North West Ambulance Service NHS Trust

Board of Directors Meeting to be Held in Public

Wednesday, 27 November 2019
9.45 am - 1.00 pm

Oak - North West Ambulance Service, Trust HQ

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
1.	Staff Story	09:45	Information	Director of Strategy and Planning	
INTRODUCTION					
2.	Apologies for Absence	10:00	Information	Chairman	
3.	Declarations of Interest	10:00	Decision	Chairman	
4.	Minutes of Previous Meeting held on 25th September 2019	10:00	Decision	Chairman	3 - 14
5.	Board Action Log	10:00	Assurance	Chairman	15 - 16
6.	Committee Attendance	10:00	Information	Chairman	17 - 18
7.	Register of Interest	10:00	Assurance	Chairman	19 - 20
8.	Chairman & Non-Executives' Update	10:00	Information	Chairman	
STRATEGY					
9.	Chief Executive's Report - Month 7	10:10	Assurance	Chief Executive Officer	21 - 36
10.	Northern Ambulance Alliance (NAA) Progress Report	10:20	Discussion	Chief Executive Officer	37 - 44
GOVERNANCE AND RISK MANAGEMENT					
11.	Board Assurance Framework and Corporate Risk Register - Quarter 2, 2019/20	10:30	Decision	Senior Risk and Assurance Manager	45 - 84
12.	Corporate Calendar 2020/21	10:40	Decision	Corporate Governance Manager	85 - 88
13.	Policy Update	10:45	Assurance	Corporate Governance Manager	89 - 96
14.	Freedom to Speak Up Report - Quarter 2, 2019/20	10:50	Assurance	Director of Strategy and Planning	97 - 142
QUALITY AND PERFORMANCE					
15.	Learning from Deaths Policy	11:00	Decision	Medical Director	143 - 164
16.	Integrated Performance Report - Month 7	11:10	Assurance	Director of Quality, Innovation and Improvement	165 - 222
17.	EPRR Annual Assurance 2019/20	11:40	Assurance	Director of Operations	223 - 242
18.	National Patient Safety Strategy Review	11:50	Assurance	Director of Quality, Innovation and	243 - 250

				Improvement	
19.	Quality and Performance Committee Assurance Report - from the meeting held on 21st October 2019 and 18th November 2019	12:00	Assurance	Prof A Chambers	251 - 260
20.	Audit Committee Assurance Report - from the meeting held on 18th October 2019	12:10	Assurance	Mr D Rawsthorn	261 - 266
21.	Resources Committee Assurance Report - from the meeting held on 22nd November 2019	12:20	Assurance	Mr M O'Connor	267 - 274
FINANCE					
22.	Charitable Funds Annual Report & Accounts 2018-19	12:30	Decision	Director of Finance	275 - 328
WORKFORCE					
23.	NHS Flu Update	12:40	Assurance	Interim Director of Organisational Development	329 - 338
COMMUNICATIONS					
24.	Communications Quarter 2 Update	12:50	Assurance	Director of Strategy and Planning	339 - 348
CLOSING					
25.	Any Other Business Notified Prior to the Meeting	13:00	Decision	Chair	
26.	Items for Inclusion on the BAF	12:00	Decision	Chair	

Date and Time of Next Meeting 9.45 am Wednesday, 29 January 2020 at Oak - North West Ambulance Service, Trust HQ

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.

NHS North West Ambulance Service NHS Trust

Minutes
Board of Directors

Details: Wednesday 25th September 2019, 9.45am
Ladybridge Hall, 399 Chorley New Road, Heaton, Bolton, BL1 5DD

Present:

Mr P White	Chairman
Mr G Blezard	Director of Operations
Prof A Chambers	Non-Executive Director
Mr S Desai	Director of Strategy & Planning
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Ms M Power	Director of Quality, Innovation & Improvement
Mr D Rawsthorn	Non-Executive Director
Prof R Thompson	Associate Non-Executive Director (Clinical)
Ms L Ward	Interim Director of Organisational Development
Mrs A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance

In attendance:

Mr D Ainsworth	Strategic Head of Emergency Operation Centres (observer)
Ms H Birkhead	Senior Paramedic Team Leader (observer)
Mr F Dreniw	Sector Manager (observer)
Ms A Harrison	Chief of Digital and Innovation (observer)
Ms A Hansen	Chief Nurse (observer)
Mr N Hearn	Contract Delivery Manager (observer)
Ms J Hedges	Senior Paramedic Team Leader (observer)
Ms N Hughes	Head of Finance (observer)
Ms J Lancaster	Corporate Governance Manager (Minutes)
Ms L McConnell	Assistant Director of Human Resources (observer)
Mr R Patel	SharePoint Developer (observer)
Ms C Turner	Communications Officer (part)

Minute Ref:

BM/1920/92 STAFF STORY

A film was shown to members, featuring Emma McGoldrick and Gill Hargreaves, Nurse Ambassadors from the Trust's 111 service. Emma and Gill provided detail in relation to their role and explained what was involved. They talked about their aspirations and what they would like to achieve over the coming months to raise the profile of nurses within 111.

Prof A Chambers stated it was great to hear staff ideas and questioned how staff could escalate ideas within the Trust. The Director of Quality, Innovation and

Improvement explained that work was being progressed in conjunction with the Right Care Strategy. This included (i) a model for improvement, and (ii) understanding the system. She added that an improvement team was in place to support staff, in addition to improvement collaborative that were being developed.

The Interim Director of Organisational Development welcomed the staff story and stated the input from Emma and Gill was crucial. The Chief Executive commented that he had met the team and the enthusiasm was fantastic.

Prof R Thomson welcomed the innovation approach and questioned what was being done in terms of Continued Professional Development (CPDs) for the Trust's workforce. The Interim Director of Organisational Development stated all of the relevant structures were in place for re-validation and work was being developed in terms of CPD's.

The Chairman advised that he had attended the Nursing Forum and witnessed some great work being carried out. He questioned if a framework was in place to support the nursing workforce. The Director of Quality, Innovation and Improvement explained a review of the integrated clinical team was being carried out and stated the Senior Leadership Group now consisted of the Medical Director, Chief Consultation Paramedic and Chief Nurse. However, further consideration was required to extend this team and stated the Trust did not employ a midwife. Members were advised that further discussions would be held at the Executive Leadership Committee.

The Board:

- Noted the staff story.

The Communications Officer exited the meeting at this point.

BM/1920/93 APOLOGIES FOR ABSENCE

Apologies for absence were submitted from Mr M Forrest, Deputy Chief Executive, Mr R Groome, Non-Executive Director, Mr M O'Connor, Non-Executive Director and Ms C Wade, Associate Non-Executive Director.

At this point in the meeting, introductions were made.

BM/1920/94 DECLARATIONS OF INTEREST

Dr C Grant declared an interest, in relation to his role as a Governing Body Member at West Cheshire CCG. It was agreed that a decision would be made in terms of any appropriate action to be taken, if the declaration resulted in a conflict in relation to agenda items at the point they were discussed.

BM/1920/95 MINUTES OF PREVIOUS MEETING HELD ON 31st JULY 2019

The minutes of the previous meeting held on 31st July 2019 were presented to members for approval.

The Board:

- Approved the minutes from the meeting held on the 31st July 2019.

BM/1920/96 ACTION LOG

The action log was reviewed and updated accordingly.

The Board:

- Noted the updated.

BM/1920/97 COMMITTEE ATTENDANCE

Members were presented with a copy of the committee attendance, for information.

The Board:

- Noted the committee attendance.

BM/1920/98 REGISTER OF INTEREST

Members were presented with a copy of the 2019/20 register of interest, for information.

It was noted that a declaration from Prof R Thompson and a revised declaration from the Chief Executive had been received and were in the process of being added to the register.

The Board:

- Noted the register of interest,
- With the proviso of the above amendments, agreed the register was up to date.

BM/1920/99 CHAIRMAN AND NON-EXECUTIVES DIRECTORS UPDATE

The Chairman advised he had recently met with a number of key partner including Donna Hall, Chair of the Bolton NHS Foundation Trust, Andy Burnham, Greater Manchester Mayor and Joe Anderson, Liverpool Mayor.

Reference was made to the Patient and Public Panel that was held on the 4th September 2019 and the Chairman thanked the team that was involved in the development of the Panel.

The Chairman advised members that he had been involved in the evaluation of the bids received for the Trust's well-led review. It was noted that a decision in relation to the provider would be made at the Executive Leadership Committee being held on 2nd October 2019.

It was noted that a number of public engagement events were being held across the North West and Non-Executive Directors had been in attendance. The Director of Strategy and Planning advised that over 250 people had attended events, to date.

The Board:

- Noted the update.

BM/1920/100 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented a report to provide members with information on a number of areas since the last report to the Trust Board on 31st July 2019. The report covered (i) performance, (ii) issues to note, and (iii) external/internal engagements.

The Chief Executive advised members of engagement he carried out with staff and stated the feedback he had received to date was overwhelmingly positive.

Members were advised that the report from the National Guardians Office following their case review visit was published on 12th September 2019. It was noted that the action plan would be presented to Board at its meeting in November 2019.

The Chief Executive commented that the Trust had been awarded the cyber essentials certification from the National Cyber Security Centre and expressed his thanks to the team for their hard work.

It was noted that a detailed performance update would be presented within the integrated performance report. Mr D Rawsthorn commented on C2 and C3 performance during August 2019 and questioned the adverse shift. The Director of Operations explained that there had been a shift in the acuity of patients and a rise in C2 patients resulted in less resources to respond to C3 patients. In addition, there had been an increase in C2 calls via the 111 service.

The Board:

- Received and noted the contents of the report.

BM/1920/101 INTEGRATED PERFORMANCE REPORT

The Director of Quality, Innovation and Improvement presented a report to provide members with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of August 2019.

The Director of Quality, Innovation and Improvement advised members that the executive team would review the data and provide the relevant narrative pertinent to their area. She added that in line with the new NHS Oversight Framework, the Trusts improvement plan for the IPR for the short, medium and long term had been included at appendix 1 of the report.

The Director of Quality, Innovation and Improvement referred to complaints and stated the number continued to reduce, as did the backlog.

The Director of Strategy and Planning advised members that the friends and family test (FFT) saw an increase in Patient Emergency Services returns during August 2019 from 67 to 89 in addition to a satisfaction rating from 77.6% to 86.5%. It was noted that the Patient Transport Service had saw an increase whilst the 111 service had saw a reduction. Members were informed that a proposal in relation to the FFT would be presented to a future meeting of the Executive Leadership Committee, as a result of revised guidance. However, concern was expressed that the guidance would not work within an ambulance trust.

Prof R Thomson commented on the use of mean as a marker against national markers and expressed concern that this did not provide a true reflection of the meaning of the data. The Director of Quality, Innovation and Improvement referred members to chart O1.3 and advised it showed the distribution of intelligence. She offered to meet with Prof R Thomson outside of the meeting to discuss how the data was presented.

In terms of the executive summary, Mr D Rawsthorn questioned if the trajectory within the ARP performance was the target and the Director of Quality,

Innovation and Improvement confirmed that this was the case.

The Medical Director referred to performance in relation to the rates of the Return of Spontaneous Circulation (ROSC) and stated in terms of performance, the Trust had been ranked first nationally. However, performance required improvement in relation to survival to discharge and partnership working with the wider system was required.

In terms of Hear and Treat (H&T) and See and Treat (S&T), Prof R Thomson made reference to the lack of AVS provision in areas and the Medical Director explained that long standing local arrangements were in place that determined AVS provision. He added that activity had increased and therefore was a challenge for primary care. He explained that as the primary care system came together in Primary Care Networks, there would not be less chance of postcode lottery system of provision.

The Director of Finance presented a report detailing the Trust's financial position to 31st August 2019. Members were advised that the position for the Trust at month 5 was a surplus of £0.546m, which was £0.054m better than the planned surplus of £0.492m. It was noted that income was over recovered by £1.393m, pay was overspent by £1.244m and non-pay was overspent by £0.095m.

In terms of the overspend of pay, it was commented that the additional income recovery, for example from unplanned events, would offset against this over pay.

A discussion ensued in relation to the level of finance data contained with the IPR and members felt this was sufficient, given the current financial position. It was added that the Resources Committee received detailed reports in relation to finance.

The Chairman commented on 111 performance and acknowledged this had deteriorated as a result of no longer utilising conduit to provide support. The Director of Finance explained the use of Conduit ceased due to the overspend within 111. It was noted that the decision had been made in conjunction with Commissioners, with the understanding that performance would likely decrease. The Director of Finance advised members that if the contract with Conduit had not ceased, the Trust would have a financial risk in terms of meeting the control total.

The Director of Operations provided an update in relation to performance. It was noted that in August 2019, Call Pick Up (CPU) performance was at 87.5%, which was an improvement.

The Director of Operations advised members that the biggest performance challenge related to C2. It was noted that throughout August 2019, performance had been affected by (i) extreme hot weather, (ii) national Adastra failure, leading to 999 demand as the 111 service was down, and (iii) a 1.1% above planned activity. However, it was noted that the general trend in terms of performance was improving.

Dr D Hanley commented on the roster changes and questioned if work was being carried out to the agreed timescale. The Director of Operations commented that the roster review was key in terms of improving C2 – C4 performance. It was noted that the Greater Manchester roster patterns would be implemented week commencing 24th January 2020. It was envisaged that roster patterns would be implemented in Cumbria and Lancashire in May 2020 and Cheshire and Merseyside three weeks later. It was noted that negotiation's were ongoing with staff side in relation to Cheshire and Merseyside rosters.

The Chairman commented on performance measures in terms of pathways and AMPDS and the Director of Operations explained that in terms of AMPDS users, the Trust was of the better performing Trusts. He added that in the long term, it was the aim to have 999 and 111 on one platform.

An update was provided in relation to 111 performance and it was noted that the ORH review had concluded that performance would likely be at 76% with the current funding. In terms of performance in relation to call back in 10 minutes, it was noted that work was being carried out to gather data to determine how efficiencies could be made. Findings would be reported to the meeting of the Quality and Performance Committee being held in November 2019.

The Medical Director commented that support in terms of resources was required to the Director of Operations, in order to improve performance.

The Director of Finance provided an update in relation to Patient Transport Service (PTS) performance and advised members that the reporting period is from July to June, as the original contact was signed in July.

It was noted that unplanned activity was the main challenge within PTS and ongoing work was being carried out with acute trusts. It was noted that Commissioners were supporting this. Members were advised that a recent meeting had been held with third party providers and service expectations were discussed. In terms of discharges from acute trusts, Prof R Thomson questioned if this was monitored and any themes identified. The Director of Finance confirmed this was the case and explained targeted work was being carried out.

The Interim Director of Organisational Development presented workforce data and explained most of the indicators were being achieved. Reference was made to the continued improvements in relation to turnover and it was noted this was a testament to the hard work that had been carried out.

An update was provided in relation to sickness and the Interim Director of Organisational Development explained there had been an increasing trend over the past four months. It was noted that there was a particular issue within 111 and as a result a detailed plan was in place to reduce sickness, in addition to more HR resource within the service.

The Interim Director of Organisational Development explained that work was being carried out with the Northern Ambulance Alliance and NHS Improvement in terms of health and wellbeing and attendance. It was noted that the North experienced higher levels of sickness compared to the South.

Prof A Chambers commented on the correlation between sickness and performance within the 111 service and questioned if plans had been put into place to improve this in the short term. The Interim Director of Organisational Development advised a deep dive would be carried out within 111 and would cover a combination of issues including reasons why staff were absent and a review of systems i.e. ESR data. It was noted that 111 had developed a database to record data and it was not as robust as it could be in terms of identifying trends. She added that a different approach was required to manage sickness for example (i) early intervention, (ii) rota patterns, (iii) approval of annual leave. In addition, a strategic approach was required in terms of leadership, recruitment and retention.

The Chairman referred to the report that had been presented and acknowledged the improvements that had been made.

The Board:

- Noted and took assurance from the update.

BM/1920/102 STRATEGIC WINTER PLAN

The Director of Operations presented the Trust's Strategic Winter Plan for members information and to provide assurance in terms of the levels of preparedness for the anticipated winter pressures.

Members were advised that following winter 2018, a national and Trust de-brief had been held and learning had been incorporated into the 2019 plan.

The Director of Operations explained that the annual winter letter had not yet been received. It was noted that upon receipt of the letter, the winter plan would be reviewed.

It was envisaged that flu would be on the increase during 2019/20 and therefore in anticipation plans had been put in place. It was noted that the Board of Directors should support and be an advocate for promoting vaccinations amongst staff.

The Board:

- Noted and took assurance from the update.

BM/1920/103 SUSTAINABLE DEVELOPMENT MANAGEMENT PLAN

The Director of Finance presented the Sustainable Development Management Plan (SDMP) for member's approval. It was noted that the plan had been presented to and supported by the Executive Leadership Committee and Resources Committee.

Members were advised that the method of assessment had changed to the Sustainable Development Assessment Tool. In terms of monitoring performance against the plan, a Sustainability Steering Group had been established and would report in to the Resources Committee.

The Director of Finance informed members that the plan included the ambitious targets from the NHS Long Term Plan that included (i) 51% reduction in carbon by 2025, (ii) net zero carbon by 2050, (iii) cut business mileages and fleet air pollutant emissions by 20% by 2023/24, (iv) ensuring that at least 90% of the NHS fleet utilised low emissions engines by 2028, and (v) phasing out primary heating from coal and oil fuel in NHS sites (it was noted the Trust had already achieved this target).

It was noted that over the past three years, the Trust had achieved an excellence award in terms of the work being carried out in relation to sustainability. In addition, the Trust was performing in the top quartile.

Mr D Rawsthorn commented that a detailed update had been presented to the Resources Committee and were advised that 30 electric RRV's would be in operation. In addition, policies in relation to new lease cars and pool vehicles were being reviewed to promote a more economic fleet.

Prof R Thomson sought assurance that work was progressing in relation to sustainability across the estate and the Director of Finance assured members that work was progressing. An example was provided in relation solar sites and efficiencies that were built into contracts.

The Board:

- Approved the Sustainable Development Management Plan.

BM/1920/104 QUALITY AND PERFORMANCE COMMITTEE ASSURANCE REPORT

Dr D Hanley provided a verbal update from the meeting of the Quality and Performance Committee held on 16th September 2019.

Members were advised that a CQC update had been provided and a risk highlighted in relation to 'vehicle check books'. It was noted that a solution was being piloted in October and work was ongoing to prepare for the anticipated inspection.

It was noted that a host of reports was presented to provide assurance in relation to delivery of objectives set out in Right Care Strategy. (i) Complaints – had reduced year to date compared to last year, of which the majority related to PTS and therefore work was ongoing to manage patient expectations. (ii) Health and Safety – positive assurance was provided to members and it was noted that RIDDORs and moving and handling injuries had reduced, site and vehicle inspections were ongoing and competency framework training was ready to be delivered. (iii) Medicines Management – limited assurance was provided. It was noted that work was being carried out in relation to CD5 and the Chief Pharmacist was now in post. (iv) Serious Incidents – decrease in incidents and back log now closed. (v) Safeguarding - Level 1 and 2 training target not achieved in PES and PTS. Level 3 was 8% behind trajectory. (vi) IPC – performance was improving but highlighted work was required to change culture. Members of the committee had requested further reports alluded to this.

Dr D Hanley advised that in terms of the Q1 Clinical Audit Progress Report the server in which the reporting tool was situated had been switched off and as a result, Clinical Performance Indicators reporting had been switched off and therefore reporting suspended. It was noted that this would be picked up via the Audit Committee.

The committee received an update in relation to the National Patient Safety Strategy, highlighting how the Trust would be implementing the strategy.

It was noted that a report had been presented in relation to sector level quality visits and a low number of visits completed in some areas. Members had advised that that some visits needed to be accelerated asap i.e. meds management.

In terms of performance, the committee had noted that during August 2019, five of the standards were not being achieved. Members were advised that activity had increased and the APAS scheme had been switched off.

Dr D Hanley advised that a report had been presented in relation to Body Worn Cameras and the committee had expressed support for the pilot.

An update was presented in relation to the Urgent and Emergency Care Strategy Implementation Plan and it was noted that in Q1 the implementation plan was developed and Q2 was focused on putting the right resources in place to deliver the strategy.

The committee noted that the mental health strategic improvement plan had been developed and would be launched on the 10th October.

The Board:

- Noted and took assurance from the update.

BM/1920/105 RESOURCES COMMITTEE ASSURANCE REPORT

Mr D Rawsthorn provided a verbal update from the meeting of the Resources Committee held on 23rd September 2019.

Members were advised that a number of work streams were discussed, prior to presentation to the Board for approval and included (i) UCP red box recorders, (ii) software and licenses, (iii) Equality, diversity and inclusion report and (iv) Sustainable Development Management plan.

Mr D Rawsthorn advised that the agenda had been arranged in conjunction with the risks listed on the Board Assurance Framework, pertinent to the Resources Committee and this had been helpful.

It was noted that in terms of risk SR07 (digital), work was being carried out to reduce this risk.

The Board:

- Noted and took assurance from the report.

BM/1920/106 EQUALITY, DIVERSITY AND INCLUSION REPORT

The Interim Director of Organisational Development presented a report to provide a brief summary update on work relating to the workforce gender, race and disability priorities. Members were asked to approve the (i) publication of gender pay gap data and actions, (ii) publication of Workforce Race Equality Standard (WRES) data and action plan, and (iii) publication of Workforce Disability Equality Standard (WDES) data and action plan.

Members were presented with the gender pay gap information and were advised that work would continue to narrow the gap.

In terms of the WRES, the Interim Director of Organisational Development explained that positive improvements had been made and the Trust had continued to make progress across all metrics, except the disciplinary (albeit small numbers) and training metrics, due to an under representation of BME staff. It was noted that the CQC 'Should Do' action could now be closed.

With regards to recruitment, it was noted that the process was non-discriminatory according to WRES and WDES data.

The Interim Director of Organisational Development made reference to the reporting of disabilities amongst staff and the disparity between ESR reporting and the staff survey results. Members were advised that further work was required to understand this.

It was noted that Equality and Diversity would be covered in detail at the Board Development session being held in December 2019.

Dr D Hanley commented on the actions that had been listed in terms of female career progression and welcomed this. However, he stated a similar approach had not been taken to progress the WRES. The Interim Director of Organisational Development stated the BME process was in relation to representation and a key challenge was in relation to the graduate intake. As a result, the Trust was working with higher education colleagues. The Chairman stated that the Trust needed to think how it could influence partners.

The Chairman suggested that consideration be given to executives championing the different strands of diversity. He thanked the Interim Director of Organisational Development for all of the hard work that had been carried out.

The Board:

- Noted and took assurance from the report,
- Approve the (i) publication of gender pay gap data and actions, (ii) publication of WRES data and action plan, and (iii) publication of WDES data and action plan.

BM/1920/106 BOARD DEVELOPMENT UPDATE

The Interim Director of Organisational Development presented a report to seek approval for the updated Board Development Framework and to provide insight and assurance in relation to the established plan surrounding Board Development and delivery to date.

Members were advised that the continued professional development (CPD) element had been refreshed and aligned to the Care Quality Commission element. It was noted that finance would also be factored into the framework.

Mr D Rawsthorn referred to the online mandatory training and stated it was accessible.

The Chairman welcomed the document and supported board development. The Director of Corporate Affairs advised the skills matrix would be populated and presented to the Board of Directors meeting being held in November.

The Board:

- Approved the CPD Board Development Framework scheduled between 2018-2021, and
- Committed to their own personal and professional development by completing all statutory and mandatory training required and engaging in the CPD programme.

BM/1920/107 ANY OTHER BUSINESS

There were no items of any other business.

BM/1920/108 ITEMS FOR INCLUSION ON THE BOARD ASSURANCE FRAMEWORK

No additional items were identified, to be included on the Board Assurance Framework.

BM/1920/109 DATE, TIME AND VENUE OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 27th November 2019 at Ladybridge Hall, Bolton. BL1 5DD.

