Board of Directors Meeting

Wednesday, 28th September 2022
9.45 am – 12.30 pm

To be held in the Oak Room, Ladybridge Hall, Bolton

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2223/64	Patient Story	09:45	Information	Deputy Chief Executive / Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2223/65	Apologies for Absence	10.00	Information	Chairman
BOD/2223/66	Declarations of Interest	10.00	Decision	Chairman
BOD/2223/67	Minutes of Previous Meeting held on 27th July 2022	10:00	Decision	Chairman
BOD/2223/68	Board Action Log	10:05	Assurance	Chairman
BOD/2223/69	Committee Attendance	10:10	Information	Chairman
BOD/2223/70	Register of Interest	10:10	Assurance	Chairman
STRATEGY				
BOD/2223/71	Chairman & Non-Executive Directors Update	10:15	Information	Chairman
BOD/2223/72	Chief Executive's Report	10:20	Assurance	Chief Executive
QUALITY AND PERFORMANCE				
BOD/2223/73	Integrated Performance Report	10:40	Assurance	Director of Quality, Innovation, and Improvement
BOD/2223/74	Learning from Deaths Q1 2022/23 Report	11:10	Assurance	Medical Director
BOD/2223/75	IPC Annual Report 2021/22	11:20	Assurance	Director of Quality, Innovation, and Improvement
BOD/2223/76	NWAS Winter Plan	11:30	Assurance	Director of Operations
BOD/2223/77	Quality and Performance Committee Chairs Assurance Report - from the meeting held on 25th July 2022	11:40	Assurance	Mrs A Chambers, Non-Executive Director
BOD/2223/78	Resources Committee Chairs Assurance Report - from the meeting held on 23rd September 2022	11:50	Assurance	Mr D Hanley, Non-Executive Director
WORKFORCE				
BOD/2223/79	2022/23 Flu Campaign	12:00	Assurance	Director of People
BOD/2223/80	EDI Statutory and Regulatory Reporting	12:10	Assurance	Director of People

CLOSING				
BOD/2223/81	Any Other Business Notified Prior to the Meeting	12:20	Decision	Chairman
BOD/2223/82	Items for Inclusion on the BAF	12.30	Decision	Chairman
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 30th November 2022 in the Oak Room, Ladybridge Hall, HQ, Bolton				

Exclusion of Press and Public:
In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Minutes
Board of Directors

Details:	9.45am Wednesday, 27th July 2022 Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chairman (Chair)
Mr G Blezard	Interim Deputy CEO/Director of Operations
Mrs C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director
Mr S Desai	Deputy CEO / Director of Strategy, Partnerships and Transformation
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director (Clinical)
Mr D Rawsthorn	Non-Executive Director
Mrs L Ward	Director of People
Ms A Wetton	Director of Corporate Affairs

In attendance:

Ms M Brooks	Deputy Director of Finance
Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2223/45 **Staff Story**

The Director of Strategy, Partnerships and Transformation introduced the staff story which involved Mr Leigh Cartwright, Advanced Paramedic, and his experience of using Language Line to communicate with a pregnant lady of Ethiopian heritage.

He reported that the story had arisen as a result of the Trust's serious incident process.

The film outlined the steps taken by the advanced paramedic to access Language Line, which was found to be accessible via a downloadable App on the Trust's iPads.

He advised that Language Line were able to translate letters to the patient and also provided an interpreter to facilitate face-to-face dialogue during a visit to the patient's home.

He explained that the interpreter had immediately put the patient at ease and removed any misunderstandings and anxiety. He added that accessing the service had resulted in a positive conclusion for the patient and enabled a fluent and genuine face to face conversation which removed any language barriers.

The Chair welcomed the staff story which provided an excellent example of equality and accessibility. He added that the observations provided an excellent case study for future practice.

The Director of People confirmed that Language Line and was available for front line staff and noted the story demonstrated the positive ethical impacts for patients.

The Medical Director confirmed that the iPads were an enabler, and that Language Line was available on all iPads. He added that an analysis of usage across the Trust would provide an opportunity to explore future developments within the organisation.

The Chair stated the story was an excellent example of improvement and supported patient safety. He noted that the benefits went beyond the ROSE process and incorporated the Trust's Freedom to Speak Up and Just Culture initiatives. He praised the practice of the Advanced Paramedic and the awareness of equality of the staff. He added that the benefits of the digital solution provided an excellent example of the Trust's strategic priorities being delivered in practical terms.

The Chair queried if Language Line provided an option to select the gender of the interpreter. The Medical Director confirmed this was an option as part of the Language Line request process.

The Board:

- Welcomed and acknowledged the content of the Staff Story.

BOD/2223/46 Apologies for Absence

Apologies for absence were received from Prof A Esmail, Non-Executive Director, Mr D Mochrie, Chief Executive and Mrs C Wood, Director of Finance.

BOD/2223/47 Declarations of Interest

There were no declarations of interest to note.

BOD/2223/48 Minutes of the Previous Meeting

The Minutes of the previous meeting held on 25th May 2022 were agreed as a true record.

The Board –

- Approved the minutes of the previous meeting held on 25th May 2022.

BOD/2223/49 Board Action Log

The Board noted the updates to the Board action log.

BOD/2223/50 Committee Attendance

The Board noted the Board and Committee Attendance Record.

BOD/2223/51 Register of Interest

The Board noted the 2022/23 Register of Interest presented for information.

BOD/2223/52 Chairman & Non-Executives' Update

The Chair reported that he had met with Sir Richard Lees, Mr M Fisher and leads of the Greater Manchester ICS.

He noted that the ICS had gone live on 1st July 2022 and NWAS continued to engage and influence stakeholders. He added that a meeting had been held with Andy Burnham, Mayor of Greater Manchester which had involved a presentation on knife crime and an insight into the work of the Trust.

He reported that he had attended a new National Wellbeing Guardian meeting which included Guardians from across the ambulance sector and noted that Dr Alison Chambers, Non-Executive Director, would deputise for him as Chair within Greater Manchester.

He stated that the NWAS Superstar Awards had been an excellent event and it had been very good to see staff enjoying the occasion.

He welcomed the recently appointed Head of Charity, Mr Ian Savage, and stated there were some significant opportunities and working initiatives to support the role, including input from the Patient and Public Panel.

He highlighted that he had met with the outgoing Public Health Registrar, and they had discussed future priorities for the Trust within the ICS framework.

He advised that he had met with Chairs of Blackpool and Bolton hospitals, who had undertaken to include a staff story from an NWAS paramedic on their Boards, to understand the challenges faced by the service in their areas.

He noted that he had also offered visits to the Trust's EOCs in their areas to understand the contact centre pressures. He added that it had been a positive meeting which had promoted the NWAS vision at Board level.

The Chair congratulated Mr Salman Desai on his recent appointment as Deputy Chief Executive Officer.

The Board:

- Noted the update from the Chairman.

BOD/2223/53 **Chief Executive's Report**

The Deputy Chief Executive Officer presented the Chief Executive's Report.

He reported that performance had been challenging during the reporting period and advised the Trust had been at REAP Level 4, with demand impacted by the heatwave and Jubilee bank holiday weekend activity.

He stated that the Trust continued to deliver its commitment to the implementation of NHS Pathways within the planned timescales and most of the training had been completed, with some impact on call pick up performance. However, the Trust had seen some stabilisation in performance of C1 and C2 calls.

He advised that the Trust had seen sickness levels increase and there had been focus on change to operational rostering and the delivery model.

He confirmed that final funding for 2022/23 had been confirmed and reported to the Trust's Resources Committee.

He noted that the Trust's pilot of SMS messaging for self-care went live in March 2022 and NWAS had seen a reduction in call handling time. He added that plans were in place to include PTS in the initiative.

He thanked staff for their presentations on knife crime and virtual reality at the recent meeting with Andy Burnham and praised the recent Superstar Awards hosted by the Trust.

He advised that the CQC reports had been published following the recent Urgency and Emergency Care system inspection and that NWAS had received good comments with six should do recommendations.

The Deputy Chief Executive Officer referred to hospital handovers and stated these remained a significant challenge for the organisation. He advised that

the Secretary of State had convened a meeting of ambulance CEOs to manage the risks to avoid these sitting exclusively with the ambulance service.

He highlighted that staff had been issued with Platinum Jubilee coins and noted the Trust had more than 1,000 volunteers who had participated in Pride month, with a range of events, including a raised flag at Headquarters.

He gave his praise to the Trust's financial teams who had worked hard to produce the Annual Accounts for 2021/22.

He recognised an Armed Forces event, hosted by the City Mayor of Manchester, which he had attended on behalf of NWAS and a recent celebration to recognise International Paramedics Day, launched at the Royal College of Paramedics. He reported that Mr Mike Jackson, the Trust's Chief Consultant Paramedic had spoken about his experience of providing care to patients.

In terms of the Integrated Care System, he noted that implementation of the White Paper and establishment of the ICS continued to move at pace and there was work underway to gain assurance that NWAS was working well within the system.

He noted the sad loss of Kath Adams, who passed away on the 8th of July 2022. He added that Kath had been a valued member of the staff team for 25 years and would be sadly missed. He passed on the Trust's condolences to her family, colleagues, and friends.

The Director of Quality, Innovation and Improvement confirmed that the CQC report was published on 22nd July and was now available online.

Mr D Rawsthorn recognised that three CQC recommendations stated the Trust should continue with work currently underway. The Director of Quality, Innovation and Improvement noted that this was an acknowledgement that the Trust were doing the right thing and to continue with the good practice.

Mr C Butterworth referred to learning from work across the sector in relation to the challenges of hospital handovers. The Director of Quality, Innovation and Improvement advised that a national response to the Department of Health via AACE had been provided and an NWAS specific piece of work expedited.

The Deputy Chief Executive Officer reported that the NHSE had issued a letter to all acute providers and system leads to do more and that AACE were co-ordinating the work of the ambulance sector, including lobbying. He added that whilst handover wasn't specifically an emergency department issue it cut across the pathway of emergency care and was a significant risk to the ambulance service.

It was also noted that a Hospital Handover Healthcare Safety Investigation Branch had been established and they had issued a letter to the NHSE on the system factors and a request for change. The Director of Quality, Innovation and Improvement confirmed that she continued to attend meetings to input into

national, regional, and local work with the integrated care boards, to push and prioritise the work required.

The Chair noted that although the northwest was in an improved position, it was important that NWAS did not become complacent and that relationships between emergency departments and Trusts were key to improvements.

He referred to the CQC findings and praised the Trust. He stated NWAS should be very pleased with the result and gave this thanks to all involved.

On behalf of the Board, the Chair thanked the corporate teams for their hard work in relation to annual finance and audit reports.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2223/54 **Q1 Board Assurance Framework Review**

The Director of Corporate Affairs presented the Q1 Board Assurance Framework Review.

She reported that Trust's Executive Leadership Committee (ELC) recommended the following Q1 changes:

- Decrease in risk score of SR02 from 20 to 16
- Decrease in risk score of SR03 from 20 to 15
- Decrease in 2022/23 target risk score of SR09 from 15 to 10
- Decrease in the final target risk score of SR09 from 10 to 5

The Director of Corporate Affairs advised that the ELC had held a lengthy debate in respect of the BAF scores.

The Chair thanked the Executive Directors and their teams for the work undertaken, which had made an impact on risk scores.

The Board:

- Agreed the decrease in risk score of SR02 from 20 to 16
- Agreed the decrease in risk score of SR03 from 20 to 15
- Agreed the decrease in 2022/23 target risk score of SR09 from 15 to 10
- Agreed the decrease in the final target risk score of SR09 from 10 to 5
- Agreed the Q1 position of the Board Assurance Framework

BOD/2223/55 **Audit Committee Chairs Assurance Report from the meeting held on 21st July 2022**

Mr D Rawsthorn presented the Audit Committee Chairs Assurance Report from the meeting held on 21st July 2022.

He noted the areas of moderate assurance and confirmed that the Committee would monitor progress and timescales.

The Chair referred to the risks associated to the MIAA follow up recommendations.

The Director of Quality, Innovation and Improvement advised that failover work scheduled in June had highlighted further action required and the detail had been discussed robustly at the recent Information Governance Sub Committee. She added that the delay did not create any additional material risk.

The Board:

- Noted the assurances provided in the Audit Committee Chairs Assurance Report.

BOD/2223/56 **Integrated Performance Report**

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report.

She advised that the report included an additional page on interpretation of the charts, the trends, and areas of Special Cause Variation.

The Director of Corporate Affairs reported that complaints had slightly increased, with improvement in the closure of complaints and decrease in accumulation level. She added that the team had focused on systems and processes to reduce duplication and there was some improvement in progressing complaints that required operational input.

The Chair welcomed improvement in terms of performance in relation to complaints.

The Deputy Chief Executive Officer and Director of Strategy, Partnerships and Transformation provided an update on Effectiveness. He reported that there had been some decrease in the number of 111 returns and this was being addressed. He advised that satisfaction levels had improved overall, however PES satisfaction levels in some areas had decreased and were related to extended call volumes and longer response times.

The Chair noted that the level of satisfaction was testament to the staff, particularly in the 111 service, with 90% satisfaction. He praised all staff for their efforts.

The Medical Director advised that the Trust's Ambulance Quality Indicators Data supported the Trust's priority of C1 and cardiac arrest patients. In terms of special cause variation, he noted that the stroke care bundle had dropped below the usual standard to 92% and reported that a deep dive had highlighted

the need for crews to accurately record blood sugars; attributed to the transition to the Electronic Patient Record and the data being recorded in the correct field.

The Medical Director advised that he was working with the Clinical Audit team and the Director of Quality, Innovation, and Improvement to redefine key measures to influence work regionally and nationally.

The Chair confirmed that staff were aware of the correct procedure and the Medical Director advised that a communications plan was in progress to support improvements.

The Director of Operations reported that Patient Emergency Services (PES) had received 131,065 calls or which 90,923 became incidents.

He reported that call pick up had been adversely affected by staff abstractions due to NHS Pathways training and increased sickness, with performance at 71.5% against a target of 95%.

In relation to Ambulance Response Performance (ARP), the Trust did not achieve any of the category standards, except for C1 90th. He advised that hear and treat and see and treat rates had been stable, however hospital handovers continued to cause a significant impact on the service and resources. He highlighted that 1,831 hour had been lost due to delayed admissions during June.

He reported that C1 and C2 long waits had improved because of the implementation of NHS Pathways and there had been a reduction in the use of private providers.

In terms of improvement plans for operations, he advised that key areas included access to the Directory of Services, mental health, reduction in lost production and digital improvements.

The Director of People noted work continued in relation to resourcing against over establishment, progression plans and forward planning in relation to paramedic recruitment.

The Chair welcomed the improvement work being undertaken.

In relation to 111, the Director of Operations reported the service had been challenged during June and achieved 32.3% compliance against standard. He noted that an improvement plan had been agreed with commissioners to improve compliance.

He advised that sickness management and recruitment and retention continued to be a challenge and plans related to additional SDF funding would be based on the timing of monies received. He added that signposting to pharmacies, where appropriate, and SMS messaging post event advice had been introduced.

He reported that access to primary care continued to impact on the 111 service and initiatives to absorb the pressure across the whole primary care system were being considered.

The Chair clarified that the additional SDF funding allowed the service to achieve 63% compliance.

The Deputy Director of Finance confirmed that the level of income in the financial plan had been supported in the plans of the Integrated Care Boards and the money was not new investment for 2022/23.

The Chair confirmed that funding and performance in 111 was an ongoing concern for the Trust due to the shift in nature and increased demand on the service. He praised the staff who were vital to the organisation.

In relation to PTS, the Director of Operations reported improved capacity due to reduced IPC requirements and an increase in internal capacity, with a reduced usage of private providers.

The Deputy Director of Finance advised that the Trust's financial position had been presented to the Trust Resources Committee and there had been a deep dive into agency spend and ambulance spend, and the Trust were working with Lancashire and South Cumbria to establish a future agency ceiling and reductions.

The Chair recognised the impact of the pandemic on agency spend.

The Director of People provided an update in terms of sickness. She confirmed that although sickness remained high and variable, there was some small improvement in non-covid sickness, which reflected the work of the Attendance Improvement Teams (AITs). She added that change in guidance meant that long covid sickness payments would move onto long term sickness arrangements.

She highlighted a reduction in turnover in 111 and that detailed analysis of the initiatives introduced had been undertaken.

Although there had been some indications that turnover had stabilised, she noted the continued priority and focus on 111 and EOC and the transfer of agency staff onto NWAS contracts.

The Chair queried surety, in relation to the transfer of agency staff.

The Director of People anticipated an 80-90% conversion rate, however highlighted the challenges faced in the recruitment market. She added that robust recruitment plans were in place to market and increase attraction.

Mrs C Butterworth thanked the Director of People and her team for working closely with the operational teams and referred to the importance of learning from national pieces of work.

The Director of People advised that the HR Directors Network planned to undertake focused work on end-to-end recruitment, to learn and address the issues related to attraction and streamlining of recruitment processes. She added there was some debate as to whether there was a longer-term solution to look at sustained plans to be adopted across the system.

The Director of Quality, Innovation and Improvement highlighted that in terms of Covid, 500 staff members were reported as having Covid in the month of June. She added that welfare arrangements were in place although arrangements for Covid sickness had changed and Test, Track and Trace had been stood down. However, the Trust continued to have surveillance of locations where cases were reported and where prevention work could be targeted.

The Director of Quality, Innovation and Improvement advised that Safety alerts data was included in the IPR, and three active alerts had been processed. She added that further data on long waits and the correlation with serious incidents had been included for reference.

The Board:

- Noted the content of the Integrated Performance Report.
- Noted the improvements seen in complaints and incident handling times.
- Noted the pressures on performance with handover times increasing.
- Noted that SI's were within the normal limits.
- Noted that long waits for C1 and C2 had reduced in May and June.
- Noted the ongoing work to maintain patient safety and regulatory compliance.
- Clarified items for further scrutiny.

BOD/2223/57 **IPC Board Assurance Framework**

The Director of Quality, Innovation and Improvement presented the IPC Board Assurance Framework (BAF).

She reported that the BAF provided assurance that the Trust had processes, policies, and systems in place to minimise the risk associated with infection, prevention and control and the Trust's progress against the Key Lines of Enquiry had been reviewed at Q&P.

She noted that the team were in a transition period following appointment of the Trust's new Director of Infection, Prevention and Control (IPC). She confirmed that the Trust continued to follow national guidance in relation to Covid and recognised the challenges in terms of public perception and national ambulance guidance.

She advised that mask compliance was a key discussion item at the Trust's recent IPC Sub Committee meeting and advised that a paper regarding future

resource would be presented to the Trust's ELC and Quality and Performance Committee in September.

The Chair welcomed future focus on Face Fit Testing by the newly appointed Director of IPC and IPC area leads. He recognised the work of the IPC team to address the challenges and encouraged all staff do their best.

The Board:

- Noted the assurance within the Trust's IPC Board Assurance Framework.
- Noted that risks had been reviewed and improvements aligned to the IPC risks and actions from the original IPC BAF and the revised board guidance.
- Acknowledged that improvements were ongoing in all areas of the KLOEs.

BOD/2223/58 Learning from Deaths Q4 2021/22 Report

The Medical Director presented the Learning from Deaths Q4 2021/22 report.

He reported that learning from deaths process provided an opportunity for the Trust to learn from deaths and advised that key themes had emerged during Q4. The themes identified related to delayed attendance and stroke patient delayed attendance and the report provided detail of the significant efforts and resource provided to focus clinical attention on Category 2 group calls. He advised that system level improvements were in place to reduce risk.

He stated that the Trust triangulated lessons learnt with coronial systems and Patient Safety learning forums, with a particular aim to disseminate lessons learnt via a pan organisational learning forum, to improve learning across all service lines. He added that this would be introduced in the forthcoming year.

There had been some system level learning from needlestick injuries and lessons learnt improved practices.

Dr A Chambers noted that the recent Quality and Performance Committee had received the report and remained focused on the evidence of triangulated learning from deaths and serious incidents.

The Director of Quality, Innovation and Improvement advised it was important to note the paper had a lot of rich information and a clinician's narrative and their ability to tell the story and pass on good practice was extremely valuable. She added it was this element of learning that changed culture in the organisation and emphasis should not be lost on the importance of those conversations.

The Chair referred to the importance of audits, to recognise changes in trends and influence new practice.

The Medical Director advised that the outstanding audit resource related to Structured Judgement Reviews in EOC, which was currently at 75% He added that this had been identified on the Trust's risk register and was sighted on the Quality and Performance Action Log for completion during Q2/Q3. He added that the ELC were fully aware of the position and that the number of audits currently undertaken was on track.

The Chair thanked the Medical Director for the update and recognised the amount of work undertaken by the team to produce the report.

The Board:

- Noted the contents of the report.
- Approved the recommendations and the Q4 position.

BOD/2223/59 **Quality and Performance Committee Chairs Assurance reports from the meetings held on 23rd May 2022 and 27th June 2022**

Dr A Chambers presented the Quality and Performance Committee Chairs Assurance Reports, from the meetings held on 23rd May 2022 and 27th June 2022.

She noted that the Trust continued to see significant challenges and the reports highlighted the levels of assurance provided.

The Board:

- Noted the content of the Quality and Performance Chairs Assurance Reports.

BOD/2223/60 **Resources Committee Chairs Assurance report from the meeting held on 22nd July 2022**

Dr D Hanley presented the Resources Committee Chairs Assurance Report from the meeting held on 22nd July 2022.

He reported that the Committee had held a very good meeting and confirmed the assurances provided.

The Board:

- Noted the content of the Resources Committee Chairs Assurance Report.

BOD/2223/61 **Communications and Engagement Team Dashboard Report Q1 2022/23**

The Deputy Chief Executive Officer presented the Communications and Engagement Team Dashboard Report Q1 2022/23.

In terms of patient and public engagement he advised that 27 virtual community engagement opportunities were attended or facilitated. He noted a 1% reduction in return rate and overall results were positive.

He advised that work continued with recruitment of youth representation and in terms of press and public relations, there had been good activity on social media platforms, which included the pending launch of the ambulance academy.

He confirmed there had been 45 proactive web or media stories launched and the team continued to provide an opportunity to engage with the wider community. In relation to Freedom of Information requests, the Trust had achieved 89% against the 90% 20 days target, and there were plans in place to improve.

He reported that Trust had improved access to its interpretation services to 999 deaf patients via the national BSL facility.

Dr D Hanley queried the process for responding to negative media stories.

The Deputy Chief Executive Officer advised that the press is requested to provide details of the incident and any incorrect or incomplete information was managed up front or collectively with NHSE and other providers, to provide a consistency in response

The Director of Quality, Innovation and Improvement noted that the new Patient Safety National Strategy asked for Trusts to identify two specific patient safety partners, from the Patient and Public Panel (PPP), by September.

It was highlighted that plans were in place to deliver the NWAS Roadshows and the Chair noted the added value of the PPP.

Mr D Rawsthorn referred to internal staff communications to staff in terms of updates on the service delivery model review.

The Director of Operations confirmed that the Trust were currently working through a communication strategy for staff with the trade unions.

The Board:

- Discussed and noted the content of the report.

BOD/2223/62 **Any Other Business Notified prior to the meeting**

There was no other business notified prior to the meeting.

BOD/2223/63 **Items for inclusion on the BAF**

There were no items identified for inclusion in the BAF.

BOD/2223/64 **Closing Remarks**

The Chair thanked the Advanced Paramedic for the staff story and praised the digital and operational teams for their hard work associated with implementation of NHS Pathways.

He referred to CQC and stated the team should be proud of the outcome of the recent inspection and thanked all for their hard work.

He welcomed the risk and assurance re Cleric, sighted in the BAF, and the good debate held in relation to the Integrated Performance Report.

He praised the teams for their good patient experience feedback, during a period of challenge, and emphasised the need for the Board to stay focused on the impact of long waits.

He recognised the hard work in 111 and the continued challenges, although the impact of future resources was yet to be seen.

He thanked Executives and corporate teams for their continued hard work and the challenges faced in terms of turnover. He referred to the importance of continued scrutiny by Board Assurance Committees and praised the Patient and Public Panel for their ongoing support.

Date and time of the next meeting –

9.45am, 28th September 2022 in the Oak Room, Ladybridge Hall, Trust HQ.

Signed __________________________ Date ______________

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Status:	
Complete & for removal	(green)
In progress	(amber)
Overdue	(red)
Included in meeting agenda	(blue)

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
65	25.05.22	33	Medicines Management Report	Progress update on EPR Project to future Board meeting.	CG	Sep-22			

NWAS Board and Committee Attendance 2022/23

Board of Directors	27th April	25th May	17th June	27th July	28th September	30th November	25th January	29th March
Ged Blezard	✔	✔	x	✔				
Prof Alison Chambers	✔	✔	✔	✔				
Salman Desai	✔	✔	✔	✔				
Prof Aneez Esmail	x	✔	✔	x				
Dr Chris Grant	✔	✔	✔	✔				
Dr David Hanley	✔	✔	✔	✔				
Daren Mochrie	✔	✔	✔	x				
Prof Maxine Power	✔	✔	✔	✔				
David Rawsthorn	✔	✔	✔	✔				
Catherine Butterworth	✔	✔	✔	✔				
Lisa Ward	✔	✔	✔	✔				
Angela Wetton	✔	✔	x	✔				
Peter White (Chair)	✔	✔	x	✔				
Carolyn Wood	✔	✔	✔	x				

Audit Committee	22nd April	12th May	17th June	21st July	21st October	20th January
Prof Alison Chambers	✔	✔	✔	✔		
Prof Aneez Esmail	✔	✔	✔	x		
David Rawsthorn (Chair)	✔	✔	✔	✔		
Catherine Butterworth	✔	x	✔	x		
Dr David Hanley				✔		

Resources Committee	20th May	22nd July	23rd September	25th November	20th January	24th March
Ged Blezard	✔	✔	✔			
Salman Desai	✔	✔	✔			
Catherine Butterworth	✔	x	✔			
Dr David Hanley (Chair)	✔	✔	✔			
Prof Maxine Power	x	✔	x			
David Rawsthorn	✔	✔	✔			
Lisa Ward	✔	✔	✔			
Carolyn Wood	✔	✔	✔			

Quality and Performance Committee	25th April	23rd May	27th June	25th July	26th September	24th October	28th November	23rd January	27th February	27th March
Ged Blezard	✔	✔	✔	✔						
Prof Alison Chambers	✔	✔	✔	✔						
Prof Aneez Esmail (Chair)	x	✔	✔	x						
Dr Chris Grant	✔	✔	✔	✔						
Dr David Hanley	✔	✔	✔	✔						
Prof Maxine Power	✔	x	✔	✔						
Angela Wetton	✔	✔	✔	✔						

Charitable Funds Committee	27th April	26th October
Ged Blezard	✔	
Salman Desai	✔	
Catherine Butterworth	✔	
Dr David Hanley	✔	
David Rawsthorn (Chair)	✔	
Lisa Ward	✔	
Angela Wetton	✔	
Carolyn Wood	✔	

Nomination & Remuneration Committee	25th May	27th July	28th September	30th November	25th January	29th March
Catherine Butterworth	No meeting	✔				
Prof Alison Chambers		✔				
Prof Aneez Esmail		x				
Dr David Hanley		✔				
David Rawsthorn		✔				
Peter White (Chair)		✔				

CONFLICTS OF INTEREST REGISTER
NORTH WEST AMBULANCE SERVICE - BOARD OF DIRECTORS

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
Catherine	Butterworth	Non-Executive Director	HR Consultant (no live commissions) for NLaG Acture Trust and Beacon GP Care Group				√	Position of Authority	Apr-22		Agreed with Chairman not to accept or start any NHS HR contracts without his prior approval and support.
			Non Executive Director - 3 x Adult Health and Social Care Companies owned by Oldham Countil				√	Position of Authority	Apr-22		Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating) - removed 25th May 2022				√	Position of Authority	Apr-22		4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	Husband works for Liverpool CCG (Cheshire and Mersey ICB)				√	Other Interest	Feb-22	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	31-Mar-22	N/A
			Pro Vice Chancellor, Faculty of Health and Social Care and Member of University Executive Group, Manchester Metropolitan University	√				Position of Authority	Apr-19	30-Apr-22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	Other Interest	Aug-19	Feb-22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Salman	Desai	Director of Strategy, Partnerships and Transformation	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	
			Employed at the University of Manchester		√			Professor of General Practice	Apr-21	3rd Mar 22	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority	Apr-21	3rd Mar 22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Chair of Association of Ambulance Chief Executives (AACE) Advisory role to the NHS Leadership Review Team		√				Jan-22	Present	No conflict.
			Member of the JESIP Ministerial Board, HM Government		√			Position of Authority	Jan-22	Present	No conflict.
			Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Member of NHSE/I Ambulance Review Implementation Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	31.3.22	N/A
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Lisa	Ward	Director of People	Member of the Labour Party	N/A	N/A	√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – The Riverside Group	√				Position of Authority	Apr-19	Jan-22	-
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict

REPORT TO BOARD OF DIRECTORS

DATE:	28 September 2022
SUBJECT:	Chief Executive's Report
PRESENTED BY:	Daren Mochrie, Chief Executive

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☒	☒	☒	☒

SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Assurance

EXECUTIVE SUMMARY:

The purpose of this report is to provide the Board of Directors with information on a number of areas since the last CEO's report to Trust Board on 27 July 2022.

The highlights from this report are as follows:

Paramedic Emergency Services

- The rollout of NHS Pathways continues to see improved response times and less conveyance to ED
- A move to Intelligent Routing Platform will take place in September to manage calls on a national basis
- Hospital handover times continue to deteriorate

NHS 111

- A drop in demand and rise in performance has been seen over the last couple of months
- Working locally and nationally to address the recruitment and retention issues
- An extension to the pilot for SMS messaging for self-care has been approved for an increased number of call types

PTS

- Discussions continue with Integrated Care System leads around Patient Transport Services as we move into post COVID

The paper also provides an update on local, regional and national activities as well as outlining our approach to a number of areas

<table>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board is recommended to:

▪ Receive and note the contents of the report.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Not applicable</td></tr>
<tr><td>Date:</td><td colspan="3"></td></tr>
<tr><td>Outcome:</td><td colspan="3"></td></tr>
</table>

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Death of Her Majesty, The Queen

On the evening of Thursday 8 September, Buckingham Palace announced the sad passing of Her Majesty, The Queen.

On behalf of the Trust Board and all staff, I forwarded via the North West Lord Lieutenants, our sincerest condolences to the Royal Family who are in our thoughts at this sad time.

The Queen devoted her life to public service and it was a proud moment for us all when she awarded NHS staff the George Cross earlier this year, for our compassion and courage over the last 74 years but particularly during the pandemic.

Following Her Majesty's death, Operation London Bridge plan was invoked and we attended many Strategic and Tactical co-ordination meetings during this time.

On Saturday 10 September St James's Palace proclaimed our new Sovereign, King Charles III and we attended the many events throughout Sunday 11 and throughout the week across the Region.

In accordance with protocol the flags, which have flown at half-mast at NWAS sites since The Queen's death, were raised again briefly to their full height to mark the start of His Majesty's reign and were lowered to half-mast again at 1pm the following day.

On Monday 19 September I was invited to attend Westminster to represent the ambulance sector, alongside colleagues from Scotland, Wales and Northern Ireland at the State Funeral of Her Majesty Queen Elizabeth which was a very emotional, poignant and reflective day for us all as the nation, and the rest of the world, bid our final farewells to Her Majesty The Queen. I wish to thank those colleagues who were deployed to London for mutual aid and other colleagues who attended over 19 ceremonial events across the region.

1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 27 July 2022.

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

July and August saw the successful introduction of NHS Pathways in Greater Manchester and Cheshire & Merse control rooms. The transition was seamless, and we are seeing the early benefits of the change, ie reduced C1 and C2 incidents, increased C3 incidents and improved Hear & Treat. These changes have seen improved response times and less patients conveyed to emergency departments. A full benefits analysis is being caried out and will be shared once complete.

Call pick up is still challenged, this is a result of high staff abstractions, mainly due to training and mentoring of the new NHS Pathways staff. It is anticipated

this will improve as we embed NHSP as business as usual and staff return to their full-time roles.

During September there will be a move to a new Intelligent Routing Platform (IRP) that will manage calls on a national basis. This will be implemented incrementally commencing with London Ambulance Service during late September before being rolled out nationally. This will replace existing 'buddy' arrangements. In practice when a service is stacking calls, any calls over 5 minutes will be passed to the next available call taker anywhere within the network of ambulance trusts. The details of the incident will be taken then passed electronically to the responding service. This should improve the patient experience in having their call answered in a timelier manner.

Improvements have been seen in both C1 and C2 mean and 90th centile targets with the C1 90th being achieved. C3 mean and 90th centile also improved. As a result of the improved response times C1 and C2 long waits have decreased significantly.

Hospital handover times continue to deteriorate with an average of 43 minutes and 33 seconds for each patient taken to ED. This equates 12,699 hours of lost resource hours. Work continues with system partners to manage this and this remains a priority for the Trust.

2.2 NHS 111

The NHS 111 service over the past 2 months has witnessed a drop in demand and an associated rise in performance; this can be viewed in the IPR.

The 111 operational team have now received the ORH (Operational Research in Health) report, and the contents will be utilised during impending future NWAS contract discussions. Initial findings show that NWAS 111 requires significantly more staff to improve and maintain performance. A number of scenarios have been published by ORH for consideration by the commissioners.

NHS 111 continues to face recruitment, retention and sickness challenges and continues to work both locally and nationally with HR teams to address these. The main cause of staff absence remains stress/anxiety/depression, and the 111 People Plan focusses on improving the workplace and the staff H&WB in the workplace. Our plan is challenging but to date we are on track to deliver the actions outlined within it.

The 111 roster review group has agreed the core principles with staff side colleagues, and the working parties will commence this month (September). Plan on schedule to be live by April 2023.

The NWAS pilot project of SMS messaging for Self-Care went live in March 2022, with the support of colleagues in NHS Pathways. Following evaluation of the data there is a reduction of 20% of the average handling time (AHT) for the calls where self-care advice is delivered using the SMS method. NHS Pathways have signed off an extension of the pilot which extends the opportunity to utilise SMS for more call types.

The 111 Priority Plan, developed with commissioners, will now be combined with the NWAS Priority Plan as some subjects do overlap. There are a number of deliverables for 111 but key are recruitment, attrition and sickness – which are showing an improvement this month.

2.3 Patient Transport Services (PTS)

Discussions continue with Integrated Care System leads around Patient Transport Services as we move into post COVID. Current performance is steady with no issues

3. ISSUES TO NOTE

3.1 Local Issues

Long Service Awards

The first of this year's long service awards ceremonies was for staff based in Greater Manchester and included 111, EOC and corporate services with events for Cheshire & Merseyside and Cumbria & Lancashire taking place later in the year. The event, held at the Last Drop Village in Bolton, celebrated staff who had reached their 10, 20, 25, 30, 35, 40 and 45 year milestones in 2021, recognising over 1,700 combined years of service.

Hosted by Dan Smith, Interim Head of Service, and joined by the Chair and myself to present awards and thank recipients for their service. Judith Bromley, Deputy Lord Lieutenant of Greater Manchester attended to present The Ambulance Service (Emergency Duties) Long Service and Good Conduct Medal on behalf of The Queen to PES staff with qualifying service

A commemorative coin for 20 years' NHS service was revealed at the ceremony, which has been specially commissioned by the trust as a way of recognising colleagues undertaking any role, who have reached their twentieth NHS anniversary. I am sure this will be a welcome addition, particularly for EOC and PTS colleagues who have for some time expressed disappointment at not being included in the criteria for the Queen's 20 years' long service and good conduct medal, which is set nationally and is specifically for staff with patient facing roles in the emergency service.

3.2 Regional Issues

ITV Tonight - 999: A National Emergency?

The trust took the decision to participate in this television programme which aired at the end of July. There has been extensive media coverage both locally and nationally about ambulances waiting outside hospitals and some of our patients waiting longer than any of us feel comfortable with. Whilst we have supplied media statements for these articles, we have never previously allowed a news crew access on this scale during such a difficult time.

We were approached to take part in the project by NHS England and, after a few discussions with national colleagues and ITV, we agreed to take part. We allowed ITV to accompany a Manchester based crew and gave them access to Parkway EOC so they could see the reality of what we have to manage day to day and how pressures on other NHS trusts can impact on our ability to respond.

The Tonight programme was a difficult watch, and as an organisation made up of a workforce which cares for people on a daily basis, some of the case studies used were shocking and are exactly the scenarios we aim to avoid.

I want to thank all the staff who took part and spoke candidly about their roles and the pressure they are under, the board of directors and senior leaders in the trust remain focused on tackling handover delays.

Visitors to Estuary Point

Together with Deputy Chief Executive, Salman Desai we hosted a visit to Estuary Point by two guests – Damien Moore, MP for Southport and Metro Mayor of the Liverpool City Region, Steve Rotheram.

It was especially pleasing to finally welcome the Mayor after COVID and various internal lockdowns had meant previous visits being cancelled no less than four times. During a short meeting, also attended by Sector Manager, Stuart Ryall, we discussed work we are undertaking for patients prone to falls and what could be done to improve services and the response to those suffering from mental health conditions. Paramedic, Claire Winters and her colleague from Mersey Care discussed their work on the local frailty car which aims to keep fall patients safe in their homes and prevent further falls. Regional EOC Call Handling Manager, Vicky Worrall and Service Delivery Manager, Jamie Dempsey, then escorted our guests around the EOC to give them an understanding of how we answer, process and respond to emergency calls.

Praise from Minister of State for Health

A recent letter from the Department of Health and Social Care expressed thanks to the trust for our response during the heatwave and our staff's 'tireless dedication, skill and professionalism to make sure patients were protected'.

3.3 **National Issues**

Influencing the Future

I have been asked by NHS England to co-chair a new task and finish group nationally, looking at the role of ambulance services in urgent and emergency care and making recommendations for the National Urgent & Emergency Care Strategy for the next decade.

Opportunities such as this are fantastic for all of us at NWAS, as they allow me to take our combined knowledge and insight of the challenges and issues we face in the North West, and use that to influence the national direction.

The group's first meeting took place at the beginning of August with many experts from various roles coming together with the collective aim of identifying the key recommendations for the strategy.

The group has been set up now because of the statutory establishment of Integrated Care Boards. The thinking is that this provides the right moment to set out a vision and strategy for urgent and emergency care in the NHS for the next decade that aligns with the NHS Long Term Plan, particularly in light of ongoing pressures and demand for urgent and emergency care.

We know that demand drivers are different across the country but generally fall into these broad categories: changes in population and health needs, wider determinants of health, service model design and access to care.

The group will consider the views of experts from ambulance services, NHS England, and partners in the NHS system, along with data, quantitative and qualitative evidence, and learning from earlier reviews.

Boosting NHS capacity ahead of winter

NHS Chief Executive, Amanda Pritchard, wrote to all NHS chief executives earlier this month to set out the NHS's approach to boosting capacity this winter.

The core objectives and actions are to:

- Prepare for variants of COVID-19 and respiratory challenges
- Increase capacity outside acute trusts
- Increase resilience in NHS 111 and 999 services
- Target Category 2 response times and ambulance handover delays
- Reduce crowding in A&E departments and target the longest waits in ED
- Reduce hospital occupancy
- Ensure timely discharge
- Provide better support for people at home

I was asked to attend the NHSE Executive team workshop to discuss this further. Our Director of Operations and his team have developed our winter plan which is being discussed with system partners and our regulators. Over the coming weeks I will share updates about what this means for us in the North West and how we are preparing our services for winter.

Our achievements

Whilst the last year has been extremely challenging for all of us in the NHS, we have many things in NWAS to be proud of. A new book of achievements from the 2021/22 year has been produced which summarises some of the progress our teams have made and includes many comments from our patients and members of the public. Copies of the book will be distributed to all sites very soon.

AGM

Our achievements and details of our operational and financial performance across all of our service lines was the subject of our annual general meeting which took place on Wednesday 31 August.

Once again, the meeting took place virtually which enabled anyone from all over the region to attend. The meeting was a great opportunity to discuss our new strategy and it was extremely heartening to look back on what we accomplished last year, despite the huge challenges we were facing.

Ambulance Leadership Forum (ALF)

This was the first face to face ALF conference since before the pandemic with a packed agenda for the duration of the conference. As the Association of Ambulance Chief Executives Chairman, I was really pleased to welcome Amanda Pritchard, NHSE Chief Executive to the conference and especially pleased that Amanda could join me in opening the conference.

NWAS was extremely well represented in various sessions and presentations, starting with a Women in Leadership seminar and then a panel discussion on Urgent and Emergency Care.

The main conference took place over two days with Deputy Chief Executive, Salman Desai, speaking on the subject of leadership in the ambulance sector. Other events involving NWAS included Chair, Peter White who chaired a session on environmental issues; Director of Quality, Innovation and Improvement, Maxine Power, presented on hospital handovers; Head of Clinical and Digital Innovation, Matt Dugdale and Head of Digital Services, Lynsey Dunn showcased our advances in digital improvement; Clinical Lead for UEC Transformation & Consultant Practitioner, Steve Scholes, presented on ambulance data sets and Public Health Registrar, Christine Camacho discussed health inequalities.

Finally, it was an honour to be able to host the gala awards dinner and thank all staff who received awards. Well done to Philippa Antoni from NWAS who received national recognition for outstanding service as an Exceptional Manager within the ambulance service.

4. GENERAL

Trust Strategy

The new trust strategy was launched at the beginning of August and was created with input from staff and sets out how we'll achieve our vision of delivering the right care, at the right time, in the right place; every time.

The strategy sets the direction we're heading in and provides a positive, future focused narrative. Based on feedback which was gathered over 40 sessions with staff across the trust, the strategy very much balances getting the basics right with striving for excellence. This is not a strategy just for the board of directors or senior leaders, but for everyone; we all have a role to play in helping people when they need us most

Members of the strategy team and Board toured NWAS sites and hospitals to speak to as many staff as possible.

Cyber Attack on NHS 3rd Party Provider

At the beginning of August, the Trust was made aware of a cyber-security incident caused by ransomware on an NHS 3rd party provider, Advanced. Whilst the cyber-security incident was not targeted towards NWAS infrastructure, it did have an indirect impact on 111 and our ability to refer patients to alternative care providers across all service lines. This incident was under investigation by the NHS Cyber Security Operations Centre (CSOC), who in turn liaised with all parties nationally.

In light of this cyber-security incident, the digital team undertook additional scanning and monitoring of our infrastructure and network, to ensure our usual strong level of protection and security was maintained. Our virus protection software continued to run as expected with no initial direct impacts detected.

NHS leaders urge government to act on rising energy costs or risk public health emergency

It is unusual for NHS leaders to comment on energy prices, but there is huge concern that if households are not safeguarded from unaffordable energy price hikes, it will fall to local NHS and social care services to pick up the pieces, with increased hospital admissions and demand on GP surgeries, emergency departments, ambulances, care homes and other social care services.

NHS Confederation, on behalf of NHS leaders across the country, has written a letter to the Chancellor calling for price rises to be limited and for targeted support for those individuals and families most in need.

The impact is not limited to our patients, but also our staff and the trust has recently set up a new hardship fund, sponsored by the North West Ambulance Service Charity.

NHSE Announces Commitment to Electric Vehicles

I was extremely proud to see NWAS being mentioned as a trail blazer in NHSE's announcement that it is the first health service in the world to commit to reaching net zero by 2040. In the press release, NHSE commented that eight ambulance trusts are trialling 21 zero-emission vehicles of various types, with six of the new green vehicles dedicated to mental health response in the community as part of a £2.1 million investment. It particularly noted the use of dedicated mental health response vehicles in the North West as a great example of trust's playing their part in preventing ill-health by looking at new ways to reduce emissions, as well as using vehicles suited to the specialist needs of our patients

In our Thoughts

The last week of August was one of heart-break and tragedy. In Merseyside, an innocent young girl, Olivia Pratt-Korbel, was fatally shot by an unknown man in her own home. A strong and emotive appeal for information followed, supported by the local newspaper, and police have since arrested a man in connection with her murder. As a key partner, Merseyside Police has involved NWAS in its strategic plans following this shocking situation, and we're fully supportive of their work to tackle crime in our communities.

In addition, our fire and rescue service colleagues in Greater Manchester received news about the loss of one of their own. The body of watch manager Daniel Lee was found after he disappeared on a night out with friends.

Our condolences are with the families and friends of both Olivia and Daniel.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implication contained within this report

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no equality or sustainability implications associated with the contents of this report.

7. RECOMMENDATIONS

The Board is recommended to:

- Receive and note the contents of the report.

REPORT TO BOARD OF DIRECTORS

DATE:	28th September 2022				
SUBJECT:	Integrated Performance Report				
PRESENTED BY:	Director of Quality, Innovation and Improvement				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	
	☒	☐	☒	☐	☐	
	SR06	**SR07**	**SR08**	**SR09**	**SR10**	**SR11**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				

EXECUTIVE SUMMARY:

The Integrated Performance Report for September 2022 shows performance on Quality, Effectiveness, Operational Performance, Finance and Organisational Health during **August 2022** unless otherwise stated.
The format of this report has been revised to ensure that there is greater clarity on the key measures. Data are presented over time using statistical process control charts. Statistical rules are applied to determine whether something significant has happened which needs to be flagged to committee.

Quality

- 199 complaints were received, against a 12-month average of 177 per month.
- 83% of complaints risk scored 1-3 were closed within the agreed time frame with the data signalling improvement
- The accumulation of complaints has significantly improved and has been below 50 for the last 9 weeks. With the last week seeing an accumulation of 37.
- During August 2022 there were 6 serious incidents reported on the StEIS database.
- Incidents risk scored 1-3 completed within SLA have significantly improved for August.
- In August 2022, 1,109 internal and external incidents were opened with an additional 17 still to be risk scored.

Effectiveness

- **Patient experience:** PTS and 111 have all seen an increase in satisfaction levels compared to last

month (PTS 2.3% and 111 0.2%) while satisfaction levels for PES have fallen by 4.8%.
- **111 First** experience rating of ‘very good/good’ has decreased by 6.5%.
- **Ambulance Clinical Quality Indicators (ACQI’s):** There is no significant change in the ACQI indicators apart from the STEMI care bundle which has increased back towards the mean. The Stroke care bundle was not reported for this month.
- **H&T, S&T, S&C:** For August we achieved 12.3% Hear and Treat, 30.5% See and Treat and an aggregate non-conveyance of 42.8%. Data on hear and treat are signalling improvement with data points beyond the upper control limit. This is due to the implementation of NHS Pathways.

Patient Emergency Service (PES)

- **Activity:** In August 2022, the Trust received 127,821 calls of which 89,655 became incidents.
- **Call Pick Up** has been adversely affected by staff abstractions due to Pathways training and increased sickness. Performance was 62.3% (target 95%) and has deteriorated from the June 2022 position.
- **Ambulance Response (ARP) Performance**

	Standard	Actual
C1 (Mean)	7:00	7:54
C1 (90th)	15:00	13:50
C2 (Mean)	18:00	36:06
C2 (90th)	40:00	1:19:44
C3 (Mean)	1:00:00	2:54:43
C3 (90th)	2:00:00	7:12:57
C4 (90th)	3:00:00	08:20:49

- For August, response time targets were not met for any ARP category apart from C1 90th.
- C1 measures did signal improvement, falling below the lower control limit within the month. By the end of August, the improvement trajectory ceased, and data points moved to the mean.
- C2, 3 and 4 are signalling some improvement with two data points close to the lower control limit.
- The trust has taken a number of measures to improve performance and maintain patient safety including an agreed plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services. The aim of this plan is to optimise existing operational resource.

- **Handover**: Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 43:33. 5,120 attendances (11%) had a turnaround time of over 1 hour, with 679 of those taking more than 3 hours 1,099 hours were lost to delayed admissions in June.
- **C1 & C2 Long Waits:** The number of C1 and C2 long waits has reduced in August compared to the previous the previous months.

NHS 111

	Standard	Actual
Calls Within 60s	95%	54.9%
Average Time to answer		3m 52s
Abandoned Calls	<5%	10.00%
Call back Within 10 min	75%	10.98%
Call back Within 20 min	90%	13.68%
Average Call Back		1hour 20min
Warm Transfer to Nurse	75%	26.93%

- Call volume decreased during August and all measures are showing improvement. Time taken for a call back continues to be well above the target.
  Safety measures are in place. Increased demand during out of hours (OOH) operation are leading to increased call volume and conversations between CCGs and OOH provides are taking place.

PTS

- PTS performance is reported one month in arrears. Activity in July was 18% below contract baselines. Year to date July 2022 - July 2022) is performing at 18% below baseline

Finance

- The year to date expenditure on agency is £2.781m which is £0.213m above the year to date ceiling of £2.568m.
- As at month 5 (August) the trust is recording a surplus position for the year to date of £0.227m.
- The agency ceiling has been revised by service line.

Organisational Health

- The overall sickness absence rate for the latest reporting month (August 2022) was 10.16%.

	• Turnover has increased to 12.45%. Both EOC and 111 have seen lower turnover whilst PES turnover is showing an upward trend but remains low in comparison with other service lines. • The overall appraisal completion rate improved to 82.37%. • Overall compliance is on trajectory against the agreed target of 85% overall by March 2023. All classroom training is ahead of trajectory. EOC are slightly behind trajectory with recovery plans in place.
RECOMMENDATIONS:	The Board of Directors are asked to: • Note the content of the report • Note the improvements seen in complaints and incidents handling times • Note pressures on performance with handover times increased • Note that SIs are within normal limits • Note that long waits for C1 Have reduced in August • Note the initial improvements in hear and treat following NHS Pathways implementation • Note the ongoing work to maintain patient safety and regulatory compliance.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	26/9/22		
	Outcome:	Not known at time of submission		

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1 PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **August 2022**. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

- How are we performing over time? (as a continuously improving organisation)
- How are we performing with respect on strategic goals?
- How are we performing compared with our peers and the national comparators?

The format of this report has been revised to ensure that there is greater clarity on the key measures. Data are presented over time using statistical process control charts. Statistical rules are applied to determine whether something significant has happened which needs to be flagged to committee.

2 SUMMARY

2.1. Quality

- 199 complaints were received, against a 12-month average of 177 per month.
- 83% of complaints risk scored 1-3 were closed within agreed timeframes. The data are signalling a more consistent position. Improved staffing is leading to lower complaints scored 1-3 and the continued use of the rapid closure process is leading to an improvement in those completed within SLA (Figure Q1.5) which is showing special cause and if this continues will show a new phase.
- 22% of level 4-5 complaints were closed within the agreed time frames. This aligns with previous numbers that are lower during the summer months.
- The number of open complaints remains below the agreed level of 180. For the past nine weeks the accumulation of overdue complaint responses is below the agreed allowance of 50 cases. At the end of the reporting period, there were 37 open and overdue cases.
- 43 Compliments were received in August, this number is lower than the previous months but is likely to increase as compliments are processed.
- During August 2022 there were 6 serious incidents reported on the StEIS database, this continues to be significantly lower than the 20 incidents reported in January and is similar to the last 7 months and remains within normal control limits.
- In August 2022, 1,109 internal and external incidents were opened against a 12-month average of 1,202, with an additional 17 still to be risk scored.
- Incidents opened with a risk score 1-3 are signalling a change with 7 data points below the mean, one more and a new phase will be created. This is being monitored to ascertain why.
- Incidents risk scored 1-3 completed within SLA is showing special cause signalling improvement for the last seven months.
- The 8 most common reasons for incidents were verbal abuse (139), information (99), 111 assessment/advice (91), 111 issue with other service (65), staff welfare (42), communication (42), threatening behaviour (41) and clinical assessment (37) and between them cover over 50% of those reported. The top 25 cover over 85%.

2.2 Effectiveness

Patient experience

- PES and NHS 111 saw an increase in returns during the reporting period from June by 7.64% and 6.6% respectively, while PTS saw a decrease of 25.8%. NHS 111 has seen a 0.5% increase in satisfaction levels compared to June while satisfaction levels for PES and PTS have fallen by 5% and 0.5% respectively.
- The decrease in PTS returns is attributed to a 20% reduction in invitations to provide feedback compared to the last reporting period. It was an exercise to see if it would impact on return rate or scores (no impact).
- For NHS 111 First the level of return has dropped during July and August by 42.9% compared to June 2022. Cumulatively to date, ie April 2022 to September 2022, 83.63% of patients describe their experience as 'very good/good'. At the end of March 2022 this was 87.85%. Additionally, 90.24% of patients felt their need for calling the service was met as opposed to 92.68% at the end of March 2022.
- The reduction in return rate for NHS 111 First service users may be attributed to a change in the group of patients contacted to provide feedback. During August patients contacted comprised solely those that had received care advice via an SMS text message instead of verbally and was to support a request for targeted patient insight following the rollout of this service.
- Cumulative experience data broken down by protected characteristics will be socialised with senior leaders to understand what we might learn from it. For example, in PTS we can see that there is a high proportion of patients with more than one disability signalling the complexity of care required and low levels of usage of all services by black and ethnic communities.

Ambulance Clinical Quality Indicators (ACQI's)

April 2022's data see us within normal limits and close to the mean across all indicators apart from the Stroke bundle which isn't reported for this month (latest is February). This is being closely monitored by the audit team and plans are in place to address these issues. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

- Return of spontaneous circulation (ROSC) achieved for the Utstein group was 45.5% (national mean 48.2%). For the overall group the rate was 31.9% (national mean 25.9%).
- Survival to Discharge rates in April 2022 were at 7.4% (national mean 7.5%).
- In April 19.1% of patients in the Utstein group survived to hospital discharge. The national mean at 26.4%.
- Mean call to PPCI time in February for patients suffering a myocardial infarction was above the national mean of 2h 36mins; the Trust's performance was 2h 43mins.
- Mean call to hospital time in August for patients suffering a hyper acute stroke was below the national mean of 1h 54mins. The trusts performance was 1h 46mins.

- The Stroke Care Bundle performance was not reported for April in line with the NHSE schedule.
- The STEMI Care Bundle performance for April was 69.8%. The national mean at 73.4%

H&T, S&T, S&C

- For August we achieved 12% Hear and Treat and ranked 4th nationally.
- See & Treat we achieved 30.5% and we are ranked 9th nationally.
- In total there was an aggregate non-conveyance of 42.8%.

Within the month of August H&T has continued to improve with two data points above the upper control limits. This improvement is primarily associated with phase two and three 'go live' of NHS Pathways within the EOC environment (Phase two, Greater Manchester go live occurred late July 22 and phase three go live, Cheshire and Mersey occurred early August 22). NHS Pathways increases H&T by enabling non clinical call handling staff to provide H&T by utilising the Directory of Service (DOS) to signpost clinically appropriate patients to local services. Currently around 5% of triages result in non clinical H&T. It is anticipated H&T will continue to improve as an increasing number of DOS services are profiled for referral.

In terms of S&T it is also anticipated this metric will improve. The associated improvement plan is managed via the North West System improvement plan and improvements to access to patient pathways. Whilst there is some correlation with increases to H&T leading to decreasing S&T, there is evidently greater opportunities for overall non conveyance when appraising NWAS against the national picture

2.3 Operational Performance - Patient Emergency Service (PES)

- **Activity:** In August 2022, the Trust received 127,821 calls of which 89,655 became incidents. Compared with August 2021, we have seen an 10% decrease in calls and an 4% decrease in incidents. This is due to the increase in signposting and duplicate calls.
- **Call volume:** call volume is 10% below the equivalent month for 2021.
- **Call Pick Up** has seen a deterioration in August and performance worsened from 71.5% in June to 60.5% in July and 62.3% in August (target 95%).

Call pick up has deteriorated within the month of August due to increased levels of staff abstractions and attrition. The primary causes of abstractions are increased levels of sickness and the final phase of NHS Pathways training. In addition abstraction levels peaked within July leading to reduced operational capacity. Increases to average handling times associated with NHSP have occurred. Whilst this was anticipated this is still a contributory factor in reduced call handling performance.

It is anticipated that call handling performance will remain challenged for September and early October. However from this point it is projected call pick up will improve. This is due to;

- Increases to deployable workforce due to recruitment (circa 35 new starter in October and 50 new starters mid November).
- A reduction in abstractions.
- Return of staff to front line roles post supporting NHSP programme.
- Improvements to AHT as staff become familiar with the new triage system.

It should be noted that risks to recruitment have been identified, primarily due to delays in NWAS recruitment process and a reducing candidate pool.

Ambulance Response (ARP) Performance

Category	Standard	August 2022 Actual
C1 (Mean)	7:00	7:54
C1 (90th)	15:00	13:50
C2 (Mean)	18:00	36:06
C2 (90th)	40:00	1:19:44
C3 (Mean)	1:00:00	2:54:43
C3 (90th)	2:00:00	7:12:57
C4 (90th)	3:00:00	8:20:49

For August response time targets were not met for any ARP measures apart from C1 90th. This continued the position this financial year. All the ARP standards have seen a downward trajectory to the lower control limits signalling improvement in the final weeks of August apart from C1 mean and C1 90th. C1 measures did signal improvement initially, falling below the lower control limit within the month however by the end of August, the improvement trajectory ceased and data points moved to the mean.

The primary drivers associated with the improved C1 performance are;

- Significant reduction in the proportion of incidents categorised as C1. This is due to the full roll out of NHSP. C1 activity has reduced by around a third as a result.
- Improvements to the percentage of C1 incidents early predicted within the triage. This is highly advantageous as early predicted C1 incidents are allocated in around 20-40 seconds from point of call (C1s not early predict are allocated in around 2 minutes). The net result of this is allocation times to C1 have improved.

Despite these significant enablers NWAS are still not meeting the C1 mean standard. This is primarily due to:

- Abstractions have started to rise due to Covid, both within the Trust and across the system. As a result operational resources are still challenged and disproportionately in certain geographical areas.
- Turnaround continues to be above the National standard of 30:00 with a turnaround time of 43:33.The trust has taken several measures to improve performance and maintain patient safety including an agreed plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services.
- Deteriorating call pick is also having an impact as clock start can occur pre call answer at peak times of demand.

The areas we are continuing to focus on in terms of improvement are:

- Our response strategy for C1, including area reviews, meaning each area now has a comprehensive C1 improvement plan.
- Dispatch audit of C1 incidents to enable learning and improvements in allocation times.

- Focus of management of 'unfunded unavailability', this is led through operational heads of service with enhanced reporting monitoring and actions taken to increase availability to increase availability of operational crews.

For ARP response standard C2 a number of the factors described above also apply, specifically operational resourcing and handover. It should be noted that August has seen an improvement in response standards vs previous months with the final three weeks of August seeing data points below the mean.

The primary enablers for this improvement are;

- A reduction in the percentage of incidents categorised as C2 due to NHSP (circa 13% reduction).
- The significant reduction in C1 incidents. For C1 incidents a much higher ratio of resources are allocated (1.6 resources per C1 vs 1.07 for C2/3 incidents). This creates addition capacity to respond to C2 and C3. In addition, we have seen a reduction in resources allocated to C2 being stood down to respond to C1.

NWAS's response to C3 incidents has also improved with the final three weeks data points in August tracking below the mean. It should be noted that NWAS vs the national picture perform poorly. There are a number of factors which include the dispatch focus on higher acuity incidents, some delays due to clinical capacity to secondary triage / validate C3/4. A review is to be conducted in to this process to ascertain based on evidence whether a wider cohort of C3/4 triages should be made available for dispatch pre validation. The review will consider those cases with a high proportion of conveyance.

