NWAS Annual Report & Accounts 2020/21

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Foreword

Annual Report 2020/21 CEO & Chair Foreword

In last year's Annual Report, in this foreword, we talked about the challenge of COVID-19 and it would be true to say that none of us could have expected to be still facing those challenges a year on.

2020/21 truly has been a year which will be forever remembered, and in particular, how the NHS persevered at the forefront of the fight against a global pandemic.

Like many organisations whose staff were on the frontline, we sadly lost three very dear colleagues to COVID-19 and we would like to begin our look back on the year to pay our respects to those and all who have lost their lives while working to help others. They were the real heroes of 2020/21.

NWAS was no different to health organisations around the country, and indeed the world, when it came to having to adapt to and manage the impact of the virus. In the first quarter of 2020/21, we had already started to introduce new ways of working and caring for our patients and our staff. We are most definitely, a very different organisation to the one pre-pandemic. There have been lots of lessons learned along the way, some initiatives we have put in place will become permanent features, we have had to be bold and make decisions quickly and we have accepted that we are likely never to go back to fully how we were before COVID-19.

In some ways, this is a positive. The pandemic has forced our hand and made us look at how we work and what we can do differently which will benefit our patients, and the health and wellbeing of our staff. For example, the majority of our corporate teams have been home working for a good proportion of 2020/21, we have invested in technology which enables staff to communicate and meet with colleagues, without having to spend hours of their time on the road. Our corporate teams also took on new roles from supporting the command and control structure, to test track and trace and Infection Prevention Control, increased fleet services, all of which supported front line service delivery and patient care.

There has been increased emphasis on the health and wellbeing of staff. Those who were shielding were regularly contacted by managers, and where possible, new roles found for them so they could assist the trust while staying safely at home. We introduced two new bulletins to help boost morale – Wellbeing Wednesday and Feelgood Friday, welfare vehicles serving refreshments at hospital emergency departments and on our intranet, we created a dedicated section to provide financial, travel and health advice.

As you will read in this report, we have recruited more than 500 permanent frontline staff to help manage the demands the pandemic presented us with and as ever, we have been overwhelmed with the support of our volunteers. Approximately 300 stepped

forward and have assisted with the distribution of PPE, stewarding our vaccination hubs and joining staff on vehicles to help respond to patients. We are eternally grateful for their efforts, which equated to 120,000 volunteer hours – this kind of support was invaluable and we are sure we speak on behalf of all our staff and patients when we say thank you.

Due to the severity of the pandemic, the trust made the decision to pause some non-critical projects but some, namely those which were crucial for patient care and improved conditions for staff, we endeavoured to continue.

Our Patient Transport Service had to adapt to new ways of working, less patients due to social distancing and taking on new roles to support our 999 emergency service colleagues. Similarly we also received support from our military and blue light partners which allowed us to rapidly increase face fit testing, undertake additional driver training and deploy additional ambulance vehicles.

We were pleased to start trials for body worn cameras for our road staff – while it is sad that this is necessary, we felt that staff would want this to go ahead as part of the continued zero tolerance stance regarding violence and aggression. Into 2021/22, we will look carefully at the results of these trials and the impact on staff safety.

The trust also continued to push forward with the electronic patient records (EPR) project, with the launch of the trial taking place in Blackpool in the Autumn. This was our first move from paper based patient record forms to an electronic device which will store the patients information which can then be transferred directly to the hospital on arrival – transforming how we deliver, monitor and improve clinical care. Following the successful trial, the scheme was rolled out into other parts of the region and is due for completion in early 2021/22.

Throughout the pandemic, we were also accompanied by camera crews, in what some might say was one of our ‘bravest’ initiatives in 2020/21! Following our past success with the popular BBC series ‘Ambulance’, we were invited one more time to share our working lives with the public as part of series seven, due to be aired in the summer of 2021/22. Shadowing crews in Merseyside, Greater Manchester and, for the first time, Lancashire, the filming captured our frontline crews as they faced the unprecedented COVID-19 challenge. Previous processes just weren’t adequate for this round of filming so a great deal of additional work was done to ensure camera crews were as protected as our staff and that they were fully compliant with all infection control measures. The result is a reflective, heart-warming and accurate view of an ambulance service in the midst of an emergency situation and we do hope you enjoy watching when it is broadcast.

As an organisation whose sole remit is to serve and provide care for the people of the North West – their views, opinions, ideas and feedback is extremely important to us. Back in 2019, we launched the Patient and Public Panel to give members of the public a

voice and the chance to have their views acted upon. The panel is made up of representatives from local communities, interest groups, the voluntary sector and partner organisations, and offers meaningful opportunities to influence improvements in our emergency, patient transport and 111 services.

The panel has gone from strength to strength with more than 150 members who get involved at varying levels. In the last year, they have contributed to the updating of the pictorial handbook – an aide for staff when communicating with those hard of hearing or with language barriers.

We also invited members with experience of using non-emergency patient transport services to attend a dedicated focus group discussion run by NHS England to influence and shape the new eligibility criteria for the service. Members provided advice and feedback which has resulted in the eligibility criteria being redrafted.

Working with the panel gives us a better idea of what is important to our patients and we will continue to involve the panel in as many projects as possible. One of our objectives for the next year is to increase the number of young people on the panel and this work has already begun in earnest.

In spite of the challenges, we continued our focus on the learning and development of our staff and while there were some delays during the peaks of the pandemic, 96 apprentices successfully completed their training and moved to permanent positions with the trust.

Investing in the training of our staff brings about a wealth of positives in terms of additional skill levels and staffing for patient facing roles, and the feeling of pride for individuals as they take the decision to develop their career and improve their knowledge.

As the financial year came to a close, more than 80 of our emergency medical technicians (EMTs) enrolled on degree courses to become registered paramedics. We wish them every success in this great step towards achieving their goals.

The trust was pleased to work in partnership with NHSE for the launch of the 111 First initiative. This is a national programme which builds on the existing integrated urgent care (IUC) service accessed through NHS 111. It encourages the use of the NHS 111 online and phone service to access a range of urgent care services including, for the first time, direct booking into emergency departments (EDs).

As the regional provider for 111, we first introduced this service in Blackpool back in August with all areas in our region now live.

The aim of the programme is to ensure that patients can access the clinical service they need, first time, both in and outside of hospital, with the convenience of a booked

appointment or time slot. Importantly, it will also help to reduce the risk of transmission of COVID-19 between patients and to staff by reducing crowding in waiting areas across services.

To prepare for the larger number of NHS 111 calls, we undertook a recruitment drive that saw us increase our staffing levels in 111 by 40%. This was a mammoth task during difficult times and during a time when we had to replace the old legacy NHS 111 patient management platform and increased estates to accommodate the new staff and of course social distancing. This is a testimony to the commitment and hard work of staff in various directorates throughout the trust, in particular our digital, training and estates teams.

It would be remiss of us not to also mention the leadership teams of the trust, from senior paramedic team leaders and supervisors, middle managers and senior leaders, who we know have also worked tirelessly, 24/7, to staff our command structure and make some really difficult decisions.

We cannot express our admiration for our staff enough for everything they have done to continue to provide a service for our patients. We try to meet as many as we can, current restrictions allowing, and we are always in awe of their stories – personal and professional, and the genuine care they have for the people they serve. This has been an immensely stressful time for all of them – no matter what role they have within NWAS. All, some way or another, have been impacted by the pandemic but their commitment hasn't wavered.

This Annual Report only gives a snap shot of what we have achieved this year – please do follow our social media pages and website to see more of what we have been doing to improve patient care and the working lives of our staff.

Finally, we would like to thank the people of the North West for their support this year. We have been inundated with messages, drawings, food, snacks and treats of all kinds and we know that our staff have been very grateful. In a world as troubled as it is now, these little gestures go a long way in making people's days that much brighter.

We hope we have made you proud, we hope you know that we have done our very best during these times and we hope that moving forward, we will all be seeing happier times soon.

Please continue to take care of yourselves and others.

Peter White
Chairman

Daren Mochrie **QAM, MBA, Dip IMC RCSEd, MCPara**
Chief Executive

Performance Report

The trust's Performance Report has been prepared under direction issued by the Department of Health Group Accounting Manual 2020/21 in accordance with Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI No 1970. The Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013.

The Accountable Officer is responsible for preparing the Annual Report and Accounts and considers taken as a whole they are fair, balanced and understandable.

Daren Mochrie QAM, MBA, Dip IMC RCSEd, MCPara
Chief Executive

Date: 11 June 2021

Overview

The purpose of the overview section is to provide:

- A statement from the Chief Executive Officer providing an overview of the performance of the trust during 2020/21.
- Information on the purpose and activities of the trust during 2020/21.
- A statement of the purpose and activities of the trust, including a brief description of the business model and environment, organisational structure, objectives and strategies.
- Details of the key issues and risks that could affect the trust in delivering its objectives.
- An explanation of the adoption of the going concern basis where this might be called into doubt; and
- A performance summary of the trust

Chief Executive Statement

In 2020/21, for the first time in our history, the trust's call volume fell by 5.1 percent with a total of 1.2m emergency 999 calls received.

Unfortunately, this was not spread across the year as call volumes rose sharply in some months as restrictions were lifted and in particular during the traditionally busy winter period. Despite this, the trust achieved one of the best 999 call pick up rates in the country with 95 per cent of our total calls being answered in five seconds.

Our hear and treat figures continue to improve with more than 73k of these 999 calls successfully dealt with by a senior clinician offering advice and help via the telephone – each call dealt with in this way frees up an emergency ambulance and is a much more effective use of resources for those who call us but do not require an urgent response. It is pleasing to note that NWAS is in the top three ambulance services in England for hear and treat services.

As a response to the challenge of the COVID-19 pandemic, we recruited more than 200 additional staff in our control centres – a decision which has played a crucial role in maintaining our service to the public. This also allowed us to support a number of other UK ambulance services at times of real pressure on them.

The NWAS 111 service perhaps has seen the highest rise in activity as the public wanted to check symptoms, ask for advice, and from the summer months use the 111 First service. An additional 385 staff were recruited into the service, including some of the student paramedics from affiliated universities who paused their studies to assist us during the pandemic.

As the NHS saw an increase in hospital admissions, outpatient appointments were vastly reduced, which saw our patient transport service (PTS) activity fall 27% below contract baseline. This gave us the opportunity to utilise our PTS staff and have them work

alongside the emergency ambulance crews. Approximately 150 PTS staff undertook training to work on urgent care vehicles attending low acuity calls, which freed up more emergency ambulances to attend the more serious, life-threatening calls.

PTS also played an important role in the transporting of patients to and from Manchester's new Nightingale Hospital, purposely set up to provide care for patients recovering from COVID-19. We are immensely proud of their role in this.

In November, call volumes were reaching such high numbers, that we requested military support and subsequently trained 120 military personnel in manual handling, driver familiarisation and basic life support. Throughout the region, they assisted with almost 2,000 patient journeys, attending low acuity calls to enable emergency crews to attend the high level category one calls.

In this report, I am pleased to share with you the more detailed data regarding our responses and achievements during 2020/21.

History of the Trust

North West Ambulance Service NHS Trust (NWAS) was established on 1 July 2006 following the merger of the Cumbria, Greater Manchester, Lancashire and Mersey Regional ambulance trusts. One of the largest ambulance trusts in England, NWAS provides services to a population of around seven million people across a geographical area of approximately 5,400 square miles.

The trust employs just over 6,300 staff who operate from over 100 sites across the region and provides services for patients in a combination of rural and urban communities, in coastal resorts, affluent areas and in some of the most deprived inner city areas in the country. We also provide services to a significant transient population of tourists, students and commuters.

The North West region is one of the most culturally diverse areas in England, with over 50 different languages spoken by members of the community. Consequently, the trust places considerable emphasis on equality and diversity and public engagement activities to ensure that our services are accessible to all members of the community.

Trust Vision and Aims

The trust's ambition is to be the best ambulance service in the UK by providing the right care, at the right time and in the right place, every time for people who access our services. In order to realise this vision we created our trust strategy and supporting five year integrated business plan.

Covid-19 had an effect on the integrated business plan, causing some initiatives to be paused or stopped; however a few (such as remote working) were accelerated.

The key underpinning strategies are the:

- Right Care (Quality)
- Urgent and Emergency Care
- Finance
- Workforce
- Fleet
- Estate
- Digital
- Communications and engagement

All the strategies were affected by, and continue to be affected by, the pandemic. As a consequence, where they have been negatively affected, we have developed plans to restore/recover our services, but also build in the opportunities where faster progess has been made.

To realise its vision, the trust adopted the NHS Culture of Caring values, customised to reflect our staff's language and interpretation.

New values were agreed by the Board of Directors in January 2021 for implementation from Q1 2021/22. Further details can be found within the Workforce Section.

Our Services:

Our core services are delivered through four distinct service lines. These are:

- **Paramedic Emergency Service (PES)** – through solo responders, double crewed ambulance response and volunteer community responders we provide a pre-hospital care emergency response to 999 and urgent calls.
- **Patient Transport Service (PTS)** – PTS provides essential transport for non-emergency patients in Cumbria, Lancashire, Merseyside and Greater Manchester who are unable to make their own way to or from hospitals, outpatient clinics and other treatment centres.
- **Resilience** – services associated with the trust's statutory responsibilities under the Civil Contingencies Act 2004.
- **111** – The trust delivers the 111 and urgent integrated care service for the North West region.

Core service delivery is supported by a number of support service functions:

- Finance
- Human Resources and Organisational Development
- Quality Improvement and Innovation
- Information Management and Technology
- Training and Development
- Fleet and Facilities Management
- Communications
- Corporate Affairs
- Programme Management Office
- Transformation

Our PES service delivery is organised around three geographical areas - Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester, thus ensuring that our services reflect local community needs. Strategic capacity and support services are provided centrally from the trust's headquarters in Bolton with managers/teams based in each area to provide local support.

Key Risks to Delivering Objectives

As part of the annual refresh of the Board Assurance Framework (BAF), a specific COVID-19 Strategic Risk was identified and any COVID-19 operational risks scored 15 and above on the organisational risk register were linked to the Strategic Risk. As approved by the Board of Directors, the primary focus for 2020/21 in Q1 was the mitigation and management of the COVID-19 Strategic Risk.

As part of the COVID-19 Recovery and Restoration Plan; there was a co-production approach from all Directorates across the organisation which encapsulated the future and further revisit of relevant organisational objectives and areas of risk.

2020/21 Strategic Risks

The trust identified ten strategic risks on the Board Assurance Framework (BAF) aligned to the Strategic Priorities during 2020/21:

1. 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
2. If we do not have effective financial management, this may impact on the trusts' financial position
3. If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care
4. If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the trust's objectives
5. If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the trusts' infrastructure and achieving environmental efficiencies
6. If we do not build and strengthen stakeholder relationships across systems, localities and neighbourhoods, this may impact on the trust's reputation and ability to achieve our vision to be the best ambulance service in the UK
7. If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation
8. If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the trusts' ability to compete and gain business and commercial opportunities that will generate income and protect our core services
9. If the organisation experiences further changes at Board level during 2021/22, this may impact on relationships and ability to deliver the trusts' strategic objectives
10. If the COVID-19 pandemic continues for an extended period, then the trust will be unable to deliver its strategic objective during 2020/21.

During Q2, a previous 2019/20 Strategic Risk was deemed sufficiently significant to be re-opened on the 2020/21 BAF and this related to the UK leaving the European Union.

- If the UK leaves the EU during the transitionary period with a no deal may impact on our ability to provide the service at the required levels resulting in inflated costs, disruption to supplies and loss of workforce.

Going Concern

After making enquiries, the Board of Directors have a reasonable expectation that the services provided by North West Ambulance Service NHS Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual. Detailed guidance in respect of going concern is set out in International Accounting Standard (IAS1) and the interpretation for the Public Sector context is set out in the Financial Reporting Manual (FREM) and the Department of Health and Social Care Group Accounting Manual (GAM) 2020/21. The trust's Letter of Representation for 2020/21 to Mazars LLP as external auditors refers to NWAS preparing its accounts on a going concern basis.

Performance Summary

In 2020/21, the trust faced its most challenging year in delivering the Ambulance Response Programme (ARP) standards. During the COVID-19 pandemic, there were periods throughout the year where standards were challenged, but there were other periods where all ARP standards were achieved. This pattern correlated with the impact of the virus and also in line with actions taken nationally, such as lockdown. Despite the trust facing such challenges due to the pandemic, it was able to act quickly and put patient safety at the forefront of its COVID-19 Response Plan. During the period of May, June and early July 2020, NWAS achieved all ARP standards.

Standard	7 mins	15 mins	18 mins	40 mins	120 mins	180 mins
	C1 Mean	C1 90th Percentile	C2 Mean	C2 90th Percentile	C3 90th Percentile	C4 90th Percentile
May 2020	00:06:50	00:11:21	00:15:11	00:28:36	01:25:46	02:10:27
June 2020	00:06:52	00:11:27	00:17:49	00:34:55	01:55:15	02:29:07

The fundamental underpinning principles of ARP, is to use the right resource at the right time in the right place, all in line with the trust's strategic aim. As reported in last year's annual report, a significant piece of work was underway to review all shift patterns to ensure resources were operating at the right time, in the right place. Despite the challenges associated with the pandemic the roster review for all operational areas was completed by the end of Q2 in 2020/21. The benefits of this roster review will come to full fruition as we move out of the pandemic.

PERFORMANCE AGAINST STANDARDS 2020/21

Standard	7 mins	15mins	18 mins	40 mins	120 mins	180 mins
Fiscal Quarter of Year	C1 Mean	C1 90th Percentile	C2 Mean	C2 90th Percentile	C3 90th Percentile	C4 90th Percentile
Q1	00:07:04	00:11:44	00:19:34	00:38:49	02:06:41	02:41:53
Q2	00:07:20	00:12:21	00:26:58	00:57:58	03:14:00	03:45:20
Q3	00:07:50	00:13:01	00:33:50	01:14:29	03:55:11	05:33:31
Q4	00:07:33	00:12:49	00:26:13	00:55:15	02:48:03	05:07:47
Grand Total	**00:07:28**	**00:12:31**	**00:26:54**	**00:58:04**	**03:02:18**	**04:06:47**

The emergency call volume across the year fluctuated with significant variance across the pandemic. The emergency call volume for 2020/21 reduced by 5.1%. Despite the significant call volume encountered during peak periods of the pandemic, the trust was able to deliver a high standard of response in answering emergency calls. This was primarily due to decisions taken at an early stage of the pandemic, to increase our workforce by 65% to answer the emergency calls.

Despite the increase in call volume, the trust continues to take less patients to hospital, delivering safe care closer to home. Delivering more safe care closer to home has been achieved by further growth in Hear and Treat and See and Treat.

During 2020/21, the trust paused its Every Minute Matters (EMM) quality improvement programme, working with NHS partners to reduce hospital handover. However as a result of the work completed under EMM, including the work led locally by the operations team in previous years, the trust were able to build on the improvements made and deliver a good hospital handover of 30 minutes and 17 seconds for 2020/21.

Emergency Operations Centres (EOC) including Clinical Hub (CHUB)

The EOC and CHUB teams have responded exceptionally well to the challenge presented by the pandemic. From the EOC's perspective, the pace of change has been significant and highlights for the year include;

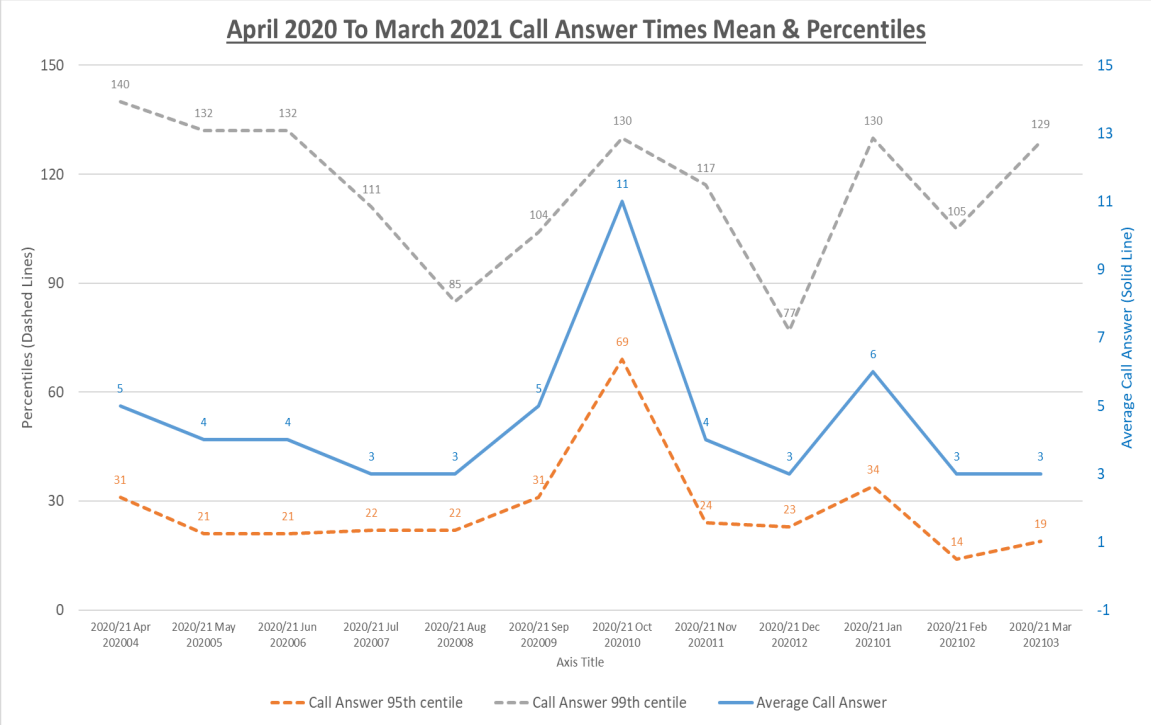
- Recruitment, training and deployment of over 250 new staff to support the pandemic.
- Development of a new call handling role – Emergency Call Handler (ECH).
- The EOC and CHUB have introduced a new service line structure. The structure moves away from leadership roles based upon geographical areas and moved to leadership based upon specialisms (call handling, dispatch, operations and CHUB).
- Development of a new technical CAD solution that enabled off-site training and expansion of the control room estate.
- Development of a new DMP** – now known as the Patient Safety Plan (PSP).
- Introduction of the protocol 36 – pandemic triage.
- Introduction of 'signposting' to enable low acuity patients to seek care without the need for an ambulatory response.
- Introduction of the pandemic levels of escalation – to enable a change in patient prioritisation due to COVID associated pressures.
- Introduction of the Clinical Co-ordination Desk (CCD) that reviews and safeguards long wait patients.
- Launch of enhanced patient safety and reporting culture within EOC and CHUB, which saw incident reporting increase month on month.
- Development and approval of a business case to move to a new triage platform.
- Enhanced IPC within the control rooms, including screens, estate reconfiguration and home and remote working for CHUB staff.
- Delivery of Building Better Rotas (BBR) for call handling and CHUB.

COVID has presented significant challenge to EOC over the year. Abstractions have been significantly higher than in previous years due to shielding, isolation and COVID

associated sickness. Despite these challenges, the team has continued to deliver outstanding call handling performance, hear and treat and improvements in allocation times. The increase in staffing delivered through recruitment and pace and scale, has ensured the EOC continues to provide improved performance, quality and patient care.

EOC: EMERGENCY CALLS AND CALL ANSWER TIMES

The primary axis shows percentile results (dashed lines) and the secondary axis relates to the average call answer time (solid line).



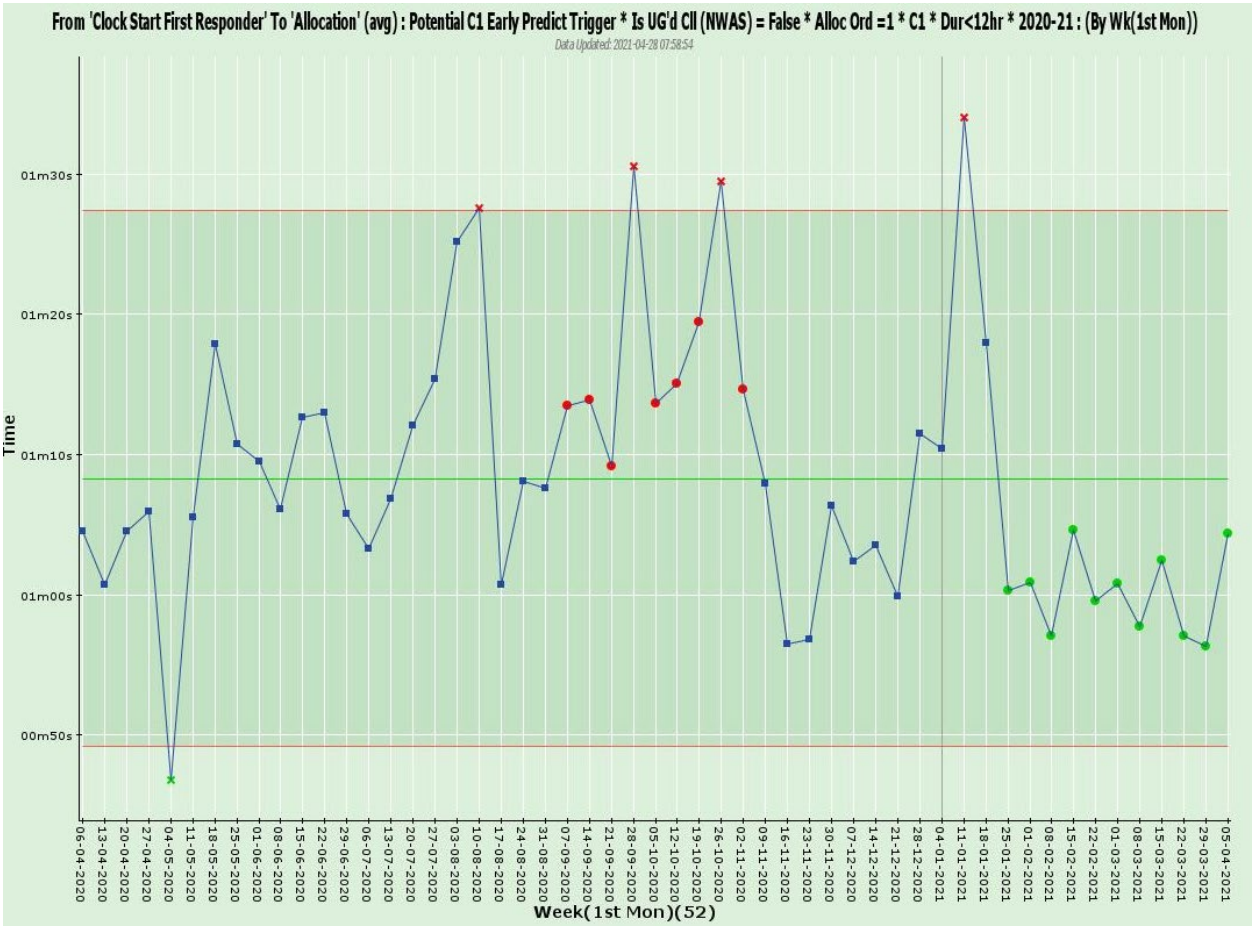
Historically call handling performance has been a challenge for the trust. In previous winters NWAS has seen excessive delays for patients accessing the service. The previous year 2019/20 saw stepped improvements in call pick up performance and this improving trend has continued through 2020/21.