Signed: _____

Date: _____

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Status:	
Complete & for removal	
In progress	
Overdue	

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
27	31/07/19	1920/54	Board Story	The Director of Strategy and Planning to feedback to the frequent caller team, the suggestion to liaise with patients with certain health conditions about the possibility of carrying a health plan to assist paramedics.	SD	25.09.19	25.09.19	It was noted that' at home' patients, liaison could be made with patients regarding a care plan. However, this would not be possible for patients with no fixed address.	
28	31/07/19	1920/65	Integrated Business Plan	An Equality Impact Assessment to be carried out in relation to the Integrated Business Plan.	SD	25.09.19	25.09.19		
29	31/07/19	1920/65	Integrated Business Plan	Consideration be given to the membership if the Corporate Programme Board and inclusion of a NED member.	AW/SD	25.11.19	25.11.19	DM/AW agreed to review following the inaugural meeting in November.	
32	31/07/19	1920/67	Fleet Strategy 2019/2024	Further work be carried out in relation to the Equality Impact Assessment.	CW	25.09.19	31.10.19	It was noted that best practice was being sought due to the complexity of an EIA being required for the strategy and business cases.	
36	31/07/19	1920/83	Draft 2018/19 Quality Account	Amends be made to the complaints and performance sections.	MP	02.08.19	02.08.19	The 2018/19 Quality Account is now published.	
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Board and Committee Attendance

Board of Directors																
	24th April		24th May	29th May		31st July		25th September		27th November		29th January		25th March	
	Part 1	Part 2	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Peter White	✔	✔	☒	✔	✔	✔	✔	✔	✔						
Richard Groome	✔	✔	✔	✔	✔	✔	✔	☒	☒						
Michael O'Connor	✔	✔	✔	✔	✔	✔	✔	☒	☒						
Maria Ahmed	✔	✔	☒	☒	☒	☒	☒								
David Hanley				✔	✔	✔	✔	✔	✔						
David Rawsthorn	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Daren Mochrie	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Mick Forrest	✔	✔	✔	✔	✔	✔	✔	☒	☒						
Ged Blezard	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Angela Wetton	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Salman Desai	✔	✔	☒	✔	✔	✔	✔	✔	✔						
Maxine Power	✔	✔	☒	✔	✔	✔	✔	✔	✔						
Lisa Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔						
Alison Chambers								✔	✔						
Rod Thomson								✔	✔						
Clare Wade						✔	✔	☒	☒						

Audit Committee					
	18th April	24th May	19th July	18th October	17th January
David Rawsthorn	✔	✔	✔	✔	
Richard Groome	✔	✔			
Michael O'Connor		✔	✔	✔	
Rod Thomson				✔	
David Hanley			✔	☒	

FIPC	Resources Committee					
	20th May	26th July	23rd September	22nd November	24th January	20th March
Michael O'Connor	✔	✔	☒	✔		
David Rawsthorn	✔	✔	✔	✔		
Richard Groome		☒	☒	✔		
Carolyn Wood	✔	Michelle Brooks	✔	✔		
Ged Blezard	✔	✔	✔	☒		
Maxine Power	✔	✔	☒	✔		
Salman Desai	✔	✔	☒	✔		
Lisa Ward	✔	✔	✔	✔		
Clare Wade		✔	✔	✔		

Quality Committee				Quality and Performance Committee						
	8th April	13th May	17th June	15th July	16th September	21st October	18th November	20th January	17th February	16th March
Maria Ahmed	✔	✔	☒	✔						
Richard Groome	☒	✔	✔	✔	✔	✔	✔			
Peter White	✔			✔ (observing)	✔ (observing)					
David Rawsthorn	✔	✔								
Maxine Power	✔	✔	✔	✔	✔	✔	☒			
Ged Blezard	✔	✔	✔	✔	✔	✔	✔			
Chris Grant	☒	✔	✔	☒	✔	✔	✔			
Michael Forrest			✔	✔	☒	✔	☒			
David Hanley			✔	✔	✔	✔	✔			
Rod Thomson					✔	✔	✔			
Alison Chambers					✔	✔	✔			
Carolyn Wood	✔	✔	✔	✔	✔	☒	✔			

Performance Committee	
	21st May
Peter White	Cancelled
Richard Groome	
Carolyn Wood	
Ged Blezard	
Lisa Ward	

Workforce Committee	
	23rd April
Peter White	✔
Richard Groome	✔
Carolyn Wood	✔
Ged Blezard	✔
Lisa Ward	✔

Charitable Funds Committee		
	24th April	30th October
David Rawsthorn	Cancelled	✔
David Hanley		✔
Richard Groome		✔
Angela Wetton		✔
Ged Blezard		✔
Salman Desai		✔
Carolyn Wood		✔
Lisa Ward		✔

Nomination & Remuneration Committee								
	24th April	11th June	31st July	25th September	30th October	27th November	29th January	25th March
Peter White	Cancelled	✔	✔	✔	✔			
Richard Groome		✔	✔	☒	✔			
Michael O'Connor		☒	✔	☒	☒			
David Hanley		☒	✔	✔	✔			
Rod Thomson				✔	✔			
Alison Chambers				☒	✔			
Clare Wade				☒	☒			
David Rawsthorn		✔	✔	✔	✔			
Angela Wetton		✔	✔	✔	☒			
Maria Ahmed		☒						

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

North West Ambulance Service NHS Trust

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	Indirect Interests		Apr-19	Mar-20	
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 ifs required with a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	Husband is a very senior NHS Manager				√	Other Interest	Aug-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
Michael	Forrest	Deputy Chief Executive	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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
			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	Present	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the Royal College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care		√			Position of Authority	Apr-19	Present	N/A
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Aintree University Hospital 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
			Secondary Care Governing Body Member - NHS West Cheshire Clinical Commissioning Group		√			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
Michael	O'Connor	Non-Executive Director	Partner in Addleshaw Goddard LLP	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Trustee of Central Manchester Concert Hall Ltd (Bridgewater Hall) (Charity)				√	Position of Authority	Apr-19	Present	N/A
			Director Trustee of Factory Youth Zone (Harpurhey) Ltd				√	Position of Authority	Apr-19	Present	N/A
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.
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
			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
Clare	Wade	Associate Non-Executive Director (Digital)	Head of Patient Safety, Roysl College of Physicians	√				Position of Authority	Jul-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	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director – Riverside Housing	√				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	Husband is Operations Director of The Senator Group who supply the NHS, amongst many others, with office and hospital furniture.				√	Other Interest	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Fnance	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 Hospotals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
Past members											
Maria	Ahmed	Non-Executive Director	Principal GP – Manchester Medical	√				Connection with organisation contracting for NHS Services	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			CQC Specialist Advisor – Primary Care	√				Position of Authority	Apr-19	Jul-19	N/A

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North West Ambulance Service NHS Trust

REPORT

AGENDA ITEM:

Board of Directors	
Date:	27 November 2019
Subject:	Chief Executive's Report
Presented by:	Daren Mochrie, Chief Executive
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of this report is to provide members with information on a number of areas since the last Chief Executive's report to the Trust Board on 25 September 2019. The highlights from this report are as follows: **Performance** • October saw an increase in calls and incidents, despite this we continued to improve in call pick up, H&T, S&T and C1 performance • Less patients were transported to hospital • The APAS scheme has been reinstated in Greater Manchester to help in the management of C3/C4 patients for GM and the wider region. A similar scheme is being discussed for the Merseyside area. • 111 performance remains below trajectory but within modelled demand parameters. Issues with staffing due to sickness and training are also impacting on performance at times. PTS activity YTD is 1% above contract baseline • A separate PTS Winter Plan for 2019-20 has been developed **Issues to note** • The Chief Executive attended a number of engagement events with local and regional stakeholders and staff. • The trust's Strategy and Integrated Business Plan was launched on Tuesday 22 October • The Senior Leadership Group was established to support the Executive Leadership Committee • The trust has moved from Resource Escalation Action Plan (REAP) level 2 (moderate pressure) to level 3 (major pressure). • The Trust was inspected by Ofsted who monitor all newly directly funded providers of apprenticeships.

Recommendations, decisions or actions sought:	Receive and note the contents of the report.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**
☒	☐	☒	☒	☐	☒	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

1.1 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 25 September 2019

2. PERFORMANCE

2.1 **999**

Date	Oct-18	Oct-19	Standard	Impact	
Calls	131,889	137,095		5,206	↑
Incidents	96,042	98,903		2,861	↑
CPU	78.26%	83.91%	95.00%	5.65%	↑
H&T	6,563	7,249		686	↑
	6.83%	7.33%		0.50%	↑
S&T	23,563	26,862		3,299	↑
	24.53%	27.16%		2.63%	↑
C1 Mean	00:08:01	00:07:30	00:07:00	00:00:31	↓
C1 90th	00:13:21	00:12:43	00:15:00	00:00:38	↓
C2 Mean	00:24:39	00:26:17	00:18:00	00:01:38	↑
C2 90th	00:52:44	00:55:56	00:40:00	00:03:12	↑
C3 Mean	01:17:57	01:29:18	01:00:00		
C3 90th	03:05:39	03:33:06	02:00:00	00:27:27	↑
C4 90th	03:19:13	03:23:07	03:00:00	00:03:54	↑
Hospital Attendances - All	66,646	65,508		1,138	↓
				1.74%	
Hospital Handover	00:32:41	00:32:33	00:30:00	00:00:08	↓

October saw an increase in calls and incidents, despite this we continued to improve in call pick up, H&T, S&T and C1 performance. Performance deteriorated in C2 to C4. This is being investigated, early indications point to an increase in patient acuity. There has been a significant rise in C1 calls by 23%. C1 calls have the highest response ratio and therefore we have a higher vehicles depletion. Upon further investigation a significant rise in respiratory, chest pain and unconscious codes have been witnessed. These changes are similar to that of other Ambulance Trusts. Notwithstanding the change in acuity we transported less patients to hospital.

To help manage the current operational pressures the Trust moved to REAP level 3.

A lot of focus has taken place in October to ensure the restoration of the Greater Manchester APAS scheme. The scheme was withdrawn earlier in the year but following evaluation and discussion it has been re-instated with a wider catchment area. This will help in the management of C3 and C4 patients not just for Greater Manchester but for the wider region too. A similar scheme is being discussed for the Merseyside area.

111

NWAS 111 has continued to experience performance pressures through September and October 2019. The ongoing performance shortfall is primarily due to staffing shortages through sickness, ongoing recruitment and training (Pathways v18), this has been further compounded at times by a number of digital failures. Despite being below trajectory demand modelling suggest performance is broadly in line with demand.

Metric	NWAS	National
Calls Answered within 60 seconds % (Target 95%)		
September 2019	73.3%	82.2%
October 2019	70.6%	
YTD		
Calls Abandoned % (Target <5%)		
September 2019	7.4%	3.5%
October 2019	9.7%	
YTD		

A number of actions have been commenced to improve performance including:

- Managers HR Masterclasses have commenced to augment management of absence
- RCA review of the IT events over the past 3 months to identify trends and system issues
- Review of predicted activity forecasts; recent 4.5% increase in demand – early winter pressures or aligned to NHS E advertising campaign
- Further recruitment of all front-facing roles – 111 will be over-established against contract value over winter
- Increased management cover at Estuary Point

PTS

Activity

Overall activity during October was 7% (8759 journeys) above contract baseline whilst the cumulative position is 1% (4986 Journeys) above baseline. Lancashire activity was 3% below baseline whilst Cumbria, Greater Manchester and Merseyside were 4%, 12% and 19% above baseline respectively. There were 23 working days in October which is more than most months (usually 21 or 22) and this will go some way to accounting for the in-month increase in activity. In terms of overall activity trends since contract commencement (July 2016) Lancashire has experienced a downward trend for the initial 18 months period however activity levels have stabilised. Conversely Greater Manchester experienced a similar increase in activity for the initial 18 month period July 2016 to around October 2018 when it plateaued. Cumbria and Merseyside are both showing little overall movement.

In terms of Unplanned activity, cumulative positions within Greater Manchester and Merseyside are 29% and 9% above baseline respectively. Weekday activity (that booked after 6pm) in Greater Manchester is 121% above plan. Cumbria and Lancashire are 19% and 11% below baseline. Within Lancashire, weekend activity is 102% above plan, evidencing a shift of activity across their 7 day Unplanned Specification.

The relevance of this information is that typically, Unplanned activity is higher acuity than planned and consists mainly of discharges which take longer to accommodate and puts pressure on available ambulance capacity and impacts on all aspects of contract performance.

Winter

In a change from previous years, when PTS contributed to area based tactical winter plans, a PTS Winter Plan for 2019-20 has been developed and shared with the Director of Operations. PTS' role both internally and across the wider healthcare system is summarised as follows:

Working with Clinical Commissioning Groups (CCGs) PTS distributes health promotion and prevention information to patients that support decision making and independence within its patient group. By supporting patients in this way it can help prevent potential 999 calls and unnecessary attendances at treatment centres. Messages are defined by CCGs and include awareness of local, alternative services such as Urgent Treatment Centres or 111, local schemes or services that support health prevention (falls prevention/isolation, for example) and include national messaging provided via Public Health England. Whilst PTS distributes information all year round, winter based campaigns such as Flu Vaccination and Stay Well This Winter messages are provided to patients during this critical period. Additionally, PTS crews are able to access clinical advice and support from the Trust's Clinical Hub, supporting the identification of risk factors to patients or in their homes. This scheme has supported patients who may be at risk of falls, isolation and fire, accessing alternative support to help prevent the need to access acute services, had they not be addressed.

During the NHS-defined Winter period PTS will suspend the application of eligibility criteria on all Unplanned bookings (those booked on the day). This will remove any barriers faced at the hospitals in terms of booking and is aimed to support the system with patient flow.

Additional Resources - within this year's CQUIN arrangements PTS will ensure the provision of additional resources from November 2019 through February 2020 – PTS has mapped key dates throughout this period by analysing historical demand, by county to ensure that additional resources are targeted at the time and place they are most needed. Furthermore, PTS has also accessed additional resources in support of low acuity journeys managed within the PES/UC system. An integrated process to ensure maximum utilisation of resources has been created between PTS control and the Trust's Clinical Hub.

PTS is heavily engaged within the wider healthcare system, ensuring it is sensitive to system surge and so that it supports flow through a range of methods. Intraday working relationships between control rooms and hospital flow teams are augmented with robust escalation routes, tri-partite meetings and through representation at AE Delivery Boards, their sub groups and other senior forums. A shared, pragmatic working methodology is supported all year round through these routes but adds significant value during the winter period.

In addition to the PTS winter plan the Trust has an overarching winter plan which has been tested locally both internally and with external stakeholders.

3 ISSUES TO NOTE

3.1 Local Issues

Engagement with local stakeholders and staff

Our first Patient and Public Panel members

We now have our very first cohort of patient and public panel members following a recent successful induction event held at Ladybridge Hall. This means we have people from communities across the North West who are able to contribute their ideas to improve the patient experience and help shape our services. Involvement is broadly available in three main ways; providing feedback and opinions via email or online,

working together on specific issues to discuss and agree outputs in a face to face setting or attending trust committees and meetings to provide the patient perspective. We currently have 31 individuals able to provide a total of 51 involvement opportunities across the Trust.

3.2 **Regional Issues**

Engagement with regional stakeholders and staff

Rossendale CFR Team

I recently met with Chris Hyde to discuss some really positive work that has been piloted with the CFR Team in Rossendale's falls project. The falls project involves a group of CFRs within Rossendale who have been trained by NWAS to attend patients who have fallen and are uninjured but unable to get off the floor, with the aim of reducing the number of ambulance attendances. The team have been trained in the use of the Razor chair and they work in collaboration with the Urgent Care Desk and Falls Car in the area between the hours of 0800-1800. The longer a patient is left on the floor, the more at risk they become of having to attend hospital. The pilot is for 6 months and is a great example of the many benefits we receive from working with our CFR volunteers.

20 Year Community First Responder Event

The event recognised the 20 years of community first responders and the invaluable work they carry out to assist us on a daily basis across the North West. I was interested to hear about how the UK CFR movement originated in the North West and has evolved to become this vital part of our service, not just here but throughout the country. There is no doubt that hundreds, if not thousands of people in our region have enjoyed a full recovery and are still with their families and friends thanks to the early intervention of the CFRs.

I have heard from many of our volunteers that they thoroughly enjoyed the celebration event at the Castle Green Hotel in Kendal and the chance to come together to recognise such a great achievement. It was great that the Secretary of State for Health & Social Care, Matt Hancock, was able to send a short video message to thank our CFR's and NWAS on behalf of the Government. My thanks to all our CFRs, they demonstrate a remarkable commitment and on behalf of the trust I am truly grateful.

Cheshire and Merseyside Long Service Awards

Chairman, Peter White and I had the pleasure of attending and presenting the Cheshire and Merseyside Long Service Awards together with Mark Blundell, the Lord Lieutenant of Merseyside, at the Formby Hall Golf Resort and Spa. I was very impressed by the commitment to the service of so many colleagues who have dedicated 20, 25, 30, 35 and even 40 years to NWAS as well as those receiving the Queen's Long Service and Good Conduct Award.

We had the honour of presenting the Donna Marie Stapleton-Vaughan Award to Angela Harrison-Fothergill in recognition of her outstanding achievement to the aims and mission of the trust. The award is a tribute to Donna who sadly died in service in 2011.

Cumbria and Lancashire Long Service Awards

We also had the pleasure of joining many of our incredible Cumbria and Lancashire staff together with Matt House, Interim Head of Service for C&L at their annual Long Service Awards. The awards ceremony was also held at Castle Green Hotel and recognised colleagues who have given between 20 and 40 years' service to the trust. This year we celebrated a grand total of 1,765 years! We were joined by Lord Shuttleworth, Lord Lieutenant of Lancashire, who presented five colleagues with the Queens Long Service and Good Conduct Medals.

A special congratulations to Nicola Miles, PA to Head of Service for Cumbria & Lancashire who was awarded the Laura Bolton Award for Outstanding Service. This award is presented in recognition of outstanding achievements to the aims and mission of the trust – a thoroughly deserved award for Nicola. A huge well done to all those who received an award and thank you to everyone involved in organising a fantastic celebration.

Merseyside community engagement and involvement event

Approximately 80 people attended the Southport Theatre and Convention Centre to find out more about the ambulance service, give their views, experiences and expectations and ask questions. Attendees came from a wide range of community groups including representatives from different cultures, health conditions and included both younger and more mature members of the community.

Nathan Hearn, Gene Quinn and Sarah Rosamond representing PTS, PES and NHS 111 delivered three rapid talks on their service areas and answered questions from the audience together with some of our GM 'Ambulance' stars, Justin Verity, Elly Hollinghurst, Graham Lawrenson and Ellis Neill who did a great job welcoming people as they arrived. Interactive table top exercises were delivered by over a dozen facilitators and the event was hosted by Salman Desai, Director of Strategy and Planning, and co-ordinated by the communications and engagement team. Our Chairman was also present and able to meet and chat to attendees.

Feedback from both this and the previous event held in Greater Manchester has been very positive and learnings from each event is being applied; next we will be meeting the communities of Cumbria at The Oval in Workington.

One of the areas we are hoping to take forward from initial feedback is the development of basic sign language training to enable our staff to be able to share simple exchanges with patients who are deaf.

East Lancashire SPTL Development Day

I recently attended a very positive session with around 20 SPTLs and managers from the East Lancashire sector in Blackburn. We discussed a wide range of topics including the roster review and its implications on staff working practices, the importance of some of the basics like how we wear our uniform and comply with dress code policy, which says a lot about individuals as well as influencing the image and professional reputation of the trust. We also talked about mentoring for student paramedics and our aspirations for an NWAS Academy for education and learning as well as my experiences in the Scottish and South East Coast Ambulance services and how they compare to NWAS. My thanks to Matt Dunn, Consultant Paramedic for inviting me to the development day session

Therapy Dogs visit Estuary Point

Following on from a previous Board report I was delighted to note the attendance of 3 therapy dogs at Estuary Point recently. The trust is committed to improving the mental health of staff through the support of initiatives like this. Spartacus, a golden retriever and 2 miniature schnauzers initially visited EOC colleagues as well as holding an 'open house' session for other Estuary Point colleagues to come and say hello. All in all the 2 hours the dogs were with us seems to have gone down a storm with staff and we will be looking to extend the arrangement for other shifts and colleagues to reap the benefit of a canine encounter.

Major Incident in Manchester

I would like to recognise the response we provided to the major incident which occurred in Manchester Arndale Centre in October. Fortunately there were no fatalities although

one patient was treated for major trauma injuries. In addition to our EOC colleagues who were the first to take the calls from frantic members of the public and then to alert the rest of the service, we dispatched 13 ambulances, HART, advanced paramedics, two doctors and two officers that day. Many other staff were involved in supporting the incident behind the scenes and I have seen from the media coverage and social media posts how grateful the public were. I know Ged Blezard, Director of Operations wrote a letter of thanks to staff but I should also like to add my own and recognise the great job they did.

I was also made aware that one of our off duty staff witnessed the whole incident and was fortunate not to have been a victim themselves. Despite this they remained on scene to treat patients and liaise with police and NWAS staff. I was so proud to hear of their selfless actions and have passed on my thanks to them. However, incidents such as this are shocking and it is often afterwards that people become fully aware of what they have faced and dealt with.

Greater Manchester Provider Federation Board (GM PFB).

The GM PFB has a key role within the Greater Manchester Health and Social Care Partnership to lead on some key transformation programmes, as well as developing a stronger model of collaboration and mutual aid. Fortnightly meetings take place at Trafford General Hospital with the GM Chief Executives and I, or our Deputy CEO, attend.

Liverpool Heart and Chest hospital meeting

I recently had an introductory meeting with Jane Tomkinson, Chief Executive of Liverpool Heart and Chest hospital (LHCH). LHCH provide specialist services in cardiothoracic surgery, cardiology, respiratory medicine including adult cystic fibrosis and diagnostic imaging, both in the hospital and out in the community. The meeting was very positive and we discussed how we might build on our already strong clinical and organisational relationship to improve patient care and enhance quality.

Hospital Handover

I chaired the North West hospital handover improvement board meeting with our commissioners, partner organisations and NHS England to discuss how we continue to work as a system to improve handover delays and patient and staff experience. We received an update on phase two of the handover collaborative initiatives following on from the recent work undertaken in phase one with six hospitals to reduce handover time in hospital emergency departments. This is aimed at improving the patient and staff experience and freeing up valuable ambulance resources to attend to other emergencies waiting in the community.

This valuable work has now been extended to include 14 hospitals who are tackling the difficult challenge of reducing patient waiting times in hospital for those patients brought in by ambulances. Learning events facilitated by the Quality Improvement Team are taking place to continue this work, the next one being on the 29 November. Managers, clinicians and improvement leads from hospitals across the North West will work together to progress the collaborative approach which is warmly supported by both the Board and our Commissioners, particularly as winter approaches.

3.3 **National Issues**

Engagement with National stakeholders

Joint Ambulance Improvement Board & Clinical Supervision Framework

I was recently in London for the Joint Ambulance Improvement Board meeting. The aim of this meeting is for a number of Ambulance Trust CEO's to work with NHSE/I colleagues to take forward a number of work streams to ensure Ambulance Trusts

reduce unwanted variation to provide the best possible care for our patients.

I chair one of the work streams which is to develop a Clinical Supervision Framework for Ambulance Trusts and we have now held two meetings to progress this work.

NASMeD meeting

As CEO lead on behalf of the Association of Ambulance Chief Executives, I also recently attended the National Ambulance Service Medical Directors (NASMeD) meeting in London together with our own Medical Director, Chris Grant. There was a joint session with the Pharmacy network and Rachel Fallon, our trust Pharmacist, was at the joint meeting. NASMeD is chaired by Julian Mark, Medical Director for the Yorkshire Ambulance Service. In addition to a number of standing items eg clinical indicators which Chris led the discussions on, we discussed hospital handovers, paramedic prescribing; vascular emergencies and falls and responders to mention but a few.

Ambulance Safe Staffing Steering Group

I also chaired the NHS England Ambulance Clinical supervision steering group and we have now produced a first draft which will shortly be circulated for wider consultation.

4 GENERAL

Estuary Point

I would like to mention the very successful migration of our EOC colleagues to Estuary Point; hopefully we will soon be able to share news on who will officially open the building for us and what that will entail. In the meantime I am grateful to our neighbours GEFCO for helping us with some additional car parking whilst our own plans to increase capacity are at the development stage. I had the opportunity to talk to a number of staff who overwhelmingly said they are well impressed with the facilities

Dying to Work Charter

I am pleased to announce that NWAS have agreed to support the TUC 'Dying to Work' charter which details ways in which employees should be supported and guided following a terminal diagnosis.

In the past we have supported a number of staff who have been diagnosed with a terminal illness and the organisational development directorate works closely with managers, staff and their families during these very difficult times.

Emergency Services Day

A day to promote and recognise the work of the emergency services, educate the public and promote volunteering opportunities. The main national event took place in Edinburgh. NWAS observed it with a 2 minute silence on corporate sites and provided NHS England with some filmed footage of colleagues talking about why they love their job. Mick Forrest, Deputy Chief Executive also attended an event held by Tameside Metropolitan Borough Council at Ashton who held a two minutes silence to remember the 7,000+ emergency services personnel killed on duty.

World Mental Health Day/launch of our Mental Health and Dementia Strategic Plan

Thursday 10th October was World Mental Health Day – the chance to raise awareness of the importance of mental health, increase understanding and reduce the social stigma that is sometimes associated with mental illness. This year the World Mental Health Federation selected suicide prevention as their main theme for their events and campaigns. A shocking 800,000 people globally take their own life and there are many more that attempt suicide. In just six months (1 September 2018 to 28 February 2019) the trust attended 102 incidents where the patient had died as a result of a suspected suicide. The impact of supporting patients who are suicidal affects all our

clinical staff and one in four emergency service workers have thought about ending their lives (Source: MIND).

I was very pleased to recognise the launch on the same day of our own mental health and dementia strategic plan to staff and key stakeholders. Gill Drummond, our mental health lead and her team have successfully captured all the excellent initiatives that we already have in place, together with our aspirations to shape and transform mental health and dementia care within the organisation and in partnership with others. The plan contains 17 key patient centred recommendations and associated actions which are based on extensive scoping and appraisals of care provision including feedback from our staff, patients and partners within mental health across the North West region.

Chris Grant, Medical Director, opened the event and highlighted some of our recent developments including the patient transport dementia pilot, the introduction of mental health first aiders into NHS 111, the mental health triage cars operating in Blackpool and Liverpool and staff mental health and wellbeing to mention a few. Attendees also heard about the outstanding studies and investigations into ambulance mental status examinations and suicide and self-harm by Darren Earley, Senior Paramedic and Craig Hayden, Advanced Practitioner. The inclusion of powerful patient experiences and some emotional and frank footage of staff mental health stories brought it all into even more sharp focus. Almost everyone in the room had experienced poor mental health, either themselves or through friends and family members. Our mental health is just as important as our physical health. The trust provides many ways to help staff; PTS peer supporters, TRiM, counselling and mental health first aiders.

National Suicide Prevention Alliance

The trust is now signed up to the National Suicide Prevention Alliance. This important organisation represents an alliance of public, private, voluntary and community organisations in England who care about suicide prevention and are willing to take action to reduce suicide and support those affected by suicide. Mental health has been identified as a priority for the trust and suicide prevention a key area for development within our Right Care Strategy and our Mental Health and Dementia Strategic Plan

Led by Gill Drummond, we are working closely with our partners in terms of embedding a multi-agency approach to suicide prevention, we have an NWAS Suicide Prevention steering group that is representative of the whole of our organisation and we have a programme of work which will take us up to 2022. We recognise that our staff are our main asset and due to the nature of their work are exposed to trauma which can impact on mental health - we are committed to promoting good mental health within our staff from recruitment until retirement and this work is underpinned by our Staff Wellbeing Framework/Strategy.

Safe Care Closer to Home

I recently met with John Pennington at Wigan Community Fire and Ambulance Station. John kindly gave me a tour of the station and it was great to see the excellent facilities we have there and chat with some of the firefighters but also to learn about some of the great results we are achieving in delivering safe care closer to home through external engagement partnerships. Initiatives like these really improve our options for providing safe patient care in the local community as well as reduce the number of often unnecessary conveyances to hospital for our patients and I am keen to see more of these being developed.

