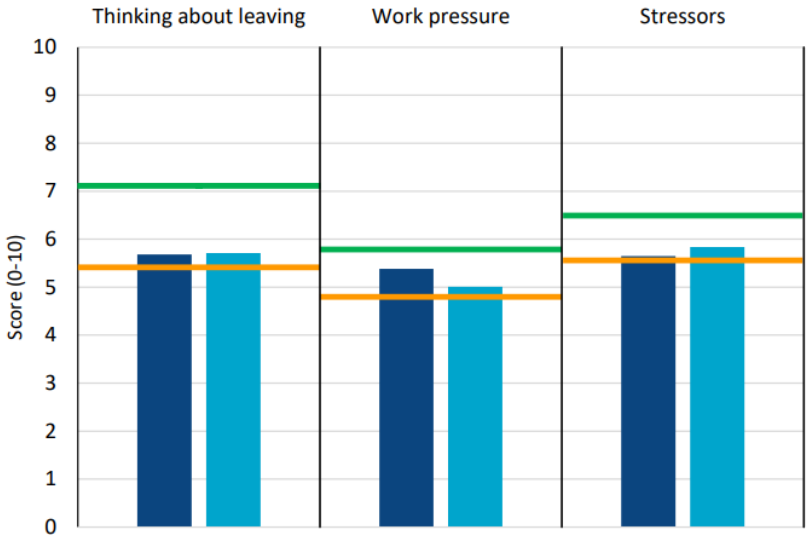
Involvement

	2019	2020	2021	2022	2023
Your org	5.66	5.49	5.01	5.21	5.36
Best result	6.96	6.40	6.18	6.54	6.77
Average result	5.67	5.52	5.40	5.42	5.59
Worst result	5.06	4.95	4.66	5.03	5.14
Responses	3374	3679	2992	2767	2660

Advocacy

	2019	2020	2021	2022	2023
Your org	6.63	6.79	5.77	5.68	5.87
Best result	6.95	7.01	6.34	6.47	6.76
Average result	6.48	6.70	6.09	5.90	6.13
Worst result	5.51	5.97	5.42	5.24	5.80
Responses	3297	3603	2875	2761	2656

Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.68	5.38	5.65
Best result	7.11	5.78	6.49
Average result	5.71	5.01	5.84
Worst result	5.41	4.80	5.56
Responses	2654	2659	2655

Thinking about leaving

	2019	2020	2021	2022	2023
Your org	6.25	6.46	5.53	5.40	5.68
Best result	6.31	6.62	6.13	6.37	7.11
Average result	5.80	6.24	5.54	5.47	5.71
Worst result	5.14	5.36	4.65	4.90	5.41
Responses	3292	3593	2850	2746	2654

Work pressure

	2019	2020	2021	2022	2023
Your org	5.71	6.21	5.01	5.22	5.38
Best result	5.71	6.21	5.01	5.22	5.78
Average result	4.91	5.24	4.43	4.65	5.01
Worst result	3.97	4.63	3.93	4.18	4.80
Responses	3372	3678	2989	2767	2659

Stressors

	2019	2020	2021	2022	2023
Your org	5.88	5.88	5.42	5.49	5.65
Best result	6.24	6.03	5.87	6.14	6.49
Average result	5.81	5.88	5.55	5.66	5.84
Worst result	5.39	5.34	5.08	5.33	5.56
Responses	3351	3650	2976	2761	2655

Workforce Race Equality Standard (WRES)

WRES results are based on a series of indicators, of which 5, 6, 7 and 8 are drawn from the NHS Staff Survey. The tables below show the results for all four indicators for WMAS compared with the average response rates for all Ambulance Trusts over the last five years.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

	2019	2020	2021	2022	2023
White staff: Your org	49.08%	48.64%	51.28%	50.90%	54.01%
All other ethnic groups*: Your org	37.88%	45.23%	49.10%	54.19%	47.62%
White staff: Average	45.78%	43.52%	44.11%	43.50%	43.57%
All other ethnic groups*: Average	41.22%	44.32%	39.36%	40.25%	38.99%
White staff: Responses	3030	3127	2539	2546	2479
All other ethnic groups*: Responses	198	325	222	179	147

A higher percentage of white staff than BAME staff said that they have experienced bullying and harassment from the public. The same is reflected in the average response rates for all Ambulance Trusts.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

	2019	2020	2021	2022	2023
White staff: Your org	25.49%	23.89%	26.75%	27.47%	29.44%
All other ethnic groups*: Your org	24.87%	26.46%	34.98%	39.66%	36.30%
White staff: Average	25.49%	24.09%	23.79%	23.25%	24.95%
All other ethnic groups*: Average	26.20%	31.08%	29.51%	26.27%	24.32%
White staff: Responses	3025	3123	2538	2541	2476
All other ethnic groups*: Responses	197	325	223	179	146

A higher percentage of BAME staff than white staff have said that they have experienced bullying and harassment from other staff. This is reflected on the average results as well.

Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

	2019	2020	2021	2022	2023
White staff: Your org	51.86%	51.33%	44.69%	45.99%	45.59%
All other ethnic groups*: Your org	47.74%	40.55%	36.61%	34.66%	41.10%
White staff: Average	51.15%	51.35%	47.70%	49.82%	51.98%
All other ethnic groups*: Average	34.64%	39.46%	40.25%	37.36%	43.39%
White staff: Responses	3035	3162	2580	2542	2481
All other ethnic groups*: Responses	199	328	224	176	146

A significantly higher percentage of white staff than BAME staff believe that the Trust provides equal opportunities for career progression. The same is reflected in the average results for all Ambulance Trusts.

Indicator 8: Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.

	2019	2020	2021	2022	2023
White staff: Your org	8.81%	8.58%	11.37%	12.54%	12.68%
All other ethnic groups*: Your org	15.82%	20.67%	22.57%	26.14%	25.17%
White staff: Average	8.81%	8.58%	10.03%	9.36%	9.69%
All other ethnic groups*: Average	15.80%	16.75%	15.75%	15.83%	14.85%
White staff: Responses	3009	3158	2577	2536	2461
All other ethnic groups*: Responses	196	329	226	176	147

A significantly higher percentage of BAME staff than white staff have said they have experienced discrimination from managers and other staff. The same is reflected in the average results for all Ambulance Trusts.

Workforce Disability Equality Standard (WDES)

WDES results are based on a series of indicators drawn from the NHS Staff Survey. The tables below show the results for all indicators for WMAS compared with the average response rates for all Ambulance Trusts over the last five years.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	54.99%	52.53%	59.84%	62.04%	60.36%
Staff without a LTC or illness: Your org	46.93%	46.84%	48.03%	46.76%	50.55%
Staff with a LTC or illness: Average	52.55%	47.50%	51.25%	50.17%	47.52%
Staff without a LTC or illness: Average	44.93%	42.12%	41.58%	40.36%	39.03%
Staff with a LTC or illness: Responses	671	771	737	785	782
Staff without a LTC or illness: Responses	2606	2722	2061	1957	1818

A significantly higher proportion of staff with a Long Term Condition (LTC) or illness at WMAS than staff without a LTC, have said that they have experienced bullying and harassment from patients and their relatives in the last five years. Whilst it is reassuring that a significant decrease is noted in the response rate for WMAS for staff with LTC when compared to 2022; a significant increase is noted for staff without a LTC or illness from 2022 to 2023. Looking at the average response rates across all Ambulance Trusts, it is noted that staff with a LTC are more likely to experience bullying and harassment from patients and their relatives than staff without a LTC or illness. It must be noted however, that the average figures for Ambulance Trusts show a sharp decrease from 2022 to 2023 for both groups of staff.

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	24.77%	25.29%	28.77%	27.09%	26.44%
Staff without a LTC or illness: Your org	13.25%	11.66%	13.96%	13.67%	14.48%
Staff with a LTC or illness: Average	23.17%	22.10%	19.20%	21.14%	18.24%
Staff without a LTC or illness: Average	13.25%	11.22%	11.06%	10.12%	10.59%
Staff with a LTC or illness: Responses	666	767	730	779	779
Staff without a LTC or illness: Responses	2596	2711	2041	1946	1795

A higher percentage of staff with a LTC or illness at WMAS than those without have said that they have experienced bullying and harassment from managers over the last five years. A slight decrease is also noted in the figures from 2022 to 2023 for staff with a LTC while an increase is observed for staff without a LTC. A similar pattern is observed on average for all Ambulance Trusts.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	25.11%	23.09%	27.61%	26.80%	30.12%
Staff without a LTC or illness: Your org	14.49%	13.49%	15.25%	15.95%	17.63%
Staff with a LTC or illness: Average	25.91%	23.09%	23.90%	23.40%	25.00%
Staff without a LTC or illness: Average	15.65%	14.74%	15.25%	14.87%	15.85%
Staff with a LTC or illness: Responses	665	771	728	776	767
Staff without a LTC or illness: Responses	2601	2713	2039	1918	1781

WMAS staff with a LTC or illness are more likely to experience bullying and harassment from other colleagues than those without. This is also true on average for all Ambulance Trusts. A significant increase in the response rates is noted from 2022 to 2023 for both groups of staff both within WMAS and across all Ambulance Trusts.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	46.43%	46.17%	43.54%	45.82%	49.48%
Staff without a LTC or illness: Your org	47.08%	48.48%	49.08%	48.84%	53.68%
Staff with a LTC or illness: Average	44.57%	46.17%	46.43%	47.26%	49.48%
Staff without a LTC or illness: Average	41.24%	45.60%	45.34%	46.49%	49.77%
Staff with a LTC or illness: Responses	392	444	480	502	477
Staff without a LTC or illness: Responses	1266	1250	1033	909	896

WMAS staff with a LTC or illness are less likely to report experiences of bullying and harassment than those without. Whereas on average across all Ambulance Trusts staff with a LTC are more likely to report their experience of bullying and harassment than those without. A sharp increase in positive responses is noted from 2022 to 2023 for all staff groups across all areas.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	48.51%	45.68%	35.75%	39.80%	38.92%
Staff without a LTC or illness: Your org	51.95%	51.25%	46.55%	47.13%	47.75%
Staff with a LTC or illness: Average	45.27%	45.26%	39.42%	42.27%	46.91%
Staff without a LTC or illness: Average	51.95%	52.04%	49.30%	51.28%	52.16%
Staff with a LTC or illness: Responses	670	775	744	784	781
Staff without a LTC or illness: Responses	2610	2753	2099	1950	1820

Overall, at WMAS and on average across all Ambulance Trusts, staff with a LTC or illness are less likely to believe that the Trust provides equal opportunity for career progression than staff without a LTC.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	58.19%	54.64%	64.55%	56.92%	53.83%
Staff without a LTC or illness: Your org	44.32%	44.86%	50.49%	46.56%	40.46%
Staff with a LTC or illness: Average	41.64%	38.28%	39.17%	37.04%	34.41%
Staff without a LTC or illness: Average	32.26%	30.77%	29.30%	26.39%	24.82%
Staff with a LTC or illness: Responses	531	582	615	650	626
Staff without a LTC or illness: Responses	1566	1371	1230	1177	1043

A significantly higher proportion of staff with a LTC or illness at WMAS have said that they have felt pressured by their manager to come to work despite being unwell compared to staff without a LTC. The same is observed on average across all Ambulance Trusts. A considerable improvement in the figures has also been observed over the last three years.

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

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	26.72%	28.26%	16.91%	16.56%	20.59%
Staff without a LTC or illness: Your org	39.87%	38.12%	26.46%	27.02%	29.74%
Staff with a LTC or illness: Average	27.84%	29.12%	20.78%	23.51%	23.83%
Staff without a LTC or illness: Average	38.89%	37.89%	29.35%	30.15%	33.14%
Staff with a LTC or illness: Responses	670	775	745	785	782
Staff without a LTC or illness: Responses	2611	2762	2105	1958	1819

Fewer staff at WMAS with a LTC or illness are satisfied with the extent to which the organisation values their work compared to staff without a LTC. The same is observed on average across all Ambulance Trusts. However, a significant improvement in is noted in the figures from 2022 to 2023.