Handover

- Average turnaround time has increased and continues to be above the national standard of 30:00 with a turnaround time of 43:33. This is the highest turnaround this calendar year.
- The data are signalling continued variation with 2 of the last 4 data points above or on the upper control limit and other 2 crossing the mean.
- 5,120 attendances (11%) had a turnaround time of over 1 hour, with 679 of those taking more than 3 hours. There were 1099 delayed admissions in August, the highest monthly figure since October 2021. Delayed admission wait-times averaged 114 minutes each with total accumulated hours of 2,089.
- The trust continues to work with those most challenged trusts and focus on trust engagement and continues to implement the delayed handover crew and managers escalation action card across the North West.

C1 & C2 Long Waits

Long waits for C1 saw an increase to 1207 in July and then decreased to 653 in August, the lowest wait long wait since April 2021. The number of long waits for C2 has increased slightly in July (from 10,374 to 14,649 respectively) however this is significantly lower than the high of 20,038 recorded in December 2021. August then saw a reduction to 8051.The highest category continues to be delays '60-75 minutes'. It should also be noted that the number of extreme long waits in both C1 and 2 have reduced.

It is anticipated with the full roll out and increased familairisation with NHSP that long waits and specifically extreme long waits will continue to reduce. It is known that the risk of harm

increases in line with wait times and it therefore also anticipated that complaints, SIs and harm associated with delay will reduce over time.

2.4 Operational Performance - NHS 111

Measure	Standard	August 2022 Actual
Calls Within 60s	95%	54.9%
Average Time to answer		3m 52s
Abandoned Calls	<5%	10.0%
Call back Within 10 min	75%	10.98%
Call back Within 20 min	90%	13.68%
Average Call Back		1hour 20min
Warm Transfer to Nurse	75%	26.93%

- Call volume decreased in August which is a primary driver for the improvement in all metrics in August. Calls answered in 60s performance remains below the standard but stable with Call to Answer time also stable within control limits. This coupled with a decrease in turnover.
- The team are still working with ORH again to demonstrate the change in profile and increase in demand over the last 12 months, this will be used during future conversations with commissioners.
- The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target but within control limits. Safety measures are in place.
  This month the new national metric for call back within 20 minutes is also included.

2.5 PTS

- Due to reporting timing issues PTS performance is reported one month in arrears.
- Activity in July for the Trust was 18% below contract baselines with Lancashire and Cumbria 32% and 30% below baselines respectively. Year to date July 2022 - July 2022) is performing at 18% below baseline.

2.6 Finance

- The year to date expenditure on agency is £2.781m which is £0.213m above the year to date ceiling of £2.568m.
- As at month 5 (August) the trust is recording a surplus position for the year to date of £0.227m.
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

- The agency ceiling has been revised by service line.

2.7 Organisational Health

Sickness

The overall sickness rate for July 2022 was 10.16% (OH1.1) with 7.1% being non-COVID (OH1.2). Sickness had been decreasing since December 21 with non-COVID sickness stabilising at around 7%. This remains higher than previous years and higher than the normal seasonal trend. Contact Centre rates remain higher than other service lines.

- The impact of COVID related sickness has continued to fluctuate based on community prevalence and was 3.1% of overall sickness in July, which was expected given the likely increase in community transmission. Levels are expected to continue to fluctuate.
- Data analysis continues to show the top 5 reasons for absence are Mental Health, Covid, Injury, MSK and Back problems.
- Following the withdrawal of COVID terms and conditions arrangements, staff absent long term with COVID have now fully transitioned onto occupational sick pay. Cases are being managed through a robust Occupational Health process in line with a nationally agreed framework with the aim of where possible returning staff to work. The extended periods of long term sickness associated with COVID reflect in higher than normal long term sickness levels.
- A dedicated Attendance Improvement Team is continuing to focus on supporting operational teams to improve attendance management and wellbeing. In the main the work focuses on ensuring organisational grip; data quality and thorough case review; coaching and developing managers to both manage and work to prevent ongoing absence.

Turnover

Staff turnover for August 22 is 12.45%. This is calculated on a rolling year average. Staff turnover has shown a steady increase in the last 12 months but is just within the upper control limit. PTS and PES are both exceeding the upper control limit, with EOC on the mean and 111 on the lower limit. The overall position is replicated across the sector.

- 111 turnover is showing an improved position to 41.05% for August 2022 which is just within the lower control limit (OH2.5). Monthly turnover for call handlers has reduced 3 months consecutively since the introduction of the short-term retention payments. Average monthly turnover over the last 6 months is now 4% compared with the 10 months prior to the bonus payments which was 5.3%.
- EOC turnover has also shown an upward trend, primarily driven by turnover amongst call handlers, however August 22 turnover was at 14.71% (OH2.4) which is the lowest position for 7 months.
- Both PTS and PES are showing special cause variation. PTS rates have returned to pre-pandemic levels, and do not present a cause for concern. PES is being closely monitored with the turnover reflecting increases in retirement and opportunities within primary care. It remains lower in comparison with other services lines. Recruitment plans are also in place.
- The Trust is working across the Ambulance Sector and with NHSEI on specific targeted interventions to support contact centre retention including the retention payments that NWAS have applied. PES turnover is showing an upward trend but remains low in comparison with other service lines.

Agency

As a result of COVID-19, restrictions in relation to agency usage were paused but these are being reinstated under the 22/23 financial regime. The position for August shows continuing agency usage with a slight increase in value on previous months but a reducing proportion of total staff costs since April. The agency ceiling, which is the maximum spend allowable, has now been confirmed as the level set out within our operational plan. Further reductions in agency usage will be required.

- Agency staff have continued to support the Contact Centre environments. The majority of Agency staff remain in EOC and a process is in place to transfer remaining Agency staff onto Trust contracts. 51 staff have transferred with a further 29 moving to Trust contracts in September with a small number (approx 5) remaining.
- Further EOC recruitment is planned during 2022/23 but this will be through normal recruitment process rather than Agency. A small number of Agency staff are continuing to be used in 111 and CHUB, in Clinical roles and reflect pre pandemic usage.
- Current agency usage is therefore anticipated to continue across Q3 but should reduce following this.

Vacancy

- Chart OH5.1 shows the vacancy gap at –5.24% in August 2022. This is an improvement on the previous two months however signals a significant change from four months ago as a result of the increases to PES & EOC establishment arising from additional investment.
- Recruitment plans for 111 are on track with the vacancy position gap of –11.74% (OH5.5). The Health Advisor gap has closed but vacancies remain within Clinical Advisors and supporting posts, the latter of which will in part be recruited from the HA pool. This is an improved position for Health Advisors as a result of positive recruitment and some reduction in monthly turnover.
- The PTS vacancy position (OH5.2) shows a widening of the vacancy gap which reflects the timing of planned PTS courses. Robust plans are in place to reduce the gap over the coming months, but PTS also have robust bank arrangements in place to bridge the vacancy position.
- PES position (OH5.3) shows the positive impact of plans to maximise recruitment into PES during 2022/23 and are 0.27% under-established. This is primarily the Paramedic workforce and mitigates risks of current turnover.
- The substantive EOC position shows at –16.24% due to the baseline establishment. Increases. Further transfer of agency staff to permanent contracts will take place in September and recruitment plans are in place to fill remaining vacancies.

Appraisal

- Appraisal completion rates are at 82% for August 22 (OH6.1) which is an improving trend.
- PES and PTS remain ahead of target (OH6.3, OH6.2) and corporate teams have all reached the 75% target. 111 are ahead of target at 80% (OH6.5) and EOC at 76%. Targets are due to be reviewed with ELC shortly.

Mandatory Training

ELC have approved the 22/23 mandatory training programme which has a primary focus on ensuring a strong foundation of statutory compliance given disruption over the last 2 years. It remains limited to a one day programme for 22/23 in recognition of operational pressures. The programme started at the end of June with a target of 85% by the end of March 2023.

Overall compliance is on trajectory. All classroom training is ahead of trajectory. EOC are slightly behind trajectory with recovery plans in place.

COVID 19

- 211 staff have tested positive for Covid-19 in August 2022. At the end of this reporting period, there was no open outbreaks on Trust sites.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

Failure to ensure on-going compliance with national targets and registration standards could render the Trust open to the loss of its registration, prosecution and other penalties

4. EQUALITY OR SUSTAINABILITY IMPACTS

The data in this report are presented at an aggregate level for the trust. An EDI view is now applied to the patient experience data which breaks data down by protected characteristics were available. A digital sprint has begun to improve our data sharing across NWAS services / systems of patient ethnicity. This will enable us to view our ACQIs by ethnicity and understand if quality of outcomes is different for different groups.
.

The effectiveness measures related to 'hear and treat' and 'see and treat' have the potential to impact on our carbon emissions however this is not explored in the report.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

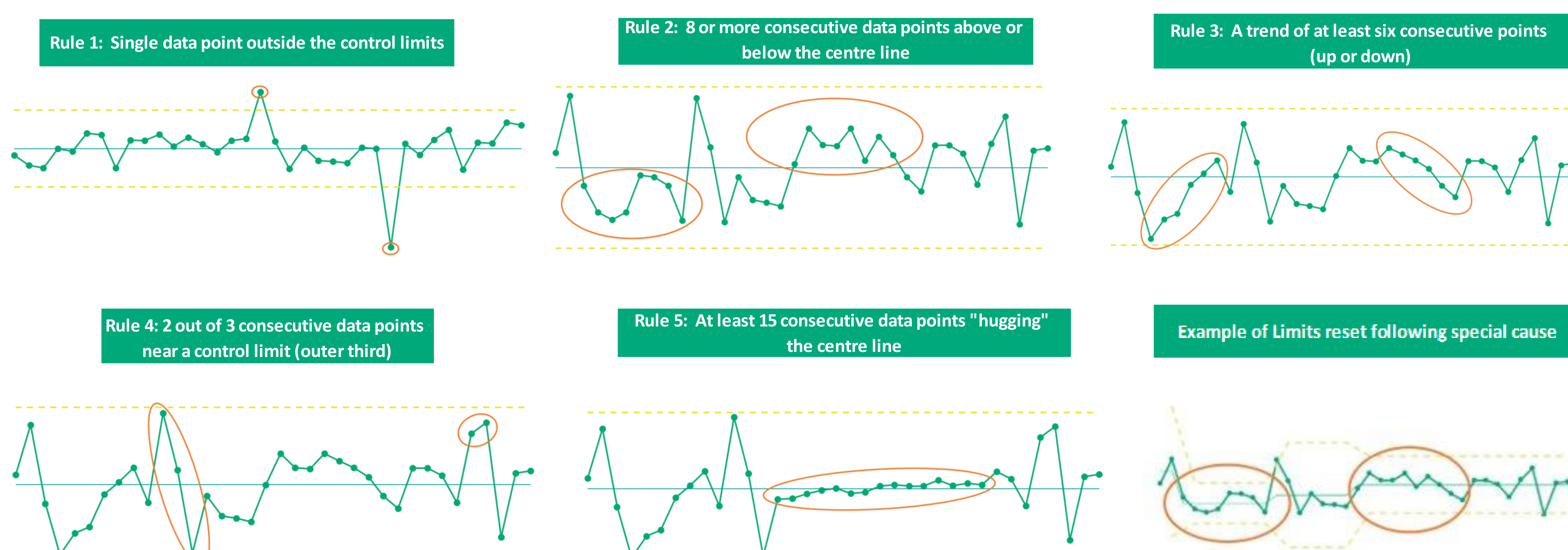
- Note the content of the report
- Note the improvements seen in complaints and incidents handling times
- Note pressures on performance with handover times increased
- Note that SIs are within normal limits
- Note that long waits for C1 Have reduced in August
- Note the initial improvements in hear and treat following NHS Pathways implementation
- Note the ongoing work to maintain patient safety and regulatory compliance.

Integrated Performance Report

Board - September 2022

Rules for interpreting SPC Charts

Most charts contained in the report are SPC (Statistical Process Control). SPC charts follow the rules shown below to determine when something statistically significant has happened. Once these rules are triggered the control limits - dotted lines above and below the mean (centre line) are adjusted around the new data – this is known as resetting the limits



Q1 COMPLAINTS

Figure Q1.1

Complaints Recieved by Month: Severity 1-3

January 2017-August 2022

No of Complaints Received

Month Recieved

193

Figure Q1.2

Complaints Recieved by Month: Severity 4-5

January 2017- August 2022

No of Complaints Recieved

Month Recieved

6

Figure Q1.3

Figure Q1.4

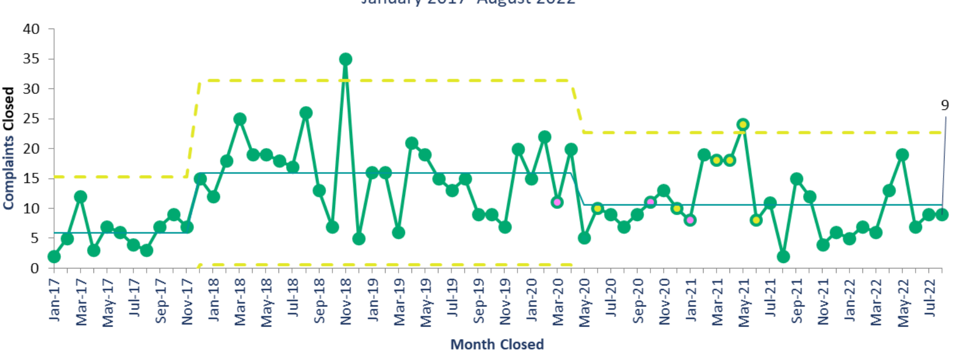


Figure Q1.5

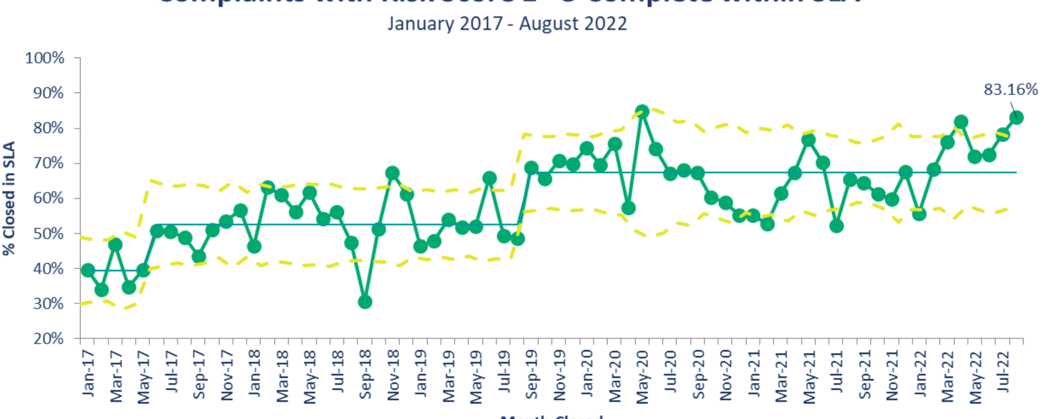


Figure Q1.6

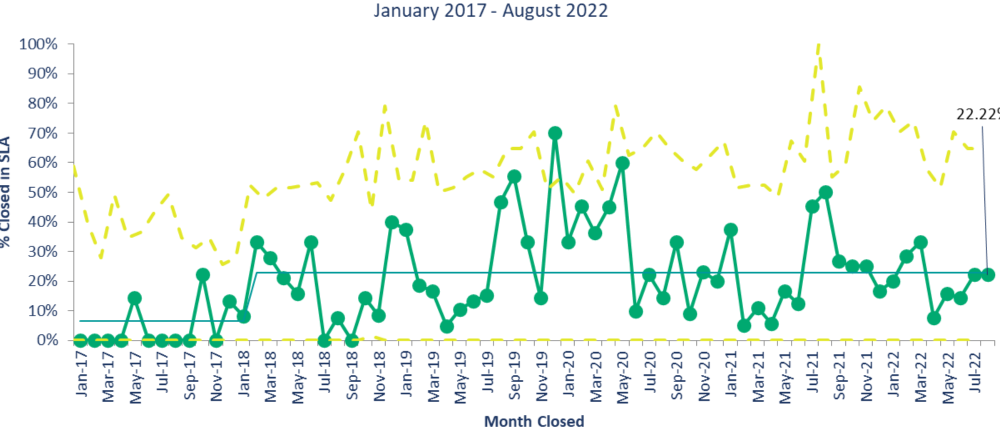
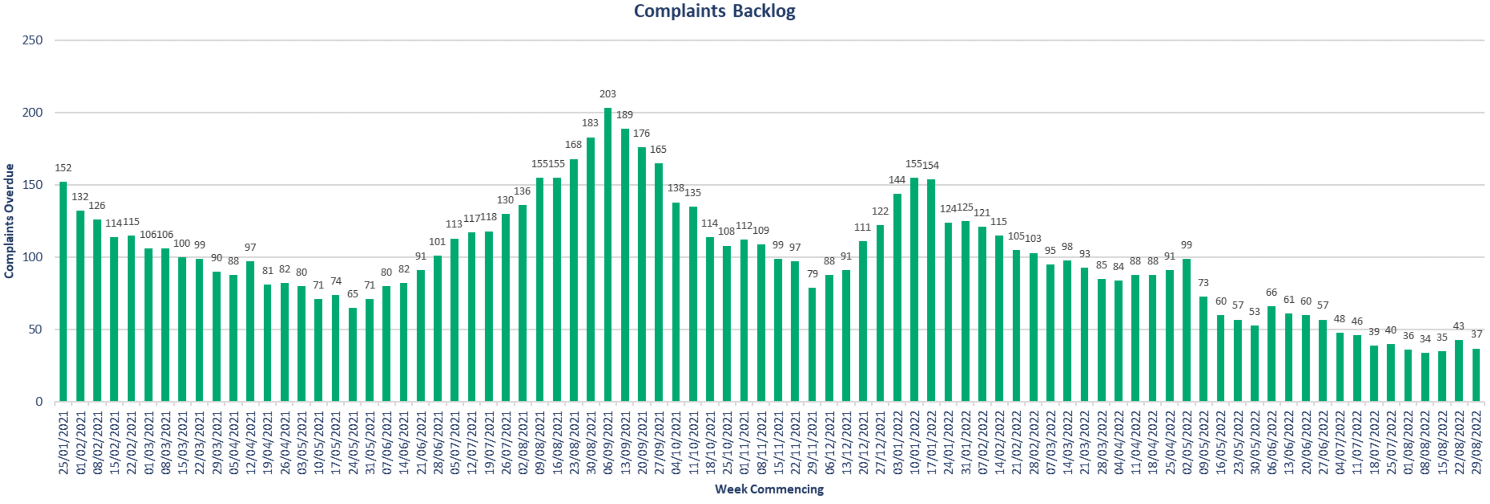


Figure Q1.7



Q2 Incidents

Figure Q2.1

Figure Q2.2

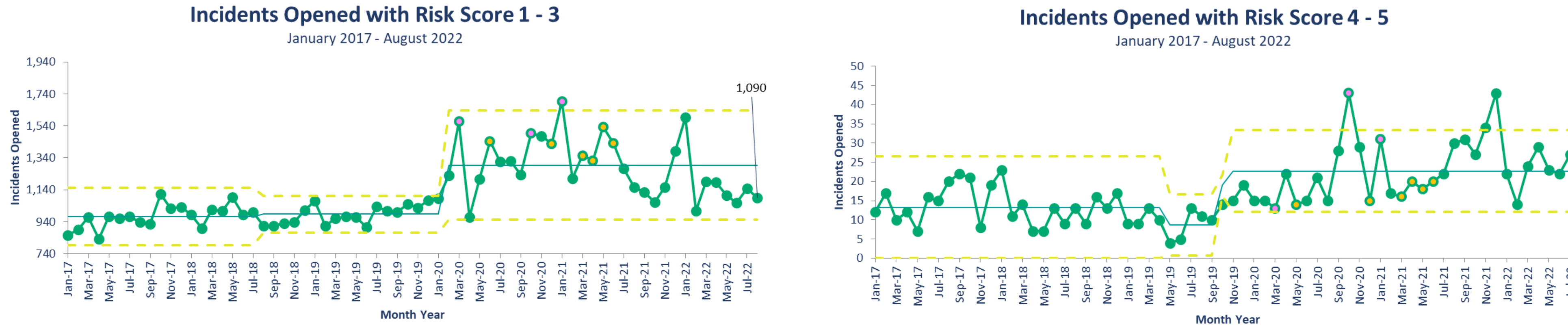


Figure Q2.3

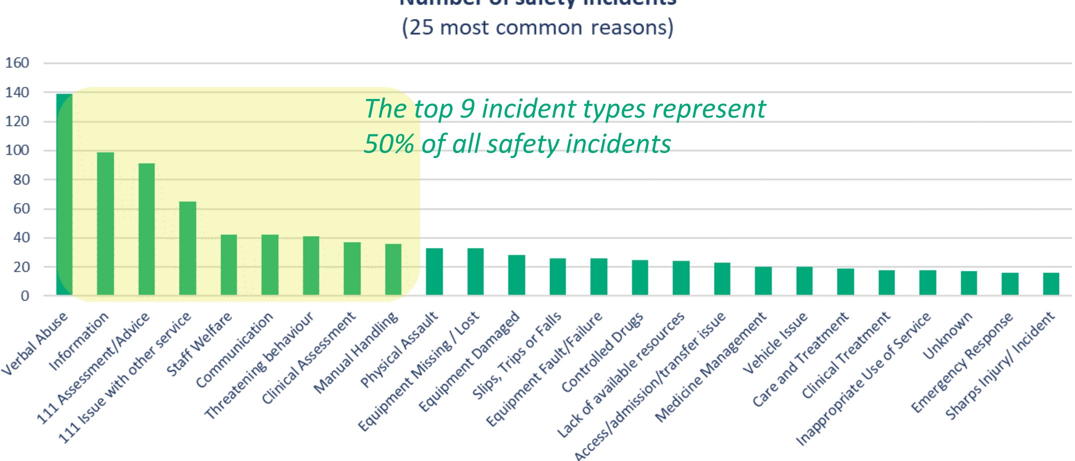


Figure Q2.4

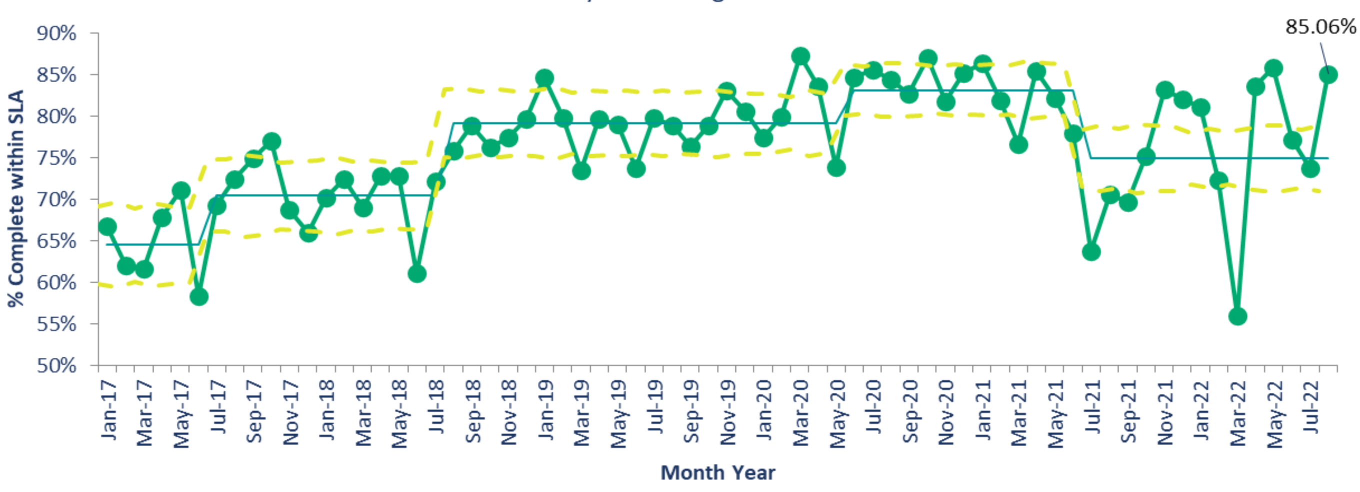
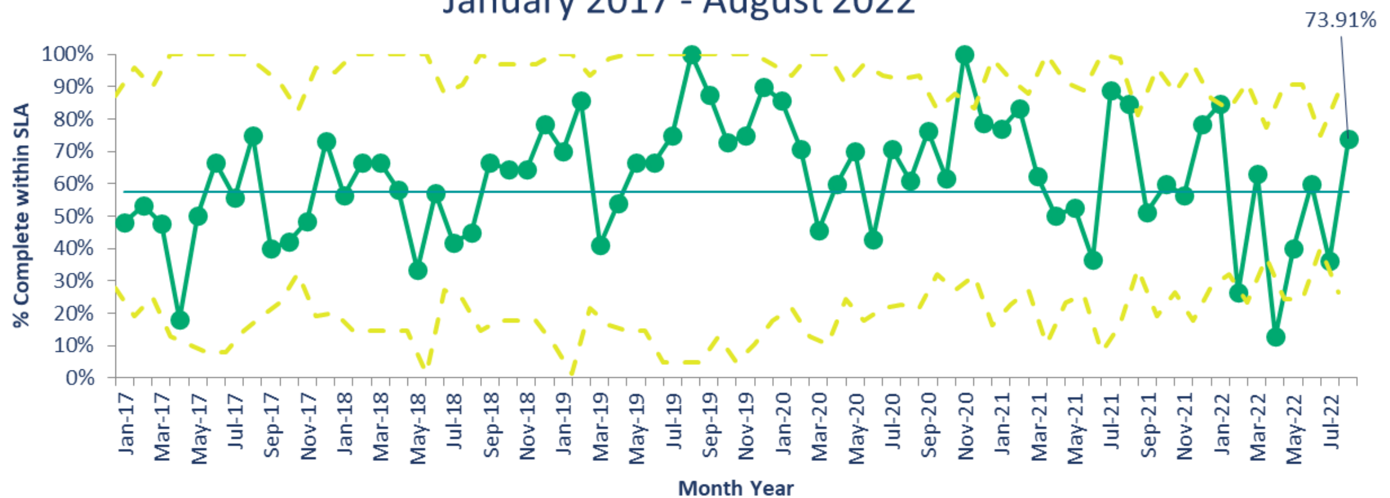


Figure Q2.5



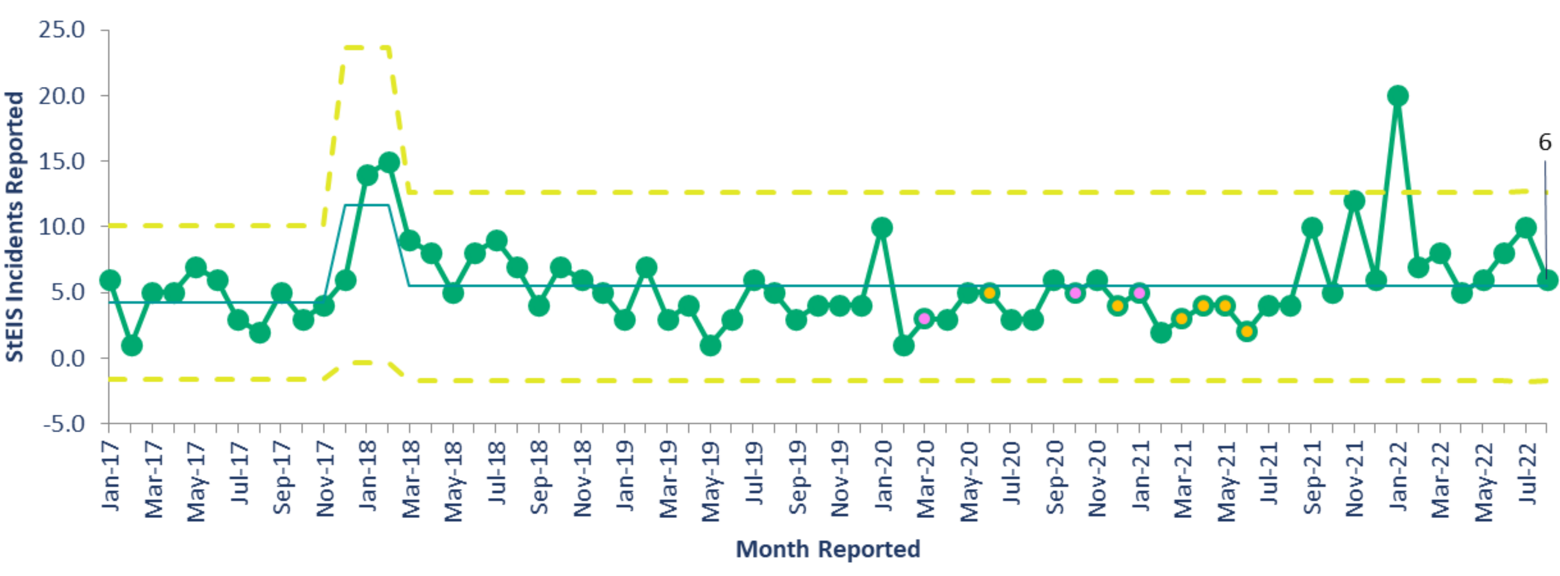
SLAs are calculated using the following measures/targets.

No exceptions are taken into account:

Risk Score	Target Days to Close Incident (From Date Received)
1	20
2	20
3	40
4	40
5	60

Q3 SERIOUS INCIDENTS

Figure Q3.1



Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Number of Alerts Received (Sept 21 – Aug 22)	Number of Alerts Applicable (Sept21 – Aug 22)	Number of Open Alerts	Notes
CAS/ NHS Improvement	8	0	0	

Safety Alerts	Number of Alerts Received (Sept 21 – Aug 22)	Number of Alerts Applicable (Sept 21 – Aug 22)	Number of Open Alerts	Notes
MHRA – Medical Equipment	8	0	0	

Safety Alerts	Number of Alerts Received (Sept 21 – Aug 22)	Number of Alerts Applicable (Sept 21 – Aug 22)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	67	1	0	Class 2 recall of Amiodarone injections. All stocks were checked an no recalled batch codes were found.

Safety Alerts	Number of Alerts Received (Sept 21 – Aug 22)	Number of Alerts Applicable (Sept 21 – Aug 22)	Number of Open Alerts	Notes
IPC	0	1	0	Continue to follow national guidance. There is a multi-faceted action plan that operates across the Trust, this includes HR, Procurement, Communications, Operations and the Quality teams. This is being discharged by E Ortton (Lead and DIPC) and the Executive Leadership Committee (ELC).

E1 PATIENT EXPERIENCE

Figure E1.1

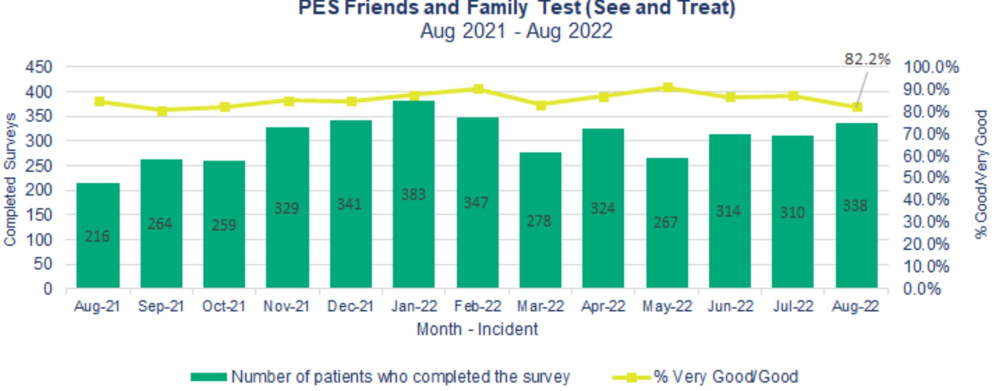
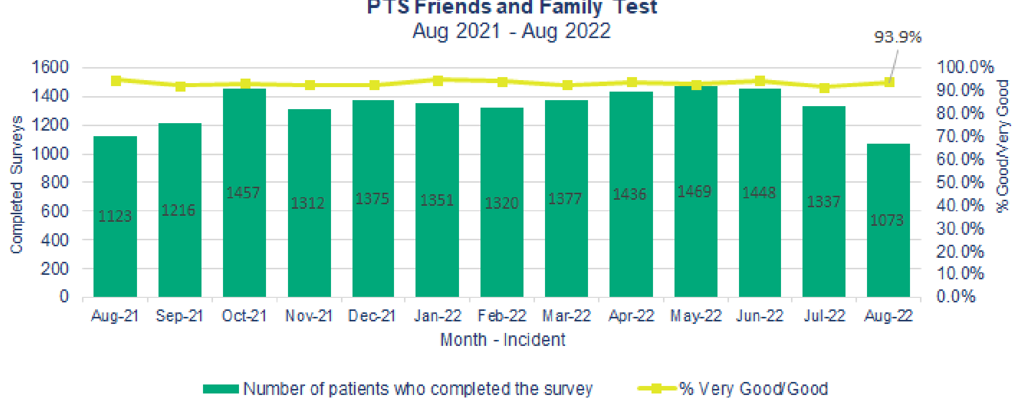


Figure E1.2



Positive

“Expected long wait time but was seen after about 1 hour. Very professional and efficient. Brilliant Paramedics. Sorted out my problem without needing to go to A&E (hypoglycaemia). Very thorough and left me with a clear plan and follow up.”

Negative

“The ambulance took 8 hours to get to me when I was suicidal. When the paramedics arrived, they didn't seem very empathetic or compassionate or understanding of mental health. I feel they needed more mental health training. Felt like a waste of time for them and for me.”

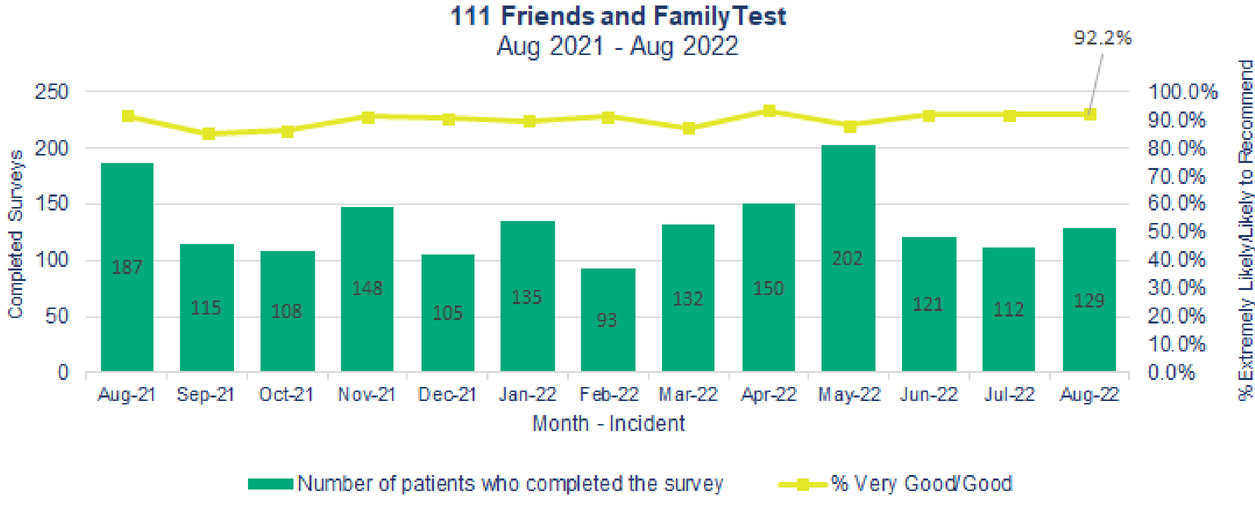
Positive

“The teams arrived in perfect time on both outward and return journeys. They used local knowledge to avoid traffic jams. Both teams were very friendly, helpful and professional and put my dad at ease. They made sure he was at exactly the right place for his appointment and that he was safely back in bed and comfortable on his return home.”

Negative

“The booking was for my husband who requires a wheelchair. He is rather poorly and very frail but was booked for a CT scan. Consequently, it was nil by mouth for 4 hours prior to the procedure which effectively meant he had nothing to eat since 5pm the previous day. We were collected at approximately 10am in the morning and his procedure was completed by 11:30. We then had to wait more than 3 hours before we were collected for our return trip home, finally arriving back home at about 4pm. He is currently suffering from pressure sores and together with his frailty and lack of nourishment the experience was altogether harrowing to say the least. I should add though that the accompanying staff on both trips was superb.”

Figure E1.3



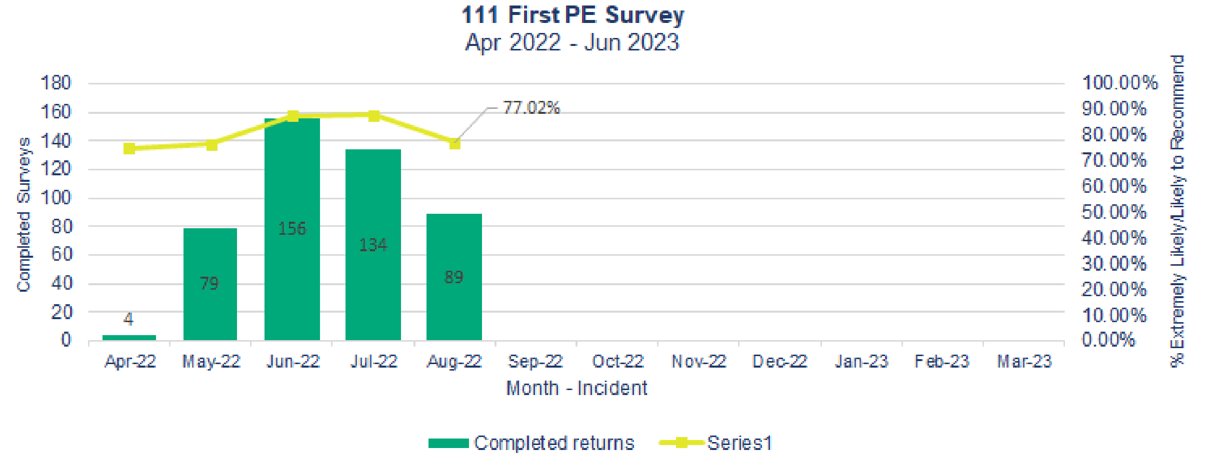
Positive

"The lady on the other end of the phone was very helpful and pleasant and listened to what I had to say. Made me feel more relaxed."

Negative

"Had to wait 40 minutes on phone before I could speak to someone at 111 only to be referred to a chemist who then told me I needed to see a doctor. All this I knew before calling 111. There needs to be an interim service to go so that people don't end up going to A and E. I ended up needing to go theatre for a severely infected finger."

Figure E1.4



Positive

"The person who dealt with the call was calm, sympathetic and efficient. Their questioning was clear and their assessment of the situation precise. The allocated time slot was reassuring."

Negative

Wanted to send me to a chemist, when I went to the walk-in centre, they didn't know I was coming."

Figure E1.5

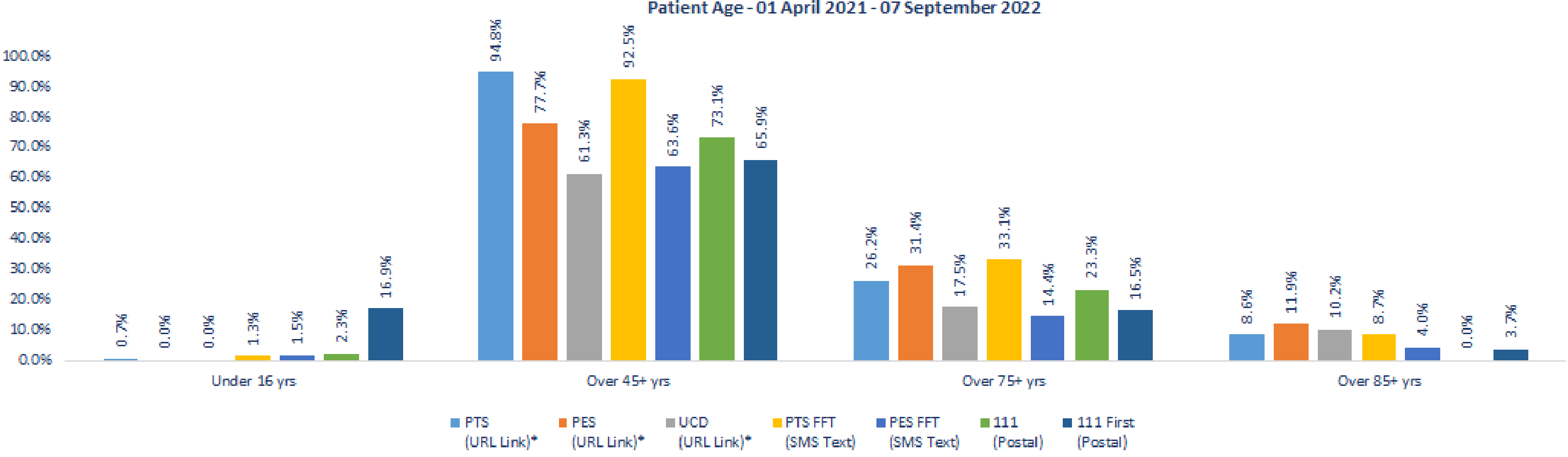


Figure E1.6

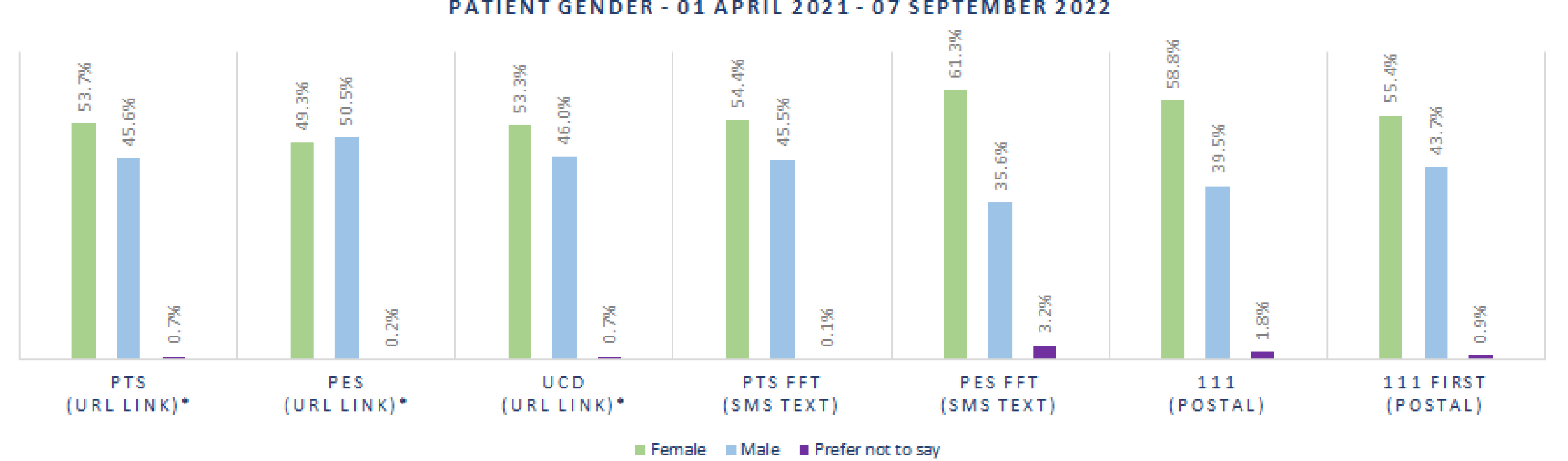


Figure E1.7

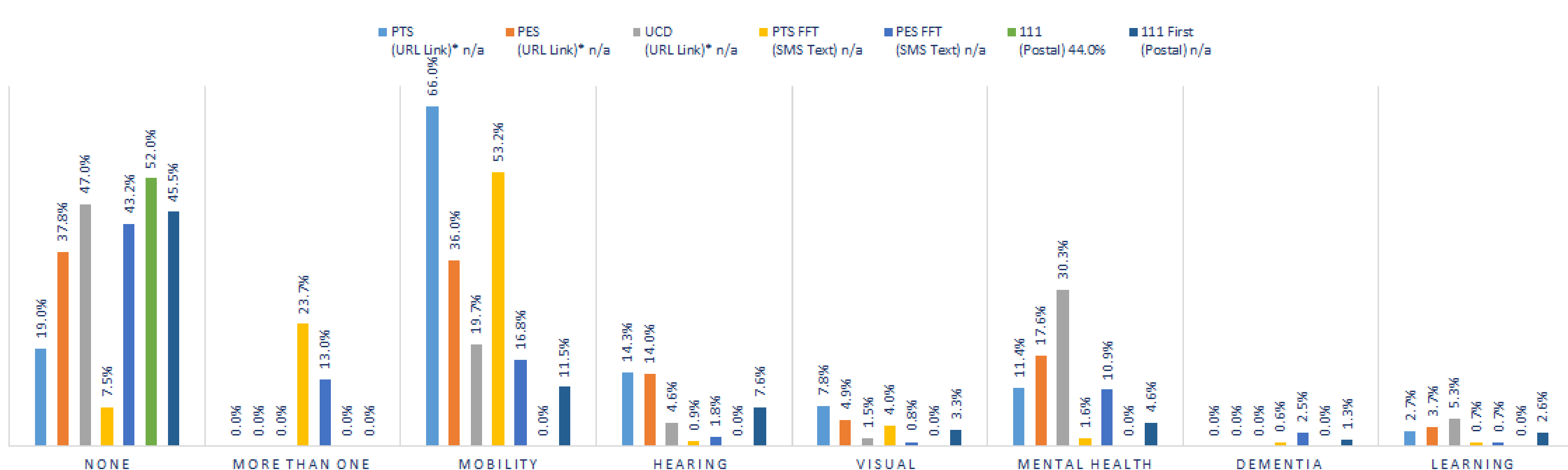
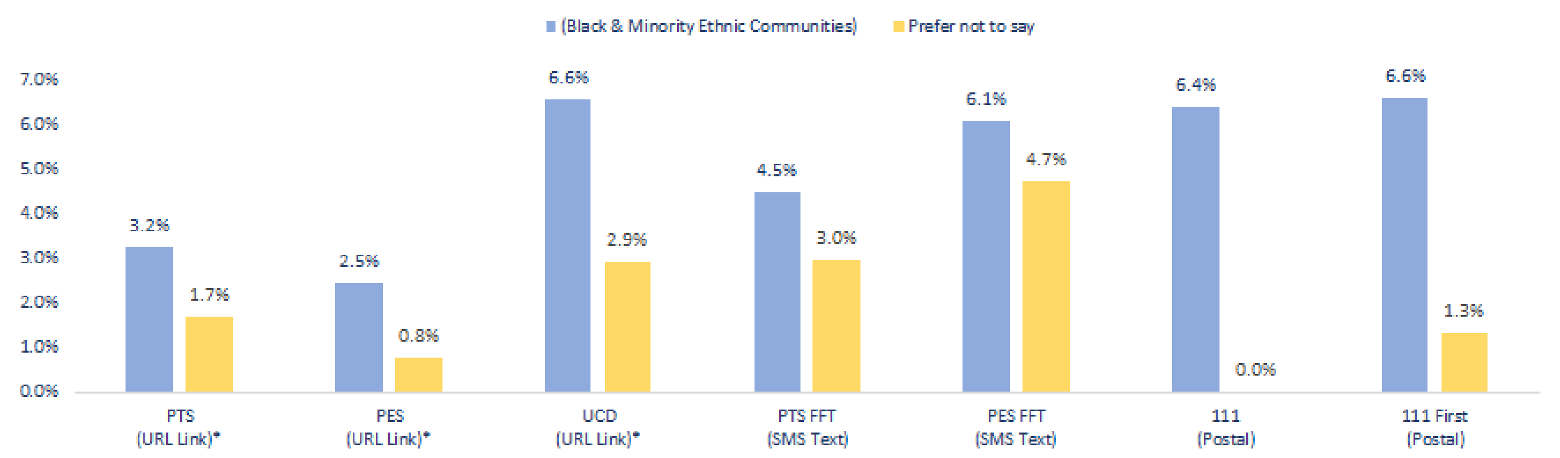


Figure E1.8



E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

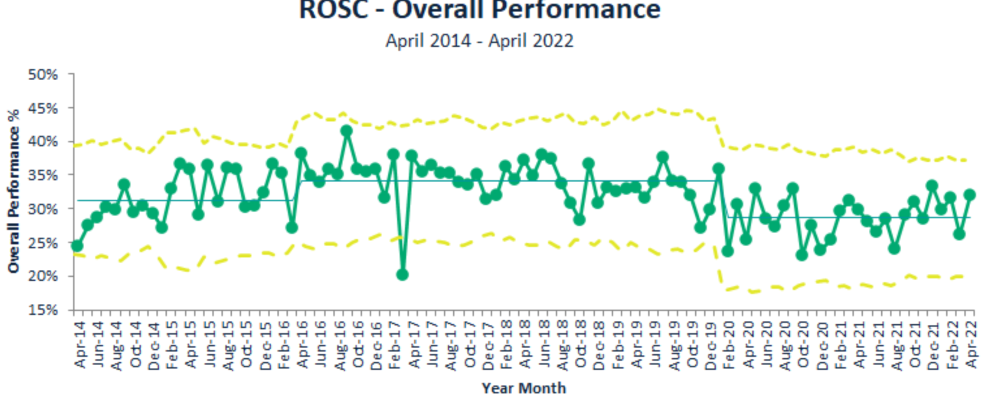


Figure E2.2

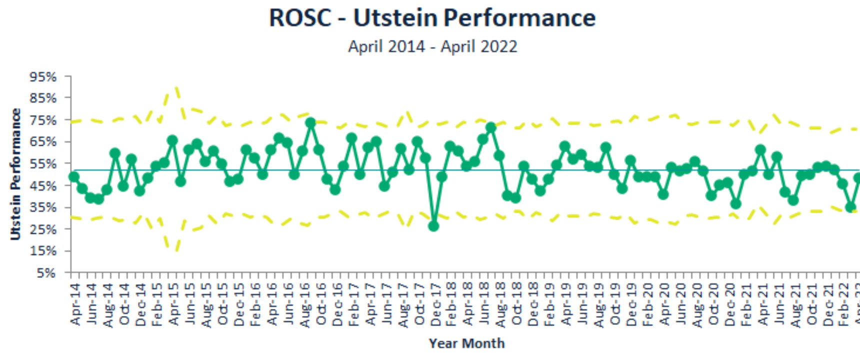


Figure E2.3

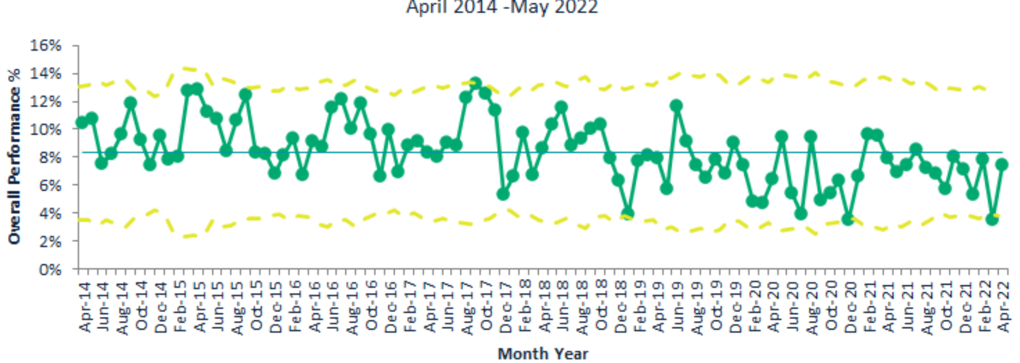


Figure E2.4

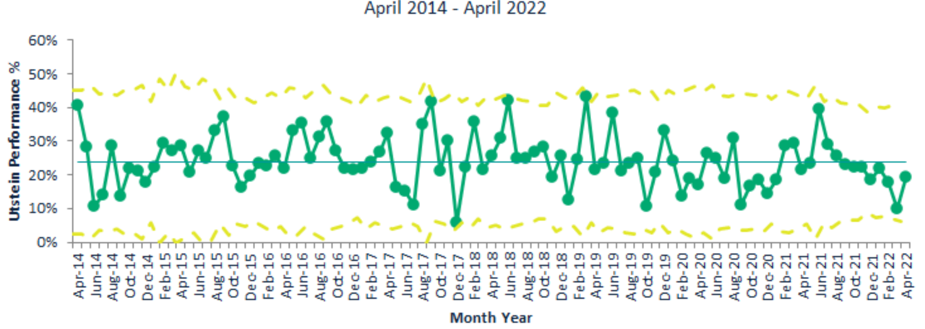


Figure E2.5

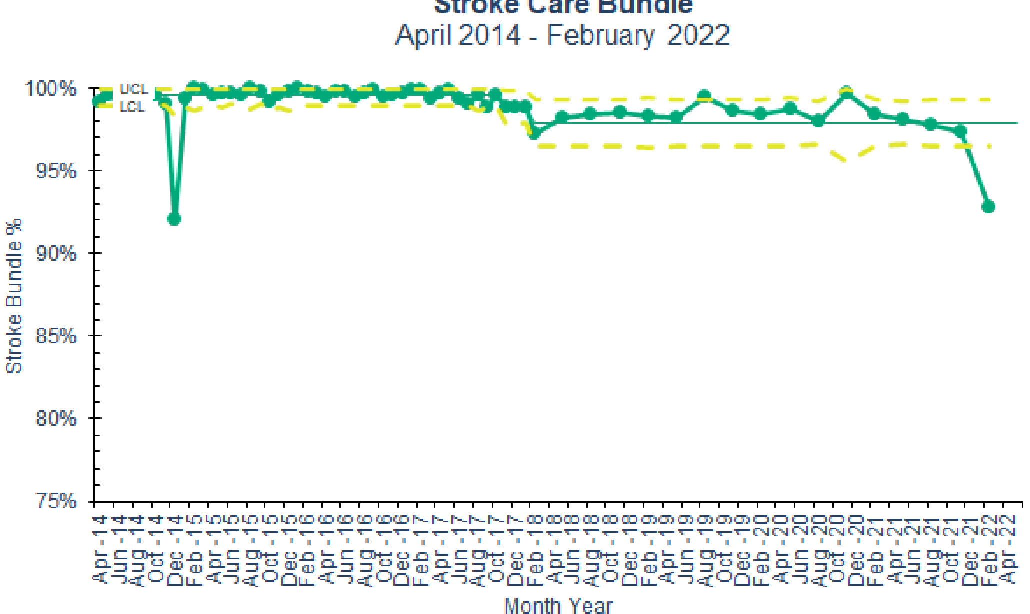
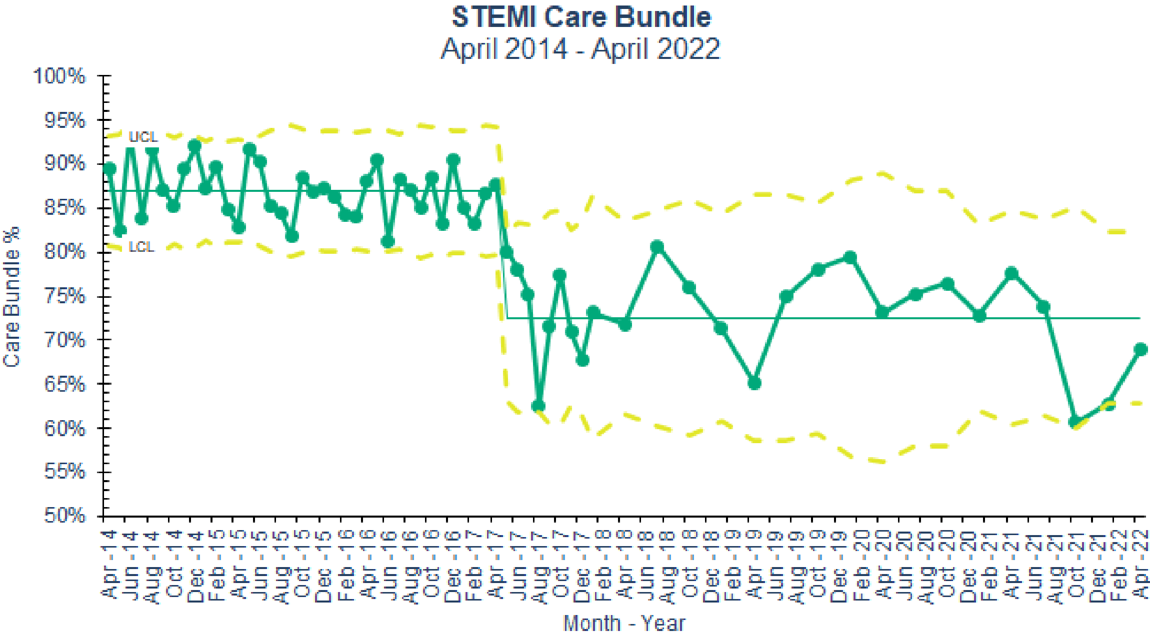


Figure E2.6



The axis for the Stroke Care Bundle starts at 75%, the axis for STEMI Care Bundle starts at 50%.