The Power of Patient stories

Whilst patient stories are often included in Q&P Committee, this was the first time a patient had been invited to tell their story in person. Dennis suffered a cardiac arrest and was successfully resuscitated by one of our CFR colleagues, Andy Powell together with paramedics Kellie Windridge and Darren Perkins. He and his wife Rosemary

came in to talk to us about the experience so we could understand the chain of survival being delivered from their perspective. This was a very powerful and emotional account and one which enables us to really understand the impact of what we do, not just from the clinical but also the human perspective

First NWAS Breakthrough Series College – 'Don't Press Snooze'

I am very pleased to announce the delivery of the very first 'Breakthrough Series College' hosted by Maxine Power, Director of Quality, Innovation and Improvement and supported by Katharine Goldthorpe, Head of Quality Improvement and her newly formed team in the Improvement Hub. 18 colleagues from across the whole of NWAS embarked on the course which is designed to develop leaders in the skills required to deliver improvement programmes at scale and will help us in our journey to become the best ambulance service in the UK. Aside of acquiring new skills, identifying commonalities and sharing experiences, a host of fabulous ideas have emerged from the 3 day event.

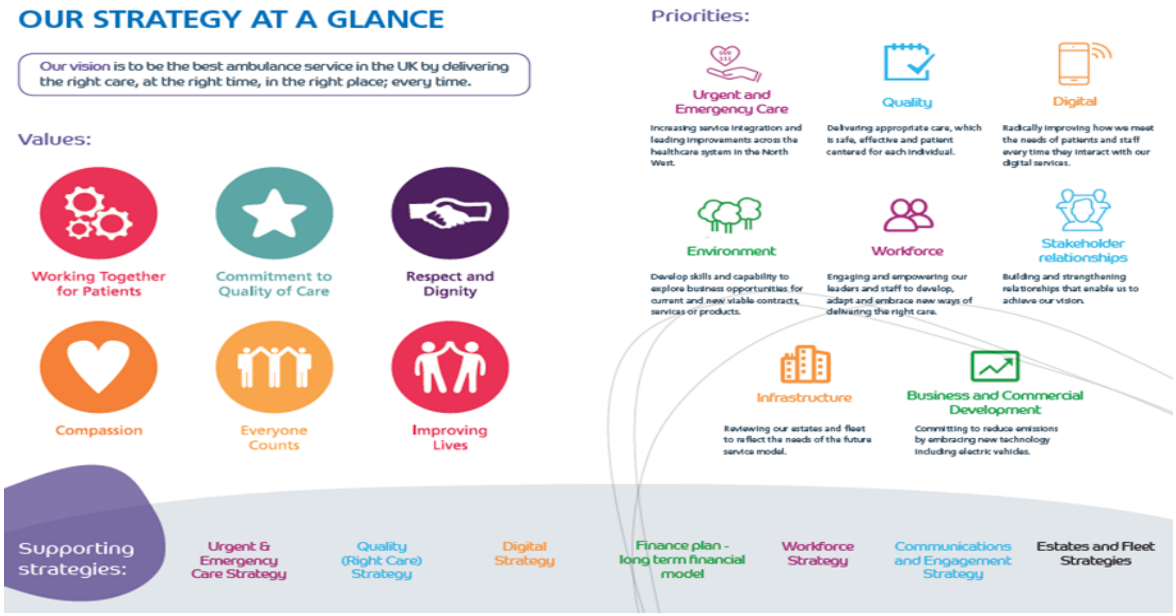
Trust AGM

The trust's Annual General Meeting took place on Monday 30 September where we presented our annual report and accounts for the 2018/19 financial year. We outlined a number of improvements including quality and finance and our accounts demonstrated the positive financial position and where funds have been invested to support staff and to improve the delivery of care to patients.

Trust Strategy

The trust's Strategy and Integrated Business Plan was launched on Tuesday 22 October to a packed audience of senior leaders from health and social care organisations across the North West together with some of our own leaders at Bolton Whites hotel. The core aspects of our strategy remain the same - 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, and our values are still a fundamental part of strategy as they shape how we do what we do.

Clare Duggan, Regional Director of Transformation, NHS England/Improvement was our guest speaker and provided a very useful context in relation to the NHS Long Term Plan and integrated care service arrangements. She also spoke about her own experience of the ambulance service which reminded us all about why we do what we do. The presentations ended on a real high with a film showcasing our achievements as an ambulance service with highlights of every aspect of the service from last year.



Freedom to Speak Up

October was the national Freedom to Speak Up month, a campaign run by the National Guardian's Office which calls on NHS organisations to increase awareness of how staff can raise concerns at work. Over 11,958 cases were raised to guardians nationally last year.

We all have a responsibility to raise any genuine concern about a risk, malpractice or wrongdoing at work at the earliest opportunity and it's really important that everyone has the confidence to be able to share any concerns and observations safely and confidentially. This creates an open and honest reporting culture within the trust. By fully supporting any concerns raised and reasonably acting upon them we're able to help keep our patients, the pubic and each other as safe as possible, as well as continuing to improve the care that we provide.

Senior Leadership Group

The Senior Leadership Group was established by the Executive Leadership Committee to support it in its duties, ensuring that ELC decision making is informed by the views of other senior leaders within the trust and that there is a high level of understanding and awareness of key strategic issues faced by the trust. The group will meet on a quarterly basis to support ELC

Over 50 senior leaders attended the inaugural meeting which was held at the Last Drop Hotel and included presentations from all the Executive Directors. Some of the topics discussed included a Brexit update, a winter briefing, CQC preparedness, our finances, operation outstanding, the launch of the flu vaccination and staff survey campaigns together with upcoming key events and milestones for the trust.

North West System Leadership Forum

I recently attended the North West System Leadership Forum at Blackburn hospital with Bill McCarthy, North West Regional Director for NHS England/NHS Improvement. The day included discussions on performance, Brexit, winter planning; improvement opportunities and the sharing of good practice in relation to staff survey results, population health and primary care networks to name a few. Finally we agreed next steps and our priorities for the north west.

Winter Warm Up Conference

Winter has arrived and our winter planning arrangements are now gathering momentum. In preparation for winter, I was delighted to present our thoughts on 'integrating the system' to the plenary session of the NHSE/I North West Winter Warm Up conference. NWAS is the only regional provider covering the whole of the North West so it is great that we are able to share our views from both an informed and experienced perspective with over 300 key health stakeholders and partners who attended. It was also fantastic to see some of our teams leading on a number of the breakout sessions too including 111, CAS, See & Treat, ambulance handovers etc.

NHS 111 winter campaign launch

Monday 21 October marked the launch of both the national, and our own, NHS 111 campaigns in support of winter pressures. The national campaign continues the theme of 'Help Us, Help You, Know What to Do' from last year with posters, leaflets and digital resources. Our take on this is our newest social media campaign #WeAre111 which gives our followers the chance to meet the great team behind the voices they hear when calling 111. The campaign will run for a month on the lead up to winter featuring facts, hints and tips on how you can make the most of NHS 111 during one of the busiest periods of the year.

During the campaign, we will feature various staff including Carole, who after nearly 30 years as a paramedic joined the 111 team to provide clinical support and advice to

patients over the phone. We'll also feature 111 Health Advisor, Helen, who swapped a career in the police for the 111 contact centre and Kieran, a senior clinical advisor, who decided he wanted to be a nurse during a lightbulb moment over an apple pie and a milkshake at 2am!

Winter Pressures/REAP

The trust has moved from Resource Escalation Action Plan (REAP) level 2 (moderate pressure) to level 3 (major pressure). This was partially in recognition of our own increasing operational demand as we enter the winter months, but also due to wider area health economy pressures.

REAP is a strategic horizon scanning tool which is used the trust's Executive Leadership Team on a weekly basis to review our ability to respond to current activity and performance levels. It provides all NHS ambulance services with a consistent and co-ordinated approach to the management of organisational responses which challenge operational delivery. Our published REAP level is also shared with other NHS partners to indicate the degree of pressure that we are operating under.

Its overarching aim is to protect staff, patients and the organisation from harm so there are varying actions that come into play, particularly in the higher levels of escalation that assist in the decision making regarding the level we operate at. The escalation plan and associated action cards are available on the trust's intranet.

NWAS flu campaign 19/20

Our trade union colleagues recently met with the Executive Leadership Committee, so took the opportunity to get their flu jabs to protect themselves, other staff and patients at the same time. Whilst we have got off to a good start with this year's campaign, we need everyone to follow our trade union reps' great example. We want to get more staff vaccinated than ever before to protect against the potentially harmful bugs and infections now that the weather is starting to turn colder.

Awards and Recognition

On Wednesday 6 November I attended the Health Service Journal (HSJ) Awards in London with a number of staff and other key stakeholders. Whilst we did not pick up any awards for the trust ourselves that evening, it was a significant accomplishment to be shortlisted for our work in supporting ex-military personnel and reservists as well as our 'Every Minute Matters' hospital handover collaborative. My congratulations to both teams involved in this fantastic work

I am delighted to hear we have been shortlisted for the Healthcare People Management Association (HPMA) award 'for the work we have done on our empowering women into leadership programmes. The HPMA is focused on improving health through people. Together with its partners and supporters, it recognises, rewards and shares the outstanding work of people managers across health and social care in the UK.

The Sir Peter Carr Award which recognises innovation and effective partnership working within a provider trust, CCG, a sustainability and transformation partnership; integrated care system or primary care service across England.

I am always extremely proud of the achievements of our trust, but I was exceptionally proud as we have recently received three awards:

- Research Paramedic, Betty Pennington, won Research Practitioner of the Year at the Greater Manchester Clinical Research Awards 2019.
- Mental Health and Dementia Lead Gill Drummond and Senior Paramedic Darren Earley received the runners up prize at the Sir Peter Carr Awards for their work on devising a mental health assessment tool BASIC STEPS. The Award recognises innovation and effective partnership working within a provider trust, CCG, a

sustainability and transformation partnership; integrated care system or primary care service across England.

- Operations Manager, John Moorhouse, received a North West Football Award alongside the medical team at Burnley Football Club after they helped save the life of ex-professional referee Eddie Wolstenholme who went into cardiac arrest

I would also like to recognise Katharine Goldthorpe, Head of Quality Improvement's successful award of an Advancing Quality Alliance (AQuA) Leadership for Improvement Fellowship. Katharine has been selected as part of the 2019/20 cohort which will allow her to think differently about how to improve outcomes for service users and their families by exploring how collaboration accelerates improvement through a programme of self-directed learning. The award provides access to the fellows, AQUA networks and resources and opportunities for study and practical learning for the term of the fellowship.

Remembering the fallen

I had the privilege of leading the two minutes' silence and laying a poppy wreath at our Headquarters. Thank you to all those who took the time to once again honour the servicemen and women involved in the two world wars and later conflicts. It was heartening to see on social media so many staff representing the trust and taking part in remembrance services across the Region.

GP contract reform

I attended a roundtable discussion which was held in London with primary care networks and other ambulance trusts to establish areas of common ground regarding the framework for the GP contract reform. We discussed the potential impact on paramedic and other clinical professions by this reform, and highlighted the risks which are to be factored into primary care network planning and national thinking.

Ofsted inspection

We have recently been inspected by Ofsted (unannounced) and as part of that I was interviewed along with the Chair and Interim Director of OD by their inspection team. Ofsted monitor all newly directly funded providers of apprenticeships, and we have apprenticeships in various sectors of the trust. The inspection mainly focussed on EMD and EMT1 apprenticeships.

The initial feedback we have received from the inspection team has been very positive and we have been congratulated in how far we have come as an apprenticeship provider in just two years. I would like to thank all those staff involved in the inspection for their contribution, time and dedication in ensuring the inspection ran smoothly. A formal rating announcement will be made in approximately 4-6 weeks

5 LEGAL IMPLICATIONS

5.1 There are no legal implications associated with the content of this report.

6. RECOMMENDATION(S)

6.1 The Board of Directors is recommended to:

- Receive and note the contents of the report.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 November 2019			
Subject:	Northern Ambulance Alliance (NAA) Progress Report			
Presented by:	Daren Mochrie			
Purpose of Paper:	For Discussion			
Executive Summary:	This paper provides the Trust Boards with an overview of progress on work to date across the Northern Ambulance Alliance (NAA). The Alliance consists of 4 Trusts: North East Ambulance Service NHS Foundation Trust, Yorkshire Ambulance Service NHS Trust, East Midlands Ambulance Service Trust and North West Ambulance Trust. The NAA Board have agreed that the NAA will take forward a work programme which focuses on the following areas: • CAD, telephony & triage • Managing the paramedic pipeline • Talent management • Research – managing links with Universities • Quality improvement collaboration/Faculty • Uniform approach to hospital handover • Managing Fleet			
Recommendations, decisions or actions sought:	It is recommended that the Board discuss and note the content of the report and next steps being taken to progress the work programme.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):								
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**
☒	☐	☒	☐	☒	☐	☒	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

This paper provides the Trust Boards with an overview of progress on work to date across the Northern Ambulance Alliance (NAA). The Alliance consists of 4 Trusts: North East Ambulance Service NHS Foundation Trust (NEAS), Yorkshire Ambulance Service NHS Trust (YAS), East Midlands Ambulance Service Trust (EMAS) and North West Ambulance Trust (NWAS)

2. BACKGROUND

2.1 At the NAA Board Away Day in August 2019, the NAA Board, comprising of the 4 CEOs and 4 Chairs from each of the Trusts, agreed the frequency of meetings for 2019/20 to support moving the programme forward. The meetings will be held bi-monthly on rotation as a one hour update call and three hour face to face meeting. In addition, the NAA CEOs have agreed to hold a monthly teleconference, so that regular oversight of the work programmes are reviewed. Notes/recommendations from the CEOs meeting will be presented at the NAA Board which will subsequently be reported into each Trust Board as an NAA briefing paper.

2.2 On the NAA Board call held on 14 November the agenda covered progress on the new programme plan which includes the priority areas agreed by the NAA Board in August and the governance required to support this. Recruitment into the permanent Managing Director & Digital Strategy Lead posts were also discussed.

3. NAA BOARD

3.1 The NAA Board have agreed that the NAA will take forward a work programme which focuses on the following areas:

- CAD, telephony & triage
- Managing the paramedic pipeline
- Talent management
- Research – managing links with Universities
- Quality improvement collaboration/Faculty
- Uniform approach to hospital handover
- Managing Fleet

3.2 These topics have been chosen as areas on which the NAA can collaborate, share best practice and resources across the 4 Trusts.

3.3 An outline programme plan has been developed in agreement with the NAA CEOs, identifying Executive Leads (Senior Responsible Owner) with accountability for delivery. The SRO will need to ensure that all NAA Trust executive leads have had input to, and are in agreement with, any proposals put forward for that work area, prior to submission.

3.4 The NAA programme plan highlights priority work areas for Year 1, based on the above list, where work is already underway or has been agreed, with delivery to commence in April 2020. The plan also identifies priority areas where further scoping is required over the next few months to determine the detail of the work and resource requirements to support implementation. These will then be considered further by the NAA Board. The remaining

work areas are suggested for Year 2 & 3. The pre-planning phase will take place between November 2019 and April 2020, to ensure that all work areas have working groups established, with a clear plan which outlines key activities, milestones and resources required (staffing and financial).

3.5 The plan will work within a standardised gateway process agreed across the NAA, working through a proposed governance structure and ultimately reporting in to each Trust Board. A standard set of PMO resources are also being agreed across the 4 Trusts, so that reporting within the NAA is more streamlined.

3.6 The programme plan will also demonstrate where each of the priority areas link across to the national plans on which each Trust are required to deliver against.

4. NAA PROGRAMME UPDATE – CONFIRMED WORK AREAS

The following provides an update on the confirmed Year 1 programmes outlining work to date:

4.1 Digital (CAD)

4.1.1 Work is progressing on development of a common integrated CAD system specification for 999,111 and PTS across NWAS, YAS and EMAS. Each member trust has worked on a separate part of the specification (EMAS 999, NWAS PTS and YAS 111). NEAS have agreed to act as a critical friend throughout the process, due to already having an integrated CAD system in operation.

4.1.2 Due to the size and scale of the programme, the 3 NAA CEOs have agreed to commission Mason Advisory Ltd to conduct a feasibility study which will advise on a suitable approach towards delivering large scale IT transformation. The new system needs to have the capability to scale to suit the needs of a growing user base (potential precursor to a national scale CAD solution). They will also advise on issues of a strategic nature in respect of migration of Ambulance Trusts from a traditionally on-premise IT architecture model to an off-site or hybrid model, delivering the scale of IT and organisational transformation referenced in the Carter report (2018).

4.1.3 Mason Advisory Ltd have been approached to work on the initial feasibility study as a direct award under G-Cloud 11 (IT Strategy and Transformation). Mason Advisory are able to meet the requirements outlined and have the necessary experience to undertake this work, having extensive experience in the emergency services, control room and telecommunications/IT sectors. Their appointment will also ensure impartiality in considering the range of options available within the marketplace.

4.2 Avoidable conveyance

4.2.1 In July 2019, the NAA CEOs agreed to fund a full-time avoidable conveyance post, for 12 months, to principally support the triage and reduction of inappropriate 999 calls received from telecare devices. This was based on an approach to the NAA from AACE (Association of Ambulance Chief Executives), where the triage tool and clinical pathways have been developed. The post will have a clinical background and will work across the 4 NAA Trusts, working for 60% of their time on telecare and

40% on auditing the implementation of other avoidable conveyance pathways. The audit will provide the NAA with suggested areas of focus in Years 2 & 3 within this programme area.

4.2.2 The post has been advertised on NHS jobs with interviews due to be held in December 2019.

4.2.3 A proportion of the funding for this post has been successfully secured from local Integrated Care Systems (ICS).

4.3 Fleet

4.3.1 There is already an established Fleet working group which is in place across the NAA to support implementation of the national fleet specification. The working group has identified the following areas of focus for the work programme going forward:

- Model ambulance/national specifications/new developments - continuing to support delivery of new initiatives as identified nationally. Work is underway with NHSI on development of Model Ambulance Fleet metrics.
- Sustainability of fleet & fleet operations – looking at the use of electric vehicles across the NAA and savings/efficiencies to be gained as a result.
- Fleet management system – all Trusts are now live on the Civica Fleet Management System with Phase 2 focusing on interfaces with other Trust systems.

5. NAA PROGRAMME UPDATE – AREAS FOR FURTHER SCOPING

The NAA Board has agreed that the following areas require further scoping before agreeing to include in as a Year 1 priority programme.

5.1 Corporate Services

5.1.1 Corporate services data has been collected from across all 4 Trusts and submitted to NHSI in line with national requirements and recommendations within the Carter Review. The data for 2018/19 was published in September 2019 and allows all providers to compare spend/configuration on key areas such as Finance, HR (including Education), Payroll, Procurement, Legal, Governance & Risk, IM&T.

5.1.2 Significant work has been undertaken with the data collectors across the 4 NAA Trusts to ensure that realistic data comparisons and benchmarking can be made with the most recent data set. Prior to this there had been concerns that not all Trusts were collecting and reporting the data in the same way within the same data lines, making real comparisons difficult to back up.

5.1.3 The information produced from these meetings has been shared with the other Ambulance Trusts nationally on request from NHSI.

5.1.4 Based on the September figures and discussions with NHSI on quick wins, the areas identified for further scoping across the NAA in Year 1 include, HR (transactional), Education, Legal, Governance & Risk.

5.2 Quality Improvement and handover delays

5.2.1 An initial meeting took place in September 2019 to consider the potential scope of this work area. It has been proposed that the work should cover 3 key components: staff engagement, training and priority improvement programmes (with the first topic to cover hospital handover).

5.2.2 The programme will also consider the following principles:

- Any initiative should add value beyond the individual organisation level strategies and support wider NAA plans
- It should be democratic in principle and process – an alliance of equals
- It could be virtual – i.e. with no central office/officers
- It should support engagement with front line staff
- It should enable building of internal capacity and capability rather than building a dependency on external organisations

5.2.3 Further discussions have taken place with all 4 Trust Executive QI leads and agreement reached that as part of next steps, a workshop will be held on 9 December. One of the key outputs will be the development of a strategic outline case (SOC), supported by all 4 Trusts, which will be presented to the NAA Board for sign off.

5.3 Workforce - Rotational Paramedics

5.3.1 Under the new five-year GP contract in England, Primary Care Networks (PCNs) will be funded to hire 22,000 additional practice staff, including paramedics, physiotherapists and pharmacists, by 2023/24.

5.3.2 Health Education England (HEE) have proposed rotating paramedics between general practice, emergency departments and ambulance services to try and avoid the loss of a skilled workforce within the ambulance sector.

5.3.3 NEAS, YAS & EMAS have been part of a 3-phase pilot with HEE, which commenced in April 2017. The pilot was designed to investigate workforce impact and service benefit of a rotational paramedic workforce model and was externally evaluated. South Central Ambulance Service were also part of the pilot.

5.3.4 The HEE report provided a number of recommendations to Ambulance Services following the evaluation. It concluded that in order to successfully deliver on the national agenda, paramedics are more likely to be retained if they have enhanced clinical decision-making skills. It is these skills which may be developed by rotation into primary care and other integrated urgent care settings.

5.3.5 The NAA Trusts are working closely with Integrated Care Systems (ICSs) & PCNs to consider how this work can be taken forward. Further scoping of this and impact across the Trusts needs to be coordinated.

6. NEXT STEPS

6.1 Agree Year 1 work programme areas to commence delivery from April 2020.

6.2 Scope out programme areas listed above to determine feasibility for inclusion in the Year 1 NAA programme.

6.3 Agree Executive Leads (SROs) for the work programme areas and PMO resources from within the Trusts to provide support.

6.4 Set up NAA Working Groups for each work programme area.

6.5 Finalise governance and gateway processes for the NAA.

6.6 Submit documents to NAA Board for approval.

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7. LEGAL and/or GOVERNANCE IMPLICATIONS

There are no legal implications associated with the content of this report.

8. RECOMMENDATIONS

It is recommended that the Board discuss and note the content of the report and next steps being taken to progress the work programme.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	Wednesday 27 November 2019
Subject:	Board Assurance Framework (BAF) Q2 Review Corporate Risk Register Q2 Review
Presented by:	Angela Wetton, Director of Corporate Affairs
Purpose of Paper:	For Decision
Executive Summary:	The Board of Directors have been provided with the Q2 2019/20 Board Assurance Framework (BAF) to review, along with the Corporate Risk Register (CRR). The BAF risks are reviewed at Committees providing opportunity to identify where assurances support potential mitigation of risks. In support of this process, the Senior Risk and Assurance Manager has collated assurance information throughout the quarter onto the Assurance Map. The review of the CRR takes place monthly at ELC to ensure risks are being actively managed. The CRR can be viewed for information in **Appendix 1**. The proposed Q2 position for the BAF risks with associated CRR scored ≥15 can be viewed in **Appendix 2**. The BAF Heat Maps for 2019/20 year to date can be viewed in **Appendix 3**. Following a full review of controls and assurances across the BAF there has been the following changes to note: • SR01; decrease in risk score from 16 to 12 • SR02; decrease in risk score from 20 to 15 • SR07; decrease in risk score from 20 to 16 • SR08; decrease in risk score from 12 to 8 • Rearticulation of SR01 Risk Description. The end of Q3 BAF reporting process and timescales can be viewed in **Appendix 4**.
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Agree the change of risk score for SR01 • Agree the change of risk score for SR02 • Agree the change of risk score for SR07 • Agree the change of risk score for SR08 • Agree to rearticulate the risk description of SR01

	• Agree the Q2 position of the Board Assurance Framework.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	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 are adequate to mitigate any significant strategic risks which threaten the achievement of strategic objectives.

This paper provides an opportunity for the Board of Directors to review the Q2 Board Assurance Framework (BAF) position along with the Corporate Risk Register risks scored 15 and above that are aligned to each BAF risk. In addition, themes and gaps that the Risk and Assurance Team have identified as part of the risk profiling work are included. This work has also been informed through discussions with Directors and senior managers across the organisation.

2. RISK ASSURANCE PROCESS

The BAF risks are reviewed at Committees providing the opportunity to identify where assurances support potential mitigation of risks, commission where appropriate, additional assurance and identify any associated risks that may require escalating or de-escalating through the Chair's reporting process. Risk identified on the Corporate Risk Register are mapped to the BAF risks and are included within the reports, providing the position in terms of the progression of each risk. This in turn, supports the identification of any additional assurances that may need to be commissioned by the Chair as well as recognising where the achievement of risk mitigation may impact positively or negatively on the BAF risks.

To support the Q2 review of the BAF, the Senior Risk and Assurance Manager has collated assurance information reported throughout the quarter onto the Assurance Map. The information has been identified through attendance at Committee meetings and review of Chair's reports from both Management and Committee meetings. The assurance mapping has been used to support discussions with Executive Directors and assist with updating of the BAF risks.

3. REVIEW OF THE CORPORATE RISK REGISTER

The review of the Corporate Risk Register takes place at Executive Leadership Committee (ELC) as well as the Board Committee meetings in the organisation. Here, assurance is sought that controls and mitigations are applied and actions are in place to ensure that the risk is being actively managed. The Corporate Risk Register can be viewed for information in **Appendix 1**.

4. REVIEW OF THE BAF STRATEGIC RISKS Q2

The quarterly review process provides an opportunity for the Director leads to meet with the Senior Risk and Assurance Manager to discuss the update of their relevant risks. These meetings have taken place either with Director leads or their senior manager responsible for updating the BAF. Adjustments to the BAF risks has subsequently been undertaken. The proposed Q2 position for the BAF risks with

associated Corporate Risk Register risks scored 15 and above can be viewed in **Appendix 2**.

The Heat Maps for 2019/20 year to date can be viewed in **Appendix 3**.

Following a full review of controls and assurances across the BAF there has been the following changes to note:

SR01: If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage

- Reduction in risk score from 16 to 12 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	2019/20 Target	Final Target	Exec Lead
16 4x4 CxL	16 4x4 CxL	12 4x3 CxL	12 4x3 CxL	8 4x2 CxL	M Power DoQII

This risk has decreased in risk score from 16 to 12 following the Q2 review with the following rationale applied by the Executive Lead:

1. The Trust has demonstrated an improved position of safeguarding mandatory training across the Trust.
2. The backlog of both open complaints and serious incidents has reduced.
3. Positive assurances have been reported pertaining to the health and safety key performance metrics as identified within the Right Care Strategy.
4. The signing of PGDs has been mitigated with MIAA Internal Audit Report providing assurance.
5. The Chief Pharmacist has commenced employment and is conducting a Medicines Management (including storage) Strategic Review.
6. CD tagging has now been implemented Trust-wide and Pharmacy Technicians are undertaking compliance visits.
7. Challenges still remain in place surrounding timely incident investigation, IPC compliance and CD05 audit being below target compliance.