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

	2022	2023
Staff with a LTC or illness: Your org	53.40%	59.75%
Staff with a LTC or illness: Average	62.97%	67.39%
Staff with a LTC or illness: Responses	470	477

Compared to the average figures for all Ambulance Trusts, fewer staff with a LTC or illness at WMAS have said that the employer has made reasonable adjustments to enable them to carry out their work. Although improvement is noted from 2022 to 2023.

Staff Engagement Score

	2019	2020	2021	2022	2023
Organisation average	6.26	6.27	5.52	5.51	5.67
Staff with a LTC or illness: Your org	5.77	5.79	4.95	5.05	5.21
Staff without a LTC or illness: Your org	6.39	6.41	5.74	5.69	5.88
Staff with a LTC or illness: Average	5.89	6.06	5.51	5.52	5.69
Staff without a LTC or illness: Average	6.43	6.45	6.06	6.00	6.25
Staff with a LTC or illness: Responses	671	778	747	788	787
Staff without a LTC or illness: Responses	2616	2765	2106	1961	1825

Overall, WMAS staff with a LTC or illness are less engaged than staff without a LTC. The same is also true on average for all other Ambulance Trusts. An improvement in the scores is noted from 2022 to 2023.

Future priorities and targets:

Priorities are decided locally with relevant staff in each locality through Listening into Action groups and staff meetings. The Staff Survey Response Action Group (SSRAG) meets regularly to interrogate the results and make recommendations for organisation-wide actions. Three key priorities have been agreed by the SSRAG and the Executive Membership Board to focus on following the 2023 Staff Survey Results.

PRIORITY 1 - WE HAVE A VOICE THAT COUNTS

Demonstrate how we listen to staff by providing regular feedback and promoting what actions are taken to address concerns and act upon suggestions made by staff.

a) Communicate positive stories from staff through Weekly Briefing, video interviews with colleagues from various localities and other platforms such as Trust Facebook page, Staff Side website, One Lan Screens .

b) Hold Listening into Action sessions locally to gain staff views on what they want include in the Local Action Plans

c) Share relevant information with staff, from various pillar committees (e.g. People Committee), through weekly briefing articles in view of keeping staff informed about all the various actions that are put in place by the organisation based on their feedback and in order to ensure that they have a positive experience of working for WMAS.

d) Create more awareness for staff to understand the ER54 reporting and feedback process. Promotion on various platforms such as WB, OneLAN, Trust media pages, Staff Side Website, Notice Boards.

e) Keep encouraging staff to come forward with ideas, suggestions, and speak up about concerns through the appropriate channels e.g. more promotion for AIM, ER54, FTSU, etc. and getting staff to share their positive experiences when they have used these channels.

f) Use Listening into Action sessions to encourage staff to share positive experiences and new ideas about what they would like to see on the Local Action Plans.

g) Use local suggestions boxes. Use simple MS Forms for staff to make suggestions for local improvements especially in localities where face to face meetings is not always possible.

PRIORITY 2 - WE ARE SAFE AND HEALTHY

a) Keep encouraging staff to report incidences of physical violence so that appropriate actions can be taken and provide feedback of the outcomes.

b) Align our actions with the national campaign #WorkWithoutFear, developed by NHSE and AACE for violence prevention and reduction against NHS Staff, and implement learnings and good practice.

c) Increase the usage of body worn cameras by staff so that evidence can be collected, and incidents can be prosecuted appropriately.

d) Create more awareness about the importance of reporting incidents of physical violence through various communications portals.

e) Investigate if miscommunication may be a contributing factor to staff feeling bullied and provide educational support on how these situations may be diffused/avoided.

f) Encourage more staff to attend development sessions such as decider skills training and personal impact sessions. Also link to Suzy Lamplugh Trust Bystander training.

g) Provide clear information to staff through Induction, mandatory training, etc. about what constitutes bullying and harassment and the difference with being managed effectively.

h) Launch of the WRES Equality Charter to emphasize the expected behaviours from all staff and the Trust's commitment to zero tolerance for bullying and harassment.

i) Investigate the reasons provided for work-related stress and assess any correlation with the reports of bullying and harassment and physical violence.

j) Investigate whether there is a correlation with staff also being immobile in ambulances and sitting in one position for prolonged waiting times due to hospital delays. Similarly, corporate staff working remotely may not be using the correct equipment such as office chairs and other set-ups which may not be appropriate for office work.

k) Provide emotional support and mental health support as required.

PRIORITY 3 - RAISING CONCERNS

a) Promote through videos and articles the importance of raising concerns and ensuring that staff know the correct mechanisms of reporting and raising concerns.

b) Improve Winningtemp surveys and data collection to encourage more staff to take part and understand the value of the platform.

c) Provide feedback and show outcomes to staff through weekly briefing, and other means of communications.

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:

- Equality Delivery System – covering all 3 Domains of the framework
- 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 including the launch of a new Student Network
- National Ambulance Diversity Group [NADG]
- National LGBT Group
- WDES Workforce Disability Equality Standard
- Gender Pay Gap
- Chaplaincy Service

Equality Delivery System - implementation of the new framework

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The third version of the EDS was commissioned by NHS England and NHS Improvement with, and on behalf of, the NHS, supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

To take account of the significant impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) by encouraging organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises of 3 Domains:
1) Commissioned or provided services
2) Workforce health and well-being
3) Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives. For 2023/24 we have completed an assessment on all 3 of the domains. Results and grading will be published in the Public Sector Equality Duty (PSED) Annual Report later on in 2024.

Recruitment

The Trust aspires 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. Research tells us that a diverse workforce provides better patient care and to compliment the WRES & WDES action plans the Trust is keen to encourage both BME and disabled applicants for all roles within the Trust. To achieve this aim the Trust has enhanced its recruitment programme by the following:

- Literature is reflective of the diversity of the Trust
- Attendance at local community events
- 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
- The Recruitment team offers support for BME & disabled applicants through the pre-assessment programme
- Encouraging applicants to disclose reasonable adjustments required at assessment stage
- Achievement of the Bronze Dyslexia Workplace Friendly accreditation and working towards Silver standard
- Achievement of Disability Confident Leader status
- Finalist in the Disability Smart Awards 2024 for Disability Confident Mental Health & Wellbeing in the Workplace Award
- Close liaison with our Staff Networks to encourage and support applicants from all backgrounds and experiences allowing them to be their authentic selves in the workplace

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), Gender Pay Gap, 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 2024.

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 organisation. This group is chaired by the CEO. The Diversity & Inclusion Steering Group meets every two 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 ONE (BME) Network**

  The ONE Network meets a number of times during the year and is supported by a HR buddy, Equality and Inclusion Lead and Executive Sponsor to further the aims of the staff network. The network is consulted on the development of the WRES action plan. Over the year the network has celebrated a number of events which are highlighted in the PSED annual report 2024.

- **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 a third cohort 2022 and a fourth cohort in 2023. Women's network also marked International Women's day by holding a successful event and further events will be planned in partnership with other networks going forward.
- **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.
- **Student Network.** In late 2023, a student staff network has been established

Chaplaincy Service: Spiritual Care Team

Since the retirement of our Chaplain in early 2023, the Trust has been successful in replacing and recruiting two further chaplains from different faiths and are looking to add more to the team. We now have three Chaplains in total which are accessible for staff throughout the Trust.

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 2024.

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 (HWB)

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

Other new frameworks have been developed which also need to link into the National HWB Framework the below all relate to Mental Health & Suicide

- AACE Employee Wellbeing and Suicide Prevention (EWSP) self-assessment matrix
- AACE self-audit tool
- Mental Health at Work Commitment [Trust signed up 2022]
- Preventing Suicide in Ambulance Sector Local Improvement Plans WMAS
- Mental Health Continuum AACE [released 10th March]

Sexual Safety

In October 2022 we launched our approach to raising awareness of sexual safety in the workplace, highlighting the support avenues for individuals who experience this unacceptable behaviour and confirming our commitment to addressing this robustly and appropriately. We have continued to work with our University colleagues and our staff networks to promote sexual safety for all of our staff and students.

Health & Wellbeing Champions

Over the last 12 months the opportunities for training & development for Champions have continued, provided by NHS England. The courses have been advertised to all of our 113 Champions currently. In addition, further in house development opportunities HWB Champions have had are as follows:

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

- Development meetings, face to face and via MS Teams, to provide updates and share ideas, working together.
- To attend HWB roadshow events across the Trust.

We regularly review the HWB champions with managers to ensure there is at least one HWB champion based at every Hub. Regular communication via our HWB champion newsletter is sent out to the HWB champions weekly and either face to face or online meetings take place with regards to updates, events, and development sessions. The newsletter was launched last year and has been a huge success with our champions to enable us to share updates, event details, religious festivals, training and general sharing of information / great ideas etc.

Health and Wellbeing Roadshows and Website

The Trust successfully launched a bespoke staff health and wellbeing website in July 2022. This provides our staff with a central single point of information that is easy to access and navigate based on their personal health needs and areas of interest. The website provides staff with access to a wide range of support services provided directly by the Trust, as well as signposting to appropriate specialist support services. To support and promote the HWB website, credit cards with the HWB logo have been developed with a QR code to enable staff to directly access the HWB website, this can be accessed on personal devices and provides new staff joining the Trust with access to support from day one. We continue to develop and promote merchandise to further advertise the website and HWB services to staff. The corporate induction package, HWB mandatory training and Trust digital display screens have all been updated with the new HWB graphics and website information.

To coincide with the website launch we ran a series of onsite health & wellbeing roadshows across the region to promote the website and further promote services available to staff, which were a great success visiting 25 sites last year. Due to this success, the Trust have decided this year to visit 24 sites, where staff are based, to promote the website, engage with staff, and encourage them to complete the health & wellbeing survey. The roadshows will be fun informative events for staff, working in collaboration with our internal partners; SALS (The Trust's peer support network), unions, HR Team, mental wellbeing practitioner team, health and wellbeing champions, diversity and inclusion lead, staff networks, freedom to speak up team and our management teams. As well as our internal partners we have built great relationships with our external partners too, who will be supporting us this year at the events.

As well as the roadshows the Trust have produced a Cultural and HWB calendar, promoting events such as, Time to talk, internal wellbeing events along with National wellbeing offerings and cultural dates of interest. Delivering the roadshows is in alignment with our People strategy and the NHS People Plan, which is split into five key themes of delivery: the health and wellbeing of our people, recruitment and retraining our people, engaging with our people, inclusion and belonging and education and learning.

Weight Management

Slimming World continues to be extremely popular with the Trust supporting staff for the first 12 weeks of their programme. Staff have continued to engage with the programme though self-funding. .

Physical Activities

Physical activity programmes are frequently advertised in the Weekly Brief and on our HWB website from discounts to apps.

- "DoingOurbit" 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.
- 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.
- Wyndley Leisure Centre in Birmingham offer staff 20% corporate discount on their one-year membership.
- Sandwell Leisure Centre offer monthly or yearly NHS discount.
- PureGym offer up to 10% off monthly membership and £0 joining fee.
- Evans cycle to work scheme which is open to staff all year round now, with an increased bike allowance of up to £3,000.
- .
- West Midlands Police Sports & Wellbeing Association, through joining the membership scheme a whole host of benefits from sports and wellbeing opportunities, days out with the family, money saving benefits, and more are available to WMAS staff.

Mental Health First Aid Courses

The Trust have 6 trained MHFA instructors, we were able to recruit 2 additional staff members to support us, which has been a great success as the new trainers are able to support us with online training courses, we ran our first online session in March 2024. . During the period April 2023 – March 2024, 150 staff were trained as Mental Health First Aiders, completing the 2-day course (12 courses).