Call pick up (CPU) is appraised through a number of KPIs including calls answered in five seconds, mean call answer and centile. The year-end performance is as follows;

- Percentage of calls answered in 5 seconds: 95%.
- Mean call answer: 3 seconds.
- 95th centile call answer: 6 seconds.

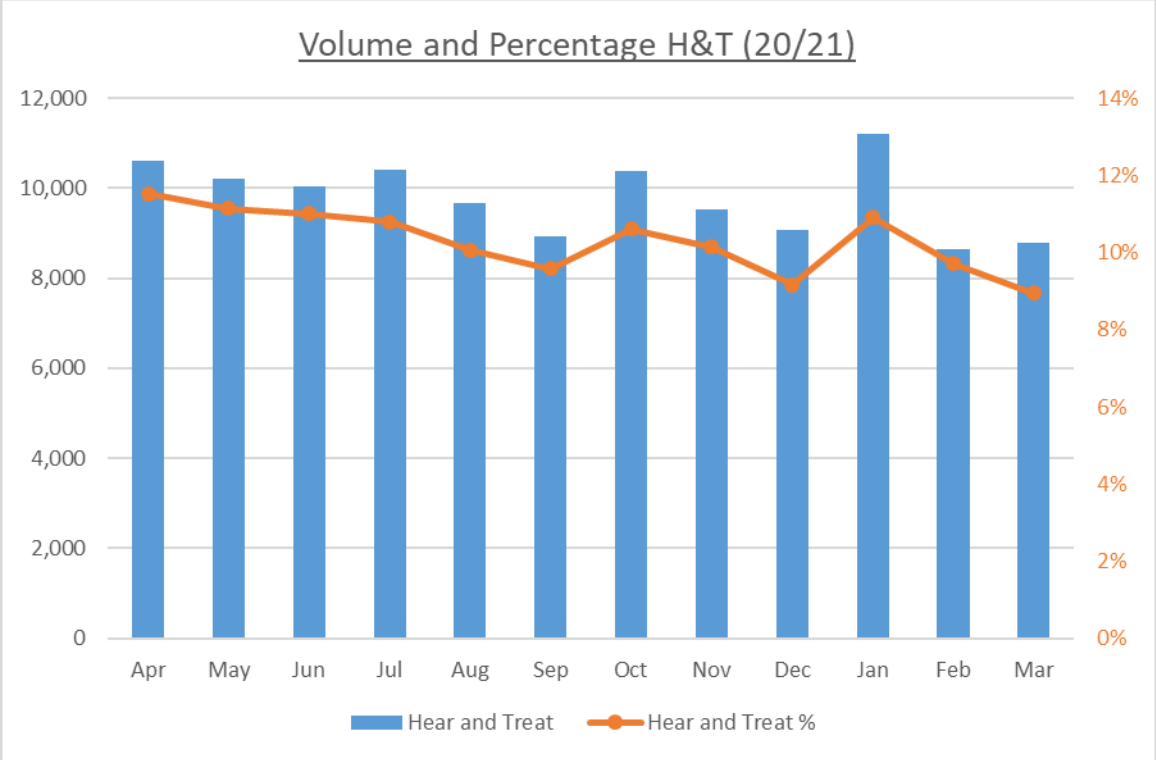
All metrics have improved vs 2019/20 and NWAS has led the ambulance sector in call pick up performance.

C1 AVERAGE ALLOCATION TIMES



The chart above reflects allocation time to Category 1 patients across the year 2020/21. Overall allocation times have improved by around 15 seconds from the previous year. Category 1 allocations times are delivered via the call handling and dispatch teams. This metric is the primary contributor to enabling effective C1 response times. This has been delivered through outstanding call pick up performance, improvements in the early prediction of C1 patients at the outset of the triage process and enhancements both in auto dispatch and dispatcher practice.

PERCENTAGE OF INCIDENTS WHERE OUTCOME IS HEAR AND TREAT % (AQI) –



NWAS continue to provide high levels of Hear and Treat (H&T) when compared to the sector. NWAS consistently rank in the top three trusts in respect to these levels. The Clinical HUB (CHUB) has been required to adapt the roles and functions within the department across the last financial year. COVID has been the catalyst for a number of these changes along with the introduction of the Clinical Co-Ordination Desk (CCD).

In terms of changes to the CHUB brought about by COVID, the primary changes are associated with the expansion of clinical review both for patient and NWAS operational crew safety. NWAS operationally has increased the non-emergency ambulance (EA), double crewed ambulance (DCA) resource by increasing operational support from St Johns Ambulance, other voluntary ambulance service (VAS)/private ambulance sector (PAS), Patient Transport Service (PTS) and, more recently, the military aid. In order to maximise the benefits of these resources and mitigate the variance in skill mix, the CHUB has focused on early clinical review of C3 incidents in order to enable more timely allocations. This approach has been beneficial to allocation times and utilisation of these DCA resources. This has detracted from H&T figures but has been absolutely the right thing to do for patients and overall performance.

Last February, NWAS received a Care Quality Commission (CQC) inspection, where EOC/CHUB received a rating of good. Following the report, an area identified that over time could move the EOC rating to outstanding, is the oversight of patients who wait for

extended periods of time. In response to this the CCD has been launched. The CCD operates by utilising senior clinicians to review incidents that wait. The clinician will review and or triage the patients and then support the dispatch team in making allocation decisions. This has provided significant safeguards to patients and enhanced the clinical leadership across NWAS dispatch functions. Since the launch of the CCD, over 45,000 patients have received a clinical review and clinical interventions appropriate the patients need.

The CHUB team have been able to maintain high performing H&T throughout the COVID pandemic, despite high levels of COVID abstractions and shielding. This has been achieved through new digital solutions. These include home working and remote working from alternative NWAS premises. These solutions have maximised the capacity within the CHUB and are likely to be maintained as we move into the new financial year.

Community First Responders

The trust has one of the largest and longest established Community First Responder (CFR) schemes in England, with some 800 active CFRs operating across all areas of the North West, providing an effective, complementary service in their local communities. This type of resource is particularly valuable in the more rural areas of our region and we are very grateful for the assistance these volunteers provide, but in any area is a vital part in the care we offer our patients.

CFRs are volunteers who live and work in local communities. They are trained and activated by the trust to attend certain calls, such as chest pain or cardiac arrest, where time to respond is critical and can make the difference between life and death. The responder provides care and support to the patient until the arrival of an emergency ambulance. Quite often, the role of a responder is one of reassurance and, in some instances, for example when a patient has chest pains, simply giving oxygen can make a big difference. However, in extreme cases, the CFR can perform cardio-pulmonary resuscitation (CPR) or use a defibrillator to restart the heart. Chances of survival decrease by 10% with each minute that a person's heart has stopped beating and CFR availability in the local area can result in a quick response to ensure that treatment is started as early as possible. Survival rates can be as high as 80% if an AED is used within the first four minutes of the cardiac arrest occurring.

We have continued to support and proactively engage with communities, organisations and individuals with the placement of automated external defibrillators (AEDs) in their communities. These life saving devices are a vital part in increasing the chances of survival form a person suffering an out of hospital cardiac arrest. Within NWAS we have over 2,788 community public access defibrillators, which are devices that are available 24 hours a day, 7 days a week. These are placed in locked, heated and coded boxes and members of the public can be directed to them in an emergency and instructed how to use via the emergency call taker in an emergency. In addition to these devices there are a further 6,600 defibrillators registered with NWAS that are located in numerous

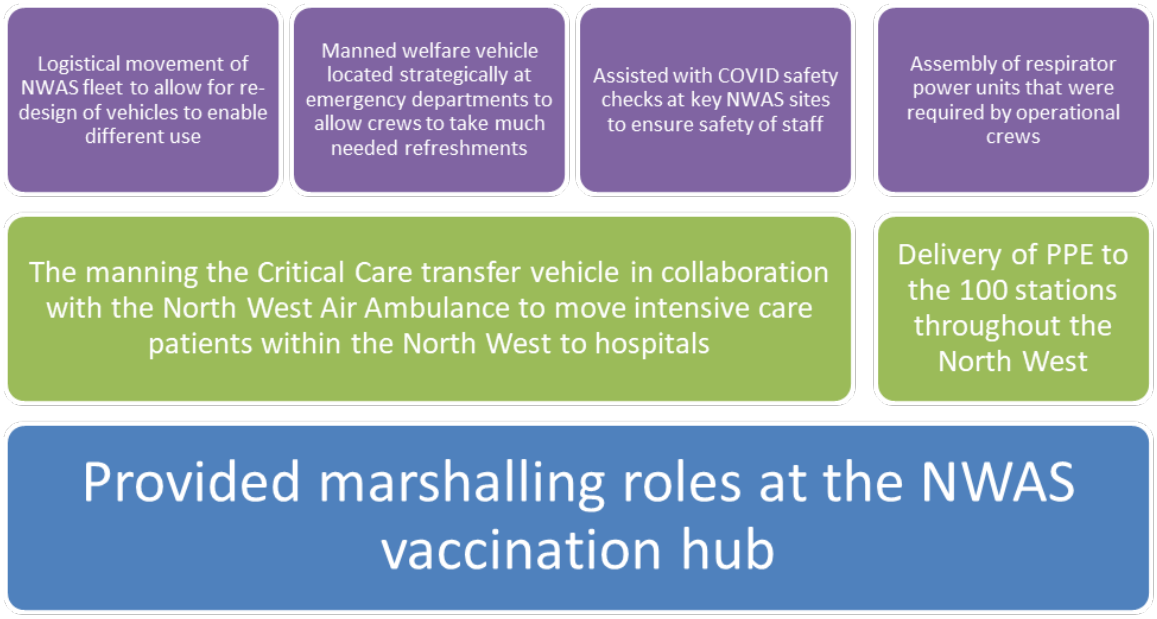
buildings and again accessible if required. These buildings range from leisure centres, shopping centres, supermarkets, healthcare setting, schools etc.

During 2020/21, our volunteers have provided unwavering support to communities and added resilience to our service. They have continued to respond to emergencies and the trust has provided appropriate personal protection equipment for them to allow patients to be cared for and treated. Over 120,000 hours' worth of volunteer support have been given to communities and the trust responding to emergency calls by this group of volunteers for the period of 2020/21.

Over the past year, the NHS has faced unprecedented times dealing with the pandemic. NWAS have faced challenges never experienced before and the support that has been given by our volunteers enabled NWAS operational crews to continue to deliver the best care to the people of the North West. We requested support from our volunteers early on in the pandemic and this has continued throughout. We had over 300 volunteers offering to support us in various ways and this enabled resources to be directed to the areas of need.

Demands placed on operational crews and the requirement for a continual supply of personal protective equipment (PPE) in huge quantities meant we had to set up PPE hubs, and have this equipment packed and made ready for use. Thousands of PPE packs where made up by our volunteers and distributed to operational stations within the North West.

In addition to this vital support many other tasks where supported by our volunteers, below outlines a snapshot of these:



The various waves of the pandemic brought an increase in emergency calls, and so we requested additional support from our enhanced community first responders. This group of responders hold additional skills and knowledge to allow them to attend an increased amount of emergencies. We placed 45 volunteers through an upskill course that enabled them to work on emergency ambulances with core staff. This increased the availability of ambulances for emergencies.

What we have seen during the last 12 months and beyond, is that the unwavering support of our volunteers has been immense, and is something that we are proud of. We value this group of people greatly and know the benefits they bring not only to us as a trust but more to the communities of the North West and the people they help.

Membership of a Community First Responder scheme can be incredibly rewarding and volunteers could be involved in saving someone's life. Anyone who lives or works in the North West can get involved with their local CFR scheme, either by becoming a First Responder or helping with other vital tasks such as fundraising, support or administration. Volunteers do not need previous first aid experience to join their local group, as full training will be provided. Further details on Community First Responder schemes are available at https://www.nwascfr.com

Patient Transport Service (PTS)

Activity

Overall activity during month 12 (financial year) was 27% below contract baseline, whilst the cumulative position (July 2020 – PTS contract year – to March 2021) was 38% below baseline. The activity position has been significantly impacted by the reduction in elective and outpatient activity throughout 2020-21 resultant from the NHS response to the COVID-19 pandemic.

NORTH WEST AMBULANCE PTS ACTIVITY SUMMARY									
			ACTIVITY						
	Current Month: March 2021					Year to Date: July 2020 - March 2021			
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	168,291	14,024	8,933	(5,091)	(36%)	126,218	68,314	(57,904)	(46%)
Greater Manchester	526,588	43,882	34,598	(9,284)	(21%)	394,941	263,231	(131,710)	(33%)
Lancashire	589,180	49,098	31,334	(17,764)	(36%)	441,885	241,125	(200,760)	(45%)
Merseyside	300,123	25,010	21,080	(3,930)	(16%)	225,092	162,526	(62,566)	(28%)
NWAS	1,584,182	132,015	95,945	(36,070)	(27%)	1,188,136	735,196	(452,940)	(38%)

Whilst activity volumes are below baseline levels, the way in which PTS is able to utilise its resources has changed significantly, as a result of social distancing measures eg. only one patient can travel in a taxi or volunteer car at a time, and a maximum of two patients can travel on an ambulance where a distance of 1m+ can be accommodated. This is causing significant challenges in meeting demand, as care systems implement their outpatient restoration plans.

Performance

At the onset of the COVID-19 pandemic, the NHS suspended PTS eligibility criteria and KPIs to enable PTS providers to support increases in the provision of urgent and emergency ambulance capacity, and to ensure maintenance of services to essential patient groups (those travelling for dialysis, cancer treatment and discharges/ transfer). These arrangements continued throughout 2020/21 however, the table below shows PTS performance from December 2020 through March 2021 and is representative of the full year's position.

PTS Quality Standards

NWAS Quality Standards																		
				Cumbria				Greater Manchester				Lancashire				Merseyside			
	Area	Metric	Target	Dec-20	Jan-21	Feb-21	Mar-21	Dec-20	Jan-21	Feb-21	Mar-21	Dec-20	Jan-21	Feb-21	Mar-21	Dec-20	Jan-21	Feb-21	Mar-21
General	Booking Systems	Online booking system availability	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Telephone booking system availability	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Call Answering	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Call Answering	75%	77%	65%	51%	46%	77%	64%	54%	50%	77%	64%	52%	49%	78%	65%	53%	48%
		Call Handling - Average Waiting Time	1 minute	26 seconds	59 seconds	117 seconds	122 seconds	35 seconds	76 seconds	109 seconds	115 seconds	33 seconds	74 seconds	114 seconds	115 seconds	26 seconds	61 seconds	113 seconds	114 seconds
	Planned	Missed Collection	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Planned	Misidentification of Patients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unplanned	Confirmation of Booking	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Eligibility	Application of eligibility criteria	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Planned	Travel time	Travel time	80%	98%	96%	97%	97%	98%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%
	Arrival at treatment centre	On time arrival	90%	88%	90%	90%	87%	80%	83%	86%	82%	90%	90%	92%	90%	85%	88%	90%	87%
	Collection from Treatment Centre	Timeliness of departure	80%	88%	89%	88%	88%	63%	68%	75%	66%	78%	80%	84%	80%	82%	84%	88%	82%
			90%	96%	96%	97%	96%	86%	89%	91%	86%	92%	93%	95%	93%	94%	93%	96%	93%
Unplanned	Travel time	Travel Time	80%	94%	95%	96%	97%	94%	94%	96%	95%	94%	91%	94%	95%	98%	98%	98%	97%
	Collection from Discharge Centre	Less than 60 minute wait	80%	81%	86%	83%	81%	64%	70%	83%	64%	69%	76%	86%	78%	79%	79%	89%	83%
		On the day pick up within 90 minutes	90%	89%	92%	92%	90%	69%	83%	91%	76%	73%	85%	92%	88%	84%	89%	95%	90%
EPS	Travel Time	Travel Time	85%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
	Arrival at treatment centre	On time arrival	90%	92%	93%	93%	87%	79%	78%	79%	79%	89%	88%	90%	91%	87%	88%	89%	89%
	Collection from treatment centre	Timeliness of departure	85%	96%	97%	96%	95%	83%	89%	89%	87%	90%	91%	93%	92%	93%	94%	94%	93%
			90%	99%	99%	99%	99%	94%	97%	97%	95%	98%	98%	99%	98%	98%	98%	99%	98%

The Patient Transport Service contribution to the Trust's COVID-19 Response

The NHS declaration of a Level 4 National Incident on 30 January 2020 in response to COVID-19 progressed activities and plans in support of the Trust, to support its strategic objectives against the backdrop of an emerging pandemic.

Due to intelligence suggesting that COVID-19 pandemic activity within the UK would see a significant increase in the number of people infected by the virus, the trust considered extraordinary ways in which to rapidly increase the PES response capability.

To that end, a 'call to action' to PTS staff was published on 24 March 2020 seeking volunteers to work alongside Urgent and Emergency crews to manage increased activity related to COVID-19, this included expanding the scope of practice of PTS staff who volunteered to provide support to their PES colleagues. Additionally, 80 PTS stretcher vehicles were modified to increase available, appropriate ambulance resource.

In support of the above, PTS repurposed up to 20% of its workforce (150 staff) and fleet (60 vehicles) throughout the response during 2020/21, with 20 further modified vehicles remaining as contingency but continuing to be used within PTS.

The joint HM Government/NHS document "COVID-19 Hospital Discharge Service Requirements", published on 19 March 2020, set out the hospital discharge service requirements for all NHS trusts, community interest companies and private care providers of acute, community beds and community health services and social care staff in England. It also set out requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities).

The document identified roles and responsibilities for all agencies named, with the aim to free up at least 15,000 hospital beds nationally. Patients were to be discharged without delay where this was clinically safe to do so.

In supporting the wider system priorities, PTS rapidly adapted its control room delivery model through the creation of a Discharge Coordination Hub (DCH) at the PTS Control & Contact Centre at Broughton, Lancashire. The DCH operated between 0800 and Midnight, seven days a week.

The hub developed integrated deployment processes with the trust's Emergency Operations Centre, ensuring flexible use of PTS resources for priority activity across the service line. This work has developed longer term into a 'business as usual' approach to both core activity and through changes to tactical delivery, such as the embedding of military aid resources across service delivery.

This service operated through Q1 and part of Q2 of 2020/21 and enabled PTS to work collaboratively with commissioners and regional partners to establish robust engagement

and liaison with integrated discharge teams, building on existing links with trusts, CCGs and providers of health and social care, including engagement with Healthwatch England in their national review of the rapid discharge programme.

PTS was also at the forefront of the pandemic response with the establishment of Manchester's NHS Nightingale Hospital. The facility acted as a dedicated Level 1 + unit, set up to manage COVID-19 positive adults stepping down from a level 3 or level 2 care unit at an acute trust. The facility hosted 648 beds and its primary function was to treat Level 1 and Level 0 patients to maintain capacity in acute trusts. Throughout 2020/21, PTS were physically based at this site and through summer 2020, were an integral member of the team ensuring the smooth running of the facility which supported patient flow across the wider care systems. Following a period of pause, the facility returned to operations in late 2020 as a step-down facility and PTS again provided on site coordination and liaison successfully, working in partnership until the formal closure of the site in March 2021.

Alongside NHS Phase 3 planning and delivery plans, a workshop (North West Outpatient Restore and Transform Programme) was held on 15 July 2020 – chaired by NHS England and Improvement - involving stakeholders from across the Integrated Care Systems (ICS) of Cheshire & Mersey, Greater Manchester and South Cumbria & Lancashire.

As presented at the workshop, pre COVID-19, the systems offered 12m outpatient appointments per year however, the impact of COVID-19 reduced outpatient appointments by nearly 50%, but at the same time provided the North West with the opportunity to accelerate transformation, with the aim to return outpatient appointments to normal levels; 70% of those provided virtually and 30% provided in a face to face setting.

In responding to this approach, and to support the healthcare system in work to achieve this aim, NWAS PTS worked with commissioners via an established PTS Review Group which looked to work collaboratively with stakeholders on this and core system priorities, prioritising access to life saving treatment services – primarily, but not exclusively, cancer and renal services – as well as responding effectively to discharge and flow.

In doing so, set against system wide challenges provided by COVID-19, PTS implemented a number of measures to ensure maintenance of services to patients travelling for haemodialysis and cancer treatment, as well as to effectively support hospitals with their on the day discharge requests.

As the further wave of COVID-19 impacts were felt by the whole healthcare system in early 2021, PTS again worked with NHSE/I, ICS Gold Command structures, commissioners and acute health and care partners, to focus the use of PTS on priority journeys across all categories of life saving and more standard outpatient activity, to

ensure resources were available to support system flow, at a time of critical challenge to capacity within hospital bed occupancy.

Military Support

As the Trust initiated partnership working with the military through a MACA arrangement, welcoming 120 military personnel in support of increased activity, 19 of those personnel were trained to support PTS staff, working in teams to be focused on system flow and discharge in Cumbria, Lancashire and Greater Manchester. During their time with PTS, military personnel supported 1,907 patient journeys providing invaluable support to the healthcare system. In addition to resources working specifically for PTS, the integrated approach to deployment between PTS control rooms and the trust's regional EOCs, established through the first wave of COVID-19 related activity, developed further to ensure the most effective use of all military assets.

111 Service

2020/21 presented another challenging but rewarding year for the 111 service in NWAS. Call demand has remained above pre-COVID-19 levels throughout the year, magnified during COVID-19 outbreaks and other COVID-19 related events, for example the commencing of testing, the track and trace service and vaccination.

Description	Target	Year	Q1	Q2	Q3	Q4	Total
Calls abandoned	**<5%**	2019/20	2.9%	6.59%	13.3%	21.57%	11.09%
		2020/21	**13.67%**	**13.12%**	**15.04%**	**5.9%**	**12.07%**
Calls answered in 60 seconds	**95%**	2019/20	86.74%	76.38%	66.9%	60.44%	72.62%
		2020/21	**64.62%**	**62.96%**	**57.56%**	**70.42%**	**64.02%**
Calls warm transferred	**75%**	2019/20	37.17%	37.36%	33.3%	21.62%	32.36%
		2020/21	**21.87%**	**19.16%**	**18.28%**	**6.86%**	**13.17**
Call backs within 10 minutes	**75%**	2019/20	47.25%	28.12%	24.33%	16.36%	29.01%
		2020/21	**20.13%**	**16.08%**	**8.60%**	**7.88%**	**13.17%**

The service began to see significant increases in volume in March 2020. Demand since then has remained high with increased volatility quite often in line with public reaction to the media.

During March 2020, calls waiting to come into the service reached a record level of over 200 at any one time, this consequently impacted the headline KPI for calls answered in 60 seconds.

In order to mitigate this extended wait for patients, the service very quickly mobilised a team of advisors to specifically take COVID-19 calls, amendments to the interactive voice response (IVR) allowed these to be filtered off to a specific skill set. This allowed the service to still answer routine calls for patients with health needs other than COVID-19. This skill set is still in place today and is being reviewed against future requirements

Further initiatives were mobilised rapidly to protect the workforce, home working for Clinicians was enabled, this allowed a significant number of the clinical staff to work from home and minimise any further staff loss due to COVID-19.

The Middlebrook site was declared an outbreak site during September 2020 and again in February 2021, this was due to multiple 'connected' cases of COVID-19. Staff abstractions due to COVID-19 isolations peaked in February 2021 with approximately 30% of call taking staff absent due to COVID-19 isolation or a COVID-19 positive status.

As COVID-19 prevalence begins to reduce, the focus is now on returning to a business as usual status, ensuring the core business functions and requirements are delivering as required.

Contract extension

The current NHS111 contract was due to expire on the 30 September 2020. In line with the trust's Urgent and Emergency Care Strategy work had been progressing to develop an integrated urgent care model to support a new (direct) contract award from 1 October 2020. Due to the NHS response to COVID-19, all negotiations in relation to contracts ceased, however the commissioners gave a commitment to the Board to extend the NHS111 contract on the 6 May 2020.

Discussions continued with commissioners and concluded with a jointly agreed final contract extension letter confirming an additional £4.7m per annum for the three years of the contract extension.

The £4.7m includes £1.9m in recognition of the underlying financial pressure associated with the current service model, and £2.8m additional investment, based on a realistic recruitment plan, to support improvements in performance.

NHS 111 First

NHS 111 First is a national programme to improve outcomes and experience of urgent and emergency care. The national go live date was 1 December 2020, this was the date media campaigns began to take place, to ensure the public are aware that they now need to contact 111 online or telephony prior to any ED attendance.

It involved further development of NHS 111 as well as local remote triage and assessment services to offer patients a different approach to the way they access and receive healthcare. The scheme recognised the importance of NHS 111 as a main point of contact for people with urgent care needs and how vital the service was during COVID-19.

The NHS 111 First model requests patients thinking about attending an emergency department (ED) to contact NHS 111 first by telephone or online, and enables those who do need to attend ED to be booked into a time slot, improving patient experience and the flow of patients into ED, supporting social distancing while waiting.

NWAS 111 supported a soft launch in two North West 'early mover' sites with the first of these, Blackpool, going live on 25 August 2020 and the second site, Warrington, going live on 8 September 2020.

Further sites, 'fast followers' have launched, and twenty-two sites were live by the end of November 2020. The remaining thirteen sites (primarily within the GM footprint) were tested and successfully went live w/c 30th November 2020.