- The risk description has been reviewed as part of the Q2 review and the proposed amendments have been made to the risk:

BAF Risk	Risk Description at 01.04.2019	New Risk Description at end of Q2
SR01	If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage	If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements

SR02: If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective

- Reduction in risk score from 20 to 15 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	2019/20 Target	Final Target	Exec Lead
20 5x4 CxL	20 5x4 CxL	15 5x3 CxL	10 5x2 CxL	5 5x1 CxL	C Wood DoF

This risk has decreased in risk score from 20 to 15 following the Q2 review with the following rationale applied by the Executive Lead:

1. The Trust has a surplus of £0.546, which is better than the planned surplus of £0.492m. Income is over recovered by £1.393m, pay is overspent by £1.244m and non-pay is overspent by £0.095m.
2. The overall financial performance rating is 1.
3. Cost Improvement Programmes for the year is £9.808m and YTD target is £2.627m with the Trust achievement of £3.011m.
4. Capital expenditure is at £4.188m*
   **Based on Month 5 position; 31 August 2019 data.*

SR07: If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity

- Reduction in risk score from 20 to 16 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	2019/20 Target	Final Target	Exec Lead
20 4x5 CxL	20 4x5 CxL	16 4x4 CxL	12 4x3 CxL	8 4x2 CxL	M Power DoQII

This risk has decreased in risk score from 20 to 16 following the Q2 review with the following rationale applied by the Executive Lead:

1. The newly formed leadership team in place.
2. Significant progress has been made to the mitigations to asset management and cyber security.
3. The Trust has an enterprise agreement in place with Microsoft to lock down prices and simplifies procurement processes.
4. The IT health dashboard has been operationalised to enable real time monitoring of assets, the level of visibility and assurance represents a significant improvement for the Trust in terms of ability to monitor and manage assets against possible threats.
5. MIAA specialists are now working onsite to produce an action plan for cyber security and the Trust has completed Cyber Essentials Assessment, but awaiting the results.

SR08: If the Board experiences significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy

- Reduction in risk score from 12 to 8 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	2019/20 Target	Final Target	Exec Lead
12 4x3 CxL	12 4x3 CxL	8 4x2 CxL	8 4x2 CxL	4 4x1 CxL	D Mochrie CEO

This risk has decreased in risk score from 12 to 8 following the Q2 review with the following rationale applied by the Executive Lead:

1. Recent appointments of Non-Executive Director to fill vacancies and the Associate Non-Executive Director posts to enable robust succession planning.
2. The Trust has a strong and varied Executive Leadership Team with the additional interim capacity of a stand-alone Deputy Chief Executive role.
3. The Shadow Board has launched within the quarter, which has identified strong deputies across the Trust preparing them to step-up as a Board member if required.
4. The completion of the Board skills matrix has been completed, identifying areas of learning and development opportunities with a robust Board Development Programme in place.
5. The Trust has commissioned an Independent Well-Led Developmental Review which is scheduled to commence within Q3.

5. LEGAL and/or GOVERNANCE 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.

4. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the change of risk score for SR01
- Agree the change of risk score for SR02
- Agree the change of risk score for SR07
- Agree the change of risk score for SR08
- Agree to rearticulate the risk description of SR01
- Agree the Q2 position of the Board Assurance Framework.

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Appendix 1: Corporate Risk Register
Board of Directors
**Extracted from Datix on 01 November 2019*

DX ID	Risk Description	Rating (Initial)	Rating (Current)	Trend	Rating (Target)
1181	There is risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales.	20	15	⟷	10
2919	There is a risk that if the Trust does not deliver on all ARP performance standards then patient care could be comprised which could result in reputational damage to the Trust, a £1 million fine and an increase in patients complaints.	25	15	⟷	5
2959	There is risk that if there are insufficient call handlers in the Carlisle Support Centre to answer the calls in a timely manner then operational staff may be delayed in reporting safeguarding referrals and vehicle breakdowns etc which could result in potential patient safety and/or crew safety.	20	15	⟷	5
2262	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact.	20	16	⟷	8
2480	There is a risk that unsupported software and hardware - due to lack of asset ownership, risk and renewal road Map for existing systems and governance for cyber security which could result in costly last minute updates, potential cyber attacks and loss of systems.	20	16	⟷	8
2748	There is a risk that we will not be able to deliver key business as usual projects and innovations due to lack of capacity and project management expertise in the IT team which could result in unsecure systems, system disruption or loss of critical systems	20	16	⟷	8
2766	There is a risk that if the Trust does not decide in a timely manner to invoke the terms of the lease break (if required) for 111 Middlebrook in September 2020 this could result in significant financial implications (5 years extra lease payments to end of lease term).	20	16	⟷	4
2976	There is a risk that failure to achieve the 2019/20 financial plan due to slippage against the CIP Plan which could result in the CIP remaining unidentified	16	16	⟷	8
3026	There is a risk that increased demand for driver training combined with national and local driving instructor shortages which could result in an impact on delivery of front-line emergency driver training and compliance with regulatory framework	20	16	⟷	8
3156	There is a risk that if consistent high rates of sickness and absenteeism occur across the 111 service line this could result in KPIs not being achieved so impacting on patient care and reputational damage to the Trust.	20	16	NEW	4

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North West Ambulance Service NHS Trust

Appendix 2

Board Assurance Framework 2019/20

Board of Directors
27 November 2019

Quality & Performance Cttee:	16/09/2019
Resources Cttee:	23/09/2019
Executive Leadership Cttee:	09/10/2019
Audit Cttee:	18/10/2019
Board of Directors:	27/11/2019

Data Extracted from Datix: 01 November 2019

Delivering the right care, at the right time, in the right place; every time

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
DoOD	Director of Organisational Development
DoS&P	Director of Strategy & Planning
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				
Operational Risk Exposure	The key areas of operational risks scored 15 and above that align with the BAF risk and have the potential to impact on the score				
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)				
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 BRAG rated assessment of how much progress has been made on the completion of the required action	Incomplete/ Overdue	In Progress	Completed	On Agenda

OUR STRATEGY AT A GLANCE

Our vision is to be the best ambulance service in the UK.

Our strategic goal is to deliver the right care, at the right time, in the right place; every time.

Our values

THE RIGHT CARE,

delivering quality services which are safe, effective and patient-centred

AT THE RIGHT TIME,

responding appropriately to patients who contact our emergency and urgent care services, and use our transport service

IN THE RIGHT PLACE;

providing patients with advice and treatment closer to home where clinically appropriate to prevent unnecessary hospital attendances and admissions

EVERY TIME.

focusing on every patient and our commitment to continuously drive down variation in our performance, working in partnership with health and care providers locally so that no patient is needlessly waiting for help

Our priorities:

RIGHT CARE

- Ensure our services are:
  - **Safe:** protecting our patients from avoidable harm
  - **Effective:** reducing unwarranted variation in treatment and outcomes
  - **Patient-centred:** providing the best experience for patients and staff

RIGHT TIME

- Provide patients with the right response, first time and attend to life-threatening emergencies as quickly as possible, by achieving the national Ambulance Response Programme (ARP) performance standards
- Answer calls as quickly as possible, both for emergency services, 111 and the Patient Transport Service (PTS) by achieving the national standards

RIGHT PLACE

- Provide the right care to more patients over the telephone (hear and treat) and face-to-face while on scene (see and treat) where appropriate
- Reduce the number of patients taken to Emergency Departments (ED) by treating them on scene or transporting them to a more suitable healthcare provider
- Provide patients with less severe conditions access to clinical advice on the phone and online, by rolling out enhanced triage across urgent care services and supporting the introduction of 111 Online and direct booking of appointments

EVERY TIME

- Empower staff by developing leadership skills and expertise
- Develop our workforce through increased access to training and development opportunities
- Engage with our workforce with a focus on increasing the staff health and wellbeing offer and achieving equality for all

To support these priorities, we will:

- Provide our staff with access to digital technologies and accurate, timely information to improve ways of working and continue to develop our premises to ensure safe and suitable workplaces
- Continue to develop our fleet of vehicles so they will meet future requirements, reducing carbon emissions and the impact on the environment
- Ensure risks are managed and lessons are learned if things go wrong
- Work with partners to promote healthy living to keep people well

You can view our full strategy at:
www.nwas.nhs.uk/strategy

www.nwas.nhs.uk
@NWambulance

BOARD ASSURANCE FRAMEWORK DASHBOARD 2019/20

SP	BAF RISK	Committee	Lead	01.04.19	Q1	Q2	Q3	Q4	2019/20 Target	Final Target
Right Care	**SR01:** If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements	Quality & Performance	DoQII MD	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL			**12** 4x3 CxL	**8** 4x2 CxL
Every Time	**SR02:** If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective	Resources	DoF	**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL			**10** 5x2 CxL	**5** 5x1 CxL
Right Time	**SR03:** If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.	Quality & Performance	DoOps	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL			**10** 5x2 CxL	**5** 5x1 CxL
Every Time	**SR04:** If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives	Resources	DoOD	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL			**8** 4x2 CxL	**4** 4x1 CxL
Every Time	**SR05:** If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives	Resources	DoF	**12** 3x4 CxL	**12** 3x4 CxL	**12** 3x4 CxL			**6** 3x2 CxL	**3** 3x1 CxL
Right Place	**SR06:** If the Trust does not establish effective partnerships within the regional health economy and integrated care systems then it may be able to influence the future development of local services leading to unintended consequences on the sustainability of the Trust and its ability to deliver Urgent and Emergency Care	Board	DoS&P	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL			**4** 4x1 CxL	**4** 4x1 CxL
Every Time	**SR07:** If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity	Resources	DoQII	**20** 4x5 CxL	**20** 4x5 CxL	**16** 4x4 CxL			**12** 4x3 CxL	**8** 4x2 CxL
Right Time	**SR08:** If the Board experiences significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy	Board	CEO	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL			**8** 4x2 CxL	**4** 4x1 CxL
Right Time	**SR09:** If the UK Government leaves the EU without a deal then availability of key medicines, equipment and resources may be challenged resulting in inflated costs, disruption to supplies and loss of workforce. The 'no deal' withdrawal may impact on our ability to share, process and access data	Resources	DoS&P	**9** 3x3 CxL	**9** 3X3 CxL	**9** 3X3 CxL			**6** 3x2 CxL	**3** 3x1 CxL

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR01: If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements

LEAD DIRECTOR: DoQII / MD

DATIX: TBC

STRATEGIC PRIORITY: Right Care

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Medicines Management; CDs
- Infection, Prevention and Control Standards

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
16	16	12			12	8
4x4	4x4	4x3			4x3	4x2
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk has reduced from a 16 to a risk score of 12 due to the improved position of safeguarding mandatory training across the Trust. Although it is recognised the Trust has not yet reached the forecasted target of L1 and L2, however compliance is measured over a three year period, as per the Intercollegiate Document. The backlog of both open complaints and incidents has reduced, recognising a large number of incidents are overdue investigation. Positive assurances have been reported pertaining to Health and Safety, but challenges still remain regarding overall IPC compliance across the Trust. The signing of PGDs has been mitigated, with external assurance provided. The Chief Pharmacist has commenced employment and is conducting a Medicines Management (including storage) Strategic Review. CD tagging has now been introduced Trust-wide with Pharmacy Technicians completing station compliance visits. CD05 Audit still remains below target of compliance and any identifiable lessons learnt from the recent CD incident are being reported and managed via Medicines Effectiveness Group.

CONTROLS	ASSURANCES	EVIDENCE
Incident Reporting		
Level 2: Incident Reporting Procedure	**Level 2:** Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Level 2: Review & Increased scruitiny at ROSE	**Level 2:** Incident reviews with severity of Level 4 & 5 to determine identification of Serious Incident	Reported to ELC
Level 2: Identiifcation of incident trends and themes	**Level 2:** Implemented Task & Finish Groups conduct further review	Reported to Safety Management Group
Serious Incidents		
Level 2: Serious Incidents Investigations Prcoedure	**Level 2:** Serious Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Level 2: Review & Increased scruitiny at ROSE	**Level 2:** Management Plans for identified Serious Incidents	Reported to ELC
Level 2: SI submission trajectory	**Level 2:** Serious Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Complaints		
Level 2: Complaints Procedure	**Level 2:** Complaints Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Health, Safety & Security		
Level 1: Mandatory Training in Health & Safety	**Level 2:** Mandatory Training Compliance Report	Reported to Safety Management Group
Level 2: Internal Health & Safety Visits/ Inspections	**Level 2:** H&S Visit Report	Reported to Safety Management Group
Safeguarding		
Level 1: Safeguarding Policies & Procedures	**Level 2:** Safeguarding Reports	Reported to ELC/ Quality & Performance Cttee/ Board of Directors
Level 1: Safeguarding Reportable Events	**Level 2:** Reportable Events Paper highlighting Safeguarding	Reported to BoD (Part 2)

Level 2: NWAS Safeguarding Practices	**Level 3:** MIAA Internal Audit Report on Safeguarding	Reported to Audit Cttee			
Infection, Prevention & Control					
Level 1: Mandatory IPC Training	**Level 2:** Mandatory Training Compliance Report	Reported to Clinical Effectiveness Management Group			
Level 1: IPC Policy and Procedures	**Level 2:** IPC Performance Data	Reported to Quality & Performance Cttee/ Board of Directors			
Medicines Management					
Level 2: Medicines Management Procedures	**Level 1:** Dashboard Monthly Reporting to Sector & Station Group **Level 2:** Reported via Quality Measures	Reported to Quality & Performance Cttee			
Level 2: Pharmacy Technician Station Audits	**Level 2:** Station Medicines Management Audit Reports	Reported to Quality & Performance Cttee			
Level 2: Medicines Management Practices	**Level 3:** MIAA Internal Audit Report	Reported to Audit Cttee			
Safety					
Level 2: Quality and Performance Data	**Level 2:** Weekly Quality & Performance Report	Reported to ELC			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Incident Reporting					
Improvements in unscored incidents	Reduce reported of unscored incidents in the Board IPR to 50	A Hansen	Q4: March 2020	Q&P Cttee	
Improvements with incident closure (severity 1-5)	Increase closure of incidents to 80% for incidents severity of 1-3 Increase closure of incidents to 60% for incidents severity of 4-5	A Hansen	Q4: March 2020	Q&P Cttee	
Serious Incidents					
Improvements with notify to confirm for SI	Increase the proportion of cases where the notify to confirm interval is within 75%	A Hansen	Q4: March 2020	Q&P Cttee	
Improvements with confirmation to report for SI	Increase the proportion of cases to 90% where the confirmation to report interval is within the agreed 60 day timeframe	A Hansen	Q4: March 2020	Q&P Cttee	
Complaints					
Reduction in the number of complaints	Reduce the overall numbers of complaints per 1000 WTE staff by 10%	A Hansen	Q4: March 2020	Q&P Cttee	
Improvements with complaint closures (severity 1-5)	Increase severity 1-2 complaints closed within 24 hours by 40% Increase the closure by 65% for complaints with a severity 1-3 Increase the closure by 40% for complaints with a severity 4-5	A Hansen	Q4: March 2020	Q&P Cttee	
Health, Safety & Security					
Reduction in the number of RIDDORs	Reduction in RIDDORs by 20%	A Hansen	Q4: March 2020	Q&P Cttee	
Reduction in lifting and handling incidents with confirmed harm	Reduction in incident reports with confirmed harm from lifting and handling by 20%	A Hansen	Q4: March 2020	Q&P Cttee	
Increase the number of Operational Managers qualified in Health and Safety Management	25% of Operational Managers with advanced training in Health and Safety Management	A Hansen	Q4: March 2020	Q&P Cttee	

Trust sites receiving Bi-Annual Health and Safety Review	80% of sites to receive a biannual rapid review of Health and Safety	A Hansen	Q4: March 2020	Q&P Cttee	
Vehicles receiving Annual Health and Safety Review	50% vehicles receiving an annual review of Health and Safety	A Hansen	Q4: March 2020	Q&P Cttee	
Safeguarding					
Lack of safeguarding performance reporting	Pilot of safeguarding performance metrics reported on a dashboard	A Hansen	Q4: March 2020	Q&P Cttee	
Implementation of a system for safeguarding	Pilot system for linking, flagging, monitoring and responding to repeat referrals with escalation to SMT and stakeholders	A Hansen	Q4: March 2020	Q&P Cttee	
Infection, Prevention & Control					
Non-compliance with vehicles deep clean standards	Increase percentage of vehicles deep cleaned within the 6 week standard to 85%	A Hansen	Q4: March 2020	Q&P Cttee	
Implementation of a system to capture IPC compliance standards	Pilot IPC audits on stations and vehicles reviewed and new compliance standards implemeted via operational managers	A Hansen	Q4: March 2020	Q&P Cttee	
Implementation of live IPC standards	Live IPC standards on stations and vehicles checked via quality visits	A Hansen	Q4: March 2020	Q&P Cttee	
Non-compliance with hand hygiene	100% compliance with the WHO 5 moments of hand hygiene before patient contact	A Hansen	Q4: March 2020	Q&P Cttee	
Medicines Management					
Reduction in expired drugs remaining in circulation	Less than 1% of medicine pouches with expired drugs remaining in circulation 1 week beyond their expiry date	Dr C Grant	Q4: March 2020	Q&P Cttee	
Reduction in medicines disposal	Reduce medicines disposal of as waste by 25%	Dr C Grant	Q4: March 2020	Q&P Cttee	
Lack of medicines management performance reporting	Pilot medicines managmeent performance metrics decoupled from bundles, agreed and reported on a monthly dashboard	Dr C Grant	Q4: March 2020	Q&P Cttee	
Safety					
Establishing a safety culture	Pilot a programme of diagnostic safety culture surveys	K Goldthorpe	Q4: March 2020	Q&P Cttee	
Introduction of safety training	Establish a programme of safety training and education for all relevant staff	K Goldthorpe	Q4: March 2020	Q&P Cttee	
Introduction of digital systems	Establish digital systems for measuring, monitoring and reducing avoidable harm	A Harrison	Q4: March 2020	Q&P Cttee	
Development of Clinical Audit Programme	Develop Clinical Audit Programme to include audits of appropriate safety practice	Dr C Grant	Q4: March 2020	Q&P Cttee	
Effectiveness					
National ACQI Measures	Improved performance against all national ACQI measures	Dr C Grant	Q4: March 2020	Q&P Cttee	
Local Clinical Quality Indicators	Approve a suit of local clinical quality improvement indicators	Dr C Grant	Q4: March 2020	Q&P Cttee	

Risks Scored 15+ Aligned to BAF Risk: SR01					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR02: If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective	**LEAD DIRECTOR:** DoF	**DATIX:** TBC

STRATEGIC PRIORITY: Every Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Calculation of holiday pay
- Cost Improvement Programme (CIP)

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
20	20	15			10	5
5x4	5x4	5x3			5x2	5x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk has reduced from a 20 to a risk score of 15 due to the Trust's financial position at Month 5 is a surplus of £0.546, which is £0.54m better than the planned surplus of £1.393m, pay is overspent by £1.244m and non-pay is overspent by £0.095m. In June 2019, the Trust was notified by NHSI of a post 2018/19 accounts event in relation to additional Provider Sustainability Fund (PSF) of £0.11m. The Trust's financial plan will achieve the notified financial control total of £2.708m surplus. The overall financial performance risk rating at 31 August is 1. Cost Improvement Programme (CIP) for the year is £9.808m, as at M5 the YTD target is £2.627m and the Trust has achieved £3.011m. Capital expenditure as at M5 is £4.188m and sale of assets is £0.091m. At 31 August, the cash and cash equivalents balance is £42.265m. The Trust has achieved the Better Payment Practice Code targets for the first five months of 2019/20.

CONTROLS	ASSURANCES	EVIDENCE
Financial Position		
Level 2: 2019/20 Financial Operating Plans	**Level 2:** Delivery against Financial Operating Plans	Reported to Board of Directors
Level 2: 2019/20 Financial Plans for Capital Programme	**Level 2:** Delivery against Capital Programme	Reported to Board of Directors
Level 2: Standing Financial Instruction, Standing Orders & Scheme of Delegation	**Level 2:** Maintenance of compliance with documentation	Reported to Audit Cttee & Board of Directors
Level 2: Business Case process for all significant change project(s)	**Level 2:** ELC monitoring of business cases	Reported to ELC
Level 2: Monthly accounts comparing actual spend against budget	**Level 2:** Review management of accounts **Level 2:** Monthly scrutiny of in year budgets statements	Reported to Resources Cttee/ ELC
Level 2: CIP Monitoring and Delivery	**Level 2:** Review of progress against CIPs	Reported to CIP Steering Group
Level 2: Patient Transport Service Financial Recovery Plan	**Level 2:** Monitoring of finances and scrutiny of budgets	Reported to Resources Cttee
Financial Score		
Level 3: NHS Improvement Single Oversight Framework	**Level 3:** Forecast Risk Rating for the Trust is 1	Reported to Resources & Board of Directors
Agency Expenditure		
Level 3: 2019/20 reporting to NHS Improvement in respect of agency costs	**Level 3:** Compliance with Regulator Guidance on Agency spend **Level 3:** NHSI monthly submissions and monitoring meetings	Reported to Board of Directors via IPR Reported to Resources Cttee & ELC

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Lack of Long Term Financial Model (5 year focus)	NHSI working with Ambulance Trusts to develop a nationally consistent Financial Model for Ambulance Services	DoF	December 2019	Resources Cttee	
Lack of CIP schemes to deliver identified value	Working with Executive Directors to identify deliverable schemes	DoF	March 2020	CIP Steering Group	

Risks Scored 15+ Aligned to BAF Risk: SR02					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2976	Finance Directorate	There is a risk that failure to achieve the 2019/20 financial plan due to slippage against the CIP Plan which could result in the CIP remaining unidentified	**16 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR03: If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.	**LEAD DIRECTOR:** DoOps	**DATIX:** TBC

STRATEGIC PRIORITY: Right Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Non-delivery of ARP Performance Standards
- Clinical Advisor Gaps in NHS111 Service
- Insufficient call handlers in Carlisle Support Centre

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
15	15	15			10	5
5x3	5x3	5x3			5x2	5x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk is maintained at a score of 15 due to activity continues to see an increase in incident/ call volume against commissioning plans. NWAS are taking less patients to Emergency Departments. There has been significant improvement in the response to the most life threatening calls, set against an increase in demand. Monitoring/ actions are relating to Hospital Handover continue and the 'Super Six' sites have been extended to include further eight Acute Trusts. It has been agreed that additional support from Private Ambulance resources will continue through to December, including New Year's Eve to support service delivery. There has been changes in primary care accessibility impacting on the Trust's ability to meet Hear and Treat and See and Treat, therefore more patients being transported to hospital.