The training plan for 2024 – 2025 will be to aim to train approximately a further 150 staff as Mental Health First Aiders across 12 courses.

Suicide Lite Courses

WMAS is the first ambulance service in the country to use National Centre for Suicide Prevention, Education and Trainings (NCSPET). The Trust initially funded 13 instructors' places, the Trust have 5 active instructors currently. The suicide lite courses have been very successful, we are trained around 500 staff Since April 2023 until March 2024, we have trained approximately 200 staff and will continue to train staff in 2024/25, we have 12 courses planned.

SALS

The SALS team has 60 advisors that provide peer support to any staff member, volunteer or students that work for WMAS. The team provide a 24/7 service for any work related or personal issues. SALS can also provide mediation service and debriefings after difficult jobs.

Menopause:

We are continuing to work with Henpicked to word towards menopause friendly employer accreditation. We have also launched our menopause policy and menopause passport to further support and encourage people to be open about their experiences and support they require in the workplace. We continue to promote menopause cafes and webinars to raise awareness and encourage a culture of this being a normal experience to talk about rather than a taboo topic. Last year we also installed the provision of free vend sanitary products across all Trust sites that are available to all people that need them in any circumstance.

Family Liaison Officers

The Trust has a number of trained Family Liaison Officers who are available alongside our Duty of Candour process, to work with bereaved families offering support and information. These Family Liaison Officers are also a Trust resource for our own staff who die suddenly to provide support for their families should it be requested.

Sanitary Products

The Trust has successfully rolled out free provision of sanitary products for all staff, across all sites. This was possible due to an initial successful funding bid to NHSE to provide free-vend units across all Trust sites. We have been able to provide an large initial stock level of products for all units and have encouraged individuals to "pay it forward" by topping up the units as and when they are able to do so.

Mental Health

The Mental Wellbeing Practitioners have seen a steady increase in patients. 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.

Financial Wellbeing

The Trust has an excellent partnership with Barclays Bank and Trussell Trust Foodbank to provide additional support to staff.

- Barclays Bank – Barclays offer staff financial health and wellbeing, including a broad range of products and services available to all UK based employees. In addition, they provide a wide range of resources to support staff in their financial life.
- The Trussell Trust Foodbank – The Trust recognises that some colleagues may need additional financial support from time to time, which is why the Trust have partnered with The Trussells Trust, a national charity who support a network of foodbanks, to make it easier for staff to access the support they need. They provide a minimum of 3 days of nutritionally balanced emergency food to people who have been referred to them in a crisis. As a partner organisation, the Trust can refer staff to their nearest foodbank and issue them with an e-vouchers for a 3-day food parcel.

Dog Visits

The Trust have had a variety of dog visits from Police dogs to Chihuahuas. Strict criteria are adhered to, this initiative always goes down well with staff, which raises morale. At present we are looking for a more formalised approach across the Trust. The Trust are also engaging with different charities and volunteers who will be happy to attend and support our HWB roadshows.

Physiotherapy

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, which are within staff vicinity. In additional, the Trust have continued to offer staff fast track physiotherapy support via TP Health, which the Trust have received positive feedback for the support offered.

Flu Vaccination

The Trust achieved a 61.63% frontline healthcare worker flu vaccination rate. The flu awards will be taking place in May to thank staff for their support and hard work to delivery this service.

Participation

The Trust is also involved with the following external groups:-

- National Ambulance Wellbeing Forum
- NHS England – cost of living workshops
- Midlands Health and Wellbeing Network Meeting
- NHS Employers Health and Wellbeing Network Conversation
- NHS Leaders Wellbeing Programme
- H&WB strategy meeting

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 Policy aims to give staff the assurance that concerns will be listened to. This is supported by a simple procedure which demonstrates 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 Guardians

The Trust employs a Lead Guardian and a Guardian who are responsible for implementation of FTSU arrangements, liaising with staff, students, volunteers and managers throughout the organisation. Pippa Wall and Lucy Butler are registered with the National Guardian's Office and are members 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 approximately 50 trained ambassadors around the region. We have at least one Ambassador per site who are known and trusted members of both the FTSU team and local teams. This helps to ensure that staff feel more comfortable discussing their concerns informally. The Ambassadors play a key role in the provision of our service across the geography that we serve. They attend regular developmental sessions and are encouraged to provide their own expertise in service developments. Digital posters showing the local A*mbassadors*' photographs and personal statements are displayed on all sites.

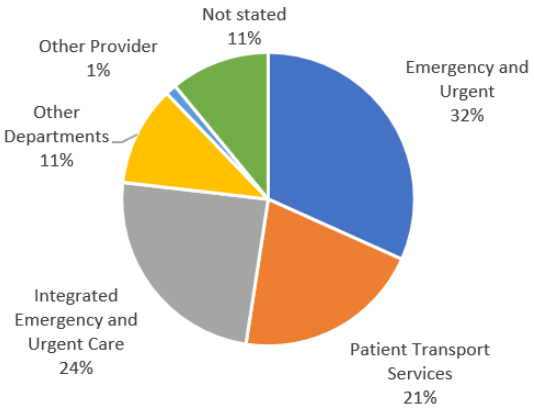
Governance

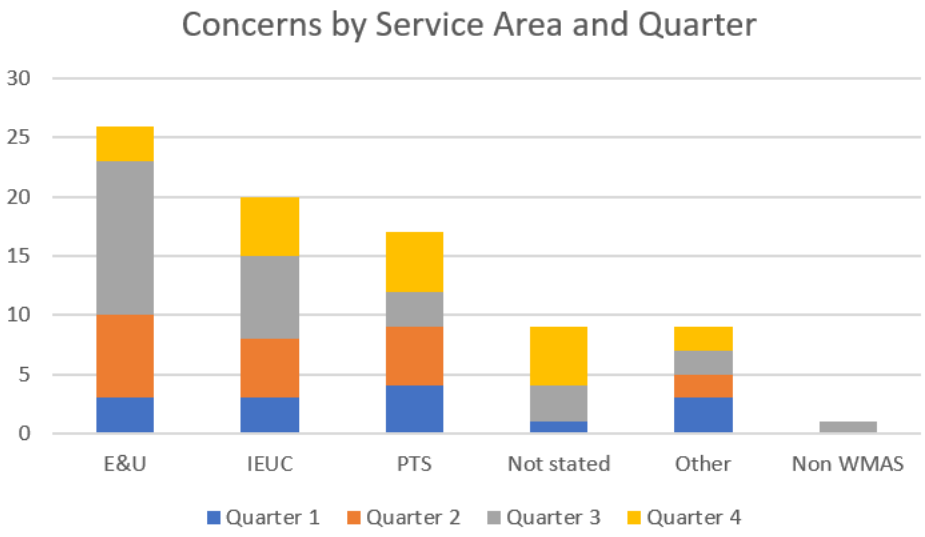
- There are number of ways in which assurance is provided for FTSU:
- Quarterly returns to National FTSU Guardian's Office
- Regular discussions with the Chief Executive Officer, Chairman and the Executive and Non Execuitve Leads for FTSU
- Quarterly reports to WMAS Learning Review Group, and bi-annual reports to the People Committee, Executive Management Board and Board of Directors
- NHS England's Reflection and Planning Tool, presented to Board of Directors in May and October 2023, and confirmed as complete by Board of Directors in January 2024.
- National Guardian's Office training modules are in place as follows:
    - All staff completed Speak Up as part of Mandatory Training during 2023/24
    - Staff on Bands 7 – 8B are required to complete Listen Up Module
    - Staff on Bands 8C and above, and Board of Directors have completed Listen Up and Follow Up modules
    - Ambassadors are required to complete Speak Up and Listen Up training modules, in addition to their induction training

Concerns Raised 2023/24

In total, during 2023/24 there were 82 concerns raised, from the following service areas:

- Emergency and Urgent 26 (32%)
- Patient Transport Services 17 (21%)
- Integrated Emergency and Urgent Care 20 (24%)
- Other Departments 9 (11%)
- Other Provider 1 (1%)
- Not stated 9 (8%)





Among these 82 concerns, the following were recorded (some concerns were recorded in multiple categories). The National Guardian's Office Annual Report for 2022/23 includes the proportion of concerns reported in the first four of these categories, which are included in the table below for comparison. Please note the difference in years to which the data relates.

	E&U	IEUC	Other	Non WMAS	PTS	Not stated	% of total 2023/24	National % 2022/23
Patient Safety / Quality	6	2	0	0	2	0	6%	19%
Staff Safety	7	7	2	0	5	1	13%	27%
Behavioural / Relationship	10	10	5	1	12	5	25%	30%
Bullying / Harassment	2	2	2	0	1	9	9%	22%
Systems / Processes	12	8	3	0	2	6	18%	Not included in the national report
Cultural	3	3	3	0	5	5	12%	
Middle Management	2	6	1	0	6	2	10%	
Senior Management	4	2	2	0	2	1	6%	
Leadership	1	0	0	0	0	1	1%	

Whilst WMAS' FTSU Concerns are increasing and overall are more in line with the national average, our concerns remain relatively low in categories such as Patient Safety, Staff Safety and Bullying / Harassment.

NHS England Review

Last year NHS England commissioned an external review into some concerns that were expressed to them. It looked at how they were managed and our response to them; the review was not about patient care or patient safety, neither was it about FTSU alone, but it included it as part of the process.

The review concluded and with a set of recommendations that the Board of Directors oversaw, with input and support from NHS England and our host Integrated Care Board, the CQC were fully sighted on this review.

The review was and remains confidential, to protect those who came forward within it, however elements of it were leaked and reported on by local press.

In response to the review itself, the national guardians report into the ambulance sector published this year and our own drive to continually improve, WMAS has been undertaking a number of actions to further improve our FTSU processes, WMAS, alongside the Ambulance sector still has some way to go. The actions we have taken include improved triangulation of information when reporting concerns, increasing the FTSU capacity within the Trust (with an additional Guardian and more ambassadors), updated training for all staff from operational managers through to the Board and more overarching awareness and briefing around FTSU into the Trust. We have also been working with our staff on breaking down perceived and real barriers to reporting concerns, alongside broader work on organisational culture and values.

In terms of progress on our actions and recommendations in relation to the review, all actions have been completed (the last action completed in October 2023). The Final action being our self-assessment against the national FTSU Planning and Reflection Tool, this is a requirement of all NHS Trust Boards to complete before January 2024. This self-assessment demonstrated improvement and progress regarding FTSU, but with areas to carry on developing and improving to.

Whilst our staff have many ways to express concerns (and do actively utilise these routes), through line managers, incident reporting, union representation, our staff and public Governors, Directors including our Non Execs, the numbers of concerns being expressed through our FTSU process have increased over four successive quarters now, this tells us staff are increasingly comfortable to speak up regarding concerns they may have, the numbers are broadly comparable to other providers of a similar scale.

We have been working with NHS England, their FTSU team and the National Guardian's office to support this improvement programme, indeed the National Guardian undertook a FTSU development session for our Board in 2023, we have welcomed their support. The National FTSU Guardian is planning to return to WMAS, so we can demonstrate the progress we have made and also benefit from feedback on the lasted best practice and potential issues for Boards to consider.