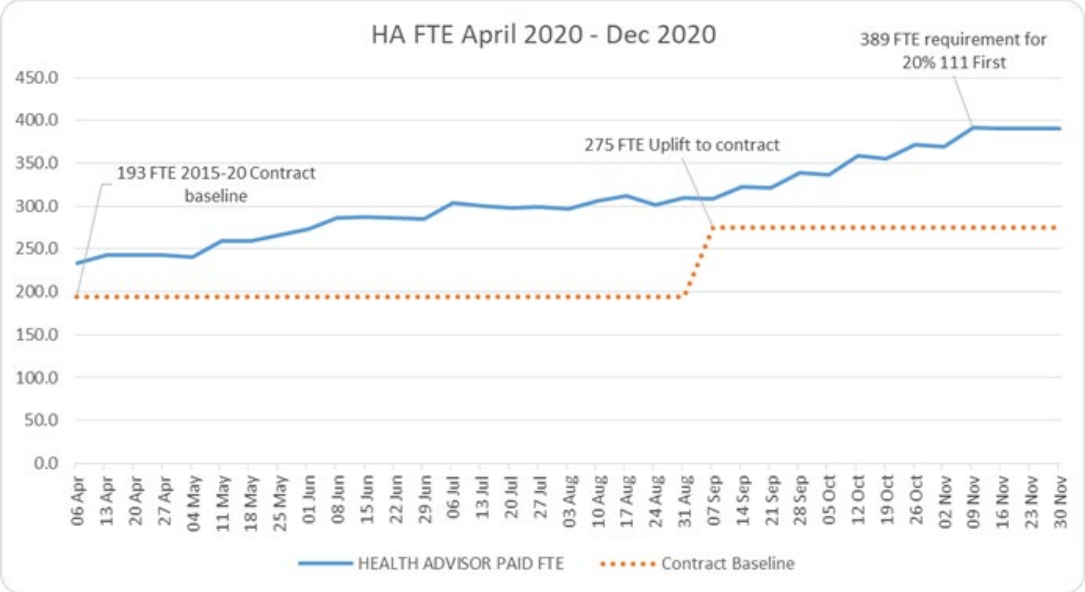
The 111 Systems team has enabled the booking of referrals into emergency departments from NWAS 111, through working collaboratively with NHS Digital and the digital teams in the acute hospitals. Deliverables included:

- Digital solution to send patient information and assessment details from 111 to ED/secondary care setting
- Digital solution developed to allocate patients into ED time slots (appointments)
- Process in place at ED to receive patients from local clinical assessment service provider
- Utilising existing interoperable systems to send referrals and enable directly booked appointments from the 111 system (Cleric) into ED/Secondary care settings (ie. UTCs/MIUs/WICs)

Original assumptions around the increase in demand to telephony was that 20% of unheralded ED activity would transfer to telephony. There was a requirement for 111 telephony to increase call handling capacity to be able to deal with 20% of unheralded ED attendances, which equated to an increase in the current 111 health advisor baseline of 114 FTE.

Demand at present is running in line with 20% assumptions, however it is difficult to specifically identify activity that has come to 111 due to the campaign. As with all media campaigns this has educated all members of the public about 111 not just those that would have attended ED.

Recruitment to the 20% unheralded volume was completed in December 2020. A further requirement to increase call taking capacity to 40% of unheralded was commissioned locally, however this activity has not been realised. The service is now concentrating on ensuring currently levels of staffing are maintained.



Due to the significant number of additional staff required to deliver care for the extra 111 First demand, 111 worked with the Estates team to identify suitable further sites for expansion. Fortunately the Stevenson Suite at Middlebrook was in the process of being leased and available to add additional 111 call handling capacity by March 2021. In the interim the first floor of the existing offices at Middlebrook were converted to accommodate call handling functionality and meeting rooms at Ladybridge were converted by IT and Estates into call taking facilities. Estates, IT and Operational teams worked tirelessly throughout March to ensure this room was available ahead of the Easter bank holiday, giving the service an addition 68 desks. Middlebrook conversion was completed in time and under budget on 29 March 2021.

COVID-19/Infection Prevention Control

Within the 111 Service the management of infection, prevention and control (IPC) has been a key priority of the 111 Senior Leadership Team (SLT). NWAS 111 Middlebrook site experienced two significant outbreaks in September 2020 and later in February 2021 resulting in 203 staff in total being affected as COVID-19 positive. These significant outbreaks were managed through an outbreak management command cell comprising of

Senior Leadership Team IPC lead, Head of Service, NWAS IPC, NWAS Track and Trace and NWAS Health and Safety representatives who met on a daily basis, and once the outbreak was under control, moved to weekly. This swift tactical approach enabled both outbreaks to be managed effectively and for the final outbreak to be closed on 26 March 2021. Important learning and improved IPC practice was developed during this time, which now forms the business as usual IPC practice across all 111 sites.

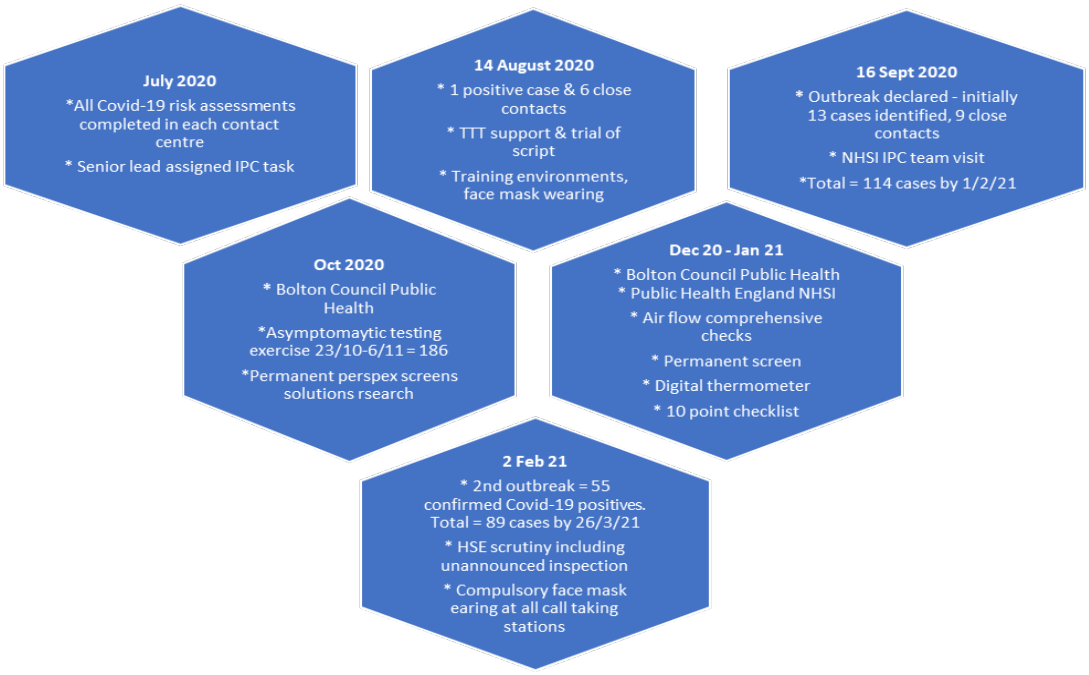
From September 2020, Middlebrook 111 needed to work in partnership with several agencies who were interested in the outbreak management of the site. This included Bolton Council Public Health Team (including enforcement division of this team), Public Health England, NHS England/Improvement (NHSE/I), IPC North West Team and the Health and Safety Executive. As the outbreak management was detailed and significant learning and mitigations were in place, it was possible to respond quickly to outside enquiries and provide the data and reports required.

Asymptomatic testing supported by the Public Health Team (local and national): In October 2020, Middlebrook 111 site was supported by Public Health England to receive asymptomatic swab testing of staff for a two week period. This proved successful in that 186 tests were completed with very few positives as a result. Feedback was provided to Bolton Council and Public Health England that the process could have been improved by the results being reported back to NWAS as well as the individual. Deloittes, the lab undertaking the testing were only able to provide the results back to the individual due to information governance reasons.

From November 2020, all staff within 111 and across NWAS were provided with lateral flow test kits to enable self-testing twice weekly for up to a period of 12 weeks, and staff to then report results back to the NWAS COVID-19 Safecheck app.

LAMP testing (saliva test using real time loop-mediated amplification) also commenced on 12 February 2021 at the Middlebrook 111 site as a trial, and is being rolled out across NWAS sites currently. NWAS was the first ambulance service in the UK to use LAMP testing with 111 leading the way with implementation of the testing within one day of agreement to access the testing centre at UCLAN.

The diagram below illustrates the timeline of outbreaks and actions taken with support from NWAS support directorates and external bodies.



Following national working safely during COVID and Ambulance Alliance Trust guidance, plus support from the NWAS Premises Recovery Group, all NWAS COVID-19 risk in the workplace assessments were completed in July 2020. Health and safety, staff side and 111 senior leadership team (SLT) representation at all sites identified any potential hazards and remedial concerns. The key areas of concern in July 2020 were those of face mask wearing compliance, temperature checking and training and call centre environment potential close contacts. Temporary perspex screens had already been installed at this time.

From the national lockdown guidance provided in March 2020, it was necessary to provide opportunities for staff who were shielding due to medical reasons or other reasons eg. childcare, to work from home rather than be medically suspended. This was done swiftly via a clinical leader taking responsibility for liaison between individual staff, HR, line management and IT, in order to provide suitable homeworking kit to 76 staff (mostly clinical). The homeworking governance and process arrangements were also subject to MIAA audit in July – Sept 2020 which received significant assurance at the NWAS Audit Committee in January 2021.

A regular daily and nightly IPC 10 point checklist was developed by the 111 IPC lead which was shared with the NWAS Regional COVID-19 Cell for feedback. This was then incorporated into a simple QR code in Microsoft that could then be scanned by duty staff when completing IPC checks around the call centre. From the initial test out in January 2021 this proved successful and was then developed to be utilised across the NWAS trust in corporate and ambulance station environments.

Initially, offers to support the 111 team to access vaccinations in the Middlebrook area were very limited and staff were reluctant to travel to the NWAS vaccination hub at Broughton due to distance.

In order to try and get more Middlebrook staff to access services the vaccine lead for 111, liaised and co-ordinated opportunities through contacts in Bolton Council and Bolton GP Federation. She made contact with Hooton's Pharmacy initially who were setting up a clinic at Bolton Wanderers Football Club; they agreed to accept 111 staff for vaccination. Currently we have access also to the Bolton Council vaccination bus and are targeting opportunities for hard to reach groups of staff.

SPMS (Single Patient Management System)

The implementation of Cleric as the new Single Patient Management System (SPMS) across NWAS 111 and Clinical Hub services, commenced in February 2020. The deadline for completion was 30 September 2020, in-line with the contract termination date with the incumbent provider, Advance Health Care (AHC).

The key deliverables of the project were:

- To develop a specification for the Cleric SPMS across 111 & Clinical Hub
- To Implement and migrate 111 & Clinical Hub services onto the Cleric SPMS
- To ensure that NWAS successfully repatriated all historical data from the Adastra platform

The 111, Digital and Transformation teams successfully achieved migration ahead of schedule and within budget, with Cleric going live across 111 on 16 September 2020. Colleagues at Cleric reported that the project was the most successful migration that they had undertaken to date, with the least number of migration issues; all of which was achieved in the shortest timeframe to date.

Benefits include:

- Delivery against a comprehensive system specification - which meets current needs of the trust and will enable us to develop the system to support the goals of the Urgent and Emergency Care Strategy;
- A robust digital contract with assurance around costs over the lifespan;
- Effective supplier relationship with Cleric;
- Provider network of Cleric users to share development ideas, capacity and costs;
- Critical system status with In Life Management support agreed – business continuity/disaster recovery plans in place with asset registered as critical system within trust. Once registered as a critical system, an enhanced critical system support package is developed;

- Cleric system development roadmap - a roadmap of strategic and BAU developments has been developed.

Unified Communication Platform

The implementation of the AVAYA telephony system was vital to the expansion of the 111 service for numerous reasons.

The previous telephony platform (CISCO) was at capacity and with the imminent launch of the 111 First programme it was essential that 111 was the first service line to go live across the trust. The 111 First launch also presented the additional issue of desk capacity for 111 staff across our estates as we had embarked on a large scale recruitment programme to meet the demands of this new service.

To ensure that we had a smooth transition from CISCO to AVAYA the decision was made to implement a 'soft launch' of the AVAYA system. The soft launch gave us the opportunity to resolve any issues and glitches within the system before the full launch.

The original plan was to launch pre Christmas Dec 2020 but due to some unresolved technical issues the decision was made to postpone the full launch until January 2021. To ensure that the January launch went ahead as planned, we continued with the soft launch through December 2020 which provided us with additional time to resolve these outstanding issues.

The full launch went ahead as planned and the success of this should not be underestimated, the team managed to train in excess of 600 frontline staff and managers on the new telephony system, as well as setting up this new telephony for all of our homeworking clinicians.

The additional capacity that the AVAYA telephony platform has given us has enabled us to create an additional 68 call taking positions on the first floor at our Middlebrook call centre that was opened pre-Easter this year, to ensure that we now have enough operational desk capacity to meet the 111 First demand.

Clinical Team

In October 2020, 111 appointed a Senior Clinical Manager (Consultant Paramedic) to lead the clinical team. Following a review of the clinical team capacity and objectives, the Senior Clinical Manager has commenced a restructure of the team including the introduction of a new role – Quality Assurance Officers to support staff, reduce incidents and drive up quality of care.

The process of reviewing the all clinical teams capacity is continuing into 2021/22 aligned to the service expansion created by the increase finding within the contract extension and NHS 111 First changes.

Over the past year NHS Pathways has made a number of revisions and updates, these include:

- Changes incorporating the evolving COVID-19 information relating to symptoms and advice
- Changes to include oxygen level saturations in relation to COVID-19 symptoms
- Changes to support the COVID-19 vaccination programme and even further changes to incorporate assessment of side effects of the vaccine.
- Changes to include the new PaCCs (Patient Care Co-ordination System) system in Pathways

Every new version of Pathways means training and off line time for some or all 111 staff, which has been a challenge in 20/21 in the context of COVID-19, implementation of the new Cleric system and new Avaya telephony system, and the recruitment of approximately 250 additional personnel.

This year for the first time in the history of NWAS 111, we got involved in research. The study is called PRINCIPLE and it is run by the University of Oxford and aims to help find treatments for coronavirus/COVID-19. As a 111 provider being contacted by a large proportion of the public with Coronavirus symptoms, we volunteered to work with the University to the enrolment (screening, informed consent, eligibility review and baseline data) of suitable patients onto the study and in June 2020, NWAS 111 got the green light to commence our work.

REGIONAL PLANNING DEPARTMENT

The Regional Planning team operates across the regional footprint and has a number of different components to support the trust in delivering its service throughout the region. The components consist of the Regional Operations Co-ordination Centre (ROCC), the Global Rostering System team and the Regional Planning team.

Regional Operations Co-ordination Centre (ROCC)

The Regional Operations Co-ordination Centre has been an integral part of the trust since its merger in 2006. The ROCC operates 24/7 365 days a year and provides an oversight across all its service lines in the North West. The ROCC also works closely with key stakeholders locally, regionally and nationally across the NHS, ambulance sector and other key partners such as police and the fire and rescue services.

In November 2019, the ROCC established a senior leadership team operating 21 hours a day throughout the year. This addition to the ROCC was key and, in terms of the COVID-19 pandemic, timely as they were integral in leading the NWAS COVID19 Response Plan starting, with the support required for the repatriation of UK citizens from abroad to Arrowe Park Hospital for a period of isolation. Being integral to the NWAS Response COVID19 Response Plan continues throughout Q1 2020/21 and beyond some 16 months later.

The ROCC senior leadership team is responsible for the regional overview of NWAS service delivery, focusing on challenges to patient care, monitoring in real-time performance, devising and implementation of tactical decision making, in response to constantly changing demand.

Within the ROCC team, it incorporates oversight of demand and hospitals across the North West. This is done by the Regional Health Control and Greater Manchester Hub. This allows the trust to respond and invoke plans enabling the trust to flex its resources to respond to patients in a timely manner.

Global Rostering System (GRS)

The trust operates a system, GRS, which enables resources to be on duty at the right time and in the right place operating across its footprint. The Global Rostering System (GRS) team provides a greater degree of management control and enables the trust to maximise effective use of available staff resources. Reports generated through GRS have fundamentally enhanced the timeliness and quality of management information providing visibility of resource levels.

FINANCIAL REVIEW 2020/21

This section of the Annual Report outlines the financial performance of the trust for the financial year ended 31 March 2021 and the results outlined in this section relate to the full 12 month period of 1 April 2020 to 31 March 2021. A copy of the full statutory audited accounts is included in this Annual Report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial Duties Review

NHS trusts have a number of financial duties.

Break Even – taking one financial year with another

NHS trusts have a statutory duty to break even taking one financial year with another and NWAS has continued to meet this duty in 2020/21. NHS trusts that merge part way through a financial year, are not measured against year on year break even duty as the performance summary relates to the financial performance of predecessor bodies. For North West Ambulance Service NHS Trust, measurement against the break-even duty commenced from 1 April 2007. The cumulative performance against this target for 2020/21 is a surplus of £35.821m.

It should be noted that included within Operating Expenses in 2020/21 and 2019/20 are fixed asset impairments of £2.950m and £2.504m respectively. These impairments have mainly arisen as a result of a downturn in land and building asset values and have been confirmed by an independent valuation. There were further impairments relating to major part problems on some vehicles and damage to IT equipment. The Department of Health and Social Care considers financial performance against the break-even duty to be assessed net of impairments.

Break Even – each and every year

NHS trusts have a regulatory duty to break even in each and every financial year. In 2020/21 the trust returned a surplus of £0.041m and therefore achieved this regulatory duty.

External Financing Limit

NHS trusts have a regulatory duty not to exceed the External Financing Limit (EFL) set by the Department of Health and Social Care. The EFL is the method by which the Treasury, through the NHS Executive, controls public expenditure in NHS trusts. The majority of the cash spent by the trust is generated through its service level agreements for NHS patient care. The EFL determines how much more (or less) cash than it generates through income agreements can be spent in a single financial year.

Each year NHS trusts are allocated EFLs as part of NHS financial planning processes. The trust's EFL for 2020/21 was £11.949m. It should be noted that trusts are allowed to undershoot the EFL but not exceed it. NWAS achieved this duty with an under-shoot of £21.600m in 2020/21.

Capital Resourcing Limit

NHS trusts have a regulatory duty to contain capital expenditure on an accruals basis, within an approved Capital Resource Limit (CRL). The CRL is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that the resources allocated by the Government for capital spending are used for capital rather than to support revenue budgets. The CRL is accruals based in contrast to the EFL which is cash based. The CRL controls the amount of capital expenditure that an NHS body may incur in the financial year.

The trust had a CRL of £22.205m for 2020/21 and had a charge against the CRL of £22.166m - an underspending of £0.039m and therefore achievement of the duty. Trusts are allowed to underspend against CRL but not overspend.

Capital Cost Absorption (CCA) Duty

NHS trusts have a duty to absorb the cost of capital at a rate of 3.5%. The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. The trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. This was achieved for 2020/21 and is the dividend paid on public dividend capital.

Apply the Better Payment Practice Code

This regulatory duty requires NHS trusts to pay all supplier invoices within 30 days. The trust achieved this duty in all categories in 2020/21 and performance is summarised below:

1 April 2020 – 31 March 2021	**Performance**
Non-NHS Creditors % paid within target – Numbers	96.6%
Non-NHS Creditors % paid within target – Value	97.2%
NHS Creditors % paid within target – Numbers	97.0%
NHS Creditors % paid within target – Value	99.3%

Overall performance by the trust against the Better Payment Practice Code has been consistently met since NWAS was established.

In summary, for the 2020/21 financial year the trust achieved all of the statutory and regulatory financial duties.

In 2020/21 the trust's income was £406.6m and was generated from the following activities:

Income from Activities	**2020/21**
	£m
PES Income	308.6
PTS Income	42.6
111	28.2
Other Income	27.2
Total Income	**406.6**

Late Payment of commercial Debts (Interest) Act 1998

Under this legislation, the Trust can claim interest on the late payment of debts by contracting partners and is required to disclose amounts of interest and compensation paid during the year. During the year, the Trust did not receive any such payments.

Financial Environment

Throughout 2020/21 the NHS has operated under the emergency financial regime due to COVID-19, where in essence, the normal contracting arrangements were suspended and trusts were paid monthly block payments and additional top-up payments relating to the costs of responding to the pandemic, including personal protective equipment; loss of non NHS income; and additional annual leave carried over by the staff.

Our achievement of the financial duties continues the trust's track record of strong financial performance and demonstrates sound financial management. Achieving the duties has been challenging, particularly in the context of the current financial regime environment and operational pressure due to COVID, whilst maintaining service quality.

NWAS' cash balance remains strong and was £60.6m as at 31 March 2021. The trust holds its cash within the Government Banking Service (GBS).

Our financial focus continues to be about resilience and sustainability, and as such, the trust continues to operate under the emergency block arrangements.

The 2020/21 capital programme for NWAS continued to invest significant capital resources to procure ambulance vehicles and equipment; enhance our digital infrastructure; investment in digital developments and to maintain and improve the quality of our estate.

The impact of the COVID-19 pandemic was felt by the trust throughout 2020/21 and additional costs were incurred in responding to COVID-19. In relation to the 2020/21 accounts this equated to £37.594m of additional expenditure.

Anti-Corruption and Anti-Bribery Matters

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in and use the NHS, conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

NWAS is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The trust does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

The trust at its most senior level encourages anyone having a reasonable suspicion of fraud, bribery or corruption to report them and no employee will suffer in any way as a result of reporting these suspicions.

The trust will take all necessary steps to counter fraud, bribery and corruption in accordance with the NHS Counter Fraud standards, as well as in accordance with relevant UK Legislation.

The trust has its own dedicated Anti-Fraud Specialist (AFS), who is accredited by the NHSCFA and accountable to them professionally for the completion of a range of preventative anti-fraud, bribery and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the trust's Director of Finance and also reports, periodically to the trust's Audit Committee.

WORKFORCE

Delivering NWAS' overarching aim of delivering the right care, in the right place, at the right time, every time, requires us to have sufficient, highly motivated, trained staff working in safe, supportive environments where they can fulfil their potential. Workforce is established as a key priority in the trust strategy, engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care.

As a trust we are focused on developing roles, careers and supporting education and development to support the transformation set out in the trust strategy. We also recognise the importance of creating an inclusive environment, where managers lead with compassion and where the safety and wellbeing of our staff is at the heart of what we do.

Workforce Strategy

The Workforce Strategy was developed to enable the delivery of the overall trust aims. It was first approved in 2018 and is reviewed annually to ensure that it remains focused on supporting the trust to deliver its people priorities. In the 2020, refreshed new improvement goals were added to reflect the emerging priorities from the national People Plan and NHS People Promise, as well as continuing to develop our work to support improving culture. In particular, including planned work to develop culture principles and approach; support our Outstanding Culture project, using an organisational healthcheck to further understand staff experience of work and the review of partnership arrangements.

The strategy reflects three main themes: develop, engage and empower, and six overall key priorities:

- Recruitment and retention
- Developing potential
- Wellbeing
- Inclusion
- Leadership
- Innovation and Improvement

The key priorities are supported by a range of measures and key improvement goals, reflected in more detail in a three year implementation plan. Regular updates on progress are provided to the Resources Committee and good progress on all key improvement goals was demonstrated during 2020/21 despite the impact of the COVID-19. There were some challenges, however in progressing some areas of work and 2021/22 will focus on recovery and continuing improvement.

Leadership Development

Leadership development at NWAS has expanded over the last year to cover a spectrum of activity to support organisational resilience. This was primarily focussed on supporting leaders throughout the pandemic but has also supported continuing activities and development of new initiatives:

- The signposting of NWAS leaders and managers to system wide leadership development opportunities, including those provided by partnering organisations such as the North West Leadership Academy and NHSI/ NHS England.

- Growth in leadership resilience activity, such as Leadership Support Circles, to enable leaders operating in unprecedented conditions to respond to change climates with agility and flexibility.

- The development of talent management pathways and programmes to enable clinical leadership advancement including the SPTL talent programme.

- The development of values based leadership approaches to recruitment, selection and retention.

- The expansion of organisational development consultancy to stretch and challenge leadership practice at the front line.

- The review and reform of people based systems and processes to drive values based leadership in appraisals, sickness absence management, grievances and disciplinaries.

NWAS has cultivated the necessary landscape to introduce its own Leadership Faculty to spearhead leadership excellence with the launch of its new flagship programme 'Making a Difference' planned for 2021.

Health and Wellbeing

The trust continues to make progress with supporting the health and wellbeing offer for staff especially as we start to move through the recovery phases of COVID-19 with particular focus given to mental health support. This work includes:-

- Improving access points and wellbeing information on the staff intranet and staff app.

- Increased utilisation of social media for promotion of Health & Wellbeing support to ensure 24/7 accessibility for all staff.

- Implemented an Employee Assistance Programme (EAP) service which is available to all staff, 24/7 for telephone support.

- Created a number of in house support guidance documents throughout the pandemic including a full support directory with key contact numbers.

- Bespoke COVID resources developed including a range of bespoke podcasts targeting stress, nutrition, exercise, sleep and based on direct feedback from staff.

- Launched a Financial Wellbeing staff benefit to all staff which includes an educational hub for financial worries or savings information as well as the offer of loans through salary sacrifice.

- Launched weekly Wellbeing Wednesday and Feel Good Friday bulletins.

- Created a Managing Mental Health in the Workplace toolkit which will enable managers to structure a conversation with a staff member about their mental health and wellbeing.

- Targeted support for families and colleagues around hospitalisation.

- Implemented health and wellbeing conversation via the appraisal route.

- Greater focus on proactively raising awareness on suicide prevention. The Suicide Prevention group meet regularly to discuss ways to enhance existing practices in how we provide support for our staff and patients we serve. A suicide prevention working group is in the process of formulating suicide prevention guidance and death in service procedures, to reflect the sensitivities of this subject matter and formulate clear suicide bereavement action cards to assist managers.

Flu vaccination campaign

The trust experienced their best flu campaign to date with 78.3% frontline staff receiving the flu vaccination. The total number of staff vaccinated within the 2020/21 flu campaign was 4737 Healthcare Workers (HCW) with direct patient contact and 517 who are not involved with direct patient contact.

WORKFORCE ENGAGEMENT

Despite the pandemic the trust has continued to focus on staff engagement and improvement. Working with our staff to improve the working environment and their experience of work remains critically important and there has been significant work undertaken to help us to better understand where to focus future interventions.

Values Refresh

The review of the trust values continued into 2020/21 with engagement activities and feedback from staff on what they valued about working in NWAS. The subsequent refresh of the NWAS values recognises the high levels of workforce resilience delivered by a committed and dedicated workforce. The refreshed values are:

- Working together
- Being at our best
- Making a difference.

These values are underpinned by a set of behaviours outlining what is important to our staff in demonstrating these values in work. The refreshed values were approved by the Board of Director in January 2021 and will be formally launched in April.

