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North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 24 November 2021
9.45 am - 1.50 pm

To be held in the
Sir Tom Finney Suite
at
Lancashire Football Association, County Ground, Thurston Rd, Leyland PR25 2LF

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2122/90	Patient Story	09:45	Information	Interim Deputy CEO / Director of Strategy, Partnerships and Transformation	
INTRODUCTION					
BOD/2122/91	Apologies for Absence	10:00	Information	Chairman	
BOD/2122/92	Declarations of Interest	10:00	Decision	Chairman	
BOD/2122/93	Minutes of Previous Meeting held on 29th September 2021	10:00	Decision	Chairman	3 - 16
BOD/2122/94	Board Action Log	10:05	Assurance	Chairman	17 - 18
BOD/2122/95	Committee Attendance	10:10	Information	Chairman	19 - 20
BOD/2122/96	Register of Interest	10:10	Assurance	Chairman	21 - 22
STRATEGY					
BOD/2122/97	Chairman & Non-Executives' Update	10:15	Information	Chairman	
BOD/2122/98	Chief Executive's Report	10:20	Assurance	Chief Executive Officer	23 - 36
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/99	Q2 Board Assurance Framework Review	10:30	Decision	Director of Corporate Affairs	37 - 74
BOD/2122/100	Use of Common Seal Bi Annual Report	10:40	Assurance	Director of Corporate Affairs	75 - 78
BOD/2122/101	Freedom to Speak Up Bi Annual Report	10:50	Assurance	Freedom to Speak Up Guardian	79 - 88
BOD/2122/102	Charitable Funds Annual Report and Accounts 2020/21	11:00	Assurance	Director of Finance	89 - 126
BOD/2122/103	Charitable Funds Committee Chairs Assurance Report - from the meeting held on 27th October 2021	11:10	Assurance	Mr D Rawsthorn, Non-Executive Director	127 - 130
BOD/2122/104	Audit Committee Chairs Assurance Report - from the meeting held on 22nd October 2021	11:20	Assurance	Mr D Rawsthorn, Non-Executive Director	131 - 134

DELIVERING THE RIGHT CARE,
IN THE RIGHT TIME,
AT THE RIGHT PLACE;
EVERY TIME.

QUALITY AND PERFORMANCE					
BOD/2122/105	Integrated Performance Report	11:30	Assurance	Director of Quality, Innovation and Improvement	135 - 186
BOD/2122/106	IPC Board Assurance Framework 6 Monthly Report	11:40	Assurance	Director of Quality, Innovation and Improvement	187 - 212
BOD/2122/107	Emergency, Preparedness, Resilience and Response (EPRR) Annual Assurance Report	11:50	Assurance	Director of Operations	213 - 254
BOD/2122/108	NWAS Strategic Winter Plan 2021/22	12:00	Assurance	Director of Operations	255 - 288
BOD/2122/109	Quality and Performance Committee Assurance Report - from the meeting held on 25th October 2021	12:10	Assurance	Prof A Chambers, Non-Executive Director	289 - 300
BOD/2122/110	Resources Committee Assurance Report - from the meeting held on 19th November 2021	12:20	Assurance	Mr R Groome, Non-Executive Director	301 - 314
WORKFORCE					
BOD/2122/111	Health and Wellbeing Update	12:30	Assurance	Director of People	315 - 332
COMMUNICATIONS AND ENGAGEMENT					
BOD/2122/112	Communications and Engagement Team Dashboard Report	12:40	Assurance	Interim Deputy CEO / Director of Strategy, Partnerships and Transformation	333 - 344
CLOSING					
BOD/2122/113	Any Other Business Notified Prior to the Meeting	12:50	Decision	Chair	
BOD/2122/114	Items for Inclusion on the BAF	12:50	Decision	Chair	

Date and Time of Next Meeting 9.45 am Wednesday, 26 January 2022 venue to be confirmed

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

Minutes
Board of Directors

Details: Wednesday, 29th September 2021
Mercure Bolton Georgian House Hotel, Manchester Road, Blackrod, Bolton, BL6 5RU

Mr P White	Chairman (Chair)
Mr G Blezard	Director of Operations
Mr S Desai	Interim Deputy CEO/Director of Strategy, Partnerships and Transformation
Prof A Esmail	Non-Executive Director (Clinical)
Dr C Grant	Medical Director
Mr R Groome	Non-Executive Director
Mr D Hanley	Non-Executive Director
Mr D Mochrie	Chie Executive Officer
Prof M Power	Director of Quality, Innovation and Improvement
Prof R Thomson	Associate Non-Executive Director
Ms L Ward	Director of People
Ms A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance

In attendance:

Ms D Earnshaw — Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2122/68 **Staff Story**

The Director of Strategy, Partnerships and Transformation presented a film which featured an NWAS employee who had been recruited via the Trust's Pre-employment course.

The employee originally joined the Trust via a Job search coach, commenced as an NWAS PTS driver and following completion of further training opportunities become an EMT apprentice; with plans to progress and develop further in PES.

The film highlighted the opportunities presented by the Trust to engage with the community and provide effective courses including work experience for the development of new employees.

The Board praised the personal achievements illustrated by the film and recognised the success of Trust's Pre-employment courses.

The Director of People thanked the PTS service for embracing the pre-employment process as a main point for recruiting into PES, which had been

vital as the Trust worked through the challenges presented by the Covid-19 pandemic.

The Chief Executive thanked the service lines, the Director of People and her team, for working hard together. He added the Trust had benefited during the pandemic from having PTS as part of the Trust's model.

The Chairman noted he had spoken to staff at a recent award ceremony and recognised the importance of PTS as an entry point into the organisation. He stated he was pleased to see that job experience had been considered by the Trust to quicken the recruitment process. He added the staff story had been an excellent case study and congratulated the member of staff on his achievements.

BOD/2122/69 **Apologies for Absence**

Apologies for absence were received from Prof A Chambers, Non-Executive Director and Mr D Rawsthorn, Non-Executive Director.

BOD/2122/70 **Declarations of Interest**

There were no declarations of interest to note.

BOD/2122/71 **Minutes of the Previous Meeting**

The minutes of the previous meeting held on 28th July 2021 were agreed as a true and accurate record of the meeting.

BOD/2122/72 **Board Action Log**

The Board noted the updates to the Board action log.

BOD/2122/73 **Committee Attendance**

The Board noted the Board and Committee Attendance Record.

BOD/2122/74 **Register of Interest**

The Board noted the 2021/22 Register of Interest presented for information.

BOD/2122/75 **Chairman & Non Executives' Update**

The Chairman reported that the recruitment of Chairs and Chief Executives to the ICS Boards was ongoing and providing challenges.

He confirmed the Trust's Virtual Annual General Meeting had taken place on 14th September 2021 with good attendance. He stated that he had recently attended a national memorial service to recognise all North west colleagues who had passed away in recent years and attended the Queen's Award Ceremonies.

The Chairman acknowledged the resignation of Ms Gillian Singh from the position of Associate Non-Executive Director and wished her well on behalf of the Board.

The Board:

- Noted the update from the Chairman.

BOD/2122/76 Chief Executive's Report

The Chief Executive presented his report and highlighted the following areas.

He reported that the Trust continued to experience demand across all service areas and highlighted that although call pick up was challenged during July and August 2021 there had been slight improvement.

He added that Category 1 and Category 2 calls continued to increase and a recruitment plan was in place to recruit over the funded establishment to support call pick up over the winter months.

He advised that NHS 111 had experienced call demand in excess of the contract value and KPIs continued to be challenged.

In relation to PTS, he noted there were 90 whole time equivalent vacancies across the service with recruitment progressing to fill positions by the end of the financial year. However, he noted the position could be further impacted as PTS volunteers undertook blue light duties, in line with the Trust's plans to increase emergency ambulances, over the winter period. He added that further detail would be provided by the Director of Operations when he presented the Trust's Integrated Performance Report.

The Trust had held an Annual General Meeting on 14th September 2021, attended by over 50 members of the public.

In terms of the organisation's response to the Covid-19 pandemic, he advised that the Trust had been requested to participate in the national response to the Public Enquiry; and the Association of Ambulance Chief Executives (AACEs) had also published documents in response to the pandemic.

He reported that the Trust had launched a Suicide prevention toolkit and recognised that alongside the wellbeing of staff and treat me right campaigns, the Trust's priority was to support and listen to staff.

He acknowledged the appointment of Amanda Pritchard, the first female Chief Operating Officer of NHS England.

The Chief Executive reported that the Trust had been nominated for a number of awards including #Inside999 a social media campaign to promote and share key messages to encourage people to use the service effectively.

He confirmed that the Unified Communications Programme which replaced the telephony platform across the organisation, had gone live and thanked the teams for their fantastic contribution to ensure a seamless launch. He added the project had involved a huge amount of planning and preparation to implement a critical system; whilst continuing to meet the needs of the public.

The Chief Executive sadly reported recent deaths of staff member Paul Scott and former staff members Bernard O'Brien and Graham (Joe) Phipps and conveyed his condolences to the family, friends and colleagues on behalf of the Board.

The Chairman praised the teams for their seamless transition to the new Unified Communications System during difficult operational circumstances and added it had been tremendous what had been achieved.

The Board:

- Noted the Chief Executive's Report

BOD/2122/77 Strategic Planning Review and Recommendations

The Director of Strategy, Partnerships and Transformation presented a Strategic Planning Review and Recommendations.

He reported that since March 2020, the strategic context for the Trust had changed significantly, with further changes due in relation to National policy and launch of the ICS'. With this in mind, he advised that a strategic planning review had been undertaken during quarter 2 to establish whether the Trust's corporate strategy and strategic planning function was relevant and responsive in light of the strategic context.

He advised key recommendations had been identified which included a short term planning exercise for the remainder of 21/22 financial year; initiation of a Trust strategy redevelopment programme to review the content of the Corporate Strategy and Strategic objectives; align the Right Care Strategy and Corporate strategy to ensure a consistent approach whilst maximising opportunities to streamline engagement and capacity and develop and implement a revised annual planning process for 2022/23, to replace the existing Integrated Business Plan and to avoid duplication. He added this would provide an increased oversight of delivery against the Trust's strategic objectives.

He referred to the Unified Communications and Electronic Patient Record projects and emphasised the need to understand the impact on individual service lines; he added that the in house review would consider how the Trust effectively engaged with the wider system.

The Director of Strategy, Partnerships and Transformation referred to s3.2 of the report which provided detail of the outcome of the review and confirmed that Q3 and Q4 priorities and overarching objectives would be presented to the Resources Committee to provide an update and a wider strategic context.

He reported that the Trust Strategy redevelopment would be conducted in stages and the Corporate Strategy aligned and cascaded throughout the Trust.

The Chairman queried if the Trust was required to have an Integrated Business Plan (IBP).

The Director of Strategy, Partnerships and Transformation advised that the annual strategic plan would replace the IBP as a more agile document, with updates on the plan presented to the Resources Committee and to the Trust's Board of Directors.

Prof Esmail referred to the Corporate Strategy for 2022/23 and queried the process to facilitate staff engagement.

The Director of Strategy, Partnerships and Transformation confirmed that the system would take 12-18 months to embed and extensive staff engagement would be part of the process through identifying connections on the issues that resonated with the various groups of staff across the organisation.

Dr D Hanley acknowledged the challenges associated with engagement of staff and welcomed the approach to adapt communication strategies to staff.

The Director of Strategy, Partnerships and Transformation agreed with the challenges and added that timescales were also a key component of the development of the strategy, with the need for flexibility; to adapt to the demands of the ICS'.

The Chairman welcomed the approach of the strategic review and that the Trust had taken a leadership role with a flexible approach. He emphasised that staff engagement was critical and developments must be relevant to the workforce. He added it was important for members of the Board to engage proactively with each other, as well as the wider system, during a time of significant change.

The Board:

- Noted the content of the report.
- Noted that a further update would be presented to Trust's Executive Leadership Committee and to the Board of Directors at the next meeting.

BOD/2122/78 Memorandum of Understanding

The Director of Corporate Affairs presented a Memorandum of Understanding (MOU) Division of Responsibilities between the Chair of the Trust Board and the Chief Executive Officer.

She reported that whilst not a Foundation Trust, NWAS sought to adhere to the Code of Governance where applicable and as such the MOU provided clarification of the roles of the Chairman and Chief Executive in the organisation.

She advised that the document would be signed and maintained on the Trust's Corporate record for Board assurance.

The Board:

- Approved the Memorandum of Understanding and requested the Director of Corporate Affairs to maintain a signed copy on corporate record.

BOD/2122/79 Deloitte Developmental Well Led Actions – Update

The Director of Corporate Affairs presented the Deloitte Developmental Well Led Actions Update. She reported that the report from Deloitte in Q4 2019/20 made 19 recommendations for areas of improvement against the Well Led Key Lines of Enquiry (KLOEs).

She advised that since the last report to Board in March 2020 and despite Covid-19 challenges, 4 actions had been closed and the Trust were working well to make progress against the outstanding actions; which included the establishment of the role of a Patient Safety Specialist.

Mr R Groome queried if the Trust had received any further information from the CQC, in terms of a well led review. The Director of Corporate Affairs confirmed that the Trust had not received any further updates.

The Chairman referred to action no. 19 which was in progress and related to the Trust's learning forums.

The Director of Quality, Innovation and Improvement confirmed that learning had continued through the chairmanship of ROSE and learning themes identified from completed investigations. She advised that the Learning Forums had been restricted due to Covid-19 and REAP Level 4 pressures.

She added that the Learning Forums would be a priority for the new Patient Safety Specialist and that pilot work had commenced to integrate learning themes from the Freedom to Speak Up Index, complaints, serious incidents and workforce data.

She confirmed that Covid-19 had affected the Trust's formal learning structures and a plan, with clearer deliverables, would be presented to the Board by the end of Q4.

The Board:

- Noted the progress made against the actions, despite the challenges of the Covid-19 response since Q4 2019/20.

- Noted the forecast closure date for the outstanding actions.

- Noted that an update on the Trust's learning plan and structures, with clear deliverables, would be presented to Board by the end of Q4.

BOD/2122/80 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report for August 2021.

The Chairman stated that the Trust had been immensely challenged operationally with significant numbers of calls and staff turnover in the 111 service. He confirmed that the Trust's Quality and Performance Committee had scrutinised the issues at their meeting on 27th September 2021.

In terms of Quality, she advised that performance indicators related to complaints and incidents continued to be a challenge. She reported that the Trust had received 202 complaints against a 12 month average of 162 per month. She confirmed that 65% of complaints with a risk score of 1-3 and 67% of risk 4-5 complaints had been closed within the timeframe; with an intensive intervention programme to improve the position. She added progress continued to be monitored by the Trust's Executive Leadership Committee (ELC).

She noted that the recovery plan involved increasing resource, including clinical expertise, to close down incidents with a longer timeframe. She added that the team had been challenged during the summer, due to accrued annual leave, however since the report improvements had emerged.

The Chairman recognised the operational impact on the position of complaints and acknowledged that ELC were aware of the challenges and considered the detail.

The Director of Strategy, Partnerships and Transformation reported that patient experience feedback had reflected the level of demand on the Trust and respondent's good ratings had been focused on respect and kindness from staff. However, he noted that in contrast, responses had also included poor response times, poor attitudes and lack of empathy. In terms of PTS, he advised that there had been an increased response from the previous month

and feedback reported an efficient service with friendly staff; although some feedback in terms of time delays.

He reported that the 111 patient experience response rate had reduced during the summer, however where respondents had replied they had reported helpfulness and reassurance.

The Chairman stated that considering the demands he was pleased to see the level of responses and returns.

The Medical Director provided an overview of effectiveness in relation to the Ambulance Clinical Quality Indicators (ACQIs) and observed that due to delays in the availability of the clinical outcomes, the report was based on April 2021 data. With this in mind, he reported that pre hospital care, such as cardiac arrest and Return of Spontaneous Circulation (ROSC) had been maintained and was in a good position.

He advised that the Trust had maintained the bundle element of care and this continued to be of continued focus with minimal change in the stroke care bundle.

In terms of the wider position, he reported that the service pressures continued, with Category 1 calls and challenges of triage systems a priority. He reported that specific work had been undertaken to identify any potential issues related to inequality and deprivation.

He added that Senior Advanced Paramedics in Emergency Operating Centres provided clinical reviews of category 2 calls, with the ability for dispatch teams and clinicians to review and observe cases that could be escalated in the system. He confirmed that evaluation of the process continued.

The Chairman noted the safety netting processes and recognised the systems in place to protect patients and staff. He referred to the deep dive into long waits, presented to the Quality and Performance Committee and thanked the Medical Director and the team for the assurance this provided.

Dr D Hanley confirmed and supported the level of assurance received from the deep dive at the Quality and Performance Committee.

The Medical Director confirmed that trends of Category 1 and 2 long waits, considered against the index of risk and compared to previous levels of SI's; provided assurance that patients were being protected, albeit the risks remained high.

He emphasised that the deep dive evidenced that risk was being mitigated and not eradicated and the challenge was to identify the most effective resources to alleviate the waits. He advised that the Quality and Performance Committee were presented with Estimated Time of Arrival (ETA) scripts to manage patient expectations.

The Director of Finance reported a break even financial position, which had been discussed in detail at the Resources Committee. She highlighted that year to date expenditure on agency was above the 2019/20 ceiling and that Covid-19 financial framework remained in place for H1.

She confirmed the H2 guidance was still unclear but imminent and that high level indications and implications had been discussed by the Resources Committee.

The Director of Operations advised that Paramedic Emergency Services (PES) had experienced a 22% annual increase in calls and a 4% decrease in incidents. He reported that call pick up performance was 72% with data signalling special cause during July.

The Director of Quality, Innovation and Improvement confirmed that work to address demand was ongoing and an initial review had been completed as part of winter planning.

In terms of REAP 4, the Director of Operations confirmed that the focus continued to be on management of the call stack and the Trust's Patient Safety Plan. He advised that deploying resources and signposting patients away from Emergency Departments were some of the strategies aimed to maximise resources.

He reported that 40 additional paramedics had been recruited into the Clinical Hub to manage the category 1 and category 2 increased call volumes and an additional 270 EMT and Ambulance blue light drivers identified to maintain driver training capacity.

He confirmed that the trajectory involved an increase in PES vehicles on a weekly basis leading up to Winter as part of the winter plan with NHS pathways to reduce and evenly distribute the lower acuity patients.

In terms of 111, the Director of Operations confirmed a 40% activity increase with a high turnover of staff which had presented significant challenges. He advised that the current job market and temporary contracts made alternative offers of permanent contracts more attractive.

He reported that the role of NWAS call taker to operate in 111 and 999 aimed to provide a more attractive career pathway for recruitment and retention and advised that the Trust had engaged with NHSE/I to consider initiatives to attract staff to the service; with call taking resource a challenge across the sector.

The Director of Operations thanked the Head of the PTS service and the team for their ongoing efforts to supply resources to PES. He advised that the service were working to full capacity at 5,000 patient journeys a day and restrictions due to revised IPC guidance. He added that 30-40 PTS staff would transfer as blue light drivers to support PES as part of the winter plan.

The Director of People reported on the workforce indicators, which had been affected by the demand on operational services. She stated that staff sickness had risen and actions involved an increased management focus; with particular attention on attendance management. She added that Health and wellbeing sessions were in place and staff well-being conversations involved prevention strategies.

The Director of People confirmed that approx. 100 staff had been impacted by long covid-19 symptoms and there had been funding identified for independent mental health check ins.

She added that over the next 6 months appraisals and mandatory training continued to be targeted, with agreed recovery plans approved by ELC. She advised that appraisals would involve a shorter more focused process and include health and well-being conversations.

She reported that the 111 service had used their appraisal feedback to provide support to the teams and PTS had maintained their appraisal levels. In terms

of PES, she advised that learning was being reassessed and classroom learning modules would focus on core statutory and mandatory standards; with recovery plans established.

The Director of Quality, Innovation and Improvement reported that there had been 97 instances of staff testing positive for Covid-19.

Prof R Thomson noted that infection rates continued to be high across the North West, particularly in Cumbria, Cheshire and Merseyside; with the variation attributed to the unvaccinated age groups.

The Chairman thanked members for the robust discussion in respect of Trust performance and welcomed the safety netting initiatives and resource management plans in operation. He recognised the Trust's break even financial position and thanked the Director of People for the change in focus related to appraisals and mandatory training targets.

Over all, he welcomed the ongoing scrutiny of the Board Assurance Committees.

The Board:

- Noted the content of the report.
- Noted the omission of reporting of the C4 90th centile for June.
- Clarified any items for further scrutiny.

BOD/2122/81 Learning from Deaths Summary Report and Dashboard Q1 2021/22

The Medical Director presented the Learning from Deaths summary report and dashboard for Q1 2021/22. He advised that the report focused on areas of good practice and emphasised that the process encouraged staff to feel confident and encouraged to engage in the process to promote learning.

He reported that digital maturity was a significant factor to the process and the development of the Datix mortality module progressed.

The Medical Director stated that the process provided a wider corporate understanding to drive improvement and the recent recruitment of Patient and Public Panel members demonstrated the Trust's approach and commitment to learning.

The report recognised the impact of the Structured Judgement Review process in identifying opportunities for improving care. He added that the Quality and Performance Committee had discussed the learning themes and good practice identified.

The Chairman queried the progress in the recruitment of the representatives from the Patient and Public Panel. The Medical Director confirmed training and introductions to the team were in progress.

The Board:

- Supported and noted the progress detailed in the Learning from Deaths summary report and quarterly dashboard.

BOD/2122/82 **IPC Annual Report 2020/21**

The Director of Quality, Innovation and Improvement presented the Infection, Prevention and Control (IPC) Annual Report for the period March 2020 – March 2021. She reported that the account had been signed off by the Trust's previous Chief Nurse and currently seconded Head of Clinical Safety; and expressed her thanks for their leadership and contribution to IPC during the pandemic.

She advised that the Quality and Performance Committee had welcomed the report and queried if the lessons learnt in the early stages of the pandemic had been captured. She confirmed that the Trust had an underlying system which captured decisions and lessons learnt via the command and control cell logs, which had been maintained and any learning captured.

The Director of Quality, Innovation and Improvement reported that the IPC BAF, presented at the last meeting, provided assurance in relation to systems to manage risks and she expressed her gratitude to the volunteers, who had provided safe systems of care to staff.

She also acknowledged staff who had lost loved ones during the pandemic and thanked all staff who had volunteered their time to support the vaccination hub.

Prof R Thomson praised the report and confirmed there had been a thorough discussion at Quality and Performance Committee.

The Chairman recognised the hard work of the IPC team during the pandemic and he thanked them for their continued hard work and significant contribution.

The Board:

- Noted the content and assurances provided in the report.
- Supported the report for publication on the Trust website.

BOD/2122/83 **Quality and Performance Committee Chairs Assurance Report from the meeting held on 26th July 2021**

Dr D Hanley presented the Quality and Performance Committee Chairs Assurance Report from the meeting held on 26th July 2021.

He reported that the Committee had received assurances in relation to changes to the Trust's Patient Safety Plan, Medicines Management and the learning from deaths process however the Committee had recognised the ongoing risk and pressures related to the Integrated Performance Report.

The Board:

- Noted the assurances provided in the Quality and Performance Committee Chairs Assurance Report from the meeting held on 26th July 2021.

BOD/2122/84 **Resources Committee Chairs Assurance Report from the meeting held on 24th September 2021**

Mr R Groome presented the Resources Committee Chairs Assurance Report from the meeting held on 24th September 2021.

He reported that the members had scrutinised the Workforce Indicators update and considered the contributory factors associated to the revised mandatory training and appraisal targets. He advised that ongoing monitoring of sickness absence and management of HR caseload continued.

The financial position was discussed in depth and an update had been delivered on the projects being undertaken in respect of the Trust's Procurement Strategy. The Green plan update reported that the Trust were making good progress against sustainability and environmental priorities.

The Board:

- Noted the assurances provided in the Resources Committee Chairs Assurance Report, from the meeting held on 24th September 2021.

BOD/2122/85 **Workforce Equality Update – Race, Disability and Gender**

The Director of People presented the Workforce Equality Update – race, disability and gender. She reported the key points in the report which included an improvement in the recruitment of ethnically diverse staff within the Trust from 4.6% to 5.4%.

She confirmed that the Staff Survey reported a strong picture in terms of an improved experience by ethnic minority staff. In relation to disabled staff, she advised that their experience was poorer with disabled staff more likely to report incidents. However, she noted that overall the results indicated that work to support the experience of disabled staff had progressed and further opportunities available to support and engage on the issues.

In relation to gender equality, the Director of People reported an increase in the number of female staff from 48.91% to 50.41% which indicated for the first time that women outnumbered men across the workforce. She advised that there had been a narrowing in statistics of the gender pay gap which evidenced progression within the Trust.

In terms of the ED&I priorities, she confirmed that action plans would be aligned and information would be shared within the networks to ensure development in the priority areas.

The Director of People confirmed that the report had been presented to the Resources Committee for scrutiny.

Prof A Esmail stated the need to focus on the priority areas in terms of recruitment and welcomed future recruitment statistics, which he felt should be improved and without anomalies due to Covid-19.

The Director of Quality, Innovation and Improvement stated the data related to gender equality was disappointing with a need for the Trust to continue to focus and prioritise via Board development sessions.

The Director of Strategy, Partnerships and Transformation referred to the experience of disabled people and acknowledged that the issue of the patient experience and the communities served across the Region were a priority, as the Trust moved into the ICS structure.

The Chairman highlighted the significance of the work to be done and expressed his concern at the bullying and harassment statistics. He stated that frontline staff should be empowered and a culture shift was required.

The Director of Strategy, Partnerships and Transformation supported the Chairman and confirmed that leadership was the responsibility of the Board, Directors and senior managers, through their distributed forums, to promote and achieve consistent messages.

The Chairman acknowledged that Board Development sessions would provide Board members with the opportunity to discuss the data in further detail and to ensure that ED&I featured on the Trust's future Board Development Programme.

The Board:

- Noted the progress on activity for WRES, WDES and gender work.
- Noted the alignment of the ED&I plans in response to the data.
- Approved the publication of the WRES, WDES and gender data.

BOD/2122/86 **Flu Campaign 2020/21 – HCW Flu Vaccination Best Practice Management Checklist**

The Director of People presented the Flu Campaign 2020/21 and Flu Vaccination Best Practice Management Checklist. She reported that the national requirement for 2021/22 Flu campaign was 100% offer with 85% compliance target, compared to the 2020/21 campaign which had specified a 75% uptake.

In view of the increased target, she confirmed that the Trust aimed to maximise focus over the next 8 weeks on the frontline impact and to promote vaccination uptake before the Christmas period. She added that through feedback from the 2020/21 campaign, the Trust had adopted a mixed approach to the delivery model.

In terms of the Best Practice Management Checklist she confirmed that the Trust had met best practice in all areas with the exception of one, which related to an incentivised vaccination scheme.

The Board:

- Received assurance from the approach to the Flu Campaign for 2021/22 and the completed Board checklist.
- Provided commitment to offer all frontline staff a flu vaccination.

BOD/2122/87 **Partnerships and Integration Progress Update**

The Director of Strategy, Partnerships and Integration presented a Partnerships and Integration Update. He reported that the Trust would work with five ICS areas and the report documented progress within each of the areas. He advised that the governance and ICS Executive teams were in the progress of being formed and this process would be completed by the end of December 2021 for all ICS areas.

He confirmed that the Trust had recently appointed the final Partnership and Integration Manager and the recruitment of Chief Executives and Chairs to the ICS' was in progress.

The Director of Strategy, Partnerships and Integration reported that a focused approach was required by the Trust to determine how new relationships with the ICS's were managed, to ensure NWAS were prepared when the systems were established.

He added that Board members would be updated further as information became available.

Dr D Hanley thanked the Director of Strategy, Partnerships and Transformation for the extremely helpful reports which had provided an understanding of the representation required. He added that the challenge would be for the Trust to ensure that appropriate representatives were identified to ensure that NWAS could contribute and make decisions rather than just attend meetings.

The Director of Strategy, Partnerships and Transformation agreed that understanding of the representative was important, particularly knowledge of the speciality of services that we operate. He confirmed that operational structures were being considered by ELC with Partnership and Integration Managers, to ensure the Trust had appropriate representation; along with issues that could be managed more effectively on a regional level.

The Chairman thanked the Director of Strategy, Partnerships and Integration for the paper and emphasised the importance of leadership and correct representation at meetings.

At this point in the meeting, the Director of Strategy, Partnerships and Transformation referred to a late question received from the Patient and Public Panel. He confirmed he would provide a dedicated response by email to all members.

The Board:

- Noted the assurance and update provided in the report.
- Supported the work of the Partnership and Integration team.
- Noted that a presentation on the work of the team and ICS structures, would be presented to Non-Executive Directors in October 2021.

BOD/2122/88 **Any other business Notified prior to the meeting**

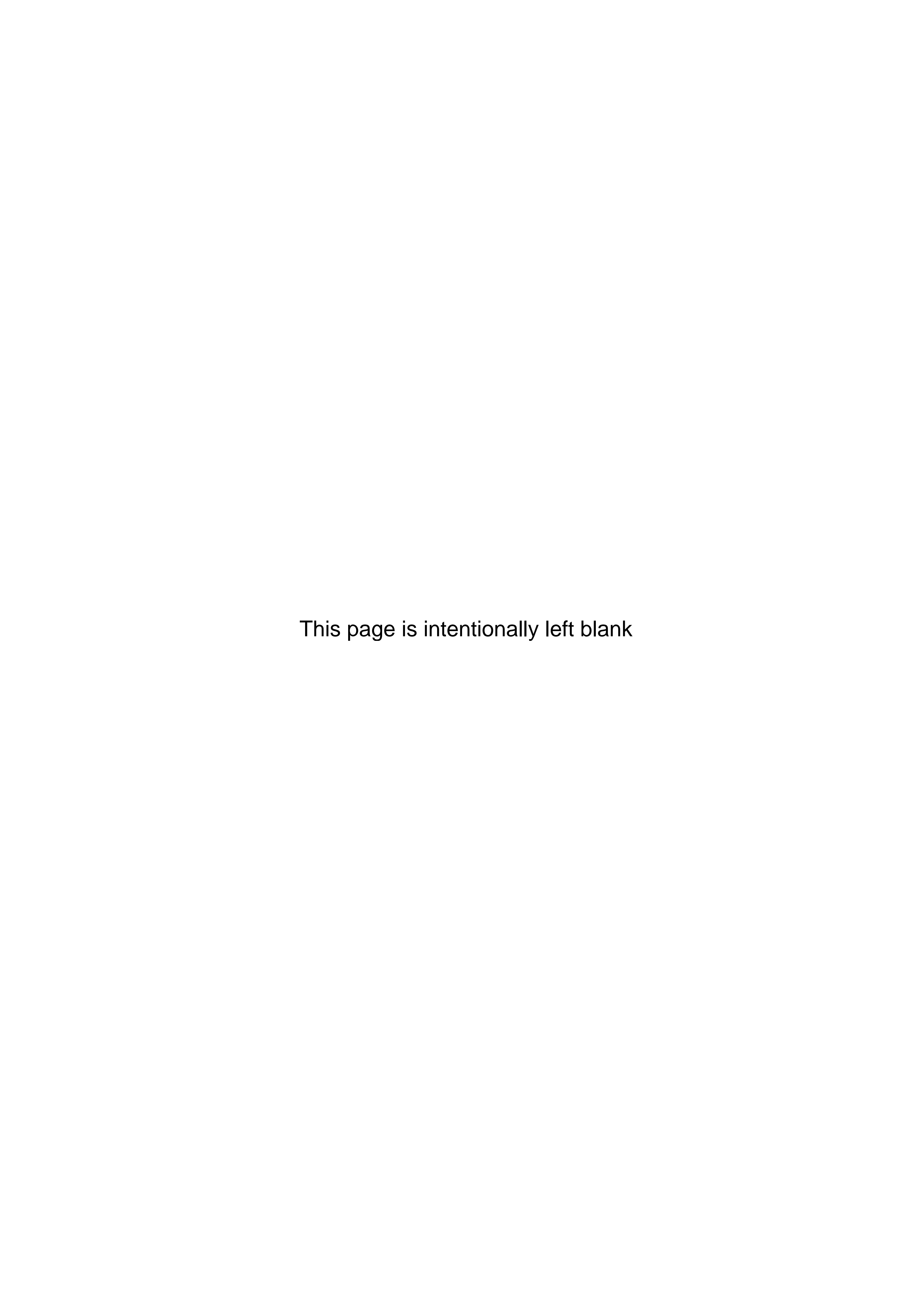
There was no other business notified prior to the meeting.

BOD/2122/89 **Items for inclusion on the BAF**

There were no items identified for inclusion in the BAF.

Date and time of the next meeting – 9.45am on 24th November 2021 venue to be confirmed.

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

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
58	28/07/21	2122/54	Board Assurance Framework Strategic Risks Review	Non Executives to be involved in the next review of the BAF strategic risks.	Director of Corporate Affairs & Execs	24.11.21	24.11.21	29.9.21 - AW discussion taken place with relevant NEDs re the additional BAF risk SR09 to be presented to November Board.	(blue)
59	28/07/21	2122/55	Freedom to Speak Up Report	To include a breakdown of the pie chart segment referred to as "other" in future reports.	Director of Corporate Affairs	24.11.21	24.11.21	Breakdown included and highlighted in in s3 of the report	(blue)

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NWAS Board and Committee Attendance 2021/22

Board of Directors

	28th April	26th May	11th June	30th June	28th July	29th September	24th November	30th March
Ged Blezard	✓	✓	✓	✓	✓	✓		
Prof Alison Chambers	✓	✓	✓	x	✓	x		
Salman Desai	✓	✓	✓	✓	✓	✓		
Prof Aneez Esmail	✓	✓	✓	✓	✓	✓		
Dr Chris Grant	✓	✓	x	✓	✓	✓		
Richard Groome	✓	✓	✓	✓	✓	✓		
Dr David Hanley	✓	x	✓	✓	✓	✓		
Daren Mochrie	✓	✓	✓	✓	✓	✓		
Prof Maxine Power	✓	✓	✓	x	✓	✓		
Gillian Singh	✓	✓	✓	✓	x			
David Rawsthorn	✓	✓	✓	✓	✓	x		
Prof Rod Thomson	✓	✓	✓	✓	✓	✓		
Lisa Ward	✓	✓	✓	✓	x	✓		
Angela Wetton	✓	✓	✓	✓	✓	✓		
Peter White (Chair)	✓	✓	✓	✓	✓	✓		
Carolyn Wood	✓	✓	✓	✓	✓	✓		

Audit Committee

	23rd April	11th May	11th June	16th July	22nd October	21st January
Prof Alison Chambers	✓	x	✓	✓	✓	
Prof Aneez Esmail	✓	✓	✓	✓	✓	
David Rawsthorn (Chair)	✓	✓	✓	✓	✓	
Gillian Singh	✓	✓	✓	x		
Prof Rod Thomson	✓	✓	✓	✓	✓	

Resources Committee

	21st May	23rd July	24th September	18th November	21st January	25th March
Ged Blezard	✓	x	✓	✓		
Salman Desai	✓	✓	✓	✓		
Richard Groome (Chair)	✓	✓	✓	✓		
Dr David Hanley	✓	✓	✓	✓		
Prof Maxine Power	✓	✓	✓	✓		
David Rawsthorn	✓	✓	x	✓		
Gillian Singh	✓	x				
Lisa Ward	✓	x	✓	✓		
Carolyn Wood	✓	✓	✓	✓		

Quality and Performance Committee

	26th April	24th May	28th June	26th July	27th September	25th October	28th March
Ged Blezard	✓	✓	Cancelled	✓	✓	x	
Prof Alison Chambers (Chair)	✓	✓		✓	✓	✓	
Prof Aneez Esmail	✓	✓		✓	✓	✓	
Dr Chris Grant	✓	✓		✓	✓	✓	
Dr David Hanley	✓	✓		✓	✓	✓	
Prof Maxine Power	✓	✓		✓	✓	✓	
Prof Rod Thomson	✓	✓		✓	✓	✓	
Angela Wetton	x	x		✓	x	✓	

Charitable Funds Committee

	28th April	27th October
Ged Blezard	✓	✓
Salman Desai	✓	✓
Richard Groome	✓	✓
Dr David Hanley	✓	✓
David Rawsthorn (Chair)	✓	✓
Lisa Ward	✓	✓
Angela Wetton	✓	✓
Carolyn Wood	✓	✓

Nomination & Remuneration Committee

	30th June	28th July	29th September	24th November	26th January	30th March
Prof Alison Chambers	x	Meeting not held	x			
Prof Aneez Esmail	✓		✓			
Richard Groome	✓		x			
Dr David Hanley	✓		✓			
David Rawsthorn	✓		x			
Gillian Singh	✓					
Prof Rod Thomson	✓		✓			
Peter White (Chair)	✓		✓			

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	Present	N/A
			Pro Vice Chancellor, Faculty of Health and Social Care and Member of University Executive Group, Manchester Metropolitan University	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Salman	Desai	Director of Strategy and Planning	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Employed at the University of Manchester		√			Professor of General Practice		Present	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority		Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director of Avantage (Cheshire) Ltd	√				Position of Authority	Dec-20	Present	Withdrawal from any Cheshire Care Home related discussions.
			Chair, Fix360 (part of Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Deputy Chair , Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
David	Hanley	Non-Executive Director	Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Member of NHSE/I Ambulance Review Implementation Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Rod	Thomson	Non-Executive Director	Visiting Professor at the Universities of Chester, Staffordshire and Liverpool John Moores University		√			Position of Authority	Sep-19	Present	No conflict
			Trustee of the mental health charity "listening ear". The charity is based in Merseyside and provides services in the NW region,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Volunteer at Severn Hospice, Shewsbury and do so as part of CPD requirements for NMC registration.		√			Volunteer	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governing Body Member, Royal College of Nursing		√			Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Locum Consultant in Public Health, Cheshire East Council	√				Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Fellow of the Royal College of Nursing and the Faculty of Public Health,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Lisa	Ward	Interim Director of Organisational Development	Member of the Labour Party	N/A	N/A	√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – The Riverside Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
Gillian	Singh (Resigned August 2021)	Associate Non Executive Director	Non Executive Director - The Riverside Group	√				Position of Authority	Jan-20		N/A

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REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="4">24 November 2021</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Chief Executive’s Report</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="4">Daren Mochrie, Chief Executive</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>SR05</td><td>SR06</td><td>SR07</td><td>SR08</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="4">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="4">The purpose of this report is to provide members with information on a number of areas since the last CEO’s report to the Trust Board on 29 September 2021.

The highlights from this report are as follows:

Paramedic Emergency Services

• A continuing increase in call volume and patient acuity
• A six-point improvement plan which includes hospital handover
• A BT duplicate call initiative to reduce the amount of repeat calls received

NHS 111
• Work ongoing to reduce the levels of attrition within 111
• The UEC Improvement Plan will contribute to the safe delivery of the service

PTS
• A number of staff to be trained as blue light drivers
• Activity steadily increasing
• A new regulation of only vaccinated staff allowed into Care Homes

The paper also provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as the Service Delivery Model Review, Strategy Refresh and the Unified Comms Programme</td></tr>
</table>

RECOMMENDATION:	The Board is requested to receive and note the contents of the report			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Not applicable			
	Date:			
	Outcome:			

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 29 September 2021

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

September and October have followed the trend of recent months of increased call volume and increased patient acuity. The increased acuity in Cat 1 and Cat 2 means that approximately 72% of the workload is in the highest categories of calls and the most resource intensive. Internal review of what is driving this is inconclusive and the Association of Ambulance Chief Executives (AACE) are now assisting in the analysis of the data along with NHSE/I. NWAS has the highest Cat 1 workload when compared to all other ambulance trusts.

To try and deal with the increased acuity and deliver a safe service NWAS, in conjunction with the NHSE/I, have jointly agreed a six-point plan, three actions for NWAS and three actions for the system. NWAS are committed to increasing operational resources as much as possible and have developed a trajectory to get to 400 vehicles deployed daily at peak (312 funded vehicles), decrease hospital conveyance through improved Hear & Treat and See & Treat, finally reduce unproductive hours by improving vehicle availability. In turn the system is committed to improving hospital handover times, improving access to mental health services and improving the directory of services therefore increasing NWAS access to community-based services. These joint actions will be monitored bi-weekly by NHSE/I.

As well as this action there have been several national changes implemented. BT have commenced a duplicate call initiative which aims to reduce the amount of repeat calls we receive from the public. This is now in place and it is too early to detect if there is any material difference yet. The second initiative is the removal of the Pandemic Protocol 36 tool. This may help to reduce the acuity of some of the calls we receive and therefore help with resourcing incidents. Again, it is too early to be able to detect any improvements

2.2 NHS 111

Pressure continues within 111 due to the call volume demand.

Current Priorities - UEC Improvement plan - The plan is made up of 6 areas that if delivered successfully will contribute the safe delivery of the service throughout the winter into 2022. The plan is jointly owned by NWAS and the wider UEC and focusses on external demand, system efficiencies, Pathways changes and increased workforce agility.

Recruitment - Planned recruitment to the end of 2021/22- Health Advisors - 80fte, Service advisors - 53fte and Clinical Advisors - 15fte

Retention - Work is ongoing to reduce the levels of attrition within 111. Exit interviews have identified the key reasons being: stress of the job, rostering, getting annual leave and returning to pre-COVID role/starting university. The senior team have

developed a Staff Health and Well-Being Plan, to support our teams and includes reviews of annual leave, rosters and our recruitment process.

2.3 PTS

A number of PTS staff have confirmed their interest in temporarily redeploying into PES as a Blue Light Driver and the impact of this on recruitment and service provision combined with existing vacancies are being worked through. The service line continues to progress the work it is doing to enable greater provision of double crewed non-emergency ambulances with a view to implementing this over the coming weeks.

Challenges around capacity associated with social distancing measures continue to impact utilisation of resource. Whilst the current IPC / social distancing measures will remain in place, discussions continue with NHSE/I and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively. Activity has steadily increased over the past 6 months to an overall level in excess of 90% of pre-covid activity. The proportion of patients requiring an ambulance is regularly close to pre-covid levels.

Regulation came into effect on 11 November 2021 which states only individuals who have received two vaccine doses will be allowed to enter a nursing home. NWAS and private ambulance staff who have not received both vaccines have been identified and their records updated on Cleric to flag to the controller and prevent nursing home journeys being allocated to ineligible staff. Communications have been sent to NWAS staff outlining the approach and a letter sent from the Chief Executive to nursing homes providing this assurance and to request mobile patients who may travel in a taxi be brought to the entrance to the home for collection.

3. ISSUES TO NOTE

3.1 Local Issues

Manchester Arena Inquiry

The Manchester Arena Inquiry has continued to hear about the experiences of the people who tragically died in the attack. There has been evidence from emergency services, including NWAS colleagues, and some of this evidence has been reported in the media. Salman Desai, Director of Strategy, Partnerships & Transformation and Interim Deputy CEO acknowledged that this part of the inquiry is particularly distressing for the families of those who died, and anyone involved or affected by the arena incident. Our colleagues who have given evidence have had to revisit the events of that evening in order to assist the inquiry, which cannot have been easy for them. We have been supporting those colleagues throughout this process and continue to do so.

The trust fully supports the inquiry and respects the right of the families and the public to have an open, independent review, which will help all the authorities involved to understand if there is learning that could be applied in future major incident scenarios. For this reason, we cannot publicly comment on proceedings before the inquiry has concluded.

The Greater Manchester Resilience Hub is available to provide mental health support for those affected by the Manchester Arena Attack, including healthcare professionals.

Incident at Liverpool Women's Hospital

On 14 November we were called to reports of a car explosion at Liverpool Women's Hospital and had resources on scene in a matter of minutes. We assessed and treated one patient before taking them to hospital and worked alongside police and fire colleagues to manage the incident on the day and subsequent days thereafter.

The exact circumstances surrounding the incident are yet to be confirmed but it is being investigated as a terrorist incident by Counter Terrorism Police. Chief Constable of Merseyside Police, Serena Kennedy, has provided reassurance to all those living and working in Merseyside that there is no specific threat to the area, but there will be increased police presence to support and reassure communities. Chief Constable Kennedy has reminded us all to remain vigilant and alert but reinforced that incidents such as this are very rare.

I, along with Stuart Ryall, Sector Manager and Strategic Commander on the day met with the Security Minister who wanted to pass on his thanks and the thanks of the Government for our response. Thank you to everyone who was involved in the response, from those who attended the scene to help the person injured, to those working behind the scenes throughout the day to support the overall emergency service response to the incident. Our thoughts are with everyone affected by the distressing incident, in particular colleagues at Liverpool Women's Hospital who I'm sure will be shaken by the events.

3.2 Regional issues

Service Delivery Model Review

Prior to the onset of the Covid-19 Pandemic, the Trust had stated its ambition to become the best performing ambulance service in the country by 2023 and it is crucial that we emerge from the pandemic as an ambulance service that can deliver sustainable ARP (Ambulance Response Programme) standards. The review considers whether the trust has the right people and vehicles to maximise resource availability.

We've enlisted external experts, Operational Research in Health (ORH), to undertake a demand and capacity review to determine the frontline resources needed based on our predicted 999 demand. Task and finish groups led by the heads of service, with trade union representatives and operational colleagues are reviewing specific areas such as the use of rapid response vehicles, PTS and urgent care support, the reason resources become unavailable, meal and rest breaks, end of shift practices to name but a few. Our part of the review is focused on maximising emergency ambulance resources to ensure patients get a timely response which will also support staff wellbeing.

Modelling shows that if we, and our commissioners, don't act now, patients will wait longer in the future. Having the right resources will also help to improve the working lives of staff and enable us to plan better for the future.

Once the review is complete, the findings will be presented to the project board, trade union leads and executive team. In the meantime however the Trust is using the non-recurring investment given to ambulance services to support us over winter. Anything that can be implemented to help ease the pressure on frontline colleagues this winter will be prioritised, with other aspects following next year.

Award Ceremonies

This year we felt that we had to take a cautious approach because of the Covid-19 pandemic and as such the Queen's medal ceremonies were held with limited attendance. The Queen's medal is awarded to those who have undertaken 20 years' emergency duties with good conduct. It is a once in a lifetime achievement and is presented to recipients by Her Majesty's local representative, the lord lieutenant. For this reason, we were able to find a safe way to deliver these events on a smaller scale than usual for qualifying staff. All other long service awards are given out by the trust and, once an employee reaches 20 years' NHS service, we recognise their commitment every five years.

Over 500 staff across the three sectors were due to collect long service awards; many had been waiting a long time, so virtual events were a way for us to celebrate with such significant numbers safely. We celebrated the dedication of colleagues in various roles across the trust during the events, which took place throughout October. The events marked the milestones of staff with 20-, 25-, 30-, 35- and 40-years' service in the NHS. There were also a couple of colleagues who had reached an incredible 45 years' service

HRH The Earl of Wessex opens state-of-the-art training centre at shared site

A number of our staff were invited to join Cheshire Fire and Rescue Service as they welcomed HRH The Earl of Wessex to Winsford to officially open their new state-of-the-art training centre based within our shared site. We were involved when all three services' skills were put into action to demonstrate how the training centre will be used to ensure Cheshire's firefighters have the expertise and knowledge to keep residents safe for years to come.

Review and Refresh of Organisational Strategy

Our strategy sets out the future direction of the trust and outlines how we will get there, by continuing to improve experiences for patients and staff. It is also about how we work in partnership with other parts of the NHS system to deliver urgent and emergency care to the people of the north west.

Over the last 18 months, the NHS has changed rapidly in response to the Covid-19 pandemic and there have been changes to structures and leadership. As we continue to focus on delivering safe and effective urgent and emergency care, we need to review our own strategy, which was last updated in 2019, to ensure it reflects the changes and learning from Covid-19 and puts us in a good position to continue to shape the future of the NHS in our region.

We're hoping to have our renewed strategy in place by the start of the next financial year, April 2022. It will be a three-year strategy that will provide clear direction to inform updates to our enabling strategies, such as the Quality Strategy, and annual planning processes which will outline in more detail the actions we will take to achieve our vision.

Our new values that were introduced at the start of this year were developed with input from staff and perfectly capture how we operate at NWAS. These values – working together, being at our best, and making a difference – will be a core part of our strategy.

While NHS governing bodies define what effective urgent and emergency care looks like, our strategy will outline how we aim to deliver that care and improve experiences for patients and staff.

A clear vision and set of common strategic goals will be essential to get us back on track and drive us forward, whilst embracing all the learning we've picked up over the last 18-24 months. It's vital we start the next financial year with an organisational strategy that is fit for purpose, for now and for the future, that we can all get on board with and contribute to.

Ideas Room

The Ideas Room is our interactive messaging board, hosted on the Green Room. A new discussion topic has been launched to capture the thoughts of staff on our future.

Unsurprisingly, delivery of high-quality patient care was a recurrent theme in recent responses. Some colleagues said they felt we needed a clearer organisational direction and voiced concerns about us not always achieving our existing vision of 'delivering the right care, at the right time, in the right place, every time' for various reasons, including the pressures we're facing.

There was a good debate about whether 'being the best' is the right measure for us to use, and other themes that came out strongly included: staff welfare and wellbeing and getting the basics right; working in partnership with other parts of the healthcare system; and needing to have the right response model to send the right resource with the appropriate skill set to incidents.

Having a clear organisational direction is vital, which is one of the main reasons we're undertaking this work this will now enable the Board to shape and decide on what our vision is going forward and how we articulate it to our wider workforce and organisations that work alongside us.

In our current organisational strategy, there are eight priorities, but we want to be more specific and really focus our efforts and attention on the areas which are most important to the trust. 'Strategic Priorities' is therefore the theme of the next discussion

Partner Universities

During October I met, in some cases virtually, with the 1st year student paramedics from all five feeder universities across the North West for a welcome and Q&A session

Remembrance Day

Thank you to everyone who attended, took part in, or represented NWAS at local Remembrance Day events over the weekend. The trust is proud to have a strong and active Armed Forced Network within our service.

I was honoured to represent the ambulance sector at the Festival of Remembrance, hosted by the Royal British Legion at the Royal Albert Hall in London on Saturday 13 November, to commemorate all those who have lost their lives in conflict.

Team Talk Live

This live briefing for all staff takes place after every Board of Directors meeting. After the September meeting Peter White and I were joined by Director of People, Lisa Ward and Director of Operations Ged Blezard.

A number of these sessions have been held and it is good to see staff joining and getting involved by asking questions or leaving comments. It's a good way for them

to get some insight into what we do as a Board and hear from us about some of the topics we've been discussing and answering staff questions; which in September included Section 2 Pay, Safeguarding and Mental Health Calls

New mental health tool

Senior Paramedic Team Leader, Darren Earley, has been working closely with NHSE/I to create the BASIC STEP tool. The BASIC STEP tool allows all ambulance staff to have a good conversation and assessment with a person experiencing mental ill-health, based on several risk factors aligned around the acronym BASIC STEP (Behaviour, Appearance, Speech, Insight, Cognition, Safeguarding, Thought, Emotional state, Plan).

Staff Survey

The annual NHS Staff Survey is one of the largest workforce surveys in the world and gives all staff the chance to share their views and have their voice counted. The responses will help give a really accurate picture of what it's like to work for the trust and will be used to make things better for staff, colleagues and our patients. It is entirely confidential and run by Picker, an independent organisation who will make sure that all responses are kept completely anonymous.

Unified Communications Programme (UCP)

Whether for 999, 111 or patient transport service our first and main point of contact with patients is by telephone and we receive thousands of telephone calls every day.

The UCP is a significant piece of work which has been underway for some time now and is replacing the many various telephony systems across the organisation, bringing us all onto one, improved platform. The UCP reached a massive milestone recently, with call handlers from our emergency operations centres (EOC) moving onto the new platform, joining EOC dispatchers, 111, PTS and support centre.

The vital importance of our telephony system meant the project team had an incredibly complex task in planning and delivering the migration to the new platform. The operational functionality and technical complexity of this task is enormous and high risk, which cannot be underestimated. The programme has involved full replacement of network and telephone switches within the data centres and introduction of the standardised telephony system, with associated tools including voice recording and wallboards for our contact centres.

I want to say a huge 'well done' and thank you to everyone who has been involved in the delivery of UCP so far to ensure the project success. There is more work to do on the programme, with corporate services being the next group to move onto the new platform and ongoing support to ensure the system is working as it should across the organisation.

EPR improvements

Following the rollout of the electronic patient record (EPR) a log has been kept of development opportunities that have been outlined by staff. The log holds around 230 suggestions and although this shows that improvements are needed it's really appreciated that staff are taking the time to submit their suggestions which will help us to make the system better for our users and patients. We are working to set up of

a wider development group with operations colleagues to help scrutinise the development log and determine priorities.

3.3 National Issues

NHS System Oversight Framework

NHSE/I recently consulted on the new NHS System Oversight Framework (SOF) for 2021/22 which introduced a new approach to provide focused assistance to organisations and systems and reinforces system-led delivery of integrated care.

NWAS has been placed in SOF Segment 2 which is the segment we were in previously, therefore no change. Segment 1 being the best with segment 4 being the segment that offers the most intensive support from the regulator.

Hospital Handover Report

Advance notice was sent to the Chairs and the Chief Executives of our area Acute hospitals giving details of an AACE report which published on 15 November. The report entitled "Delayed hospital handovers: impact assessment of patient harm". was commissioned on behalf of the national medical directors and quality group following serious concerns about harm to patients. The assessment reflects the very extensive delays ambulance services across the country were experiencing in January and our inability to respond to patients in the community.

The report was not intended to be critical of, or lay blame on, acute providers. We are very fortunate in the north-west to enjoy constructive and collaborative relationships with our acute partners, some of which have been or are currently actively involved in improvement schemes to reduce ambulance turnaround times, improving patient experience and safety. As a direct result of the joint working, none of the north west hospitals appeared in the national top 35 hospitals with the longest handover delays; that said we still loose significant numbers of ambulance availability which means we cannot then respond to 999 calls in the community, not to mention the impact on staff. Whilst the report received considerable media attention, both I and the trust's Board consider this an opportunity to work together to provide safe and effective patient care ahead of what we all anticipate will be a very challenging winter.

A communications plan was produced and all aspects were managed and coordinated by the Head of Communications at AACE in conjunction with myself as Chair, the Managing Director and Deputy Managing Director of AACE to ensure the provision of accurate, appropriate, and consistent responses to the media about the report.

As part of my AACE Chairman's role, I have been engaging with NHS England/Improvement and their feedback has been incorporated into the final version of the report. The findings of the report have been taken very seriously and follows on from a recent letter from Pauline Philip and Steven Powis to ICS leads, acute and ambulance trust Chief Executives, requiring action to improve handover delays.

Ambulance pressures hitting the headlines

There has been a number of reports in the press recently about the continuing pressures ambulance services are facing nationally, with headlines about long waits for patients and delays with hospital handovers.

This doesn't make for pleasant reading or viewing, but I know it largely reflects the situation we are facing and it's what colleagues tell me, the Executive Team and their line managers. The thought of patients waiting when they need help is distressing and emotionally draining, it is not what any of us who choose to work in the NHS want. The Board and I are fully committed to taking all possible steps to help manage demand.

Together with our Communications Team, we are responding to these press reports to be open about the challenges we face but also to highlight that, despite the current pressures, all of our colleagues are doing their best and working incredibly hard across 999, 111, patient transport and support services to be there for those who need us.

Flu

We know how important it is to protect staff, their colleagues and their families. The predictions are that flu could be really prevalent this year given lower than normal immunity so the vaccine is more important than ever. The trust's aim is to run a short campaign across October and November to make sure we can provide the vaccine to as many staff as possible before Christmas

4. GENERAL

Black History Month

October was Black History Month and this year's theme was 'proud to be'. Wesley Proverbs, Paramedic and Chair of the trust's Race Equality Network, started the celebrations by sharing his 'proud to be' video.

Black History Month is an important time for us to reflect on a history of racial inequality, educate ourselves and celebrate Black heritage and culture. Doing so will allow us to understand how we can better support people from all of our diverse communities in the North West.

We are committed to driving change and improving diversity within NWAS. In January, we established our first ever Race Equality Network for staff to give their views and talk about their experiences, as well as looking at workforce equality issues. The BHM celebrations are the perfect way to showcase the work of our network and celebrate all of our diverse staff members.

Salman Desai, Director of Strategy, Partnerships & Transformation and member of the Race Equality Network also shared his thoughts on Black History Month and why it is so important that we all do more to understand and take action to address inequalities that still exist today.

Salman also hosted a round table discussion about race and racism in the ambulance service. This was the first in a series of round table discussions where staff will be invited to take part in conversations about live issues, with the aim of promoting and improving equality, diversity and inclusion for our workforce and our communities.

Talking mental health with Prince William

As part of my role as Chairman of the Association of Ambulance Chief Executives, I am fortunate to sit on the Emergency Responders Senior Leaders Board, set up by The Royal Foundation.

The Duke and Duchess of Cambridge set up the board in response to a recommendation airing from a research project commissioned by The Royal Foundation in 2018, looking into the mental health and wellbeing of emergency responders in the UK.

I had my regular meeting with the Duke of Cambridge at Kensington Palace to update him on work across the ambulance sector. We discussed working with police and fire colleagues to share ideas, learn from each other and develop strategies for supporting our staff and volunteers.

His Royal Highness was particularly interested to hear about the suicide prevention toolkit developed by Craig Hayden, Advanced Practitioner and Suicide Prevention Lead at NWAS. I updated Prince William on the current pressures across the ambulance sector and the stress that our frontline staff are working under. We hope to launch several other developments at an event hosted by the Duke and the Royal Foundation planned for late November. He told me that he has met a number of ambulance staff and their families over the past few months and wanted to pass on his thanks, and those of the Duchess, to all emergency service staff and volunteers for everything they are doing

Meeting with the military

I also met up with senior officials at the Ministry of Defence at Whitehall, including Lt Col Stephen Bartlett. We discussed many things, including the UK ambulance sectors response to Covid, our current pressures, our plans going into winter, future modelling and forecasting of threats and pressures

Ambulance Programme

As we come to the end of this series of BBC's Ambulance documentary, I have been reflecting on the impact of the programme. This is our third series of Ambulance and the first which has featured our Lancashire staff. Millions of people tune in each week and it gives them an insight into our world that they otherwise wouldn't see. It showcases our incredible staff.

Every single week, I am so proud to see the thousands of messages of support on social media, not just from the public but from our NHS colleagues too, with many thanking us for the care, compassion and excellent clinical skills we demonstrate when we deal with our patients, but also sharing an appreciation of how busy we are. It allows the public to see what I see every day – a caring, dedicated, professional team that works together under incredibly difficult circumstances to care for the people of the north-west

Care and compassion was a big theme in the most recent episode which was the last in the series and I'd like to thank everyone who has been involved and supported the production of the programme.

Healthier Planet, Healthier People

Recently we saw first-hand the effects of increasingly extreme weather patterns caused by long-term climate change, with flooding and weather warnings in parts of the north-west. Cumbria was particularly affected, with access issues in parts of the county due to flooding, impacting our ability to respond quickly to emergencies.

It is appropriate, therefore, to mention the Carbon Action Literacy Day, which was held on Monday 2 November to coincide with the start of the United Nations Climate Change Conference, COP26.

The trust hosted an open training course on the carbon literacy ambulance toolkit across the Ambulance Sector. We were the first NHS organisation to use the carbon literacy ambulance toolkit as a permanent feature on our training offer to staff and our Environmental Sustainability Officer Karen Aguilera delivered that same training to attendees from our own executive team, chief executives from other ambulance services and representatives from NHS England and Greener NHS.

The training covers topics such as: the impacts of climate change; carbon footprints and workplace emissions; and how we can take action. As an organisation, it's vital we are aware of our carbon footprint and taking steps to reduce it as far as possible. As individuals, we should all understand more the impact of climate change and take responsibility for our actions, making small steps where possible to make a difference.

The issue of climate change is being addressed by the NHS as part of a 'Healthier People, Healthier Planet' campaign which launched recently. As the campaign will highlight, climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS, and the situation is getting worse.

Burnout programme

To support the mental health of staff the trust is running a burnout programme, which includes weekly webinar's, meditation sessions and a four-week resilience recovery plan, hosted by Manchester Stress Institute. The feedback we have received so far has been extremely positive with the sessions making a real difference.

International Control Room Week

International Control Room Week took place during October and the trust celebrated all of our fantastic contact centre staff who work tirelessly to answer the region's 999, 111 and Patient Transport Service calls. Since last year's NHS Staff Survey, a number of improvements have been made within our contact centres including increased training and awareness sessions for call handlers in EOC, a review of our open talk procedures which we have worked to standardise across the trust and a number of health and wellbeing initiatives such as the launch of the Treat Me Right toolkit which supports staff and managers to directly address bullying and harassment in the workplace.

New team members

We would like to welcome Andrea Long to #TeamNWAS. Andrea is the new head of estates and started in the role on 27 September. Andrea began her career in estates and facilities within the NHS more than 25 years ago.

At the start of the month, we welcomed Stephen Down, our new Health Education England (HEE) mental health education transformation specialist. Stephen is based within our trust but will work nationally with all ambulance services in the UK to determine a minimum and mandatory level of knowledge in respect of mental health for all new starters into ambulance roles. This role has been specifically created to support the development of educational projects to improve capacity, capability and culture in ambulance workforce to support people in mental health crisis.

Stephen began his career as a social worker working mainly in adult mental health and has since worked in safeguarding before taking up this position.

Death of staff members

It is with great sadness that I report on the death of Mark Stephens who, aged 49, sadly passed away after a short illness. Marked worked as a rotational specialist paramedic in in the Clinical Hub at Estuary Point having previously worked in many roles within the Trust.

The trust sends sincere condolences to the families, colleagues and friends of Mark at this sad time.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implication contained within this report

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

7. RECOMMENDATIONS

The Board is requested to receive and note the contents of the report.

North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="4">24 November 2021</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Q2 Board Assurance Framework Review</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="4">Angela Wetton, Director of Corporate Affairs</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>SR05</td><td>SR06</td><td>SR07</td><td>SR08</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="4">For Decision</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="4">The Corporate Risk Register can be seen in Appendix 1 and the proposed Q2 (as of 30 September 2021) of the Board Assurance Framework (BAF) with the associated Corporate Risk Register (CRR) risks scored ≥15 can be viewed in Appendix 2. The BAF Heat Maps for 2021/22 year to date can be viewed in Appendix 3.

The Executive Leadership Committee (ELC) recommends the following Q2 changes (s4):
• Proposed change to the risk articulation of SR05
• Proposed change to the risk articulation of SR06
• Newly identified strategic risk pertaining to cyber-security.

ELC recommends the newly identified strategic risk to be included on the BAF from 01 October 2021 onwards, this can be seen in s5.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors requested to:
• Agree the proposed new risk articulation for SR05
• Agree the proposed new risk articulation for SR06
• Agree the newly identified strategic risk; SR09 pertaining to cyber-security
• Agree the Q2 position of the Board Assurance Framework.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust’s Risk Appetite Statement has been considered as part of the paper decision making process:

☒ Financial/ VfM
☒ Compliance/ Regulatory
☒ Quality Outcomes
☒ Innovation
☒ Reputation</td></tr>
</table>

ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Assurance Committees, ELC and Audit Committee			
	Date:	Throughout Q2		
	Outcome:	For Assurance		

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1. PURPOSE

The Board of Directors has overall responsibility for ensuring that systems and controls are in place to mitigate any significant strategic risks which have the potential to threaten the achievement of the Trust's strategic objectives.

This paper provides an opportunity for the Board of Directors to review the 2021/22 Q2 position of the Board Assurance Framework (BAF) along with the Corporate Risk Register (CRR) risks scored 15 and above that are aligned to each BAF risk.

2. ASSURANCE PROCESS

The BAF and associated corporate risks are reviewed via the Integrated Governance Structure.

The evidenced based assurance information reported throughout the quarter via the assurance committees and identified via a review of Chair's Assurance Reports is collated on the Assurance Map. The assurance mapping has been utilised to support and inform discussions with Executive Directors and assist with the population of the assurance framework.

3. REVIEW OF THE CORPORATE RISK REGISTER

The review of the CRR takes place monthly at the Executive Leadership Committee (ELC) as well as via the Integrated Governance Structure. The CRR is available for review in Appendix 1.

4. REVIEW OF THE Q2 BAF POSITION

The Executive Leadership Committee has reviewed the Q2 position and recommends the following changes to the Board of Directors for approval:

SR05:

Current Risk Articulation	Proposed New Risk Articulation
There is a risk that the required organisational culture change does not sufficiently develop to support the organisational changes and improvements required to meet the changing demands on the service, resulting in poor quality services	There is a risk that the organisational change does not sufficiently develop, impacting adversely on staff wellbeing and engagement with organisational changes, resulting in poor quality services and staff harm

SR06:

Current Risk Articulation	Proposed New Risk Articulation
There is a risk that non-compliance with legislative and regulatory standards could result in staff and/or patient harm	There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

5. IDENTIFICATION OF A NEW STRATEGIC RISK

Following the Board of Directors meeting on 28 July 2021 and feedback from some Non-Executive Directors that the absence of a digital strategic risk was a potential

gap for the organisation and should be given further consideration for inclusion on the 2021/22 BAF, an engagement session was held to fully explore the concerns relating to digital which concluded specific concerns surrounding cyber-security.

The Head of Risk and Assurance and the Chief of Digital and Innovation have undertaken a full root and branch review of cyber-security associated risks to ensure the risk profile reflects the articulated strategic risk.

Below is the proposed cyber-security risk that has been developed for inclusion onto the BAF from Q3, 01 October 2021:

SR09	There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.	Director of Quality, Innovation & Improvement

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Board Assurance Framework and the Corporate Risk Register forms part of the Trust's risk management arrangements and supports the Board in meeting its statutory duties.