E3 ACTIVITY & OUTCOMES

Figure E3.1

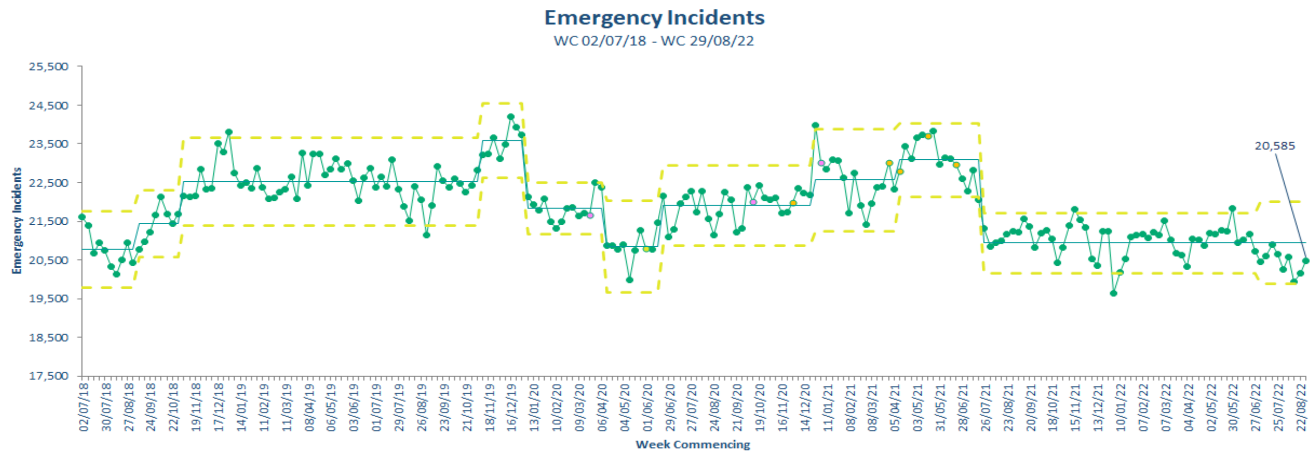


Figure E3.2

Sector	No. of Emergency Incidents
G Central	9,626
G South	9,446
M North	8,899
G West	8,430
G East	8,254
CL East Lancashire	7,246
M East	7,181
M West	5,995
CL South Lancashire	5,787
M South	5,120
CL Fylde	4,924
CL North Cumbria	4,437
CL Morecambe Bay	4,240

Figure E3.3

Emergency Incidents

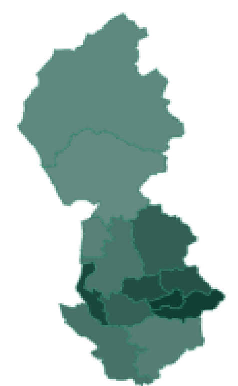


Figure E3.4

Aug	Calls	% Change from previous year	Incidents	% Change from previous year
2019	115,867		97,656	
2020	116,022	0%	96,134	-2%
2021	141,607	22%	93,354	-3%
2022	127,821	-10%	89,655	-4%

Figure E3.5

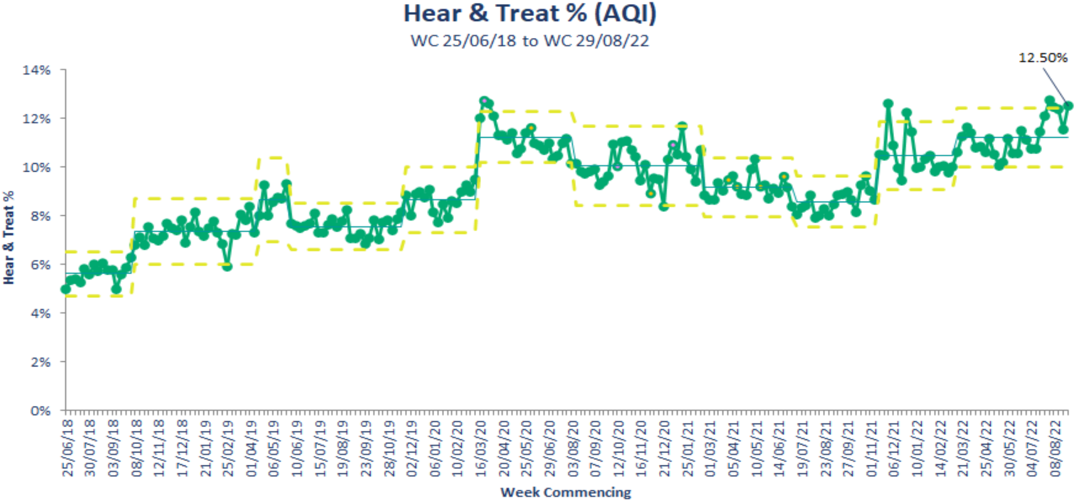


Figure E3.6

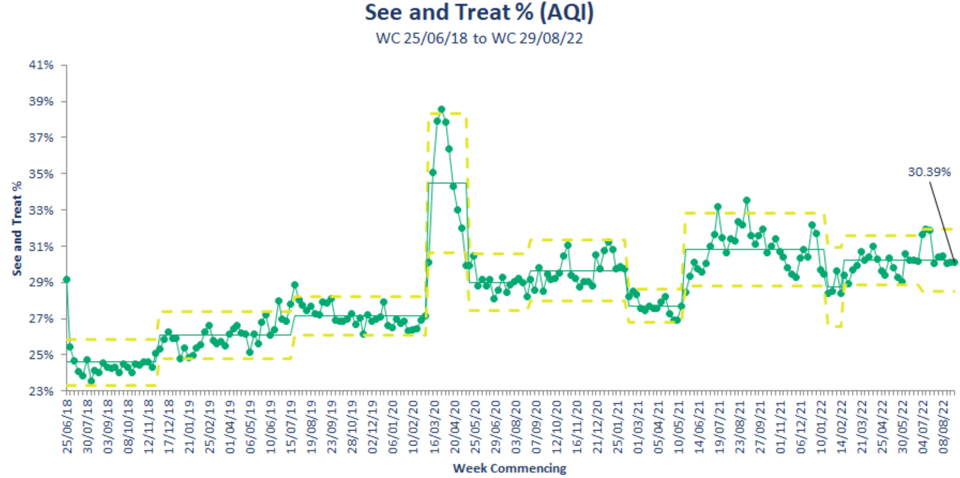


Figure E3.7

Sector	Hear & Treat	%
CL Fylde		15.76%
G Central		15.57%
G West		13.75%
G East		13.67%
CL East Lancashire		13.00%
CL South Lancashire		12.55%
G South		12.04%
M East		11.15%
M North		10.64%
M West		10.51%
M South		10.02%
CL Morecambe Bay		9.48%
CL North Cumbria		8.20%

Figure E3.8

Sector	See & Treat	%
M South		33.07%
CL South Lancashire		31.64%
CL Morecambe Bay		31.58%
G Central		31.54%
CL Fylde		31.36%
CL North Cumbria		31.12%
M West		30.81%
G West		30.37%
G East		30.34%
M North		30.06%
G South		29.74%
CL East Lancashire		28.58%
M East		28.34%

Figure E3.9

Figure E3.10

Figure E3.11

Sector	See & Convey	%
CL Fylde		52.88%
G Central		52.89%
CL South Lancashire		55.81%
G West		55.88%
G East		56.00%
M South		56.91%
G South		58.23%
CL East Lancashire		58.42%
M West		58.68%
CL Morecambe Bay		58.94%
M North		59.30%
M East		60.51%
CL North Cumbria		60.67%

Figure E3.12

Sector	See & Convey to AE	%
G Central		46.37%
G West		47.62%
G East		48.41%
CL South Lancashire		49.20%
CL Fylde		49.41%
M West		49.71%
G South		51.36%
M South		51.39%
CL East Lancashire		51.49%
M East		52.65%
M North		52.79%
CL North Cumbria		54.29%
CL Morecambe Bay		54.32%

Figure E3.13

Sector	See & Convey to Non AE	%
CL Fylde		3.47%
CL Morecambe Bay		4.62%
M South		5.53%
CL North Cumbria		6.38%
M North		6.51%
G Central		6.51%
CL South Lancashire		6.62%
G South		6.87%
CL East Lancashire		6.93%
G East		7.58%
M East		7.85%
G West		8.27%
M West		8.97%

Figure E3.14

Rank	Trust	Hear & Treat	%
1	West Midlands		13.8%
2	London		13.2%
3	East Midlands		12.9%
4	North West		12.3%
5	South Western		11.0%
6	South Central		10.8%
7	South East Coast		9.5%
8	Isle of Wight		8.5%
9	North East		8.2%
10	East of England		8.2%
11	Yorkshire		6.9%

Figure E3.15

Rank	Trust	See & Treat	%
1	South Western		40.0%
2	South Central		35.7%
3	Isle of Wight		33.8%
4	East of England		33.0%
5	East Midlands		32.5%
6	London		32.4%
7	South East Coast		32.3%
8	West Midlands		31.9%
9	North West		30.5%
10	Yorkshire		29.3%
11	North East		28.6%

Figure E3.16

Rank	Trust	See & Convey	%
1	South Western		48.9%
2	South Central		53.6%
3	West Midlands		54.3%
4	London		54.4%
5	East Midlands		54.6%
6	North West		57.2%
7	Isle of Wight		57.7%
8	South East Coast		58.2%
9	East of England		58.8%
10	North East		63.2%
11	Yorkshire		63.8%

Operational

O1 CALL PICK UP

Figure O1.1

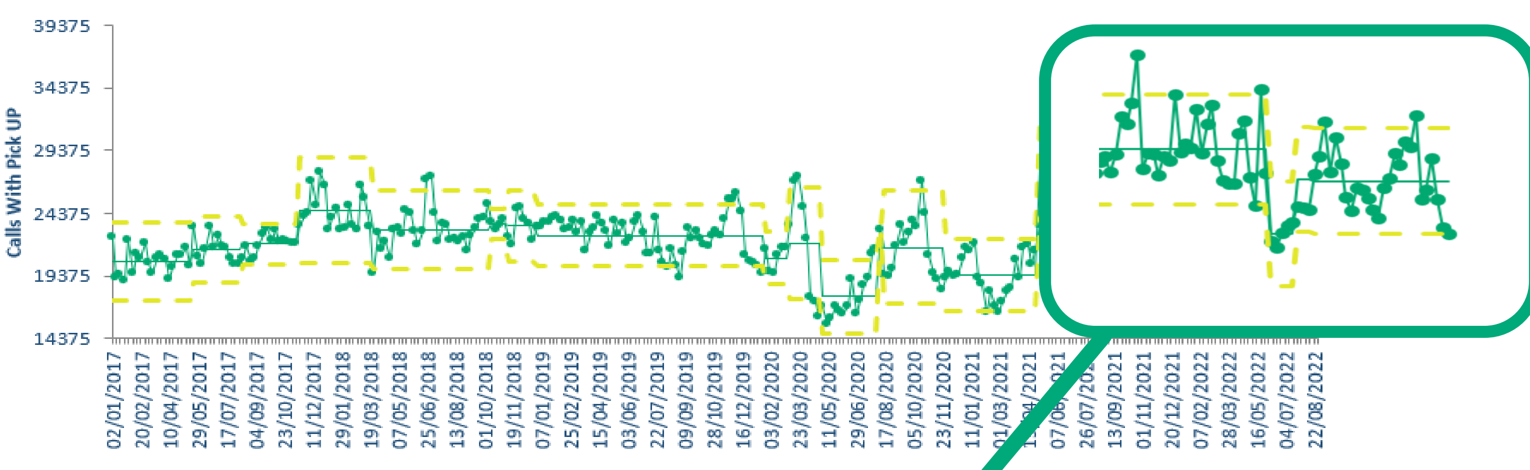
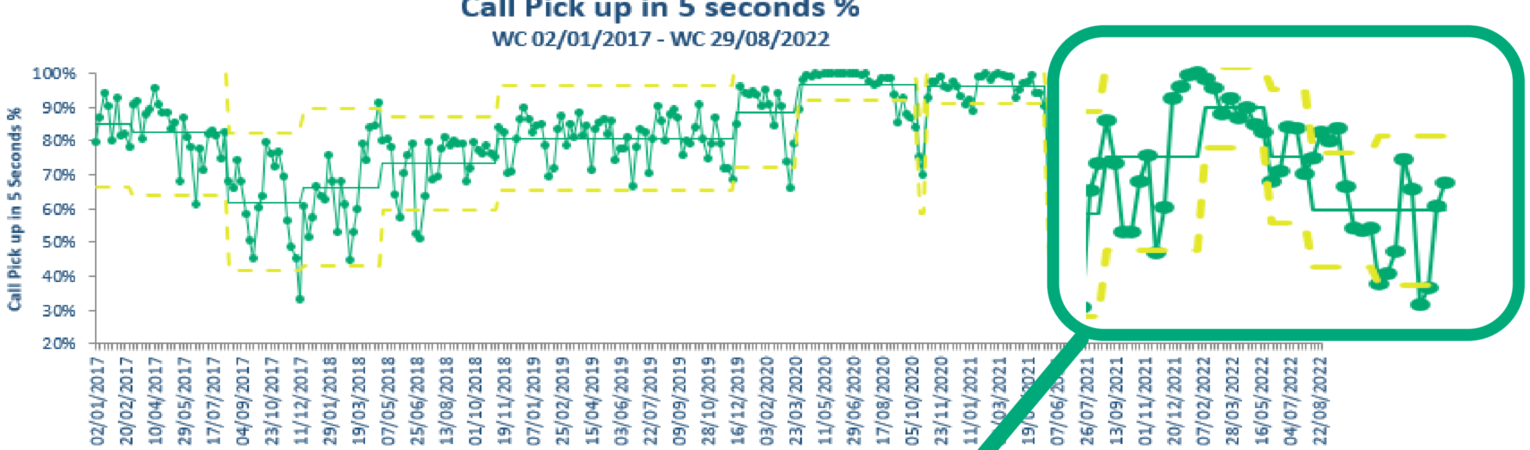


Figure O1.2



02 A&E TURNAROUND

Figure O2.1

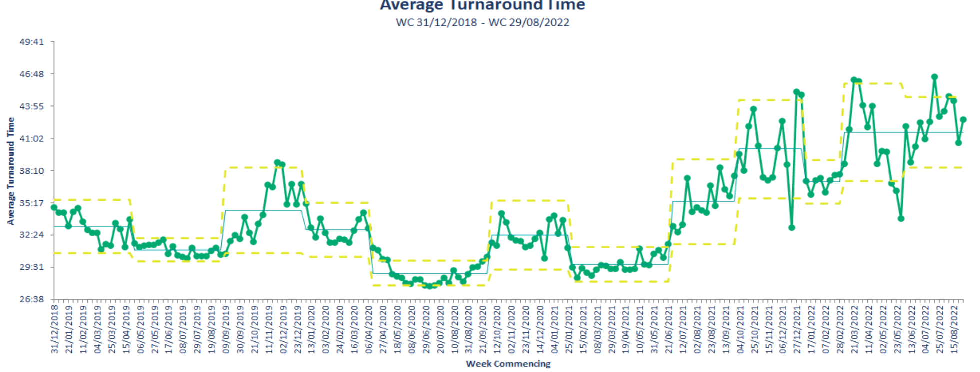


Figure Q1.2

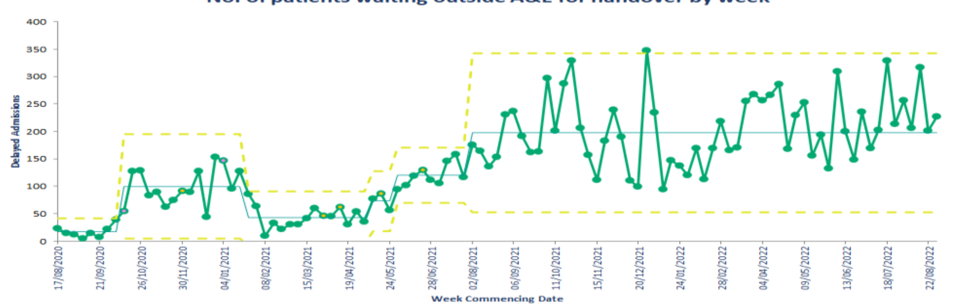


Table Q1.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Sep-21	47,467	0:36:49	0:25:26	11:41
Oct-21	38,181	0:39:27	0:27:56	11:25
Nov-21	48,412	0:38:29	0:27:28	11:34
Dec-21	47,723	0:39:22	0:27:58	11:18
Jan-22	47,332	0:39:09	0:27:47	11:31
Feb-22	45,232	0:37:13	0:25:56	11:15
Mar-22	47,939	0:42:06	0:30:57	11:48
Apr-22	45,768	0:42:27	0:30:52	11:22
May-22	49,135	0:37:56	0:26:22	11:34
Jun-22	47,276	0:39:45	0:27:56	11:40
Jul-22	46,006	0:42:52	0:31:39	11:14
Aug-22	45,186	0:43:33	0:31:50	11:22

Table Q1.2

Top 5 Trusts with most hours lost due to delayed	
Trust	Hours lost to delayed admissions
Royal Preston Hospital	433.1
Royal Lancaster Hospital	323.1
Fairfield General Hospital	319.5
Blackpool Victoria Hospital	214.7
Royal Oldham Hospital	139.5

Table Q1.3

Month	No. of patients waiting outside A&E for handover
Aug-20*	38
Sep-20	46
Oct-20	355
Nov-20	347
Dec-20	406
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct-21	1156
Nov-21	739
Dec-21	824
Jan-22	708
Feb-22	590
Mar-22	936
Apr-22	1057
May-22	891
Jun-22	926
Jul-22	975
Aug-22	1099

O3 ARP RESPONSE TIMES

August 2022

Figure O3.1

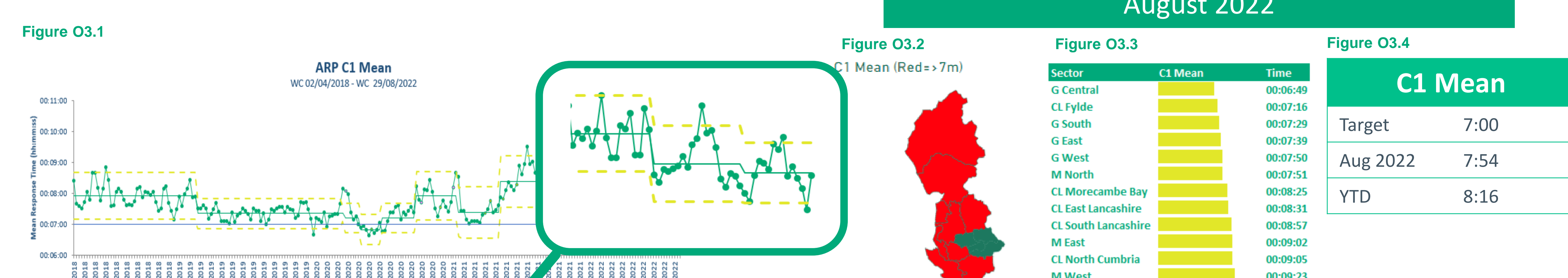


Figure O3.2

C1 Mean (Red=>7m)

Figure O3.3

Sector	C1 Mean	Time
G Central		00:06:49
CL Fylde		00:07:16
G South		00:07:29
G East		00:07:39
G West		00:07:50
M North		00:07:51
CL Morecambe Bay		00:08:25
CL East Lancashire		00:08:31
CL South Lancashire		00:08:57
M East		00:09:02
CL North Cumbria		00:09:05
M West		00:09:23
M South		00:10:45

Figure O3.4

C1 Mean	
Target	7:00
Aug 2022	7:54
YTD	8:16

Figure O3.5

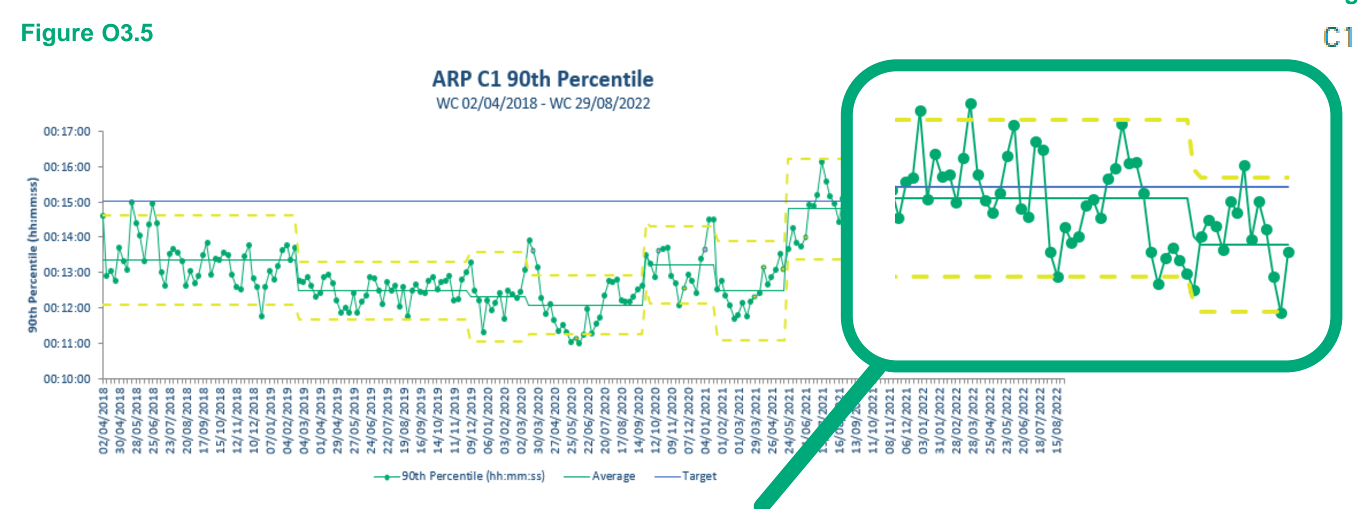


Figure O3.6

C1 90th (Red=>15m)

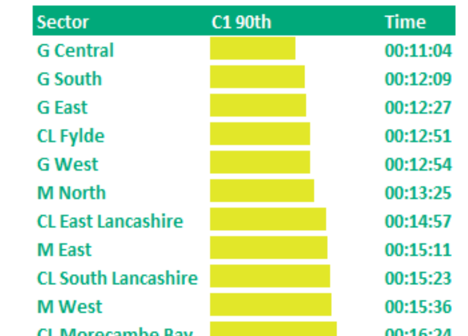


Figure O3.7

Sector	C1 90th	Time
G Central		00:11:04
G South		00:12:09
G East		00:12:27
CL Fylde		00:12:51
G West		00:12:54
M North		00:13:25
CL East Lancashire		00:14:57
M East		00:15:11
CL South Lancashire		00:15:23
M West		00:15:36
CL Morecambe Bay		00:16:24
CL North Cumbria		00:17:20
M South		00:18:23

Figure O3.8

C1 90th	
Target	15:00
Aug 2022	13:50
YTD	14:07

August 2022

Figure O3.9

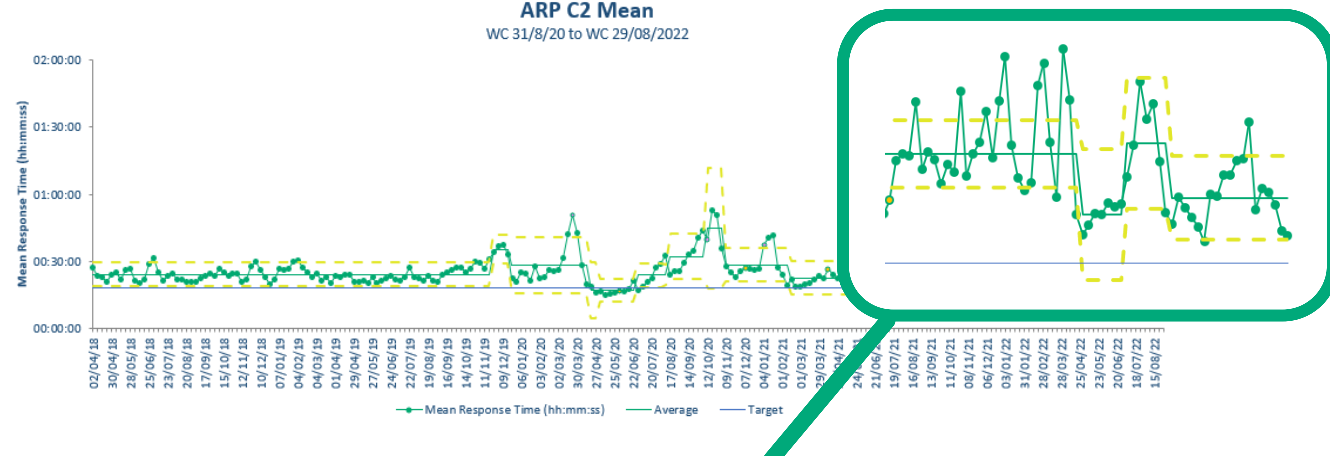


Figure O3.10

C2 Mean (Red=>18m)

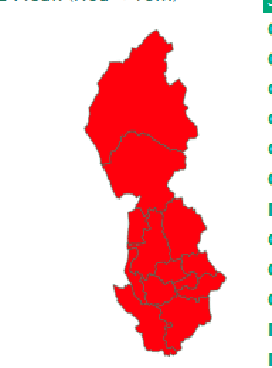


Figure O3.11

Sector	C2 Mean	Time
CL North Cumbria		00:24:10
CL Morecambe Bay		00:27:26
G South		00:27:46
G East		00:29:58
G Central		00:30:46
CL East Lancashire		00:33:50
M South		00:36:43
G West		00:37:00
CL South Lancashire		00:38:51
CL Fylde		00:42:21
M West		00:44:37
M North		00:46:55
M East		00:47:59

Figure O3.12

C2 Mean	
Target	18:00
Aug 2022	36:06
YTD	41:27

Figure O3.13

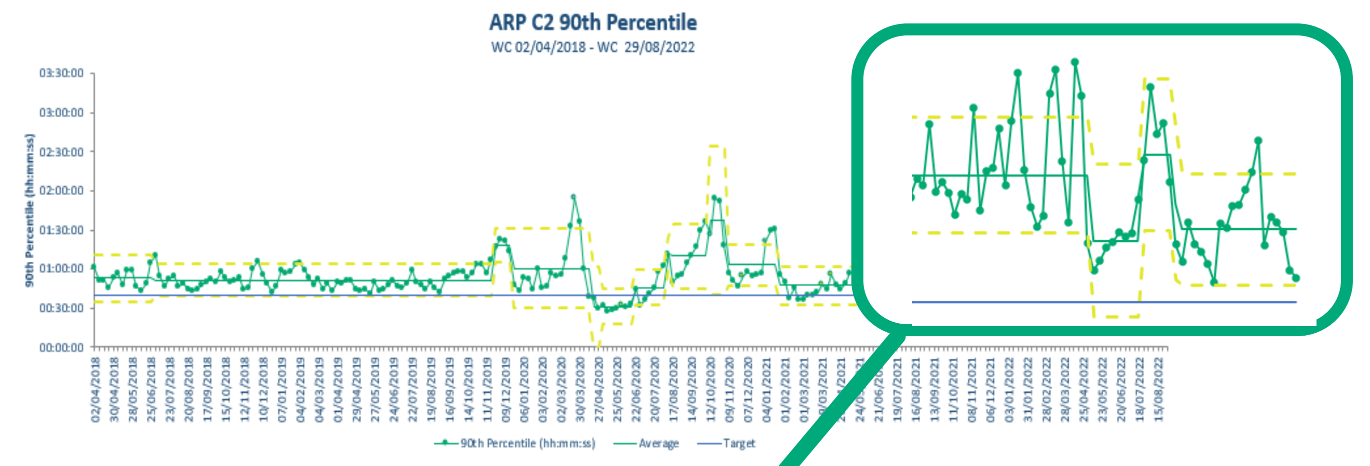


Figure O3.14

C2 90th (Red=>40m)

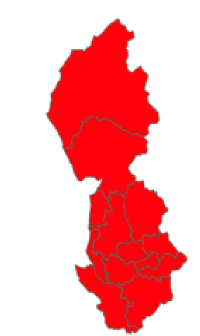


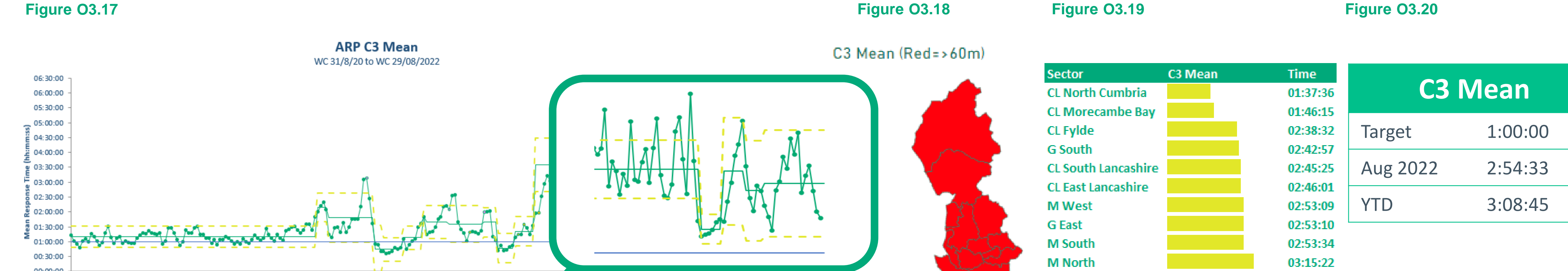
Figure O3.15

Sector	C2 90th	Time
CL North Cumbria		00:48:33
CL Morecambe Bay		00:58:29
G South		01:01:32
G East		01:03:46
G Central		01:05:32
CL East Lancashire		01:11:33
M South		01:17:46
G West		01:20:37
CL South Lancashire		01:20:40
M West		01:37:18
CL Fylde		01:41:03
M North		01:44:27
M East		01:45:59

Figure O3.16

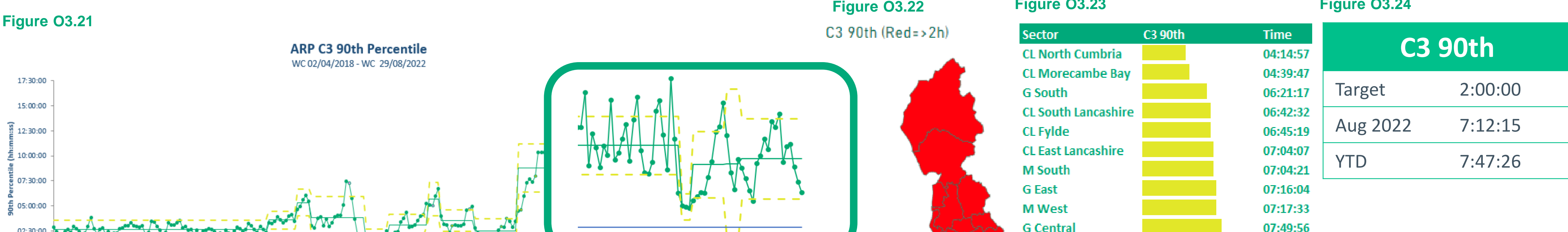
C2 90th	
Target	0:40:00
Aug 2022	1:19:44
YTD	1:32:49

August 2022



Sector	C3 Mean	Time
CL North Cumbria		01:37:36
CL Morecambe Bay		01:46:15
CL Fylde		02:38:32
G South		02:42:57
CL South Lancashire		02:45:25
CL East Lancashire		02:46:01
M West		02:53:09
G East		02:53:10
M South		02:53:34
M North		03:15:22
G Central		03:19:29
G West		03:23:25
M East		03:42:28

C3 Mean	
Target	1:00:00
Aug 2022	2:54:33
YTD	3:08:45



Sector	C3 90th	Time
CL North Cumbria		04:14:57
CL Morecambe Bay		04:39:47
G South		06:21:17
CL South Lancashire		06:42:32
CL Fylde		06:45:19
CL East Lancashire		07:04:07
M South		07:04:21
G East		07:16:04
M West		07:17:33
G Central		07:49:56
G West		07:53:38
M North		08:09:34
M East		09:45:57

C3 90th	
Target	2:00:00
Aug 2022	7:12:15
YTD	7:47:26

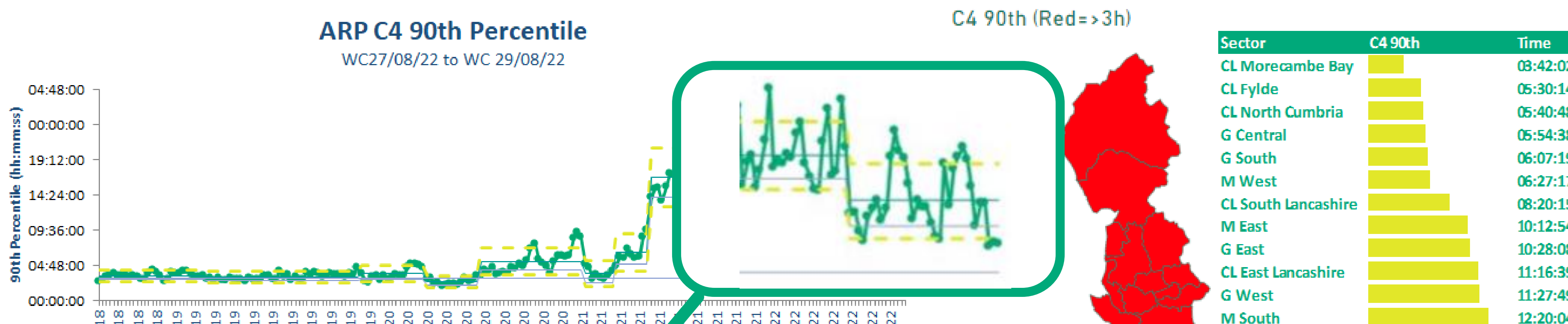
August 2022

Figure O3.25

Figure O3.26

Figure O3.27

Figure O3.28



Sector	C4 90th	Time
CL Morecambe Bay		03:42:02
CL Fylde		05:30:14
CL North Cumbria		05:40:48
G Central		05:54:38
G South		06:07:19
M West		06:27:17
CL South Lancashire		08:20:15
M East		10:12:54
G East		10:28:08
CL East Lancashire		11:16:39
G West		11:27:49
M South		12:20:04
M North		12:27:58

C4 90th	
Target	3:00:00
Aug 2022	8:18:25
YTD	10:42:20

O3 ARP Provider Comparison

Figure O3.25

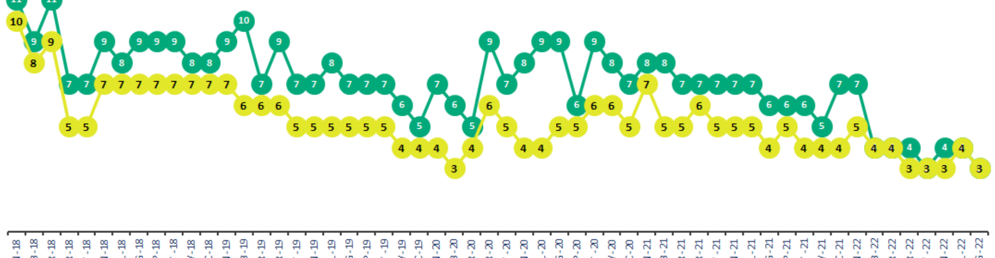


Figure O3.26

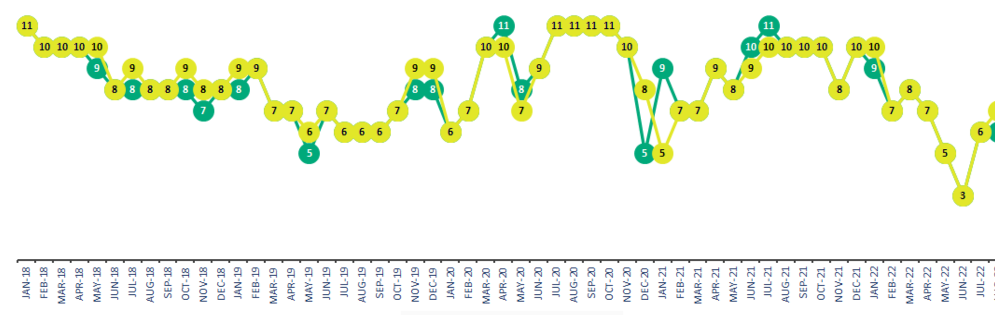


Figure O3.27

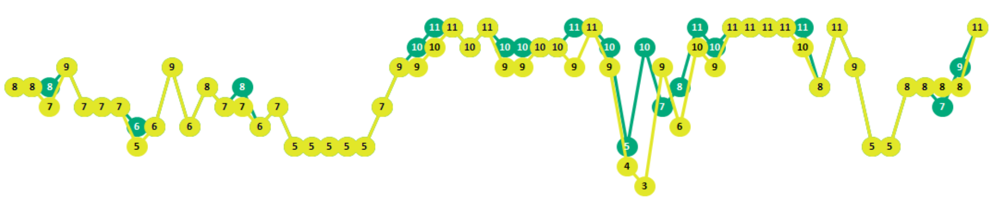
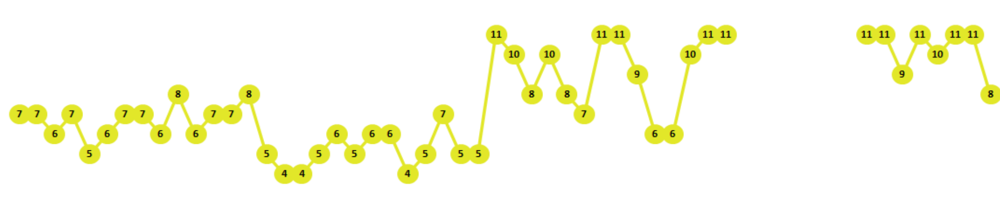
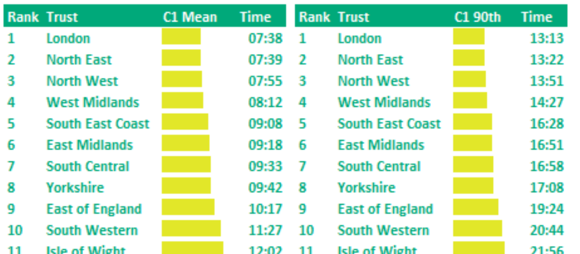


Figure O3.28





Rank	Trust	C1 Mean	Time
1	London		07:38
2	North East		07:39
3	North West		07:55
4	West Midlands		08:12
5	South East Coast		09:08
6	East Midlands		09:18
7	South Central		09:33
8	Yorkshire		09:42
9	East of England		10:17
10	South Western		11:27
11	Isle of Wight		12:02

Rank	Trust	C1 90th	Time
1	London		13:13
2	North East		13:22
3	North West		13:51
4	West Midlands		14:27
5	South East Coast		16:28
6	East Midlands		16:51
7	South Central		16:58
8	Yorkshire		17:08
9	East of England		19:24
10	South Western		20:44
11	Isle of Wight		21:56

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:28:32
2	South Central		0:31:46
3	Yorkshire		0:32:38
4	South East Coast		0:35:29
5	West Midlands		0:35:50
6	North West		0:36:06
7	North East		0:37:32
8	London		0:42:14
9	East Midlands		0:53:07
10	South Western		0:59:45
11	East of England		1:01:22

Rank	Trust	C2 90th	Time
1	Isle of Wight		0:57:31
2	South Central		1:01:31
3	Yorkshire		1:11:47
4	South East Coast		1:13:30
5	North East		1:18:11
6	West Midlands		1:19:32
7	North West		1:19:43
8	London		1:36:19
9	East Midlands		2:00:01
10	South Western		2:05:09
11	East of England		2:17:46

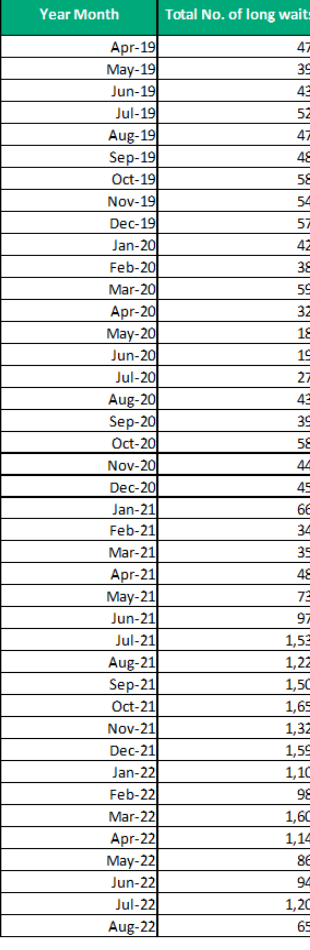
Rank	Trust	C3 Mean	Time
1	Isle of Wight		01:08:02
2	Yorkshire		01:25:40
3	London		01:46:19
4	South Central		01:52:09
5	North East		01:56:59
6	South Western		02:09:29
7	West Midlands		02:33:13
8	East Midlands		02:34:06
9	South East Coast		02:44:11
10	East of England		02:49:13
11	North West		02:54:33

Rank	Trust	C3 90th	Time
1	Isle of Wight		02:38:32
2	Yorkshire		03:21:32
3	South Central		04:11:14
4	London		04:30:12
5	North East		05:05:06
6	South Western		05:44:44
7	East Midlands		06:27:54
8	West Midlands		06:39:10
9	South East Coast		06:49:13
10	East of England		06:57:20
11	North West		07:12:15

Rank	Trust	C4 90th	Time
1	Isle of Wight		02:51:14
2	Yorkshire		03:24:15
3	North East		04:54:52
4	South Central		05:25:16
5	South Western		06:54:27
6	West Midlands		07:34:34
7	London		08:02:14
8	North West		08:18:25
9	East Midlands		11:13:12
10	South East Coast		11:14:23
11	East of England		11:54:22

O3 LONG WAITS

Table O3.29



Year Month	Total No. of long waits
Apr-19	471
May-19	393
Jun-19	436
Jul-19	523
Aug-19	471
Sep-19	482
Oct-19	582
Nov-19	542
Dec-19	575
Jan-20	425
Feb-20	385
Mar-20	594
Apr-20	329
May-20	186
Jun-20	196
Jul-20	274
Aug-20	437
Sep-20	394
Oct-20	586
Nov-20	447
Dec-20	455
Jan-21	663
Feb-21	340
Mar-21	358
Apr-21	489
May-21	734
Jun-21	971
Jul-21	1,534
Aug-21	1,226
Sep-21	1,501
Oct-21	1,650
Nov-21	1,329
Dec-21	1,590
Jan-22	1,109
Feb-22	985
Mar-22	1,609
Apr-22	1,145
May-22	869
Jun-22	940
Jul-22	1,207
Aug-22	653

Figure O3.29

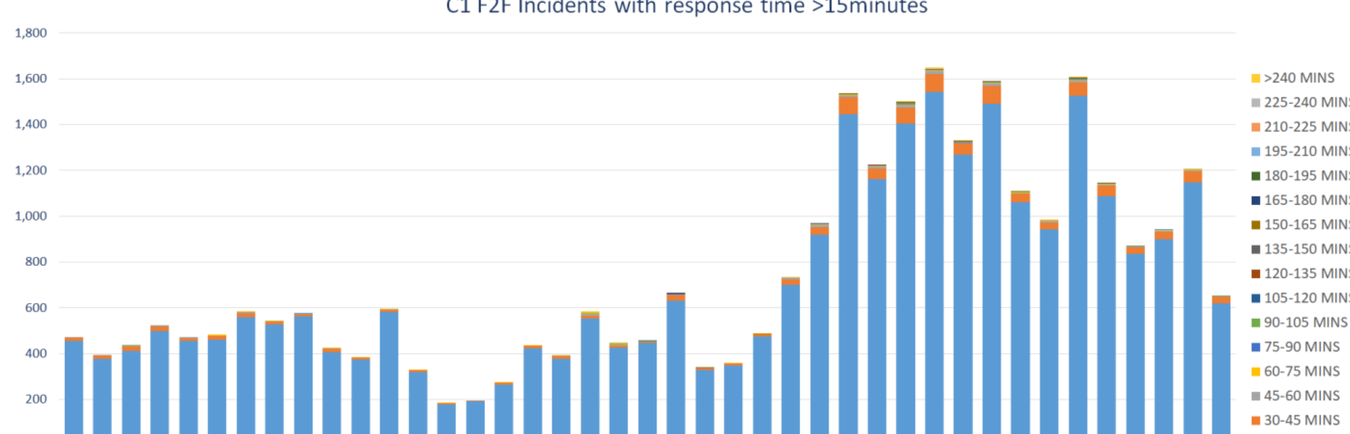


Figure O3.30

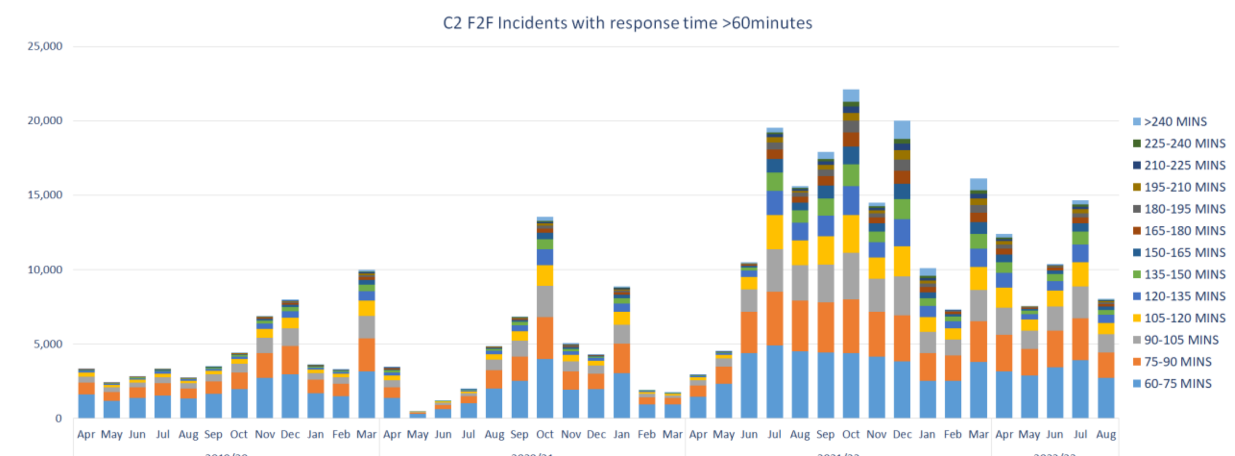
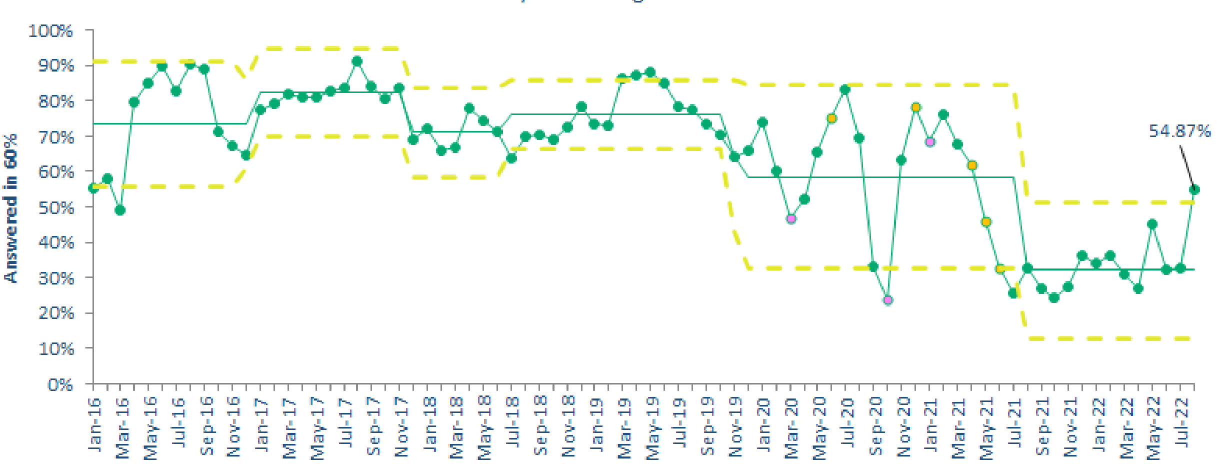


Table O3.30

Year Month	Total No. of long waits
Apr-19	3,344
May-19	2,412
Jun-19	2,817
Jul-19	3,332
Aug-19	2,765
Sep-19	3,479
Oct-19	4,412
Nov-19	6,888
Dec-19	7,998
Jan-20	3,604
Feb-20	3,303
Mar-20	10,001
Apr-20	3,458
May-20	483
Jun-20	1,193
Jul-20	2,003
Aug-20	4,860
Sep-20	6,874
Oct-20	13,563
Nov-20	5,090
Dec-20	4,290
Jan-21	8,889
Feb-21	1,908
Mar-21	1,739
Apr-21	2,918
May-21	4,523
Jun-21	10,503
Jul-21	19,540
Aug-21	15,612
Sep-21	17,922
Oct-21	22,113
Nov-21	14,518
Dec-21	20,038
Jan-22	10,127
Feb-22	7,349
Mar-22	16,135
Apr-22	12,400
May-22	7,564
Jun-22	10,374
Jul-22	14,649
Aug-22	8,051

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
Aug 2022	54.9%
YTD	38.37%
National	51.7%

Figure O4.2

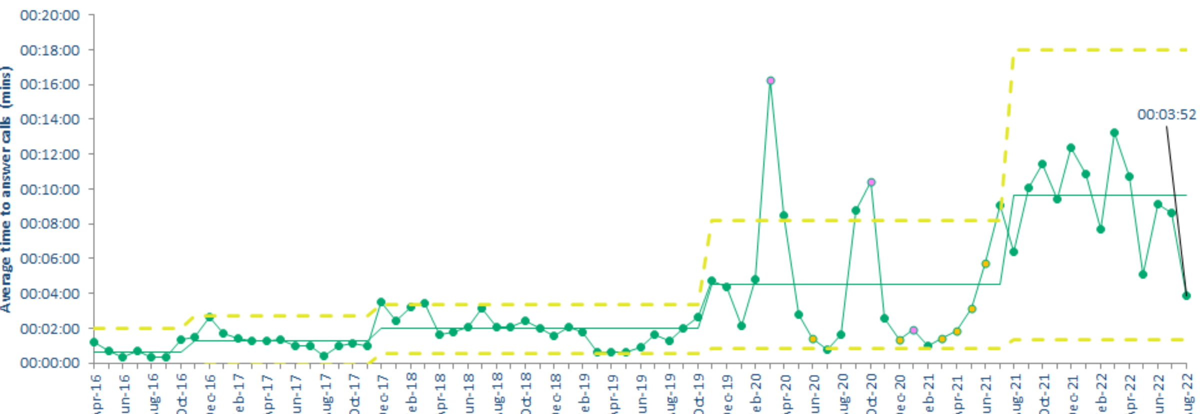
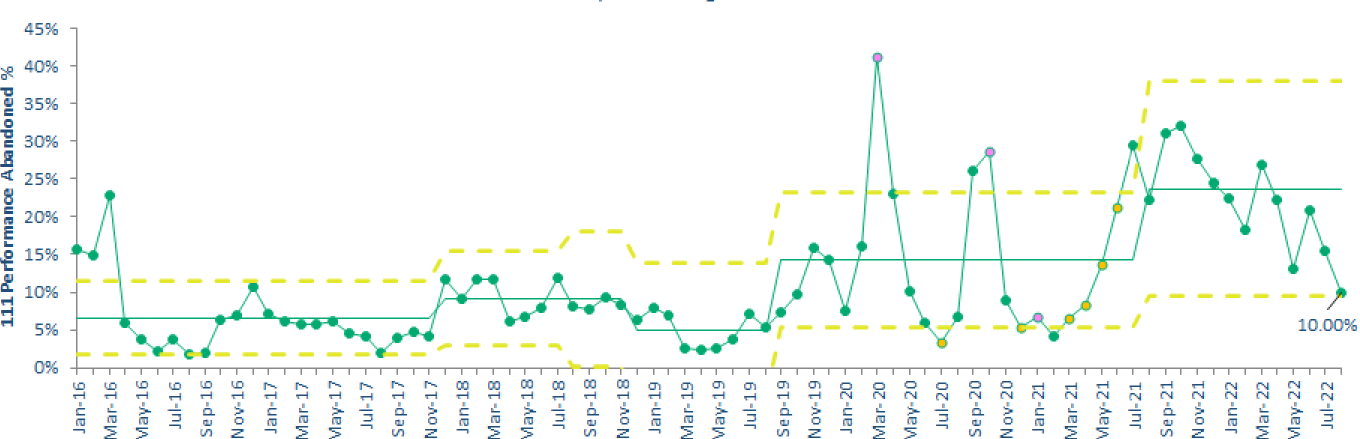


Figure O4.3



Calls Abandoned %	
Target	<5%
Aug 2022	10.00%
YTD	16.32%
National	16.8%

Figure O4.4a

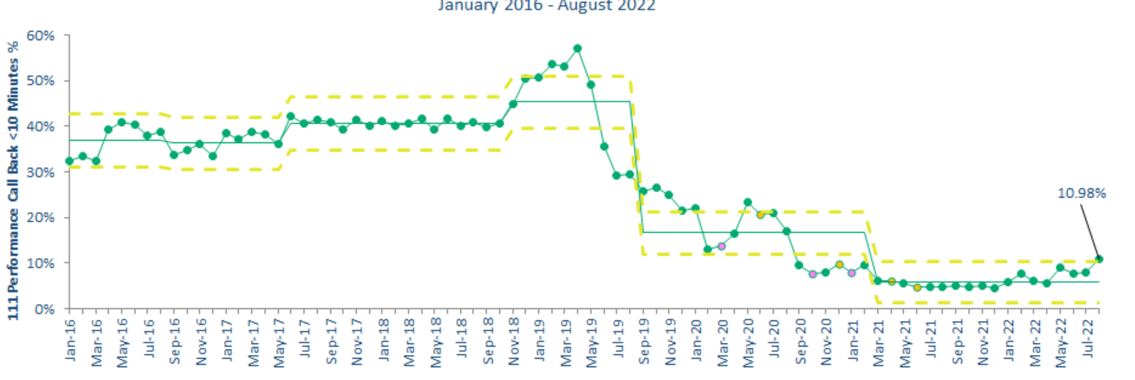
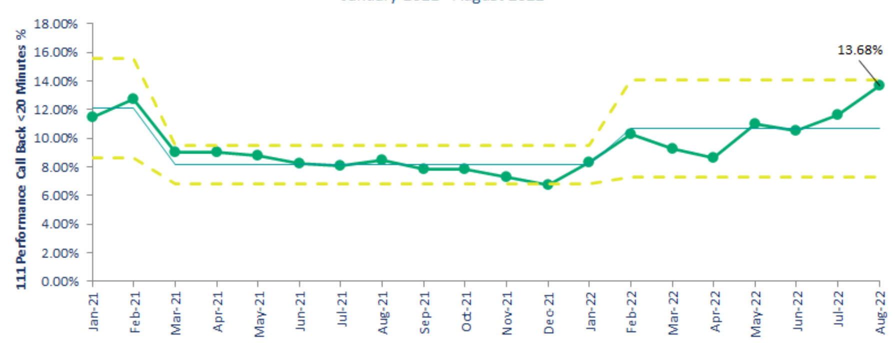


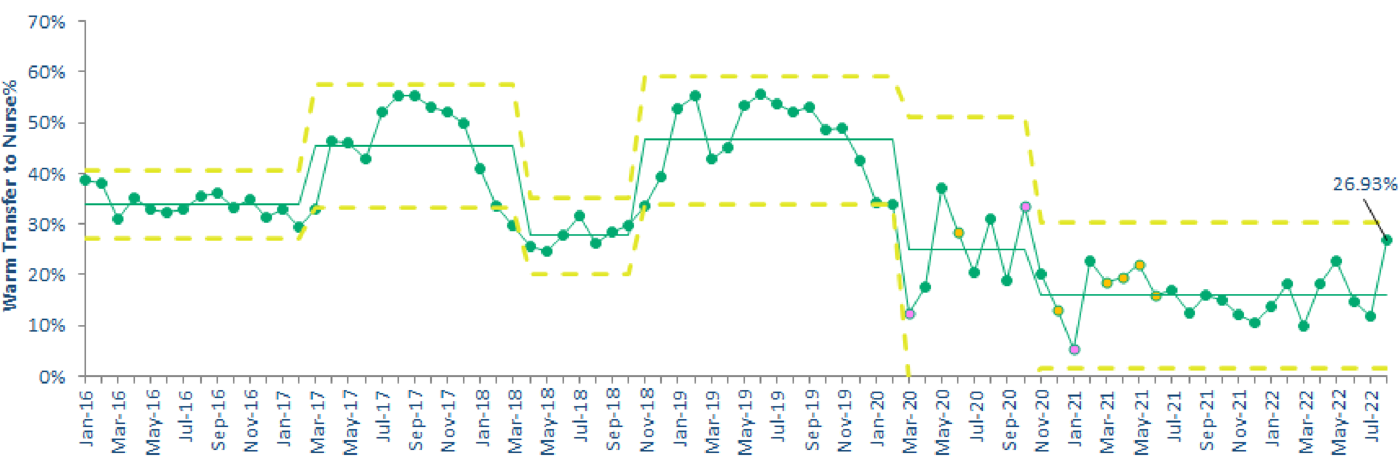
Figure O4.4b



Calls Back <10 Mins	
Target	75%
Aug 2022	10.98%
YTD	8.24%

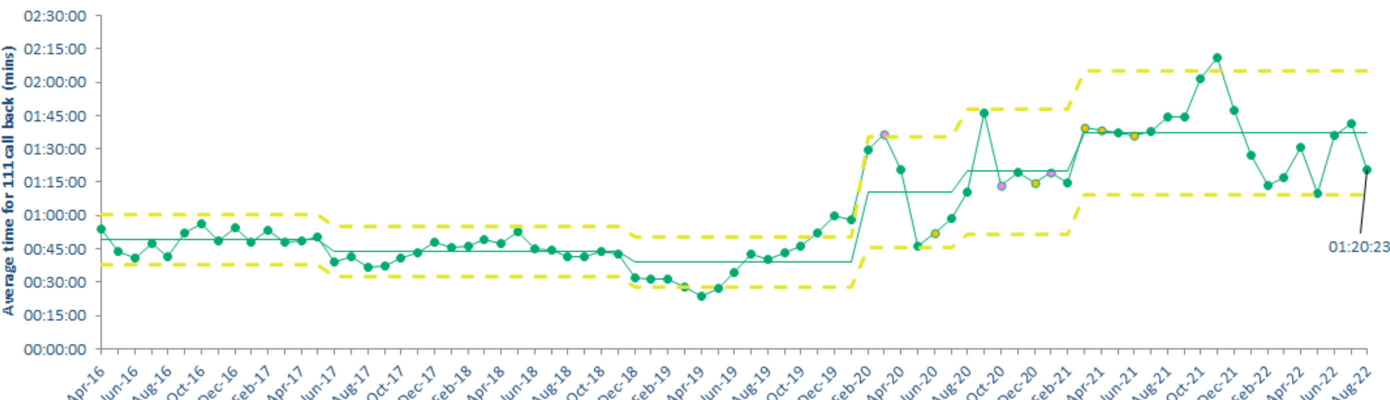
Calls Back <20 Mins	
Target	90%
Aug 2022	13.68%
YTD	11.08%

Figure O4.5



Warm Transfer %	
Target	75%
Aug 2022	26.93%
YTD	18.91%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY

TOTAL ACTIVITY

	Current Month: July 2022					Year to Date: July 2022 - July 2022			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	9,494	(4,530)	(32%)	14,024	9,494	(4,530)	(32%)
Greater Manchester	526,588	43,882	41,486	(2,396)	(5%)	43,882	41,486	(2,396)	(5%)
Lancashire	589,181	49,098	34,185	(14,913)	(30%)	49,098	34,185	(14,913)	(30%)
Merseyside	300,123	25,010	22,736	(2,274)	(9%)	25,010	22,736	(2,274)	(9%)
NWAS	1,584,182	132,015	107,901	(24,114)	(18%)	132,015	107,901	(24,114)	(18%)

UNPLANNED ACTIVITY

	Current Month: July 2022					Year to Date: July 2022 - July 2022			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	457	(790)	(63%)	1,247	457	(790)	(63%)
Greater Manchester	49,133	4,094	4,213	119	3%	4,094	4,213	119	3%
Lancashire	58,829	4,902	3,008	(1,894)	(39%)	4,902	3,008	(1,894)	(39%)
Merseyside	22,351	1,863	1,462	(401)	(22%)	1,863	1,462	(401)	(22%)
NWAS	145,282	12,107	9,140	(2,967)	(25%)	12,107	9,140	(2,967)	(25%)

ABORTED ACTIVITY

	July 2022								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	246	6,551	4%	45	510	9%	90	3,612	2%
Greater Manchester	1,951	20,343	10%	994	4,252	23%	1,247	17,667	7%
Lancashire	1,175	20,399	6%	574	3,224	18%	453	13,402	3%
Merseyside	693	10,961	6%	283	1,588	18%	747	11,193	7%
NWAS	4,065	58,254	7%	1,896	9,574	20%	2,537	45,874	6%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