CONTROLS	ASSURANCES	EVIDENCE
Performance		
Level 1: Demand Management Plan	**Level 2:** Dynamic Performance Data	Reported to Quality & Performance Cttee
Level 1: Increased EMD Deployment	**Level 2:** Improvements in Call Performance	Reported to Quality & Performance Cttee
Level 1: Auto Divert for Cagtegory 1	**Level 2:** Improvements in C1 Allocation and Performance	Reported to Quality & Performance Cttee
Level 1: Enhanced Working Practices in EOC/ Clinical Hub	**Level 1:** Reduction in conveyance **Level 2:** Hear & Treat Performance Improvements	Reported to Quality & Performance Cttee
Level 2: NHS 111 Performance Improvement Plan	**Level 2:** NHS 111 Performance Report	Reported to Quality & Performance Cttee
Level 2: See & Treat Action Plan	**Level 2:** Action Plan Progress Report	Reported to Quality & Performance Cttee
Level 2: Service Delivery Improvement Plan	**Level 2:** Performance Recovery Timeline	Reported to Quality & Performance Cttee
Activity		
Level 1: Hospital Ambulance Liasion Officers	**Level 3:** NHS Improvement Scheme; reduction in Hospital Handovers	Reported to Quality & Performance Cttee
Level 2: Adverse Weather Plan 2019/20	**Level 2:** Contigency Planning	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Trained Commanders	**Level 2:** Emergency Planning Preparedness Report	Reported to Quality & Performance Cttee
Level 3: Joint Strategic Partnership Framework for Ambulance Handover and Turnaround	**Level 2:** Improvements in Hospital Handover & Turnaround Times	Reported to Quality & Performance Cttee
Level 2: Robust Civil Contingencies	**Level 3:** NARU HART Compliance & Quality Assurance Standards	Reported to Quality & Performance Cttee
Resources		
Level 1: Management structure to support staff	**Level 1:** 24/7 management presence providing leadership support	Reported to Quality & Performance Cttee

Level 1: Management structrue to improve performance	**Level 1:** 24/7 management presence providing operational support	Reported to Quality & Performance Cttee			
Level 1: Increased number of Double Crewed Ambulances	**Level 1:** Paramedics on majority of responding vehicles	Reported to Quality & Performance Cttee			
Level 1: Recruitment of additional staff in EOC	**Level 1:** Increased improvements on performance targets	Reported to Quality & Performance Cttee			
Level 1: PES Vehicle Replacement Programme	**Level 2:** Deliverables against Fleet Strategy 2019/23	Reported to Resources Cttee			
Level 2: National Resource Escalation Action Plan (REAP)	**Level 2:** Challenges to activity or capacity experienced by the Trust	Reported to ELC			
Level 2: Roster Review for 111 Service/ PES/ EOC & CHUB	**Level 2:** Project plan to deliver the roster review	Reported to Resources Cttee & Quality & Performance Cttee			
Level 2: EOC Management Restructure	**Level 2:** Regional wide uniformity	Reported to Quality & Performance Cttee			
Level 3: Private Ambulance Providers	**Level 2:** Resources in line with workforce plan and demand	Reported to Quality & Performance Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Lack of detailed performance information at vehicle level to enable management oversight of individual performance	External review of performance data & system capabilities commissioned to inform future reporting	DoQII	September 2019	Q&P Cttee	
Implementation of a new PES & 111 Structure	Structure that supportds regular performance management and improved sector governance and compliance	DoOps	September 2019	Q&P Cttee	
Primary care provisons	Discussions with local health economy to reinstate primary care provisions	DoOps	December 2019	Q&P Cttee	
Improvements in PES performance in line with ORH Modelling	Continued monthly improvements in ARP 999 call pick up	DoOps	December 2019	Q&P Cttee	
	Cat 1 to 4 performance towards the Mean and 90th Centile national targets	DoOps	December 2019	Q&P Cttee	
	Develop innovative ways to improve Cat 3 & C4 performance	DoOps	December 2019	Q&P Cttee	
Preparation for NHS 111 CQC Inspection	Audit team to identify any gaps and to take action	DoOps	December 2019	Q&P Cttee	
Meal Break Policy	Robust enforcement of the Meal Break Policy	DoOps	December 2019	Q&P Cttee	
Improvements in NHS 111 performance in with contract by year-end	Positioning the Trust for the new EUC 111 specification	DoOps	March 2020	Q&P Cttee	
Resourcing model is not responsive to levels of 2019 demand	External review of whole system rota to identify opportunities to improve flexibility of resource	DoOps	June 2020	Q&P Cttee	

Risks Scored 15+ Aligned to BAF Risk: SR03					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2262	Organisational Development	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact	**20 Significant**	**16 Significant**	8 High
2919	Service Delivery Directorate	There is a risk that if the Trust does not deliver on all ARP performance standards then patient care could be comprised which could result in reputational damage to the Trust, a £1 million fine and an increase in patient complaints	**25 Significant**	**15 Significant**	5 Moderate
2920	Service Delivery Directorate	There is a risk that insufficient workforce resources are not in place across NHS 111 Service leading to inability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust	**20 Significant**	**16 Significant**	4 Moderate
2959	Service Delivery Directorate	There is a risk that insufficient call handlers in the Carlisle Support Centre to answer the calls in a timely manner then operational staff may be delayed in reporting safeguarding referrals and vehicle breakdowns which could result in potential patient safety and/ or crew safety	**20 Significant**	**15 Significant**	5 Moderate
3156	Service Delivery Directorate	There is a risk that if consistent high rates of sickness and absenteeism occur across the 111 service this could result in KPIs not being achieved so impacting on patient care and reputational damage to the Trust	**20 Significant**	**16 Significant**	4 Moderate

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR04: If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives

LEAD DIRECTOR: DoOD

DATIX: TBC

STRATEGIC PRIORITY: Every Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Increased demand for driver training
- Clinical Advisor Gap in NHS 111

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	12			8	4
4x3	4x3	4x3			4x2	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk is maintained at a risk score of 12 due to recognising the number of high risks focused on a small area of the Trust. The continual reporting of the Workforce Indicators remain positive throughout the quarter demonstrated positive delivery against the Workforce Strategy and Objectives. Ongoing progress against the Workforce Strategy remains broadly on track with good levels of assurance being reported against the delivery.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Level 2: Workforce Strategy	**Level 2:** 3 Year Implementation Plan	Reported to Resources Cttee
Level 2: 2019/20 Objectives	**Level 2:** Progress Report against delivery of objectives	Reported to ELC, Resources Cttee & Board of Directors
Level 2: Integrated Business Plan	**Level 2:** Identified Deliverables	Reported to Board of Directors
Recruitment and Retention		
Level 2: Recruitment & Selection Prcoedure	**Level 2:** Complaince against procedure	Reported to Resources Cttee
Level 2: Workforce Plan	**Level 2:** Vacancy Gap **Level 2:** Workforce Indicators Report	Reported to Audit Cttee/ Resources Cttee/ ELC/ Board of Directors
Level 2: Criminal Records Checks	**Level 3:** MIAA Internal Audit	Reported to Audit Cttee
Level 2: Clinical Registration Policy (Revised 2019)	**Level 2:** Compliance against policy	Reported to ELC
Level 2: Safer Staffing Assessment	**Level 2:** Completion against national safe staffnig requirements	Reported to Resources Cttee
Level 3: HEE & HEI Paramedic Supply Plan (Revised 2019)	**Level 3:** Funding agreed for commissioned places **Level 2:** Internal Progression Programme	Reported to ELC
Developing Potential		
Level 2: Mandatory Training Procedure	**Level 2:** Workforce Indicators Report **Level 2:** Bi-Annual Audit	Reported to Resources Cttee/ Board of Directors via IPR
Level 2: Appraisal Policy and Procedure	**Level 2:** Workforce Indicators Report **Level 2:** Bi-Annual Audit	Reported to Resources Cttee/ Board of Directors via IPR Updated procedure reported to EMT
Level 2: Perceptorship Policy	**Level 2:** Monthly return to NHSI, National AIP WF Development Group	Reported to AIP WF Development Group/ NENAS
Level 2: Apprenticeships	**Level 2:** Self assessment report **Level 2:** Annual Quality Improvement Plan	Reported to Annual Public Sector Duty Return/ ELC
Level 2: Paramedic Upskilling Training Plan	**Level 2:** Delivery of upskilling training plan **Level 2:** Monthly return to NHSI	Reported to Resources Cttee/ NHS I & National AIP
Level 3: Future Quals	**Level 3:** Future Quals Accreditation	Reported to ELC

Wellbeing		
Level 1: Attendance Improvement Plan: PTS & NHS 111	**Level 2:** Compliance with Improvement Plan	Reported to Resources Cttee & National AIP
Level 2: Sickness Absence Procedure & Action Plan	**Level 2:** Workforce Indicators Report **Level 2:** Quarterly Sickness Absence Audits **Level 3:** Action Plan with NHSI **Level 3:** MIAA Internal Audit	Reported to Resources Cttee/ Audit Cttee/ Board of Directors via IPR
Level 2: Bullying & Harassment Action Plan	**Level 2:** Policy Review **Level 2:** Establishment of Working Group	Reported to Resources Cttee, ELC and Board of Directors
Level 2: Flu Campaign	**Level 2:** Annual Flu Plan for 2019/20	Reported to Resources Cttee, ELC and Board of Directors
Level 2: Staff Survey Action Plan	**Level 2:** Localised Engagement Plan	Reported to Resources Cttee, ELC and Board of Directors
Level 3: Occupational Health Contract	**Level 2:** Agreed and signed by Board of Directors **Level 2:** Monitoring of monthly KPIs	Reported to NWAS Contract Manager/ Board of Directors
Level 3: Occupational Health Procedure	**Level 2:** Procedure Review	Reported to ELC
Level 3: NHSI Health & Wellbeing Diagnostic Tool	**Level 2:** Completion of self-assessment tool	Reported to NHS Improvement/ Resources Cttee
Level 2: Health and Wellbeing Practices	**Level 3:** Distinction in Health and Wellbeing Award	Reported to Board of Directors
Inclusion		
Level 2: WRES Measure	**Level 2:** Annual WRES Report & Action Plan **Level 2:** EDI Annual Report	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: WDES Measure	**Level 2:** Annual WDES Report **Level 2:** WDES Action Plan	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: Gender Pay Gap Action Plan	**Level 2:** Monitoring & Reporting of Action Plan **Level 2:** Women in Leadership Programme	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: Equlaity & Diversity Assessment 2	**Level 2:** Delivery of action plan	Reported to Resources Cttee
Level 2: Annual Equality & Diversity Plan	**Level 2:** WF Strategy Measures	Reported to Board of Directors/ ELC/ Board of Directors
Level 2: Reservist Procedure (Revised 2019)	**Level 3:** Gold Standard Accredition Recognition	Reported to ELC/ Board of Directors
Leadership		
Level 2: Leadership Framework	**Level 2:** Implementation Plan **Level 2:** Delivery against identified milestones	Reported to ELC/ Board of Directors Reported to Resources Cttee
Level 2: Board Succession Planning in Place	**Level 2:** Summary of talent conversations and potential **Level 2:** Shadow Board Development Plan	Reported to Resources Cttee
Level 2: Talent Management Tool	**Level 2:** Tool part of succession planning guidance	Reported to Resources Cttee
Level 2: Leadership Recruitment Approach		
Level 2: Leadership Induction Programme	**Level 2:** Revised induction developed, pilot with SPTLs	Reported to ELC
Level 3: CMI Accreditated Centre	**Level 3:** External Assurance Visits	Reported to ELC/ Board of Directors

Improvement and Innovation					
Level 2: Organisational Change Policy	**Level 2:** Agreed Policy	Reported to ELC			
Level 2: Rota Review Programme	**Level 2:** Funding agreed **Level 2:** Project Steering Group	Reported to ELC/ Board of Directors			
Level 2: Rotational Working Project	**Level 2:** Evaluation of UCP Pilot Scheme **Level 2:** Internal & External Roational Working Task & Finish Groups	Reported to ELC			
Level 2: Policy Framework	**Level 2:** Partnership Agreement **Level 2:** Policy Group	Reported to Resources Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Monitoring the progress of the first 4 cohorts of apprentice EMT1s	OfSted assessment and ESFA assessment to be completed to ensure cohorts are on track for completion	DoOD	September 2019	Resources Cttee	
Paramedic Programme inline with National Paramedic Programme	Review plans for Paramedic supply, assessing impact of HEE funding arrangements and implementation of degree model	DoOD	September 2019	ELC	
Completion of management actions from MIAA sickness absence audit	Analysis of current quarterly audit to ensure MIAA actions have been implemented	DoOD	October 2019	Resources Cttee	
Address high turnover in Call Centres	Evaluate EOC Retention Programme	DoOD	October 2019	Resources Cttee	
Backlog of DBS Checks	Clear backlog of retrospective DBS Checks	DoOD	December 2019	ELC	
Address shortage of Nurses across the Trust	Deliver Nurse Recruitment Plan	DoOD	March 2020	Resources Cttee	
Leadership Framework Review	Deliver milestones for Year 2 of implementation	DoOD	March 2020	Resources Cttee	
Paramedic upskilling training plan	Training plan to be at 60% complete, on track for September 2019	DoOD	March 2020	Resources Cttee	
Paramedic supply from GP Report regarding paramedics in Primary Care	Development of External & Internal Task and Finish Groups to assess impact and develop offer	DoOD	March 2020	Programme Board	
Induction Compliance	Annual compliance report submitted	DoOD	March 2020	Resources Cttee	
WDES Reporting	Reporting of Action Plan	DoOD	March 2020	Resources Cttee	
EDA 3 to be implemented	Equaliy and Diversity Assessment 3 to be implemented	DoOD	March 2020	Resources Cttee	

Risks Scored 15+ Aligned to BAF Risk: SR04					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2262	Organisational Development	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact	**20 Significant**	**16 Significant**	8 High
3026	Organisational Development	There is a risk that increased demand for driver training combined with national and local driving instructor shortages will impact on delivery of front-line emergency driver training and compliance with regulatory framework	**20 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR05: If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives

LEAD DIRECTOR: DoF

DATIX: TBC

STRATEGIC PRIORITY: Every Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Terms of lease breaks
- National restraints on Capital Funding

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	12			6	3
3x4	3x4	3x4			3x2	3x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk has remained at a risk score of 12, there has been some risk mitigations that have taken place including the procurement of the facet survey and the improved assurance of reporting compliance with statutory requirements. The Trust has recently devised and approved its Sustainable Development Management Plan. It is recognised that they are on-going works in relation to ORH, Make Ready Schemes; including Hub and Spoke. They are ongoing concerns with the 111 Estates and the EOC reconfiguration.

CONTROLS	ASSURANCES	EVIDENCE
Level 1: Levels of backlog maintenance within current Estate	**Level 3:** Drivers Jonas completed 6-facet surveys (2016)	Reported to Resources Cttee
Level 2: Station relocation and closures	**Level 2:** Annual Capital Reciepts for reinvestment	Reported to Resources Cttee
Level 2: Committed expenditure in line with funding	**Level 2:** Identified programmes and costings established for 2019/20	Reported to Resources Cttee
Level 2: Sustainable Development Management Plan	**Level 2:** Deliverables against NHS Carbon Reduction Strategy	Reported to Resources Cttee
Level 2: Compliance with statutory requirements	**Level 2:** Fleet & Estates Assurance Report	Reported to Resources Cttee
Level 2: Partnership with other services	**Level 3:** Shared facilities with other blue light services/ public bodies	Reported to Resources Cttee
Level 2: Performance Measurement and Benchmarking	**Level 3:** Participation in benchmarking & DoH's Annual Estates Returns Information Collection (ERIC)	Reported to Resources Cttee
Level 3: Energy Performance of Buildings	**Level 3:** New buildings designed to achieve BREEAM excellence	Reported to Resources Cttee

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Backlog Maintenance Improvement/ Lack of a detailed plan	Develop backlog maintenance improvements plan for existing sites Procurement for Facet Survey to be completed for Estates	DoF	December 2019	Resources Cttee	
Improved communications across the Trust regarding estate issues	Improve Trust-wide communications regarding estates, including a suggestion scheme	DoF	December 2019	Resources Cttee	
Delivery against PES 5 Year Estates Plan	Estates Team to lead on development based upon Optima Modelling to assure ARP provides prime focus	DoF	March 2020	Resources Cttee	
Delivery against PTS 5 Year Estates Plan	Estates Team to lead on development based upon demand analysis and contractual parameters	DoF	March 2020	Resources Cttee	
Estates rationalisation	Reduction in running costs of estate	DoF	March 2020	Resources Cttee	
Maintenance of the estate	Compliance with statutory and regulatory requirements	DoF	March 2020	Resources Cttee	
Implementation of Trust's Sustainable Development Plan	Delivering the requirements of the NHS Carbon Reduction Strategy	DoF	March 2020	Resources Cttee	

Risks Scored 15+ Aligned to BAF Risk: SR05					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2766	Finance	There is a risk that if the Trust does not decide in a timely manner to invoke the terms of the lease break (if required) for 111 Middlebrook in September 2020 this could result in significant financial implications (5 years extra lease payments to end of lease term).	**20 Significant**	**16 Significant**	4 Moderate

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR06: If the Trust does not establish effective partnerships within the regional health economy and integrated care systems then it may be able to influence the future development of local services leading to unintended consequences on the sustainability of the Trust and its ability to deliver Urgent and Emergency Care	**LEAD DIRECTOR:** DoS&P	**DATIX:** TBC

STRATEGIC PRIORITY: Right Place

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Sustainability and Transformation Partnerships (STPs)/ Integrated Care Systems

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
8	8	8			4	4
4x2	4x2	4x2			4x1	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk is maintained at a score of 8 due to the capacity to engage with STPs and system partners, in addition the complexity of the environment, for example, STPs are at different stages across the North West. The capacity is being addressed and it is envisaged that we will mitigate this as time progresses. Work will continue across the three areas to ensure that we continue to engage with STPs across the areas, and put in place mechanisms to work together effectively going forward.

CONTROLS	ASSURANCES	EVIDENCE
Level 1: Representation and attendance at key meetings	**Level 2:** Early indictors of potential changes that may be introduced to the system	Reported to Board of Directors
Level 1: Designated Executive Lead for each of the STP footprints/ County areas	**Level 2:** Executive Leads in each of the STP areas allows for focus within each area	Reported to ELC and Board of Directors
Level 1: Nominated Senior Management Leads for each area	**Level 2:** Reports of ongonig work within allocated area	Reported to ELC and Board of Directors
Level 2: Representation on STP Finance & Investment Group	**Level 2:** Senior Trust representation across the STP workstreams	Reported to ELC and Board of Directors
Level 2: Feedback in gathering and sharing strategic intelligence with key staff across the Trust	**Level 2:** Emerging strategic issues and consequential impact on the Trust's operational function	Reported to ELC and Board of Directors
Level 2: Centralised process for collating and cascading information from adhoc meetings	**Level 2:** Sharepoint site provides a central repository for all information from key meetings to enable access to key leads	Reported to ELC and Board of Directors
Level 2: Changes to Commissioning landscape	**Level 2:** Review of system wide reconfiguration through use of Optima to understand collective impact	Reported to ELC and Board of Directors
Level 2: Executive leads aware of roles in light of changes to leadership	**Level 2:** Adeuate coverage across STP footprint	Reported to ELC and Board of Directors
Level 2: Board Development Session surrounding GM Devolution	**Level 2:** Updates and chamges regarding GM Devoultion and emerging changes in Commissioning	Reported to Board of Directors

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Bi-Annual Reporting to Board of Directors	Introduce a bi-annual report to summarise the changes in the GM landscape and commissioning arrangements	DoS&P	December 2019	BoD	
Trust engagement with STP's LAED's & HOSC's ensuring appropriate representation	Options to make the case for change and seek opportunities for additional sourcing of funding	DoS&P	December 2019	BoD	
	Articulate the Trusts "once for NW region" offering to the Health & Social Care system to secure investment in the Trust and achieve buy in	DoS&P	December 2019	BoD	
Lack of robust feedback loop	Implementation of robust feedback loop to discuss issues and consequential impact on the operational function of the Trust	DoS&P	December 2019	BoD	

Risks Scored 15+ Aligned to BAF Risk: SR06					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR07: If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity	**LEAD DIRECTOR:** DoQII	**DATIX:** TBC

STRATEGIC PRIORITY: Every Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Inability to deliver business as usual projects due to capacity and capability within the IT team
- Critical Telephone Systems
- Lack of robust risk and renewal road map for Trust wide systems
- Lack of asset ownership for hardware and software
- Unsupported software and hardware potential cyber-attacks

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
20	20	16			12	8
4x5	4x5	4x4			4x3	4x2
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 risk score of this BAF risk has decreased to a score of 16 due to the newly formed leadership team in place including the funding of a fixed term Head of Digital Delivery to lead large projects. Mitigations to Asset Management and Cyber Security have made significant progress; The Trust are able to identify all assets in the organisation and have a list of assets with associated owners. There has been an enterprise agreement with Microsoft which locks down prices and simplifies procurement processes. The CAD has been migrated to a new server and is no longer unsupported. The IT health dashboard has been operationalised to enable real time monitoring of assets, this level of visibility and assurance represents a significant improvement for the Trust in terms of ability to monitor and manage assets against possible threats. MIAA specialists are now working onsite to produce an action plan for cyber security and the Trust has completed the Cyber essentials assessment, but awaiting the results.

CONTROLS	ASSURANCES	EVIDENCE
Executive Leadership		
Level 1: Executive Leadership vacancies within Digital	**Level 1:** Leadership structure in place	Reported to ELC
Cyber Security		
Level 1: Cyber Security Specialist Support	**Level 3:** MIAA contracted to provide specialist support	Reported to ELC & Resources Cttee
Level 1: Cyber Essentials Assessment	**Level 1:** Assessment completed	Reported to Digital Oversight Forum
Level 1: IT Health Dashboard	**Level 2:** Monitoring of assets, visability of security threats and vulnerabilities & assurance of completion of mitigation	Reported to Digital Oversight Forum
Level 2: Asset License Management	**Level 3:** Monitoring provided by Trustmarque	Reported to Resources Cttee
Level 3: Cyber Essentials Framework	**Level 3:** MIAA Internal Audit Report	Awaiting to be reported to ELC
Level 3: Cyber Security/ Email User Behaviour Exercise	**Level 3:** MIAA Internal Audit Report	Reported to ELC & Audit Cttee
Level 3: Testing for vulnerabilities	**Level 3:** Microsoft Report	Reported to ELC & Audit Cttee
Digital System & Developments		
Level 1: Change Control Processes	**Level 1:** Review of changes and widely communicated	Reported to Change Advisory Board
Level 1: Supplier Engagement on high impact service changes	**Level 2:** Service Level Agreements in place with suppliers	Reported to ICT SMT
Level 2: Review and prioritisation of unsupported critical systems	**Level 2:** Critical Systems Recovery Plan	Awaiting to be reported to ELC
Level 2: IT Health Dashboard	**Level 2:** Live Status Data for Reporting	Reported to ELC/ Resources Cttee
Level 2: Business Continunity Plans	**Level 2:** Review of BCM Plans	Reported to Board of Directors

Level 3: Data Protection Practices	**Level 3:** ICO Audit Report	Reported to ELC			
Level 3: External Penetration Testing and Social Engineering	**Level 3:** External Audit Report	Awaiting to be reported to ICT Security Forum/ IG Management			
Level 3: Assessment of readiness for transition to cloud based	**Level 3:** Shape and Cloud Review/ Audit	Awaiting to be reported to ELC			
Level 3: Mobile Computering Device Audit	**Level 3:** MIAA Internal Audit	Reported to ELC/ Resources Cttee & Audit Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Lack of specific training for agreed Information Asset owners in relation to requirements of the role and core standards	Develop & deliver a programme of training for Information Asset Owners	Chief D&I	December 2019	IG Management	
ICT Standards require review in light of Cyber Essentials Plus to ensure there are clear auditable standards for the ICT architecture	Review ICT Standards as part of Cyber Essentials Plus action plan	Chief D&I	March 2020	ELC	
Lack of specific system resilience testing as part of Business Continuity Testing	Develop Programme of system resilience testing in line with ICT structure review	Chief D&I	March 2020	ELC	
5 areas of improvement identified from Internal Audit review covering system controls	Development of an overarching plan to address findings from both assessments and demonstrate compliance with Cyber Essentials Plus	Chief D&I	March 2020	IG Management	
Action plan in response to the NHS Digitial Assessment of Cyber readiness to be developed - to be monitored by IMG					

Risks Scored 15+ Aligned to BAF Risk: SR07					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
1181	Quality Directorate	There is a risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales	**20 Significant**	**15 Significant**	10 High
2480	Quality Directorate	There is a risk that unsupported software and hardware due to the lack of asset ownership, risk and renewal road map for existing systems and governance for cyber security will lead to costly last minute updates, potential cyber-attacks and loss of systems	**20 Significant**	**16 Significant**	8 High
2748	Quality Directorate	There is a risk that we will not be able to deliver key business as usual projects and innovations due to lack of capacity and project management expertise in the IT team which may lead to unsecure systems, system disruption or loss of critical systems	**20 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR08: If the Board experiences significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy	**LEAD DIRECTOR:** CEO	**DATIX:** TBC

STRATEGIC PRIORITY: Right Time

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Embedding to the Corporate Governance Structure & Meetings
- Independent Well-Led Review

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	8			8	4
4x3	4x3	4x2			4x2	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q2 score of this BAF risk has decreased to a score of 8 due to the recent appointments of the Non-Executive Director vacancies and the Associate Non-Executive Directors to enable robust succession planning. The Trust has a strong and varied Executive Leadership Team with additional capacity of a Deputy Chief Executive. The launch of the Shadow Board is a key enabler of Board Succession Planning, identifying a strong Deputy structure across the Trust with the potential to step-up to as a Board member in the future. The Board skills matrix has been completed which has identified any learning and development opportunities with a robust Board Development Programme.

CONTROLS	ASSURANCES	EVIDENCE
Level 2: Executive Portfolio Reviews	**Level 2:** Executive Objectives & Priorities agreed and set	Reported to NAR Cttee
Level 2: NED Induction Programme	**Level 2:** Completed Induction Checklist	Reported to Board of Directors
Level 2: Board Skills Matrix	**Level 2:** Board Development Programme for 2019/20	Reported to Board of Directors
Level 2: Board Succession Plan	**Level 2:** Approved NHS Leadership Academy Shadow Board	Reported to Board of Directors
Level 2: Chief Executive Visits	**Level 2:** Chief Executive Report on Internal Engagement Visits	Reported to Board of Directors
Level 3: External engagement meetings	**Level 2:** Chief Executive Report on External Engagement Meetings	Reported to Board of Directors

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Executive Structures	Review Executive structures and sumbission of proposals	CEO	November 2019	BoD	
Board Well-Led Self Assessment	Undertake a Board Well-Led Self Assessment	CEO	November 2019	BoD	
Lack of recent independent Well-Led/ Board Effectiveness assessment	Commissioning Indpendent Well-Led review/ Board Effectiveness Review	CEO	November 2019	BoD	
Preparation for forthcoming CQC Inspection	Preparation, review of domains and governance systems and processes	CEO	December 2019	BoD	
Brand and reputation of NWAS	Maintain increased stakeholder engagement, where appropriate	CEO	March 2020	BoD	

Risks Scored 15+ Aligned to BAF Risk: SR08					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

Appendix 3:
Board Assurance Framework (BAF) Heat Maps
Quarter 2 Position

NHS North West Ambulance Service NHS Trust

2019/20 Opening BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR03 15	SR02 20	25
4 Major	4	SR06 8	SR04 12 SR08	SR01 16	SR07 20
3 Moderate	3	6	SR10 9	SR05 12	15
2 Minor	2	4	6	8	SR09 10
1 Insignificant	1	2	3	4	5

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR03 15	SR02 20	25
4 Major	4	SR06 8	SR04 12 SR08	SR01 16	SR07 20
3 Moderate	3	6	SR10 9	SR05 12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Likelihood

Populated: 31 July 2019
Owner: Snr Risk & Assurance Manager

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR03 15 SR02	20	25
4 Major	4	SR06 8 SR08	SR04 12 SR01	SR07 16	20
3 Moderate	3	6	SR09 9	SR05 12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Likelihood

Populated: 01 October 2019
Owner: Snr Risk & Assurance Manager

2019/20 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	SR02 10 SR03	15	20	25
4 Major	SR06 4	SR04 8 SR08	SR01 12 SR07	16	20
3 Moderate	3	SR05 6 SR10	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

Final Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	SR02 5 SR03	10	15	20	25
4 Major	SR04 4 SR06 SR08	SR01 8 SR07	12	16	20
3 Moderate	SR05 3 SR10	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

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Appendix 4

BAF: End of Q3 Process & Timescales

Friday 13th December 2019

INFORMATION TO BE CIRCULATED TO EXECUTIVE DIRECTORS:

- Assurance Mapping
- Risks Scored 15+

Monday 18th November 2019

Quality & Performance Cttee
PAPER DEADLINE: 11 Nov 2019
Proposed Q3 BAF Position reported to Cttee for review

w/c. Mon 16th December 2019

QUARTERLY REVIEW MEETINGS
Executive Directors/ Senior Managers to conduct end of Q3 BAF review

Friday 17th January 2020

Q3 BAF REVIEW PRESENTED TO AUDIT CTTEE
PAPER DEADLINE: 09 Jan 2020
Q3 BAF Review & BAF Heat Maps

Wednesday 29th January 2020

Q3 BAF REVIEW PRESENTED TO BOARD OF DIRECTORS

- Q3 BAF Review
- Corporate Risk Register
- BAF Heat Maps

NHS
North West Ambulance Service
NHS Trust

Friday 13th December 2019

DATA LOCK DOWN DAY
Risks Scored 15+ updated against the BAF risks up until ELC Paper Deadline

Friday 22nd November 2019

Resources Cttee
PAPER DEADLINE: 14 Nov 2019
Proposed Q3 BAF Position reported to Cttee for review

Wednesday 8th January 2020

Q3 BAF REVIEW PRESENTED TO ELC
PAPER DEADLINE: 31 Dec 2019
Q3 BAF Review & BAF Heat Maps
Corporate Risk Register

Tuesday 21st January 2020

PAPER DEADLINE: 21 Jan 2020

- Q3 BAF Review
- Corporate Risk Register
- BAF Heat Maps

Wednesday 29th January 2020

APPROVAL Q3 BAF POSITION

- Update BAF
- Process Map for Q4 Review

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27th November 2019			
Subject:	Corporate Calendar 2020/21			
Presented by:	Jenna Lancaster, Corporate Governance Manager			
Purpose of Paper:	For Decision			
Executive Summary:	The report details meeting dates for 2020/21 for the Board of Directors and Committees.			
Recommendations, decisions or actions sought:	It is recommended that the Board of Directors: • Approve the Corporate Calendar			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks): none

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	No.
Previously Submitted to:	Executive Directors consulted with, in terms of the corporate calendar 2020/21
Date:	1st November 2019
Outcome:	Approved/supported

PURPOSE

The purpose of this report is to confirm the Board of Directors and Committee dates for 2019/20.