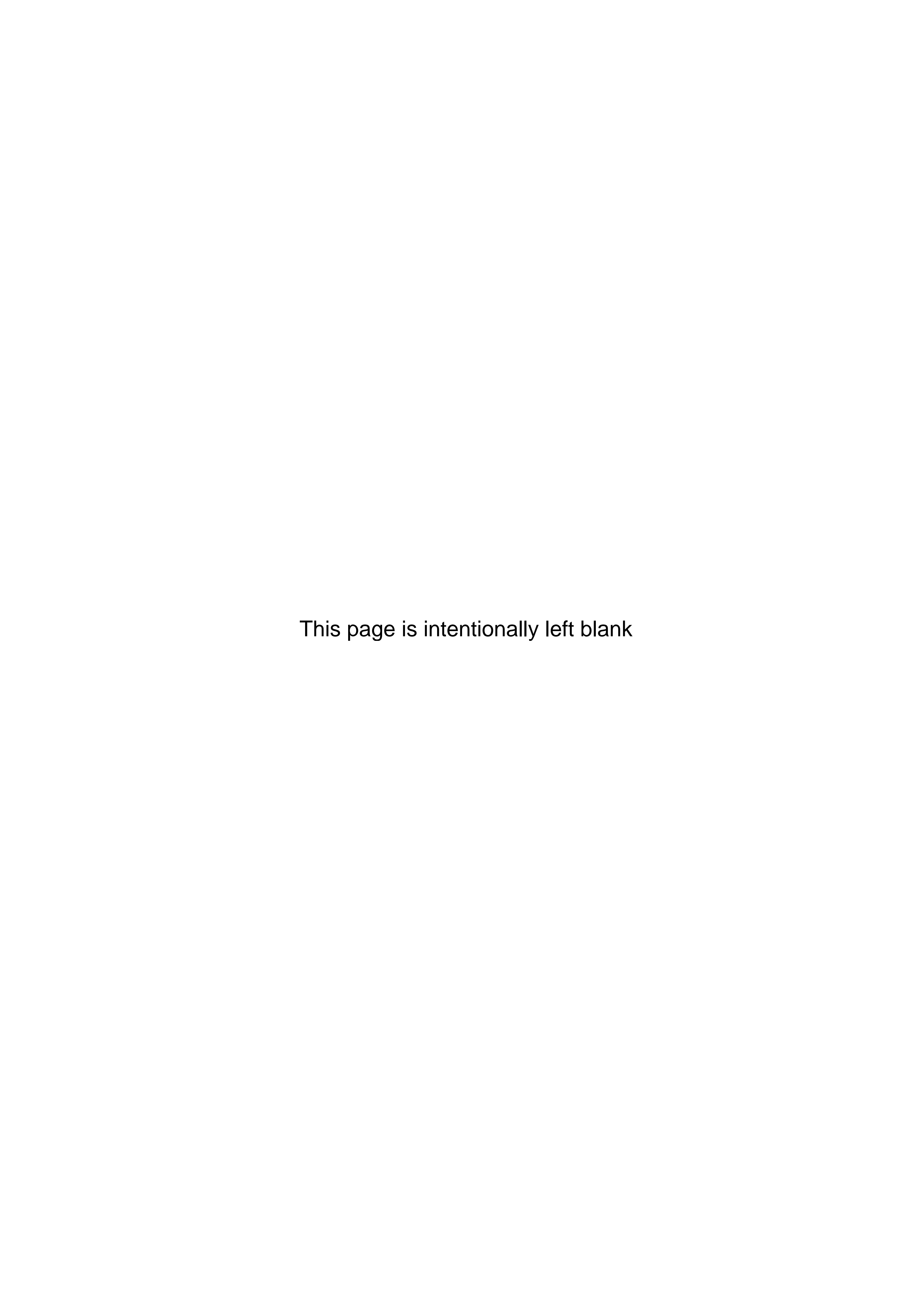
7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

8. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the proposed new risk articulation for SR05
- Agree the proposed new risk articulation for SR06
- Agree the newly identified strategic risk; SR09 pertaining to cyber-security
- Agree the Q2 position of the Board Assurance Framework.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Appendix 1: Corporate Risk Register
End of Q2 Position
**Extracted from Datix on 08 October 2021*

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Key Controls in Place	Likelihood (current)	Consequence (current)	Rating (current)	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
2507	01/02/18	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	Strategic Meal Break Guidance. NWAS Meal & Rest Break Management Working Arrangements Procedure. Strategic Meal Break Dining Instructions. Meal Break Policy. Return to base procedure/ guidance. Effective Meal Break Management of Operational Resources within Meal Break Window memorandum. Establishment of Meal Break Review Group to review current practices including review of the Policy. Terms of Reference for Meal Break review group. Paper presented to Workforce Committee in August 18 (07.08.18) and then October 18 (23.10.18) for further review re update on current meal break review. NWAS Strategic meetings taken place re Meal Break Management. (May 19 & 23 July 19). MB Workshop took place (8th July), led by Strategic Head of EOC to discuss SMB etc. Paper to be developed and presented back to Strategic Group by end of September 19 (DA). Additional focus in C&M EOC re adherence to the meal break policy to take place for a four week period throughout December 19. Rota Review which may support meal break management due to stagger times implemented in GM and C&L. Additional focus from the Covid-19 command cell re meal break management compliance (currently at 70%).	4	4	16	01. Review and Implement new Meal Break Policy - GB - March 21. 02. TU engagement and agreement to amend existing Policy	Meal Break Policy/Procedures. Meal Break Reports submitted to SD SMT. ORH and ACE to support NWAS model with recommendations made Links with Trade Unions and have their agreement Interim Head of Service for Cheshire & Merseyside reviewing Demand and Capacity Daily measurement of meal break compliance.	Gaps in compliance following MIAA Reporting re Meal Break Management.	4	07/09/21	07/10/21
2568	26/03/18	There is a risk that due to the majority of MTA staff being stationed in or around Liverpool and Manchester, there may be a delayed response to MTA incidents outside of this area resulting in delay to triage, treatment and transport.	Approved Risks	Operational	Emergency Preparedness	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	02. NWAS Major Incident Response Plan/Joint Decision Making Model/JESIP ethos embedded across NWAS. 03.Ballistic Personal Protective Equipment issued to trained staff. 04. Numerous multi agency `live` and `table top` exercises conducted. 05. Cadre of specially trained Ambulance Intervention Team Commanders available. 06. All Tactical Advisors and National Interagency Liaison Officers (NILOs) have been trained. 07. Specialist medical equipment procured. 08. Mutual Aid available from adjacent Trusts under the national mutual aid procedure. 09. Trained Commanders identify themselves to Support Centre when on call. 10. Operational uplift staff on duty identified on C3 and PROCLUS twice daily. 11. Random sampling of trained staff on duty. 12. Under JOPS 2, Non-specialist staff can work within a `Warm Zone' 13. New SORT Enhancement Programme implementation phase now active. 01. Ballistic PPE strategically placed on ISU`s across the whole of NWAS.	3	5	15	01.There is a lack of staff trained in MTA who cover the Lancashire & Cumbria area	01.Approved Policies and Procedures. 02.Workforce Committee re reporting of staff trained. 03.National Capabilities Audit to NARU/NHSE. 04.Service Delivery SMT. 05.Approval of Option 12 has been given and commissioned and funded from April 2021 06. The deployment of resources into the hot and warm zones may include both specialist and non-specialist multi-agency responders with the correct PPE. 07.Commanders should decide when and how their responders are deployed (informed by the attack methodology). 08.The intention to deploy should be to minimise the risk to the public (including the injured) whilst maximising the safety of responders. 09. Substantive Training Manager has been appointed. 10. SORT Enhancement Project commenced May 2021.	03. Receipt of additional funding. 02. Ability to recruit 290 staff by 31/03/2022.	5	07/07/21	07/10/21
						gister			duce the risk.	1. Domain Policy (including password security) 2. Patching Policy 3. Processs for the dissemination of CareCERTS Bulletins issued by NHS Digital 4. De-militarized zone in place to limit threat footprint from external risks									

ID	Date	Risk description	Status	Type	Category	Register	Owner	Initial score	Treatment	Controls	L	C	Score	Gaps in control	Assurance	Gaps in assurance	Target	Date	Date
2833	15/01/19	There is a risk that without an established and embedded System Security Testing Programme The Trust is vulnerable to cyber attack resulting in a loss of critical systems, business disruption or exfiltration of confidential data.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Reg	Maxine Power	16	Treat - Implement controls and mitigating actions to re	5. Mobile Device Management in use to control services on some mobile devices 6. Externally facing firewalls 7. Anti-virus protection (including malware protection) on both physical and virtual clients/server's 8. Device encryption on all laptops and some mobile devices mobile devices to protect data 9. Regular security updates deployed for the latest security patches 10. Software in place to detect key loggers 11. Automated daily threat assessment in place for Windows 10 12. Spam filtering in place 13. Business Continuity Plans 14. Temporary Security Management support in place 15. Cyber Essentials certification achieved. 16. New Cyber Security Manager recruited and in place.	3	5	15	Lack of annual cycle of patching and key resource to deliver it Lack of vulnerability scanning to ensure systems are hardened	New Cyber Security Manager recruited and in place (Oct 2020) NHS Digital Security Testing (Jan 18, May 18) MIAA assessment of Cyber Readiness Jan 2019	Lack of defined KPI's relating to Cyber Security & governance/assurance process Lack of regular assurance reporting to Board Level Committee in relation to Cyber KPI's Actions from NHS Digital & MIAA assessments to be addressed &b monitored Lack of independent evaluation of security training re Social Engineering	10	18/08/21	18/09/21
3027	03/07/19	There is a risk that the combined outcome of the ORH demand analysis, Paramedic skill mix change and GP reform will create a Paramedic shortfall resulting in inability to meet operational demand.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Increased numbers for direct entry and in-service conversion programmes for 2019/2020 starts. 02. 2019/20 in-service conversion rescheduled to maximise staff availability over winter periods (2019 and 2020) 03. Active recruitment 12. ELC decision to pause rotational pilots 13. HEE 2021/22 approval to increase apprenticeship - starts to 90 04. Paramedic apprenticeship preferred supplier in place and contract award approved by Board. 05. Turnover remains stable. 06. Plans agreed with HEIs to prevent COVID from delaying completion of programmes 07. HCPC approval of U of C apprenticeship programme. 08. HEE funding secured for rotational working pilots and recruitment to infrastructure posts commenced 09. ELC approved key decisions for Paramedic apprenticeship, including supporting posts, cohort size and pay and conditions 10. Paper approved for application of sponsor license. 11. 120 paramedic apprenticeship starts 2021	4	4	16	01. Local Paramedic supply insufficient to meet potential demand 02. Impact of GP reform on retention unclear 03. Change in GP contract to band 7 funding for Paramedic posts. Further proposal also suggest Band 8A might be added to the ARRS. 04. PCN recruitment plans unclear	01. EMT1 AAP CPD Bridging Programme expansion, with over 250 EMT1s on track to achieve the AAP qualification. 02. AACE and HRD oversight of impact of GP reforms 03. Paper to EMT approving over-establishment of paramedics and increases in provision - July 2021 05. Agreed ToR and project plan for rotational working groups 06. ELC approval of Paramedic apprenticeship supplier - January 2020 07. Confirmation of HCPC validation of apprenticeship course. 08. Contract for apprenticeship awarded. 12. ELC report Nov 20, confirmed continuation of two pilot scheme 13. ELC report Nov 2020, assurance on Paramedic apprenticeship progress and key decision milestones 14. Resources Committee, assurance on Paramedic apprenitcesip and ORH plans - November 2020	STP/ICS oversight of paramedic demand outside of ambulance trust Clear understanding about how the healthcare system is proposing to use paramedics to fill staffing gaps	4	11/08/21	30/09/21
3056	31/07/19	There is a risk that due to the backlog of complaints, complainants and reporters of external incidents are not receiving timely responses resulting in a poor complainant experience, non-regulatory compliance and delayed learning from adverse events.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Maxine Power	12	Treat - Implement controls and mitigating actions to reduce the risk.	Complaints closure trajectory in place and under regular review to reflect the changing nature of complaint and external numbers. Plan on a page in place to support the Right Care Strategy Close working with PTS to amend their systems to aid the closure of complaints in a more timely manner Support sought from wider team to assist with the review and closure of low risk complaints. Data available to support understanding weekly position which is reported to ELC each week. Action plan developed to support recovery of previous progress. Use of additional agency staff Use of light duties clinical staff additional fixed term recruitment agreed Rapid Closure process in place Complaints review panels in place with all Service Line Heads of Service	4	4	16	Operating at REAP level 4 Increase workload Incident management added to the team Delays in approvals process for high isk complaints/externals Timely response required from all service lines in all cases Evidence of difficulty in obtaining patient report forms in a timely manner in order to address the complaint	Quality & Performance Committee oversight Board oversight through the IPR Weekly EMT reporting Ombudsman review of referred complaints Head of Service review panels in place	No gaps in assurance identified	4	05/10/21	05/11/21
3171	2/11/19	There is a risk that media coverage during the Manchester Arena inquiry detailing the role and response of the Trust during the incident will result in sustained negative publicity and reputational damage.	oved Risks	putational	ncy Preparedness	ercially Sensitive Risk Register	man Desai	20	nd mitigating actions to reduce the risk.	Patient and Public Engagement Patient and Public Panel engagement Press and Public Relations Stakeholder Communications Communications on Social Media Platforms Trust Campaigns and Communications (External) Positive Communications on NWAS (External Sources) Procured Media Monitoring Platform to capture all media coverage Monitoring of Media Coverage via Platform Regular Staff Briefings	4	4	16	3. Timeframes of Inquiry 4. Oucome of the Inquiry 5. Specialist Training: Institute of Public Relations (Increase Crisis Comms Skills) 6. Recruitment in Comms Team to manage additional workload 7. Media Speciliast Training for Executive	Quarterly Communications Report to Board of Directors Daily Briefings for Chairman and CEO External Publicity (Media/ Social Media)	Communication Plan for Manchester Arena Inquiry	4	9/03/21	1/10/21

	1		App	Rep	Emergen	Corporate and Comm	Salm		Treat - Implement controls a	Key messages regarding refraining from commenting publicly Key messages shared via Staff Facebook group and CEO Bulletin Stakeholders briefed ahead of NWAS witnesses giving evidence Liaison between Legal and Comms Teams Media/ Social Media handling protocol agreed for Comms Team				7. Media Specialist Training for Executive Directors 2. Unknown communication plan 1. Unknown nature of publicity	External Publicity (Media/ Social Media)			2	3
3254	24/04/20	There is a risk that due to staff taking carried over leave accrued during the COVID-19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	Maximum abstraction rates. Option to carry some leave over into the next financial year. Introduction of the NWAS annual leave buy back scheme. (8.47% of staff within PES took up the offer). NHS Employers guidance re annual leave carry forward provision (2 years). NWAS Operational Performance Calls. Operational, Tactical and Strategic Management. Performance Management Framework. Overtime opportunities. Use of Third Party Providers and VAS. Increase scope of Third Party Providers and VAS. NWAS Patient Safety Plan. NWAS Communications and use of Social Media Clinical Leadership Model. ROCC Tactical and Strategic Commanders. Deferring of Mandatory training. PTS resources used in PES Support work. Implementation of National Pandemic Card 36. NWAS COVID-19 Response Plan. Agreed additional funding to increase PES workforce establishment. Issue of taking carried over leave in Q1 of 2021 raised with ELC again on the 16 Dec 2020 and awaiting a decision - Q1 is likely to see continued high demand. ELC have agreed to extend the period of time in which annual leave can be taken (up to 20 days carried forward in line with National recommendation). Resources from MACA and eCFRs Annual leave to be taken across the leave period 1 April 2021 - 31 March 2022.	4	5	20	01.Number of operational staff opting to utilise the annual leave buy back scheme. 02.Use of Overtime and impact on Trust Financial position 03.Increased use of PAS/VAS impacting on Trust financial position 04.Sustainability of using non-PES clinical resources 05.Timescale of staff vaccination programme 06.Subsequent COVID-19 peaks/waves 07.Changing regional tier system and national/local lockdown restrictions. 08.Evolving guidance on higher risk individuals who should be shielding 09.Feedback on National ARP Standards. 10.Funding for additional resources. 11. Continued increases in staff sickness across Service Delivery.	01.Abstraction Reports. 02.NWAS Annual Leave Buy Back Scheme. 03.National Performance Data 04.ORH Modelling Report 05.NWAS Integrated Performance Report 06.NWAS Performance Reporting to Commissioners 07.NWAS Performance Reporting to NHSE/I 08.NWAS Workforce Indicators Report 09. Return to Work process in place for those who have been shielding. 10. Confirmation on the amount of annual leave that can be carried over from HR.	Adherence to abstraction rates on abstraction reporting. Mandatory Training deferred until February 2021 Sustainability of using University Students for PES Support PTS Uplift staff working in PES Support roles There will be additional impact due to staff have been provided with an additional days annual leave across 2021/22.	5	07/09/21	07/10/21
3315	14/05/20	There is a risk that the cessation of mandatory training as a result of COVID19 will lead to an extended recovery plan and adverse regulatory scrutiny	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	16	Treat - Implement controls and mitigating actions to reduce the risk.	National guidance allows for cessation of training during this period Guidance to staff to continue to complete online elements of training especially during self-isolation Full compliance in PES & PTS for 2019 programme means many staff remain within refresher timescales PES & EOC CQC inspections completed prior to COVID-19 PTS classroom training resumed 11 May 2020 at reduced level EOC online learning resumed. PES classroom training commenced August 2020 Mandatory training programme extended to 31 March 2021 Completion targets reset to meet revised timelines ELC and Resource committee approval for revised targets	5	4	20	COVID impact placing pressure on MT abstractions. The PES face to face programme has been paused for over 2 months Increased CQC scrutiny of MT compliance No monitoring of individual module compliance	01. Mandatory Training circulated monthly to managers. 02. Mandatory training reported to Board in IPR. 03. ELC Approved commencement of programmes and revised timelines and trajectories for completion 04. Resources Committee workforce indicators bi-monthly. 05. ELC and Resources Committee approval of revised compliance requirement 06. NHSE/I Guidance (Jan 21) Reducing burden and releasing capacity to manage the COVID-19 pandemic	Completion of priority actions potential recovery following second wave pause of MT	4	11/08/21	11/11/21
3316	14/05/20	There is risk that due to the cessation of appraisals, the revised trajectory of 75% for Operations by Sept 2021 will not be achieved resulting in potential regulatory scrutiny.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	16	Treat - Implement controls and mitigating actions to reduce the risk.	National guidance allows for cessation of appraisals during this period PES & EOC CQC inspections completed prior to COVID-19" Revised appraisal paperwork for recovery context developed and implemented 23/09/21 Revised Appraisal compliance target continuation for Ops services at 75% approved. Virtual workshops being delivered for managers in revised appraisal process. ELC and Resources Committee papers approving revised compliance targets L&OD business partnering for appraisal recovery implemented in level 3 senior meetings	4	4	16	There are no plans currently to recover appraisal compliance Appraisal rates were already below Trust target especially within call centres	01. Revised paperwork for recovery planning to include focus on staff resilience and health and wellbeing introduced for Ops services 23/9/21 02. Appraisal data circulated to all managers monthly. 03. Appraisals reported to Board on IPR. 04. ELC report July 2020/ September 2020/November 2020 / Sept 21. 05. CQC Should Do action plan monitored through Resources Committee every two months 06. ELC and Resource committee approval of revised target for Ops Services extended	Learning from Appraisal audits Service Line SMT recovery action plans not yet developed - in train	4	11/08/21	28/09/21

3320	14/05/20	There is a risk that the backlog and reduction in hearings will lead to conduct or capability matters not being effectively dealt with which may negatively impact on patient care.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	20	Treat - Implement controls and mitigating actions to reduce the risk.	Any suspensions that were in place at the start of the pandemic are still in place and being regularly reviewed. A small number of more serious cases have continued to be brought to conclusion. A risk assessment process has been developed to flag a priority order when resuming investigations / hearings. HRBP Team are looking at ways in whih cases can be expediated by reviewing and suggesting a temporary adjustment to the Scheme of Delegation. Principles regards employee relations cases agreed with Trade Unions to recommence March 21. Prioritisation process in place to clear back log Monitoring implemented to Board Pre Investigation panel to reduce case duration Pauses in hearings lifted Arrangements for virtual hearings in place	3	5	15	01. ET application responses from the Trust being delayed due to postal service delays and home working arrangements within the Team. 02. Lack of Operational and Clinical resources to pursue cases resulting in very lengthly investigations and potentially adverse impact on individual staff members. 03. The impact of the current situation with regards the Trusts strategic intentions around Just and Learning Culture and the associated review of the Disciplinary Procedure. 04. Further pause to hearings agreed Jan 13 2021	01. Temporary Scheme of delegation approved by ELC. 02. SPF document issued to Trusts to pause until 30/09 unless agreements reached. 03. Principles for managing ER cases agreed with local trade Unions. 04. HR Team prioritising cases in line with agreed principles. 05. ER tracker with ER cases now reported on a monthly basis to ELC. 06. Workforce indicators report Resources Committee July 2021 07. CQC enquiring response - shared with RC, ELC, Board.		5	11/08/21	30/09/21
3410	11/09/20	There is a risk that diverting operational resource to a major incident would create a delay to 999 allocation resulting in reduced ARP response time and delayed patient care.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Major Incident Response Plan 02. Action Cards within the MIRP for Dedicated Roles 03. Major Incident Training for all operational staff at induction 04. Command and Control System in Operation 24/7 05. Dedicated NILO role 24/7 06. Annual refresher training for On Call Commanders 07. HART Teams located in Liverpool and Manchester 08. NWAS Cascade System 09. Business Continuity Plans 10. Internal Movement of Resources (Strategic Redeployment) 11. National MoU with other UK Ambulance Trusts 12. Attendance at Local Resilience Forums (LRFs) 13. Engagement with Emergency Services & other Agencies 14. Joint exercises with agencies 15. NWAS have TACC Advisors who advise on Major Incident planning; 16. A Safety Advisory Group is in place. 17. Mutual Aid can be requested 18. PSP Scripts used in EOC 19. Monitoring of resources within ROCC 20. Engagement with NWAS Comms Team to advise public of Major Incidents	3	5	15	01.BCM Plans are not in place across all Directorates 02.Deficiency of Commissioner funded EAs in line with ORH modelling (demand and capacity review).	01.PSP/Clinical Safety Plans 02.Major Incident Response Plan 03.Mass Casualty Dispersal Plan 04. Commission of EAs/Resources following ORH Review	BCM Plans	5	07/09/21	08/10/21
3433	26/10/20	There is a risk that without recurrent funding in place for NHS 111 First recruited staff and committed funds associated with Estates and IMT this will result in a large financial risk in 2021/22 and beyond.	Approved Risks	Financial	Value for Money/ Efficiency	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	16	reat - Implement controls and mitigating actions to reduce the risk.	The Director of Finance presented a paper to the Regional Leadership Group on 14th October, which outlined the 2020/21 and recurrent funding required. 2020/21 funding was agreed but there has been no agreement yet on recurrent funding. NHSE/I, commissioners and the Regional Leadership Group are all aware of the recurrent financial impact for NWAS. Ongoing dialogue between Finance and 111 Operations to minimise the recurrent impact as possible without impacting on service provision. 111 Operations, Finance and HR are in regular dialogue regarding the trajectory of recruitment to mitigate the recurrent impact. Confirmation of funding within the H1 plan, which is going to Resources Committee and Trust Board for approval in May, of £1.300m national SDF for July (end of M4) and £1.822m regional system funding for H1. National funding for 2021/22 Q2 and beyond will be dependent on the conclusions drawn from the full 111 First programme evaluation which will occur during Q1. NHSI also have an interim evaluation that should be completed imminently which may give some insight of what we can expect in the full evaluation. NWAS has submitted the 2021/22 staff in post trajectory to the NHSEI UEC Team which is anticipated to form part of the funding evaluation for the remainder of 2021/22.	4	4	16	No confirmed recurrent funding information available. The Phase 3 financial regime covered 1st October 2020 to 31st March 2021 only and NHSE/I have confirmed that the national SDF will currently cover 2021/22 Q1 only, pending the outcome of a programme evaluation and workforce trajectories.	Reported to the Regional Leadership Group on 14th October Continued dialogue with regional NHSEI on the funding requirements Continued engagement with the NHS 111 First Operational Delivery Group The national planning guidance has now been released for H2 (Oct21-Mar22) which has identified that national funding in relation to 111 service pressures will continue to be provided, via Service Development Funding (SDF)	NHSE/I have confirmed that the current financial framework will roll over into 2021/22 H1, however national funding has only been confirmed for July (end of M4) and no further information has been received relating to recurrent values.	4	27/09/21	27/10/21

									T	National funding has been announced for 111 service pressures for Aug and Sept, and agreement has been reached with the Lead Commissioners for NWAS's share of that allocation. This will cover both the H1 income gap and also provide further investment over the 2 months. Confirmation has been received that from H2 onwards 111 funding will need to be managed through the ICS financial envelopes.									
3445	17/11/20	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	Local management engagement with hospitals Executive management engagement with hospitals Implemented HALOs at hospital sites to improve delays Hospital Handover Project Installed Hospital Arrival Screens for all hospitals across the NW A&E Delivery Board with NWAS representation NWAS Demand Management Plan Attendance at National Calls regarding Hospital Handover QI Approach to Hospital Handover Safety Checklists Every Minute Matters Collaboration with Hospitals Attendance at NHSE/I North West Winter Planning Meeting Attendance at NHSE/I Hospital Handover Delays Review Meetings Identification of Hospitals to participate in Every Minute Matters NWAS concerns raised with AACE Strategic Meeting Chaired by Prof. A Marsh to review delays Hospital outliers reported to NHSE/I Escalations with Hospital Chief Executive Officer NWAS concerns raised with NHSE/I NW & Lead Commissioners Targeted Recovery Plans for Hospital Handover Improvements There is continued liaison between NWAS and Acute services (Gold Cell meetings in Cheshire and Mersey Region); Monitoring is taking place between Acute and CQC 23 Joint monitoring arrangements between Lead Commissioners and NWAS. National Handover meeting with AACE Operational Orders being reviewed.	4	5	20	01. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 02. Unpredictable increases in demand across the Service Directorate 03. Awaiting specific Guidance from Medical Director relating to rapid handover	01.National Performance Data 02.National Hospital Handover Performance Data 03.NWAS Hospital Handover Performance Data to Commissioners 04.NWAS Hospital Handover Performance Data to NW NHSE/I 05.NWAS Integrated Performance Report 06.Hospital Handover Project Documentation 07.Every Minute Matters Project Docmentation 08. DATIX reports have seen a measured reduction in the number of vehicles being delayed opustide of hospitals. 09. PES abstraction rates are reducing 10. Right Care Closer to Home` allocated to SPTLs. 12. Regular meetings to review hospital turnaround times between Heads of Service and Chief Officer of Regulatory Compliance to agree targeted actions 13. Acute Fraility Unit at Whiston Hospital as of September 2021 14. Introduction of Same Day Emergency Care Unit at RPH	01. Continued hospital presssures 02. Abstraction rates of PES staff and Acute Trust staff remain high.	5	07/09/21	07/10/21
3446	17/11/20	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	Local management engagement with hospitals HALOs at hospital sites to prevent cohorting of patients NWAS Patient Safety Plan NWAS Concerns raised with AACE Hospital outliers reported to NHSE/I NWAS Concerns raised with Lead Commissioners DATIX Incident forms monitored and escalated accordingly Executive management engagement with hospitals A&E Delivery Boards with NWAS representation National Calls regarding Delayed Handover & Cohorting Strategic Meeting Chaired by Prof. A Marsh Escalations with Hospital Chief Executive Officer Hospital handover Action Cards have been developed SPTLs link in with their local hospitals as required.	4	5	20	01. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 02. Severe pressures being experienced by external stakeholders	05. Incidents leading to patient harm are montiored via DATIX incident reports 06. DATIX reports have seen a measured reduction in the number of vehicles being delayed outside of hospitals. 08. Daily report supporting improvements for turnaround times. 04. ELC approval to engage locally to progress Patient Safety Checklist starting with 3 as per NHSEI plan for improvement. 03. New mitigations and reduced incident numbers reflect reduction in risk 01. Delays are monitored by the ROCC 02. Incidents leading to patient harm are montiored via DATIX incident reports	01. Working with Acutes to sign up to `Every Minute Matters` 02. Ambulance turn -around times currently 34 minutes	5	07/09/21	07/10/21
3447	17/11/20	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety	Approved Risks	Operational	People	Corporate and Commercially	Ged Blezard	16	Treat - Implement controls and	01.Local Health and Wellbeing Plans 02. Organisational Policies and Procedures 03. Self-Referral Schemes 04. Health & Wellbeing initiatives 05. Occupational Health 06. HR Business Partnering Team 07. Short term investment from Commissioners	4	4	16	01. Outcome of internal service delivery model review	02. Reinforcement of local level engagement and partnership with Trade Unions 03. Sickness and Data Officer position created to manage sickness. 04. Return to Work procedures taking place for those who have been shielding.	01. Receipt of commissioner funding following ORH review	4	07/09/21	07/10/21
										01.Shared learning via AACE and other NHS Ambulance Trusts									

3452	17/11/20	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	25	Treat - Implement controls and mitigating actions to reduce the risk.	02.Preparatory workforce planning including overtime and recruitment opportunities 03. Senior operational representation at National level 04. NWAS representation on monthly conference calls 05. Implemented Pre-Determined Attendance (PDAs) part of ARP v2.3 and frequent reviews of PDAs 06. Implemented clinical leadership across all EOCs and Trauma cells 07. Auto-allocation to improve response times 08.Management of IFT/ HCP activity 09. DCA, RRV and ORH Modelling Review Building & Better Rota's Project 10. Fleet Replacement Programme 11. Operational Policies & Procedures and Operational Guidance 12. Operational, tactical and Strategic Management 13. Performance Management Framework 14. Additional resources utilised to support performance, e.g. use of Third Party Providers with increased scope of practice, use of CFRs and PTS supporting PES work 15. NWAS Communications; use of social media 16. Clinical Leadership Model 17. NWAS Operational Performance Calls 18. ROCC Tactical Commanders & Strategic Commanders 19. Cancellation of mandatory training & appraisals 20. Implementation of National Pandemic Card 36 21. NWAS Winter Plan 22. Engagement with System Leaders & Acute Hospitals 23. Engagement with NHSE/I 24. Engagement with NWAS Lead Commissioner 25.Temporary suspension of Mandatory Training and Clinical supervision 26.Initiated Actions for REAP 3 and REAP 4 as agreed by ELC 27.Weekly review of strategic intentions with increases in pressures. 28. 55 EAs being utilised as part of Winter plan 29. Additional 90 PTS staff being upskilled for PES 30. Additional funding for 111 Service	5	5	25	01.Confirmation of the receipt of additional finances from Commissioner 02.Delivery of Urgent and Emergency Care Strategy 03.Workforce Planning 04. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 05. Escalation to REAP 4 on 4 June due to external pressures have remained consistent. 06. Unpredictable escalations and de-escalations of REAP levels. 07. Continued increases in abstraction rates across Service Delivery (circa 14.5% PES - 10% PTS)	01.National Performance Data 02.National ARP Data 03.ORH Modelling Report 04.NWAS Integrated Performance Report 05.NWAS Performance Reports to Commissioners 06.NWAS Performance Reports to NHSE/I 07.NWAS Business Cases for Fleet Replacement 08.NWAS Workforce Indicators Report 10. National Hospital Handover Performance Data 11. NWAS Hospital Handover Performance Data to Commissioners 12. NWAS Hospital Handover Performance Data to NW NHSE/I 13. NWAS Integrated Performance Report 14. Hospital Handover Project Documentation 15. Every Minute Matters Project Documentation 16. DATIX reports have seen a measured reduction in the number of vehicles being delayed outside of hospitals. 17. PES abstraction rates are reducing 18. Right Care Closer to Home` allocated to SPTLs. 19. Improvement of turnaround times for ambulances of 28 mins (set against 30 mins). 20. £6.2 million investment to cover short-term increase in resources over six months. 21. Ambulance and Systems Pressures cell established to source resources and plan the introduction of those resources	01. AACE to simplfy the operating model. 02. Continued hospital pressures 03. Awaiting outcome of AACE Specialist who is supporting NWAS to review current model and support chance implementation. 04. Receipt of monies from Commissioners	5	07/10/21	05/11/21
3455	17/11/20	There is a risk that across PES, resources will be limited or not available for effective and efficient utilisation across the region because of an increase in operational demand and patient acuity which may result in delayed responses to patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	Operational, Tactical and Strategic Management Performance Management Framework Overtime opportunities Recruitment opportunities Use of Third Party Providers Increased scope of practice for Third Party Providers Additional resources utilised to support performance NWAS Demand Management Plan NWAS Communications; use of social media Clinical Leadership Model Trauma Cell in EOCs Utilisation of CFRs NWAS Operational Performance Calls ROCC Tactical Commanders & Strategic Commanders Cancellation of mandatory training & appraisals PTS Resources being utilised for PES Support Work Implementation of National Pandemic Card 36 NWAS COVID-19 Response Plan NWAS Winter Plan ORJ Modelling Review Engagement with System Leaders & Acute Hospitals Engagement with NHSE/I Engagement with NWAS Lead Commissioner BT Scripts for COVID-19 Calls into NWAS Agreed additional funding to increase PES workforce establishment	4	5	20	01. Continued high abstraction rates of staff and limited resources. 02. Unpredictable changes in demand across the Service Directorate 03. Increased number of pre-alerts into Acute hospitals	01. Daily monitoring of resources 03. Reduction in NWAS REAP Levels to Level 3 in August 2021 04. Multi-Directorate weekly Strategic Systems Pressures Cell meetings.	01. Inability to cover all abstractions 02. External pressures have decreased Trust REAP Levels to Level 3 03. Confirmation of Commissioner funding to increase resources in line with ORH Demand and Capacity Review recommendations	5	07/09/21	07/10/21
						...ister			...o reduce	01. Agreed increase in EMD establishment 02. Agreed implementation of EMD Support Staff 03. Performance Management Framework					01. National Performance Data 02. NWAS Integrated Performance Report 03. NWAS Performance Data to Commissioners				

ID	Date	Risk Description	Status	Type	Category	Register	Owner	Score	Treatment	Controls	L	C	Score	Gaps in Control	Assurances	Gaps in Assurance	Target	Reviewed	Next Review
3456	17/11/20	There is a risk that due to increasing numbers of 999 calls and patient acuity to EOCs, callers may experience call pick up delays resulting in increased emergency response times and negative impact on operational performance standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Reg	Ged Blezard	20	Treat - Implement controls and mitigating actions t the risk.	04. Call Pick Performance Data 05. Wallboards in EOCs 06. Implementation of BT Scripts for screening COVID-19 Calls 07. Implementation of National Pandemic Card 36 08. NWAS Patient Safety Plan 09. EMD Recruitment 10. EMD Training and Mentoring 11. Additional EMDs and EMD Support Staff recruited & operational 12. Reduction in duplicate calls 13. Additional workforce resources for EOCs being managed via NHSE/I 14. HI reporting enables planning for Building Better Rota's 15. Use of agency staff	4	5	20	02. Unpredicted increased activity from members of the public due to follow-up calls 03. Increased pressures on the workforce 04. Increased acuity - Cat 1 and Cat 2 combined increased by 70% as of 06 August 2021 05. Increase in call demand/ follow-up calls 01.NWAS' obligation to provide buddy support for other NHS Ambulance Services during periods of high demand	Commissioners 04. Performance Management Framework 05. Recruitment of 120 EMDs above base line by end of Q3. 06. A number of Agency EMDs have been offered fixed term NWAS contracts until end September 2021 07.Additional recruitment supported by NHSE/I 08. EMD training will release 40 staff over three sessions to assist with resourcing and mentoring 09. EOC Procedure for Subsequent Calls (EOC0015) - reviewed September 2021 10. NWAS Medical Director approved use of Emergency Disconnect via Clinical SMT	01. Confirmation of attaining recruitment of 140 ECH's	5	07/09/21	07/10/21
3459	19/11/20	There is a risk that due to increasing operational demands the Service Delivery Directorate will not achieve operational performance standards having a negative impact on workforce wellbeing.	Approved Risks	Operational	People	Corporate and Commercially Sensitive	Ged Blezard	16	Treat - Implement controls and mitigating	01. BCM in place across Service Delivery areas 02. Access to Occupational Health 03. Organisational Policies and Procedures 04. Alternative Duties 05. HR Business Partnering Team for Advice & Support 06. PTS to be trained in Blue-light driving. 07. Local Health and Wellbeing Plans & initiatives 08. Self-Referral Schemes	5	4	20	01. Outcome of internal service delivery model review	01. Military assets (50) have been requested to provide support to PES or PTS. 02. Staff abstraction rates have reduced; 03. Sickness and Data Officer position created to manage sickness. 04. Reinforcement of local level engagement and partnership with Trade Unions	01. Waiting for confirmation that application for military support is to be granted.	4	07/09/21	07/10/21
3519	14/04/21	There is a risk that due to incompatible IT infrastructure at GMP HQ a multi-agency response to a major incident would be severely compromised.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially	Maxine Power	16	Treat - Implement controls and	Wifi provided by GMP (very limited) NWAS Infrastructure currently permits one user with limited or no access to systems other than email. GMP, HEADQUARTERS,4 NORTHAMPTON ROAD,, M40 5BR is due to get a network link upgrade to 50mb as part of WAN upgrade	4	4	16	Resilient NWAS IT infrastructure for multiple user access to NWAS systems across the 4 pods at GMP HQ – IT Request in place Resilient WIFI Systems as a backup for NWAS systems	Debrief Reports Incident Logs Incident Reporting	No design of requirements has been submitted and that C3 can only run on a sub 7ms latency network. Connectivity Report	4	01/09/21	30/11/21
3521	21/04/21	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner critical network communications will be lost resulting in failure of systems negatively impacting service delivery across the Trust.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk	Maxine Power	20	Transfer - Transfer / Distribute the risk to	Duplicate hardware providing resilience Monitoring current performance of memory leakage still valid Switch to be rebooted (completed April 2021) Switch core replacement procured and awaiting installation (Awaiting agreement of Date with EOC post COVID) Work starting on Business Impact Analysis of Trust systems in conjunction with the BCP	3	5	15	scheduled downtime for regular maintanace	MIAA business continuity and resilience audit - MODERATE ASSURANCE	no plan for delivery	5	06/08/21	30/09/21
3537	17/06/21	There is a risk, that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	15	Treat - Implement controls and mitigating actions to reduce the risk.	IT health dashboard enabling real time monitoring of assets, visibility of security threats and vulnerabilities, and assurance around completion of mitigation (e.g. patching and CareCERTs) Cyber essentials Compliant assessment completed (2019 - 2020) Desktop central is utilised for maintaining software updates. Radically reduced the number of servers below 2012 - as of 17/06/2021 25 2008 servers are left Patching effectiveness is very high. Regular security updates deployed for the latest security patches New Cyber Security Manager recruited and in place (Oct 2020) New Firewalls were implemented at the end of 2020 offering better security and visibility Implementation of Mimecast email security service. Protecting NWAS from new and emerging threats through email Microsoft ATP implemented on all servers. providing protection and visibility. This is monitored by the Trust and NHSD Mobile Device Management in use to control services on some mobile devices Anti-virus protection (including malware protection) on both physical and virtual clients/server's Device encryption on all laptops and some mobile devices mobile devices to protect data Automated daily threat assessment in place for Windows 10 Business Continuity Plans Regular Audits undertaken by MIAA Regular Pen Tests undertaken	3	5	15	Admin Accounts have internet access There is only 1 backup No MFA on backups High number of Global Admin accounts Out of support software No SIEM No Specific Cyber Incident Management Plan/Policy Lack of uptake in staff security awareness	ITHealth Dashboard - brithd01.northwestambulance.nhs.uk Cyber Essential Certificate Desktop Central - http://epdskc01.northwestambulance.nhs.uk:2581/homePage.do?actionToCall=homePageDetails Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of unsupported Operating Systems Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of patched/unpatched devices and servers Firewall alerts and dashboard Mimecast dashboard - https://login-uk.mimecast.com/u/login/?gta=apps&link=/home#/login ATP Dashboard - https://security.microsoft.com/endpoints/dashboard# MDM Intune portal - https://endpoint.microsoft.com/#@nwas.nhs.uk/dashboard/private/b259b43f-b7b8-47df-b8e0-a2109214d03a Malware protection dashboard - https://eptrnd01:4119/SignIn.screen BC plans are managed within continuity2 Yearly Staff Training figures reported to IG team Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021	Lack of defined KPI's relating to Cyber Security & governance/assurance process Actions from NHS Digital, Pen Tests & MIAA assessments to be addressed &b monitored Lack of independent evaluation of security training re Social Engineering	5	09/09/21	11/11/21

										Mandatory staff cyber training via ESR					Pen Test - External Vulnerability & DSPT				
1181	30/01/14	There is a risk that the unsupported critical telephony system and voicemail service could fail resulting in an inappropriate response and delay in patient care and a breach in target timescales.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the risk.	Robust National 999 Network Constantly monitored by National Operator Centre Full Business Continuity plans developed in partnership with all telecom providers. Resilient telephone system and network design including diverse routing. NWAS operate a virtual regional network 24/7 specialist support from NWAS staff and Third party suppliers There is constant liaison with the core provider 999 liaison teams who will monitor and advise of any threat that may interrupt the service. SMT Team meetings to review system updates/ outages Change request process in place and meets weekly as part of a formal CAB A back up voicemail server is being purchased to enable a swap out in the event of failure, greatly reducing downtime. Unified Communications Programme has submitted a business case to replace all telephony and the voicemail solution which will eliminate this risk. Unified Communications Business case approved and work underway. Soft launch underway in EOC, clinical hub already on new telephony new 111 telephony in place	3	5	15	Current telephony systems are end of life and are no longer supported by Avaya with only limited support from BT available. Full Business Continuity plans need to be reviewed and tested in partnership with the providers and EOC Avaya are no longer providing any security patching or updates after April 19 The Voicemail server is end of life ,vulnerable to cyber attack and sits on the NWAS LAN, any outages would result in no messages being heard and dropped call rates	BT providing interim maintenance and support Any system downtime reported to ICT SMT meetings Changes to telephony are strictly monitored and controlled via CAB	Report from third party to show preventative maintenance outcome	5	20/08/21	29/10/21

APPENDIX 2

Board Assurance Framework 2021/22

BOARD OF DIRECTORS PART 1

WEDNESDAY 24 NOVEMBER 2021

nwas.nhs.uk

Q2 2021/22 Reporting Timescales:

Quality & Performance Cttee:	27/09/2021
Resources Cttee:	24/09/2021
Executive Leadership Cttee:	20/10/2021
Audit Cttee:	22/10/2021
Board of Directors:	24/11/2021

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

Consequence ↓	Likelihood → Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Major 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Moderate 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Minor 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Negligible 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

Director Lead:

CEO	Chief Executive
DoQII	Director of Quality, Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoP	Director of People
DoSPT	Director of Strategy, Partnerships & Transformation
DoCA	Director of Corporate Affairs

Board Assurance Framework Legend

Strategic Priorities	The 2018/2023 strategic priority that the BAF risk has been aligned to				
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives				
Controls	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority				
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk				
Evidence	This is the platform that reports the assurance				
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Action Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
Monitoring	The forum that will monitor completion of the required action				
Progress	A RAG rated assessment of how much progress has been made on the completion of the required action	Incomplete/ Overdue	In Progress	Completed	Not Commenced

OUR STRATEGY AT A GLANCE

Our vision is to be the best ambulance service in the UK by delivering the right care, at the right time, in the right place; every time.

Values:

WORKING TOGETHER.

We work together to understand and value every role in achieving our shared purpose. We live and breathe inclusivity, everyone matters.

BEING AT OUR BEST.

We challenge ourselves to be the best we can be. We are curious and push boundaries to improve everything we do.

MAKING A DIFFERENCE.

We make a difference through doing the right thing by our staff, patients, partners and communities. We act with compassion and kindness.

Priorities:

Urgent and Emergency Care

Increasing service integration and leading improvements across the healthcare system in the North West.

Quality

Delivering appropriate care, which is safe, effective and patient centered for each individual.

Digital

Radically improving how we meet the needs of patients and staff every time they interact with our digital services.

Business and Commercial Development

Developing skills and capability to explore business opportunities for current and new viable contracts, services or products.

Workforce

Engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care.

Stakeholder relationships

Building and strengthening relationships that enable us to achieve our vision.

Infrastructure

Reviewing our estates and fleet to reflect the needs of the future service model.

Environment

Committing to reduce emissions by embracing new technology including electric vehicles.

Supporting strategies:

- Urgent and Emergency Care Strategy
- Quality (Right Care) Strategy
- Digital Strategy
- Finance plan - long term financial model
- Workforce Strategy
- Communications and Engagement Strategy
- Estates and Fleet Strategies

BOARD ASSURANCE FRAMEWORK DASHBOARD 2021/22

BAF Risk	Committee	Exec Lead	01.04.21	Q1	Q2	Q3	Q4	2021/22 Target	Final Target
SR01: 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	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL			**10** 5x2 CxL	**5** 5x1 CxL
SR02: 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	**Resources**	**DoF**	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL			**15** 5x3 CxL	**5** 5x1 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL			**15** 5x3 CxL	**5** 5x1 CxL
SR04: 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	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL			**8** 4x2 CxL	**4** 4x1 CxL
SR05: There is a risk that the required organisational culture change does not sufficiently develop to support the organisational changes and improvements required to meet the changing demands on the service, resulting in poor quality services	**Resources**	**DoP**			**12** 4x3 CxL			**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in staff and/or patient harm	**Quality & Performance**	**DoQII**			**20** 5x4 CxL			**10** 5x2 CxL	**5** 5x1 CxL
SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	**Resources**	**DoSPT**			**12** 4x3 CxL			**8** 4x2 CxL	**4** 4x1 CxL
SR08: [Commercially Sensitive Risk]	**Resources**	**DoSPT**			**12** 4x3 CxL			**8** 4x2 CxL	**4** 4x1 CxL

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR01: 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	**Strategic Priority:** Quality & Digital	**Executive Director Lead:** MD
	Risk Appetite Category: Quality Outcomes – Low	

BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	15	15	15			10	5
	5x3	5x3	5x3			5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded			Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:

The risk score for Q2 of this BAF risks has maintained at a score of 15 due to the continuing impact of COVID-19 on responses times and SR03 directly correlating with delays in the delivery of care which affects quality, safety, and patient experience. There have been continual improvements in relation to quality during Q2, however, work is continuing to recover, maintain and improve quality to deliver our strategic intentions to be the best ambulance service in the context of COVID-19 recovery. The pandemic has highlighted the importance of having the right clinical leadership structure, particularly preventing harm while waiting, ensuring clinical best practice, and learning when things go wrong. The biggest risk for 2021/22 continues to be the resource required to fund the proposed leadership model for both operations and corporate is yet to be secured due to the prolonged pause in financial planning. The ongoing focus will include delivering the milestones in the Right Care Strategy, refreshing the strategy, and delivering on the requirements of the new regulatory regime.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report	Reported to BoD (BoD/2122/80) Reported to BoD (BOD/ 2122/11)
Clincial Audit	**Level 2:** Clinical Audit Plan 2021/22 **Level 2:** Clinical Audit Q1 Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/15) Reported to Q&P Cttee (Q&PC/ 2122/88)
Quality Surveillance	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/87)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/85)
CQC Transitonal Monitoring	**Level 2:** CQC Assurance Report & Action Plans	Reported to Q&P Cttee (Q&PC/ 2122/34)
Quality Systems and Process	**Level 2:** MIAA Quality Audit Plans	Reported to Audit Cttee (AC/ 2122/12)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to BoD (BoD/2122/61)
DIGITAL		
Digital Strategy	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2122/65)
Data Security and Quality	**Level 3:** Data Secruty Protection Toolkit **Level 3:** MIAA Digital Audit Plans	Reported to Audit Cttee (AC/ 2122/10)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					

Complaints & Incident Management	Develop and deliver a new operating model (stage 2) service line accountability for the management of complaints and incidents	Prof M Power	Q4	Q&P Cttee	In Progress
Midwifery Strategic Plan	Develop and deliver the Midwifery Strategic Plan	Dr C Grant	Q3	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU index	Prof M Power	Q4	Q&P Cttee	In Progress
NHS Patient Safety Strategy	Implement appropriate elements of the NHS PS Strategy	Prof M Power	Q4	Q&P Cttee	In Progress
Mental Health, Dementia, LD & Autism Strategic Plan	Develop and delivery of MH, Dementia, LD & Autism Strategic Plan Devise and embed appropriate pathways for patients	Prof M Power	Q4	Q&P Cttee	In Progress
Electronic Quality Measurement Auditing/ Reporting Systems	Embed automated systems for non-clinical audits	Prof M Power	Q4	Q&P Cttee	In Progress
Digital Capture and Monitoring of Clinical Outcomes	Deliver EPR roll out and embed systems for automating clinical audit	Prof M Power	Q4	Q&P Cttee	In Progress
Quality Assurance & Improvement Plan	Draft the next iteration of the Right Care Strategy	Prof M Power	Q4	Q&P Cttee	In Progress
DIGITAL					
Strategic Key Functionality of EPR	Development of Business Case to meet national strategic requirements	Prof M Power	Q3	Resources Cttee	In Progress
Stable 999 Telephony Platform	Implementation of the UCP Programme	Prof M Power	Q2	Resources Cttee	Completed
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Prof M Power	Q3	Resources Cttee	In Progress
Single Primary Triage System	Migration to Single Primary Triage System	Prof M Power	Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR01

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
1181	Operational/ Digital & Innovation	There is a risk that the unsupported critical telephony system and voicemail service could fail resulting in an inappropriate response and delay in patient care and a breach in target timescales.	20 Significant	15 Significant	⇔	5 Moderate
2833	Operational/ Digital & Innovation	There is a risk that without an established and embedded System Security Testing Programme the Trust is vulnerable to cyber-attack resulting in a loss of critical systems, business disruption or exfiltration of confidential data.	16 Significant	15 Significant	⇧	5 Moderate
3056	Operational/ Patient Safety	There is a risk that complainants and reporters of external incidents are not receiving responses to their queries in as timely a manner as possible due to the backlog of complaints within the system which could result in a poor complainant experience, non-regulatory compliance, and delayed learning from adverse events.	12 High	16 Significant	⇧	3 Low
3410	Operational/ Emergency Preparedness	There is a risk that diverting operational resource to a major incident would create a delay to 999 allocation resulting in reduced ARP response time and delayed patient care.	20 Significant	15 Significant	⇧	5 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇧	5 Moderate
3446	Operational/ Patient Safety	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇧	5 Moderate
3519	Operational/ Emergency Preparedness	There is a risk that due to incompatible IT infrastructure at GMP HQ a multi-agency response to a major incident would be severely compromised.	16 Significant	16 Significant	⇔	3 Low
3521	Operational/ Patient Safety	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner critical network communication will be lost resulting in failure of systems negatively impacting service delivery across the Trust.	20 Significant	15 Significant	⇔	5 Moderate

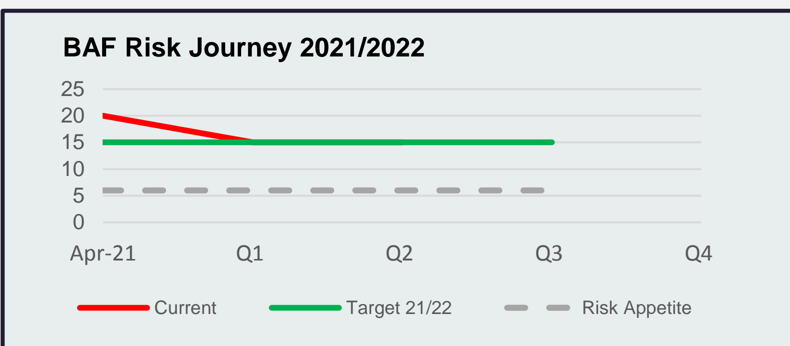
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR02:
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

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20	15	15			15	5
	5x4	5x3	5x3			5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded			Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q2 of this BAF risk has maintained a scored of a 15 due to the Month 5 position remains on plan and forecasting delivery of break even for H1. Recent Annual Report from External Auditors provided assurance in relation to systems and controls in place. At the time of the BAF review, guidance from H2 had been received the impact for the organisation for H2 and beyond has not been fully worked through.

CONTROLS	ASSURANCES	EVIDENCE
Financial Plans	**Level 2:** 2021/22 Financial Plans	Reported to BoD (BOD 2122/15)
Financial Controls	**Level 3:** MIAA Internal Audit – Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Significant Change Projects	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB
2021/22 Capital Plan	**Level 2:** 2021/22 Captial Plan **Level 3:** NWAS 2021/22 Captial Plan	Reported to BoD (BOD/2122/15) Reported to Lancashire & South Cumbria ICS Board
Annual Accounts/ VfM Statement	**Level 3:** Audit Completion Report (ISA 260) **Level 3:** Independent Auditors Report **Level 3:** Audited Annual Accounts 2020/21	Reported to BoD (BOD/2122/20) Reported to BoD (BOD/2122/21) Reported to BoD (BOD/2122/22)
Financial Performance	**Level 2:** M05 Financial Report	Reported to Resources Cttee (RC/2122/59)

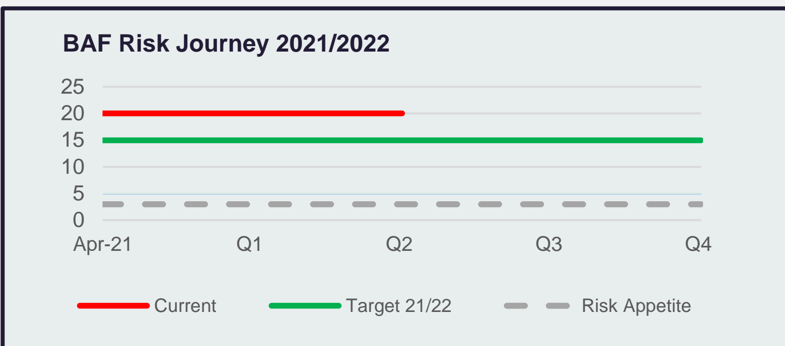
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
H2 Planning Guidance	Receipt of H2 Planning Guidance from NHSI	Ms C Wood	July 2021	Resources Cttee	Completed
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	January 2022	Resources Cttee	In Progress
2021/22 H2 Revenue Financial Plan	Approved 2021/22 H2 Revenue Financial Plan	Ms C Wood	November 2021	Resources Cttee	In Progress
2021/22 H2 Efficiencies	Delivery of 2021/22 H2 Efficiency Savings	Ms C Wood	November 2021	Resources Cttee	In Progress
2022/23 Planning Guidance	Receipt of 2022/23 Planning Guidance from NHSEI	Ms C Wood	January 2022	Resources Cttee	Not Commenced
2022/23 Financial Plan Revenue	Approval of 2022/23 Financial Plan (Revenue)	Ms C Wood	March 2022	Resources Cttee	Not Commenced
2022/23 Financial Plan Capital	Approval of 2022/23 Financial Plan (Capital)	Ms C Wood	March 2022	Resources Cttee	Not Commenced
DIGITAL					

Funding for Digital Strategy Delivery	To source alternative funding models (ICS/ National)	Prof M Power	September 2021	Resources Cttee	Overdue
Funding for key risk mitigation within the Digital portfolio	Develop proposal to mitigate data quality, clinical records governance, records management and development support	Prof M Power	September 2021	Resources Cttee	Overdue

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2833	Operational/ Digital & Innovation	There is a risk that without an established and embedded System Security Testing Programme the Trust is vulnerable to cyber-attack resulting in a loss of critical systems, business disruption or exfiltration of confidential data.	16 Significant	15 Significant	⇧	5 Moderate
3433	Financial/Value for Money/ Efficiency	There is a risk that without recurrent funding in place for NHS 111 First recruited staff and committed funds associated with Estates and IMT this will result in a large financial risk in 2021/22 and beyond.	16 Significant	16 Significant	⇔	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Strategic Priority:** Urgent & Emergency Care	**Executive Director Lead:** DoOps
	Risk Appetite Category: Quality Outcomes – Low	



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20	20	20			15	5
	5x4	5x4	5x4			5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded			Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 of this BAF risk has maintained a scored of a 20 due to sustained levels of operational pressures the Trust has seen across 999 and NHS 111 throughout Q2, resulting in remaining at REAP Level 4 for a sustained period. The Trust continues to apply appropriate mitigating measures in place to assist with the operational pressures, including the use of third-party providers, shift enhancements and PTS providing support to PES. ETA scripts have remained in place throughout Q2 to minimise the number of duplicate 999 calls. Plans to deploy recruitment to over establishment is underway and expected to be completed by December 2021. During Q2, NWAS received additional non-recurrent funding from the Government that will be used to assist with the current operational pressures. The providing of evidence as part of the Manchester Arena Inquiry will cease by the end of October 2021. AACE and ORH have delivered the Demand and Capacity Review with recommendations provided to the Trust.

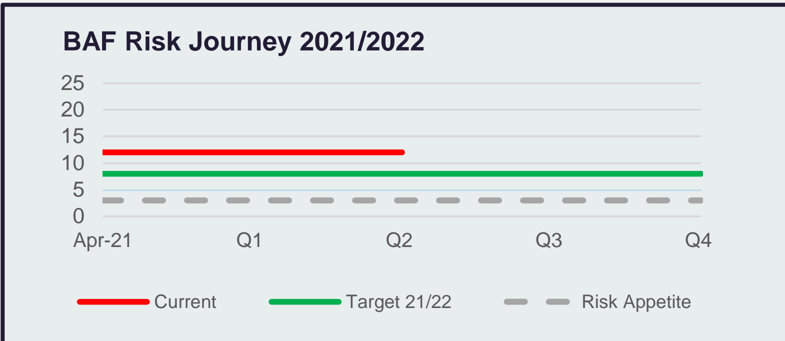
CONTROLS	ASSURANCES	EVIDENCE
Optima Independent Review of NWAS Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&P Cttee (Q&PC 2021/145)
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/2122/80)
Adverse Weather Planning	**Level 2:** NWAS Annual Heatwave Plan	Reported to Q&P Cttee (Q&PC 2122/69)
ARP Performance	**Level 2:** Deep Dive	Reported to Q&P Cttee (Q&PC 2122/84)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Delayed ARP	Undertake a thematic analysis into long waits & resource modelling	Mr G Blezard	July 2021	Q&P Cttee	Completed
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	March 2022	Q&P Cttee	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve patient care	Mr G Blezard	March 2022	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate
2568	Operational/ Emergency Preparedness	There is a risk that due to the majority of MTA staff being stationed in or around Liverpool and Manchester, there may be a delayed response to MTA incidents outside of this area resulting in delay to triage, treatment and transport.	20 Significant	15 Significant	⇔	5 Moderate
3027	Operational/ People	There is a risk that the combined outcome of the ORH demand analysis, Paramedic skill mix change and GP reform will create a Paramedic shortfall resulting in inability to meet operational demand.	20 Significant	16 Significant	⇔	4 Moderate
3254	Operational/ Performance	There is a risk that due to staff taking carried over leave accrued during the COVID19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	20 Significant	20 Significant	⇧	5 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇧	5 Moderate
3446	Operational/ Patient Safety	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇧	5 Moderate
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 Significant	25 Significant	⇧	5 Moderate
3455	Operational/ Patient Safety	There is a risk that across PES, resources will be limited or not available for effective and efficient utilisation across the region because of an increase in operational demand and patient acuity which may result in delayed responses to patients.	20 Significant	20 Significant	⇧	5 Moderate
3456	Operational/ Performance	There is a risk that due to increasing numbers of 999 calls and patient acuity to EOCs, callers may experience call pick up delays resulting in increased emergency response times and negative impact on operational performance standards.	20 Significant	20 Significant	⇧	5 Moderate
3459	Operational/ Workforce	There is a risk that due to increasing operational demands the Service Delivery Directorate will not achieve operational performance standards having a negative impact on workforce wellbeing.	16 Significant	20 Significant	⇧	4 Moderate
Commercially Sensitive Risk – FOI Act Section 22 – Intended for Future Publication						
3171	Reputational/ Emergency Preparedness	There is a risk that as the Manchester Arena Inquiry progresses, the Trust may be subject to reputational damage because of the details that emerges in the media outlining the role and response of NWAS during the incident, which may result in sustained negative publicity and reputation damage.	20 Significant	16 Significant	⇧	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR04: 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	**Strategic Priority:** Workforce	**Executive Director Lead:** DoP
	Risk Appetite Category: Quality Outcomes – Low	



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	12	12	12			8	4
	4x3	4x3	4x3			4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded			Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q2 of this BAF risk has maintained a score of 12, whilst delivery of services is under pressure, Q1 and Q2 recruitment plans have been successfully delivered and clear agreed plans are in place to deliver additional staffing resources across Q3 and Q4. COVID related absences have reduced, and plans are in place to dedicate additional resources to attendance management. Whilst turnover has started to return to pre-COVID levels these remain within tolerance except for 111. The risks around PCN recruitment of Paramedic have not emerged at the rate originally projected.

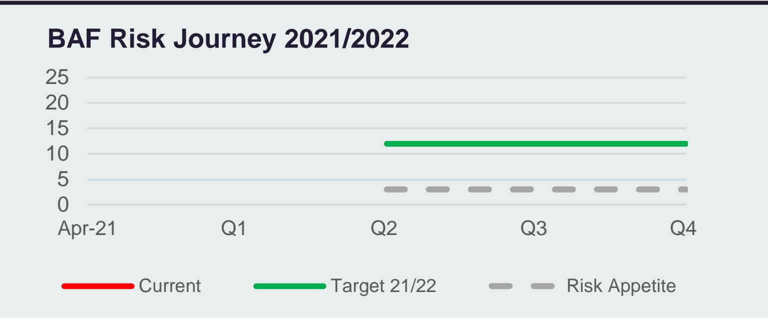
CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to BoD (BOD/ 2122/37)
Strategic Workforce Plan	**Level 2:** H1 Planning Submission **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to BoD (BOD/ 2122/10) Reported to Resources Cttee (RC/2122/69)
Diversity & Inclusion Plans	**Level 2:** Diversity & Inclusion Assurance Report	Reported to Resources Cttee (RC/ 2122/22)
People Metric Surveillance	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Report **Level 2:** Staff Survey and Culture Audit Deep Dive	Reported to BoD (BOD/ 2122/80) Reported to Resources Cttee (RC/ 2122/66) Reported to Resources Cttee (RC/ 2122/07)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Confirmation of Q2 recruitment plans	Ms L Ward	July 2021	Resources Cttee	Completed
Vaccination	Develop plans for Flu and COVID booster roll out	Ms L Ward	September 2021	Resources Cttee	Completed
111 Retention	Development of an action plan to improve retention in 111	Ms L Ward	December 2021	Resources Cttee	In Progress
Vaccination	Delivery of target compliance of 85% for Flu and COVID booster	Ms L Ward	February 2022	Resources Cttee	In Progress
Recruitment Plans	Delivery of Q3 & Q4 recruitment plans	Ms L Ward	March 2022	Resources Cttee	In Progress
Attendance	Delivery of actions to improve attedance	Ms L Ward	March 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3027	Operational/ People	There is a risk that the combined outcome of the ORH demand analysis, Paramedic skill mix change and GP reform will create a Paramedic shortfall resulting in inability to meet operational demand.	20 Significant	16 Significant	⇔	4 Moderate
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 Significant	25 Significant	⇧	5 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR05: There is a risk that the required organisational culture change does not sufficiently develop to support the organisational changes and improvements required to meet the changing demands on the service, resulting in poor quality services.	**Strategic Priority:** Workforce	**Executive Director Lead:** DoP
	Risk Appetite Category: Quality Outcomes – Low	



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			12			12	4
			4x3			4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded			Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q2 of this BAF risk is a 12 as the Trust is facing a significant amount of change and in a climate where the pressures on staff and managers from demand, activity an COVID-19 continue to be significant. Whilst there is a lot of positive support in place and progress in delivering improvements to staff experience, such as values, wellbeing support, these need to be consistently embedded. The Staff Survey and Wellbeing Audit data suggests that this consistency has not been achieved.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
NHS People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2021/131) & BoD (BoD2122/37)
NWAS People Plan Implementation	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69) & BoD ((BoD2122/37)
Implementation of Revised Trust Values	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Appraisal Policy & Procedure	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/66) & BoD (BoD/2122/80) Reported to Resources Cttee (RC/2122/69)
Staff Survey Inc. Local Plans	**Level 1:** Local Wellbeing Plans **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Equality & Diversity Priorities	**Level 2:** WRES, WDES, Gender Pay Gap **Level 2:** EDI Annual Report **Level 2:** Diveristy & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/212267) & BoD (BoD/2122/85) Reported to Resources Cttee & BoD (BoD/2122/36) Reported to Resources Cttee (RC/212247)
Staff Networks	**Level 2:** Diveristy & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/212247)
Leadership Development Inc. BTD Leadership Recruitment	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Health and Wellbeing Provision	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
CULTURE		
Culture & Wellbeing Audit	**Level 2:** Culture & Wellbeing Deep Dive	Presented to Resources Cttee (RC/2122/07)
Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/55)
Just Culture Inc. Displinary & DAW Processes and Treat Me Right	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** Assurance on People Practices (Inc. Just Culture)	Reported to Resources Cttee (RC/2122/66) & BoD (BoD/2122/80) Reported to Resources Cttee (RC/2122/69) Reported to BoD (Sept 20)
Culture Dashboards	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress

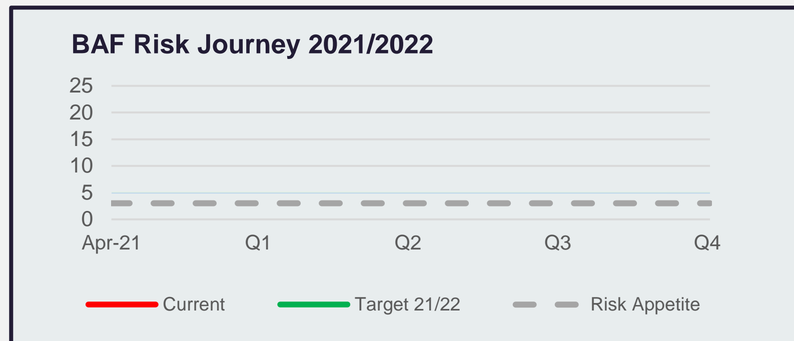
Fully embeddeding Just Culture Principles	Retender and implementation of investgations training	Ms L Ward	Pilot: September 2021	Resources Cttee	Completed
	Investigation training compliance	Ms L Ward	2022/23	Resources Cttee	In Progress
	Review of Disciplinary Procedure	Ms L Ward	December 2021	Resources Cttee	In Progress
Health and Wellbeing Guardian	Appointment of a Health & Wellbeing Guardian	Ms L Ward	November 2021	Resources Cttee	In Progress
Operations and Medical Management Restucture	Implementation of Phase 1 Senior Management Restructure	Mr G Blezard Ms L Ward	March 2021	SDMR Project Board	In Progress
FTSU Action Plan	Delivery of agreed actions	Ms L Ward Ms A Wetton	March 2022	Resources Cttee	In Progress
Additional H&WB Funding	Implementation of H&WB Plans associated with NHSEI Funding	Ms L Ward	March 2022	Resources Cttee	In Progress
EDI Priorities	Delivery of Year 1 Action Plans (Workforce Elements)	Ms L Ward	March 2022	Resources Cttee	In Progress
Leadership	Develop and Approval of a Leadership Framework Delivery of full Making a Difference Programme	Ms L Ward	March 2022	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Evalution of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	2022/23	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR05

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate
3320	Operational/ People	There is a risk that the backlog and reduction in hearings will lead to conduct or capability matters not being effectively dealt with which may negatively impact on patient care.	20 Significant	15 Significant	⇔	5 Moderate
3447	Operational/ Workforce	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	16 Significant	16 Significant	⇔	4 Moderate
3459	Operational/ Workforce	There is a risk that due to increasing operational demands the Service Delivery Directorate will not achieve operational performance standards having a negative impact on workforce wellbeing.	16 Significant	20 Significant	⇧	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR06: There is a risk that non-compliance with legislative and regulatory standards could result in staff and/or patient harm	**Strategic Priority:** ALL	**Executive Director Lead:** DoQII
	Risk Appetite Category: Compliance & Regulatory – Low	



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			20			10	5
			5x4			5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded			Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q2 of this BAF risk is a 20 due to the continued challenges in place responding to the pressures and the prolonged period at REAP Level 4. All clinicians have returned to operational duties resulting in delayed complaint and incident processing. The Trust continues to face IPC clusters and outbreaks during Q2. Throughout Q2, the number of handover delays and associated harm due to delayed admission to Emergency Departments have continue to be high levels. Audit processes are showing low levels of compliance for essential checks due to time constraints, although work to rationalise quality assurance audit systems is scheduled for Q3. The introduction of new processes to manage patient safety events and HR case management in a timely manner have been established. Additional resources have been added into the Private Provider Contracting Team to strengthen assurance processes.

CONTROLS	ASSURANCES	EVIDENCE
PATIENT SAFETY		
CQC Overall Rating of 'Good'	**Level 3:** CQC Inspection Report	Reported to BoD (2020)
CQC Inspection Action Plan	**Level 2:** CQC Action Plan Assurance Report	Reported to Q&P Cttee (Q&PC 2122/13)
CQC Regulation	**Level 2:** CQC Regulation Assurance Report	Reported to Q&P Cttee (Q&PC 2122/34)
IPC Practices	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (Q&PC 2122/61)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/85)
Quality Assurance Processes	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/87)
PEOPLE		
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC 2122/66)
Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/55)

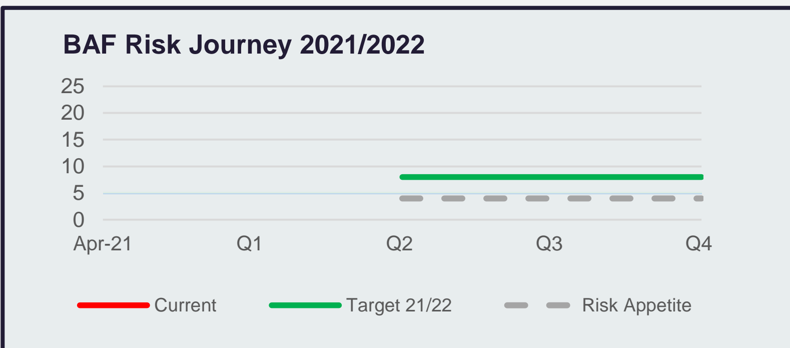
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
PATIENT SAFETY IMPROVEMENTS					
Clinical Audit Submissions	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant	December 2021	Q&P Cttee	In Progress
Essential Checks (Vehicle)	Improve compliance with essential checks and provide assurance	Mr G Blezard	January 2022	Q&P Cttee	In Progress
Essential Checks (Premises)	Improve compliance with essential checks and provide assurance	Ms C Wood	January 2022	Resources Cttee	In Progress

Response Model Inc. Long Waits & Handover Delays	Improvements to reduce long waits and handover delays	Dr C Grant	January 2022	Q&P Cttee	In Progress
Patient Safety Management (Incidents & Complaints)	Improve compliance with patient safety metrics	Prof M Power	March 2022	Q&P Cttee	In Progress
Non-Compliance with IPC & RPE	Improve compliance with IPC practices and RPE across the Trust	Prof M Power	March 2022	Q&P Cttee	In Progress
Freedom to Speak Up Index	Improve all Index Indicator Scores	Prof M Power	March 2022	Q&P Cttee	In Progress
PEOPLE					
HR Casework	Improving the timeliness of HR cases	Ms L Ward	March 2022	Resources Cttee	In Progress
Mandatory & Statutory Training Compliance	Achieve 75% compliance by March 2022	Ms L Ward	March 2022	Resources Cttee	In Progress
Appraisal Compliance	Achieve 85% compliance by March 2022	Ms L Ward	March 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3056	Operational/ Patient Safety	There is a risk that complainants and reporters of external incidents are not receiving responses to their queries in as timely a manner as possible due to the backlog of complaints within the system which could result in a poor complainant experience, non-regulatory compliance, and delayed learning from adverse events.	12 High	16 Significant	⇧	3 Low
3315	Operational/ People	There is a risk that the cessation of mandatory training as a result of COVID19 will lead to an extended recovery plan and adverse regulatory scrutiny.	16 Significant	20 Significant	⇧	8 High
3316	Operational/ People	There is risk that due to the cessation of appraisals, the revised trajectory of 75% for Operations by Sept 2021 will not be achieved resulting in potential regulatory scrutiny.	16 Significant	16 Significant	⇧	8 High
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇧	5 Moderate
3487	Operational/ Information Governance	There is a risk that due to the cessation of mandatory training across the Trust there is low compliance with the Data Security Awareness Mandatory Training Module, resulting in non-compliance with the National Data Guardian's 10 data security standards which is assessed by completion of the Data Security Protection Toolkit.	12 High	15 Significant	⇔	3 Low

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	**Strategic Priority:** Stakeholder Relationships	**Executive Director Lead:** DoSPT
	Risk Appetite Category: Reputation – Moderate	



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			12			8	4
			4x3			4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded			Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q2 of this BAF risk is a 12 due to the new structures and work programmes being put in place by the Trust will help to ensure that the changes in place nationally for the ICS are mitigated. However, there is a degree of uncertainty going forward, whilst the legislation is turned into practice and implemented across the footprint. The Trust will work with the approval processes. The ICS has begun to implement some changes with Executives and Chairs now appointed. However, other positions need to be filled. The intention is that the full Executive Team should be in place, in each ICS by December 2021. The ongoing issue remains around clarity on how the Ambulance Service will work and function with the various ICSs.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		
CEO via AACE Role Engagement with NHSE/I	**Level 2:** CEO Report	Reported via the Integrated Governance Structure to BoD
Designated Executive Director Lead for each ICS	**Level 2:** Executive Portfolios	Reported via the Integrated Governance Structure to BoD
Partnership & Integration Team	**Level 2:** Established in September 2021	Reported via the Integrated Governance Structure to BoD
NWAS Manager Representation at Key Meetings	**Level 2:** Assessment to ensure the right expertise is in attendance	Reported via the Integrated Governance Structure to BoD
Stakeholder Mapping	**Level 2:** Full mapping exercise is in place	Reported via the Integrated Governance Structure to BoD
ICS		
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported via the Integrated Governance Structure to BoD
Working & monitoring national, regional & local groups	**Level 2:** Relevant NWAS Managers are part of these groups	NWAS attendance at groups. Reporting of progress and proposals

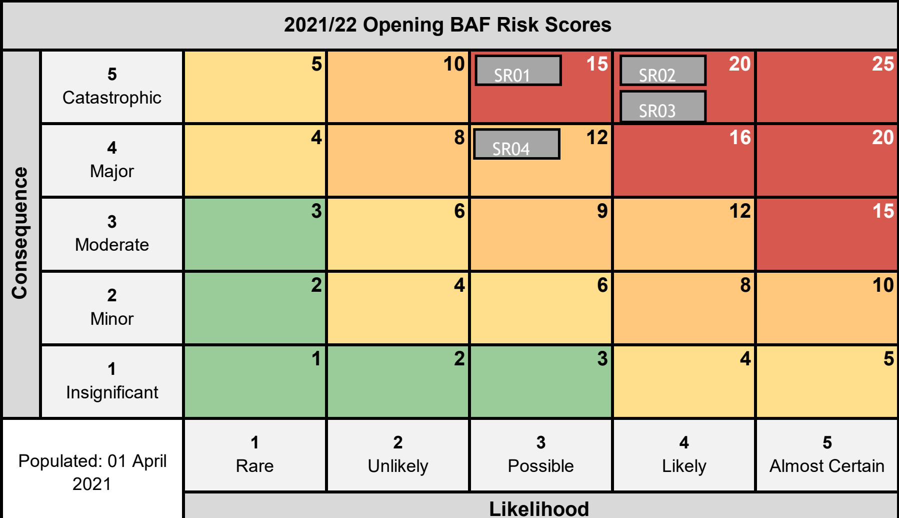
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Information Sharing across Key Partners	Update and refresh the reconfiguration matrix	Mr S Desai	Q2	Resources Cttee	In Progress
Knowledge Vault	Design, develop & implement so intelligence & information is shared	Mr S Desai	Q3	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

Appendix 3:

2021/22 Board Assurance Framework (BAF) Heat Maps

Quarter 2 Position



2021/22 Opening BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01	20 SR02, SR03	25
4 Major	4	8	12 SR04	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 01 April 2021	Likelihood				

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01, SR02	20 SR03	25
4 Major	4	8	12 SR04	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 07 July 2021	Likelihood				

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01, SR02	20 SR03, SR06	25
4 Major	4	8	12 SR04, SR05, SR07, SR08	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 07 October 2021	Likelihood				

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated:	Likelihood				

Q4 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated:	Likelihood				

2021/22 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	SR01, SR06 10	SR02, SR03 15	20	25
4 Major	4	SR04, SR07, SR08 8	SR05 12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 01 April 2021	Likelihood				

Final Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	SR01, SR02, SR03, SR06 5	10	15	20	25
4 Major	SR04, SR05, SR07, SR08 4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 01 April 2021	Likelihood				

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NHS
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Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	24th November 2021			
SUBJECT:	Use of Common Seal Bi-Annual Report			
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
	SR05	**SR06**	**SR07**	**SR08**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	Use of the Common Seal is determined by Section 8 of the Trust's Standing Orders. Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on a bi-annual basis with the previous report received by the Board on 28th April 2021. During the period 1st April 2021 to 30th September 2021, the Trust's Common Seal was applied on a total of 7 occasions and the details can be found in s2.			
RECOMMENDATIONS:	The Board of Directors is recommended to: • Note the occasions of use of the Common Seal as detailed in s2 of the report. • Note compliance with s8 of the Standing Orders.			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to report the use of the Common Seal to the Board of Directors between the period 1st April 2021 to 30th September 2021.

2. USE OF COMMON SEAL

Use of the Common Seal is determined by Section 8 of the Trust's Standing Orders. Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on a bi-annual basis with the previous report received by the Board on 28th April 2021.

During the period 1st April 2021 to 30th September 2021, the Trust's Common Seal was applied on a total of 7 occasions. There were:

Reg No	Date	Reason
146	28 April 2021	Transfer of Ulverston Ambulance Station to Cumbria County Council
147	14 July 2021	Renewal of Preston Fire Station
148	14 July 2021	Renewal Lease Northern Trust Company Ltd (Croftwood Square)
149	14 July 2021	Lease for PTS Stretford (Christie Road)
150	14 September 2021	Lease for PTS Oldham (Jackson Street)
151	14 September 2021	Lease for PTS Audenshaw (Shepley Road)
152	14 September 2021	Blackpool Ambulance Station

A Register of Use of the Common Seal is maintained by the Director of Corporate Affairs and includes either the supporting documentation for each entry or details of the final distribution of the relevant documentation. The Director of Corporate Affairs is responsible for the safe custody of the Common Seal. Authorisation for Use of the Common Seal requires the signatures of both the Chief Executive and Director of Finance and the application of the Seal is witnessed by a further 2 senior managers.

Authorisation and witness signatures are incorporated in the Trust's Register of Sealings. Compliance with the requirements of Section 8 of Standing Orders is being maintained.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Trust is required to comply with Section 8 of the Trust's Standing Orders relating to the Use of the Common Seal.

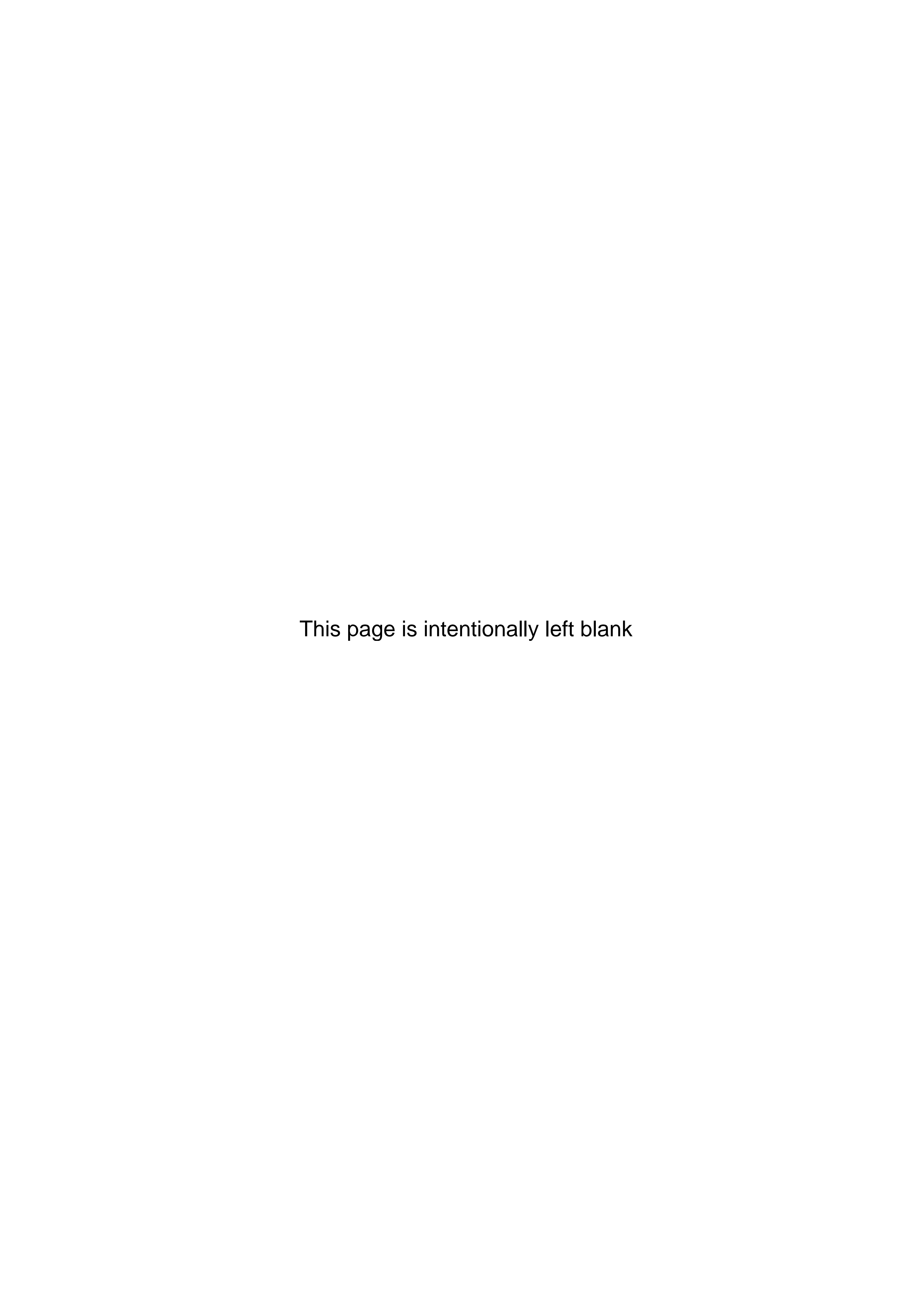
4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

Not applicable.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the occasions of use of the Common Seal as detailed in s2 of the report.
- Note compliance with s8 of the Standing Orders.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NHS
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REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="4">24 November 2021</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Freedom to Speak Up Bi-Annual Assurance Report</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="4">Ms Rachael Foot, Freedom to Speak Up Guardian</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>SR05</td><td>SR06</td><td>SR07</td><td>SR08</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="4">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="4">2021 Q1/Q2 Freedom to Speak Up National Guardians Office statistics show the cases raised for each Quarter under the 5 categories monitored:
• Number of Cases: 67
• Raised Anonymously: 5
• Patient Safety: 6
• Unacceptable Behaviours: 29
• Staff Detriment : 2</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Board is asked to:
• Note the work of the Guardian
• Support the provision of the Trust’s Freedom to Speak Up strategy
• Actively promote and robustly support the Freedom to Speak Up principles
• Support the development of the Freedom to Speak Up training plan that is aligned to the NGO’s recommendations
• Support ‘embedding any learning from concerns being raised across the Trust’
• Consider any risks and further actions for the Trust</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)</td><td colspan="4">The Trust’s Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
</table>

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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1 PURPOSE

This paper provides a bi-annual summary of the Trust's raising concerns processes and demonstrates the purpose of creating a speaking up culture to keep our patients safe, improve the working environment of staff and to promote learning and improvement.

The Freedom to Speak Up Guardian (FTSUG) and Freedom to Speak Up Champions role aims to support the development of cultures where safety concerns are identified and addressed at an early stage.

This assurance report details the progress the Trust has made during Q1 and Q2 to ensure that everyone in the Trust works together to develop a culture that welcomes speaking up, and where action is taken to address anything that is an obstacle to providing great care. To speak up and be heard not only improves the quality and safety of patient care, but also, in tackling bullying and discrimination.

This assurance report demonstrations that speaking up and listening up occurs at NWAS and the steps that we have so far taken to creating a healthy speaking up culture, in order to protect patients and improve the experience of our NHS workers.

2 BACKGROUND

Freedom to Speak Up (FTSU) is a national programme that supports staff, students and volunteers to raise concerns in confidence. Mid staffs hospital demonstrated the negative impact on an organisation if staff feel unable to raise a concern. It is vital that everyone at NWAS knows how to raise concerns and to feel safe when they do so.

The Freedom to Speak Up Guardian and Champions remain determined in our commitment to ensure that staff feel they can speak up safely and that their concerns will be heard and taken seriously. No-one should experience detriment or be discriminated against for speaking up, but we know fear of this can prevent staff from doing so, The Freedom to Speak Up Guardian thanks our staff for speaking up, and thanks our Champions for helping make NWAS a safe place.

3 CONCERNS RAISED DURING Q1/Q2 /2021

Freedom to Speak Up has continued to promote the role of speaking up, whilst supporting staff who raise concerns via this route. This section provides a summary of concerns raised during the reporting period.

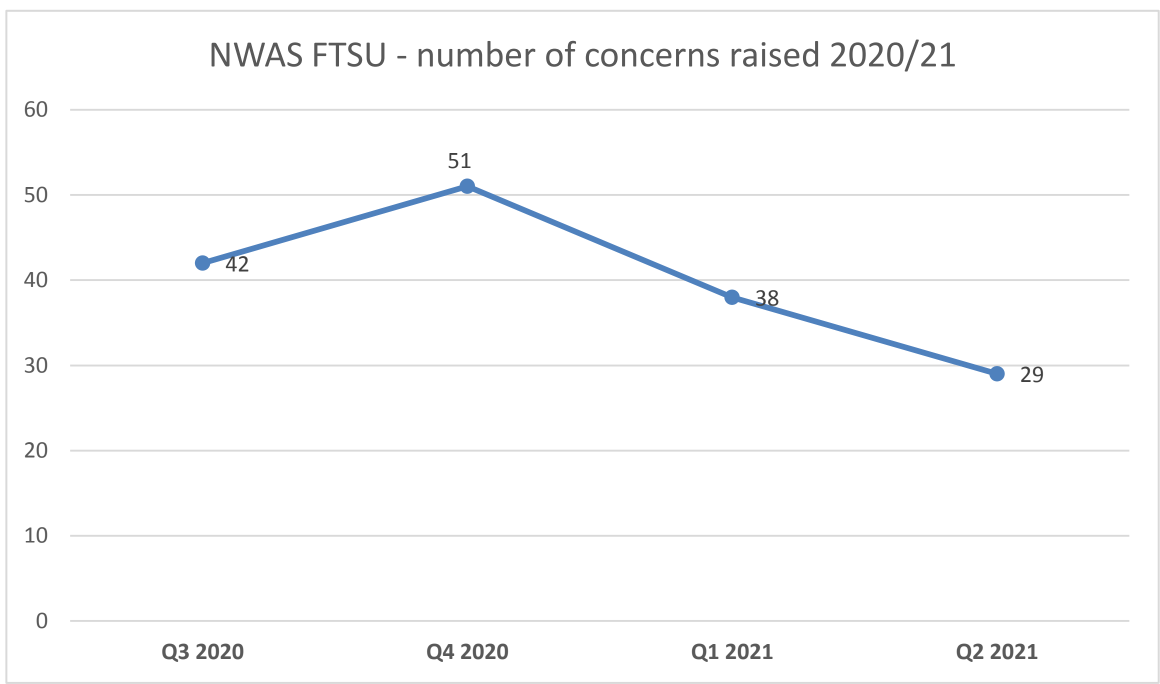
It is the responsibility of the FTSU Guardian to record and monitor all concerns raised and report them to the Trust's Board of Directors on a bi-annual basis and the National Guardian's Office on a quarterly basis.