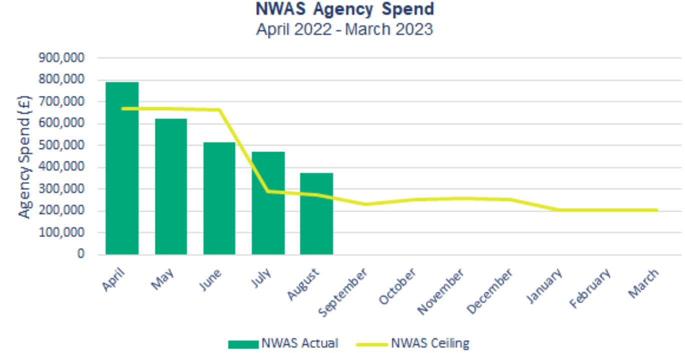


Figure F1.2

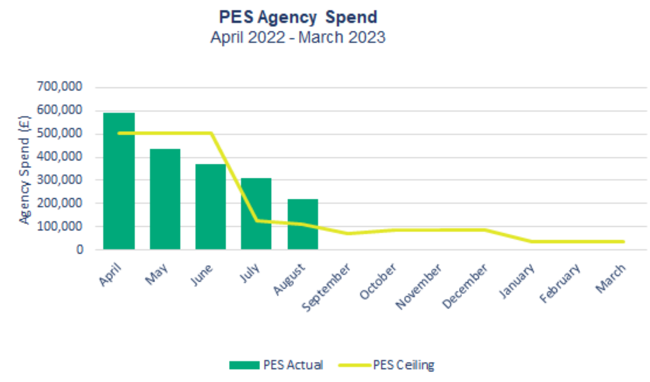


Figure F1.3

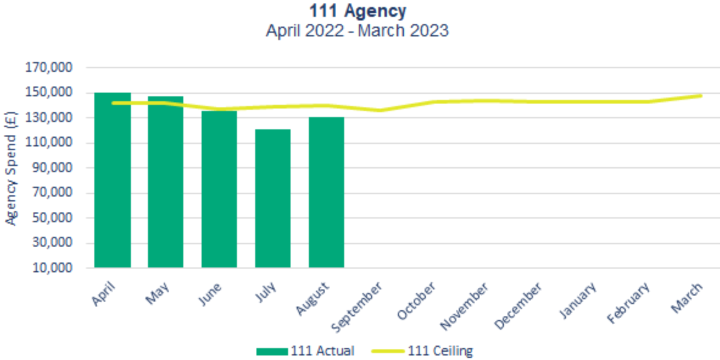


Figure F1.4

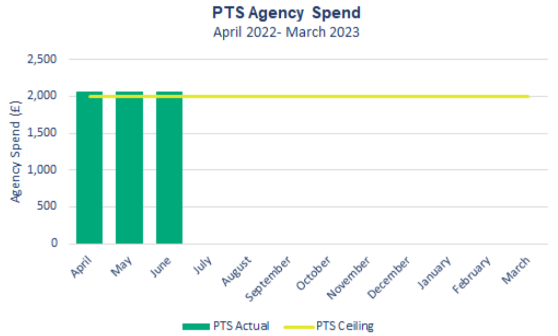


Figure F1.5

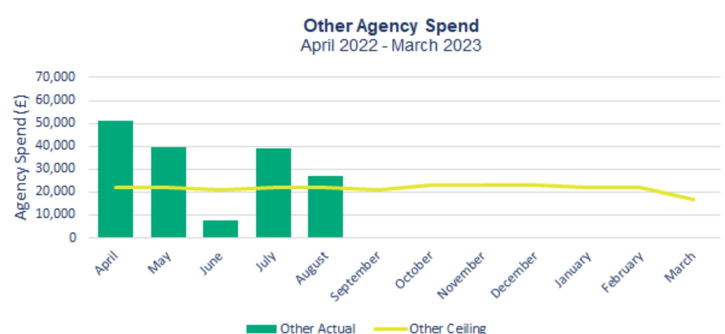
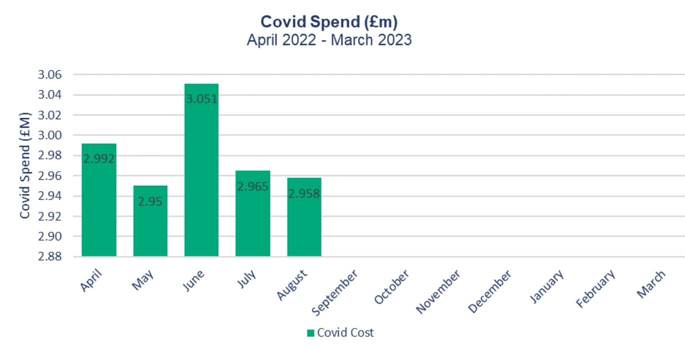


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

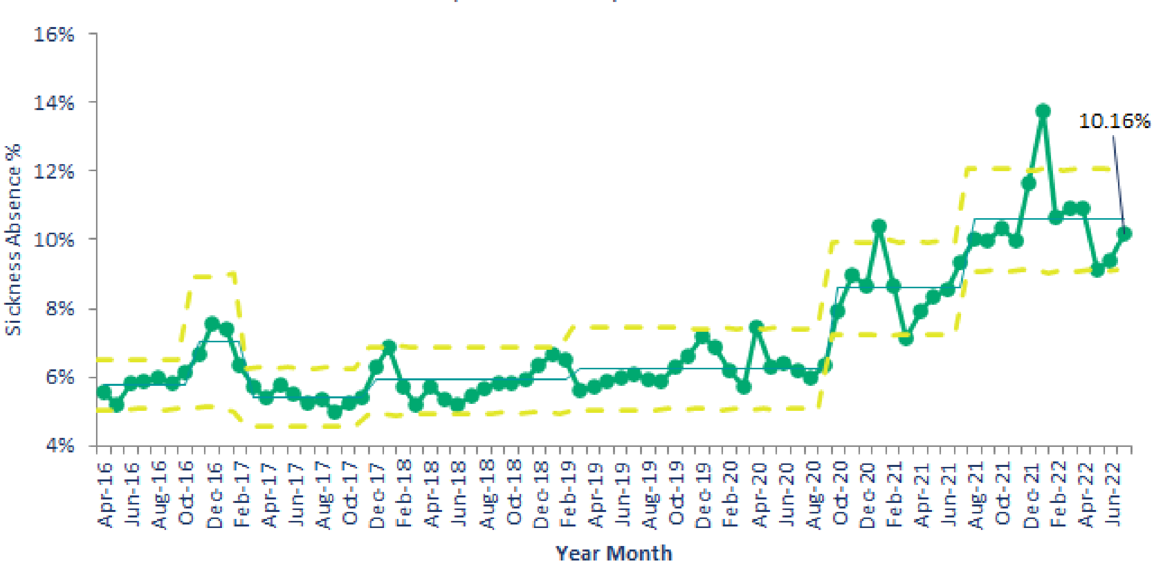


Table OH1.1

Sickness Absence	Aug-21	Sep-21	Oct-21	Nov-21	Dec -21	Jan-22	Feb-22	Mar-22	Apr -22	May -22	Jun -22	Jul – 22
NWAS	10.00%	9.97%	10.32%	9.97%	11.66%	13.74%	10.56%	10.91%	10.92%	9.15%	9.40%	10.16%
Amb. National Average	8.17%	8.22%	8.32%	8.23%	9.41%	9.91%	8.56%	9.10%	9.18%			

Figure OH1.2

NWAS Sickness Covid & Non Covid

25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22

NWAS Covid % NWAS Non Covid %

Figure OH1.3

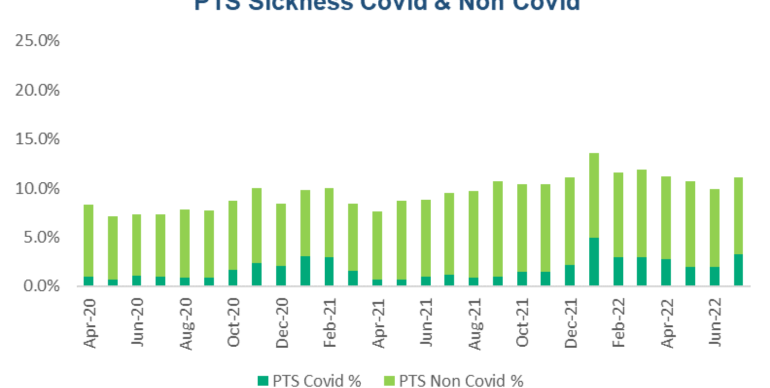


Figure OH1.4

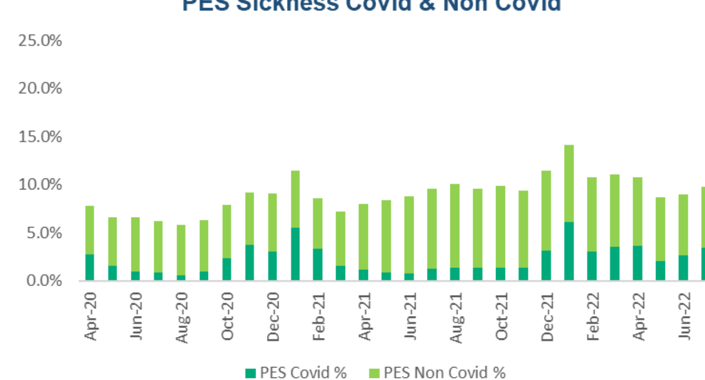


Table OH1.2

NWAS			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.2%	5.2%	7.4%
May-20	1.1%	5.2%	6.3%
Jun-20	0.8%	5.6%	6.4%
Jul-20	0.7%	5.5%	6.2%
Aug-20	0.6%	5.4%	6.0%
Sep-20	0.8%	5.5%	6.4%
Oct-20	2.1%	5.8%	7.9%
Nov-20	3.0%	6.0%	9.0%
Dec-20	2.4%	6.3%	8.7%
Jan-21	4.3%	6.1%	10.4%
Feb-21	3.1%	5.5%	8.6%
Mar-21	1.5%	5.6%	7.1%
Apr-21	1.1%	6.8%	7.9%
May-21	0.9%	7.4%	8.3%
Jun-21	0.8%	7.7%	8.6%
Jul-21	1.3%	8.0%	9.3%
Aug-21	1.4%	8.6%	10.0%
Sep-21	1.4%	8.6%	10.0%
Oct-21	1.5%	8.8%	10.3%
Nov-21	1.5%	8.4%	10.0%
Dec-21	2.8%	8.9%	11.7%
Jan-22	5.8%	8.0%	13.7%
Feb-22	3.0%	7.6%	10.7%
Mar-22	3.3%	7.6%	10.9%
Apr-22	3.6%	7.3%	10.9%
May-22	2.0%	7.2%	9.1%
Jun-22	2.4%	7.0%	9.4%
Jul-22	3.1%	7.1%	10.2%

Table OH1.3

PTS			
Month Year	Covid %	Non Covic	Total %
Apr-20	1.0%	7.4%	8.4%
May-20	0.7%	6.5%	7.2%
Jun-20	1.1%	6.2%	7.3%
Jul-20	0.9%	6.4%	7.4%
Aug-20	0.9%	6.9%	7.9%
Sep-20	0.9%	6.9%	7.7%
Oct-20	1.7%	7.0%	8.7%
Nov-20	2.4%	7.6%	10.0%
Dec-20	2.1%	6.3%	8.4%
Jan-21	3.0%	6.7%	9.8%
Feb-21	2.9%	7.0%	10.0%
Mar-21	1.6%	6.8%	8.4%
Apr-21	0.7%	6.9%	7.6%
May-21	0.7%	8.1%	8.8%
Jun-21	1.0%	7.9%	8.8%
Jul-21	1.2%	8.4%	9.6%
Aug-21	0.9%	8.8%	9.7%
Sep-21	0.9%	9.7%	10.7%
Oct-21	1.5%	8.9%	10.4%
Nov-21	1.5%	8.9%	10.4%
Dec-21	2.2%	8.9%	11.1%
Jan-22	4.9%	8.6%	13.6%
Feb-22	3.0%	8.6%	11.6%
Mar-22	2.9%	9.0%	11.9%
Apr-22	2.7%	8.4%	11.2%
May-22	1.9%	8.7%	10.7%
Jun-22	2.0%	7.9%	9.9%
Jul-22	3.3%	7.8%	11.1%

Table OH1.4

PES			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.7%	5.1%	7.7%
May-20	1.6%	5.0%	6.6%
Jun-20	1.0%	5.6%	6.6%
Jul-20	0.8%	5.4%	6.2%
Aug-20	0.6%	5.3%	5.8%
Sep-20	1.0%	5.3%	6.3%
Oct-20	2.4%	5.5%	7.9%
Nov-20	3.8%	5.4%	9.1%
Dec-20	3.1%	6.1%	9.1%
Jan-21	5.5%	5.9%	11.4%
Feb-21	3.3%	5.3%	8.6%
Mar-21	1.5%	5.7%	7.2%
Apr-21	1.1%	6.9%	8.0%
May-21	0.9%	7.5%	8.4%
Jun-21	0.7%	8.0%	8.8%
Jul-21	1.3%	8.4%	9.6%
Aug-21	1.3%	8.8%	10.1%
Sep-21	1.4%	8.2%	9.6%
Oct-21	1.4%	8.5%	9.9%
Nov-21	1.3%	8.0%	9.4%
Dec-21	3.1%	8.4%	11.5%
Jan-22	6.1%	8.0%	14.1%
Feb-22	3.0%	7.8%	10.8%
Mar-22	3.6%	7.5%	11.1%
Apr-22	3.6%	7.2%	10.8%
May-22	2.0%	6.7%	8.7%
Jun-22	2.6%	6.4%	9.0%
Jul-22	3.5%	6.3%	9.8%

Figure OH1.5

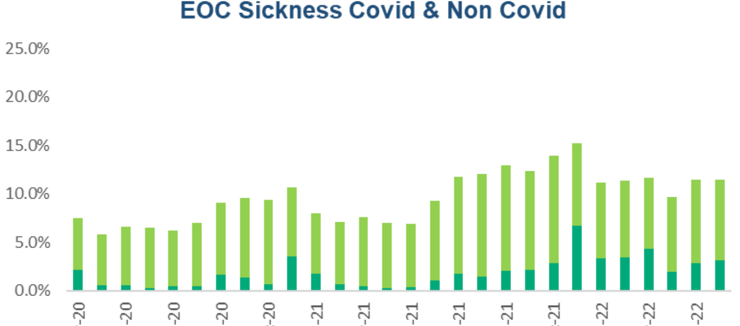


Figure OH1.6

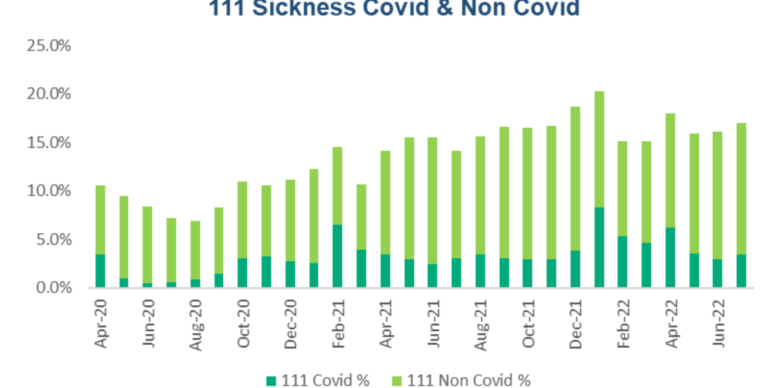


Figure OH1.7

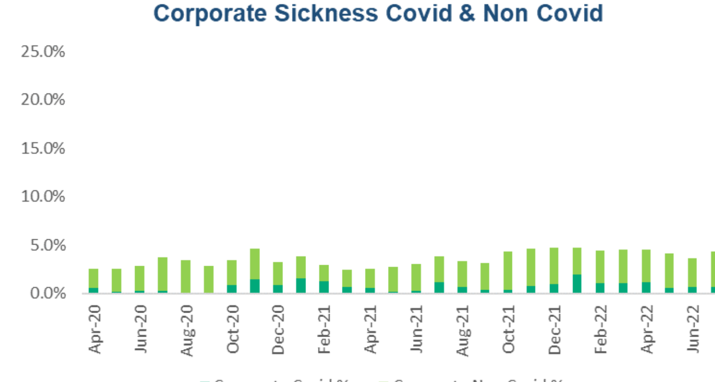


Table OH1.5

EOC			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.2%	5.3%	7.5%
May-20	0.6%	5.2%	5.8%
Jun-20	0.5%	6.1%	6.6%
Jul-20	0.3%	6.2%	6.5%
Aug-20	0.4%	5.8%	6.2%
Sep-20	0.5%	6.5%	7.0%
Oct-20	1.7%	7.4%	9.1%
Nov-20	1.4%	8.2%	9.6%
Dec-20	0.7%	8.7%	9.4%
Jan-21	3.6%	7.1%	10.7%
Feb-21	1.8%	6.2%	8.0%
Mar-21	0.6%	6.4%	7.1%
Apr-21	0.4%	7.1%	7.5%
May-21	0.3%	6.8%	7.0%
Jun-21	0.3%	6.6%	6.9%
Jul-21	1.1%	8.2%	9.3%
Aug-21	1.7%	10.0%	11.8%
Sep-21	1.5%	10.5%	12.0%
Oct-21	2.0%	10.9%	12.9%
Nov-21	2.1%	10.3%	12.4%
Dec-21	2.8%	11.1%	13.9%
Jan-22	6.7%	8.5%	15.2%
Feb-22	3.3%	7.9%	11.2%
Mar-22	3.4%	7.9%	11.3%
Apr-22	4.4%	7.3%	11.6%
May-22	2.0%	7.7%	9.7%
Jun-22	2.8%	8.7%	11.5%
Jul-22	3.1%	8.3%	11.4%

Table OH1.6

111			
Month Year	Covid %	Non Covic	Total %
Apr-20	3.5%	7.1%	10.6%
May-20	1.0%	8.5%	9.4%
Jun-20	0.4%	8.0%	8.4%
Jul-20	0.6%	6.6%	7.2%
Aug-20	0.8%	6.1%	7.0%
Sep-20	1.4%	6.8%	8.3%
Oct-20	3.0%	8.0%	11.0%
Nov-20	3.3%	7.3%	10.6%
Dec-20	2.7%	8.4%	11.1%
Jan-21	2.6%	9.7%	12.2%
Feb-21	6.5%	8.0%	14.6%
Mar-21	3.9%	6.8%	10.7%
Apr-21	3.4%	10.7%	14.1%
May-21	2.9%	12.7%	15.6%
Jun-21	2.5%	13.1%	15.5%
Jul-21	3.0%	11.2%	14.2%
Aug-21	3.4%	12.2%	15.6%
Sep-21	3.0%	13.6%	16.6%
Oct-21	2.9%	13.6%	16.5%
Nov-21	3.0%	13.7%	16.7%
Dec-21	3.8%	14.9%	18.7%
Jan-22	8.3%	12.0%	20.3%
Feb-22	5.3%	9.8%	15.1%
Mar-22	4.6%	10.5%	15.1%
Apr-22	6.2%	11.9%	18.0%
May-22	3.5%	12.5%	16.0%
Jun-22	2.9%	13.2%	16.1%
Jul-22	3.5%	13.6%	17.0%

Table OH1.7

Corporate			
Month Year	Covid %	Non Covic	Total %
Apr-20	0.6%	1.9%	2.5%
May-20	0.2%	2.4%	2.6%
Jun-20	0.3%	2.6%	2.8%
Jul-20	0.2%	3.5%	3.8%
Aug-20	0.1%	3.4%	3.4%
Sep-20	0.1%	2.8%	2.9%
Oct-20	0.8%	2.6%	3.5%
Nov-20	1.4%	3.2%	4.6%
Dec-20	0.9%	2.4%	3.2%
Jan-21	1.5%	2.3%	3.9%
Feb-21	1.2%	1.8%	3.0%
Mar-21	0.7%	1.8%	2.5%
Apr-21	0.5%	2.0%	2.6%
May-21	0.2%	2.6%	2.7%
Jun-21	0.3%	2.7%	3.0%
Jul-21	1.1%	2.7%	3.8%
Aug-21	0.7%	2.7%	3.4%
Sep-21	0.4%	2.8%	3.1%
Oct-21	0.4%	3.9%	4.3%
Nov-21	0.7%	3.9%	4.6%
Dec-21	0.9%	3.8%	4.7%
Jan-22	1.9%	2.8%	4.7%
Feb-22	1.1%	3.3%	4.4%
Mar-22	1.0%	3.5%	4.5%
Apr-22	1.1%	3.4%	4.5%
May-22	0.6%	3.6%	4.2%
Jun-22	0.6%	3.0%	3.6%
Jul-22	0.7%	3.7%	4.3%

OH2 STAFF TURNOVER

Figure OH2.1

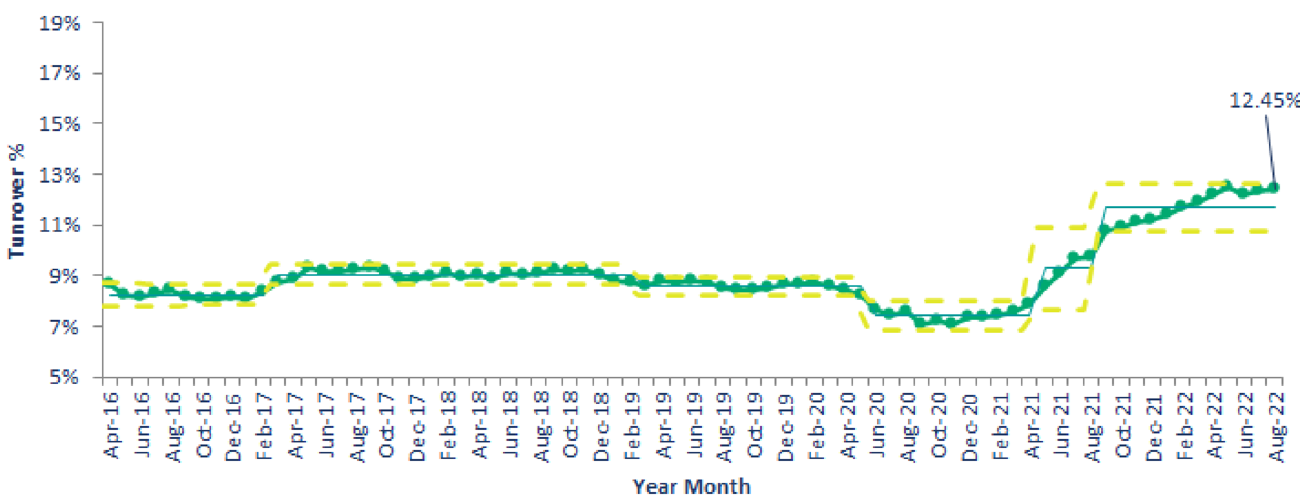


Table OH2.1

Turnover	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22
NWAS	10.76%	10.93%	11.11%	11.21%	11.37%	11.68%	11.94%	12.17%	12.49%	12.19%	12.35%	12.45%
Amb. National Average	9.25%	9.69%	10.09%	10.36%	10.80%	11.09%	11.43%	12.09%	12.10%			

Figure OH2.2

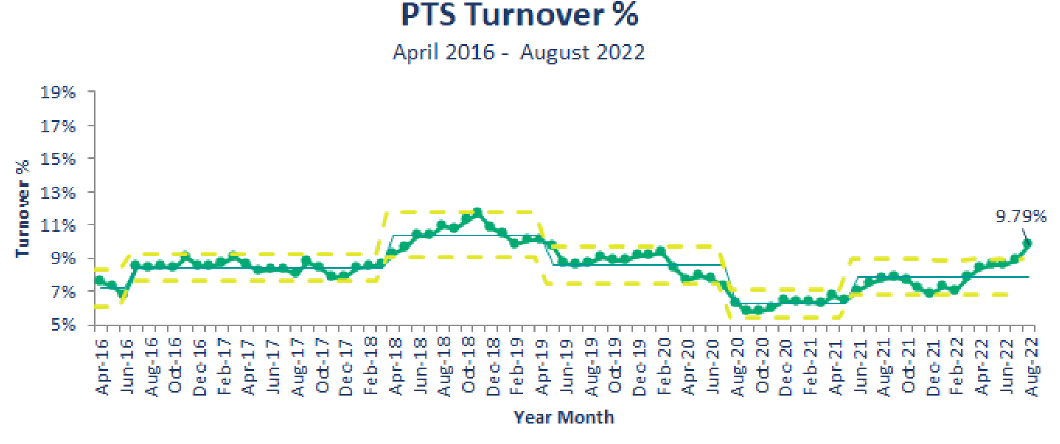


Figure OH2.3

PES Turnover %

April 2016- August 2022

19%
17%
15%
13%
11%
9%
7%
5%
3%
1%
-1%

Turnover %

7.83%

Apr-16 Jun-16 Aug-16 Oct-16 Dec-16 Feb-17 Apr-17 Jun-17 Aug-17 Oct-17 Dec-17 Feb-18 Apr-18 Jun-18 Aug-18 Oct-18 Dec-18 Feb-19 Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22 Aug-22

Year Month

Figure OH3.4

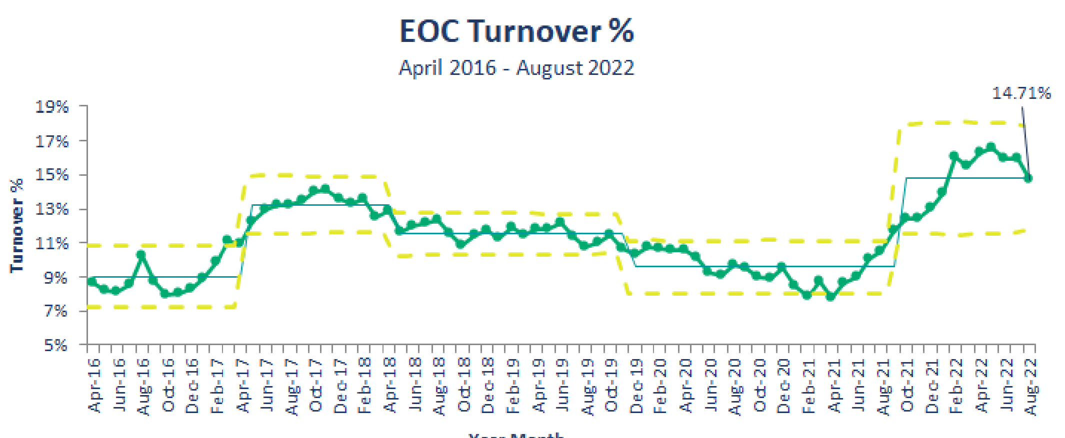
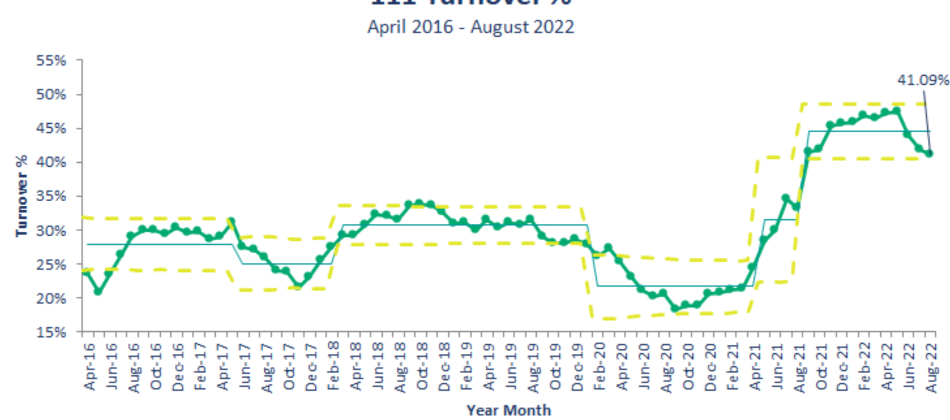


Figure OH3.5



The scale on the 111 Turnover % is different to the others. 15%-55% for 111 and 0% to 19% for the others.

OH4 TEMPORARY STAFFING

Figure OH4.1

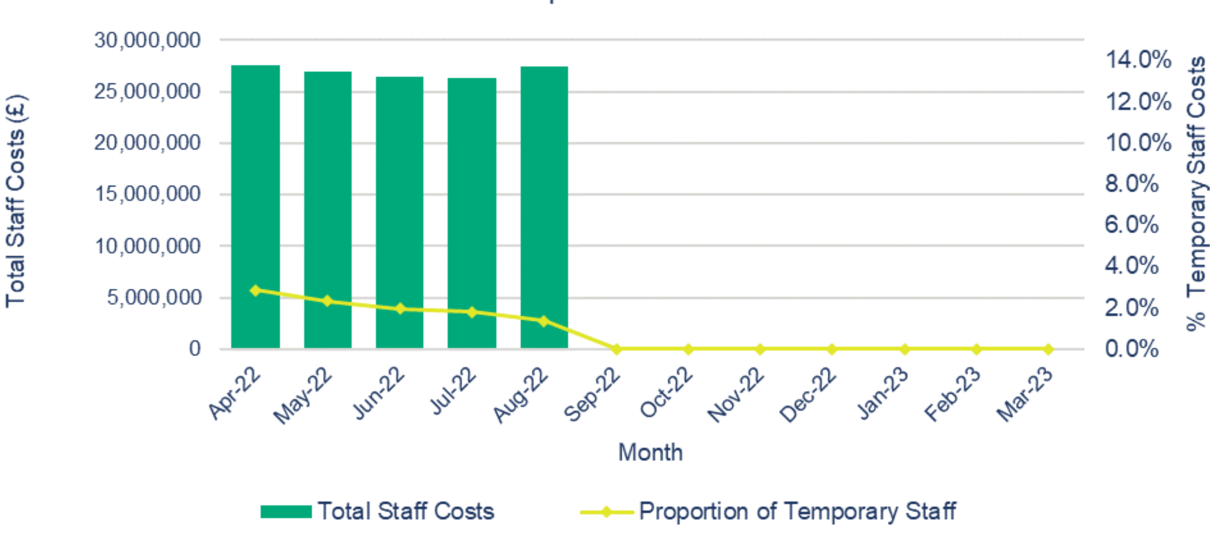


Table OH4.1

NWAS	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July -22	Aug-22
Agency Staff Costs (£)	518,275	444,941	553,502	796,039	783,115	864,691	1,072,794	792,309	624,873	514,594	472,303	376,736
Total Staff Costs (£)	29,910,317	26,091,860	26,356,720	26,930,619	27,466,754	26,722,244	42,104,411	27,581,772	26,920,461	26,399,198	26,352,765	27,478,110
Proportion of Temporary Staff %	1.7%	1.7%	2.1%	3.0%	2.9%	3.2%	2.5%	2.9%	2.3%	1.9%	1.8%	1.4%

Figure OH4.3

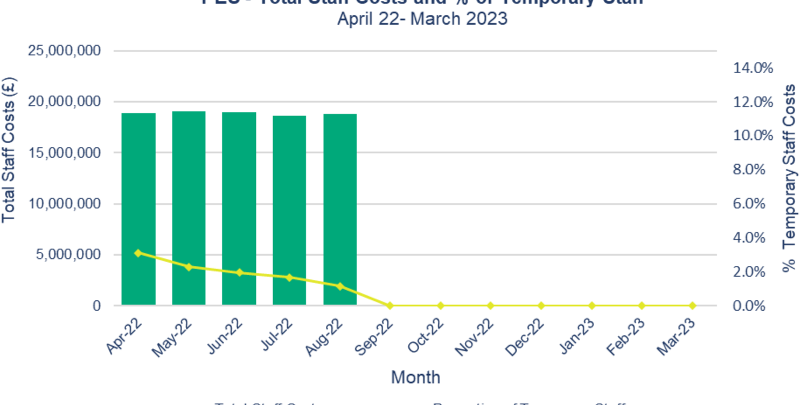


Figure OH4.4

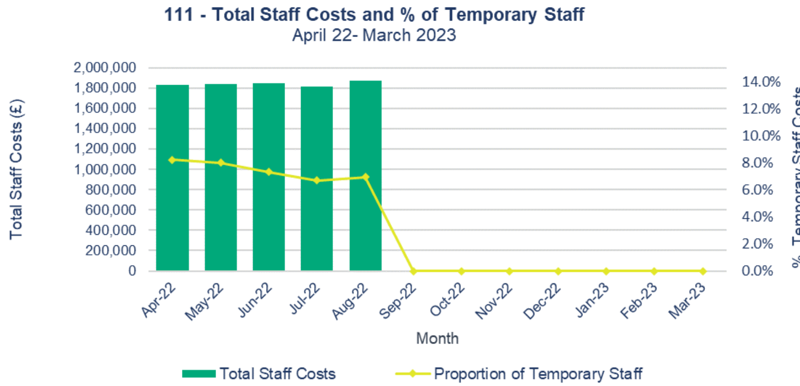


Figure OH4.5

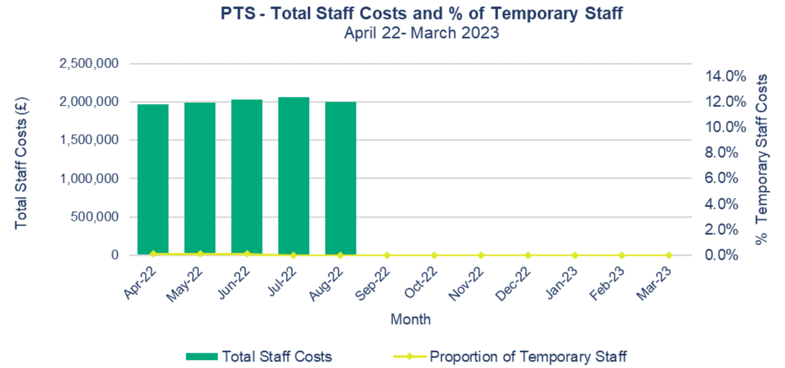
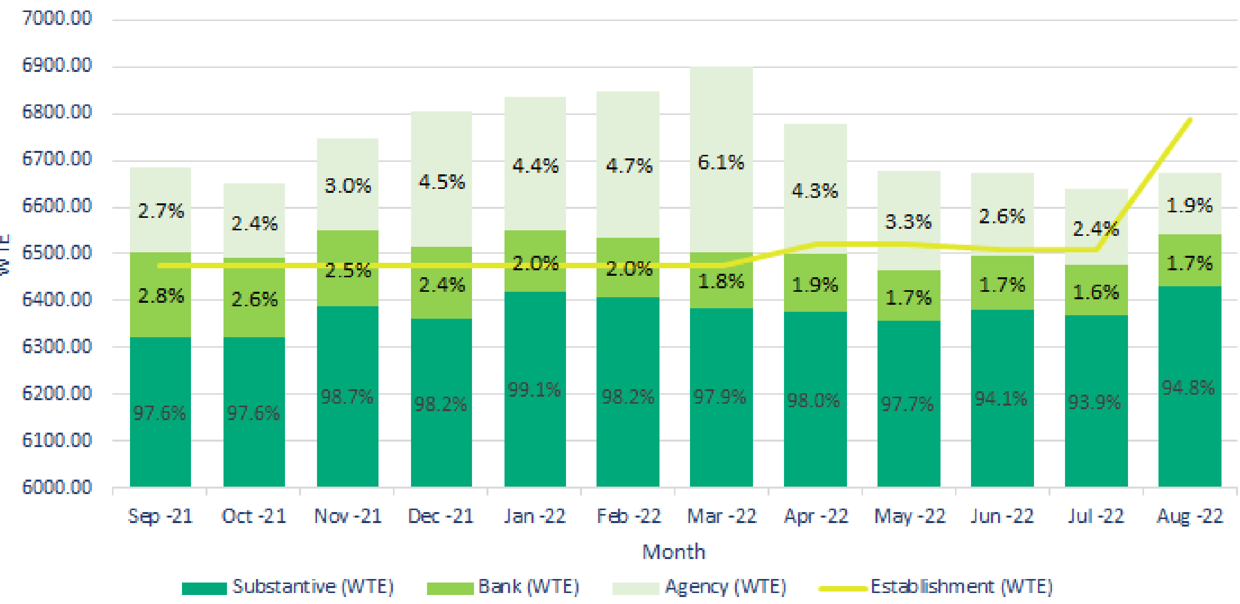


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

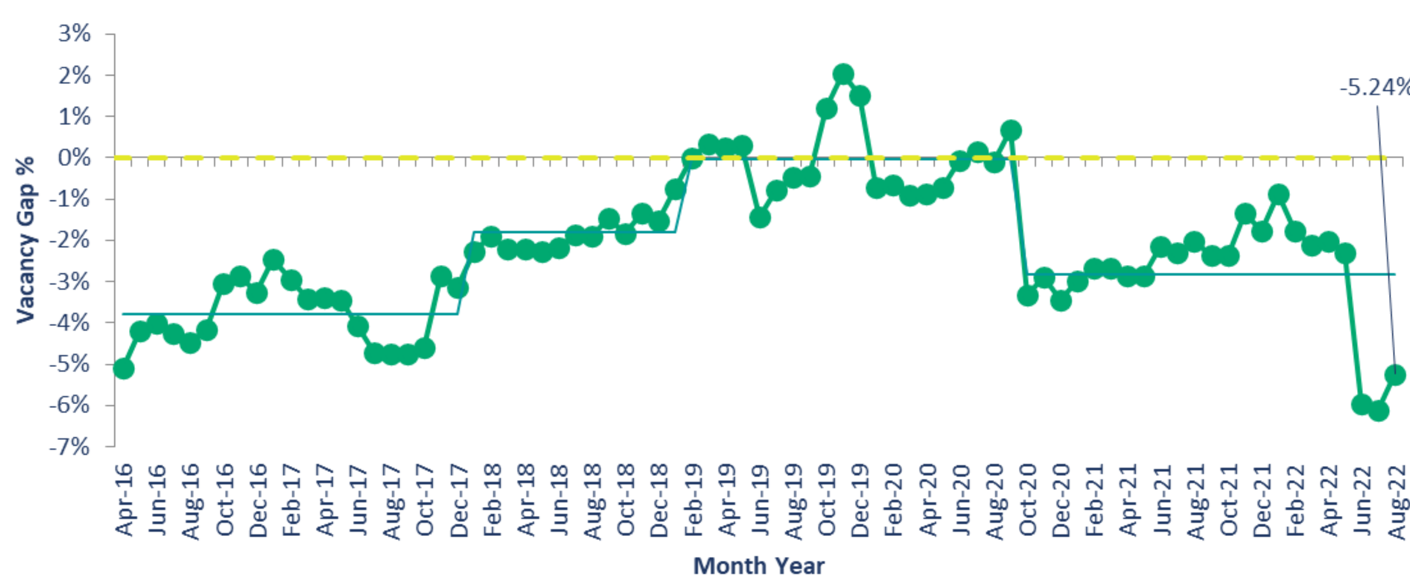


Table OH5.1

Vacancy Gap	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22
NWAS	-2.36%	-2.37%	-1.35%	-1.78%	-0.87%	-1.77%	-2.10%	-2.03%	-2.30%	-5.95%	-6.13%	-5.24%

Figure OH5.2

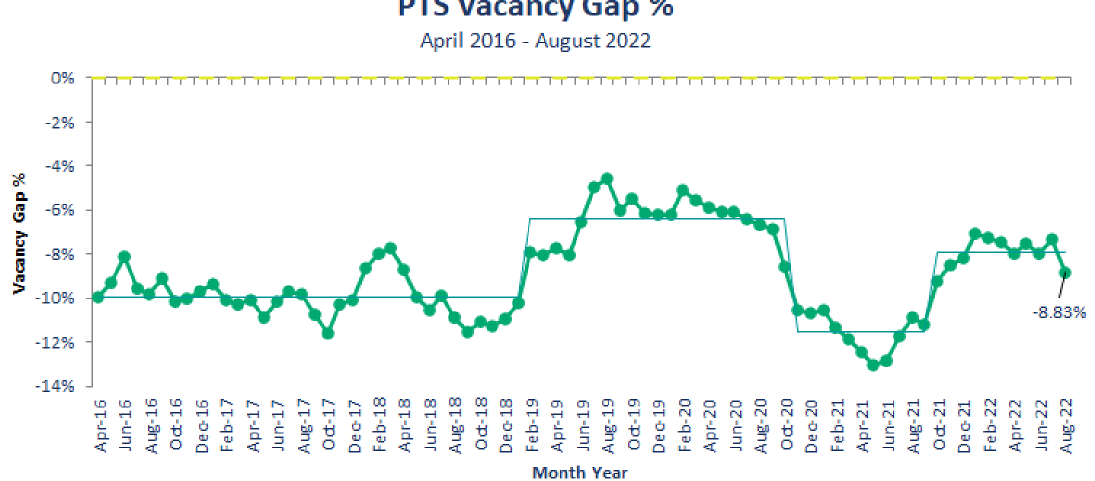


Figure OH5.3

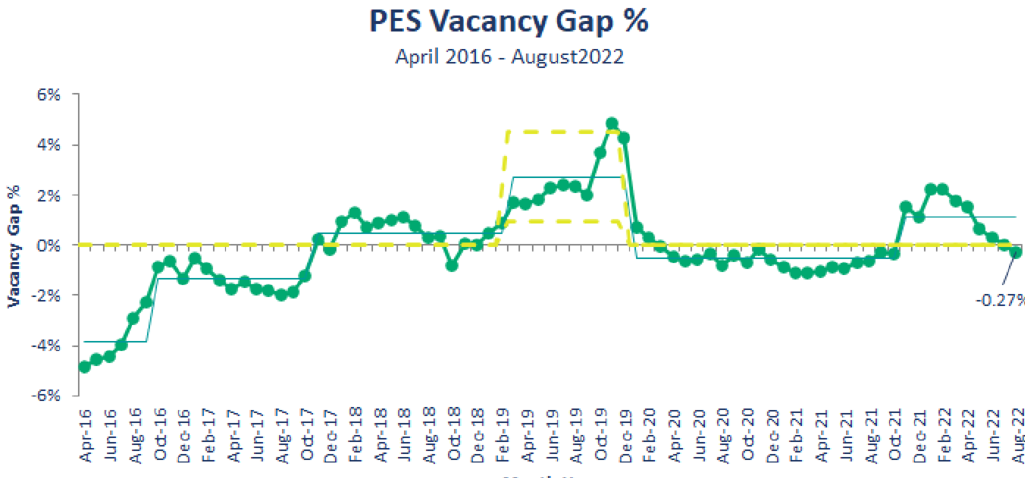


Figure OH5.4

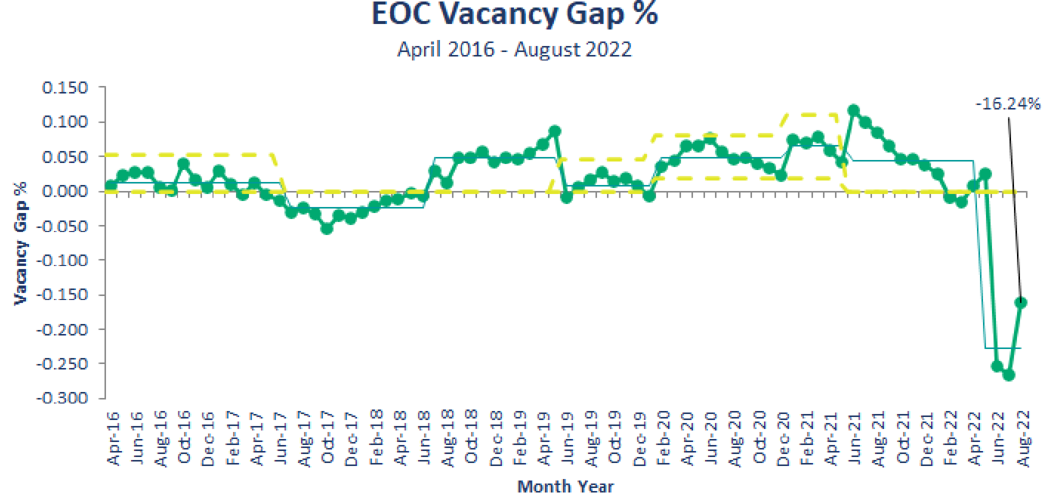
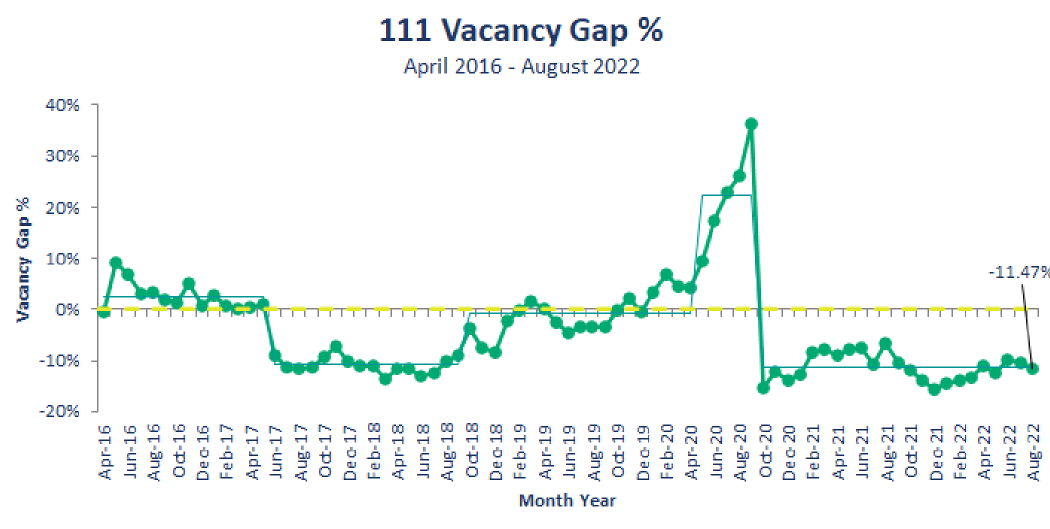


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

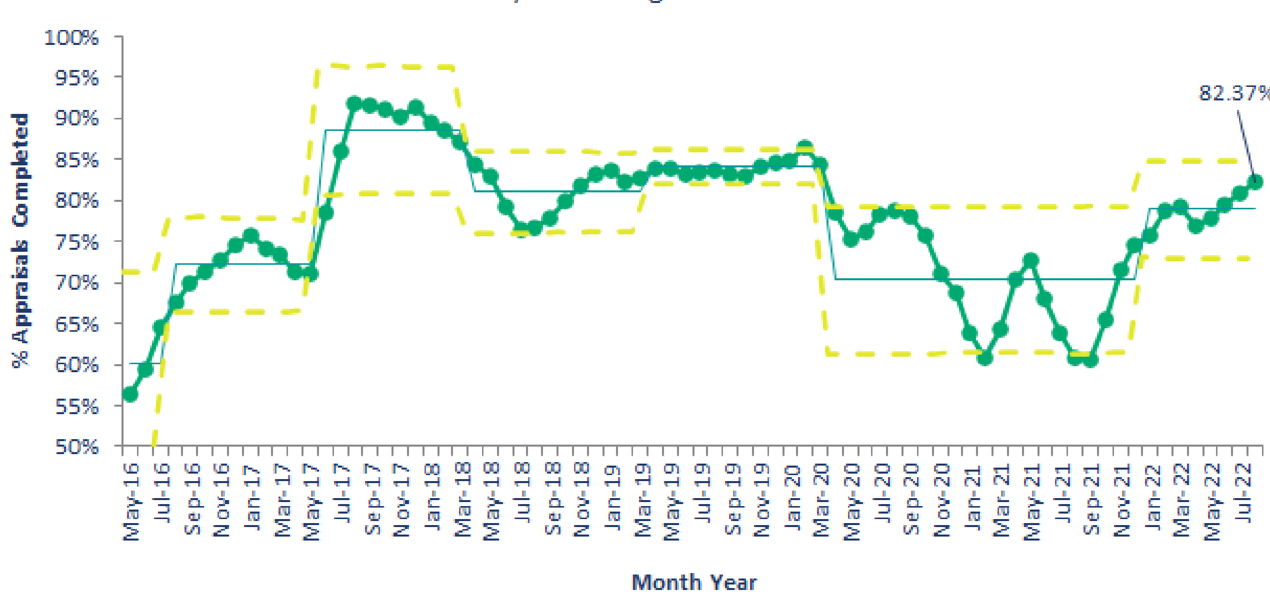


Table OH6.1

Appraisals	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
NWAS	59%	65%	72%	75%	76%	79%	79&	77%	78%	79%	81%	82%

Figure OH6.2

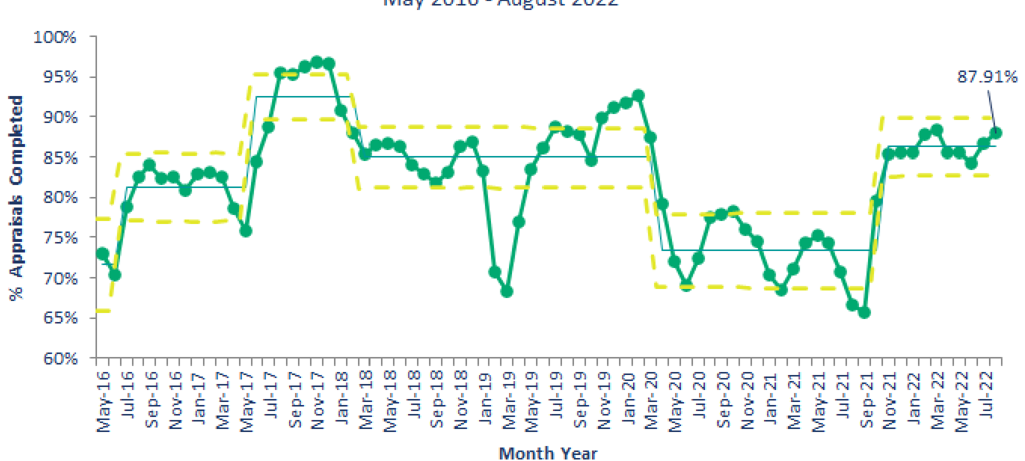


Figure OH6.3

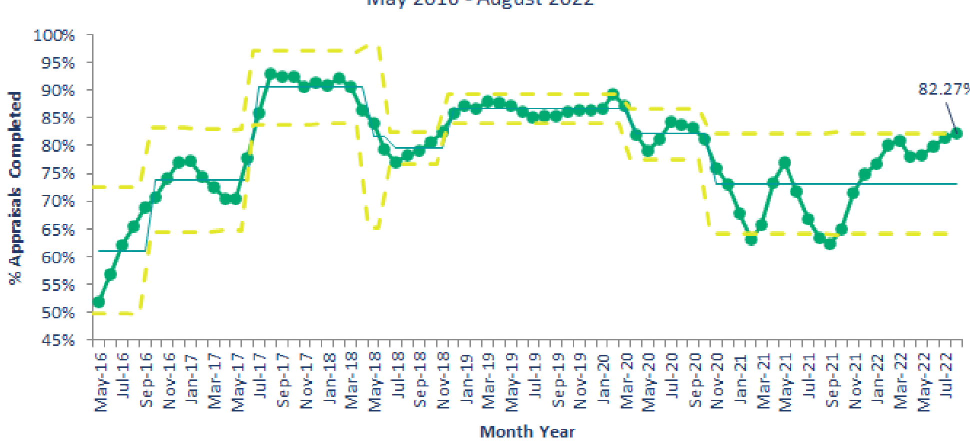


Figure OH6.4

EOC Appraisals Completed

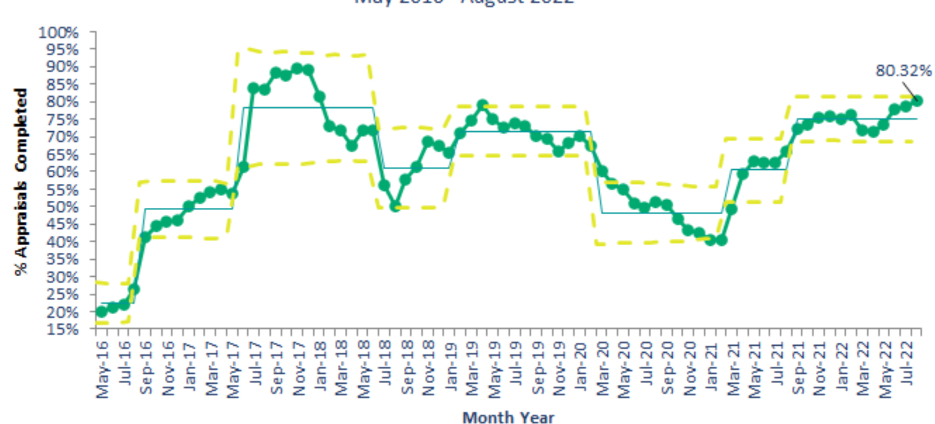
May 2016 - August 2022

% Appraisals Completed

Month Year

76.93%

Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

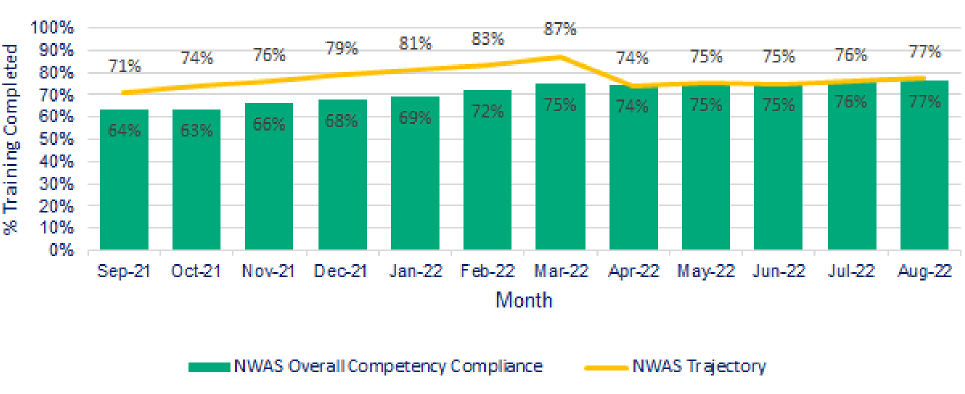


Figure OH7.2

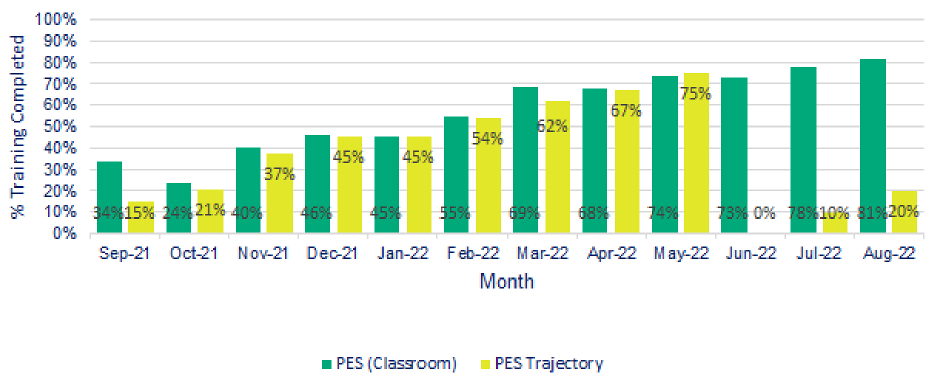


Figure OH7.3

Figure OH7.4

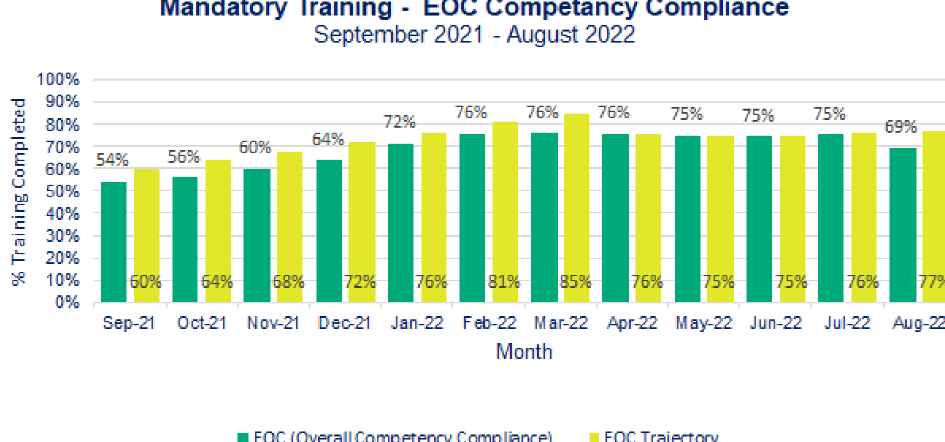


Figure OH7.5

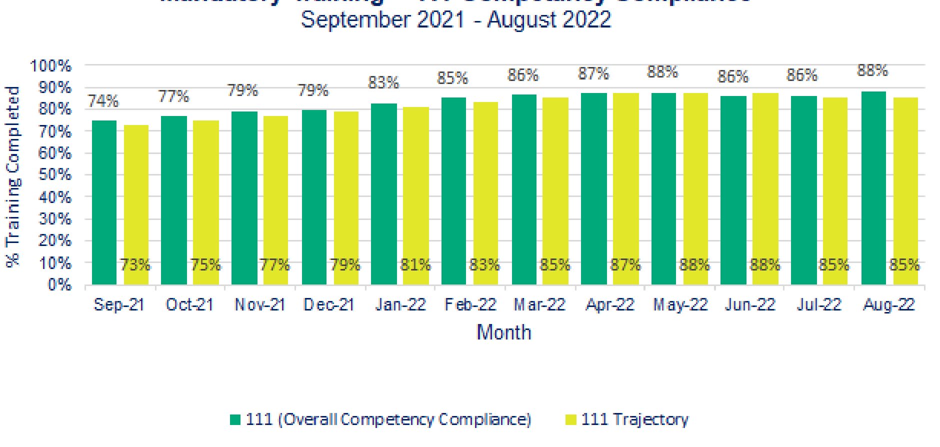
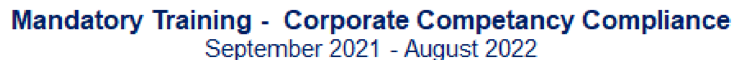
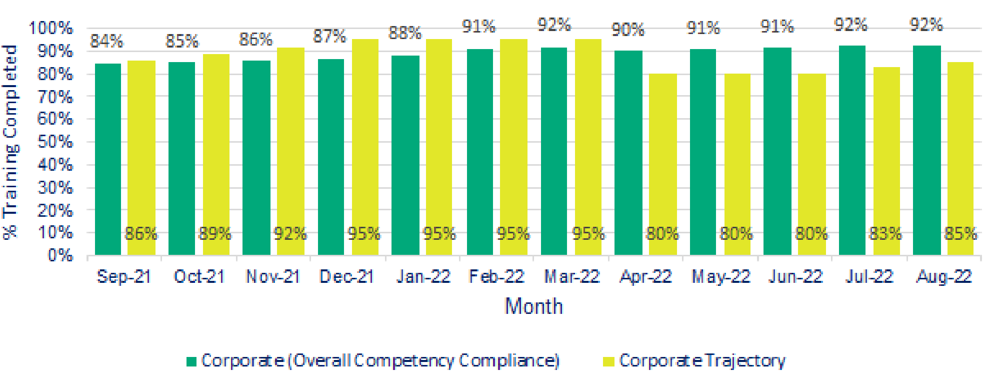


Figure OH7.6





OH8 CASE MANAGEMENT

Figure OH8.1

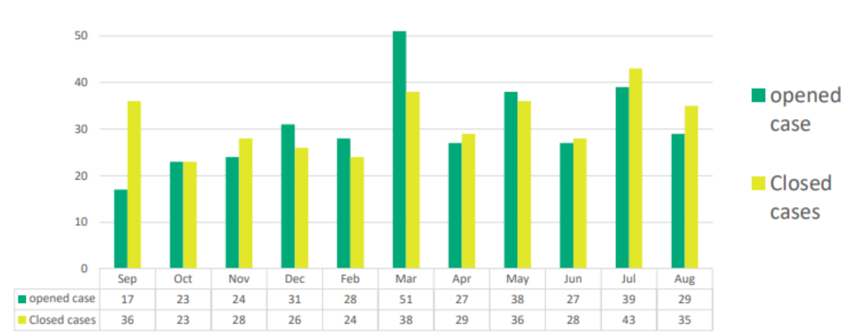
Employee Relation Dashboard @ 5th September 2022 All information related to Dignity at work, Disciplinary, Fact Finding and Grievance cases only

NWAS Summary			
Service Line	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	47	191	13.32
Operations ~ EOC	6	30	8.83
Operations ~ Resilience	1	0	7.01
Operations ~ 111	6	56	12.86
Operations ~ PTS	9	34	21.00
Corporate	1	15	11.96
Other*	13	47	12.82
NWAS Summary	**83**	**373**	**12.06**

* In ER data base, where more than one employee is grouped under any particular case then they couldn't be identified under one particular department and hence they are grouped under other.