2020/21 CORPORATE CALENDAR

Dates and membership of the Board of Directors and Committees are detailed below:

COMMITTEE	DATES 2020/21	MEMBERSHIP
Board of Directors 9.45am-3.00pm (Last Wednesday) (Bi-monthly)	**2020** 27th May 29th July 30th September 25th November **2021** 27th January 31st March	All Board Members
Board Development 10.00am-4.00pm (Last Wednesday) (Bi-monthly)	**2020** 24th June 26th August 28th October 16th December **2021** 24th February	All Board Members
Audit Committee 10.00am – 12 noon (Friday)	**2020** 17th April 22nd May (Ann Rep & Accts only) 10th July 23rd October **2021** 15th January	David Rawsthorn (Chair) Dr David Hanley Michael O'Connor Prof Rod Thomson
Nominations & Remuneration Committee (Prior to Board Meetings)	**2020** 29th April 27th May 29th July 30th September 25th November **2021** 27th January 31st March	All Non-Executive Directors
Quality and Performance Committee 1.00pm – 4.00pm (3rd Monday) (Monthly)	**2020** 20th April 18th May 15th June	Prof Alison Chambers (Chair) Dr David Hanley Mr Richard Groome Prof Rod Thomson

	20th July 21st September 19th October 16th November **2021** 18th January 15th February 15th March	 Dr Chris Grant Prof Maxine Power Ged Blezard Carolyn Wood Michael Forrest
Resources Committee 10.00am - 1.00pm (3rd Friday) (Bi-monthly)	**2020** 18th May 24th July 25th September 20th November **2021** 22nd January 26th March	Michael O'Connor (Chair) Richard Groome David Rawsthorn Clare Wade Carolyn Wood Ged Blezard Lisa Ward Maxine Power Salman Desai
Charitable Funds Committee 3.00pm -4.00pm (Last Wednesday) (Bi-Annual)	**2020** 29th April 28th October	David Rawsthorn (Chair) Richard Groome Dr D Hanley Carolyn Wood Ged Blezard Lisa Ward Salman Desai Angela Wetton

LEGAL and/or GOVERNANCE IMPLICATIONS

There are no specific legal implications, however, there are governance implications in terms of the establishment and membership of Board committees.

Membership of the Board and Committees is set in conjunction with the Trust's Standing Orders and Reservation of Powers and Terms of Reference have been established for each committee.

RECOMMENDATIONS

It is recommended that the Board of Directors:

- Approve the Board of Directors and Committee dates for 2020/21.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th November 2019
Subject:	Policy Framework Update 1st July 2019 – 20th November 2019
Presented by:	Jenna Lancaster, Corporate Governance Manager
Purpose of Paper:	For Assurance
Executive Summary:	A robust Policy Framework is a key element of a corporate governance framework, recognising that out of date policies can leave the trust at risk. During the period 1st July 2019 – 20th November 2019, 20 policies/procedures were approved. 11 of which had minor changes and were therefore approved by the relevant executive. 9 policies/procedures were approved by the Executive Leadership Committee. The review dates for two of the policies were extended. The Medical Director approved to extend the review date of the Public Health Plan 2017-2022 to April 2020. The Executive Leadership Committee agreed to extend review date of the Lease Car Policy to December 2019. At its meeting held on the 20th November, the Executive Leadership Committee approved the revised Policy and Procedure Process, to include the Learning from Deaths Policy that requires Board approval. 10 policies are currently under review.
Recommendations, decisions or actions sought:	The Board of Directors are asked to: (i) note the policies and procedures approved during the period during 1st July 2019 – 20th November 2019 and to note that work is being carried out to review the policies that have expired review dates, (ii) Note that at its meeting held on the 20th November, the Executive Leadership Committee approved the revised Policy and Procedure Process, to include the Learning from Deaths Policy that requires Board

	approval.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**	
☒	☒	☒	☒	☒	☒	☒	☒	☒	

Are there any Equality Related Impacts:	EIA required to be completed for each policy
Previously Submitted to:	N/A
Date:	N/A
Outcome:	N/A

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1. PURPOSE

The purpose of this report is to provide details of the policies and procedures approved by either the Executive Leadership Committee or individual Executive Directors during the period. During 1st July 2019 – 20th November 2019. The report also includes details of policies and procedures that have expired review dates.

2. BACKGROUND

At its meeting on the 9th May 2018, the Executive Management Team agreed a revised process for approving policies and procedures, to prevent overloading committees and Board meetings with policy approval.

Approval process for policies and procedures.

New Policies

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor. New policies may also be required as a result of the development of a new service or new way of working.

1. The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure. The aim should be to keep the number of policies to a minimum. The lead director should be able to provide a clear justification for the development of any new policy.
2. It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process with key stakeholders e.g. Unions; HR; Legal; etc.
3. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
4. Following approval – the corporate governance team will update the Policy Database
5. The lead director will be responsible for dissemination and training in relation to the policy and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

Amendments to Existing Policies

1. The lead director reviews the policy on the agreed cyclical basis and if nothing requires updating, signs off the policy with a new review date; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated.
2. If changes are made but they are minor, e.g. job titles, then the lead director signs off the amended policy; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated
3. If the changes needed are significant i.e. driven by legislative changes, then the lead director is responsible for ensuring that the revised document is consulted on with key stakeholders e.g. Unions; HR; Legal; etc.

4. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
5. Following approval – the corporate governance team will update the policy database
6. The lead director will be responsible for dissemination and training in relation to the policy changes and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

The Policy and Procedures Process has been reviewed in light of NHSI guidance stating that the Trust is required to have a Board approved Learning from Deaths Policy and was approved by the Executive Leadership Committee held on 20th November 2019.

The Policy and Procedures Process is attached at appendix A, for information.

3. APPROVED POLICIES

During the period 1st July 2019 – 20th November 2019., 20 policies/procedures were approved. 11 of which had minor changes and were therefore approved by the relevant executive.

9 policies/procedures were approved by the Executive Leadership Committee.

The review dates for two of the policies were extended. The Medical Director approved to extend the review date of the Public Health Plan 2017-2022 to April 2020. Steve Bell, Consultant Paramedic is working with Public Health Consultants in relation to the Plan.

The Executive Leadership Committee agreed to extend review date of the Lease Car Policy to December 2019.

Policies approved between 1st July 2019 – 20th November 2019.

	Approved by	**Date**
Jul-19		
Capital Assets Procedure	DOF	03/07/19
Income and Debtors Financial Procedure	DOF	03/07/19
Purchasing and Payments with End User Requisitioning	ELC	10/07/19
Capacity to Consent Policy	MD	11/07/19
Policy on Volunteer Staff Responder	DOO	19/07/19
Vehicle Fuel Card Guidance and Procedures	DOF	25/07/19
Access to Legal Services Procedure	ELC	24/07/19
Data Protection & Security Policy	DQII	11/07/19
Aug-19		
Waste Management Policy	DOF	16/08/19
Clinical Audit Policy	ELC	07/08/19
Health Notifications, Alerts & Guidance Review Procedure	ELC	07/08/19
Flexible Retirement & re employment guidelines	DOOD	30/08/19
Sep-19		
Charitable Funds Procedure	DOF	02/09/19

Public Health Plan 2017-2022 (agreed to extend review date to April 2020)	MD	11/09/19
Lease Car Policy (agreed to extend review date to December 2019)	ELC	11/09/19
Pool Vehicle Policy	ELC	18/09/19
Oct-19		
Finance Training Policy	DOF	03/10/19
Procedure for Checking Registration of Clinical Staff	ELC	11/10/19
PRF Quality Management Procedure	ELC	21/10/19
Nov-19		
Wound Care Policy	ELC	13/11/19
Driving Policy	ELC	13/11/19
Occupational Health Procedure	DOOD	11/11/19

4. POLICIES DUE FOR REVIEW

10 of the trust's policies/procedures are currently due to be reviewed.

Policy	Executive Lead	Review Date	Status
HIV	Lisa Ward	December 2018	Currently under review, in conjunction with national guidance
Relief Staff Policy	Director of Operations	March 2019	Currently under review, in conjunction with Trade Unions.
Road Traffic Collision Procedure	Carolyn Wood	April 2019	In process of being updated.
Bank Worker Procedure	Interim Director of Organisational Development	April 2019	In process of being updated.
General Medicines Toolkit	Medical Director	May 2019	In process of being updated.
Controlled Drugs Toolkit	Medical Director	May 2019	In process of being updated.
Recruitment and Selection Procedure	Interim Director of Organisational Development	May 2019	In process of being updated.
Dress Code Policy	Interim Director of Organisational Development	October 2019	In process of being updated.
NW Divert and Deflection Policy	Director of Operations	November 2019	In process of being updated.
Fleet Maintenance Plan	Director of Finance	November 2019	In process of being updated.

Regular contact is made by the Corporate Governance Team with each policy owner to ensure that the latest position is recorded.

All of the policies with an expired review date are currently under review.

5. RECOMMENDATION(S)

The Board of Directors are asked to

(i) Note the policies and procedures approved during the period during 1st July 2019 – 20th November 2019 and to note that work is being carried out to review the policies that have expired review dates,

(ii) Note that at its meeting held on the 20th November, the Executive Leadership Committee approved the revised Policy and Procedure Process, to include the Learning from Deaths Policy that requires Board approval.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	**27th November 2019**			
Subject:	**Freedom to Speak Up Update Q2 2019-20**			
Presented by:	**Rachael Foot, Freedom to Speak Up Guardian**			
Purpose of Paper:	**For Assurance**			
Executive Summary:	**Quarter 2 2019-20** Total number concerns raised : 49 • Patient Safety : 5 • Working Practices : 8 • Grievances : 8 • Data Breach : 5 • Bullying & Harassment Allegation : 18 • Other : 5 By comparison Q2 2018-19 : 12 concerns raised in total • Concerns raisers reporting suffering detriment as a result of raising concerns : 0 • Anonymous concerns raised : 2 • Concerns raised whereby the concern raiser has requested the Guardian and/or Champion protect their anonymity : 22 A summary of the cases closed during Q2 can be seen at **Appendix 1** – this shows the length of time the cases were open; the themes and the outcome/learning identified. A full action plan arising from this review can be seen at **Appendix 2** The latest supplementary guidance for boards on Freedom to Speak Up can be seen at **Appendix 3**			
Recommendations, decisions or actions sought:	The Board is asked to: • Note the key themes of the concerns raised during Q2 2019-20 • Take assurance that no whistle-blowers have reported suffering detriment during the reporting period. • Take assurance that from a Freedom to Speak Up perspective; the majority of concerns raised are closed off in a timely manner.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐
Link to Board Assurance Framework (Strategic Risks):				

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☒	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

This report provides the Board with an overview of the Freedom to Speak Up activity during Quarter 2, 2019-2020

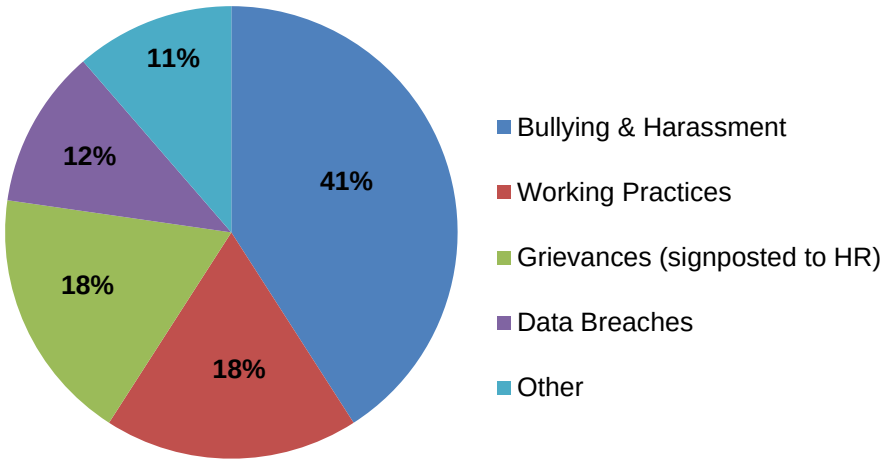
It is the expectation of the National Guardian's Office, CQC and NHSI/E that senior leaders are knowledgeable on Freedom to Speak Up matters and work in partnership with the Freedom to Speak Up Guardian to actively shape the speaking up culture.

2. QUARTER 2 2019-20 ACTIVITY

During the reporting period forty nine concerns were received, by comparison during the same reporting period of the previous year, twelve concerns were raised. This represents a 408% increase in activity during the same period in the previous year.

During the last twelve months the awareness of FTSU has increased dramatically and the recruitment of more Champions across the geographical spread along with the continued promotion of FTSU have helped to increase this awareness which will impact on the number of number of concerns raised.

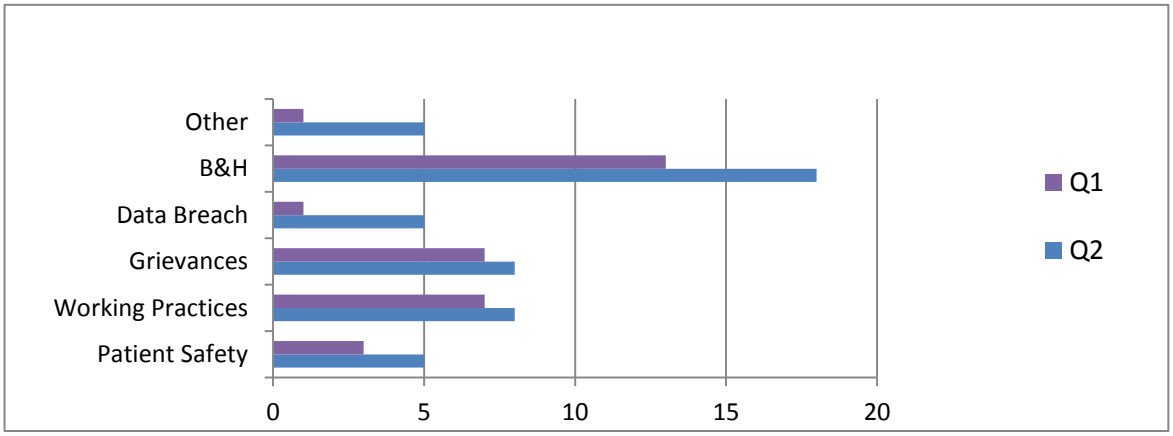
The largest number of concerns raised during Q2 2019-20 fall within the 'Bullying & Harassment category:



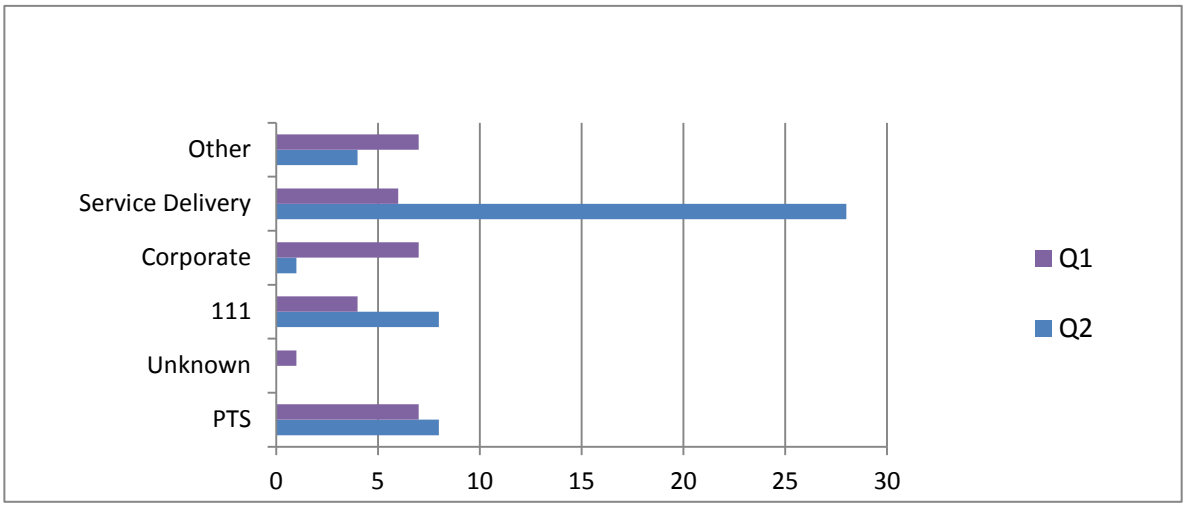
These figures have been reported to the National Guardian's Office.

Shown below are further breakdowns of the data alongside the same reporting period for the previous year (2018-19) for comparison purposes:

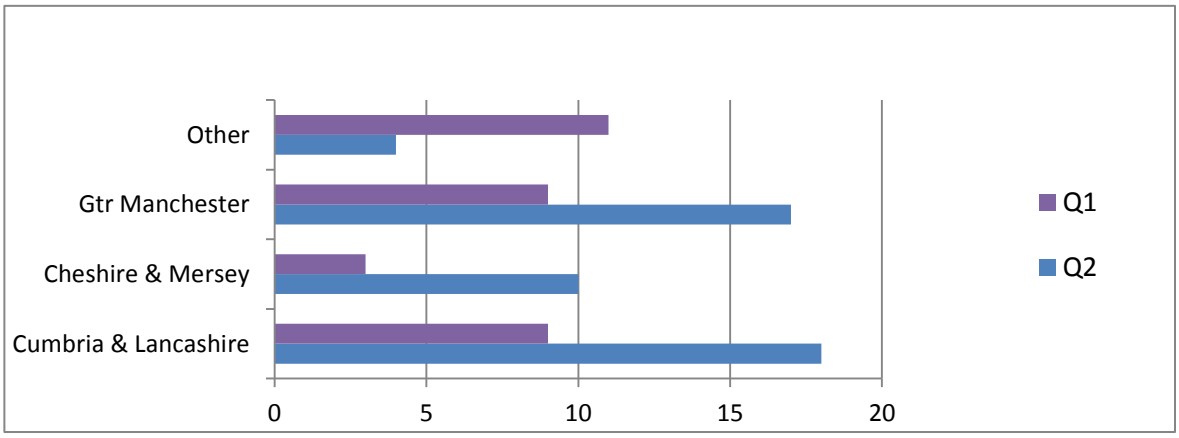
Q2 2019-20 Concerns by National Reporting Category:



Q2 2019-20 Number of Concerns By Service Line:



Q2 2019-20 Concerns by Area:



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

During the reporting period, there have been two anonymous concerns raised with the Guardian and twenty concerns raised whereby the concern raiser has requested the Guardian and/or Champion protect their anonymity – therefore 56% of concern raisers were happy for their anonymity to be waived. In keeping with the Trust's desire to create an open culture where all staff feel able and safe to raise concerns, further support is needed to create a culture where raising concerns is part of everyday business. This should be reflected in a lower number of staff asking to have their anonymity protected.

During the reporting period, no one has reported having suffered detriment as a result of raising a concern - the Guardian regularly confirms this with concern raisers both during the period the case is open and after the case has been closed.

Feedback is requested from members of 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. Not all staff respond to the request and little feedback is obtained. This appears to be a National issue according to the discussions at network meetings and is not isolated to NWAS.

Outstanding Cases from Q1 2019-20

Currently eight cases remain open from Q1:

- Two cases relate to an allegation that TRiM has not been utilised consistently. An investigation has been carried out and a procedure is to be put in place. The Guardian is currently awaiting a copy of the investigating officer's final report including summary, recommendations and any lessons learned identified.
- One case relates to pay queries, including unsocial hours pay (Annex 5 or Section 2) – HR is currently considering the case details.
- One case relates to an allegation of inadequate PTS training. There has been a delay in exploring this concern further due to the concern raiser being unable to provide more specific information due to workplace absence.
- Three cases relate to allegations of workplace bullying and conflicts which are currently being investigated.
- One case relates to an allegation of bullying within the EOC. This case is currently being investigated. There has been a delay in progressing with this case due to the current workload of the appointed investigating officer.

Twenty two cases were closed during the reporting period and further detail can be seen in A**ppendix 1**

Lessons Learned

There have been a number of lessons learned during Q2, the main three are:

- Investigations must be conducted by someone trained and suitably independent – there should be no conflicts of interest, including loyalties.
- Feedback must be provided on investigation/outcomes to the concern raiser. This includes feedback on who is investigating the concern, where possible timescales and 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) and helps create a positive culture.

- Support for staff involved in speaking up, this applies to both the concern raiser and the person who has had the concern raised about them. A simple thank you when someone speaks up is key, as is empathy and understanding of the personal impact speaking up.

Supporting Freedom to Speak Up

In order to support Freedom to Speak Up at North West Ambulance Service, a number of activities were undertaken during Q2:

- Revised Raising Concerns at Work Policy (Whistleblowing) – This will be presented at the December Policy Group
- Monthly meetings held between the FTSU Guardian and Chief Executive which provide guidance and support for challenging cases
- Fortnightly meetings held with FTSU Exec lead to discuss challenging cases and seek guidance – alongside this are daily conversations
- Dedicated diary time scheduled with Non-Executive Director to feedback themes that are emerging from speaking up activity
- Training sessions for FTSU Guardians scheduled with the national guardian's office
- Quarterly sessions scheduled for the FTSU Guardians to come together as a support and learning network (Regional and NAN)

FTSU Staff Engagement

Awareness of Freedom to Speak Up has been delivered through attendance at:

- Disability Forum
- LGBT Network
- Station visits
- Hospital visits
- 111 visits
- Staff Forums
- CFR Network
- Fleet services
- SMT Meetings

The Guardian continues conducting targeted visiting of areas that staff identify as areas of concern. This approach may be one of the reasons for the continued rise in activity.

The NGO recommended that the Guardian hold regular engagement sessions with the CQC relationship holder for NWAS. The Guardian met with Pritpal Singh-Jagatia during September and these meetings will continue on a quarterly basis.

Future activity planned

- Further promotion of FTSU roles during freedom to speak up month, October 2019
- Following the NGO review of NWAS FTSU arrangements, a report has been published by the NGO. NHSI have requested an Action plan from NWAS which has been

provided to them.

- Work to be done in conjunction with HR to devise a way to capture demographic information i.e. certain background characteristics relating to concern raisers to give a richer understanding
- Guardian will continue to benchmark NWAS against recommendations made from the National Guardians Office Case Reviews of other Trusts
- Guardian and Champions will proactively undertake activities to make themselves accessible and open to staff raising concerns;
- Awareness survey (by ZEAL) will take place for staff about FTSU processes and their understanding of FTSU; The work will be designed through engagement with staff and will aim to focus on the cultural and leadership changes required to improve employee experience and well-being
- Discussion with our risk department about the use of DATIX as a confidential reporting platform for raising concerns to empower and encourage staff to speak up safely;
- A secure mailbox has already been established and is communicated to staff on FTSU promotional materials and the intranet. This mailbox can only be accessed by the Guardian; and
- Continuing to promote the role of the FTSU Guardian and Champions at trust induction, staff networks, and other staff forums.

The National Guardians Office Review

The National Guardians Office (NGO) published their report on the speaking up arrangements in NWAS in early September 2019.

The NGO reviewed the handling of two speaking up cases referred to them by two members of staff in order to identify areas of learning for NWAS and also other Trusts.

The review found areas where the trust's response to the issues raised by the workers could be improved, including in relation to providing feedback on the progress of the trust's investigation into their concerns along with the independence of investigators. The review also found that timeliness of investigations was an issue. This still remains an issue in a number of cases. The NGO also found that there was lack of clarity among workers about the scope of the Freedom to Speak Up Guardian role and what matters could be raised with them.

A full action plan arising from this review can be seen at **Appendix 2**

National Context

Dr Henrietta Hughes remains the National Guardian with the support of the NGO. NHS Improvement and the National Guardian's Office have jointly produced the latest "Guidance for boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts (July 2019).

The updated guide supports boards to create a culture where staff feel safe and able to speak up about anything that could prevent delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment (not individual incidents). To support this, managers need to feel comfortable having their decisions and authority challenged, speaking up should be embraced. Speaking up, and the matters that speaking up highlights, should be

welcomed and seen as opportunities to learn and improve.

The guide also contains some process changes particularly around the handling of any concerns received about Board members.

Expectations:

- Behave in a way that encourages workers to speak up
- Demonstrate commitment
- Have a strategy to improve your FTSU culture
- Support your FTSU Guardian
- Be assured your FTSU culture is healthy and effective
- Be open and transparent with external stakeholders

The supplementary guidance covers:

- Individual responsibilities
- Evaluating Guardian resource
- Communication strategy
- FTSU improvement strategy
- Triangulating data
- Board assurance
- Guardian report content
- Speaking Up policy audits

The supplementary guidance can be seen at **Appendix 3**

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

The Board is asked to:

- Note the key themes of the concerns raised during Q2 2019-20
- Take assurance that no whistle-blowers have reported suffering detriment during the reporting period.
- Take assurance that from a Freedom to Speak Up perspective; the majority of concerns raised are closed off in a timely manner.