Part 3
Review of Performance against 2023-24 Priorities

Our priorities for 2023-24 were based upon the following overarching priorities:

- Mental Health
- Integrated Emergency and Urgent Care Clinical Governance
- Use of Alternative Pathways
- Developing Our Role in Public Health
- Reducing Patient Safety Incidents

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 committed to developing and implementing a work plan as part of our Quality Account:

Planned Action	Progress	Status
Establishing and embedding 24/7 mental health clinician coverage within the emergency operations centre and work with partners to increase alternative care pathway utilisation	• MH Clinicians retained from 111 • Continuing recruitment • All vacancies recruited to	
Establishing and embedding the mental health response vehicle provision in line with the NHS Long Term Plan and agreements with ICBs	• Funding confirmed and recruitment commenced, majority complete by October 2023. • Mental Health Response Vehicles live December 2023	
Developing and commencing delivery of a Clinical Education and Improvement plan relating to mental health education for ambulance staff	• Funding confirmed • All vacancies recruited to	

Integrated Emergency and Urgent Care Clinical Governance

As the Trust's delivery model changes following our exit from the NHS111 contract, it is important to demonstrate our short- and medium-term priorities, along with assurance in relation to clinical governance of call handling, partnership working and ambulance dispatch

Planned Action	Progress	Status
Significant proportion of patients requiring urgent or emergency care have mental health needs. 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 to deliver equity of care.	Clinical audits in place, including call assessor advice and Navigator decision making. Audit compliance is reported through the Senior Management Team and Clinical Audit and Research Group.	

Learning to take place because of Serious Incidents raised or notification of WMAS54's.	Good process in place through Learning Review Group. Trends and themes monitored throughout the year.	
Plan to introduce individual clinical dashboards for all Clinical Validation Team (CVT) clinicians to show competencies and mandatory training undertaken	An options appraisal to determine the best platform and solution for delivering an individual dashboard, along with a review of the information reported.	
Additional clinical training for all clinicians around recognition of sepsis (mandated for CVT)	Additional Sepsis training is currently being developed and scheduled for completion during Q3.	
Opportunity for clinical development to support CVT role in the form of minor injuries, minor illness, prescribing v300 qualification and Masters.	V300 prescribing qualification is available and supported by the Trust, with several prescribing clinicians in place and a further cohort undertaking training. Minor illness & injury will be undertaken by those completing the Master's degree course.	

Use 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, developing a community-based response to urgent patient needs.

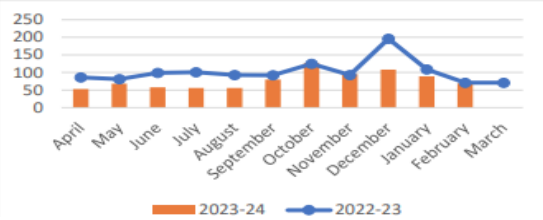
Planned Action	Progress	Status
Continued efforts to maintain and where appropriate, further reduce rate of conveyance	WMAS remains top 1 or 2 in non conveyance out of 10 ambulance trusts, with conveyances sometimes below 40% Mental Health Response Vehicles launched in December 2023 covering 5 out of 6 ICBs and have responded to over 700 patients, avoiding the need to dispatch an ambulance	
Support individual ICBs areas in the development of alternative care pathways	Joint work with WMAS includes: SWFT and partners have received a parliamentary award for treatment of older people relating to frailty pathways improvement. BSOL "call before you convey" model for urgent mental health NHS England call before you convey policy implemented in December 2023 for all ICB areas for patients >75 years age with non life threatening conditions	
CVT with UCR teams have regular touch points during the day to review the call stack	UCR teams call our CVT teams regularly to review outstanding calls. This was temporarily turned off as part of a test of change to release CVT time, however, this resulted in a significant drop in referrals into alternative pathways, so was reversed. The CVT Team has been expanded to cope with increased workload and drive forward improvements in patient care	

Our Role in 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. We have defined our priorities to improve public health our new Public Health Strategy to better support and anticipate the health needs of our population:

Planned Action	Progress	Status
we will ensure robust and effective planning is undertaken to ensure service provision and response during increased prevalence of seasonal respiratory infectious disease	Seasonal Influenza programme Winter plan updated by the EPRR team to reflect health protection planning for 23/24. Pandemic Plan updated November 2023.	
we will deliver an effective Communications Strategy that will foster health promotion across social media and other means of key messaging we will implement an Antimicrobial Resistance (AMR) programme with effective Antimicrobial Stewardship (AMS)	Public Health SharePoint page populated, to recognise the various public health related campaigns	
	National Ambulance Service IPC Group to commence an AMS workgroup, to understand the IPC aspects that supports the national pharmacy group in their implementation of 'AMS within the Ambulance Sector'.	

Patient Harm Incidents

Planned Action	Progress	Status
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.	Patient Harm incidents remained consistent throughout the year, although some periods were higher than the same periods the previous year. Whilst overall there was a slight rise incidents, this is in line with demand The main theme still remains delayed ambulance response which is directly related to handover times at hospital, which accounted for 11% of total ambulance hours 	

Service-based Annual Reports 2023-24

Whilst the above tables represent the overall progress in relation to the quality priorities that were established for 2023/24, 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
- 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 submitted and published by 30 June 2024.

The Annual Report for Equality, Diversity & Inclusion will be published by July 2024

Patient Safety

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.

The Serious Incident Framework mandated that any incident where *severe harm or above* had occurred was investigated as a Serious Incident. Over time, this has meant that NHS organisations were using additional resources to investigate the same incidents over and over again where there was minimum opportunity to learn and improve healthcare with preventative work to stop incidents reoccurring.

The PSIRF makes no distinction between patient safety incidents and Serious Incidents promoting a proportionate response highlighting that learning can be identified and actioned through other methods rather than just an investigation meaning that patient safety/quality improvement teams can focus on improvement.

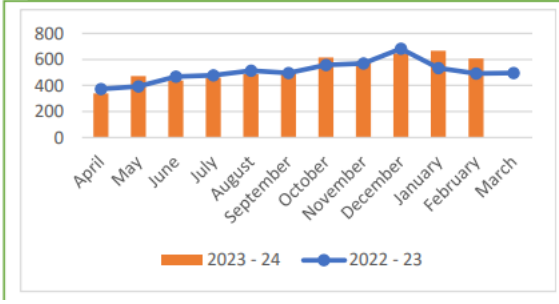
The biggest change for our staff will be no more Serious Incidents and no more Root Cause Analysis (RCA) meetings. Instead, you may be involved in an **after-action review**, which is a facilitated case review with our **Patient Safety Learning Leads**. The limitations of Root Cause Analysis means that even though the intention was that they would not be blameworthy - the idea of identifying the earliest opportunity where something could have changed the outcome for the patient, meant that onus was being put onto individuals, and moving away from RCAs is beneficial to creating the positive safety culture we are striving for.

A positive safety culture is indicated by organisational culture that places a high level of importance on safety beliefs, which are shared by those working in the organisation and staff feel safe in reporting concerns without fear of being punished this is also known as psychological safety. This can be reflected in the number of incidents reported by staff. Staff

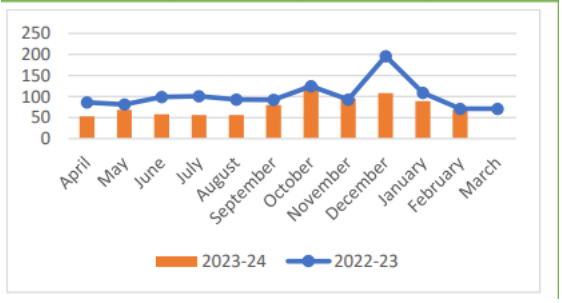
Analysis of all incidents takes place and is supported by triangulation with other information such as complaints, claims, coroners' inquiries, clinical audit findings and safeguarding cases. These are discussed monthly at the Serious Incidents Review Group (SIRG) and Learning Review Group (LRG). These meetings are chaired by the Paramedic Practice & Patient Safety Director 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

Total Patient Safety Incidents		Year to date	
	Last reported month (Feb 24)	2022-23	2023-24
WMAS	624	5559	5826



Harm Incidents		Year to date	
	Last reported month (Feb 24)	2022-23	2023-24
WMAS	69	1146	859



Themes (Patient Safety/)

Serious Incidents

The trust moved away from serious incidents from 1st April 2024 and align to the Patient Safety Incident Response Framework. The Trust will undertake Learning Responses under PSIRF and the way we review and respond to patient safety incidents will change and there will be a number of response available to the Trust.

After Action Review (AAR)

After Action Review (AAR) is a structured approach for reflecting on the work of a group or an actions at an incident and identifying strengths, challenges and areas for improvement. AARs are not investigations, are non-judgemental and do not apportion blame. In simple terms it is a structured facilitated debrief, or similar to a case review.

Multidisciplinary Team (MDT) Review

The multidisciplinary team (MDT) review supports health and social care teams to:

1. Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents)
2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.
3. To explore a safety theme, pathway, or process.
4. To gain insight into 'work as done' in a health and social care system.

Multiple people from different areas of the Trust can be involved to look at changing processes, policies etc to make work safer.

System Engineering Initiative for Patient Safety (SEIPS)

During the discussion, the Learning Lead will use a framework called the System Engineering Initiative for Patient Safety (SEIPS). SEIPS analyses the work system and assists to understand outcomes within this work system. It is a problem-solving tool that can be used to guide improvement in patient safety. More information on SEIPS can be found here.

SWARM

A Swarm is a post-incident huddle where staff involved in a patient safety incident meet with the Patient Safety Team. Staff "swarm" to the site to gather information about what happened and why is happened as quickly as possible to decide what needs to be done to reduce the risk of the same thing happening in the future.

It is a structured forum encouraging openness and honesty by reassuring participants they are in a blame free environment where everyone's input is valued.

Patient Safety Incident Investigation (PSII)

A PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Investigations explore decision or actions as they relate to the situation. The method is based on the understanding that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

PSIIs do not apportion blame. We understand that our staff come to work wanting to care for patients and patient safety incidents are unintended and the goal of a PSII is to understand why an action and/or decision occurred by those involved at the time.

When we learn about why a patient safety incident happened, we can change or improve things to try and make sure it doesn't happen again.

Work As Done

By "work as done" we mean how care is delivered in the real world, not how is envisaged in policies and procedures (work as prescribed) or recounted in a walk through or a talk through (work as described).

Exploring "work as done" allows Patient Safety Teams to identify everyday work hassles/frustrations and hazards in existing procedures or tasks.

By talking directly to the "boots on the ground" we can explore why policies are not followed, and if the design of work needs changing.

Top Patient Safety Risks

Duty of Candour

The Trust promotes a culture of openness to ensure it is open and honest when things go wrong, and a patient is harmed. 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.

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment. It ensures communication is open, honest and occurs

as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Saying sorry when things go wrong is vital for the patient, their family and carers, as well as to support learning and improve safety. Of those that have suffered harm as a result of their healthcare, fifty percent wanted an apology and explanation.

Patients, their families and carers should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm that has occurred.

Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team.
A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

Saying sorry is not an admission of legal liability; it is the right thing to do.

Safeguarding

In 2023/2024 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 always protected 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 Trust has experienced significant and sustained demand on the service, this combined with continuing delays in the ability to handover patients at hospital has led to on occasions patients waiting significant times for an ambulance response. These delays have led to concerns raised around the response to some of our more vulnerable patients from external stakeholders. WMAS continues to work at a local and national level to improve the situation and the safeguarding team reviews these cases and provides assurance to the local authority on the actions undertaken to mitigate the risk.

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%
2021/2022	38048	- 4.8%	15110	7.0%
2022/2023	41175	8.20%	15301	1.30%
2023/2024	42166	2.4%	15009	-1.9%

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, Local Child Safeguarding Practice review's, Offensive Weapon Homicide Reviews, Serious Incident Reviews, Social Care and Prevent panels and networks.

The Head of Safeguarding 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.

Despite the operational pressures on the Trust, we have delivered training to ensure all Paramedics are trained to level 3 in Safeguarding, which has refreshed and enhanced 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) 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.

Eligibility for Non-Emergency Patient Transport – patients have to go through an eligibility criteria set by the Integrated Care Board and a patient may raise a concern based on the outcome of the eligibility criteria.

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.

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 408 complaints raised so far compared to 632 2022/23. The main reason relates to timeliness (response) raised.