During this reporting period 67 cases were reported by the Freedom to Speak Up (FTSU) Guardian or Champions. This is a noticeable decrease on the previous reporting period (2020/21) where 93 cases were raised and this has been the common narrative throughout the Regional and National network. It has been speculated upon that employees may have felt

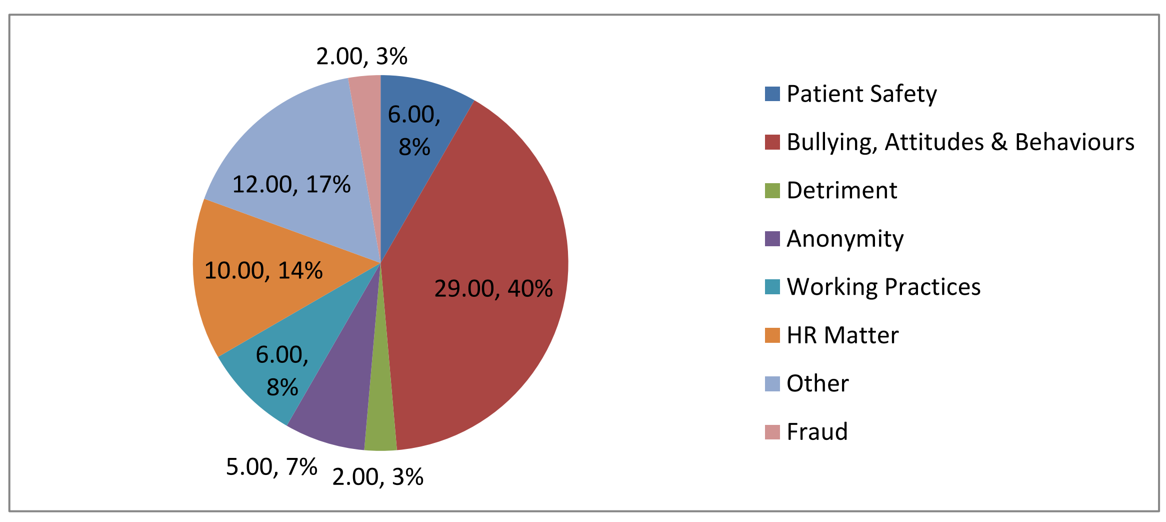
reluctant to raise their concerns during the enormously challenging day to day experience of the pandemic.

The table below provides a summary of information provided by North West Ambulance Service to the National Guardian's Office.

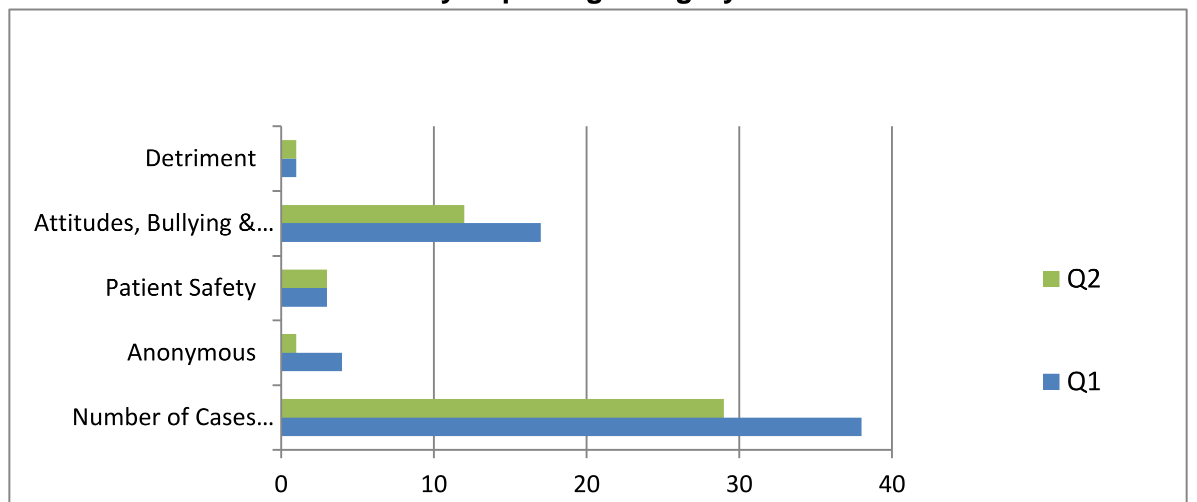
Freedom to Speak Up Concerns raised during 2020-21 Per Quarter



Details of Concerns Q1 and Q2 2021/22

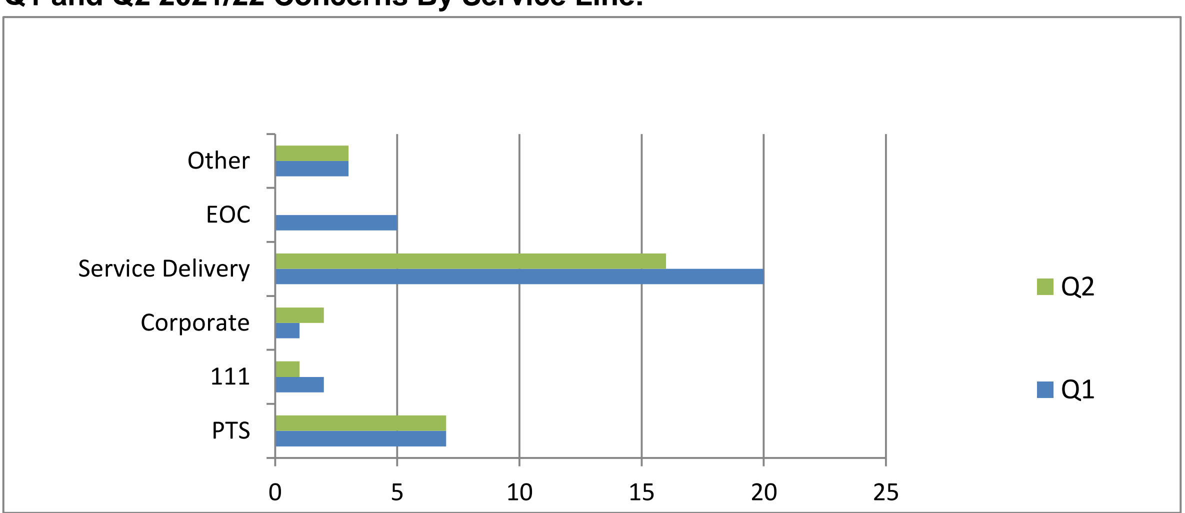


Q1 and Q2 2021/22 Concerns by Reporting Category



Please note - the activity as detailed above reflects only cases reported via FTSU. Concerns raised with local managers and HR are not included in these figures.

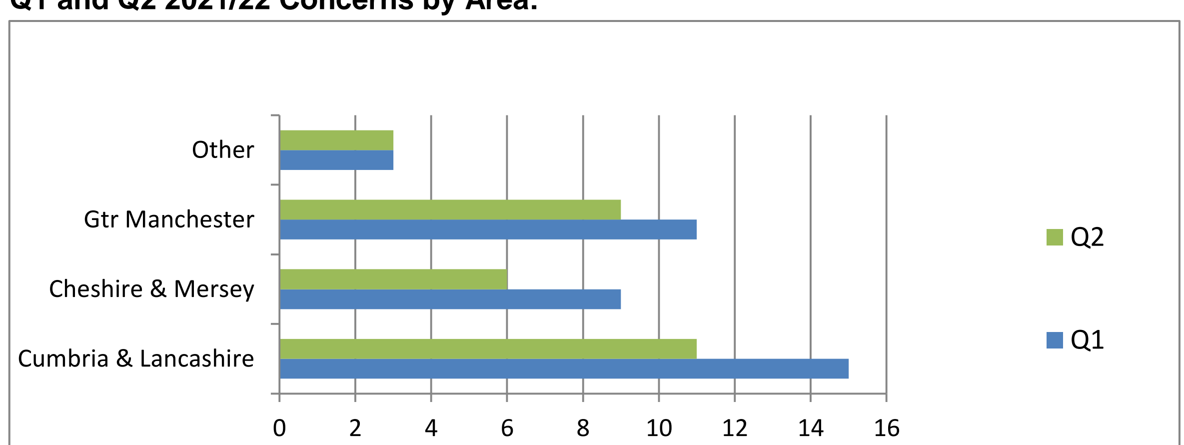
Q1 and Q2 2021/22 Concerns By Service Line:



Please note – Other incudes concerns raised by private provider, other Trust and unknown

**The activity as detailed above reflects only cases reported via FTSU. Concerns raised with local managers and HR are not included in these figures.*

Q1 and Q2 2021/22 Concerns by Area:



Please note - the activity as detailed above reflects only cases reported via FTSU. Concerns raised with local managers and HR directly are not included in these figures.

Other includes- Unknown and Private provider

Data
Using data helps to improve not just NWAS but also the NGO and their understanding of the speaking up landscape, this way the NGO are better able to support improvements in the way speaking up takes place across the whole of healthcare. One way in which the NGO track the progress of healthcare providers to embed speaking up is by looking at the number of cases raised to Freedom to Speak Up Guardian.

Covid-19
The COVID-19 pandemic has significantly impacted both service delivery and the way in which employees work. Covid-19 has had an impact on everybody's lives and the Trust recognises the effect this has had on colleagues. During this reporting period the Freedom to Speak Up Guardian and Champions have not received any concerns relating to this subject.

Feedback
Feedback is requested from staff who have raised concerns and monitored to assess any inequalities that require addressing and to identify any areas for improvement in the handling of the concerns. The Guardian has seen a decrease in the amount of feedback being received either verbally or in writing. In line with recommendations from the National Guardian's Office, the evaluation process has been widened to enable colleagues to provide feedback verbally instead of only in writing. The limited feedback showed that the majority of 'would speak up again given their experience of doing so'.

There have been a number of concerns relating to poor management behaviours towards those individuals who have spoken up in their own departments and this has been raised during the Freedom to Speak Up monthly meetings with the Head of HR. The Guardian also takes this opportunity, whilst obtaining verbal feedback to capture the demographics of the person raising the concern where possible.

The Guardian can report that FTSU has received a number of concerns raised by staff identified as 'vulnerable' and from diverse backgrounds.

The Guardian has been working with HR, sharing FTSU data to enable information to be correlated and triangulated allowing common themes to be identified using a workforce dashboard to identify any 'hot spots'.

Common Themes Identified
There have been a number of themes identified during this reporting period, the four main themes are consistent with the previous year's themes;

- Bullying, Attitudes and Behaviours continue to dominate the theme of the concerns being raised. These are significant in terms of impact on the individuals concerned and the management resource to respond to these concerns. The majority of these cases are individual grievances.
- Alleged Non-adherence to policies, for example recruitment policies.
- Feedback – the qualitative level of feedback provided to the Freedom to Speak Up Guardian remains inconsistent irrespective of the reporting method (i.e. Datix). This includes feedback on who is investigating the concern, where possible the timescales and ultimately the outcome of the investigation. Feedback is essential to avoid misunderstandings (a sense that nothing happened or that it wasn't important enough causes unnecessary stress and anxiety for concern raisers) and helps create

a positive learning culture. A Pro-Forma is currently in place to help address this matter, however it is not being utilised effectively and often only gets completed at the end of a process. The Guardian has asked the Head of HR to help promote the use and purpose of the pro-forma to encourage investigating officers to use the form more effectively.

- Staff reporting concerns in confidence to the guardian but who do not wish to proceed with taking their concerns forward, where there are safeguarding matters the FTSU Guardian ensures appropriate escalation.

Supporting Freedom to Speak Up

- Monthly meetings held between the FTSU Guardian; Chief Executive, FTSU Executive Lead and the Director of People to provide oversight that the Trust's systems and processes for speaking up are working effectively
- Monthly meetings between FTSU Guardian and Head of HR to follow up outstanding cases and to identify themes and hot spots
- Regular 1:1 meetings held with FTSU Executive Lead to discuss FTSU matters and seek support when necessary
- Dedicated diary time scheduled with Non-Executive Director to feedback themes that are emerging from speaking up activity
- Six weekly meeting with the Head of Service EOC to review open FTSU cases relating to this function.

Staff Engagement

In order to encourage and promote Freedom to Speak Up at NWAS, a number of activities have been undertaken this reporting period and are set out below:

- EOC (walk rounds – FTSU Champions)
- Guardian attendance - Violence and Aggression forum
- Guardian attendance - Disability Forum
- Guardian attendance - BAME Forum
- Guardian attendance - LGBT Forum
- Guardian attendance – Policy Group
- Guardian attendance – Clinical Learning Forum
- Guardian attendance - Non-Clinical Learning Forum
- Guardian attendance - Wellbeing and Engagement Group
- Guardian attendance - Health, Wellbeing & Culture Assurance Group
- Guardian attendance - SMT Meetings
- Guardian attendance – Peer Support Network
- A FTSU intranet page on the Green room and staff app is in place. This includes details of the FTSU Guardian, FTSU champions and how to raise concerns

The Guardian continues engaging with staff across the Trust and working with Champions to ensure FTSU obtains maximum exposure.

The FTSU Guardian will be focusing for the remainder of this year to ensure more positive attitudes and behaviors across the organisation are displayed and work closely with the People Directorate to explore this further.

Learning and Improvement
The Trust is committed to continuing to learn and improve its systems and processes for raising concerns.

This is done via:

- Meetings held between the Freedom to Speak Up Guardian, CEO, Executive Lead, Interim Director of Organisational Development and the Non-Executive Lead
- Meetings with Head of EOC to discuss open cases relating to that department
- Noting and acting on recommendations from NGO case reviews, surveys and other publications and guidance
- Responding to themes and significant issues highlighted by speaking up
- Taking account of best practice in speaking up developed in other sectors
- Encouraging workers to be involved in driving improvement at organisational level
- You said, we did (Published on NWAS Intranet and FTSU App)
- FTSU feeds in to the Trust's Learning forum
- Key messages and awareness are raised to all staff through the intranet, weekly communications bulletins and other internal communications e.g. screensavers
- Lessons and feedback on cases are also shared locally with staff via the Service Directors, through team meetings and face-to-face meetings where relevant.

Conclusion
The reporting period saw a decrease in the number of concerns being raised via FTSU in comparison to the same reporting period of the previous year (Q1/Q2 2020/21 – 135 cases) However, as highlighted during this reporting period, no Covid-19 related concerns have been raised during 21/22 in comparison to the thirty seven raised in the previous year. The majority of concerns raised are from clinical colleagues in various roles. Whilst there has been a decrease in overall concerns being raised, the data shows there are fewer colleagues raising concerns truly anonymously which may suggest colleagues feel more able to raise concerns at North West Ambulance Service and access the FTSU Service in confidence and without fear of detriment.

Concerns raised around patient safety are shared with the Executive Director of Operations and Medical Director to give an overview of the types of concerns and it enables these Directors to monitor and address common themes identified across their directorates and to take ownership, share and embed any learning from them.

All concerns raised are directed to the Executive lead for the directorate the concern relates to and actions are put in place to address these concerns which are audited to ensure concerns are being taken seriously. Some concerns are escalated to more than one person as the concerns may include more than one category or area of concern.

Although the Service continues to evaluate well, work continues to promote the FTSU Service and improving our culture to ensure all staff have the confidence to raise and discuss any concerns they may have.

3 LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

All NHS Trusts and NHS Foundation Trusts are required by the NHS contract to have a nominated Freedom to Speak Up Guardian.

4 EQUALITY OR SUSTAINABILITY IMPLICATIONS

Protected Characteristics of staff raising concerns will be monitored by the Freedom to Speak Up Guardian through the Feedback Forms following the raising of a concern.

Though demographic monitoring is not part of the NGO reporting requirements, the Guardian will endeavour to do this in the coming year and this information will be shared with the WRES team.

5 RECOMMENDATIONS

The Board of Directors is requested to:

- Note the work of the Guardian during the reporting period
- Note the progress made against delivery of the Trust's Freedom to Speak Up strategy
- Actively promote and robustly support the Freedom to Speak Up principles
- Note the development of the Freedom to Speak Up training plan that is aligned to the NGO's recommendations
- Note the process for 'embedding any learning from concerns being raised across the Trust'
- Consider any risks and further actions for the Trust

REPORT TO BOARD OF DIRECTORS

DATE:	24 November 2021			
SUBJECT:	Charitable Funds Annual Report and Accounts 2020/21			
PRESENTED BY:	Director of Finance			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☒	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Decision			
EXECUTIVE SUMMARY:	The purpose of this paper is to present the audited Charitable Funds Annual Report and Accounts for 2020/21 to the Board of Directors, as the Corporate Trustee for approval and adoption. The main points for noting are: - Income for the year amounted to £354k; - Total expenditure during 2020/21 was £191k, where main element was the planned purchase of medical equipment and staff welfare; and - Overall the funds have increased by £163k.			
RECOMMENDATIONS:	As Corporate Trustee, the Board of Directors is asked to: • Approve and adopt the Charitable Funds Annual Report and Accounts for 2020/21; and • Approve the signing of the letter of representation and Statement of Trustees Responsibilities on behalf of the Corporate Trustee.			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 6 for detail)	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Charitable Fund Committee			
	Date:	27 October 2021		
	Outcome:	Supported		

1. PURPOSE

1.1 The purpose of this paper is to present the independently reviewed Charitable Funds Annual Report and Accounts 2020/21 to the Board of Directors, as Corporate Trustee, for approval and adoption.

2. BACKGROUND

2.1 The Annual Report and Accounts are prepared in accordance with guidance issued by both the Audit and Charity Commissions. The Board of Directors are the Corporate Trustee for Charitable Fund purposes.

3. CURRENT SITUATION

3.1 The attached Annual Report (Appendix 2) and Accounts (Appendix 1) were independently reviewed by the independent examiner Mark Surridge, Mazars LLP during September 2021.

3.2 As part of sign-off of the Annual Accounts and Annual Report, a letter of representation (Appendix 3) and a Statement of Trustees Responsibilities (Appendix 4), signed on behalf of the Corporate Trustee, must be included.

3.3 The Charitable Funds Committee has reviewed the Accounts and Annual Report, Independent Examiner's Report, Letter of Representation and Statement of Trustees Responsibilities for 2020/21 and is recommending them for adoption and approval.

3.4 The deadline for submission of the Annual Report and Accounts to the Charity Commission is the 31 January 2022.

4. SUMMARY OF FINANCIAL PERFORMANCE 2020/21

4.1 In summary, the income of the charitable funds in 2020/21 amounted to £354k, out of which £180k was for the unrestricted fund, where the main element came from legacies of £110k, and the remaining £174k was for restricted funds where the largest income element was £127k from NHS Charities Together for the welfare of staff.

4.2 Expenditure in 2020/21 amounted to £191k of which £37k was from unrestricted funds and £154k from restricted funds.

4.3 The overall available resource in 2020/21 has increased by £163k where unrestricted funds increased by £143k while restricted funds increased by £20k. The largest element of expenditure was the purchase of medical equipment, mainly defibrillators, and staff welfare, all in line with donor's wishes.

4.4 The trustees are required to approve the Annual Accounts attached at Appendix 1; the Annual Report can be found at Appendix 2.

5. INDEPENDENT EXAMINATION

5.1 The independent examination of the Charitable Funds accounts for 2020/21 was undertaken by the independent examiner Mark Surridge, Mazars LLP. The examination was undertaken in September 2021. There were no concerns and no other matter in connection with the examination to which attention should be drawn.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

6.1 There are no equality or sustainability implications associated with this paper.

7. RECOMMENDATIONS

7.1 The Board of Directors, as Corporate Trustee, is asked to:

- approve and adopt the Annual Accounts and Annual report for 2020/21; and
- approve the signing of the letter of representation and Statement of Trustees Responsibilities on behalf of the Corporate Trustee.

Appendix 1

CHARITABLE TRUST ACCOUNT - NORTH WEST AMBULANCE SERVICE NHS TRUST

Data entered below will be used throughout the workbook:

This year	2020-21
Last year	2019-20
This year ended	2021
Last year ended	2020
This year beginning	1 April 2020
This year name	31 March 2021
Last year name	31 March 2020

North West Ambulance Service NHS Trust Charitable Fund
Statement of Financial Activities and Income & Expenditure for the 12 months ended 31 March 2021

	Note	Unrestricted Funds £000	Restricted Funds £000	**12 months to 31 March 2021 Total Funds £000**	12 months to 31 March 2020 Total Funds £000
Income and Endowments					
Donation and Legacies	3	180	174	**354**	472
Total Income and Endowments		180	174	**354**	472
Expenditure					
Raising Funds	4	-	-	**-**	4
Expenditure on Charitable Activities	5, 6	37	154	**191**	150
		-	-	**-**	
Total Expenditure		37	154	**191**	154
Net Income/(Expenditure)		143	20	**163**	318
Net Movement in funds		143	20	**163**	318
Reconciliation of Funds					
Total Funds brought forward 1 April 2020		464	336	**800**	482
Total Funds carried forward 31 March 2021		607	356	**963**	800

North West Ambulance Service NHS Trust Charitable Fund
Balance Sheet as at 31 March 2021

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total Funds 31 March 2021 £000**	Total Funds 31 March 2020 £000
Current Assets:					
Stock	8	-	1	**1**	2
Cash at bank and in hand		609	388	**997**	803
Total Current Assets		609	389	**998**	805
Creditors: Amounts falling due within one year	9	(2)	(33)	**(35)**	(5)
Net Current Assets		607	356	**963**	800
Total Assets less Current Liabilities		607	356	**963**	800
Total Net Assets		607	356	**963**	800
Funds of the Charity					
Restricted income funds	10		356	**356**	336
Unrestricted income funds		607		**607**	464
Total Charity Funds		607	356	**963**	800

Notes 1 to 11 form part of these accounts.

Signed ……………………………………………………………………

Daren Mochrie, Chief Executive

Date:

Notes on the Accounts

1 Accounting Policies

(a) Basis of preparation

The accounts (financial statements) have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011.

The trust constitutes a public benefit entity as defined by FRS 102.

The financial statements have been prepared on a going concern basis which the Trustees consider to be appropriate for the following reasons.
The business model of the charity is such that its charitable activities are limited to those which it has sufficient funds to support from the excess of funding received over the costs of administering the charity. The charity therefore has no specific commitments and no committed costs beyond its fixed costs of operation which are detailed in note 4.
The Trustees have reviewed the cash flow forecasts for a period of 2 years from the date of approval of these financial statements which indicate that the charity will have sufficient funds to meet its liabilities as they fall due for that period. The Trustees have also considered the implications of COVID-19 on these cash flow forecasts and consider that as a result of its operating model explained above, even if no further funding is received in the 12 month period, the charity has sufficient cash reserves to pay all committed costs.
Consequently, the Trustees are confident that the charity will have sufficient funds to continue to meet its liabilities as they fall due for at least 12 months from the date of approval of the financial statements.

(b) Income and Endowments

All income is recognised once the charity has entitlement to the income, it is probable that the income will be received and the amount of income receivable can be measured reliably.

Donations, are recognised when the Charity has been notified in writing of both the amount and settlement date. In the event that a donation is subject to conditions that require a level of performance before the charity is entitled to the funds, the income is deferred and not recognised until either those conditions are fully met, or the fulfilment of those conditions is wholly within the control of the charity and it is probable that those conditions will be fulfilled in the reporting period. Gifts in kind are valued at estimated fair market value at the time of receipt.

Legacy gifts are recognised on a case by case basis following the granting of probate when the administrator/executor for the estate has communicated in writing both the amount and settlement date. In the event that the gift is in the form of an asset other than cash or a financial asset traded on a recognised stock exchange, recognition is subject to the value of the gift being reliably measurable with a degree of reasonable accuracy and the title to the asset having been transferred to the charity.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

(c) Expenditure Recognition

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

All expenditure is accounted for on an accruals basis. All expenses including support costs and governance costs are allocated or apportioned to the applicable expenditure headings. For more information on this attribution refer to note (e) below.

Grants payable are payments made to third parties in the furtherance of the charitable objects of the Charity. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grants awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Charity.

Provisions for grants are made when the intention to make a grant has been communicated to the recipient but there is uncertainty as to the timing of the grant or the amount of grant payable.

The provision for a multi-year grant is recognised at its present value where settlement is due over more than one year from the date of the award, there are no unfulfilled performance conditions under the control of the Charity that would permit the Charity to avoid making the future payment(s), settlement is probable and the effect of discounting is material. The discount rate used is the average rate of investment yield in the year in which the grant award is made. This discount rate is regarded by the trustees as providing the most current available estimate of the opportunity cost of money reflecting the time value of money to the Charity.

(d) Allocation of support and governance costs

Support costs have been allocated between governance costs and other support costs. Governance costs comprise all costs involving the public accountability of the charity and its compliance with regulation and good practice. These costs include costs related to independant examination and legal fees.

Governance costs and support costs relating to charitable activities have been apportioned based on total expenditure. The allocation of support and governance costs is analysed in note 4.

(e) Expenditure on charitable activities

Costs of charitable activities include grants made, governance costs and an apportionment of support costs as shown in note 4.

(f) Irrecoverable VAT

Irrecoverable VAT is charged against the expenditure heading for which it was incurred.

(g) Structure of Funds

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Where the restriction requires the gift to be invested to produce income but the Trustees have the power to spend the capital, it is classed as expendable endowment. There are no expendable endowments at 31 March 2021.

Restricted funds include legacy funds where the donor has made known their non binding wishes or where Trustees, at their discretion, have created a fund for a specific purpose. The Trustee ring fences legacy funds within the restricted and insures that the funds are used in a way that is consistent with the wishes of the donor.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects.

The Charity has no endowment funds. The major funds held in both the restricted and unrestricted categories are disclosed in note 10.

(h) Fixed asset investments

The North West Ambulance Service NHS Charitable Trust has held no fixed asset investments in the financial year ended 31 March 2021.

(j) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the period end and opening market value (purchase date if later).

(k) Change in the Basis of Accounting

The Accounts of the Charitable Trust have been prepared on a going concern basis.

(l) Stocks

Stocks are valued at the lower of cost and net realisable value.

2 Related Party Transactions

The Trustee is the North West Ambulance Service NHS Trust. All expenditure made from the Charitable Funds are for the benefit of the North West Ambulance Service NHS Trust. During 2020/21 none of the members of the NHS Trust Board or senior NHS Trust staff or parties related to them were beneficiaries of the Charity. NWAS is the creditor in the Charitable Funds Accounts.

3 Analysis of voluntary income

	Unrestricted Funds £000	Restricted Funds £000	**12 months to 31 March 2021 Total £000**	12 months to 31 March 2020 Total £000
Donations from individuals and organisations	198	46	**244**	178
Legacies - General fund	110	-	**110**	294
	308	46	**354**	472

4 Expenditure on raising funds

	Unrestricted Funds	Restricted Funds	12 Months to 31 March 2021	12 Months to 31 March 2020
	£,000	£,000	Total	Total
Seeking donations	0	0	**0**	4
Total Expenditure on raising funds	**0**	**0**	**0**	**4**

In 2017/18 a dedicated post was created to help raising funds while prior to this the Charitable funds didn't have this resource and didn't incure this type of costs. The post was terminated in June 2019, so no costs in 20/21

5 Allocation of support costs

Once the allocation of support costs has been made to Governance Costs, the balance is allocated to Charitable Activities.

	12 months to 31 March 2021 Total	Allocated To Charitable Activities	Allocated to Governance	12 months to 31 March 2020
	£000	£000	£000	£000
Independent Examiner's Remuneration	**2**		2	4
Administration	**1**	0	1	7
Total	**3**	-	3	11

6 Analysis of charitable expenditure

The Charity undertook direct charitable activities mainly on the provision of staff welfare and the purchase of medical and surgical equipment and sundries with regards to the First Responder Funds.

	Activities undertaken directly	Support Costs	12 months to 31 March 2021 Total	12 months to 31 March 2020
	£000	£000	£000	£000
Staff Education and Welfare	76	1	**77**	7
Purchase of New Equipment	112	2	**114**	142
Patient Education and Welfare	-	0	**-**	1
Total	188	3	**191**	**150**

7 Independent Examiner's Remuneration

	12 months to 31 March 2021 Total	12 months to 31 March 2020 Total
	£000	£000
Independent Examiner's Remuneration	2	4
Total Cost	**2**	**4**

8 Analysis of current assets

(a) Stocks

	12 months to 31 March 2021 Total	12 months to 31 March 2020
	£000	£000
Raw materials and consumables	1	2
	1	2

Stocks relate to medical and surgical equipment and sundries held by the Lancashire First Responders.

(b) Analysis of cash and deposits

	12 months to 31 March 2021 Total	12 months to 31 March 2020
	£000	£000
National Westminster Deposit Account	997	803
Total	**997**	803

9 Analysis of current liabilities and long term creditors

Creditors under 1 year

	31 March 2021 Total £000	31 March 2020 Total £000
Other creditors	**35**	5
Total	**35**	5

Other creditors represent sums owed at the year end by the charity to a related party, North West Ambulance Service NHS Trust, for costs incurred by the NHS Trust on behalf of the charity in the furtherance of the charity's objects.

10 Analysis of charitable funds

	Balance 31 March 2021 c/fwd	Balance 1 April 2020 b/fwd
Type of Funds	**£000**	£000
Unrestricted - General Purpose Funds	**607**	464
Restricted - Designated Funds	**244**	299
Restricted - Other Funds	**112**	37
	963	800

(a) Restricted funds

	Balance 1 April 2020 b/fwd	Resources expended	Incoming resources	**Balance 31 March 2021 c/fwd**
	£000	£000	£000	**£000**
First Responders Community Fund	2	0	0	2
Greater Manchester First Responders	31	0	0	31
Lancashire First Responders	5	(4)	0	1
Station Specific	221	0	23	244
Cardiac Smart	77	(78)	23	22
Charity Together	-	(72)	128	56
Grand Total	336	(154)	174	**356**

Name of Fund	**Description, nature and purpose of the fund**
First Responders Community Fund	The objects of this restricted fund are to promote and support volunteer First Responder Teams operating in the Mersey & Cheshire area through fund raising and access to training and medical equipment.
Lancashire First Responders Fund	The objects of this restricted fund are to promote and support volunteer First Responder Teams operating in the Lancashire area through fund raising and access to training and medical equipment.
Mayor of Wigan RRV Fund	This restricted fund was established to purchase and maintain a Rapid Response vehicle operating in the Wigan area.
Greater Manchester First Responders	This is donation given specifically for development of an application which will alert volunteers of the cardiac arrest in their immediate vacinity.
Station Specific	The legacy and donations funds are the funds that are restricted to be used for a specific purpose or an area.

The detailed funds below are all legacy restricted funds relating to various areas:

	31 March 2021 £000	31 March 2020 £000
Nelson Ambulance Station	1	1
Cumbria- Penrith area	5	5
Cumbria area- for purchase of new equipment	54	54
Cumbria Ambulance Service	25	25
Runcorn Ambulance Station	133	133
Sedbergh Station	1	1
Flimby	1	1
Warrington	1	1
PTS	23	
	244	221

Restricted legacy funds have been further bolstered this year by a legacy of £56k for use Cardiac smart (Various areas in NWAS).

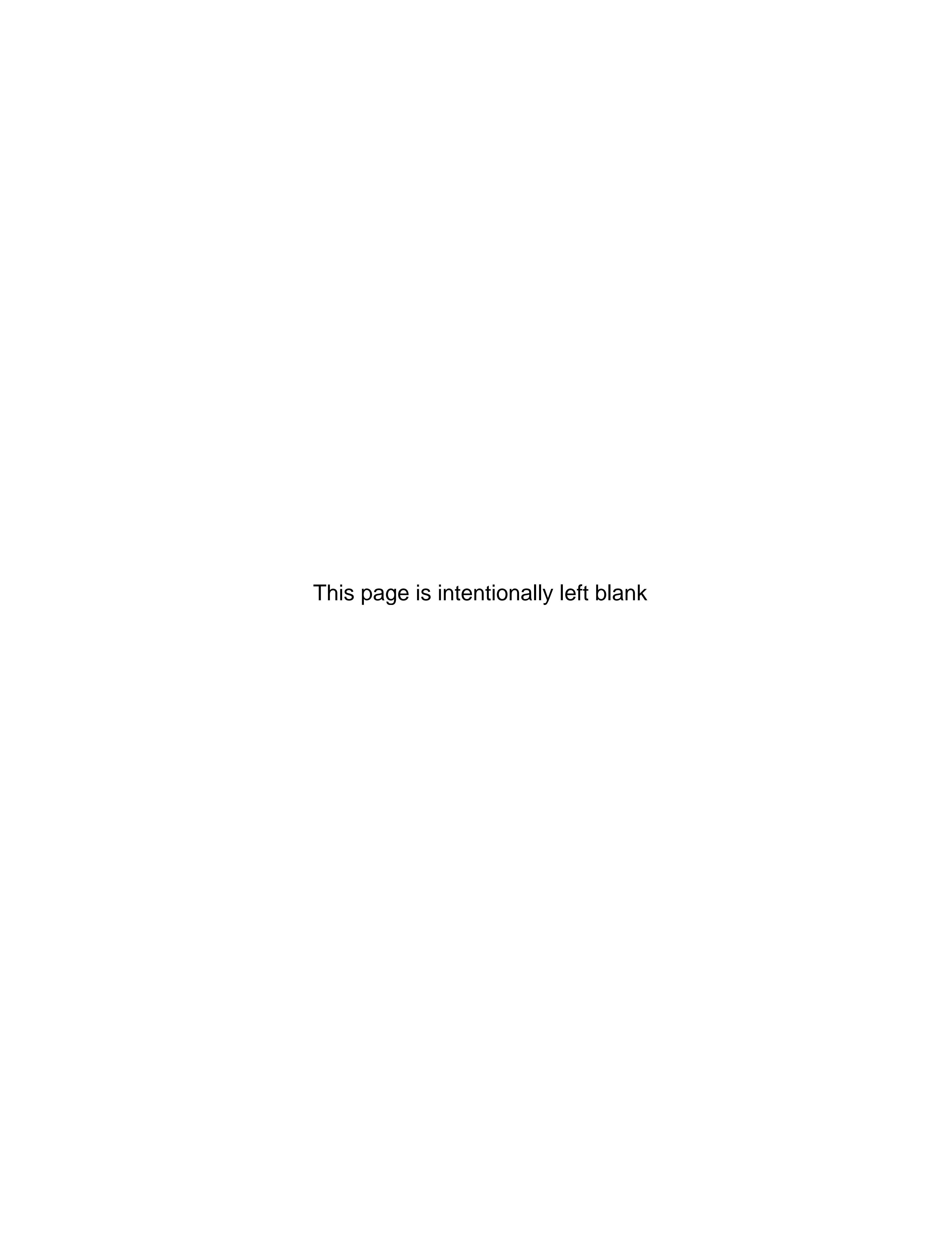
(b) Unrestricted funds

	Balance 1 April 2020 b/fwd	Resources expended	Incoming resources	**Balance 31 March 2021 c/fwd**
	£000	£000	£000	**£000**
Unrestricted- General Purpose Funds	464	(37)	180	**607**
	464	(37)	180	607

Name of Fund	**Description, nature and purpose of the fund**
North West Ambulance Service General Fund	This general fund represents the merger of general funds from the previous four Ambulance Trusts. This fund has general objects for any charitable purpose relating to the North West Ambulance Service NHS Trust or purposes relating to the National Health Service.

11 Post Balance Sheet Events

There were no post Balance Sheet events.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North West Ambulance Service NHS Trust

Charitable Fund

Unaudited Trustee's Annual Report &

Annual Accounts

For the Year to 31st March 2021

Registered Charity No. 1122470

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Reference and administrative details

Principal Office:	North West Ambulance Service NHS Trust Charitable Fund Ladybridge Hall Chorley New Road Bolton BL1 5DD
Registered Charity no:	1122470
Bankers:	National Westminster Bank PLC Preston Branch 35 Fishergate Preston PR1 3BH
Solicitors:	Hempsons The Exchange Station Parade Harrogate HG1 1DY
Independent Examiner:	Mark Surridge FCCA Mazars LLP First Floor 2 Chamberlain Square Birmingham B3 3AX

Foreword

The Corporate Trustee presents the Charitable Funds Report together with the Annual Accounts for the 12 months ended 31 March 2021. The Charity's report and accounts have been prepared by the Corporate Trustee in accordance with Part VI of the Charities Act 2011 and the Charities (Accounts & Reports) Regulations 2008.

The Charity's report and accounts include all the separately established funds for which the North West Ambulance Service NHS Trust is the sole beneficiary.

Structure, Governance and Management

CORPORATE TRUSTEE

The sole corporate trustee of the Charity is the North West Ambulance Service NHS Trust.

The North West Ambulance Service NHS Trust has been the Corporate Trustee of the charitable fund and its four predecessor charitable funds since 1 July 2006 and is governed by the law applicable to Trusts, principally the Charities Regulations 2008 and the Charities Act 2011.

The Corporate Trustee is managed by its Board of Directors which consists of executive and non-executive directors. It has responsibility for planning, directing and controlling the activities of the entity, ensuring that the NHS body fulfils its duties in managing the charitable funds.

Non-Executive Directors of the Trust Board are appointed by NHS Improvement on behalf of the Secretary of State and Executive Directors of the Board are subject to recruitment by the North West Ambulance Service NHS Trust Board of Directors.

The members of the North West Ambulance Service NHS Trust Board of Directors who served during the 12 months were as follows:

Peter White	Chair
Daren Mochrie	Chief Executive
Michael Forrest	Deputy Chief Executive
Carolyn Wood	Director of Finance
Ged Blezard	Director of Operations
Angela Wetton	Director of Corporate Affairs
Salman Desai	Director of Strategy & Planning
Maxine Power	Director of Quality, Innovation & Improvement
Lisa Ward	Interim Director of Organisational Development
	Director of People (from 1 August 2020)
Michael O'Connor	Non-Executive Director
Richard Groome	Non-Executive Director
David Rawsthorn	Non-Executive Director
David Hanley	Non-Executive Director
Alison Chambers	Non-Executive Director
Clare Wade	Associate Non-Executive Director (left 1 November 2020)
Rod Thomson	Associate Non-Executive Director
Gillian Singh	Associate Non-Executive Director (started 1 March 2021)

The Charitable funds were established by the Trust deed on 31st January 2007.

The Charitable Funds were registered with the Charity Commission (No. 1122470) on 25th January 2008 in accordance with the Charities Act 1993.

CHARITABLE FUNDS COMMITTEE

The North West Ambulance Service NHS Trust has been the Corporate Trustee of the charitable fund and its four predecessor charitable funds since 1 July 2006 and is governed by the law applicable to Trusts, principally the Charities Regulations 2008 and the Charities Act 2011.

The NHS Trust Board devolved responsibility for the management, monitoring and reviewing of the charitable funds of the Trust to the Charitable Funds Committee.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources.
- Provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of income.
- Ensure that 'best practice' is followed in the conduct of all its affairs fulfilling all of its legal responsibilities.
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The accounting records and the day to day administration of the funds are dealt with by the Finance Department located at Trust's Headquarters at Ladybridge Hall situated on Chorley New Road, Bolton.

The names of those people who served as members of the Charitable Funds Committee, as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990 for the 12 months to March 2021 were as follows:

David Rawsthorn	Non-Executive Director (Chair)
Richard Groome	Non-Executive Director
David Hanley	Non-Executive Director
Carolyn Wood	Director of Finance
Ged Blezard	Director of Operations
Angela Wetton	Director of Corporate Affairs

Salman Desai Director of Strategy and Planning
Lisa Ward Director of People

The Head of Technical Accounts attended the meetings along with Independent examiners.

SCHEME OF DELEGATION

For the period up to the 31st March 2021 the Trust Scheme of Delegation and level of authorised expenditure is detailed below in table 1.

Table 1, Scheme of Delegation to 31st March 2021:

Expenditure	Authorisation Limits
Up to £2,499	Deputy Director of Finance or Head of Technical Accounts or Director of Corporate Affairs
£2,500 to £24,999	Director of Finance or Chief Executive
Above £25,000	Board of Directors on behalf of Corporate Trustee

NOTE: In line with Charitable Funds Committee decision, with the exception of flowers and retirements expenditure, all other expenditure requests are authorised by the Director of Finance. The scheme of delegation above is for reference.

RESTRICTED AND UNRESTRICTED FUNDS

The charity's unrestricted fund was established using the model declaration of trust and all funds held on trust as at the date of registration were either part of this unrestricted fund or registered as separate restricted funds under the main charity. Subsequent donations and gifts received by the charity that are attributable to the original funds are added to those fund balances within the existing charity.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds the Trustee respects the wishes of the donors to benefit patient care and the good health and welfare of staff. Where funds have been received, which have specific restrictions set by the donor; a restricted fund has been established.

Funding held within the General or unrestricted legacy fund may be used in-line with the Charitable Aims as authorised by the Trustees without pre-existing or specific restrictions by donors or legators.

The charitable funds available for spending during the 12 months reporting period have been allocated to the charitable fund managed in accordance with the North West Ambulance Service NHS Trust Scheme of Delegation.

As at 31st March 2021 the charity comprised of 9 individual funds, namely:

Unrestricted Funds:

1. General Fund, including unrestricted legacies

North West Ambulance Service NHS Trust General Fund for use against charitable aims and unrestricted legacy funds that are designated funds without specific areas and purposes.

Restricted Funds:

2. Mayor of Wigan Rapid Response Vehicle Fund
3. Greater Manchester First Responders Fund
4. Lancashire First Responders Fund
5. Manchester First Responders Fund
6. Cheshire and Mersey Responders Fund
7. NHS Charities Together
8. Cardiac Smart Fund (regional)
9. Station Specific Funds

Charitable funds received by the charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

The Corporate Trustee is responsible for ensuring that all charity related activity is managed effectively and it is therefore essential that key objectives are met, with actions implemented to safeguard the charity's funds and assets.

Objectives and Strategy

The objectives of the Charitable Fund are defined in the Trust Deed as:

"For the general or specific purposes of North West Ambulance Service NHS Trust or for a charitable purpose or purposes relating to the National Health Service"

The aim of the North West Ambulance Service (NWAS) Charitable Trust is to fund education, projects and equipment to further benefit the health and wellbeing and safety of patients, staff and the wider community over and above the services that the Trust is commissioned to provide.

Core Charity Priorities:

1. To provide equipment, uniform and training for our volunteer Community First Responders
2. To build awareness of life-saving skills and defibrillators in our communities
3. To support NWAS staff with new equipment and better working environments

Policies, procedures and reserves are regularly reviewed as the charitable trust remains committed to ensuring that there are sufficient funds to secure its objectives.

Public Interest Benefit

The Corporate Trustee ensures that the *public interest benefit criteria*, as detailed in the Charities Act 2011, are met by critically assessing each request for expenditure presented to the charity. Applications can be made by any member of North West Ambulance NHS Trust Staff with prior authorisation of their line manager and applications are only restricted by the availability of funds, the quality of the application and that the application meets the Charitable Aims of the Charity.

Where possible, funds are used to provide benefit to a wide range of patients, and funds used for staff enablement are allocated to projects where a benefit to staff and/or patients can be demonstrated.

Reserve Policy

In accordance with Charity Commission guidance, the Corporate Trustee acknowledges that there is a requirement to hold reserves. The reserves policy should take into account future commitments from the general unrestricted funds held by the Charity. Assuming that funds have been designated appropriately and will be spent within a reasonable timescale the charity should not rely on the unrestricted designated funds for the absorption of overheads on a continuing basis. Therefore the level of reserves held in the general unrestricted funds of the charity should be sufficient to cover the annual support costs and overheads of the charity.

The charity approves expenditure on a case by case basis taking into account the level of funds available and the Corporate Trustee reserves the right to cancel any past delegation and transfer monies to the general unrestricted funds of the Charity. This may be considered where designated funds have not been spent within a reasonable timescale or where the original purpose of the designation no longer exists. Likewise the Corporate Trustee may choose to designate funds for a particular purpose.

Level of reserves
As at 31st March 2021 the Corporate Trustee considers that a six month minimum reserve of £35k in the unrestricted general purpose fund should be permanently maintained.

MONITORING
The Director of Finance and Head of Technical Accounts report on the progress of the reserves and make recommendations to the Charitable Funds Committee in order to comply with the policy. The Charitable Funds Committee has the authority to vary the minimum level of reserves.

Investment Policy

Where NHS charitable funds have surplus monies in excess of the minimum reserves plus those required to fund commitments that have not yet been realised, Trustees may elect to invest some or this entire surplus in order to generate additional income to fund future charitable activities.

Cash surpluses shall be held only in such public or private sector investments as approved by the Secretary of State and authorised by the Trustees and reviewed periodically.

The Financial Accountant is responsible for periodically reporting the cash balances to the Director of Finance and the options available for investment. The Director of Finance is responsible for authorising the investment of any trust funds.

Annual Review of Income and Expenditure 2020-2021

The net assets of the Charitable Funds as of 31st March 2021 are £963k.

Overall net assets increased by £163k being the excess of income £354k over expenditure £191k.

The general fund has received £180k in income, while restricted funds income amounted to £174k (£354k total).

Total expenditure of £191k was spent as follows:

- £188k on direct charitable activity;
- £3k on support costs;

Direct charitable activity expenditure included:

- Purchase of new equipment, £112k (mainly defibrillators);
- Staff Education and Welfare, £76k;

COVID-19 Donations

NHS Charities Together Donations

During 2020/21, the Charity received significant donations from NHS Charities Together as a result of Captain Sir Tom Moore (Captain Tom) walking laps of his garden in aid of NHS Charities Together with the goal of raising £1,000 by his 100th birthday which attracted over 1.5 million donations. He also featured in a cover version of You'll Never Walk Alone and the proceeds also went to NHS Charities Together and managed to raise £32.79 million by his 100th birthday. All members of NHS Charities Together received a proportion of the funds raised and the NWAS Charity received a total of £77,500 in April 2020, with a further donation of £50,000 received in December 2020.

The purpose of the donations was to improve staff and volunteers health and wellbeing during the COVID-19 pandemic. To date through the money donated solely by NHS Charities Together, the Trust has been able to fund the following projects. Some of these initiatives have been delivered during the reporting period, however due to the impact on resource levels to identify and deliver projects, these will continue to be delivered throughout 2021/22.

- **Welfare Vehicles**

  To support staff welfare and wellbeing through the COVID19 Wave 2 and 2020/21 Winter Period, vehicles were hired from Arnold Clark to provide dedicated welfare vehicles located at 'hot spot' hospital sites to support PES and PTS staff with hot drinks and snacks, concentrating on peak hours of 12:00-00:00, but local management teams given the flexibility

to tailor to their local staff needs. The welfare vehicles included a wider provisions offering including individually wrapped confectionary products, cereal bars, instant hot soups and large hot water dispensing flasks.

- Insulated Water Bottles for Community First Responders
- Picnic Benches and Seats for staff at Ambulance Stations.
- **Manchester Stress Institute: 4 week Resilience Programme for 20 Managers:**
  A Health and Wellbeing Initiative to support Managers during the recovery phase of COVID. A bespoke coaching transformation programme designed to improve resilience, performance and recover of staff when working under pressure. Programme to include 4 private consultations, 1 performance coach and a private consultation with a hypnotherapist and a Kickstarter Wellbeing Programme to supplement the plan consisting of Reboot the Adrenal Glands; Boost Energy; Improvement Digestion; Enhance Sleep; Increase concentration and Boost Memory. This project is planned for delivery during 2021/22.
- **Manchester Stress Institute 4 week Burnout Programme for Staff:**
  A Health and Wellbeing Initiative to support all staff during the recovery phase of Covid. Targeted on burnout and stress, this is a 4 week programme accessible via x 4 weekly live webinars that staff can attend and content is recorded and made available digitally for all staff to access. This project is planned for delivery during 2021/22.

In addition, during April 2020, Winifred Page set up her own challenge by walking 100 lengths of her driveway before turning 100 and managed to raise a total of £19,145. At her request all funds will be restricted for use by Patient Transport Services.

Stage 2 - Grant Award to Ambulance Charities

In February 2021, the charity submitted a grant application to NHS Charities Together as NHS Charities Together identified a further £7m allocated by population across all the ambulance charities in England, Wales, Scotland and Northern Ireland. The funds were received during April 2021 and will be accounted for in the 2021/22 annual report.

The projects will be delivered over a 2 year period and the details are as follows:

1. **Equip CFRs with Mangar Elk Lifting Cushions**
   This will enable CFRs to give early assistance to patients who have experienced a non-injury fall, reducing potential complications associated with long lies and prevent a double crewed ambulance (DCA) from attending the patient.

2. **Supply and install 125 community public access defibrillators (CPADs)**
   25 CPADs per county will be placed in areas that need it most. CPADs are accessed by calling the ambulance service via 999 where the caller will be given the nearest address for a CPAD and the code to unlock the cabinet, whilst emergency crew is dispatched simultaneously. Providing emergency life support skills (basic life support) and access to early defibrillation within the first 4 minutes during out of hospital cardiac arrest increases the chances of survival to 80%.

3. **Purchase of JRCALC CFR Plus App**
   1,000 licences to be purchased which will enable the integration of the app and provide community first responders with additional updated resources on how to deal with medical emergencies, enhancing their knowledge and skills.

4. **Appoint 3 x Community Engagement Officers**
   To appoint 3 x Community Engagement Officers to engage with hard to reach communities in Liverpool, Blackburn/Burnley and Greater Manchester for a two year period. It is hoped this will develop community first responder schemes within hard-to-reach communities to help to ensure that community first responder and bystander care can be delivered quickly across the whole region.

5. **To increase youth representation on the Patient and Public Panel (PPP)**
   To increase youth involvement on the PPP to enhance career prospects and create potential employees for the NHS.

6. **To develop an online youth zone**
   By creating a dedicated online youth zone, teachers/group leaders will benefit from having access to online resources in order to deliver sessions. The creation of a new online resource hub

supports the trust in providing a digital offering to communities to continue important engagement work.

Projects Supported 2020/2021

The Charity continues to support and fund many projects authorised in line with the Scheme of Delegation. Projects supported during 2020/2021 included:

- CFR Training Equipment
  The training equipment was required for new CFR courses within in Cumbria. The equipment included:
  - An anti-choking trainer worn by students in CPR to learn the Abdominal Thrust Manoeuvre (Heimlich). The trainer includes a foam back slap pad to allow students to practice backslaps as recommended by the UK Resuscitation Council and practice choking rescue protocols.
  - A Laerdal Resusci Anne: an adult CPR training manikin with multiple feedback options that provide opportunity to focus on student competency.
- AEDs & CPADs
- The charity provided funding for the provision of Community Public Access Defibrillators (CPADs) and Automated External Defibrillators (AED). CPADs are placed into lockable steel, heated cabinets on the external of buildings and AEDs are located within buildings and require no additional power or heating. The use of a CPAD/AED with effective CPR (Cardio Pulmonary Resuscitation) increases ROSC (Return of Spontaneous Circulation) from c.5% to a potential 75% for out of hospital cardiac arrests.
- Resusci Anne Manikins
- Chocolates for PTS Volunteer Car Drivers
  To thank PTS volunteers who provided their services during the pandemic. The volunteers have been flexible and adaptable to all the changes implemented as a result of COVID-19.
- Two full Community First Responder kits including defibrillators were purchased to equip new Community Responder Teams in Lancashire.
- Plants for ambulance stations
  Plants for the rest areas at ambulance stations within East Lancashire to improve the environments during crew rest breaks aiding health and well-being.
- Printing Charges – supporting Central Manchester Ambulance Football Club
- To print the NWAS Charity logo onto the Central Manchester Ambulance Football Club kits to enter into the Emergency Service Football League. The football club was created to assist with health and well-being and camaraderie at the ambulance station and has improved the moral of the whole ambulance station.
- Refreshments for CFR CPD event

In addition to these projects and equipment purchases, the charity also funded gifts/buffets or flowers for:

- 33 retirements
- 4 babies
- 12 bereavements/death in service

Future Plans

The Charitable Funds Strategy was updated during the reporting period to reflect the current position of the charity. The future development of the Charity will be investigated during 2021/22.

ACKNOWLEDGEMENT

The Corporate Trustee would like to extend its sincere appreciation to those that have contributed to the charitable funds through fundraising, donating, leaving legacies or gifts in lieu.

Particular gratitude is extended to those who donate to the charity in times of personal bereavement or loss.

We also take this time to thank corporate sponsors and grant giving trusts that have supported the charity during 2020/21 with fundraising activities, promotions or awarding of grant funding for or acceptance of projects and initiatives. We thank them and welcome their support for future years.

The Corporate Trustee would also like to thank and acknowledge the support of our amazing staff and volunteers across the Trust.

Approved on behalf of the Corporate Trustee.

………………………………………………………………………………….. Dated ……xx November 2021…………………

Daren Mochrie

Chief Executive – North West Ambulance Service NHS Trust

Statement of Trustee's Responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and
- Reports) Regulations and the provisions of the trust deed; and Safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The Charity trustees having given consideration to the major risks to which the charity is exposed and satisfied themselves that systems or procedures are established in order to manage those risks. (Charities (Accounts and Reports Regulations 2008). The financial statements set out have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee and signed on its behalf by:

…………………………………………………………………………………… Dated: …………………………………………….

Peter White
Chairman, Board of Directors - North West Ambulance Service NHS Trust

…………………………………………………………………………………… Dated: ……………………………………………

Carolyn Wood, Director of Finance - North West Ambulance Service NHS Trust

Mazars LLP
Two Chamberlain Square
Birmingham B3 3AX

Dear Sir/Madam,

North West Ambulance Service NHS Trust Charitable Fund – independent examination of the financial statements for the year ended 31st March 2021

This representation letter is provided in connection with your Independent Examination of the financial statements of the Fund for the year ended 31st March 2021.

We confirm that the following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience (and, where appropriate, inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

Our responsibility for the financial statements and accounting information

We believe that we have fulfilled our responsibilities for the true and fair presentation and preparation of the financial statements in accordance with applicable law and the applicable Financial Reporting Framework.

Our responsibility to provide and disclose relevant information

We have provided you with:

- access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other material;
- additional information that you have requested from us for the purpose of the Independent Examination; and
- unrestricted access to individuals within the charity you determined it was necessary to contact in order to obtain Independent Examination evidence.

We confirm as trustees that we have taken all the necessary steps to make us aware, as trustees, of any relevant Independent Examination information and to establish that you, as examiners, are aware of this information.

As far as we are aware there is no relevant information of which you, as examiners, are unaware.

Accounting records

We confirm that all transactions undertaken by the charity have been properly recorded in the accounting records and are reflected in the financial statements. All other records and related information, including minutes of all management and trustee meetings, have been made available to you.

Accounting policies

We confirm that we have reviewed the accounting policies applied during the year in accordance with the requirements of applicable law and applicable Financial Report Framework and consider them appropriate for the year.

Accounting estimates, including those measured at fair value

We confirm that any significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Contingencies

There are no material contingent losses including pending or potential litigation that should be accrued where:

 information presently available indicates that it is probable that an asset has been impaired or a liability had been incurred at the balance sheet date; and the amount of the loss can be reasonably estimated.
There are no material contingent losses that should be disclosed where, although either or both the conditions specified above are not met, there is a reasonable possibility that a loss, or a loss greater than that accrued, may have been incurred at the balance sheet date.

There are no contingent gains which should be disclosed.

All material matters, including unasserted claims, that may result in litigation against the charity have been brought to your attention. All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to you and accounted for and disclosed in accordance with applicable law and applicable Financial Reporting Framework.

Laws and regulations

We confirm that we have disclosed to you all those events of which we are aware which involve known or suspected non-compliance with laws and regulations, together with the actual or contingent consequences which may arise therefrom.

We have complied with all aspects of contractual agreements that would have a material effect on the accounts in the event of non-compliance.

Fraud and error

We acknowledge our responsibility as trustees of the charity, for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

We have disclosed to you:

- all the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- all knowledge of fraud or suspected fraud affecting the entity involving:
- management and those charged with governance;
- employees who have significant roles in internal control; and
- others where fraud could have a material effect on the financial statements.

We have disclosed to you all information in relation to any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Related party transactions

We confirm that all related party relationships, transactions and balances, (including sales, purchases, loans, transfers, leasing arrangements and guarantees) have been appropriately accounted for and

disclosed in accordance with the requirements of applicable law and the applicable Financial Reporting Framework.

We have disclosed to you the identity of the charity's related parties and all related party relationships and transactions of which we are aware.

Impairment review

To the best of our knowledge, there is nothing to indicate that there is a permanent reduction in the recoverable amount of the fixed assets below their carrying value at the balance sheet date. An impairment review is therefore not considered necessary.

Charges on assets

All the charity's assets are free from any charges exercisable by third parties except as disclosed within the financial statements.

Future commitments

We have no plans, intentions or commitments that may materially affect the carrying value or classification of assets and liabilities or give rise to additional liabilities.

COVID-19

We have considered the uncertainty associated with the company's future prospects, trading performance and funding in regard to COVID-19 and are not aware of any significant impact to the business as a result. We confirm that provisions in relation to the business impact of COVID-19 have been recognised in the accounts as appropriate. We confirm that we have paid particular attention to the going concern status of the company and whether there are any events after the balance sheet date that would require highlighting to you.

Subsequent events

We confirm all events subsequent to the date of the financial statements and for which the applicable law and applicable Financial Reporting Framework require adjustment or disclosure have been adjusted or disclosed.

Should further material events occur after the date of this letter which may necessitate revision of the figures included in the financial statements or inclusion of a note thereto, we will advise you accordingly.

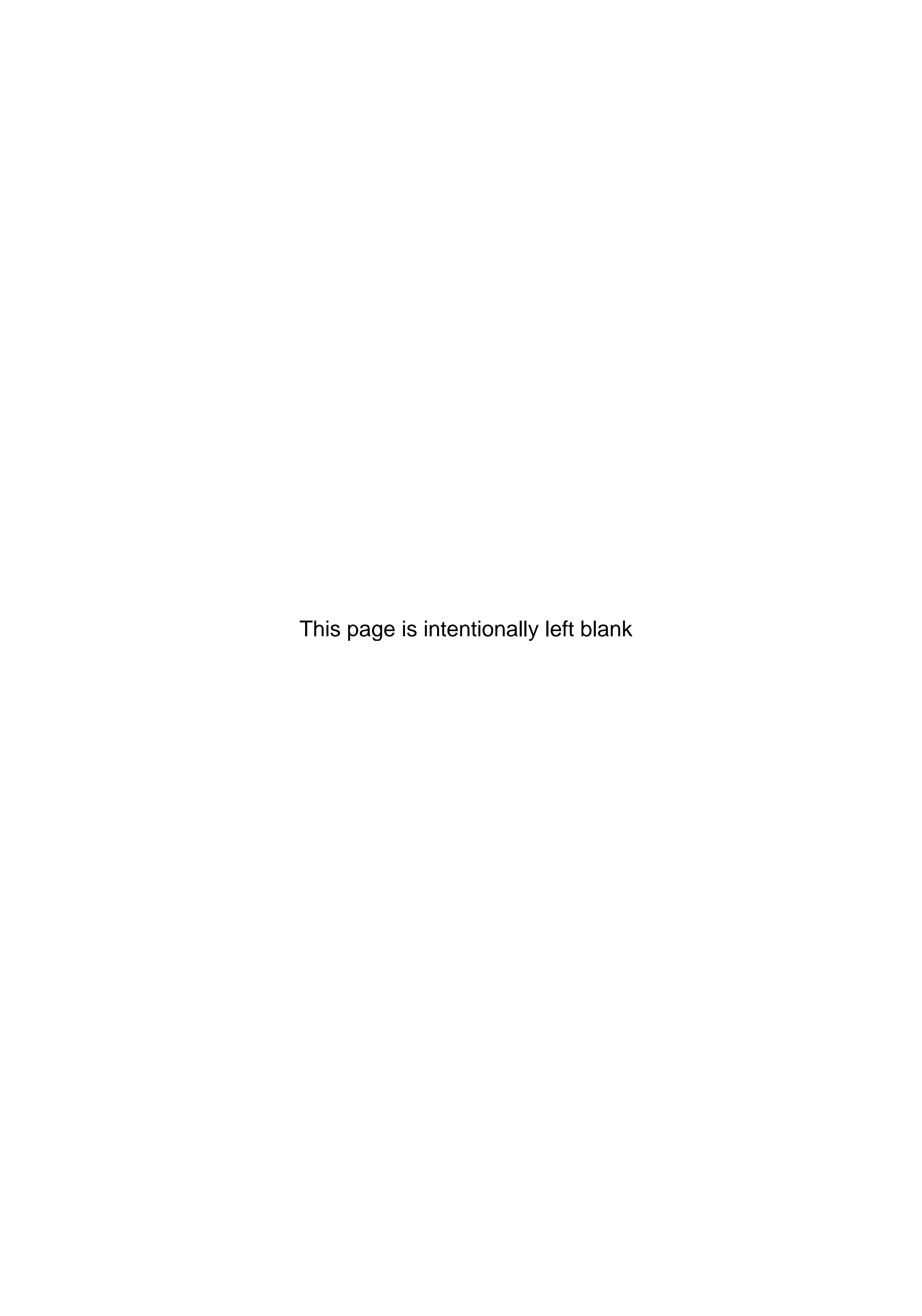
Audit requirement

We confirm that there are no specific requirements for an audit to be carried out in the governing document of the charity, in any special trusts associated with the charity or as a condition of any grants made to the charity.

Yours faithfully

Trustee …………………………….

Date ………………………………..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Statement of Trustee's Responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the Charity's financial activities during the year, and of its financial position at the end of the year. In preparing financial statements that give a true and fair view, the Trustee should follow best practice and:

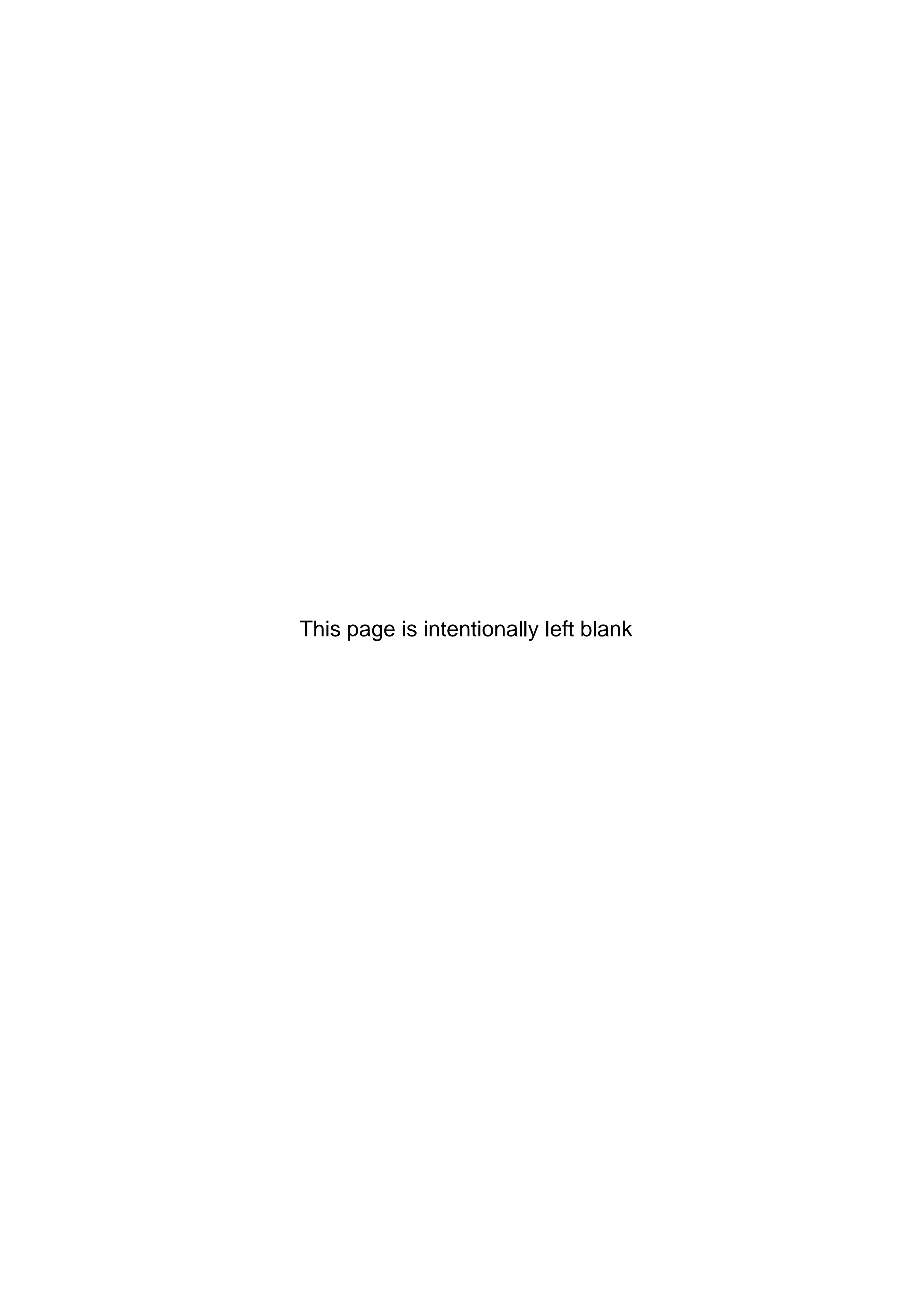
- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation;
- keep proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Charity, and which enables the Trustee to ensure that the financial statements comply with the requirements in the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed; and
- safeguard the assets of the Charity, therefore taking reasonable steps in the prevention and detection of fraud and other irregularities.

The Corporate Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The Charity trustees having given consideration to the major risks to which the charity is exposed and satisfied themselves that systems or procedures are established in order to manage those risks. (Charities (Accounts and Reports Regulations 2008). The financial statements set out have been compiled from, and are in accordance with, the financial records maintained by the Corporate Trustee.

Approved by the Corporate Trustee and signed on its behalf by:

……………………………………………………………………………… Dated: …………………………………………….
Peter White
Chairman, Board of Directors - North West Ambulance Service NHS Trust

……………………………………………………………………………… Dated: …………………………………………….
Carolyn Wood, Director of Finance - North West Ambulance Service NHS Trust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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Charitable Funds Committee			
Date of Meeting:	27th October 2021	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Leads:**	Carolyn Wood, Director of Finance Angela Wetton, Director of Corporate Affairs
Members Present:	Mr G Blezard, Director of Operations Mr S Desai, Director of Strategy, Partnerships & Integration Mr R Groome, Non-Executive Director Dr D Hanley, Non-Executive Director Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs C Wood, Director of Finance	**Key Members Not Present:**	All present

Link to Board Assurance Framework (Strategic Risks): N/A

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

Key	
(red)	No assurance - could have a significant impact on quality, operational, workforce or financial performance
(amber)	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
(green)	Assured – no or minor impact on quality, operational, workforce or financial performance

Annual Report & Accounts 2021/22	The Committee received the Annual Report and Accounts for 2020/21 for onward recommendation to the Board of Directors. Information to be provided to the next meeting relating to steps taken or that could be taken to try and increase expenditure from restricted funds or legal reclassify restricted funds.	Recommended for onward Board approval on behalf on the Corporate Trustee.	
Letter of Representation & Statement of Trustees Responsibilities	As part of sign-off of the Annual Accounts and Annual Report for 2020/21, , the Committee reviewed the Letter of Representation and Statement of Trustees Responsibilities prior to recommendation to the Board of Directors on behalf of the Corporate Trustee.	Recommended the adoption of the Letter of Representation and Statement of Trustees Responsibilities to the Board of Directors for sign off on behalf of the Corporate Trustee.	
Letter of Independence	The Committee were presented with the Letter of Engagement which confirmed the external examiner's independence.	Noted the assurance provided.	
Independent Examiners Report on the Annual Accounts 2020/21	The Committee received the Independent Examination Report and noted there were no matters to report and no concerns to highlight to the Committee.	Noted the assurances provided.	
Charitable Funds Half Year Update 2021/22	The Committee noted: • Income received by the charitable funds year to date amounted to £731k: – £30k unrestricted – £701k restricted with £687 via NHS Charities Together	Noted the assurances provided.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
	Assured – no or minor impact on quality, operational, workforce or financial performance

	• Expenditure during the same period amounted to £74k. • Therefore as at the 31 September 2021, the total available resource is £1.621k: – £614k unrestricted – £1.007k restricted • The largest item of expenditure was for the purchase of medical equipment, mainly defibrillators. The Committee noted the areas of spend for the Stage 1 funding relating to NHS Charities Together.		

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
	Assured – no or minor impact on quality, operational, workforce or financial performance

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CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	22nd October 2021	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Prof R Thomson, Associate Non-Executive Director	**Key Members Not Present:**	
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Clinical Governance-Quality and Performance Chair's Assurance Reports	The Committee received the Chairs Assurance Reports from the meetings held on 24th May 2021 and 27th July 2021 and items relating to Clinical Governance.	Noted the assurance provided within the reports.	
Clinical Audit Q1 2021/22 Progress Report	The Deputy Director of Quality presented the Clinical Audit Q1 2021/22 update to the Committee.	Noted the assurance provided.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
	Assured – no or minor impact on quality, operational, workforce or financial performance

Critical and High Risk Recommendations	MIAA continued to follow up recommendations. It was noted 2 high risk recommendations remain outstanding and partially implemented relating to Freedom To Speak Up and one relating to Data Quality which is due for completion in March 2022.	Noted the update provided.	
Internal Audit Progress Report Q2 2021/22	The Committee noted the assurance reviews completed within Q2: Mandatory Training – Substantial Assurance Recording of Staff Hours – Substantial Assurance Assurance Framework Stage 1 – review completed Risk Management – Substantial Assurance Data Security Protection Toolkit (DSPT) – Substantial/Moderate Assurance	Noted the assurances provided.	
Internal Audit Follow Up	The Committee noted the good progress within the reporting period and that 5 recommendations were followed up during the period.	Noted the assurance provided.	
Anti-Fraud Progress Report	The Committee received the Anti-Fraud Progress Report outlining the wide range of activities undertaken in relation to Strategic Governance; Inform and Involve; Prevent and Deter and Hold to Account since the last meeting.	Noted the assurance provided.	
External Audit Progress Report and Technical Update	The Committee noted the Audit Strategy Memorandum would be presented to the next meeting. It was noted the timeline for the 2021/22 audit assumed a return to pre-Covid deadlines.	Noted the assurances provided.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
	Assured – no or minor impact on quality, operational, workforce or financial performance

Board Assurance Framework Q2 2021/22	The Committee received the updated BAF prior to submission to the Board of Directors for approval on 24th November 2021. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurances provided.	
Losses and Compensation Report	The losses and compensations position year to date totalled £483k.	Noted the assurances provided.	
Waiver of Standing Orders Q2 2021/22	A total of seven waivers were approved during Q2 2021/22.	Noted the assurances provided.	
Chairs Assurance Report – Resources Committee	The Committee received the report from the meeting held on 24th September 2021. The Committee now has sight of the work undertaken by both the Resources Committee and Quality and Performance Committee through the Chairs Assurance reports for those committees. This means that good practice, as set out in the HfMA NHS Audit Committee Handbook, is followed.	Noted the assurances provided.	
Chair's Assurance Reports – Information Governance Sub Committee	The Committee received reports from the meetings held on 23rd August 2021 and 12th October 2021.	Noted the assurances provided.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
	Moderate assurance – potential moderate impact on quality, operational, workforce or financial performance
	Assured – no or minor impact on quality, operational, workforce or financial performance

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NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	24/11/2021			
SUBJECT:	Integrated Performance Report			
PRESENTED BY:	Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			

EXECUTIVE SUMMARY:

The Integrated Performance Report for November 2021 shows performance on Quality, Effectiveness, Finance Operational Performance and Organisational Health during **October 2021** unless otherwise stated.

Quality

- 201 complaints were received, against a 12 month average of 175 per month.
- 61% of complaints risk scored 1-2, 59% of level 3 and 25% of level 4-5 complaints were closed within the agreed time frames.
- A plan is in place to address the complaints backlog which rose to 203 at the beginning of September and fallen to 108 at the end of October.
- During September and October 2021 there were 15 serious safety incidents reported on the StEIS database (10 in September and 5 in October).
- There were 9 new safety alerts. One safety alert is applicable and is being managed.
- In October 2021, 1,128 internal and external safety incidents were opened against a 12-month average of 1,383, with an additional 76 still to be scored.
- Content analysis of safety incidents by type shows that the top two reasons (by volume) are incidents associated with 111 services or staff welfare.

Effectiveness

- **Patient experience:** PES and 111 have seen a decrease in returns (1.9% and 6.1% respectively) with PTS having seen an increase in returns of 19.8%. All three have seen an increase in satisfaction levels compared to last month (1.5%, 0.9% and 1% respectively).

- This report contains a high level summary of the experience of patients using NHS 111 First, which shows a decrease in responses (117 to 82) but a marginal increase in satisfaction (85.3% to 87.5%) in October compared to September.

Ambulance Clinical Quality Indicators (ACQI's):

Cardiac Outcomes

- **Return of spontaneous circulation (ROSC)** achieved for the Utstein group was 58.1% (national mean 46%). For the overall group the rate was 26.6% (national mean 25.7%).
- **Survival to Discharge** rates in June 2021 were higher than the previous month at 7.4%. Although the data remain within control limits and so this does not represent a significant change.
- In June 39.3% of patients in the Utstein group survived to hospital discharge, significantly higher than the previous month the national mean at 26.9%. This remains within the control limits.

- **H&T, S&T, S&C:** For October we achieved 8.9% Hear and Treat, 31.7% See and Treat and an aggregate non-conveyance of 40.6%.

Finance

- The year to date expenditure on agency is £2.753m which is £0.939m above the year to date ceiling of £1.814m.
- As at month 7 the trust is reporting a deficit position for the year to date, however the income level for H2 (01 October 2021-31 March 2022) was not agreed at the time of closure and it is expected the trust will return to approximately break-even once final income levels are agreed and H2 planning is concluded in line with national deadlines.
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- **Activity:** In October 2021, the Trust received 152,673 calls of which 92,879 became incidents. Compared with October 2019, we have seen a 24% increase in calls and a 6% decrease in incidents. The decrease in incidents is due to the use of signposting to self-transport or other services.
- **Call volume:** call volume is 25% above the equivalent month for 2020 and 2019.
- **Duplicate calls** are the most significant contributory factor to the increase in call volume. October's average daily duplicate call volumes equate to 1,552 per day and an increase of 94 duplicate calls per day compared with September 21.

- **Call Pick Up** has been adversely affected by call volume and performance was 61.2% (target 95%). and has deteriorated slightly from the September 2021 position.

Ambulance Response (ARP) Performance

	Standard	Actual
C1 (Mean)	7:00	9:14
C1 (90th)	15:00	15:33
C2 (Mean)	18:00	1:07:42
C2 (90th)	40:00	2:28:44
C3 (Mean)	1:00:00	4:06:33
C3 (90th)	2:00:00	10:27:54

- For October, response time targets were not met for any ARP category.
- The trust has taken a number of measures to improve performance and maintain patient safety including a robust winter plan and an agreed 6 point plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services. The aim of this plan is to optimise existing operational resource. This is being supplemented with additional investment of £6.2m in additional staff, vehicles and winter schemes. Details are included in this report.

Handover

- Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 39:27. This is the fifth consecutive month the trust has been above the standard and the sixth time since January. 4,490 attendances (11.8%) had a turnaround time of over 1 hour, with 374 of those taking more than 3 hours. 1,481 hours were lost to delayed admissions in June up from 1,379 in September.

C1 & C2 Long Waits

- The number of C2 long waits has risen sharply in October with over 20,000 patients waiting more than 60 minutes. This is a significant patient safety concern and measures in place to continuously review patients who are waiting through the clinical control desk which are helping but not eliminating the risk.

NHS 111

	Standard	Actual
Calls Within 60s	95%	24.33%
Average Time to answer		11m 24s
Abandoned Calls	<5%	31.98%
Call back Within 10 min	75%	4.69%
Average Call Back		2 hour 2min
Warm Transfer to Nurse	75%	0.71%

- Call volume remains high. The gap between activity and resource continues to be as high as 50% at various points of the day.
- The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target. Safety measures are in place. Increase demand during out of hours (OOH) operation are leading to increased call volume and conversations between CCGs and OOH provides are taking place. Work is ongoing to review options with Pathways (nationally) about increased self care and call truncation.

PTS

- Due to reporting timing issues PTS performance is reported one month in arrears.
- Activity in September for the Trust was 21% below contract baselines, whilst the year to date position (July 2021 – September 2021) is performing at 23% below baseline.