Case Type Summary			
Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	14	51	13.64
Disciplinary	36	74	21.92
Fact Finding	12	166	7.22
Grievance	21	82	11.99
Case Summary	**83**	**373**	**12.06**

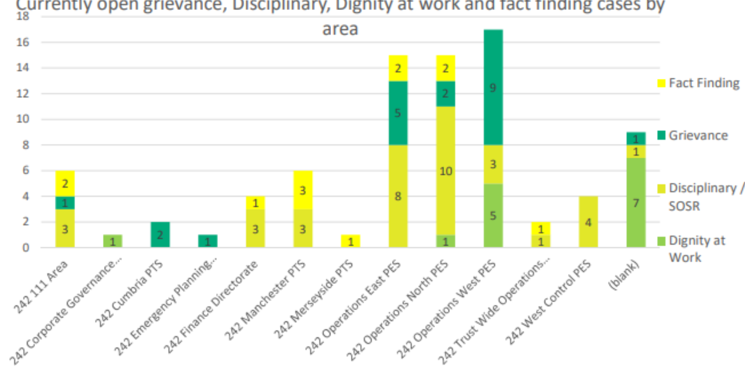
Cases Opened compared to cases closed each month in past 12 months



Reason for opening Disciplinary cases in the past 12 months	
Opening reason	Number of cases in 12 months
Any actions that bring the Trusts reputation into disrepute	6
Assault/threatening behaviour	3
Breach of social media policy	2
Carelessness in the use of equipment or resources	3
Discriminatory behaviour	2
Failure to follow reasonable management instructions/procedures	7
Fraud	10
Incapacity through alcohol/substance misuse	5
Inappropriate / Unprofessional Behaviour	18
Misrepresentation/Deception	1
Negligent Behaviour	4
On-Going Lateness	1
Police Investigation	2
Poor patient care	2
Theft	2
Unauthorised Absence	7
DIS - appeal received ref: Final Written Warning	1
Victimisation/Bullying and Harassment	2
SOSR	1
Sexual misconduct	3
DIS - Appeal received ref: Dismissal	2
NWAS Summary	**84**

*table shows a rolling 12 months so can go down as well as up

Length of current live cases				
Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	5	4	4	1
Grievance	13	6	1	1
Fact Finding	10	2	0	0
Disciplinary / SOSR	19	13	4	0
Case Total	**47**	**25**	**9**	**2**



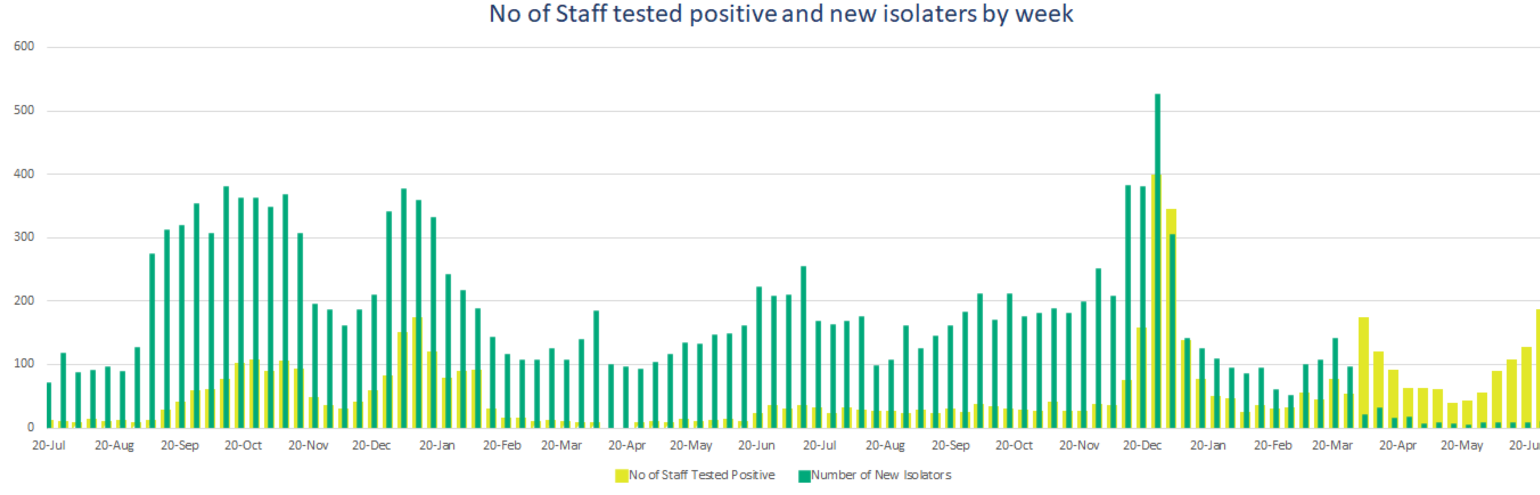
Covid

COVID 19

Figure CV1.0

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	09-Aug	21
27-Jul	3	16-Aug	19
03-Aug	1	23-Aug	20
10-Aug	7	30-Aug	17
17-Aug	3	06-Sep	22
24-Aug	5	13-Sep	17
31-Aug	2	20-Sep	24
07-Sep	6	27-Sep	18
14-Sep	22	04-Oct	30
21-Sep	34	11-Oct	27
28-Sep	53	18-Oct	23
05-Oct	54	25-Oct	21
12-Oct	71	01-Nov	19
19-Oct	96	08-Nov	35
26-Oct	101	15-Nov	20
02-Nov	83	22-Nov	19
09-Nov	99	29-Nov	30
16-Nov	87	06-Dec	28
23-Nov	42	13-Dec	69
30-Nov	28	20-Dec	152
07-Dec	24	27-Dec	393
14-Dec	34	03-Jan	339
21-Dec	52	10-Jan	132
28-Dec	75	17-Jan	71
04-Jan	144	24-Jan	43
11-Jan	168	31-Jan	39
18-Jan	113	07-Feb	18
25-Jan	72	14-Feb	28
01-Feb	83	21-Feb	23
08-Feb	84	28-Feb	26
15-Feb	24	07-Mar	48
22-Feb	9	14-Mar	37
01-Mar	9	21-Mar	70
08-Mar	3	28-Mar	46
15-Mar	6	04-Apr	168
22-Mar	4	11-Apr	114
29-Mar	1	18-Apr	84
05-Apr	2	25-Apr	55
12-Apr	0	02-May	55
19-Apr	0	09-May	54
26-Apr	1	16-May	33
03-May	4	23-May	36
10-May	2	30-May	49
17-May	8	06-Jun	82
24-May	4	13-Jun	100
31-May	5	20-Jun	121
07-Jun	7	27-Jun	180
14-Jun	4	04-Jul	176
21-Jun	17	11-Jul	167
28-Jun	28	18-Jul	92
05-Jul	24	25-Jul	80
12-Jul	29	01-Aug	85
19-Jul	26	08-Aug	49
26-Jul	17	15-Aug	31
02-Aug	26	22-Aug	32
		29-Aug	34

Figure CV1.1



REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="6">28th September 2022</td></tr>
<tr><td>SUBJECT:</td><td colspan="6">Learning from Deaths - Summary Report and Dashboard Q1 2022/23</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="6">Dr C Grant, Executive Medical Director</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td colspan="2">SR05</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td><td>☐</td><td colspan="2"></td></tr>
<tr><td>SR06</td><td>SR07</td><td>SR08</td><td>SR09</td><td>SR10</td><td>SR11</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="6">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="6">The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning.

The Q1 Dashboard (Appendix A) describes the opportunities to learn from deaths. In summary, from Datix records, the contributory factors to patient deaths were identified and were attributed to the incorrect call categorisation and demand exceeding available resources.

The peer review process identified that most (67%) of patients received ‘appropriate’ care. The key areas identified for improvement were:

• need for more than one set of clinical observations,
• correct utilisation of Manchester Triage System,
• performing ECGs when indicated,
• completing capacity to consent fully,
• recording the details of specific worsening advice
• quality of patient records (documentation)

The peer review identified areas of good practice, including face to face discussions with a GP and family.

The review panel has welcomed new representatives from the Clinical Hub and the Patient and Public Panel. The Clinical Hub clinician allows the insights from Hear and Treat perspective.

In addition, the panel will have regular observers in attendance to raise awareness of the process and embed learning further across the organisation.

The DCIQ Mortality Module dashboard is still under development and should be ready by Q2 reporting.</td></tr>
</table>

RECOMMENDATIONS:	The Board of Directors is recommended to: • Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths. • Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths. • Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust. • Acknowledge the good practice identified
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐

PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub Committee Quality and Performance Committee	
	Date:	13th September 2022 26th September 2022
	Outcome:	Assurances provided for onward submission to the Board of Directors.

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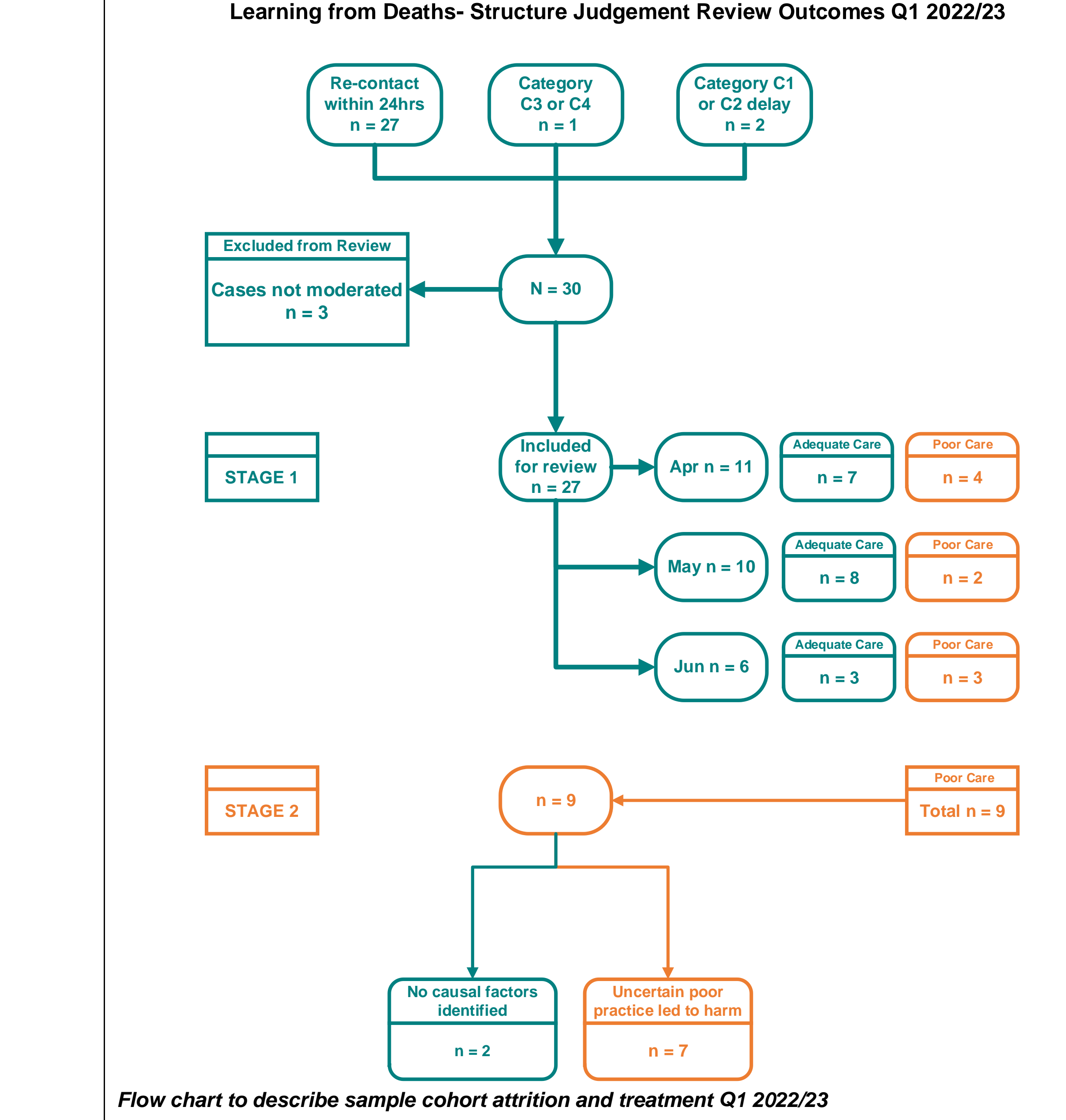
1.	**PURPOSE**
1.1	The purpose of this report is to meet the requirements of the national guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing, and learning from deaths in care as referenced in the trust Learning from Deaths Policy. Appendix A is a summary dashboard of the Q1 2022/23 Learning from Deaths review; it is proposed this document is published on the Trust's public accounts by 30th September 2022 in accordance with the national framework and trust policy. The Q1 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q1. The learning from the panels is discussed later in this paper. The next phase of dashboard development will require dedicated Emergency Operations Centre subject experts to undertake the dispatch and triage review. It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2022/23 progresses.
2.	**BACKGROUND**
2.1	Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement.
3.	**LEARNING FROM DEATHS DASHBOARD Q1 2022/23: APPENDIX A**
3.1	The number of patients whose deaths were identified as in scope for review was 106. 76 concerns raised in Datix and 30 sampled for SJR - *table 1, Fig.1.*
3.2	***Datix Cohort Discussion*** Of the 76 patient deaths: • 62 internal concerns were raised through Incidents module • 12 external concerns were raised through the Patient Experience module • A further 2 concerns were raised both internally and externally.
3.2.1	***Internal Concerns: Tables 2 and 3, figures 2 and 3*** Of the 62 patients, 44 were reviewed and closed. In 6 cases, the investigation concluded the Trust had potentially contributed in some way to that patient death. No available clinical resource was cited as the main contributing factor to those deaths.

3.2.2	***External Concerns: Tables 4 and 5 and figure 4***
	
	Of the 12 patients reported, 11 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. One concern has been closed as there were no causal factors identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:
	
	• EOC
	  o Delay in responding to a chest pain patient, resulting in cardiac arrest
	  o Delay in responding to a patient in labour
	
	• PES
	  o Delay in crew informing hospital staff that patient was in ambulance
	  o Patient left at home, when MTS outcome suggested conveyance to hospital
	  o Patient who did not have documented capacity to refuse treatment

3.2.3	***Concerns raised internally and externally: Tables 6 and 7 and figure 5.***
	
	2 patient deaths were raised both internally and externally. Both of these investigations are still under review with preliminary learning identified as:
	• EOC:
	  o Delay in responding to a patient with difficulty in breathing
	  o Significant delay in responding to a patient

3.3	***Structured Judgement Review (SJR): Cohort Discussion: tables 8, 9 and fig 6.*** Of the 30 patient deaths: • 27 patient deaths occurred where patients were not initially conveyed, and the service was re-contacted within 24 hours* • 1 patient death occurred where the incident was coded as a Cat 3 • 2 deaths occurred where they were initially coded as Cat 1 or Cat 2 and were subjected to a long wait. * *These categories are taken from the national framework; the results should not be correlated to the results of the Safe Care Closer to Home audit due to significant differences in audit methodology.* The flow chart below provides a summary of which of the cases identified were reviewed and how the numbers referred to in tables 8 and 9 and fig 6 of the Q1 dashboard change. There are several reasons why the whole cohort identified are not reviewed: • Without a patient report form the review cannot be undertaken • Death not in scope post clinical review • SJR not moderated

Learning from Deaths- Structure Judgement Review Outcomes Q1 2022/23



Flow chart to describe sample cohort attrition and treatment Q1 2022/23

Clinical Hub specialists joined the panel in April 2022 to undertake the hear and treat (H&T) reviews.

3.3.1 ***Structured judgement review methodology***

The process requires the reviewing clinicians to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible to use each of the statement's multiple times in a single review.

	The review comprises of Stage 1: review of clinical practice and call handling/ resource allocation. Where "less than adequate" overall care is identified, a Stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.
3.3.2	***SJR Stage 1 Outcomes:***

27 patient deaths were presented by reviewers and following the moderation panels, the outcomes of the reviews were determined as described in the table below. 18 patients (67%) received adequate care.

Month	Very Poor	Poor	Adequate	Good	Very Good
Apr 22		4	7		
May 22		2	8		
Jun 22		3	3		

Moderation Panels held on 07/06/2022, 19/07/2022, & 09/08/2022

It should be understood the mid-range statement of *'adequate'* practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as *'good'*. Any practice identified as not reaching expected practice is defined as *'poor'*.

The Patient and Public Panel (PPP) representatives joined the moderation panels for May and June, and their initial feedback was around the 'adequate care' rating. They have asked if this rating can be changed to something more suitable such as 'appropriate care'. It was explained that these are nationally agreed statements which would require national group approval.

3.3.3 ***SJR Stage 2 Outcomes:***

9 cases were identified as needing second stage review. In 2 cases, no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect.

The second stage review for the 7 remaining patients remained as uncertain whether 'poor' practice had led to harm.

3.3.4 ***SJR Learning Outcomes: Tables 11 -12***

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to:

- Record repeated observations
- Perform ECGs when appropriate to do so
- Assess and document capacity to consent appropriately
- Apply Manchester Triage System (MTS) correctly
- Document patient and family wishes for joint decision making

	• Provide a comprehensive clinical narrative within the EPR, especially details around GP discussions and specific worsening advice *Good Practice: Table 12 fig 8.* The panel review identified numerous positive examples of practice over and above expected practice. This included: • Crew waited for GP to arrive and discussed patient's condition with GP and family. Clear documentation of GP discussions with family and actions. *Actions:* • Requested configuration changes to the EPR around the diagnosis of death form • Case escalated to Review of Serious Events (ROSE) meeting • Case escalated for a local clinical review • Feedback to private provider around their paper PRF and used of pathfinder
3.4	***Dissemination Process*** A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums and individual clinicians. Good practice letters have been circulated to commend 10 clinicians who through their care and professionalism have supported families and patients to experience a good death during Q1. Observers continue to join the panels during Q1 and this demonstrates to staff an open and transparent process of review. Immediate feedback from the observers has been extremely positive and this inclusivity will certainly support closing the gaps in care.
3.5	***Report Development*** DCIQ: Mortality Module The Clinical Audit Team has been working with the DCIQ team to improve the mortality module. Improvements have been made to the forms to improve data capture and reporting. Work is still ongoing to develop the dashboards.
4.	**LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS**
4.1	There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance to the Data Protection Act 2018.

5.	EQUALITY OR SUSTAINABILITY IMPLICATIONS
5.1	No equality or sustainability implications identified.
6.	**RECOMMENDATIONS**
6.1	The Board of Directors is recommended to: • Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths. • Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths. • Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust. • Acknowledge the good practice identified

NWAS Learning From Deaths Dashboard Quarter 1 2022-2023 (April - June)

Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

	Total Number of Deaths in scope (sample cohort and Datix incidents)*	Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	47	33	70.2%	8
May	33	22	66.7%	4
June	26	17	65.4%	3
This Quarter	106	72	67.9%	15
This Financial Year	106	72	67.9%	15

* Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of initial contact where the decision was not to convey the patient. The sample must contain incidents across the categories outlined in the document.

Table 1.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 12/08/2022.

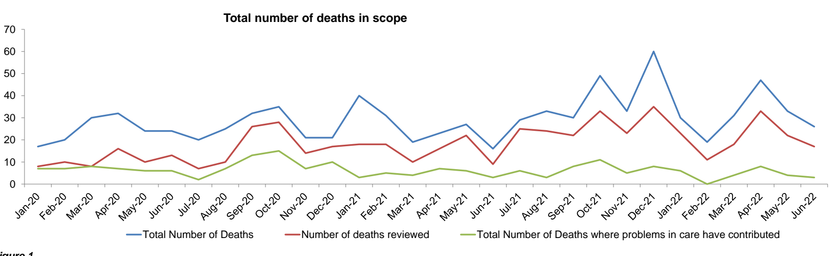


Figure 1.

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occurred; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death- Caused by the incident'. Patient Experience module data, is included in the cohort where the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death'.

Internal Concerns - Incidents (including SIs)

	Total Datix Death incidents in scope	Risk grading		
		1 or 2	3	4 or 5
April	28	9	4	15
May	17	3	4	10
June	17	2	6	9
Total	62	14	14	34

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
April	22	4	4
May	12	2	2
June	10	0	0
Total	44	6	6

Table 3.

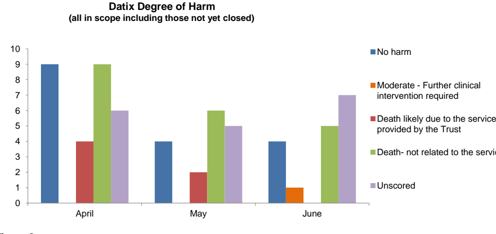


Figure 2.

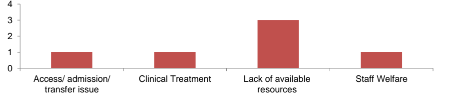


Figure 3.

Data source: Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc.: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 08/08/2022. Last accessed 09/08/2022.

External Concerns - Complaints

Month	Number of Complaints	Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
April	5	0	0
May	4	0	0
June	3	1	0
Total	12	1	0

Table 4.

(Note- This is the month the incident occurred, not when the notification of raised concern for care was received)

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 08/08/2022. Last accessed 09/08/2022.

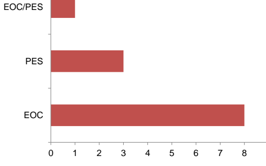


Figure 4.

Service Line	Summary of concern	Frequency	Action Themes (may have multiple)
EOC	Significant delay in responding to a chest pain patient	1	Still under review
	Significant delay in responding to patients	5	Demand outstripped resources; System/procedure review/update requested (x1) Still under review (x4)
	Significant delay in responding to a patient in labour	1	Demand outstripped resources; External Out Complaint , Staff feedback and/or reflection, Incident shared with internal meeting/committee
	Further information required from enquirer	1	Still under review
PES	Significant delay in crew informing hospital staff that patient was in ambulance	1	Still under review
	Patient left at home when should have been taken to hospital (sepsis)	1	Still under review
	Patient with mental health issues did not have capacity to refuse treatment	1	Still under review
EOC/PES	Significant delay in responding to patient	1	Still under review

Table 5.

Internal and External Concerns - Incidents and Complaints

Month	Number of concerns that have been raised internally and externally	Incidents Closed on both modules	Number closed and Deaths likely due to the service provided by the Trust
April	1	0	0
May	1	0	0
June	0	0	0
Total	2	0	0

Table 6.

(Note- This is the month the incident occurred, not when the notification of raised concern for care was received)

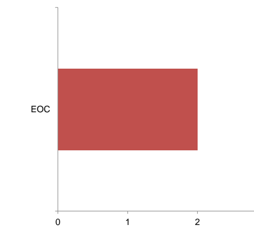


Figure 5.

Service Line	Summary of concern	Frequency	Action Themes
EOC	Significant delay in responding to a patient with difficulty in breathing (DIB)	1	Still under review
	Significant delay in responding to a patient	1	Still under review

Table 7.

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter: last extracted 08/08/2022. Information recorded on these incidents: last accessed 09/08/2022. Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc.: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report': last extracted on 08/08/2022. Last accessed 09/08/2022.

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initially conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review

	Incidents used for the Sample criteria	Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	13	11	4
May	11	10	2
June	6	6	3
Total	30	27	9

Table 8.

Month	SJR Category Type: C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
April	2	0	11
May	0	1	10
June	0	0	6
Total	2	1	27

Table 9.

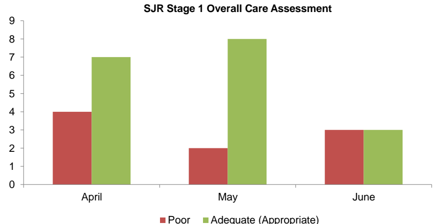


Figure 6.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	5	22	0	21 from a 27 patient cohort	81%
	Management Plan/Procedure Rating	9	17	1	18 from a 27 patient cohort	67%
Right Place	Patient Disposition Rating	6	21	0	21 from a 27 patient cohort	78%

Table 10.

† SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards; **Poor/Very Poor:** Care that is lacking and/or does not meet expected standards; **Good/Very Good:** Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

‡ EOC subject matter expert required to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 27 patients)

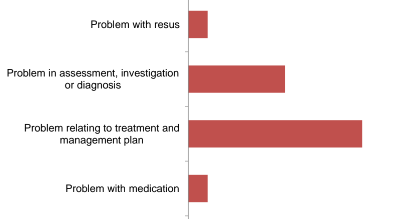


Figure 7.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Problem in assessment, investigation or diagnosis	No repeated observations recorded	7
	No medical model used (including those that lack detail)	4
	No chest examination recorded	2
	Breathing assessment lacks details	1
	No assessment of confusion (delirium, 4ATs, fluids and urine)	1
	No pertinent negatives recorded	1
	No ECG performed when appropriate to do so	2
	Capacity to consent not assessed correctly	4
Problem relating to treatment and management plan	MTS not used	2
	MTS not applied correctly	4
	No specific worsening advice/red flags/risk	4
	Details of the GP discussions not recorded	2
	No referral to AVS/GP/alternative providers when appropriate to do so	5
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
	No Safeguarding referral made when appropriate to do so	1
	No documentation of patient/family wishes for a joint decision	2
	No evidence of sepsis being considered	3
	No senior advice being sort	1
Problem with resus	Poor Senior clinical advice given around the continuation of ALS for 20 mins despite airway being comprised, asystole and ineffective bystander CPR.	1
Problem with medication	IV paracetamol administered to a ?sepsis patient when no reason was clearly indicated.	1
Problem of any other type	Quality of EPR	7
	No documented use of the COVID assessment tool for conveyance decision support	1

Table 11.

Evidence of Good/Very Good Practice

Other

Additional treatment and management plans

0 1 2 3 4 5

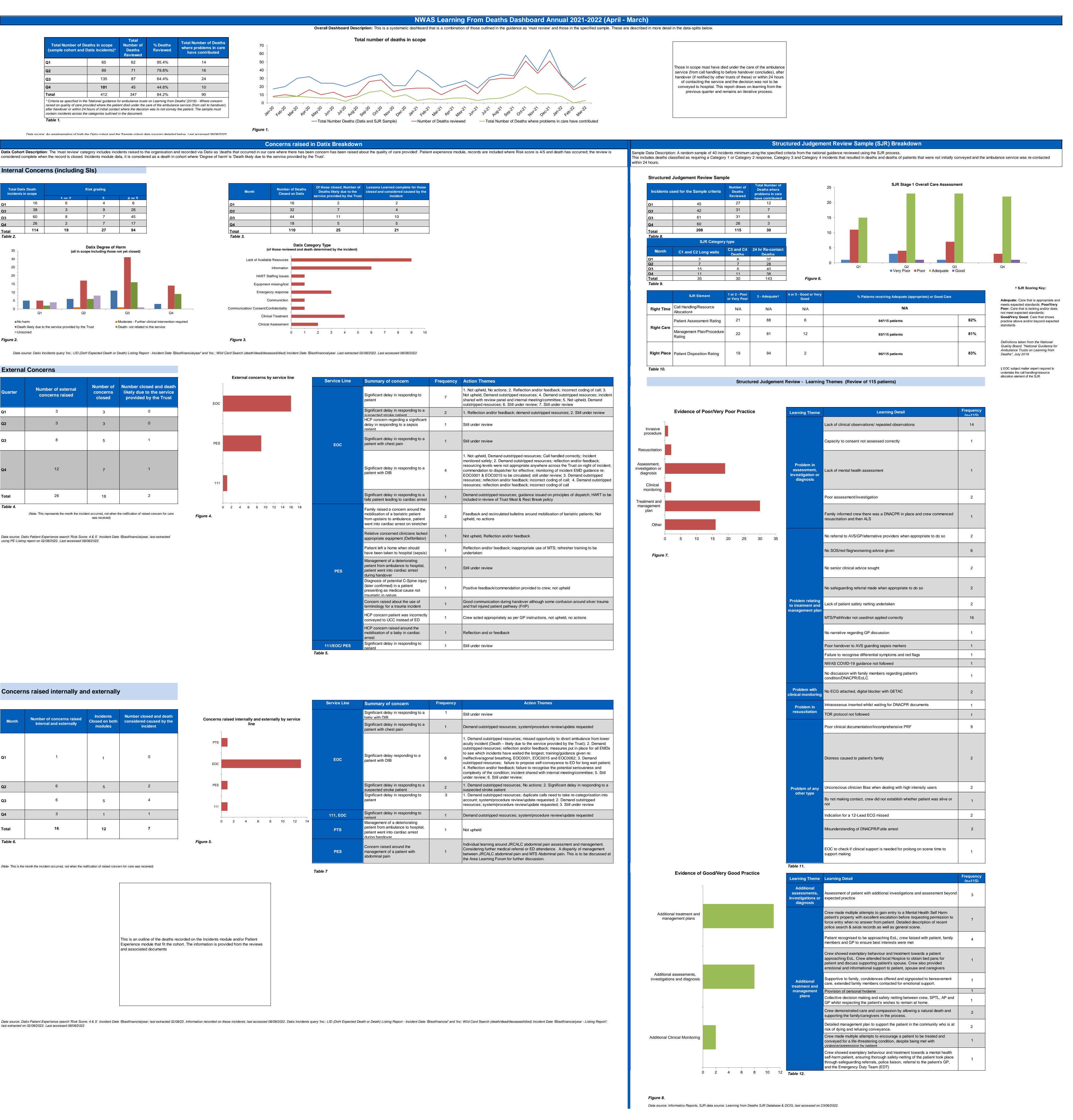
Figure 8.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Additional treatment and management plans	Crew waited for GP to arrive and discussed patient's condition with GP and family. Clear documentation of GP discussion with family and actions.	1
Other	Quality of EPR	4

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. 27 reviews took place, 13 less than the minimum random sample size of 40 required. 3 H&T cases were allocated but were unable to be moderated by the panel due to delays with external auditing and rollout of pathways.

Data source: Informatics queries, SJR data source: DCIQ Learning from Deaths module, last accessed on 12/08/2022.



NWAS Learning From Deaths Dashboard Annual 2021-2022 (April - March)

Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

	Total Number of Deaths in scope (sample cohort and Datix incidents)*	Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Q1	65	62	95.4%	14
Q2	89	71	79.8%	16
Q3	135	87	64.4%	24
Q4	101	45	44.6%	10
Total	412	347	84.2%	90

* Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of initial contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.

Table 1.

Figure 1.

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 08/08/2022

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occurred; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death likely due to the service provided by the Trust'.

Internal Concerns (including SIs)

	Total Datix Death incidents in scope	Risk grading 1 or 2	Risk grading 3	Risk grading 4 or 5
Q1	16	6	4	6
Q2	38	3	9	26
Q3	60	8	7	45
Q4	26	2	7	17
Total	114	19	27	94

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and considered caused by the incident
Q1	16	2	2
Q2	32	7	4
Q3	44	11	10
Q4	18	5	5
Total	110	25	21

Table 3.

Figure 2.

Figure 3.

Data source: Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastfinancialyear' and 'Inc.: Wild Card Search (death/dead/deceased/died) Incident Date @lastfinancialyear. Last extracted 02/08/2022. Last accessed 08/08/2022

External Concerns

Quarter	Number of external concerns raised	Number of concerns closed	Number closed and death likely due to the service provided by the Trust
Q1	3	3	0
Q2	3	3	0
Q3	8	5	1
Q4	12	7	1
Total	26	18	2

Table 4.

(Note- This represents the month the incident occurred, not when the notification of raised concern for care was received)

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastfinancialyear, last extracted using PE Listing report on 02/08/2022. Last accessed 08/08/2022.

Figure 4.

Service Line	Summary of concern	Frequency	Action Themes
EOC	Significant delay in responding to patient	7	1. Not upheld, No actions; 2. Reflection and/or feedback; incorrect coding of call; 3. Not upheld, Demand outstripped resources; 4. Demand outstripped resources; incident shared with review panel and internal meeting/committee; 5. Not upheld, Demand outstripped resources; 6. Still under review; 7. Still under review
EOC	Significant delay in responding to a suspected stroke patient	2	1. Reflection and/or feedback; demand outstripped resources; 2. Still under review
EOC	HCP concern regarding a significant delay in responding to a sepsis patient	1	Still under review
EOC	Significant delay in responding to a patient with chest pain	1	Still under review
EOC	Significant delay in responding to a patient with DIB	4	1. Not upheld, Demand outstripped resources; Call handled correctly; Incident monitored safely; 2. Demand outstripped resources; reflection and/or feedback; resourcing levels were not appropriate anywhere across the Trust on night of incident; commendation to dispatcher for effective; monitoring of incident EMD guidance re: EOC0001 & EOC0015 to be circulated; still under review; 3. Demand outstripped resources; reflection and/or feedback; incorrect coding of call; 4. Demand outstripped resources; reflection and/or feedback; incorrect coding of call
EOC	Significant delay in responding to a falls patient leading to cardiac arrest	1	Demand outstripped resources; guidance issued on principles of dispatch; HART to be included in review of Trust Meal & Rest Break policy
PES	Family raised a concern around the mobilisation of a bariatric patient from upstairs to ambulance, patient went into cardiac arrest on stretcher	2	Feedback and recirculated bulletins around mobilisation of bariatric patients; Not upheld, no actions
PES	Relative concerned clinicians lacked appropriate equipment (Defibrillator)	1	Not upheld, Reflection and/or feedback
PES	Patient left a home when should have been taken to hospital (sepsis)	1	Reflection and/or feedback; inappropriate use of MTS; refresher training to be undertaken
PES	Management of a deteriorating patient from ambulance to hospital, patient went into cardiac arrest during handover	1	Still under review
PES	Diagnosis of potential C-Spine injury (later confirmed) in a patient presenting as medical cause not traumatic in nature	1	Positive feedback/commendation provided to crew; not upheld
PES	Concern raised about the use of terminology for a trauma incident	1	Good communication during handover although some confusion around silver trauma and frail injured patient pathway (FrIP)
PES	HCP concern patient was incorrectly conveyed to UCC instead of ED	1	Crew acted appropriately as per GP instructions, not upheld, no actions
PES	HCP concern raised around the mobilisation of a baby in cardiac arrest	1	Reflection and or feedback
111/EOC/ PES	Significant delay in responding to patient	1	Still under review

Table 5.

Concerns raised internally and externally

Month	Number of concerns raised internal and externally	Incidents Closed on both modules	Number closed and death considered caused by the incident
Q1	1	1	0
Q2	6	5	2
Q3	6	5	4
Q4	3	1	1
Total	16	12	7

Table 6.

(Note- This is the month the incident occurred, not when the notification of raised concern for care was received)

Figure 5.

Service Line	Summary of concern	Frequency	Action Themes
EOC	Significant delay in responding to a baby with DIB	1	Still under review
EOC	Significant delay in responding to a patient with chest pain	1	Demand outstripped resources; system/procedure review/update requested
EOC	Significant delay responding to a patient with DIB	6	1. Demand outstripped resources; missed opportunity to divert ambulance from lower acuity incident (Death – likely due to the service provided by the Trust); 2. Demand outstripped resources; reflection and/or feedback; measures put in place for all EMDs to see which incidents have waited the longest; training/guidance given re: ineffective/agonal breathing, EOC0001, EOC0015 and EOC0002; 3. Demand outstripped resources; failure to propose self-conveyance to ED for long wait patient; 4. Reflection and/or feedback; failure to recognise the potential seriousness and complexity of the condition; incident shared with internal meeting/committee; 5. Still under review; 6. Still under review;
EOC	Significant delay in responding to a suspected stroke patient	2	1. Demand outstripped resources, No actions; 2. Significant delay in responding to a suspected stroke patient
EOC	Significant delay in responding to patient	3	1. Demand outstripped resources; duplicate calls need to take re-categorisation into account; system/procedure review/update requested 2. Demand outstripped resources; system/procedure review/update requested; 3. Still under review
111, EOC	Significant delay in responding to patient	1	Demand outstripped resources; system/procedure review/update requested
PTS	Management of a deteriorating patient from ambulance to hospital, patient went into cardiac arrest during handover	1	Not upheld
PES	Concern raised around the management of a patient with abdominal pain	1	Individual learning around JRCALC abdominal pain assessment and management. Considering further medical referral or ED attendance. A disparity of management between JRCALC abdominal pain and MTS Abdominal pain. This is to be discussed at the Area Learning Forum for further discussion.

Table 7

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date '@lastfinancialyear', last extracted 02/08/22. Information recorded on these incidents; last accessed 08/08/22. Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date '@lastfinancial' and 'Inc.: Wild Card Search (death/dead/deceased/died) Incident Date '@lastfinancialyear - Listing Report'; last extracted on 02/08/22. Last accessed 08/08/22

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initially conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review Sample

	Incidents used for the Sample criteria	Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Q1	45	27	12
Q2	42	31	7
Q3	61	31	8
Q4	60	26	3
Total	208	115	30

Table 8.

Month	SJR Category type: C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
Q1	2	6	37
Q2	7	7	28
Q3	15	6	40
Q4	11	11	38
Total	35	30	143

Table 9.

Figure 6.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate*	4 or 5 - Good or Very Good	% Patients receiving Adequate (appropriate) or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	21	89	6	94/115 patients	82%
Right Care	Management Plan/Procedure Rating	22	81	12	93/115 patients	81%
Right Place	Patient Disposition Rating	19	94	2	96/115 patients	83%

Table 10.

* SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards; **Poor/Very Poor:** Care that is lacking and/or does not meet expected standards. **Good/Very Good:** Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

‡ EOC subject matter expert required to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review - Learning Themes (Review of 115 patients)

Figure 7.

Learning Theme	Learning Detail	Frequency (n=115)
Problem in assessment, investigation or diagnosis	Lack of clinical observations/ repeated observations	14
	Capacity to consent not assessed correctly	1
	Lack of mental health assessment	1
	Poor assessment/investigation	2
	Family informed crew there was a DNACPR in place and crew commenced resuscitation and then ALS	1
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	2
	No SOS/red flag/worsening advice given	6
	No senior clinical advice sought	2
	No safeguarding referral made when appropriate to do so	2
	Lack of patient safety netting undertaken	2
	MTS/Pathfinder not used/not applied correctly	16
	No narrative regarding GP discussion	1
	Poor handover to AVS guarding sepsis markers	1
	Failure to recognise differential symptoms and red flags	1
	NWAS COVID-19 guidance not followed	1
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
Problem with clinical monitoring	No ECG attached, digital blocker with GETAC	2
Problem in resuscitation	Intraosseous inserted whilst waiting for DNACPR documents	1
	TOR protocol not followed	1
Problem of any other type	Poor clinical documentation/Incomprehensive PRF	9
	Distress caused to patient's family	2
	Unconscious clinician Bias when dealing with high intensity users	2
	By not making contact, crew did not establish whether patient was alive or not	1
	Indication for a 12-Lead ECG missed	2
	Misunderstanding of DNACPR/Futile arrest	2
	EOC to check if clinical support is needed for prolong on scene time to support making	1

Table 11.

Figure 8.

Learning Theme	Learning Detail	Frequency (n=115)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessment beyond expected practice	3
Additional treatment and management plans	Crew made multiple attempts to gain entry to a Mental Health Self Harm patient's property with excellent escalation before requesting permission to force entry when no answer from patient. Detailed description of recent police search & seize records as well as general scene.	1
	Patient recognised to be approaching EoL; crew liaised with patient, family members and GP to ensure best interests were met	4
	Crew showed exemplary behaviour and treatment towards a patient approaching EoL. Crew attended local Hospice to obtain bed pans for patient and discuss supporting patient's spouse. Crew also provided emotional and informational support to patient, spouse and caregivers	1
	Supportive to family, condolences offered and signposted to bereavement care, extended family members contacted for emotional support.	1
	Provision of personal hygiene	1
	Collective decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home.	1
	Crew demonstrated care and compassion by allowing a natural death and supporting the family/caregivers in the process.	2
	Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance.	2
	Crew made multiple attempts to encourage a patient to be treated and conveyed for a life-threatening condition, despite being met with violence/aggression by patient	1
	Crew showed exemplary behaviour and treatment towards a mental health self-harm patient, ensuring thorough safety-netting of the patient took place through safeguarding referrals, police liaison, referral to the patient's GP, and the Emergency Duty Team (EDT)	1

Table 12.

Data source: Informatics Reports, SJR data source: Learning from Deaths SJR Database & DCIQ, last accessed on 23/06/2022.

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="6">28.09.2022</td></tr>
<tr><td>SUBJECT:</td><td colspan="6">IPC Annual Report</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="6">Emma Orton, Assistant Director of Nursing & Quality</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td colspan="2">SR05</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td colspan="2">☐</td></tr>
<tr><td>SR06</td><td>SR07</td><td>SR08</td><td>SR09</td><td>SR10</td><td>SR11</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="6">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="6">The purpose of this paper is to introduce the Infection Prevention and Control Annual Report for 2021/2022.

This IPC Annual Report is the second annual report written during the COVID-19 pandemic and the importance of IPC in practice has been further emphasised as the driver to achieve patient and staff safety in unprecedented times. This report is a summary of the efforts and challenges the Trust has faced and overcome during the last 12 months of the pandemic, whilst working to national IPC guidance.

Assurance on delivery of IPC within the trust is monitored through the updated IPC Board Assurance Framework, which is presented to Quality and Performance Committee, as well as Board of Directors.

The annual report aligns assurance and provides understanding of risks to the organisation during the reporting period.

It also demonstrates the significant progress and achievements that have been made in delivering effective staff and patient safety during COVID-19 and responding to ever changing national guidance due to fluctuations in prevalence and transmissibility in variants of COVID-19.

IPC Governance: The IPC Team has been reviewed and additional posts were created in the team to ensure robust arrangements were in place for the Trust. The team consists of an IPC Specialist Lead, an IPC Manager, 4 IPC Practitioners and an administrator. The team are overseen by the Director of Infection Prevention and Control.</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">Covid 19: The Covid 19 pandemic has continued to challenge the Trust, however significant work has been completed which has ensured the safety of both Trust patients and staff. These achievements include the Test Track and Trace Service which also allowed for monitoring of outbreaks. An internal vaccination programme and a mobile testing unit. And compliance and monitoring of personal protective respiratory equipment.

Risks: There are currently three risks aligned to IPC and two from the previous year have been closed.

The report also outlines all other activities that the IPC team lead on, collaborative working with other Trust services and provides a summary of any mandatory reporting.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">Board of Directors is asked to
• Note the content of the Report
• Note the assurances it provides
• Note the arrangements for ongoing monitoring via the IPC board assurance framework
• Note the key risks and mitigations</td></tr>
<tr><td>CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td colspan="5">INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☒</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality & Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">26.09.2022</td></tr>
<tr><td>Outcome:</td><td colspan="3"></td></tr>
</table>

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1. STATEMENT BY THE DIRECTOR OF INFECTION, PREVENTION & CONTROL

1.1 The Coronavirus pandemic has had huge impacts on the National Health Service (NHS). It has led to an unprecedented demand on NHS resources and has seen a huge surge in the demand for urgent and emergency care. Covid 19 was the most significant issue faced in relation to Infection Prevention and Control (IPC) in the Trust and across the NHS. Throughout the year, we have developed policies to prevent the transmission of coronavirus. These have been informed by public health and Government guidance that have been continually updated as our understanding of coronavirus has evolved, leading to challenges in terms of their rapid implementation at a local level. Working in such a rapidly developing situation, while maintaining our focus on IPC practice, has required a comprehensive and collaborative effort.

2. PURPOSE

2.1 The purpose of this report is to provide the Quality and Performance Committee with an overview of Infection Prevention and Control activity during 2021-2022 for the North West Ambulance service. This report will include all aspects of IPC and the ongoing response to the coronavirus pandemic.

3. BACKGROUND

3.1 This report summarises the management of Infection prevention and control (IPC) in the North West Ambulance Service (NWAS). The reporting period is 1 April 2021 until the 31 March 2022. During this time NWAS was delivering both its strategic ambitions with respect to IPC and also responding to the COVID-19 global pandemic. This report covers all aspects of IPC including our organisational response to the ongoing pandemic.

Effective systems for the management of Infection prevention and control (IPC) are essential for all NHS providers. NWAS has a legal duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Our approach to IPC is taken from the guidance published by Public Health England who remain the trusted NHS authority on the implementation of research evidence into NHS practice.

The IPC policy can be located on the NWAS Green Room and is supplemented with several procedural documents for key areas of IPC practice. These policies are regularly reviewed and updated to ensure they are aligned to best practice guidance. In most cases

this will happen annually, however, during the second year of the COVID-19 pandemic there has continued to be a requirement to review and update staff in real time as guidance changed frequently. To ensure our staff have up to date guidance we also have robust internal communications via IPC bulletins which are distributed to all staff and discussed at operational meetings.

We monitor compliance to our policies, procedures, and training via a series of audits which are carried out locally, by IPC specialist practitioners and by external assessors (such as public health, environmental health, NHSI and NHSE). During 21/22 we designed and launched our first IPC Audit Dashboard which allows all service lines to digitally input audit data and review in real time their progress.

We also learn about IPC practices from when things go wrong by reviewing IPC incidents through our incident management system, Datix. The themes from incidents occurring in each area are used alongside audit data to inform our intelligence about which systems need to be improved, where additional training is required or where risk management systems need to be put in place.

The NWAS executive leadership team and DIPC take joint responsibility for IPC oversight and have conducted leadership walk rounds throughout the year to ensure staff feel supported and key issues of PPE supply, compliance and the additional burden of continuous use of PPE are understood.

4. COMPLIANCE WITH REGULATORY CQC

4.1 CQC Assurance

The Care Quality Commission (CQC) are the regulating body for health and Social Care organisations within England. The CQC during their inspection ensure that the IPC element of the service is safe, effective, compassionate and of high quality. The CQC last inspected the 111 and emergency care elements of the service in 2020 and the overall rating was good.

In 2021/2022 the CQC continued to regulate providers using a risk-based model under their transitional regulatory approach (TRA). This includes regular local level provider engagement meetings and a periodic transitional monitoring approach (TMA), via a multi-disciplinary documentation return and follow-up, virtual interview.

In March 2022 the CQC announced a system level inspection of the Lancashire and South Cumbria Integrated Care System (ICS) and each of the partner agencies within the ICS. As of the 1st of April, the CQC were present within the Lancashire and South Cumbria ICS. NWAS as a provider have not been subject to an individual inspection. In

preparation for this inspection NWAS has developed a working group of senior leaders, including representation from the Director of Infection Prevention Control.
In order to prepare for the CQC inspections NWAS carry out its own Quality Assurance Visits (QAV). The purpose of the QAV is to provide assurance to the Trust regarding the quality and safety of our services and premises. The QAV's are aligned to the CQC inspection process, through alignment to the CQC key lines of enquiry.

QAV's specifically for IPC enable us to identify what we are doing well, what we need to do better and enable us to continually drive for improvement.

4.2 Regulatory Compliance

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) The Health and Safety Executive requires deaths and injuries to be reported only when:

- there has been an accident which caused the injury
- the accident was work-related
- the injury is of a type which is reportable

Guidance was issued by the HSE with respect to COVID 19 reporting which stated that: You should only make a report under RIDDOR when one of the following circumstances applies:

- an accident or incident at work has, or could have, led to the release, or escape of coronavirus (SARS-CoV-2). This must be reported as a dangerous occurrence.
- a person at work (a worker) has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus. This must be reported as a case of disease.
- a worker dies because of occupational exposure to coronavirus. This must be reported as a work-related death due to exposure to a biological agent.

NWAS were instrumental in supporting the practical application of this guidance in the ambulance sector leading this work via the quality directors' group of the association of ambulance chief executives.
RIDDOR incident reports are completed within 15 days of knowing about the incident via Datix. The target for 2021/22 was to achieve 70% within 15 days.
The number of RIDDOR (non-disease) incident reports received in 2021/22 was 130, and of these 107 were reported to the HSE within 15 days of the incident lodged in Datix. This means the referral rate that met the target was achieved with 82%.

4.3 H&S Inspections

Each of the 141 premises (including shared premises) received an annual rapid review of health and safety by 31 March 2022. This is an excellent achievement by the HSS team given the challenges of resourcing experienced in the year.
All actions arising from the reviews are reported and managed via the established quality assurance visit governance process.

5. IPC GOVERNANCE ARRANGEMENTS

5.1 Overall accountability for infection prevention and control within NWAS sits with the Chief Executive who delegates responsibility to the Director of Infection Prevention and Control (DIPC). The DIPC is the Assistant Director of Quality and Nursing within the organisation.

The Chief Nurse is responsible for the Infection Prevention and Control Team. The IPC team has undergone significant change over the past 12 months and has seen significant expansion. The team is now fully staffed and consists of 1 x Infection Prevention and Control Lead, 1 x IPC Manager, 4 x IPC Practitioner (1 x 12-month fixed term contract), 1 x IPC Administrator (12-month fixed term secondment). The team sits within the Quality, Improvement and Innovation directorate and are overseen by the Assistant Director of Quality and Nursing (Chief Nurse).

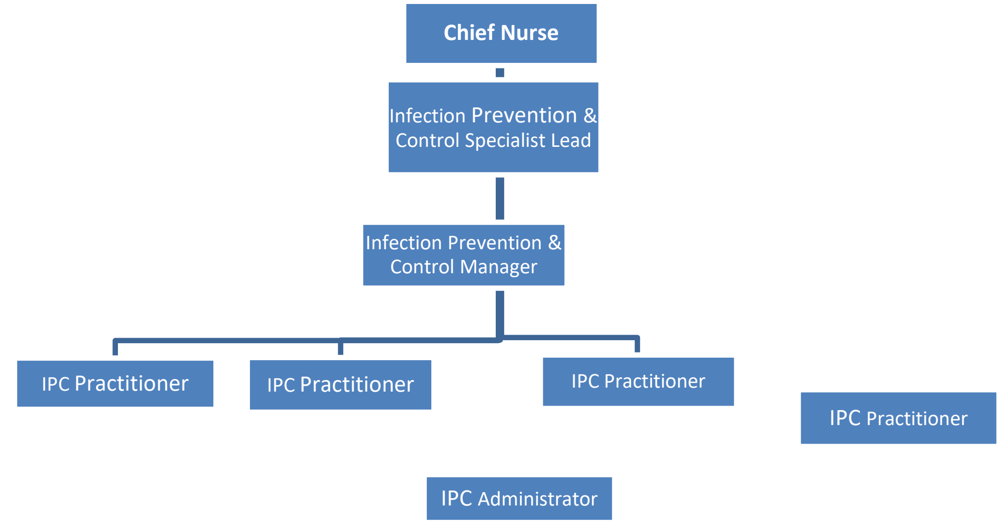

Chart 1 demonstrates the structure of the Infection Prevention and Control Team

5.2 Supervision & Specialist Advice

In addition to the specialist IPC team who sit within the corporate function of the Quality, Improvement and Innovation directorate, additional support is given to operational hear and treat and see and treat staff via supervision and specialist support. To provide appropriate supervision within operations, the Trust already has in place a robust clinical leadership structure with Senior Paramedic Team Leaders (SPTL) responsible for the leadership and supervision of set numbers of operational staff. That clinical leadership structure is further enhanced with a 24/7 Advanced Paramedic (AP) capability working both operationally alongside staff but also based in each of the Emergency Operations Centres (EOC) as a point of contact for clinical or IPC enquiries.

5.3 Progress Against BAF Key Lines of Enquiry (2021-22)

The BAF outlines the systems in place to manage and monitor infection and risks of infection.

IPC guidance was routinely revised and reissued throughout 2021/22 to ensure alignment with national emerging guidance, particularly related to the management of nosocomial infection, NWAS test, track and trace, outbreak management and working safely. Covid-19 risk assessment processes were standardised and fully implemented across all stations, offices and control centres and were updated every 90 days (or after any Covid-19 outbreak).

5.4 Provide and maintain a clean environment

A review of organisational cleaning allocations was completed, and additional cleaning facilities and hours were introduced where indicated based on footfall, layouts and occupancy and to support outbreak management. Additional vehicle cleaning contracts were continued until 31st March 2022 across hospital sites upon patient handover at Emergency Department.

5.5 Provide suitable information on infections for staff and patients

National guidance and local operating processes disseminated regularly to staff via bulletins, social media, internal intranet and the IPC cell. All training materials for staff and volunteers were reviewed throughout the reporting period.

6. ASSURANCE

6.1 The NWAS Board Assurance Framework includes a strategic risk related to the safe delivery of high-quality care which is articulated as follows: 'If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety'.

6.2 IPC Risk Management

During 2021/22 risks in relation to COVID-19 and Infection Prevention and Control (IPC) have been aligned, managed, and monitored as part of the COVID-19 Board Assurance Framework (BAF), in addition to the organisational Board Assurance Framework (BAF) and the Corporate Risk Register (CRR).

This Board Assurance Framework was developed to monitor NWAS standards against key healthcare criteria and provided evidence and assurance surrounding the management of any risks identified within this criterion. Risks are continually reviewed, and newly identified risks added to the organisational risk register. The BAF continued to be reviewed on a quarterly basis and is presented to the Quality and Performance Committee and the Audit Committee for assurance, prior to the Board of Directors, for approval. The Executive Leadership Committee monitors the organisational management of the BAF.

There are currently three risks that are aligned to IPC. These include risks attached to FFP3 face fit testing compliance, aerosol generated procedure (AGP) audits, and COVID-19 safe systems of work. Of these three risks, only one risk has a risk rating of 12 by the end of March 2022. All risks identified are in relation to areas highlighted in the report, including areas of improvement and additional assurances.
Risks Scoring >12

Risk 3593 (12) There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods being past their service date, staff are unable to respond to Aerosol Generating Procedures (AGPs) leading to risk to staff personal safety.
During 2021/22 risks in relation to COVID-19 and Infection Prevention and Control (IPC) have been aligned, managed, and monitored as part of the COVID-19 Board Assurance Framework (BAF), in addition to the organisational Board Assurance Framework (BAF) and the Corporate Risk Register (CRR).

This Board Assurance Framework was developed to monitor NWAS standards against key healthcare criteria and provided evidence and assurance surrounding the management of any risks identified within this criterion. Risks are continually reviewed, and newly identified risks added to the organisational risk register. The BAF continued to be reviewed on a quarterly basis and is presented to the Quality and Performance Committee and the Audit Committee for assurance, prior to the Board of Directors, for approval. The Executive Leadership Committee monitors the organisational management of the BAF.

6.3

Risks that improved during 2021/22:

Risk 3474 (16 to 9) There is a risk that the Aerosol Generated Procedure (AGP) audit '24 hr later voice to voice live ring back' between operations and identified crews will fail due to a suitable robust resource not being identified which would lead to NWAS not being able to assure the HSE that clinical staff are adequately protected when attending an AGP incident.

6.4

Mitigated risks (closed) during 2021/22

Risk 2716 (12 to closed) There is a risk that Infection, Prevention and Control Standards are not met, measured, and monitored due to a lack of compliance, audit and specialist support leading to increased risk of harm which could result in a breach of regulatory standards

Risk 3389 (12 to closed) There is a risk that the Trust may fail to comply with Health and Safety at Work Act 1974 due to the Trust not having a robust system for monitoring compliance with respiratory protective equipment which may impact on our compliance with legislative requirements and potential for staff being exposed to avoidable harm.

7. POLOCIES AND PROCEDURES

7.1 Throughout the last 12 months national guidance on PPE, Covid testing (both for health care staff and the public), isolation and measures implemented to minimise onward transmission has changed numerous times. National guidance often focuses on acute care, Association of Ambulance Chief Executives (AACE) ensure that any guidance that they approve in line with the nationally published guidance, is more suitable for the ambulance sector.

The Infection Prevention and Control Specialist Lead attends the weekly National Ambulance Service Infection Prevention and Control Group (NASIPCG) and contributes to AACE guidance prior to approval. Once the AACE guidance is approved the IPCT work closely with Communications in NWAS to ensure an update bulletin is distributed to inform staff of changes and the IPCT also support the Heads of Service in implementing the changes.

The IPCT work closely with the Test, Track & Trace (TTT) Team to ensure that they are aware of any changes in guidance on testing and isolation to inform staff when they are contacting them following a positive Covid result.

NWAS also has responsibility to keep its internal policy and procedures in place in line with the Health and Social Care Act – the current policies that are in place include:

- Infection Prevention and Control Policy
- Health, Safety and Security Policy
- Wound Care Policy
- Peripheral Intravenous Cannulation Policy
- Linen Policy
- Aseptic Non-Touch Technique Policy

We monitor compliance to our policies, procedures, and training via a series of audits which are carried out locally, by IPC specialist practitioners and also by external assessors (such as public health, environmental health, NHSI and NHSE). During 21/22 we designed and launched our first IPC Audit Dashboard which allows all service lines to digitally input audit data and review in real time their progress.

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The NWAS executive leadership team and DIPC take joint responsibility for IPC oversight and have conducted leadership walk rounds throughout the year to ensure staff feel supported and key issues of PPE supply, compliance and the additional burden of continuous use of PPE are understood.

8. GOVERNANCE

8.1 To ensure the ongoing compliance was met during the covid 19 pandemic the Trust established the IPC Sub Committee. The IPC Sub Committee terms of reference were agreed and include the oversight of the use of RPE and the RPE audit. This is now an established feature of IPC governance.

At the start of the COVID-19 pandemic there was no standardised way of reporting sickness within NWAS. From the 13 August 2020, all staff were required to report sickness and COVID-19 related absence in the first instance to Carlisle Support Centre, as well as in accordance with normal departmental sickness absence reporting procedures. This change in reporting helped to build several reports using data from Marvel to capture daily COVID-19 positive cases, the number of people shielding, the number isolating due to close contacts or having been traced by the national TTT team.

This data was reviewed weekly by the executive cell and regulatory and compliance cell to understand the impact of COVID-19 on the workforce and service delivery. Chart 1 below shows the total numbers of positive covid tests per month which were reported in through the Support Centre during 2021/22. In addition to the numbers included in the chart below 11 Community First Responders also reported unfit for duty due to positive covid tests.