Breakdown of Complaints by Service Type YTD:

	2022/2023	2023/2024	Variance
CFR	0	0	0
E&U	208	151	27.4
EOC	272	145	46.7
IUC	62	0	100
Other	8	1	87.5
Press	0	0	0
PTS	82	111	35.4
WMAS	632	408	35.4

Upheld Complaints

The table below indicates that of the 408 complaints, 90 were upheld & 130 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	6	17	20	0	43
Call Management	6	14	12	1	33
Clinical	9	36	56	2	103
Driving/Sirens	0	1	1	0	2
Eligibility	3	2	19	1	25
Info Request	4	5	15	0	24
Lost/Damaged	0	1	2	0	3
Other	1	1	1	0	3
Patient Safety	3	3	6	1	13
Response	57	49	38	7	151
Safeguarding	1	1	6	0	8
WMAS	90	130	176	12	408

Patient Advice and Liaison Service (PALS) Concerns

This year has seen an increase in concerns with 2360 concerns raised in 2023/24 compared to 2047 in 2022/23. The main reason for a concern be raised is 'timeliness (response).

Learning from complaints / PALS

You said	We did
Concern not eligible for patient transport	A patient assessment form issued to PTS staff undertaking assessments of patients to ensure consistency
Concern around appropriate parking	Staff on hub remaindered and notes added to the computer aided dispatch system
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
Review of patients travelling in situ slings	A prompt added to the PTS system to ensure patients are identified when booking to travel in an insitu sling, under the current process has been 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 (PHSO). During 2023/24 –We have received 26 contacts from the Ombudsman. 12 cases the PHSO has requested information or taken to investigation, 3 have been investigated and closed as not upheld. 11 were not taken to investigation. 5 independent reviews were carried out in 2022/23.

Patient Feedback / Surveys

The Trust received 278 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	Renal Survey	FFT Survey	PTS and Small Survey
Very Good	31	14	95
Good	22	0	70
Neither Good nor Poor	9	5	5
Poor	4	6	2
Very Poor	3	6	1
Don't Know	0	2	1
Total	**69**	**33**	**176**

Discharge on Scene Survey:

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

Emergency Patient Survey:

109 responses received in 2023/24

1 maternity survey responses.

Compliments

The Trust has received 2402 compliments in 2023/24 compared to 2666 in 2022/23.

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 and the professional Standards Group.

Single Oversight Framework (SOF)

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 been rated within segmentation 2, in recognition of the pressures and support required to address ambulance handover delays and response times. The Trust is working closely with our six integrated care systems and NHS England to jointly address the factors that are affecting patient care throughout the West Midlands.

Category	Performance Standard	Achievement April 2023 to March 2024
Category 1	7 Minutes mean response time	8 minutes 15 seconds
	15 Minutes 90th centile response time	14 minutes 30 seconds
Category 2	30 minutes mean response time	36 minutes 03 seconds
	40 minutes 90th centile response time	80 minutes 48 seconds
Category 3	120 minutes 90th centile response time	428 minutes 59 seconds
Category 4	180 minutes 90th centile response time	502 minutes 20 seconds

Listening to feedback

Comments Received Relating to 2022/23 Quality Account

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 2022/23 report, along with some constructive feedback in relation to the challenges the Trust has faced and the chosen priorities. These are included below:

Comments Received	Comments / Action to be taken
On behalf of all NHS commissioners of the West Midlands region, I would like take the opportunity to thank all of our hard working WMAS employees for the commitment and passion to delivering a nationally leading and responsive 999 service. Despite the significant pressures and demands upon NHS urgent and emergency care services, WMAS continues to deliver a highly effective response to patients with the most clinically urgent needs. During 2023-23 the service has also taken fewer patients than ever to hospital, instead treating many patients in their own home or directing them to more appropriate alternative services, something that can only be good for patients and our NHS partners across the region. West Midlands commissioners continue to work progressively and in partnership with the ambulance service to secure additional investment, stabilise performance and positively transform the way the service operates to improve patient care.	Comments noted with thanks.
Members are pleased to have had the opportunity to provide scrutiny to the WMAS Quality Accounts. Highlighted priorities included progress in improving maternity care and mental health, including staff mental health. Collaborative working with the Integrated Care Board has led to a reduction in ambulance conveyances to hospital. The service recognises it has opportunities to influence public health and will continue its priority to help reduce inequalities and improve public health leading into 2023-4.	Comments noted with thanks.
Committee Members sought assurance that in the development of alternative pathways, patients were not inappropriately being refused conveyance to hospital Accident and Emergency departments where clinically indicated. They were informed that the data to support this was available and could subsequently be provided.	Information requested has been provided. Further information is available on request, should this be required in future.
The lack of progress on some of the mental health priority areas was noted, and the establishment in mid-2023 of a patient forum to support coproduction in service design and delivery was welcomed.	Comments noted with thanks.

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Committee Members sought assurance that in the development of alternative pathways, patients were not inappropriately being refused conveyance to hospital Accident and Emergency departments where clinically indicated. They were informed that the data to support this was available and could subsequently be provided.	Assurance has been provided and is available, should this be required.
The lack of progress on some of the mental health priority areas was noted, and the establishment in mid-2023 of a patient forum to support coproduction in service design and delivery was welcomed.	Mental health has been a key priority during 2023/24 and will continue to be developed throughout 2023/24.
The Staffordshire County Council's Health and Care Overview and Scrutiny Committee received an informative and useful session on the WMAS Quality Accounts. For future years we would urge the trust to provide meaningful data from a Staffordshire perspective so that we may draw in on what concerns our residents in Staffordshire. We would welcome a far more in depth view in Staffordshire, perhaps as an appendix to the main	This was discussed with the Committee at the time, and has since been discussed as part of the current year's engagement. As a complex statutory document, it has to be produced at a Trust level. It would not be possible to provide the data sets at local levels, however we have included performance figures at ICS level. Also, in engagement with specific areas, we are very happy to provide any data required at a more localised level.
The Worcestershire Health Overview and Scrutiny Committee (HOSC) welcomes receipt of the draft 2022-23 Quality Account for West Midlands Ambulance Service University NHS Foundation Trust and the engagement event provided. Members of the Committee have appreciated the support the Trust has given to the scrutiny process during the year. In particular the Trust has played a positive role in scrutiny of how health and social care organisations are working to try and improve patient flow, to help alleviate issues like ambulance hospital handover delays, which have been a huge concern to the Committee. The Members look forward to working with the Trust in the future. Through the routine work of HOSC, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire.	Comments and ongoing support noted with thanks.
Regrettably, this past year has seen the demands on NHS services reach unprecedented levels, peaking over an extremely difficult Winter period. In this respect, Healthwatch Walsall both recognises and appreciates the level of commitment by staff at the Trust in	Comments noted with thanks. Since the latest CQC inspection in 2023, our updated rating is included in the 2023/24 report.

maintaining ambulance services throughout such challenging conditions. In addition, it is pleasing to note that the WMAS University NHS Foundation Trust has in recent months undergone a CQC inspection and is currently rated as outstanding.	
Comments Received	**Comments / Action to be taken**
Historically, WMAS services in Walsall have been very good and consequently patient experience has generally been favourable. Despite this, given the prevailing pressures within the system, achieving national standards has proved extremely difficult. From an operational perspective, of the 4 categories of call, the Trust has only been able to attain the 90th centile category 1 target for people with life- threatening illnesses. It is hoped that this next operational year will yield a better performance against all the quality indicators, despite the ongoing difficulties experienced.	Comments noted. Operational performance has continued to be extremely challenging throughout 2023/24 across the country. WMAS' updated performance is included in the 2023/24 report. We continue to strive for improvements in our response times, despite extreme pressures and lengthy delays at hospitals continuing.
In reviewing the Trust's progress against the 2022 -23 priorities it appears that generally, plans are in place to facilitate ongoing objectives. Indeed, the 2022-23 priorities of Maternity, Mental Health, Integrated Emergency & Urgent Care Clinical Governance, Use of Alternative Pathways and Developing Our Role in Public Health are also the same priorities for 2023 - 2024. However, it is noted that the Trust confirms that the delivery plan for Mental Health is subject to funding from ICB's and therefore this is a concern for service users given that the **current** dashboard still has some actions to be completed in this specific area.	Comments noted with thanks. Mental Health has been a key priority for the Trust in 2023/24 and will continue to be in 2024/25. Funding was received for the planned developments, which are proving to be extremely successful, as demonstrated within this report.
When considering patient safety and safeguarding, not all the data for the year 2022-23 was available at the time of writing. However, trends indicate that the major source of harm to patients correlates directly to delayed ambulance responses and delays in handovers at hospitals. Hopefully, as pressures ease within the system, then the Trust can seek to reduce such occurrences.	Comments noted, and data updated within the 2023/24 report.
It is good that the Trust acknowledges the necessity to learn from past incidents as an open and transparent organisation and at the same time promotes a culture of high incident reporting.	Comments noted with thanks.
Regrettably, safeguarding referrals at 41175, (adults), and 15301, (children), are both increased over 2021-22 by 8.2% and 1.3% respectively. Once again, handover delays are cited as the prime contributor affecting vulnerable patients. It is noted that WMAS continues to take actions to reduce these referrals and it is encouraging to see that all Paramedics are now trained to level 3 in safeguarding.	Comments noted with thanks.
Looking at patient experience, complaints at 627 were increased over the previous year's figure of 505. This is an increase of circa 24%. Not surprisingly key themes were timelines, conduct of professionals and the loss/damage of personal belongings. The Trust has a robust policy of investigating complaints and of those raised, 205 were upheld & 153 part upheld. It is helpful to see that the complaints process is used positively by the Trust to better inform future service provision.	Comments noted with thanks.
The friends and family test is accessible to patients via the Trust's website. Of those completed surveys received regarding the patient transport service, the majority confirmed that service users thought their experience was either good or very good.	Comments noted with thanks.
In addition, the Trust received 2472 positive compliments compared to 2070 for the previous year, a 19% increase.	Comments noted with thanks.

Comments Received	Comments / Action to be taken
The Trust is compliant with the National Guidance for Ambulance Trusts on Learning from Deaths Framework. To support this guidance a full-time patient safety officer has now been recruited. Unfortunately, there has been an increase during 2022-23 in the number of deaths which were considered more likely than not attributable to the care provided to the patient. Of 812 deaths, some 256, (31.52%) were deemed to be due to problems in care. This is more than triple compared to 2021-22 where the numbers were 77 of 788 deaths, (9.89%).	The Trust thoroughly reviews every patient death as part of the framework, and reporting has changed and developed over the years. 212 of the 256 cases in 2022-23 involved a delayed response, which would have been directly influenced by handover delays at hospital.
Again, the Trust has a culture of learning from the Serious Incident process and works to identify root causes to avoid reoccurrence.	Comments received with thanks. The embedding of the Patient Safety Incident Response Framework (PSIRF) is a key priority during 2024/25, which will provide further improvements.
Under the Workforce Race Equality Standard, it is hoped that in 2023 - 24 the Trust can work to alleviate some of the negativity surrounding attitudes to staff, both internally and externally. Some employees, (responding to the NHS survey), experienced harassment, bullying and abuse. This was noticeably higher and increased for ethnic groups. Approximately a quarter of respondents reported negatively re internal incidents and around 40% for incidents from patients, relatives, and members of the public:(the number of staff respondents were: circa 2500, white & circa 170, ethnic). The latter figure concerning harassment, bullying and abuse from the public is a worrying statistic and the safety of staff must continue to be paramount in the Trust's thinking. The new NHS National Wellbeing Framework was launched in 2022 and it is positive to see that the Trust is investing heavily in its People strategy to improve the health and wellbeing of all its employees including several varied initiatives.	We continue to work hard to encourage staff to report unacceptable behaviour and attitudes at work. This can be done through a variety of channels. The Trust is developing a network of diversity champions who will work alongside our Staff Networks and Freedom To Speak Up Ambassadors. All of which are designed to support staff from all backgrounds to speak up. The safety and wellbeing of all staff and patients is paramount, and the Trust regularly reviews its policies and actions to ensure best practice is followed and that staff are fully supported.
It is evident that the Trust is seeking to ensure that patient experience is adequately reflected in its service provision planning. Patient safety and improved clinical outcomes are embedded within strategic objectives. However, it would be helpful if public engagement plans were shared in greater detail, both publicly, (using easy read communications) and with strategic partners, considering the importance of service user feedback.	The Trust continues to review and improve its plans and engagement activities with the view of improvement where possible. To better hear patient voices, we are establishing a Patient Advisory Group who will assist us to gain a better insight into perceptions of our service. We will also engage this group in our Patient Safety work. The first meeting is planned in June 2024. Once meaningful feedback is obtained, we will use this in our improvement work and share with strategic partners.