Organisational Health

- **Sickness:** The overall sickness absence rate for the latest reporting month (September 2021) was 9.97% including COVID related sickness of 1.4%. Additional resource has been identified to provide additional focus on managing attendance and wellbeing.
- **Turnover** was 10.93% with the main increases arising in call centres which mirrors national trends.
- Agency: Due to the impact of Covid-19 agency costs at the trust stands at 1.7% in October.
- **Vacancy**: Positions across the trust are under establishment by 2.37%. This is mainly as a result of establishment changes and turnover in 111 and vacancies in PTS. EOC are over-established by 24%
- **Appraisal**: The overall appraisal completion rate improved to 65.50% against a revised trust target

	of 75% by March 2022 for the service lines and to 85% by March 2022 for Corporate and band 8a and above. • **Mandatory Training:** A new cycle of mandatory training started in April with additional online topics included and a new classroom cycle. The starting Trust compliance position was 63% in April 21 as a result new topics being added. This rate will build during the year but has been impacted by pauses in mandatory training at Reap 4. We are currently off track at 63% against the agreed ELC target of 87% overall by March 2022. This target is made up of 85% for service lines and 95% Corporate services by March 2022. A recovery plan for classroom training has been implemented and this will run in parallel with a focus on recovery of online completion. **COVID 19** 108 staff have tested positive for Covid-19 in October 2021 . At the end of this reporting period, there were 3 open outbreaks on Trust sites.
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the increased demand across all service lines and the impact of this demand on quality, performance and workforce. • Note the ongoing work to maintain patient safety and regulatory compliance and mitigate the impact of increased demand and long waits. • Note the continued high performance on the patient reported friends and family test across all service lines. • Note the deficit position for the year to date, and and the plan to break-even once final income levels are agreed. • Note the plans in place to improve mandatory training and appraisal compliance. • Note the plans in place to close recruit more staff across all service lines and close the vacancy gap. • Note the partnership delivery of a whole system 6 point improvement plan to optimise performance. • Note the controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively. • Clarify any items for further scrutiny through the appropriate assurance committee

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

PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee	
	Date:	22/11/2021
	Outcome:	Not known at time of submission

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **October 2021**. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

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

2. SUMMARY

Quality

- 201 complaints were received, against a 12 month average of 175 per month.
- 61% of complaints risk scored 1-2, 59% of level 3 and 25% of level 4-5 complaints were closed within the agreed time frames.
- A plan is in place to address the complaints backlog which rose to 203 at the beginning of September and fallen to 108 at the end of October.
- During September and October 2021 there were 15 serious safety incidents reported on the StEIS database (10 in September and 5 in October).
- There were 9 new safety alerts. One safety alert is applicable and is being managed.
- In October 2021, 1,128 internal and external safety incidents were opened (Q2.1 and Q2.2) against a 12-month average of 1,383, with an additional 76 still to be scored.
- Content analysis of safety incidents by type shows that the top two reasons (by volume) are incidents associated with 111 services or staff welfare.

Effectiveness

- **Patient experience:** PES and 111 have seen a decrease in returns (1.9% and 6.1% respectively) with PTS having seen an increase in returns of 19.8%. All three have seen an increase in satisfaction levels compared to last month (1.5%, 0.9% and 1% respectively).
- This report contains a high level summary of the experience of patients using NHS 111 First, which shows a decrease in responses (117 to 82) but a marginal increase in satisfaction (85.3% to 87.5%) in October compared to September.

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- As at month 7 the trust is reporting a deficit position for the year to date, however the income level for H2 (01 October 2021-31 March 2022) was not agreed at the time of closure and it is expected the trust will return to approximately break-even once final income levels are agreed, as part of the conclusion of H2 planning.
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- **Activity:** In October 2021, the Trust received 152,673 calls of which 92,879 became incidents. Compared with October 2019, we have seen a 24% increase in calls and a 6% decrease in incidents. The decrease in incidents is due to the increased use of signposting to self-transport or others services.
- **Call volume:** call volume is 25% above the equivalent month for 2020 and 2019.
- **Duplicate calls** are the most significant contributory factor to the increase in call volume. October's average daily duplicate call volumes equate to 1,552 per day and an increase of 94 duplicate calls per day compared with September 21.
- **Call Pick Up** has been adversely affected by call volume and performance was 61.2% (target 95%). and has deteriorated slightly from the previous month.
- **Acuity:** over recent months we have seen increasing acuity of our patients. C1 calls have risen from 9% to 17%, C2 calls have risen from 52% to 56%. This means that 73% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat.

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- NWAS are working with AACE to understand the increase in acuity. All trusts have seen an increase but not to the same extent as NWAS.

Handover

- Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 39:27. This is the fifth consecutive month the trust has been above the standard and the sixth time since January. 4,490 attendances (11.8%) had a turnaround time of over 1 hour, with 374 of those taking more than 3 hours. 1,481 hours were lost to delayed admissions in June up from 1,379 in September.

C1 & C2 Long Waits

- The number of C2 long waits has risen sharply in October with over 20,000 patients waiting more than 60 minutes. This is a significant patient safety concern and measures in place to continuously review patients who are waiting through the clinical control desk which are helping but not eliminating the risk.

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- The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target. Safety measures are in place. Increase demand during out of hours (OOH) operation are leading to increased call volume and

conversations between CCGs and OOH provides are taking place. Work is ongoing to review options with Pathways (nationally) about increased self care and call truncation.

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- **Sickness:** The overall sickness absence rate for the latest reporting month (September 2021) was 9.97% including COVID related sickness of 1.4%. Additional resource has been identified to provide additional focus on managing attendance and wellbeing.
- **Turnover** was 10.93% with the main increases arising in call centres which mirrors national trends.
- **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 1.7% in October.
- **Vacancy**: Positions across the trust are under establishment by 2.37%. This is mainly as a result of establishment changes and turnover in 111 and vacancies in PTS following the use of PTS staff on PES. EOC are over-established by 24% and PES are fully staffed.
- **Appraisal**: The overall appraisal completion rate was improved at 65.50% against a revised trust target of 75% by March 2022 for the service lines and to 85% by March 2022 for Corporate and band 8a and above.
- **Mandatory Training:** A new cycle of mandatory training started in April with additional online topics included and a new classroom cycle. The starting Trust compliance position was 63% in April 21 as a result new topics being added. This rate will build during the year but has been impacted by pauses in mandatory training at Reap 4. We are currently off track at 63% against the agreed ELC target of 87% overall by March 2022. This target is made up of 85% for service lines and 95% Corporate services by March 2022. A recovery plan for classroom training has been implemented and this will run in parallel with a focus on recovery of online completion.

COVID 19

108 staff have tested positive for Covid-19 in October 2021 . At the end of this reporting period, there were 3 open outbreaks on Trust sites.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

The data in this report are presented at an aggregate level for the trust and so any issues related to equality and diversity are not highlighted. An initial review of the potential to understand EDI measures against the friends and family test has demonstrated that although data are available, it is complex and requires further work to define correctly, in order to drive meaningful information. We are also looking to add EDI measures into the complaints process. This work has been delayed due to the teams focus on clearing the backlog and changes in leadership of the team but with the new patient safety manager in post will now be prioritised.

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

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the increased demand across all service lines and the impact of this demand on quality, performance and workforce.
- Note the ongoing work to maintain patient safety and regulatory compliance and mitigate the impact of increased demand and long waits.
- Note the continued high performance on the patient reported friends and family test across all service lines.
- Note the deficit position for the year to date, and and the plan to break-even once final income levels are agreed.
- Note the plans in place to improve mandatory training and appraisal compliance.
- Note the plans in place to close recruit more staff across all service lines.
- Note the partnership delivery of a whole system 6 point improvement plan to optimise performance.
- Note the controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively.
- Clarify any items for further scrutiny through the appropriate assurance committee

Q1 COMPLAINTS

Figure Q1.1

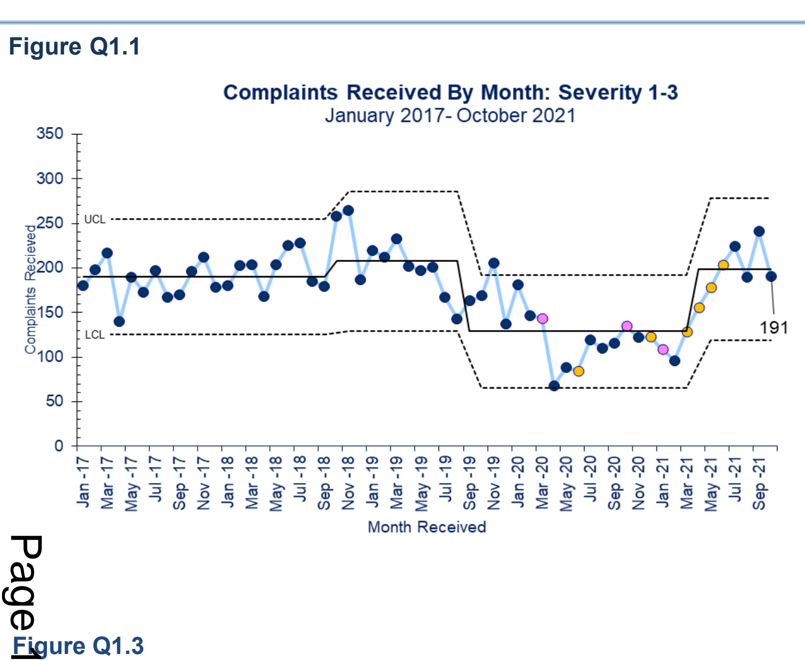


Figure Q1.2

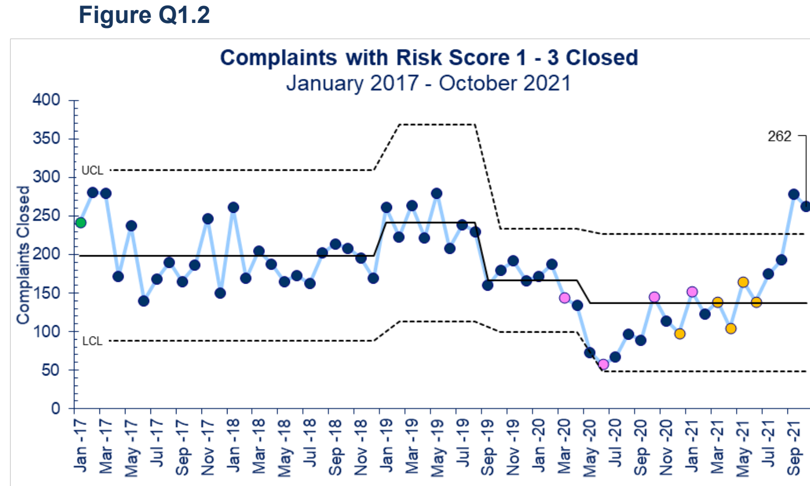


Figure Q1.3

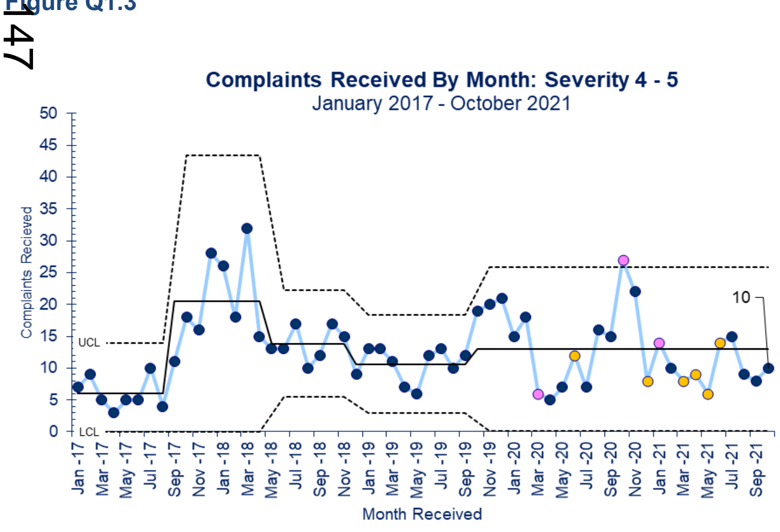
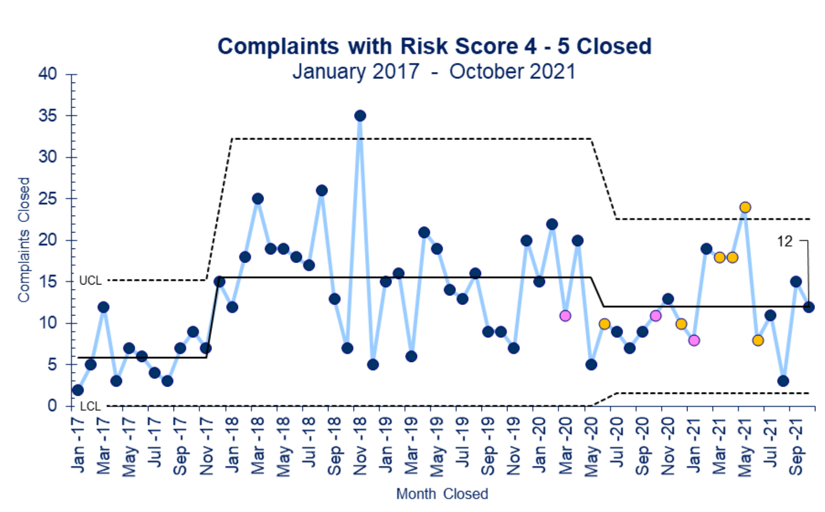


Figure Q1.4



* *Lockdown* *Easing of Restrictions*

Complaints & Compliments

In October, **201 complaints** were received (figures Q1.1 & Q1.3), with a further **1** which was unscored, against a total 12-month average of **175** per month.

229 compliments were received this month.

The rate of complaints in October 2021 was **32 per 1000 WTE**. The average for the fiscal year (1 April 2021 – 30 April 2022) is **33** per 1000 WTE. The rate for both the month of October and the year to date are above the strategy goal for 2021/22 of **27**.

A total of **274** complaints were closed in October 2021 (**262** were risk scored 1-3 Q1.2 and **12** were risk scored 4-5 Q1.4).

The process for rapid closure on those scored 1-2 is being trialled on complaints scored 3 were possible which has helped increase the numbers closed (Q1.2) this is shown as special cause to the good. An internal target has been set to close lower scored complaints within 3 days rather than the mandated 5.

Figure Q1.5

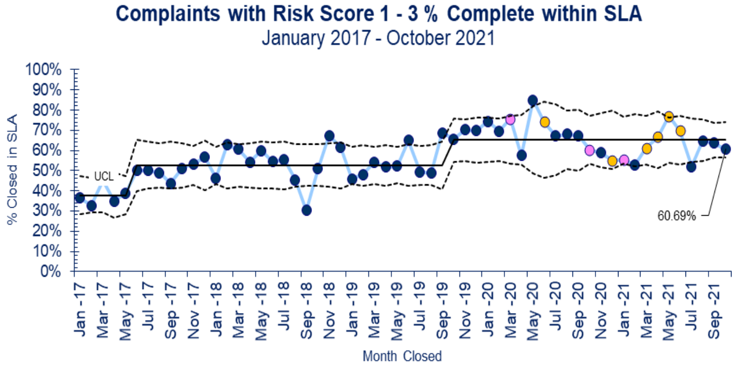


Figure Q1.6

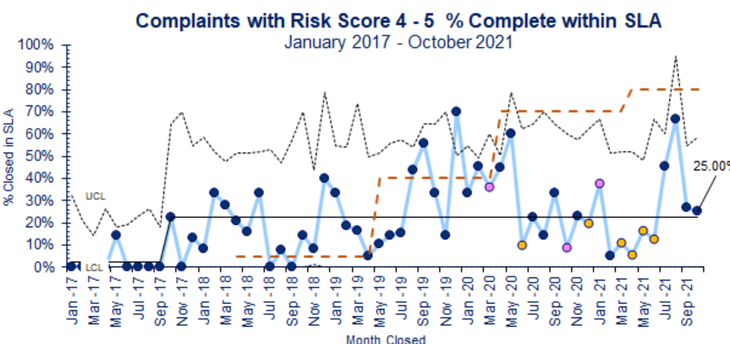
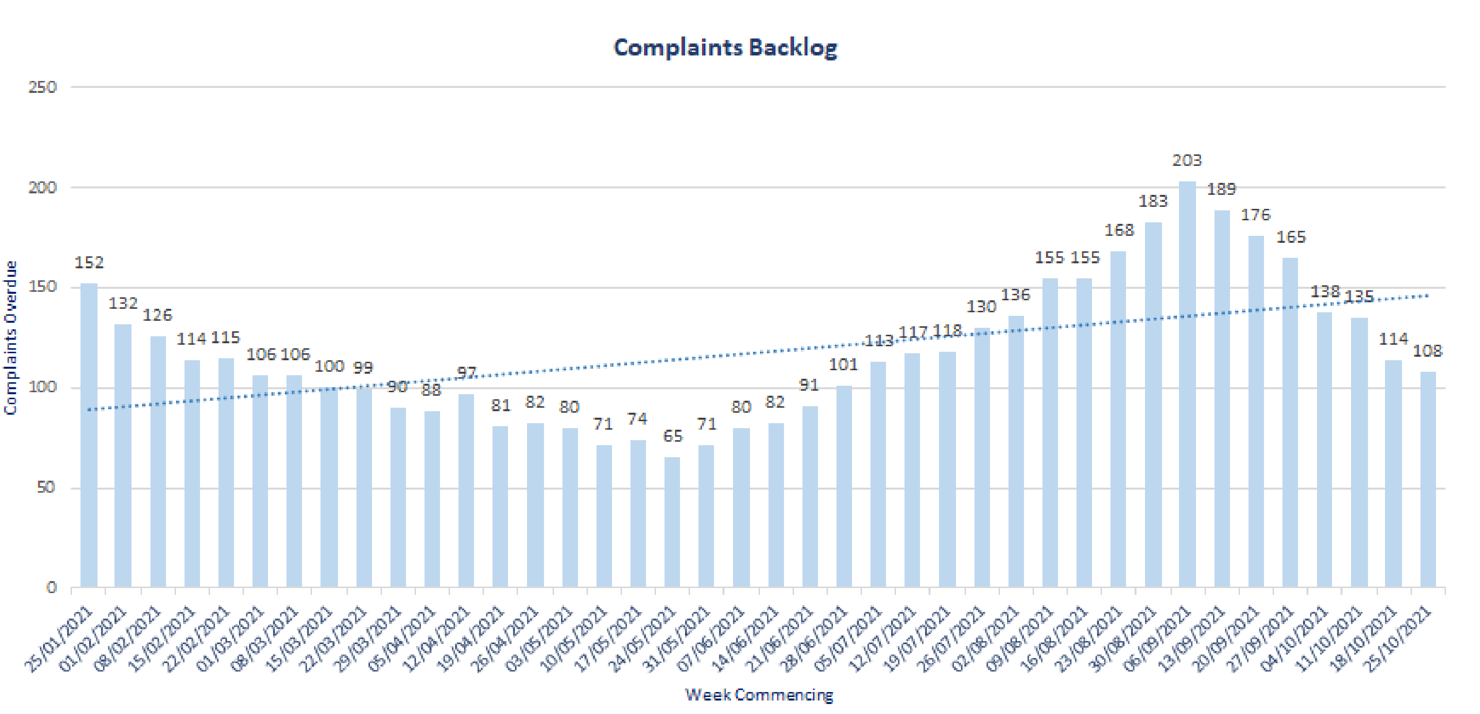


Figure Q1.7



* *Lockdown* *Easing of Restrictions* Right care strategy goal

Complaints Closure

Overall, **61%** of cases risk scored 1-3 were closed within the agreed timescales (Q1.5).

The updated Right Care strategy goals break down complaints with a score of 1-2, 3 and 4-5 rather than 1-3 and 4-5.

61% of level 1-2 complaints were closed within agreed timescales against a right care strategy goal of **75%** by the end of 21/22

59% of level 3 complaints were closed within agreed timescales against a right care strategy goal of **70%** by the end of 21/22

25% of level 4-5 complaints were closed within agreed timescales (Q1.6) against a right care strategy goal of **80%** by the end of 21/22.

The decrease in complaints scored 4-5 closed in SLA is due to resource issues due to Covid abstractions , general sickness and leave. Also availability of operational staff due to REAP 4.

The backlog of complaints has been rising since May but has seen a fall from **203** at the start of September to **108** for WC 25th October. The backlog has started to increase since the introduction of REAP 4 (Q1.7). Overall the backlog has moved to **c54%** of the total volume of complaints. A trajectory and improvement plan has been agreed with the Executive Leadership Team where the backlog will be back to low levels **c30** by the end of November.

Q2 INCIDENTS

Figure Q2.1

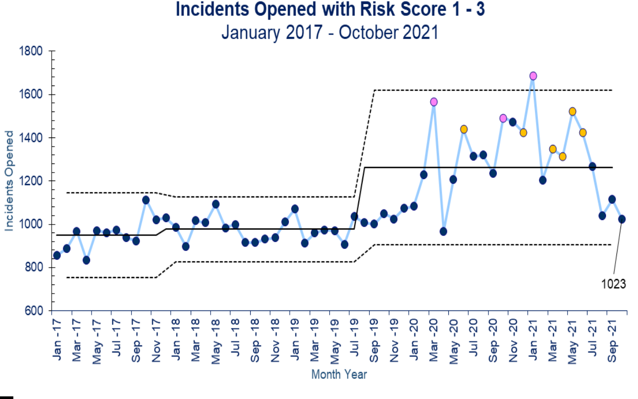


Figure Q2.3 - Highest number of safety incidents October 2021 by subcategory are from 111

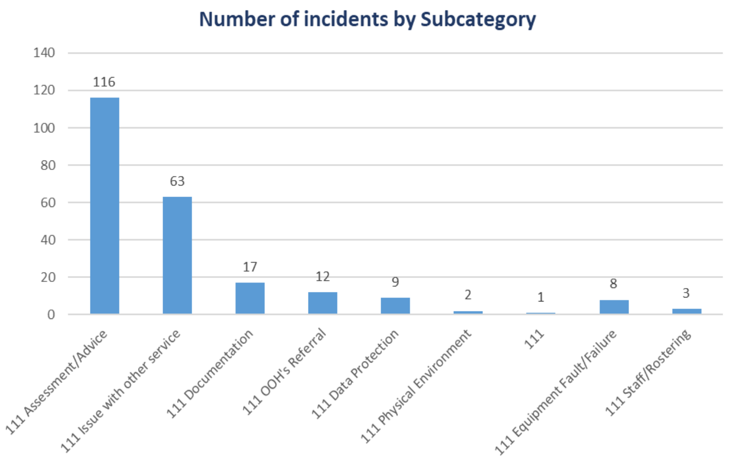


Figure Q2.2

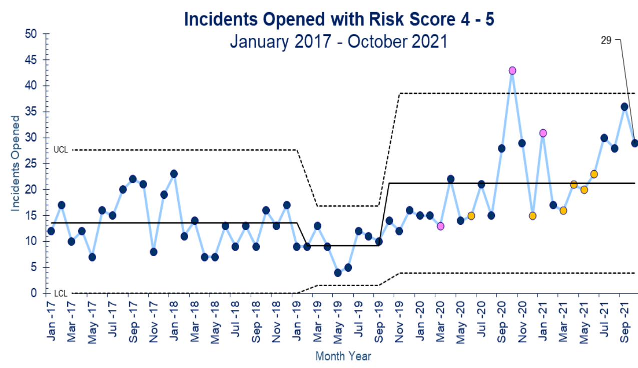
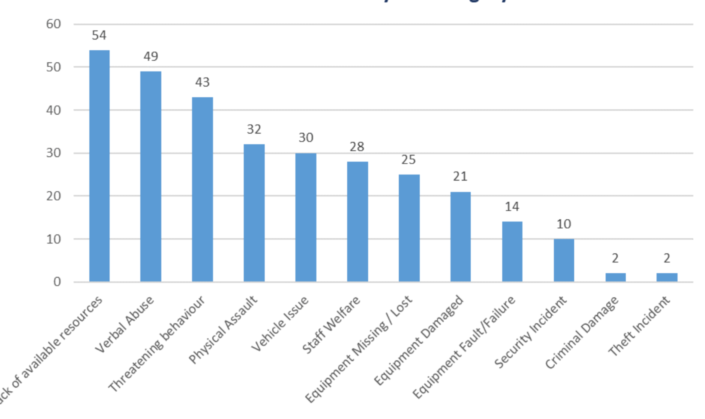


Figure Q2.4 - Second highest number of safety incidents October 2021 by subcategory are staff welfare



* Lockdown Easing of Restrictions

Reporting: In October 2021, **1,128** internal and external safety incidents were opened (Q2.1 and Q2.2) against a 12-month average of **1,383**, with an additional **76** still to be scored. High levels of reporting are important and considered a marker of a positive culture where staff feel able to speak up.

Unscored Safety Incidents (RCS): In October, **76** safety incidents were unscored which is above the end of year Right Care Strategy goal of **25** unscored safety incidents in the previous month reported in the IPR. The scoring and management of safety incidents in a timely way is monitored via the clinical effectiveness and operation outstanding meetings and plans are in place to ensure the end of year target is achieved.

Safety Incidents by Type: Content analysis of incidents by type shows that the top two reasons (by volume) are safety incidents associated with 111 services or staff welfare. Figures 2.3 and 2.4 show the subcategories within these two themes and help to explain the reasons for the themes.

111: It is important to frame the total number of safety incidents in 111 against the total number of calls received (**232** safety incidents from **255,432** calls). Many of these safety incidents are raised by healthcare professionals who want clarity on outcome decisions. All calls are audited and action taken where concerns are upheld. The majority of 111 safety incidents have been raised because of concerns about the assessment or advice given (n=**116**), because we have had issues with another NHS service (n=**63**), for documentation or data protection issues (**n=10+7**) or for out of hours referrals (n=**12**). Around **15% -20%** of safety incidents raised within 111 can be resolved locally and do not relate to

Staff Welfare Safety Incidents: Two of the most common reasons for reporting are; violence and aggression towards staff, which includes threatening behaviour, verbal abuse and physical assault, and resource or equipment issues. The Trust has an active Violence and Aggression working group (a sub-group of the Health, Safety and Security sub-committee) with work streams to reduce assaults on staff and to assist in increasing appropriate prosecutions. A lack of available resources has also continued to be a key concern for staff in October.

Figure Q2.5

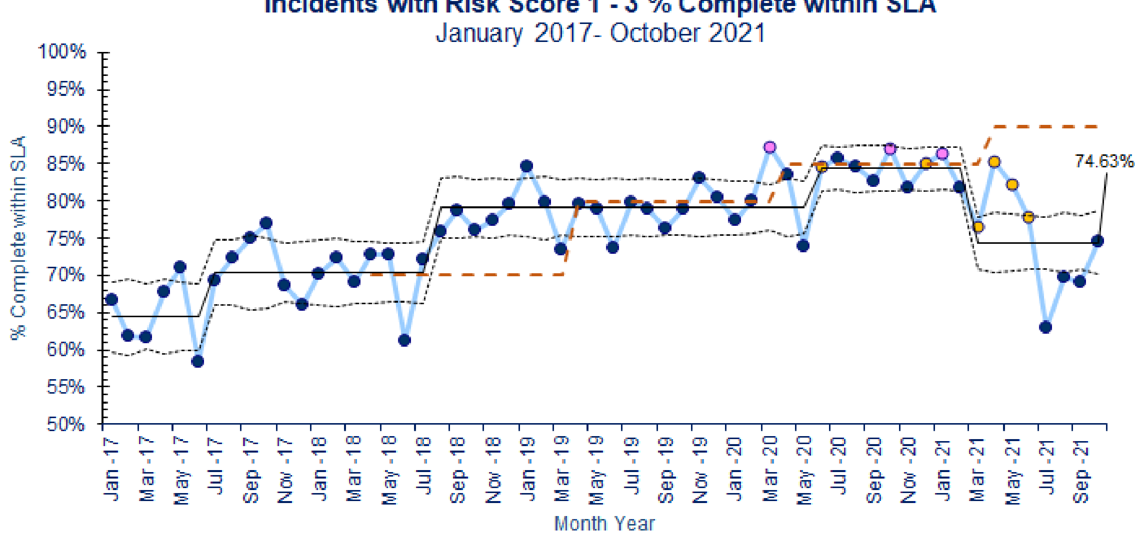
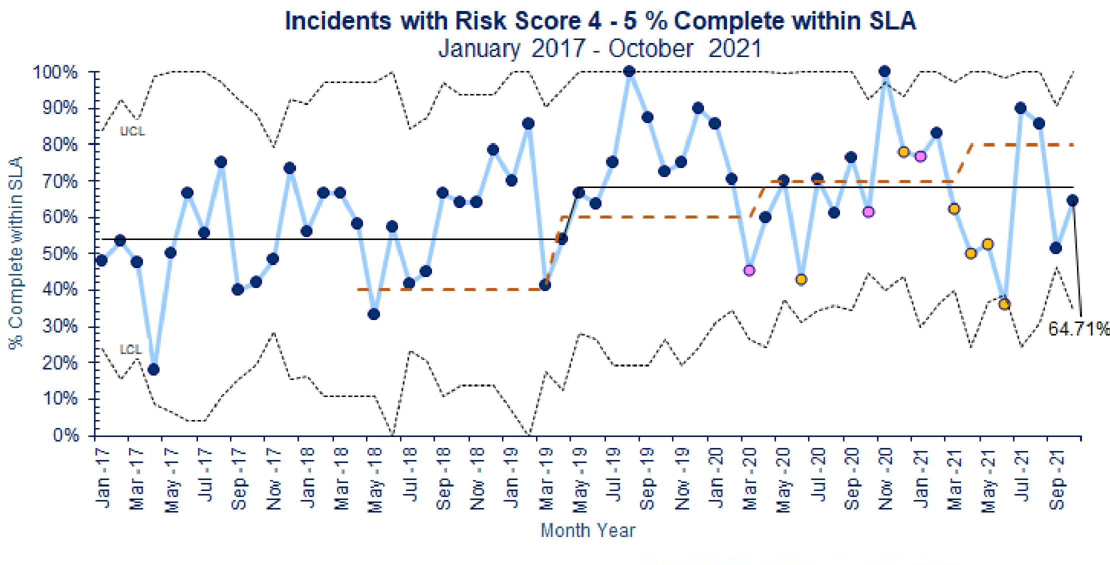


Figure Q2.6



* *Lockdown* *Easing of Restrictions* Right care strategy goal

SLAs are calculated using the following measures/ targets.
No exceptions are taken into account:

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

Incidents Closure

In total, **971** safety incidents (level 1-5) were closed during October 2021.

75% level 1-3 were closed within agreed standard (Q2.5) which is currently showing as special cause variation and below the right care strategy goal of 90%.

65% of level 4-5 safety incidents were closed within the agreed standard (Q2.6) against a right care strategy goal of 80% for the end of 2021/22

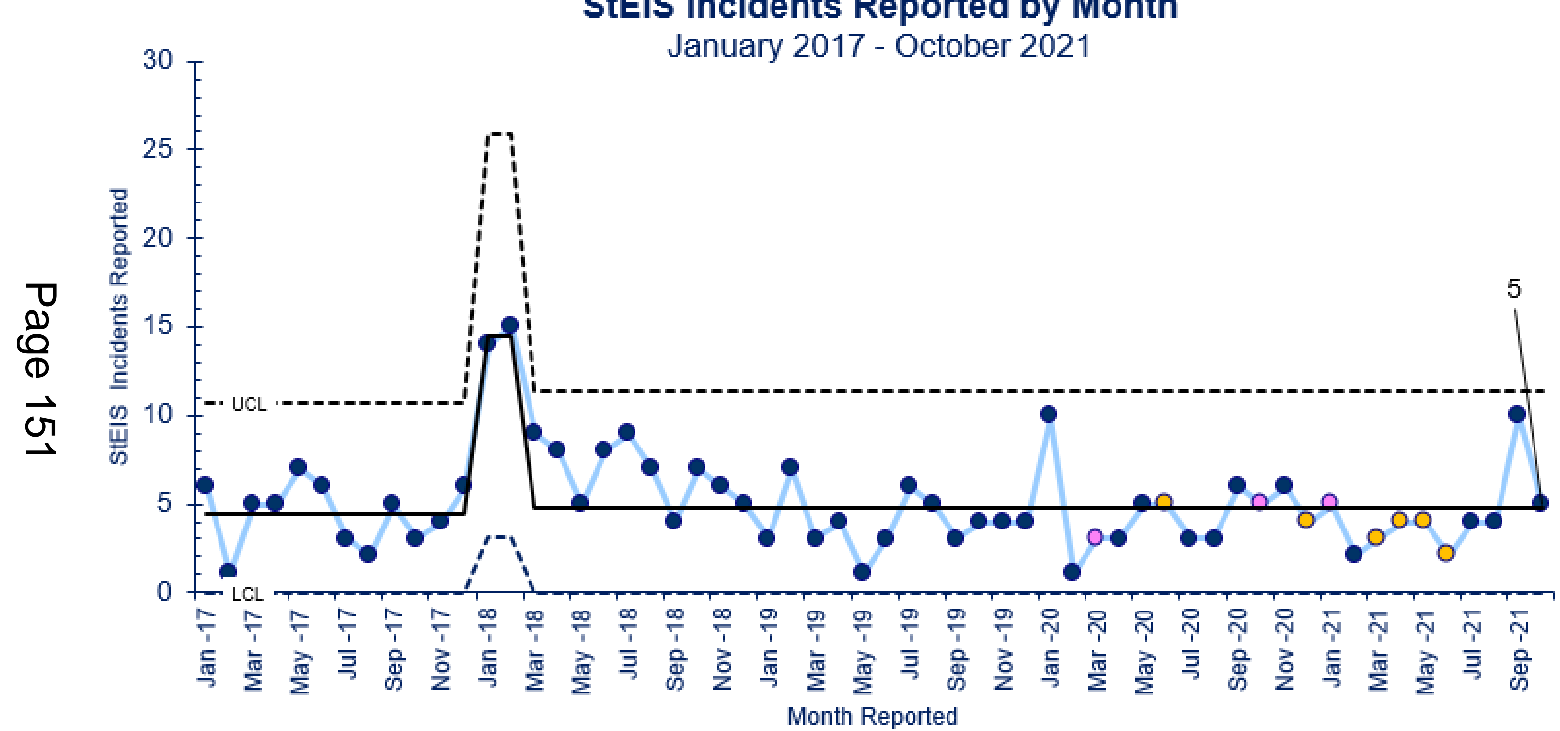
Both have been affected by periods of REAP Level 4 which impacts on the ability of the front line to produce the required statements and investigation reports, in a timely manner, to close off these safety incidents. The Patient Safety team are supporting this as much as they can during periods of REAP level 4.

The scoring, management and learning from safety incidents remains a priority. Each area and head of service has a plan for recovery of their back log and a goal to get safety incidents scored and closed in a timely way. A trust wide working group was established but is currently suspended due to REAP4 .

Due to the continuation of REAP level 4, we anticipate recovery will take until beyond the end of Q4. However, the closure of incidents in a timely way will remain a goal throughout the year and will be reported via Quarterly right care strategy updates to the Quality and Performance Committee.

Q3 SERIOUS INCIDENTS

Figure Q3.1



Serious Safety Incidents

5 Serious safety Incidents (SIs) were reported in October 2021.

4 SI reports were due with the commissioners in October 2021. 1 was submitted within the 60 day timescale.

4 were due to be submitted in October **1** submitted early, **1** has an extension approved and is not due until November. **2** where submitted after their due date.

Significant work has been undertaken to ensure quality and safety, learn from previous serious incidents and ensure clinical support within the EOC.

This work is described in more detail in the recently published Quality Account: Quality Account 20/21 – NWAS Green Room

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Nov 20 – Oct 21)	Number of Alerts Applicable (Nov 20 – Oct 21)	Number of Open Alerts	Notes
CAS/ NHS Improvement	29	0	0	

Safety Alerts	Number of Alerts Received (Nov20 – Oct 21)	Number of Alerts Applicable (Nov 20 – Oct 21)	Number of Open Alerts	Notes
MHRA – Medical Equipment	3	0	0	

Safety Alerts	Number of Alerts Received (Nov 20 – Oct 21)	Number of Alerts Applicable (Nov 20 – Oct 21)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	51	0	0	

Safety Alerts	Number of Alerts Received (Nov 20 – Oct 21)	Number of Alerts Applicable (Nov 20 – Oct 21)	Number of Open Alerts	Notes
IPC	1	1	0	Coronavirus is a viral disease (COVID-19). The Delta variant (Indian variant) is the prominent variant in the UK and there is an increase of cases in the North West. There is a multi-faceted action plan that operates across the Trust, this includes HR, Procurement, Communications, Operations and the Quality teams. This is being discharged by L Yeomans (Lead and DIPC) and the Executive Leadership Committee (ELC).

NWAS Response

There has been **9** new safety alerts in October 2021.

The total number of CAS/NHS Improvement alerts received between November 2020 and October 2021 is **29**, with no alerts applicable.

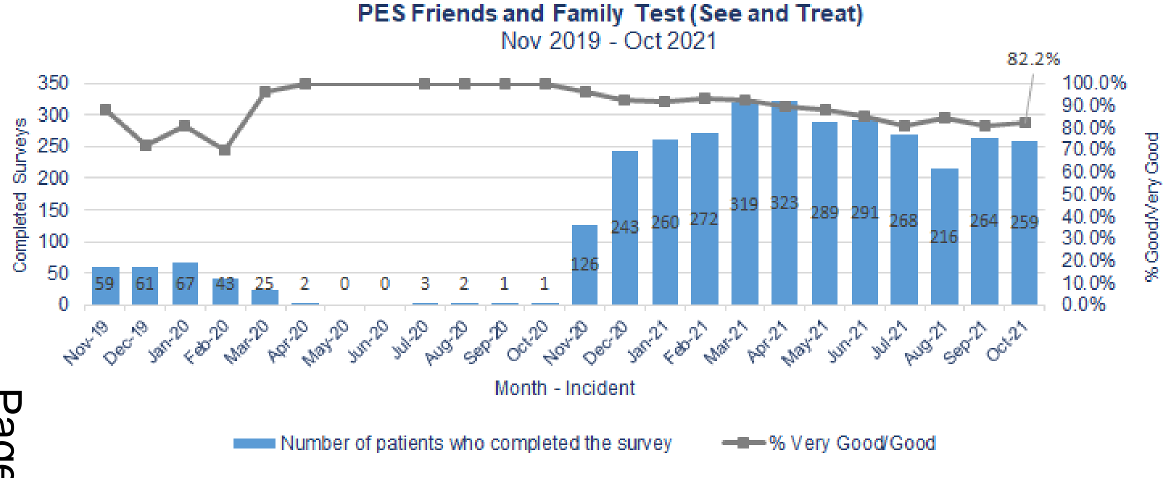
3 MHRA Medical Equipment Alerts have been received with no alerts applicable.

51 MHRA Medicine alerts have been received, with no alerts applicable.

1 IPC alert have been received, with **1** alert applicable.

E1 PATIENT EXPERIENCE

Figure E1.1



Patient Experience

The service line narratives and data below relates to all our patient respondents' feedback. We have started to explore any variation in the data related to equality, diversity and inclusion measures and more detail together with associated charts will be reported in future reports. In addition, potential service improvements are also being discussed with service line improvement ambassadors on a monthly basis.

Patient Experience (PES)

The **259** return for October 2021 is **1.9%** less than the **264** returned for September 2021, with returns containing comments seeing an increase of **6.4%**; (**199** for October and **187** for September).

The overall experience for October of **82.2%** shows an increase of **1.5%** compared to the previous month of September of **80.7%**

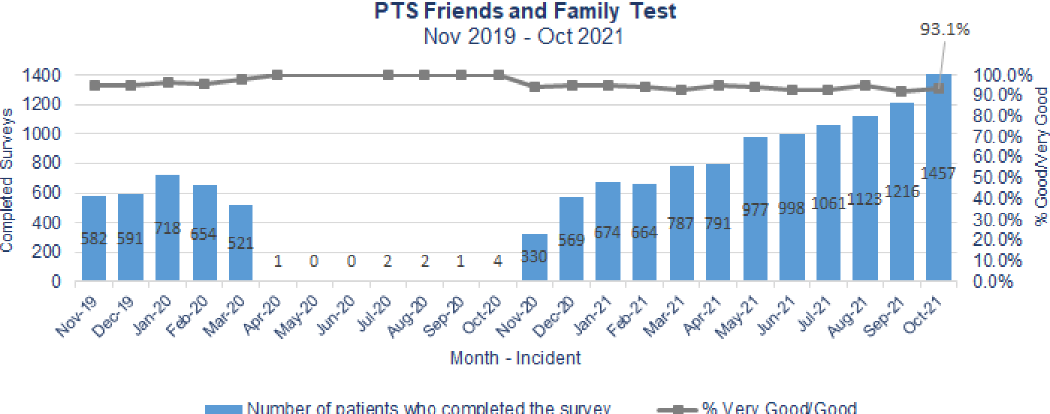
Where respondents indicated **'very good/good'**, the corresponding themes were around speed of response, being treated with kindness; dignity and respect, the empathy, reassurance provided both on the phone and by the paramedics, teamwork and professionalism of the paramedics and explanation of what was being done and why. Comments included:

- *"They respected my dignity, explained everything they were going to do and reassured me when I was anxious and very scared. I was alone at home with my daughter who was also quite anxious, and they engaged extremely well with her, giving her reassurance and explained what they were doing with me. They had a student paramedic with them, and they all supported me and cared and made me laugh at a time when I was scared yet remained professional throughout. The NWAS team especially the paramedics who attended that evening are a credit to the country and the NHS."*
- *"I was triaged and felt that paramedic was person centred, listened to me and took appropriate action to get me seen promptly."*

Where respondents indicated '**poor/very poor**', the corresponding themes were around response times, poor attitude; lack of empathy and poor patient care. Comments included:

- *"Waited 12hrs for ambulance."*
- *"Phone call was good but rushed... More interested in getting to the next call! Time wise for an ambulance... absolutely horrendous..."*

Figure E1.2



Patient Experience (PTS)

The return of **1,457** for October is **19.8%** higher than the **1,216** for September, with those with comments also seeing a marked increase of **24.1%**; (**1,188** for October and **957** for September).

The overall experience for October of **93.1%**, sees an increase of **1.0%** compared to the previous month of September of **92.1%**

Where respondents indicated **'very good/good'**, the corresponding themes continue to be around polite, friendly and helpful staff, efficient and excellent service, timely pick up, being treated with dignity and respect, patient comfort and safety, professionalism reinforced with going the extra mile. Comments included:

- *"The crew went above and beyond. They took me to an appt that had not been booked correctly stayed with while is tried to be sorted reassured me gave me time extra oxygen and when I ended up having to go to accident and emergency. They took me didn't wait for a porter booked me in took me to a cubicle got me a drink and stayed with me as long as they could very kind as am single and have a hospital phobia nothing was too much trouble and the crew that took me home were the same."*
- *"Driver turned up on time, was very polite and helpful, and waited for me at the hospital instead of me having to wait for someone else to come back for me."*
- *"They treat you as a person not just a patient, they make sure your safe at all times, every journey overall has been an excellent experience, they are all well-mannered, caring and thoughtful it's a pleasure, thank you."*

Where respondents indicated '**poor/very poor**', the corresponding themes were around waiting time delays (inward and outward journeys), third party service providers, staff attitude and patient safety concerns. Comments included:

- *"The ambulance on the way to the hospital was superb. The taxi on the way home was terrible. I was bashed from side to side by the driving and the driver said there was no key in the key safe, so I was left outside. Luckily, a postman arrived and got the key from the safe and pushed my wheelchair into the house."*
- *"The last advisor I spoke to book the next appointment basically made me feel like I was a lazy incompetent person for not being a driver or having family that will help without moaning about it."*
- *"The driver that dropped me off he dropped me off at the wrong place and I had to walk to the other side of the hospital. The driver that picked me up made me sit in the back of the car and made a comment to my wife saying that he would need a can opener to get me out."*
- *"Appointment at 15:30, sat dressed and ready from 13:30, transport arrived around 16:45."*

Figure E1.3

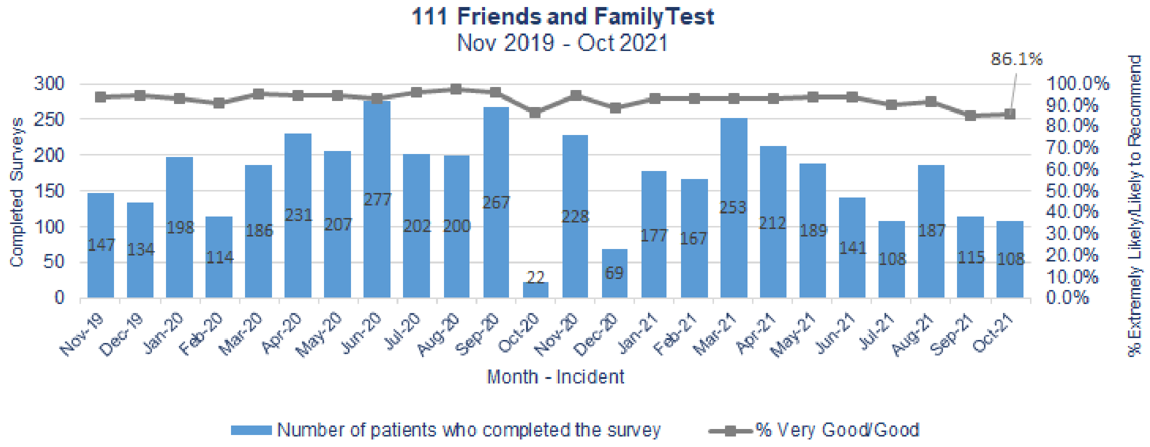
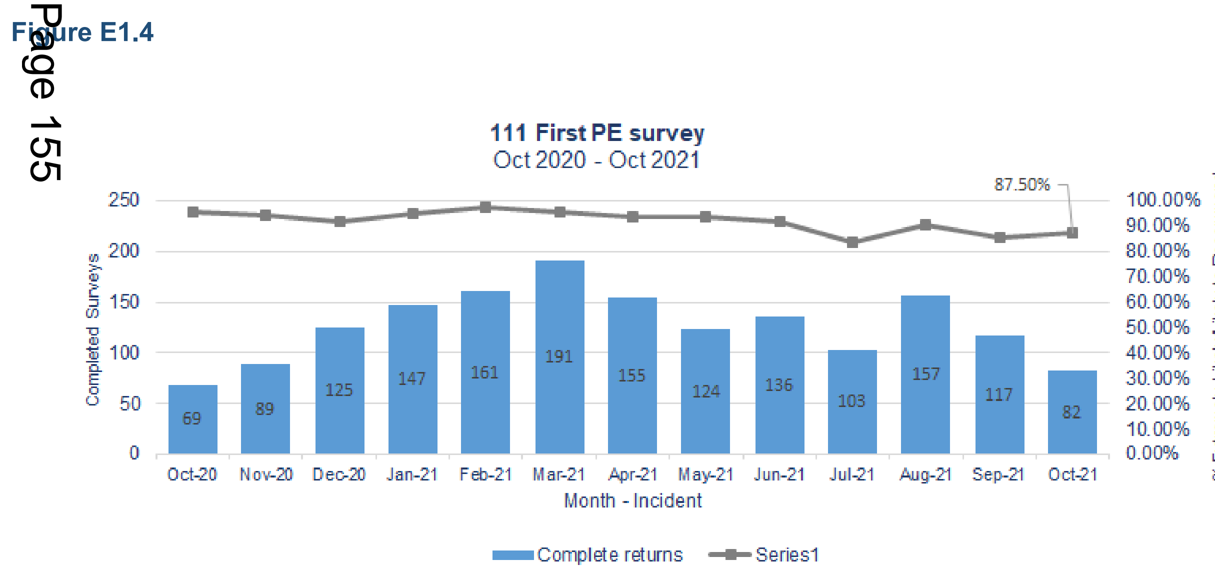


Figure E1.4



Patient Experience (NHS 111)

October saw an **86.1%** likelihood of recommending the service, an increase of **0.9%** compared to the previous month of September of **85.2%.**

Where respondents indicated they were '**extremely likely/likely**' to recommend the service, themes included: professionalism, clear advice and helpfulness, reassurance and empathy, hospital/GP referral and booking process and speed of response. Comments included:

- *"Extremely helpful lady on the phone. Arranged us an appointment at our walk-in centre."*
- *"It would be better if someone could explain the wait time as how the procedure goes, especially to a person who is new to the country. Otherwise, everything was fine. I was disappointed at sending an ambulance to me rather than seen by a doctor which I requested."*
- *"Took a while to get through due to it being a Sunday, we couldn't get advice elsewhere. Polite understanding, caring staff. Thank you for all your help."*
- *"Very helpful empathetic members of staff. Felt more cared for than with my own GP."*
- *"They were very helpful and compassionate as I was in so much pain and quite teary. Excellent, efficient service. Thank you, NHS 111."*

Where respondents indicated they were '**extremely unlikely/unlikely**' to recommend the service, themes included: number and length of questions, delayed call back and waiting time. Comments included:

- *"I spoke to a female first who asked me several questions, she then put me through to a male who asked me the exact same questions, which was annoying as I'd already answered them and was in pain."*
- *"The wait times and the fact they are just call handlers."*
- *"They only ask lots of questions and do nothing about it."*
- *"Was promised a call back from GP within the hour, got a call back 9 hours later second time I rang 111 got a call back 12 hours later from GP."*

NHS 111 First

Also reported is a high-level summary table showing the number of returns, reasons for using the service, outcome and the levels of overall patient satisfaction. Cumulatively since the service commenced last August **92.28%** (previously **92.77%**) of patients describe their experience as '**very good/good'** and 95.01% (previously **95.11%**) of patients felt their need for calling the service was met.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

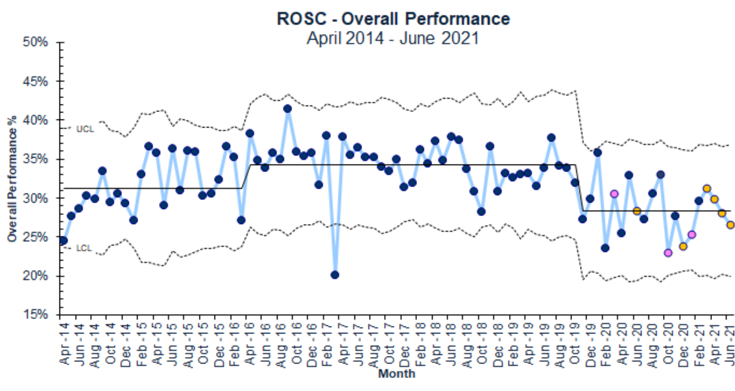
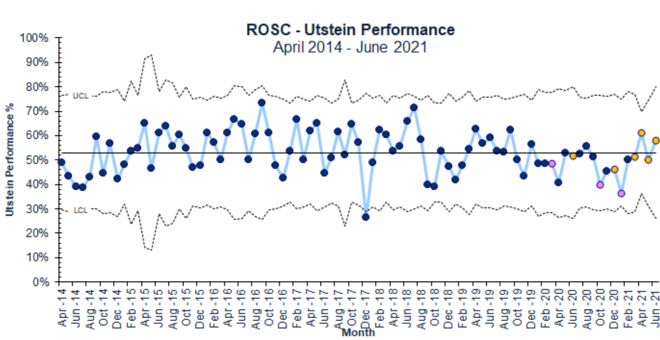


Figure E2.2



* Lockdown Easing of Restrictions

Figure E2.3

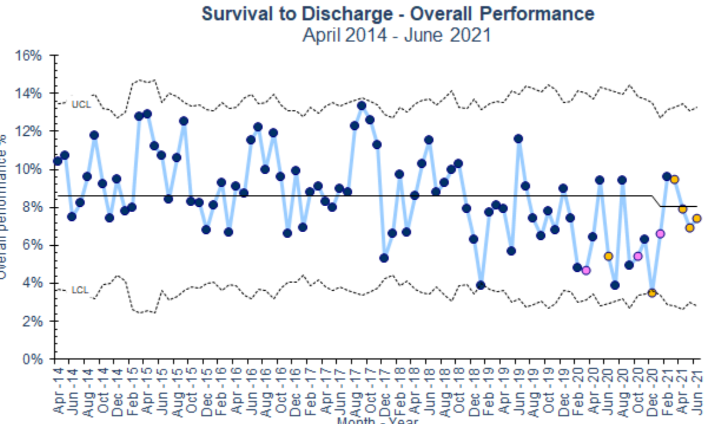
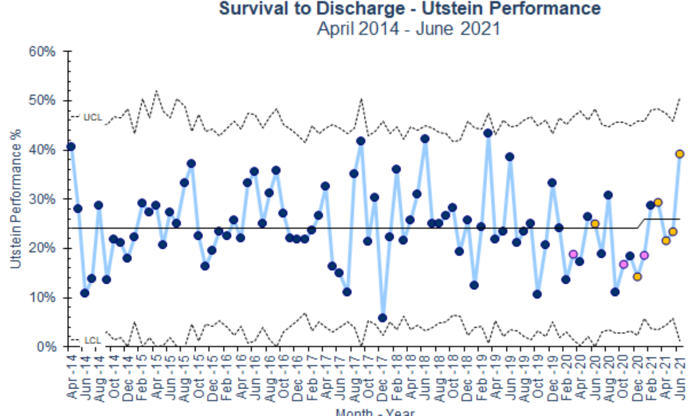


Figure E2.4



ACQIs (Last data point: February 2021)

June's data see us within normal limits and close to the mean across all indicators, signalling no significant change overall. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

E2.1 ROSC & E2.2 ROSC (Utstein)

The ROSC achieved for the Utstein group was **58.1%** (national mean **46%**), For the overall group the rate was **26.6%** (national mean **25.7%**). This indicator is predominantly influenced by pre-hospital factors.

E2.3 ROSC Survival to Discharge &
E2.4 ROSC (Utstein) Survival to Discharge

Survival to Discharge rates in June 2021 were higher than the previous month at **7.4%**. Although the data remain within control limits and so this does not represent a significant change.

In June **39.3%** of patients in the Utstein group survived to hospital discharge, significantly higher than the previous month the national mean at **26.9%.** This remains within the control limits.

This indicator can be considered as a 'system indicator' and is influenced by in-hospital factors, overall system pressures as well as pre-hospital performance.

F1 FINANCIAL SCORE

Figure F1.1

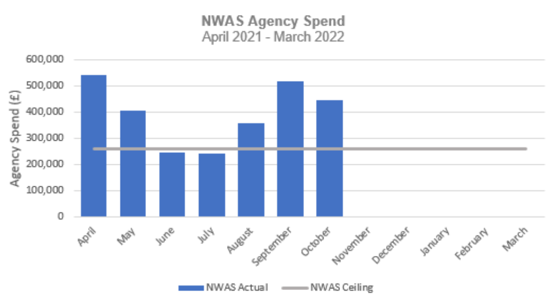


Figure F1.2

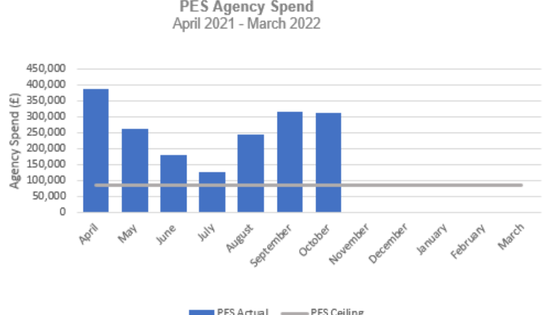


Figure F1.3

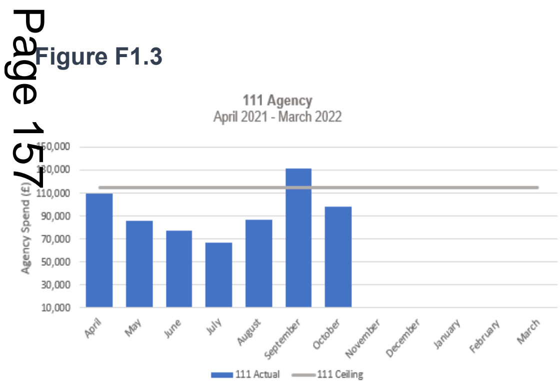


Figure F1.4

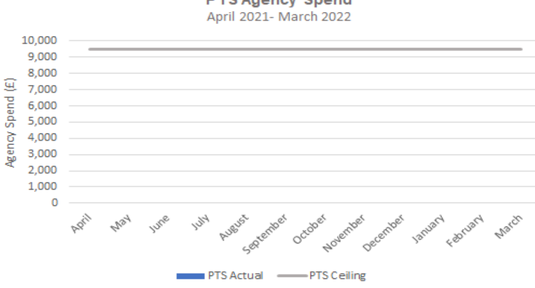


Figure F1.5

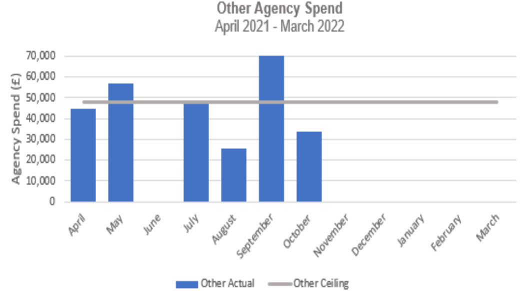
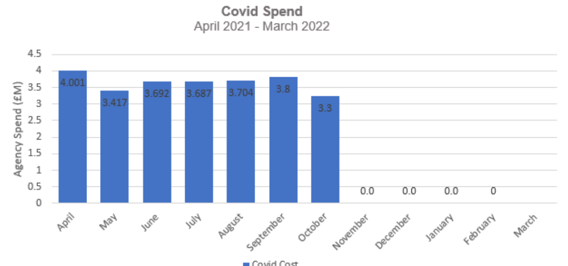


Figure F1.6



Finance Position

Month 7 Finance Position

As at month 7 the trust is reporting a deficit position for the year to date, however the income level for H2 (01 October 2021-31 March 2022) was not agreed at the time of closure and it is expected the trust will return to approximately break-even once final income levels are agreed, as H2 planning is concluded. Spending remains in line with the previous financial year though increased costs are being experienced within PTS, as the NHS moves to restoration and recovery, whilst social distancing requirements remain in place for the service. There has also been funded increased investment in the 111 and 999 services causing a growth in expenditure in that area.

Agency Expenditure

The year-to-date expenditure on agency is **£2.753m** which is **£0.939m** above the year-to-date ceiling of **£1.814m**.

Please Note: The agency ceiling is based on 2019/20 ceiling figures, no further updated has been received from NHSE/I.

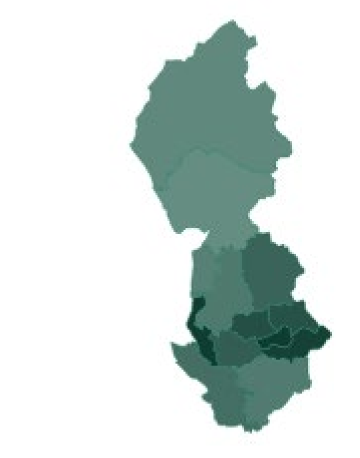
Risk Rating

The COVID-19 financial framework in place for H1 (1 April 2021-30 September 2021) and the redesigned monthly financial returns collect a minimum dataset to reduce the burden on organisations wherever possible, has remained in place for H2 (1 October 2021 - 31 March 2022).

The Financial Risk Rating metrics have been removed and we will add back once the new operating framework is launched after transition from the COVID-19 financial framework.

E3 ACTIVITY & OUTCOMES

Figure E3.1 Activity by Sector (Deeper shade is more)



INCIDENTS

Figure E3.2

Emergency Incidents
wc 02/04/2018 to wc 25/10/21

Emergency Incidents

Week Commencing

* Lockdown Easing of Restrictions

Activity:

In October 2021 the Trust received **152,673** calls of which **92,879** became incidents. Compared with October 2019, we have seen a **24%** increase and **6%** decrease in calls and incidents respectively. The data for wc 25th October are signalling a reduction in incidents with the data being on the lower confidence limit (Figure E3.2). This is due to the use of signposting (self transport or other services).

Oct	Calls	% Change from 2019	Incidents	% Change from 2019
2019	122,662		98,904	
2020	131,457	7%	97,865	-1%
2021	152,673	24%	92,879	-6%

Figure E3.1 shows the regional footprint of NWAS with the borders of each sector delineated. The deeper the shade of green the more activity in that sector. We can see from the sector map for June that Mersey North continues to have the greatest volume of incidents with three GM sectors (Greater Manchester (GM) South, GM Central and GM East) also showing high levels of incidents compared with other sectors. This correlates with the incident heat map and the city regions of Manchester and Liverpool. This is aligned to population density and where the majority of resource will be based.

H&T, S&T, S&C Outcomes

For October we achieved 8.9% Hear and Treat and ranked 11th nationally. See & Treat has decreased to 31.7%. In total there was an aggregate non-conveyance of 40.6%.

Figure E3.4

Hear and Treat % (AQI)
wc 02/04/2018 to wc 25/10/2021

Figure E3.5

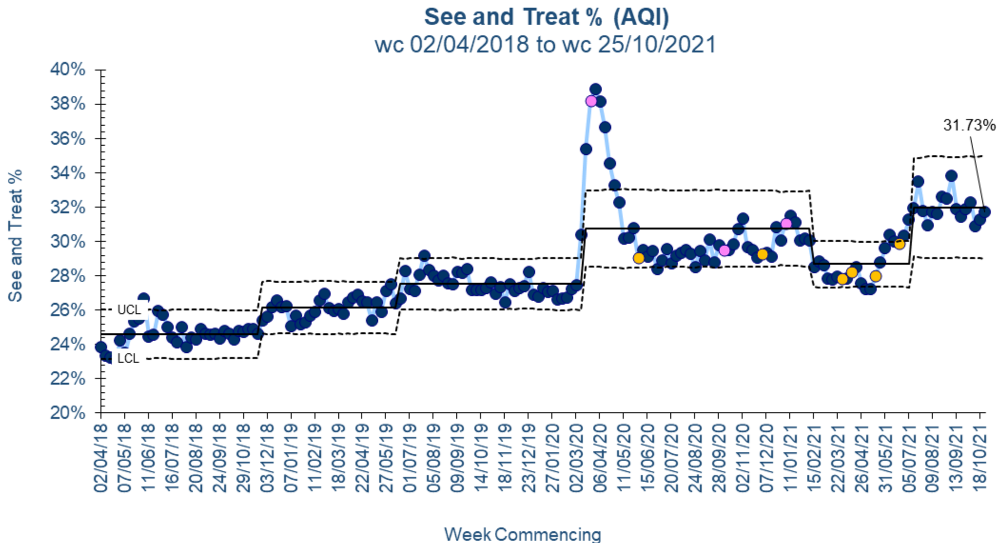
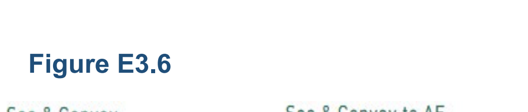
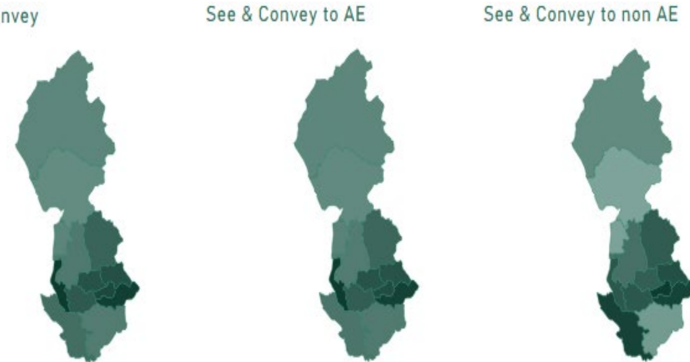


Figure E3.6





**the darker the colour the higher the level of activity*

* *Lockdown* *Easing of Restrictions*

- **Hear and Treat rates** have been consistent since June at around **9%**. It is encouraging to note that NWAS are consistently delivery about **9%** H&T across the region. The Clinical Hub continues to split its focus between patient safety, Crew Advice and Hear & Treat. In line with the 6 point plan Clinical Hub are recruiting for more clinicians, the aim is to be delivering **12%** H&T by the end of March 2022. Recruitment will be key to this, however, is also a risk to delivery due to the difficulty recruiting clinicians in current workforce climate.

- **See and Treat rates** vary between sectors and are contingent on primary care and out of hospital commissioned services responding promptly to requests for clinical consultation. We have seen the percentage of calls triaged into higher acuity categories is increasing however on face-to-face assessment patients are not necessarily as acutely unwell as the initial triage would suggest therefore we are maintaining higher levels of S&T despite an increase in acuity. There has also been an increase in calls for mental health which require see and treat.

- **See and Convey rates:** The maps in E3.6 show this variation by sector and it is possible to see that areas like Morecambe Bay, Fylde and South Manchester have lower 'see and convey' rates than for other sectors within NWAS. The reason for their success is being reviewed and learning shared through the Right Care at Home Collaborative. However, this is still in pilot and will need time to mature and significant focus to have widespread impact across NWAS. The transformation team, community paramedics, frequent caller team and mental health team are also focussed on these efforts.

Outcome Provider Comparison Figures October 2021

Figure E3.7

Provider	Hear & Treat
	17.5%
	16.3%
	13.7%
	13.3%
	12.4%
	10.8%
	10.6%
	10.4%
	9.9%
	9.3%
North West	8.9%

11/11

FigureE3.8

Provider	See & Treat
	38.2%
	33.6%
	32.9%
	32.9%
North West	31.7%
	30.9%
	30.6%
	29.9%
	29.7%
	28.6%
	25.7%

5/11

Figure E3.9

Provider	See & Convey
	51.1%
	52.6%
	52.7%
	53.9%
	56.3%
	56.7%
	57.2%
	59.1%
North West	59.4%
	61.0%
	62.1%

9/11

- **HEAR & TREAT**: The Trust is performing poorly on Hear and Treat when compared with the rest of the ambulance sector and is in **11th** place (since August 2021). This is due to both the increase in C1 and C2 incidents and the re-direction of clinicians within our clinical hub to stack management and patient safety. The trust is working closely with clinical assessment service providers to increase the number of calls closed through the clinical assessment service and this is likely to improve H&T throughout Q3 & Q4. As part of the winter initiatives we are also increasing the number of clinicians within contact centres.

- **SEE & TREAT: The Trust has seen its See and Treat Rates increasing and is preforming 5th in the national rankings.** In July 2020 we moved up to **9th** and remained in that position moving to **7th** in June and July, then moving to **6th** in August and **5th** in September and October. This increase in See and Treat rates is like to be attributable to fewer patients being assessed on the telephone (reduced H&T), more patients refusing to attend hospital and improved access to pathways in the community.

- **SEE & CONVEY:** See and Convey rankings were steadily improving between Jan 2018 and September 2019 but since October 2019 we have been ranked **9th** out of 11 ambulance services.

NOTE: There is a robust improvement plan in place to increase both hear and treat and see and treat rates, supported by commissioners and regulators.

Hear and Treat: This is contingent on attracting more clinicians to NWAS to work in the clinical hub. Funding has been approved by ELC to recruit and plans are being implemented to expedite this process. We are also working with ICS footprints to develop innovative approaches to the management of C3 and C4 incidents.

See and Treat: The RIGHT care at Home Improvement Programme is working with 3 health economies (with the most challenged A&E systems) to increase See and Treat Rates. These are multiagency improvement programmes which are overseen by the Chief of Regulatory Compliance and Improvement and the Director of Quality, Innovation and Improvement.

O1 CALL PICK UP

Figure O1.1

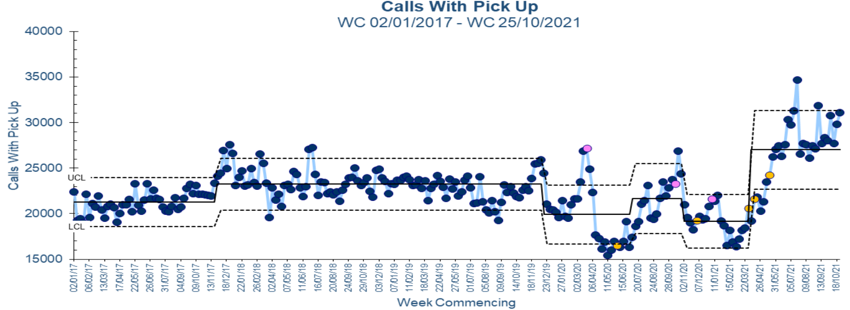


Figure O1.2

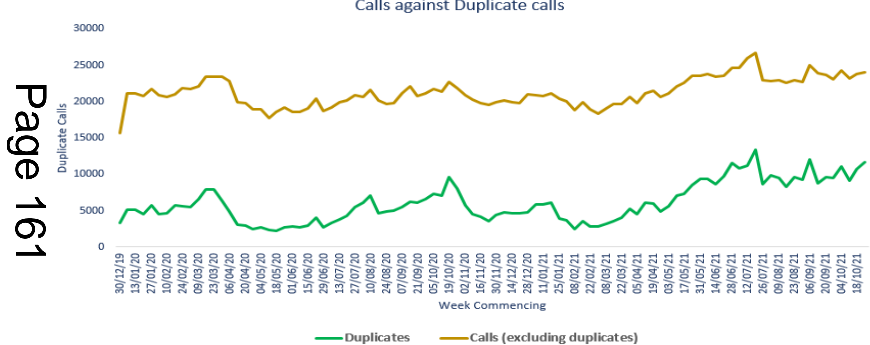
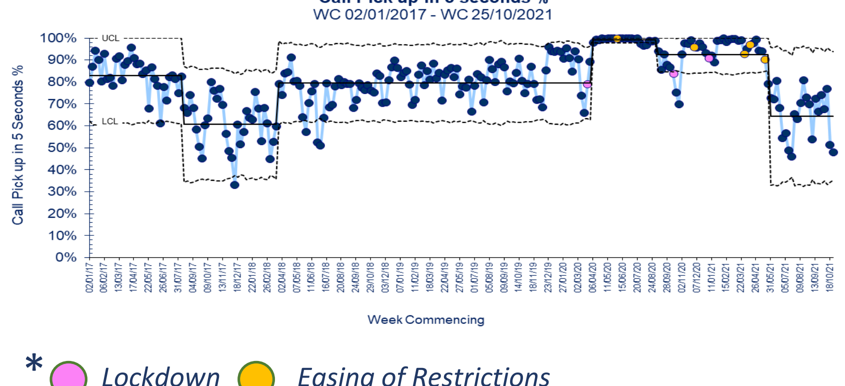


Figure O1.3



* *Lockdown* *Easing of Restrictions*

Call Pick Up

Definition: The percentage of emergency calls recorded in the CAD system and answered with 5 seconds, excluding 111 direct entries. Call pick up is not a national standard but is widely used by ambulance trusts to monitor call handling performance with a target of **95%**.

Performance: Call pick up performance has deteriorated slightly in some areas from the previous month, however there have been improvements in two key performance areas detailed below.

Mean call answer 34 seconds (deterioration of 1 second vs Sep 21)
90th centile call answer 1 min 45 seconds (improvement of 8 seconds vs Sep 21 – 01:53)
95th centile call answer 2mins 26 seconds (improvement of 19 seconds vs Sep 21 02:41)
Percentage of calls answered within 5 seconds 61.8%% (deterioration of 3.8% vs Sep 21).

National Context: The deterioration is also reflected across the ambulance sector. The number of national two-minute delays continues to rise each month. October saw **47,565** delays which is an increase of **14,800** delays compared to September. Three weeks of October saw above **10,000** two- minute delays each week. A number of factors have increased the pressure on Trusts including call volume and abstractions. NWAS remain in a similar position to previous month which is an average position (middle of the pack) when measured against other Trusts. Continued high call volumes continues to impact however we are starting to see an improved and consistent staffing position due to newly recruited call handlers being signed off to take live calls.

Figure O1.1 reflects the increase in call volume NWAS continue to face. This increase has been sustained throughout recent months including October. Whilst the peak weekly activity has not reached July 21's busiest week, it should be noted demand remains very high. For context October 21 call volume is around **25%** above the equivalent month for 2020 and 2019. Projecting demand forward is complex given the COVID activity and change to demand profile (increase in demand weekdays mornings). However, it is highly likely the call volume will remain high and may increase further both in terms of the core number of calls received and when compared to previous years. The data are signalling high levels of calls for two weeks during October with data being near the upper control limit.

Figure O1.2 reflects the current challenge managing the volume of duplicate calls. Duplicate calls have been on the increase since February 21. October's average daily duplicate call volumes equates to **1,552** per day and increase of **94** duplicate calls per day vs September 21. Duplicate calls are widely recognised to be the most significant contributory factor to the national increase in call volume. As response times extend operationally the proportion of duplicate calls increase. In response to this increase in call demand BT have proposed a new approach to deflect some of the duplicate call demand at BT source. This is conducted on an ad hoc basis when BT staffing allows.
NWAS continue to manage the demand and current levels of abstractions via ongoing recruitment. To date the winter recruitment plans are on track and will deliver **140** additional staff by January 22.

O2 A&E TURNAROUND

Figure O2.1

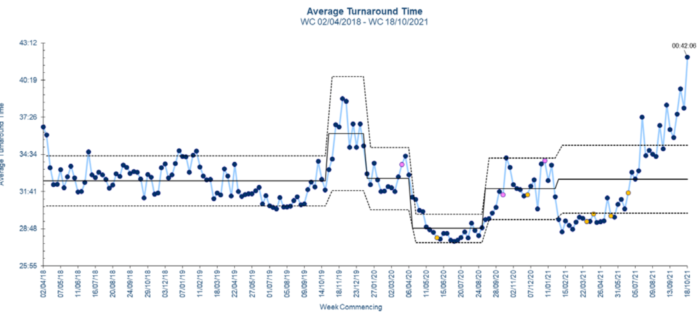


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Nov-20	49,885	31:49	20:31	11:08
Dec-20	53,723	31:54	20:56	10:56
Jan-21	53,179	33:00	21:58	11:08
Feb-21	47,620	29:09	17:47	11:17
Mar-21	54,174	29:25	17:57	11:42
Apr-21	53,552	29:26	18:14	11:18
May-21	57,212	29:56	18:46	11:17
June-21	52,324	31:20	20:11	11:24
July-21	51,396	34:16	23:12	11:20
Aug-21	49,377	35:06	23:45	11:32
Sep-21	47,467	36:49	25:26	11:41
Oct-21**	38,181	39:27	27:56	11:25

Figure O2.2

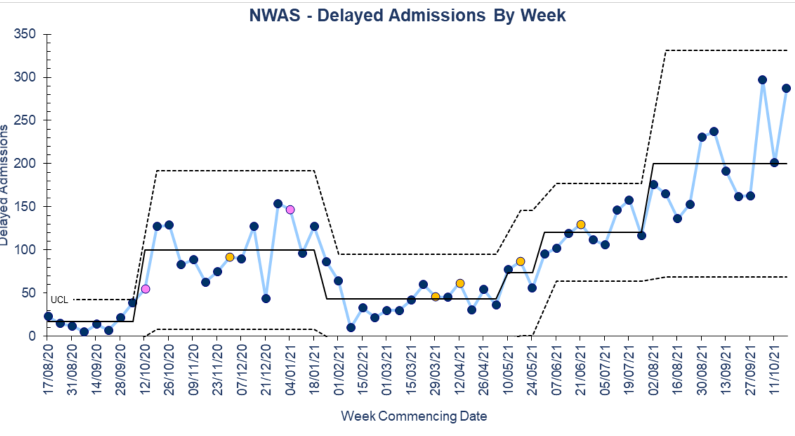


Table O2.2

Month	No. of Delayed Admissions
Aug-20*	38
Sep-20	46
Oct-20	355
Nov-20	347
Dec-20	406
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct 21**	827

*Data only started being collated from 17/08/2020
Increased data capture made possible from October 2020 due to use of Call+ to record Delayed Admissions

** Data for WC 25/10/21 missing due to data issue

A&E Turnaround Times

**** Due to issues with the data the week commencing 25th October is not included.**
#denotes only three weeks of data

Average turnaround time was **#39:27** (Table O2.1). This is the fifth consecutive month that the trust has not met the standard of 30 minutes and the 5th since January and the 8th time in 12 months that the standard has not been met. The increase is primarily in the arrival to handover time which has increased from **18.46** in May to **#27:56** in October (Table O2.1)

#4,490 attendances (11.8%) had a turnaround time of over 1 hour, with **#374** of those taking more than 3 hours. When including the missing week data this will have seen an increase with comparison to August and Septembers' figures (**3,796** and **4,506** respectively). In October, **#826** cases of delayed admissions were reported – which when including the missing week will be higher than the **902** reported in September (Table O2.2). In September we lost **#1,481** hours to delayed admissions - up from **1,379** hours in September. Below are tables showing both the 5 trusts with the highest mean arrival to handover time and the most hours lost due to delayed admissions.