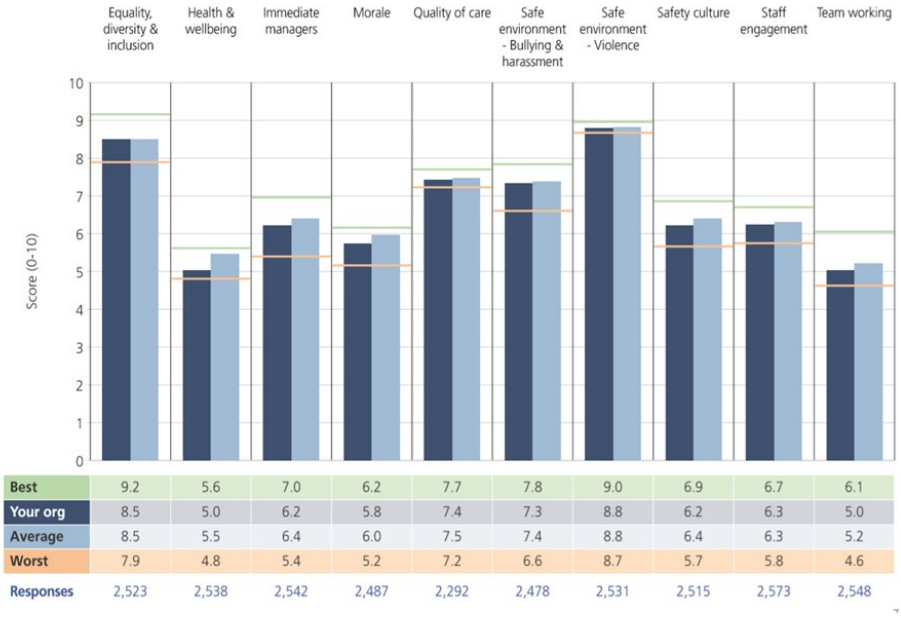
Staff Survey Result 2020

The NHS staff survey is carried out annually in the autumn. The survey was completed during a period when the trust was experiencing pressures of the second wave of COVID and followed immediately after a more in-depth audit commissioned directly by the trust. Nevertheless, the final response rate was 41% (2,622 respondents) which is marginally lower than previous years. Overall the finding of the survey illustrates a picture of stability with little significant decrease/increase in most areas with our scores being around the average for the sector.

The following chart presents the significance testing conducted on this year's theme scores and those from last year. In the main the tables illustrates no significant statistical changes. Although the movement in score is only 0.1 and 0.2 respectively, there are two areas of identified as significant in terms of reduction for staff engagement and team working. It also positively shows a significant increase for health and wellbeing.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.4**	2688	**8.5**	2523	Not significant
Health & wellbeing	**4.9**	2707	**5.0**	2538	↑
Immediate managers †	**6.3**	2708	**6.2**	2542	Not significant
Morale	**5.8**	2653	**5.8**	2487	Not significant
Quality of care	**7.5**	2447	**7.4**	2292	Not significant
Safe environment - Bullying & harassment	**7.4**	2674	**7.3**	2478	Not significant
Safe environment - Violence	**8.8**	2671	**8.8**	2531	Not significant
Safety culture	**6.2**	2672	**6.2**	2515	Not significant
Staff engagement	**6.4**	2750	**6.3**	2573	↓
Team working	**5.2**	2718	**5.0**	2548	↓

The following chart illustrates the themed results:-



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.2	5.6	7.0	6.2	7.7	7.8	9.0	6.9	6.7	6.1
Your org	8.5	5.0	6.2	5.8	7.4	7.3	8.8	6.2	6.3	5.0
Average	8.5	5.5	6.4	6.0	7.5	7.4	8.8	6.4	6.3	5.2
Worst	7.9	4.8	5.4	5.2	7.2	6.6	8.7	5.7	5.8	4.6
Responses	2,523	2,538	2,542	2,487	2,292	2,478	2,531	2,515	2,573	2,548

Local staff survey data will be shared and combined with the outcomes of the Culture audit, pulse surveys and workforce data, to enable a wide reaching view of local culture and inform improvement plans. The key themes will also be used to inform a review of the Workforce Strategy. The recovery of existing key initiatives will be critical in ensuring that we can build on and improve the current position, in particular the planned work around:

- Review and refresh of the Workforce Strategy
- 'Just Culture' work, combined with review of investigation processes and early interventions

- Launch of the new Values and Behaviours
- Launch of Treat me Right campaign – Bullying & Harassment support tool
- Equality and Diversity strategic actions
- Recovery and refresh of the leadership offer

Culture and Wellbeing Audit

During 2020/21, the trust worked with an external provider to develop and undertake a culture and wellbeing audit. The audit was developed with input from staff and has been overseen by a Steering Group incorporating staff, trade union, Freedom to Speak Up and network members. The audit aims to help us understand the experience of work in more detail, with particular focus on how work conditions impact positively and negatively on staff wellbeing; how psychologically safe staff feel, covering issues such as bullying and speaking up; and the interaction between experience and leadership. The audit aims to identify areas for improvement but also those factors which already positively impact on staff experience which can be further strengthened. The survey ran in early autumn 2020, with results starting to be shared before the close of the financial year which will feed into 2021/22 plans.

Partnership Working

The trust continues to work in partnership with four recognised trade unions - GMB, Unison, Unite and RCN. The trust meets every month with staff side representatives through the Trust Policy Group, to discuss the development and revision of workforce policies and procedures. Trade Unions also attend Health and Wellbeing meetings and are also heavily involved in Health and Safety groups. Each service line has its consultative mechanism which focuses on staff and patient experience and the management of change. This has been enhanced during COVID with more frequent meetings with trade union leads to ensure that they could contribute to the rapidly changing situation.

The trust commissioned ACAS to assist in reviewing the partnership agreement and arrangements with the trade unions. The aim of the review is to build constructive inter-TU relationships and management, agree a set of behavioural standards and ways of working, including informal dispute resolution process, in readiness for review of the partnership agreement and working together on future challenges.

The ACAS review was due to be completed by March 2020 however, due to the impact of COVID-19, this has not been possible. This review forms part of the Recovery Plans for the People Directorate in 2021/22.

EQUALITY, DIVERSITY AND INCLUSION

The impact of the pandemic, alongside world events highlighting the ongoing disproportionate impact of racism and discrimination, has caused many organisations to pause and reflect on the experiences that ethnic minority colleagues face on a daily basis. In turn this has led the trust to reflect on our own efforts to support and progress the diversity and inclusion agenda.

Alongside our own internal efforts and measurement of progress, there are external drivers inducing an enhanced focus. The NHS People Plan published in 2020 set out a need for trusts to create an organisational culture where everyone feels they belong and to improve the experience of BAME employees.

Following approval from ELC in October 2020, the trust has moved to a formalised infrastructure to support staff networks. Approval has been given for formal release of network chairs and core group members, along with a small budget to support the progress of annual activities and initiatives. Following the ED&I Board development session in late 2019, there was a commitment within the Board to identify Executive Champions to support the progress of staff networks. Each Director has now taken on an executive champion role either aligned with a network or supporting a particular strand of diversity. The trust has also identified the Medical Director as the ED&I lead for Patient Care.

As a trust we have recognised the need to change our approach to Diversity and Inclusion. Whilst acknowledging that good incremental progress has been made over recent years to improve representation and staff experience, it is recognised that there is a need to increase our ambition and provide a clear and resourced commitment to make a step change in the experience of staff and patients.

In January 2021 the trust agreed to a set of three ED&I priorities:

1. *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.*

2. *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 patient.*

3. *We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities.*

The pandemic has undoubtedly impacted the pace at which we have been able to development key areas of work. However, the trust has been able to make significant progress in a number of areas:

- NWAS published the Workforce Disability Equality Standard metrics and Workforce Race Equality Standard metrics accompanying action plans during summer 2020.
- The trust formally launched the Race Equality Network in January 2021 marking the transition from a Corporate HR run forums to a staff run network.
- ED&I Recruitment Task and Finish group aimed to overhaul the approach to recruitment in response to the NHS People Plan
- In February 2021, the trust launched the Guaranteed Interview Scheme to veterans and currently serving reservists and cadet force adult volunteers.
- Celebrating Pride with a virtual Manchester Pride video in August 2020 showing LGBT members and trust-wide staff
- The Disability forum has led on the development of a Work and Wellbeing passport that will be formally launched in 2021/22.
- Launch of the Religion and Belief Forum in June 2020
- Extension of a Disability Confident Scheme for a further 12 months until November 2021
- Continuing to develop the Race and Disability forums to ensure a continuing strong voice is heard from our staff.
- The trust also focused on risk assessments and support for those groups most seriously affected by the pandemic. In particular we had a comprehensive risk assessment process focused on age, disability, ethnic background and pregnancy which aimed to support the physical and mental wellbeing of staff.

RESOURCING

The impact of COVID-19 has led to a number of changes to the initial plans in place for recruitment during 2020/21.

To support resource levels during COVID-19, the trust put in a number of initiatives:

1. Upskill of PTS staff to work on PES – a programme of around 150 staff were invited to undertake a short training course at the start of April 20 to enable the staff to move onto PES and support front line emergency service delivery.

2. Inviting ex-staff to return to support resources. Some ex-staff have returned in a bank capacity to support PES, EOC and senior management groups.

3. Paramedic students at the North West universities were brought in to support the trust on a bank contract working in EOC, 111 and in PES, as urgent care assistants. The staff mainly worked during the first wave, but were also contacted to support resources in the second wave.

4. Internal corporate staff have been released where possible to support resources levels in variety roles. These staff worked predominantly during wave one, but some have returned during wave two.

5. Recruitment of a number of agency staff to support call taking in EOC

Alongside the specific recruitment activities to support COVID-19, the trust has continued to recruit in line with the workforce plan. Whilst no growth was added to the establishment in 2020/21, recruitment has focussed on maintaining establishment levels.

During 2020/21, the trust recruited and trained 53 paramedics from the North West Universities and 46 paramedics from outside of the North West, coming from other universities or ambulance services. Due to the impact of COVID-19 on both university programmes and our own training course capacity, we have a further 34 NW graduates starting on training courses in 21/22. In addition the trust has internal progression staff who have progressed to an NQP paramedic during Q4.

To support PES resource levels at the start of COVID-19, the trust put together a training package for 155 PTS to gain an increased skill set to support front line PES. The Executive Leadership Committee agreed in July 2020 to recruit up to 60 of these staff into EMT 1 apprenticeships on courses, commencing prior to Christmas 2020 and 54 completed the programme by the end of Q4. Engagement with the group has identified a further group of staff who would wish to progress to EMT 1 positions and a further 43 are due to start EMT 1 courses in 2021/22. During the latter half of 2020/21, the trust undertook an EMT recruitment campaign, which was particularly successful and courses to training successful applicants from this campaign are scheduled during 2021/22.

For EOC, the normal recruitment plans were paused due to COVID. At the start of the pandemic, the Executive Leadership Committee approved a request to increase the EOC call handling workforce by 180 staff to support the increased levels of activity. Recruitment was undertaken at pace, utilising an agency previously used by the trust for call handling staff, this was supplemented with corporate staff redeployments and recruitment of student paramedics onto bank contracts. By May 2020, the new staff were released from training courses and became operational, achieving an increase of 172 EMDs and 30 EMD support staff. A total of 94 of these staff were agency.

In November 2020, activity began to increase again due to both the impact of COVID-19 and the start of winter pressures. It was agreed by ELC that within the EOC there should be an increase of 123 agency staff, which, along with utilising student paramedics on bank contracts would support the return to the additional staffing levels seen at the start of the pandemic. The additional staffing levels will continue into 2021/22, to support the training required for the trust's Single Primary Triage project and the current agency staff have been offered fixed term contacts until the end of March 2022.

The PTS workforce has been impacted by the deployment of 155 staff to support PES. Recruitment for permanent and bank recruitment has continued during 2020/21. The plan for 2021/22 focusses on trying to support PTS reaching establishment levels.

The recruitment in the first half of 2020/21 for 111 reflected the need to mobilise for increased staffing, linked with the revised contract for NHS 111 commencing in October 2020 and the emerging 111 First project. The trust held an aggressive recruitment campaign during Q2 and was able to recruit and deploy resources in line with the 111 First implementation plans.

Recruitment has focussed meeting establishment requirements for both health advisor and clinical advisor vacancies. Due to the impact of the pandemic, agency staff and student paramedics have also been used to support call taking resources.

The trust has continued to have a vacancy gap in its clinical advisor workforce. Strategic work to support closing this gap has been impacted by the pandemic, although we have seen a slight improvement.

The following table summarises the numbers of frontline staff recruited during 2020/21:

Numbers Recruited in 2020/2021						
Staff Group	**Permanent**	**Fixed term**	**Bank**	**Covid Support**	**Internal Progression**	**Grand Total**
UCS/EMT1/Apprentice EMT1	11	27	20	226	31	315
Paramedics	41	2	246	0	165	454
PTS	31	50	40	0		121
EOC	54	68	24	36		182
111	385	42	12	46		485
Grand Total	**522**	**189**	**342**	**308**	**196**	**1557**

Leadership Assessment Centres have become a critical feature of the trust's approach to fair, equitable and ethical recruitment practice. The approach has matured into a streamlined process that has standardised best practice. For 2020/21, the assessment process has focused on ensuring that all leadership and management roles are recruited in alignment to the corporate agenda for inclusion and framed around the trust's leadership framework: Be, Think, Do. The Assessment Centre process has been revised to ensure all components of the process contribute meaningfully to selection, so that selection decisions are weighted around the themes of role competency, leadership and management capability, corporate priorities for inclusion and responsiveness to the NHS change context.

From April 2020 to March 2021, assessment centres have been adopted across the spectrum of NWAS service lines, professional roles and from Board to the front line. The next year will focus on the continual mainstreaming of transformative practice in recruitment that has developed at pace this year.

COVID-19 resourcing response

To support the trust's resources levels during the response to COVID-19 there has been a comprehensive recruitment campaign focussing on:

- Recruiting ex-NWAS staff to front line EMT, paramedic and senior operational management positions on bank contracts
- Recruiting 303 student paramedics to work within 111, EOC and as urgent care assistants
- Utilising support offered nationally for nursing, medical and AHP support from existing practitioners and returners to practice
- Upskilling 155 PTS staff and 12 UCS staff to support the paramedic emergency service

A call to action was placed with our emergency community responders (eCFRs). As a result, 38 eCFRs undertook a comprehensive training programme to enable them to support and assist paramedic emergency operations in January 2021.

In order to further reduce the potential impact on the services provided to the public during the winter months and to maximise frontline resources, NWAS engaged with the military in terms of providing support via the Military Aid to the Civil Authorities (MACA) mechanism in the maintenance of service. NWAS welcomed 138 military assets to our service, who received a comprehensive training programme and were then deployed across our footprint to support paramedic emergency operations. Further discussions of collaboration and mutual aid were also scoped out with the Fire and Rescue Service.

COVID-19 vaccination uptake and approach

A vaccination governance structure was put into place to manage the trust COVID-19 vaccination programme. Executive sponsorship was led by the Director of People in the capacity of being chair of the COVID-19 Workforce Cell. The trust developed a COVID Vaccination Cell and this has overseen the COVID immunisation plan for NWAS staff, volunteers, students and third party providers.

The COVID cell focused on the development and delivery of our in house vaccination offer, along with engaging with ICS leads in the region on the vaccination programme. Whilst staff have had the opportunity to have the vaccination at the Broughton vaccination hub, staff have also been provided with details of hospitals and vaccination hubs throughout the North West where they have been able to access the vaccine.

The Broughton Vaccination Hub was set up via a specific multi-functional sub cell focussing on the set up and operation of the hub covering aspects such as IPC, estates, procurement and IT.

The Hub opened on 18 January 2021 for the first dose phase of the vaccination programme, operating on specific dates up to the end of February 2021. Overall 2,023 first dose vaccinations were administered to staff, volunteers, third party providers and the supporting military personnel. The operation of the hub was then paused until second dose vaccinations of staff were due.

On 29 March 2021 the hub reopened to commence the second dose vaccination phase. All individuals who were provided with the first dose at the hub were invited back for their second dose. Take up of the second dose has been carefully managed and the hub is due to close for second vaccination in early May 2021.

WORKFORCE DEVELOPMENT

Apprenticeships

NWAS continued to deliver its internal EMT1 and call handler apprenticeships in 2020, which were rated as 'good' overall in the previous year's full inspection by OFSTED. During the COVID pandemic, a range of flexibilities was introduced to enable employer providers, like NWAS, to continue to support their apprenticeship delivery whilst the impact of the pandemic was being felt. Apprentices could not participate in their planned face-to-face end point assessments (EPAs) in the usual format and all had an approved break in learning, to ensure that their focus remained on keeping both themselves and their patients safe.

During 2020/21, in spite of the COVID-19 pressures, NWAS had recovered most of the delays borne out by the pandemic and 96 apprentices successfully completed their EPA and moved to permanent positions with the trust.

Since January 2021, the number of EPAs undertaken has doubled and continues to rise. This is a credit to the apprentices themselves, as well as the entire delivery team who worked tirelessly to adapt education and training delivery.

From the pool of PTS staff who stepped up and undertook upskilling training to work in a support role in PES, we were able to develop a talent pool of future apprentice EMT1s. These staff were supported to gain additional driving and functional skills as part of a pre-apprenticeship development programme; with 43 moving on to apprenticeships in 2020/21 and a pool of 46 continue to be supported to access future apprenticeships courses

The trust has continued to expand its apprenticeship offer through two new programmes;

- March 2021 saw the first cohort of 82 EMT staff enrol on the new paramedic apprenticeship at the University of Cumbria. The paramedic degree

apprenticeship is the trust's development pathway for our internal EMT1 staff towards paramedic registration.

- Throughout the year we were able to start a mix of nine advanced paramedics (AP) and community specialist paramedics (CSP) on the HEE supported two-year Advanced Clinical Practice (ACP) Apprenticeship programme.

Widening Participation

As well as our approach to patient and public engagement, the trust also attends a range of community events to promote recruitment and development opportunities to support our approach to widening participation in employment and training.

Due to the pandemic, our usual attendance at these face-to-face events has been significantly affected, although every effort has been made to still connect with our stakeholders across communities. The development of virtual platforms has seen us reach large numbers of people differently to offer the support and guidance needed to support their career aspirations. Individuals have also engaged with bespoke virtual 1:1 support throughout the pandemic, engaging with opportunities we offer for information advice and guidance, next steps to health careers, application support and interview skills.

We have undertaken 33 virtual events this year and provided 1:1 support for 84 individuals.

Latterly in 2021, the trust has worked Health Education England who are supporting our ambition to develop a virtual work experience programme to harness the lessons learned from a more technologically enabled approach to this work.

Supporting Staff Development

In 2020/21, the trust continued to offer staff access to further modules of study (non-mandatory) with 534 higher education modules funded.

The EMT1 bridging programme has continued to be a successful route whereby staff gain the qualification which will support their aspirations to develop and become paramedics. 305 EMT1s have now achieved the qualification with an additional 77 currently on the programme.

A further 79 members of staff have been supported through a range of professional development courses and qualifications. These include BSc and MSc qualifications, Post Graduate Certificates and professional qualifications such as CIPS and CIPD Diplomas.

Appraisal compliance

The trust saw an impact on appraisal performance during the year, correlating with the operational pressures caused by the pandemic. Although the formal appraisal process has been affected, there has been a continuing focus on staff wellbeing discussions not least through the extensive risk assessments undertaken with the workforce.

During the year the appraisal paperwork was refreshed, with health and wellbeing conversations forming a key part of the appraisal. Managers have continued to be supported with revised guidance, virtual development and drop-in sessions and video guidance.

In line with the NHS Guidance 'Reducing burden and releasing capacity to manage the COVID-19 pandemic', the trust reset its approach to appraisals, with the focus on ensuring existing NWAS processes continue to provide 1:1 discussions, with health and wellbeing a key element of those conversations.

The trust's end of year compliance for appraisal was 64%, which was an increase on previous months.

Mandatory Training

From March 2020 onwards, the increased service pressures and staffing level impacts associated with the COVID pandemic, necessitated pauses in the delivery of face to face mandatory training programmes so services could continue to respond to the needs of patients.

In line with the NHS Guidance 'Reducing burden and releasing capacity to manage the COVID-19 pandemic', the trust reset the mandatory training competency compliance target to 75%, in line with the CQC recommended minimum threshold.

The trust's end of year compliance for mandatory training competencies met revised targets at 75.46%.

Promotion of Equality, Diversity and Inclusion

The Trust has due regard to the aims of the Public Sector Equality Duty in the way is manages its workforce and the way in which it provides services to its communities. The Trust publishes an annual report into its equality and diversity activities with particular focus on its work towards both the general and specific duties. The report is published on our website but the following provides some highlights from the report in respect of patent and community engagement and service delivery.

- Continued use of patient stories to inform board and committee including a focus on maternity, laryngectomy patients and mental health.
- Extensive community and patient engagement which has primarily moved to virtual platforms during COVID. This shows a good spread of protected characteristics and positive learning and service delivery change, for example addressing the issue of PPE affecting lip reading for the deaf community.
- Continued development of the patient and public panel, ensuring a diverse cross section of patients and the public with whom we consult and co-produce pieces of work.
- Promoting partnership working with many of our hard to engage and vulnerable groups including with CFR volunteering opportunities and our Patient and Public Panel (PPP) membership.

The Trust also has an annual Patient Engagement Plan which for 2020/21 included the following aims:

1. To engage and educate a range of patient, public and community groups, on what to expect from and how to access ambulance services.
2. To work in partnership with our patient, public and community groups, stakeholders and patient and public panel (PPP) members to design services which meet their needs.
3. To capture and share changes which have been made as a result of patient, public and community group feedback.
4. To enhance patient, public and community groups access to ambulance employment opportunities.
5. To ensure that engagement is embedded throughout the organisation and that priority messages are shared with our patients, public and community groups.

The Trust has not easily been able to produce service delivery KPIs and metrics disaggregated on grounds of protected characteristics as not all of this information is gathered in the pre-hospital setting and there remain constraints whilst the majority of emergency services data is still gathered on paper report forms. This will improve in the future as the electronic patient record is rolled out.

Patient Satisfaction across Service Delivery

An extensive patient engagement programme was successfully completed during 2020/21. In addition, to our NHS 111 postal survey offer and FFT comment/postcards on vehicles, we continue to develop our digital offer by offering the opportunity to complete our patient surveys via sms text and online https://www.nwas.nhs.uk/get-involved/share-your-experience/tell-us-how-we-did/ Also, instead of our traditional face to face engagement that would normally take place with patient and community groups, we have been hosting and joining virtual engagement sessions via MS Teams and Zoom.

Figure 1 below shows a summary of survey response feedback data including FFT by quarter.

2020 - 2021 Patient Engagement Surveys
Postal/On-line
(01 April 2020 - 31 Mar 2021)

	Cared for appropriately with Dignity, Compassion and Respect (Strongly Agree/Agree)					Overall Satisfaction Received (Very Satisfied/Fairly Satisfied - Yes)					Overall Experience of Service (Very Good/Good)					Recommend Ambulance Service to Friends and Family (Very Good/Good)				
	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD
Patient Transport Service *	No Data	100%	80.0%	No Data	87.5%	n/a	n/a	n/a	n/a	n/a	No Data	100%	80.0%	No Data	87.5%	n/a	n/a	n/a	n/a	n/a
Paramedic Emergency Service	No Data	89.1%	86.4%	91.7%	88.2%	n/a	n/a	n/a	n/a	n/a	No Data	91.3%	86.4%	91.7%	96.2%	n/a	n/a	n/a	n/a	n/a
Urgent Care Service *	No Data	100%	No Data	100%	100%	n/a	n/a	n/a	n/a	n/a	No Data	100%	No Data	100%	100%	n/a	n/a	n/a	n/a	n/a
NHS 111 Service	n/a	n/a	n/a	n/a	n/a	94.9%	95.2%	92.3%	94.2%	94.3%	n/a	n/a	n/a	n/a	n/a	94.5%	95.9%	91.6%	93.7%	94.2%
NHS 111 First Service	n/a	n/a	n/a	n/a	n/a	No Data	No Data	94.1%	96.6%	96.4%	No Data	No Data	91.7%	95.6%	95.2%	n/a	n/a	n/a	n/a	n/a

Figure 1 - Survey Response Feedback data by Quarter.

Feedback received during 2020/21, shows a high regard for ambulance services and in particular the care and treatment provided by staff. A high 96.2% of PES patients found their overall experience of the service either good or very good with 88.80% stating that they were 'cared for appropriately with dignity, respect, kindness and compassion'.

95.2% of NHS 111 First patients and 87.5% of PTS patients also found their overall experience of the respective services either good or very good with 87.5% of PTS patients stating that they were 'cared for appropriately with dignity, respect, kindness and compassion'.

Equality Objectives

The Trust set new equality objectives in January 2021, one of which is specifically focused on Health Inequalities. The objective will be in place for the next three years but with the following focus in year one.

- We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities.
- We will deliver parity in 999 response times for patients with mental health conditions

- We will develop our understanding of the impact of deprivation on cardiac outcomes and deliver improvements
- We will improve our understanding of the impact of English as a second language on access to 111 and EOC
- We will develop the Electronic Patient record to support the delivery of culturally competent care

PERFORMANCE ANALYSIS (Optional to omit)

In response to COVID 19, changes to the Annual Reporting requirement have been made and this section became ‘optional to omit’.

The Accountability Report

The trust's Accountability Report has been prepared to meet key accountability requirements to parliament and is based on matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2013 No 1981.