Comments Received	Comments / Action to be taken
WMAS continues to work towards achieving national targets, however delays in handover are critical to patient outcomes. The Trust's priority objective for greater utilisation and understanding of alternative pathways is extremely important in helping to ensure that hospital delays are minimised as much as possible. By working closely with other service providers at local levels, patients not in urgent need of treatment can potentially access services other than hospitals and therefore reduce pressures in this area.	The Trust continues to work relentlessly on improvements to targets and patient experience and improvements to targets based upon the best pathways available.
Finally, Healthwatch Walsall congratulates the Trust in successfully facilitating services to the recent Commonwealth Games. Many years of planning went into providing medical cover for the Games which was safely enjoyed by competitors and spectators alike.	Comments noted with thanks.
Healthwatch Worcestershire [HWW] has a statutory role as the champion for those who use publicly funded health and care services in the county. Healthwatch Worcestershire welcomes the opportunity to comment on the West Midlands Ambulance University NHS Foundation Trust Quality Account [QA] for 2022/23. This has been another challenging year for providers of NHS services and Healthwatch Worcestershire acknowledges the effort and commitment of the staff at the Trust who have been working hard to do their best for patients under difficult circumstances. WMAS is not commissioned to deliver Non-Emergency Patient Transport in Worcestershire.	Comments noted with thanks.
Of the five improvement priorities identified for 2022/23 four are being carried forward as improvement priorities for 2023/24 the exception to this is Maternity, which was an improvement priority in 2021/22 and 2022/23. Whilst good progress has been made not everything has been completed and it would be of benefit if the continued progress around maternity could be reported again in the 2023/24 Quality Accounts.	Whilst maternity was not highlighted as a Quality Account Priority in 2023/24, our development plan for maternity services has continued throughout the year and is reflected in the 2023/24 updates.
The five improvement priorities for 2023/24: Healthwatch Worcestershire recognises that the five identified improvement priorities for 2023/24 are likely to improve patient experience, safety and outcomes although four of them have been carried over from 2022/23. However, there is a lack of detail around how the Trust will achieve its objectives and little in the way of measurable targets except in the final improvement priority of reducing patient harm incidents across the Trust. Therefore progress against the other four priorities will be subjective and difficult to evaluate. **Mental Health:** we welcome the continued focus on mental health supporting many of the most vulnerable patients. We note the proviso around funding from Integrated Care Boards to enable the delivery plan to be completed. **Integrated Emergency and Urgent Care Clinical Governance**: we acknowledge that the ability to quickly and accurately assess patient needs and identify the best response is key to achieving the best patient outcome and that a renewed focus on this after exiting the NHS111 contract is reasonable. However, there is little detail about how this will be achieved and no specific targets or measures against which progress can be assessed.	The comments around the measurement of some of our priorities is acknowledged and understood. We try to include developmental priorities, which are based around implementation of actions. The updates included in the report for 2023/24 demonstrate the progress made in each of the priority areas.

Utilisation of Alternative Pathways we are aware that as part of providing an effective emergency service to those who need it, there is also a benefit in creating the appropriate links into other services for those patients who do not have immediately life and limb threatening illness and injury. We note the continuing development of the Urgent Care Response pathway, the emphasis on collaboration and the pleasing number of referrals in Worcestershire. The QA improvement priority for 2023/24 mentions the continuing work to develop the most appropriate service model within each locality to most effectively manage long term conditions at home. However there is very little detail as to how this will be achieved or progress monitored. **Developing Role in Improving Public Health** whilst recognising that WMAS has an opportunity to support and improve public health through liaison with both patients and other healthcare providers, there is very little detail as to how this priority might be achieved and how progress will be evaluated **Reducing patient harm incidents across the Trust**. This is a very straightforward improvement priority introduced this year and there is a clear link with improving patient care and patient outcomes. Reducing patient harm incidents, whilst retaining high incident reporting is key to continuous improvement which should enhance the standard of care received by the patient. The number of harm incidents for both Emergency and Non-Emergency patients will be recorded by quarter. Whilst there is no target set due to data fluidity and variance it will be a clearly measurable outcome	
Healthwatch Worcestershire's principal concern is that patients who live or work in Worcestershire receive safe and quality services from the Trust. The main feedback we receive from patients and which is also reflected in the WMAS QA is around response times. Whilst we understand that this is largely a system issue there is very little in the improvement priorities which will impact on those response times. We acknowledge that this has been another difficult year for NHS providers with system pressures continuing throughout the year We appreciate the challenges that the Trust has faced particularly from Ambulance Handover delays. Comparing with the 2021/22 QA we note that there has been a deterioration in response times in all four categories in 2022/23. This is particularly noticeable for Category 3 & Category 4. We are aware that this has occurred against a national background of deteriorating response times and ambulance handover delays. We note that WMAS has continued to exceed the national average in Category 1 response times.	Comments noted and understood. The Trust is currently working through an Improvement Plan which is based specifically on improving our response times to patients. This is documented within the 2023/24 Quality Account and will be the basis of future updates to stakeholders.
Reviewing the Ambulance Quality Indicators (AQIs) we note that there has been a deterioration against previous years for the implementation of the STEMI and Stroke Care bundles and whilst the STEMI compares favourably with the National average the Stroke does not being ~9% lower. There has been a small increase in the SEPSIS Care Bundle application year on year which compares favourably with the National Average. It would be useful to have an explanation of the significance of changes in AQIs for patients and the public.	Following Quality Improvement work completed the Stroke figures are now at over 99% and ranking 1st nationally. STEMI figures have also improved following this work and the last nationally reported figures showed being 2nd within English Ambulance Services. Sepsis no longer is a national AQI and is due to be replaced.

Comments Received	Comments / Action to be taken
In the section on Quality Priorities for 2023/24 there is a statement that: "In deciding our quality priorities for 2023/24 for improving patient experience, patient safety and clinical quality, we have reviewed outputs from discussions with stakeholders throughout the year, 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." There is no other evidence that patients and the public have been involved in the production of the Quality Account**.** We are not aware of the extent of patient engagement by WMAS in Worcestershire but would welcome any contact with the Public Governor representing the county. Healthwatch Worcestershire acknowledges that a significant level of technical detail and content is required in the QA by NHSE and this makes it difficult to present the Quality Account clearly for patients and the public. However the 2022/23 QA is long, technically complex and contains many acronyms and a significant level of jargon which is not always explained. We suggested last year that perhaps the Trust could consider asking their patient group to review the QA template to provide input on a clearer and more approachable format. It would also be of benefit to patients and the public if a summary and easy read version were available.	We serve 5.9m patients across six Integrated Care Boards (ICBs), each with multiple places and stakeholder organisations. A single acute hospital by comparison sits in one ICB and often one place area. Patient engagement on any subject matter including the quality account and its content across our geography is challenging. Our approach is to directly engage with a range of stakeholders to get patients perspective, for example our staff, Health Watch, Local Authority Health Scrutiny Committees, our Non-Executive Directors, Governors and membership. Each of these represents the views of patients across the West Midlands footprint and have a role to play in the development of our quality account. Our Council of Governors has welcomed several new appointments during the last twelve months, including two new Governors for Worcestershire. Now these Governors are in post, we would be happy for them to take a more active role in stakeholder engagement, if they are free to do so. However, we do want to do more around patient engagement and involving patients in how we shape our services As you will have read in the Quality account, we are in the process of creating a patient participation / engagement group, which will begin discussing matters this year. Going forward, we will take the quality account to that group for input and discussion. Comments about the length and complexity of the document are noted, and in many ways agreed with. The document is a statutory requirement, which includes explicit requirements for much of the content. We do provide a summary version of the document which focuses mainly on our priorities. We recognise the requirement for a review of format and content of the summary document and will ensure that these comments are taken into account when producing the Summary Document for 2023/24.
Stoke-on-Trent City Council held all out elections on 4 May 2023. Members were not appointed to the Adult Social Care, Health Integration and Wellbeing Overview & Scrutiny Committee until the Annual Council meeting on 25 May. Mindful of training needs and deadlines, the authority was not in a position to comment on Quality Accounts for 2022/23. However, we were assured that the Director of Adult Social Care would share the Quality Accounts with the new Administration and he and the Cabinet would work with us to help achieve the agreed priorities.	Comments noted with thanks.

Complaint received from a member of the public with regard to the content of the Freedom to Speak Up section of last years quality account.

A member of the public complained to WMAS regarding why an external review into FTSU was not mentioned in the FTSU section of the previous year's quality account.

NHS England commissioned an external review into some concerns that were expressed to them. It looked at how they were managed and our response to them; the review was not about patient care or patient safety, neither was it about FTSU alone, but it included it as part of the process. The review was and remains confidential, to protect those who came forward within it, however elements of it were leaked and reported on by local press.

The review concluded with a set of recommendations that the Board of Directors oversaw, with input and support from NHS England and our host Integrated Care Board, the CQC were also sighted on the review.

An update on the review was provided to the recipients of the quality account, and we are now able to confirm that all the actions within our agreed action plan have been completed and signed off by NHS England.

Alongside the review, the National Guardian's Office published their review into the ambulance sector in February 2023, which provide a broader perspective on our own drive to continually improve. Since then, WMAS has been undertaking a number of updates and improvements to our FTSU processes. The actions we have taken include improved triangulation of information when reporting concerns, increasing the FTSU capacity within the Trust (with an additional Guardian and more ambassadors), updated training for all staff from operational managers through to the Board and more overarching awareness and briefing around FTSU into the Trust. We have also been working with our staff on breaking down perceived and real barriers to reporting concerns, alongside broader work on organisational culture and values.

As with the NHS England review, our actions in relation to the National Guardian's recommendations have been completed and this has been agreed by our Board of Directors, along with our self-assessment against the national FTSU Planning and Reflection Tool, which was completed in October 2023, in advance of the nationally determined deadline of January 2024.

Whilst our staff have many ways to express concerns (and do actively utilise these routes), through line managers, incident reporting, union representation, our staff and public Governors, Directors including our Non Executives, the numbers of concerns being expressed through our FTSU process have continued to increase, we belive this indicates our staff are increasingly comfortable to speak up regarding their concerns.

We have been working with NHS England, their FTSU team and the National Guardian's office to support this improvement programme, indeed the National Guardian undertook a FTSU development session for our Board in May 2023, which will be followed up in September 2024. We continue to welcome their support.

Comments Received Relating to 2023/24 Quality Account

- Comments from our Lead Commissioner, on behalf of all Associate Commissioners
  Received 24/5/2024

  On behalf of all NHS commissioners of the West Midlands region, I would like take the opportunity to thank all of our hard working Ambulance Service staff for their collective efforts to meet patient's needs. Whilst protracted emergency department patient handover delays at some hospitals have contributed to challenges in meeting national ambulance response targets, it is important to remember that despite these significant pressures WMAS continues to deliver a highly effective response to patients with the most clinically urgent needs. Mirroring previous years, in 2023-24 the service has also taken fewer patients than ever to hospital and increased significantly its use of 'hear and treat' pathways, treating patients in their own home, or directing them to more appropriate alternative services. Within this challenging space West Midlands Integrated Care Board commissioners continue to work with WMAS to stabilise performance, reduce lost hours to handover delays and improve patient outcomes.