Top 5 Trusts with the highest Arrival to Handover time	
Trust	**Mean Arrival to Handover time**
Royal Oldham	00:46:42
Fairfield General	00:44:06
Whiston	00:43:39
Royal Albert Edward Infirmary	00:36:00
Wythenshawe	00:34:57

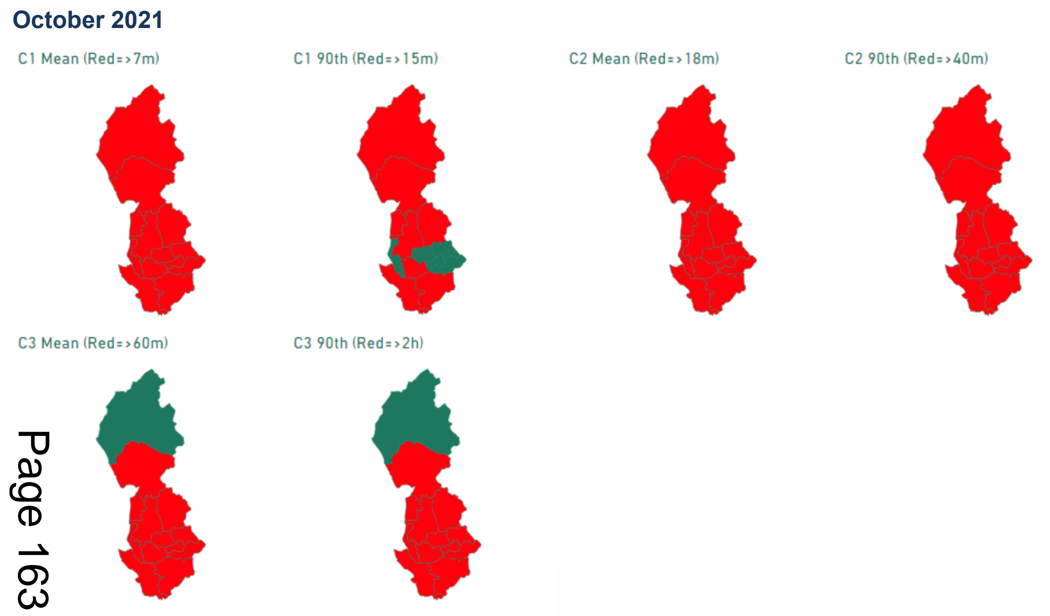
Top 5 Trusts with most hours lost due to delayed admissions	
Trust	**Hours lost to delayed admissions**
Royal Oldham	427.9
Fairfield General	359.4
Blackpool Victoria	170.7
North Manchester General	140.8
Royal Bolton	119.6

Over the last five months we have seen overall turnaround time exceed the standard of 30 minutes (Table O2.1) and this has increased each month. This is challenging for the trust and the wider system, however the results remain consistent within a tight distribution with a number of trusts who have high turnaround times.

The number of delayed admissions is deteriorating month by month with 826 delayed admissions in the three reported weeks of October (Table O2.2). Delayed admissions are continuing to increase in both frequency and length.

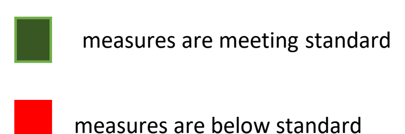
The trust continues to work with those most challenged trusts and is also ensuring a focus on patient safety while the system is challenged. The trust is currently engaged with 20 acute sites. Whilst performance for turnaround is outside the standard we are seeing similar performance around the country for other ambulance trusts. The increase in turnaround times is also seen nationally and is of high priority as seen by the head of NHS England & Improvement writing to acute trust to ask for improvement in this area.

O3 ARP RESPONSE TIMES



The heat maps show the sectors within NWAS where the standards are being met. It is important to note that:

1. **C1 mean: No** sector met the standards for C1 mean
2. **C1 90th: Five** sectors (Mersey North, , Manchester West, Manchester East, Manchester Central and Manchester South) met the standards
3. **C2 Mean: No** sector met the standard
4. **C2 90th: No** sector met the standard
5. **C3 Mean: One** sector met the standard (North Cumbria)
6. **C3 90th: One** sector met the standard (North Cumbria)



Activity: ARP Response Times

For October, response time targets were not met for any ARP measures. This continues the position from September. This is the second time since January 2018 that the trust has not met the standard of 15mins for C1 90th. For WC 25th October, C2 90th and C3 mean are both showing special cause variation by being above the upper control limit. The data also shows that for wc 25th October response times for C1 and C2 mean are close to the upper control limit and are at the highest they have been over the three years measured in this report.

There are a number of reasons for worsening performance:

- A further significant increase in delayed admissions with average turnaround time continuing to be above the 30m standard and increasing month on month.
- Although we have not seen an increase in incidents, we have seen a significant increase in the proportion of incidents which are higher acuity - C1 and C2.
- Continuous high call levels which has partly been driven through an increase in duplicate calls.
- During recent months we have seen increasing acuity of our patients. C1 calls have risen from 9% to 17%, C2 calls have risen from 52% to 56%. This means that 73% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat.

The trust has taken a number of measures to improve performance and maintain patient safety including an agreed 6 point plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services.

The £6.2M for increase for winter to be used for

- Increase in 999 call handlers
- Expanded capacity for crews on the road
- Additional clinical support
- Extended HALO (Hospital Ambulance Liaison Officer) cover
- Retention of Emergency Ambulances to increase the fleet for winter

The trust has been working with ORH and AACE and is now ready to start delivery focusing on those elements that do not require funding. The trust is working with AACE to understand the increase in acuity. All trusts have seen an increase in but not to the same extent as NWAS.

We continue to focus on patient safety with a particular focus on long waits to ensure we avoid patient harm. We have not seen an increase in serious incidents reports (section Q3). We are also seeing patient satisfaction levels remaining constant (section E1).

Figure O3.1

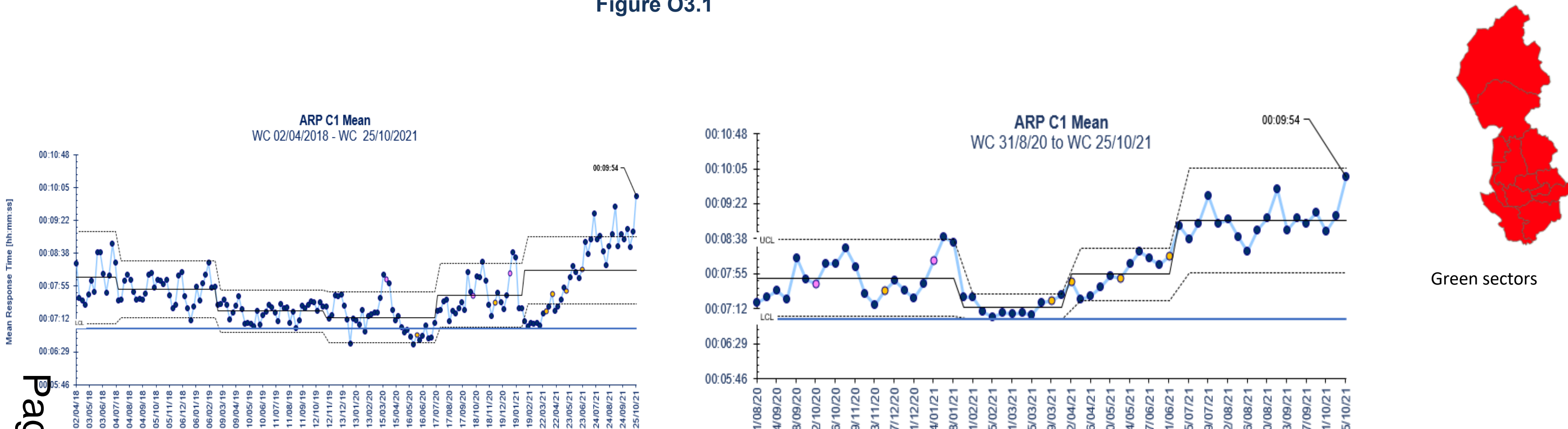
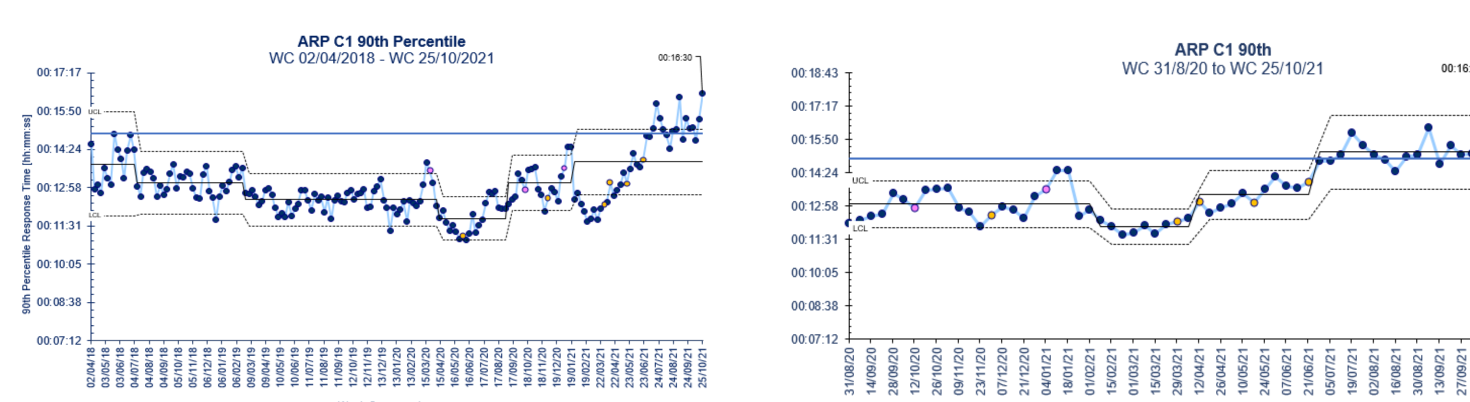
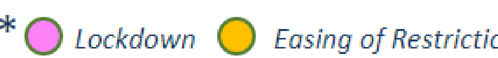


Figure O3.2



Green sectors

M North, , G West, G East, G Central, G South,



C1 Performance

C1 Mean

Target: **7 minutes**

NWAS

October 2021: **9:14**

YTD: **8:37**

C1 response times for both mean and 90th are showing the as the longest in over 3 and a half years and are also showing a process with less control, with data points showing greater divergence since summer 2021.

C1 90th Percentile

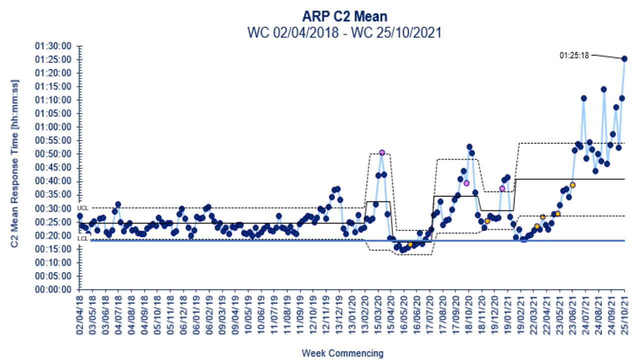
Target: **15 Minutes**

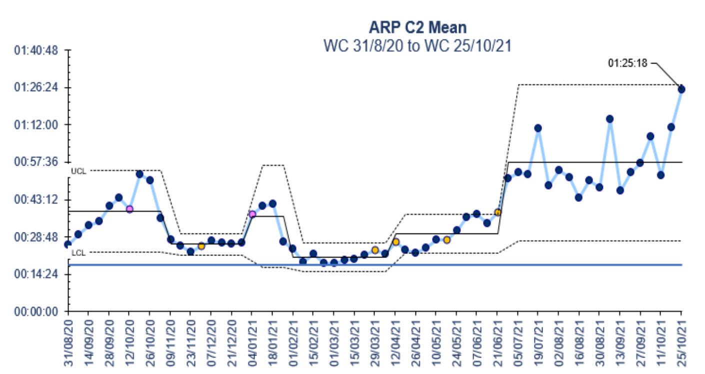
NWAS

October 2021: **15:33**

YTD: **14:38**

Figure O3.3

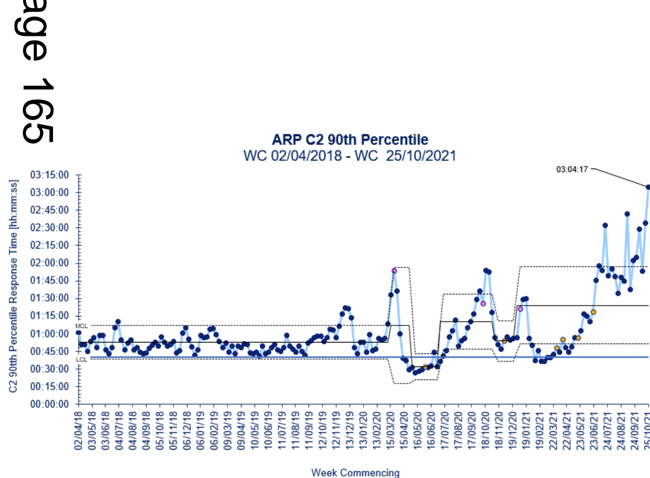


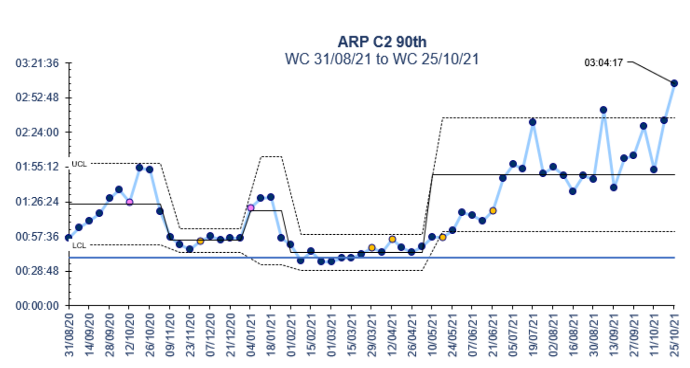


C2 Mean (Red=>18m)

Green sectors

Figure O3.4





C2 90th (Red=>40m)

Green sectors

C2 Performance

C2 Mean

Target: **18 minutes**

NWAS:

October 2021: **1:07:42**

YTD: **45:29**

C2 response times for both mean and 90th are showing as the longest in over 3 and a half years and are also showing a process with less control, with data points showing greater divergence since summer 2021.

Additional focus is being placed on long waits ensuring incidents are responded to in order of acuity, ensuring we minimise any patient harm.

C2 90th Percentile

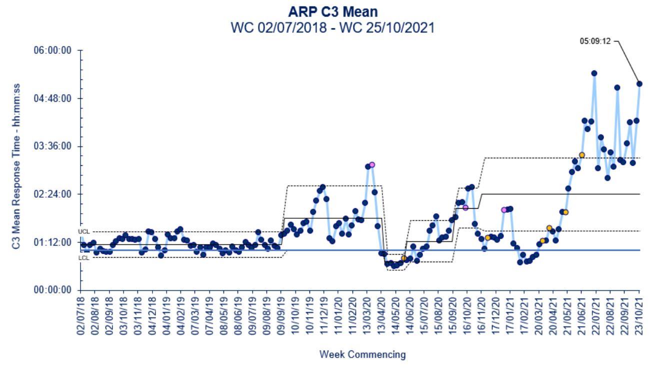
Target: **40 Minutes**

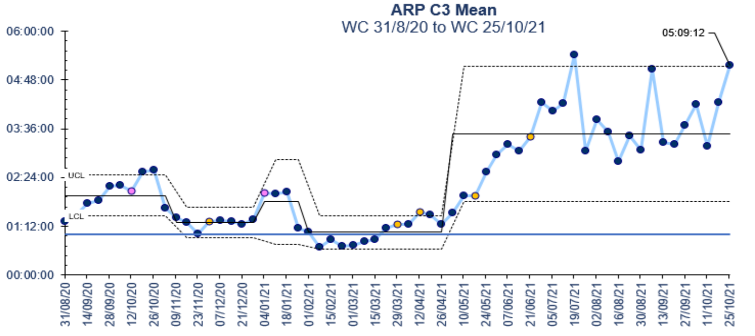
NWAS

October 2021: **2:28:44**

YTD: **1:37:35**

Figure O3.5

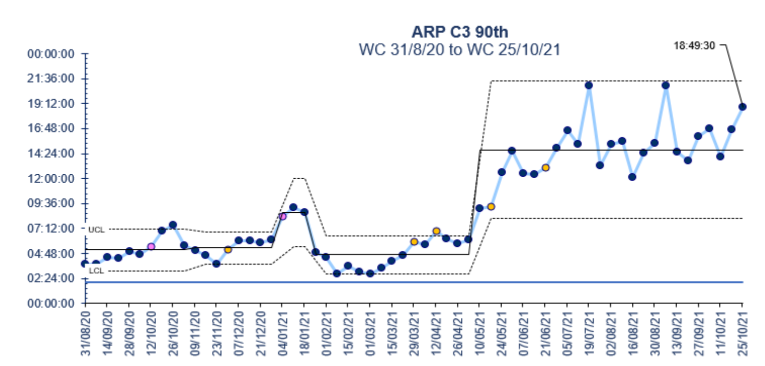




C3 Mean (Red=>60m)

Green sectors
CL North Cumbria

Figure O3.6



C3 90th (Red=>2h)

Green sectors
Bay CL North Cumbria

C3 Performance

C3 Mean
Target: **1 Hour**

NWAS:
October 2021: **4:06:33**
YTD: **2:56:41**

C3 response times for both mean and 90th are showing the as the 2nd longest in over 3 and a half years and is also showing a process with less control, with data points showing greater divergence since summer 2021.

C3 90th Percentile
Target: **2 Hours**

NWAS
October 2021: **10:27:54**
YTD: **7:15:36**

C4 Mean and 90th Percentile

C4 data has not been included. A system change to the CAD is planned on the 24th November which will correct an issue with reporting. It had originally been planned for October but this was not possible for the supplier. From this point on data will be correct and will be reported. A piece of work will follow to backdate the data. NHS E/I have agreed this approach.

Figure O3.8

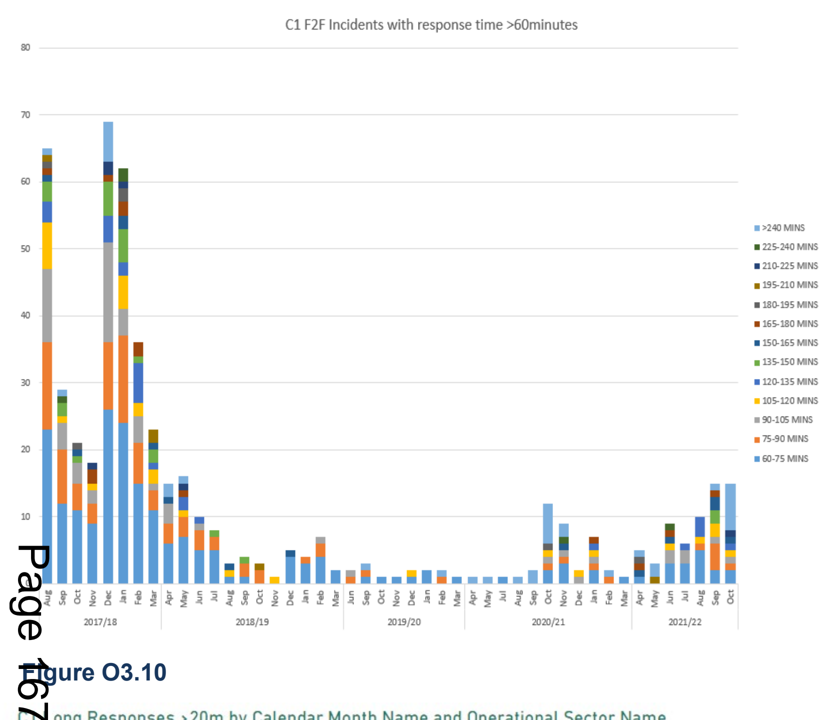


Figure O3.9

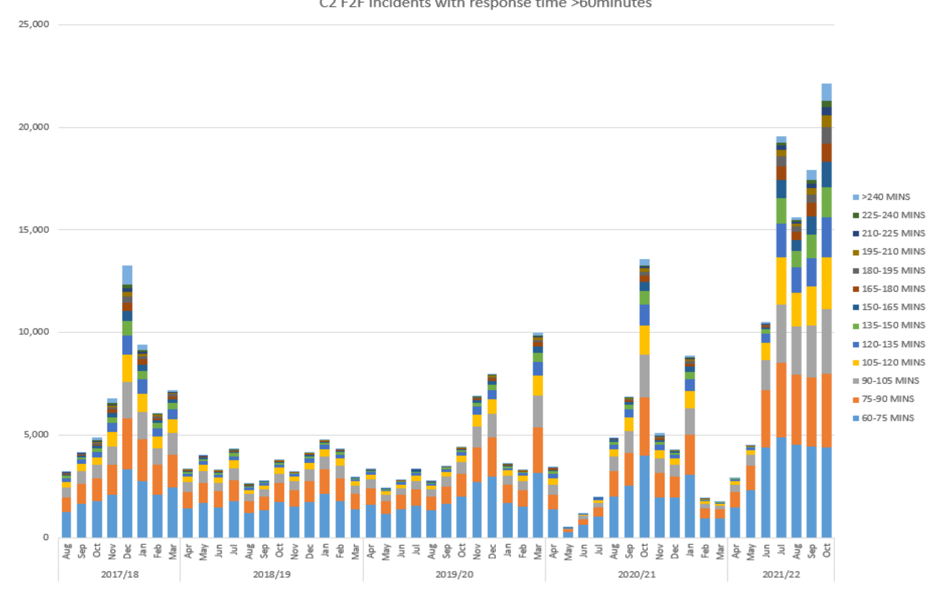


Figure O3.10

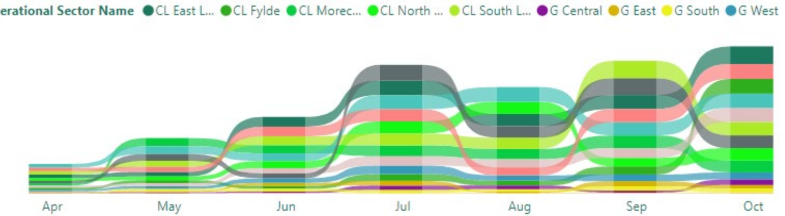
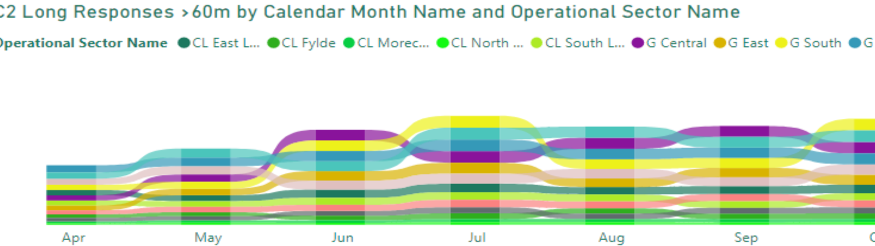


Figure O3.11

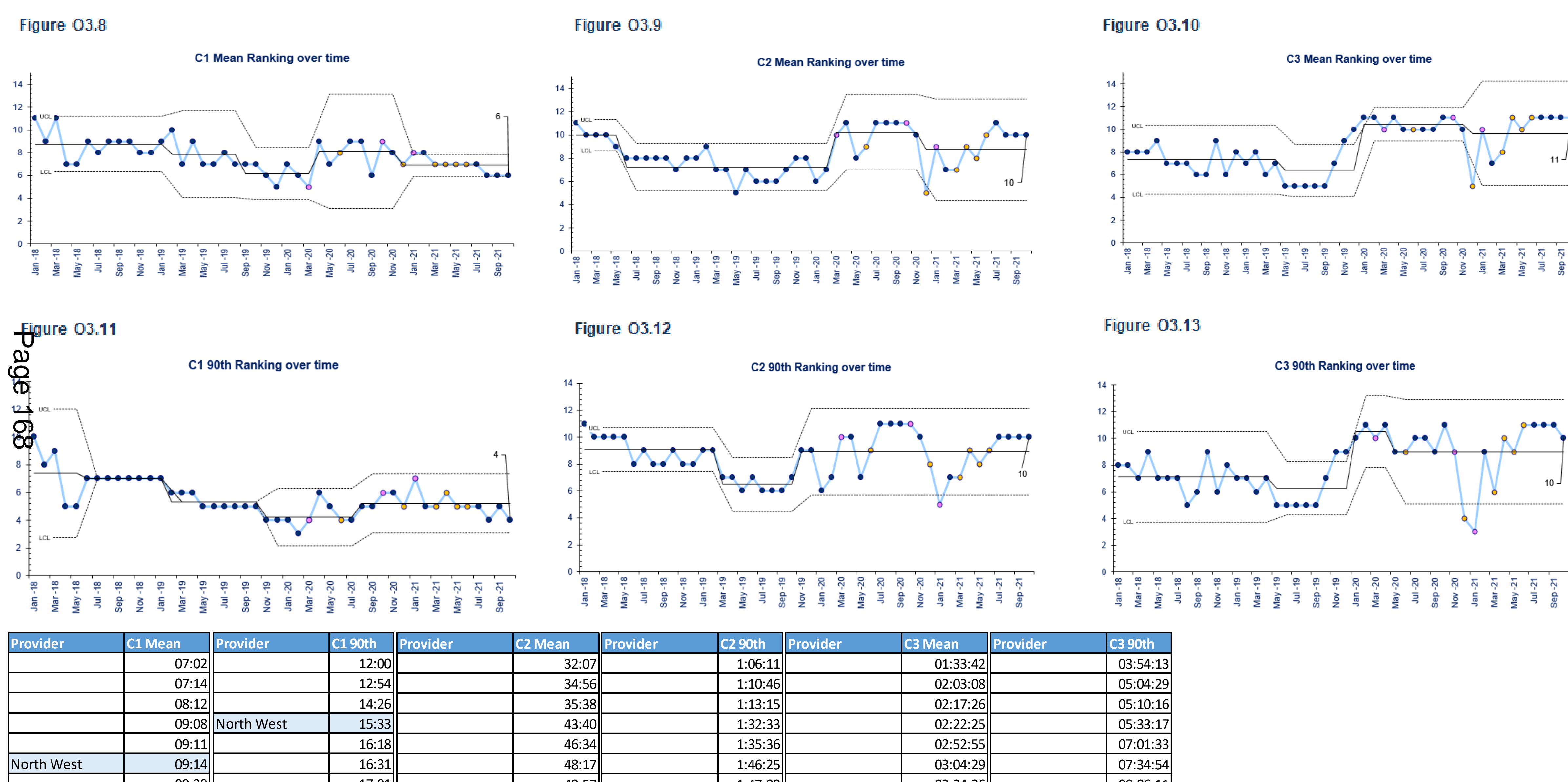


C1 & C2 Long Waits

The level of increase in the long waits for both C1 and C2 has continued. This corresponds with the overall increase in activity in both categories. As would be expected the increase is lower in C1 than C2.

The number of C2 long waits has been significantly high since June. This is a major patient safety concern and there are measures in place to review patients through the clinical control desk which are helping but not eliminating the risk.

ARP Provider Comparison Figures October 2021



Provider	C1 Mean	Provider	C1 90th	Provider	C2 Mean	Provider	C2 90th	Provider	C3 Mean	Provider	C3 90th
	07:02		12:00		32:07		1:06:11		01:33:42		03:54:13
	07:14		12:54		34:56		1:10:46		02:03:08		05:04:29
	08:12		14:26		35:38		1:13:15		02:17:26		05:10:16
	09:08	North West	15:33		43:40		1:32:33		02:22:25		05:33:17
	09:11		16:18		46:34		1:35:36		02:52:55		07:01:33
North West	09:14		16:31		48:17		1:46:25		03:04:29		07:34:54
	09:29		17:01		49:57		1:47:09		03:24:26		08:06:11
	09:55		17:39		56:01		2:00:02		03:58:59		09:43:04
	10:37		18:44		59:05		2:07:06		03:59:45		09:57:02
	11:04		19:19	North West	01:07:42	North West	2:28:44		04:00:41	North West	10:27:54
	11:48		21:12		01:24:25		3:04:58	North West	04:06:33		10:33:45

O4 111 PERFORMANCE

Figure O4.1

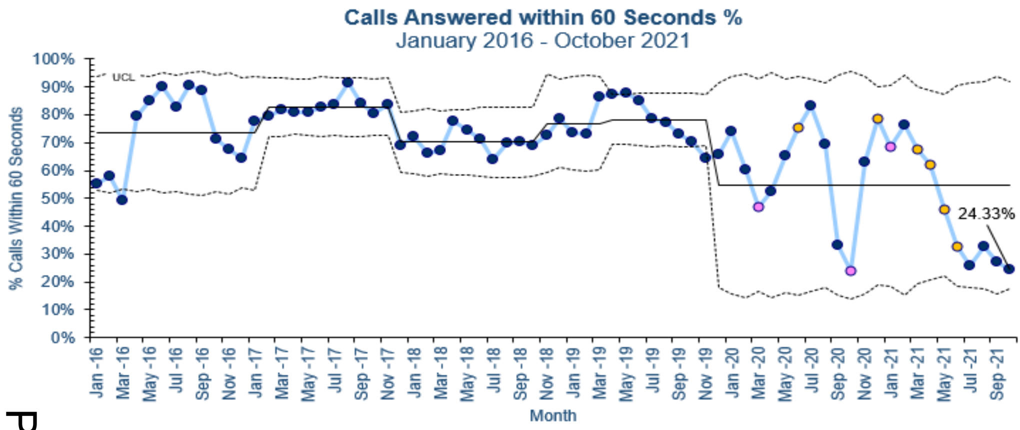
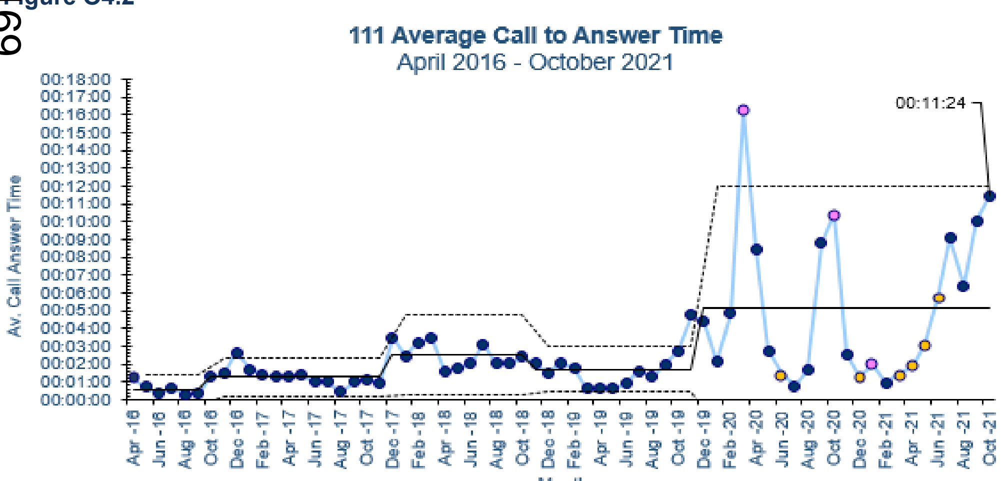
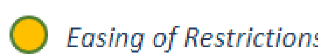


Figure O4.2



Lockdown  Easing of Restrictions

111 Performance

Calls Answered within 60 seconds %

Target: **95%**

NWAS
October 2021: **24.33%**
YTD: **36.96%**

National **29.1%**

Performance for the headline KPI continues to challenge the service.

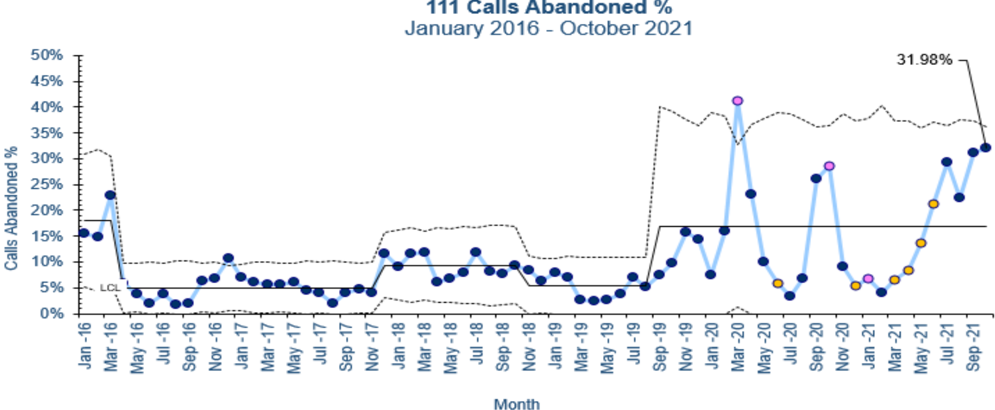
Calls Answered within 60s, Average Call To Answer Time and Calls Abandoned directly relates to available resource (Q4.1).

The senior team are working with commissioners and have developed a plan support the delivery of the service throughout winter. The plan focuses on 6 main areas of delivery.

Call volumes remain high. This increase in activity is unfunded and presents a resource gap at some points in the day of about 50%. The additional volume is also variable in its profile with significant swings causing significant pressures with forecasting.

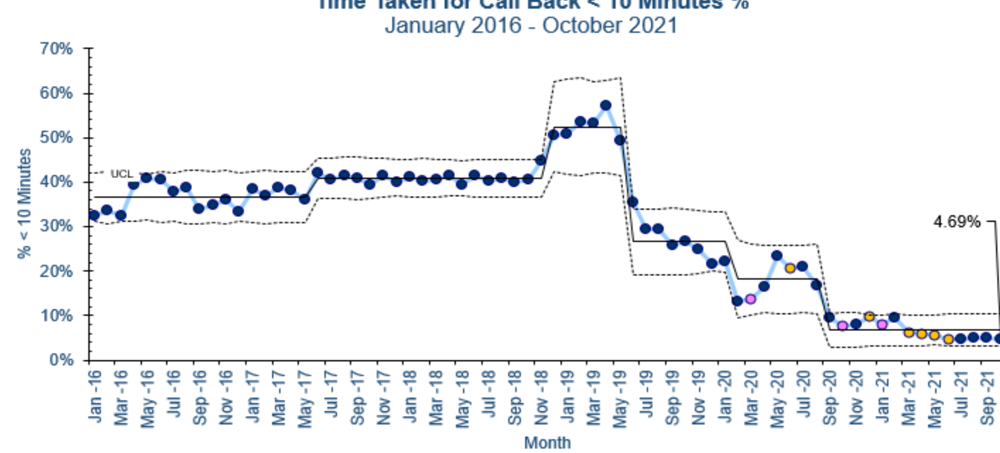
Work is ongoing to review the primary care activity and commissioning colleagues continue to engage with Primary care to challenge outliers.

Figure O4.3:



** From April 2021 the method of calculating abandoned calls has changed, the difference between the two methods means that the figure for April is 0.5% higher than would have been under the old method*

Figure O4.4



* *Lockdown* *Easing of Restrictions*

Calls Abandoned %

Target: **<5%**

NWAS

October 21: **31.98%**

YTD: **22.68%**

National 27.8%

Call Back < 10 Minutes %

Target: **75%**

NWAS

October 21: **4.69%**

YTD: **5.12%**

As with previous comments call abandoned directly correlates with the answered in 60 KPI.

Further work is ongoing to review several options with Pathways about increased self care and call truncation. These two options would potentially provide relief on the clinical queue and a reduction in Average Handle Time. They also have further implications for onward referral so a review into this impact is currently underway.

Time taken for a call back (10 mins). The increase in demand on the 111 service has directly impacted the size of the clinical advice queue. This has resulted in much larger queues and therefore fewer calls being called back within 10 minutes. The CAQ is managed 24/7 by the Clinical Duty Manager (CDM) and any calls of concerns are flagged for Clinicians to pick up as a priority.

Figure O4.5

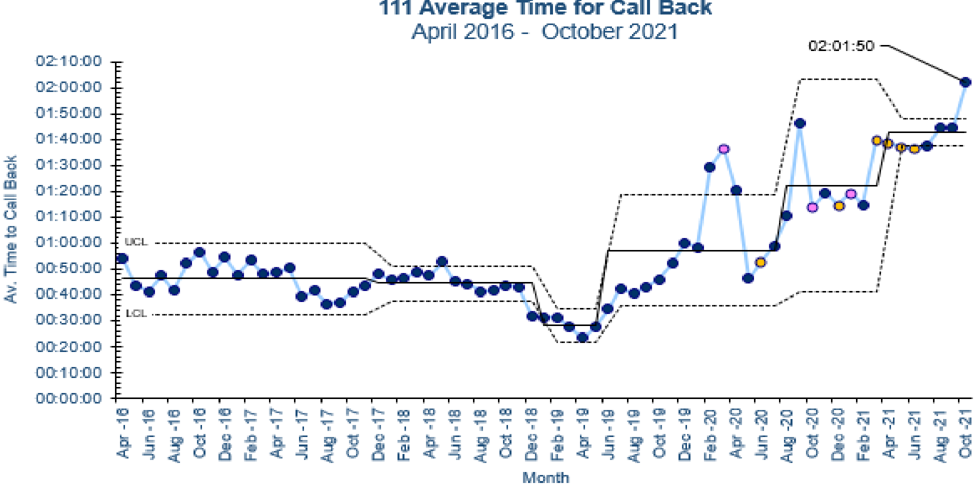
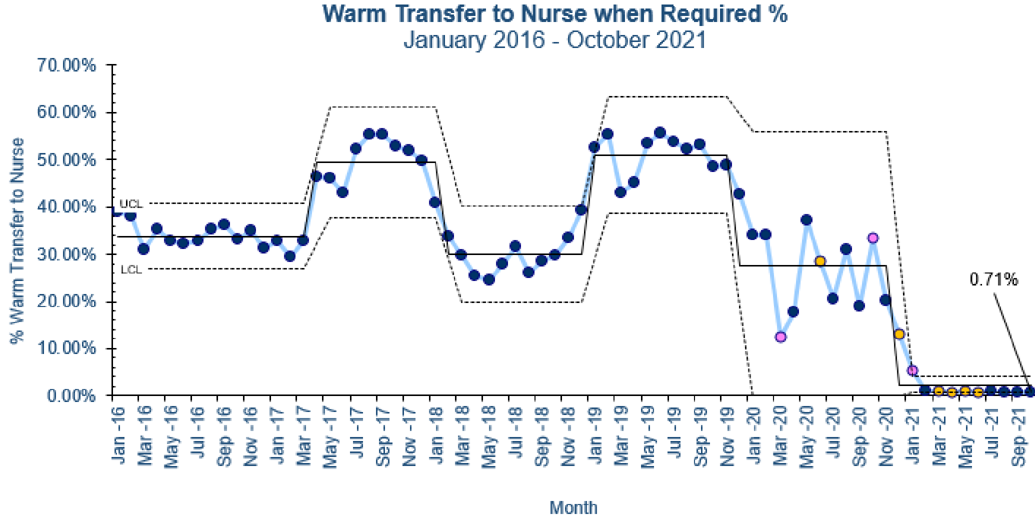


Figure O4.6



* Lockdown Easing of Restrictions

Warm Transfer to Nurse when Required%

Target: **75%**

NWAS

October 21: **0.71%**

YTD: **0.84%**

As per previous commentary due to the increase in demand warm transfer to Clinicians has been affected.

This has resulted in a 'bottle neck' with health advisors being on hold for prolonged periods of time waiting to get through to the next available clinician.

Many of these calls are now checked with the Clinical Duty Manager and were appropriate are then placed on the Clinical advice queue to be called back.

This then releases the HA to take another incoming call. The CDM will monitor the CAQ and assign any calls of concern to a clinician to pick up as their next call.

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY

TOTAL ACTIVITY

Contract	Current Month: September 2021					Year to Date: July 2021 - September 2021			
	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	9,685	(4,339)	(31%)	42,073	28,129	(13,944)	(33%)
Greater Manchester	526,588	43,882	37,991	(5,891)	(13%)	131,647	110,700	(20,947)	(16%)
Lancashire	589,181	49,098	34,770	(14,328)	(29%)	147,295	100,598	(46,697)	(32%)
Merseyside	300,123	25,010	22,271	(2,739)	(11%)	75,031	65,890	(9,141)	(12%)
NWAS	1,584,182	132,015	104,717	(27,298)	(21%)	396,046	305,317	(90,729)	(23%)

UNPLANNED ACTIVITY

Contract	Current Month: September 2021					Year to Date: July 2021 - September 2021			
	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	555	(692)	(56%)	3,742	1,800	(1,942)	(52%)
Greater Manchester	49,133	4,094	4,538	444	11%	12,283	13,751	1,468	12%
Lancashire	58,829	4,902	3,529	(1,373)	(28%)	14,707	10,764	(3,943)	(27%)
Merseyside	22,351	1,863	1,784	(79)	(4%)	5,588	5,294	(294)	(5%)
NWAS	145,282	12,107	10,406	(1,701)	(14%)	36,321	31,609	(4,712)	(13%)

ABORTED ACTIVITY

Contract	September 2021								
	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	207	6,379	3%	34	545	6%	47	2,689	2%
Greater Manchester	1,733	17,925	10%	875	4,424	20%	916	15,201	6%
Lancashire	933	18,468	5%	561	3,466	16%	407	12,578	3%
Merseyside	515	8,863	6%	231	1,717	13%	460	11,501	4%
NWAS	3,388	51,635	7%	1,701	10,152	17%	1,830	41,969	4%

PTS Performance

Due to timetable issues PTS will always report a month behind other operational areas.

Activity during September 2021 was **21%** below contract baselines with Lancashire **29%** below contract baselines whilst Merseyside is operating at -11% (-2739) Journeys below baseline. For the year to date position (July 2020 - September 2021) PTS is performing at **-23% (-90729**) journeys below baseline. Within these overall figures, Cumbria and Lancashire are operating at **33%** and **32%** below baseline whilst Greater Manchester and Merseyside are operating at **16%** and **12%** below baseline respectively.
In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are **12%** (1468 journeys) an**d -5% (-294)** journeys against baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges achieving contract KPI performance. Cumbria and Lancashire are **-52% (-1942)** journeys and **-27% (-3943)** journeys below baseline.

In terms of overall trend analysis, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas with daily averages having increased from circa **4,500** journeys per day in early 2021 to circa **4,800** currently.

Aborted activity for planned patients averaged **7%** during September 2021 however Cumbria experiences **3%**, Greater Manchester operates with **10%** whilst Lancashire and Merseyside both experience **5%** & **6%** aborts respectively. There is a similar trend within EPS (renal and oncology) patients with an Trust average of **4%** aborts whereas Cumbria has **2%** and Greater Manchester **6%** Lancashire and Merseyside operate with **3%** and **4%** respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average **17%** (**1** in **6** patients) with variances of **6%** in Cumbria, **20%** in Greater Manchester, **16%** in Lancashire and **13%** Merseyside.

Looking ahead, a number of PTS staff have now confirmed their interest in temporarily redeploying into PES as a Blue Light Driver and the impact of this on recruitment and service provision combined with existing vacancies are being worked through. Following on from the previous report, the service line continues to progress the work it is doing to enable greater provision of double crewed non-emergency ambulances with a view to implementing this over the coming weeks.

Challenges around capacity associated with social distancing measures continue to impact utilisation of resource. Whilst the current direction is that current IPC / social distancing measures will remain in place discussions continue with NHSE/I, and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively. Activity has steadily increased over the past 6 months to an overall level in excess of 90% of pre covid activity. The proportion of patients requiring an ambulance is regularly close to pre-covid levels.

Regulation comes into effect on 11 November 2021 which states only individuals who have received two vaccine doses will be allowed to enter a nursing home. NWAS and private ambulance staff who have not received both vaccines have been identified and their records updated on Cleric to flag to the controller and prevent nursing home journeys being allocated to ineligible staff. Communications have been sent to NWAS staff outlining the approach and a letter sent from the Chief Executive to nursing homes providing this assurance and to request mobile patients who may travel in a taxi be brought to the entrance to the home for collection.

Discussions continue with commissioners and colleagues internally with respect to a new service model(s) for PTS with a view to the procurement of a new service due to commence in April 2023 and as reported previously outputs from these discussions are reported at the UEC Oversight Forum.

OH1 STAFF SICKNESS

Figure OH1.1

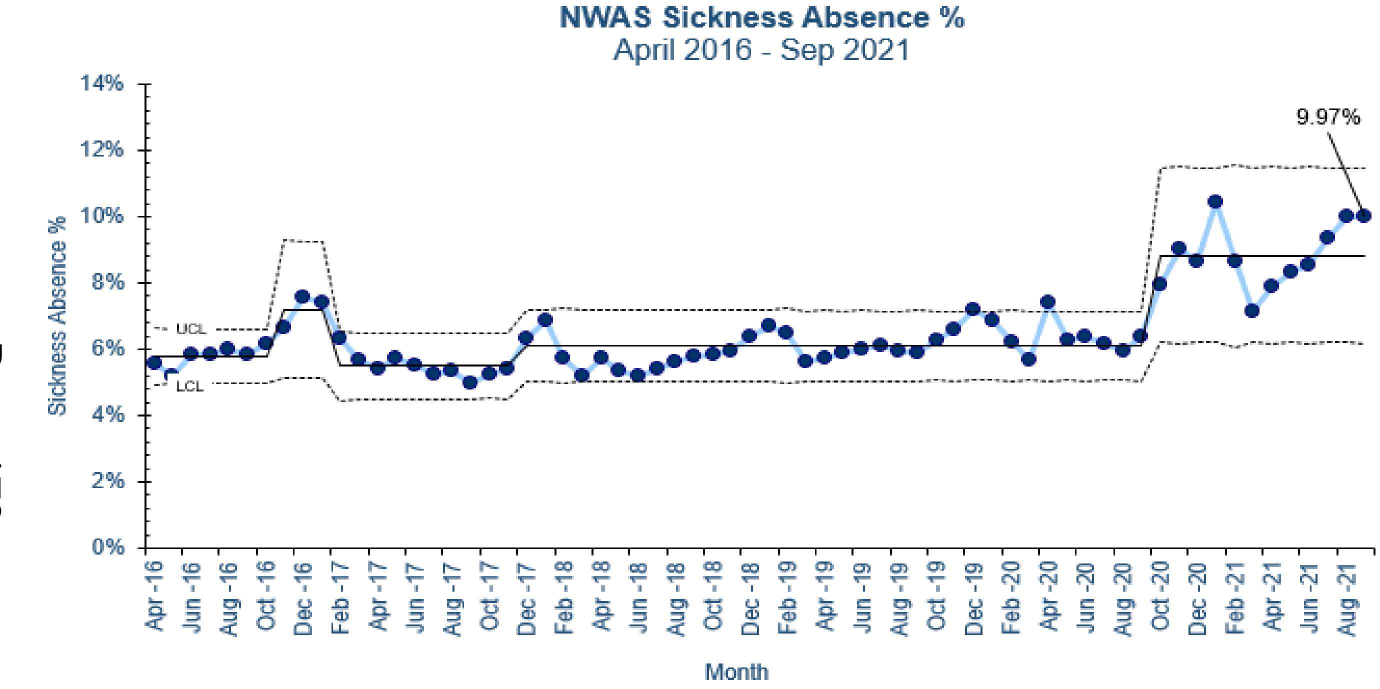


Table OH1.1

Sickness Absence	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
NWAS	7.94%	9.00%	8.66%	10.41%	8.65%	7.15%	7.90%	8.32%	8.55%	9.33%	10.00%	9.97%
Amb. National Average	6.10%	6.51%	6.75%	9.37%	7.03%	6.06%	6.36%	6.59%	6.98%			

Staff Sickness

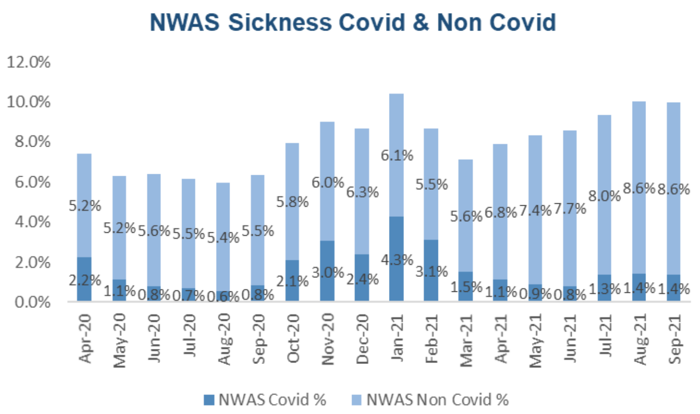
The overall sickness rates for September 2021 were **9.97%** (OH1.1). The current position being within the control limits but above the Trust target of **0.5%** reduction on previous year which would be **5.7%**. Sickness has continued to increase for 6 consecutive months. Data analysis shows the top 5 reasons for absence being Mental Health, Covid, Injury, MSK and Back problems. Short term sickness absence is broadly equal to long term sickness in PES and PTS however short-term sickness in 111 is high which is likely to be as a result of sustained demand on the service .

The impact of COVID related sickness has increased slightly to **1.37%** (OH1.2). The underlying non-COVID position is **8.60%** which is higher than the same period last year which was **6.35%** and is clearly showing an upward trend.

In addition to sickness reported via ESR, COVID 19 self-isolating absences have been captured by GRS, Teliopi and Marval.

The People directorate have identified additional resources to establish a dedicated Team to focus on supporting operational teams to improve attendance management and wellbeing.

Figure OH1.2:



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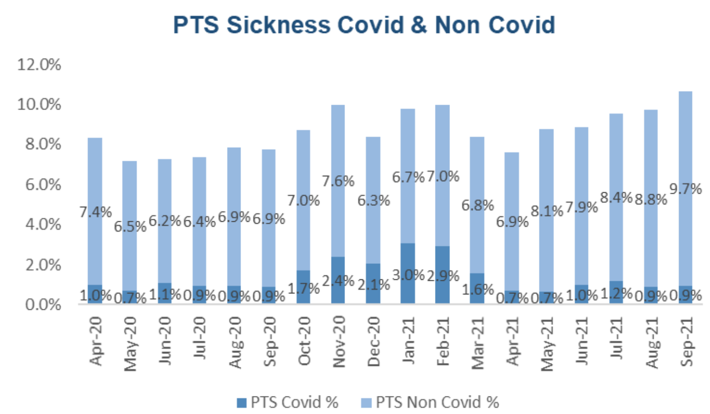

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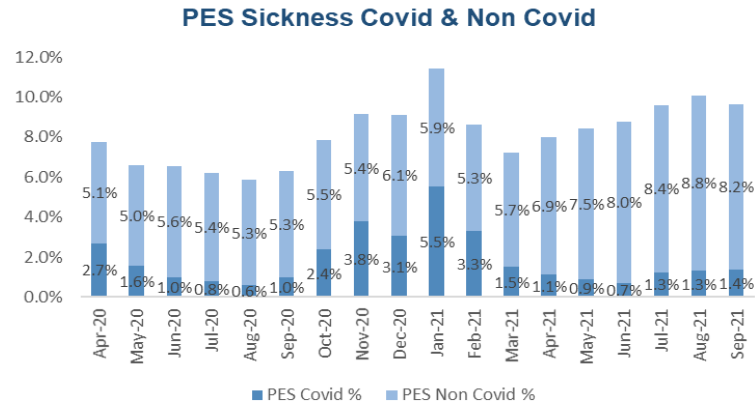
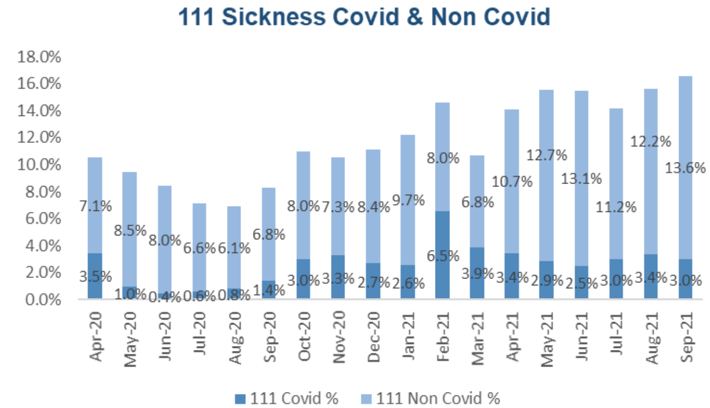


Figure OH1.5:

EOC Sickness Covid & Non Covid

EOC Covid % EOC Non Covid %

Figure OH1.6:



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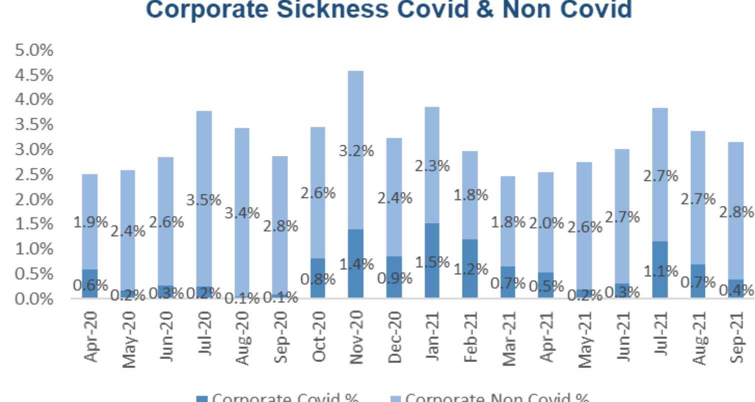


OH2 STAFF TURNOVER

Figure OH2.1

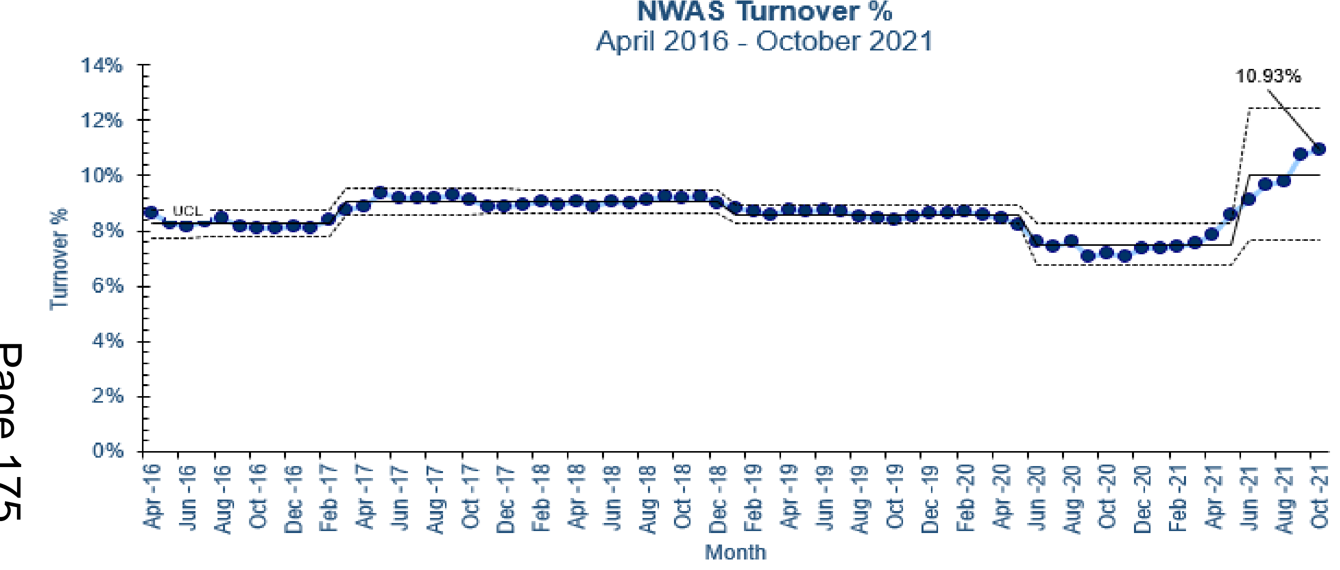


Table OH2.1

Turnover	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
NWAS	7.08%	7.35%	7.34%	7.41%	7.57%	7.87%	8.56%	9.10%	9.67%	9.77%	10.76%	10.93%
Amb. National Average	7.75%	7.67%	7.58%	7.41%	7.35%	7.57%	7.52%	8.07%	8.44%			

Staff Turnover

Staff turnover for October is **10.93%**. This is calculated on a rolling year average.

Staff turnover has shown a steady increase in the last 6 months. 111 turnover is showing a significant upward trend to **41.85%** in October 2021 which is outside of the upper control limit (OH2.5)

Detailed analysis on leavers is ongoing but there is a spike in leavers within the first 12 months which is likely to indicate the pressure within the service. NHSE/I and the Regional People Team are supporting a national approach to improving retention in both 999 and 111 call taking.

EOC has also seen an increase with October turnover at 12.40% (OH2.4), it is slightly up on previous months. Some of this reflects the loss of fixed term staff seeking permanent positions. These staff are now being transferred to NWAS permanent posts. However EOC staffing position is stable moving into the winter period given the level of over recruitment and training.

Both PES and PTS turnover are showing a small upward trend, however, overall the Trust has not seen the anticipated loss of Paramedics to PCNs in Q1 and Q2.

Overall Trust turnover is now above the sector average but the trend seen in contact centres is being mirrored nationally.

Figure OH2.2

PTS Turnover %
April 2016 - October 2021

Turnover %
Month
UCL
LCL
7.67%

Figure OH2.3

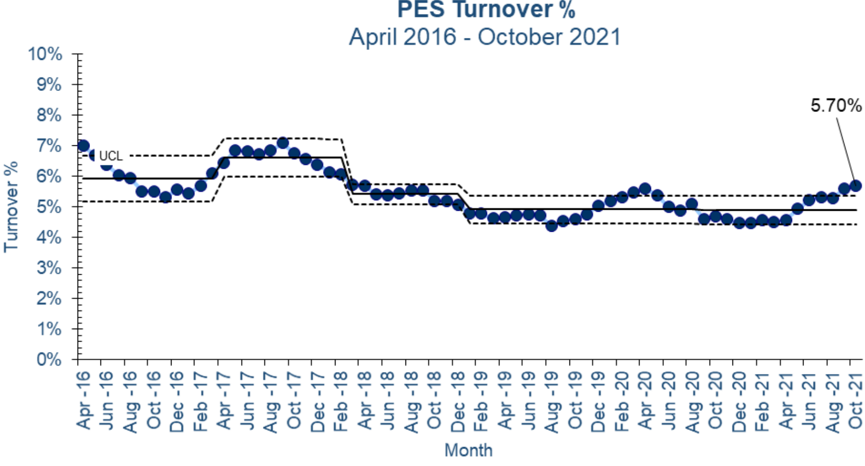


Figure OH2.4

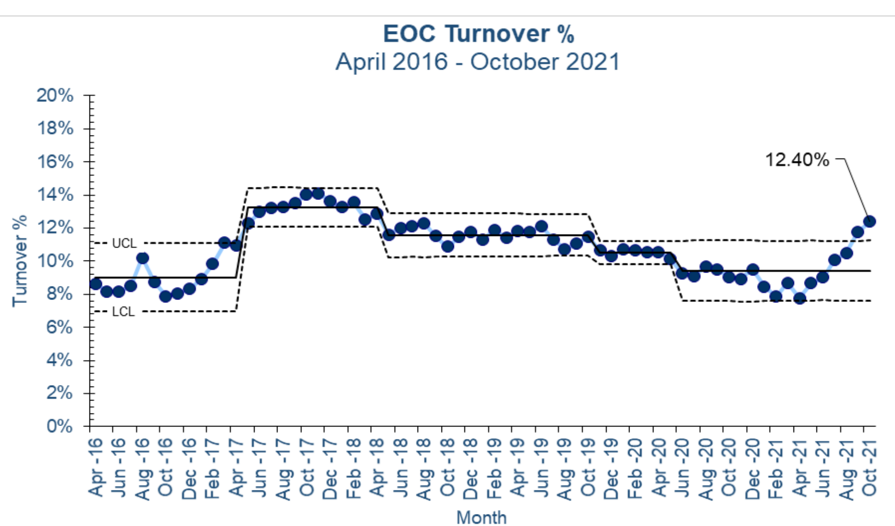
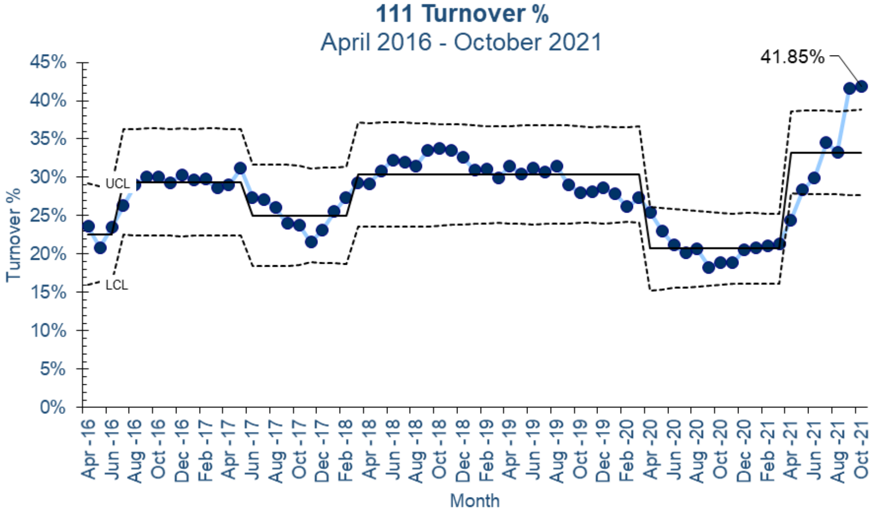


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:

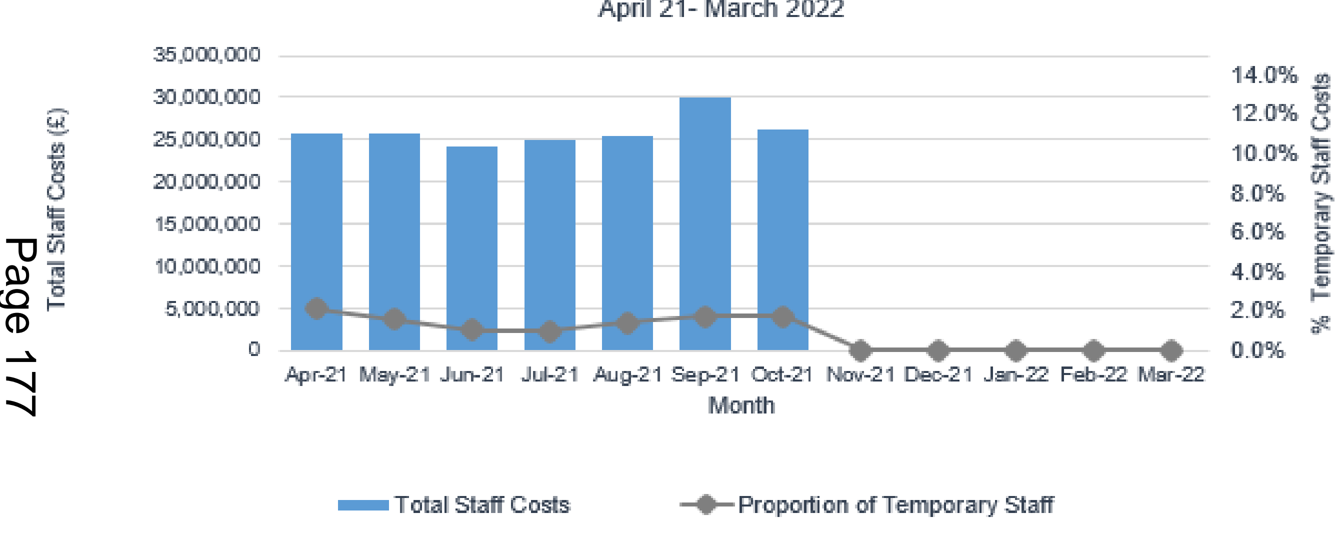


Table OH4.1

NWAS	Nov-19	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Agency Staff Costs (£)	502,967	541,395	636,447	478,564	647,483	541,873	404,321	245,748	241,475	356,466	518,275	444,941
Total Staff Costs (£)	24,985,757	24,466,230	25,444,774	25,353,362	48,192,045	25,673,168	25,780,966	24,317,963	24,909,469	25,379,411	29,910,317	26,091,860
Proportion of Temporary Staff %	1.7%	1.6%	2.5%	1.9%	1.3%	2.1%	1.6%	1.0%	1.0%	1.4%	1.7%	1.7%

Temporary Staffing

As a result of COVID-19 the Trust Agency usage and expenditure is projected to exceed the Agency ceiling, although this does not form part of the reporting under the emergency arrangements. The agency ceiling is a maximum amount of agency spend allowable.

Agency staff have continued to support the Contact Centre environment.

ELC have confirmed the recruitment of up to 140 call handlers in EOC to support the roll out of SPT and also support the ongoing winter pressures.

111 have also had temporary funding to recruit into Service Advisor posts for a 3 month period. To support ongoing recruitment, these Agency staff will then be considered at the end of the 12 week period to transfer on to a Trust contract to support vacancy gaps overall.

Current agency usage is therefore anticipated to continue across Q3

Figure OH4.2:

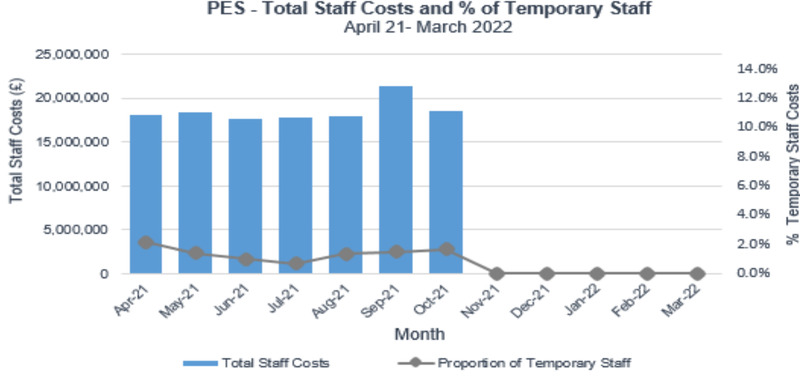
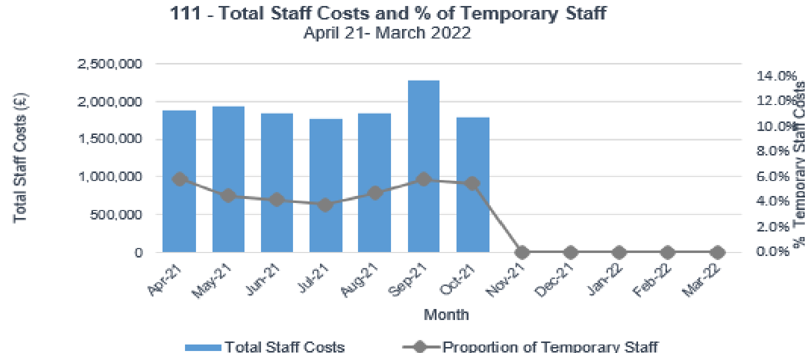


Figure OH4.3:



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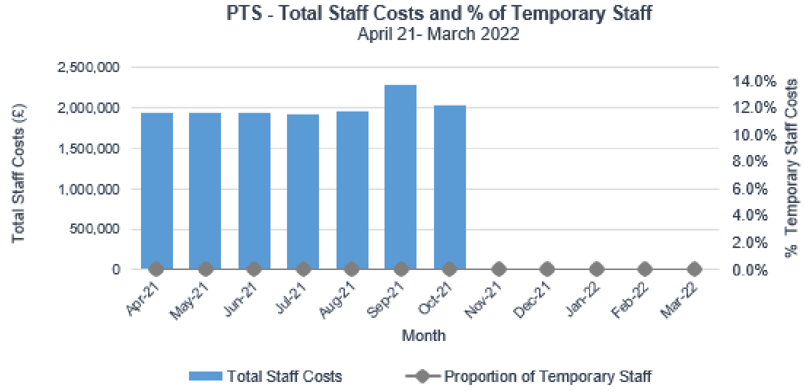
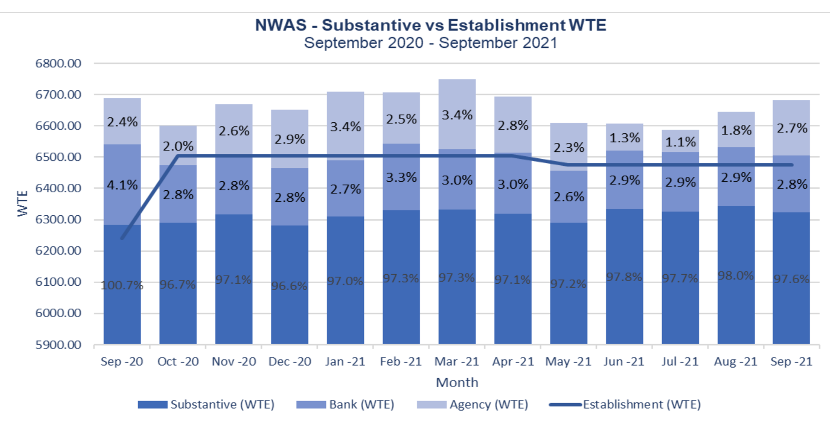


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

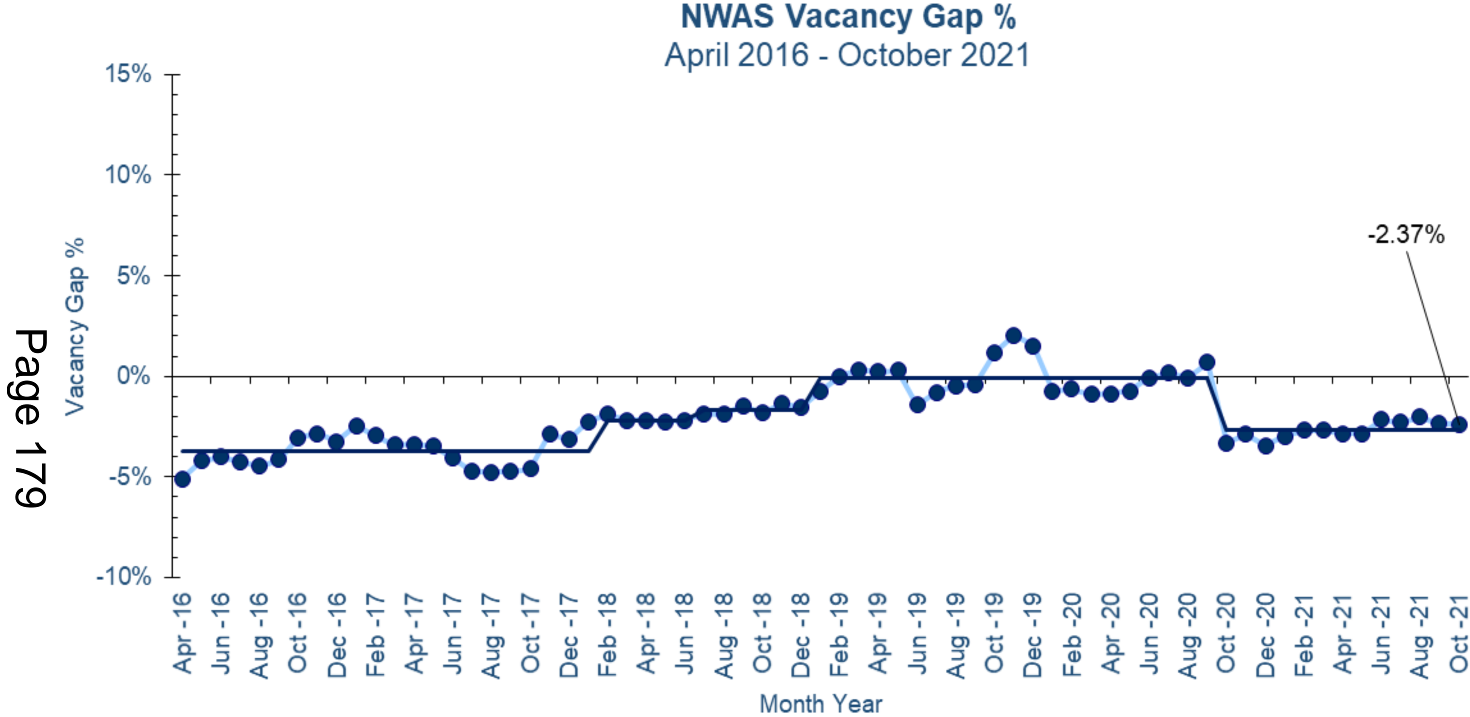


Table OH5.1

Vacancy Gap	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
NWAS	0.69%	-3.31%	-2.88%	-3.44%	-2.97%	-2.68%	-2.67%	-2.86%	-2.85%	-2.16%	-2.30%	-2.03%	-2.36%	-2.37%

Vacancy Gap

Chart OH5.1 shows the vacancy gap at circa **–2%** reflecting overall a positive position.

Although recruitment plans for 111 are on track the establishment change now shows the current position against all the growth as a gap of **11.80%** (OH5.5). This is mainly the result of increased turnover which has moved the service into a deficit position. The recruitment plan focuses on maximising Health Advisor and Clinical Advisor recruitment. Additional Agency staff are also being recruited for an initial 12 week period with a view to being move onto Trust contracts after this period. Agency staff are not shown in this data.

The PTS vacancy (OH5.2) has been created due to a large number of PES upskill staff taking up apprentice EMT1 positions. There is a robust recruitment and training plan is place which will deliver an increase in staff with **12** PTS courses planned throughout the year. This plan has been revised to front load courses to ensure deployment Pre-Christmas with ongoing review in place. The progress in narrowing the gap can be seen in the data.

The PES and EOC position remains very stable. The EOC position shows **4.69%** above establishment due to ELC approving the continued recruitment at risk to maintain and improve frontline staffing. This excludes agency recruitment with the current position including **104** agency staff being **24.4%** above establishment

Figure OH5.2

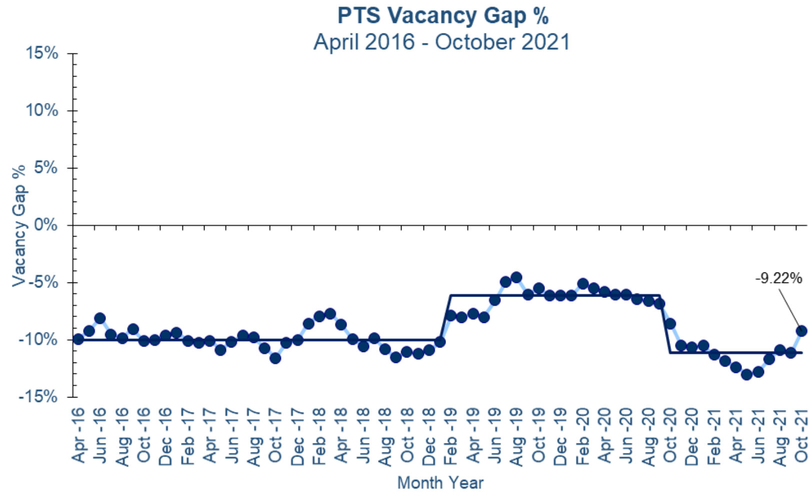


Figure OH5.3

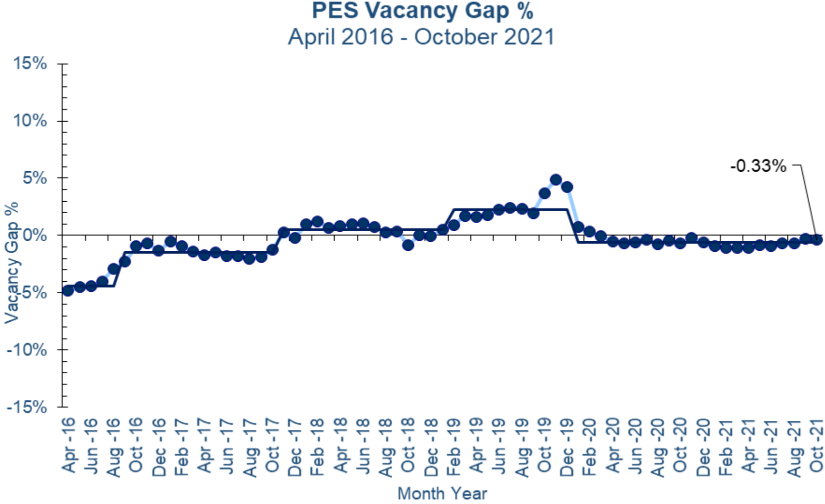
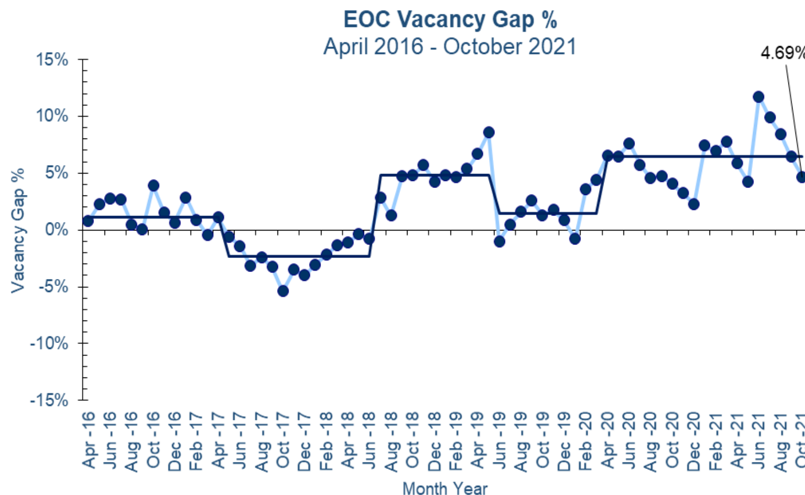
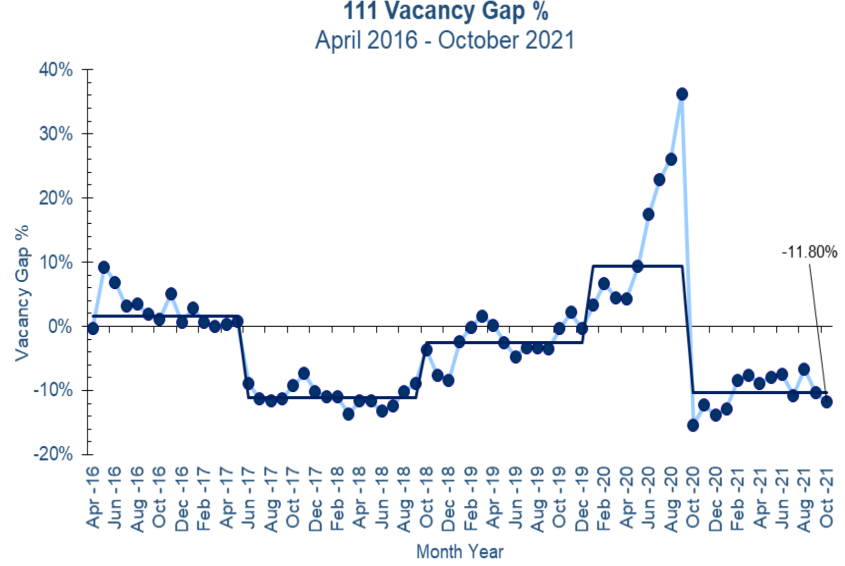


Figure OH5.4





OH6 APPRAISALS

Figure OH6.1

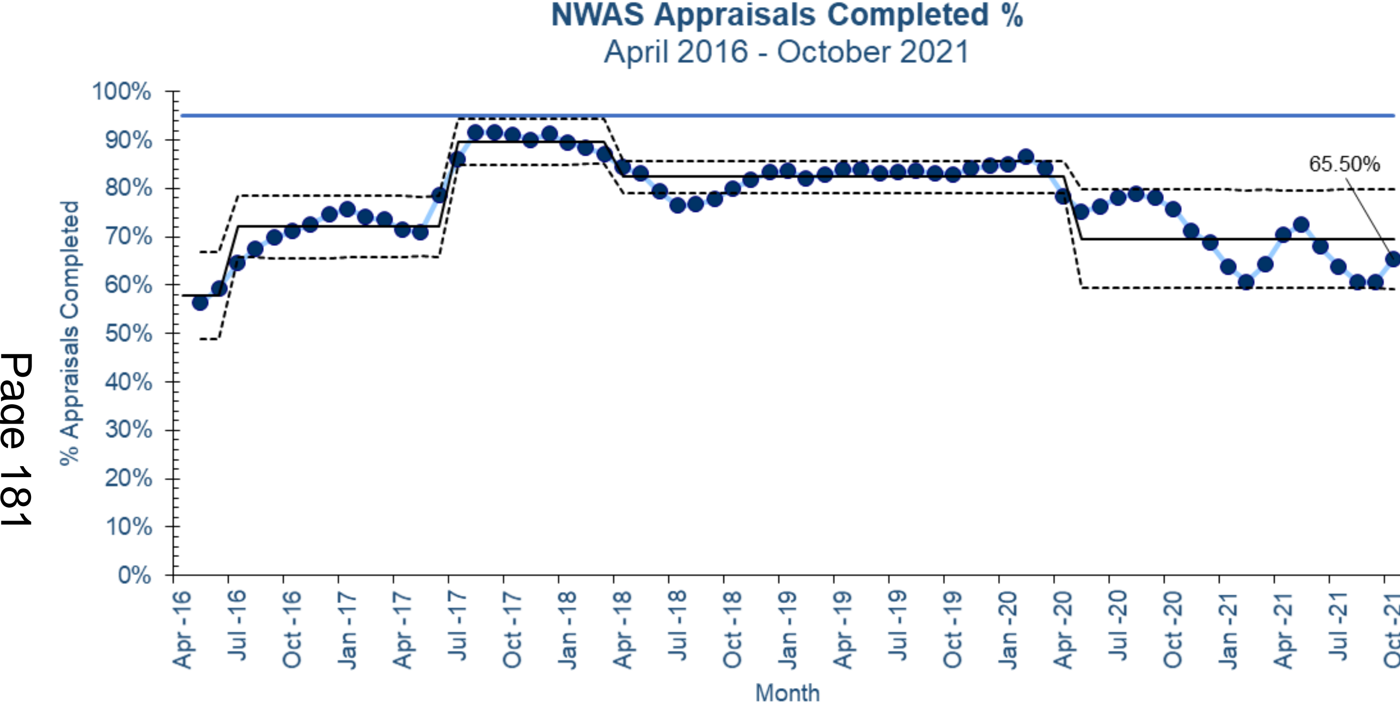


Table OH6.1

Appraisals	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
NWAS	71%%	69%	64%	61%	64%	70%	73%	68%	64%	61%	59%	65%

Appraisals

Appraisal completion rates are at **65%** for October 21 (OH6.1). The impact of operational pressures since June and the move to Reap 4 has impacted on compliance but good progress is now being seen. ELC have now approved revised targets in light of operational pressures and demands on Service Lines.