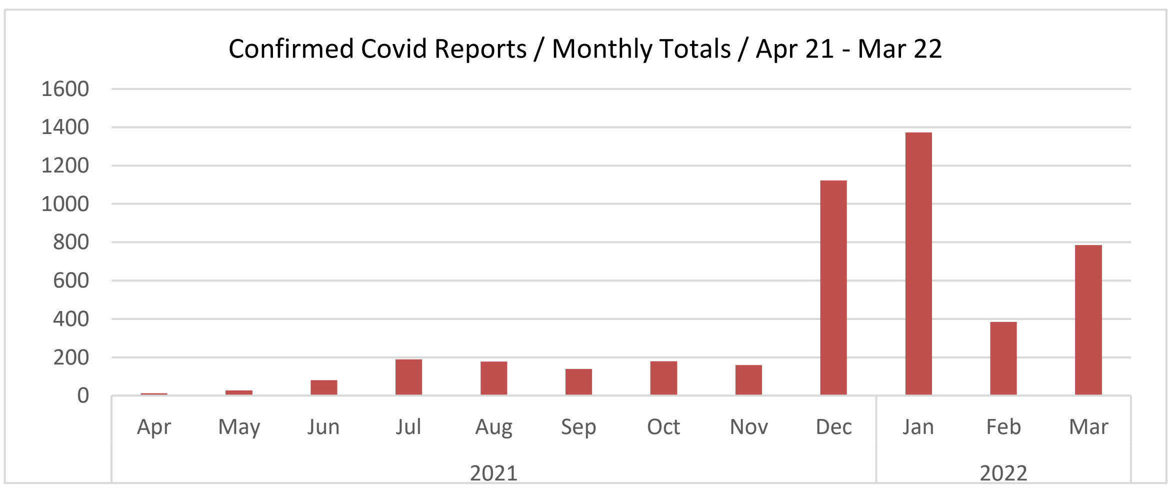

Chart 1

8.2 Test, Track and Trace Service

NWAS Test, Track and Trace (TTT) service continued throughout the year to protect staff, partners, and patients, in response to a mandated national request from NHS England/NHS Improvement. The NWAS TTT service is a supplemental service to the

National Test Track and Trace system, which does not trace NHS staff at work.

NWAS TTT was designed using national guidance provided by AACE to complete a risk assessment where a positive COVID-19 test (either PCR or Lateral Flow Test) is reported by a staff member to NWAS. Financial resources were secured to ensure consistency for the service and some of the staff were kept on with the team until the 31st of March. NWAS Staff who were shielding or recovering from long COVID-19 were offered alternative duties and worked as tracer until they were well enough to return to their substantive post. The workload of the team has been variable and reflects the prevalence in the wider community, during higher demand periods, such as in December/January, when we saw a rise in the Omicron variant, it was necessary to pull support from wider teams to cope with the demand. Standard Operating Procedures, flow charts and internal processes continue to be developed and reviewed in line with national guidance.

The service is offered 7 days a week and the staff work a rota and have a duty manager on weekdays. The service was also supported by the ROCC out of hours and operational managers in times of high demand.

The Support Centre was used as the primary point of contact for staff as this service is available on a 24-hour basis. The Support Centre would transfer the information across into the TTT who would then then record the data, and action any tracing that was required.

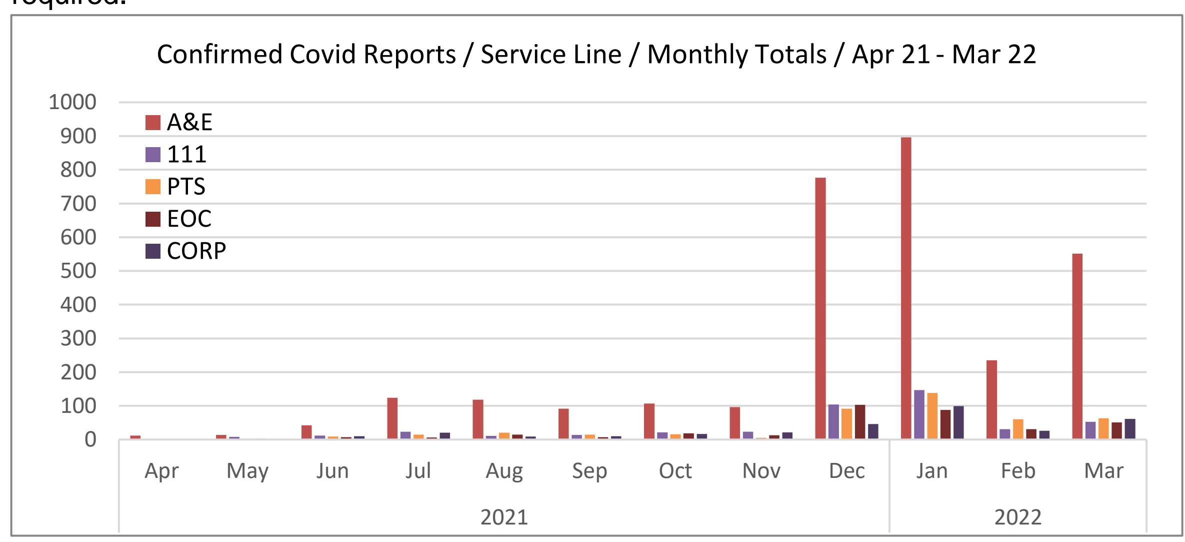

Chart 2
Chart 2 gives a breakdown of positive covid 19 tests against each service line. Patient facing staff were consistently the highest reporting service line.

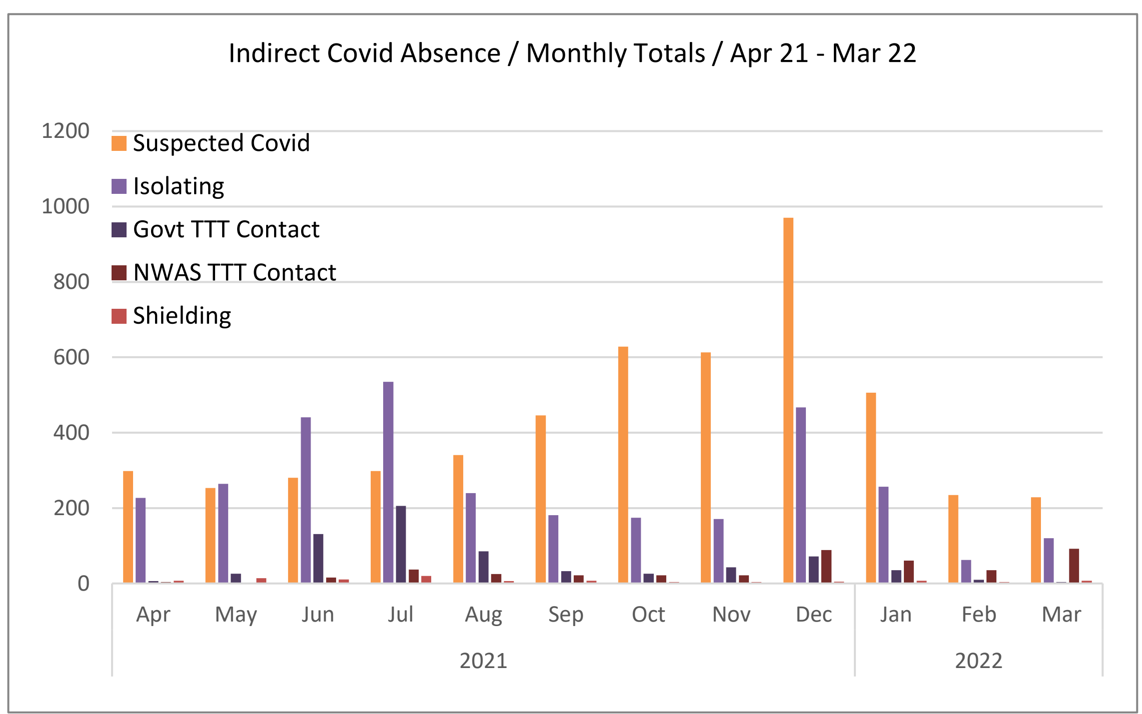

Chart 3
Chart 3 reflects numbers captured across the Trust per month reflective of positive lateral flow tests, isolating due to positive PCR test results, staff who were traced and told to isolate and those staff who were shielding.

8.3 Outbreak Management

In the year 2021-22 NWAS continued to report clusters and outbreaks of Covid as per definition in the Public Health England document - COVID-19: Epidemiological definitions of outbreaks and clusters. NWAS were required to report to NHS E/I initially via email submission daily on the National Portal System.
Clusters or outbreaks of COVID-19 are declared by the Director of Infection Prevention and Control, the Head of Clinical Safety, or an appointed deputy. A standard process of outbreak declaration and the appointment of an outbreak control team then triggers the NWAS cluster management and outbreak operating procedures.
An outbreak of COVID-19 is where 2 or more cases of COVID-19 are linked in time or place. In the ambulance service this could be cases linked on specific stations, call centres or between crew members where the cases have occurred within 14 days of the first identified case (the index case). A cluster is two or more test-confirmed cases of COVID-19 among individuals associated with a specific non- residential setting with illness onset dates within a 14-day period. These are cases without direct linked exposure.

The NWAS Cluster and Outbreak Management Standard Operating Procedure COVID-19 was first approved by the Executive Leadership Committee in August 2020, and this is currently under review. This procedure ensures an effective and coordinated approach is taken to an outbreak of COVID-19 within NWAS, from initial detection to formal closure

and review of lessons identified. It promotes a consistent approach across all levels of NWAS and includes a set of standards for a response to a declared outbreak.

During September 2021 it was agreed at the IPC cell that NWAS would no longer declare clusters of Covid and just continue to report outbreaks of infection amongst staff.

8.4 Outbreak Reporting

NWAS continued to report outbreaks and clusters to our regulators via the national portal. NWAS staff attended numerous online meetings with regulators throughout the pandemic provided real time information to ensure all regulators were fully briefed and to provide assurance that IPC measures were being implemented.
For each new outbreak or cluster, a standard IIMARCH notification form was completed and submitted to NHSE/I. These briefings were used to ensure that the appropriate actions were in place to control the outbreak and that any risks were identified. The IIMARCH consists of a summary of the facts, actions taken and any further measures necessary to implement.

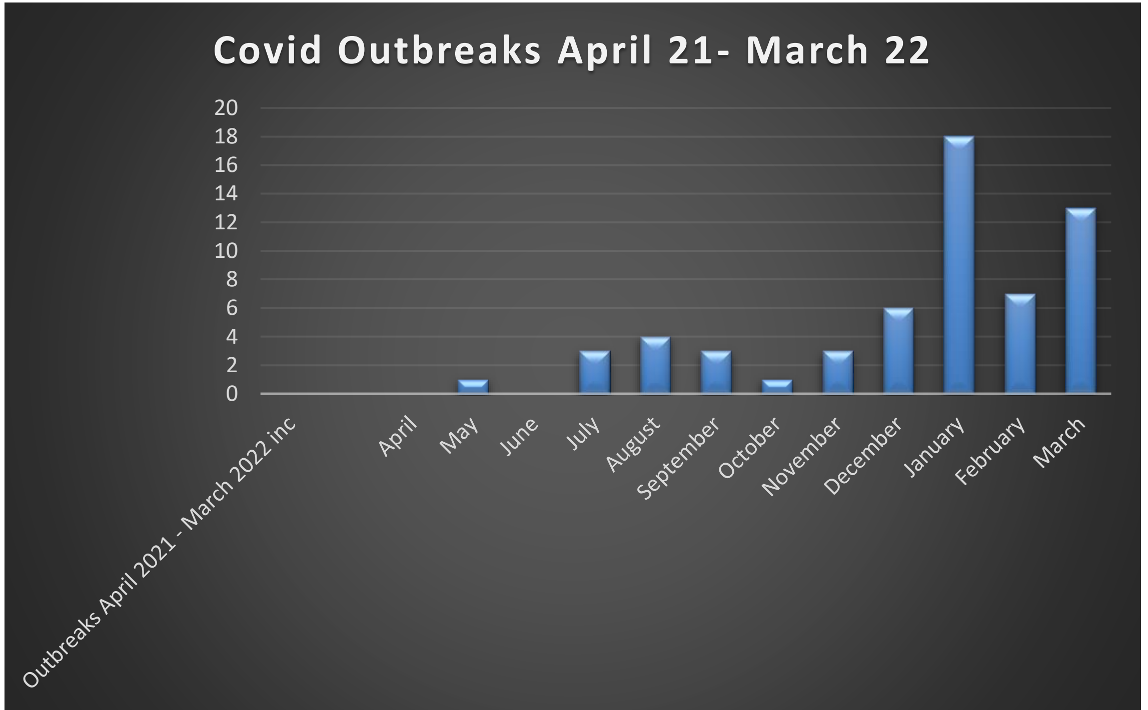

Chart 4

Chart 4 shows the number of covid outbreaks which were reported during 2021/22. January 2022 recorded the highest amount of outbreaks, which was reflective of the increase in reporting of cases both for the Trust and nationally.

8.5 Outbreak Escalation

In February 2021 the NWAS Cluster and Outbreak Management Standard Operating Procedure COVID-19 were updated with an outbreak escalation procedure which was implemented to address long standing or rapidly expanding outbreaks. This was used for cases where outbreaks or clusters had been open for longer than 2 months duration and

where there was a growth in the frequency of positive COVID-19cases reported by staff, to a rate of more than 5 cases a week.
Outbreak sites that were escalated received enhanced support to the local outbreak management team including more frequent IPC audit, daily operational IPC leadership and support to implement the NWAS IPC improvement module which was specifically developed to address key IPC improvements based on learning from other outbreak sites. Risk assessments for the locality and associated action plans were reviewed daily supported by the COVID-19operational group led by the Trust Outbreak Lead. Escalated sites were de-escalated when 14 days had elapsed without a positive case, and all actions were closed. Sites then reverted to the standard outbreak management process until the outbreak was formally closed.

8.6 Outbreak Data

There was a total of 61 outbreaks across NWAS between 1st April 2021 and 31st March 2022. These were dispersed across the NWAS geographical footprint and were closely linked to the Public Health England rates of community prevalence, which were extremely high across the Northwest throughout the reporting period.
There was a hiatus between Feb 2021 and July 2021, with only one Outbreak declared in that time. However, the number of outbreaks steadily increased with a total of 24 being declared during the national 'wave' in December 2021 and January 2022. February saw a decline in the numbers of staff infection, but unfortunately this again increased dramatically in March, with a total of 14 outbreaks and several stations and call centres reporting high numbers of positive cases. The staff have reported 3,390 Covid-19 Positive cases from 1st April 2021 – 29th March 2022.

8.7 Covid testing for staff

There was a requirement of the Trust to have measures in place during the COVID-19 pandemic to ensure that staff were completing covid tests on a regular basis to ensure the ongoing safety of staff and patients. Testing took place during 2021/22 via a number of testing methods, lateral flow tests, PCR tests, and LAMP tests.

8.8 Lateral Flow Testing

All NHS staff are advised to complete a lateral flow test on a twice weekly basis, this is done to minimise the spread of the COVID-19 virus and keep NHS staff and patients safe. The LFD testing has continued throughout and is still being used as first line regular testing by all staff across NWAS as part of the wider test and trace element of the regulatory cell.

The purpose of asymptomatic lateral flow testing is to reduce the nosocomial infection and spread of COVID-19 between staff and from staff to patients. Asymptomatic lateral flow testing continues to play a key part of NWAS's COVID-19 infection prevention and control strategy, thereby helping to prevent larger COVID-19 outbreaks occurring on our sites.

The Trust continues to follow the national and Association of Ambulance Chief Executives (AACE) COVID IPC guidance with the trade unions being consulted both locally and nationally. The guidance has over the year changed on several occasions as higher numbers of the public and healthcare workers have been double vaccinated and also

received the booster which has led to a decrease in numbers reporting as infected and of those the symptoms reported are minor. This is also due to the Omnicron variant becoming the dominant variant over the delta variant.
The uptake of the LFD testing has been consistently high within NWAS, and this trend has continued as the government has lifted most of the restrictions within England and staff are allowed to socialise and travel abroad.
Clinical staff are encouraged to conduct LFD tests prior to attending the workplace to ensure the safety of other staff and more importantly the patients.
Staff report all positive lateral flow tests as well as the follow up PCR confirmatory test results via Carlisle Support Centre. Systems were also established to ensure lateral flow positivity data could be reviewed by the Test, Track and Trace team to ensure all positive staff members were traced swiftly.

8.9 Lamp Testing

As part of its COVID 19 asymptomatic testing programme NWAS strengthened the availability of its LAMP Testing (Loop – Mediated Isothermal Amplification) for staff. NWAS began working in partnership with South Cumbria and Lancashire LAMP in the early stages of the second wave of the pandemic in February 2021 and made LAMP available across all its Critical Infrastructure Sites at Middlebrook Broughton, Parkway, Estuary Point and Salkeld Hall.

In June 2021 South Cumbria and Lancashire LAMP launched a smartphone application called HiPRES which became an enabler for NWAS to broaden the availability of LAMP Testing widely across Cumbria and Lancashire and to some specific sectors in Cheshire and Mersey and Greater Manchester. To roll out LAMP into frontline Operations was a logistical challenge for NWAS simply because of the geographical spread and number of its station estate and the need to move the samples onto the LAMP Laboratory at UCLAN, Preston in a reliable and timely daily schedule. This involved establishing drop off points at hospitals across Cumbria and Lancashire and the establishment of a courier service utilising our PTS Volunteer Service to collect from sectors in other areas.

Overall, the LAMP programme was well received by staff and complimented the Lateral Flow Testing Service made available by the UK Government. Nationally, the programme in line with COVID Strategy has been closed on 31st March 2021 with staff now signposted to being part of the Lateral Flow testing programme. The partnership between NWAS and South Cumbria and Lancashire LAMP is a good example of how the NHS worked together to help protect our staff and the patients we serve from COVID 19.

8.10 Mobile Testing – Broughton

As a response to the significant increase in community prevalence of the Omicron variant in January and the resulting difficulty in obtaining PCR tests, all ambulance Trusts were offered a mobile testing unit (LAMP Testing) to support rapid detection and isolation of Covid positive cases. A task and finish group were established as the mobilisation of the unit was within days – after a scoping exercise it was agreed that the location of the site should be at Broughton with the option of utilising volunteers to drive to staff members homes to deliver testing kits and then return to Broughton to be processed. Staff members would get results within several hours of the specimen being received at the site.

Staff were given the option of booking into the site when they rang the support centre in Carlisle reporting symptoms/positive LFT test or were known contacts of a positive case

and had been in contact with the TTT team, although a number declined due to distance or already having a slot at a PCR testing site.

The mobile testing site was also installed at a time when the testing guidance changed so it was not necessary for a confirmatory PCR test following a positive lateral flow – although staff appeared to continue to attend for further testing.
The testing unit operated between the hours of 9-3 and had the capacity to carry out 200 tests a day and was in-situ for 6 days, it became evident that not all testing slots would be used by NWAS staff and therefore slots were opened to family members.

9. COVID-19

9.1 The Covid pandemic continues to impact considerably on NWAS staff and daily workload, the focus remains on keeping our patients and staff as safe as possible. This year has been one that has required us to move at pace to deliver our pandemic response in line with ever changing guidance and competing pressures.
Effective recording processes in now place for recording positive cases in NWAS and staff are followed up by the Test, Track and Trace team who check on the welfare of staff as well as identifying any contacts of the Covid positive case in the workplace. Advise in given by the team in line with national guidance. For a small number of colleagues there were inpatient stays. As we describe our IPC successes and challenges, our thoughts are with all our NWAS colleagues and their families, particularly those who lost their lives during the pandemic.

The principles of our IPC practice during the pandemic followed the PHE hierarchy of controls:

- Executive oversight
- Limit exposure wherever possible by containing the number of staff exposed
- Identify staff at increased risk via risk assessment and limit their exposure in the workplace
- Strict adherence to government guidance for all staff in NWAS workplaces/ buildings
- Consistent delivery of standard infection control precautions (SICPs). The elements of SICPs are:
  - patient assessment & communication of infection risk
  - hand hygiene
  - respiratory and cough hygiene
  - personal protective equipment (see below)
  - safe management of the care environment (see below)
  - safe management of care equipment (see below)
  - safe management of healthcare linen
  - safe management of blood and body fluids

- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management
- maintaining social/physical distancing (new SICP for COVID-19)

- Escalating levels of personal protective equipment (level 2 and level 3) based on the assessment of each individual case and /or procedure being performed.
- Clear protocols for staff participating in high-risk procedures (known as Aerosol Generating Procedures –AGP's) to increase their levels of PPE to include FFP3 mask as the primary respiratory protection.
- Work with senior managers and the trade unions to develop regular IPC bulletins which describe how national policy is being put into practice within the workplace.

9.2 Personal Protective Equipment (PPE)

The term 'personal protective equipment' is the term used to describe products that are either PPE or medical devices that are approved by the Health and Safety Executive (HSE) and the Medicines and Healthcare products Regulatory Agency (MHRA) as protective solutions in managing the COVID-19 pandemic.

PPE is designed to protect you from harmful substances such as chemicals or infectious agents. In a pandemic situation, it can also help prevent the transmission of infection between staff and patients. PPE is one measure within the hierarchy of controls used in the workplace. The type of PPE you need will depend on a risk assessment which should include the environment you work in and the procedures you carry out. Respiratory protective equipment (RPE) such as FFP3 and FFP2 masks are a form of PPE and, where a risk assessment or national guidance indicates that they should be used, they must be fit tested.

During Covid the national guidance is that all staff should wear Level 2 PPE as a minimum when in a clinical setting/within 2 metres of a patient.

9.3 PPE stock ordering and distribution

NWAS procurement team have full responsibility for the ordering and supply of PPE in NWAS. During the financial year 2021-22 they have continued to work tirelessly to ensure that essential PPE supplies were always available. There was a requirement for the Trust to procure PPE within new systems for stock distribution from NHSE/I who continued to adopt a 'push' system. NWAS' stock was replenished on a weekly basis. The Trust submitted its PPE stock volumes into NHS Foundry on a weekly basis and an automatic replenishment delivery was delivered early the following week to the central store. Stock was held

regionally at central stations across each geographical region. At no point have NWAS run out of supply of any PPE stocks, a remarkable achievement in the circumstances. As national PPE stock availability has increased local PPE teams have disbanded and the above distribution model has been implemented across the region. Prepacked L2 & L3 kits are not currently produced, and stock is available at station level to allow replenishment to all frontline operational vehicles.

9.4 PPE contingency plans

During the financial year 2021-22 the contingency process has evolved so that any short falls are escalated the via NHS Foundry system. Deliveries are then scheduled on the next available day.

9.5 PPE Recalls and Safety Alerts

NWAS received no PPE recalls in 2021/22 which was applicable to our procured stock. NWAS uses its incident logs to document and investigate any PPE recalls when alerts have been issued. We were able to provide a good level of assurance that none of the alerts were applicable to our Trust.

The MHRA issues notice of safety alerts from the Central Alerting System (CAS). The NWAS Board of Directors are notified via the integrated performance report of safety alerts received. During 2021/22 NWAS has received 79 safety alerts through CAS and MHRA.

9.6 Respiratory Protective Equipment

The filtering face piece (FFP3) respirator mask covers the mouth and nose to protect against particulate hazards, such as airborne infectious viruses and is an essential part of personal protective equipment (PPE) for clinical staff who carry out aerosol generating procedures (AGP's). An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route e.g., tracheal intubation or suctioning.

During 2021-22 the use of FFP3 respirators increased globally as it was recognised that COVID-19 transmission was predominantly via airborne droplets. The supply chain of FFP3 masks from NHS Supplies was in high demand and transitioned to a new system known as 'push stock' where masks were distributed on availability rather than as a specific make and model request from Trusts. In practice this meant that NWAS required a rolling programme of FFP3 FIT testing to ensure that every member of staff has a mask with the correct seal and that it is available on the vehicle that they are working on.

During 2021-22 the Trust has encountered significant challenges during the fit testing process, these challenges have been for a number of reasons:

- Number of accredited fit testers available within the Trust
- Availability of staff due to the pressures of covid
- Availability of masks due to the extreme demand nationally

Measures were taken to try and ensure that all staff were adequately fit tested and that they all had access to the correct FFP3 masks. Local procedures were put into place with guidance from the IPC Team which would allow for rapid testing, across the whole Trust footprint. This local arrangement provided a consistent approach for all staff to enable safety monitoring of the appropriate FFP3 equipment.

13 Portacount machines were procured for the Trust and training was delivered to a number of individuals within the Trust. The Trust have 14 fully accredited Portacount fit testers who all operate within the Hazardous Area Response Team (HART). In addition to that 14 further staff undertook a portacount operator course during the pandemic to be able to fit test, but they did not complete their accreditation.

This programme of FFP3 face fit testing has ensured our front-line clinical teams:

- Had adequate numbers of trained FIT testers in place to meet their requirements
- Had procedures in place locally to ensure a consistent approach was adopted
- Had Fit testing machines (Portacount machines) were available in the right places
- Were able to stand down staff from operational duties to be fit tested
- Had sufficient Portacount testing capacity was available
- Were able to report compliance data back to the FIT testing sub cell

Staff who fail qualitative fit testing or are unable to complete a qualitative test are referred for a quantitative test (called Portacount) which is carried out by NWAS HART team. The number of staff who failed both qualitative and quantitative tests was closely monitored by the steering group who reported daily to the strategic commander via the strategic command cell (regulatory compliance update).

9.7 Respiratory Hoods

NWAS issued Respiratory Protective Equipment (RPE) as personal issue to all patient facing staff, the respiratory hoods which the Trust use is the Sundstrom Safety SR700 Fan unit and the SR 520 Hood.

This RPE solution comprises of a small motor unit that sits on an IPC compliant belt, in the small of the back. A corrugated hose runs up the wearers back to a hood. The motor unit sucks air in, via two filters, filter it, blows it up the hose and into the hood creating positive pressure. This enables staff with beards, stubble, spectacles, and facial disfigurement to wear the equipment. There is no need for fit testing, however, the user does needs to be shown how to check, test, don, wear and clean the equipment.
An Equality Impact Assessment (EqIA) identified issues with the FFP3 masks not being suitable for individuals with beards worn for religious reasons. These staff were prioritised for respiratory hoods if their beard was associated with a protected characteristic (BAME) or religious belief.
There is a requirement for the Sundstrom hood filtering units to be serviced on an annual basis, to ensure the equipment continues to meet the requirements of the warranty and assurance can be given in relation to the safety compliance for staff. The filter units are serviced in line with the Trust servicing of oxygen regulators. All filter units will have been tested by the end of August 2022.

9.8 Monitoring Compliance to RPE training and Standards

The Trust has developed audit systems for monitoring operational compliance of our staff with our training and standards. This RPE audit was carried out by clinicians in the control room who would directly contact staff attending category one incidents to ascertain whether they had performed an AGP on the patient. If yes, the clinicians would go through a standard proforma to ask about respiratory protection. The responses were recorded and analysed by the clinical audit team who then reported the findings back to the executive leadership group and operational management team. The primary reasons for non-compliance were reported to the RPE cell and the ELC, along with the actions being taken.

10. VACCINATION

10.1 The Vaccination Hub provided second doses for NWAS staff from 29th Mar to 4th May. A total of 3829 doses were administered, 2030 first doses and 1799 second doses. When the vaccination hub closed NWAS staff were encouraged to utilise local vaccination hubs to be vaccinated.
The vaccination programme for Covid consisted of an initial vaccine, with a second dose 12 weeks later followed by a booster which was announced on the 14th of September in line with the advice from the Joint Committee on Vaccination and Immunisation (JCVI) – the booster was administered 6 months after the second vaccine. An additional booster has been offered in Spring 2022 to vulnerable groups.

10.2 Vaccination as Condition of Deployment

On 14 December 2021 Parliament agreed regulations, which were made on 6 January 2022, which extend vaccination as a condition of deployment beyond residential care settings to any other Care Quality Commission (CQC) regulated activity in health and

social care, subject to certain exemptions and conditions. The regulations to which this guidance relates would have come into force on 1 April 2022. In advance of this date, there is a 12-week grace period to allow people sufficient time to be vaccinated.
Making COVID-19 vaccination a condition of deployment for people providing direct, face to face CQC-regulated activities is intended to:

- protect those people receiving care and support and
- reduce the spread of COVID-19 in adult social care settings, including in people's own homes

The regulations mean that where a registered person employs or otherwise engages someone to provide direct, face to face CQC-regulated social care activity, the registered person will need to obtain evidence that the individual:

- meets the vaccination requirements set out in the regulations
- is medically exempt, or
- is covered by certain other exceptions

As a result of this NWAs set up weekly meetings to discuss how these new regulations would impact on the organisation. Workstreams were set up to identify staff who were not vaccinated, support staff to get fully vaccinated and to provide advice on any misunderstandings staff may have of the vaccination programme. One to one meetings were arranged between HR, unions and staff members to who did not want to be vaccinated to discuss how this would impact on their future with NWAS.

At the end of January, the Secretary of state announced that's this guidance was being reconsidered and so organisations were advised not to take any further steps until a decision had been made.

Regulations revoking vaccination as a condition of deployment came into force on 15 March 2022. This means that it will not become a requirement for people to have received a COVID-19 vaccine to deliver face to face CQC-regulated activities in wider social care settings.

NWAS still continue to promote the Covid vaccination programme to maintain staff safety and reduce the risk of transmission in the workplace.

10.3 Reporting

The vaccination data of staff has been carefully managed. Where required nationally daily

Sitrep reports on the number of vaccinations administered by the Trust haven been provided within the required timescales.

In addition, the Trust has also been required to report on the number of front-line staff who have had the vaccine against the total number of front-line staff. This includes staff who have received the vaccine both through the internal vaccination hub as well as through hospitals, vaccination sites and GP's. Data is pulled from the national NIVS and NIMS systems to identify staff who have received each dose of the vaccine. These reports have been provided within the required timescales.

Work commenced in December 2021 to ensure that all staff in a front-line role would be required to have had the first two doses of the COVID-19 vaccination by 1 April 2022. The Trusts commenced activities to ensure that all staff in scope for this mandate were aware of this and processes were put not to place to encourage staff to take up the offer.

On 31 January 2022, Secretary of State for Health and Social Care announced to the House of Commons that it was no longer proportionate to require COVID-19 vaccination as a condition of deployment for NHS workers. The Government announced that there would be a consultation regarding the intention to revoke the requirement imposed by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 and the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No.2) Regulations 2022 (collectively referred to as 'the regulations').

The revocation of VCOD regulations for health and social care workers, will came into effect 15 March 2022. This removed the requirements that were due to come into force in health and wider social care settings on 1 April 2022.

10.4 Flu Vaccination Programme

The Trust managed its annual Flu Vaccination programme for 2021/22 with a similar model as with previous years. Several clinics were set up across the Trust to encourage all staff to have the vaccine. In addition, flu vaccination was deployed across the Trust to offer vaccines via a roving model.

The Trust officially concluded its campaign at the end of February 2022 and the final uptake of the flu vaccine 56.5% of staff. Whilst this was lower than previous years, it should be noted that across the NHS, Trusts reported a lower uptake than previous years.

10.5 Staff Welfare - Supporting staff and families

NWAS employs over 8,000 staff and volunteers. The trust conducted one-to-one risk assessments with staff throughout the pandemic which have been fundamental to understanding individual difficulties, risks and identifying appropriate support measures to minimise those risks. Covid risk assessments have been on all staff – these risk assessments are dynamic and constantly updated to reflect any changes in personal circumstances or changes in national guidance.

Guidance was provided to the assessor about how to manage the risk conversation to enable an individual to feel comfortable to raise any concerns they were experiencing and highlighting possible support mechanisms available. These support mechanisms included:

- Regular welfare checks
- Stress risk assessment
- Sign-posting an individual to appropriate therapy or agencies
- Highlighting the wellbeing resources available on the intranet
- identifying a work buddy
- Modifying duties or work arrangements

Regular welfare contact has been carried out with staff during periods of COVID-19 related absence, such as during medical stand down/ shielding, isolation periods and COVID-19 sickness. This enabled staff to maintain contact and inclusion with NWAS and ensure any support required is identified and accessible. In cases where staff have become seriously unwell and hospitalised, regular contact has been maintained with the staff member's family and help and assistance provided wherever possible. Counselling services continue to be provided through the Occupational Health provider and is available to all staff.

NWAS have also funded other additional specialist therapeutic support during the pandemic to ensure staff are supported as much as possible.

10.6

National Guidance on Covid

Throughout the pandemic guidance has been updated on a regular basis to minimise the transmission of Covid – guidance is updated in line with any new research on the virus, new variants or to restrict further onward transmission during waves of the pandemic. In the last 12 months there has been drastic changes in the government advice on testing, isolation, and vaccination of both the public and health care staff. Often changes are announced much in advance of the guidance being published – adding further confusion.

The responsibility for ensuring NWAS was updating their guidelines in a timely way was overseen by the executive command cell who met daily and were updated by the Director of Quality, Innovation and Improvement who led the regulatory compliance sub cell. Throughout the pandemic both clinical and operational bulletins have been utilised to clarify new guidance which were then cascaded through the operational command cells.

Clear infection prevention and control (IPC) guidelines for staff on personal protective

equipment (PPE) can be located by accessing the Green Room (the Trust's internal website). This includes clear guidance on what level of PPE is required for each response and the importance of adhering to Public Health England (PHE) guidance. The Green Room was updated on a weekly and sometimes daily basis to ensure it contained links to all the PHE and government websites to direct staff to further information and evidence pertaining to the risks associated with COVID-19. This also includes guidance that is in place to mitigate these risks. All staff have access to the JRCALC PLUS application which contains the latest regional and local guidance from the Joint Royal Colleges Ambulance Liaison Committee.

11. FACILITIES MANAGEMENT

11.1 Review of Cleaning Regimes Across All Sites

The NHS published the National Standards of Healthcare Cleanliness in April 2021 mandatory for all healthcare settings except for ambulance services trusts. NHSE formed a national working group to develop the standard specific for the ambulance sector and the head of facilities management (FM) is a member of this group. Considering these impending changes to cleaning regimes, the FM planned review of the cleaning provision at all sites was temporarily paused. Through 2021 and the continuing pandemic, progress from NHSE on the standard was slow and it is only recently, February 2022, that the group meetings have been re-established. It is anticipated that the new standard will be published in late 2022.

FM continues to follow the operating procedures from NHSE regarding the safe cleaning of patient and non-patient facing environments through the contractor, JPR Solutions, using the Bacticlean product. This product was originally used for the ambulance deep cleaning and approved by IPC team in the early stages of the pandemic for premises cleaning use. The internal procedures jointly developed by FM and the IPC leads for cleaning of workstations and decontamination remain in place.
Social distancing measures installed at the outbreak of the pandemic by FM have been updated in line with changing IPC and Trust policy requirements.

11.2 Decontamination

The procedure for colleagues to request decontamination of workstations has evolved in response to need during the pandemic. Considering the high number of requests received, particularly from the call centres, FM worked with the contractor to meet these demands. Several JPR staff assigned to Estuary Point and Middlebrook received decontamination training to enable fast response to deal with these requests whilst on site. Systems remain in place for outbreak scenarios, whereby all sites have access to decontamination cleaning crews 12 hours over 7 days. The FM approved mobile operative continues in role to support decontamination requests should the need arise.

11.3 Premises Cleaning and Increase to Cleaning Provision

In 2020, due to the pressures from the pandemic, the cleaning provision at contact centres and large stations was increased. In early 2021, from continued monitoring of the

premises cleaning decontamination records, data was compiled of the confirmed cases of Covid-19 per day v increases to cleaning to establish the impact of this cover. The results showed that the increase to 24/7 cleaning within some of the contact centres had no real impact or benefit in reducing cases of the virus. With the involvement of the Executive Leadership Committee (ELC) and IPC the contact centre hours were reduced to a more sustainable level whilst maintaining an enhanced provision on the original contract.

The large stations continue to receive the temporary, enhanced provision of premises cleaning.

A review of impact and need from the increased provision was undertaken and results show that the increases were warranted and have proved beneficial in most cases. The ELC confirmed the continuation of this cover for the financial year 2021/2022. The temporary mobile operative appointed by FM to deal with decontamination requests, now also provided resilience for the large stations in times of need. All other stations and premises remain largely on the original contracted hours. There is some flux in reaction to the temporary or permanent change of use at some stations as the need requires.

FM continue to closely monitor the contract standards provided by NHSPS at the Parkway site.

FM has recently introduced a programme, through JPR, for the annual complete deep clean of the stainless-steel kitchens which are installed at several sites, until these are replaced.

11.4

Ambulance Concierge Service at ED

The A&E ‘concierge cleaning’ or contract cleaning was delivered by JPR solutions, who already provide deep clean services for the Trust as a contract extension. During 2020 and at the start of the covid 19 pandemic a decision was reached by senior management to introduce an external cleaning company to carry out ambulance cleaning at emergency departments. This was to ensure that the risk of both non aerosol generated procedures (AGP) and AGP procedures were mitigated at a time of high IPC risk to patients and staff. The cleaning was carried out whilst the ambulance crews handed the patient over within the ED. The cleaning of the ambulances continued during 2021-2022, across 23 ED sites.

To evaluate the impact of the cleaning service a steering group was convened. The steering group comprised of internal experts from operations, finance, fleet, informatics, evaluation, and IPC. External advisors were also appointed from the national IPC team and University of Manchester to provide an independent review of the methods and statistical analysis.

A mixed-methods evaluation was completed in 2021 focusing on the following areas.

- Does the contract cleaning service provide higher standards of cleanliness than ‘business as usual’ cleaning undertaken by ambulance crews?
- What impact, if any, does the contract cleaning service have on crew availability time?

- What impact, if any, does the contract cleaning service have on staff welfare?

It was recognised that the cleaning standard provided was on par with the service in which we were delivering previously when our own crews cleaned the vehicles between patients. It showed us that crew availability was also not significantly improved, however, it was rated very highly by all our staff members, highlighting staff felt their welfare had improved with its implementation. The trust kept the service in place for all the FY21/22 to support the workforce's wellbeing and was stepped down as part of returning to business as usual in 22/23.

The IPC Team were tasked with producing a cleaning standard operating procedure for staff to reference when cleaning their ambulances. The deep cleaning cycles remain in place.

11.5 Clinical Waste

The Trust has robust systems in place for disposing safely and effectively of clinical waste. The clinical waste disposal contract with Stericycle is managed by the Fleet Logistics Department. Due to the increased usage of PPE during the pandemic, it was necessary to increase the amount of clinical waste collections. This was done across the Trust geographical footprint and ensured there was no build-up of clinical waste.

Clinical waste streams are reviewed on a monthly basis during contract management meetings, there is flexibility within the contract for collections to be amended based on fluctuating demand. This is managed by the Fleet team in partnership with Stericycle.

12. TRAINING

12.1 IPC forms part of the mandatory training programme for all clinical staff who complete 2 modules at recruitment and update annually via the mandatory training programme. During the FY21/22 mandatory training was stood down due to escalating pressures within the Trust. This was reviewed as part of the organisational risk register and was reinstated in December 2021. The IPC team have focused on local training for staff in the workplace and are continually working on local training based on audit findings.

IPC is a core component of mandatory training. To augment the mandatory training programme during the COVID-19 pandemic bespoke training materials have been developed on key aspects of IPC. A training video was produced in line with PHE guidance on the safe donning and doffing of PPE (including FFP3 masks) in response to the COVID- 19 pandemic. This was also loaded onto the staff central learning management system and to the NWAS learning platform. Training time was incorporated into the face fit testing programme and documented evidence of completion maintained on the staff training record on My ESR. A strict version control system was applied to the video based on the dated release of the corrected versions of the public health guidance.

As part of the upskilling of our external and internal resources, the video was also shown to learners in class. Dynamic Operational Risk Assessment (DORA), which is an integral component of the trusts mandatory training was reiterated as part of this upskilling

13. COMMUNICATIONS AND ENGAGEMENT

13.1 IPC Team

The IPC team continue to work hard to maintain their visibility across the Trust. Attendance at locality meetings to share information on IPC is a regular occurrence and the IPC team act as integral support to the QAV processes across the Trust.
In addition to the internal engagement, the IPC team have formed strong infrastructures with hospital IPC leads, the UKSHA IPC leads and NHSE IPC Leads. Work will continue during 2022/23 to gain points of contact within the Integrated Care Systems.

13.2 Covid briefings for staff

Communications bulletins and notices to staff for issues relating to COVID-19 are cascaded when new guidance is published or to reiterate existing guidance to enhance compliance. Staff from the Communications Team within NWAS attend the IPC cell meetings to ensure that they are up to date with any new guidance and to support the cascade of this information. Updates were placed on the noticeboards of each station and were circulated electronically to each staff member via specialist communications. There is also a Staff Facebook group with over 2500 members which staff use to raise questions or queries to the Trust and a series of Facebook Live presentations have been delivered.

13.3 IPC Communications

The IPC team communicate with NWAS staff through bulletins and updates which are issued by the Trust communications team. Information at local levels is conducted through Consultant Paramedics and Advanced Paramedics for dissemination to staff.

14. INNOVATION

14.1 The IPC audit data has moved from SNAP to Safecheck, SNAP is an audit tool that was purchased by the Trust with development support from the company that provided it before the development of our in-house SafeCheck audit tool. SNAP was used by the IPC Team to capture IPC audits completed by operational staff. Before SNAP was introduced into the Trust the audit process was dependant on a paper-based system.

The move to SafeCheck meant that all of the Trust audits are housed on one system, the system is designed to encourage staff to complete audits in a format which is familiar to them and is easy to pull reports from. The improvement project has developed an advanced information system which will ensure the Trust can improve its analysis of IPC data and compliance and provide broader comparative data from all audits.

15. IPC COMMITMENTS 2022/23

15.1 NWAS will continue to maintain its regulatory compliance for infection prevention and control, in addition to this the IPC team will align closely to the workplan which includes the following ambitions:

- A program of work to build on the important learning from the global COVID-19 pandemic
- Completing a training needs analysis for the organisation to build on the educational foundations already in place
- Develop further our digital solutions to support IPC Audits and analysis
- Enhance our assurance in relation to improving auditing and compliance with Respiratory Protective Equipment including Fit Testing
- Improve compliance with key IPC measures and use of PPE by our front-line staff
- Develop and implement operational processes to maintain ambulance cleaning standards following the use of a contracted concierge cleaning service
- Improving HealthCare associated Gram Negative Bloodstream Infections (GNBSI) and working with each local ICS in supporting this ongoing agenda
- Improving NWAS compliance with Aseptic Non-Touch Technique (ANTT)
- Continue to move towards the goals set within the Right Care strategy and the pillars of quality goals
- Develop an IPC dashboard, which will provide links to the Quality Assurance Visits (QAV) for supporting teams conducting visits to review IPC

16. RECOMMENDATIONS

16.1 The Quality and Performance Committee is asked to

- Note the content of the Report
- Note the assurances it provides
- Note the arrangements for ongoing monitoring via the IPC board assurance framework
- Note the key risks and mitigations

REPORT TO BOARD OF DIRECTORS

DATE:	28th September 2022
SUBJECT:	NWAS Strategic Winter Plan 2022-23
PRESENTED BY:	Ged Blezard, Director of Operations

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☐	☒	☒	☐

SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☐	☐	☐	☐

PURPOSE OF PAPER:	For Assurance
EXECUTIVE SUMMARY:	The intention of this paper is to introduce the Board of Directors to the NWAS Strategic Winter Plan 2022-2023 following the annual review and revision. The document describes the establishment of winter planning arrangements across the Service Delivery directorate including mitigations to meet predicted demand. Included within the Strategic Winter Plan are detailed forecast summaries which utilise several years historical data combined with current influencing factors to provide forecasting data to support operational planning. The Strategic Winter Plan also places into context the challenges NWAS and the whole health system faces during this winter period to create disruptive impacts due to winter demand, COVID-19, and the seasonal influenza season.
RECOMMENDATIONS:	The Board of Directors is recommended to take assurance from the content of the attached plan and notes the contents of the report.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee			
	Date:	17th August 2022		
	Outcome:	Assurance provided and ELC supported for onward sharing to the Quality and Performance Committee and Board of Directors		

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1. PURPOSE

The purpose of this paper is to present the Board of Directors with the NWAS Strategic Winter Plan for 2022-2023.

2. BACKGROUND

2.1 This winter will see NWAS and the whole health system under considerable pressure due to the ongoing sustained high demand, unknown impacts of COVID-19, potential for industrial action across public and private sectors, the uncertainty around the UK economic position which could potentially lead to vulnerable members of our community, particularly around energy costs, in what is predicted to be a colder than average winter.

2.2 The annual 'Winter Letter' from the NHS has been generally issued later each year and given the earlier timeline requested by NHS England this year, at this stage there has been no official correspondence. This communication has been vital in the past as it sets out for all Trusts; national strategy, expectations, planning milestones and timescales for plan and data submissions. It also provides key messages and areas of focus to assist with whole system integration and risk mitigation which in previous years for example were described as:

- Reducing numbers of long-stay patients in hospital
- Triaging patients away from A&E Departments and admitted pathways
- Healthcare worker flu vaccination
- Primary care
- Mental Health

In lieu of this letter, there is guidance included in the NHS 2022/23 Priorities and Operational Planning Guidance (NHS, 2022) where systems have been asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards
- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
  - eliminating handover delays of over 60 minutes
  - ensuring 95% of handovers take place within 30 minutes
  - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

2.3 A priority in developing NWAS' winter planning arrangements has been the finalisation of the overarching Strategic Winter Plan providing internal and external assurance and for the development of area and service level specific winter plans. These contain detailed and focussed information with a more introspective direction to support operational arrangements in each service line; PES areas (GM, C&M

and L&SC) and Integrated Contact Centres (EOC, 111 and PTS) and PTS Operations.

2.4 As part of the NHS Winter Assurance/Preparedness process, Trusts are normally required to complete and submit an assurance template towards the end of September. This NWAS document was received on the 23rd August 2022, and the NWAS Strategic Winter Plan will provide assurance of the planning undertaken and the mitigations in place to prepare for this year's winter period and support compliance of the assurance process. The NWAS Strategic Winter Plan was shared with NHSE and the commissioners on 30th August 2022.

3. LEGAL, RISK and/or GOVERNANCE IMPLICATIONS

3.1 The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the Civil Contingencies Act (2004), the Health and Care Act 2022 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

3.2 The Trust also has to meet the obligations outlined in the Ambulance Standard Contract, all CQC Domains and the key requirements of the NHS England EPRR Framework.

4. EQUALITY OR SUSTAINABILITY IMPACTS

4.1 None identified at the time of writing this report.

5. RECOMMENDATIONS

5.1 The Board of Directors are recommended to note the content of this report and the content of the appended Plan and take assurance of the levels of preparedness for the anticipated winter pressures.

NWAS

Strategic Winter Plan 2022-2023

Recommended by	NWAS Resilience Team
Approved by	A Wood, Head of Contingency Planning (interim)
Approval date	10 August 2022
Version number	1.0
Review date	March 2023
Responsible Director	G Blezard, Director of Operations
Responsible Manager (Sponsor)	A Jackson, Resilience Manager - Business Continuity
For use by	All Trust employees

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	06/07/2022		A Jackson	Annual Review
0.2	18/07/2022		A Jackson	Updated a number of sections in the body of the document
0.3	27/07/2022		A Jackson	Changes following comments by SH
0.4	01/08/2022		A Jackson	Changes following comments by SH
0.5	09/08/2022		A Jackson	Reviewed by GB – no changes.
1.0	10/08/2022	10/08/2022	A Jackson	Approved by GB and AW

NWAS Strategic Winter Plan

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1.0 INTRODUCTION

1.1 The North West Ambulance NHS Trust (NWAS) has developed this strategic document to ensure that the high quality of service delivery expected by our patients and stakeholders is maintained throughout the winter period.

The winter period creates particular challenges for the entire Health Economy regardless of the additional pressures of seasonal illness or severe weather. This year is anticipated to be no exception, set against the background of a sustained period of increased demand combined with the uncertainty of the ongoing impact and potential of the latest strain (BA.4 and BA.5) of COVID-19. The UK Government stance has been to ensure that COVID-19 is managed alongside other respiratory viruses such as seasonal influenza.

1.2 This document is intended to draw on the experiences of past winters and experience of responding during a global pandemic. Paramount is the blending of actions for winter 2022-2023 with current procedures and processes within NWAS. Such actions cannot themselves be considered in isolation, only through the collective preparations of the whole system can the potential impacts of winter pressures and the continued impact of COVID-19 be appropriately mitigated.

1.3 In order to maintain the strategic focus of this document the detail is concentrated on key actions and expectations that are incumbent on NWAS, as reported to NHS England – North Region, as part of the individual (and Lead) Integrated Care Systems (ICS) Winter Assurance preparations offering assurances on winter preparedness to NHS England and this document will augment that assurance process.

This document concentrates on a small number of year-round processes and key, seasonal initiatives that will deliver real resilience during the winter period and ensure engagement with local health systems. It is designed to offer assurance at a strategic level that the levels of preparedness for winter in NWAS are high and that this will contribute to the resilience of the whole system. It also serves as an overarching plan to bring together the tactical and operational arrangements in each of the three NWAS Areas (Cheshire & Mersey, Cumbria & Lancashire and Greater Manchester), and all NWAS Contact Centres (EOCs (Emergency Operations Centres), NHS111 and PTS (Patient Transport Services)) in associated documents.

1.4 Staff and patient welfare remain the primary focus for NWAS, actions and initiatives within this document set out the commitment to plan for and mitigate where possible challenges predicted to develop during what is likely to be a demanding winter period.

2.0 PLANNING FRAMEWORK

2.1 Overview

The winter planning framework supports the continued commitment of NWAS to deliver high quality levels of the right care, at the right time and in the right place; every time.

The majority of the actions undertaken in preparation for and response to winter challenges are underpinned by normal NWAS plans and procedures which are designed to be sufficiently flexible and scalable to ensure an appropriate response but also to integrate with the wider health system.

2.2 This plan functions in conjunction with a number of other key plans and documents, specifically:

- NWAS Major Incident Response Plan
- NWAS Pandemic Influenza Plan
- NWAS COVID-19 Response & Recovery Plan
- National Ambulance Resilience Unit (NARU) Resource Escalation Action Plan
- NWAS Departmental Business Continuity Plans
- North West Divert & Deflection Policy
- NHS Operational Pressures Escalation Levels (OPEL) Framework
- NWAS Patient Safety Plan
- NARU National Command and Control Guidance
- NWAS Winter Communications Framework and Plan
- NWAS Area specific, Winter Tactical and Operational arrangements including Festive Arrangements

2.3 Some of these documents also have their own links to or associations with multi-agency plans published under the auspices of the five Local Resilience Fora in the North West. It also serves to:

- Ensure the wider health community and partners are aware of the NWAS strategy, capacity and potential challenges for this period.

- Ensure that resilience is maintained and the Trust is able to respond to changes in core business activity, up to and including declaration of a major incident.

- Provide a 'signpost' to other NWAS, core-planning documents including the Trusts Business Continuity arrangements.

2.4 Audit and Review

The plan will be subject to periodic audit and review to identify areas of improvement and good practice following the winter period.

In response to the on-going and developing impact of COVID-19, the NWAS COVID-19 Response & Recovery Plan will provide continual review of dynamic changes to government

or Trust guidelines which require implementation and communicated effectively to those staff and stakeholders affected.

This will be achieved through the current senior management regular governance meeting structure and through the communication methods utilised through the Communication Team.

2.5 Assurance

This plan relates to ambulance specific issues that have been communicated, with NHS England winter planning leads and the lead commissioning ICB (NHS Lancashire & South Cumbria) as part of the NHS England - North Region Winter Assurance process, to ensure a whole systems approach. It will also aid with any additional assurances requested by NHS Improvement and support the planning processes of the A&E Delivery Boards.

2.6 Delivery

2.6.1 The delivery of this strategic plan within NWAS will be achieved through comprehensive operational and organisational arrangements, which are designed to provide a quality service to meet the needs of our local communities. The overall strategy will be delivered through the local NWAS plans; three PES Area's, EOC, PTS and 111 Plans. Ensuring arrangements remain sufficiently flexible to match local demand.

2.6.2 The operational arrangements include the identification of key dates of anticipated high demand, which are derived from analysis of historical data. Such predictions will be subject to adjustment based on shorter-term impacts such as forecasts of severe weather, high seasonal flu levels, fuel shortages or other Business Continuity disruptions including industrial action within or outside of the NHS.

2.6.3 The outcomes of such data analysis will be considered in context with the need for NWAS Operational arrangements to create surge capacity to manage increases in demand of up to 15% for a sustained period of 4-6 weeks. The NARU Resource Escalation Action Plan (REAP) will be a key driver in the facilitation of such provision alongside partnership working and constant engagement with partners in the wider NHS under the provisions of OPEL.

2.6.4 Consideration must also be given to the continued impact of COVID-19 and any guidance in place currently or which develop through the coming months. Impacts such as local area variations or increased restrictions, adherence to social distancing advice, these are just a number of factors, which will need necessary cognisance moving forward.

2.7 Area Distinctions

Due to the size, topography, demography and differential demand and capacity patterns of the NWAS footprint, it is necessary to view the requirements of each distinct geographical area individually. To this end, this plan serves to underpin the arrangements in each of the NWAS functional areas, in terms of the demands on healthcare resilience.

Operational arrangements dealing with the NWAS response in each of the functional areas (Cheshire & Mersey, Cumbria & Lancashire and Greater Manchester) will provide the local,

operational detail required to underpin this strategic plan, North West NHSE Winter Plan and local winter planning groups.

2.8 Flexibility

Given the potential for significant changes to the predicted demands, influenza season and those that may be anticipated in respect of COVID-19, which may unfold over the winter period, this plan will be subject to regular review. It is likely that further resource escalation and changes to the NWAS response will be required to be developed in a dynamic fashion as circumstances develop. Any such changes will be conducted as part of a partnership approach with other organisations in the wider health economy and in line with existing partnership agreements and policies but may also need to be measured in relation to emerging national ambulance service strategies or threats. NARU REAP arrangements can also be invoked to mitigate the effects of prolonged or acute periods of pressure or periods of Industrial Action.

2.9 Lessons Identified

2.9.1 In the development stages of this Plan, lessons identified from the Winter Period of 2021-2022 have been considered and changes have been made to ensure that active learning has taken place to enhance the organisations and the wider NHS resilience capabilities.

2.9.2 Incorporated as part of this learning are lessons identified relating to the ongoing response and management of the COVID-19 pandemic. Including the NWAS COVID-19 Response & Recovery Plan, this details a methodological approach to a return to a new normal. NWAS undertook a number of interim debriefs during the first and second waves of the pandemic involving staff from across the Trust. Many of the lessons identified were themed which allow the Trust to capture learning and implement key changes where applicable; these sections of changes included cross working of PTS resources into front line resource; better application of clinical home working (111) and a single authoritative repository for guidance that was immediately accessible to the staff encouraging health and wellbeing.

2.9.3 An internal debrief will be arranged for early 2023 so that lessons from the winter can be captured formally and integrated into planning for winter 2023-2023.

3.0 OPERATIONAL IMPLICATIONS

3.1 Mutual Aid

NWAS has in place cross border arrangements with neighbouring Ambulance Services including the devolved administrations of Wales and Scotland, under a national Ambulance Mutual Aid Memorandum of Understanding (MOU). These arrangements have been vigorously tested during past incidences of acute pressure through public gatherings, industrial action, flooding and snow, in neighbouring services. It should be noted however that should system pressures be widespread or national, then such mutual aid may be limited in extent or difficult to negotiate when neighbouring Trusts are under similar pressures.

3.2 Demand Management

- Within NWAS, resources between areas will be managed through the planning process and the evaluation of activity on a daily basis. This function will be conducted through the appropriate NWAS Strategic Commander who may during periods of pressure, be required to operate from the Regional Operational Coordination Centre (ROCC) based at Parkway, Manchester, but is also available for each NWAS Area as an on-call resource.

- The ROCC will ensure that resource allocation is managed in a way that addresses regional demand through monitoring of activity patterns.

- NWAS operates a robust on-call system which enables the activation of Strategic, Tactical and Operational Commanders together with Loggists, at any time, to incidents (including hospital turnaround issues) in any part of the Trust footprint. A member of the Trust Executive Team is also available at any time as are NWAS National Inter Agency Liaison Officers (NILO/Tactical Advisor).

- Each NWAS geographical areas (Greater Manchester, Cheshire & Merseyside and Cumbria & Lancashire) Area has its own Strategic Commander on call who has the latitude to maintain overall command of each area and the ability to commit funds without recourse to higher authority.

- The three delivery areas within NWAS will assess their respective activity demands and resource availability on a daily basis and where possible will allocate resources to the areas of greater demand.

- Staffing levels are managed and monitored via the Trusts rostering system so it is possible to actively manage abstractions and ensure that maximum cover is available for the vehicle fleet. There is also the ability to manage the provision of additional vehicles at agreed times given appropriate commissioning arrangements. Emergency Operations Centre (EOC) and 111 staffing levels may also be adjusted to meet predicted or short-term demand in such a way.

- Mutual aid support for the Trust will also be requested when appropriate from the nearest Ambulance Services of West Midlands, Yorkshire, East Midlands and North

East as well as Wales and Scotland. This request will be made under existing national ambulance mutual aid arrangements but can also include the deployment of air assets.

- NWAS is also obligated to provide mutual aid to other Ambulance Services, on request in response to major incident or to assist if an Ambulance Trust declares a very high REAP level. Such negotiations will take place at Strategic level and release of resources will be highly dependant on available capacity. NARU maintain the national Mutual Aid Plan for Ambulance Services (including the Devolved Administrations).

3.3 Plan Scope

The NWAS Strategic Winter Plan 2022-2023 covers the period 31 October 2022 until 3 April 2023 unless otherwise stated.

- The plan covers the identified winter pressure reporting period (to be advised by the NHS) and details the Trust's intentions for delivering its core business.
- Analysis of historical data for this period over previous years has been utilised to identify the anticipated periods of increased demand.
- The NWAS Strategic Winter Plan has relationships with other plans and documents as detailed within section 2.0 of this plan.

3.4 Festive Period

NWAS Tactical and Operational arrangements will give due consideration to the Christmas and New Year period, which is traditionally a time of extremely high demand.

Each NWAS area will produce its own area specific Winter Plan, encompassing:

- The analysis of historical data has provided the key dates where activity is expected to rise considerably.
- During this period there are likely to be extremely high levels of activity and demand with peaks expected around the Christmas and New Year periods. The last working day before the Christmas Public Holidays and New Years Eve are recognised as particular risks. However, it is also recognised that other factors may change the dynamics of activity levels such as severe weather, seasonal influenza challenges, industrial action or infrastructure disruption.
- The Tactical Winter Plan detail the Trusts intentions and methodologies for dealing with the increase of activity and maintaining an appropriate safe delivery of service.
- Appropriate additional operational/staff resources from the Paramedic Emergency Service (PES), EOC, Clinical Hub, 111 and the Patient Transport Service (PTS) will be identified and profiled for the key dates.

- The related cost pressures will be identified and calculated for all additional resources required.

3.5 Demand Analysis

The capacity levels for NWAS are designed to address the forecasted demand for the winter period. The plans consider previous and current demands.

- Planned levels of activity have been based on historical data, tempered with any seasonal Influenza related demands which may have caused unusual spikes in the anticipated activity levels.

- All available emergency resources (PES and EOC) will be utilised on key dates and assistance will be sought from the Voluntary Aid Societies (VAS e.g. British Red Cross, St John Ambulance and Mountain Rescue Teams), Private Ambulance Services (PAS- contracted in via an intermediary) as required, as circumstances dictate and as financial constraints allow. Other NWAS resources may also be deployed in support of PES, such as PTS staff trained to respond alongside frontline PES colleagues.