  Jason Evans
  Deputy Director
  West Midlands: Emergency Ambulance and NHS 111 Commissioning Team

- Comments from Health, Overview and Scrutiny Committees

Received from Shropshire Council 10/5/2024	**WMAS Responses To Points Raised**
The Shropshire Council Councillor's thanked you for sharing the draft account with them and fed back that while the report is generally comprehensive, there is no data included on the performance of WMAS in Shropshire, despite the front page of the document displaying the 6 ICBs for whom it provides services. They felt that the data for each ICB should be published in comparative tables, to allow adequate scrutiny.	Comments noted with thanks. Whilst the document is a lengthy and complex document even at Trust level, we have included a table within this year's account to reflect Performance by ICB.
The Members also fed back that despite WMAS leaving the National 111 service, the report included no data of emergency calls, apart from stating that "often" 40% of these are dealt with in ways other than dispatching an ambulance. While this may show improvement, they recommended that including this data would enable comparison with previous years and other ambulance services.	Additional content included in respect of Hear and Treat / Call before you convey
Finally, the Councillors said that it would be helpful for there to be an update on the progress of the new Shrewsbury Hub.	Updates will be provided directly as and when information becomes available
Received from Worcestershire Council 10/5/2024	**WMAS Responses To Points Raised**
The Worcestershire Health Overview and Scrutiny Committee (HOSC) welcomes receipt of the draft 2023-24 Quality Account for West Midlands Ambulance Service University (WMAS) NHS Foundation Trust and the engagement event provided. Members of the Committee have appreciated the support that WMAS has given to the scrutiny process during the year. In particular the WMAS played a positive role in a scrutiny session of how health and social care organisations are working to try and improve patient flow in acute hospitals and Emergency Departments, which involved representatives from across the system. Ambulance hospital handover delays remain a considerable concern however HOSC Members were encouraged by the collective message from the health and social care system, and the Ambulance Service, that each organisation recognised it had a part to play, and for the first time there was a joint commitment to tackle the problem.	Comments noted with thanks

The HOSC has also been interested to hear how WMAS has adapted ways of working to reflect the current pressurised healthcare system, so that more people may be redirected through the 'Hear and Treat' approach, which reduces conveyance to hospitals, where appropriate. The HOSC was also pleased to learn that numbers of Freedom to speak advocates has increased, with more staff coming forward. The Members look forward to working with the Trust in the future. Through the routine work of HOSC, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire.	
Received from Staffordshire County Council 17/5/2024	**WMAS Responses To Points Raised**
The Staffordshire County Council's Health and Care Overview and Scrutiny Committee received an informative and useful session on the WMAS Quality Accounts. We understand the difficulty in providing county specific data in the existing format of quality accounts as per our comments last year, but we feel it would be beneficial to have a rural and urban split on performance. We welcome the section within the quality accounts relating to the Regulation 12 notice and support the work being undertaken to address the concerns. We also note the trend in increased number of deaths and would welcome additional information to identify what is driving that. We welcome the work ongoing within the trust to improve staff morale in a difficult operating environment. We understand the difficulty of getting high numbers of responses to staff surveys and welcome any initiatives to drive up the current response rate.	Comments noted with thanks. Whilst the document is a lengthy and complex document even at Trust level, we have included a table within this year's account to reflect Performance by ICB. The Trust thoroughly reviews every patient death as part of the framework, and reporting has changed and developed over the years. 212 of the 256 cases in 2022-23 involved a delayed response, which would have been directly influenced by handover delays at hospital. We continue to work hard to encourage staff to respond to surveys. We provide incentives by way of time off shift to do this, and we do what we can to reassure staff that their responses are anonymous. Despite this, our response rates remain consistent.

Received from Dudley Council 10/6/2024	WMAS Responses To Points Raised
Members are pleased to have had the opportunity to provide scrutiny to the 2023-4 WMAS Quality Accounts. Significant work has been undertaken during the year on mental health provision, response vehicles and clinical education for paramedics. Clinical governance arrangements, including audits of call assessor advice and reviews of serious incidents, have been delivered as planned. The focus on developing and improving alternative care pathways to avoid conveyance to hospital where it is not essential for patient care has been successful and this will continue to be a priority. A further priority has been supporting the public health agenda, for example through a seasonal influenza programme and antimicrobial resistance. The Patient Safety Incident Response Framework (PSIRF) has been introduced to manage patient safety and reduce incidents of harm. This will be a priority for the coming year, along with patient experience and mental health. Ambulance handover delays at hospital have been one of the biggest challenges for the service, and have been highlighted in a Care Quality Commission (CQC) review and a Regulation 12 notice. Members expressed concern that the CQC's rating of the service had been downgraded from "outstanding" to "good", but it was unlikely that any service would meet the challenging standards required to be outstanding given pressures on all hospitals over recent months. The service aspires to achieve an outstanding rating again as soon as possible and has plans in place that aim to achieve this. The number of complaints was also highlighted, but many of these concern response times and the rate of complaints is low in comparison to the number of calls received. The Committee looks forward to working constructively with WMAS in the future.	Comments noted with thanks.

- Comments from Health Watch Groups

Received from Healthwatch Walsall 8/5/2024	WMAS Responses To Points Raised
Healthwatch Walsall welcomes the opportunity to respond to WMAS Quality Account for 2023/ 2024. It is noted that the document is still a work in progress as at its date of sharing. The Trust's latest CQC rating of **good,** published 23rd February 2024, demonstrates that the organisation continues with a high level of performance at an operational level. WMAS staff should be congratulated in maintaining this standard, despite industrial difficulties during 2023/2024. Consequently, patient and service user experience remain a high priority and focus of the Trust, firmly embedded in practice when determining service provision. This is noted in that **collaboration and engagement** form one of the Trust's annual key objectives and for 2024/2025 the organisation will be implementing a **Patient Advisory Committee** to support the arrangements already in place to gather public feedback.	Comments noted, with thanks.
The purpose of this Committee is that patients, carers and Foundation Trust members will share experiences with the intention of learning from and improving services. However, it is noted that these quarterly meetings are currently scheduled to be online with only **one** held annually face to face. To better maximise service user feedback, the Trust may consider holding **all meetings on a face to face basis** via locally advertised public events.	We note your suggestion to hold all meetings face to face and will consider the best approach to this. The difficulty with holding all meetings face to face with such a vast geographical footprint, it will create barriers for some to attend.
Indeed, given the difficulty in facilitating meaningful engagement with patients, consideration could also be given to independent focus group work undertaken by local and regional Healthwatch to better inform WMAS service delivery and staff training. In assessing WMAS performance against key operational targets in respect of response times, it is encouraging to see that the Trust has consistently achieved faster than the	Thank you for the comment with regard to independent focus group work, we will consider the best approach to this.

National average for categories 1 & 2, (life threatening & emergency). Equally it is pleasing to note that WMAS recognises and understands the barriers to achieving better than the National average for categories 3 & 4, (urgent & non-urgent) need to be addressed with partner organisations. It is paramount that the Trust works closely with other stakeholders to maximise options to increase alternative care pathways, therefore alleviating pressures and delays at some major Hospitals. One area of concern is the increase in mental health patients requiring urgent or emergency care. Given that mental health remains one of the local priorities for the Walsall Borough, Healthwatch Walsall will be interested to see how WMAS utilises investment received via the ICB in 2023/2024 in the new year. A positive step towards this is the placement of mental health nurses within the emergency response centre. In addition, the plan to provide mental health response vehicles, **where** commissioned by the ICB. Could this be affected by funding restrictions? Finally, looking at patient harm statistics; they were still being updated at the time of response. If the annualised data reflects quarter 3 for 2023/2024, then serious incidents have decreased. In quarter 3 there were 91 serious incidents concerning patient harm, compared to 109 in the previous year. This is a reduction of 17%. Nevertheless, the Trust needs to continually review its operations to significantly reduce harm to patients when in process. In closing, Healthwatch Walsall wishes to recognise the ongoing dedication and hard work undertaken by all of the staff within the WMAS.'	We continue to work tirelessly with stakeholders across the region to maximise the use of alternative pathways. The latest initiative "Call Before You Convey" is having a significant impact on Conveyance rates. The investment from ICBs as part of the NHS Long Term Plan is particularly welcomed in supporting improvements in how we respond to mental health patients presenting to the ambulance service. As Healthwatch rightly point out, the Mental Health Nurses within EOC are a key part of this, and we have already seen significant benefit in ensuring patients are signposted so that their needs are best met by other services. The provision of Mental Health Response Vehicles, is determined by funding allocation and restrictions. Comments about the need to review operations to reduce harm to patients are noted. This is a priority to us and we work hard across all Directorates and Service areas to ensure that we learn from incidents and incorporate risk assessment, patient complaints and other related to data to inform our future planning.

Received from Healthwatch Dudley 10/5/2024	WMAS Responses To Points Raised
As the independent champion for people who use health and social care services in the Dudley borough, Healthwatch Dudley welcomes West Midlands Ambulance Service's strategy which focuses on the safety and experience of patients. We are pleased to note that WMAS have assessed progress against the priorities for 2023/24 and reviewed outputs from discussions with stakeholders throughout the year through a variety of methods. We welcome the continued focus on mental health service delivery and the steps being taken to determine the success of a variety of actions, including pre/post learning staff feedback. Healthwatch Dudley are very interested to note plans to set up a Patient Advisory Committee to enable patients, carers and Foundation Trust members to share experiences to allow the Trust to learn and influence change and to read about the ways in which the success of this priority area of work will be monitored. These initiatives underscore a strong commitment to listening to patients and enhancing services. The decrease in PALS/complaints, from 630 to 415, demonstrates responsiveness to feedback and commitment to improvement. It is concerning that hospital handover delays remain a significant and increasing problem. It is therefore reassuring that a Performance Improvement Plan has been created which includes a review of all Paramedic secondments and schemes, as well as working with stakeholders and conducting an independent capacity review. We are pleased to read the 2023 National NHS Staff Survey results which show a significant improvement in the positive responses compared to the 2022 results. However, it is concerning to note that WMAS scored significantly worse when compared to other Ambulance Trusts. It is encouraging to learn, therefore, that Priority 1 is ensuring that staff are listened to and note the various initiatives being put in place to address this.	Comments noted with thanks

It is pleasing to note the planned actions for the use of Alternative Pathways, linking in with other services to provide the right response, to the right patients at the right time. We are reassured to note that WMAS acknowledges the opportunity to support and improve public health, especially because of the wider impacts of COVID-19 and to note the defined priorities of the new Public Health Strategy. As supporters of community health, we're keen to understand the lasting impact of WMAS's hard work. Given our commitment to valuing patient perspectives, we're naturally interested in their progress. We're enthusiastic about any future opportunities to collaborate and work together to enhance healthcare in Dudley	
Received from Healthwatch Worcestershire, 21/05/2024	**WMAS Responses To Points Raised**
Healthwatch Worcestershire's response to the Quality Account (draft sent 18/04/2024) of the West Midlands Ambulance University NHS Foundation Trust (WMAS) for the year 2023/24. Approved at HWW closed board meeting 20th May 2024. Healthwatch Worcestershire [HWW] has a statutory role as the champion for those who use publicly funded health and care services in the county. Healthwatch Worcestershire welcomes the opportunity to comment on the West Midlands Ambulance University NHS Foundation Trust Quality Account [QA] for 2023/24. This has been another challenging year for providers of NHS services and Healthwatch Worcestershire acknowledges the effort and commitment of the staff at the Trust who have been working hard to do their best for patients under difficult circumstances. We note that WMAS is not commissioned to deliver Non-Emergency Patient Transport in Worcestershire. We have used national Healthwatch England guidance to form our response below. We would make the following comments: 1. **Do the priorities of the provider reflect the priorities of the local population?** **Progress against 2022/23 Improvement Priorities:** • Mental Health:	