The revised targets approved by ELC are:

75% by March 2022 – Service Lines

85% by March 2022 – Corporate and Band 8a and above

Most service lines are just within or above the control limits apart from EOC where recovery work is required (OH6.4) despite a **10%** improvement in month. Operational pressures are still impacting on completion rates however good progress is being made with PES rates are at **64%** and PTS at **80%** which exceeds target. The 111 data position has improved significantly with the data point above the upper control limit at **73%.**

A revised process has set a minimum expectation for staff check-in conversations with a focus on

- Health, wellbeing, safety, and any support that may be needed
- Personal and professional resilience in the current operating environment, and
- Identification of any development needs that may arise out of the previous discussion points

Figure OH6.2

PTS Appraisals Completed %
April 2016 - October 2021

% Appraisals Completed
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
79.60%
Apr-16 Jul-16 Oct-16 Jan-17 Apr-17 Jul-17 Oct-17 Jan-18 Apr-18 Jul-18 Oct-18 Jan-19 Apr-19 Jul-19 Oct-19 Jan-20 Apr-20 Jul-20 Oct-20 Jan-21 Apr-21 Jul-21 Oct-21
Month

Figure OH6.3

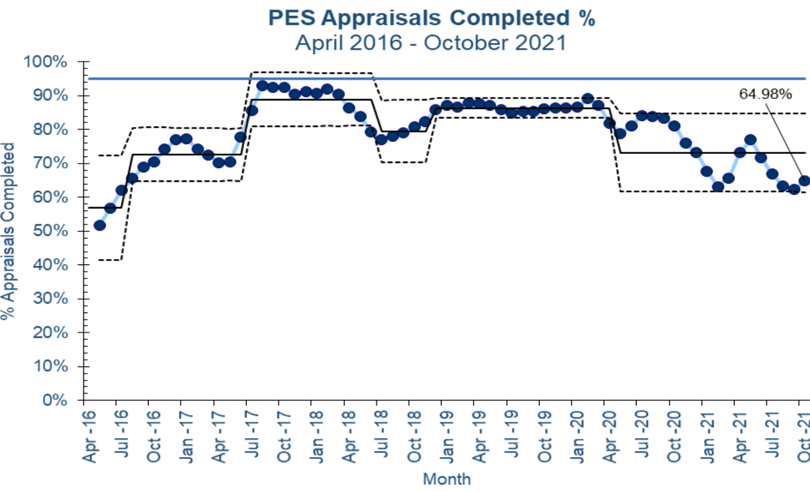


Figure OH6.4

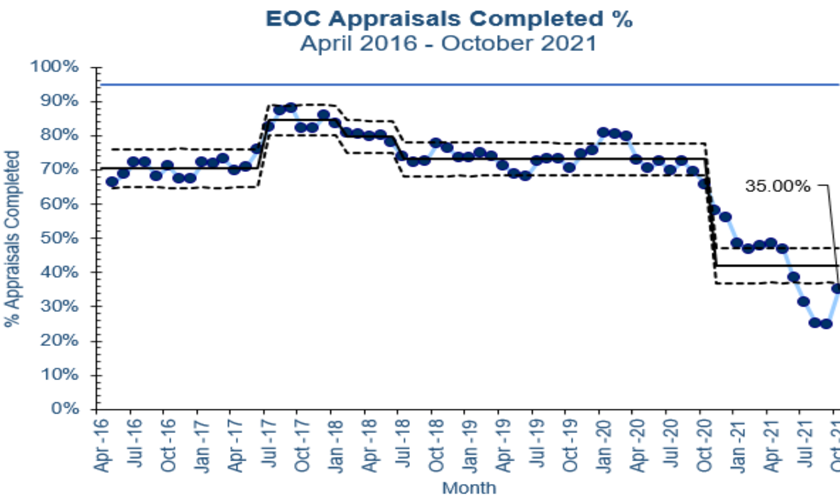
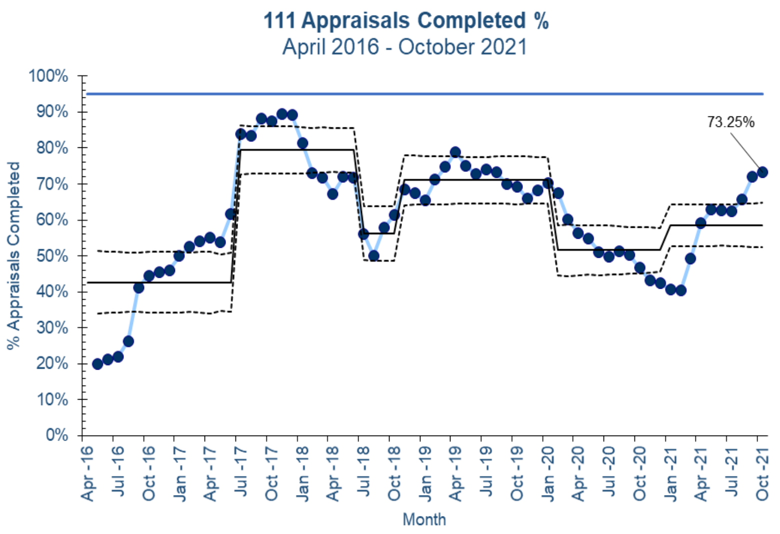


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

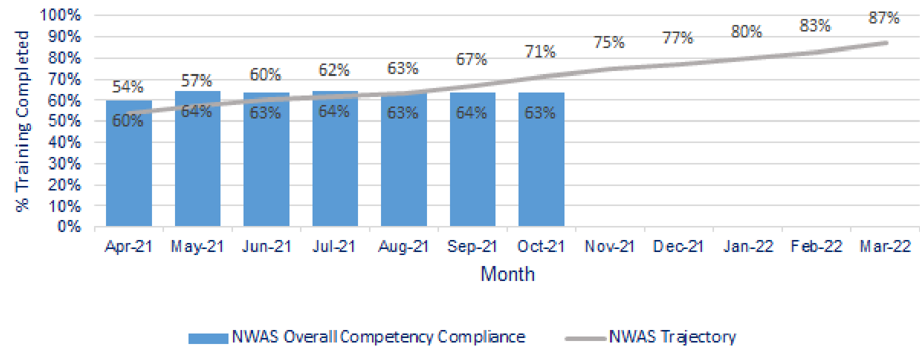
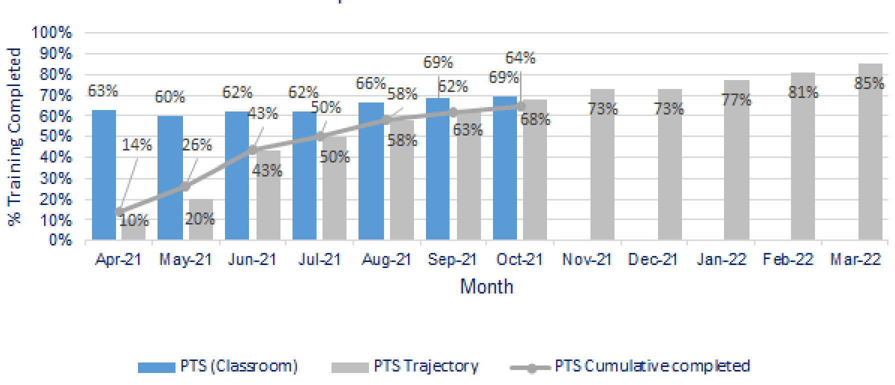


Figure OH7.2



Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and runs across the financial year. The target for 2021/22 was to achieve **95%** compliance. However, as a result of REAP 4 , ELC have agreed a revised target of **85%** compliance for all Service Lines apart from Corporate Services remaining at **95%** compliance.

Additional mandatory topics have been introduced for 2021/22. The introduction of new modules not previously completed, combined with the impact of pressures, has reduced overall compliance to **63%** in October. This will build up across the remainder of the year with targets as detailed above.

The new cycle of classroom activity commenced on 12th April 2021 for PTS and PES with the emphasis on continued recovery of topics which could not be delivered face to face for some staff during the cessation of programme during the pandemic.

PTS classroom are slightly behind trajectory at **64%** at the end of October against a target of **68%** but there are no concerns with recovery. PES classroom training was paused from June until August, restarted in September. Extensive work has been done jointly with Operational teams to reprofile the training plan. The profiled training should deliver the **85%** if attendance levels are maintained. ELC approved a revised programme of 1 day training, which will still deliver the main learning outcomes through a smaller staff to trainer ratio allowing condensing of content. Further work is also being undertaken to recover Level 3 Safeguarding training for those missing classroom training last year, this will move to online.

Figure OH7.3

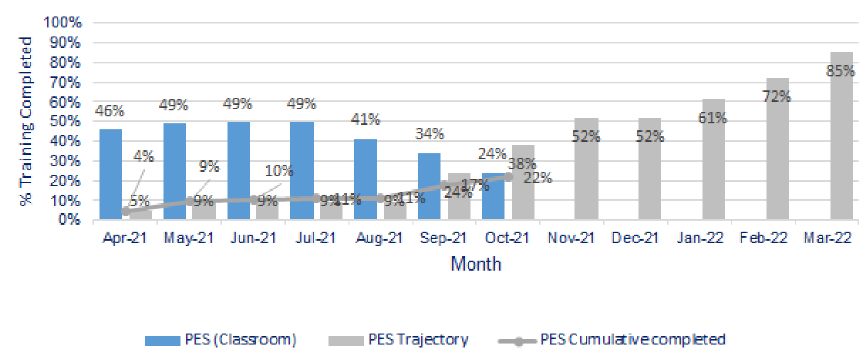


Figure OH7.4

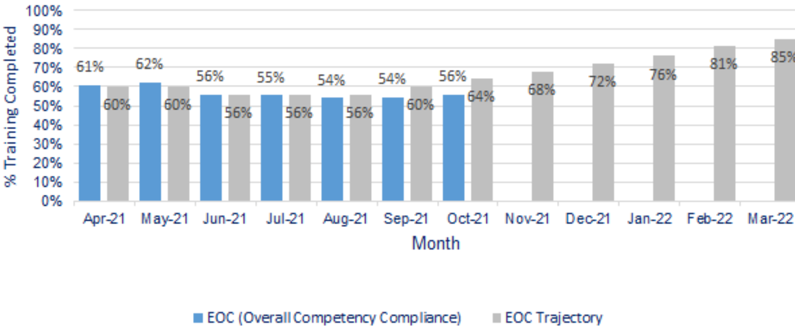


Figure OH7.5

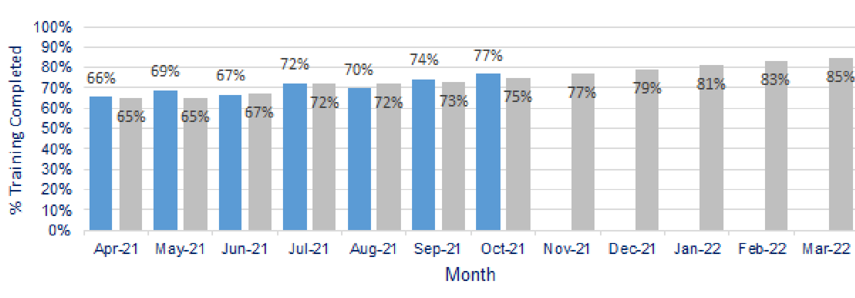
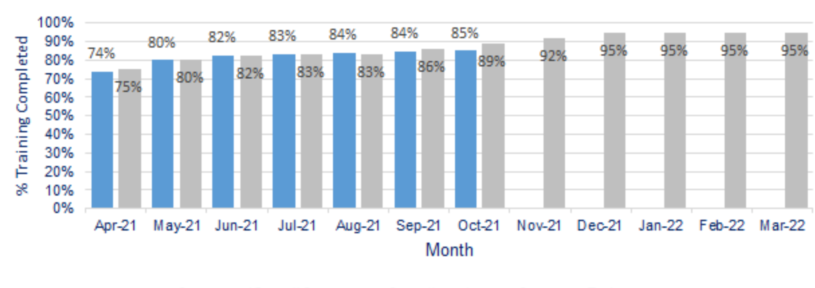


Figure OH7.6



COVID 19

Table CV19.1 – Number of staff tested positive by week

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	15-Mar	6
27-Jul	3	22-Mar	4
03-Aug	1	29-Mar	1
10-Aug	7	05-Apr	2
17-Aug	3	12-Apr	0
24-Aug	5	19-Apr	0
31-Aug	2	26-Apr	1
07-Sep	6	03-May	4
14-Sep	22	10-May	2
21-Sep	34	17-May	8
28-Sep	53	24-May	4
05-Oct	54	31-May	5
12-Oct	71	07-Jun	7
19-Oct	96	14-Jun	4
26-Oct	101	21-Jun	17
02-Nov	83	28-Jun	28
09-Nov	99	05-Jul	24
16-Nov	87	12-Jul	29
23-Nov	42	19-Jul	26
30-Nov	28	26-Jul	17
07-Dec	24	02-Aug	26
14-Dec	34	09-Aug	21
21-Dec	52	16-Aug	19
28-Dec	75	23-Aug	20
04-Jan	144	30-Aug	17
11-Jan	168	06-Sep	22
18-Jan	113	13-Sep	17
25-Jan	72	20-Sep	24
01-Feb	83	27-Sep	18
08-Feb	84	04-Oct	30
15-Feb	24	11-Oct	27
22-Feb	9	18-Oct	23
01-Mar	9	25-Oct	21
08-Mar	3		

Table CV19.1 – Number of staff tested positive and Isolating by Month

Week Commencing	No of Staff Tested Positive	Number of New Isolators
01-Jul	8	166
01-Aug	17	408
01-Sep	86	1151
01-Oct	346	1555
01-Nov	326	1280
01-Dec	166	894
01-Jan	536	1448
01-Feb	200	653
01-Mar	22	481
01-Apr	4	530
01-May	18	524
01-Jun	48	735
01-Jul	107	871
01-Aug	97	611
01-Sep	82	648
01-Oct	108	823

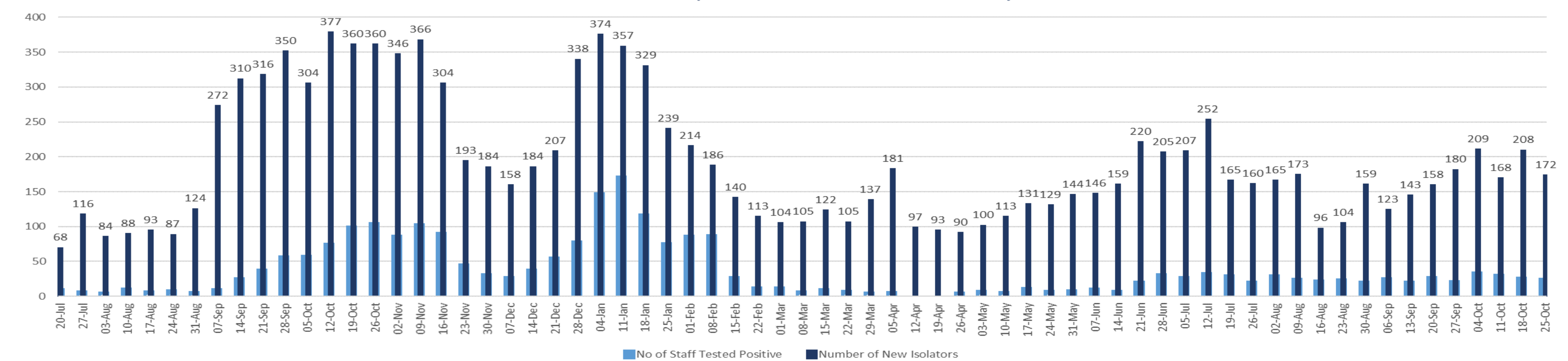
Covid-19

Trust Position
In the Trust there have been **108** instances of staff that have tested positive for Covid-19 in October 2021 with **2,171** instances since July 2020 (Table CV19.1). Weekly breakdowns are shown in both Table CV19.1 and Figure CV19.1.

Outbreaks
As at the end of October 2021 there were **3** outbreaks on trust sites. This covered **17** staff who tested positive and **9** staff isolating.

There have been **105** outbreaks since reporting began with **102** outbreaks closed.

Figure CV19.1 – Number of staff tested positive and isolating by week



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REPORT TO BOARD OF DIRECTORS

DATE:	24th November 2021			
SUBJECT:	Infection Prevention and Control Board Assurance Framework 6 Monthly Report			
PRESENTED BY:	Prof M Power, Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☒	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	NWAS Infection Prevention and Control (IPC) Board Assurance Framework (BAF) provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of COVID 19 and other transmissions to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry (KLOEs). A comprehensive refresh of the November IPC BAF has been carried out and the document re-formatted to align with the NWAS BAF (Appendix 1). There are four areas of non-compliance which are rated red on the RAG rating scale which will be discussed at Quality and Performance Committee on 22nd November 2021. Gaps in control are articulated and a timeline to improve included, which is a priority for the IPC team and the new IPC Consultant Nurse who joins NWAS to lead IPC on 1st December 2021.			
RECOMMENDATIONS:	The Board of Directors are asked receive assurance that: 1. IPC risks are being adequately identified against key lines of enquiry. 2. IPC risks have been reviewed. 3. IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance.			

	The Board of Directors are asked to acknowledge that IPC improvements are still ongoing and that further improvement will be identified in the next 6 monthly report.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	22nd November 2021		
	Outcome:	Pending		

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1. PURPOSE

1.1 The purpose of this report is to update the Board of Directors with assurance against core aspects of infection prevention and control. The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) provides a framework for review.

2. BACKGROUND

2.1 The BAF key lines of enquiry (KLOES) were developed by NHS England and Improvement (NHSE/I) to support providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance. The framework is used to identify gaps in assurance risks and evidence the corrective actions applied.

2.2 The trust continues to enhance and establish new processes and systems for IPC, based on the development of the IPC board assurance framework which focuses attention of the following 10 key lines of enquiry;

IPC BAF KLOEs	
1.	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7.	Provide or secure adequate isolation facilities
8.	Secure adequate access to laboratory support as appropriate
9.	Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections
10.	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.3 For each KLOE there is a requirement to provide evidence, identify any gaps in assurance and provide a high level overview of mitigating actions. This report provides an update against the achievements made and risk status against the initial 10 KLOEs.

2.4 The framework was initially presented to and approved by the Trust Board on the 30 September 2020 with a bi-annual update agreed to be presented to the Quality and Performance Committee.

2.5 NHS E/I last published a revised version of the framework in July 2021 which is now include in this paper. However, it is to be noted that the new version of the BAF identifies multiple areas for assurance that are not applicable to an ambulance service. As a Trust we have, where possible, reported levels of assurance on areas which would be seen as additional to the requirements for an ambulance service.

2.6 The trust has identified some gaps in control, which, for clarity have been RAG rated as red and this paper provides assurance that these areas are reviewed as part of an IPC Team's ongoing work plan and a trajectory for improvement is reviewed as part of IPC Team and IPC Sub-Committee meetings.

2.7 The recent appointment of an IPC Specialist Nurse (Band 8b), commencing with the trust on 1 December 2021, will provide the trust with a specialist resource to prioritise areas in which we require to improve and provide the board with the full assurance that it requires.

2.8 The IPC BAF is reviewed, evidenced and updated regularly. The documents used to monitor and identify progress against the BAF include risk registers and the IPC Sub-Committee action log. These documents are appended, and a summary of the key issues is provided in s3 of this report.

3. ASSURANCE

3.1 Risk Register

There are currently 4 active operational IPC risks identified on the risk register (see Appendix 1), which is a significant reduction from the 15 reported to Board of Directors in July 2021.

3.2 IPC Sub-Committee Action Tracker

The IPC Sub-Committee action tracker reflects the operational detail linked to risks on the risk register.

3.3 IPC Bulletins

Below is a list of the bulletins produced since July 2021;

- CV210 – Estuary Point – Covid-19 Cluster Notification
- CV212- PPE update- protecting ourselves and others
- CV214- COVID-19- Self-isolation changes
- CI881- Migration of IPC Site and PES Vehicle Medications Audits to Safecheck
- PTS124- Tracheotomy/Laryngectomy, Tracheostomy Tube, Bi-pap/C-pap patients
- CV216 - Staff contact self-isolation changes
- CV218- Changes to LAMP Testing

4 KEY LINES OF ENQUIRY – NO/LIMITED ASSURANCE (RAG RATED RED)

4.1 The agreement of the Trust to appoint an IPC specialist (commencement date 1 December 2021) will allow for additional dedicated focus to the management of all KLOEs but as a priority to the following four areas identified on the IPC BAF as still requiring assurance that the KLOEs are being adequately controlled;

- Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff.
- That the role of PPE guardians/safety champions to embed and encourage best practice has been considered
- Robust IPC risk assessment processes and practices are in place for non-COVID-19 infections and pathogens
- Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

5.1 The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The framework has been structured around the existing 10 criteria set out in

Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5.2 The Health and Safety at Work Act 1974 places wide-ranging duties on NWAS, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

5.3 The management of the IPC Board Assurance Framework and action plan is the responsibility of the Director of Infection Prevention and Control (DIPC) and monitored through the following groups and committees:

- Infection Prevention and Control Sub Committee (Bi-Monthly)
- Quality and Performance Committee Bi- annually
- Board of Directors – Bi annually

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

6.1 Equality Impact assessments have been completed for relevant issues including a review of the EQI for FFP3 face fit testing.

7. RECOMMENDATIONS

7.1 Quality & Performance Committee receive assurance that:

- IPC risks are being adequately identified against key lines of enquiry.
- IPC risks have been reviewed.
- IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance.

APPENDIX 1

Infection, Prevention & Control (IPC)

Board of Directors

24th November 2021

Q2 2021/22 Reporting Timescales:

IPC Sub-Cttee	14/09/2021
	09/11/2021
Quality & Performance Cttee:	22/11/2021
Executive Leadership Cttee:	20/10/2021
Board of Directors:	24/11/2021

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

Consequence ↓	Likelihood → Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Major 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Moderate 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Minor 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Negligible 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

IPC Responsibilities:

DoQII	Director of Quality, Innovation & Improvement
DIPC	Director of Infection, Prevention & Control
IPCS	Infection, Prevention, and Control Specialist
IPCP	Infection, Prevention, and Control Practitioner
HoS	Head of Service
CP	Consultant Paramedic
HoFM	Head of Facilities Management
HoC	Head of Communications
SEM	Senior Education Manager

Board Assurance Framework Legend

Key Line of Enquiry	This is a question that will help to establish whether NWAS is safe, caring, effective, responsive, and well-led
Evidence	This is the platform that reports the assurance
RAG Status	A RAG rated assessment of the level of assurance — Not Assured/ Limited Assurance; Moderate Assurance; Assured
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the IPC BAF risk
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the IPC BAF risk
Required Action	Actions required to close the gap in control(s)/ assurance(s)
Action Lead	The person responsible for completing the required action
Target Completion	Deadline for completing the required action
Monitoring	The forum that will monitor completion of the required action
Progress	A RAG rated assessment of how much progress has been made on the completion of the required action — Incomplete/ Overdue; In Progress; Completed; Not Commenced

Operational IPC Risks

Datix ID	Directorate	Service Line/Area	Risk Description	Current Risk Score	Risk Owner

OPERATIONAL IPC RISKS IDENTIFIED ON THE RISK REGISTER

3421	Service Delivery	PES/ GM	There is a risk that due to staff being non-compliant with the wearing of COVID PPE during non-clinical duties, specifically whilst on station, in the cab of an ambulance or outside ED which would lead to harm to staff and reduced resources in GM	**12 High**	D Smith
3250	Service Delivery	Directorate-wide	There is a risk that due to failing FFP3 face fit testing or staff not yet receiving FFP3 face fit testing staff being unable to respond to Aerosol Generating Procedures (AGPs) which would lead to detrimental patient care, an increase in complaints and reputational damage to the Trust	15 Significant	G Blezard
3496	Service Delivery	PTS	There is a risk of non-compliance with the COVID requirements because of insufficient space to accommodate the number of staff on the Oldham site which would lead to staff having to undertake inappropriate practice	6 Moderate	C. Marshall
3481	Service Delivery	PTS	There is a risk to staff safety due to inappropriate allocation to a journey requiring Level 3 PPE which would lead to potential exposure to Covid-19	6 Moderate	C. Marshall

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 1:
Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff	Check: Generic IPC Risk Assessment & COVID-19 IPC Risk Assessment	
The documented risk assessment includes: • a review of the effectiveness of the ventilation in the area; • operational capacity; • prevalence of infection/variants of concern in the local area.	Assurance to IPC Sub-Cttee: • NWAS premises ventilation assurance report • NWAS vehicles (PES & PTS) ventilation assurance report • Paper: For Information – Prevalence of infection/ variants of concern in the North West, with updated risk assessment Evidence required for this KLOE: • Discussions with PHE and National IPC Teams • Test, Track & Trace workforce	
Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways	**This KLOE is not applicable for an ambulance service**	
When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given	Assurance to IPC Sub-Cttee: • RPE Policy Evidence required for this KLOE: • Communications surrounding PPE for AGP procedures, L3, L2 PPE and PPE for Corporate Staff	
There are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative	**This KLOE is not applicable for an ambulance service**	
That on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance	Within PES, there are no cohorting of patients on ambulances. Assurance to IPC Sub-Cttee: • PTS Patient Cohorting Risk Assessment Evidence required for this KLOE: • PTS Patient Cohorting Risk Assessment	
Resources are in place to enable compliance and monitoring of IPC practice including: • staff adherence to hand hygiene; • patients, visitors, and staff can maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting. • monitoring of staff compliance with wearing appropriate PPE, within the clinical setting	Assurance to IPC Sub-Cttee: • IPC Audits: Including Hand Hygiene Audits • IPC Audits: Including FRSM usage (Clinical and Corporate) • IPC Audits: Including Compliance with PPE (Clinical and Corporate) • Ad-hoc Spot Checks: Local Operational Managers Evidence required for this KLOE: • IPC Policy & Procedures	

	• IPC Audit Results/ Compliance • IPC Compliance Communications & Bulletins • Agile Working Group ToR/ Project Plan	
That the role of PPE guardians/safety champions to embed and encourage best practice has been considered	Evidence required for this KLOE: • PPE Guardians/ IPC Champions for each area across NWAS	
That twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace	Assurance to IPC Sub-Cttee: • Workforce Test, Track and Trace Assurance Report; including LAMP Testing Evidence required for this KLOE: • LFT & LAMP testing Communications/ Bulletins • ELC weekly reports • TTT Evidence	
Additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team	Evidence required for this KLOE: • LAMP Testing at ‘outbreak’ sites including corporate • NWAS Communications/ Bulletins surrounding ‘outbreaks’ • Outbreak management plans/ process • Enhanced IPC Support provided to outbreak sites	
Training in IPC standard infection control and transmission-based precautions is provided to all staff	Assurance to IPC Sub-Cttee: • IPC Mandatory Training Compliance Report (Clinical & Corporate) Evidence required for this KLOE: • IPC Mandatory Training Modules on MyESR • MT Recovery Plan	
IPC measures in relation to COVID-19 are included in all staff induction and mandatory training	Evidence required for this KLOE: • IPC Measures for COVID-19 at Trust Induction	
All staff (clinical and non-clinical) are trained in: • putting on and removing PPE • what PPE they should wear for each setting and context	Assurance to IPC Sub-Cttee: • IPC Mandatory Training Compliance Report (Clinical & Corporate) Evidence required for this KLOE: • IPC Mandatory Training Modules on MyESR • Communications/ Bulletins	
All staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance	Evidence required for this KLOE: • COVID-19 Checkpoints at all entrances to premises • PPE available to clinical and non-clinical staff	
There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	Evidence required for this KLOE: • Visuals displayed for wearing face masks • Visuals displayed for hand hygiene • Visuals displayed for physical distance	
IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Evidence required for this KLOE: • Notification of changes to national guidance • Communications/ Bulletins of changes	

Changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Assurance to IPC Sub-Cttee: • Paper: For Information – Changes to national guidance • Paper: For Assurance – Compliance against changes to national guidance – identifying risks and mitigations required Evidence required for this KLOE: • Papers/ Chairs Assurance Reports from IPC Sub-Cttee to Q&P Cttee • Chairs Assurance Reports from Q&P Cttee to BoD • IPC Bi-Annual/ Annual Assurance Reports	
Risks are reflected in risk registers and the board assurance framework where appropriate	Assurance to IPC Sub-Cttee: • Paper: For Assurance – IPC BAF • Local IPC Assurance Reports Evidence required for this KLOE: • Operational IPC Risks & Risk Reviews	
Robust IPC risk assessment processes and practices are in place for non-COVID-19 infections and pathogens	Check: Generic IPC Risk Assessments: Sharps, Waste Disposal and Management, Ambulance Cleaning, Ambulance Deep Cleaning, ANTT, Hospital Acquired Infections, Laundry, Spillage Management, Non-Clinical IPC Risk Assessment (Cleaning)	
The Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	**This KLOE is not directly applicable for an ambulance service** Although, all staff cases are reviewed by the DIPC ahead of submission to NHSEI Evidence required for this KLOE: • Staff Data Submissions to NHSEI	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	Evidence required for this KLOE: • BoD IPC BAF Reports	
The Trust Board has oversight of ongoing outbreaks and action plans	Evidence required for this KLOE: • BoD IPC Reports of outbreaks & action plans	
There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Evidence required for this KLOE: • IPC Practitioners 'Check and Challenge' • Local Clinical and Operational leaders 'Check and Challenge' • DIPC 'Check and Challenge' • 10 Point Plan	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
RISK ASSESSMENT					

Generic COVID-19 IPC Risk Assessment	Creation and approval of a generic COVID-19 IPC Risk Assessment	IPC Practitioners	January 2022	IPC Sub-Cttee	Not Commenced
Dissemination of Generic COVID-19 Risk Assessment	Local managers to disseminate Generic COVID-19 Risk Assessment	HoS/ CPs	January 2022	IPC Sub-Cttee	Not Commenced
NWAS Premises Ventilation Risk Assessment	Undertake ventilation assessments across NWAS premises	Head of Estates	January 2022	IPC Sub-Cttee	In Progress
NWAS Vehicles Ventilition Risk Assessment	Undertake ventilation assessments across all PES & PTS vehicles	Head of Fleet	January 2022	IPC Sub-Cttee	In Progress
Prevalence of infection/ variants of concern in the North West	Review generic IPC Risk Assessment and report to IPC Sub-Cttee	IPC Specialist	January 2022	IPC Sub-Cttee	In Progress
Test, Track and Trace (TTT) Workforce	Review of TTT workforce resources to meet operational demand	IPC Specialist	March 2022	IPC Sub-Cttee	In Progress
OPERATIONAL AND CORPORATE TEAMS					
IPC Policy Compliance	Local clinical and operational managers to improve compliance	HoS/ CPs	March 2022	IPC Sub-Cttee	In Progress
PPE Compliance	Local clinical and operational managers to improve PPE compliance	HoS/ CPs	March 2022	IPC Sub-Cttee	In Progress
PPE Guardians/ IPC Champions	Establish and identify PPE Guardians/ IPC Champions	IPC Specialist	March 2022	IPC Sub-Cttee	Not Commenced
IPC Mandatory Training	Improve IPC mandatory training compliance inline with Trust trajectory	HoS/ CPs	March 2022	IPC Sub-Cttee	In Progress
COVID-19 Measures	Improve IPC COVID-19 Measures at Trust Induction, inc. Corporate	L&OD Team	March 2022	IPC Sub-Cttee	In Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 2:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Evidence required for this KLOE: • All patient facing staff are adequately trained	
Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Assurance to IPC Sub-Cttee: • Contract Cleaning Training and PPE Evidence required for this KLOE: • All patient facing staff are adequately trained	
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	**This KLOE is not directly applicable for an ambulance service** Although, all there are Ambulance Decontamination Processes in place. Evidence required for this KLOE: • Ambulance Decontamination Processes	
Assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk	Assurance to IPC Sub-Cttee: • Decontamination Processes Evidence required for this KLOE: • Post Decontamination Processes: Premises • Post Decontamination Processes: Vehicles	
Cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Assurance to IPC Sub-Cttee: • Cleaning and Decontamination Process: Premises • Cleaning and Decontamination Process: Vehicles Evidence required for this KLOE: • Cleaning disinfectants used across NWAS	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance	Evidence required for this KLOE: • Cleaning products used across NWAS	
A minimum of twice daily cleaning of: • areas that have higher environmental contamination rates as set out in the PHE and other national guidance; • 'frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails; • electronic equipment e.g., mobile phones, desk phones, tablets, desktops & keyboards • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff	Assurance to IPC Sub-Cttee: • Routine Ambulance Cleaning • Ambulance Deep Cleaning • Premises Cleaning Schedules/ Frequencies Evidence required for this KLOE: • Cleaning schedules • Contractor Cleaning Ambulances at Acute NHS Sites	
Reusable non-invasive care equipment is decontaminated: • between each use	Evidence required for this KLOE: • Decontamination documentation for reusable equipment	

• after blood and/or body fluid contamination • at regular pre-defined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment		
Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Evidence required for this KLOE: • Linen management	
Single use items are used where possible and according to single use policy	Assurance to IPC Sub-Cttee: • Single Use Policy Evidence required for this KLOE: • Single Use Policy • Single use items	
Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk	Evidence required for this KLOE: • Decontamination documentation for reusable equipment	
Cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Assurance to IPC Sub-Cttee: • Non-clinical cleaning standards and frequencies • Non-clinical cleaning audits Evidence required for this KLOE: • Monitoring of cleanliness for non-clinical areas	
Where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	Evidence required for this KLOE: • Communications/ Bulletins – Ventilation/ Window Opening	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLEANING					
Contract Cleaning	Establish if cleaning contract are appropriately trained and use PPE	Head of FM	January 2022	IPC Sub-Cttee	In Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 3:
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Arrangements for antimicrobial stewardship are maintained	Assurance to IPC Sub-Cttee: • Antimicrobial stewardship for NWAS • Paramedic Drug Formulary: Antibiotics Evidence required for this KLOE: • Above assurance documents	
Mandatory reporting requirements is adhered to and boards continue to maintain oversight	Assurance • This is completed by the Chief Pharmacist	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
ANTIMICROBIAL STEWARDSHIP					
Antimicrobial Stewardship Reporting	Adherance to reporting requirements and Board have oversight	R Fallon	January 2022	IPC Sub-Cttee	In Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 4:
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
National guidance on visiting patients in a care setting is implemented	**This KLOE is not applicable for an ambulance service**	
Areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access	**This KLOE is not applicable for an ambulance service**	
Information and guidance on COVID-19 is available on all trust websites with easy read versions	Evidence required for this KLOE: • COVID-19 information on trust website • COVID-19 guidance on trust website	
Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	**This KLOE is not applicable for an ambulance service**	
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face, and space advice	Evidence required for this KLOE: • Information displayed in saloon of ambulances	
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Assurance for IPC Sub-Cttee: • Toolkit • Implementation Action Plan • Progress against implementation action plan	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
GUIDANCE					
Easy read versions of COVID-19 information and guidance	Develop easy read version of COVID-19 information and guidance	Head of Communications	January 2022	IPC Sub-Cttee	Not Commenced
Supporting Excellence in IPC Behaviours Implementation Toolkit	Implement the Supporting Excellence in IPC Behaviours Toolkit	IPC Specialist	March 2022	IPC Sub-Cttee	Not Commenced

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 5:
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases	Evidence required for this KLOE: • Screening/ triaging scripts/ processes/ questions	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance	**This KLOE is not applicable for an ambulance service**	
Staff are aware of agreed template for triage questions to ask	Evidence required for this KLOE: • Screening/ triaging scripts/ processes/ questions	
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	**This KLOE is not applicable for an ambulance service**	
Face coverings are used by all outpatients and visitors	**This KLOE is not applicable for an ambulance service**	
Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation	**This KLOE is not applicable for an ambulance service**	
Clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	Evidence required for this KLOE: • Advice on calls surrounding face masks • Public communication surrounding mask wearing	
Monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs	**This KLOE is not applicable for an ambulance service**	
Patients, visitors, and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff	**This KLOE is not applicable for an ambulance service**	
Isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative	**This KLOE is not applicable for an ambulance service**	
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	**This KLOE is not applicable for an ambulance service**	
There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	**This KLOE is not applicable for an ambulance service**	
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Evidence required for this KLOE: • PTS patients & COVID-19 Management/ Transportation	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 6:
Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	**This KLOE is not applicable for an ambulance service**	
All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe	Assurance to IPC Sub-Cttee: • Training Compliance (Clinical and Corporate) Evidence required for this KLOE: • Training Modules • Guidance • Specific Risk Assessments	
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it	Assurance to IPC Sub-Cttee: • Training Compliance (Clinical) Evidence required for this KLOE: • Training Modules • Guidance	
A record of staff training is maintained	Evidence required for this KLOE: • Training Records/ MyESR	
Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Evidence required for this KLOE: • Audits on PPE • Action plan to mitigate any identified risks	
Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff, and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities including instructional posters; • good respiratory hygiene measures; • staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care • staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; • frequent decontamination of equipment and environment in both clinical and non-clinical areas; • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Evidence required for this KLOE: • Hand washing instructional posters • Alcohol hand rub instructional posters • Respiratory hygiene posters • Social distancing messaging • Enhanced cleaning arrangements • Decontamination processes • Face covering advice • COVID-19 Secure Risk Assessments • IPC Checklists • Agile Working Group	
Staff regularly undertake hand hygiene and observe standard infection control precautions	Evidence required for this KLOE: • Hand hygiene evidence	

The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	Evidence required for this KLOE: • No hand air dryers used in clinical areas • Paper towel dispensers are next to handwashing sinks	
Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Evidence required for this KLOE: • Guidance displayed in public/ staff toilet areas	
Staff understand the requirements for uniform laundering where this is not provided for onsite	Evidence required for this KLOE: • Staff laundry procedure/ process	
All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Evidence required for this KLOE: • Advice/ communications/ bulletins issued	
A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Evidence required for this KLOE: • Surveillance data of infection rates across the North West • Surveillance data of infection rates within NWAS	
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	**This KLOE is not applicable for an ambulance service**	
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	Evidence required for this KLOE: • Policies and procedures for outbreaks • Outbreak meetings taken place & minutes	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Add Header					
Uniform Laundry	Production of staff laundry policy or procedure	IPC Specialist	March 2022	IPC Sub-Cttee	Not Commenced

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 7: Provide or secure adequate isolation facilities.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors, or staff	**This KLOE is not applicable for an ambulance service**	
Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	**This KLOE is not applicable for an ambulance service**	
Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	**This KLOE is not applicable for an ambulance service**	
Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	**This KLOE is not applicable for an ambulance service**	
Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	**This KLOE is not applicable for an ambulance service**	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 8:
Secure adequate access to laboratory support as appropriate.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Testing is undertaken by competent and trained individuals	**This KLOE is not applicable for an ambulance service**	
Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	**This KLOE is not applicable for an ambulance service**	
Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	**This KLOE is not applicable for an ambulance service**	
Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	**This KLOE is not applicable for an ambulance service**	
Screening for other potential infections takes place	**This KLOE is not applicable for an ambulance service**	
That all emergency patients are tested for COVID-19 on admission	**This KLOE is not applicable for an ambulance service**	
That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	**This KLOE is not applicable for an ambulance service**	
That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	**This KLOE is not applicable for an ambulance service**	
That sites with high nosocomial rates should consider testing COVID negative patients daily	**This KLOE is not applicable for an ambulance service**	
That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	**This KLOE is not applicable for an ambulance service**	
That patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation	**This KLOE is not applicable for an ambulance service**	
That all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	**This KLOE is not applicable for an ambulance service**	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 9:
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Staff are supported in adhering to all IPC policies, including those for other alert organisms	Evidence required for this KLOE: • IPC Policies	
Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Evidence required for this KLOE: • Change record/ log od PHE national guidance • Communication/ bulletin of changes	
All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Evidence required for this KLOE: • COVID-19 SOP: Clinical Waste/ Laundry management	
PPE stock is appropriately stored and accessible to staff who require it	Evidence required for this KLOE: • PPE stock levels • List of PPE that can be accessed by which staff members	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 10:
Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

KEY LINE OF ENQUIRY	EVIDENCE	RAG
Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Evidence required for this KLOE: • HR Risk Assessment Tool • Guidance • H&WB Support Mechanisms	
That risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian, and Minority Ethnic and pregnant staff	Evidence required for this KLOE: • HR Risk Assessment Tool • Guidance	
Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Evidence required for this KLOE: • FFP training programme • Training Record (Trust-wide) • Training Record (MyESR)	
Staff who carry out fit test training are trained and competent to do so	Evidence required for this KLOE: • FFP trainer the trainer programme/ certifications of FFP testers • Competencies	
All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Evidence required for this KLOE: • Staff member vs types of FFP mask tested	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Evidence required for this KLOE: • What staff members receive of face fit test results • Evidence held on MyESR	
Those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Evidence required for this KLOE: • Fail record given to staff member • Evidence held on MyESR	
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	Evidence required for this KLOE: • Protective Hoods issued to staff member	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Evidence required for this KLOE: • Example proforma of discussion template • Discussions held at local level/ HR file	
Following consideration of reasonable adjustments e.g., respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Evidence required for this KLOE: • Redeployment information those failed FFP • Personal HR record/ Occupational Health Service Record	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Evidence required for this KLOE: • RPE Steering Group • IPC Sub-Cttee • Board – assurance FFP test programme; assurance pass/ fail	

Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	**This KLOE is not applicable for an ambulance service**	
All staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas	Evidence required for this KLOE: • Contact centre screen installation • Agile working group	
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Evidence required for this KLOE: • COVID-19 Safe Workplace Risk Assessments	
Staff are aware of the need to wear facemask when moving through COVID-19 secure areas	**This KLOE is not applicable for an ambulance service**	
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Evidence required for this KLOE: • Staff absence monitoring and support mechanisms • PCR testing	
Staff who test positive have adequate information and support to aid their recovery and return to work	Evidence required for this KLOE: • Staff information and support provided • RTW following COVID-19	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

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North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	24th November 2021			
SUBJECT:	EPRR Annual Assurance 2021/2022			
PRESENTED BY:	Ged Blezard, Director of Operations			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	This paper describes NHS England 2021/22 Emergency Preparedness, Resilience and Response assurance process and presents the NWAS submission approved by the Trust Accountable Emergency Officer as agreed with Blackpool CCG as Lead Commissioners.			
RECOMMENDATIONS:	The Board of Directors to note the content of this paper and attached self-assessment templates and Statements of Compliance and seeks assurance from the details enclosed.			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	25th October 2021		
	Outcome:	Assurance provided and supported for onward presentation to the Board of Directors.		

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1. PURPOSE

This paper describes NHS England 2021/22 Emergency Preparedness, Resilience and Response (EPRR) assurance process and presents the NWAS Statement of Compliance for NWAS111 which has been signed by the Trust Accountable Emergency Officer (AEO - Director of Operations). The 2021/22 Assurance document is described in Section 2 and was submitted to Blackpool CCG on 27 October 2021 for their scrutiny and challenge before being forwarded by them, to NHS England & Improvement (Lancashire) as the responsible body.

2. BACKGROUND

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect patient care or public health. The manifestations of this could be precipitated by a wide range of triggers from infectious diseases, as with the on-going COVID-19 pandemic and subsequent variants, transport emergencies, industrial incidents/action, infrastructure failures or terrorist attacks. The Civil Contingencies Act (2004) requires all NHS organisations and providers of NHS-funded care, to demonstrate that they can effectively respond to such incidents whilst maintaining core services.

Under the EPRR arrangements, all NHS Trusts which are also designated Category 1 Responders under the Civil Contingencies Act (2004), are required to undertake an annual, self-assessment process in order to determine the level of compliance of resilience arrangements measured against the NHS England & Improvement core standards.

The NHS England & Improvement Board has a statutory requirement to formally assure itself of both its own, and the NHS in England's EPRR readiness. This is provided through a national EPRR annual assurance process and assurance report which is submitted to the Secretary of State for Health and Social Care.

This process is supported by an extensive self-assessment checklist for each group of provider organisations which has been designed to allow comparisons to be made between all of the core standards and the prevailing resilience arrangements pertaining to that particular standard. Suggestions of the types of evidence which would satisfy that standard are also included in the checklist.

Due to the progress of the COVID-19 pandemic, last year's annual assurance required no self-assessment process and was replaced by a short question set based on the initial learning from the COVID-19 response, review of plans and relevance to enhance the winter planning process.

This year, in addition to the general EPRR Core Standards applicable to NWAS, the 2021/22 document includes a separate set of 'Deep Dive' standards which do not contribute to the overall compliance calculations; this year's focusses heavily on

supply chain disruptions/planning; however, the assessment questions are focused on Acute Trusts and therefore, no requirement for response.

NHS England & Improvement requires that this assurance exercise identifies any areas of limited or no compliance (as well as highlighting areas of complete compliance) of resilience arrangements against the EPRR core standards and that any deficiencies in particular areas inform an individual Action Plan. This plan will demonstrate the intention of each Trust to address any outstanding issues and give an indication of priority and timescale for resolution.

NHS England & Improvement also require a formal statement of compliance from each Trust based on the findings from the self-assessment process and taking into account those core standards which necessitate additional attention through the Action Plan. For 2021/22, the process requires three separate Statements of Compliance to be made to indicate performance across EPRR Core Standards (NWAS), EPRR Core Standards (NW111) and Interoperable Standards (NWAS response). There is a requirement for these statements to be ultimately presented formally to the NWAS Board for assurance but given challenging national and local time scales it was agreed with the Lead CCG that the Statements of Compliance would be submitted to Blackpool CCG as well as NHS England (Lancashire) as the EPRR lead agency, on 8 October 2021 and prior to being shown to the NWAS Board. The main requirement however was that the statements were signed off by the AEO as being a satisfactory assessment of NWAS' preparedness.

The NWAS Resilience Senior Management Team has comprehensively assessed NWAS resilience arrangements against the EPRR core standards and found that almost all criteria are currently being met. An Action Plan will be generated to record those standards that are not fully compliant at this point in time and this will be used by the Commissioners and the NHS England EPRR Lead to monitor progress towards full alignment. The NWAS Resilience Senior Management Team has also comprehensively assessed 111 resilience arrangements against the EPRR core standards and found that all criteria are currently being met.

The overall results of the self-assessment process are based on potential ratings of Fully Compliant, Substantially Compliant, Partially Complaint and Non-compliant and the results are presented below;

NWAS EPRR Assessment

Core Standards

Out of 32 applicable standards, NWAS have self-assessed full compliance with 32 and partial compliance with 0. This represents a compliance figure of 100% and therefore an overall rating of **'FULL'**.

Interoperable Standards

Out of 163 applicable standards, NWAS have self-assessed full compliance with 145 and partial compliance (including 1 non-compliant) with 17. This represents a

compliance figure of 89% and therefore an overall rating of **'Substantially Compliant'**.

The rating of **'Substantially Compliant'** represents 89-99% compliance with the appropriate core standards with **'Full'** compliance requiring a 100% rating in each category.

The full Statements of Compliance (Appendix 1 and 2) and self-assessment documents/action plans (Appendix 3) and are provided with this paper.

111 EPRR Assessment

Core Standards

Out of 29 applicable standards, NWAS have self-assessed full compliance with 29 and partial compliance with 0. This represents a compliance figure of 100% and therefore an overall rating of **'FULL'.**

The rating of **'Fully Compliant'** represents 100% compliance with the appropriate core standards.

The full Statements of Compliance (Appendix 4) and self-assessment documents (Appendix 5) are provided with this paper.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the Civil Contingencies Act (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified at the time of writing this report.

5. RECOMMENDATIONS

The Board of Directors are asked to note the contents of this paper and consider the evidence provided in support of the assurance requirements for the Trust for 2021/22. The Board of Directors is also requested to take assurance from the submissions to

NHS England & Improvement and recognise the significant work conducted by the Resilience Team and 111 to achieve the levels of preparedness that they represent.

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-22

STATEMENT OF COMPLIANCE

North West Ambulance Service – EPRR Core Standards has undertaken a self-assessment against the NHS England Core Standards for EPRR.

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2021-22 standards: **Full**

Compliance Level	Criteria
Fully compliant	The organisation if fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against **89-99%** of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against **77-88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
32			32
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29** NWAS: **32/163*** NHS111:**29****			

**NWAS should report two assurance ratings, demonstrating compliance with the core standards for EPRR and Interoperable capabilities. **NHS111 should be reported separately.*

Where areas require further action, this is detailed in the attached EPRR Action Plan and will be reviewed in line with the organisation's governance arrangements.

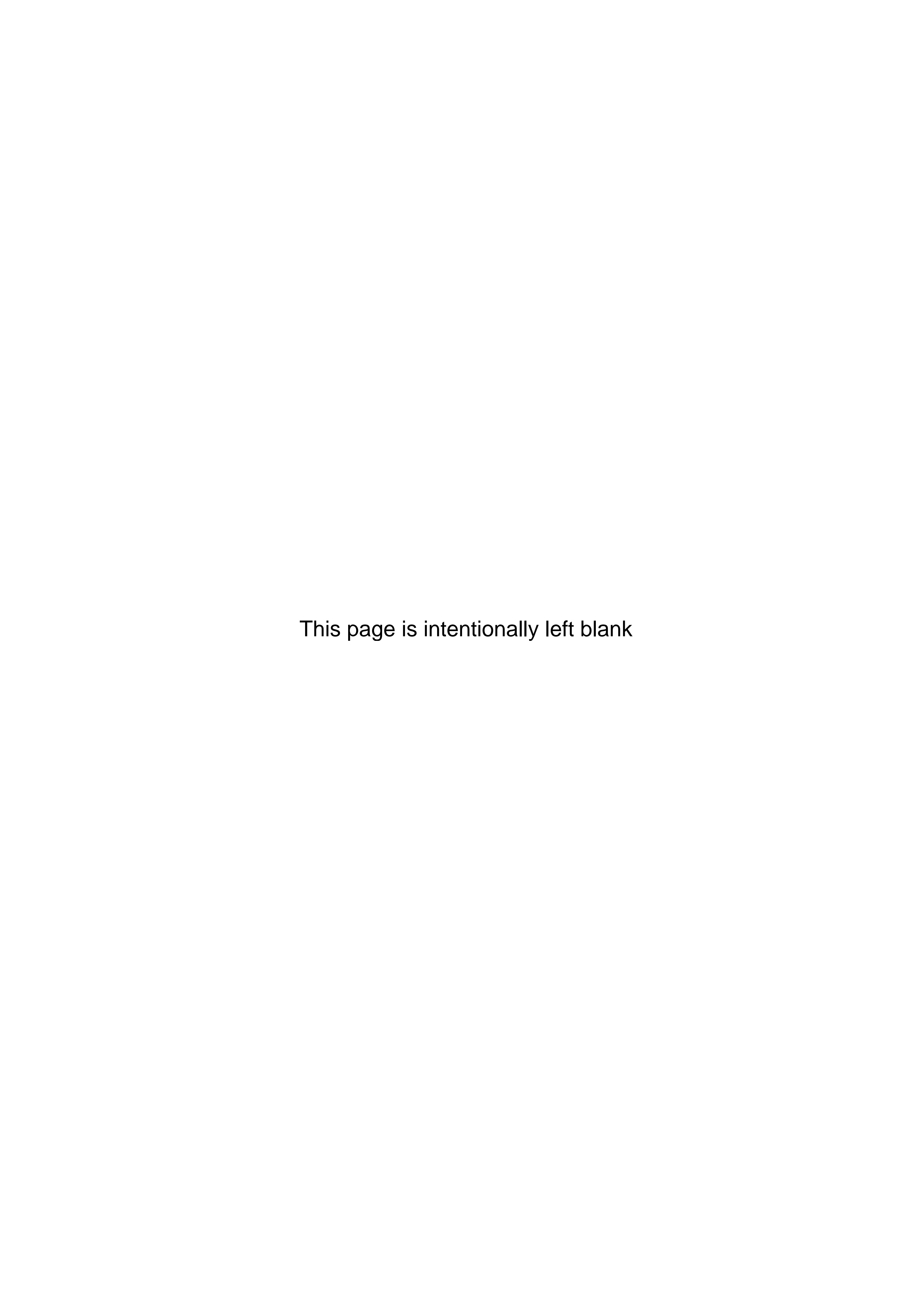
I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

G.A.Blezard

Signed by the organisation's Accountable Emergency Officer

06/10/2021
Date of board / governing body meeting

07/10/2021
Date signed



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Appendix 2 - NWAS EPRR Statement of Compliance - Interoperable Capabilities

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-22

STATEMENT OF COMPLIANCE

North West Ambulance Service – Interoperable Capabilities has undertaken a self-assessment against the NHS England Core Standards for EPRR.

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2021-22 standards: **Substantial**

Compliance Level	Criteria
Fully compliant	The organisation if fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against **89-99%** of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against **77-88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as Red	Standards rated as Amber	Standards rated as Green
163	1	17	145
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29** NWAS: **32/163*** NHS111:**29****			

*****_NWAS should report two assurance ratings, demonstrating compliance with the core standards for EPRR and Interoperable capabilities. **NHS111 should be reported separately._

Where areas require further action, this is detailed in the attached EPRR Action Plan and will be reviewed in line with the organisation's governance arrangements.

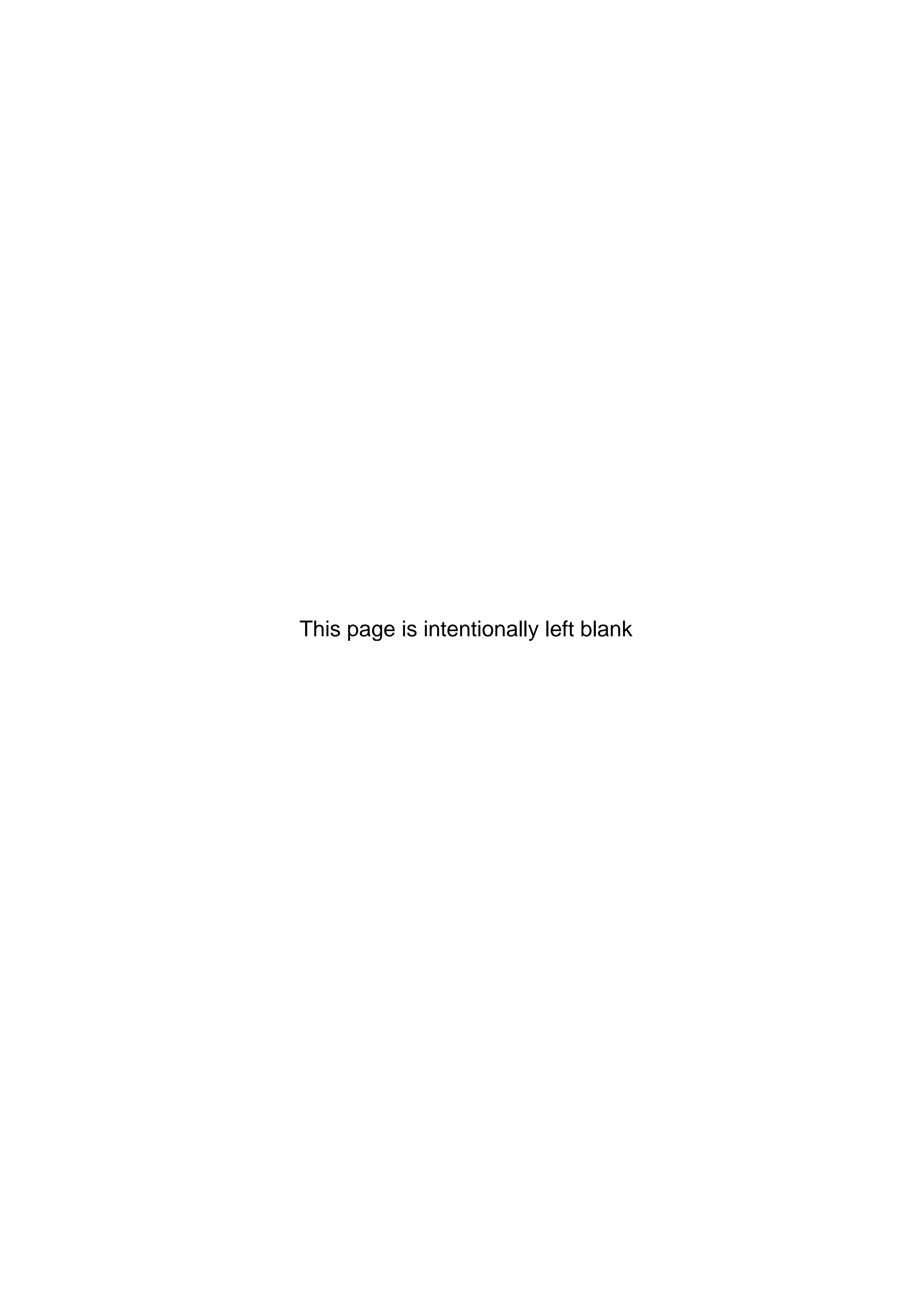
I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

G.A. Blezard

Signed by the organisation's Accountable Emergency Officer

06/10/2021
Date of board / governing body meeting

07/10/2021
Date signed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Appendix 3 - NWAS EPRR Annual Assurance Full Submission Return

EPRR Core Standards

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Domain 1 - Governance										
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Director of Operations (Ged Blezard) is AEO. Lead NED for Resilience is Dr David Hanley. Support and advice from Resilience Team SMT available when required. 111 is part of the Service Delivery Directorate and reporting lines run to Director of Operations.	Fully compliant			
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	A new development of the EPRR subgroup has been in place since May 2021. This group has a work programme in place that provides assurance to the Board of Directors that the Trust is meeting the required standards. EPRR strategy part of Service Delivery annual Business Plan which outlines responsibilities for EPRR compliance.	Fully compliant			
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Governance structure in place - EPRR Subgroup is chaired by the Director of Operations and exploited via the Quality and Performance Committee giving assurance to the Board of Directors in regards to EPRR compliance	Fully compliant			
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Governance structure in place - EPRR Subgroup is chaired by DOPS and reports through to Trust Board	Fully compliant			
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Dedicated Resilience Manager (Quality and Improvement0 who focuses on debriefing and learning from incidents and events. The learning is captured through exercising and training. All details are captured and reported through the EPRR sub-group	Fully compliant			
Domain 2 - Duty to risk assess										
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Regular monthly review of EPRR risks by the Trusts Risk & Governance team with the Head of Contingency Planning (interim) and updated on the Corporate Risk Register.	Fully compliant			

8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	As above - DATIX system records and assists in management of risks. Regular scrutiny and advice from risk specialists to support EPRR risk management.	Fully compliant			
Domain 3 - Duty to maintain plans										
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Business Continuity Plans have been reviewed through the new Continuity2 software which will have gone through Business Impact Analysis allowing for risk mitigations to take place. Major Incident Response Plan and associated Action Cards in place and review schedule adhered to. Critical Incident Manager role within our EOCs to focus specifically on identifying and managing this time of incident.	Fully compliant			
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partners and stakeholders are involved in Contingency and Business Continuity Planning where an when appropriate and required. Multi agency planning is conducted via specific planning groups or through wider LRF. Plans are reviewed on average an annual basis however this can change if identified learning has taken place earlier. A new framework of Incident Management Training has been developed for the EOC management team which strengthen the knowledge around incident management and major incident response. A dedicated EOC Resilience Manager works to ensure any changes or lessons identified through Major Incidents are embedding in the current review of the Major Incident Plan	Fully compliant			
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NWAS Heatwave Plan covers these issues. No inpatient facilities in NWAS but Ambulance air conditioning systems are maintained as a priority during periods of hot weather. Cool rooms can be established in line with Heatwave Plan at large administrative and Control Room sites. The heatwave plan can be accessed by all staff using the green room and Resilience Direct should the partner agencies require the plan.	Fully compliant			
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold weather arrangements are dealt with through Winter Planning documents (Strategic Winter Plan, Area and Service line Tactical Plans which define specific Operational arrangements). Major Incident arrangements and LRF Partnership working underpin Trust response to wider area or prolonged impacts. this includes utilisation of specialist vehicles/support (from military if required and authorised) to access patients.	Fully compliant			
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Mass Casualty Distribution Plans in place across the region, tested through incidents and exercises. Major Incident Response Plan supports management of Mass Casualty incidents and 111 assistance is embedded in process.	Fully compliant			
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	N/A	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required		N/A			
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Site evacuation, lockdown and sheltering arrangements in place and supported by BC Plans.	Fully compliant			

21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	EOC Lockdown Procedure EOC0020 is element of EOC Action Cards in Major Incident Response Plan (Action card 21). Lockdown arrangements follow NHS published Guidance.	Fully compliant			
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Operational Narvik can be attained to note the working and planning between agencies of High Profile VIP which took place September 2021.Management of VIPs/VVIPs is often a component of single/multi agency planning. 'Carbon Steeple' plans can be invoked if required but all arrangements are considered in conjunction with Police and CT contacts.	Fully compliant			
Domain 4 - Command and control										
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	24/7 365 days are covered by an on call robust rota. This covers the entire Trust.	Fully compliant			
Domain 5 - Training and exercising										
Domain 6 - Response										
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Contact Centres (routine and emergency) are fundamental to core business. Additional C2 structures are supported fully (with competent staff) in the event of Critical/Major Incidents through local Major Incident Suites and Regional Operational Coordination Centre.	Fully compliant			
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	A new investment towards a later versions of an on line tool has been purchased 'Continuity2' All departments have own Business Continuity Plans which are tested and exercised before sign off. Dedicated BC Manager in place to support Trust BC Programme.	Fully compliant			
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Formal sitreps for transmission outside the Trust are coordinated via the Regional Operational Coordination Centre and authorised by a Strategic Commander.	Fully compliant			
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	N/A	• Guidance is available to appropriate staff either electronically or hard copies		N/A			
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	N/A	• Guidance is available to appropriate staff either electronically or hard copies		N/A			
Domain 7 - Warning and informing										
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	COVID has allowed the communication plans to be updates via lessons learnt. Major Incident Communications Plan in place and Comms Team staff support exercises and participate in live incidents via formal on call rota. Comms toolkit now in place including action cards to sit outside Major Incident. Response plan. Trust has robust policy to manage Social Media use by staff.	Fully compliant			
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	As above - Comms Team use all available methods to pass messages to public in conjunction with partners. 111 has additional role in providing specific information to callers based on nationally generated advice messages.	Fully compliant			

39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Stand alone Major Incident Communications Plan and reference in Major Incident Response Plan. Specific strategies are developed as required. These have recently been updated due to the recent COVID Pandemic	Fully compliant
Domain 8 - Cooperation							
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Formal , national (NARU) MOU is adhered to and training sessions have been delivered to Strategic Commanders on its implementation. EMT has had MACA awareness and this function is managed by the Resilience SMT. Strategic Commanders have MACA input on MAGIC Courses but any intended action is always considered in conjunction with military JRLO.	Fully compliant
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Y	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	NWAS has a robust GDPR policy in place which outlines the arrangement DATA Protection Officer govern release of information outside formal MOU in place. These will include LRF and multiagency information sharing agreement.	Fully compliant
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	N/A	• Detailed documentation on the process for managing the national health aspects of an emergency		N/A
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 ‘duty to communicate with the public’.	NWAS overarching GDPR arrangements and Data Protection Officer govern release of information outside those formal MOUs and agreements in place. Examples include LRF and multi agency information sharing agreements.	Fully compliant
Domain 9 - Business Continuity							
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Continuity2 a software procured aligned all processes of ISO 22301 to be completed by each directorate in the trust	Fully compliant
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	As above - Continuity2 is aligned to IS22301	Fully compliant
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	IM&T department ISO compliant and follow GDPR obligations.	Fully compliant
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	All directorate have recently gone through BAI and full plan review to align into the new Continuity2 software	Fully compliant
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	A quality report is now produced by the Trust BC Manager which is submitted to the new established EPRR subgroup (chaired by Director of Operations) this is an upto date current review of Trust BIA/Exercises and Plans	Fully compliant
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	As above - Through regular audit and review and maintenance of BC Manager competencies. BC Manager sits on national Ambulance BC group.	Fully compliant
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Assessed through NHS Purchasing Framework, through tendering process and by Procurement Team with support from BC manager who integrates with major project delivery teams.	Fully compliant
Domain 10: CBRN							

56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	N/A	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Technical advice is available 24/7 via Trust Tactical Advisors/NILOs who have reach back to specialists if required.	Fully compliant			
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	N/A	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Structure for on call are in place / CBRN plan current	Fully compliant			
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	N/A	• Impact assessment of CBRN decontamination on other key facilities	Risk assessments are taught on annual commander training and included on front line induction training and mandatory training. NWAS has a contract for management of hazardous waste, this can be sort through the Tactical advisor but lead through the EOC.	Fully compliant			
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	N/A	• Rotas of appropriately trained staff availability 24 /7	There is a capability of staff on duty but will be significantly increase due to the new SORT enhancement program	Fully compliant			
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/ https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	N/A	• Completed equipment inventories; including completion date	Assets registers are available for the vehicle but not fully for individual equipment items this is a new ongoing project	Fully compliant			
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	N/A	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Annual checks of equipment takes place with the CBRN Manager - all significant equipment such as generators suits etc have an annual maintained contract by an external company so that certification is provided.	Fully compliant			
63	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	N/A	• Completed PPM, including date completed, and by whom	Annual maintenance program in place - Respirex International and Nation wider Service company. Both companies will either service RPS suits or equipment on the Decontamination /ISU vehicles (equipment service begins again 25 October 2021)	Fully compliant			
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	N/A	• Organisational policy	Trust policy in place	Fully compliant			
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	N/A	• Maintenance of CPD records	Certified NARU PRPS instructor, RPS , qualified trainer.	Fully compliant			
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	N/A	• Maintenance of CPD records	Cadre of certified NARU PRPS instructors used on courses.	Fully compliant			

68	CBRN	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	N/A	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	All non-specialist operational are staff trained to carry out Initial Operational Response (IOR) and Remove, Remove, Remove. All specialist operational staff are trained to carry out IOR and Remove, Remove, Remove as well as Special Operational Response (SOR) procedures.	Fully compliant			
69	CBRN	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	N/A		All operational staff are fit tested/ trained to use and supplied with FFP3 masks as part of standard Infection Prevention Control (IPC) procedures. Those staff that are not able to be fit tested for FFP3 masks are also provided with Sundstrom powered hoods	Fully compliant			

Interoperable Capabilities

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale
HART Domain: Capability									
H1	HART	HART tactical capabilities	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y	Full capabilities maintained through recruitment, training and assessment together with robust management of equipment and vehicles.	Fully compliant			
H2	HART	National Capability Matrices for HART	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y	Training records and asset database	Fully compliant			
H3	HART	Compliance with National Standard Operating Procedures	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	SOPS always available to HART Team Leaders to support training and operating instructions.	Fully compliant			
Domain: Human Resources									
H4	HART	Staff competence	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y	HART Training Manager creates and monitors training schedules and ensures currency (or withdrawal of staff from duty).	Fully compliant			
H5	HART	Protected training hours	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y	Dedicated Training team rota pattern for each team at each site.	Fully compliant			
H6	HART	Training records	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y	All training records maintained and robust process for checking in place.	Fully compliant			
H7	HART	Registration as Paramedics	All operational HART personnel must be professionally registered Paramedics.	Y	HCPC Registration	Fully compliant			
H8	HART	Six operational HART staff on duty	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y	PROCLUS updated at the start of each shift, as part of NACC and national monitoring of HART asset availability. However, full compliance is virtually unachievable as it only requires a single member of staff to report sick short notice on one occasion to resulting failure of this standard. Staff are available from the training teams.	Partially compliant	Maintaining full HART establishment and routine management of rotas, abstractions and absences. Dynamic changes to cover on day if opportunities available. Numbers of staff on duty are reported twice daily on PROCLUS.	Head of Special Operations/ HART Operations Manager	On-going issue

H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y	Part of recruitment process.	Fully compliant			
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	PCA process is undertaken by all HART Operatives on a regular basis and any failures are supported and managed to complete the test successfully.	Fully compliant			
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y	Routinely managed as part of the return to work process.	Fully compliant			
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y	Awareness of HART capabilities forms part of Commander Training and Emergency Operations Centre Major Incident Training.	Fully compliant			
Domain: Administration									
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y	A Number of EOC Procedures are in place and well embedded within the organisation: EOC0014 - Deployment of HART Team EOC EOC0029 - marauding Attack and Major Incidents EOC0035 - NWAS Attendance at Chemical & Nuclear Sites EOC0057 - HART RRV Cat 1 Diverts	Fully compliant			
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y	A Number of EOC Procedures are in place and well embedded within the organisation: EOC0014 - Deployment of HART Team EOC EOC0029 - marauding Attack and Major Incidents EOC0035 - NWAS Attendance at Chemical & Nuclear Sites EOC0057 - HART RRV Cat 1 Diverts	Fully compliant			
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y	This was only done for one rotation of training during the height of the pandemic	Fully compliant			
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y	HART resource levels and deployments are recorded via PROCLUS.	Fully compliant			
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y	HART response time standards will be captured in the SOE / CAD. HART deployments are internally captured and inputted into PROCLUS and a deployment spreadsheet documenting time of allocation and number of staff deployed.	Non compliant	Requests made to Business Informatics and IT to generate an automated report to capture accurate time standards for HART in line with national standards	Chief of Digital and Innovation/Head of Special Operations	Feb-22
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	GERA's are set by NARU and are accessible via PROCLUS. Training venues are risk assessed either by the user or service provider. High risk sites have site specific quick reference sheets which are accessible to operational staff.	Fully compliant			
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Internal lessons identified and debriefing processes.	Fully compliant			
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Utilise the NARU Safety Alert system via PROCLUS. Several alerts have been raised by NWAS and shared with national colleagues.	Fully compliant			
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y	All safety alerts received by management team and team leaders. Safety alert reviewed, actioned and returned to NARU in line with request.	Fully compliant			
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y	All change requests are approved by management before inputted into PROCLUS for the attention of NARU TUGs.	Fully compliant			
Domain: Response time standards									

H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y	EOC0014 Procedure and captured in HART deployment spreadsheet and PROCLUS.	Fully compliant			
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y	EOC0014 Procedure and captured in HART deployment spreadsheet and PROCLUS.	Fully compliant			
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y	Location of HART teams in line with Home Office Model Response plan. Every effort is made to ensure six HART personnel are on duty 24/7 to ensure HART capabilities and Safe systems of Work.	Fully compliant			
H26	**HART**	**Mutual aid**	Organisations must ensure that their ‘on duty’ HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the ‘on duty’ HART team is already deployed at a local incident requiring HART capabilities.	Y	NWAS HART follow the national service specification in order to maintain the 30 minutes notice to move.	Fully compliant			
Domain: Logistics									
H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y	Depreciation details on vehicles IGT is available via finance and within the budget line	Fully compliant			
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	Equipment procured adheres to the National Equipment Data Sheets in order to ensure consistency / compliance across both teams	Fully compliant			
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y	All equipment follows the national buying frameworks where they are specified.	Fully compliant			
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y	Both HART fleets and incident technology are fully compliant with the national specification.	Fully compliant			
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y	All equipment follows an inspection, service and maintenance package in line with national or manufacturers recommendations. Reports are held centrally for compliance.	Fully compliant			
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Asset register is recorded on PROCLUS complete with procurement dates, service and maintenance dates, end of life / replacement dates.	Fully compliant			
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y	Ashburton Point fully complaint Croxteth none compliant and however we have a derogation in place supplied by NARU until a new HART site is established at Liverpool	Fully compliant			
MTFA									
Domain: Capability									
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y	Compliant but moving toward the new sort standards April 2022	Fully compliant			
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y	Compliant but moving toward the new sort standards April 2022	Fully compliant			
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y	Training around MTA is aligned to national training competencies / equipment / PPE	Fully compliant			
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y	SOP's located through PROCLUS. HART Team Leaders have access to PROCLUS SOP's and regular update training in the form of daily SOP awareness. SOP's can be accessed whilst deployed to an incident via the team leader tough book.	Fully compliant			
Domain: Human Resources									
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y	Monitored via PROCLUS and CAD	Fully compliant			
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y	Records of PCA maintained by MTA manager	Fully compliant			