- In identifying the key dates through historical demand analysis, we are able to forecast busiest days by regional footprint and at NWAS operational area level (Appendix 2). This allows for resource planning depending on anticipated activity levels but will be reviewed against any changes in anticipated or unscheduled activity. NWAS REAP arrangements are also available to deal with any surge in demand or adverse pressure on the Trust.

- Information regarding those dates of predicted NWAS high demand will be shared with Commissioners and NHS England North, enabling appropriate measures to be taken to reduce the impacts on the whole system.

- Analysis of attendances at each Acute Trust has been developed and will be detailed within the area Tactical Winter Plans as they are developed.

4.0 NWAS STRATEGY

4.1 NWAS planning will be continuous up to and through winter with regular meetings scheduled to ensure that focus is not lost. This will include dedicated agenda items on a range of existing and regular meeting schedules. Periodic performance teleconferences will also continue with the option to revert to a daily occurrence should pressures dictate.

NWAS Operate a 24/7 Command and Control structure, based upon national standards and in-line with JESIP response principles.

Figure 1 – JESIP Response Principles

The NWAS Strategic Commander will ensure a set of Strategic Intentions are developed and reviewed to ensure consistency should these be required during any period covered by this plan.

In terms of decision-making, the Trust command team utilise the JESIP Joint Decision Making (JDM) Process:

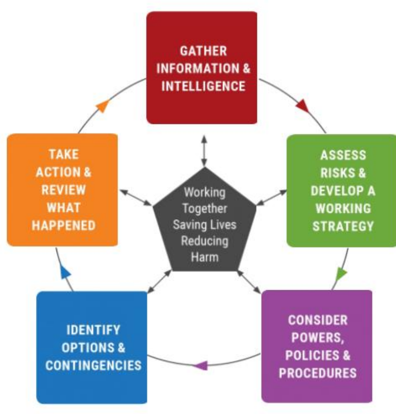


Figure 2 – JESIP JDM

4.2 Within the Emergency Operations Centres (EOC) environment, NWAS has in place long-standing processes, which work to achieve rapid call pick-up and allocation times. Should a disruptive event occur which impacts the effectiveness of EOC, well established and tested mutual aid processes are in place with other UK ambulance service – through what is commonly known as the 'buddy' system – where neighbouring ambulance service share the affected services activity. Resource profiling is completed in a way which best matches demand to maximise effectiveness and meet the national response measures in place across service lines.

The NWAS Regional Planning Team will ensure that demand and resource profiles are matched through analysis of staff abstraction rates (training, leave and sickness) and monitoring of unit hour utilisation for the Paramedic Emergency Service. The following sections outline key factors, which underpin the NWAS response during the winter period.

4.3 PES Core Response Measures

NWAS uses the internationally established Medical Prioritisation Dispatch System (MPDS). This allows NWAS to identify and prioritise all life-threatening emergency calls.

In July 2017, the Department of Health and NHS England announced new ambulance service standards as part of the Ambulance Response Programme (ARP). The aim of the ARP programme is to improve patient care and survival. ARP is the result of the largest study of an ambulance system ever completed, anywhere in the world. More than 14 million ambulance calls were monitored as part of a trial, with no patient safety concerns.

The system enables ambulance services to be much more stable and able to deal with unexpected events and peaks in demand. ARP will make sure the best, most appropriate response is provided to patients, first time.

From 7 August 2017, there have been four categories of call:

Category	Mean	90th Percentile
Life threatening Category 1	7 minutes	15 minutes
Emergency Category 2	18 minutes	40 minutes
Urgent Category 3	60 minutes	120 minutes
Less Urgent Category 4	-	180 minutes

Figure 3 - Response Categories

- Call pick up times are constantly monitored against nationally agreed standards in all EOC's. This information is displayed in real time on the Trusts performance management dashboard, which is accessible to all appropriate managers.
- This information is also monitored within the Regional Operational Coordinating Centre (ROCC) and in each Major Incident Suite when activated.

- Activation times are monitored and reviewed daily by Sector and Operational Managers. Improvements aimed at reducing activation times include the utilisation of strategically placed deployment points as part of a Patient Safety Plan (PSP).
- The North West Divert and Deflection Policy provides an agreed process for Senior Trust Commanders to follow to ensure safe treatment and movement of patients across the region and to address any short-term blockages through agreed deflections.
- The NWAS Clinical Hub and Directory of Services (DoS) are designed to augment the management of 999 calls.
- Analysis of historical data ensures that NWAS are able to place resources appropriately and use relief staff in an effective manner.
- The Patient Transport Service (PTS) is also integral to NWAS strategic planning for winter in consideration of the overall provision of contracted, non-emergency transport services. It should be noted that NWAS is the contract holder for PTS in Cumbria, Lancashire, Greater Manchester and Merseyside while the West Midlands Ambulance Service provides the same function in Cheshire, Warrington and the Wirral.
- NWAS will be required to provide event cover (i.e. sporting events and mass gatherings) during the winter period. The resourcing of these events is over and above that which is required to deliver the operational delivery plan. These events may coincide with dates of anticipated high activity, as identified in the key date information. Such events are managed through partnership between the Trust Resilience and Operations Teams together with the event organisers, Police and Local Authorities.
- The ‘Make the Right Call’ (https://www.nwas.nhs.uk/get-involved/campaigns/make-the-right-call/) campaign is aimed at advising the public on the appropriate use of the of the Ambulance Service and signposting suitable alternatives for minor ailments. The Trust Communications Team will provide public information through broadcast and social media outlets utilising national templates for any publicity.

4.4 Demand Surge Mitigation

NWAS can meet a sustained increase in activity and cope with significant activity increases over short peak periods but acknowledges the challenges that may face the region and the wider NHS, particularly in respect of any widespread event such as subsequent waves of illness associated to COVID-19. It is recognised (and a lesson identified by all health partners in previous winters) that the Ambulance Service reaches its capacity limits very quickly during severe challenges, and this capacity to cope is heavily influenced by NHS Providers releasing resources in a timely manner.

A dynamic but constant evaluation and review of the pressures on the Trust is made weekly at the Executive Leadership Committee (ELC) and daily within the ROCC, including any standing COVID-19 strategic groups.

The NARU REAP arrangements can be used at short notice to mitigate demand and generate additional capacity short of declaring a major incident. This is coordinated through the National Ambulance Coordination Centre (NACC). Shorter-term effects can be realised through application of the Patient Safety Plan (PSP) levels to deflect demand in a measured and safe manner.

4.5 Staff Health and Wellbeing

4.5.1 Vaccination Offer

Flu - At the begging of October the Trust will launch its annual Flu campaign. In line with national requirements the ambition is to offer 100% of the workforce the flu vaccine and to vaccinate between 70% and 90%. A project team has started the preparatory work in summer and has a robust project plan in place which seeks to aim to vaccinate staff. The intention is to undertake a focussed 8 week period between October and November to ensure that as many staff as possible receive the vaccination by December 2022.

COVID booster – plans for the CVID booster are current in development regionally. NWAS is seeking to understand the offers that might be in place for staff to access the booster outside of the mass vaccination sites. There are no plans for the Trusts to stand up an internal vaccination hub for the COVID booster and current indication are that the Pfizer vaccine will be used, and the Trusts does not have the internal storage facilities for this particular vaccine.

4.5.2 Wellbeing Offer to Staff

- Push for all areas to progress their local People Plans based on the 2021 Staff Surveys results and recent Q2 Quartey Pulse Survey Results
- Employee Assistance programme
- Treat me right campaign and toolkit – aimed at tackling bullying and harassment
- Mental Health awareness toolkit for managers and staff
- Focus on manager having wellbeing conversations
- Trust champions on: Wellbeing - Further develop and strengthen the network of HWB Leads and Champions
- F2SU Champions
- Staff networks – LGBTQ, Disability, Race and the armed forces
- Gambling support guidance
- Peer Supporter / MHFA’s / Blue Light Champions
- TRiM – Trauma Risk Management
- Burn out programmes for staff and managers
- Suicide Prevention, Postvention and Awareness Toolkit

The below diagram provides an overview of the offer:

Supporting employees to thrive

Financial wellbeing i.e. Salary Finance / Ask Bill / Angel Debt Advice / Money Helper
Employee Assistance provision – 24/7 Support
Chaplaincy Support
REACT MH Training
Invest in Yourself - HWB Support Hub
Staff Networks/ Peer Support
Support resources & apps e.g. Headspace – free access
Mental Health Toolkit & Wellbeing conversations
Treat me Right' Campaign - bullying & harassment/civility
Staff Benefits Cycle to work scheme/home electronics/car scheme

Targeted support for those who are struggling

Ambulance Service Charity
OH Counselling Services
Burnout & resilience programmes for all staff and managers
Just B Pro-active, confidential and emotional wellbeing support
Partnership with Northwest Resilience Hubs
Able Futures
MSK/ Physiotherapy services
Mental Health First Aid (111)
Remploy
Trauma Risk Management (TRiM)

Tailored support for those who are ill

Suicide Prevention & Postvention toolkit
Long COVID Support Group
Occupational Health support
Specialist Counselling

4.5.3 Further Work - Q2/Q3/Q4

- Continue to develop the Invest in Yourself Support Hub on the Green Room to support staff understanding the wellbeing offer
- Commencement of the mental health Continuum Group to look at several pieces of national work:
  - Roll out of the mental health continuum – it is used to show that an individual can move between the different states of wellbeing; thriving, surviving, struggling and crisis
  - Mental health at Work Commitment - NWAS has signed up to this Commitment, endorsed by The Royal Foundation, which is made up of six standards, based on the Thriving at Work standards and developed with the knowledge and expertise of mental health charities, leading employers and trade organisations
  - Employee wellbeing and suicide prevention self-assessment matrix - This self-assessment tool has been developed by the Association of Ambulance Chief Executives and comprises of 10 implementation areas relating to staff wellbeing and suicide prevention
- Trust champions on: Wellbeing - Further develop and strengthen the network of HWB Leads and Champions
- Consultant Psychologist - we will be evaluating current mental health support, understanding access challenges and barriers to access and developing management confidence and competence
- Review of Peer Support Networks
- Further develop a Financial Wellbeing offer for staff with resources and tools to help with management of finances
- Explore the feasibility of establishing a Hardship Fund for staff struggling through the cost of living crisis
- Continue to work with Just B to undertake proactive wellbeing conversations through externally provided mental health check ins
- Support managers to have wellbeing conversations

5.0 MITIGATION INITIATIVES

5.1 NWAS employs the following initiatives to enhance service delivery:

- The NARU Resource Escalation Action Plan identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.
- Trigger mechanisms have been established through REAP arrangements that allow NWAS to respond promptly to substantial increases in demand, in either specific areas or Trust wide.
- NWAS REAP arrangements remain active at all times. The Strategic Winter Plan should be viewed as an adjunct to this and not as a replacement.
- The Trust is engaged with national partners to ensure the REAP elements are reflective of current and future challenges including the NHS OPEL (Operational Pressures Escalation Level) Framework, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS.

5.2 By adopting a consistent NWAS approach, the overall ethos of OPEL can still be reflected in NWAS actions. Indeed, the NHS England OPEL Framework document underscores that system wide pressures can be resolved through close partnership working in order to manage surges in demand or capacity challenges. It also recognises that local A&E Delivery Boards have the latitude to align existing systems to the standard OPEL triggers and terminology as well as identifying that a rigid, sequential escalation is not always necessary or appropriate. Importantly, the Framework continues to emphasise:

"*Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.*"

5.3 In order to communicate the NWAS stance to any given request for the Trust to escalate in parity with an Acute Trust (excepting regional challenges beyond normal surges i.e. significant or major incident) a standard approach will be adopted to ensure consistency of message and action. Each request for escalation or notification that a particular Acute Trust is escalating to a higher OPEL Level will be responded to with a statement which echoes the following declarations:

- All necessary actions for NWAS under REAP have been considered and already implemented or held in reserve should the situation become more challenging.
- NWAS is committed to support both whole system resilience and the management of local surge pressures against the background of patient care and protection of NWAS core business obligations.
- NWAS will support any local measure to relieve pressures as far as practicable and within the overall confines of our prevailing REAP level which reflects the overall pressures experienced by NWAS and cannot be flexed locally.

- Engagement with local NWAS managers on duty or on-call is essential so that appropriate supportive measures can be discussed.

- NWAS will work in partnership with the Ambulance Sector across the UK ensuring any pre-planned or live escalation as required. Pre-planning will take place for specific key dates over the winter period e.g. New Year's Eve through to New Year's Day. For live escalation procedures are clearly defined which incorporate the National Ambulance Co-ordination Centre (NACC).

5.4 North West 111

5.4.1 Forecasting and Planning

NW 111 now possesses a number of years of historical data. This assists with accurate demand forecasts that will deliver improved roster efficiency and accuracy. As with previous years, activity is anticipated to increase from 19 December through to its peak on the weekend Christmas falls, with demand remaining high throughout December into January. The ever-changing COVID situation continues to make forecasting more of a challenge as demand has been volatile as infection rates change across the region. To ensure the best roster cover NW111 reduce levels of managed shrinkage, such as annual leave and planned offline activities, for these key weeks.

The improved accuracy of forecasts allow for more accurate recruitment planning. NW 111 have commenced winter recruitment for Service Advisors, Health Advisors and Clinicians.

5.4.2 111 Service Delivery

NW 111 operates a diverse approach to delivery, with the aim of improving patient experience. NW 111 will utilise the delivery methods of the previous winter. Patients are presented with a range of options as well as assessment, dependant on the needs of the patient.

Homeworking for clinical staff – to increase clinical numbers, especially on peak days, NW 111 operate homeworking. This has increased significantly due to COVID meaning a larger number of Clinicians are able to work from home and these clinicians can log on for key shifts at home.

This year NWAS will further promote the use of NHS 111 online and CPCS Pharmacy Services especially during busy periods. These services offer support to patients to self-assess their health needs, whilst ensuring access to all the services open to 111 callers are aligned to the clinical need. The NW 111 service aim to provide approximate waiting times and options to receive further guidance via SMS.

To ensure the optimisation of all the potential 111 workforce over the peak days and winter overall, NWAS 111 will utilise non-front-line staff, such as;

- Pathways trained administrative staff will perform front line call taking role.

- Audit and Governance Team deployed into front line support roles.

- Front line managers supporting front line and operational roles.
- Increased senior management support.
- Clinical Managers able to work additional hours from home

5.5 Clinical Safety Plan

The NWAS Clinical Safety Plan (CSP) is designed to be both simple and dynamic and is to be utilised in situations of excessive call volume or reduction in staff numbers. This will enable NWAS to respond in a timely and appropriate manner to increased service pressure, enabling an NWAS wide response as soon as identified triggers are met. The plan provides a risk based framework to enable flexible resourcing decisions to be made in the Emergency Operations Centres (EOC). The overriding function of this plan is to ensure that NWAS maintains the highest achievable level of clinical care in the face of demand levels that greatly exceed capacity.

This plan:

- Is applicable to the EOCs, the Clinical Hub, 111 and the Regional Operational Coordinating Centre (ROCC).
- Is considered in conjunction with the National REAP levels and will be employed in conjunction with this plan where appropriate and necessary but is routinely used as a standalone plan.
- Provides an escalating set of flexible, tactical options which may allow the trust to mitigate and manage the risks presented by a significant surge in activity and/or delayed responses to patients. Patients are always informed of the appropriate disposition of their call.

5.6 Emergency Operations Centres and Clinical Hub

5.6.1 Emergency Operations Centres

Across the North West footprint there are three Emergency Operation Centres (EOC); one in each of the operational areas – namely, Cumbria & Lancashire, Greater Manchester and Cheshire & Merseyside.

The EOC's are responsible for managing the emergency 999 call activity through their dedicated call handling suites and once calls are received an ambulance dispatch team are focused on communicating with operational resources to ensure a timely and appropriate response is deployed.

The primary method of managing this process is through a Computer Aided Dispatch (CAD) system, which allows for the inputting of call data, and the rapid electronic communication with resources. To compliment this function within the EOC, a clinical leadership model has been established to ensure appropriate decision-making support is available to both operational and EOC colleagues - enhancing patient safety.

5.6.2 **Clinical Hub**

The NWAS Clinical Hub operates as a virtual 'hub' with bases in Merseyside, Lancashire and Greater Manchester, providing a number of functions.

Primarily the desks utilise a robust telephone triage tool to support patients through a Hear & Treat model, answering low acuity calls.

The virtual hub also provides clinical advice and support to NWAS operational staff and a process for clinical leadership and support for all staff and managers has to facilitate access to Paramedic, Nurse, Senior Paramedics, Advanced Paramedics, Mental Health Practitioners, Clinical Pharmacist, Consultant Paramedics and occasionally, Doctors.

Police/Fire & Rescue Command colleagues can also access this clinical advice through a SPOC (Single Point of Contact) telephone number; this will support on scene decision making and reduce on scene time.

These desks are able to provide:

- Clinical advice
- Support for solo responders to enable them to leave scene whilst awaiting transport; including booking taxis where appropriate
- Access to senior clinical support for the Advanced Paramedics
- Direct telephone consultations with patients after initial categorisation
- Clinical validation of low acuity incidents, that being Category 3 or below, by a senior clinician. This allows for the trust to focus operational resources on incidents which are more likely to require attendance and subsequent transfer by an ambulance.

5.7 Regional Operational Coordination Centre (ROCC)

5.7.1 ROCC operates across a 24 hour period and staffed by a ROCC Duty Manager 24 hours and ROCC Tactical Commanders provide cover 7 days a week between the hours of 0600 and 0300.

The ROCC is managed by a Duty Manager and supported by the ROCC Tactical Commander whose role is to monitor and review operational pressures across the NWAS footprint and provide direct management to the Regional Health Control Desk (RHCD) and Greater Manchester Urgent and Emergency Care Hub (GMUEC) Coordinators. Liaise with EOC's, NWAS Managers, other UK Ambulance Services and Wider NHS Management regarding Provider Organisation pressures and provide reports to NWAS and the wider NHS on system pressures.

5.7.2 The primary role of the ROCC based at Parkway is to be responsible for:

- Resource oversight/monitoring – Emergency Operations Centre (EOC)/Operations/Clinical Hub
- Activity/demand monitoring – Patient Safety Plan (PSP)
- Coordination – Business as Usual and Major/Large scale Incidents
- Single point of contact for UK Ambulances services and wider health economy partners

Regional overview - for UK Ambulances services and wider health

5.7.3 ROCC Tactical Commander

Responsible for the regional overview of NWAS Service Delivery, focusing on challenges to patient care, monitoring in real-time performance inhibitors; devise and implement tactical decision making, in response to constantly changing demand to develop long term plans in order to achieve Trust/Directorate objectives.

Assume the role of senior point of contact on behalf of NWAS during the hours of operation, in relation to operational performance and hospital turnaround pressures, after this time it devolves to the on call structure

5.7.4 Regional Health Control Desk

The RHCD provides real-time monitoring of health economy pressures, through daily contact with Acute Provider organisations, gathering soft intelligence relating to capacity and demands within these organisations, reviewing against activity and working to mitigate where possible any impact of increases in demand. The RHCD team consistently monitor and scrutinise delays in handover and any delays noted in clearing by ambulance crews are pro-actively managed.

The RHCD is covered 24/7 and works alongside the GM UEC Hub Coordinators, both of whom are managed by the ROCC Duty Manager as well as being supported by the ROCC Tactical Commander. This dovetailing of local and regional perspectives provides rich intelligence and a pragmatic approach to problem solving. Ensuring pre-emptive and timely escalation occurs to Acute Provider on-call/management teams to request mitigation occurs at the earliest opportunity to support the risk of patients waiting in the community due to delays occurring within Acute Providers.

RHCD Coordinators continue to escalate delays over 60 minutes to Executives at Provider Organisations and continue to proactively monitor delays over the 15 minute threshold for clinical handover. The ethos of early escalation continues to be relevant and practiced by all ROCC functions.

5.7.5 **Greater Manchester Urgent and Emergency Care (GMUEC) Hub**

All GM health care providers are signed up to the hub and it is seen as neutral and an 'honest broker' between health and social care systems and now has live data feeds from each acute trust and NWAS; GMHSCP is looking to gain direct input from primary care and community to give a whole system overview. This live data is used to identify pressured systems and provide support / intervention where necessary.

The hub is has become a single point of contact for GM Systems and is accepted as the conduit between GM Heath and social care systems and National / Regional Colleagues, by having a real time understanding of activity and pressures the Hub managers are able to respond to National enquiries on the previous day where trusts have hit performance triggers.

The hub is also seen as a mediator/facilitator between systems which has enabled the team to resolve issues with transfers and repatriations when capacity is challenged across GM, an SOP for this process is in place. The GM UEC Hub holds central records of transfer and repatriation requests with delay and escalation triggers with associated actions. The hub also acts as a mediator between acute trusts and NWAS where there is the potential for, or are actual turnaround delays enabling a working plan to avoid unintentional batching of activity to individual ED sites and ensure ambulances are released in a safe manner. Acute trust senior management teams accept feedback from data analysis on trends and repeated issues and associated suggestions to smooth the flow, the UEC Hub team is seen to provide this feedback in a non-judgemental and supportive way.

The Hub also provides a watching brief on large scale incidents and issues which do or have the potential to affect the GM healthcare economy, this has assisted systems to prepare for predicted issues e.g. outbreaks, extreme weather events.

Across the winter period the GM UEC Hub will operate as the GM Winter Room and coordinate the GM oversight and reporting to regional / national level as appropriate.

5.8 Urgent and Emergency Care (UEC) Directory of Service (DoS)

5.8.1 The UEC DoS is an essential resource to safely and appropriately onward refer patients, therefore contributing to reducing avoidable conveyance and delivering **the right care**, at **the right time** in **the right place** for **every** patient, **every time**.

5.8.2 The UEC DoS is a central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the Urgent and Emergency Care services. NWAS are currently migrating all three of the 999 Emergency Operations Centres (EOCs) from the current AMPDS triage tool over to NHS Pathways to have a Single Primary Triage (SPT) tool across 111 and 999. This is set to be complete in summer 2022. Once fully implemented, this will enable 999 EOCs to onward refer patients appropriately at the time of the NHS Pathways assessment, during the initial call via the DoS (as currently happens in 111). Work will

need to continue to strive for equity and parity in the service referral opportunities available to a patient, irrespective of contact being made via either 111 or 999.

5.8.3 The North West has also had a focus on maximising service referral opportunities into services such as Same Day Emergency Care (SDEC) and Urgent Community Response (UCR) along with virtual wards to further enhance Emergency Department (ED) avoidance. The expansion of service referral opportunities and agreed referral criteria across the North West will further improve the patient experience and reduce admissions through winter 2022/2023.

5.8.4 All front line, patient facing clinicians have the ability to access NHS Service Finder as they cannot currently access DoS when considering onward patient referrals following a face to face assessment. The North West of England continues to be the largest user group of NHS Service Finder in the country. NHS Service Finder is fed by real time information from the DoS but does not cater for digital onward referrals. All face to face assessment referrals are made via telephone. NWAS are currently scoping how DoS can be integrated into the Electronic Patient Report (EPR) to enable digital onward referrals from scene.

5.9 Patient Transport Services (PTS)

NWAS is able to provide patient transfers at short notice, based on system priorities e.g. clinical priority or response to hospital pressures to moving patients between hospitals, or to discharge patients. With mature escalation and engagement links across the healthcare system, PTS will work with commissioners and hospitals to monitor system activity, adapting to changing circumstances and surge and is able to mobilise an enhanced approach to support system priorities in line with relevant national guidance e.g. HM Govt/NHS' Hospital Discharge Service Requirements in the event of an escalation event is felt be by the system e.g. impact of Flu or Covid-19.

Through effective engagement with partner colleagues, NWAS PTS leads will establish the needs of individual Trusts e.g. requests for additional PTS non–emergency vehicle requirements in addition to current contractual arrangements for out of hours in those areas where NWAS holds the contract. NWAS-operated PTS services will be staffed throughout the identified critical periods and support the demand placed upon the Service where appropriate arrangements exist. Arrangements with approved Private Providers will continue to provide support over the winter period in support of the whole system challenges including supporting the Paramedic Emergency Service (PES) through effective demand surge management.

5.10 Additional Measures

The NWAS approach to winter will be 'business as usual' as far as practically possible but a range of additional measures will be employed to mitigate the effects of increased demand or loss of capacity. These include:

- Executive focus – individual members of the NWAS Executive Leadership Committee have been allocated geographical areas of responsibility and this level of engagement supports wider ELC scrutiny of winter plans and performance.

- PTS staff and vehicles can be utilised to assist PES in reducing admission, discharge and transfer pressures as and when required under the Trusts REAP arrangements and, in such times as a major incident. This will require engagement with and agreements from the Commissioner(s).

- Additional front line staff together with operational management support will be deployed on the key dates identified in the Operational Delivery Plan, subject to appropriate capacity and identified investment to meet the need.

- Annual leave and other staff abstractions for all Service Delivery staff will be monitored and strictly controlled for the period encompassing the Christmas and New Year Public Holidays and beyond. For identified weeks during this time, an adjusted limit on leave allowed has been agreed. Staff sickness absence will be subject to the same level of scrutiny and management.

- The NWAS Fleet care department is available to meet operational requirements throughout the critical period. They will also provide a 24/7 on call facility as dictated by demand and capacity.

- The Trust is able to mobilise certain VAS/PAS resources during times of high activity to lower acuity incidents, however there is a cost for some parts of this service and its activation requires sanction by an NWAS Strategic Commander/ Head of Service. It should be noted that SJA are often subject to the same event and activity pressures as NWAS during the winter period and have their own issues with volunteer sickness or event commitments so such support cannot always be guaranteed.

- A Memorandum of Understanding (MOU) exists between NWAS and St John Ambulance in the event of a Major Incident.

- A national MOU for mutual aid from other NHS Ambulance Trusts exists. This is predominantly for Major Incident support but in the case of a Business Continuity disruption - including widespread severe weather, national high activity, and when informal support from adjacent Ambulance Trusts cannot be guaranteed.

- At times of excessive demand, the triggers within the NARU REAP may require redeployment of seconded clinical staff fulfilling a non-clinical role. This decision will be taken in line with the processes detailed in the Plan.

- Extensive Business Continuity arrangements are in place to minimise the impact of any additional disruptive challenge to the operation of the Trust.

- The standing NWAS ‘On-call’ arrangements (Commanders and support staff) continue as usual but may be enhanced/augmented for times of experienced or predicted pressure. These arrangements include senior clinicians on call.
- NWAS Commanders have been provided with a North West Divert and Deflection Policy which summarises the actions to be taken in the event of pressures at individual hospitals or across entire Acute Trusts.
- Hospital Arrival Screens are well established in EDs and other locations to assist with patient flow through the departments. Additional Ambulance Liaison Officers have been recruited to provide a physical presence at ED’s experiencing delays in transfers of care from NWAS to Provider Trust clinician and assist in the release of vehicles to increase availability. Early escalation of any delays in transfer of care issues through the NWAS on call structure is considered as essential.
- Staffing levels over a 24hr period are an integral part of service delivery.
- Sector and Operational Managers (PES, EOC and PTS) have confirmed staffing levels, which are communicated at the weekly service delivery meetings. Additional hours are profiled to meet demand on key dates and these will be subject to scrutiny at the appropriate meetings. Staff Abstraction rates are monitored closely.
- Vigorous management of absenteeism though NWAS Sickness Absence Procedure.
- The NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan contains contingencies for support staff redeployment during the risk period.
- The Trust’s BCM arrangements include departmental and staff mapping analysis to enable support to be re-directed to critical functions if required, at times of severe pressure. Dedicated arrangements to deal with periods of Industrial Action are also in place.
- Additional front line staff, together with operational management support, will be deployed on the key dates identified in the Operational Level Plans.
- Staffing levels are profiled according to demand patterns. Contact Centres (EOC and 111) will be profiled aligned to key dates throughout the winter plan.
- Planning with voluntary agencies (SJA, BRC, and Mountain Rescue) is regular and ongoing.

6.0 NWAS CONTINUOUS IMPROVEMENT INITIATIVES

6.1 Fleet Configuration

Forty retained Double Crew Ambulances (DCA) from Winter Plan 2021 – 2022 have remained in service and have become part of part of the core fleet which now totals 521 DCA. A replacement program will commence September 2022 and conclude in January 2023 to receive 69 DCA. The oldest fleet numbers retained from Winter 2021 – 2022 will be disposed and replaced during this period. The core fleet will remain 521 post Winter pressures.

6.2 Emergency Control Centres (EOC) Efficiencies

EOC changes are critical to the maintenance of patient safety and delivery against performance standards and to these ends the following areas are subject to tight focus.

- Monitor and manage mean and 90 percentile call-pickup by matching call-taker availability to demand, managing staffing levels, average handling time (AHT) and call-taker “not ready” time.
- Earlier identification of category 1 calls through the pre-triage sieve, key words and nature of call processes and improvements in call flow.
- Noting on the work to reroute to alternatives to ED as part of SDEC.
- Increases in EOC staffing and profiling of recruitment, training and induction in advance of winter period.
- Clinical Coordination Desk. This role is provided by a AP and reviews patients who we anticipate will wait longer than the ARP centile performance. The AP can chose based on clinical need to dispatch a resource, they may review the notes and conclude the patient is safe to wait or pass to a clinician to ring back as potential for H&T.
- Clinical validation of low acuity incidents, that being category 3 or below, by a senior clinician. This allows for the trust to focus operational resources on incidents which are more likely to require attendance and subsequent transfer by an ambulance.
- Implementation of NHS Pathways as the primary triage tool, this change should allow for a reduction in C1 incidents and an increase in incidents closed at the call-handler level, the system interrogates the DOS allowing the trust to interact with the wider healthcare system in a safe and effective manner.

6.3 Workforce

- Regular recruitment and training plans in place across all service lines.
- PES - Winter planning has focussed on trying to maximise training capacity

Paramedic Recruitment

- 156 Paramedics who will be trained between August 22 and March 23
    - 84 will be deployed by December
    - 72 will deploy between Jan 23 and May 23
- 14 Australian NQP will be deployed in August in an 'attend-only' role for the first 12 months
- 37 Qualified Paramedics are in the plan to commence in 22/23

EMT Recruitment

Since 2022 the Trust moved EMT 1 courses to a modular course, this allows for deployment after an initial eleven-week classroom and blue light driving course:

- **PES** - 118 EMT1's will be trained between August 22 and April 23
    - 70 will deploy by December
    - Remaining 48 will deploy in Q4 of 22/23 and Q1 of 23/24
- **PTS** - workforce plan aims to close current the vacancy gap during 22/23 (gap of just 0.7% in December 22).
- **111** - ongoing actions to support closing the current vacancy gap and improving turnover for Health Advisors. Actions include:
    - the continued roll out of the short-term retention payments for existing staff and new starters who commenced between Jan 22 and March 22
    - Review of rotas
    - Refresh of recruitment and advertising materials and methods
    - Review of induction training
- **EOC** – ongoing recruitment to support workforce plans.

6.4 Hospital Handover

6.4.1 Overview

NWAS has been leading on a quality improvement programme to support the challenges across the North West and beyond with Hospital Handover. The QI programme has been in partnership with NHSEI NW and the Acutes across the region. The *Every Minute Matters* QI programme have developed a collaborative package '*15 Steps to Ambulance Handover Improvement'* (July 2022). The QI continues to demonstrate improvement with hospital handover by use of resources which include the handover safety checklist, Fit2Sit and escalation cards.

6.4.2 Implement Initiatives

These initiatives form part of the 2022-2023 Priority Workstreams, commonly known as the *Six-Point Plan*. These set of actions and priorities have been agreed system wide with engagement from multiple partners and stakeholders, committed to reducing patient harm. The first priority of the *Six-Point Plan* details actions to be taken to support hospital handovers and ambulance turnaround times:

- Ambulance Trust to monitor crew compliance with Fit to Sit (sector led) and report to senior service delivery meetings and onwards to performance committees
- Hospital trusts to monitor long waits over 1 hour (daily) & report to Trust board (monthly) and A&EDB (quarterly)
- Hospital trusts to set internal improvement goals for reducing waits over 1 hour by 50% within 6 months and monitor via AEDB
- Hospital trusts to implement zero tolerance on patients waiting outside A&E (monitor daily and review case by case for possible harm)
- A quarterly review of harm from handover delays to be included in regional quality board, ICB quality boards and provider Trust quality and safety meetings.
- Clear governance escalation process via single item QSG for systems who are repeatedly failing on handover with implications for SOF and CQC rating

6.4.3 **Regional Quality Improvement Collaboratives**

The commitment is the establishment of regional quality improvement collaboratives to systematically reduce handover delays.

Establish regional handover improvement board by 1 August 2022:

- Each ICB, acute Trust, primary care network, OOH provider and ambulance trust to nominate an Executive SRO for handover to attend Regional Handover Improvement board.

- ICB SRO to act as system convener for HH improvement collaborative, securing the resources and including partners expertise as appropriate

Establish Collaborative (within each ICS) by 1 September 2022 to:

- jointly review long waits for access to: PC / 111/ 999/ ED/acute hospital – development of patient stories which articulate the impact of waiting and can be used for learning

- alongside local handover data

- set improvement goals for increasing Fit to Sit / Access to SDEC / MH referrals / alternative entry points to ED

- review data on handover delays and set improvement goals for reducing the time lost

- share data and learning

7.0 COMMUNICATIONS

7.1 Overview

NWAS has in place robust Winter Communications Plans which supports the NWAS Strategic Winter Plan, seasonal Influenza vaccination programme and NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan as well as contributing to trust compliance with the Civil Contingencies Act (2004) in terms of 'warning and informing'.

7.1.2 The NWAS Communications Team is well linked across the NW system through regular attendance and participation in the regional ICS and NHS England communications leads 111/UEC and winter planning meetings. These meetings also include system based and locality partner trusts and facilitate co-ordinated approaches to demand management and winter planning across the wider healthcare system. The NW approach to the roll out of NHS 111 First provides a good example of local system communication networks working effectively.

7.1.3 Messaging to the public is considered on a local, regional and national footprint using insights from demand data and patient experience. For example, a range of self-care videos have been produced on identified common conditions which are suitable for use across the local system. We are currently looking at a joint approach to a prescriptions campaign based on the high demand for this service to NHS 111. Myth busting and other creative techniques will be used to help the public to choose services wisely and o signpost them to the most appropriate route to care.

7.1.4 A further key 111 message to service users is that they can access the same assessment from 111 online to encourage as many people as possible to use this route. 111 IVR message encourages use of 111 online – we are also looking at a development for the IVR to include an option to receive a text message with details of 111 online.

7.1.5 Communication toolkits and winter plans are discussed and shared together with regular updates on local system hotspots and identified themes in order to signpost patients to the most appropriate/alternative service. National and regional funding to support communication and engagement campaigns is also allocated and held on a local system basis.

7.2 Communications Activity

7.2.1 The Communications Framework covers five broad areas of activity:

- General Winter and Flu communication – The trust will support national campaigns around flu and 'help us help you' supplemented with dedicated ambulance service campaigns and messaging.
- Communications specifically relating to COVID-19.
- Pressure related communication – in reaction to increases in operational and demand pressures relating to use of 999, NW111 and NHS111 online.
- Business Continuity Management – staff communications during periods of pressure to ensure continuity of core services.
- Communications specific to the post winter recovery period.

- Public safety messages around key dates (e.g. 5th November, New Year's Eve).

7.2.2 Messages will be disseminated over a range of platforms and media (Social Media, print and broadcast). Face to face opportunities will also be exploited or targeted with messages tailored to audiences for maximum impact.

During the winter months, new campaigns will be implemented to support the objectives below.

7.3 Specific Objectives

Communication activity will assist in mitigating some of the demand pressures that NWAS will face during the winter period. Specific actions will include:

- Providing our staff, our volunteers and the public with health and wellbeing advice including why they should have the flu vaccination
- Informing the public about making the right choices to access care if they are unwell, especially when to call 999 and when to use other services such as NW 111
- Raising awareness of the ambulance services role in tackling winter pressures amongst NHS organisations and key stakeholders
- Engaging with staff about our efforts so they feel informed, listened to and able to act as a trusted source of information to patients on winter health matters

7.4 UK Health Security Agency – Cold Weather Plan for England

7.4.1 The Cold Weather Plan for England is a framework intended to protect the population from harm to health from cold weather. It aims to prevent the major avoidable effects on health during periods of cold weather in England by alerting people to the negative health effects of cold weather and enabling them to prepare and respond appropriately.

It recommends a series of steps to reduce the risks to health from cold weather for:

- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups

The Cold Weather Plan has been published annually since 2011. This year's plan continues to build on the experience of developing and improving the ability of the health and social care sector and its partners to deal with significant periods of cold weather.

7.4.2 The cold weather alert service comprises 5 levels (Levels 0 to 4), from year-round planning for cold weather, through winter and severe cold weather action, to a major national emergency. Each alert level aims to trigger a series of appropriate actions which are detailed in the plan.
A series of steps are recommended by the plan to reduce the risks to health from cold weather and these include ensuring the receipt of the regular Meteorological Office, Cold Weather Alerts and associated Planning Advice. These emails contain detailed forecasts (or alerts should trigger thresholds be breached) to signal impending cold weather and allowing appropriate actions to be taken.

These alerts and forecasts are received by the NWAS Resilience Team, Emergency Operations Centres, the ROCC and Communications Team.

7.4.3 The current version of the UK Health Security Agency Cold Weather Plan can be found here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1031106/UKHSA_Cold_Weather_Plan_for_England.pdf

Local Resilience Fora all have multi-agency severe weather arrangements and NWAS remains an active partner in the planning and response to such incidents to support patient care, wider public safety and staff support.

8.0 REPORTING MECHANISMS

8.1 Although no direct arrangements have been confirmed formally by NHS England, it is likely their response and overview will be in line with last year, involving the establishment of their North West Winter Room. Anticipated to be stood up during the beginning of the winter period and maintain through to April 2023. Similar to last year, the function will operate 0800-1700hrs each day (excluding 25 & 26 December). Outside of these times, winter escalation will transfer through to established on-call arrangements for each of the North West Localities (C&M/LSC/GM).

8.2 In terms of specific routine reporting through to the NW Winter Room, this will be done through existing system which this function has been granted access – namely NWAS Hospital Arrival Screen (HAS) and the NACC Dashboard (ProClus). This will provide real-time and live access to NWAS capacity and capabilities.

As in previous years, the NW Winter Room will chair twice weekly calls with NW Ambulance Services (NWAS, NEAS and YAS). This call will provide ambulance trusts the opportunity to raise any ongoing concerns over internal or external threats and pressures to service delivery. The NW Winter Room lead is then able to escalate and intervene with health systems should be the issue be protracted or sustained.

8.3 NWAS managers will continue to represent local sectors on A&E Delivery Boards/ICSs and provide detailed, local assurances or data as requested.

9.0 SPECIFIC CONTINGENCY & BUSINESS CONTINUITY PLANNING

9.1 Seasonal Influenza

At the begging of October the Trust will launch its annual Flu campaign. In line with national requirements the ambition is to offer 100% of the workforce the flu vaccine and to vaccinate between 70% and 90%. A project team has started the preparatory work in summer and has a robust project plan in place which seeks to aim to vaccinate staff. The intention is to undertake a focussed 8-week period between October and November to ensure that as many staff as possible receive the vaccination by December 2022.

9.2 COVID-19 Response & Recovery Plan

9.2.1 COVID- Response

The NWAS COVID-19 Response Plan was activated during March 2020 in response to the emerging virus and remains in place to manage the ongoing response including those attributed to potential subsequent waves of infection.

The aim of the NWAS COVID-19 Response is to describe the response arrangements that have been implemented by NWAS and its staff during the disruptive challenge associated with the outbreak of COVID-19 virus whilst ensuring, as far as reasonably practicable, the safety of all staff and members of the public.

Command and Control arrangements detailed within the NWAS Major Incident Response Plan will form the basis of the structure during any outbreak.

As part of the response to the COVID-19 pandemic, a structure is in place to provide appropriate governance arrangements as required

The objectives of the response are:

- To identify potential challenge to NWAS functions through risk assessment.
- To ensure that appropriate and flexible contingencies are put in place at the earliest opportunity to minimise compromise to NWAS and to its staff including during the “Roadmap to Recovery” as announced by the UK Government for the period of March to June 2021.
- To ensure that appropriate levels of assessment and patient care are provided to members of the public that are affected by the virus.
- To ensure that appropriate levels of patient care to those members of the public not affected by the virus are maintained.
- To ensure that the appropriate level of staff welfare of all employees of NWAS is maintained as far as reasonably practicable.

- To ensure the contingencies employed by NWAS are compatible with those of the other agencies to provide a consistent and flexible response in the management of those affected by the virus

9.2.2 **COVID-19 Recovery**

The COVID-19 pandemic presented unprecedented challenges across the whole of NWAS, diverting resources and operational delivery away from business as usual and Departmental planning to provide an immediate, coordinated response to COVID-19.

It is good practice in emergency response and business continuity planning, to consider recovery as soon as possible during the response phase. This is because the actions taken in the response phase will affect recovery, sometimes detrimentally so consequences of decisions need to be examined throughout the response phase.

NWAS COVID-19 Recovery identifies those areas within NWAS where change has taken place and the process by which a return to a “new normality” will be facilitated. The arrangements contained within the plan will be reviewed on an on-going basis in light of changes in guidance from the Department of Health & Social Care, UKHSA and the World Health Organisation.

The key objectives of recovery include:

- To identify those changes to pre-pandemic NWAS practices
- To ensure that appropriate and flexible contingencies and timescales are put in place to enable a return to pre-pandemic practices or new ways of working
- To ensure the contingencies employed by NWAS are compatible with those of the other NHS organisations and are in line with national guidance and best practice
- To provide a framework for the revision of NWAS business continuity plans
- Ensure NWAS can escalate back to response phase should further waves of COVID-19 (including variants of concern) require enhanced arrangements to be re-established
- To provide guidance on the options available and consideration that should be made through response and into the recovery phase when planning for recove

9.3 Severe Weather

9.3.1 Severe winter weather provides one of the greatest challenges to NWAS with snow, ice and flooding all affecting the road infrastructure. The NWAS response is detailed in the Area Operational Winter plans but essentially relies on the augmentation of the usual fleet with the following:

- NWAS PES vehicles have been fitted with all-weather/Winter tyres

- NWAS 4x4 RRVs already in service including HART fleet
- Consideration of short-term hire of additional 4x4 vehicles
- St John Ambulance and British Red Cross 4x4 vehicles
- Those managers with 4x4 lease vehicles
- Civilian Mountain Rescue Teams and other Search and Rescue charities
- Partner agencies e.g. Police, Fire & Rescue Service, RNLI, MCA, Local Authority
- Maritime and Coastguard Agency Search and Rescue helicopters (immediate lifesaving interventions)
- Military Aid to the Civil Community in extreme situations upon exhaustion of NWAS contingencies

9.3.2 Additionally, ambulance stations will receive supplies of grit/salt and, as in previous years, maintain contract arrangements with hospital estates departments or commercial companies to provide a snow moving and gritting service. HART bases have their own snowplough capabilities to maintain access and egress.

Vehicle recovery arrangements are in place either through NWAS Fleet Support or externally contracted sources.

9.3.3 Existing departmental Business Continuity Plans and staff mapping information will be activated in the event of major difficulties in maintaining staff cover with particular emphasis on EOC operations and other core functions. Staff welfare is paramount, but individuals are encouraged to attempt to access normal work locations where safe or nearest NWAS site/alternative site as designated in local Business Continuity Plans.

9.3.4 NWAS Strategic Commanders have Government Purchasing Scheme (GPC) Credit Cards to support the out of hours provision of financial support for emergency accommodation or catering supplies in the event of staff being stranded or required to be billeted near a place of work.

9.4 Industrial Action

9.4.1 Existing departmental Business Continuity and staff mapping arrangements underpin the NWAS response to any threatened periods of industrial action.

9.4.2 Experience gained from previous industrial action, has led to a specific NWAS plan being developed to deal with the impacts of disruption through strikes and action short of strike. This plan is sufficiently flexible to be tailored to the specific type or period of potential disruption. Knowledge of potential areas of disruption or challenge has been acquired from mitigation of Ambulance Staff, Fire and Rescue Service and Junior Doctors disputes/actions over recent years and this has been factored into a range of contingency plans to ensure enhanced resilience.

9.4.3 This ‘Constant Care’ Plan can be initiated in the face of planned or spontaneous action and provides a flexible and scalable response to maintain the Business Continuity of NWAS and protect core response in the face of any degradation of capability. This plan has been updated and reconfigured for each specific sector, which may be affected by industrial action e.g. Fire and Rescue Service, fuel transport or parts of the health sector. The threat of more widespread and coordinated industrial action during the winter period has been recognised and considered in terms of NWAS and multi-agency planning.

9.4.4 The country, over the last year, has already seen both actual and threats of industrial action caused in part by the unprecedented rise in UK Inflation Rates and cost of living concerns, combined with pay increases across a number of sectors being less than anticipated by Trade Union organisations.

June, July and August saw national rail strikes across both National Rail and the Train Operating Companies and this is likely to continue at short notice short a resolution by unachievable.

The Public Sector Trade Union organisations have indicated that strike action or action short of strike action remains an option across NHS organisations, including doctors, nurses and dentists.

10.0 DOCUMENT REVIEW

10.1 This document remains in a constant state of review and will be updated and amended as situations develop or change but will be formally reviewed and revised in July 2022.

11.0 APPENDICES

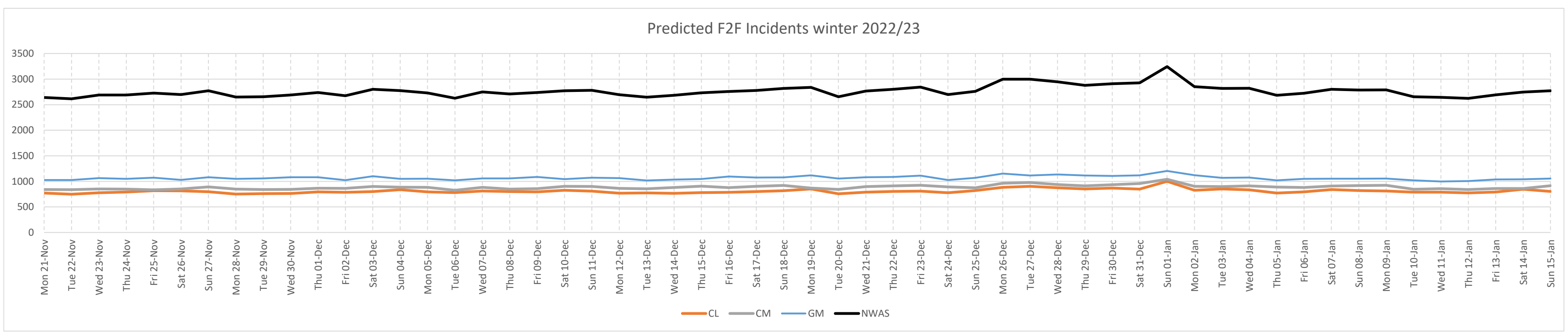
Appendix 1 - Predicted Response Demand

Appendix 2 - Forecasted Responses – Top 10 Busiest Days

Appendix 3 - Forecasted Responses – Total Numbers

Appendix 4 - 111 Activity Forecast

Appendix 1 - Predicted Response Demand



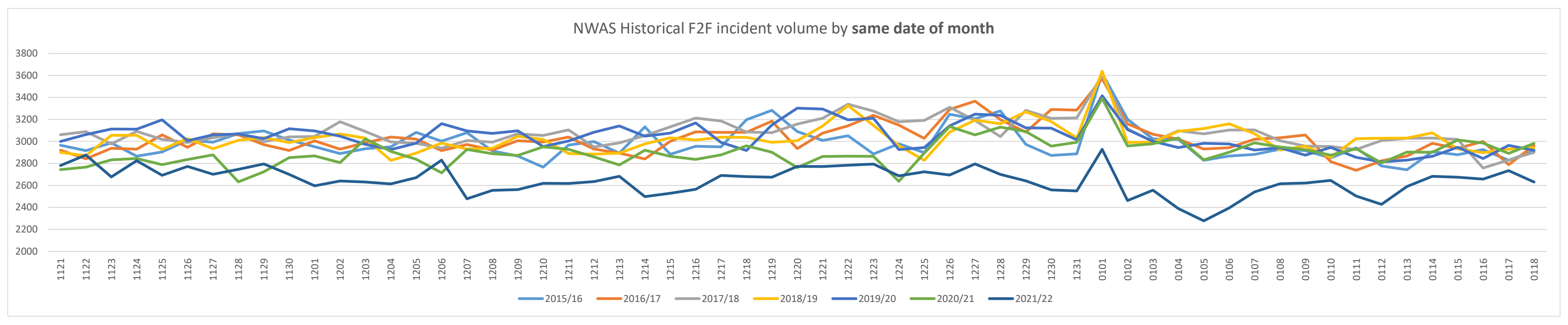
Appendix 2 - Forecasted Responses – Top 10 Busiest Days

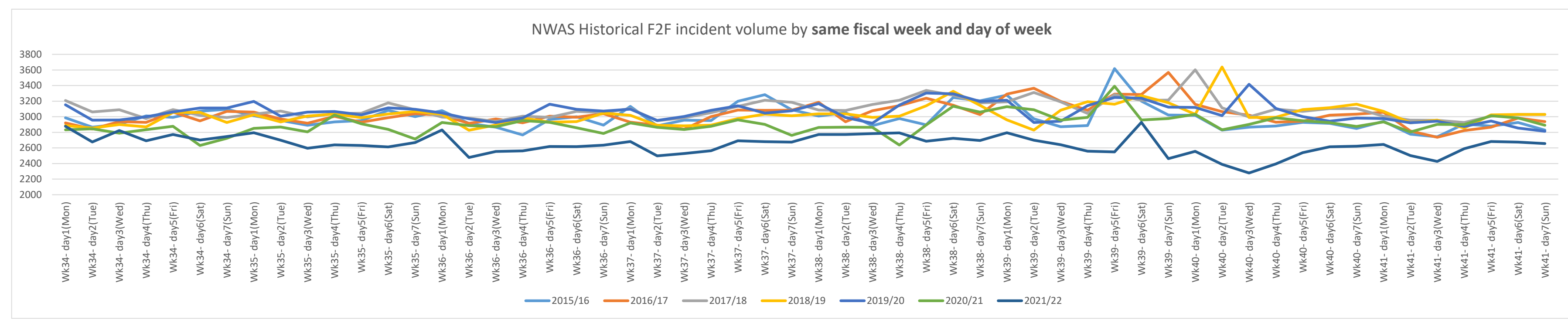
Predicted F2F Incidents winter 2022/23: Cumbria and Lancashire, with top 10 busiest days shown

Predicted F2F Incidents winter 2022/23: Cheshire and Mersey, with top 10 busiest days shown

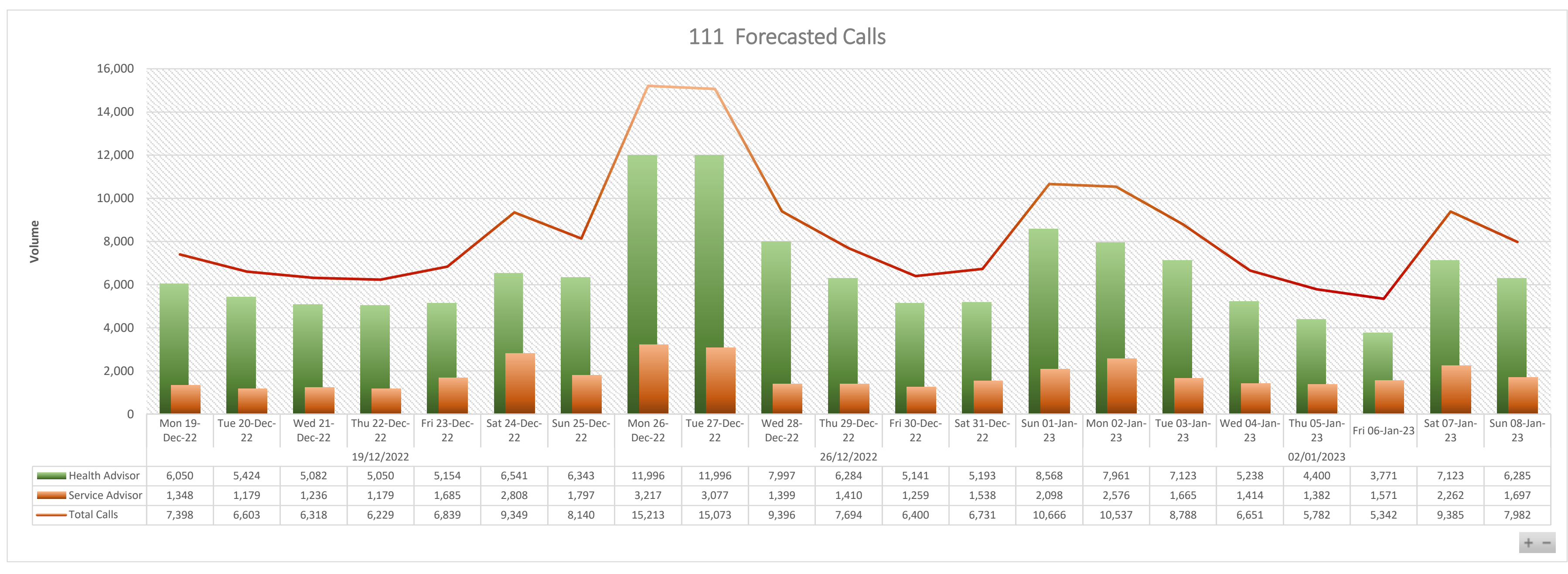
Predicted F2F Incidents winter 2022/23: Greater Manchester, with top 10 busiest days shown

Appendix 3 - Forecasted Responses – Total Numbers





Appendix 4 - 111 Activity Forecast



	Mon 19-Dec-22	Tue 20-Dec-22	Wed 21-Dec-22	Thu 22-Dec-22	Fri 23-Dec-22	Sat 24-Dec-22	Sun 25-Dec-22	Mon 26-Dec-22	Tue 27-Dec-22	Wed 28-Dec-22	Thu 29-Dec-22	Fri 30-Dec-22	Sat 31-Dec-22	Sun 01-Jan-23	Mon 02-Jan-23	Tue 03-Jan-23	Wed 04-Jan-23	Thu 05-Jan-23	Fri 06-Jan-23	Sat 07-Jan-23	Sun 08-Jan-23
Health Advisor	6,050	5,424	5,082	5,050	5,154	6,541	6,343	11,996	11,996	7,997	6,284	5,141	5,193	8,568	7,961	7,123	5,238	4,400	3,771	7,123	6,285
Service Advisor	1,348	1,179	1,236	1,179	1,685	2,808	1,797	3,217	3,077	1,399	1,410	1,259	1,538	2,098	2,576	1,665	1,414	1,382	1,571	2,262	1,697
Total Calls	7,398	6,603	6,318	6,229	6,839	9,349	8,140	15,213	15,073	9,396	7,694	6,400	6,731	10,666	10,537	8,788	6,651	5,782	5,342	9,385	7,982

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	25th July 2022	**Chair:**	Dr A Chambers, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation, and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director Mrs A Wetton, Director of Corporate Affairs
Members Present:	Dr A Chambers Dr D Hanley Mrs A Wetton Mr G Blezard Prof M Power Dr C Grant	**Key Members Not Present:**	Prof A Esmail, Non-Executive Director

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☒	☐	☐	☒	☐	☐	☐	☐	☐

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

Key		
(red)	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
(amber)	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
(green)	Assured	No or minor impact on quality, operational, workforce or financial performance

Board Assurance Framework	• Received the Q1 closing position of the BAF, prior to approval by Board of Directors. • Discussed SR03 and the potential impact of staff abstractions on performance during Q2. • Recognised increased annual leave during the quarter and challenges expected throughout August. • Noted additional funding and investment for resources into operations. • Reviewed challenges and noted action taken to mitigate risks.	• Gained assurance that BAF risks were being managed effectively.	
Integrated Performance Report	• Noted call pick up in 999 had been challenged during June, due to implementation of NHS Pathways training, which was now completed. • Noted stable performance in C1 and C3, with C2 long waits stabilised. • Noted the Trust was an outlier for C4 and work ongoing to identify the cause. • Discussed response times and the pressures of hospital handover delays. • Reported that Medical Director and Director of Quality, Innovation and Improvement continued to work actively with A&E departments.	• Noted improvement in some areas of performance. • Continued challenges and pressures in relation to hospital handover delays, staff retention and recruitment challenges.	

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	• Recognised the impact of job cycle time on available resource and explored the issues associated with increase in job cycle time. Recognised as a future theme for a deep dive to the Committee. • 111 – increased demand from patients seeking primary care. Discussed importance of health care partners in receiving referrals efficiently from NWAS. • Agreed action plan with commissioners to focus on staffing, availability, sickness, attrition, demand management and technology. • PTS continued to work well. • In terms of additional investment into the emergency service, queried the issue of staffing and availability of staff. • Noted that some challenges in terms of trainer capacity and factoring of 3-year lead in time for qualified paramedics. • Challenges in recruiting call takers to 111 service. • Recognised feedback in relation to patient experience and noted trends in relation to demographics across the region.		

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CFR Assurance Report Q1	• Acknowledged the progress made in the assurance report provided. • 592 active CFR volunteers across the region and during the quarter there had been 8,232 individual episodes of availability which created a total of 32,928 hours of volunteer time available for incident allocation and mobilisation. • Good assurance in relation to compliance and clarified the process for deploying staff with overdue checks. • Reported that a 2–3-year strategic view of the CFR service across the Trust would be undertaken to include location of defibrillators for future consideration by Executive Leadership Committee.	• Received assurance from the report.	
Service Delivery Oversight Forum Assurance Report	• First meeting of the Forum held in July with future bimonthly meetings. • Three key areas of focus which included Senior Leadership Review, NHS Pathways and NAA CAD programme. • Received an update on progress to date and further areas of focus would be reported as the forum developed.	• Received assurance from the report.	

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Annual Review of the Heatwave Plan	• Received the Trust's Annual Heatwave Plan. • Included consideration of the ongoing impact of the pandemic and produced in line with the National Heatwave Plan for England.	• Received assurance from the review of the annual plan.	Assured (green)
EPRR Sub Committee Chairs Assurance Report	• Written assurances provided from service lines except for EOC and 111. • Recognised the need to ensure future reporting is provided. • Noted the absence of commander training in EOC and although this wasn't a statutory requirement the Trust had appointed a compliance resilience manager to implement relevant training and provide operational assurances in relation to control rooms. • Received revised Terms of Reference and Work Plan for approval.	• Noted written assurance reports required from all service lines. • Approved the revised Sub Committee Terms of Reference and Work Plan for 2022/23.	Moderate Assurance (amber)
Incidents and Serious Incidents Q1 Assurance Report	• The Director of Corporate Affairs provided an overview of action taken to improve management of incidents and serious incidents. • Noted number of incidents received and steps made to ensure objectives and actions were SMART. • Noted framework for scoring of high-level incidents.	• Received assurance from the report.	Assured (green)

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	• Noted the increased workload for ROSE and work to streamline processes in progress with Corporate Affairs and Medical Directorate. • Acknowledged a need to monitor the demand, impact on the team and resource. • Report continued to develop, and future assurances required by the Committee to be explored. • Discussed themes and learning from Sis which included meal break procedure and effectiveness reviews in EOC. • Received assurance that action was being taken to mitigate risks and address the areas of learning identified by the SI process.		
Complaints Assurance Report Q1	• The Trust had received 456 new complaints during Q1, 12 high risk complaints. • 127 open complaints with 48 overdue a response. • The accumulation of overdue complaints continued a downward trajectory. • Work had been completed to review the structure and alignment of processes.	• Received assurance from the report.	