Daren Mochrie QAM, MBA, Dip IMC RCSEd, MCPara **Date: 11 June 2021**
Chief Executive

Corporate Governance Report

Directors' Report

Membership of the Board of Directors for the 2020/21 reporting period:

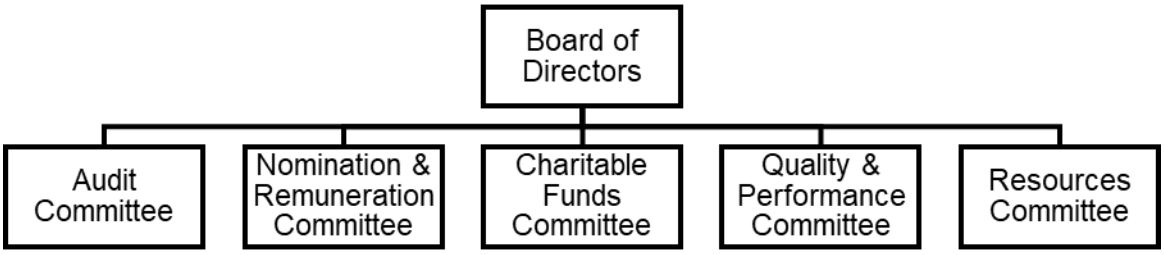
Peter White Chairman	Daren Mochrie Chief Executive
Richard Groome Non-Executive Director	Michael Forrest Deputy Chief Executive
Michael O'Connor Non-Executive Director and Senior Independent Director	Carolyn Wood Director of Finance
David Rawsthorn Non-Executive Director	Ged Blezard Director of Operations
David Hanley Non-Executive Director	Dr Chris Grant Medical Director
Alison Chambers Non-Executive Director	Salman Desai Director of Strategy and Planning
Clare Wade Associate Non-Executive Director (left 1 November 2020)	Maxine Power Director of Quality, Innovation and Improvement
Prof Roderick Thomson Association Non-Executive Director	Angela Wetton Director of Corporate Affairs
Gillian Singh Associate Non-Executive Director (Started 1 March 2021)	Lisa Ward Director of People (Substantive 1 August 2020)

Attendance of Board of Directors Meetings and Committees during 2020/21:

Board Member	Term of Appointment	Board of Directors	Audit Committee	Nominations & Remuneration Committee	Charitable Funds Committee	Quality & Performance Committee	Resources Committee
		Attendance (actual/max)					
		Non-Executive Directors					
Peter White (Chairman)	1/2/19 – 1/2/23	14/14		9/9			
Michael O'Connor	1/04/20 – 31/03/21	12/14	3/5	8/9			5/5
Richard Groome	06/08/19 – 05/08/21	14/14		6/9	1/2	10/10	5/5
David Rawsthorn	25/3/19 – 24/03/21 25/3/21 – 24/03/23	14/14	5/5	9/9	2/2		5/5
David Hanley	28/5/19 – 27/5/21	13/14	5/5	7/9	2/2	10/10	
Alison Chambers	1/8/19 – 31/7/21	12/14		9/9		9/10	
Rod Thomson	1/9/19 – 31/8/21	12/14	5/5	7/9		10/10	
Clare Wade	1/6/19 – 31/5/21 Left 1/11/21	8/9		3/5			2/2
Gillian Singh (Started 1 March 2021)	1/3/21 – 28/2/23	1/1					1/1
		Executive Directors					
Daren Mochrie		13/14					
Michael Forrest		13/14				8/10	
Ged Blezard		12/14			1/2	9/10	2/5
Chris Grant		13/14				9/10	
Salman Desai		13/14			2/2		5/5
Angela Wetton		14/14			2/2		
Maxine Power		10/14				10/10	4/5
Lisa Ward		13/14			2/2		5/5
Carolyn Wood		14/14			2/2		5/5

Committees

A number of assurance committees reported to the Board of Directors during 1 April 2020 and 31 March 2021, these committees were as follows:



During 2020/21, the Board of Directors and its assurance committees adapted to virtual meetings to ensure appropriate governance arrangements were maintained throughout the COVID-19 pandemic, further detail regarding these arrangements has been included within the Annual Governance Statement.

The Terms of Reference for the Audit Committee are based on the model terms of reference incorporated in the HFMA Audit Committee Handbook. The Committee completed its annual self-assessment during March 2020, all responses were collated by Mersey Internal Audit Agency (MIAA) in readiness for the annual self-assessment session scheduled for 20 March 2020 which was cancelled due to COVID-19. The outcomes were reported to the Audit Committee on 22 May 2020, with a further session held on 25 September 2020, to agree the self-assessment outcomes and subsequent actions and formally reported to the Audit Committee in October 2020. The self-assessment was based on the HFMA Audit Committee handbook which provides two checklists to aid facilitation of the self-assessment. The first is designed to test the committee processes and the second to test its effectiveness.

Members of the Audit Committee during 2020/21 were David Rawsthorn (Chair), David Hanley, Michael O'Connor and Roderick Thomson. The Chair of the Committee has the relevant financial experience. The Chair of the Audit Committee presented the Annual Report of the Audit Committee to the Board of Directors on 28 April 2021 to provide a summary of the activities undertaken by the Committee and how the Terms of Reference and key priorities were met during 2020/21. The Audit Committee Terms of Reference for 2021/22 were also approved. The trust's External Audit service is provided by Mazars LLP and the cost for audit of the 2020/21 financial statements was £64,924. Mazars have not provided the trust with any non-audit services during the reporting period.

In April 2021, the Audit Committee received an update relating to the trust's compliance with the FT Code. The FT Code is based on the UK Code of Governance to reflect latest and best practice application of good corporate governance and provides a tried

and tested framework for the leadership and direction of board led organisations in the UK. Whilst the trust is not a foundation trust, it takes full account of the NHS Foundation Trust Code of Governance published by Monitor (now NHS Improvement) for trust boards. A summary of the trust's corporate governance arrangements against the FT Code was provided to the committee for assurance and the trust was able to declare compliance with all relevant clauses with the exception of one clause (A.2.1). Work will be undertaken during Q1 2021/22 to declare compliance against this clause.

Each committee has formal terms of reference which are approved by the Board of Directors and set out the powers and functions of the committees. These terms of reference are subject to annual review by the relevant committee with outcomes subsequently reported to the board of directors for approval. This annual review process incorporates a review of committee effectiveness which includes; an assessment of how functions have been discharged during the reporting period, evaluation of committee member attendance and identification of any committee development needs.

Register of Interests

The trust maintains a Register of Interest for the Board of Directors and is subject to bi-monthly review by the board. Where details of company directorships have been declared and where those companies are likely to do business or are possibly seeking to do business with the NHS, Board members declare their interest and withdraw from any decision-making process. During 2020/21, there were no identified breaches in respect of any declarations made by the Board of Directors.

As far as the executive directors are aware, there is no information relevant to the auditors for the purposes of their audit report. The executive directors have taken all of the steps they ought to have taken to ensure they are aware of any relevant audit information and to establish that the auditors are aware of that information.

The board considers that its non-executive directors are independent in character and judgement insofar as:

- No non-executive director has a third party business relationship with the trust
- No non-executive director has an income from the trust other than remuneration for their non-executive position
- No non-executive director financially relies on the income earned in their role or is either a supplier or customer of the trust
- No non-executive director has a personal connection to any senior trust managers, and,
- No non-executive director has been on the board for more than nine years.

The Board of Directors Register of Interest is available to view here.

Fit and Proper Persons Requirements: Directors and Non-Executive Directors

In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the trust is required to ensure that all individuals appointed to or holding the role of executive director (or equivalent) or non-executive director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

In March 2021, the Board of Directors received the Chairman's Annual Declaration confirming that all existing executive and non-executive directors met the requirements of Fit and Proper Persons Test which was informed by the application of the Board approved Procedure on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:
    - Proof of identity
    - Disclosure and Barring Service check undertaken at a level relevant for the post
    - Occupational Health clearance
    - Evidence of the right to work in the UK
    - Proof of qualifications, where appropriate
    - Checks with relevant regulators, where appropriate
    - Appropriate references, covering at least the last three years of employment, including details of gaps in service.
- Additional checks for all directors on the following appropriate registers:
    - Disqualified directors
    - Bankruptcy and insolvency
- Confirmation from the Chair of appointment panels of compliance with the checks process
- All new appointments for non-executive director positions are undertaken in conjunction with NHSE/I. The pre-employment checks undertaken by NHS E/I checks are shared with the trust so there is a retained record in the trust of the individual's fitness to undertake their role as non-executive director.
- A review of checks by NHSE/I in circumstances of the reappointment of non-executive directors to ensure that they remain 'fit and proper'
- Assessment of the Ongoing Independence of non-executive directors carried out by the Director of Corporate Affairs
- Annual and on-going declarations of interest for all Board members
- Annual Fit & Proper Persons Test self-declarations completed by all executive and non-executive directors.
- If there have been any individual concerns raised regarding directors during the previous year, the outcome of any investigations is reviewed to provide continuing assurance that directors remain 'Fit and Proper'.
- The retention of checks data on personal files.

Information Governance

Data is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. Information Governance (IG) and data protection is concerned with the way NHS organisations handle information about patients/clients and employees, in particular personal and special category information. Data protection gives organisations and individuals assurance that personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care. The programme of work associated with IG in 2020/21 has been progressed through the trust's Information Management Group (IMG) and from assertions set out in Data Security and Protection Toolkit (DSPT).

The final submission deadline for the DSPT has been moved to the end of June. The trust submitted the baseline at the end of February, the status of the submission is 67 of 111 mandatory evidence items provided. There are two detailed action plans in place for IG and ICT to ensure the evidence is provided for the final submission at the end of the June. Mersey internal Audit has completed a readiness audit which aims to provide assurance based upon the readiness of its intended June submission.

The IG team prepared a first draft of a Corporate Records Policy, which went to the Information Management Group. Work is continuing on this policy built upon the feedback received from this meeting. The trust's internal and external Privacy Notice has also been reviewed and updated, providing new and detailed information for staff and patients on how information is used within NWAS. Work is also ongoing for the Asset Owner project. The asset register is now populated on MARVEL and is evolving as the feedback comes in from Information Asset Owners (IAOs), Information Asset Administrators (IAAs), and Procurement. IAO/IAAs have completed e-learning training from Exemplar ltd which has been well received.

The trust uses the Datix Incident Report Form to capture data breaches reported by all levels of staff. During 2020/21 a total of 108 breaches relating to information governance were reported. Five of the total number of breaches were reported through a complaint to the data protection officer. Of these, one was externally reported on the DSPT. All externally reported breaches met the criteria for notification to the Information Commissioners Office (ICO).

The data protection officer also received a total of eight complaints. All complaints have been escalated and the majority have been closed. One complaint was made regarding the trust process for handling subject access requests.

The information Governance Team has dealt with a number of Data Protection Impact Assessments, all of which are at different stages of progress. A total of 16 DPIAs are being progressed by the Information Governance Team, four of which have been approved by ELC. These include 111 homeworking, ambulance data set, Hemsworth, and Electronic Patient Record (EPR).

The IG team developed a short Data Protection Impact Assessments (SDPIA) template in-line with the ICO guidance. SDPIAs are completed for information processing for COVID-19, if the processing continues as normal practise then a full Data Protection Impact Assessment (DPIA) must be completed. An additional seven short DPIAs have been completed. These include: lateral flow testing, antibody and asymptomatic COVID-19 testing, test, track and trace, fit testing, Microsoft 365 recording functions, CFR questionnaire, and Survey Monkey for Workforce questionnaire. One is in progress for vaccinations.

Additionally, many third party contract reviews, screening questions, and short screening questions have been completed in 2020/21 to provide further assurance. The third party contract reviews provide assurances on contractual data protection clauses and ensures specific information is included in the contract to protect the trust and its personal data. Screening questions are part of regular due diligence checks such as checking Privacy Notices, ICO registration, ISO 270001 certifications, and identifies the IAO and IAA of the system/service. The screening questions assess whether a full DPIA is required for the system/service. Short Screening Questions have also been developed in conjunction with Procurement to standardize and improve the process.

Our Individual Rights process has received SARs, Access to Health Requests, and numerous redirections of requests across the trust. A total of 2,204 requests (including SARs, Access to Health requests, and redirections) came into the trust in 20/21.

All key performance indictors (KPI) for Information Governance were met for every quarter. The table below highlights each KPI and the percentage achieved.

KPI	Target	Q1	Q2	Q3	Q4
Freedom of Information Requests	To respond to 90% of requests within 20 working days.	95% (approx.)	97%	96%	97%
Subject Access Requests	To respond to 85% of requests without undue delay and at the latest, within one month.	100%	99%	97%	97%
Data Protection Requests	To respond to 85% of requests within 40 working days	100%[1]	100%[1]	100%[1]	100%[1]
Data Breaches	To have a 15% reduction in externally reported data breaches and a 15% reduction in reported data breaches.	KPI not agreed	KPI not agreed	External 90% reduction Internal 23% reduction	External 100% reduction Internal 50% reduction

The Information Governance KPI's gives the Trust assurance that we are monitoring our

[1] Excluding data from Cheshire and Mersey which was not received.

processes and complying with data protection legislation ie: Data Protection Act 2018, UK General Data Protection Regulation 2020 and Freedom of Information Act 2002.

Modern Slavery Act 2015 – Transparency in Supply Chains

The Modern Slavery Bill was introduced into parliament on 10 June 2014 and passed into UK law on 26 March 2015. The Modern Slavery Act is an Act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude
- The person requires another person to perform forced or compulsory labour and the circumstance are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour

Larger organisations must publicly report steps they have taken to ensure their operations and supply chains are trafficking and slavery free.

This disclosure duty, contained in the Modern Slavery Act 2015, applies to companies and partnerships supplying goods or services (wherever incorporated or formed) with global turnovers of £36 million and above, providing they carry on business in the UK.

The trust has previously produced a Modern Slavery statutory statement for:

- Year ending March 2017;
- Year ending March 2018;
- Year ending March 2019; and
- Year ending March 2020.

Organisational Structure

North West Ambulance Service NHS Trust serves an approximate population of 7 million covering an area of 5,500 square miles and employs over 6,000 staff. The trust receives 1.3 million emergency calls per year, which is 16% of the national (999) activity. To meet this demand the trust has three emergency control centres and approximately 700 emergency vehicles.

The trust also provides urgent care and patient transport services across the region and manages the NHS non-emergency helpline, 111, regionally.

The trust has an overall annual budget of around £390 million.

The trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the trust adhere to the same ethical principles.

The trust has a non-pay budget of £102m of which over £80m per annum is spent on goods and services. Over 80% of the £80m is spent with the trusts top 250 suppliers.

Our Supply Chain

It is important to ensure that suppliers to the trust have in place robust systems to ensure that their own staff, and organisations within their own supply chain are fully compliant with the requirements of the Modern Slavery Act 2015.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the trust continues to monitor its supply chains with a view to confirming that such behaviour is not taking place.

The following actions in terms of Modern Slavery and Code of Conduct have been embedded within procurement processes:-

- The trust has developed a Modern Slavery Statement and a Supplier Code of Conduct.
- NHS Procurement template documents – ensure that Modern Slavery is considered in procurement exercises.
- NHS Terms and Conditions – requires suppliers to comply with all relevant law and guidance and to use good industry practice to ensure that there is no slavery or human trafficking in its supply chains.
- All current trust suppliers have been contacted to provide evidence of compliance with the Act and have been issued with the “Supplier Code of Conduct”. In addition, suppliers have been made aware of how to inform the trust if they become aware of any breaches to the act within their own supply chain. The same process has been adopted for new suppliers.
- When we write to new suppliers for information to enable them to be set up on our systems, we ask them for certain information and this has been expanded to cover a Modern Slavery Declaration.
- We have a Modern Slavery section in our “Procurement Manual” which is an internal guidance document that should raise awareness for all staff.
- The Senior Procurement team has completed the “Ethical Procurement and Supply Certificate” that is a recognised qualification of the Chartered Institute of Procurement & Supply.

Safeguarding

- The Safeguarding Vulnerable Persons Policy was reviewed in May 2019 and makes reference to modern slavery.
- The Safeguarding team has added Modern Day Slavery to the level 3 training and the induction training for the trust.
- The safeguarding crib sheets has a modern day slavery tick box option for staff who are raising concerns if they feel that the patient is a victim of modern day slavery.
- It has been made very clear to staff during training that modern day slavery is a crime and so if a patient is at risk of MDS or is believed to be a victim then the police should be contacted.

Recruitment

The trust has a robust recruitment policy and follows all the NHS Employment checks standards including right to work and identity checks. The checks standards are rigorously applied to all prospective employees and bank workers, whether in paid or unpaid employment. Agency staff are sourced through agencies listed on the Procurement Framework.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2021.

External Compliance

The trust's functions are organised to ensure effective compliance with the external requirements placed upon it by bodies such as the Department of Health and Social Care, the Care Quality Commission, NHS England and NHS Improvement (NHSE/I) and NHS Resolution. The trust aims to comply with, and meet, all statutory, legislative and regulatory requirements placed upon it as an employer, an ambulance service and an NHS trust. These include:

- National targets for ambulance response times
- Statutory and regulatory financial duties
- Care Quality Commission registration requirements
- NHS Model Employer standards
- Civil Contingencies Act 2004
- NHS Constitution

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Daren Mochrie QAM, MBA, Dip IMC RCSEd, MCPara
Chief Executive Officer Date: 11 June 2021

STATEMENT OF DIRECTORS' RESPONSIBLITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Date…11 June 2021…… Chief Executive:

Date:…11 June 2021……Director of Finance:

Annual Governance Statement 2020/21

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of North West Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North West Ambulance Service NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The Board of Directors has overall responsibility for providing strategic leadership of risk management throughout the organisation, which includes maintaining oversight of strategic risks to achieving Trust objectives via the Board Assurance Framework (BAF) and leading by example in creating a culture of risk awareness. The Director of Corporate Affairs is accountable to the Board of Directors and the Chief Executive for North West Ambulance Service NHS Trust's governance and risk management activities. With Executive responsibility for corporate governance and risk management, the Director of Corporate Affairs, with the support from the Head of Risk and Assurance, provides a clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements.

The Board of Directors is presented with a quarterly risk management assurance report, containing the BAF and the Corporate Risk Register (CRR), both of which are subject to scrutiny at the Executive Leadership Committee meetings.

Executive Directors of the Trust are responsible for the consistent application of the Risk Management Policy within their areas of accountability, which includes maintaining an awareness of the overall level of risk within the organisation, the management of specific risks that have been identified and promoting a risk aware culture within their Directorates. Senior Management Teams scrutinise Directorate and Service Risk Registers at their meetings.

Managers within the Trust are responsible for making active use of risk registers to support the management of their service, the management of specific risks that have been identified, promoting a risk aware culture and ensuring that risk assessments are carried out within their service.

Risk Training

Risk management training is incorporated in the Trust's induction programme and annual statutory and mandatory training programme.

Over previous years, several Board Development Sessions on risk management; risk appetite and Board Assurance Frameworks (BAF) have been held with the Board of Directors including during 2020/21. These focused sessions provide the Board of Directors with an additional opportunity to discuss and debate the strategic risks and Risk Appetite Statement prior to formal approval and to understand risk tolerance.

The risk and control framework

Risk Management Strategy

During 2020/21, the Risk Management Strategy was subject to a full review and refresh. The Risk Management Strategy enables the achievement of good risk management and risk assurance reporting which underpins other Trust strategies. This strategy focuses on the integration of both clinical and corporate risk management across the organisation, improving risk management systems and processes, enhancing organisational risk maturity in order to provide the Board of Directors and key internal and external stakeholders with evidenced based assurance regarding the quality of services that the Trust provides.

The Risk Management Strategy defines the broad aims and principles of risk management activities across the Trust, and sets out key targets and milestones for the coming three years at which point, it will be refreshed. The primary aim of the strategy is to provide a supportive framework that ensures integration of risk management into policy making, planning and decision making processes and specifically:

- To protect patients, carers, staff and others who come into contact with the Trust;
- To create awareness though the Trust of the importance of recognising and managing risk and providing staff with the appropriate knowledge, skills and

support;

- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management

Risk Management Policy

The Risk Management Policy was also reviewed during 2020/21. The Policy defines the approach taken by North West Ambulance Service NHS Trust in applying risk management to its decision-making at all levels. The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The Risk Management Policy applies to all areas of the Trust and at all levels. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making. The Trust has refreshed the Trust Risk Scoring Matrix to allow standardisation of risk assessment across the Trust, utilising a common currency. All risks are recorded and managed via the RLDatix System that is used across the Trust.

Risk management is everybody's responsibility and the principles of effective risk management should form an integral component of decision-making at all levels.

Where a risk is identified but cannot be managed without some significant change to the way the organisation operates, it is escalated through the relevant line management structure. The policy also requires risk action plans to be determined and implemented for those risks that are inadequately controlled.

Board Assurance Framework

The BAF is an effective method for the management of the organisation's strategic risks to meeting its corporate objectives and links with the Trust's mission, vision and strategic priorities. It provides structure for evidence to support the Annual Governance Statement and as a result, streamlines reporting to the Board of Directors. The BAF has matured into a comprehensive system and is embedded within the organisation's Corporate Governance Structure.

The Board Assurance Framework includes the following key elements:

- Strategic risks of the Trust, aligned to the Executive Director Lead and mapped to a Board Assurance Committee for monitoring;
- A description of the strategic risk, including opening, quarterly, in-year and final target scores;
- The corporate risks which link to the strategic risk, including risk scoring;
- Alignment of the strategic risk to the organisation's strategic priorities;
- Risk appetite category;
- Key controls in place to manage the risks;
- Assurances from the key controls;
- Evidence of the controls and assurances identified;
- Any gaps in controls and assurances;
- Action plans to address gaps in controls and assurance
- The corporate risks which link to the strategic risk, including scores.

The Board Assurance Framework is approved by the Board of Directors at the commencement of the financial year and is managed through delegation to its Board Assurance Committees. The Executive Leadership Committee continues to promote effective risk management and leadership whilst overseeing and monitoring the management of the Board Assurance Framework.

The Board of Directors reviews the Board Assurance Framework on a quarterly basis and approves the quarterly position. The final version of the 2020/21 Board Assurance Framework will be approved at the end of April 2021, by the Board of Directors.

Risk Management

Risk management is embedded within the organisation via a number of techniques and approaches. All departments within Directorates maintain a live, dynamic and well populated risk register via the RLDatix System. Risk is a key agenda item on all meeting agendas across the Trust. The Trust supports staff throughout the organisation to manage risk at the most appropriate level and ensuring there is a clear process for risk escalation. Risks are escalated via departmental and Directorate risk registers to the Corporate Risk Register in line with the Risk Management Policy.

Any business cases must include a full risk assessment and Equality Impact Assessment (EIA) prior to formal approval. All efficiency schemes have processes in place to identify and mitigate risks to quality.

Risk Appetite

As part of the cyclical Board Development Programme, the Board of Directors received a focused session pertaining to risk appetite. Collectively, the Board of Directors has assessed its risk appetite and this is reviewed annually. It is also taken into account when considering the tolerance level of any risk and when making decisions.

Quality Governance

Quality Governance is overseen via the Trust's Quality and Performance Committee which monitors the delivery of the Trust's Quality (Right Care) Strategy and compliance with the Care Quality Commission (CQC) and other regulatory requirements. The Quality and Performance Committee has been supported by the Executive-led Clinical Effectiveness Management Group, Safety Management Group and Review of Serious Events meeting.

There are clear Terms of Reference (ToR) for each Board Assurance Committee and reporting sub-group with the effectiveness of the groups and Board Assurance Committees being reviewed on an annual basis. At the end of 2020/21, the Board Assurance Committees completed effectiveness reviews and the exercises concluded that whilst the Board Assurance Committees are fulfilling their duties, there are areas of development to further strengthen their remit which will be implemented during 2021/22. These include a re-fresh of the supporting Sub-Committee structure, previously known as Management Groups and governance arrangements. The following Sub-Committees will be established for 2021/22; Health, Safety and Security (HSS) Sub-Committee, Infection, Prevention and Control (IPC) Sub-Committee, Patient Safety Sub-Committee, Clinical Effectiveness Sub-Committee, Emergency Preparedness Resilience & Response Sub- Committee and Diversity and Inclusion Sub-Committee. Each of these sub-committees will submit a Chair's Assurance Report after each meeting to the Quality & Performance Committee.

In addition, Board Assurance Committees will carry out regular 'deep dives' into key areas of risk during the year, driven by gaps in assurances highlighted on the Board Assurance Framework in a continued drive for improved quality of assurance reports.

During 2020/21, the Trust followed up the Board Assurance Committee effectiveness review recommendations from 2019/20 and included greater visibility of the Board Assurance Framework at Management Groups. In addition, a further improvement included allowing Board Assurance Committees to escalate items from their agendas to the Audit Committee. Collectively, improvements have been seen in the quality and content of both assurance reports and Chair's Assurance Reports from Management Groups. These changes were made to allow more effective triangulation and consideration of information and also increase in scrutiny.

There were three Board Assurance Committees, chaired by a Non-Executive Director that oversaw risk management; both clinical and non-clinical and these were:

- Audit Committee; which sought assurance over the risk management processes and controls in place rather than the content and management of individual risks themselves
- Quality and Performance Committee
- Resources Committee.

Clinical risk is monitored via the Trust's Clinical Effectiveness Management Group and Quality and Performance Committee.

Whilst clinical risk management is everyone's responsibility, it is managed on a day-to-day basis by operational staff and monitored by the Quality, Innovation and Improvement Directorate. Clinical risk is reported through the Patient Safety Management System, RLDatix, which allows themes and trends to be identified to inform wider organisational learning. All clinical practices are carried out using the best available clinical evidence base; this includes advice that is given to patients via telephone as well as advice and skills performed when our clinicians are in a face to face situation. In the former, the evidence base is largely taken from papers published in the UK and for the latter the evidence base is the Joint Royal Colleges Ambulance Liaison Committee's (JRCALC) latest Clinical Guidelines.

The Quality and Performance Committee is authorised by the Board of Directors to obtain and provide assurance on all aspects of quality, safety and operational performance relating to the provision of care and services ensuring the best clinical outcomes and experience for patients. Reporting into the Quality and Performance Committee are three Management Groups; Clinical Effectiveness Management Group, Safety Management Group and the Non-Clinical Learning Forum.

The Audit Committee reviewed the establishment and maintenance of an effective system of governance, risk management and internal control, across the entire organisation's activities. This includes activities that were both clinical and non-clinical.

2020/21 Strategic Risks

The Trust identified ten strategic risks on the Board Assurance Framework (BAF) aligned to the Strategic Priorities during 2020/21:

1. 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
2. If we do not have effective financial management, this may impact on the Trusts' financial position
3. If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care
4. If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trust's objectives
5. If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the Trusts' infrastructure and achieving environmental efficiencies
6. If we do not build and strengthen stakeholder relationships across systems,

localities and neighbourhoods, this may impact on the Trust's reputation and ability to achieve our vision to be the best ambulance service in the UK

7. If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation
8. If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to compete and gain business and commercial opportunities that will generate income and protect our core services
9. If the organisation experiences further changes at Board level during 2021/22, this may impact on relationships and ability to deliver the Trusts' strategic objectives
10. If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objective during 2020/21.

During Q2, a previous 2019/20 Strategic Risk was deemed sufficiently significant to be re-opened on the 2020/21 BAF and this related to the UK Government leaving the European Union.

- If the UK Government leaves the EU during the transitionary period with a no deal may impact on our ability to provide the service at the required levels resulting in inflated costs, disruption to supplies and loss of workforce.

Future 2021/22 Strategic Risks

Due to the release of the NHS Planning Guidance on 25 March 2021, the Trust proposed four strategic risks to be in place for the first two months of the year until the planning round has been completed and the strategic plans and objectives of the Trust have been reviewed and potentially revised. The additional strategic risks that were identified prior to the release of the NHS Planning Guidance, will be revisited and either added to the Board Assurance Framework (BAF), if they remain relevant, or revised if required.

The key risks for the Trust as is moves into the new financial year remain focused around patient safety, financial effectiveness and value for money, operational performance and workforce recruitment and retention.

The following list denotes the risks identified for the first two quarters of 2021/22:

1. There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction
2. There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure
3. There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or poor quality care
4. There is a risk that the Trust is unable to attract or retain suitably qualified and

diverse staff, this may impact on our ability to deliver safe services.

The Governance Framework of the organisation

Whilst the Trust is not obliged to comply with the FT Code of Governance, the Board of Directors constantly reviews its governance arrangements to ensure alignment where applicable. The Board of Directors recognises its accountabilities and provides leadership within a framework of prudent and effective controls which enables risk to be assessed and managed throughout the organisation.