M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y	Training is aligned to competencies within TIS within PROCLUS	Fully compliant			
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y	Partially compliant as working towards the new SORT enhancement program.	Partially compliant	Sort enhancement program began on the 06/09/2021 approx. 14 course have been scheduled for delivery	Head of Special Operations /MTA Training Manager	Apr-22
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y	All Operational /Tactical Commanders have training on the deployment on MTA. This may be part of the mandartory training program or annual commander training.	Fully compliant			
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y	Comprehensive training has been delivered to Greater Manchester FR and Merseyside FR	Fully compliant			
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y	100% of Commanders are compliant this may have been obtained through national course or annual commander training. It is no clear through the ESR route if 80% of all operational staff have completed the familiarisation training.	Partially compliant	Liasions with the Workforce Information teams to obtain a clear breakdown of front line operational staff completing the familiarisation training	Head of Special Operations /Workforce Information Analyst	Apr-22
Domain: Administration									
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	Processes are included in procedures within the EOCs	Fully compliant			
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y	EOCs maintain a robust policy supported by advice on specific calls from HART Team Leaders / NILO	Fully compliant			
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y	NARU procedures followed when necessary.	Fully compliant			
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y	No live deployments of full MTFA capability have yet been made but process is in place.	Fully compliant			
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y	Monitored and reported daily by PROCLUS.	Fully compliant			
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y	Recorded on PROCLUS and daily ROCC log.	Fully compliant			
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	The definition of high risk or iconic sites is not always revealed by the Police for reasons of national security however for most, NWAS and/or multi agency arrangements and plans are in place or being developed Local risk assessments in place. NWAS has adopted a site specific reference sheet for some sites of significant numbers.	Fully compliant			
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y	Process in place supported by wider Trust guidance. (including JESIP JOL and PROCLUS LiD)	Fully compliant			
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y	Process is followed and information shared in a timely fashion.	Fully compliant			
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y	Process is followed and information shared in a timely fashion. This will also be included in any debrei	Fully compliant			
Domain: Response time standards									
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y	In accordance with HART readiness (2 Teams) and MTFA mobilisation procedures in EOC. The capability will be increase with the new SORT enhancement program commencement date September 2021	Fully compliant			
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y	Policy and procedure in place across EOCs.	Fully compliant			

Domain: Logistics									
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y	PPE is checked regularly and logged by users and on training sessions by instructors. Issues of kit are in compliance with national spec.	Fully compliant			
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y	Procurement has a reconised framework for this type of purchasing.	Fully compliant			
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y	Maintenance and servicing is in accord with this.	Fully compliant			
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y	Depreciation in place in conjunction with Finance Team	Fully compliant			
M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Asset registers maintained. However may not include all areas of detail	Partially compliant	A review of a database is undergoing to assess the asset and staff aligned	Head of Special Operations / MTA Operations Manager	Mar-22
CBRN									
Domain: Capability									
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y	Training records are in place and are available on request .	Fully compliant			
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y	NWAS is compliant with the national capabilities through training and currently working towards the new SORT enhancement programme	Fully compliant			
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y	SORT teams are trained in accordance with national SOPs	Fully compliant			
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y	Technical advice is available 24/7 via the Trust Tactical Advisor/NILOs who have reach back to specialist if required	Fully compliant			
Domain: Human resources									
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y	Some ommanders have to complete CBRN courses to maintain competency. However, there has been a lack of external courses for the commanders to attend due to the pandemic.	Partially compliant	profile commanders on the national course once established and after the COVID pandemic	Head of Special Operations	Sep-22
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y	Procedures are in place aligned to national competencies i.e man down procedures. DATIX system in place to report such incident	Fully compliant			
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y	Entry Control Officer monitors times and durations of entry beyond the cordon and logs.	Fully compliant			
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y	CBRN/SORT staff levels are maintained and monitored to above the threshold to achieve this. They are reported via PROCLUS	Fully compliant			
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y	CBRN Manager is a substantive position in the Trust and he is trained to Instructor level across a number of disciplines.	Fully compliant			
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y	PRPS trainers are supported by CBRN Manager and newly appointed MTA Training Manager.	Fully compliant			
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y	Training complies with this. TIS is mapped across training	Fully compliant			

B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y	All operational staff are fit tested/ trained to use and supplied with FFP3 masks as part of standard Infection Prevention Control (IPC) procedures. Those staff that are not able to be fit tested for FFP3 masks are also provided with Sundstrom powered hoods	Fully compliant			
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y	All operational staff trained in IOR by Mandatory Training.	Fully compliant			
Domain: administration									
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y	Plan on RD and on NWAS shared drive (Special Operations)	Fully compliant			
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y	Deployment procedures in place for EOC. Resilience Manager EOC Walkthrough exercises completed/ Evidence through the EPRR sub group with findings	Fully compliant			
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y	Resilience Managers have completed full site specific plans for iconic sites	Fully compliant			
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y	JESIP and NARU guidance underpin all Special Operations deployments.	Fully compliant			
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y	Multiagency plans includes communication to key stakeholders	Fully compliant			
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y	A CBRN plan is in place however does not cover a procedure to access national stocks. This process is currently known to the CBRN/MTA manager.	Fully compliant			
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y	NWAS has a dedicated contract with a specialist hazardous waste contractor. This is also available to Acute Trusts.	Fully compliant			
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y	Transition arrangements are a section of the Major Incident Response Plan and are discussed in multi agency fora.	Fully compliant			
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y	Risk assessment in place for working in and around CBRN environment. Training of new dedicated Safety Officers are now implemented throughout the Trust	Fully compliant			
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y	The definition of high risk or iconic sites is not always revealed by the Police for reasons of national security however for most, NWAS and/or multi agency arrangements and plans are in place or being developed. NWAS CBRN capability is sufficiently flexible and robust to respond to a range of sites or incident types/magnitudes effectively. Commanders and responders are encouraged to make dynamic decisions based on the nature of the incident and geography of the site, under JESIP principles. The overall CBRN response function has its own risk assessments in place based on the need to respond to a wide range of sites and in wide range of circumstances. publication of risk profiles of pre identified sites (or locations of potential CBRN facilities) is guarded against to avoid them becoming targets.	Fully compliant			
Domain: Response time standards									
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y	EOC SORT mobilisation procedures - key site for holding of CBRN vehicles	Fully compliant			
Domain: logistics									
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y	All CBRN equipment compliant with national capability matrix.	Fully compliant			
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y	All CBRN equipment is procured and maintained using national framework agreements approved by NARU.	Fully compliant			
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y	All CBRN equipment serviced and maintained annually or in line with manufacturers instructions.	Fully compliant			

B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y	Annual service and maintenance programme.	Fully compliant			
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	All equipment is serviced annually by NSC according to vehicle registration numbers but there is no asset database as such for the equipment on each vehicle.	Partially compliant	During the annual servicing of the equipment in November 2021 all equipment will be asset tagged and entered onto a database	Head of Special Operations/ CBRN Manager	Nov-21
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y	In compliance with NARU and NHS England instructions	Fully compliant			
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y	Replacements are funded form existing budgets when required but additional stock has been drawn from national reserves.	Fully compliant			
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y	Managed by the Trust CBRNe Manager (Anthony Shryane)	Fully compliant			
Mass Casualty Vehicles **Domain: Administration**									
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y	Vehicles located at HART Base undercover and plugged into shorelines.	Fully compliant			
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y	HART Teams regularly run and check all vehicles.	Fully compliant			
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y	EOC systems have be adapted to identify incident where these vehicles can be mobilised including a new Pre-determined Attendance (PDA) that was introduced in November 2020. Mobilisation of specialist vehicles is prompted by major incident actions cards for all appropriate roles and functions.	Fully compliant			
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y	All vehicle equipment is maintained regularly by engineers contracted by the Trust.	Fully compliant			
Domain: NHS England Mass Casualties Concept of Operations									
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y	Introduction of new PDA which include the deployment of the NVMCV vehicles. Annual Commander Training 2021 - includes show and tell all Incident management vehicles. Mass Casualty arrangements have been devised in line with this guidance and tested through major exercises and live deployment.	Fully compliant			
V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y	NACC plan is adhered to and Strategic Commanders have received awareness training in its content. Reporting mechanisms are via the ROCC	Fully compliant			
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y	Communication links are tested regularly and Ambulance Liaison Officer Action Cards are part of Major Incident arrangements. Airwave talkgroups to be utilised.	Fully compliant			
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y	Plans are agreed across all Trauma Networks.	Fully compliant			
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y	Recommendations from the current Manchester Arena Inquiry may change the practice of CCS but current CCS capability is predicated on Incident Support Units and HART capabilities which are replicated across the Region. Major Incident Response Plan describes CCS function and staffing.	Fully compliant			
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y	Major Incident Response Plan covers theses areas. Access to the providers can be sourced using the forward planning teams in the ROCC	Fully compliant			
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y	This requirement is recognised (although distribution plans are designed to reduce this need) and practiced through exercise. Alternative support is used regularly in normal operations so relationships are established.	Fully compliant			
Command and control **Domain: General**									
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y	NWAS C2 arrangements are in accordance with national best practice and guidance.	Fully compliant			

C2	C2	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y	NWAS C2 arrangements are in accordance with national best practice and guidance.	Fully compliant			
C3	C2	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y	Major Incident Response Plan and action cards cover this point.	Fully compliant			
C4	C2	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y	AEO receives assurance from the annual EPRR Assurance Assessment as a full Board member.	Fully compliant			
Domain: Human resource									
C5	C2	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y	24/7 365 rotas are in place for all command roles across the Trust. A comprehensive training record for each commander is in place and can be accessed if required	Fully compliant			
C6	C2	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y	Succession planning is being addressed to support the maintenance of all rotas in the future. Any gaps currently are filled from existing trained and qualified managers. 24/7 365 days support roles in place provided by NILO and Forward Doctors. New roles of the Safety officer in place, this role cannot be fully regonised to capture 365 days however, further courses are profiled	Fully compliant			
C7	C2	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	Currently commanders have received and acknowledge letters of changes to their contract in regards to ensuring they comply to the NHS Ambulance Service Command and Control (Schedual 2) also included the acknowledgement of National Occuapational Standards.	Partially compliant	Discussion at the EPRR sub group to take forward	Director of Operations/ Workforce Planning/ Head of Special Operations	11-Oct-21
C8	C2	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y	All Commanders have received a formal Contract Variation Letter to enshrine Command role in contract of employment.	Fully compliant			
C9	C2	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y	PPE is a personal issue to all substantive commanders on the on call rota. 2020-2021 has seen further measures of PPE being accessible for all staff on the PSU and MI vehicles	Fully compliant			
C10	C2	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y	New procedures within the EOC have given greater accesses to open communications to all three blue light services. Airwave resources are issued to all on call commanders and can be augmented from spares/major incident stocks. HART Ground Technology can establish locally interoperable networks to support existing redundancy across all 3 EOCs.	Fully compliant			
Domain: Decision making									
C11	C2	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y	Commanders are taught how to manage risk as per method in the NARU guidance. Risk is also included in mandatory training and annual commander training.	Fully compliant			
C12	C2	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y	JDM is embedded in all Commander training and NWAS plans.	Fully compliant			

C13	C2	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y	All Commanders are issued with personal copies of NARU C2 standards and are mandated to comply.	Fully compliant			
Domain: Record keeping									
C14	C2	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y	All decision logs are retained indefinitely in NWAS.	Fully compliant			
C15	C2	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y	Commanders have been given logging training and this is tested on exercises and incidents when logs are reviewed and feedback given. Trained loggists are also available.	Fully compliant			
C16	C2	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y	Loggist rota in place with one currently available on call 24/7/365. Sufficient additional loggists can be called via Cascade system and those on duty in EOCs can step up to role as can admin and clerical staff across most functions in Trust.	Fully compliant			
Domain: Lessons identified									
C17	C2	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y	2021 seen a new position of a Resilience Manager Quality and Improvement established. This allows a direct route for lessons identified being reviewed, in turn using those lessons in exercise and training to embed learning. NWAS debrief processes based on College of Policing methods and trained structured debrief facilitators are available from within NWAS or from partner agencies. PROCLUS LiD is used to share lessons as is the JESIP JOL	Fully compliant			
Domain: Competence									
C18	C2	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	Some commanders will have completed exercises and a comprehensive NOS	Partially compliant	Oppurtunities will become more frequent as the pandemic eases.	Head of Contigency Planning (Interim)	Apr-22
C19	C2	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y	Commander participation in national courses is logged by the Resilience Team.	Fully compliant			
C20	C2	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	NWAS systems fully aligned to Schedule 2 . Commander NoS is scrutinised periodically to maintain a place on the rota.	Fully compliant			
C21	C2	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	Commander participation in national courses is logged by the Resilience Team.	Fully compliant			
C22	C2	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	NWAS systems fully aligned to Schedule 2 . Commander NoS is scrutinised periodically to maintain a place on the rota.	Fully compliant			
C23	C2	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y	Commander participation in national courses are logged by the Resilience Team.	Fully compliant			
C24	C2	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y	Maintenance of CPD/NoS portfolios is mandated. A procedure regarding the NOS framework is currently being developed and led by Head of Special Operations and Assistance Director of workforce development. The NOS is framework is currently being reviewed nationally	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations	Mar-22

C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y	COVID seen a lack in exercise opportunities in relation to internal and external multiagency over the last 12 months however annual commander training has been aligned to lessons identified. EOC have seen a series of mini exercise which have allowed assessment of current training programs Exercise play is monitored on a central database and individual reflections are expected in each NoS portfolio. Live incident attendance is also logged.	Partially compliant	LRF groups are starting to converse which will allow for multiagency planning to take place in regards to exercise and embedding objectives	Head of Special Operations/ Head of Contingency Planning (Interim)	Mar-22
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y	Area Heads of Service have the ability to remove any participant from command (and on call) duties if minimum criteria are not met or maintained.	Fully compliant			
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y	Current Commander NOS is inspected periodically. Awaiting a framework for NOS to be signed off	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y	All NWAS Tactical Advisors are mandated to attend the national NILO course. A national workbook for NILO/Tactical Advisors is currently under review	Fully compliant			
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y	NILOs also maintain NoS portfolios. A framework for NOS to be signed off	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y	All NWAS loggists have been trained by internally validated Loggist trainers. Syllabus adhere to national best practice.	Fully compliant			
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	Loggists are also expected t maintain CPD portfolios (no specific NoS for Loggist role.) (As of C29)	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y	A MERIT rota is in place outlining the percentage of compliance of both Medical Advisor and Forward Doctor. Currently there are only 29 live doctors out of the WTE of 40 therefore, it is difficult to maintain a 100% compliance. The Medical Director holds the Strategic Medical Advisor rota.	Partially compliant	Recruitment up to 40 is on going	Head of Special Operations / MERIT Manager/ Deputy Medical Director	Mar-22
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y	Training records are kept in regards to refreshing skills. Lack of exercises during the pandemic has impacted on an exercise every 12 months however, as exercises are starting the inclusion of the MERIT doctors will be part of objectives	Partially compliant	Objective built within exercises to include MERIT participation where possible	Head of Contingency Planning (Interim) MERIT Manager	Mar-22
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y	All Commanders must attend face to face multi agency JESIP training in a 3 year cycle and adhere to all JESIP Principles and Doctrines. Annual JESIP refreshers are conducted as part of Mandatory Training and content is discussed on command training sessions. Documents lodged in personal resource files.	Fully compliant			
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y	Bespoke training provided for EOC staff in Incident Management Training and interoperable capabilities. EOC Duty Managers/SMT also attend annual commander training	Fully compliant			

C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y	NARU Major Incident Action Cards have currently been updated - July 21. A mapping process with outcomes from change is pending 31 October 21. Bespoke NWAS Action Cards (which have been mapped across to the NARU cards so that no key features are lost) are available on all operational vehicles and Mandatory Training covers basic principles. Major Incident Response Plan is also available to all staff including Action Cards for all roles. Annual Mandatory training 2021 includes an extended version of Incident Management Training which included first vehicle on scene. Gaps can be found that not all staff are fully converse with the function roles of Incident Management	Partially compliant	Training to be address in regards to new front line staff induction into Incident Management. Continuation and awareness program in regards to functional roles.	Director of Operations / Head of Contingency Planning (interim)	Nov-21
JESIP Domain: Embedding doctrine									
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y	All NWAS plans, policies and procedures (including operational orders) include JESIP references and principles where required. This includes use of JESIP terminology and approved graphics.	Fully compliant			
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y	NWAS planning outputs are underpinned by prevailing JESIP Joint Doctrine with reminders in plans including diagrams and graphics to support comprehension.	Fully compliant			
J3	**JESIP**	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y	Major Incident Response Plan covers this criteria and even minor plans and orders address the pertinent sections of JESIP Doctrine.	Fully compliant			
J4	**JESIP**	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y	2020 / 2021 has seen further training in the EOC for the use of M/ETHANE, however this has been ambulance standard for many years and all plans and guidance reference this where required. This is taught on induction and mandatory training and is a core element of the major Incident Response Plan. Emergency Operations Centre dispatches request METHANE reports and this process is exercised with multi agency partners.	Fully compliant			
J5	**JESIP**	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y	JESIP JDM is the only permitted decision support model in NWAS and the graphic is repeated in Operational Orders, Plans Aide Memoirs and the major Incident Response Plan.	Fully compliant			
J6	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y	Majority of NWAS plans and documents are on an annual review cycle. Some multi agency plans that we contribute to are on a 3 year cycle but all are amended accordingly when the opportunity presents. All NWAS plans are fully JESIP compliant and have been for a number of iterations.	Fully compliant			
J7	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y	Aide Memoir cards and other official JESIP products have been distributed to staff and Commanders, the JESIP App is promoted widely and other products are signposted frequently through communication bulletins. Links to the regular JESIP Newsletters are published in all staff bulletin each time they are published by JESIP. JESIP support 'tools' are promoted in NWAS plans and documents.	Fully compliant			
Domain: Training									
J8	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y	Annual Mandatory Training for all front line staff (and commanders) includes JESIP awareness and discussion on use of JESIP Doctrine. Annual Commander Training 2021 has seen the introduction of a multi question assessment paper on the JESIP principles	Fully compliant			
J9	**JESIP**	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y	2020/2021 has seen a framework of training for EOC staff which include the awareness of JESIP principles. EOC Duty Managers/SMT attend the NWAS Annual Commander Training which includes a JESIP multi question assessment.	Fully compliant			
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y	Competencies maintained through multi agency JESIP course delivery, NWAS Mandatory Training (incorporating JESIP awareness), on-line training resources and multi agency exercise opportunities. Management of incidents and feedback from debriefs also reinforces this process.	Fully compliant			
J11	**JESIP**	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y	Central records of training attendance maintained and reported to JESIP on quarterly basis. Mandatory Training records are maintained and enhanced detail kept for individuals on ESR. The recent EPRR sub group reports quarterly on commander JESIP training	Fully compliant			

J12	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y	JESIP course currency is considered mandatory for Command roles and non attendees are prioritised for attendance on courses at earliest opportunity. Monitored in line with national Command Standards.	Fully compliant			
J13	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y	JESIP e learning encouraged and NWAS annual Mandatory Training contains a JESIP session aligned to JESIP specified learning outcomes. Recent requirement to record refresher courses on NWAS database now incorporated into quarterly EPRR sub-group reports.	Fully compliant			
J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y	Mandatory for all Commanders and records maintained on central spreadsheet with scrutiny by Resilience Managers/ JESIP Delivery Managers .	Fully compliant			
J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y	As in C25 COVID has delayed participation in joint exercises however, the scene of recovery should now enable this multiagency exercises to take place	Partially compliant	Encouragement of multiagency training exercises via LRF route	Head of Contingency Planning (interim) / Resilience Managers	Feb-22
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y	JESIP principles is part of Mandatory Training	Fully compliant			
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y	Internal courses are reviewed annually and official JESIP products are also employed. Appropriate changes are made on each review of training material. JESIP have reviewed the training 2021 to include EOC staff, this is currently being BETA tested in the C&M multiagency teams, feedback will be given to the JESIP senior team to	Fully compliant			
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y	NWAS Resilience Manager are a part of the multiagency trainers in regards to delivering the JESIP training packages. Planning meetings by the agencies take place at the start of a program of delivery and at the end of training this allows any changes to take place. 2021 see's a new set of material produced by JESIP for multiagency training	Fully compliant			
Domain: Assurance									
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y	Trust complies with this as well as quarterly returns to the EPRR sub group	Fully compliant			
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y	Training records cover this element and use of METHANE as situation reporting tool is standard practice in NWAS.	Fully compliant			
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y	JESIP objectives are integrated into wider exercise aims. Annual exercise programme across 5 LRFs is extensive and wide ranging in scope/subject. Multi agency partners have similar imperative to conform to JESIP Doctrine and exercise outcomes.	Fully compliant			
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y	Retention JESIP knowledge is assessed on annual internal, Commander training - between 3 yearly (multi-agency) refresher training sessions. On line awareness and training currently not tracked as hosted outside NWAS systems but widely promoted to staff and Commanders. Use of Umpire templates at exercises captures competency data from participants and exercise objectives promote competencies.	Fully compliant			
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y	NWAS Annual Command training using a multi question assessment sheet to capture evidence around knowledge or gaps within the JESIP environment. Use of templates is encouraged and part of multi agency exercise conduction. Templates are being integrated into Commander competency assessments as part of Commander Service Specification introduction.	Fully compliant			

Deep Dive

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**												
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	If applicable	If applicable	Head of Procument and sector lead ensure programme of works in place for medical gases	N/A			
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	If applicable	If applicable	Robust BC plans in place should issues arise with low stocks - staff are trained at entry front line training into the service which includes safe storage of gases. Annual contract in place for services front line vehicles pipelines	Fully compliant			
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	If applicable	If applicable	Plans and procument in place, Annual contracts in place for services in front line vehicle	Fully compliant			
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	Y	If applicable	If applicable	N/A	N/A			
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	If applicable	If applicable	Robust BC plans in place. Agreements via procurment for extra supplies to be delivered should the need arise	Fully compliant			
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	If applicable	If applicable	Annual contract in place	Fully compliant			
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	If applicable	If applicable	N/A	N/A			

Action Plan

H17	**HART**	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y	HART response time standards will be captured in the SOE / CAD. HART deployments are internally captured and inputted into PROCLUS and a deployment spreadsheet documenting time of allocation and number of staff deployed.	Non compliant	Requests made to Business Informatics and IT to generate an automated report to capture accurate time standards for HART in line with national standards	Head of Special Operations/HART Operations Manager	Feb-22	Several discussions and meetings held with BI and IMT had to determine a way to develop an automated data capture system.
H8	**HART**	Six operational HART staff on duty	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y	PROCLUS updated at the start of each shift, as part of NACC and national monitoring of HART asset availability. However, full compliance is virtually unachievable as it only requires a single member of staff to report sick short notice on one occasion to resulting failure of this standard. Staff are available from the training teams.	Partially compliant	Maintaining full HART establishment and routine management of rotas, abstractions and absences. Dynamic changes to cover on day if opportunities available. Numbers of staff on duty are reported twice daily on PROCLUS.	Head of Special Operations/ HART Operations Manager	On-going issue	Only a change to Commissioning support and increase in base level establishment to increase the numbers of Operatives on duty can rectify this. Abstraction from Training Team causes consequential risks to compliance in core competencies and creates further rostering difficulties.
M8	**MTFA**	Training records	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y	Partially compliant as working towards the new SORT enhancement program.	Partially compliant	Sort enhancement program began on the 06/09/2021 approx. 14 course have been scheduled for delivery	Head of Special Operations /MTA Training Manager	Apr-22	
M11	**MTFA**	Staff training requirements	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y	100% of Commanders are compliant this may have been obtained through national course or annual commander training. it is no clear through the ESR route if 80% of all operational staff have completed the familiarisation training.	Partially compliant	Liasions with the Workforce Information teams to obtain a clear breakdown of front line operational staff completing the familiarisation training	Head of Special Operations /Workforce Information Analyst	Apr-22	
M28	**MTFA**	MTFA asset register	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	Asset registers maintained. However may not include all areas of detail	Partially compliant	A review of a database is undergoing to assess the asset and staff aligned	Head of Special Operations / MTA Operations Manager	Mar-22	
B5	**CBRN**	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y	Some ommanders have to complete CBRN courses to maintain competency. However, there has been a lack of external courses for the commanders to attend due to the pandemic.	Partially compliant	profile commanders on the national course once established and after the COVID pandemic	Head of Special Operations	Sep-22	

B29	**CBRN**	Equipment maintenance - assets register	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y	All equipment is serviced annually by NSC according to vehicle registration numbers but there is no asset database as such for the equipment on each vehicle.	Partially compliant	During the annual servicing of the equipment in November 2021 all equipment will be asset tagged and entered onto a database	Head of Special Operations/ CBRN Manager	Nov-21	
C7	**C2**	Recruitment and selection criteria	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	Currently commanders have received and acknowledge letters of changes to their contract in regards to ensuring they comply to the NHS Ambulance Service Command and Control (Schedual 2) also included the acknowledgement of National Occuapational Standards.	Partially compliant	Discussion at the EPRR sub group to take forward	Director of Operations/ Workforce Planning/ Head of Special Operations	11-Oct-21	There will need to be a discussion between the Director of Operations/ Head of Special Operations and Workforce Development to review the possibilities of applying for a role but applying seperatley to be a commander. Currently not all operational /senior managers are commanders.
C18	**C2**	Strategic commander competence - National Occupational Standards	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y	Some commanders will have completed exercises and a comprehensive NOS	Partially compliant	Oppurtunities will become more frequent as the pandemic eases.	Head of Contigency Planning (Interim)	Apr-22	Oportunities are starting to come through the LRF for joint exercises,also exercises developed internally for NWAS.
C24	**C2**	Commanders - maintenance of CPD	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y	Maintenance of CPD/NoS portfolios is mandated. A procedure regarding the NOS framework is currently being developed and led by Head of Special Operations and Assistance Director of workforce development. The NOS is framework is currently being reviewed nationally	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations	Mar-22	

C25	**C2**	Commanders - exercise attendance	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y	COVID seen a lack in exercise opportunities in relation to internal and external multiagency over the last 12 months however annual commander training has been aligned to lessons identified. EOC have seen a series of mini exercise which have allowed assessment of current training programs Exercise play is monitored on a central database and individual reflections are expected in each NoS portfolio. Live incident attendance is also logged.	Partially compliant	LRF groups are starting to converse which will allow for multiagency planning to take place in regards to exercise and embedding objectives	Head of Special Operations/ Head of Contingency Planning (Interim)	Mar-22	
C27	**C2**	Assessment of commander competence and CDP evidence	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y	Current Commander NOS is inspected periodically. Awaiting a framework for NOS to be signed off	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22	
C29	**C2**	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y	NILOs also maintain NoS portfolios. A framework for NOS to be signed off	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22	
C31	**C2**	Loggist - CPD	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y	Loggists are also expected t maintain CPD portfolios (no specific NoS for Loggist role.) (As of C29)	Partially compliant	Awaiting National outcomes / NWAS sign off to NOS framework	Head of Special Operations / EPRR sub-group	Mar-22	
C32	**C2**	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y	A MERIT rota is in place outlining the percentage of compliance of both Medical Advisor and Forward Doctor. Currently there are only 29 live doctors out of the WTE of 40 therefore, it is difficult to maintain a 100% compliance. The Medical Director holds the Strategic Medical Advisor rota.	Partially compliant	Recruitment up to 40 is on going	Head of Special Operations / MERIT Manager/ Deputy Medical Director	Mar-22	
C33	**C2**	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y	Training records are kept in regards to refreshing skills. Lack of exercises during the pandemic has impacted on an exercise every 12 months however, as exercises are starting the inclusion of the MERIT doctors will be part of objectives	Partially compliant	Objective built within exercises to include MERIT participation where possible	Head of Contingency Planning (Interim) MERIT Manager	Mar-22	

C36	**C2**	Responders awareness of NARU major incident action cards	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y	NARU Major Incident Action Cards have currently been updated - July 21. A mapping process with outcomes from change is pending 31 October 21. Bespoke NWAS Action Cards (which have been mapped across to the NARU cards so that no key features are lost) are available on all operational vehicles and Mandatory Training covers basic principles. Major Incident Response Plan is also available to all staff including Action Cards for all roles. Annual Mandatory training 2021 includes an extended version of Incident Management Training which included first vehicle on scene. Gaps can be found that not all staff are fully converse with the function roles of Incident Management	Partially compliant	Training to be address in regards to new front line staff induction into Incident Management. Continuation and awareness program in regards to functional roles.	Director of Operations / Head of Contingency Planning (interim)	Nov-21	This action will be address at the EPRR sub group 11 October 21
J15	**JESIP**	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y	As in C25 COVID has delayed participation in joint exercises however, the scene of recovery should now enable this multiagency exercises to take place	Partially compliant	Encouragement of multiagency training exercises via LRF route	Head of Contingency Planning (interim) / Resilience Managers	Feb-22	

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Appendix 4 - 111 Statement of Compliance - EPRR Core Standards

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2021-22

STATEMENT OF COMPLIANCE

NHS 111 has undertaken a self-assessment against the NHS England Core Standards for EPRR.

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating the following level of compliance against the 2021-22 standards: **Full**

Compliance Level	Criteria
Fully compliant	The organisation if fully compliant against **100%** of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against **89-99%** of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against **77-88%** of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to **76%** of the relevant NHS EPRR Core Standards

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
29	xx	xx	29
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29** NWAS: **32/163*** NHS111:**29****			

**NWAS should report two assurance ratings, demonstrating compliance with the core standards for EPRR and Interoperable capabilities.*
***NHS111 should be reported separately.*

Where areas require further action, this is detailed in the attached EPRR Action Plan and will be reviewed in line with the organisation's governance arrangements.

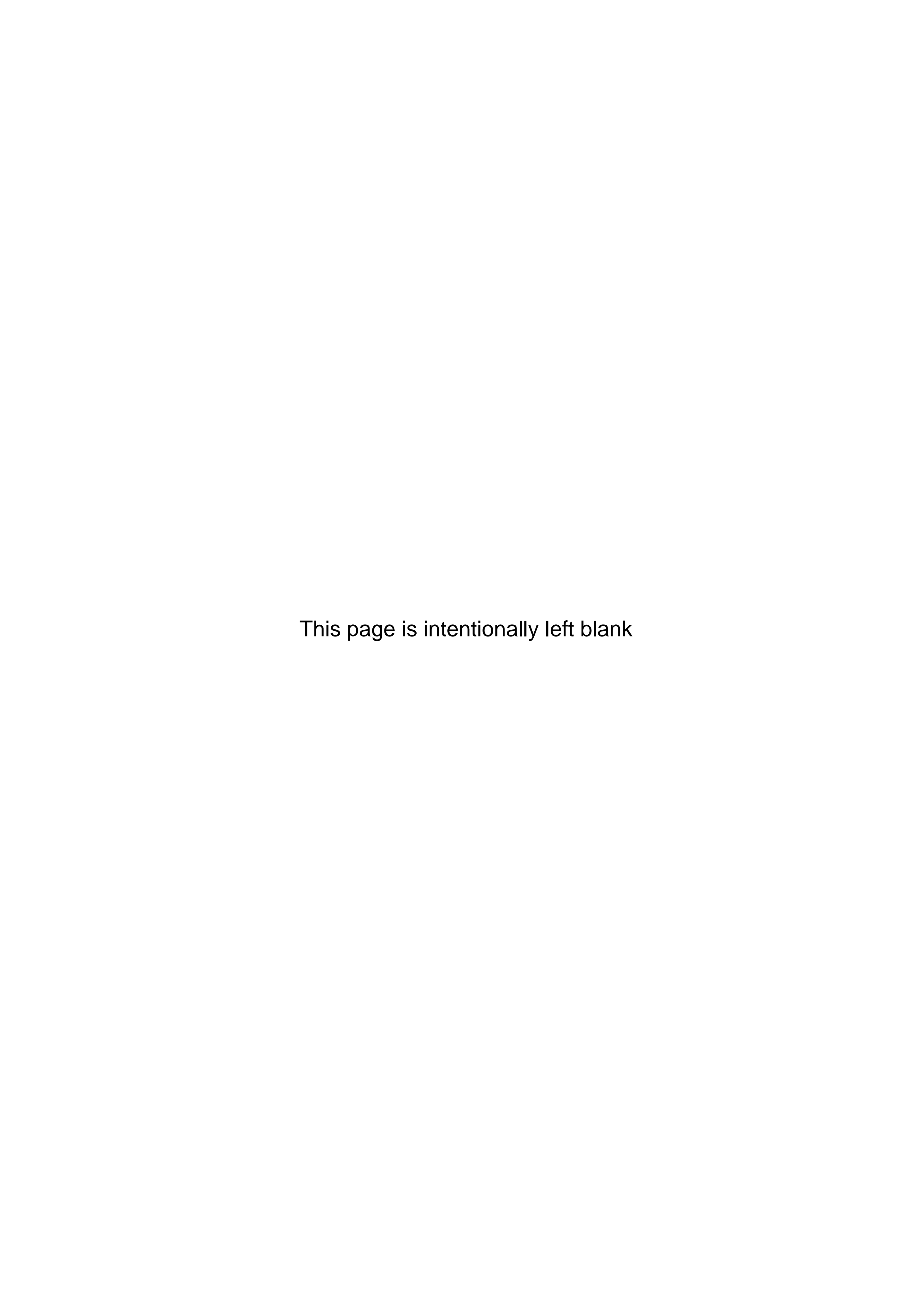
I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

G.A. Blezard

Signed by the organisation's Accountable Emergency Officer

03/11/2021
Date of board / governing body meeting

27/09/2021
Date signed



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Appendix 5 - 111 EPRR Annual Assurance Full Submission Return

Ref	Domain	Standard	Detail	NHS111	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
Domain 1 - Governance										
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Director of Operations (Ged Blezard) is AEO. Lead NED for Resilience is Dr David Hanley. Support and advice from Resilience Team SMT available when required. 111 is part of the Service Delivery Directorate and reporting lines run to Director of Operations.	Fully compliant			
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	A new development of the EPRR subgroup has been in place since May 2021. This group has a work programme in place that provides assurance to the Board of Directors that the Trust is meeting the required standards. EPRR strategy part of Service Delivery annual Business Plan which outlines responsibilities for EPRR compliance.	Fully compliant			
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	A new development of the EPRR subgroup has been in place since May 2021. This group has a work programme in place that provides assurance to the Board of Directors that the Trust is meeting the required standards. EPRR strategy part of Service Delivery annual Business Plan which outlines responsibilities for EPRR compliance.	Fully compliant			
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Governance structure in place - EPRR Subgroup is chaired by Director of Operations and reports through to Trust Board. Terms of reference are available which will include particpants.	Fully compliant			
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	111 have a dedicated learning forum with TOR. A dedicated Resilience Manager (Quality and Improvement0 who focuses on debriefing and learning from incidents and events. The learning is captured through exercising and training. All details are captured and reported through the EPRR sub-group	Fully compliant			
Domain 2 - Duty to risk assess										
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Regular monthly review of EPRR risks by the Trusts Risk & Governance team with the Head of Contingency Planning (interim) and updated on the Corporate Risk Register.	Fully compliant			
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	As above - DATIX system records and assists in management of risks. Regular scrutiny and advice from risk specialists to support EPRR risk management. NHS111 have a dedicated risk manager to support upload and mitigation of risks	Fully compliant			
Domain 3 - Duty to maintain plans										

11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Business Continuity Plans have been reviewed through the new Continuity2 software which will have gone through Business Impact Analysis allowing for risk mitigations to take place. Major Incident Response Plan and associated Action Cards in place and review schedule adhered to. Dedicated oncall specialist structures are in place for the NHS111 structoures	Fully compliant			
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partners and stakeholders are involved in Contingency and Business Continuity Planning where an when appropriate and required. Multi agency planning is conducted via specific planning groups or through wider LRF. Plans are reviewed on average an annual basis however this can change if identified learning has taken place earlier. A new framework of Incident Management Training has been developed for the EOC management team which strengthen the knowledge around incident management and major incident response.	Fully compliant			
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	NWAS Heatwave Plan covers these issues. No inpatient facilities in NWAS but Ambulance air conditioning systems are maintained as a priority during periods of hot weather. Cool rooms can be established in line with Heatwave Plan at large administrative and Control Room sites. The heatwave plan can be accessed by all staff using the green room and Resilience Direct should the partner agencies require the plan.	Fully compliant			
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold weather arrangements are dealt with through Winter Planning documents (Strategic Winter Plan, Area and Service line Tactical Plans which define specific Operational arrangements). Major Incident arrangements and LRF Partnership working underpin Trust response to wider area or prolonged impacts. this includes utilisation of specialist vehicles/support (from military if required and authorised) to access patients.	Fully compliant			
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Mass Casualty Distribution Plans in place across the region, tested through incidents and exercises. Major Incident Response Plan supports management of Mass Casualty incidents and 111 assistance is embedded in process.	Fully compliant			
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	N/A		N/A	N/A			
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Site evacuation, lockdown and sheltering arrangements in place and supported by BC Plans.	Fully compliant			
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	N/A	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	N/A	N/A			
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	N/A	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	N/A	N/A			
Domain 4 - Command and control										

24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	A robust on call structure is in place for NHS111 24/7 365 days on call rota. This can be complimented with the on call rota within the other parts of the Service delivery network.	Fully compliant			
Domain 5 - Training and exercising										
Domain 6 - Response										
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y	Contact Centres (Emergency, Urgent and 111) are fundamental to core business. Additional C2 structures are supported fully (with competent staff) in the event of Critical/Major Incidents through local Major Incident Suites and Regional Operational Coordination Centre.	Fully compliant			
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	A new investment towards a later versions of an on line tool has been purchased 'Continuity2' All departments have own Business Continuity Plans which are tested and exercised before sign off. Dedicated BC Manager in place to support Trust BC Programme.	Fully compliant			
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	Formal sitreps for transmission outside the Trust are coordinated via the Regional Operational Coordination Centre and authorised by a Strategic Commander.	Fully compliant			
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	N/A	• Guidance is available to appropriate staff either electronically or hard copies	N/A	N/A			
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	N/A	• Guidance is available to appropriate staff either electronically or hard copies	N/A	N/A			
Domain 7 - Warning and informing										
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	COVID has allowed the communication plans to be updates via lessons learnt. Major Incident Communications Plan in place and Comms Team staff support exercises and participate in live incidents via formal on call rota. Comms toolkit now in place including action cards to sit outside Major Incident. Response plan. Trust has robust policy to manage Social Media use by staff.	Fully compliant			
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	As above - Comms Team use all available methods to pass messages to public in conjunction with partners. 111 has additional role in providing specific information to callers based on nationally generated advice messages.	Fully compliant			
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Stand alone Major Incident Communications Plan and reference in Major Incident Response Plan. Specific strategies are developed as required. These have recently been updated due to the recent COVID Pandemic	Fully compliant			
Domain 8 - Cooperation										
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	National Contingency are in place should impact to buisness on NHS111 take place. Formal , national (NARU) MOU is adhered to and training sessions have been delivered to Strategic Commanders on its implementation. EMT has had MACA awareness and this function is managed by the Resilience SMT. Strategic Commanders have MACA input on MAGIC Courses but any intended action is always considered in conjunction with military JRLO.	Fully compliant			
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	N/A	N/A			
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	N/A	N/A			

46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	NWAS overarching GDPR arrangements and Data Protection Officer govern release of information outside those formal MOUs and agreements in place. Examples include LRF and multi agency information sharing agreements.	Fully compliant			
Domain 9 - Business Continuity										
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Continuity2 a software procured aligned all processes of ISO 22301 to be completed by each directorate in the trust	Fully compliant			
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	As above - Continuity2 is aligned to IS22301	Fully compliant			
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	IM&T department ISO compliant and follow GDPR obligations.	Fully compliant			
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	All directorate have recently gone through BAI and full plan review to align into the new Continuity2 software	Fully compliant			
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	A quality report is now produced by the Trust BC Manager which is submitted to the new established EPRR subgroup (chaired by Director of Operations) this is an upto date current review of Trust BIA/Exercises and Plans	Fully compliant			
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	As above - Through regular audit and review and maintenance of BC Manager competencies. BC Manager sits on national Ambulance BC group.	Fully compliant			
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Assessed through NHS Purchasing Framework, through tendering process and by Procurement Team with support from BC manager who integrates with major project delivery teams.	Fully compliant			
Domain 10: CBRN										
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements					
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.		Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies					
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.		• Impact assessment of CBRN decontamination on other key facilities					
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		• Rotas of appropriately trained staff availability 24 /7					

60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/		• Completed equipment inventories; including completion date					
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		• Record of equipment checks, including date completed and by whom. • Report of any missing equipment					
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		• Completed PPM, including date completed, and by whom					
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		• Organisational policy					
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		• Maintenance of CPD records					
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		• Maintenance of CPD records					
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.		• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique					
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.							

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REPORT TO BOARD OF DIRECTORS

DATE:	24th November 2021			
SUBJECT:	NWAS Strategic Winter Plan 2021-2022			
PRESENTED BY:	Ged Blezard, Director of Operations			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The intention of this paper is to introduce the Board of Directors to the 2021/2022 Strategic Winter Plan following the annual review and revision. The document describes the establishment of winter planning arrangements across the Service Delivery directorate including mitigations to meet predicted demand. Included within the Strategic Winter Plan are a series of forecast analysis summaries which utilise a number of years historical data combined with current influencing factors to provide forecasting data to support operational planning. The Strategic Winter Plan also places into context the challenges NWAS and the whole health system faces during this winter period to create disruptive impacts due to winter demand, COVID-19, and predicted demanding seasonal influenza season.			
RECOMMENDATIONS:	The Board of Directors takes assurance from the content of the attached and notes the contents of the report.			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			

<table>
<tr><td rowspan="1">ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">25th October 2021</td></tr>
<tr><td>Outcome:</td><td colspan="3">Assurance provided and supported for onward presentation to Board of Directors</td></tr>
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1. PURPOSE

The purpose of this paper is to present the Board of Directors with the NWAS Strategic Winter Plan for 2021/2022.

2. BACKGROUND

2.1 This winter will see NWAS and the whole health system under considerable pressure due to the continuing effects of the global COVID-19 pandemic. The NHS continues to remain under pressure, including the significant pressure of delayed electives, the on-going threat of COVID-19 variants and the predicted worsen seasonal influenza period.

2.2 The annual 'Winter Letter' from the NHS has been issued later each year (early September in previous years) and given the current impact of the COVID-19 pandemic, at this stage there has been no official letter. This communication has been vital in the past as it sets out for all Trusts; national strategy, expectations, planning milestones and timescales for plan and data submissions. It also provides key messages and areas of focus to assist with whole system integration and risk mitigation which in previous years for example were described as:

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

It is likely that these areas of focus will remain with the addition of supply chain resilience for medical and PPE supplies given the current challenges faced.

2.3 The main priority has been the finalisation of the Strategic Winter Plan for external assurance and for the development of area and service level winter plans. These contain detailed and focussed information with a more introspective direction in order to support operational arrangements in each service line; PES areas (GM, C&M and C&L), EOC, 111 and PTS

2.4 Operational winter arrangements including festive period plans will be completed before winter as these will be requested by partners. The current timeline for area and service level plans is the 25 October for all overarching plans, with the caveat that resourcing and staffing data will be further updated before the end of November to ensure accurate details can be shared as we move through winter.

2.5 As part of the NHS Winter Assurance/Preparedness process, Trusts are required to complete and submit this year's template on the 30 September 2021. The NWAS document has been reviewed and completed by each NWAS service line and externally by NWAS Commissioners, and subsequently ratified by the Deputy

Director of Operations to provide assurance of the planning undertaken and the mitigations in place to prepare for this year's winter period.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

3.1 The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the Civil Contingencies Act (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

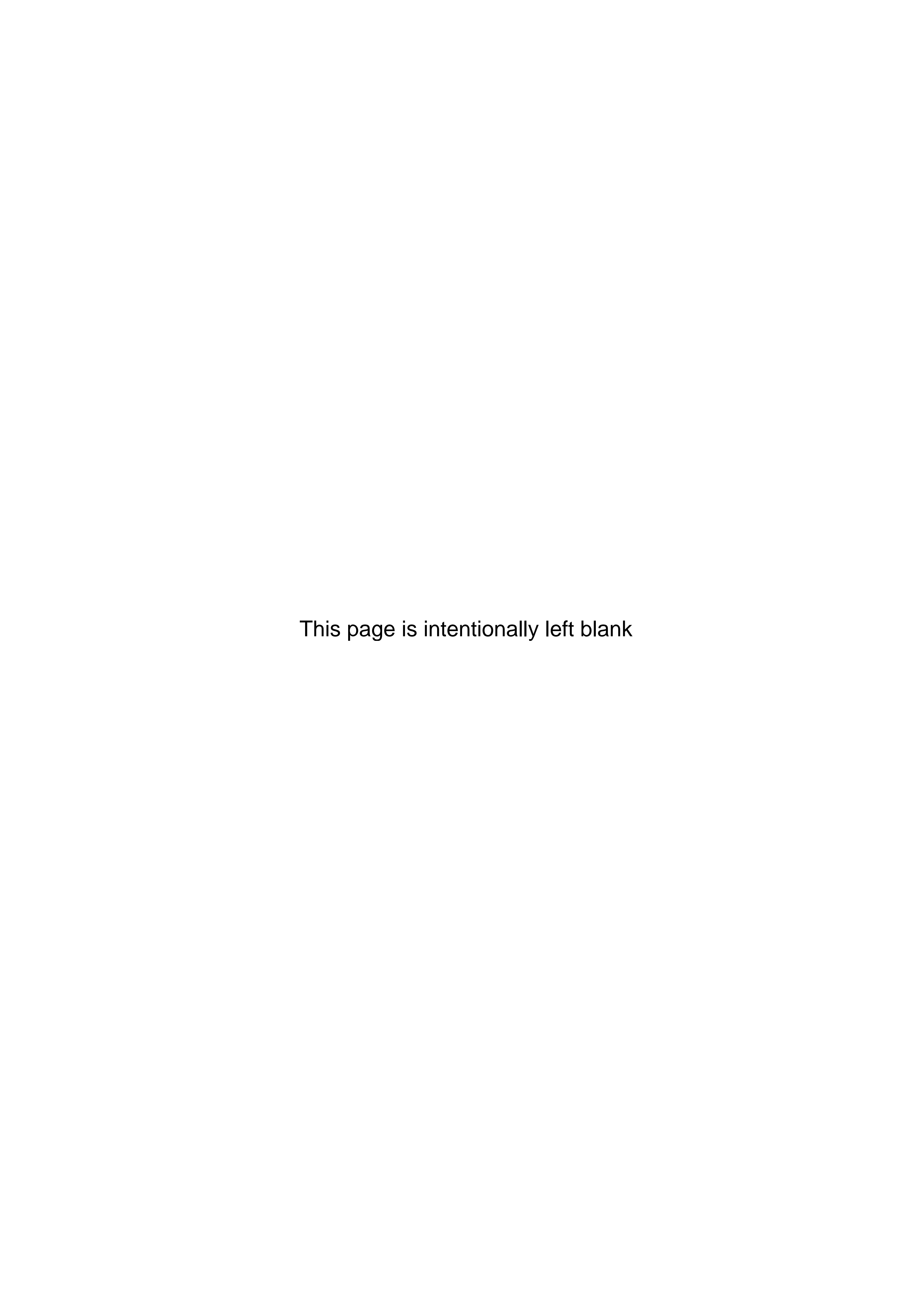
3.2 The Trust also has to meet the obligations outlined in the Ambulance Standard Contract, all CQC Domains and the key requirements of the NHS England EPRR Framework.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

4.1 None identified at the time of writing the report.

5. RECOMMENDATIONS

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

2021 – 2022

NWAS Strategic Winter Plan 2021-22		Page:	1 of 35
Author:	Resilience Team	Version:	1.0
Date of Approval:		Status:	FINAL
Date of Issue:		Date of Review	1 July 2022

Recommended by	Service Delivery
Approved by	Executive Leadership Committee
Approval date	
Version number	1.0
Review date	1 July 2022
Responsible Director	Director of Operations
Responsible Manager (Sponsor)	Head of Contingency Planning
For use by	All Trust employees

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

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	02 Sept 2021		A Jackson	Annual Review
0.2	03 Sept 2021		A Jackson	Sections refreshed and updated. Forecast data added.
0.3	07 Sept 2021		A Jackson	Removed Appendix – Strategic Winter Acton Card, as no longer in use – actions have been incorporated into both Strategic and Exec MIRP Action Cards.
0.4	10 Sept 2021		A Jackson	Changes made to body of document following review by Head of Contingency Planning.
0.5	14 Sept 2021		A Jackson	Changes made to body of document following review by Deputy Director of Operations
0.6	20 Sept 2021		A Jackson	Changes made to body of document following review by NWAS Commissioners
0.7	21 Sept 2021		A Jackson	Review of forecasting data with Head of Regional Planning
1.0	27 Sept 2021		A Jackson	Approval by Deputy Director of Operations

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1.0 Introduction

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

The winter period creates particular challenges for the entire Health Economy regardless of the additional pressures of seasonal illness or severe weather. This year is anticipated to be no exception but this winter will be set against the background of a sustained period of increased demand combined with the uncertainty of the ongoing impact and potential for a further wave of COVID-19, the UK Government also warned that respiratory viruses such as seasonal influenza, are likely to have a significant impact. As such they have released the COVID-19 Response – Autumn and Winter Plan 2021.

This document is intended to draw on the experiences of past winters and experience of responding during a global pandemic. Paramount is the blending of actions for winter 2021/22 with current procedures and processes within NWAS. Such actions cannot themselves be considered in isolation, only through the collective preparations of the whole system can the potential impacts of winter pressures and the continued impact of the COVID-19 pandemic, be appropriately mitigated.

In order to maintain the strategic focus of this document the detail is concentrated on key actions and expectations that are incumbent on NWAS, as reported to NHS England – North Region, as part of the individual (and Lead) Clinical Commissioning Groups (CCG) Winter Assurance preparations. NWAS is also obliged to offer assurances on winter preparedness to NHSE Improvement and this document will augment that assurance process.

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

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

2.0 Planning Framework

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

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

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

- NWAS Major Incident Response Plan
- NWAS Pandemic Influenza Plan
- NWAS COVID-19 Response & Recovery Plan
- National Ambulance Resilience Unit (NARU) Resource Escalation Action Plan
- NWAS Departmental Business Continuity Plans
- North West Divert & Deflection Policy
- NHS Operational Pressures Escalation Levels (OPEL) Framework

- NWAS Patient Safety Plan
- NARU National Command and Control Guidance
- NWAS Area specific, Winter Tactical and Operational arrangements including Festive Arrangements
- NWAS Winter Communications Framework and Plan

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

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

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

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

2.1 Audit and Review

The plan will be subject to periodic audit and review to identify areas of improvement and good practice following each winter. It has already been approved prior to publication by the Strategic Winter Planning Group, Executive Leadership Committee and presented to the Board of Directors for assurance.

As a result of the on-going and developing impact of the COVID-19 pandemic, the NWAS COVID-19 response plan will provide a continual review. Ensuring any dynamic changes to government or Trust guidelines can be implemented and communicated effectively to those staff and stakeholders affected. This will be achieved through the current senior management regular meeting structure and through the communication methods utilised through the Communication Team.

A formal, structured debrief will be scheduled in quarter four of 2022 so that experiences of the winter and learning points can be explored to shape the planning process for the following winter.

2.2 Christmas and New Year

There will be specific arrangements for the key dates over the Christmas and New Year period 2021/22, which include provision of additional operational resources (both NWAS and externally contracted) and appropriate, focussed managerial support. In addition, these arrangements will be extended both in duration and depth (where necessary and practicable) in accordance with the identified 'winter period' span and any forecasted challenges of seasonal flu, continued impact of COVID-19 pandemic or industrial unrest.

2.3 Assurance

This plan relates to ambulance specific issues that have been communicated, with NHSE/I winter planning leads and the Lead Commissioning CCG NHS Blackpool as part of the NHS England - North Region Winter Assurance process, to ensure a whole systems approach. It will also aid with any additional assurances requested by NHS Improvement and support the planning processes of the A&E Delivery Boards.

2.4 Delivery

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

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

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

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

2.5 Area Distinctions

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

Operational arrangements dealing with the NWAS response in each of the functional areas (Cheshire & Mersey, Cumbria & Lancashire and Greater Manchester) will provide the local, operational detail required to underpin this strategic plan, North West NHSE/I Winter Plan and local winter planning groups.

2.6 Flexibility

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

2.7 Lessons Identified

In the development stages of this Plan, lessons identified from the Winter Period of 2020/21 have been considered and changes have been made to ensure that active learning has taken place to enhance the organisations and the wider NHS resilience capabilities.

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

An internal debrief will be arranged for early 2022 so that lessons from the winter can be captured formally and integrated into planning for winter 2022/23.

3.0 Operational Implications

3.1 Mutual Aid

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

3.2 Demand Management

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

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

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

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

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

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

- Mutual aid support for the Trust will also be requested when appropriate from the nearest Ambulance Services of West Midlands, Yorkshire, East Midlands and North East as well as Wales and Scotland. This request will be made under existing national ambulance mutual aid arrangements but can also include the deployment of air assets.

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

3.3 Plan Scope

The NWAS Strategic Winter Plan 2021 covers the period 1 November 2021 until 3 April 2022 unless otherwise stated.

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

3.4 Festive Period

NWAS Tacical and Operational arrangements will give due consideration to the Christmas and New Year period, which is traditionally a time of extremely high demand. Each NWAS area will produce its own aree specific Winter Plan.

- The analysis of historical data has provided the key dates where activity is expected to rise considerably.

- During this period there are likely to be extremely high levels of activity and demand with peaks expected around the Christmas and New Year periods. The last working day before the Christmas Public Holidays and New Years Eve are recognised as particular risks. However, it is also recognised that other factors may change the dynamics of activity levels such as severe weather, seasonal influenza challenges, industrial action or infrastructure disruption.

- The Tactical/Operational Winter Plan detail the Trusts intentions and methodologies for dealing with the increase of activity and maintaining an appropriate safe delivery of service.

- Appropriate additional operational/staff resources from the Paramedic Emergency Service (PES), EOC, Clinical Hub, NW111 and the Patient Transport Service (PTS) will be identified and profiled for the key dates.

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

3.5 Demand Analysis

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

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

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

- In identifying the key dates through historical demand anaylysis, we are able to forecast busiest days by regional footprint and at NWAS operational area level (Appendix 4). This allows for resource planning depending on anticipated activity levels but will be reviewed against any changes in anticipated or unscheduled activity. NWAS REAP arrangements are also available to deal with any surge in demand or adverse pressure on the Trust.

- Information regarding those dates of predicted NWAS high demand will be shared with

Commissioners and NHSE/I North West, enabling appropriate measures to be taken to reduce the impacts on the whole system.

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

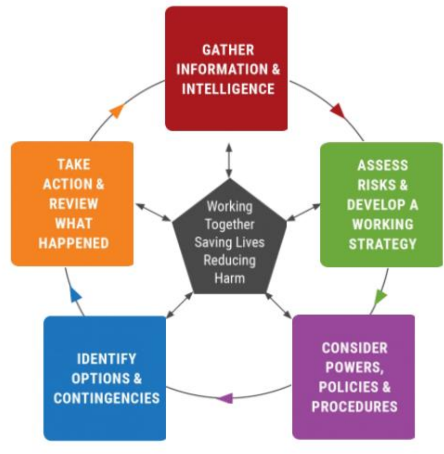
4.0 NWAS Strategy

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

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

The NWAS Strategic Commander will ensure a set of Strategic Intentions (Appendix 1) are developed and reviewed to ensure consistency should these be required during any period covered by this plan.

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



(JESIP)

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

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

4.1 PES Core Response Measures

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

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

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

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

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

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

- Activation times are monitored and reviewed daily by Sector and Operational Managers. Improvements aimed at reducing activation times include the utilisation of strategically placed deployment points as part of a Patient Safety Plan (PSP).

- The North West Divert and Deflection Policy provides an agreed process for Senior Trust Commanders to follow to ensure safe treatment and movement of patients across the region and to address any short-term blockages through agreed deflections.

- The NWAS Clinical Hub and Directory of Services (DoS) are designed to augment the management of 999 calls.

- Analysis of historical data ensures that NWAS are able to place resources appropriately and use relief staff in an effective manner.

- The Patient Transport Service (PTS) is also integral to NWAS strategic planning for winter in consideration of the overall provision of contracted, non-emergency transport services. It should be noted that NWAS is the contract holder for PTS in Cumbria, Lancashire, Greater Manchester and Merseyside while the West Midlands Ambulance Service provides the same function in Cheshire, Warrington and the Wirral.

- NWAS will be required to provide event cover (i.e. sporting events and mass gatherings) during the winter period. The resourcing of these events is over and above that which is required to deliver the operational delivery plan. These events may coincide with dates of anticipated high activity, as identified in the key date information. Such events are managed through partnership between the Trust Resilience and Operations Teams together with the event organisers, Police and Local Authorities.

- The 'Make the Right Call' (http://www.maketherightcall.co.uk) campaign is aimed at advising the public on the appropriate use of the of the Ambulance Service and signposting suitable alternatives for minor ailments. The Trust Communications Team will provide public information through broadcast and social media outlets utilising national templates for any publicity.

4.2 Demand Surge Mitigation

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

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

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

4.3 Staff Health and Wellbeing

Vaccination offer

Flu - At the begging of October the Trust will launch its annual Flu campaign. In line with national requirements the ambition is to offer 100% of the workforce the flu vaccine and to vaccinate 84%. A project team has been in place since the summer and has a robust project plan in place which seeks to aim to vaccinate staff in a focussed 8 week period between October and November to ensure that as many staff as possible receive the vaccination by December 2021.

COVID booster – plans for the CVID booster are current in development regionally. NWAS has engaged with each area (GM, C&M and C&L) to secure support for NWAS staff to access vaccination sites for the booster. There are no plans for the Trusts to stand up an internal vaccination hub for the COVDI booster and current indication are that the Pfizer vaccine will be used and the Trusts does not have the internal storage facilities for this particular vaccine.

Wellbeing offer to staff

- Push for all areas to progress their local People Plans based on the 2020 Staff Surveys results and recent Q2 Quartey Pulse Survey Results
- Employee Assistance programme
- Treat me right campaign and toolkit – aimed at tackling bullying and harassment
- Mental Health awareness toolkit for managers and staff
- Focus on manager having wellbeing conversations
- Trust champions on: Wellbeing; F2SU
- Staff networks – LGBTQ, Disability, Race and the armed forces
- Gambling support guidance
- Peer Supporter / MHFA's / Blue Light Champions
- TRiM – Trauma Risk Management
- Burn out programmes for staff and managers
- Suicide Prevention, Postvention and Awareness Toolkit launched in September

Further work planned in Q3 / Q4

- Support Hub to launch in Q3 specific pages on the Greenroom (intranet) to focus on support for staff (this replaces the current Invest In Yourself microsite and is a refresh and re-brand)
- REACT Mental Health Training
- Review of Peer Support Networks
- Wellbeing Offering included as part of L&D courses and Education & Training Modules

NHSE/I Wellbeing funding:

- Enhancing opportunity for proactive wellbeing conversations through externally provided mental health check ins (external provider)
- Engaging consultant psychologist support to support development of current and future offer, including mental wellness framework, providing check in / specialist support , development of a resilience package and develop resources for managers.
- Welfare vehicles - provide access to drinks/food at hospital sites.
- Fast-track access to support for staff suffering Long COVID

5.0 Mitigation Initiatives

NWAS employs the following initiatives to enhance service delivery:

- The NARU Resource Escalation Action Plan identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.

- Trigger mechanisms have been established through REAP arrangements that allow NWAS to respond promptly to substantial increases in demand, in either specific areas or Trust wide.

- NWAS REAP arrangements remain active at all times. The Strategic Winter Plan should be viewed as an adjunct to this and not as a replacement.

- The Trust is engaged with national partners to ensure the REAP elements are reflective of current and future challenges including the NHS OPEL (Operational Pressures Escalation Level) Framework, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS.

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

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

- All necessary actions for NWAS under REAP have been considered and already implemented or held in reserve should the situation become more challenging.

- NWAS is committed to support both whole system resilience and the management of local surge pressures against the background of patient care and protection of NWAS core business obligations.

- NWAS will support any local measure to relieve pressures as far as practicable and within the overall confines of our prevailing REAP level which reflects the overall pressures experienced by NWAS and cannot be flexed locally.

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

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

5.1 North West 111

5.1.1 Forecasting and Planning

NW 111 now possesses a number of years of historical data. This assists with accurate demand forecasts that will deliver improved roster efficiency and accuracy. As with previous years, activity is anticipated to increase from 17 December through to its peak on the weekend following Christmas, with demand remaining high into January. The ever-changing COVID situation continues to make forecasting more of a challenge as demand has been volatile as infection rates change across the region. To ensure the best roster cover NW111 reduce levels of managed shrinkage, such as annual leave and planned offline activities, for these key weeks.

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

111 Service Delivery

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

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

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

This winter NWAS 111 have recruited additional service advisors to 'front end' calls that enables the calls to be prioritised quickly whilst continuing to utilise Health Advisors by warm/cold transfer.

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

- Pathways trained administrative staff will perform front line call taking role.
- Audit and Governance Team deployed into front line support roles.
- Front line managers supporting front line and operational roles.
- Increased senior management support.
- Clinical Managers able to work additional hours from home

5.2 Patient Safety Plan

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

This plan:

- Is applicable to the EOCs, the Clinical Hub, 111 and the Regional Operational Coordinating Centre (ROCC).
- Is considered in conjunction with the National REAP levels and will be employed in conjunction with this plan where appropriate and necessary but is routinely used as a standalone plan.
- Provides an escalating set of flexible, tactical options to apply a further level of triage (over AMPDS) which may result in certain calls being rung back for reassessment, deflected or be assigned a delayed response in order to priorities resources to the most immediately life threatening calls. Patients are always informed of the appropriate disposition of their call.

5.3 Emergency Operations Centres and Clinical Hub

5.3.1 Emergency Operation Centres

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

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

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

5.3.2 Clinical Hub

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

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

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

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

These desks are able to provide;

- Clinical advice
- Support for solo responders to enable them to leave scene whilst awaiting transport; including booking taxis where appropriate
- Access to senior clinical support for the Advanced Paramedics
- Direct telephone consultations with patients after initial categorisation

The Clinical Coordination Desk, provided by a CHUB AP, reviews patients who we anticipate will wait longer than the ARP centile performance. The AP can choose based on clinical need to dispatch a resource, they may review the notes and conclude the patient is safe to wait or pass to a clinician to ring back as potential for H&T.

5.4 Regional Operational Coordination Centre (ROCC)

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

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

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

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

5.5 Regional Health Control Desk

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

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

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

5.6 Greater Manchester Urgent and Emergency Care (GMUEC) Hub

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

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

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

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

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

5.7 ROCC Tactical Commander

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

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

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

The UEC DoS is a national service, provided by NHS England, which is led on regionally. In the North West of England, the UEC DoS is exceeding IUC KPI 11 and NHS Service Finder Quality KPIs and is a top performer across England.

The UEC DoS is critical to the operations of NHS Service Finder, NHS 111 Online, NHS 111 Telephony and 999 Clinical Hub. The North West is the only region to fully support NHS Service Finder and it is a critical tool that should be used by all NHS staff that are involved in patient care irrespective of setting. The UEC DoS was also critical to the delivery of NHS 111 First as it rolled out through autumn and winter 2020.

5.9 Patient Transport Services

NWAS is able to provide patient transfers at short notice, based on a hospital's priorities e.g. clinical priority or response to hospital pressures to moving patients between hospitals, or to discharge patients. With mature escalation and engagement links across the acute healthcare system, PTS will work with commissioners and hospitals to monitor system activity, adapting to changing circumstances and surge and is able to mobilise an enhanced approach to support system priorities in line with relevant national guidance e.g. HM Govt/NHS' Hospital Discharge Service Requirements in the event of an escalation of Covid-19 impacts felt by the system. The NWAS PTS leads will be available to establish the needs of individual Trusts e.g. requests for additional PTS non–emergency vehicle requirements in addition to current contractual arrangements for out of hours in those areas where NWAS holds the contract.

NWAS operated PTS services will be staffed throughout the identified critical periods and support the demand placed upon the Service only where appropriate arrangements exist.

Arrangements with Private Providers will continue to provide support over the winter period

PTS continues to support the Paramedic Emergency Service (PES) through repurposing of staff to support delivery of urgent and emergency care.

5.10 Additional measures

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

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

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

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

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

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

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

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

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

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

- Extensive Business Continuity arrangements are in place to minimise the impact of any additional disruptive challenge to the operation of the Trust.

- The standing NWAS 'On-call' arrangements (Commanders and support staff) continue as usual but may be enhanced/augmented for times of experienced or predicted pressure. These arrangements include senior clinicians on call.

- NWAS Commanders have been provided with a North West Divert and Deflection Policy which summarises the actions to be taken in the event of pressures at individual hospitals or across entire Acute Trusts.

- Hospital Arrival Screens are well established in EDs and other locations to assist with patient flow through the departments. Additional Ambulance Liaison Officers have been recruited to provide a physical presence at ED's experiencing delays in transfers of care from NWAS to Provider Trust clinician and assist in the release of vehicles to increase availability. Early escalation of any delays in transfer of care issues through the NWAS on call structure is considered as essential.

- Staffing levels over a 24hr period are an integral part of service delivery.

- Sector and Operational Managers (PES, EOC and PTS) have confirmed staffing levels, which are communicated at the weekly service delivery meetings. Additional hours are profiled to meet demand on key dates and these will be subject to scrutiny at the appropriate meetings. Staff Abstraction rates are monitored closely.

- Vigorous management of absenteeism though NWAS Sickness Absence Procedure.

- The NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan contains contingencies for support staff redeployment during the risk period.

- The Trust's BCM arrangements include departmental and staff mapping analysis to enable support to be re-directed to critical functions if required, at times of severe pressure. Dedicated arrangements to deal with periods of Industrial Action are also in place.

- Additional front line staff, together with operational management support, will be deployed on the key dates identified in the Operational Level Plans.

- Staffing levels are profiled according to demand patterns. Contact Centres (EOC and 111) will be profiled aligned to key dates throughout the winter plan.

- Planning with voluntary agencies (SJA, BRC, and Mountain Rescue) is regular and ongoing.

6.0 NWAS Continuous Improvement Initiatives

6.1 Fleet Reconfiguration

Additional forty five retained Double Crew Ambulances (DCA) will be added to the fleet over the establishment baseline to support the winter plan. Planned delivery of fifty five new DCA's will enter the fleet (between Oct 21– Jan 22) on top of the retained (forty five) vehicles that would ordinarily be disposed as part of the replacement program. Post winter pressures these vehicles will be subsequently disposed.

6.2 Emergency Operation Centres (EOC) Efficiencies

EOC changes are critical to the maintenance of patient safety and delivery against performance standards and to these ends the following areas are subject to tight focus.

- Increase in call pick up (CPU) performance to 95% within 5 seconds. To be achieved by rota realignment to match call-taker availability to demand.
- Reduction in average handling time (AHT), and monitoring of downtime between calls ('not ready time') to improve call taking productivity.
- Earlier identification of category 1 calls through the pre-triage sieve, key words and nature of call processes and improvements in call flow.
- Noting on the work to reroute to alternatives to ED as part of SDEC.
- Increases in EOC staffing and profiling of recruitment, training and induction in advance of winter period. This includes additional operatives with distinct remit to manage routine calls into EOCs.
- Clinical Coordination Desk. This role is provided by a CHUB AP and reviews patients who we anticipate will wait longer than the ARP centile performance. The AP can chose based on clinical need to dispatch a resource, they may review the notes and conclude the patient is safe to wait or pass to a clinician to ring back as potential for H&T.

6.3 Increases in Hear and Treat (H&T)/See and Treat (S&T)

NWAS continues to lead nationally in the closing of incidents through hear and treat outcomes, we continue to utilise local clinical assessment services and are continually working with partners to expand the patient presentations seen by these services. The move to the Cleric platform is now embedded to strengthen the technology and systems used to provide telephone triage. H&T incidents reduce inappropriate use of resources and maximises the availability of responding vehicles. S&T performance has also increased with the introduction of a range of enhanced patient triage tools, clinical pathways and alternative referral dispositions.

6.4 Workforce

Regular recruitment and training plans in place across all service lines.

- PES - Winter planning has focussed on trying to increase the number of blue light drivers to be deployed pre-Christmas and as a result there have been some changes to the training plan. Discussions with Staff Side have centred on options to increase driver capacity and the favoured option is to seek expressions of interest from current PTS Upskill staff and UCS staff to undertake training to drive on blue lights in a PES Assistant role.
- There are 110 EMT 1's who are either currently in training or who will be trained and deployed by the end of March 2022. Further to this there are a further 96 EMT 1's who will commence courses in 21/22 but will not deploy until 2022/23.

- Trust has moved two EMT 1 courses to a modular course to ensure blue light driver training is completed pre-Christmas with a proportion of the classroom training to be delayed and undertaken at a later date. All Paramedic induction courses pre-Christmas will have a two-week induction with the driver training element to be deferred and picked up in the New Year. These changes are aimed at ensuring the maximum numbers of blue light drivers operational to increase the number of vehicles available to be deployed.

- PTS - workforce plan seeks to seeks to front load the recruitment in-between Q1 and Q3. Further courses are also planned during Q4

- 111 short-term funding has been provided to increase the Band 2 service Advisor workforce by 40 wte for three months up to the end of Q3. These are to be engaged via an agency to ensure a swift recruitment process. To support Health Advisor workforce plan, the agency srtaff are to be offered opportunity to train as Health Advisors at the end of 12 weeks and move onto a Trust contract

- Ongoing Health Advisor and Clinical Advisor courses – with all courses in Q3 deployed by beginning of December

- EOC – ongoing recruitment to support workforce plans.

6.5 Hospital Handover

NWAS has been proactively working with North West hospitals on improving hospital handover since 2018 through an improvement collaborative called Every Minute Matters. Focused improvement work has continued during 2021 with North West hospital sites who have engaged with NWAS to implement the handover safety checklist, Fit2Sit, process redesign or SDEC pathways e.g. low risk chest pain.

Other interventions led by NWAS to avoid hospital handover delays are:

- Monthly handover data packs are produced and shared with NWAS sectors and hospital sites.

- NWAS and hospitals senior engagement meetings being planned for Q3 21/22 to discuss opportunities for system working and overcoming barriers.

- A programme of work is underway to improve service finder which links to the Directory of Service and provides details of alternative community providers. Work has started with the ICS leads across the North West around the 2 hour crisis response service.

- Focused hospital handover improvement work with Royal Oldham and Whiston is taking place as part of the national NHS E/I handover programme. Work will commence with Royal Lancaster during August 2021.

- NWAS are designing a hospital handover training package which will be hosted on MyESR for ambulance and hospital teams to use. The training package pulls together learning from the NWAS Every Minute Matters Collaborative. This work is being funded with a small bid from NHS E/I. This will be available to test in Q3 21/22.

- Sharing learning regionally and nationally with other ambulance and hospital trusts.

7.0 Communications

NWAS has in place robust Winter Communications Plans which supports the NWAS Strategic Winter Plan, seasonal Influenza vaccination programme and NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan as well as contributing to the Trust compliance with the Civil Contingencies Act (2004) in terms of ‘warning and informing’.

The NWAS Communications Team is well linked across the NW system through regular attendance and participation in the regional ICS and NHS England/Improvement communications leads meetings. These meetings also include local CCG, partner trusts and in some case local councils and facilitate co-ordinated approaches to demand management and winter planning across the wider healthcare system. The NW approach to the roll out of NHS 111 First provides a good example of local system communication networks working effectively.

Messaging to the public is considered on a local, regional and national footprint using insights from demand data and patient experience. For example a range of self-care videos have been produced on identified common conditions which are suitable for use across the local system. NWAS and other trusts also share NHS 111 First patient feedback and data on the reasons people turn up at A&E's to better understand how to help the public to choose services wisely.

Communication toolkits and winter plans are discussed and shared together with regular updates on local system hotspots and identified themes in order to signpost patients to the most appropriate/alternative service. National and regional funding to support communication and engagement campaigns is also allocated and held on a local system basis.

111 have approached NWAS Communications Team for support getting the message out to service users that they can access the same assessment from 111 online to encourage as many people as possible to use this route.

111 IVR message encourages use of 111 online – we are also looking at a development for the IVR to include an option to receive a text message with details of 111 online.

7.1 Communications Activity

The Communications Framework covers five broad areas of activity;

- General Winter and Flu communication – The trust will support national campaigns around flu and 'help us help you' supplemented with dedicated ambulance service campaigns and messaging.
- Communications specifically relating to the COVID-19 pandemic.
- Pressure related communication – in reaction to increases in operational and demand pressures relating to use of 999, 111 and 111 online.
- Business Continuity Management – staff communications during periods of pressure to ensure continuity of core services.
- Communications specific to the post winter recovery period.
- Public safety messages around key dates (e.g. 5th November, New Year's Eve).

Messages will be disseminated over a range of platforms and media (Social Media, print and broadcast). Face to face opportunities will also be exploited or targeted with messages tailored to audiences for maximum impact.

During the winter months, new campaigns will be implemented to support the objectives below.

7.2 Specific Objectives

Communication activity will assist in mitigating some of the demand pressures that NWAS will face during the winter period. Specific actions will include:

- Providing our staff, our volunteers and the public with health and wellbeing advice including why they should have the flu vaccination

- Informing the public about making the right choices to access care if they are unwell, especially when to call 999 and when to use other services such as NW 111
- Raising awareness of the ambulance services role in tackling winter pressures amongst NHS organisations and key stakeholders
- Engaging with staff about our efforts so they feel informed, listened to and able to act as a trusted source of information to patients on winter health matters

7.3 Public Health England, Cold Weather Plan

The national Cold Weather Plan is a framework document which is intended to protect the health of the population due to the effects of cold weather. By alerting people to the negative health consequences of prolonged or severe cold weather, the plan aids both health organisations and the general public in preparing and responding accordingly to cold weather.

A series of steps are recommended by the plan to reduce the risks to health from cold weather and these include ensuring the receipt of the regular Meteorological Office, Cold Weather Alerts and associated Planning Advice. These emails contain detailed forecasts (or alerts should trigger thresholds be breached) to signal impending cold weather and allowing appropriate actions to be taken. The four levels - Level 0 (Year-round planning) to Level 4 (Major Incident) each have their own targeted and tiered actions for various agencies which will be considered or enacted upon issue of the appropriate alert.

These alerts and forecasts are received by the NWAS Resilience Team, Emergency Operations Centres, The ROCC and Communications Team.

The current version of the Public Health England Cold Weather Plan can be found here; https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

Local Resilience Fora all have multi-agency severe weather arrangements and NWAS remains an active partner in the planning and response to such incidents to support patient care, wider public safety and staff support.

8.0 Reporting Mechanisms

NHSE/I have confirmed their North West Winter Room will be stood up in November 0800-1700 each day excluding Christmas Day, until 18 April 2022. Outside of these time, winter escalation will transfer through to established on-call arrangements for each of the North West Localities (C&M/LSC/GM).

In terms of specific routine reporting through to the NW Winter Room, this will be done through existing system which this function has been granted access – namely NWAS Hospital Arrival Screen (HAS) and the NACC Dashboard (ProClus). This will provide real-time and live access to NWAS capacity and capabilities.

NHSE/I Winter Assurance documents have been provided to NHS Providers with a timeline for submission, this document supports that submission process in providing confirmation of preparedness.

Confirmation has been receive that, as in previous years, the NW Winter Room will chair twice weekly calls with NW Ambulance Services (NWAS, NEAS and YAS). This call will provide ambulance trusts the opportunity to raise any ongoing concerns over internal or external threats and pressures to service delivery. Which the NW Winter Room lead is then able to escalate and intervene with health systems should be the issue be protracted or sustained.

NWAS managers will continue to represent local sectors on A&E Delivery Boards/ICSs and provide detailed, local assurances or data as requested.

9.0 Seasonal Influenza

Last year's flu campaign was based on achieving a minimum of 75% uptake The last campaign was the best year to date with 78.3% frontline staff vaccinated.

The Department of Health and Social Care sets targets each year; this year they are:

- Aim to offer the vaccine to 100% of staff
- Aim to vaccinate 85% of staff.

The proposal is for the campaign to be run over an 8-week period between October and November to ensure a targeted approach. The proposal is to aim to conclude the campaign prior to December, to support the project as significant winter pressures are anticipated this year. A decision can be taken once the campaign has commenced on whether a small number of vaccinators continue to offer the vaccine over the remaining months of the campaign.

The Trust support and will engage as required in the recent government announcements on the planned delivery of COVID-19 vaccination boosters for those who have already been double vaccinated.