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	• Noted plan to produce a triangulation report with the Trust's Patient Safety Specialist. • Requested future detail of the number/percentage of complaints that were upheld in future reporting.		
Legal Services Assurance Report Q1	• Received an overview of legal activity during Q1. • Noted the number of new claims and coroner's inquests and referred to comparative data. • Noted learning disseminated and advised NWAS activity was reflective of demand on the service and change to coronial practice. • Recognised that claims remained high with an ongoing need to understand trend, by using comparative data from previous years.	• Received assurance from the report.	
Medicines Management Q1 Report	• Chief Pharmacist presented an overview of work completed by the medicines management team. • Noted good performance against Enduring Standards. • Discussed the outstanding areas of compliance which were reported as small gaps and risk assessments had been undertaken; with any risks identified on the Trust's risk register.	• Received assurance from the report.	

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Learning from Deaths Q4 Report	• Learning from Deaths activity reported for Q4 2021/22 and included the key learning themes identified. • Themes included delayed responses and coding of ineffective breathing. • Reported the impact of hospital handover delays across the system which caused risk to category 2 cases in the community. • Emphasised the need for the wider health system to understand that to maintain patient flow was critical to the care of patients. • Discussed poor practice issues and noted the importance of contact shifts to enable SPTLS to share good practice and reflect on challenges or issues faced by crews. • Acknowledged that contact shifts had been impacted by the impact of Covid-19 however the Trust had renewed its focus on ensuring contact shifts were undertaken. • Recognised the need to ensure learning was disseminated across the Trust via Area Learning Forums.	• Received assurance from the report.	
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Received an overview of the assurances received by the Sub Committee.	• Noted the content of the Chairs Assurance Report.	

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	• Noted the Prof A Esmail had observed the meeting. • Advised that assurance reporting in relation to Medical Devices would be considered by the Trust's Executive Leadership Committee in response to recent CQC recommendation.		
Health, Safety and Security Chairs Assurance Report	• Received updates on the assurances received by the Health, Safety and Security Sub Committee.	• Noted the content of the Chairs Assurance Report.	
Patient Safety Sub Committee Chairs Assurance Report	• Noted that service line reporting continued to develop to the Sub Committee. • Recognised the assurances provided and a review of the work plan to ensure focus on learning.	• Noted the content of the Chairs Assurance Report.	
Diversity and Inclusion Sub Committee Chairs Assurance Report	• Noted the work completed to revise the Sub Committee Terms of Reference and Work Plan, including membership. • Terms of Reference had been split to facilitate reporting of health inequalities to the Quality and Performance Sub Committee. • Inclusion of the various networks continued with development and refocus required on EDI goals.	• Approved the revised Terms of Reference and Work Plan. • Noted the progress made in relation to the EDI goals. • Acknowledged further development of the subcommittee, including frequency of meetings from quarterly to bi-monthly.	

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CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	23rd September 2022	**Chair:**	Dr D Hanley, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Dr D Hanley Mr D Rawsthorn Ms C Butterworth Ms C Wood Ms L Ward Mr S Desai Mr G Blezard	**Key Members Not Present:**	Prof M Power, Director of Quality, Innovation, and Improvement

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☒	☒	☒	☒	☐	☒	☒	☒	☒	☒

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

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Board Assurance Framework	• Discussed SR09, SR11 and SR05 related risks and progress against mitigating actions. • Noted review of BAF strategic risks in relation to the Trust Strategy, was underway with Board members	• Received assurance that the BAF risks were being managed effectively.	
Finance Report to 31st August 2022 – Month 5 2022/23	• Reported the financial position for the Trust to 31 August 2022. • Noted an underspend of £0.227m against a planned break-even position. • Income had been over recovered by £0.143m; pay underspent by £1.407m and non-pay overspent by £1.354m. • The annual efficiency and productivity target for 2022/23 was £15.502m, included a recurrent efficiency target of £8.178m and non-recurrent efficiency target of £7.324m. • To the end of the month savings of £4.685m had been achieved with annual savings of £15.502m forecast in line with plan. • Reported that a balance of £4.353m was still to be identified and work required to identify the gap was the benefits realisation from the introduction of the NHS Pathways and a half year review of the funded 2022/23 cost pressures, inflation, and developments.	• Received assurance from the financial report, up to 31st August 2022 – Month 5 2022/23.	

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	• Noted the financial position included impacts of 2% pay award in line with national planning guidance and the impacts of the settlement agreed would be reported in future reports to Committee. • Received the capital programme 2022/23 position, year to date gross capital expenditure and net capital expenditure.		
Procurement of Servicing, Maintenance, Repair and Installation of Appliance Bay and Garage Doors	• Endorsed a Contact Award for Procurement of Servicing, Maintenance, Repair and Installation of Appliance Bay and Garage Doors. • Recommended approval to the Board of Directors on 28th September 2022.	• Recommended approval to the Board of Directors.	
Contract Award Managed Print Solution	• Endorsed a Contact Award for a Managed Print Solution. • Recommended approval to the Board of Directors on 28th September 2022.	• Recommended approval to the Board of Directors.	
Mobile Phone Voice and Data Contract Renewal	• Endorsed the contract renewal for mobile phone voice and data. • Recommended approval to the Board of Directors on 28th September 2022.	• Recommended approval to the Board of Directors.	
United Tech Funding	• Endorsed the decision to accept in year funding from NHSX, subject to final NHSE approval.	• Recommended approval to the Board of Directors.	

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	• Discussion related to the risks and consideration of the trust's risk appetite statement. Agreed in principle, should money be received. • Recommended approval to Board of Directors on 28th September 2022.		(green)
Contract Extension: Occupational Health Services	• Endorsed the contract extension of the Trust's Occupational Health Contract. • Recommended approval to the Board of Directors on 28th September 2022.	• Recommended approval to the Board of Directors.	(green)
Revised Capital Programme for 2022/23 and indicative 5 Year Capital Review	• Received the changes to the opening capital plan and noted the revised capital plan for 2022/23. • Significant discussion on the risks identified in relation to the indicative five-year capital programme and the re-prioritisation work required to be completed; to finalise a rolling programme within the capital resource levels and in line with Trust strategy and annual plans. • Discussed the mitigation options in relation to prioritisation of the 2023/24 programme, which had been presented and discussed at ELC on 21st September 22. • Confirmed ELC planned to discuss strategy and re-prioritisation at an away day in November. Committee to	• Received the revised capital programme for 2022/23 and indicative 5 Year Capital Review. • Discussed the risks associated with capital resource and the re-prioritisation required of the 5-year programme. • Requested an update on the strategy and reprioritisation of plans at a future Resources Committee meeting and following ELC discussion in November 2022.	(amber)

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	be presented with further report in Q1 in terms of a capital strategy and proposed spend priorities.		
Relocation of Liverpool HART - Outline Business Case	• Received an outline business case, including risks associated to the relocation of Liverpool HART. • Discussed the option appraisal and the preferred option considered and recommended by ELC on 21st September 2022. • Recognised risks associated with HART redevelopment in terms of timescales and costs. • Full Business Case and contingency plans supported for future consideration by the Resources Committee.	• Endorsed the option proposal and undertaking of a Full Business Case for the relocation of Liverpool HART. • Recognised the risk associated with delivery of the scheme in terms of timescales and costs. • Recommended undertaking of full business case for approval to the Board of Directors	
PES Vehicle Replacement Programme 2023/24	• Provided with the dual crew ambulance vehicle replacement programme (VRP) for the financial year 2023/24. • Business case aimed to secure approval at an early opportunity to enable replacement of vehicles within the financial year 2023/24. • Noted indicative capital requirement for financial year 2024/25 for financial planning purposes.	• Endorsed the dual crew ambulance vehicle replacement programme 2023/24. • Recognised priorities of the capital plan and expenditure however priorities were still to be considered.	

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	• Discussed, and endorsed replacement proposal based on recent ELC recommendations. • Recognised final agreement on capital priorities to be achieved.		
Purchase of HART Gen 3 Vehicles	• Received request for approval to replace the current fleet and mobile technology used by the Hazardous Area and Response Teams (HART) in line with the 3rd generation requirements mandated by the National Resilience Response Unit (NARU). • Noted the elements for consideration and the capital requirement for the NARU recommended replacement programme. • Discussed the options proposed and the preferred option and related revenue requirements and capital charges; however, recognised the overall need to agree priorities of capital plans and spend.	• Endorsed the purchase of HART Gen 3 Vehicles. • Recommended approval to the Board of Directors. • Recognised the need to prioritise spending against the capital plan.	
Procurement of additional 21 Double Crewed Ambulances (DCAs)	• Endorsed the procurement of additional 21 Double Crewed Ambulances (DCAs). • Recommended approval to the Board of Directors on 28th September 2022.	• Recommended approval to the Board of Directors.	

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Sustainability Update	• Received an update on the key work areas related to sustainability and environmental targets, and desired outcomes. • Updates included significant work in relation to data, completion of energy surveys, and work with One Public Estate and collaboration with other blue light services, working with Transport for Greater Manchester to encourage staff to use more sustainable methods of transport. • Noted the Sustainability Group continued to monitor progress across the Trust, set against the Green Plan.	• Noted the content of the Sustainability Update and the assurances contained within the report.	
Annual Plan 2022/23 Progress Update	• Received an update on the Strategic Planning Review and an updated Annual Plan for 2022/23. • Noted the updated Annual Plan had been reconciled to incorporate full year priorities. • Recognised the condensed plan would provide the framework for quarterly reporting to the Committee on strategic plans. • Progress update on the deliverables and programmes of work reported. • Road map to include capital spend priorities and available resources, to	• Noted the content of the Progress Update. • Road map to reflect capital priorities and available resources to be presented to future Committee meeting.	

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	be produced and presented to future Committee meeting.		
Workforce Indicators Report	• Workforce Indicator dashboard highlighted key activity in relation to sickness absence, appraisals, mandatory training, staff turnover, vacancy position and HR case management. • Appraisals and mandatory training making good progress. • Key areas: staff turnover, sickness, and recruitment and retention discussed. • Covid related sickness and progress of management of long covid cases reported. • Work undertaken by AITs including coaching style audit to identify key themes for managers. • Recognised ongoing pressures in relation to turnover, attraction and recruitment as approach the operational challenges associated with the winter period.	• Noted performance against workforce indicators. • Recognised continued challenges associated with sickness, turnover and recruitment and retention.	
Flu Campaign 2022/23	• Received detail of the learning and outcomes from the Flu Campaign 2021/22 and to provide key recommendations for the Flu Campaign 2022/23.		

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	• Noted the impact of the Covid vaccination programme, which resulted in lower flu vaccination rates in 2021. • 2021/22 campaign based on 100% offer with 85% ambition of uptake amongst frontline healthcare workers. • Trust achieved 56.5%. • Flu Campaign for 2022/23 aligned to quality indicator identified in the 2022/23 Commissioning for Quality and Innovation with a goal of vaccinating 70% to 90% of staff. • Noted funding had been received and included in the baseline, with no risk of financial penalty for not achieving targets. • Trust had procured vaccinations and the campaign would be operated via a peer led model with the inclusion of a clinical lead and administrator. • Noted the communication plans, which included role modelling through Board, of the vaccination.	• Endorsed the plans for the Trust's Flu Campaign in 2022/23. • Recommended approval of Best Practice Checklist to the Board of Directors for publication.	
EDI Statutory and Regulatory Reporting	• Acknowledged key themes highlighted in the report. • Noted WRES data for 2021 highlighted some areas of improvement, however evidenced a worsening regarding the experiences of colleagues from black	• Noted EDI report. • Acknowledged the further work to be undertaken to address key findings in relation to BAME and disability workforce.	

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	and minority ethnic backgrounds (BAME). Although some of the metrics were positive, the data indicated that further work was required. • WDES data showed an overall increase in the representation of disabled staff at most levels of the organisation. • Data in relation to recruitment had shown an increase in the raw number of disabled candidates appointed from shortlisting from the previous year but a slight worsening in the likelihood of appointment from shortlisting measure. • Gender pay gap data showed an ongoing increase in the number of female staff in the workforce from 51.24%. to 51.60%. The pay quartile information showed that female representation had also increased in the upper quartile from 34.18% in 2019 to 37.78% in 2022. • Key areas of concern noted as shortlisting to appointment and proportion of staff entering disciplinary processes metrics. • Discussed initiatives to be undertaken to improve the current position in response to data findings which included three trust wide priorities and	• Monitoring of the position required via Trust's EDI Sub Committee and Resources Committee.	

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	continued monitoring by the Trust's EDI Sub Committee.		
Strategic Workforce Sub Committee Chairs Assurance Report from the meeting held on 15th September 2022	• Received the assurance provided to the Sub Committee meeting held on 15th September 2022.	• Noted the assurances received by the Strategic Workforce Sub Committee at the meeting held on 15th September 2022. • Approved recommendation from sub-Committee to submit the Trust's HEE Placement Provider Self-Assessment for 2022	
Diversity and Inclusion Sub Committee Chairs Assurance Report from the meeting held on 8th July 2022 (Including revised Terms of Reference)	• Received the assurance provided to the Sub Committee meeting held on 8th July 2022. • Approved the updated Terms of Reference 2022/23.	• Noted the assurances received by the Diversity and Inclusion Sub Committee. • Approved the updated Terms of Reference 2022/23.	
Digital Strategy Update	• Key highlights were reported against the five workstreams of the Digital Strategy. Solving Everyday Problems; Our Digital Journey; Secure and Joined Up Systems; Smarter Decisions and Risks. • Acknowledged ongoing management of risk which included risk in relation to capacity resource to deliver programmes.	• Noted the updates on the digital strategy. • Acknowledged further assurance required in terms of resource capacity to deliver programmes.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

Key		
(red)	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
(amber)	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
(green)	Assured	No or minor impact on quality, operational, workforce or financial performance

REPORT TO BOARD OF DIRECTORS

DATE:	28 September 2022
SUBJECT:	2022/23 Flu Campaign
PRESENTED BY:	Lisa Ward, Director of People

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☐	☐	☐	☒	☐

SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Assurance

EXECUTIVE SUMMARY:

The purpose of the paper is to provide assurance to the Board of Directors on the learning and outcomes from the Flu Campaign 2021/22 and the plans for the Flu Campaign 2022/23.

The impact of the pandemic and roll out of COVID vaccinations, had a significant impact on the 2021/22 flu campaign. As a result of this and the announcement of the national VCOD mandate, there was a general lethargy in staff to accept the offer of a flu vaccine. Last year's campaign was based on achieving a 100% offer with an 85% ambition of uptake amongst frontline health care workers. The Trust achieved a vaccination rate of 56.5%.

This year the flu programme is aligned with one of the quality indicators in the 2022 to 2023 Commissioning for Quality and Innovation (CQUIN) with a goal of vaccinating between 70% to 90% of staff. However, it should be noted that this funding has already been received and is in the baseline. There is no risk of financial penalty for not achieving targets.

OVERVIEW OF LAST YEAR'S CAMPAIGN

The campaign was modelled on the previous year which included flu leads taking full control of their allocated area. However, for the first time the campaign was a run with the support a clinical lead who was released for a proportion of time from their substantive role. This has been approved for 2022/23 by Executive Leadership Committee (ELC) and is in place.

Executive Leadership Committee (ELC) and Resources Committee have received a more detailed analysis of learning from last year's campaign but in summary the following are the key areas of learning and improvement for 22/23.

- **Clinical Lead** – having a clinical lead in the 21/22 campaign improved governance and co-ordination and

is replicated along with additional administrative support for this campaign.

- **ESR Training modules –** Refresh of ESR training. Provide additional guidance for vaccinators on the completion of ESR training modules to resolve previous technical delays.

- **Data and Reporting -** Vaccinators will input vaccinations on both Flumis and NIVS at the Point of Care (POC) to maximise reporting and monitoring capability. This will be supported by regular dashboards to support how we drive the campaign.

- **Flu fridges –** full review of fridges for consideration of either repair or replacement

- **Vaccinator Numbers –** focus is being given to reduce overall numbers of vaccinators with the use of light duties staff as a core full time vaccinators to improve overall governance and reduce operational abstractions.

FLU CAMPAIGN 2022/23

To commence this year's campaign, the Trust has procured 5000 Seqirus vaccines. This is a single vaccine and is suitable for all ages and is egg free.

The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model.

It is proposed to replicate the project team model used last year with the inclusion of a clinical lead and administrator and leadership from with HR and the medicines management team.

COMMUNICATION AND ENGAGEMENT

The Communications Plan has been developed and will be clinically led in terms of messaging with senior management role modelling. Board will be given the opportunity for vaccinations to show visible support for the campaign. Based on learning from previous years and from other Trusts, the best approach to engage staff to have a vaccination comes from their management teams. It is therefore intended that there is clear engagement from management teams to support the flu leads and directly encourage staff to have the flu vaccine.

FLU CHECKLIST

The annual flu checklist has been prepared and is included in Appendix1. This provides a summary of the more detailed information in this report and provided previously to ELC and Resources Committee and is designed to provide public assurance to the Trust Board that robust plans are in place.

COVID-19 VACCINATIONS

The latest advice from the Joint Committee on Vaccination and Immunisation's (JCVI's) indicates that an autumn booster programme will be offered to identified groups including frontline health and social care workers.

<table>
<tr><td></td><td colspan="4">It is clear that in the main staff will need to access their booster jabs via the national booking line and community provision, as very few hospital hubs will be in a position to offer vaccination to our staff. This does pose a risk for the Trust, particularly in respect of the lack of oversight of COVID vaccination rates.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors are asked to:
• Receive assurance of the plans for delivery of the annual flu vaccination campaign.
• Note the access to COVID vaccination boosters for our staff.
• Support Communication plans through Board role modelling of vaccination.</td></tr>
<tr><td>CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☒ Financial/ VfM
☐ Compliance/ Regulatory
☒ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td colspan="5">INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☒</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Executive Leadership Committee & Resources Committee</td></tr>
<tr><td>Date:</td><td colspan="3">20/07/22 & 23/09/22</td></tr>
<tr><td>Outcome:</td><td colspan="3">Annual flu vaccination programme supported</td></tr>
</table>

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1. PURPOSE

1.1 The purpose of the paper is to provide assurance to the Board of Directors that the best practice checklist in relation to flu preparations has been followed and robust plans are in place for the 2022/23 Campaign.

2. BACKGROUND

2.1 The Department of Health and Social Care issued its annual letter in April 2022 and highlighted that as a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, reduced social interactions and international travel) flu activity levels were extremely low globally in 2020 to 2021 and at present continue to be low. As social contact returns to pre-pandemic norms there is likely to be a resurgence in flu activity in winter 2022 to 2023 to levels similar to or higher than before the pandemic. As such it is particularly crucial this year that the Trust encourages its workforce to take up the offer of a flu vaccine.

2.2 Last year's campaign was based on achieving a 100% offer with an 85% ambition of uptake amongst frontline health care workers. The Trust achieved a vaccination rate of 56.5%. It should be noted that this was around the average vaccination uptake across the majority of trusts in the sector. This was impacted by the COVID vaccination booster programme and the Vaccination as a Condition of employment (VCOD) announcements which coincided with the campaign.

2.3 This year the flu programme is aligned with one of the quality indicators in the 2022 to 2023 Commissioning for Quality and Innovation (CQUIN) with a goal of vaccinating between 70% to 90% of staff. However, it should be noted that this funding has already been received and is in the baseline. As such there is not a financial penalty should the Trust not reach the targeted vaccination rate.

2.4 The annual letter also states that all frontline health care and social care workers should be offered vaccination by their employer, placing emphasis on the responsibility of employers to help protect their staff. The expectation set is that employers should commission or implement a vaccination programme which makes access to the vaccine easy for all frontline staff, encourages staff to get vaccinated, and monitors the delivery of their programme. Last year a number of staff accessed the flu vaccine from a variety of sites offering the vaccination to NHS staff. However, this complementary NHS flu vaccination offer for frontline NHS staff to access from other vaccinations sites has not been extended for the 2022 to 2023 influenza season.

2.5 As a result, the Trust needs to ensure that is a fully supported and resourced flu campaign to ensure that all staff have the opportunity for a vaccine.

3. OVERVIEW OF LAST YEAR'S CAMPAIGN

3.1 Last year's campaign was based upon learning from both previous flu campaigns, but also the COVID vaccination campaign which ran in early 2021. A detailed review of the learning from last year's campaign has been provided to the Executive Leadership Committee and the Resources Committee.

3.2 The lessons learnt from last years campaign should be considered against the context of the period of the campaign. As highlighted, there was a general apathy amongst health care workers to receive the flu vaccination last year given the roll out of the Covid vaccine and boosters and the issues arising from vaccination as condition of deployment (VCOD). As such it is difficult to assess what worked well or could be improved. However, the following provides a summary of the key areas of learning.

3.3 **Project team**

Ensure there is a core project team in place that includes the recurrent funding of the following posts for the duration of the campaign:

- **Clinical lead** – to replicate the clinical lead duties undertaken in the 2021/22 campaign. A clinical lead was a new role for the 21/22 campaign and supported improved governance and co-ordination.

- **Administrator** – to support collation of Trust level reports, national returns and oversee and troubleshoot any vaccinator access requirements for Flumis and NIVS

3.4 **ESR Training modules**

Improvements to the ESR training modules will be made based on feedback from vaccinators and actions to address technical issues experienced. The Trust has decided to continue with the use of a PGD to cover vaccination governance.

3.5 **Data and Reporting**

Vaccinators will be asked to input vaccinations on both Flumis and NIVS at the Point of Care (POC). This will ensure accuracy of data and help to meet the requirement for all vaccinations to be inputted onto NIVS within 7 days.

As frontline staff all have access to iPads this will support this approach. In case of a loss of IT access, paper forms will be available for use, but will require vaccinators to input onto both Flumis and NIVS at the earliest opportunity.

Discussions have also commenced within the Quality Directorate around options to develop a dashboard with an overview of vaccine uptake on a Trust and sector level. It is hoped this will allow flu leads and Heads of Operations to support the management of the vaccination campaign in their areas.

3.6 **Flu fridges**

Last year there were reported incidences of fridges failing and these were managed on a case by case basis. For this year there is a review of all fridges in the Trust to consider suitability and the potential relocation to key sites. In addition, a replacement programme for older fridges will be put in place for this year.

There is also a review of the process for temperature breaches including monitoring, actions and responses to alarms received. These actions will support the overall improvement in cold chain management.

3.7 **Vaccinator Numbers**

Last year's campaign delivery model was based on trying to reduce the number of trained vaccinators to support ongoing operational pressures. A total of 95 vaccinators were trained last year and this was a significant reduction in the 297 vaccinators who were trained during 2020/21. The reduction in vaccinators helped to strengthen the overall governance issues around the vaccination programme including the monitoring of vaccinators and their adherence to completing the required training modules. There is a focus on trying to utilise alternative duties staff where possible to support this year's campaign and reduce abstractions.

4. FLU CAMPAIGN 2022/23 – DELIVERY MODEL

4.1 The approach for this year's campaign is based on the learning outlined from last year's campaign along with noting the contents of letter issued in April 2022 by Department of Health and Social Care.

4.2 To commence this year's campaign, the Trust has procured 5000 Seqirus vaccines. This is a single vaccine and is suitable for all ages and is egg free. This addresses equality concerns enabling us to deliver to all age groups, address religious and lifestyle concerns.

4.3 The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involves the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.

4.4 However, for staff who are in site-based roles such as in our contact centres, corporate sites, the existing approach of advertising flu clinics will remain in place. In the past we have also put specific clinics into place for PTS staff and in particular those in GM who are not necessarily on the same sites as PES staff. It is proposed that a similar approach for PTS is taken for this year's campaign.

5. PROJECT TEAM

5.1 The flu campaign is led by the Corporate HR Team in conjunction with the Medical Management team.

5.2 As in previous years the Corporate HR Team will support the overall project, provide administration support, ensure that all designated vaccinators have access to vaccinations recording systems and have the appropriate training on the use of the system. The Corporate HR team also take a lead on fulfilment of national reporting requirements.

5.3 The Medical Management Team, along with the Chief Pharmacist support the overall leadership and governance of the project, whilst also taking an overall lead in a number of areas including the procurement of vaccines, cold chain management and overall stock management. In addition, the team also lead on the review of the training modules that all vaccinators must complete

5.4 Last year the project team also included a clinical lead and this role had a remit to oversee all vaccinators to ensure that those who are administering vaccines were fully trained, HCPC / NMC registered, engaged with the flu leads, chairing regular project meetings and oversaw the management of training and competence assessments for the vaccinators. The role also had a remit to trouble shoot clinical issues throughout the campaign. As outlined above ELC have approved implementation of this role for the six-month duration of the campaign. This will also be supported by a dedicated administrator.

5.5 Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.

6. COMMUNICATION AND ENGAGEMENT

6.1 The communications plan has been developed in line with previous years. The plan will largely reflect last year's plan with social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support for the campaign in the form of social media and bulletin features. Arrangements will be made for a face to face opportunity for Board vaccinations once vaccinations arrive on site.

6.2 Based on learning from previous years and from other Trusts, the best approach to engage staff to have a vaccination comes from their management teams. It is therefore proposed that there is clear engagement from management teams to support the flu leads and directly encourage staff to have the flu vaccine. Last year the aim was to try and encourage the majority of vaccines to be offered within the first 8 weeks of the campaign, prior to the commencement of winter pressures. It is proposed that the same approach should be encouraged this year. Further consideration will be given on providing flu leads with monthly targets to aim for in order to help encourage offers to all staff. The intention would be that monthly targets would be set and would then be supported and managed by local Heads of Operations.

7. FLU CHECKLIST

7.1 The annual flu checklist has been completed and is included in Appendix 1. This document aims to provide assurance to the Trust Board that all the core components of a successful flu campaign have been implemented or are built into plans. The checklist reflects a summary of the plans. It has been presented to Resources Committee and supported as an appropriate representation of detailed plans.

8. COVID-19 VACCINATIONS

8.1 The latest advice from the Joint Committee on Vaccination and Immunisation's (JCVI's) indicates that an autumn booster programme will be offered to identified groups including frontline health and social care workers.

8.2 In previous campaigns staff have been able to access vaccinations via a number of hospital and community sites. The remit of hospital hubs has now narrowed with them in the main only being resourced to vaccinate their own staff and in patients. As a result, our staff are in the main being directed to access appointments via the national booking line and convenient local community provisions.

8.3 Whilst we are confident that this will provide robust local access, we are unlikely to be able to monitor uptake from our staff as we do not have access to the national systems which

would enable reporting. Despite this we will continue to actively promote and encourage booster uptake.

9. LEGAL and/or GOVERNANCE IMPLICATIONS

9.1 There are no legal implications from this report.

10. RECOMMENDATIONS

10.1 The Board of Directors are asked to:

- Receive assurance of the plans for delivery of the annual flu vaccination campaign.
- Note the access to COVID vaccination boosters for our staff.
- Support Communication plans through Board role modelling of vaccination.

Appendix A

HCW Flu Vaccination Best Practice Management Checklist

For public assurance via trust boards by December 2022.

A	**Committed leadership**	**Trust self- assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Commitment recorded through September public board meeting
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	The Trust has ordered 5000 vaccines which can be delivered to the majority of our staff taking into account age and religious belief.
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	Both Resources Committee and the Board of Directors have received an evaluation of learning from the 2021/22 flu programme and the in house delivery of COVID vaccination and how changes have been built into the 2022/23 programme. Presented to September meetings.
A4	Agree on a board champion for flu campaign	The Director of People will be the champion for the Flu campaign.
A5	All board members receive flu vaccination and publicise this	Plans will be put in place once the campaign commences to ensure the opportunity for take up by Board and this forms a clear part of the communications campaign
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Cross functional flu team has been established. Strengthened this year by a clinical lead. Trade Unions briefed at JPC September and involved in campaign.
A7	Flu team to meet regularly from September 2022	Regular meetings already commenced.
B	**Communications plan**	

A	**Committed leadership**	**Trust self- assessment**
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Communications campaign will include clinical and evidence base with direct support from Medical Director, Chief Pharmacist, Chief Consultant Paramedic and Assistant Director of Nursing.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Individuals will be invited to drop in clinics prior advertised in the weekly bulletin. Mobile vaccination will be led by local Flu Coordinators with both regional and local communications.
B3	Board and senior managers having their vaccinations to be publicised	Board and senior manager commitment to uptake and subsequent publicity.
B4	Flu vaccination programme and access to vaccination on induction programmes	Vaccination will be offered at induction.
B5	Programme to be publicised on screensavers, posters and social media	Range of communications methods included in the plan
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Flu leads will have access to daily reporting through the FLUMIS system to enable them to target uptake but weekly reports will also be circulated to senior leaders and will be shared with the Executive Leadership Committee.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	The Trust approach is to identify a small cohort of dedicated vaccinators who will work at either the static sites or on a roaming model. The number of vaccinators has been build based on previous experience.
C2	Schedule for easy access drop in clinics agreed	Appointments in drop in clinics will be made available in advance of the campaign
C3	Schedule for 24 hour mobile vaccinations to be agreed	Schedule for roaming vaccination will be agreed but flexed based on data as the campaign progresses

A	**Committed leadership**	**Trust self- assessment**
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Incentives are not being offered this year because of the interplay with the COVID booster vaccination.
D2	Success to be celebrated weekly	This forms part of the flu communications plan.

REPORT TO BOARD OF DIRECTORS

DATE:	28th September 2022					
SUBJECT:	EDI Regulatory reporting – Gender Pay Gap, WRES, WDES					
PRESENTED BY:	Lisa Ward, Director of People					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	
	☒	☐	☐	☒	☒	
	SR06	**SR07**	**SR08**	**SR09**	**SR10**	**SR11**
	☒	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	This paper provides an overview of Equality data along with an end of year position relating to these three areas of workforce equality – race, disability and gender. The data has identified areas for focus over the next twelve months and the paper will consider how these actions align against the agreed ED&I priorities that were agreed by the Board in January 2021 along with any other actions or development. **WRES** The WRES data for 2021 is set out in Appendix 1. Whilst there are some areas of improvement, in the main it shows a worsening with regards the experiences of colleagues from black and minority ethnic backgrounds (BAME). While some of the metrics are positive, the data indicates that further work is required. The headcount of BAME staff saw a slight decrease over the last year equating to a reduction of 0.2% from 5% to 4.8% of the overall workforce. The challenges in relation to the recruitment agenda over the last year have already been discussed at the D&I Sub-Committee. As detailed in ED&I Priorities action plan, we are aiming to achieve 8% BAME representation in the NWAS workforce by 2024. As such further work is required to ensure we reach this stretch target. Data relating to the recruitment and appointment of BAME staff, the data with regards likelihood of being appointed to an NWAS role shows a worsening of the position. The paper details the restrictions on the accurate reporting abilities of					

the recruitment system Trac. However, work is ongoing to track BAME candidates during mass recruitment campaigns to look at how to support and signpost staff with an overall aim at increasing the BAME representation in the workforce.

The report also considers the data in relation to disciplinary cases and shows that the likelihood of BAME staff entering the formal disciplinary process has also worsened, with work ongoing to look at the reasons for this. The Disciplinary Policy is under review.

Positively, the data around mandatory training and CPD access shows no difference in the likelihood of access for BAME staff when compared to white staff. This has been an area of challenge in previous years.

The staff survey results for BAME staff show a mixed picture and the report discusses the areas of focus for the forthcoming year.

WDES

This the fourth year of reporting for WDES and Appendix 2 details the themes of the nationally set WDES metrics.

The data shows an overall increase in the representation of disabled staff at most levels of the organisation. Data in relation to recruitment has shown an increase in the raw number of disabled candidates appointed from shortlisting from the previous year but a slight worsening in the likelihood of appointment from shortlisting measure.

Metric 3 looks at staff entering the formal performance process. The figures have significantly improved from last years likelihood score of 2.71, to a score this year of zero.

Metrics 4 to 8 are staff survey scores and Metric 9 is an engagement score, calculated using several scores together. The staff experience of disabled staff was overall poorer on each factor than for non-disabled staff. Overall, the results indicate a mixed picture with good improvements in the experience of disabled staff in relation to harassment and bullying from the public and managers but a worsening of experience in other areas such as career progression. Work to support the experience of disabled staff needs continued focus to understand how the Trusts can support and engage with our disabled staff.

GENDER EQUALITY

Appendix 3 details the data collated for the gender pay gap submission. This data is collated as at 31st March 2022.

The data shows an ongoing increase in the number of female staff in the workforce from 51.24%. to 51.60%. The pay quartile information shows that female representation

	has also increased in the upper quartile from 34.18% in 2019 to 37.78% in 2022. The data also shows that female representation in the lower quartiles of pay which is where a significant amount of our recruitment takes place has reduced in the last year from 60.95% to 55.10%. Alongside this there has been a 2% increase in the lower to middle and upper middle quartiles, suggesting that female staff have been progressing from the lower pay quartile. There has been an overall decrease in the pay gap mean and median gaps. Overall the picture is positive and reflect that some of the actions taken under the ED&I priorities plan, specifically around recruitment, are starting to embed and make a positive impact. **TRUST WIDE ACTIONS** The WRES, WDES and gender pay gap data provides an important benchmark to assess the impact of ongoing work to support minority groups and address inequalities in the workplace. The worsening position we have seen in a number of metrics this year reflects some of the challenges experienced overall within the Trust in relation to operational pressures and capacity to focus on the diversity agenda. The Trust has committed to three key priorities and the work to deliver these will remain the main focus on the actions being taken in the Trust, supported by engagement through the networks on specific issues. The workplan for the sub-committee over the year will focus on assurance against the following key workforce related actions: • Improvements to recruitment with the aim of improving representation and shortlisting to appointment metrics • Improvements to career progression and development processes to improve fairness and support improvements in appointment to shortlisting, staff survey scores and representation across the organisation. • Leadership development aimed at developing overall compassionate leadership approaches but with specific Inclusive leadership modules which should impact positively on staff survey results • Continued support for networks In addition, work associated with the Disciplinary Policy review, the wellbeing passport and the focus om addressing and supporting improved mental health should all contribute to improvements in key metrics.
RECOMMENDATIONS:	The Board of Directors is recommended to:

	• Note progress on the work undertaken relating to WRES, WDES and Gender Pay Gap agendas • Note the planned activities relating to improve the race, disability and gender metrics over the next 12 months • Approve the publication of the data presented
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee/Resources Committee			
	Date:	21st & 23rd September 2022		
	Outcome:	ELC recognised the requirement for organisational wide action to address the adverse metrics and considered how the challenging conversations being held at a senior level could better translate into wider actions across directorates. Both Committees endorsed the requirement to continue to focus on the key priorities set by Board with close monitoring through the EDI sub-committee.		

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1. PURPOSE

1.1. The purpose of this paper is to provide the Board of Directors with the most recent workforce data in relation to race, disability and gender which the Trust is required to publish.

2. BACKGROUND

2.1. The Trust has a legal responsibility to publish gender pay gap data on an annual basis. In addition, there is a contractual requirement under the NHS Contract to publish annual data in respect of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

2.2. Working to address inequalities identified by the workforce data demonstrates compliance with the Equality Act 2010 and the Public Sector Equality Duty.

2.3. This paper and associated appendices, set out an overview of the data for 2021-22 relating to workforce information around race, disability and gender.

2.4. The data has identified areas of focus for the coming year, and this paper considers how the intended actions align to the ED&I priorities confirmed by the Trust Board in January 2021.

2.5. The three priorities are:

- We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
- We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.
- We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities

2.6. The priorities have been agreed for a three-year period and each have specific measures identified to monitor progress. Additionally, they form the basis of our statutory equality objectives.

3. WORKFORCE RACE EQUALITY STANDARD (WRES)

3.1 The WRES data for 2021 is set out in Appendix 1.

3.2 This data relates to the period of 1st April 2021 – 31st March 2022. In line with nationally mandated timeframe, the data was submitted to NHS England in August 2022. As in previous years, the data includes results from the national Staff Survey which has been previously shared with ELC and the D&I Sub-committee.

3.3 In the main it shows a worsening with regards the experiences of colleagues from black and minority ethnic backgrounds (BAME). While some of the metrics are positive, the data

indicates that the challenges of the last year have impacted on experiences and further work is required.

3.4 The headcount of BAME staff saw a slight decrease over the last year, falling from 342 in 2021 to 325 at the end March 2022, equating to a reduction of 0.2% from 5% to 4.8% of the overall workforce. This was the first time that BAME numbers had reduced since 2019.

3.5 The Trust is committed to developing a representative workforce of the communities we serve, thereby improving the overall BAME representation within our employee numbers. As detailed in ED&I Priorities action plan, we are aiming to achieve 8% BAME representation in the NWAS workforce by 2024. This however requires significant effort to ensure 20% of our new recruits each year are from ethnically diverse backgrounds.

3.6 An additional Positive Action Officer has recently joined the Inclusion & Engagement to add capacity, help support and increase our outreach into communities across the North West.

3.7 Furthermore, the establishment of a new cross directorate ED&I Recruitment Management Group will help maintain a focus on achieving our ambitions around a representative workforce. The work of this group will be informed by an external audit of our recruitment processes which is being commissioned from ENEI.

3.8 The remit of the group is around reviewing and overseeing the implementation of the action plan to support Priority 1 of the ED&I Corporate Objectives in respect of recruitment in the following areas:

- We will use targets to drive improvements in recruitment
- We will proactively seek to attract candidates from under-represented groups
- Support applicants who may face barrier in our recruitment process
- Diversify each stage of the recruitment process from shortlisting the interview panels

We will learn from the experiences of staff and applicants and make changes in response.

3.9 When looking at data relating to the recruitment and appointment of BAME staff, the data with regards likelihood of being appointed to an NWAS role shows that White staff are nearly twice as likely (1.98) to be appointed from shortlisting compared to BAME staff. This metric has worsened compared to last year which was 1.51 and when trying to explore the reasons for this, an issue was identified in relation to the restrictions with the data which is pulled from the recruitment system, Trac.

3.10 Discussions with Trac have identified that the data based on a financial year only considers recruitment campaigns that have been completed within that financial year. A campaign is considered completed on Trac at the point that all appointees from a campaign have commenced in post. As such if there is a vacancy that opening on 1 March 2022 and the individual does not commence in post until 15 April 2022, this recruitment will not be counted in the data.

3.11 A further note to this point is that the Trust manages several mass recruitment campaigns each year such as for EMT 1 and EOC call taking positions and time period between the offer and start date can be lengthy and cover two financial years. In addition, in the scenario of mass recruitment campaigns, there may be some applicants who are delayed

in starting on a course. The system will only fully complete a vacancy at the point when every individual in offer has started. In the case of mass recruitment campaigns this will lead to distorted data as often there can be up to twelve months between a campaign opening and the last individual commencing on a training course. As a result the data that is requested for the WRES submission does not accurately reflect our actual position. Whilst the issue around Trac reporting restrictions is not new, the impact of some of the previous recruitment through the pandemic, will have only shown on this years submission. In addition, whilst we have conducted a lot of recruitment in EOC via an agency in the last two years, a significant proportion the agency staffing have transferred onto Trust contracts since April 2022.

3.12 Whilst this is disappointing, a number of Trusts use Trac so the issue will not be unique to our Trust. However, within in the ambulance sector, this issue will be fairly unique as the prevalence of length mass recruitment campaign is uncommon in the acute sector.

3.13 We have however started to track BAME applicants through each stage of the recruitment process to understand where applicants may withdraw or fail, with the view of providing onward support or signposting. Whilst this does not help our external reporting at this point, this does provide some internal intelligence to provide learning for our recruitment processes.

3.14 Data relating to staff entering formal disciplinary processes has also shown a worsening with BAME staff now being more than twice as likely (2.23) to enter the formal disciplinary process compared with White staff. This metric saw a slight improvement from 2020 to 2021 (1.89 to 1.70) but has gone up in the last year. The numbers of individual staff is small (7) which does mean that the impact on the measurement is higher for each individual, however, this remains a worsening position. Last year there were 8 BAME staff who entered the disciplinary process out of a total of 101 cases. However this year there were 7 BAME staff out of 80 cases, so proportionally the cases have risen for BAME staff even though the number has fallen.

3.15 An exploration of the reasons for this rise are being investigated with the HR Business Partnering Team. In addition, the Disciplinary Policy is currently under review at Policy Group with an aim to focus on learning and managing cases in a pragmatic way. Once the revised Policy is in place this should also help to reduce this metric in the future.

3.16 With regards data on the likelihood of BAME staff accessing non-mandatory training and CPD as compared with White staff, this has improved considerably with there now being virtually no difference between the experiences of White and BAME staff.

3.17 The data shows a figure of 1.01 while the target figure is 1.0 which would indicate no difference in likelihood of accessing non-mandatory training and CPD.

3.18 A number of metrics within the WRES relate to the results of the Annual Staff Survey. These include questions around:

- experiencing harassment bullying or abuse from patients/relatives or staff
- equal opportunities for career progression or promotion
- experiencing discrimination at work from manager/team leader or other colleagues

3.19 The percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months has seen a decrease for both White and

BAME staff. 37.1% (38.2% in 2020) of BAME colleagues in the Staff Survey reported experiencing harassment etc, compared to 40% (43.5%) of White staff. This reduction could be down to several factors including an ongoing communications campaign on the importance of treating our staff with respect. The ongoing work with the Violence and Aggression group will maintain a continued focus on reducing this data. However, there has been an increase in the percentage of BAME staff experiencing bullying, harassment, or abuse from other staff compared to the previous year – 29.5% in 2021, 24.2% in 2020. For White staff on the other hand, there has been a reduction of nearly 2% in the same metric, and a lower number of staff in this demographic have reported experiencing harassment etc – 23.6% in 2021, 25.7% in 2020.

3.20 The results in these areas are of a particular concern and do not reflect the HR case work data. Over the last year the Trust has launched campaigns on the Trusts values and the Treat Me Right Campaign, both of which should have supported a positive movement in this area. However, there are clearly some key issues which need to be uncovered to understand the meaning behind the data. Discussions are ongoing with the REN Network to try and understand the meaning behind the data and to try and identify specific actions to tackle these issues but there has been no indication of increased issues being raised formally or informally so understanding the cause is proving difficult.

3.21 The Staff Survey also looks at the perception of whether the Trust provides equal opportunities for career progression or promotion. The data indicated the number of staff believing there has also been a decrease in opportunities for career progression or promotion from BAME colleagues – 39.1% in 2020 to 33.6% in 2021. The response from White colleagues has followed the same trend on this question as BAME staff, but not to the same extent. A project has been commenced to look at career progression and promotion processes within the Trust seeking to address the overall negative trend in this staff survey data.

3.22 One of the most significant results of the Staff Survey was from the questions relating to the percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues. For BAME staff, the number jumped from 8.6% in 2020, to 22.4% in 2021. Response from White colleagues remained virtually static. Networks have been asked to incorporate specific actions into their annual action plans to explore this issue and assurance have been sought by the ED&I Advisor.

3.23 Results from the Staff Survey with a deep-dive of the findings broken down by equality groups were shared with ELC, Trust Sub-Committees and Staff Networks for information and planning.

4.0 WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

4.1 This is the fourth year of reporting for WDES and Appendix 2 details the themes of the nationally set WDES metrics. This was submitted to NHS England in August 2021 and is based on data as at the end of March 2021.

4.2 The data shows an overall increase in the representation in most levels of the organisation. The increase in the percentages reported can be explained in part due to an internal communications campaign aimed at encouraging staff to record and update their disability status on My ESR. This work was driven by the Disability Network and aims to ensure that the Trust has an accurate record of staff representation.

4.3 There remain 642 staff who have a 'null' or 'disability unknown' record in their ESR record. However, this is a significant decrease from 805 staff who reported a null category in last year's submission. Work will continue to encourage staff to declare their status and to amend it when it alters, along with other protected characteristics that can be recorded in ESR.

4.4 Data in relation to recruitment has shown an increase in the raw number of disabled candidates appointed from shortlisting from the previous year. This is positive and may also reflect the increase in the number of candidates declaring their disability status. As with the WRES data, the collection of protected characteristic information during the recruitment stage has been impacted by the Trac reports and the limitations with the data reports.

4.5 The additional Positive Action Officer will also have a specific focus on encouraging applications from candidates with a disability and sharing case studies of our staff who have disabilities and the adjustments that have been made by the Trusts.

4.6 Metric 3 looks at staff entering the formal performance management process, this excludes sickness capability processes and focuses on performance management only. The figures have significantly improved from last years likelihood score of 2.71, to a score this year of zero.

4.7 This suggests that staff with a disclosed disability or no more or less likely to enter a formal capability process. Whist the number of overall staff who enter the formal performance process is low, it is pleasing that the data indicates this position for disabled staff. Work will however, continue to ensure that this position remains.

4.8 Metrics 4 to 8 are staff survey scores and Metric 9 is an engagement score, calculated using several scores together. The 2021 Staff Survey results have been shared with the Committee earlier in 2022. The staff experience of disabled staff was overall poorer on each factor than for non-disabled staff.

4.9 The questions relating to the number of disabled staff experiencing harassment, bullying or abuse from managers or from patients, service users, their relatives or members of the public, do reflect a positive trend with improved experience for disabled staff. Harassment or bullying from colleagues has remained fairly static but overall in these indicators there has not been a narrowing of the gap in experience compared with non-disabled colleagues.

4.10 The questions relating to perceptions in relation to fairness of career progression, pressure to attend work and reasonable adjustments all show a reduction in positive responses and a widening of the gap in experience with non-disabled staff.

4.11 The overall gap in experience between disabled and non-disabled experience measured through the Feeling Valued metric shows a worsening experience for both disabled and non-disabled staff but a narrowing of experience gap by almost 1%.

4.12 Overall, the results indicate a mixed picture and that work to support the experience of disabled staff needs continued focus to understand how the Trusts can support and engage with our disabled staff.

4.12 The actions under the ED&I priorities seek to ensure improvement for all diverse groups and there will be continued work with the Disability Network to ensure that specific actions for our disabled staff are identified and addressed.

5.0 GENDER EQUALITY

5.1 Appendix 3 details the data collated for the gender pay gap submission. This data is collated as at 31st March 2022. The Trust has until March 2023 to publish this data to meet statutory requirements.

5.2 The data shows an ongoing increase in the number of female staff in the workforce from 51.24%. to 51.60%.

5.3 The pay quartile information shows that female representation has also increased in the upper quartile from 34.18% in 2019 to 37.78% in 2022. This indicates a sustained level of improvement in addressing representation in progression in NWAS. It remains the fact that this quartile shows the greatest gap in representation.

5.4 The data also shows that female representation in the lower quartiles of pay (broadly bands 1-3) which is where a significant amount of our recruitment takes place has reduced in the last year from 60.95% to 55.10%. However, there has been a 2% increase in the lower to middle (bands 3-5) and upper middle quartiles (bands 5-6), suggesting that female staff have been progressing from the lower pay quartile. The data in the Upper middle quartile shows a fairly even spread of representation between genders and this will support improvements in the Upper quartile (bands 7 and above) over time.

5.5 There has been an overall decrease in the pay mean and median gaps. The mean calculation has decreased from 10.89% to 9.8%. The pay gap using the median calculation has also decreased from 9.26% to 8.66% this indicates that there is an improved position for our female staff. As detailed in the Appendix 3, the position worsened considerably last year and it is pleasing to see that the position is now showing a positive trend.

5.6 Due to the clarification of the scope of the calculation for the bonus payments under the Gender Pay Gap, there is some ongoing work to finalise this years information. This has been reviewed as a sector, based on legal advice provided by NHS Employers and will require us to report additional information under the bonus payments category such as the short term retention payments in 111. Once this information is finalised it will be reported through the Committee structure.

5.7 Overall the picture is positive and reflects that some of the actions taken under the ED&I priorities plan, specifically around recruitment, are starting to embed and make a positive impact.

6. TRUST WIDE ACTIONS

6.1 The WRES, WDES and gender pay gap data reflect the ongoing work to support minority groups and address inequalities in the workplace. Whilst there has been some worsening

of the position with some of the data, the continued focus on the data will help to develop actions to support improvement.

6.2 The intention is to continue the work already set through the EDI Priorities. These priorities were chosen as the key areas to influence in order to deliver an improvement in experience. Other areas of data will be picked up by individual teams e.g. such as improvements in disciplinary practice through the Policy review and continued roll out of the wellbeing passport to support reasonable adjustments.

There will be a continued focus through Priority 1 to look at the fairness of recruitment and progression across key protected characteristics which will support the overall strategic intent of this priority. This work is being reported separately to the D&I sub-committee and forms part of our overall priorities. These actions should improve the representation, gender pay and appointment from shortlisting data.

6.3 The key areas of work being progressed this year under the priorities are as follows:

- improvements in the attraction and recruitment of BAME staff. Additional investment has been made in outreach capacity, an independent audit of our processes through a diversity lens is being commissioned and a cross functional steering group to drive changes in practice is being established
- a project has commenced to review progression and promotion and development pathways, to address the overall worsening of the perceptions of fairness in career progression. This will consider and seek to address the barriers to progression and explore options for positive action
- The introduction of Beyond Bias Training and Leadership for Inclusion learning modules are aimed at identifying the types of bias that can exist in the workplace and how highlighting the impact that this can have. This should support improvements in staff survey scores related to harassment and discrimination. Beyond Bias is due to commence delivery in Q3.

6.4 In addition to the above, the ongoing work around mental health is aimed at educating managers and staff on the risks of suicide within the workplace, promoting good practice, and encouraging healthy conversation to remove the stigma often associated with mental health problems. This should support improvements in disability scores particularly around feelings of value and pressure to attend work.

6.5 The recruitment of a fixed term appointment of a consultant psychologist to critical analyse and support the mental health support offer for staff will help to improve the experience of our disabled staff.

6.6 The staff networks continue to embed themselves within the Trusts and this provides a platform to discuss and analyse the results with an aim to identify key areas for improvement and organisational learning.

7. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

7.1 As stated above, the WRES and WDES metrics and action plans are to be published in line with the commitments of the NHS Contract. The submission and publication of gender pay gap information is a legal requirement for an organisation of more than 250 staff.

8. EQUALITY OR SUSTAINABILITY IMPACTS

8.1 The work around WRES, WDES and the Gender Pay Gap supports our commitment to ensure compliance with the Equality Act 2010 and with the Public Sector Equality Duty.

8.2 The work contributes to the Well Led domain of the CQC priorities, but the impact is felt across all areas.

9. RECOMMENDATIONS

9.1 The Board of Directors is asked to:

- Note progress on the work undertaken relating to WRES, WDES and Gender Pay Gap agendas
- Note the planned activities relating to improvement of the race, disability and gender metrics over the next 12 months
- Approve the publication of the data presented

Appendix 1

Workforce Race Equality Standard (WRES) data
Collated: August 2022

1. **Workforce data – percentage of staff BAME / White categories**

	Data as of 31 March 2019	Data as of 31 March 2020	Data as of 31 March 2021	**Data as of 31 March 2022**
Total workforce	6356	6598	6807	**6815**
Number of BAME staff	286	304	342	**325**
% BAME staff in total workforce	4.5%	4.6%	5.0%	**4.8%**

2. **Recruitment data – relative likelihood of White staff being appointed from shortlisting compared to BAME staff**

	2020	2021	**2022**
Likelihood	1.29	1.51	**1.98**

The target figure is 1.0 which would indicate no difference in experience in likelihood of being appointed.

3. **Relative likelihood of BAME staff entering formal disciplinary process compared with White staff**

	2019	2020	2021	**2022**
Likelihood	1.32	1.89	1.70	**2.23**

The target figure is 1.0 which would indicate no difference in likelihood of entering formal disciplinary process.

4. **Relative likelihood of BAME staff accessing non-mandatory training and CPD as compared with White staff**

	2019	2020	2021	**2022**
Likelihood	1.45	1.31	1.34	**1.01**

The target figure is 1.0 which would indicate no difference in likelihood of accessing non-mandatory training and CPD.

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

	2017 survey	2018 survey	2019 survey	2020 survey	**2021 survey**
White	49.8%	47.0%	47.9%	43.5%	**40.0%**
BAME	45.7%	38.0%	34.6%	38.2%	**37.1%**

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

	2017 survey	2018 survey	2019 survey	2020 survey	**2021 survey**

White	27.5%	25.8%	24.5%	25.7%	**23.6%**
BAME	30.9%	27.5%	25.0%	24.2%	**29.5%**

7. **Percentage of staff believing that Trust provides equal opportunities for career progression or promotion**

	2017 survey	2018 survey	2019 survey	2020 survey	**2021 survey**
White	47.6%	52.6%	52.7%	51.3%	**47.8%**
BAME	30.5%	36.8%	38.8%	39.1%	**33.6%**

8. **Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues**

	2017 survey	2018 survey	2019 survey	2020 survey	**2021 survey**
White	13.4%	10.6%	10.6%	10.1%	**10.0%**
BAME	23.2%	12.80%	13.6%	8.6%	**22.4%**

9. **Percentage difference in board voting membership and overall workforce**

(This metric had previously collated data relating to the local population; it now looks at the current workforce).

	2019	2020	2021	**2022**
White	-17.2%	-5.9%	-5.5%	**-17.1%**
BAME	3.2%	1.3%	0.9%	**10.6%**
Ethnicity unknown / NULL as per ESR	14.0%	4.6%	4.6%	**6.4%**

Difference = (Total Board number - Overall workforce number)

Appendix 2

Workforce Disability Equality Standard (WDES) data
Collated: August 2022

Metric 1 – Workforce information

	Percentage of disabled staff			
	2019	2020	2021	**2022**
Non clinical staff – Cluster Bands 1 - 4	5%	4.7%	6.7%	**10.7%**
Non clinical staff – Cluster Bands 5-7	2%	3.5%	5.8%	**6.2%**
Non clinical staff – Cluster Bands 8a-8b	3%	0%	0.0%	**4.7%**
Non clinical staff – Cluster Bands 8c-9 and VSM	3%	2.6%	5.1%	**5.0%**
Clinical staff – Cluster Bands 1-4	3%	3.65%	4.5%	**4.5%**
Clinical staff – Cluster Bands 5-7	4%	4.05%	4.5%	**5.0%**
Clinical staff – Cluster Bands 8a-8b	2%	3.70%	5.2%	**6.9%**
Clinical staff – Cluster Bands 8c-9 and VSM	8%	7.69%	13.3%	**11.1%**

Metric 2 – Recruitment
This metric looks specifically at the likelihood of being appointed from shortlisting. The outcome is a figure of 1.0 and means that disabled candidates are no more or less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

	2019	2020	2021	2022
Likelihood	1.0	1.1	1.39	1.56

Metric 3 – Formal Performance Process
This metric was voluntary and not reported by NWAS in 2019. As with recruitment, a figure of 1.0 or below is desired as this would indicate staff with disclosed disabilities are no more or less likely to enter into a formal capability process with the Trust than staff without disclosed disabilities. Only the Performance policy is used by NWAS to calculate this figure, in line with the technical guidance; it does not include sickness capability processes.

	2020	2021	2022
Likelihood	5.52	2.71	0.00

Metric 4 – Staff Survey
This metric collates the data from four Annual National Staff Survey questions relating to bullying, harassment, abuse, discrimination and reporting such behaviours.

4.1. % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	45.8%	45.0%	42.1%	**37.8%**
Disabled	52.0%	56.2%	47.0%	**45.9%**

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

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	13.2%	11.8%	14.5%	**11.3%**
Disabled	25.8%	23.2%	22.1%	**18.6%**

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

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	15.6%	14.5%	15.5%	**14.1%**
Disabled	26.5%	26.7%	23.0%	**23.6%**

4.4. % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	38.2%	43.7%	43.4%	**43.8%**
Disabled	39.9%	49.1%	49.3%	**46.3%**

Metric 5 – Equal opportunities for career progression

The data from this metric also comes from the Staff Survey. It shows that 39.4% of disabled staff felt that the organisation provided equal opportunities for career progression compared with 49.7% of non-disabled staff feeling that there were equal opportunities.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	53.9%	53.7%	52.0%	**49.7%**
Disabled	43.3%	45.5%	44.9%	**39.4%**

Metric 6 – Attending work

The Staff Survey question relating to this metric asks about staff feeling under pressure to come into work from their manager when they don't feel well enough to perform their duties.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	32.6%	30.8%	29.5%	**28.6%**
Disabled	45.3%	44.0%	38.9%	**40.6%**

Metric 7 – Feeling Valued

This Staff Survey question asks about staff feeling satisfied with the extent to which the organisation values their work. The data showed that 27.5% staff with a disability felt satisfied with the extent to which the organisation values their work; this compares to 32.9% of non-disabled staff.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	36.7%	39.5%	35.2%	**32.9%**
Disabled	25.3%	29.1%	29.1%	**27.5%**

Metric 8 – Reasonable Adjustments

This Staff Survey question asks staff with a disability to advise whether the organisation has made adequate adjustments to enable them to carry out their work.

	2018 survey	2019 survey	2020 survey	**2021 survey**
Disabled	60.3%	58.6%	71.0%	57.8%

Metric 9 – Staff engagement

This metric provides an engagement score, calculated from 9 specific questions from the Staff Survey. There remains a gap between the engagement score for staff with and without disabilities in staff survey responses, and while the gap was narrowing in previous years, it has slightly increased in 2021.

Engagement score:

	2018 survey	2019 survey	2020 survey	**2021 survey**
Non-disabled	6.5	6.5	6.4	**6.2**
Disabled	5.7	5.8	6.0	**5.6**

This metric also asks whether the organisation has taken action to facilitate the voices of disabled staff to be heard, to which NWAS has said 'Yes'.

NWAS has held several Disability Forums to hear the voice of disabled staff. There have been different guest speakers to explain the experiences of having different conditions and how these can affect staff in the workplace. Proactive work has included the development of a Procurement Flowchart in response to queries about difficulties in understanding the process of purchasing equipment as part of a reasonable adjustment. The Disability Forum moved to Network status in the past 12 months and has created a terms of reference and action plan and is currently recruiting for committee members to support its objectives/aims.

Metric 10 – Board representation

The data again shows an overall underrepresentation of disabled people on the Board, voting membership and executive membership when compared with the overall workforce (-5%). This is due to no Board members having declared a disability which has been recorded on ESR; there are 4 of the 13 Board members who have not advised of their disability status.

Appendix 3

Gender Pay Gap as at 31st March 2022

The NWAS Gender Pay Gap data is as follows:

Hourly wages gap

	2018	2019	2020	2021	**2022**
Average hourly pay gap	7.9%	8.85%	8.79%	10.89%	9.80%
Median hourly pay gap	6.9%	5.42%	7.2%	9.26%	8.66%

Pay quartile information

	2019 F %	2019 M %	2020 F %	2020 M %	2021 F %	2021 M %	**2022 F %**	**2022 M %**
Lower pay quartile	54.85%	45.15%	55.26%	44.74%	60.95%	39.05%	55.10%	44.90%
Lower middle quartile	51.15%	48.85%	53.65%	46.35%	56.04%	43.96%	58.52%	41.48%
Upper middle quartile	47.13%	52.87%	46.81%	53.19%	47.43%	52.57%	49.42%	50.58%
Upper quartile	34.18%	65.82%	36.74%	63.26%	37.23%	62.77%	37.78%	62.22%

Bonus payments

The data on bonus payments is yet to be finalised.