The Board of Directors sets the strategic aims for the organisation and ensures that resources are in place to meet its objectives. It receives reports at each meeting held in public on the principal strategic risks through a combination of risk management assurance reports and/or Chair's Assurance Reports from the Board Assurance Committees.

The Board of Directors currently meets at least six times per annum and during the reporting period consisted of:

- The Chairman plus 5 other Non-Executive Directors, including a Senior Independent Director (SID)
- The Chief Executive Officer and 4 other voting Executive Directors
- 4 non-voting Directors
- 2 non-voting Associate Non-Executive Directors

The Board of Directors has three key roles:

- Formulating strategy for the organisation
- Ensuring accountability by; holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- Shaping a healthy culture for the Board of Directors and the organisation.

Quality is a central element of all Board of Director meetings. The Integrated Performance Report, which continues to be developed, is aligned to the Single Oversight Framework with focus on key quality indicators.

Either a staff or patient story is used to open each meeting of the Board, to ensure that the focus is on quality of patient care remains at the heart of all Board of Directors activity and decision making.

At each Board of Director meeting, the Board reviews reportable events which includes near misses, serious case reviews, claims and coroners' inquests. The Quality and Performance Committee also reviews these matters in more detail on a monthly basis, along with complaints and concerns, and learning is disseminated via the Trust Learning Forums which are held both corporately and locally in geographical

areas for both clinical and non-clinical matters. During the year, no nationally defined 'Never Events' have occurred as a result of Trust care or its services.

The Executive Management Team via the Executive Leadership Committee meets weekly and is accountable for the operational management of the Trust. The primary functions of the Executive Management Team include management of organisational governance; investment and disinvestment; performance delivery; horizon scanning; strategy and policy development, interpretation and implementation, and stakeholder and partner engagement.

Arrangements are in place through the Board of Directors and Board Assurance Committees to review and confirm that the Trust discharges its statutory functions. The Trust is satisfied that it has been compliant with these functions during 2020/21.

Attendance levels at Board of Directors and Board Assurance Committees meetings throughout 2020/21 are detailed on pages 61 of the Annual Report.

Whilst NHS Trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS Improvement (NHSI) to ensure that NHS Trusts comply with the conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS Trust where necessary to ensure compliance. In accordance with this, the Trust is required to submit to NHSI a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with FT4 (8) Condition of the Provider Licence as the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks. The Statement was drafted and approved by the Board of Directors at its meeting on 27 May 2020 and published on the Trust's website within the prescribed timescales. The Statement from the Board of Directors evidenced the current arrangements in place to mitigate the risks to compliance and concluded that there were no material risks. As mentioned elsewhere in this Annual Governance Statement the effectiveness of the Board Assurance Committees is reviewed at least annually and the Trust's performance is considered at each Board of Director meeting with presentation of the Integrated Performance Report based upon the Single Oversight Framework.

Workforce

The Trust has an approved Workforce Strategy in place and a supporting three year implementation plan reinforced by a set of clear measures. Progress against implementation of the strategy is monitored on behalf of the Board of Directors by the Resources Committee, with any key trust-wide projects also overseen by the Corporate Programme Board (CPB). The Workforce Strategy is aligned with the overall Trust Strategy and also reflects the requirements of core delivery strategies such as the Right Care Strategy and the Urgent and Emergency Care Strategy. The strategy is reviewed

annually in order to ensure it remains fit for purpose and to incorporate any key changes in the internal or external environment which have emerged over the previous year. The last review was undertaken in Q4 of 2020/21 to incorporate the national People Plan developments, the emerging impact of the GP contract reform and internal drivers such as work around just culture.

The impact of the COVID-19 pandemic has resulted in some of the strategic developments set out in the strategy being paused or delayed. This has enabled a focus on meeting the immediate workforce requirements, such as implementation of temporary staffing to support the Trust's response to the impact of the pandemic and to maintain safe staffing.

The Trust's approach to workforce planning and deployment fully considers the best practice set out in the Developing Workforce Safeguards, providing appropriate governance and monitoring at the strategic, tactical and operational levels. The Trust takes a robust approach to the development, management and oversight of its workforce plans. Whilst in previous years, the workforce element of the operational plan is submitted and approved at the Board of Directors and the plans are reviewed regularly by the Trust Board, Resources Committee and Executive Leadership Committee (ELC), the operating plan was paused in 2020/21 with an emergency budget being in place. Despite this, Senior Management Teams have continued to receive monthly reports on workforce data through the integrated performance report, which demonstrates the position against planned establishment. The People Directorate have worked closely with service lines to support short term workforce requirements and this has included recruitment of agency staff in our Emergency Operations Centres (EOC) and in NHS 111, engaging student paramedics to work in both front line roles as well as in EOCs and NHS 111 and recruiting ex-staff to return on a bank basis to support resource demands.

During 2020/21, assurance has been provided against the workforce and recruitment plan including the temporary COVID-19 workforce response. Ad hoc reports were also provided on specific risks associated with the workforce plan to the Executive Leadership Committee and Board Assurance Committees and during 2020/21 has included assurance pertaining to the management of agency staffing. The Resources Committee also received an in depth analysis of workforce issues at least annually, which includes integrated analysis of resource usage and deployment in the context of performance and quality.

At a tactical level, agreed plans are actively managed with service lines and Finance on a monthly basis so that developing trends can be identified and addressed. The planning process is dynamic and plans are reviewed monthly to allow the opportunity to discuss emerging issues that may impact on the plans and allow for flex to accommodate changes. The anticipated turnover rate is mapped throughout the plans to allow a forward view over the next twelve months to enable service lines to visualise the anticipated workforce position. These detailed one year plans sit within the context of a

five year plan focused on ensuring appropriate paramedic supply and which has informed regular engagement with Health Education England (HEE) and Health Education Institute (HEI) partners.

Operationally, levels of deployment against plan are monitored on an hour by hour basis with overall reporting to the Executive Leadership Committee. Managers work within the context of financial boundaries and governance processes, especially regarding the appropriate use of agency within the delegated ceiling and agency framework.

The Trust utilises the Model Ambulance dashboard metrics to gain an overview of clinical and non-clinical workforce composition including staff numbers, pay costs, skill mx ratios and productivity in terms of clinical output. This in turn supports the Trust to identify potential opportunities to improve efficiencies and productivity.

The risk framework is used effectively at strategic, tactical and operational level to identify and manage workforce risks. Significant risks during 2020/21 have reflected nursing vacancies in NHS 111, risks to paramedic supply arising from GP contract reform, and the impact of COVID-19 on availability of resources. These have been mitigated and monitored closely at the Executive Leadership Committee, Board Assurance Committees and by the Board of Directors.

The impact of the pandemic has meant that the Trust significantly increased the agency use in our Emergency Operations Centres (EOC), Clinical Hub and NHS 111 during 2020/21. All increased agency usage levels have been cited and approved by the Executive Leadership Committee (ELC). The Trust is currently operating under an emergency budget due to COVID-19 and any changes to agency ceiling arrangements and/or ceiling value are expected to be confirmed for Q3 of 2021/22 onwards. In order to prepare for the increased agency usage in remaining agency usage would be specifically for additional clinical staff who are engaged to support the existing vacancy gap. It is expected that agency use in these areas will return to pre COVID-19 levels by the end of Q1 of 2021/22.

Whilst there was no operating planning cycle in 2020/21, the Trust continued to manage the workforce plans within the current establishment. A particular focus was been made to ensure that paramedic workforce levels remains at establishment levels to prepare for the potential impact on GP reform in 2021/22. Workforce plans have been modelled to consider various levels of increased paramedic attrition during 2021/22 and mitigation strategies are in place to ensure that paramedic workforce levels remain safe and sustainable.

The Trust paramedic workforce supply continues to be strengthened through longer term strategic plans to develop and support internal development routes to paramedic, to increase external supply, to develop partnerships and to actively recruit. This includes the commencement of Paramedic degree apprenticeships for internal staff during

2020/21. Risks and plans have been closely monitored through the Resources Committee and Quality and Performance Committees. Targets for 2020/21 staffing were delivered.

The trust is fully compliant with the registration requirements of the Care Quality Commission.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

COVID-19

The response to the coronavirus (COVID-19) emergency situation required the Trust to operate differently to normal business as usual practice. The Trust was cognisant of national guidance issued around a variety of issues relating to the pandemic that was sweeping the country, including guidance on 'reducing the burden'.

Strategic Governance

In the context of COVID-19, the strategic governance of the Trust had to be and continues to be agile, making effective use of digital technologies. Throughout the year, meetings have been reviewed to ensure they are focused and streamlined and all meeting have been quorate. The Board of Directors agreed an amendment to clause 5.2 of the Trust's Standing Orders relating to Emergency Powers and Urgent Decisions. This enabled Emergency Powers to be exercised, should they be required, by the Chairman and Chief Executive having consulted with two Non-Executive Directors (NEDs) and two Executive Directors. At no time during 2020/21 were these emergency powers used.

During Q1 of 2020/21, the Board of Directors agreed the only Strategic Risk on the Board Assurance Framework should be:

1. If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objective during 2020/21.

A specific COVID-19 operational risk register was efficiently used across the Trust to support this strategic risk and incident management. During Q2, the wider Board Assurance Framework was re-introduced, with assurance on all key areas was being received through the remaining governance structure.

Under the leadership of the Chief Executive, an Incident Command Structure was rapidly established in line with the organisation's role as a Category 1 Emergency Responder in March 2020. Throughout the year as things escalated and de-escalated frequency of oversight meetings changed and these were agreed through the Executive Leadership COVID 19 committee. The purpose of the Incident Command Structure was to have oversight and make Trust-wide decisions relating to performance, patient and staff safety, clinical priorities, COVID-19 pressures and to enact National guidance. The Executive Leadership Committee (ELC) COVID 19 Committee was supported by various Executive led cells and a Strategic command structure. The strategic command structure updated the Trusts' Strategic Intentions on a regular basis setting out the priorities as to how as a Trust we were managing the incident.

Clinical Governance

NHS England/ Improvement (NHSEI) announced that the Trust needed to publish its Quality Account before 15 December 2020 and the Trust complied with this deadline.

Local Care Quality Commission (CQC) Inspectors continued to liaise with the Trust during the pandemic. As the Chief Executive for the Trust, telephone calls with the Head of Hospital Inspections continued to take place, fortnightly during the first wave and these were scaled back to general stakeholder briefings.

Initially, clinical audit activity was suspended as per the NHSEI guidance relating to 'reducing the burden'. However, NHSEI undertook a collaborative approach with Ambulance Services to identify an agreed approach to the recovery of data during the suspension period. A recovery plan was released by NHSEI which laid out the plans for the suspended months to be submitted to NHS England by 10 December 2020, which the Trust complied with.

Financial Governance

A detailed review of the financial systems and controls alongside the business continuity plans was undertaken to ensure the Trust's financial governance arrangements during the pandemic to ensure that decisions to commit resources in response to COVID-19 are robust.

In adherence with the NHS England/ Improvement (NHSEI) governance guidance, the Trust had set emergency budgets for the period of 01 April to 31 July 2020 in line with latest guidance. The emergency budgets were presented to the Board of Directors in May 2020.

In line with the Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation any investment decisions required in relation to responding to COVID-19 pandemic was documented and followed the appropriate approval process in line with current organisational procedures.

In addition, the authorised signatory list was reviewed to ensure sufficient signatories, so financial transactions were not slowed down, should key staff within the finance team were unavailable. There were no changes made to budget holder delegated limits, however, in order to support and release operational management capacity at the start of the response the authorisation of good and services for the Paramedic Emergency Service (PES) Head of Service, NHS 111, Emergency Operations Centres (EOC) and Patient Transport Service (PTS) were temporarily transferred to the Deputy Director of Finance and Head of Finance.

Human Resources Governance

During the pandemic, a significant focus on the capacity, capability and resilience of our workforce needed to meet the challenges of COVID-19.

The Trust has followed NHS England, Health Education England and Council of Deans guidance on the deployment of students from University Programmes, appropriate payments arrangements and resumption of programmes. Students formed an important part of the Trust's COVID-19 deployment and was managed without risk to end of programme dates.

The Trust Appraisal procedure and paperwork has been streamlined to enable effective and timely completion of appraisals. However, given the pause in appraisals for 2020/21, the Trust has reviewed the appraisal trajectory and target.

The Trust provided a detailed response to the Regional Chief People Officer for the North West with regards to the support and protection of our BAME colleagues, following his letter to the Trust. As the Chief Executive of the Trust, I wrote to all affected staff to reassure staff of the actions that the Trust were taking locally and across the Health Sector in the UK to ensure that staff were protected. The Trust wanted to be clear that we would do all we could to ensure that staff felt safe and supported at work.

The Trust had actively been undertaking risk assessments for those staff who were identified to be at a higher risk due to being from a BAME background, pregnancy, age and disability/ serious underlying health conditions or living with someone who was shielding. The Trust worked closely with our Occupational Health partner throughout the

pandemic, in order to provide clear guidance on levels of risk through a risk stratification document.

In addition, our workforce have been signposted to the Trust's Health, Wellbeing and Engagement support for staff. In addition, if staff did not feel comfortable raising a concern with their line manager, the Trust Freedom to Speak Up Guardian (FTSU) was available for staff to speak to in strict confidence.

Throughout the pandemic, the Trust has worked tirelessly promoting the help, support and advice available.

Information Governance

During COVID-19, the Trust still has a statutory responsibility to ensure that effective and robust information governance arrangements in place and remain accountable for handling personal data during the public health emergency.

The Trust has not met standards in the Data Security and Protection Toolkit, however, this is not due to COVID-19. The Trust had submitted evidence for 115 of the assertions out of 116. The Trust has not met the annual Data Security Awareness training assertion. An improvement plan had been submitted to mitigate and support meeting the assertion.

All operational systems and assurance processes for the management of cyber risks have been maintained and none have been neglected or configured in a way that would be compromised. The Cyber Essentials controls have been in full effect. Boundary firewalls remained active, the secure configuration of system have remained the same, access controls have been fully in place; including the increased amount of remote working levels across the Trust. Malware protection remained active and fully updates with patch management in full operation.

Major Incident

On 02 November 2020, the NWAS Strategic Command Team declared a major incident due to a sustained increase in demand throughout that day, that seen the Trust escalate through its internal Demand Management Plan (DMP).

The decision to invoke a major incident was due to demand outstripping resources available to the Trust at that time. This was compounded by a combination of increased patient acuity and hospital admissions, particularly in the Greater Manchester area on Sunday 01 November 2020, exceptional call demand throughout Monday 02 November 2020 and high hospital turnaround times across Greater Manchester. This resulted in high numbers of calls waiting, particularly across Category 2, which triggered the Demand Management Plan escalation thresholds to maintain patient safety.

The NWAS Strategic Command Team took a number of actions to manage the escalating situation throughout the day. Prior to declaring a major incident, actions taken were primarily focussed on mitigating patient safety risks. No Serious Incidents (SIs) have been identified following this major incident.

NWAS is committed to learning the lessons from Monday 02 November 2020 and embedding these within future plans to prevent reoccurring incidents.

Review of economy, efficiency and effectiveness of the use of resources

The Trust secures economy, efficiency and effectiveness use of resources through a variety of ways including:

- A well-established policy framework including Standing Orders, Standing Financial Instructions and Scheme of Delegation
- An organisational structure which ensures accountability and challenge
- Effective corporate functions supporting the planning and management of resources
- Detailed financial reporting to the Resources Committee including income and expenditure; statement of financial position; capital expenditure programmes; expenditure relating to responding to the COVID-19 pandemic and key financial risks.

The Trust invests significant time in improving systems and controls to deliver a more embedded range of monitoring and control processes. The in-year use of resources is closely monitored by the Board of Directors and the following Board Assurance Committees:

- Audit Committee
- Nominations and Remuneration Committee
- Resources Committee
- Quality and Performance Committee

Day to day management of resources is monitored through the Executive Leadership Committee (ELC). The ELC takes the lead in planning, delivery and taking actions for recovery to bring variances back to plan when needed. Throughout the year, the ELC regularly reviews performance against clinical, performance, workforce and financial indicators.

The Trust employs a number of approaches to ensure best value for money (VfM) in delivering its services. Benchmarking is used to provide assurance and to inform and guide service redesign. This leads to improvements in the quality of services and patient experience as well as financial performance. Financial governance arrangements are supported by an internal audit plan and the external auditors. Through this process, the Trust has gained an independent and objective assurance to

the Audit Committee and the Board of Directors that the Trust's risk management, governance and internal control processes are operating effectively.

The Trust has a dedicated, qualified Local Counter Fraud Specialist (LCFS) supported as required by other LCFSs.

It should be noted that the Trust implemented additional expenditure monitoring and control measures throughout 2020/21, to ensure financial control reporting was maintained whilst responding to the COVID-19 pandemic.

Information governance

The programme of work associated with Information Governance throughout 2020/21 has been reported to the Trust's Information Management Group and onwards to the Resources Committee.

The final submission date of the Data Security Protection Toolkit (DSPT) has been changed from 31 March 2021 to the end of June 2021, by NHS Digital. The Trust submitted the baseline at the end of February 2021, with the status of the submission being 67 of the 111 mandatory evidence items provided. Mersey Internal Audit Agency (MIAA) have completed a readiness audit which aims to provide assurance based upon the readiness of the intended submission in June 2021.

The Trust effectively uses the Datix System to capture data breaches via the incident module. During 2020/21, a total of 108 breaches relating to information governance was reported. Five out of the total number of breaches was reported through a complaint to the Data Protection Officer (DPO). Of these, one was externally reported on the Data Security Protection Toolkit. All externally reported breaches met the criteria for notification to the Information Commissioners Office (ICO).

The externally reportable data breach was a patient confidentiality breach, which required a full root cause analysis investigation by the Trust.

Data quality and governance

In order for the Trust to ensure it maintains a strong level of data quality, the Trust has developed a strong set of procedures and processes. These processes are well embedded and adhered to within the Business Intelligence Team. A robust management review of these procedures occurs periodically, which includes any updates to written procedures. These procedures and processes forms part of the Short Term Data Quality Strategy, this will be further developed and enhanced through the Longer Term Data Quality Strategy, of which plans are already progressing.

Shorter Term Data Quality Strategy

The Trust has implemented clear procedures and processes in terms of manual data validation checks, this applies to both internal and external (NHS England/ Improvement) outputs. The controls that have been implemented, whilst they are manual, provide some assurance and level of data quality checking within the Trust's Business Intelligence outputs. The processes already in place are operated by the Trust's Analyst Team and involves data checks on measures and/or dimensions, in line with pre-set tolerances. If measures exceed outside a set tolerance, this would trigger a manual check, look specifically for any spurious data or data anomalies. The Trust has set database (NWAS Data Warehouse) level data validation rules; including data formatting rules, for example a date format is set to 'DD-MM'YYYY, HH:MM:SS' and geographic data is captured as UK registered postcode format.

Longer Term Data Quality Strategy

The next phase in the Trust's Data Quality Strategy is to secure a substantive Data Quality Manager within the Trust, who will be responsible for creating the Data Quality Strategy, Policy and implementation of automated monitoring tool. The automated monitoring tool will be deployed against the Trust's Data Warehouse and continually monitor the Trust's data quality levels, altering any anomalies and spurious data entries. This will feed the Data Quality Improvement Plan, through identifying common and recurring data quality issues that sit within the underlying data sets, will drive improvement to data extracts and possibly the source systems where data is captured.

Alongside both short and long term data quality measures, the Trust also receives an annual Internal Audit of Data Quality, which is conducted by Mersey Internal Audit Agency (MIAA). This audit provides the Trust with both actions to be completed, continually enhancing and developing the Trust's data quality approach, as well providing assurances to the Audit Committee. The Business Intelligence function reports on data quality performance to the Quality and Performance Committee. This further highlights how data quality is truly embedded into the Business Intelligence Strategy, in terms of monitoring and continual improvement.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee; the Quality and Performance Committee and the Resources Committee and a plan to address weaknesses and ensure continuous improvement of

the system is in place.

My review is informed in a number of ways:

- The Head of Internal Audit provides me with an independent opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work;
- Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance;
- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the key risks to the organisation achieving its strategic objectives have been reviewed;
- The outcome of the Care Quality Commission (CQC) inspection during Q4 of 2019/20, the official outcome was published during Q1 of 2020/21 and the overall rating of 'Good' was received, however, the Trusts' urgent and emergency care was rated as 'Outstanding' under the responsiveness key line of enquiry.

My review is also informed by:

- The NHS Data Security and Protection Toolkit
- Assessment against the NHS Counter Fraud Authority Standards for Providers
- Peer reviews within the ambulance service sector
- Internal Audit reports
- Clinical Audit findings
- External Audit reports
- External consultancy reports on key aspects of Trust governance

The Board of Directors seeks assurance that risk management systems and processes are identifying and managing risks to the organisation appropriately through the following:

- At least annually; a review of the effectiveness of the Trust's system of internal control
- The Board of Directors ensure that the review covers all material controls, including financial, clinical, operational and compliance controls, and risk management systems
- A two yearly review of the Risk Management Policy
- A quarterly presentation of the Board Assurance Framework at Board of Directors

meetings
- Monthly integrated performance reporting at Board of Directors meetings, outlining achievements against key performance, safety and quality and finance indictors
- Assurance reports at each meeting, providing information on progress against compliance with national standards
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented

The follow-up of internal audit recommendations are regularly monitored by the Executive Leadership Committee, Internal Audit and the Audit Committee. The Trust has a comprehensive risk-based internal audit plan in place and this programme was delivered in during 2020/21, with the exception of one audit that was deferred to 2021/22. The outcomes of the 2020/21 internal audit programme, reported via the Head of Internal Audit Opinion, which overall gave the Trust substantial assurance – there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. During the year, the following audit assurance outcomes were reported:

- 6 audits were assessed as High Assurance
- 8 audits were assessed as Substantial Assurance
- 2 audits were assessed as Moderate Assurance
- 0 audits were assessed as Limited Assurance, and;
- 0 audits were assessed as No Assurance

The Trust's internal auditors have also supported the organisation in strengthening arrangements in respect of risk management and internal control. The 2020/21 Internal Audit programme of audit work has provided assurance across the Trust's critical business systems, namely, Financial Systems, IM&T, Performance, Quality, Workforce, Governance and Risk and Legality. Recommendations made have resulted in actions take to further strengthen systems and controls in year.

There has been effective utilisation of internal audit in respect of advice and guidance relating to the Trust's system and processes. There have also been flexibility and amendments to the audit plan to reflect emerging risks and issues during 2020/21, where required which has added value. The impact on the organisation of COVID-19 has required a review of the internal audit programme for 2020/21 on a regular basis, with the focus remaining on the delivery of our Head of Internal Audit Opinion. The provision of briefings, involvement through Mersey Internal Audit Agency (MIAA) learning events and information provided related to benchmarking and outcome reporting have also supported the organisation in strengthening arrangements.

During 2020/21, the Trust's Clinical Audit department participated as provider of information to the national clinical audits and these are as follows:

- National Ambulance Clinical Quality Indicators, a national audit of the care of the patients who were assessed by ambulance clinicians as:
    - Suffering a pre-hospital cardiac arrest
    - Suffering a pre-hospital heart attack
    - Suffering a stroke
    - Suffering from sepsis

Conclusion

Following my review and taking into account the contents of this report and the evidenced based assurance seen at the Board Assurance Committees, I confirm that no significant internal control issues have been identified.

Signed
Chief Executive Date: 11 June 2021

Remuneration Report

The North West Ambulance Service NHS Trust has established a Nominations and Remuneration Committee that advises the Board of Directors with regard to the appropriate remuneration and terms of service of the Chief Executive and other executive directors including:

- All aspects of salary
- Provision of other benefits
- Arrangements for termination of employment and other contractual terms.

The members of the committee are the Chairman and non-executive directors. The Chief Executive, other directors and any other officers in attendance are not present for discussions about their own remuneration and terms of service.

Policy on Remuneration

The determination of salaries for senior managers for 2020/21 onwards is informed by national guidelines regarding Very Senior Managers' (VSM) pay which cover the Chief Executive, Executive Director and the majority of director posts and where appropriate are approved by NHS England/Improvement.

Contracts of Employment

The Executive Leadership Team are employed on full time contracts. The period of notice required for these posts is six months.

Termination payments are governed by guidelines set by HM Treasury that allow for compensation to be paid in relation to the notice period given, together with any statutory redundancy settlement, if applicable. Any exceptions to this require the prior approval of NHS Improvement and the Treasury.

Performance Related Pay

The broad arrangements for annual salary uplifts and the performance bonus scheme are specified in The Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts (June 2013) and in the subsequent Guidance on pay for Very Senior Managers in NHS Trusts and Foundation Trusts (February 2017).

The nationally agreed salary uplift was applied to the salaries of directors in 2020/21 subject to the qualifying criteria laid out by NHSI. This was a consolidated increase of 1.03% paid in November 2020 and backdated to April 2020. There is the option to apply a performance bonus to the top 25% of directors based on comparative

performance and this can be a maximum of 5% of salary paid on a non-consolidated basis for one year. The award can only be paid to directors rated as outstanding or exceeding expectations. The application of these arrangements locally are determined by the Nominations and Remuneration Committee, which has responsibility for determining the pay of the Chief Executive and directors on VSM contracts, working within the terms of the VSM pay framework. Where required under the national guidance, approval for Nominations and Remuneration Committee decisions is sought from NHSE/I. Evaluation of performance is based on SMART objectives which are incorporated in the performance plans of directors subject to the VSM pay framework. Performance in delivering these objectives at the year-end is reviewed via individual performance review meetings but would be signed off ultimately on a collective basis by the Nominations and Remuneration Committee.

The remuneration paid to senior managers during 2020/21 would include performance related pay for the previous year. It was agreed that an award of 3% should applied to two executive directors based on their performance during 2019/20.

Details of senior managers' remuneration and pensions are shown in the following tables.