10.0 COVID-19 Response & Recovery Plan

10.1 COVID-19 Response

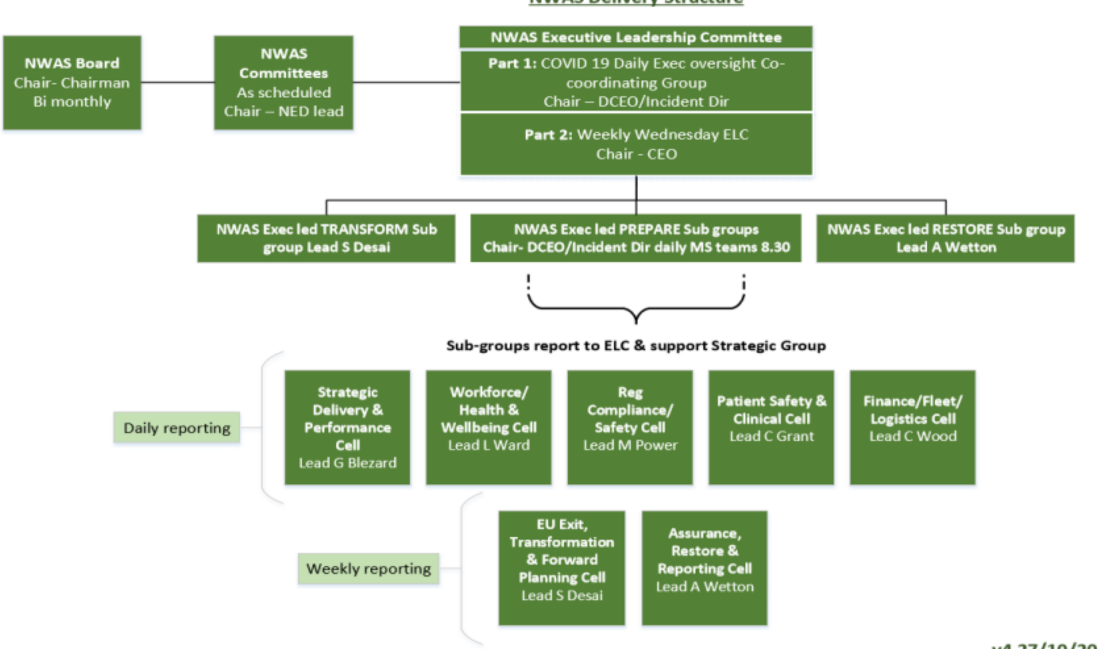
The NWAS COVID-19 Response Plan was activated during March 2020 in response to the emerging virus and remains in place to manage the ongoing response including those attributed to potential subsequent waves of infection.

The aim of the NWAS COVID-19 Response is to describe the response arrangements that have been implemented by NWAS and its staff during the disruptive challenge associated with the outbreak of COVID-19 virus whilst ensuring, as far as reasonably practicable, the safety of all staff and members of the public.

Command and Control arrangements detailed within the NWAS Major Incident Response Plan will form the basis of the structure during any outbreak.

As part of the response to the COVID-19 pandemic, a structure is in place to provide appropriate governance arrangements as required:

North West Ambulance Service NHS Trust Incident Command Governance Structure
NWAS Delivery Structure



The objectives of the response are:

- To identify potential challenge to NWAS functions through risk assessment.
- To ensure that appropriate and flexible contingencies are put in place at the earliest opportunity to minimise compromise to NWAS and to its staff including during the "Roadmap to Recovery" as announced by the UK Government for the period of March to June 2021.
- To ensure that appropriate levels of assessment and patient care are provided to members of the public that are affected by the virus.
- To ensure that appropriate levels of patient care to those members of the public not affected by the virus are maintained.
- To ensure that the appropriate level of staff welfare of all employees of NWAS is maintained as far as reasonably practicable.
- To ensure the contingencies employed by NWAS are compatible with those of the other agencies to provide a consistent and flexible response in the management of those affected by the virus

10.2 COVID-19 Recovery

The COVID-19 pandemic presented unprecedented challenges across the whole of NWAS, diverting resources and operational delivery away from business as usual and Departmental planning to provide an immediate, coordinated response to COVID-19.

It is good practice in emergency response and business continuity planning, to consider recovery as soon as possible during the response phase. This is because the actions taken in the response phase will affect recovery, sometimes detrimentally so consequences of decisions need to be examined throughout the response phase.

NWAS COVID-19 Recovery identifies those areas within NWAS where change has taken place and the process by which a return to a "new normality" will be facilitated. The arrangements contained within the plan will be reviewed on an on-going basis in light of changes in guidance from the Department of Health & Social Care, Public Health England and the World Health Organisation.

The key objectives of recovery include:

- To identify those changes to pre-pandemic NWAS practices
- To ensure that appropriate and flexible contingencies and timescales are put in place to enable a return to pre-pandemic practices or new ways of working
- To ensure the contingencies employed by NWAS are compatible with those of the other NHS organisations and are in line with national guidance and best practice
- To provide a framework for the revision of NWAS business continuity plans
- Ensure NWAS can escalate back to response phase should further waves of COVID-19 (including variants of concern) require enhanced arrangements to be re-established
- To provide guidance on the options available and consideration that should be made through response and into the recovery phase when planning for recovery

11.0 Severe Weather

Severe winter weather provides one of the greatest challenges to NWAS with snow, ice and flooding all affecting the road infrastructure. The NWAS response is detailed in the Area Operational Winter plans but essentially relies on the augmentation of the usual fleet with the following;

- NWAS PES vehicles have been fitted with all-weather/Winter tyres
- NWAS 4x4 RRVs already in service including HART fleet
- Consideration of short term hire of additional 4x4 vehicles
- St John Ambulance and British Red Cross 4x4 vehicles
- Those managers with 4x4 lease vehicles
- Civilian Mountain Rescue Teams and other Search and Rescue charities
- Partner agencies e.g. Police, Fire & Rescue Service, RNLI, MCA, Local Authority
- Maritime and Coastguard Agency Search and Rescue helicopters (immediate lifesaving interventions)
- Military Aid to the Civil Community in extreme situations upon exhaustion of NWAS contingencies

Additionally, ambulance stations have received supplies of grit/salt and many have contract arrangements with hospital estates departments or commercial companies to provide a snow moving and gritting service. HART bases have their own snowplough capabilities to maintain access to their garages.

Vehicle recovery arrangements are in place either through NWAS Fleet Support or externally contracted sources.

Existing departmental Business Continuity Plans and staff mapping information will come into play in the event of major difficulties in maintaining staff cover with particular emphasis on EOC operations and other core functions. Staff welfare is paramount but individuals are encouraged to attempt to access normal work locations where safe or nearest NWAS site/alternative site as designated in local Business Continuity Plans.

NWAS Strategic Commanders have Government Purchasing Scheme (GPC) Credit Cards to support the out of hours provision of financial support for emergency accommodation or catering supplies in the event of staff being stranded or required to be billeted near a place of work.

12.0 Industrial Action

Existing departmental Business Continuity and staff mapping arrangements underpin the NWAS response to any threatened periods of industrial action.

From experience gained from previous industrial action, a specific NWAS plan has been developed to deal with the impacts of disruption through strikes and action short of strike. This plan is sufficiently flexible to be

tailored to the specific type or period of potential disruption. Knowledge of potential areas of disruption or challenge has been acquired from mitigation of Ambulance Staff, Fire and Rescue Service and Junior Doctors disputes/actions over recent years and this has been factored into a range of contingency plans to ensure enhanced resilience.

This ‘Constant Care’ Plan can be initiated in the face of planned or spontaneous action and provides a flexible and scalable response to maintain the Business Continuity of NWAS and protect core response in the face of any degradation of capability. This plan has been updated and reconfigured for each specific sector, which may be affected by industrial action e.g. Fire and Rescue Service, fuel transport or parts of the health sector. The threat of more widespread and coordinated industrial action during the winter period has been recognised and considered in terms of NWAS and multi-agency planning.

13.0 Document Review

This document remains in a constant state of review and will be updated and amended as situations develop or change but will be formally reviewed and revised in July 2022.

14.0 Appendices

Appendix 1 - NWAS Generic Strategic Intentions Template

Appendix 2 - Predicted Call Activity/Demand

Appendix 3 - Forecasted Responses – Top 10 Busiest Days

Appendix 4 - Forecasted Responses – Total Numbers

Appendix 5 - 111 Activity Forecast

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	25 October 2021	**Chair:**	Prof A Chambers
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation and Improvement Dr C Grant, Medical Director
Members Present:	Prof A Chambers Prof A Esmail Dr D Hanley Prof R Thomson Prof M Power Dr C Grant Ms A Wetton Mr S Desai (part)	**Key Members Not Present:**	Mr G Blezard Director of Operations

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☒	☐	☒	☐	☐	☒	☐	☐

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

Key		
(red)	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
(amber)	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
(green)	Assured	No or minor impact on quality, operational, workforce or financial performance

Board Assurance Framework (BAF)	• Noted the proposed Q2 position, previously reported to the Trust's Executive Leadership Committee and Audit Committee, for onward approval to the Board of Directors. • Held a focused discussion on the mitigating actions. • Confirmed the role of the Committee to commission any work necessary to provide further assurance, through the sub committees. • Discussed SR06 and acknowledged that the recruitment of a dedicated fire officer was pending in Q3 and Q4. • Reviewed SR01 particularly 24/7 resilience in response to unplanned down time of critical systems and noted measures in place to manage risk, with oversight and scrutiny provided at the Resources Committee. • In terms of risk 3410 and emergency preparedness, noted that initial risk score had reduced but recent activity had resulted in escalation to Trust's Corporate Risk Register. • Noted the planned additional resource in 111, however noted the recruitment challenges associated to short term funding.	• Gained assurance that each BAF risk was managed effectively.	

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	• Recognised the pressures caused by staff abstractions and sickness levels. • Chair of Committee to discuss the requirement for a deep dive into sickness levels with the Chair of the Resources Committee.		
Integrated Performance Report	• Acknowledged ongoing REAP Level 4 demand and pressures on all service lines, particularly PES. • Noted that care bundle outcomes for patients were maintained. • Observed the increased number of Level 4-5 serious incidents and complaints and noted that more recently good progress had been made to address the backlog. • Newly appointed Patient Safety Specialist to revisit the previously implemented quality review process, halted due to Covid-19. • In terms of Hear and Treat, reported an anticipated improvement during Q3. It was noted the improvement trajectory was based on additional recruitment to the clinical hub and the acuity of demand during winter months. Noted that ongoing monitoring was required.	• Noted the limited assurance provided in relating to the continued operational pressures caused by REAP Level 4 and the demand on the service lines.	

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	• Reported the outcome of ORH would be instrumental to the future allocation of resources.		
Deep Dive – Hospital Handover Delays	• Received comprehensive deep dive into hospital handover delays. • Noted the work and improvements made by the collaborative since 2018 and the recent worsening position. • The key challenge recognised as being acute trusts making handover a priority and adjusting PDSAs and taking appropriate measures. • Highlighted that patient stories had been used to illustrate the risks and pressures and had been well received. • A case study at Stepping Hill hospital shared and an overall timeline of improvements provided. • Noted a variance in hospital handover times across the NWAS region. • Reported that Cheshire and Mersey had engaged in early discussion with acute settings. • Acknowledged the need to share lessons within the Trust and noted work was ongoing to identify further detail, to share and implement lessons within teams.	• Noted the moderate assurance provided in relation to the worsening position and risk to patients caused by hospital handover delays.	

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	• Noted IPC requirements had impacted on waiting times and noted a national worsening position across ambulance trusts. • Discussed the importance of discussions with ICS' and the need for leadership amongst clinicians within the emergency departments. • Recognised the Collaborative was instrumental to the overall impact on hospital handover position and noted that resources to support future work was essential.		
Complaints Bi Annual Report	• Reported the Trust had received an average of 198 complaints per month, with an increase of 100 per month in 2020/21 and 30 per month in 2019/20. • Operational processes including review panels had improved the complaints backlog position. • Six key risks reported with five rated good with the exception of closure of complaints, given moderate assurance. • Acknowledged that ELC continued to monitor the back log position via bi weekly reports and meetings.	• Noted the moderate assurance provided in relation to the risk associated with the closure of Level 4-5 complaints within the required timeframe.	
Serious Incidents Bi Annual report	• Reported that 100% of serious incidents (SIs) had been reported		

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	within the required timescale against end of year compliance target of 95%. • Noted the end of year compliance target for the time taken from confirmation to report of an SI was on track. • Welcomed breakdown of SI's and the progress made. • Challenge to close SIs remained, due to the input required from operational staff; currently restricted due to REAP Level 4 pressures. • Noted that ROSE continued to provide a robust process with an action tracking system to capture learning. • Assurance received from the level of SI's which demonstrated a healthy culture within NWAS to report incidents. • Noted the work of the EOC to promote a healthy safety culture and contribution of the quality directorate and the newly appointed Patient Safety Specialist. • Recognised the moderate assurance related to the backlog, however received assurance that patient safety continued to be a priority; supported by a robust ROSE process.	• Noted the moderate assurance provided in relation to the risk associated to the closure of Serious Incidents within the required timeframe.	

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	• Acknowledged the improved and comprehensive report which included learning themes identified through SI processes.		
Public Health Plan	• Received a 6 month progress report against the Trust's Public Health Plan approved in April 2021. • Noted onward reporting of the report to the Clinical Effectiveness Committee and Executive Leadership Committee. • Highlighted four areas of focus within the Plan which included Strategy; Data and Intelligence; Capability and Delivery. • Milestones for delivery of the Plan were on track. • The need for future recurrent investment recognised, to support a dedicated public health expertise. • Prof R Thomson confirmed his support to the team in relation to a pending National restructure.	• Noted the assurance provided.	
Legal Services Quarterly Report Q2	• Noted the year on year trends in number of new HM Coroner Inquests and claims made during the Q2 period. • Themes consistent with the pressures experienced by the Trust with regard to delayed attendances and demands on capacity.	• Noted the assurance provided.	

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	• Team continued to support the Manchester Arena Inquiry. • Learning form the legal team discussed and future triangulation with SI and Learning from Death processes. • Noted that a shared dashboard would be progressed during Q3/Q4. • Discussed the level of mental health inquests and a report had been commissioned by the Trust's Audit Committee.		
Non-Clinical Learning Forum Chairs Assurance Report	• Noted the assurances provided at the meeting on 9th August 2021. • A draft of the Trust's Non-Clinical Lessons Learnt Annual Publication had been received with final input required from operational teams prior to publication. • Departmental newsletters submitted and learning identified. • Learning from deaths newsletter well received.	• Noted the assurance provided.	
CFR Assurance Report Q2	• Received an update on the work of the Trust's Community First Responders highlighted 24,266 hours had signed onto the service from February to October 2021, which equated to 97,064 hours over 4044 days.	• Noted the assurance provided.	

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	• Reported that CFR's received regular welfare checks for support following shifts. • Noted a review of the current MOU would be undertaken by the CFR Lead and Deputy Director of Operations. • Acknowledged the excellent work of the Trust's CFRs in their support of PES and via welfare units. • Received details of future training and development initiatives.		
Urgent & Emergency Care Strategy Assurance Report Q2	• An update on the work to deliver the strategy which included an adjusted implementation plan. • Noted the plan included three work streams the UEC service delivery model; Integrated Response Model and Reducing Avoidable Conveyance. • Identified senior officers were identified to deliver actions within the implementation plan. • Recognised the recent Service Delivery Model Review to identify the Trust wide resources required. • Received the risks associated with the Strategy which were reviewed and managed by the Trust's UEC Oversight Forum and issues escalated to Corporate Programme Board.	• Noted the assurance provided.	

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	• Acknowledged that work related to the Integrated Response Model provided amber assurance; due to large numbers of abstractions and demand on call taking capacity. Noted that ELC had approved a revised plan to adjust the end date and NAA CAD programme development and Clinical Assessment Service were on track. • Discussed the restructuring of pathways and the impact of winter pressures. • Reported that ELC had agreed no further delays, with additional EMDs and single primary triage work progressing.		
NWAS Strategic Winter Plan 2021-22	• Presented with the Trust's Strategic Winter Plan which reflected Covid-19 challenges, flu and general winter pressures. • Discussed the demands of staff training required alongside delivery of the winter plan. • Deputy Director of Operations reported that risks related to training timescales and threats to response levels were closely monitored and reviewed. • The Committee noted the completed Winter Planning 2021/22 Planning – System Flow Assessment and Risk	• Noted the NWAS Strategic Winter Plan 2021/22.	

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	Log and noted this was submitted on 30 September 2021, in addition to the associated appendices included within the Winter Plan 2021-22. • Reported that blue light training and recruitment plans were progressing well.		
EPRR Annual Assurance Report 2021/22	• Received the Trust's EPRR Annual Assurance report for onward reporting to the Board of Directors. • Acknowledged performance against the NHSE core standards and compliance against the interoperable standards. • Noted area of low assurance related to capturing HART response times. • Discussed work ongoing to address compliance standard and acknowledged work achieved to date. • Onward reporting of the Trust's performance against the EPRR compliance standards would be received by the EPRR Sub Committee and to Committee via the Chairs Assurance Report.	• Noted the assurance provided.	
EPRR Sub Committee Chairs Assurance Report from the meeting held on 11th October 2021	• Received assurances from the third meeting of the sub-committee. • Noted robust discussion and scrutiny through improved assurance reports.	• Noted the moderate assurance received from the report.	

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	• Discussed debrief from incidents and acknowledged as an area of ongoing concern for the Committee. • Action taken to identify responsible person to implement a formal policy and promote the debrief process. • Noted the concerns of the subcommittee regarding the current status and the need for continuity and learning to be embedded.		
Diversity & Inclusion Sub Committee Chairs Assurance report from the meeting held on 8th October 2021	• Received assurances that work progressed on equality systems and better care outcomes in line with EDI priorities. • Black History Month featured in the update with summary of learning, training and recruitment initiatives. • Noted that there was no written assurance report from PES, this had been requested for discussion by the subcommittee. • Discussed recruitment data to evidence trends were improving and recognise the outstanding actions required.	• Noted the moderate assurance received from the report.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee

Date of Meeting:	19th November 2021	**Chair:**	Mr R Groome, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Mr R Groome Mr D Hanley Ms C Wood Ms L Ward Mr S Desai Prof M Power Ms A Wetton Mr G Blezard	**Key Members Not Present:**	-

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☐	☒	☒	☒	☒	☐	☒	☒

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Received BAF report due for approval by Board of Directors in November. • Noted the closing position of Q2.	• Received assurance from the BAF report.	(Green)

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	• Discussed SR07 and ICS developments. • In terms of SR04 noted the risk associated to future impact of a mandated Covid-19 vaccination for staff; confirmed risk score would be reviewed in Q3. • Discussed Risk 3452 and significant risk score of 25 related to increase and impact on service caused by operational demand. • Director of Operations confirmed the action being taken to address the risk which included ORH modelling and maximising resourcing through PTS. • Explained the challenges attributed to the nature of short term funding and the ability to recruit additional staff on short term contracts. • Noted the risk related to cyber security aligned to SR09, updated in full in the Digital Progress Update. • Acknowledged the significant pressure on workforce indicators during the quarter. • Acknowledged that the Digital Risk related to security had reduced due to DDOS software being purchased but not yet implemented.		

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Progress of H2 Financial Plans and Month 7 2021/22 Financial Position	• Received an update on progress related to H2 financial plans and noted that at time of closing Month 7 the financial plans and allocation of system envelopes had not been finalised. • Acknowledged that Month 8 would include updated financial plans for the H2 period, in line with the final agreement with Lancashire and South Cumbria ICS. • The year to date financial position to 31st October 2021 reported a deficit of £1.237m, compared to a surplus of £0.304m at the end of Month 6. • Explained that the £1.541m movement was an effect of pay award costs exceeding additional income by £1.086m year to date, plus no other additional income had been received to date for agreed winter plans; whilst expenditure totalled £0.528m. • Noted that the financial position had been reported to NHSE/I and completed in line with National guidance. • Actual financial performance, comparisons to estimated plans and run rates were reported to provide	• Received assurance from the H2 financial plans and Month 7 financial position.	(Green)

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	assurance in the absence of agreed budgets for the month. • Income in month 7 reported as £34.819m, pay costs £26.092m and non-pay costs £10.268m. Additional income received from Lead Commissioner was a continuation of system allocation payments whilst H2 plans and allocations were being finalised. • Summary of H2 financial planning to date provided and noted the overall position based on the Trust's latest draft H2 financial planning submission.		Assured (green)
Update on Agency Expenditure Report to Quarter 2 (30th September 2021)	• Noted the agency expenditure up to 30th September 2021, following last report in July 2021. • Advised that since suspension of NHS operational planning and contracting process and revised financial regime due to Covid-19, the Trust had not received notification of any change to annual agency ceiling. • As such, noted that ceiling assumed to remain at historical ceiling of £3.109m. • Reported that agency expenditure for Q2 was £1.116m, £0.339m above the ceiling. • Acknowledged that the Trust's monitoring returns had been submitted	• Noted the assurances provided in the report.	Assured (green)

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	to NHSE/I and there had been no breaches in relation to the agency price cap, wage cap and approved supplier framework rules.		
2021-22 Capital Programme Update	• Received an update on the Trust's 2021/22 Capital Programme. • Noted the latest capital forecast was £15.594m a net reduction of £2.767m which had been declared to the ICS as in year slippage and required as a first call on the system envelope for 2022/23. • Advised of year to expenditure figure of £4.154m at 31 October 2021, less £0.340m for disposals; resulting in a net position of £3.814m against our CDEL. • Further detail of Vehicle, Estates, IMT and PMO schemes provided for assurance.	• Noted the assurances provided in the report.	
Estates, Fleet and Facilities Management Assurance Report	• Noted progress on key areas of work aligned to the Trust's Estates and Fleet strategies during June to September 2021. • New format in the reporting format split into two parts for activity and longer term project progress. • Key areas of work highlighted including progress in retaining vehicles and the Green Plan.	• Noted the assurances provided in the report.	

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	• Provided a Carbon Literary Course specific for ambulance trusts with the support of NHSE/I with good attendance by CEOs across the country and recommended for members of the Board. • ELC approved Electric Charging across key sites which are due to be implemented in the new financial year. • Green initiatives on sites progressed and Blackpool Hub business case based on net zero site. Noted that decant site work progressed. • Preston acquisition plan to locate to the new site in early 2022. • Discussed electrical charging facilities and the ongoing work to deliver against the Trust's Estates Strategy.		
Major Incident Vehicle Replacement Programme 2022/23	• Received business case for Trust's Vehicle Replacement Programme during 2022/23 which included replacement of 18 vehicles. • Previously considered by the Executive Leadership Committee in September 2021. • Due to timeline for replacement of vehicles recommended early approval of business case to ensure replacement in next financial year.	• Noted and received assurance from the report and recommended for approval by the Board of Directors.	

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	Assured	No or minor impact on quality, operational, workforce or financial performance

	• Noted capital and revenue evaluation had been completed with capital costs of £2.001m. Noted that opening capital programme for 2022/23 to be confirmed and replacement programme would be prioritised and managed. Highlighted that costs could reduce following tendering exercise. • Revenue costs of £2.264m related mainly to capital charges and costs planned and budgeted as part of Trust's capital planning work.		
Emergency Vehicle Conversion Contract Award	• Received the outcome of the national procurement exercise undertaken to appoint preferred suppliers to convert emergency vehicles.	• Noted and received assurance from the report and recommended for approval by the Board of Directors.	
Measure Term Maintenance Contract (Estates)	• Received a proposal to extend current Measured Term Maintenance (estates maintenance) for Greater Manchester, Lancashire and Cheshire and Mersey areas.	• Noted and received assurance from the report and recommended for approval by the Board of Directors.	
H2 Planning Update	• Presented with H2 Planning narrative and four submission templates.	• Noted the assurances provided in the report.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	• Received an update on the system approach taken to planning alongside specific templates for completion and submission to the ICS. • Noted NWAS made their submission to ICS on 11th November 2021 and had shared submission with key stakeholders prior to submission. • Acknowledged that the templates and narrative would be uploaded on the SCDS portal by the deadline of 25th November 2021.		
Digital Progress Update	• Noted progress against the digital strategy and key areas of development including patching, asset ownership and security. • Acknowledged the delay in Switch replacement at Parkway which was now scheduled for 24th November 2021 and advised that Broughton replacement would be scheduled for March/April 2022. • Explained that delays were caused by additional assurances required to ensure safe practice and manage risk associated to taking service offline. • Discussion related to the process for assessing the impact of digital investment and outcomes for frontline service and staff.	• Noted the assurances provided in the report.	

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	• Noted that ELC had also requested evaluation of benefit realisation of digital investment/innovation on operational services. • Noted that the process would be part of new framework to assess impact of project implementation and outcomes. • Initiatives to encourage uptake of Information Governance mandatory training were discussed. • Discussed Body Worn Cameras Pilot and feedback from frontline staff which was noted as a common theme across the ambulance service. • Reported that initiatives to promote and encourage utilisation of the cameras was ongoing and although project implementation was rated green, uptake was being monitored and addressed.		
Workforce Indicators Assurance Report	• Received an update on appraisal compliance and noted improvement in current performance at 66% against an end of year target of 75%. • Operational pressures still impacting on PES rates at 56%, however PTS had met their target at 80% and 111 improved position to 73%. EOC had most challenged rates at 27%.	• Received limited assurance from the Workforce Indicators report due to continued increase and upward trend in level of sickness and staff turnover in 111 service. • Requested a deep dive into the factors, to be presented to the next Resources Committee meeting.	

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	• Acknowledged that teams in EOC would be supported with recovery plans. • In terms of Mandatory training reported that target had been revised by ELC to 85% for service lines and 95% for corporate departments. • Current compliance at 63% due to the introduction of new modules for the year's online training and impact of classroom position, with recovery plan in place. • Sickness absence reported as fairly static but above normal levels for the time of the year which included Covid-19 related sickness. • Noted that Non-Covid Sickness levels were higher than in previous years across service lines and increase pronounced in 111 service. • Reported that a dedicated HR team to focus on supporting operational teams to support attendance had been established. • In relation to vacancies, reported a positive position with plans on track in PES and EOC to over-establish over the winter period. • In terms of 111 reported a high vacancy position linked to increase in		

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	staff turnover. PTS vacancy position improving in line with plan. • Discussed in depth the issues associated to staff turnover in 111 service which had increased and showed significant upward trend at 41.85%. • Acknowledged that the Trust was receiving support from NHSE/I and regional People Team who had offered support to the Trust. • A shared and agreed concern related to the level of staff turnover and deep dive requested for further understanding of the issues. • Noted number of outstanding Employee Relations Casework cases and an increase of 26 new cases since the last report; attributed to sickness absence. • Reported that there were no cases over 12 months old and 13 number of cases between 6-12 months old; with 9 Panels held and considered 59 cases with good levels of early resolution. • Covid-19 vaccination rate for fully vaccinated staff stands at 89% and 2.8% for staff partially vaccinated.		

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	8.3% of staff were yet to be vaccinated and 39% of staff had received a booster vaccination. • Noted the need to manage emerging requirements for mandating the vaccine.		
NWAS People Plan 6 month review	• Received a bi annual update on the one year implementation plan of the NWAS People Plan, approved by Board in May 2021. • Acknowledged progress during first six months and adjusted realistic achievements for remainder of the year. • Noted significant focus on culture and wellbeing with launch of Values, Treat Me Right Campaign and Mental Health and Suicide Prevention Tool kits. • Highlighted the continued work related to delivery of recruitment and training targets and the effects of the launch of paramedic and EMT apprenticeships. • Advised that some priorities had been deferred to 2022 due to the challenges of continued recovery and capacity across the organisation. However, additional objectives had emerged during 2021/22; in particular the need to mobilise plans to spend additional Health and wellbeing investment.	• Noted the assurances provided in the report.	

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	• Welcomed emerging new priorities and the progress against plan.		
Health and Wellbeing Update	• An Assurance Report presented work undertaken to promote wellbeing with in the Trust. • Acknowledged that a Wellbeing Guardian would be appointed within the Non-Executive Board members to enhance assurance processes related to wellbeing, to provide a reflective role and sense check the organisations position. • Noted that the Chair of the Trust would take on the position initially until future Guardian appointed. • National guidance detailed 9 principles for the role of the Wellbeing Guardian and areas for future development. • Report included assurance against these 9 areas. • Reported that NWAS had been selected as one of two Trusts in the North West to act as a trailblazer for the new Health and Wellbeing Framework. • Advised that the Trust had been involved in a Regional Wellbeing pledge, involving North West Trusts, to focus on wellbeing for 95% of staff in work; including developing policies and	• Noted the assurances provided in the report and recommended adoption of the regional Wellbeing Pledge to the Board of Directors.	

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	practices in the prevention and individualised care.		
Diversity & Inclusion Sub Committee Chairs Assurance Report from the meeting held on 8th October 2021	• Received the assurances obtained via the subcommittee from operational representation on the EDI priorities including Education and Training; Mental Health inequalities and Equality Delivery System Goals. • Noted verbal assurance from PES service line, with formal written report requested for the next meeting. • Presentation by the Chair of the Race Equality Network had provided opportunity for robust discussion. • Highlighted that mental health paper had been deferred to the next meeting. • Acknowledged that the key members not present did not impact on quoracy of the meeting.	• Noted the assurances provided in the Sub Committee Chairs Assurance report.	

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REPORT TO BOARD OF DIRECTORS

DATE:	24 November 2021			
SUBJECT:	Health and wellbeing update			
PRESENTED BY:	Lisa Ward – Director of People			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☒
	SR05	**SR06**	**SR07**	**SR08**
	☒	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The role of the Board of Directors is to seek assurance that the Trust is providing a safe supportive environment for the holistic wellbeing of our workforce. This paper outlines plans which will support the assurance process. Wellbeing is about much more than health. It describes our perception of the quality of our lives in their entirety and is influenced by a range of physical, emotional and psychological factors. Work is a key element in this for many people and our learning from the wellbeing survey is that the way in which work is organised and the way people are managed can also have a significant effect on wellbeing. The tools set out in this paper will support us in continuing to move out approach towards prevention and individualised care. <u>Wellbeing Guardian</u> The Staff and Learners Wellbeing review undertaken in 2019, identified a lack of uniformity in in board level leadership in relation to workforce health and wellbeing. One of the recommendations was the introduction of the Wellbeing Guardian, preferably from the non-executives Directors of the Trust. The role aims to enhance assurance processes around wellbeing, providing a reflective role, able to sense check the organisation's position and ensure wellbeing remains at the forefront of decision making. The Chair has agreed to take on this role initially. The national guidance also sets out 9 principles or areas of focus for the Guardian. Appendix A sets out the Trusts current provision, immediate plans and areas for future development. <u>H&WB Framework Trailblazer</u> NWAS has used the previous national H&WB framework to assist in self-assessing our current position and developing			

	future plans. The new framework has been expanded to take a more holistic approach to wellbeing and to place greater emphasis on prevention and inclusion. NWAS has been selected as one of two Trusts in the NW and the only ambulance Trusts to act as a trailblazer for the new framework. In this role we are committed to using the revised diagnostic tool over the next six months, to support in the development of learning and good practice and to act as an advocate for the framework. As a Trust we recognise that this will provide a good foundation to assess our current provision and drive future improvement. <u>Regional wellbeing pledge</u> The NW region has also being working with RAND Europe to focus on the links between wellbeing, presenteeism and productivity in work. As a result Trusts are being asked to commit to a pledge to focus work on the wellbeing of the 95% of staff in work and to continue to develop policies and practices in the prevention and individualised care approach. NWAS is already developing this work through resources such as the mental health and suicide prevention toolkit and menopause policy and training.
RECOMMENDATIONS:	The Board of Directors is recommended to: • Note and receive assurance from the appointment of a wellbeing guardian • Note the role of NWAS as a trailblazer for the revised national H&WB framework and provide commitment to the use of this tool to help drive strategy • Approve adoption of the Regional Wellbeing Pledge

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

PREVIOUSLY CONSIDERED BY:	Resources Committee	
	Date:	19th November 2021
	Outcome:	Received assurance and recommended adoption of Wellbeing Pledge to Board

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1. PURPOSE

1.1 The role of the Board of Directors is to seek assurance that the Trust is providing a safe supportive environment for the holistic wellbeing of our workforce. The purpose of this paper is to outline the enhancement of the opportunities for assurance on this issue through the implementation of the Wellbeing Guardian role, the Trust's involvement as a trailblazer for the revised Health and Wellbeing Framework and through the regional wellbeing pledge.

2. BACKGROUND

2.1 Wellbeing forms a fundamental part of the People Promise and in particular the following promise:

We are safe and healthy
We look after ourselves and each other.
Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.
We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

2.2 Wellbeing also forms a fundamental part of the NWAS People Plan and Resources Committee have received previous assurance on the extensive work undertaken to enhance the wellbeing offer and ensure that we are able to deliver a safe and supportive environment.

2.3 Wellbeing is about much more than health. It describes our perception of the quality of our lives in their entirety and is influenced by a range of physical, emotional and psychological factors. Work is a key element in this for many people and our learning from the wellbeing survey is that the way in which work is organised and the way people are managed can also have a significant effect on wellbeing. We are therefore continuing to develop our approach and to interweave leadership, engagement and inclusion into wellbeing initiatives and frameworks.

2.4 The global pandemic has started to change how we perceive health and wellbeing. The NHS became more empowered to place greater emphasis on how caring for the diversity of our NHS people, enables them to care for the diversity of our patients and service users. It also enabled us to move away from the rhetoric of reducing sickness absence and toward creating a culture of wellbeing that focuses on prevention and culture change.

2.5 The thinking around Board responsibilities and the framework through which Trusts' approach wellbeing has also continued to evolve. The Staff and Learners Wellbeing review undertaken in 2019, identified a lack of uniformity in in board level leadership in relation to workforce health and wellbeing and the proposals in this paper represent some of the national response to support the development of greater oversight of wellbeing.

3. WELLBEING GUARDIAN

3.1 One of the recommendations arising from the Staff and Leaners Wellbeing Review which was adopted in the national People Plan was the appointment of a Wellbeing Guardian. Whilst NHS Chief Executives hold legal responsibility or health, safety and wellbeing of the

workforce with the Director of People holding executive accountability and responsibility for the delivery of the wellbeing agenda, the national guidance is clear that the role of the wellbeing guardian is to seek assurance at board level that the organisation is discharging its duties properly and effectively. Furthermore, it suggests the role of the Guardian is a reflective role, sense checking and seeking assurance on wellbeing matters and prompting remedial actions where necessary, but should not expand into the territory or duties which are clearly defined as executive responsibilities.

3.2 It is therefore recommended in guidance that the role is best suited to a non-executive director. Given recent and anticipated changes in the non-executive team and the existing breadth of portfolios, the Chair has agreed to take on this role initially but an individual with the appropriate skills and background to take on this role will be sought through future recruitment.

3.3 The national guidance also sets out a set of nine principles against which Wellbeing Guardians should seek assurance. These are set out below:

Principle 1: The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised by the work they do for the NHS

Principle 2: the wellbeing guardian will ensure that where there is an individual or team exposure to a clinical event that is particular distressing, time is made available to check the wellbeing impact on those NHS staff and learners.

Principle 3: The Wellbeing guardian will ensure that wellbeing check in meetings will be provided to all new staff on appointment and to all learning on placement in the NHS as outline in the Commission recommendations

Principle 4: All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential Occupational Health service that promotes and protects wellbeing.

Principle 5: The death by suicide of any member of staff or a learner working in an NHS organisation will be independently examined and the findings reported through the Wellbeing Guardian to the board.

Principle 6: The NHS will ensure that all staff and learners have an environment that is both safe and supportive of their mental wellbeing.

Principle 7: The NHS will ensure that the cultural and spiritual need of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS.

Principle 8: The NHS will ensure the wellbeing and make the necessary adjustment for the nine groups protected under the Equality Act 2010.

Principle 9: The Wellbeing Guardian, working with system leaders and regulators, will ensure that wellbeing is given equal weight in organisational performance assessment.

3.4 In order to assist in providing a baseline of our current position, Appendix A includes a mapping tool which demonstrates what we currently have in place against the nine principles, areas of further development planned for this year and any gaps which could be strengthened

in the future. Ongoing assurance will be provided through the workforce governance structures and Resources Committee with regular engagement with the Guardian.

3.5 In addition, the Chair has already been engaged with the regional Guardian's group but we are exploring the benefit of forming an ambulance sector Guardian's group which can share best practice and can be directly linked into the national Wellbeing and Suicide Prevention group.

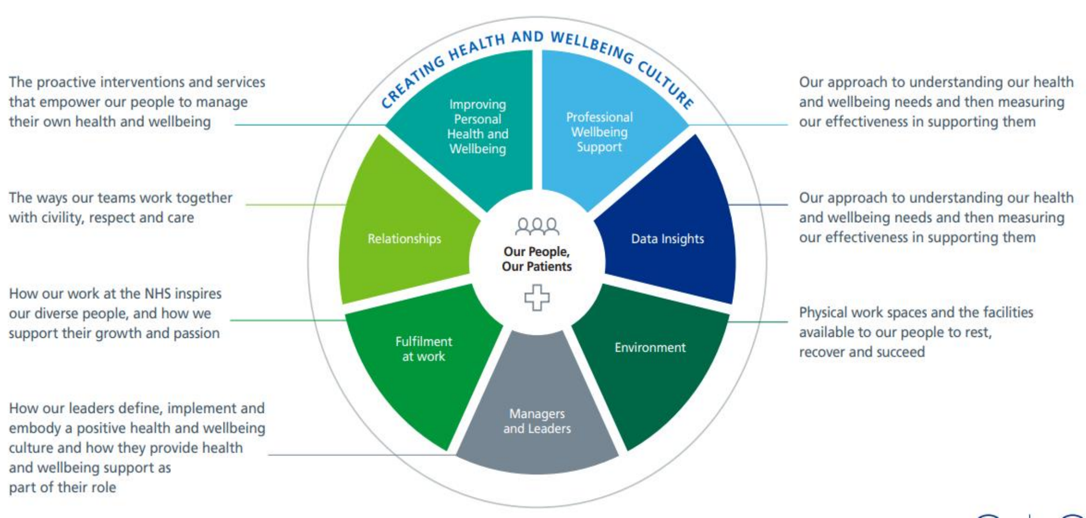
4. HEALTH AND WELLBEING FRAMEWORK - TRAILBLAZER

4.1 The national People Team has also built on the outcomes of the review in order to refresh the national framework for helping organisations to assess their current position in relation to the Health and Wellbeing of our people and to identify both priority areas and interventions. The original framework was launched in 2018 and used within the Trust to focus our wellbeing plans, many elements of which have been delivered since that date. The new framework has been expanded to reflect the more holistic approach to wellbeing outlined above and to have a much greater focus on presenteeism and prevention.

4.2 The redesign focuses on the creation of a wider health and wellbeing culture:

- Placing greater emphasis on the preventative health and wellbeing interventions.
- Embedding equality, diversity and inclusion.
- Providing a clear rational and case for change

4.3 The framework is set out below and provides a diagnostic tool to support organisation's to self-assess and prioritise interventions.



4.4 NWAS has been selected as one of only two organisations in the North west to be a trailblazer for the tool. This enables us to work closely with the national and regional teams on the implementation of the framework, benefit from a community of practice and as a result we are committed to sharing our journey and the benefits of the approach. As the only ambulance service engaged in this piece of work we are in a good position to influence and support the sector.

4.5 As a trailblazer we have been allocated £5000 to support the project and are committed to:

- Work with the Board and the Wellbeing Guardian to gain organisational commitment to the HWB Framework
- Work through the HWB diagnostic tool and identify any gaps and improvements
- Develop a HWB Strategy to align with the seven elements of the HWB Framework (this will be incorporated into our People Plan)
- Work with the HWB national team to develop a managers and teams toolkit to support the HWB Framework.
- Share learning through a case study of the process, capture any barriers or key learning to feedback to the national HWB team.
- Gather any impact evaluation of aligning policies and practices to the HWB Framework
- Be an advocate of the HWB Framework with peers, sharing your experience through national events and materials.

4.6 We intend to work through the diagnostic tool over the coming months and will share the developing work with stakeholders through existing health and wellbeing groups, along with other engagement activities. Progress will be reported through the Wellbeing and Culture management group to the Strategic Workforce Sub-Committee, with the full diagnostic and supporting plans being shared with Board at an appropriate point.

4.7 The framework has been presented to Committee and Board at this stage to seek support for use of the framework as a means of driving strategy in this area.

5. REGIONAL WELLBEING PLEDGE

5.1 The North West region has also undertaken some work through RAND Europe building on the evidence emerging about the equity of the challenge arising from presenteeism alongside absenteeism. The work of RAND has demonstrated a clear link between the wellbeing of those in work and productivity. Evidence from their work indicates that whilst traditional approaches to wellbeing have focused on the small percentage who are absent, a focus on those who are in work but may not be fully well, combined with prevention can be a more effective strategy.

5.2 This work aligns with the approach being set out in the health and wellbeing framework above but seeks a specific public pledge from the Board of Directors to shift the approach to wellbeing to focus on the 95% of staff in work and to an individualised approach to holistic wellbeing. NWAS is already starting to create this shift through initiatives such as the preventative work undertaken around mental health and wellbeing conversations, suicide prevention and the work commenced around just culture in our HR processes.

5.3 The commitment reinforces the national drive through the framework and the wellbeing guardian to ensure that wellbeing is a priority at board level and that the lens of workforce wellbeing is considered in decision making.

5.4 The commitments being sought from Board are set out below:

Our pledge for the **wellbeing of our NHS people**

Insert organisation logo

Signed....................................

Name....................................

We pledge to shifting the focus from sickness absence (the 5%) to holistic wellbeing for everyone:

- **preparing our board for the change** to take a more holistic, person-centred individual and flexible approach, which is driven through policy and aligns with embedding a just culture.
- **evidencing that wellbeing is a priority with our board by** understanding the wellbeing of our people, giving them a voice, making sure all decisions have a wellbeing lens applied and addressing any issues.
- **committing to the three North West's themes of enabling work**
  - Holistic wellbeing services that support all of our colleagues
  - a new person-centred wellbeing approach and an attendance management policy framework
  - leadership development that supports managers in our new approach.

5.5 Organisations committing to the pledge are also asked to develop an enabling plan. This work will be undertaken in parallel with the outcomes of the health and wellbeing diagnostic and our wider wellbeing plans.

6. RESOURCES COMMITTEE

6.1 Resources Committee received and considered this report. The Committee were positive about the additional assurance that this would provide. In particular Committee expressed an interest in understanding the Health and Wellbeing framework in more depth, to provide all Board members with a greater in depth understanding of the drivers for holistic wellbeing and the strengths and weaknesses of current provision. It was agreed that this should be considered for a future development day once further progress had been made in completing the diagnostic element of the framework.

7. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

7.1 There are no legal or governance implications from this report.

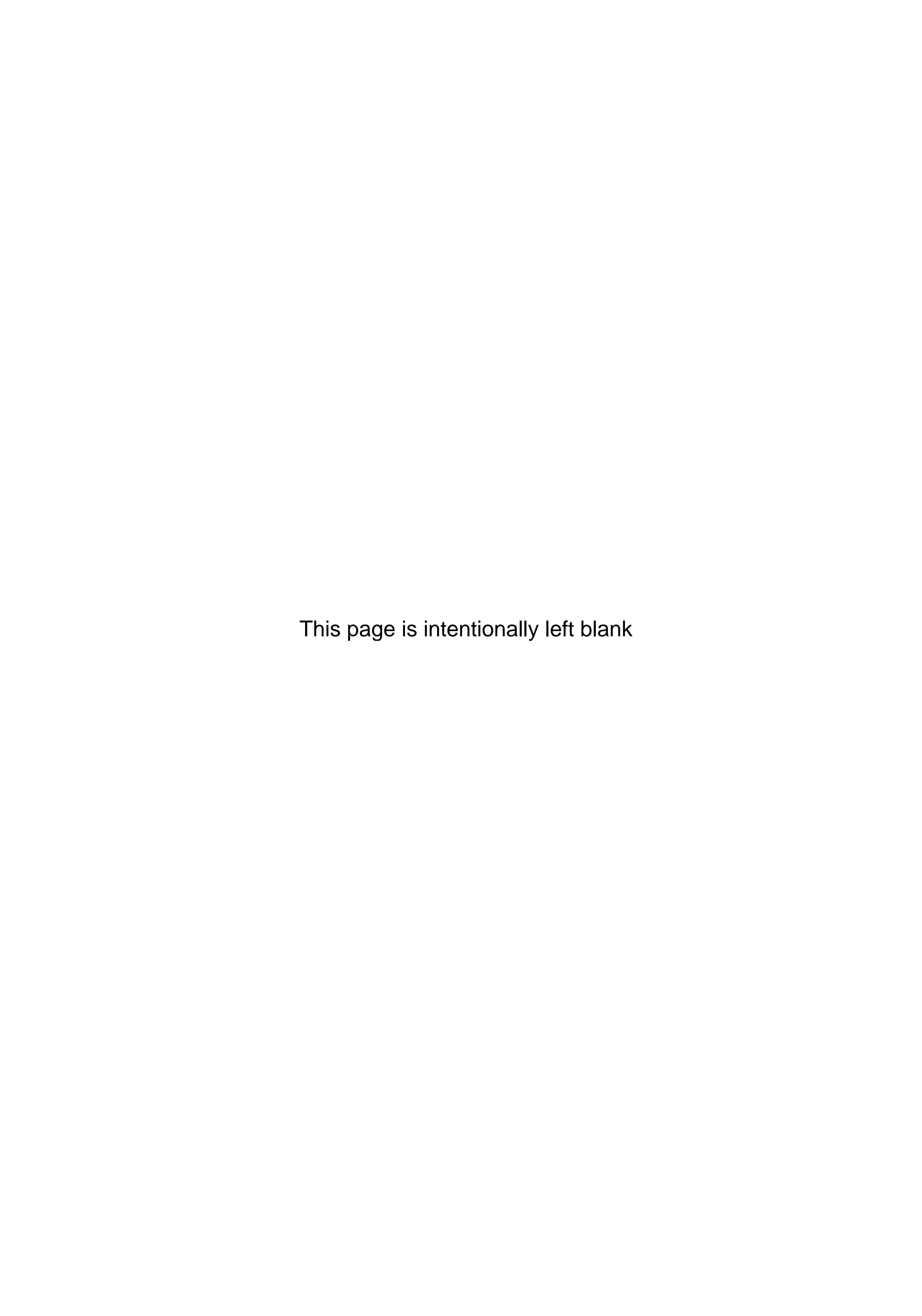
8. EQUALITY OR SUSTAINABILITY IMPLICATIONS

8.1 Both the health and wellbeing framework and the wellbeing pledge incorporate the considerations of inclusion and an individualised approach to managing wellbeing. Use of the H&WB framework diagnostic toll should enable us to consider how current practices impacts on different protected groups to identify any risks of differential treatment and supportive interventions.

9. RECOMMENDATIONS

9.1 The Board of Directors is recommended to:

- Note and receive assurance from the appointment of a wellbeing guardian
- Note the role of NWAS as a trailblazer for the revised national H&WB framework and provide commitment to the use of this tool to help drive strategy
- Approve adoption of the Regional Wellbeing Pledge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Current provision	Planned Work 2021/22	Areas for further improvement
Principle 1 : The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised by the work they do for the NHS		
The Trust has developed a mental health Toolkit for managers. This aims to provide clear support and guidance for managing mental health and information on how to signpost staff for additional support. The Trust has developed a Suicide Prevention toolkit and is designed to help, support, and educate everyone in the organisation around the risks of suicide within the workplace, promoting good practice, and encouraging healthy conversation to remove the stigma often associated with mental health problems and suicide. Commissioning of staff and managers resilience programmes to support staff who may feel burnt out following the pressures associated with the pandemic including REACT MH training. Launch of the Treat me Right campaign which supports the management of bullying and harassment issues with a key focus on early resolution and civility in the workplace. Health, Wellbeing and Culture Assurance Committee meets on a quarterly basis to maintain a strategic overview of the Trust's Workforce Health and Wellbeing with a specific emphasis on improving culture,	Ensure sickness management of mental health is linked to EDI strategies for addressing the disparity in mental health support for underrepresented groups. Using temporary funding to bring in a clinical psychologist to support the development of current and future offer. Enhancing opportunity for proactive wellbeing conversations through externally provided mental health check ins, providing signposting and escalation into self-help; Trust supported provision or specialised support. Launch of an internal 'Support Hub' to ensure that staff can easily access information and signposting to further sources of wellbeing support.	Understanding the gaps in the provision of wellbeing support to staff Ensure that staff and managers are fully aware of provisions in place. Evaluate effectiveness of Mental Health Toolkit campaign based on Staff Survey results / ER data / local plans feedback. Deliver recommendations from Clinical Psychologist work and outputs from national work with Royal Foundation and HEE.

Current provision	Planned Work 2021/22	Areas for further improvement
through leadership of the staff engagement and health and well-being plans to deliver the Trust's values in practice. Employee Assistance Programme available with access to 24 hour counselling support and advice. Access to self referral counselling services via OH contract. Range of signposting to external support including local resilience hubs.		
Principle 2 : The Wellbeing Guardian will ensure that where there is an individual or team exposure to a clinical event that is particularly distressing, time is made available to check the impact on those NHS staff and learners		
The Trust offers the following to staff: - TRiM Assessments - Access to the counselling service - Peer Support (PTS and EOC) - MH First Aiders (111) - Blue Light Champions Operationally hot debriefing is encouraged. Availability of stand-down for EOC and frontline crews following difficult incidents with EOCs having quiet space available.	Review the overall support provided to staff involved in Peer Support, TRiM and Blue Light Champions to ensure it remains appropriate and consistent.	Development of a single offering of peer support. TRiM would continue as a standalone offering due to it specific nature of support
Principle 3: The Wellbeing Guardian will ensure that wellbeing 'check in' meetings will be provided to all new staff on appointment and to all learners on placement in the NHS as outlined in the Commission recommendations		

Current provision	Planned Work 2021/22	Areas for further improvement
All managers are encouraged to undertake regular wellbeing 'check in' meetings with staff utilising the support toolkits available. The appraisal documentation includes a section on staff wellbeing to encourage a structure discussion. Implemented Mental Health Toolkit, using it to support the embedding of health and wellbeing conversations.	Roll out of resilience training for new starters	Further development work with managers to look at how to ensure that wellbeing check in discussions are embedded.
Principle 4 : All NHS staff and those learning in the NHS will have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing		
Occupational Health Service provides a confidential counselling service for all staff to access via self -referral. Staff also have access to the Employee Assistance Programme via our salary sacrifice provision. The trust work with Able Futures which staff can access if needed. This service provides up to 9 months support from a mental health professional at no cost to staff. There is no waiting list, and all staff are eligible for support. Staff are also able to access the ICS resilience hubs confidentially.	Launch of an internal 'Support Hub' to ensure that staff can easily access information and signposting to further sources of wellbeing support.	Ongoing assessment of use and effectiveness of provisions in place.

Current provision	Planned Work 2021/22	Areas for further improvement
Principle 5: The death by suicide of any member of staff or a learner working in an NHS organisation will be independently examined and the findings reported through the Wellbeing Guardian to the board		
The Suicide Prevention toolkit is designed to help, support, and educate everyone in the organisation around the risks of suicide within the workplace, promoting good practice, and encouraging healthy conversation to remove the stigma often associated with mental health problems and suicide. Close working partnership with AACE and NMC to ensure NWAS are represented in national guidance and support. National suicide register and learning from suicide across the sector.	Further work to look at how the Suicide Prevention Lead can support the learning from the death by suicide of staff or learners.	Evaluate the effectiveness of the toolkit and areas for further learners
Principle 6: The NHS will ensure that all staff and learners have an environment that is both safe and supportive of their mental wellbeing		
The Trust is part of the Health and Wellbeing framework Trailblazers. This includes utilising the revised diagnostic tool to self-assess against the national framework. Review and ongoing development of the local wellbeing people plans to ensure staff support is in place across all sectors with adequate signposting for all staff groups.	Undertaking the Workforce Health and Wellbeing diagnostic tool and formulating some. Using temporary funding to bring in a clinical psychologist to support the development of current and future offer.	Ensure that gaps identified in the diagnostic tool are used to form an action plan.

Current provision	Planned Work 2021/22	Areas for further improvement
The annual staff survey is used to monitor progress on how safe and supported staff feel. H&WB assurance group in place to monitor progress.		
Principle 7: The NHS will ensure the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS		
Evaluate the recommendations from the Wellbeing and Culture audit, focussing on psychological safety, the role of leadership and wellbeing. Continue to develop the Race Equality Network Continue to develop the Religion and Belief forum. Scope out the options around a formal role for a Chaplaincy / Spiritual guidance offer	Consider how the recommendations can be embedded into Trust wide work Understand the key areas of focus from the 2021 Staff Survey To take an options appraisal on the Chaplaincy Spiritual guidance role to ELC for consideration	Ensure that there is a comprehensive and consistent offer for staff on cultural and spiritual needs Further work to explore gaps in the spiritual and cultural needs of overseas staff
Principle 8: The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010		
The Trust has staff networks in place for Race Equality, Disability, LGBTQ+, Armed Forces, women in leadership and a Religion and Belief Forum	Transition of the Disability Forum into a formal network Analysis of the Staff Survey and NQPS results to understand the views of staff Ongoing development of Executive Champions	Further work to look at intersectionality needs Evaluation of the Wellbeing Passport Ensure that all leaders understand and support the work identified through the

Current provision	Planned Work 2021/22	Areas for further improvement
Suite of policies, procedures, guidance and toolkits in place to support staff protected under the Equality Act Introduction of Executive Champions Successful bid for the Reciprocal mentoring Programme Introduction of the Wellbeing Passport to support staff who require reasonable adjustments Plans in place to address areas of development from the WRES, WDES and Gender pay gap submissions The Trust has a clear set of ED&I objectives with underpinning action plan Development of proactive policies guidance for specific EDI matters e.g. menopause policy, breastfeeding policies , trans and non-binary policy, support for learning difficulties.	Roll out of Reciprocal mentoring programme Ongoing work on WRES, WDES and Gender pay gap areas of focus Ongoing review of progress against ED&I objectives	WRES, WDES and Gender pay gap submissions
Principle 9: The Workforce Wellbeing Guardian, working with system leaders and regulators, will ensure that wellbeing is given equal weight in organisational performance assessment		
Assurance provided in the H1 and H2 Operational Planning responses on the work in place to support Staff Wellbeing	Signing of the Regional Wellbeing Pledge Ongoing review of actions against the ED&I objectives	Placing greater emphasis on senior managers having staff wellbeing as a key part of the performance appraisals objectives

Current provision	Planned Work 2021/22	Areas for further improvement
Being part of only two organisations in the North west to be a trailblazer for the Health and Wellbeing Framework tool ED&I objectives focus on: - Ensuring that staff have fair opportunities, for roles and progression within the organisation - Leaders u have the cultural competence to deliver a step change in the experience to staff and patients - Use of data and patient experience to drive improve in access and health inequalities from diverse communities Trust engaged in national sector work through the Royal Foundation and AACE groups. Wellbeing Guardian engaged in regional wellbeing group.	Establishment of sector Wellbeing Guardians groups	

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NHS North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	24 November 2021			
SUBJECT:	Communications and Engagement Team Dashboard Report – Q2 (July-September) 2021/22			
PRESENTED BY:	Salman Desai, Director of Strategy, Partnerships and Transformation			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Discussion			
EXECUTIVE SUMMARY:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. For quarter 2 (Q2 – July - September 2021), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q2. It includes the number of virtual engagement opportunities attended and feedback gathered, and information about our patient surveys. For example, this quarter: • 16 virtual community engagement opportunities were attended or facilitated. • New patient service improvement ambassadors are in place to discuss feedback and identify opportunities for improvement. • 56% more patient surveys were issued, thanks in part to a new pilot where SMS text messages prompt survey completion for PES and PTS patients. • Response rates declined slightly but are expected to increase as the trial of the SMS prompts begins to make an impact on responses in Q3. • Satisfaction with services declined for the second quarter in a row, based on survey responses: - 90% were likely to recommend the service to friends and family, down 1% from Q1. - 87% were very or fairly satisfied with the overall service they received, down 5% from Q1. **Patient and public panel (PPP)** A summary of the Q2 activity for the PPP, including up-to-date figures for panel recruitment and performance against objectives for the year. For example, this quarter:			

- 28 new panel members were confirmed and inducted to the trust
- 181 panel members in total, a 15% increase from Q1
- 51 new expressions of interest in Q2
- 9 new requests for panel involvement in Q2
- Reached 18% against a target of 20% for youth representation on the panel by end of the year
- Reached 11% against a target of 20% for diverse community representation on the panel by the end of the year
- Exceeded the target for 15 opportunities for panel involvement

Press and public (patient) relations
A summary of our media relations activity for Q2. This includes the number of incident check calls and some highlights of the media relations work that has been undertaken this quarter. In Q2:

- 561 incident check calls
- 43 proactive web or media stories, a 43% increase from last quarter
- 40 statements prepared in response to press enquiries, a huge 122% increase from Q1
- The increase in statements is due to media enquiries about two main issues: high demand causing delays and resident reactions to proposed changes to Alston ambulance provision.
- These issues led to an increased amount of press coverage that we would categorise as negative, but it is important to highlight that we respond to each enquiry with a balanced statement from NWAS to ensure we are represented in any article.

Social media: Facebook, Twitter and Instagram
A summary of our social media statistics for this quarter. The social media statistics are presented slightly differently this quarter to help make them more meaningful.

The report highlights our:

- **Audience** – which has grown by 3.2% across our channels in Q2, with a combined following of more than 143,000 people.
- **Engagement** – which shows our 1,040 social media posts potentially reached more than 12 million people in Q2 and achieved an engagement rate of 4.9% (very high compared to an industry standard of 2.5%).
- **Content** – our most successful social media content was about BBC's Ambulance documentary and contained educational information about the service.

Green Room
A summary of statistics for the Green Room – our staff intranet - including page views and visitor numbers. In Q2, staff accessed the Green Room almost 360,000 times. The Ideas Room – which launched in Q1 as a space for staff to

share ideas – was visited more than 5,500 times and generated over 100 ideas.

The report also includes a summary of new Green Room features for Q2, including improved search functionality to enhance user experience.

Website
A summary of statistics for our website, accessed by members of the public and partner organisations. In Q2, the website was visited almost 195,000 times.

The most popular pages were vacancies, patient transport service, and 'contact us'. The majority of people found our website by searching on Google or clicking through from social media.

FOI performance
An update on the FOI performance against the national target of 90% completion within 20 days. 75 FOIs were completed in Q2 (up 34% from Q1) and 96% were within the 20 working day target, a 1% improvement from Q1.

Stakeholder communications
A summary of stakeholder activity for Q2, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 1 stakeholder bulletin
- 7 MP letters

Publications
The summer edition of Your Call was drafted, designed and issued in July. It was read 9,525 times during Q2, with 13 articles shared on social media to increase readership.

Reflections, a publication highlighting the achievements of the last 12 months, was drafted, designed and issued with 200 printed versions distributed to staff bases and a digital version shared with stakeholders and community groups.

Internal projects and campaigns
Highlights and figures about the main internal communication projects and campaigns from Q2, including:

- Beat the Burnout programme
- Menopause policy launch
- Suicide prevention toolkit launch
- Staff surveys
- Star Awards
- Ideas Room
- Digital developments
- Single primary triage
- Service delivery model review
- Long service awards

	Internal bulletins and the Staff App Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q2: • 10 CEO bulletins • 25 Clinical bulletins • 30 Operational bulletins • 818 staff app downloads **Films produced in-house** A summary of in-house videography activity. 18 films were completed this quarter, 50% more than Q1, with an average of six new films per month – one of our busiest ever periods. They included: a patient story about our partnership with Deafway, the AGM film, 'Looking Back' highlights from 2020/21, and 2 Team Talk Lives. **Focus on…** • **Thank you week -** a campaign to thank staff and mark 999 day by sending small gifts, distributing the COVID-19 pin badges and encouraging everyone to pass on the positivity. • **BBC Ambulance documentary** – more information about the Ambulance series which started in Q2 and reached an audience of 2.7 million people each week.
RECOMMENDATIONS:	For discussion, noting and the provision of any comments.
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

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1. PURPOSE

To provide the Board of Directors with a summary of key outputs and associated highlights on the work of the combined Communications and Engagement Team for Q2 (July - September 2021).

2. BACKGROUND

The Communications and Engagement Team has created a dashboard providing high level statistical content and themes from Q2 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- Stakeholder communications
- Social media: Facebook, Twitter and Instagram
- Website and Green Room
- Internal projects and campaigns
- Internal communications including the staff app
- Films produced in-house

Each report also goes into more detail on some priority pieces of work. This quarter's dashboard provides an overview of our 'Thank you week' campaign and the BBC Ambulance documentary.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.

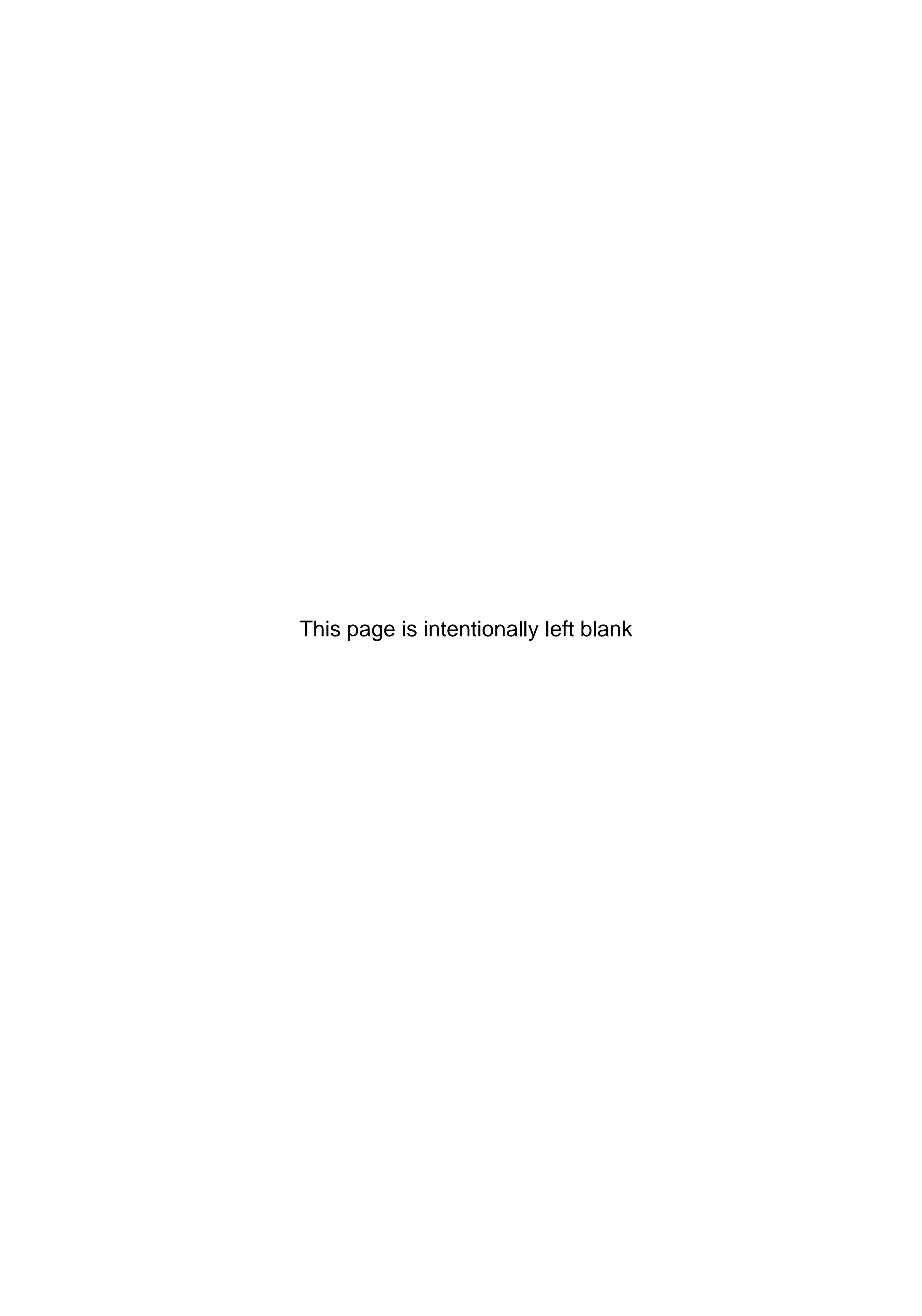
NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

All of the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all.

5. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.



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Communications and engagement dashboard

Q2 2021/22: July - Sept

PATIENT AND PUBLIC ENGAGEMENT

16 virtual engagement opportunities with groups including: Stockport Youth Forum, Macclesfield Visually Imparied Forum, Healthwatch Wirral Bridge Session, and Cumbria and Lancashire over 55s group.

Feedback included:

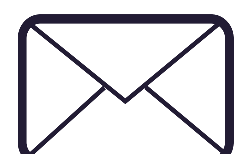
111 lack of awareness about certain elements of the 111 service.

PTS lack of awareness of mental health being part of the eligibility criteria, plus questions around discharges.

PES questions about resource, activity and demand, with groups seeking reassurance as we head into winter.

The above themes will be a focus of engagement for Q3 and part of the winter communications plan.

Patient service improvement ambassadors have now been agreed with all service lines to discuss feedback and identify opportunities for improvement on a regular basis.



11,007 ▲56% surveys sent

992 ▼4% surveys returned

In Q2, more surveys were sent because of an increase in NHS 111 postal surveys and the start of a pilot in September to test SMS text messaging prompts for PES and PTS surveys, which we hope will increase return rates.

90% were likely to recommend the service to friends and family ▼1%

87% were very or fairly satisfied with the overall service they received ▼5%

93% agreed they were cared for with dignity, compassion and respect

For a second consecutive quarter, there is a decline against two of the response measures. The third measure was not reported in Q1 due to low response rate which has been improved with the SMS pilot.

PATIENT AND PUBLIC PANEL (PPP)

51 new expressions of interest in Q2

28 new panel members in Q2

181 panel members now in total

15%

9 new requests for panel involvement in Q2

16 structured and/or task orientated involvement opportunities delivered

9 ad hoc opportunities (virtual only) offered for panel members in Q2

PERFORMANCE AGAINST OBJECTIVES:

- Increasing youth representation – target is to have **20%** of the PPP made up of young people (16-24 years old) by the end of the year. During Q2, we reached **18%** against the target.
- Ensuring we represent our diverse communities – target is to increase the representation of panel members from our diverse communities by **20%** by end of this year. In Q2, this increased to **11%** from 7.8% a year ago.
- A minimum of 15 opportunities for PPP involvement - exceeded in Q2
- Enhance two-way communication with PPP - in Q2, the new PPP forum was launched on the website as space for members to engage with each other
- Recognise PPP involvement - an achievements book was developed and 15 members received thank you letters following nominations from NWAS staff

PRESS AND PUBLIC (PATIENT) RELATIONS

561 'Incident checks' handled

43 proactive website and media articles ▲**43%**

40 statements in response to press enquiries ▲**122%**

22 broadcast media interviews arranged

We have seen regular media interest in our performance and many queries about delays in responding to patients.

Proposed changes to Alston ambulance resources has also attracted interest from several local and national outlets.

In a proactive push to help the public understand how busy we have been and share key messages, a number of media interviews were arranged with Dr Chris Grant as spokesperson, including regional TV and radio.

Also, as the latest series of Ambulance aired on BBC One, we facilitated several promotional regional and national interviews featuring the staff starring in the new series.

157 pieces of media coverage

121 were reports of incidents including a mention of NWAS with details provided by our press office about what resources were there, number of patients and nature of injuries. This is considered 'neutral' coverage as the story itself about an incident may be considered positive or negative, but the information about NWAS is factual and neutral in tone.

30 pieces were considered negative. These are stories that overall, reflect negatively on NWAS, but will include a statement from us in response to a situation. This amount of negative coverage is higher than usual and is proportionate to the significant increase in work preparing statements during Q2. The negative coverage is centred on two main issues: residents of Alston reacting to proposed changes to resources and high demand causing delays.

The remaining coverage was positive and included stories overtly praising NWAS' response to certain incidents and coverage of our patient engagement work to improve services for deaf patients.

NOTES: This is coverage available online and may not include all mentions of NWAS in local publications or on broadcast media outlets, although most broadcast outlets also publish online stories which will be captured.

SOCIAL MEDIA - FACEBOOK, TWITTER AND INSTAGRAM

AUDIENCE

69,922 Facebook page likes

59,276 Twitter followers

14,547 Instagram followers

3.2% Overall audience growth in Q2

ENGAGEMENT

1,040 posts published across all channels (around 11 per day)

12,550,715 Impressions

617,832 engagements (comments, likes, retweets, shares etc)

80% more than the average engagements of all other ambulance trusts

4.9% overall engagement rate

CONTENT

Many of our most successful posts were related to BBC's Ambulance. In comparison to our overall social media activity:

247 posts, making up 24% of our activity for Q2

4,819,833 Impressions (39%)

241,256 Engagements (39%)

NOTES:

For this quarter, we have changed the way we present our social media statistics to hopefully make it more meaningful and demonstrate the impact of our activity.

'Impressions' means a post has appeared on someone's social media feed. It is the number of times our content may have been seen by a member of the public.

'Engagements' is when someone engages with our content e.g. clicks a link, reacts to it by clicking 'like', or shares or retweets it.

'Engagement rate' shows us how many people engage, for example for every 1,000 people who see our post, 49 engage. According to social media industry experts, the average engagement rate is less than 0.5% for Facebook, 2.5% for Twitter and 1.5% for Instagram, making our engagement very high.

THE GREEN ROOM (INTERNAL)

358,460 visits in Q2 - the number of times staff members have used it

1,094,616 page views - meaning every time a person visits, they view approx 3 pages

HIGHLIGHTS:

5,578 visits to the Ideas Room, which was launched in Q1 as a space for staff to share ideas. More than 100 ideas were posted and shared with senior managers for consideration.

50% increase in views to the 'news' section, due to a new approach where the weekly email bulletin links back to the Green Room

NEW FOR Q2:

- New search feature on the Library - we have an A-Z filter to help people narrow down search results, as well as quick links to most frequently used topics at the top of the page.
- Contents - users can now 'go to' a particular part of a page, using a contents list at the top of a page, which is useful on pages with lots of information
- Updated search bar on homepage to make it more user-friendly

NWAS WEBSITE (EXTERNAL)

194,712 visits in Q2 - the number of times people have visited our website

431,672 page views - meaning every time someone visits, they view approx 2 pages

MOST VIEWED:

- Vacancies - 104,773 views
- Patient Transport Service - 45,016 views
- Contact us - 22,488 views

ROUTE IN:

- Search (Google etc) - 163,534 visits
- Social media - 46,957 visits
- Direct address (typing in URL) - 40,779 visits
- Referral from other site - 5,385 visits

HIGHLIGHTS:

On NHS Thank You Day, we shared three life-saver stories and linked to these on social media. It led to **2,745** views to the website, **1,551** of which came from social media.

NEW FOR Q2:

Launch of Patient and Public Panel (PPP) only area which includes a forum for members to communicate with each other. It has been accessed **825** times since its launch.

FREEDOM OF INFORMATION (FOI)

75 FOIs completed ▲34%

96% within 20 working day target ▲1%

96% year to date on 20 working day target ▲1%

Topics included:

- Call outs to Amazon sites
- Low traffic neighbourhood issues
- Contracts (mainly IT contracts)
- Staff numbers

NOTES:

FOIs: We have a statutory duty to reply to FOIs within 20 working days. The national target is 90% for this and we set an internal stretch target of 95%. Q2 was busy with an increase in the number of FOIs completed. Despite this, performance against targets improved by 1%.

Stakeholders: this group is external audiences such as MPs, commissioners, patient groups and other healthcare professionals / partner organisations.

STAKEHOLDER COMMUNICATIONS

1 stakeholder bulletin

Covering topics including: the new series of Ambulance, the virtual AGM invitation, making services more accessible to deaf communities, link to 20/21 quality account, introducing the newly appointed partnership and integration managers.

7 MP letters

Covering topics including: trust funding, ambulance delays, resources in Southport, and wheelchair access in vehicles.

PUBLICATIONS

Meet Paramedic Nutan who talks about her career, culture and upcoming TV role.

Giving birth in a pandemic.

Making a difference to children's lives through fostering.

YOUR CALL - SUMMER EDITION

9,525 reads in Q2, from when it was issued in July.

13 articles shared across social media to increase readership.

TOP STORIES:

- Paramedic Ruth and Ambulance Care Assistant Charlie - starting a family in a same sex couple
- Who says you can't start a new career at 60? Student Paramedic Chris story
- How do you know if your career is right for you? Emergency Medical Technician (EMT) Ellis talks about having dyslexia
- HART Paramedic Hannah's Olympic dreams

REFLECTIONS

Our 2020/21 achievements publication was produced. A digital version was made available, along with 200 printed copies, and it was distributed to staff bases and shared with external stakeholders and community groups.

FILMS

18 completed ▲50%

5 underway

- PPE update: fiilm
- Patient story: Partnership with Deafway
- 2 x Team Talk Lives with the Chair, CEO and executives
- 10 x Beat The Burnout films
- NWAS AGM 2021
- Looking Back: April 2020 to March 2021 highlights
- Staff Story: Pre-employment programme Patient Transport Service to EMT apprentice
- Proud to Be – Black History Month launch film

NOTES:

Videos are filmed in-house using team skills and equipment.

An average of 6 films per month were produced in Q2, one of our busiest ever periods.

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

10 CEO bulletins **25** Clinical bulletins **30** Operational bulletins

plus 47 others, including Manchester Arena Inquiry, HR, 111, and PTS bulletins

Topics included:

- Shift enhancements
- Manchester Arena Inquiry updates
- Suicide prevention toolkit
- Manager's mental health and resilience programme
- Gaining access to care homes for PTS staff

818 staff app downloads in Q2, most used for accessing GRS and emails

INTERNAL (STAFF) ACTIVITY

Beat the Burnout programme

- Supported programme of webinars by managing 12 MS Teams live sessions and uploading recordings onto YouTube and Green Room for all staff to access.
- Promoted with bulletin articles, staff testimonials, Facebook posts, and staff app notifications.

Menopause policy

- Supported launch of policy by creating a central space for resources on the Green Room.
- Wrote a feature on Menopause Champion Marie Fisher and shared in Bulletin.

Suicide prevention toolkit

- We supported the launch of the toolkit on World Suicide Prevention Day with a dedicated HR bulletin and promotion of free training materials.
- The Green Room page for the toolkit was viewed **395** times following the September launch.

Staff surveys

- Developed and delivered communications plan to promote the 'National Quarterly Pulse Survey'.
- Developed communications plan in preparation for the annual national staff survey in Q3.
- Worked with HR to communicate results of the Zeal Health, Wellbeing and Culture Audit through sharing of short weekly screencasts to help staff understand the complexities of the report, supported with a bulletin from our Director of People and promotion in the CEO message and on the Green Room.

Star Awards

- As the Star Awards could not go ahead, trophies, certificates, prizes and copies of the nominations were arranged by the Communications Team and presented to the winners by managers.
- Each week a winner was featured in the bulletin and on social media to congratulate their success. All the winners and runners up were featured on the Green Room.

INTERNAL (STAFF) ACTIVITY continued...

Ideas Room
- Following the launch of the staff collaboration forum in Q1, the first round of ideas resulted in more than 100 suggestions from staff.
- All staff were acknowledged and thanked for their contributions.
- Ideas were shared with senior managers for consideration with feedback shared via the bulletin and Green Room.

Digital
- Informed staff of digital investment in the form of iPads and continue to support the delivery project.
- Branded the smart ID cards that will be introduced to all staff in the near future.
- Exploring opportunities to communicate key messages through digital wallboards.

Single Primary Triage
- Introduced the new triage system in an article to external stakeholders and liaised with Partnerships and Integration Team about external engagement opportunities for project leads.

Service Delivery Model Review
- Issued bulletins with progress updates and featured key managers involved in the review in 'quick fire questions' articles. Shared staff feedback from the Ideas Room with working group leads.

Long Service Awards
- Gathered content from colleagues and celebrities to celebrate significant career milestones in the form of 5 long service films, an awards programme and virtual events, and supported the delivery of Queen's Medal presentations.

FOCUS ON...Thank You week

To support staff at a time of high demand, we launched a campaign to spread positivity and kindness across the organisation. The campaign was launched to coincide with 999 Day and involved a number of tactics.

- **500** small gifts were delivered to staff selected at random with a call to action to pass on the positivity with their own act of kindness.
- This was accompanied by the launch of the COVID-19 thank you pin badges to recognise the contribution of all our staff during the pandemic. Despite some initial negativity online from a small number of staff, the badges have had an extremely positive uptake. 7,000 were initially distributed across the trust and a further 1,000 have now been requested from various teams.
- The Reflections book - created in-house to look back on the pandemic, challenges that have been overcome and achievements of our staff - was launched during thank you week and shared with staff and stakeholders both digitally and with printed copies.
- A highlights film featuring some of the achievements was shared at our Annual General Meeting and both internally and externally via social media.
- To continue the positivity beyond 'Thank you week', staff shout outs were introduced as a new feature to the weekly bulletin giving colleagues a platform to share a thank you or well done to someone within the organisation. Uptake has been very positive with regular contributions from a variety of teams and areas.

FOCUS ON...BBC Ambulance documentary

The first six episodes of BBC's Ambulance documentary, which were filmed in early 2021 at the height of the second wave and national lockdown, aired during Q2 from 12 August to 30 September 2021.

2.7 MILLION
viewers on average each week - 18% of total TV audience, and the highest rating factual documentary series that BBC 1 airs.

1,200+
messages of support on social media from the public every week, putting #Ambulance in the top 5 'trending' (most popular) topics on Twitter.

100%
of the public engagement was positive and showed how respected and valued our staff and the service are in the public eye.

We engage with our followers on social media throughout the programme, helping to educate the public on aspects they may not be aware of, for example the support services accessed by staff (mental health), the patient safety plan, medical interventions, reasons for transporting to specialists hospital, control room procedures (emergency disconnect).

We support media requests for interviews with staff members appearing on the programme and ensure partner organisations are briefed ahead of each episode.

The first four episodes featured a high number of COVID-19 cases and demonstrated the pressures the service faced and the affect the pandemic was have on our staff and the NHS as a whole. The remaining epsiodes will air in Q3.