We welcome the appointment of Head of Clinical Practice for Mental Health and the 24/7 clinician coverage and especially the mental health response vehicles where these have been commissioned by the ICB. It is not stated whether Herefordshire & Worcestershire ICB has commissioned mental health response vehicles. We also support the aim of WMAS ensuring equity in the delivery of mental health care at the point of need and the use of mental health nurses within the emergency operations centre and its impact on this vulnerable group of patients. • Integrated Emergency and Urgent Care Clinical Governance: Of note is the transition during 2024, to the Patient Safety Incident Response Framework (PSIRF) and the focus on support of patient safety. • Utilisation of Alternative Pathways We recognise the establishment of rapid handover escalation process at Worcestershire Emergency departments, Hospital Ambulance Liaison Officers (HALO), Call Before You Convey for patients over the age of 75 with non-life threatening conditions and mental health response vehicles, Same Day Emergency Care (SDEC) and the use of single point of access (SPS). These alternative pathways aim to reduce the pressure on Worcestershire Hospitals. • Developing Role in Improving Public Health Whilst the actions around public health messaging are welcome. We would ask whether there is an assessment of the effectiveness of the messaging and how this will be carried out? • Reducing patient harm incidents across the Trust There is a recognition that hospital handover delays remain a significant and increasing problem. The CQC has served WMAS with a Regulation 12 notice in relation to operational performance standards – a Performance Improvement Plan has now been created. Also, as the operational performance of WMAS has fallen behind the performance standards across the West Midlands, it would be useful to see this broken down by county to enable a view on the operational performance of WMAS in Worcestershire.	Yes, funding has been provided for Mental Health Response Vehicles in Hereford and Worcestershire The effectiveness of our plans and communications in respect of public health will be monitored and reported during the year. Performance by Integrated Care Board has now been included within the document.

We note the CQC report published on 23rd February 2024 has upgraded the rating of the WMAS Emergency Operations Centres from Good to outstanding and the rating for Emergency and Urgent Care from Good to outstanding with the overall rating for the Trust is Outstanding for Caring. **Improvement Priorities for 2023/24:** **Mental Health** We welcome the continued inclusion of mental health in the improvement priorities as this is an area which is of concern with patients and has been raised with us. We note the actions but are concerned that whilst these are commendable actually evaluating progress will be difficult as there are few objective measurable outcomes. **Patient Experience** The plan to set up a Patient Advisory Committee to include patients, carers as well as Foundation Trust members is clearly welcomed. It's not clear how this committee will draw on individuals to gain representation from counties like Worcestershire and how this will inform the Trust policies and procedures. **Patient Safety Incident Response Framework (PSIRF)** This has been set up as a statutory requirement in 2024 and is transitioned from the previous Serious Incident Framework (SIF). The plans include the use of surveys and focus groups for patient safety incidents; audit to help reduce complaints and concerns and comparisons of patient response types compared to SIF. We look forward to seeing how this will be implemented and would welcome a breakdown to see the impact in Worcestershire. **Ambulance Handover Delays:** The main feedback we receive from patients and carers which is also reflected in the WMAS QA is around response times. We welcome the inclusion of Ambulance Handover Delays as an improvement priority. However, WMAS CQC report, published on 23 February 2024, served a Regulation 12 notice in relation to operational performance standards. In order to maximise operational resourcing to respond to patients in the community a Performance Improvement Plan has been created. The WMAS Quality Report notes that	The action plan is based upon key developments to establish the infrastructure and support for staff in order to deliver the best service for patients. The priorities will be monitored in a measurable way as the year progresses. Arrangements for the new group are currently being established. Stakeholders will be included and informed as the group starts to take shape. The work of the group will be linked to our existing governance arrangements to ensure the Trust's policies and procedures are fully linked.

	the success of these plans will be determined by a system wide approach in order to achieve a reduction in over 15 minute hospital handovers across the Region.	
1.	Are there any important issues missed? Healthwatch Worcestershire's principal concern is that patients who live or work in Worcestershire receive safe and quality services from the Trust. There has been a change in the delivery of the NHS 111 service. We note that WMAS has handed back the 111 contract it provides for the West Midlands to commissioners. Although this change was announced back in 2022 it went live on 9th April 2023. NHS 111 mobilisation is managed by DHU Healthcare and covers East and West Midlands. There is no reference to the success of the transfer and it is unclear at this time what impact this has had on users of the NHS 111 service in Worcestershire.	The Transfer of the 111 service was covered in the Quality Account 2022/23 and was the reason for the priority in relation to IEUC Clinical Governance during 2023/24. This was set to ensure the optimum prioritisation and flow of calls, post 111 contract exit. The service, now run by DHU is running well and there is regular engagement with our commissioners where any operational issues are raised.
	There has been a reduction in some CQC ratings that have not been commented on. In the CGQ report on 22nd August 2019 the Trust had achieved an overall rating of Outstanding as a result of five domains achieving Outstanding. In the CQC report published 23rd February 2024 the Trust achieved an overall rating of Good with one domain rated as Outstanding. In one domain 'Is the Service Effective' the rating was downgraded to requires improvement. This was commented on in the WMAS website but not in the Quality Account 2023/24 or the Summary Document.	The CQC ratings have been updated within the report to provide further service level detail.
	Healthwatch Worcestershire are aware that there has been discussion between the ICBs and WMAS on the improvement plan to address the CQC ratings. This is also missing from the WMAS Quality Report. We look forward to seeing a report on the impact of this improvement plan in the 2024/25 Quality Report.	A note has been included to reference ongoing discussions with the ICBs in relation to the improvement plan, handover delays and workforce.
	Comparing with the 2022/23 QA we are pleased to note that that there has been an improvement in response times in all four categories in 2023/24. However, the 428m 59s achieved against the 120m 90th centile standard for Category 3 and the 502m 20s achievement against the 180m 90th centile standard for Category 4 is quite stark though	

reflected to some extent in the national figures. We are concerned about the implications for the rural population of Worcestershire. We note that WMAS has continued to exceed the national average in Category 1 response times. Reviewing the Ambulance Quality Indicators (AQIs) we are pleased to note that there has been an improvement against previous years for the implementation of the STEMI (95.97% from 77.45%) and Stroke Care (99.44% from 87.15%) bundles. The Cardiac arrest numbers are slightly lower than last year and have a wide variation so unable to determine the clinical performances in Worcestershire. There is no commentary on achievements for the Sepsis bundle. 1. **Has the provider demonstrated that they have involved patients and the public in the production of the Quality Account?**	
There is no other evidence that patients and the public have been involved in the production of the Quality Account beyond the normal feedback gained from compliments and complaints received by WMAS. In particular, we are not aware of the extent of patient engagement by WMAS in Worcestershire but would welcome any contact with the Public Governor representing the county. Maybe the Patient Advisory Committee will have a role in next year's Quality Accounts – further detail on this would be welcomed? 1. Is the Quality Account clearly presented for patients and the public?	The engagement process that is utilised for the production of the Quality Account relates to various activities throughout the year. Some directly involve patients, others stakeholders who represent patients. Our priorities are compiled by Senior Leads who reflect on Complaints, Compliments and incident reporting in their areas, among other activities and engagements. The Patient Advisory Committee will be a key input in future years.
The Summary Document that has been provided is a useful overview in an accessible format. It is hoped that that versions will be made available for those who need other presentations. As WMAS covers a number of counties across the West Midlands a breakdown to county level would be useful. The patients, carers and service users across Worcestershire would benefit from being able to compare WMAS performance across the different geographies that make up the West Midlands.	Further county level breakdowns and summary level information will be organised for future years' reports.

- Statement from the Council of Governors

On behalf of the Council of Governors, we welcome this detailed Quality Account for 2023/24. I would like to begin this statement by acknowledging the amazing efforts that have been made by all staff throughout West Midlands Ambulance Service. Year on year we see the pressures on the NHS grow but the staff, volunteers and students at the Trust have shown great resilience and continue to deliver excellent patient focused care, which is central to all that the Trust does.

This year, a CQC inspection was caried out at the Trust and although the overall rating dropped from Outstanding to Good, which is disappointing, we were delighted to see that the inspectors continue to believe that the patient care remains outstanding, as well as the Emergency Operations Centres. The biggest change the inspectors noted was effectiveness, which dropped from outstanding to requires improvement. The Council of Governors is assured that the Trust continues to work tirelessly with partner organisations and Integrated Care Systems to do everything it can to improve the hospital handover delays, that have a huge impact on the Trust's ability to reach patients waiting in the community. During 2023/24 Trust lost a staggering 254,090 hours due to these handover delays.

We are pleased to see the progress made on last year's priorities and the Council of Governors welcome the new priorities that have been set for the coming year including mental health, ambulance handover delays and patient experience amongst others. It has also been great to see the Trust continuing to expand pre-hospital research opportunities during 23/24 and collaboration with local universities.

The Trust has continued to host all its Council of Governors meetings and has ensured that the Council has been equipped with the skills and knowledge that we need to undertake our roles. Governors have continued to receive in-depth briefings from the Chief Executive Officer and Chairman, as well as presentations from other members of staff within the organisation. In turn, we Governors have been able to ask our own questions, all of which are always answered.

This year the Trust welcomed Non-Executive Director, Alex Hopkins, who took up her role on 1st April 2023. The Service also said farewell to Wendy Farrington-Chad at the end of January as she retired from her role of Non-Executive Director/ Deputy Chair. This saw the governors undertake a second recruitment exercise for Wendy's successor and following a competitive interview process Suzanne Banks was offered the position of NED, with Suzanne commencing in post from 1st April 2024. Alex Hopkins was appointed as Deputy Chair/ Senior Independent Director from 1st February 2024 following approval from the Trust Board and Council of Governors.

It would be impossible within this short statement to highlight all of the excellent work that has been carried out and fulfilled to such a high standard throughout the organisation. Once again, I on behalf of the Council of Governors would like to thank all the staff within WMAS. You have accomplished so many achievements under such immense pressures.

Eileen Cox, Lead Governor and Public Governor – Staffordshire. 22/5/2024

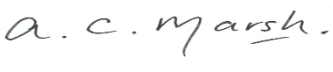
Appendix 1 - Statement of Directors' Responsibilities

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, as per guidance for the 2023/24 report
- 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 2023 to March 2024
  - papers relating to quality reported to the Board over the period April 2023 to March 2024
  - feedback from commissioners dated 24/5/2024
  - feedback from governors dated 22/5/2024
  - feedback from local Healthwatch organisations dated May 2024
  - feedback from Overview and Scrutiny Committee dated from May 2024
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29/5/2024.
  - the [latest] national staff survey published March 2024
  - the Head of Internal Audit's annual opinion contained within the Annual Governance Statement. This was discussed and agreed at the Trust's Audit Committee on 17/6/2024, attended by External Auditors.
  - CQC inspection reports dated 22/08/2019; 15/03/2023 and 24/2/2024
  - 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:

Professor Anthony Marsh
Chief Executive
Date:

Appendix 2: The External Audit Limited Assurance Report

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.

The Quality Account is presented to and approved by Quality Governance Committee each year, and progress updates are reported to this committee as each year progresses.

WMAS' Audit Committee is an established sub-committee of the Board of Directors, which is attended by the Trust's external auditors. The Head of Internal Audit Opinion was presented at the meeting on 17th June 2024. This meets the requirements of the Quality Account and is referenced in the Statement of Directors Responsibilities.

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.**