Salaries and Allowances 2020/2021 (subject to audit)

Table 1: Single Total Figure Table

Name	Title	FROM 1ST APRIL 2020 TO 31ST MARCH 2021						FROM 1ST APRIL 2019 TO 31ST MARCH 2020					
		Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000	£	£	£000	£000	£000	£000
Peter White	Chair	35 - 40	0				35 - 40	35 - 40	0				35 - 40
Executive Directors													
Daren Mochrie	Chief Executive	185 - 190	4,400			290 - 292.5	445 - 450	185 - 190	5,900			167.5 - 170	360 - 365
Michael Forrest	Deputy Chief Execituve	140 - 145	11,000				150 - 155	135 - 140	11,500				145 - 150
Gerard Blezard	Director of Operations	120 - 125	11,200			80 - 82.5	210 - 215	105 - 110	4,300			22.5 - 25	135 - 140
Maxine Power	Director of Quality, Improvement and Innovation	120 - 125	10,200			57.5 - 60	190 - 195	110 - 115	10,600			10 - 12.5	135 - 140
Angela Wetton	Director of Corporate Affairs	95 - 100	10,200				105 - 110	90 - 95	9,800				100 - 105
Salman Desai	Director Strategy and Planning	105 - 110	10,300			80 - 82.5	200 - 205	120 - 125	4,500			15 - 17.5	140 - 145
Lisa Ward	Director of Organisational Development	105 - 110	5,300			55 - 57.5	165 - 170	95 - 100	5,100			37.5 - 40	140 - 145
Chris Grant	Medical Director	135 - 140	8,200			195 - 197.5	335 - 340	95 - 100	1,100			160 - 162.5	255 - 260
Carolyn Wood	Director of Finance	120 - 125	400			127.5 - 130	250 - 255	120 - 125	0			60 - 62.5	180 - 185
Non-Executive Directors													
Michael O'Connor	Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
Dr David Hanley	Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
R Groome	Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
Clare Wade	Associate Non-Executive Director (till 01/11/2020)	5 - 10	0				5 - 10	5 - 10	0				5 - 10
David Rawsthorn	Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
Prof Alison Chambers	Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
Prof Rod Thomson	Associate Non-Executive Director	10 - 15	0				10 - 15	5 - 10	0				5 - 10
Maria Ahmed	Non-Executive Director (till 31/07/2019)	0	0				0	0 - 5	0				0 - 5
Gillian Singh	Associate Non-Executive Director (from 01/03/2021)	0 - 5	0				0 - 5						

Table 2: Pension Benefits (subject to audit)

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2021	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employers Contribution to Stakeholder Pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Daren Mochrie	Chief Executive	12.5 - 15	20 - 22.5	80 - 85	185 - 190	1,449	261	1,141	27
Gerard Blezard	Director of Operations	2.5 - 5	5 - 7.5	50 - 55	120 - 125	1,093	107	954	17
Maxine Power	Director of Quality, Improvement and Innovation	2.5 - 5	2.5 - 5	35 - 40	70 - 75	709	59	623	17
Salman Desai	Director Strategy and Planning	2.5 - 5	5 - 7.5	30 - 35	70 - 75	561	65	475	15
Lisa Ward	Director of Organisational Development	2.5 - 5	2.5 - 5	25 - 30	55 - 60	531	51	459	15
Chris Grant	Medical Director	10 - 12.5	7.5 - 10	50 - 55	65 - 70	734	142	564	19
Carolyn Wood	Director of Finance	5 - 7.5	5 - 7.5	40 - 45	90 - 95	736	111	598	18

Benefits and related CETVs do not allow for any potential future adjustment arising from the McCloud judgment

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Notes to accompany remuneration tables:

Auditable Content
Salaries and Allowances 2020/21
Pension Benefits
Staff Numbers and Costs
Exit Packages
Pay Multiples

Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director / member in North West Ambulance Service NHS Trust in the financial year 2020-21 was £189k (2019-20, £186k). This was 6.14 times (2019-20, 6.11 times) the median remuneration of the workforce, which was £30.7k (2019-20, £30.4k).

The range of staff remuneration during 2020/21 was £15,000 - £20,000 to £185,000 - £190,000 (2019/20 £15,000 - £20,000 to £185,000- £190,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Cash Equivalent Transfer Values – A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation for Loss of Office

There were no such payments made during 2020/21.

Payments to Past Directors

There were no such payments made during 2020/21.

Staff Report

Executive Directors

During the year, the trust had nine director positions for which VSM salaries are payable. One of these individuals was internal interim appointments to cover the Director of Organisational Development post until July 2020. A permanent appointment to the Director of People (superseding the Director of Organisational Development post) commenced in post from August 2020.

For further details please see the Remuneration Report table.

Non-Executive Directors

During the year the trust had the following non-executive directors in place:

- Five non-executive directors on non-executive pay bands
- Two associate non-executive directors on non-executive pay bands
- Chair of the Trust Board on Chair pay band

Whilst non-executive directors and the Trust Board Chairman are senior managers of the organisation, they are not trust staff and their terms and conditions are determined by NHSE/I. During 2020/21, one associate non-executive director resigned from the trust and one non-executive director's term came to an end of 31 March 2021. Recruitment to replace these appointments were made during 2020/21 with one associate non-executive directors recruited and a non-executive directors was appointed by NHSE/I (for commencement in April 2021), and one non-executive director had their term renewed by NHSE/I. The associate non-executive directors are recruited by the trust for a period of two years.

During 2019/20, NHS England and NHS Improvement introduced a pay restructure for non-executive directors and chairs with a staged increase between October 2019 and April 2021. This restructure also included the discretion for trusts to award supplementary payments up to £2,000 per annum to individuals with designated extra responsibilities. The trust has awarded supplementary payments to two non-executive directors based on their additional responsibilities for the trust.

For further details please see the Remuneration Report table.

Senior Manager by Band

The trust's definition of a senior manager is the chief executive and director posts. For a breakdown of salary bands, please refer to the Salaries and Allowances detailed within the Remuneration Report.

Staff Numbers and costs (subject to audit)

The breakdown of staff at 31 March 2021 is as follows:

Staff costs

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	248,886	227	**249,113**	212,023
Social security costs	23,401	-	**23,401**	20,740
Apprenticeship levy	1,177	-	**1,177**	1,057
Employer's contributions to NHS pension scheme	41,353	-	**41,353**	37,439
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	9	-	**9**	-
Temporary staff	-	5,934	**5,934**	1,569
Total gross staff costs	**314,826**	**6,161**	**320,987**	**272,828**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**314,826**	**6,161**	**320,987**	**272,828**
Of which				
Costs capitalised as part of assets	347	25	**372**	79

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	3	-	**3**	3
Ambulance staff	5,544	-	**5,544**	5,390
Administration and estates	553	10	**563**	543
Healthcare assistants and other support staff	99	128	**227**	102
Nursing, midwifery and health visiting staff	98	31	**129**	96
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	1	-	**1**	-
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	2
Total average numbers	**6,298**	**169**	**6,467**	**6,136**
Of which:				
Number of employees (WTE) engaged on capital projects	8	-	**8**	1

Staff Composition and Staff Policies

NWAS continues aiming towards having a workforce which is representative of the communities we serve across the North West and being an employer of choice for all.

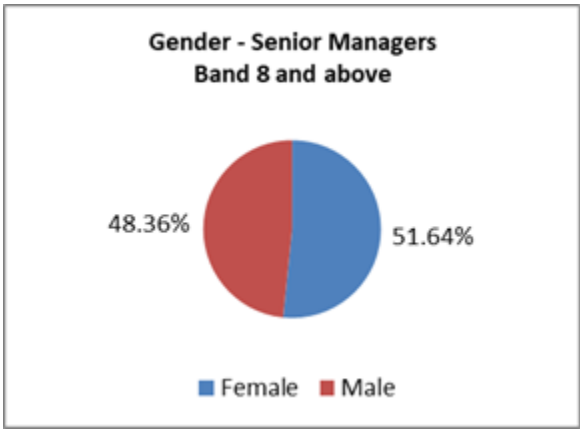
As required within the NHS contract, the trust published the Workforce Race Equality Standard (WRES) data during the summer of 2020. Overall the WRES showed a mixed

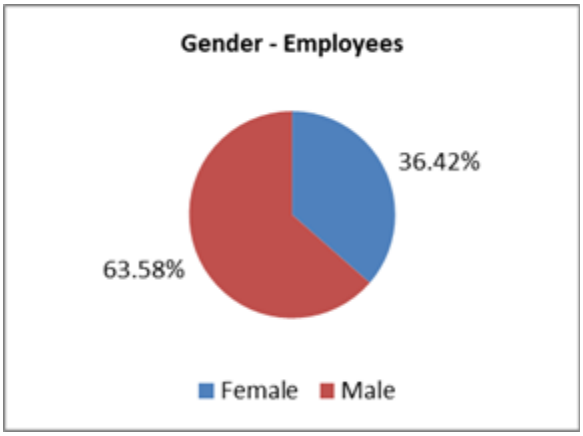
picture of results with some positive improvements in staff experience and representation but some areas for continued focus in recruitment, disciplinary processes and training.

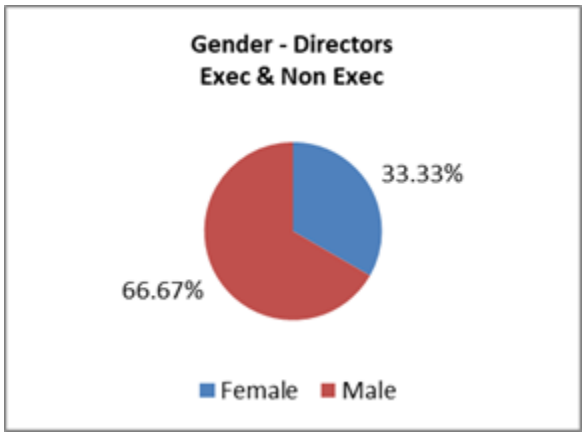
Gender Pay Gap reporting up to end March 2021 shows that the gap in the hourly rate of pay between male and female staff widened from 8.79% in March 2020 to 10.89% in March 2021 (using the average calculation) and from 8.28% to 9.2% using the median calculation. The average hourly rate for male and for female staff increased during the same period. Representation within each of the quartiles showed an increase, with the top-earning quartile having been a key area of focus. Progression into the highest paid roles is also dependent on vacancies created through the year which require recruitment.

The number of disabled staff within NWAS has increased by 62 individual staff to 314, which now represents 4.63% of the overall workforce by the end of March 2021. For the second year, the trust was required to publish the Workforce Disability Equality Standard (WDES) data, in line with NHS contract commitments. The data did highlight some differences in staff and candidate experience between staff who have a disability and staff who do not. An action plan to address this had been developed and published. The Disability Forum continues to develop and has clear links to improving staff experience for the future.

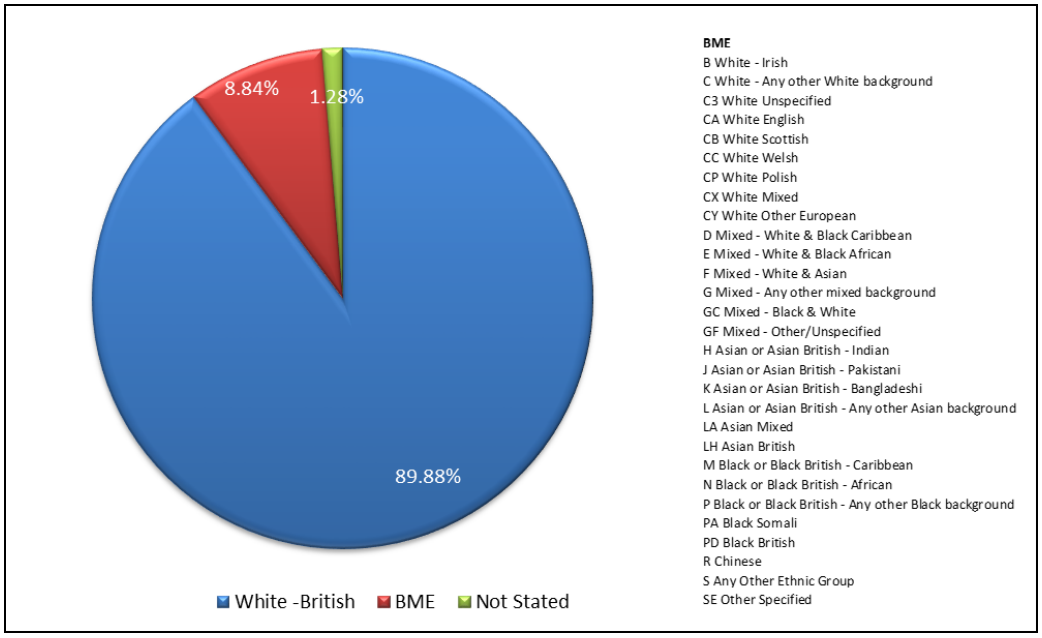
NWAS continues to review various other aspects of the workforce. There are regular inter-departmental meetings on race, gender and disability.







BME Percentage of Staff as at 31st March 2021



Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. The regulations require public sector employers to publish information on how much time is spent by their union officials on paid 'trade union facility time' and is detailed for 2020/21 in the tables below:

Number of employees who were relevant union officials during the relevant period	
106	
Full time Equivalent employee number	
100.71	
Percentage of Time Spent on Facility Time	
Percentage of time	No of employees
0%	23
1-50%	71
51%-99%	6
100%	6
Percentage of Pay Bill Spent on Facility Time	
First Column	Figures
Provide the total cost of facility time	£473,961
Provide the total pay bill	£304,353,000
Provide the % of the total pay bill spent on facility time, calculated as: (total cost of facility time/ total pay bill x 100)	0.2%
Paid Trade Union Activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/ total paid facility time hours x 100)	

Sickness Absence Data

In response to COVID-19, changes to the Annual Reporting requirement have been made and this section became 'optional to omit'. NHS Sickness Absence Rates can be reviewed here.

Expenditure on Consultancy

The expenditure on consultancy costs during 2020/21 was £108k in year.

Ill Health Retirements

During 2020/21 there were 9 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £356k (£249k in 2019/20).

Off-Payroll Engagements

There are no off-payroll engagements to disclose during 2020/21.

Table 1: Off-Payroll Engagements longer than 6 months

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	0
For 4 or more years at the time of reporting	0

Table 2: New Off-Payroll Engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and March 2021, for more than £245 per day and that last for longer than six months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which.	
No assessed as caught by IR35	0
No assessed as not caught by IR35	0
No engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No of engagements reassessed for consistency/assurance during the year	0
No of engagements that saw a change to IR35 following the consistency review	0

Table 3: Off-payroll board Member/Senior Official Engagements

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements or board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	0

Exit Packages (Subject to Audit)

There were no exit packages during 2020/21.

Independent auditor's report to the Directors of North West Ambulance Service NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of North West Ambulance Service NHS Trust ('the Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements
As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception
We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer
As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of North West Ambulance Service NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Karen Murray, Key Audit Partner
For and on behalf of Mazars LLP

Karen Murray

One St Peter's Square
Manchester
M2 3DE

11 June 2021

North West Ambulance Service NHS Trust

Annual accounts for the year ended 31 March 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	406,631	360,007
Other operating income	4	33,373	10,575
Operating expenses	6, 8	(442,007)	(368,907)
Operating surplus/(deficit) from continuing operations		**(2,003)**	**1,675**
Finance income	11	9	302
Finance expenses	12	79	(54)
PDC dividends payable		(468)	(1,542)
Net finance costs		**(380)**	**(1,294)**
Other gains / (losses)	13	119	77
Surplus / (deficit) for the year from continuing operations		**(2,264)**	**458**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	31	(894)
Revaluations	17	362	547
Other reserve movements		-	0
Total comprehensive income / (expense) for the period		**(1,871)**	**111**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(2,264)	458
Remove net impairments not scoring to the Departmental expenditure limit		2,950	2,504
Remove I&E impact of capital grants and donations		17	20
Remove 2018/19 post audit PSF reallocation (2019/20 only)			(111)
Remove net impact of inventories received from DHSC group bodies for COVID response		(662)	
Adjusted financial performance surplus / (deficit)		**41**	**2,871**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	1,408	1,681
Property, plant and equipment	15	99,292	91,985
Investment property	17	160	160
Receivables	19	1,217	1,355
Total non-current assets		**102,077**	**95,181**
Current assets			
Inventories	18	1,735	1,009
Receivables	19	14,815	11,219
Non-current assets for sale and assets in disposal groups	20.1	-	396
Cash and cash equivalents	21	60,628	43,368
Total current assets		**77,178**	**55,992**
Current liabilities			
Trade and other payables	22	(53,447)	(33,511)
Provisions	26	(5,374)	(4,571)
Other liabilities	23	(2,546)	(1,375)
Total current liabilities		**(61,367)**	**(39,457)**
Total assets less current liabilities		**117,888**	**111,717**
Non-current liabilities			
Borrowings	24	(78)	(78)
Provisions	26	(19,068)	(18,634)
Total non-current liabilities		**(19,146)**	**(18,712)**
Total assets employed		**98,742**	**93,005**
Financed by			
Public dividend capital		107,009	99,400
Revaluation reserve		2,614	2,638
Income and expenditure reserve		(10,881)	(9,033)
Total taxpayers' equity		**98,742**	**93,005**

The notes on pages 6 to 32 form part of these accounts.

Name	Carolyn Wood
Position	Director of Finance
Date	11 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**99,400**	**2,638**	**(9,033)**	**93,005**
Surplus/(deficit) for the year	-	-	(2,264)	**(2,264)**
Other transfers between reserves	-	(341)	341	**-**
Impairments	-	30	-	**30**
Revaluations	-	362	-	**362**
Transfer to retained earnings on disposal of assets	-	(75)	75	**-**
Public dividend capital received	7,609	-	-	**7,609**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2021	**107,009**	**2,614**	**(10,881)**	**98,742**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**99,341**	**3,349**	**(9,855)**	**92,835**
Surplus/(deficit) for the year	-	-	458	**458**
Other transfers between reserves	-	(329)	329	**-**
Impairments	-	(894)	-	**(894)**
Revaluations	-	547	-	**547**
Transfer to retained earnings on disposal of assets	-	(35)	35	**-**
Public dividend capital received	59	-	-	**59**
Taxpayers' and others' equity at 31 March 2020	**99,400**	**2,638**	**(9,033)**	**93,005**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the trust, is payable to the DHSC as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(2,003)	1,675
Non-cash income and expense:			
Depreciation and amortisation	6.1	12,971	12,275
Net impairments	7	2,950	2,504
(Increase) / decrease in receivables and other assets		(2,760)	1,190
(Increase) / decrease in inventories		(726)	(112)
Increase / (decrease) in payables and other liabilities		20,187	(1,203)
Increase / (decrease) in provisions		1,322	289
Net cash flows from / (used in) operating activities		**31,941**	**16,618**
Cash flows from investing activities			
Interest received		9	302
Purchase of intangible assets		(440)	(534)
Purchase of PPE and investment property		(21,202)	(12,994)
Sales of PPE and investment property		515	467
Net cash flows from / (used in) investing activities		**(21,118)**	**(12,759)**
Cash flows from financing activities			
Public dividend capital received		7,609	59
Interest paid on finance lease liabilities		(6)	(8)
PDC dividend (paid) / refunded		(1,166)	(1,503)
Net cash flows from / (used in) financing activities		**6,437**	**(1,453)**
Increase / (decrease) in cash and cash equivalents		**17,260**	**2,406**
Cash and cash equivalents at 1 April - brought forward		**43,368**	**40,962**
Cash and cash equivalents at 31 March	21.1	**60,628**	**43,368**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.3 continued

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.8 Property, plant and equipment. Continued

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.
Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when the assets are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.
Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.
Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.
Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.8 Property, plant and equipment. Continued

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	0	0
Buildings, excluding dwellings	15	66
Dwellings	0	0
Plant & machinery	4	25
Transport equipment	5	14
Information technology	1	15
Furniture & fittings	2	20

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.9 Intangible assets. Continued

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	1	8

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method .

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract asset, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 29 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 30 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

NWAS is in the process of finalising the lease register and the project of designing new processes is under way.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

For the Trust there are no standards , amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

Note 1.24 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

Operating Lease Commitments

The Trust leases a number of its vehicles. As management has determined that the Trust has not obtained substantially all the risks and rewards of ownership the leases have been classified as operating leases and accounted for accordingly.

Segmental Reporting

Management has determined that it operates only in one segment, that of healthcare.

Note 1.25 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Revaluation of Property, Plant and Equipment

The valuation exercise was carried out in February 2021 with a valuation date of 31 March 2021. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'). The valuer has declared their valuation is NOT reported as being subject to 'material valuation uncertainty' in the valuation report as property markets are functioning again and market evidence exists upon which to base opinions of value.
Carrying value of Trust's land and buildings at 31st March 2021 is £36,187k.

Provisions

The Trust has taken a prudent view on estimating potential risk associated with various staff related costs i.e. tribunals, Permanent Injury Benefits (PIB) and others. These are based upon most current information available from various bodies such as NHS Resolution (formally NHS Litigation Authority (NHSLA)), national census information, legal professionals etc. Carrying value of provisions is £24,442k.

Note 2 Operating Segments

The Trust has judged that it only operates as one business segment, that of healthcare.

99% (£436m) of the Trust's income in 2020/21 (2019/20 £364m, 98%) is received from NHS organisations such as Commissioners for NHS patient care services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.

Note 3.1 Income from patient care activities (by nature)	**2020/21**	**2019/20**
	£000	**£000**
A & E income	308,652	275,542
Patient transport services income	42,588	43,067
Other income***	42,828	30,063
Additional pension contribution central funding**	12,563	11,335
Total income from activities	**406,631**	**360,007**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Other income inlcudes the following items: 111 funding at £28,153k, £6,061k central funding relating to annual leave, £7,905k income relating to resilience and £711k relating toi income recovery from RTAs.

Note 3.2 Income from patient care activities (by source)

	2020/21	**2019/20**
Income from patient care activities received from:	**£000**	**£000**
NHS England*	22,736	12,267
Clinical commissioning groups	382,639	345,851
Department of Health and Social Care	113	-
Other NHS providers	170	453
Local authorities	1	23
Non-NHS: private patients	-	2
Injury cost recovery scheme	711	1,001
Non NHS: other	261	410
Total income from activities	**406,631**	**360,007**
Of which:		
Related to continuing operations	406,631	360,007
Related to discontinued operations	-	-

* In 2020/21 NHS England has provided income to cover extra pressure relating to various aspects of annual leave of £9,554k and pensions contribution of 6.3% as per note 3.1.

Note 4 Other operating income

	2020/21	2019/20
	Contract income	Contract income
	£000	£000
Education and training	3,351	3,277
Non-patient care services to other bodies	661	918
Provider sustainability fund (2019/20 only)		2,819
Reimbursement and top up funding*	19,206	
Charitable and other contributions to expenditure**	8,956	1,129
Other income	1,199	2,432
Total other operating income	**33,373**	**10,575**
Of which:		
Related to continuing operations		

* retrospective top-up income from NHS England relating to COVID-19 costs during months 1 to 6.

** Charitable and other contribution contains donated inventories below capitalisation threshold for COVID response of £7,653k, there is an associated expenditure in the note 6.1

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,375	**874**

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	2,351	1,943
Staff and executive directors costs	317,316	269,686
Remuneration of non-executive directors	119	95
Supplies and services - clinical (excluding drugs costs)*	11,035	4,443
Supplies and services - general	4,949	2,774
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,858	1,771
Inventories written down**	559	-
Consultancy costs	108	80
Establishment	9,922	5,695
Premises	16,771	12,494
Transport (including patient travel)	45,534	39,383
Depreciation on property, plant and equipment	12,490	11,695
Amortisation on intangible assets	481	580
Net impairments	2,950	2,504
Movement in credit loss allowance: contract receivables / contract assets	12	34
Change in provisions discount rate(s)	1,056	1,543
Audit fees payable to the external auditor		
audit services- statutory audit	78	78
Internal audit costs	91	115
Clinical negligence	3,419	2,743
Legal fees	1,007	641
Insurance	3	2
Education and training	5,510	5,314
Rentals under operating leases	3,730	4,349
Redundancy	9	-
Hospitality	8	14
Losses, ex gratia & special payments	513	668
Other	128	263
Total	**442,007**	**368,907**
Of which:		
Related to continuing operations	442,007	368,907

* Supplies and services - clinical includes expenditure of £6,432k for personal protective equipment that was procured centrally and there is an associated income line in other income note 4.
** Inventories writen down relates to the centrally procured personal protection consumables where costs at 31st March was lower than the cost at the point of purchase

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	117	288
Loss as a result of catastrophe	308	-
Changes in market price	2,525	2,216
Total net impairments charged to operating surplus / deficit	**2,950**	**2,504**
Impairments charged to the revaluation reserve	(31)	894
Total net impairments	**2,920**	**3,399**

2009/10 was the first year of adoption for IFRS standards. From 2010/11 the new major adaption of IAS36 is that if an impairment arises from a clear consumption of economic value, this must be taken in full to the SOCE/revenue account, whatever the revaluation reserve on that asset.

The Standard's requirement to take impairments in all cases to reserves in the first instance does not apply.
Where impairments are posted to the revenue account and a revaluation reserve balance does exist, a transfer is to be made from Revaluation Reserve to the General Fund/I&E Reserve. That transfer will be the lower of the total impairment or the balance available on the Revaluation Reserve. In 2020/21 three types of assets that suffered an impairment are estates, IT equipment and vehicles. The 2020/21 impairment on estates is attributable to the revaluation of estates. The revaluation impairment is due to the price variation and not consumption of economic value.

In order to establish the correct estates value the Trust had its assets revalued as at 31 March 2021. Assets were revalued at £36,345m which is £2,030k less than the carrying value on the Statement of Financial Position (SOFP). This created a decrease in revaluation reserve of £392k and an impairment of £2,422k charged to operating expenses.

A number of vehicles were part impaired due to major parts problems. The total value of the impairment incurred was £220k and £117k is shown as impairment due to unforeseen obsolescence relating to major part problems and £103k relates to changes in market price of the vehicle.

In addition to the above, some IT equipment was impaired due to damage, incurring £307k.

Note 8 Employee benefits

	2020/21	2019/20
	£000	£000
Salaries and wages	249,113	212,023
Social security costs	23,401	20,740
Apprenticeship levy	1,177	1,057
Employer's contributions to NHS pensions	41,353	37,439
Termination benefits	9	-
Temporary staff (including agency)	5,934	1,569
Total staff costs	**320,987**	**272,828**
Of which		
Costs capitalised as part of assets	372	79

Note 8.1 Retirements due to ill-health

During 2020/21 there were 9 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £356k (£249k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 9.1 National Employment Savings Pension Scheme (NEST)

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013 when the scheme came into operation in the Trust (its staging date), staff who are not eligible to join the NHS Pension Scheme are automatically enrolled into NEST. The scheme is a defined contribution pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

Contributions payable to a defined contribution plan are recognised as an expense as the employee provides services in exchange for the contribution. The Trust contributes 1% of their pensionable pay. The total contribution by the Trust for 2020/21 has been fully charged to expenses in the period. Details of the scheme can be found on the NEST Pensions website at: http://www.nestpensions.org.uk

Note 10 Operating leases

Note 10.1 North West Ambulance Service NHS Trust as a lessor

The Trust does not act as lessor for any leases.