Appendix 1 – Freedom to Speak Up (cases closed during Q2 2019-20)

Case Number	Date Opened	Theme	Date Closed	Outcome/Learning
151	01/07/2019	Bullying	20/08/2019	Awaiting details
152	03/07/2019	Bullying	08/08/2019	Case not pursued
153	04/07/2019	Grievance	09/08/2019	HR matter
154	04/07/2019	Working Practices	30/09/2019	Awaiting details
155	10/07/2019	Data Breach	28/08/2019	Action plan in place
156	11/07/2019	Fraud	30/09/2019	Outcome report and lessons identified
157	11/07/2019	Bullying	13/08/2019	Case not pursued
158	12/07/2019	Grievance/Working Practices	09/08/2019	Early resolution
159	12/07/2019	Grievance/Working Practices	09/08/2019	Early resolution
160	12/07/2019	Grievance/Working Practices	09/08/2019	Case not pursued
161	15/07/2019	Working Practices	04/09/2019	Outcome report and review of policy
162	18/07/2019	Bullying	29/09/2019	Outcome report lessons identified
164	19/07/2019	Working Practices	26/07/2019	Early resolution
166	25/07/2019	Bullying	29/07/2019	Early resolution
167	26/07/2019	Patient Safety	26/07/2019	Case not pursued
168	27/07/2019	Grievance	15/08/2019	HR matter
169	28/07/2019	Grievance	28/07/2019	HR Matter
170	31/07/2019	Patient Safety	31/07/2019	HR Matter
171	05/08/2019	Working Practices	11/09/2019	Outcome Report
182	25/08/2019	Other	28/09/2019	Memo Issued
183	27/08/2019	Patient Safety	30/09/2019	Report obtained and learning identified
184	28/08/2019	Patient Safety	30/09/2019	Report obtained
192	18/09/2019	Other	27/09/2019	Report obtained and lessons Identified

195	19/09/2019	Patient Safety	23/09/2019	Report obtained
197	23/09/2019	Bullying	29/09/2019	Case not Pursued
198	25/09/2019	Grievance	29/09/2019	Early resolution

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NHS
North West
Ambulance Service
NHS Trust

Freedom To Speak Up

Consolidated Action Plan 2019-20

FREEDOM TO SPEAK UP ACTION PLAN

The National Guardians Office (NGO) visited NWAS on 31 January and 1 February 2019 to gather information for its review. The NGO returned in May 2019 with NHS Improvement to discuss the provisional findings and to agree actions which the Trust need to put in place.

Their recommendations have helped furnish the NWAS Freedom to Speak Up (FTSU) Action Plan, which also incorporates internal actions the Trust has identified. The consolidated actions are shown below in the draft NWAS FTSU Action Plan 2019/20:

The 13 identified areas are:

- Training Requirements
- Vision
- Meetings
- Exec Lead access to FTSU Files
- Assurance
- Monitoring
- Feedback
- Scope of FTSU Guardian
- Single Policy
- Engagement Process
- Timeliness and handling of Investigations
- Mediation
- Clarity around FTSU Champions/Advocacy

Area: Training Requirements						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
1	Training requirements to be embedded for FTSU Guardian and Executive Lead	The FTSU Guardian/s and the Executive Lead for FTSU should be given training in the HR processes of the organisation such that they apply to the management of grievances, investigations, disciplinary cases, etc. Ongoing Training schedule Bespoke session to be delivered by HR to Guardian/Executive Lead. Guardian to attend Dignity at Work and disciplinary masterclasses.	Director of OD	Bespoke session February 2020 Masterclasses During 2020		NGO
2	Trust Board to be knowledgeable, up to date and able to articulate the FTSU vision as well as aware of all NGO guidance	Formal Training for Board, linked into the Board Development matrix. Liaising with NHSE/I to facilitate a development session for Senior Leadership Group; Executive Leadership Committee and Board	FTSU Guardian	Q4		Internal
3	Trust Board to challenge and scrutinise FTSU	Monitoring information on FTSU to be provided on a regular basis where Trust Board can develop a culture of scrutiny and continuous improvement. FTSU Guardian reports to Board on a quarterly basis and captures all items identified within the NHSI/E board guidance.	FTSU Guardian	Complete		Internal
Area: Vision						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**

4	Develop a clear FTSU Vision incorporating patient safety, staff experience and continuous improvement	Develop a FTSU Strategy and Vision A FTSU Vision & Strategy was approved by the Board during Q3 2018-19, however, this is being reviewed and refreshed during Q4 2019-20	Director Corporate Affairs	Q4		Internal
5	FTSU Champions to be aware, understand and support the vision	Communications and training around Vision and Values A review and refresh of the current Champion model is underway and a proposal as to the shape of the model and the support/training required will be presented to Executive Leadership Committee during Q4	Director Corporate Affairs	Q4		

Area: Meetings

No.	Goal	Action Required	Lead Manager	Target Date	Complete	Plan
6	Ensure regular cooperation and consultation between FTSU and nominated lead non exec for FTSU	NWAS should ensure that regular meetings take place between the FTSU Guardian/s and the nominated lead NED for FTSU. Programme meetings for remaining months of 2019/20	FTSUG and NED	Ongoing		NGO

Area: Exec Lead access to FTSU Files

No.	Goal	Action Required	Lead Manager	Target Date	Complete	Plan
7	Policy for access to FTSU files	NWAS to develop a clear policy in relation to authorising the Executive Lead's access to FTSU	Director Corporate	Q4		NGO

		Files in circumstances where there are concerns relating to the actions (or otherwise) of the FTSU Guardian. This policy should be developed with the NGO	Affairs			
Area: Assurance						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
8	Annual review of FTSU Policy and Process	• Review internally in line with NGO guidance • Internal Audit As per the Board report the policy has been reviewed and refreshed and will be approved during Q4.	FTSU Guardian	January 2020		Internal
9	Quarterly reporting to Board	Quarterly reporting of all FTSU complaints received and progress being made Quarterly reporting to Board has been in place since 2017, however, the report continues to be refined in line with guidance.	FTSU Guardian	Complete		Internal
10	Review of guidance and case reviews	FTSU Guardian and Executive Lead to review all guidance and case reviews from NGO to identify improvements	Director Corporate Affairs & FTSU Guardian	Q4		Internal
11	Annual survey of FTSU	Via survey monkey	FTSU Guardian	Q4		Internal

Area: Monitoring						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
12	Sample review by external audit of all FTSU cases to ensure consistent application of policy and process	• Identify cases to be reviewed per quarter • Review fully and provide report	FTSU Guardian	Q3		Internal
13	Regular quarterly auditing	Quarterly audit via Datix Datix goes live April 2020 First audits Q2 2020	FTSU Guardian	Q1 2020		Internal
14	Comparative Data	Compare data over differing periods and Quarters to ascertain trends This is already being done in Q2 Board Report	FTSU Guardian	Ongoing		Internal
Area: Feedback						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
15	Build in feedback stages for complainants	Ensure regular feedback to complainants to advise of status of investigation This has been in place since the launch of FTSU	FTSU Guardian	Ongoing		NGO
16	Feedback from complainants to inform improved processes	Gain feedback and operationalise improvements This has been in place since the launch of FTSU	FTSU Guardian	Ongoing		Internal
Area: Scope of FTSU Guardian						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
17	Greater clarity of remit around the	Follow NGO guidance around remit of FTSU	Director Corporate	Q3		NGO

	scope of the FTSU Guardian.	Guardian regardless of type of issue raised	Affairs			
		Deliver FTSU awareness through mandatory training with requisite reference to the new guidance. Previous mandatory training already delivered. Mapping against revised national guidance and action plan to be developed for implementation	Director of OD	February 2020		NGO
		NWAS to look for positive ways to promote FTSU	Director Corporate Affairs			NGO
18	FTSU Guardian to have access to Senior Managers and Trust Board	Put in place reporting arrangements / access / flowchart so that patient safety issues can be progressed rapidly	Director Corporate Affairs/FTSUG	Q3		Internal
19	FTSU Guardian to have bilateral relationships with regulators / inspectors and other FTSU Guardians	FTSU to arrange regular meetings with NGO and other FTSU Guardians FTSUG meets quarterly with CQC and attends both national network meetings and ambulance sector meetings. Local buddying arrangements in place.	FTSUG	Ongoing		Internal
Area: Single Policy						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
20	Single Policy	Ensuring the new policy is clear that all workers can seek support from FTSU Guardian about any	Director Corporate	January 2020		NGO

		issue by merging the Policies of: • Raising Concerns at Work (Whistle Blowing) Policy and Procedure • Freedom to Speak up Policy As per the Board report the policy has been reviewed and refreshed and will be approved during Q4.	Affairs			
		Revise Freedom to Speak to Policy to reflect the updated national policy As per the Board report the policy has been reviewed and refreshed and will be approved during Q4.	Director Corporate Affairs	January 2020		NGO
		Advise staff of all revisions to policies through communications	Director Corporate Affairs	Q4		NGO
Area: Engagement Process						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
21	Trust Board to be visible and use variety of methods to seek feedback regarding FTSU	• Progress Executive Walkarounds • Engagement interaction Workshops • FTSU campaigns • Senior Manager briefings	Director Corporate Affairs	Q4		Internal
22	Encourage staff to speak up	Work with HR to promote the FTSU principles Monthly meetings with HR are taking place to support the Guardian's work	FTSUG	Ongoing		Internal

23	Thanking Staff for Speaking Up	The trust will ensure: The trust's new speaking up policy will include a reference to thanking all workers who speak up. As per the Board report the policy has been reviewed and refreshed and will be approved during Q4	FTSUG	January 2020		NGO
Area: Timeliness and handling of Investigations						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
24	Timescales , handling and reporting back mechanisms to be reviewed	Ensure that policy reflects reasonable timescales are set for investigations and that these are fed back. The trust is continuing to train managers in investigation training to address this issue.	Director of OD	January 2020 - revised policy		NGO
		Ensure that details of which policy or procedure is being used is communicated at the outset	Director of OD	January 2020 – revised policy		NGO
		Give proper scope and clarity to investigators	Director of OD	January 2020 – revised policy		NGO
		Review the protocols setting out the working arrangements between FTSU guardian and HR to	Director of OD	31 March 2020.		Internal

		ensure principles are embedded				
25	Review of current policies to incorporate independence of investigators as a key element	The trust to review its relevant policies in relation to investigations to ensure that: Policies take proper and reasonable account of workers' objections relating to the perceived independence of investigators, and that a clear rationale for any decisions regarding investigators is given to workers in response to such objections. Policies provide more transparency about the way in which the trust will manage potential conflicts of interest relating to investigations.	Director of OD	January 2020 – revised FTSU policy Disciplinary policy review – June 2020 Already covered in investigations training		NGO
Area: Mediation						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
26	Explaining the benefits of mediation at the outset	Trust to take appropriate steps to ensure that managers and HR staff are up to date with existing guidance on explaining the value of mediation to workers.	Director of OD	Mediation summary guidance by 31 December 2019.		NGO
Area: Clarity around FTSU Champions / Advocacy						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
27	Clarity around description and role	Clear definition of role of FTSU in revised Policies	Director of OD	January 2020 –		NGO

	of FTSU Champions in terms of "Advocacy", "Impartiality" and "Objectivity"			revised FTSU policy		
		Engage with existing Champions to ensure they are clear on role, responsibilities and objectives especially when individuals hold more than one voluntary role which may create conflict or confusion to the works they support e.g. peer supporter role A review and refresh of the current Champion model is underway and a proposal as to the shape of the model and the support/training required will be presented to Executive Leadership Committee during Q4	Director Corporate Affairs / Director of OD	Q4		NGO
		Clarity around Champions being impartial and objective and not "taking sides" or acting as "advocates" (see above)	Director Corporate Affairs	Q4		NGO
		Gain guidance and support from NGO in ensuring this is met going forward Awaiting further NGO Guidance Nationally	FTSUG	Ongoing		NGO

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Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts

July 2019

Contents

About this resource

This supplementary information accompanies the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* and the *Freedom to Speak Up review tool for NHS trust and foundation trusts*.

We are happy to provide further explanation about any of the following information. Please contact nhsi.ftsulearning@nhs.net

1. Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the Freedom to Speak Up (FTSU) Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair role-model high standards of conduct around FTSU, and are responsible for ensuring the annual report contains information about FTSU and the trust is engaged with both the regional FTSU Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

The chief executive should approve all confidentiality clauses that appear in settlement agreements to ensure they are assured that their use is in accordance with the good practice set out by NHS Employers. If the chief executive is party to the settlement agreement, the chair should obtain this assurance.

Executive lead for FTSU

The executive lead is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from the National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence

- ensuring their FTSU Guardian has access to any emotional and psychological support they may need
- conducting a biennial review of the strategy, policy and process
- operationalising the learning from speaking up issues
- ensuring instances where individuals may have suffered detriment for speaking up are promptly and fairly investigated and acted on
- providing the board with a variety of assurances about the effectiveness of the trust's strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from National Guardian's Office
- challenging the chief executive, executive lead for FTSU and the board to reflect on whether they could do more to create a healthy and effective speaking up culture
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up matters regarding board members – see below.

We appreciate it can be challenging to maintain confidentiality and objectivity when investigating issues raised about board members. This is why the role of the designated non-executive lead is critical. Therefore, in exceptional circumstances, we would expect the non-executive lead to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an appropriate fair and impartial investigation can be conducted, is proportionate, and what the terms of reference should be for escalating matters to regulators, as appropriate.

Depending on the circumstances, it may be appropriate for the non-executive lead to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive lead does take the lead, they inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive lead informs NHS Improvement and CQC that they are overseeing an investigation into a board member (depending on the circumstances we may require you to provide the name of the board member under investigation). NHS Improvement and CQC can then provide the non-executive with support and advice. The trust needs to consider how to enable a non-executive lead to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for ensuring that:

- Values and behaviours associated with FTSU, such as courage, impartiality, empathy and learning, are embedded throughout the recruitment, appraisal and termination processes.
- All workers have the capability and the access to appropriate resources to enable them to role-model high standards of conduct around FTSU.
- Speaking up is understood and interpreted in the broadest sense: there is no artificial distinction made between ‘whistleblowing’ and other speaking up activities, or between ‘formal’ and ‘informal’ ‘concerns’. Workers and managers understand that speaking up encompasses matters that might be referred to as ‘raising concerns’, ‘complaining’, ‘raising a grievance’ or ‘whistleblowing’. It also includes making suggestions for improvement.
- The trust understands the impact that worker experience, including bullying and harassment, engagement levels, and other ‘cultural’ issues, can have on patient safety, staff health and wellbeing, and on trust performance.

- The trust has a robust process to review claims that workers have suffered detriment as result of speaking up, which could include asking the non-executive lead for FTSU to review the claims.

- The trust evaluates all speaking up routes (including speaking up to the FTSU Guardian) and assesses why particular routes are used, addressing any barriers that prevent workers from using non-Guardian routes. Similarly, the FTSU Guardian monitors and responds to any barriers that may prevent workers speaking up to them, as well as looking more broadly at barriers to speaking up in the organisation

- Values and behaviours associated with FTSU such as courage, impartiality, empathy and learning, are role-modelled and assessed during recruitment and appraisals.

- The FTSU Guardian has the full support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other cultural and worker experience indicators.

- The trust has a leadership development programme that supports managers to have meaningful and compassionate conversations; give and receive feedback constructively; and support others to work productively and develop themselves.

- Managers and executives are able to evidence how they reflect on the impact of their behaviour in 1-1s and appraisals. This self-reflection could be supported by a range of peer and staff feedback.

- Effective and, as appropriate, immediate action is taken when potential worker safety issues are highlighted by speaking up.

Medical director and director of nursing

The medical director and director of nursing are responsible for ensuring:

- role-modelling high standards of conduct around FTSU

- the FTSU Guardian having appropriate support and advice on clinical, patient safety and safeguarding issues

- effective and, as appropriate, immediate action taken when potential patient safety issues are highlighted by speaking up

- learning in relation to patient safety being disseminated across the trust
- learning operationalised within the teams and departments they oversee.

2. Evaluating Guardian resource

FTSU Guardians should be able to demonstrate they have the capacity and capability to fulfil the requirements of the National Guardian's FTSU Guardian job description**.** Ultimately, this means the board must satisfy itself that the way the role is implemented meets the needs of workers in the organisation.

Capability

The National Guardian's Office has developed an education and training pack to help FTSU guardians assess their strengths and weaknesses and identify potential training needs. FTSU Guardians should be given the time and access to the right support to enable them to address any areas for improvement and build on their strengths.

Wellbeing

Given the nature of the post, FTSU Guardians should be given the opportunity and time needed to access supervision, mentoring, and other sources of emotional and psychological support and advice.

Capacity

As the FTSU Guardian role is driven by the needs of workers, there is no minimum standard amount of time and support FTSU Guardians need. However, the National Guardian expects that the trust will allocate ringfenced time.

Other considerations

When considering the amount of ringfenced time required for the role, boards should consider:

- the needs of the job in the round, including the reactive elements (responding to workers who speak up) and the proactive elements (looking at barriers to speaking up and working in partnership to help reduce them, communicating the role, ensuring there is appropriate training on speaking up)

- the number of workers in the organisation, geographic spread, diversity, and, in particular, the needs of the most vulnerable
- the need to fulfil the expectations of the National Guardian, including recording cases, reading and carrying out gap-analyses based on case review reports, writing and presenting board reports, reporting data locally and nationally, supporting information-gathering exercises, ensuring contact details are kept up-to-date
- playing an active part in the FTSU Guardian network regionally and nationally, including attending regional and national meetings, training, and other events
- the requirement to, where necessary, liaise with external partners including CQC, NHS Improvement and the NGO
- the general environment in which the trust is currently operating – FTSU Guardians may have an increased workload at times of change, such as mergers, organisational and operational restructuring, changes in CQC rating, and entering special measures or being placed on the challenged provider list.

The board may also want to seek advice from trusts that provide similar services and have a similar size workforce, geographical spread and regulatory circumstances.

3. Communication strategy

Why a strategy is important

To create a positive FTSU culture, workers need to know how to speak up and to whom. They need regular messages that reinforce the message that speaking up is welcomed and actions result from speaking up.

Demonstrating the impact of speaking up, the improvements made and learning generated as a result are therefore important elements of any FTSU communications strategy.

Communications strategies need to consider ways in which more inaccessible workers can be reached and also how appropriate messages can be tailored to, and reach, vulnerable workers and those who may face particular barriers to speaking up. They should also be accompanied by measures so that impact can be assessed. Strategies should be regularly refreshed so that messaging remains effective and impactful.

Any FTSU-branded communication should be in line with NGO guidelines (for details contact enquiries@nationalguardianoffice.org.uk)

Ways to communicate across a dispersed trust

Written communication	Verbal communication
Intranet pages	All staff events
Electronic newsletters	Executive/senior leader drop in sessions
Screen savers	Executive/senior leader walkabouts
Posters/ flyers/business cards	Senor leader surgeries
Payslips	Directorate/Team meetings
Social media	Staff forums/ network meetings
Electronic message boards	Working groups to develop change ideas

Mobile phone app	Speaking Up culture awards
Paper newsletters	Speaking Up managers network
E learning	Pop up market stalls
Merchandise – mouse mats, pens, coasters, calendars, lanyards	Training webinars
Pop up PC/laptop screen alerts	Induction/training on FTSU as well as references within other training on bullying and harassment, effective communication

Ways to evaluate a communication strategy

Ways to track engagement
Email tracking tools – count how many people have opened, clicked through or deleted FTSU-related emails.
Polls/pulse surveys – track response rates and how knowledge and confidence increase. Quantify the number of positive versus negative verbatim comments.
Number of concerns – count the number of concerns raised via each speaking up channel. Identify which directorates they are coming from.
Track social media – count comments, likes and retweets and video views in relation to FTSU posts. Quantify the number of positive versus negative verbatim comments.
Intranet analytics – count page views or document downloads in relation to FTSU.
Online discussion forum – number of participants/comments. Quantify the number of positive versus negative verbatim comments.
Listen to what people are talking about!!!

4. FTSU improvement strategy

Creating your strategy

- Your strategy could be a separate document or a distinct section within a relevant policy or strategy (ie a quality or OD strategy). Regardless of presentation, it needs to set out clearly how it fits in with the trust's overall strategy and how it supports the delivery of related strategies.
- It aligns to your gap analysis against the recommendations from the National Guardian.
- It describes ambitions and aims based on a diagnosis of the issues the trust currently faces in relation to FTSU.
- It includes clear objectives, measures and targets to demonstrate improvement.
- The objectives include a focus on the development of leadership values, behaviours, skills and knowledge that would support the delivery of the speaking up vision. Any training in FTSU should be in accordance with national guidance from the National Guardian.
- It contains information about the systems needed to support delivery (ie IT, HR, quality, governance, communication and data analysis).
- Ideally, it will be co-produced with a diverse range of relevant stakeholders (including the FTSU Guardian) but at a minimum the draft plan should be shared with key stakeholders (eg staff side and employee representative groups) and their feedback acted on.

Evaluating your strategy

Strategy
What does our FTSU strategy describe?
Does the strategy contain an effective set of measures?
How have workers and managers been involved in the production of the strategy?
How has the board been involved in sign off the strategy?
Oversight
How is the implementation of the strategy monitored?
How have we tested the effectiveness of our assurance?
Systems to support delivery
What are we doing to support delivery of the strategy?
How are we evaluating the effectiveness of that support?
Managers
How are we involving managers in the implementation of the strategy?
Values and behaviours
What values and behaviours are we monitoring in relation to FTSU?
How effectively are we challenging when values and behaviours are not upheld?
Skills/capability/knowledge
What skills/capabilities/knowledge are we looking to develop to deliver the FTSU strategy?
How are workers being provided with these skills/capabilities/knowledge?
How are we assessing the capability of workers, managers and senior leaders in this respect?

5. Triangulating data

Data that could be compared to identify wider issues

Patient safety	Employee experience
Patient complaints	Grievance numbers and themes
Patient claims	Employment tribunal claims
Serious Incidents	Exit interviews themes
Near misses	Sickness rates
Never Events	Retention figures
	Staff survey results
	Polls/pulse surveys
	Workforce Race Equality Standard and Workforce Disability Equality Standard data
	Levels of suspension
	Use of settlement agreements

Questions to ask of your data

- Why do some departments and staff groups have no issues?
- Who are the outliers and why?
- Which departments and staff groups have consistently occurring issues?
- Why have some departments been able to reduce the number of issues?
- What is the cause of unexpected spikes?
- Do patient and employee issues overlap in a department or directorates?

People should be supported by experts to interpret statistical significance and all data and other intelligence should be presented in a way that maintains confidentiality.

6. Board assurance

Elements a board should seek assurance on

- Workers know how to speak up.
- Workers speak up with confidence and are treated well.
- Workers are not victimised or do not suffer reprisals after they have spoken up.
- Managers and senior leaders role-model the right behaviour to encourage speaking up.
- Confidentiality is maintained.
- Concerns are processed in a timely manner.
- Risks are quickly escalated.
- Action is taken to address any evidence that workers have been victimised as a result of speaking up.
- Workers who have suffered victimisation as a result of speaking up are provided with appropriate support and redress.
- Appropriate patient safety and worker experience data is triangulated with the themes emerging from speaking up channels to identify wider concerns or emerging issues.
- Learning is identified and shared across the trust.
- Improvement actions are monitored and evaluated to ensure they lead to improvements.
- The trust's FTSU arrangements are compliant with guidance from the National Guardian and NHS Improvement.

Examples of assurance

- Speaking up concerns: numbers and themes
- Incident reporting: numbers, quality of reports, levels of feedback
- Grievances: numbers and themes
- Initiatives like Safety Huddles or Listening into Action: number and quality
- FTSU Guardian user feedback
- Polls/surveys/focus group reports
- Analysis of exit interview themes
- Analysis of social media comments including internal electronic message boards
- Reports from boards doing walk-abouts
- FTSU focus group/steering group reports
- Gap analysis against case reviews produced by the National Guardian
- National staff experience surveys
- FTSU Guardian board report
- Internal audit reports
- Employment tribunal judgements
- National Guardian Office case reviews
- CQC/NHS Improvement led focus groups
- External culture reviews
- CQC inspection reports

National Guardian
Freedom to Speak Up

7. Guardian report content

Assessment of cases

- Information on the number and types of cases being dealt with by the FTSU Guardian and their local network.
- Analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of issue, particular groups of workers who speak up, areas in the trust where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up.
- Information on what the trust has learnt and what improvements have been made because of workers speaking up.

Potential patient safety or worker experience issues

- Information on how FTSU matters fit into a wider patient safety/worker experience context, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built.

Action taken to improve FTSU culture

- Actions taken to increase the visibility of the FTSU Guardian and promote all speaking up channels.
- Actions taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up.
- Assessments of the effectiveness of the speaking up process and individual case handling – including user feedback; pulse surveys and learning from case reviews.

- Information on instances where workers feel they have suffered detriment – including what the detriment was; what action has been taken, whether the issue has been resolved, and any learning.
- Information on actions taken to improve the skills, knowledge and capability of workers to speak up; to support others to do so, and respond to the issues they raise effectively

Recommendations

- Suggestions for any priority action needed.

Data and other intelligence must be presented in a way that maintains confidentiality.

8. Speaking Up policy audits

What a comprehensive audit report could include
Do workers feel safe to speak up?
Is the trust acting on allegations of victimisation or perceived detriment?
Is confidentiality being effectively maintained?
Do all workers, bank and agency staff, temporary workers, volunteers and governors know about the policy? How does the trust measure this?
Are managers responding effectively to workers who speak up?
Is the FTSU Guardian responding effectively to workers who speak up?
Are the executive and non executive leads for FTSU responding effectively to workers who speak up?
Are issues that raise patient safety concerns escalated quickly?
Is the training for workers and managers in relation to speaking up effective?
Do workers know about the support that is available to them to speak up?
Are workers thanked, updated and given feedback?
Is the FTSU Guardian collating, evaluating and responding to user feedback?
Is the trust identifying, compiling and sharing learning effectively?
Is the impact of change being measured?
Do board meeting minutes evidence informed and rigorous discussion on FTSU matters?
Are the trust's FTSU arrangements based on the latest guidance from NHS Improvement and the National Guardian?