Note 10.2 North West Ambulance Service NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where North West Ambulance Service NHS Trust is the lessee.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	3,730	4,349
Total	**3,730**	**4,349**

	Buildings Leases	Other Leases	Total 31 March 2021	31 March 2020
	£000	£000	£000	£000
Future minimum lease payments due:				
- not later than one year;	1,610	1,596	3,206	2,925
- later than one year and not later than five years;	4,838	3,241	8,079	7,196
- later than five years.	11,764	-	11,764	13,543
Total	**18,212**	**4,837**	**23,049**	**23,664**

Future minimum sublease payments to be received

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts	9	302
Total finance income	**9**	**302**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Finance leases	6	8
Unwinding of discount on provisions	(85)	46
Total finance costs	**(79)**	**54**

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	119	77
Total other gains / (losses)	**119**	**77**

Note 14.1 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**5,021**	**107**	**5,128**
Additions	-	208	**208**
Reclassifications	107	(107)	-
Valuation / gross cost at 31 March 2021	**5,128**	**208**	**5,336**
Amortisation at 1 April 2020 - brought forward	**3,447**	**-**	**3,447**
Provided during the year	481	-	**481**
Amortisation at 31 March 2021	**3,928**	**-**	**3,928**
Net book value at 31 March 2021	**1,200**	**208**	**1,408**
Net book value at 1 April 2020	**1,574**	**107**	**1,681**

Note 14.2 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**4,386**	**262**	**4,648**
Additions	257	223	**480**
Reclassifications	378	(378)	-
Valuation / gross cost at 31 March 2020	**5,021**	**107**	**5,128**
Amortisation at 1 April 2019 - as previously stated	**2,867**	**-**	**2,867**
Provided during the year	580	-	**580**
Amortisation at 31 March 2020	**3,447**	**-**	**3,447**
Net book value at 31 March 2020	**1,574**	**107**	**1,681**
Net book value at 1 April 2019	**1,519**	**262**	**1,781**

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**11,527**	**25,314**	**8,339**	**18,947**	**62,922**	**13,377**	**4,187**	**144,613**
Additions	-	3,347	15,639	1,169	180	1,858	161	**22,354**
Impairments	-	(150)	-	-	-	-	-	**(150)**
Reversals of impairments	-	181	-	-	-	-	-	**181**
Revaluations	42	(4,070)	-	-	-	-	-	**(4,028)**
Reclassifications	-	-	(8,759)	277	4,518	3,365	599	**-**
Transfers to / from assets held for sale	-	-	-	(11)	(1,565)	-	-	**(1,576)**
Disposals / derecognition	-	-	-	(21)	(278)	-	(85)	**(384)**
Valuation/gross cost at 31 March 2021	**11,569**	**24,621**	**15,219**	**20,361**	**65,777**	**18,600**	**4,862**	**161,009**
Accumulated depreciation at 1 April 2020 - brought forward	**2**	**2**	**-**	**11,319**	**29,194**	**9,890**	**2,220**	**52,627**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	2	1,966	-	1,461	7,328	1,401	332	**12,490**
Impairments	-	3,273	-	-	221	308	-	**3,802**
Reversals of impairments	(42)	(810)	-	-	-	-	-	**(852)**
Revaluations	40	(4,430)	-	-	-	-	-	**(4,390)**
Transfers to / from assets held for sale	-	-	-	(11)	(1,565)	-	-	**(1,576)**
Disposals / derecognition	-	-	-	(21)	(278)	-	(85)	**(384)**
Accumulated depreciation at 31 March 2021	**2**	**2**	**-**	**12,748**	**34,900**	**11,599**	**2,467**	**61,718**
Net book value at 31 March 2021	**11,567**	**24,620**	**15,219**	**7,613**	**30,877**	**7,001**	**2,395**	**99,292**
Net book value at 1 April 2020	**11,525**	**25,311**	**8,339**	**7,628**	**33,728**	**3,487**	**1,967**	**91,985**

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**12,250**	**27,900**	**4,872**	**19,542**	**61,888**	**12,796**	**4,094**	**143,342**
Additions	-	1,754	13,719	110	381	581	88	**16,633**
Impairments	(238)	(802)	-	-	-	-	-	**(1,040)**
Reversals of impairments	-	146	-	-	-	-	-	**146**
Revaluations	(250)	(3,095)	-	-	-	-	-	**(3,345)**
Reclassifications	(23)	(137)	(10,252)	-	10,233	-	19	**(160)**
Transfers to / from assets held for sale	(212)	(452)	-	(695)	(9,382)	-	-	**(10,741)**
Disposals / derecognition	-	-	-	(10)	(198)	-	(14)	**(222)**
Valuation/gross cost at 31 March 2020	**11,527**	**25,314**	**8,339**	**18,947**	**62,922**	**13,377**	**4,187**	**144,613**
Accumulated depreciation at 1 April 2019 - as previously stated	**3**	**428**	**-**	**10,640**	**31,255**	**8,512**	**1,869**	**52,707**
Provided during the year	2	1,980	-	1,382	6,588	1,378	365	**11,695**
Impairments	298	2,676	-	2	840	-	-	**3,816**
Reversals of impairments	(48)	(1,304)	-	-	-	-	-	**(1,352)**
Revaluations	(253)	(3,639)	-	-	-	-	-	**(3,892)**
Transfers to / from assets held for sale	-	(139)	-	(695)	(9,382)	-	-	**(10,216)**
Disposals / derecognition	-	-	-	(10)	(107)	-	(14)	**(131)**
Accumulated depreciation at 31 March 2020	**2**	**2**	**-**	**11,319**	**29,194**	**9,890**	**2,220**	**52,627**
Net book value at 31 March 2020	**11,525**	**25,311**	**8,339**	**7,628**	**33,728**	**3,487**	**1,967**	**91,985**
Net book value at 1 April 2019	**12,247**	**27,472**	**4,872**	**8,902**	**30,633**	**4,284**	**2,225**	**90,635**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	11,462	24,620	15,219	7,607	30,877	7,001	2,395	**99,181**
Finance leased	105	-	-	-	-	-	-	**105**
Owned - donated/granted	-	-	-	6	-	-	-	**6**
NBV total at 31 March 2021	**11,567**	**24,620**	**15,219**	**7,613**	**30,877**	**7,001**	**2,395**	**99,292**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	11,420	25,311	8,339	7,620	33,713	3,487	1,967	**91,857**
Finance leased	105	-	-	-	-	-	-	**105**
Owned - donated/granted	-	-	-	8	15	-	-	**23**
NBV total at 31 March 2020	**11,525**	**25,311**	**8,339**	**7,628**	**33,728**	**3,487**	**1,967**	**91,985**

Note 16 Revaluations of property, plant and equipment

Historically the Trust has used the Capital Charges Estimates indices published by the Department of Health to revalue its assets. In 2008/09 these indices were discontinued and the Trust applied the % movement detailed in the updated forecast indices for assets issued by HM Treasury (ref: PES (2009) 02) which reflected the economic climate and negative pressure on prices. This was in line with guidance issued by the Department of Health.

Due to the fact that the last national revaluation exercise had an effective date of 1 April 2005 (so requiring that values at the preceding balance sheet date of 31 March 2005 reflected the new values), it meant that all NHS bodies must have completed a full property revaluation every 5 years by 31 March, and that the most recent full valuation must be, for specialised property, on a MEA basis.

This year the Trust's land and building assets were revalued by desktop exercise as at the 31st March 2021, using an independent external valuer Deloitte LLP while last year a full revaluation exercise was undertaken as part of the 5 year full revaluation cycle. The revaluation exercise was undertaken by the valuers who visited each of Trust's properties in order to establish the fair value of the Trust's estates as at the 31st March 2020. This year 2 sites were inspected where the largest capital investment was undertaken in year. The basis of valuation for all assets under IFRS is Fair Value. Assets that are classified as (Property, Plant and Equipment) PPE and have been valued to Fair Value assuming a continuation of their existing use. This is synonymous with Existing Use Value in the Red Book. The valuation is fully compliant with the requirements of the RICS Valuation Standards - Global Standard 2020 including UK national supplement ("The Red Book"). The signatory to the valuation is Edwin Bray MRICS Partner at Deloitte LLP.

All properties categorised as PPE have been split into land and buildings, and a remaining economic life provided. The componentisation elements of each building have been

- Structure;
- Windows and Doors;
- External Works;
- Roof; and
- Services, fixtures and fittings.

Where provided, they have relied on the site areas from North West Ambulance Service NHS Trust (NWAS). Where no site area has been provided, they sought to ascertain Land Registry plans of the site from NWAS and then measured the site using Ordnance Survey plans in accordance with observed boundaries.

The estimated useful lives of the Trust's property, plant and equipment are as follows:

	Min Life (Years)	Max Life (Years)
Buildings [excluding dwellings]	15	66
Plant & Machinery	4	25
Transport Equipment	5	14
Information Technology	1	15
Furniture and Fittings	2	20

Note 17.1 Investment Property

	31 March 2021 £000	31 March 2020 £000
Carrying value at 1 April - brought forward	**160**	**-**
Reclassifications to/from PPE	-	160
Carrying value at 31 March	**160**	**160**

Note 17.2 Investment property income and expenses

	31 March 2021 £000	31 March 2020 £000
Direct operating expense arising from investment property which generated rental income in the period	(16)	(1)
Total investment property expenses	**(16)**	**(1)**
Investment property income	82	79

Note 18 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	48	70
Consumables	1,381	604
Energy	306	335
Total inventories	**1,735**	**1,009**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £7,440k (2019/20: £897k). Write-down of inventories recognised as expenses for the year were £559k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,653k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 19.1 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	10,855	9,138
Allowance for impaired contract receivables / assets	(719)	(743)
Prepayments (non-PFI)	2,989	2,413
PDC dividend receivable	769	71
VAT receivable	646	43
Other receivables	275	297
Total current receivables	**14,815**	**11,219**
Non-current		
Contract receivables	1,217	1,355
Total non-current receivables	**1,217**	**1,355**
Of which receivable from NHS and DHSC group bodies:		
Current	9,383	5,908

Note 19.2 Allowances for credit losses

	31 March 2021	31 March 2020
	£000	£000
Allowances as at 1 April - brought forward	**743**	**709**
New allowances arising	755	743
Reversals of allowances	(743)	(709)
Utilisation of allowances (write offs)	(36)	-
Allowances as at 31 Mar 2021	**719**	**743**

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 19.3 Exposure to credit risk

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

Note 20.1 Non-current assets held for sale and assets in disposal groups

	31 March 2021 £000	31 March 2020 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**396**	**209**
Assets classified as available for sale in the year	-	525
Assets sold in year	(396)	(298)
Impairment of assets held for sale	-	(40)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	**396**

Two stations were declared as held for sale and sold in 2020/21 which are Barrow-in-Furness and Billinge, which were sold for £530k.

Note 21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2021 £000	31 March 2020 £000
At 1 April	**43,368**	**40,962**
Net change in year	17,260	2,406
At 31 March	**60,628**	**43,368**
Broken down into:		
Cash at commercial banks and in hand	2	2
Cash with the Government Banking Service	60,626	43,366
Total cash and cash equivalents as in SoCF	**60,628**	**43,368**

Note 21.2 Third party assets held by the Trust

The Trust dose not hold any third party assets.

Note 22.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	1,732	1,954
Capital payables	6,791	5,871
Accruals	34,554	16,377
Social security costs	3,624	3,307
Other taxes payable	2,683	2,287
Other payables	4,063	3,715
Total current trade and other payables	**53,447**	**33,511**
Of which payables from NHS and DHSC group bodies:		
Current	3,833	1,686

Note 22.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2021 £000	31 March 2021 Number	31 March 2020 £000	31 March 2020 Number
- to buy out the liability for early retirements over 5 years	356		249	
- number of cases involved		9		3

Note 23 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	2,546	1,375
Total other current liabilities	**2,546**	**1,375**

Note 24.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Obligations under finance leases	78	78
Total non-current borrowings	**78**	**78**

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21

	31 March 2021 Finance leases £000		31 March 2020 Finance leases £000
Carrying value at 1 April 2020	**78**	**Carrying value at 1 April 2019**	**78**
Financing cash flows - payments and receipts of principal	-	Financing cash flows - payments and receipts of principal	(1)
Financing cash flows - payments of interest	(6)	Financing cash flows - payments of interest	(8)
Non-cash movements:		**Non-cash movements:**	
Additions	-	Additions	1
Application of effective interest rate	6	Application of effective interest rate	8
Carrying value at 31 March 2021	**78**	**Carrying value at 31 March 2020**	**78**

Note 25 Finance leases

Note 25.1 North West Ambulance Service NHS Trust as a lessor

The Trust does not act as a lessor for any finance leases.

Note 25.2 North West Ambulance Service NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**470**	**479**
of which liabilities are due:		
- not later than one year;	8	8
- later than one year and not later than five years;	33	33
- later than five years.	429	438
Finance charges allocated to future periods	(392)	(401)
Net lease liabilities	**78**	**78**
of which payable:		
- later than one year and not later than five years;	2	2
- later than five years.	76	76

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	**18,092**	**1,808**	**400**	**592**	**2,313**	**23,205**
Change in the discount rate	1,056	-	-	-	-	**1,056**
Arising during the year	252	385	140	36	2,377	**3,190**
Utilised during the year	(719)	(243)	-	-	(25)	**(987)**
Reversed unused	-	(211)	(87)	-	(1,639)	**(1,937)**
Unwinding of discount	(87)	2	-	-	-	**(85)**
At 31 March 2021	**18,594**	**1,741**	**453**	**628**	**3,026**	**24,442**
Expected timing of cash flows:						
- not later than one year;	850	417	453	628	**3,026**	**5,374**
- later than one year and not later than five years;	4,364	592	-	-	**-**	**4,956**
- later than five years.	13,380	732	-	-	**-**	**14,112**
Total	**18,594**	**1,741**	**453**	**628**	**3,026**	**24,442**

The provision relating to other staff pensions consists of £18,594k (2019/20 £18,092k) relating to claims for Personal Injury Benefits recharged by the NHS Pensions Agency. The amounts detailed are amounts that are paid annually to the individuals. The amounts are calculated by the pensions agency following assessment of the individuals claims. The provision includes a prudent assessment of known claims that may result in future liability.

Within legal claims £1,433k (2019/20 £1,490k) represents an amount payable quarterly to an individual. The remaining £309k (2019/20 £320k) relates to Employers Liability Claims recharged monthly by the NHS Resolution Authority as and when cases are successful for which the Trust pays up to the first £10k. In addition there is £190k (2019/20 £228k) included in contingent liabilities.

Equal Pay (Agenda for Change) provision relates to expected back-pay liability for Agenda for Change £453k (2019/20 £400k),which is based upon expected assimilation using national profiles for staff and the associated payscales published within the Agenda for Change Terms and Conditions. Once these staff have assimilated to Agenda for Change contracts the Trust is obliged to pay outstanding arrears (based on national profiles) have been included within provisions. All outstanding cases are proceeding using the agreed Agenda for Change procedures.

Note 26.2 Clinical negligence liabilities

At 31 March 2021, £24,395k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of North West Ambulance Service NHS Trust (31 March 2020: £18,945k).

Note 27 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(190)	(228)
Gross value of contingent liabilities	**(190)**	**(228)**

Note 28 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	11,770	7,270
Total	**11,770**	**7,270**

Note 29 Defined benefit pension schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 30 Financial instruments

Note 30.1 Financial risk management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust can borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
The majority of the Trust's revenue comes from contracts with other public sector bodies therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk
The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from available cash funds . The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	11,628	**11,628**
Cash and cash equivalents	60,628	**60,628**
Total at 31 March 2021	**72,256**	**72,256**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	10,047	**10,047**
Cash and cash equivalents	43,368	**43,368**
Total at 31 March 2020	**53,415**	**53,415**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Total book value £000
Obligations under finance leases	78	**78**
Trade and other payables excluding non financial liabilities	47,140	**47,140**
Total at 31 March 2021	**47,218**	**47,218**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Total book value £000
Obligations under PFI, LIFT and other service concession contracts	78	**78**
Trade and other payables excluding non financial liabilities	26,542	**26,542**
Total at 31 March 2020	**26,620**	**26,620**

Note 30.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020
	£000	£000
In one year or less	44,599	26,550
In more than one year but not more than five years	33	33
In more than five years	429	438
Total	**45,061**	**27,021**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	51	51	-	-
Bad debts and claims abandoned	11	10	53	35
Stores losses and damage to property	286	110	393	109
Total losses	**348**	**171**	**446**	**144**
Special payments				
Compensation under court order or legally binding arbitration award	32	140	26	114
Ex-gratia payments	86	727	86	711
Total special payments	**118**	**867**	**112**	**825**
Total losses and special payments	**466**	**1,038**	**558**	**969**
Compensation payments received		-		-

Note 32 Related parties

During the year none of the Department of Health Ministers, Trust Board of Director's or members of the key management staff, or parties related to any of them, has undertaken any material transactions with North West Ambulance Service NHS Trust.

The Department of Health is regarded as a related party. During the year 2020/21 Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

	Expenditure with Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
CCGs & NHS England	16	412,051	1,091	8,241
NHS Foundation Trusts	2,620	867	492	308
NHS Trusts	205	30	58	46
NHS Resolution (formally Litigation Authority)	3,419			
Department of Health and Social Care		113		
Health Education England		3,007	311	

Note 33 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	47,398	201,419	47,869	164,356
Total non-NHS trade invoices paid within target	45,785	195,774	46,310	160,469
Percentage of non-NHS trade invoices paid within target	96.6%	97.2%	96.7%	97.6%
NHS Payables				
Total NHS trade invoices paid in the year	462	2,773	544	3,181
Total NHS trade invoices paid within target	448	2,754	521	3,042
Percentage of NHS trade invoices paid within target	97.0%	99.3%	95.8%	95.6%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000	2019/20 £000
Cash flow financing	(9,651)	(2,348)
External financing requirement	**(9,651)**	**(2,348)**
External financing limit (EFL)	11,910	13,316
Under / (over) spend against EFL	**21,561**	**15,664**

Note 35 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	22,562	17,113
Less: Disposals	(396)	(389)
Charge against Capital Resource Limit	**22,166**	**16,724**
Capital Resource Limit	22,166	16,903
Under / (over) spend against CRL	**(0)**	**179**

Note 36 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	41
Breakeven duty financial performance surplus / (deficit)	**41**

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,041	2,065	1,558	2,707	2,786	513
Breakeven duty cumulative position	3,678	4,719	6,784	8,342	11,049	13,835	14,348
Operating income		242,220	252,840	259,176	261,312	261,944	266,952
operating income		1.9%	2.7%	3.2%	4.2%	5.3%	5.4%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	135	6,965	6,031	5,319	2,982	41
Breakeven duty cumulative position	14,483	21,448	27,479	32,798	35,780	35,821
Operating income	282,429	316,422	327,731	341,787	370,582	440,004
operating income	5.1%	6.8%	8.4%	9.6%	9.7%	8.1%

The breakeven duty is stated in the National Health Service Act 2006 and it states that: each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account.

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

Appendix – Glossary of Terms

(This glossary does not form a part of the statutory accounts)

STATEMENT OF COMPREHENSIVE INCOME

- **Income and Expenditure**
  Often called a Profit and Loss account or an Income and Expenditure account. Public Sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

- **Income from activities**
  Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

- **Other operating income**
  Income from non-patient care services such as commercial training, research funding etc.

- **Operating surplus**
  The surplus generated by the normal operations of the Trust before taking into account interest, depreciation and amortisation

- **Depreciation**
  When a fixed asset is purchased, the cost of that asset needs to be charged to the income and expenditure account over the life of the asset to recognise the contribution of that asset to the work of the Trust in each year of ownership. On purchase of a fixed asset, the expected life is assessed and the cost is spread over that life. The value of the asset therefore diminishes, or depreciates, over time.

- **Amortisation**
  Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets, such as loans to the Trust.

- **Profit / (loss) on disposal of fixed assets**
  The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

- **Public Dividend Capital (PDC)**
  PDC originated in NHS Trusts as the difference between the valuation of its assets and liabilities on establishment as an NHS Trust. This originating debt is deemed an asset of the Secretary of State, and equates to taxpayers equity in the organisation. The Trust has to make a return on this capital equivalent to 3.5%

per annum, and this amount has to be paid over to the Treasury. The original debt can increase over time due to the allocation of additional capital funds, and is repayable over time.

STATEMENT OF FINANCIAL POSITION

- **Fixed Asset / Non-Current Assets**
  An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods – as opposed to current assets, which are realisable immediately or in the next accounting period. Fixed assets are typically equipment or buildings.

- **Current Assets**
  These are assets that are held on the balance sheet of the organisation that have an immediate cash value. These include stocks, that could be sold and realise cash quickly, debtors that can be collected quickly to realise cash or cash held in a bank account.

- **Stock / Inventories**
  Material held as stock which could be sold to realise cash quickly. Can either be valued at **cost** where stock is valued in the books at the purchase price or, **net realisable value** where stock is valued in the books at a value that it could reasonably be expected to fetch if it was sold on the open market today.

- **Debtors / Receivables**
  Money owed to the Trust for services provided.

- **Creditors / Payables**
  Money owed by the Trust for goods and services received.

- **Total Taxpayers' Equity**
  See Public Dividend Capital

NOTES TO THE ACCOUNTS

- **Historical Cost Convention**
  The value of an asset carried in the balance sheet is the amount paid for it on the purchase date.

- **Accruals Convention**
  The accounts are prepared taking account of all income received and receivable, and all expenditure paid and payable for the goods and services delivered and received in the period, and are not based on cash receipts and payments in the period.

- **Off Balance Sheet**
  Refers to fixed assets that are in use by the trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership.

- **Liquid Resources**
  Resources that can be released quickly to enable the organisation to settle debts. Typically, cash in hand or in the bank in short term accounts.

- **Prepayment**
  Where the Trust has paid in advance for goods or services – for example, quarterly payment in advance for telephone rentals.

- **Deferred Income**
  Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

- **Reserves**
  Funds set aside in recognition of a future event, project or change, where the need has been recognised but the event has not happened.

TERMINOLOGY

- **Going Concern Basis**
  The accounts are prepared on the basis that the Trust will still be in existence in the next financial year, and that it will therefore be in a position to recover any debtors due to it, and that it will be around to cover its long term liabilities. If it is likely that an organisation will not be in existence beyond this set of accounts, then long term liabilities would become immediately due, and the position of long term debtors would be called into question, resulting in the need to recognise that in the results presented in this set of accounts.

- **Capital Expenditure**
  The amount expended by the Trust that enhances the value of fixed assets whose useful life extends beyond the current accounting period.

- **Revenue Expenditure**
  Expenditure on the day to day operations of the Trust, pay and rations as opposed to capital expenditure.

- **Consumables**

Non pay expenditure on items that have a life of less than one year and are therefore not fixed assets. The term relates to everything from drugs, uniform, stationery through to pieces of disposable equipment.

- **CCGs – Clinical Commissioning Groups**
  Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are now 31 CCGs in the North West of England.

- **Liability**
  A situation where an organisation has an obligation to pay for something that has already occurred, and around which there is certainty, but is not yet physically paid for.

- **Provisions**
  An allowance in the accounts for a known item, but where the value or timing of the event giving rise to it is uncertain. An example may be where a pay award from 1 January in a given year has not yet been agreed, and the settlement date is uncertain. The organisation would typically provide an estimate for inclusion in the accounts to ensure that the relevant charge to Income and Expenditure is made in the correct year.

- **Contingent Liability**
  A situation where a financial obligation to pay for something that has already happened may arise, but where there is uncertainty or where the final value is difficult to quantify due to dependencies on other things. For example, an outstanding legal claim against the organisation, where if the verdict goes against the organisation, there will be an obligation to pay for an unquantifiable amount. Amounts carried in the accounts under this heading will inevitably be estimates based on the best information available at the time.

- **Value Added Tax (VAT)**
  May be in the form of **output tax** – VAT charged on sales, or **input tax** – VAT paid on purchases. In the NHS, normal NHS healthcare activity does not attract VAT.

- **Post Balance Sheet Event**
  Something that is recognised after the accounts have been finalised, but before publication, which impacts on the results as they are presented, and has a significant impact on how the results should be interpreted.

- **Risk Pooling Scheme**
  This is essentially the NHS insurance scheme, where we pay an annual premium to cover any insurance claims that may arise during the year. The scheme covers all the usual insurance risks around buildings, equipment, fire etc, as well as clinical negligence issues.

- **NHS Resolution**
  NHS Resolution (NHS R) is the body responsible for handling negligence claims against NHS organisations. NHS R also advises NHS organisations on risk management.

- **Losses and Special Payments**
  Any payments made in respect of bad debts, stock write offs, insurance excesses or compensation payments that are not considered a part of the normal business of the Trust.

Things to consider when reading a set of accounts

- **True and Fair View**
  A set of annual accounts is a snapshot at a point in time of how the business is performing. Is it profitable? Is it viable? Is it fit for purpose? It is not and probably never will be 100% accurate. What is important is that the accounts present a fair reflection of performance and viability, and that the items presented in there have been treated according valid and accepted accounting principles, and can be explained and justified in that context.

- **No Surprises**
  The annual accounts should only ever confirm what the Board have been expecting in light of the monitoring reports that have been presented by Director of Finance during the year, and should bear a close resemblance to figures reported at Month 12. If there are significant differences between what the Board was expecting, or from the Month 12 report, then the Director of Finance should include explanations for this in a commentary that accompanies the accounts, and the auditors should be asked to comment on any items of significance.

- **Previous Year**
  It can be useful to compare this year's figures with those of the previous year. Again, the Board should already be aware of any significant movements, and the reasons for them, so any changes should be expected. If there are any changes that have not been explained, then these should be queried and satisfactory explanations obtained to approval.

- **Fixed Assets / Non-Current Assets**
  The Board should be assured that the changes in the fixed asset figures from one year to another reflect the decisions made by the Board on capital investment and disposals during the year. If a revaluation has taken place during the year, this should be explained in the notes, and the Board should ensure that they are fully aware of the impact that this has had on both the Income and Expenditure account and Balance Sheet.

- **Current Assets**
  Again, differences between years should be looked at. Particular things to look for include:

    - Stock – large swings in stock levels year on year can indicate that stock management is inefficient. As a general rule, the Trust should look to carry out as little stock as possible commensurate with ensuring that the right supplies are available at the right time. A very large reduction in stocks in any given year, combined with a reduction in cash balances, may be an indication that the trust is experiencing cash flow problems.
    - Debtors – high levels of debtors may be a result of inefficient debt collection in the Trust and this may be impacting on the cash flow performance.
    - Cash at bank and in hand – this is an indication of the liquidity of the Trust. We should make sure that we have sufficient readily accessible cash available to meet our immediate needs. Significant swings from year to year may indicate that cash management is not as efficient as it should be.

Further Information

Contact the Director of Corporate Affairs at the address, e-mail or telephone number below for information about the Board of Directors or if you would like:

- To view the register of Board of Directors' interests
- To contact the Chair or any member of the Board of Directors
- Information about Board of Directors meetings which are open to the public. Details of meetings are also available on the Trust's website.
- To contact the Chief Executive's office for more information or if you have any comments

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