NHS England and NHS Improvement
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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27 November 2019
Subject:	Policy on Learning from Deaths
Presented by:	Chris Grant, Executive Medical Director
Purpose of Paper:	For Decision
Executive Summary:	Following the 2019 publication of the National Quality Board's (NQB) *'National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care'* the Trust is mandated to introduce and publish a Policy on Learning from Deaths. Following events in Mid Staffordshire, the NHS and CQC have consistently identified deficiencies in NHS approaches to reduce genuinely avoidable deaths. Valuable opportunities to learn from deaths are missed and many families and carers do not experience open and transparent processes. A standardised approach adopted by all ambulance trusts will make cross organisational learning easier. All ambulance trusts are required to undertake case reviews of incidents where patients have died in our care. The paper provides the background to this requirement and outlines the scope and associated processes that determine the case reviews. The Policy requirements are clearly stipulated in the NQBs Framework and are endorsed by the Association of Ambulance Chief Executives (AACE). Board approval is mandated by NHSE prior to implementation. Once approved, the processes required to support the Policy will be determined as part of the implementation phase in early 2020. Given the significance of the resource implication, this will require Project Management Board support.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: – Approval the Policy on Learning from Deaths

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☒	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**Clinical Effectiveness Management Group** **Quality & Performance Committee** **Executive Leadership Committee**
Date:	**November 2019**
Outcome:	**Amendments to Section 8, 9 & 10. Addition of Section 11.**

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1. PURPOSE

The purpose of this paper is to provide the background to the NHS England requirement for the Trust to implement a Policy on Learning from Deaths and the associated process of structured judgement reviews of the deaths of patients within our care.

The Policy is presented and members are asked to formally approval the Policy on Learning from Deaths. The Policy requires Board approval as mandated by NHSE prior to implementation. The processes associated with the requirements made within the Policy will be operationalised following approval and during the implementation phase in early 2020; this will require Project Management Office support.

2. BACKGROUND

Published in 2019, the National Quality Board's (NQB) 'National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care' sets the national standards and requirements for ambulance trusts to undertake a process of learning from deaths. A central part of the specification is a mandatory requirement that all ambulance trusts formally develop and publish a Policy on Learning from Deaths based around the national framework and that Trust Boards commit to its implementation within the organisation.

The NQB's guidance was developed following similar national guidance for all NHS acute, mental health and community trusts implemented in 2017. This work was largely informed by the publication of the 2016 Care Quality Commission (CQC) report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'. This found that learning from deaths was not being given sufficient priority in many NHS organisations and consequently valuable opportunities for improvement were being missed.

The North West Ambulance Service Policy on Learning from Deaths compliments the commitments made within the Right Care Strategy and commits the organisation to a process of learning in order to improve the care delivered to our patients and reducing avoidable deaths.

This Policy is consistent with the requirements of the national framework and is informed by recommendations from the membership of the National Ambulance Risk and Safety Forum. As such it is recognised that there is no overt reference to establishing formal processes within NWAS NHS 111 operations or within our Patient Transport Services (PTS). As an organisation we are committed to ensuring learning is embedded across the organisation and during the Policy implementation phase we will actively consider full integration across all service lines.

There is a recognised, necessitate need to conduct a formal implementation phase for this Policy which will include operationalising the processes outlined within it, scoping the necessary resource requirements and establishing the processes of identification and review into the core business of the Trust. This implementation phase will commence on approval of the Policy and will include multidisciplinary stakeholders from across the organisation and is likely to be established during early 2020 with the support of the Project Management Board.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

The Trust is mandated by the publication of the NQB national framework to develop, approve and implement a Policy on Learning from Deaths. Approval of the Policy presented here is the first phase in meeting this requirement and ensures the Trust is compliant with the NQB directive.

4. RECOMMENDATIONS

The Board of Directors is asked to:

1. Approve the Policy on Learning from Deaths.

North West Ambulance Service NHS Trust

Policy on

Learning from Deaths

Safe, Effective and Patient Centred Care, Every Time

Recommended by	Quality & Performance Committee
Approved by	Board of Directors
Approval date	
Version number	1.0
Review date	December 2021
Responsible Director	Executive Medical Director
Responsible Manager (Sponsor)	Consultant Paramedic (Medical Directorate)
For use by	All Trust employees and volunteers

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
1	September 2019	November 2019	Steve Bell	Document creation
1	November 2019	November 2019	Steve Bell	Amends following review by Clinical Effectiveness Management Group (CEMG); Sections 8, 9 & 10.
1	November 2019	November 2019	Steve Bell	Addition of Section 11 following Head of Legal Services review

Policy on Learning from Deaths

Contents

1. Introduction

In 2016 the Care Quality Commission (CQC) published their report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'. It found that learning from deaths was not being given sufficient priority in many NHS organisations and consequently valuable opportunities for improvement were being missed. The report highlighted NHS organisations could do more to engage families and carers with recognition that their insights are a vital learning source. In 2017, the National Quality Board's (NQB) 'Learning from Deaths framework' applicable to all NHS acute, mental health and community trusts was published.

In 2018, the Department of Health and Social Care announced its intent to extend the principles of the learning from death process to ambulances trusts. Under the auspices of the Association of Ambulance Chief Executives (AACE), the National Ambulance Service Medical Directors (NASMeD) committed to a formal process with the NQB for the production of a national framework for the sector.

The NQB 'National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care' was published in 2019. It sets the national standards and requirements for ambulance trusts to undertake a process of learning from deaths and makes a requirement that all ambulance trusts formally develop and publish a Policy on Learning from Deaths. The North West Ambulance Service Policy on Learning from Deaths compliments the commitments made within the Right Care Strategy and commits the organisation to a process of learning in order to improve the care delivered to our patients and reducing avoidable harm and deaths.

2. Executive Summary

The Trust's Right Care Strategy sets a clear ambition and direction to be the best ambulance service in the UK. It describes how the North West Ambulance Service (NWAS) will deliver safe, effective and patient centred care for every patient. These commitments are underpinned by a promise to become a sector leading learning organisation whereby the care we deliver is informed by a constant process of scrutiny.

This Policy on Learning from Deaths compliments the Right Care Strategy and sets out the practices that will be used within NWAS to review and learn from the deaths of patients who had been under our care. This learning will ensure we are able to protect future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care. This Policy is consistent with the national guidance for ambulance trusts on learning from deaths and formally introduces the implementation of a standardised and transparent approach to learning.

This policy goes far beyond a process of simply counting, classifying and reporting deaths; it is a commitment to supporting our journey towards providing an outstanding service to patients, their families and carers.

3. Scope

This policy applies to all Trust staff, including volunteers.

4. Duties and Responsibilities

Board of Directors

The Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate learning across the organisation.

Chief Executive

The Chief Executive has overall responsibility for ensuring a Learning from Deaths process in place within the trust and for meeting all internal and external reporting requirements. The Chief Executive will delegate this responsibility to the Executive Medical Director.

Executive Medical Director

The Executive Medical Director has ownership of the policy on behalf of the Chief Executive. They will ensure that any changes in legislation or national guidance relating to Learning from Deaths are made known to the Executive Leadership Committee and the Board of Directors via the Quality & Performance Committee.

Executive Directors

It is the responsibility of Executive Directors to ensure compliance with this policy within their area of control, to monitor all relevant learning resulting from the learning from deaths process and ensuring that any recommendations regarding actions are implemented.

Consultant Paramedic (Medical Directorate)

It is the responsibility of the Consultant Paramedic (Medical Directorate) to provide professional clinical advice and guidance with regard to the learning from deaths process and ensure reports are completed in order that learning is disseminated and actioned within the organisation.

All Senior Clinicians and Managers

It is the responsibility of senior clinicians and managers to ensure this policy and associated procedures are implemented within their areas of responsibility and to participate fully with the review process in a timely manner. All senior clinicians and manages will commit to providing feedback to their staff on the review process and subsequent learning. Senior clinicians and managers have the responsibility to provide assurance to their management team on the progression and quality of case reviews.

All Employees

It is the responsibility of all employees, and volunteers where necessary, to participate in the learning from deaths process promptly, openly and honestly.

5. Our Approach to Learning From Deaths

Our Policy on Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. In developing a robust methodology to learn from deaths, and in particular to determine whether harm has occurred during the final episodes of life, we will enable the opportunity to evolve our systems of care to deliver against our core purpose to save lives and reduce harm. This policy challenges the organisation to scrutinise the care we deliver to patients who die within our care. NWAS must identify suboptimal care which reaches the patient because of something we should have done but didn't, or something we did do but shouldn't have; it challenges us to get better and supports the identification of areas for improvement.

We will adopt a process of structured judgement review in order to systematically and consistently scrutinise the care provided to patients. We will commit to a programme of education and training for key senior clinicians in the methodology associated with structure judgement reviews and use the opportunity to increase safety and reliability as well as promote the adoption of improvement methodology to make real changes to practice.

This policy contributes to the systems and processes already established within the Trust and whilst it formally commits the organisation to a process of learning from deaths which occur whilst patients are within our care, it serves to augment organisational learning and compliments the established clinical governance, patient safety and quality improvement procedures including those around Serious Incident investigation and clinical audit.

This policy seeks to strengthen and develop our partnership approach to information sharing and joint learning. We recognise that opportunities for system based learning should be actively sought and that working in isolation is detrimental to patients. We will work with our partners across the healthcare system in the North West to proactively share information and collaborate with the aim of supporting system level and cross-agency learning and improvement. This is not a new commitment, but through the implementation of this policy we will seek to formalise the

arrangements we currently have with our partners and commit to a central role within the health system of the North West in learning from the deaths of patients in our care.

In the emotive period following bereavement, this Policy makes a commitment to family members, carers and loved ones that we will apply a genuinely empathetic approach to listening to concerns and communicating openly with them throughout.

6. Determining Deaths in Scope for Review

This Policy on Learning from Deaths aligns with the definitions and recommendations within the National Framework for NHS ambulance trusts in describing the scope for patients considered as appropriate for case record review. However, it is clear that this does not mean that all deaths in scope must be reviewed. Section 7 articulates how we will determine of those cases that are eligible for consideration, which ones will actually be subject to a review. Hence, the deaths that are initially in scope are as follows:

- Any patient who dies while under the care of NWAS. These are patients who die from the point of a 999 call being made and their care being transferred to another part of the system, or to the point they are discharged from NWAS after a decision is made not to convey them to hospital. This category includes patients who are transported using subcontracted alternative patient transport. This definition includes the periods of time where the 999 call is being handled, in the time between the 999 call being handled and a resource arriving at the scene, whilst at the scene, during transport or before the handover concludes.

- Any patient who dies after handover. As it is acknowledged that patient identification may be an issue; NWAS is only to consider these deaths in scope when they are notified of them by a partner agency.

- Any patient who dies within 24 hours of contact with NWAS where a decision was taken not to convey them to hospital. This includes ‘hear and treat’ as well as a visit by ambulance clinicians but excludes patients at the end of life and where a specific care plan or advanced directive is in existence.

7. Determining Which Deaths Should be Reviewed

In accordance with the national framework, not all deaths in scope must be or will be reviewed. A two-tier process of selection to determine which cases are selected for case record review will be utilised which is both recommended within the framework and appropriate to ensure maximum benefit for organisational learning within NWAS.

The national guidance stipulates that the Trust must review **all** deaths where ambulance service personnel, other health and care staff, and / or families or carers have raised a concern about the care provided, including concerns about end of life care. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern.

In addition, the Trust will review a sample of each of the four categories listed below.

- Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response.

- Deaths of patients assessed as requiring category 3 and category 4 responses.

- Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known by way of notification to NWAS.

- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with NWAS within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

The Trust will determine a number across the four identified categories listed above which would equate to 40 to 50 case reviews per quarter; this sample size produces a rich source of information on care quality and on problems in care (Royal College of Physicians, 2016).

Additional Reporting Requirements:

- **Deaths of Patients with Learning Disabilities**

The Trust must report all deaths of those aged over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached, and share its review findings with LeDeR when relevant. The Learning Disabilities Mortality Review programme is aimed at reviewing all cases of death of an adult or child with learning disabilities, in order to identify any factors associated with that death that may have been preventable, and to learn from them. Where it is known or suspected that that an adult or child has a learning disability and has undergone a diagnosis of death, or termination of resuscitation, then details of the learning disability must be recorded on the Diagnosis of Death form and reported to the Support Centre for formal reporting. The Trust commits to participating fully in LeDeR programme reviews when approached to do so.

- **Maternal and Neonatal Deaths**

Maternal deaths will be reported to the Healthcare Safety Investigations Branch (HSIB) and the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). The Trust's Resuscitation (Diagnosis of Death) Policy should be followed for all maternal deaths.

Neonatal deaths are managed in line with the guidance and processes detailed within the Trust's Sudden Unexpected Death in Infancy, Children and Adolescents (SUDICA) procedures which includes formal notification to partner agencies.

The Trust will contribute to HSIB, MBRRACE and SUDICA review processes through this information sharing process and will, when approached, contribute to reviews and investigations and share its review findings when relevant.

- **Paediatric Deaths**

The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust will participate in child death review meetings, including Child Death Overview Panel (CDOP) meetings, whenever

notified. In the event of a sudden unexpected death in a patient under 18 years, the Trust's Sudden Unexpected Death in Infants, Childhood or Adolescents (SUDICA) procedures for the management of these incidents including the involvement of the police and partner agencies will be followed. Attendance at Child Death panels may be required and this governance resides under the Trust's Safeguarding Team.

- **Safeguarding Concerns**

Any deaths where there are safeguarding concerns (either adult or child) should be referred to the Trust's Safeguarding Team or Head of Safeguarding (Head of Clinical Safety) in line with our statutory duties. The Safeguarding Team has the responsibility for the liaison with partner agencies and for facilitating Trust involvement in any subsequent review processes.

- **Deaths in Custody**

These deaths fall under the relevant police forces' remit; the Trust will participate and contribute to any formal reviews arising from deaths in custody whenever approached.

There may be cases, in addition to reporting provisions listed above, when the Trust will make the decision to conduct our own review of the death in addition to the formal, national process. This is likely only to be applicable if we identify at early stage that there are potential learning improvement actions which need to be taken in advance of the national review process to prevent reoccurrence or further harm. However, this is discretionary and will always be in addition to the Trust's requirements to notify and contribute to the national review programmes of the death.

The Trust will consider each case individually in order to determine whether it should also undertake a review in each circumstance, and will consider its decision to undertake an independent review of these deaths in discussion with the relevant review programme, to minimise duplication.

8. Case Record Reviews

We will introduce a structured method of case review for those deaths identified for inclusion utilising a standard methodology based upon an adaptation of the Royal College of Physicians'

Structured Judgement Review process. The objective of the structured judgement review methodology is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the systems and processes in use where care goes well and to identify points where there may be gaps, problems or difficulty in the care process. In order to identify the strengths and weaknesses of individual patient contact episodes there is a need to look at the full range of care provided to an individual; adopting this holistic care approach allows for the nuances of individual cases and the outcomes of interventions to be considered.

An important feature of this method is that the quality and safety of care is judged and recorded whatever the overall judgement of the case and good care is judged and recorded in the same detail as care that has been judged to be problematic; we commit to doing this. Evidence shows that most of the care provided within the NHS is of good or excellent quality; there is much to be learned from the consideration of high-quality care and these opportunities should not be overlooked. By supporting the implementation of this methodology the knowledge and expertise gained will be transferable to other areas of reflection and review within the organisation. The methodology could, for example, be used to rigorously assess the care provided for people who have had a cardiac arrest and therefore enhance the organisational learning we can derived from such cases in addition to those identified by the learning from deaths process.

The structured judgement reviews for Learning from Deaths will be undertaken by members of our established clinical leadership structure and the appropriate subject matter experts depending on each individual case. We will commit to investing in the necessary training for these individuals in order to provide a consistent and standardised approach across the organisation. Following implementation of the structured judgement reviews methodology and training there is the opportunity to use this acquired expertise in other areas of the Trust's investigation and learning processes; any decision for further adoption of the methodology lies with the responsible managers and directors for those processes.

9. Learning from Reviews

Our Right Care Strategy commits the organisation to develop and work on our culture to become a learning organisation. This policy will support the Right Care Strategy aim of achieving this and contribute to our development as a learning organisation through the processes highlighted.

In accordance with the NQB Framework requirements we will publish quarterly Learning from Deaths reports commencing in Quarter 1 of 2020/21. These reports will draw upon learning from deaths data acquired in the previous quarter and will be submitted to the Clinical Effectiveness Management Group, Quality and Performance Committee and the Executive Leadership Committee. Following approval Trust wide dissemination of the reports will take place together with associate briefing documents to ensure learning is accessible to all clinicians and staff. The Area and Regional Learning Forums will be utilised as key vehicles to present and share reports and key learning ensuring the dissemination is embedded within the formal sharing arrangements within the Trust.

The Trust will commit to share learning from reviews and investigations through the National Ambulance Risk and Safety Forum who will highlight trends to the National Ambulance Quality, Governance and Risk Directors Group (QGARD).

10. Serious Investigations

This Learning from Deaths Policy enhances and does not replace the Trust's existing policies on Serious Investigations.

Any concerns with care identified at any stage of the Learning from Deaths process should be reported as a high risk (4 or 5) incident on the Datix system. Incidents assessed at this risk score are escalated to the Review of Serious Events (ROSE) Group for consideration for reporting as a Serious Incident. This is now a well-established process that facilitates compliance with Serious Incident National reporting requirements including database submissions. This process is separate from the Learning from Deaths case review and wherever possible, duplication in case review should be avoided.

The Trust will ensure that any staff involved in the investigation are treated in a consistent, constructive and fair way throughout the process and that all are conducted in accordance with the Investigation Policy and other associated professional standards.

11. Coronial Engagement

In addition to the statutory and legal requirements place upon us to contribute to and participate in coronial processes, through the implementation of this policy we commit to strengthening the relationships we have with Coroners across the north west region and proactively engage with

Coroner's Offices in order to both share learning and enhance the opportunity for learning for us as an organisation.

Through this policy we will commit to embedding the learning and lessons learnt from Coroner's Hearings and conclusions and will implement a process of dissemination across the organisation utilising the Area and Regional Learning Forums as a key vehicle to share learning with clinicians and staff. Learning from Deaths reports will, where appropriate, contain significant learning from coronial processes as an included section and key messages will be disseminated within the associated briefing documents.

We recognise that proactive engagement with Coroners will strengthen professional relationships; selected and appropriate learning that the Trust derives as a result of the implementation of this policy will be shared with Coroner's Offices where the learning will be of interest from those incidents occurring within individual Coroner's jurisdictions.

12. Bereaved Families and Carers

A culture of openness, transparency and candour is essential to improving patient safety. The Trust's established 'Being Open' Policy will be used to guide the processes for the interaction with bereaved families and carers during reviews of cases identified. NWAS is committed to engaging in a meaningful and compassionate way with bereaved families and carers. They will be provided with a primary point of contact and consulted on how they wish to receive feedback following the process. This will include cases where a joint review is being undertaken and where a death has been referred to the coroner and will be the subject of an inquest.

The Trust also has a statutory and contractual duty to meet the NHS standards of the Duty of Candour wherever there has been a notifiable patient safety incident. Where a case review identified through the Learning from Deaths process identifies concerns, the initiation of the Duty of Candour process will be rigorously applied.

In accordance with the Right Care Strategy, a greater voice to the bereaved families and carers will be established through a patient panel. This panel will provide scrutiny of our learning from death processes and provide assurance that we are meeting the needs of the population we serve. This panel will be Non-Executive Director lead and will shape its terms of reference to ensure that we embed our ability to learn from patients in the organisation. The membership of this panel will include families and stakeholders from across the North West.

13. Supporting Our Staff

NWAS is committed in supporting our staff in the event of a death of family member, friend, colleague or patient. Occupational health provide staff with access to independent and confidential counselling and support to help them deal with work related and personal issues. Contact details can be found on the *Invest in Yourself* pages on the intranet.

The Trust also provides a safe and robust Trauma Risk Management (TRIM) assessment service for any member of staff to access. The TRIM system is a post traumatic peer led risk assessment tool which aims to keep staff functioning after a traumatic event, such as a death of a patient, and provides information about personal resilience to staff and managers as well as identifying staff that may need specialised help. The Trust also has an extensive network of peer support / Blue Light Champions who are also available to provide a listening ear and signpost to further services where necessary.

Our commitment to staff is to have a just culture. The basis for this is a shared set of values in which our staff trust that all case reviews, and where applicable investigations, will result in a timely, fair and comprehensive process. Staff are assured that any actions, omissions or decisions that reflect the conduct of a reasonable person under the same circumstances will not be subject to inappropriate or punitive sanctions.

14. Reporting and Monitoring Arrangements

The Trust will present quarterly reports on the outcomes of the Learning from Death reviews to the Clinical Effectiveness Management Group, the Quality and Performance Committee, Executive Leadership Committee and ultimately to the Board of Directors. Scrutiny will be provided via this established governance process and serve to ensure that this Policy and the associated processes are fit for purpose and delivering upon their intended aims.

The Trust will produce an annual summary of learning from deaths within its Quality Account (from June 2021). This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

References

CQC (2016) ‘Learning, Candour and Accountability: A Review of the Way NHS Trusts Review and Investigate the Deaths of Patients in England’. London: CQC

NHS England (2015) ‘Serious Incident Framework’. London: NHS England

NHS Improvement (2018) ‘Just Culture Guide’. London: NHS Improvement

National Quality Board (2018) ‘Learning from Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers’. London: National Quality Board

National Quality Board (2019) ‘National Guidance for Ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care’. London: National Quality Board

Royal College of Physicians (2016) ‘Using the Structured Judgement Review Method: A Guide for Reviewers (England)’. London: Royal College of Physicians

North West Ambulance Service NHS Trust

REPORT

AGENDA ITEM: 24

Board of Directors	
Date:	27 November 2019
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for November 2019 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during October 2019. The highlights from this report are as follows; **Quality** • 146 compliments, the highest for 12 months, were received this month. • The Trust is on track with the strategy goal of reducing the Complaints per 1000 WTE staff. The fiscal year monthly average is 31 complaints per 1000 WTE staff for 2019/20, and 31 in October 2019, against a target of 35. • Complaints with a risk score of 1-3 that are complete within the SLA are 66% for the month, this is outside the normal variation and therefore has special cause variation with performance exceeding the upper control limit. A reduction in the backlog of cases has helped improve the closure within the agreed timescales. • 4 Serious Incidents (StEIS) were reported during October. • There have been no new safety alerts in October. **Effectiveness** • PES, PTS and NHS 111 FFT returns and satisfaction rates remain within our expected control limits. • Performance against all Ambulance Clinical Quality Indicators has improved this month with the exception of the call to door time for patients suffering a hyper acute stroke, although the Trust was still marginally inside the national mean for this target.

Finance

- The overall year to date actual and forecast financial risk score remains at 1.

Operational Performance

Patient Emergency Service (PES)

- Call pick up performance was at 87.5% in October.
- October Hear & Treat performance was 7.33% and affected by the suspension of services from two Greater Manchester providers, during the month.
- October See &Treat performance was 27.2%
- Conveyance rates continue to reduce (69% to 65%) over the past 12 months.
- The average turnaround time for October was 32 minutes 34 seconds across the North West.

ARP Performance

Category	Trajectory	Actual	Ranking
C1 (Mean)	7:00	7:30	7/10
C1 (90th)	15:00	12:43	5/10
C2 (Mean)	18:00	26:17	6/10
C2 (90th)	40:00	55:55	6/10
C3 (Mean)	1:00:00	1:29:16	6/10
C3 (90th)	2:00:00	3:33:05	6/10
C4 (90th)	3:00:00	3:23:17	6/10

NHS 111

- 70.6% of NHS 111 calls were answered in less than 60 seconds during October, with a year to date figure of 80.3%, against a target of 95%.
- Call back in 10 Minutes is at 26.6%, against a target of 75%.

PTS

- Activity in October for the Trust was 7% above contract baselines, whilst the year to date position (July 2019 - October 2019) is performing at 1% above baseline.

Organisational Health

- **Sickness**: The overall sickness absence rate for the latest reporting month (September 2019) was 5.86%.
- **Turnover:** The turnover figure for October was 8.41%.
- **Agency:** The Trust remains in a very strong position regarding agency costs, at 0.3%.
- **Vacancy** positions across the Trust remain stable.

	• **Appraisal:** The overall appraisal completion rate for October was 83% against a Trust target of 95%. • **Mandatory Training:** The overall Mandatory Training completion rate for October was 89% against an 95% trajectory.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: 1. Note the content of the report 2. Clarify any items for further scrutiny through the appropriate assurance committees

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☒	☒	☒	☒	☐	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	**None**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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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 2019. The report shows the historical and current performance on quality, effectiveness, finance, operational performance and organisational health. 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. INTEGRATED PERFORMANCE SUMMARY

2.1 Quality

Q1 – Complaints and Compliments

In October 2019, 188 complaints were received, against a 12 month average of 208 per month. 146 compliments, the highest for 12 months, were received this month. Complaints received in the month is currently showing common cause variation for both 1-3 and 4-5 risk scores. NWAS is on track with the goal to reduce complaints per 1000 WTE staff, with a fiscal year monthly average of 31 complaints per 1000 WTE staff for 2019/20, and 31 in October 2019 alone. The months in 2019/20 has seen a general reduction in complaints per 1000 WTE staff. Also in the month, 189 complaints were closed (180 cases were risk scored 1-3 and 9 were risk scored 4-5). Overall, 66% of level 1-3 and 33% of level 4-5 complaints were closed within agreed standard. The Trust has been on track with our performance goal for risk score 1-3 complaints closed in agreed timeframes for the last 2 months, however the monthly average for the fiscal year so far reports 57% closed in SLA. Whilst our closure in SLA rates for high risk complaints have improved in recent months, with August and September at over 40%, our monthly average in 2019/20 has been 24% closed in SLA.

Q2 – Incidents

1062 internal and external incidents were opened in October 2019 at a rate of 173 incidents per 1000 WTE staff. 94 ‘unscored’ incidents were recorded for October 2019, which accounts for 8.9% of the total number of incidents opened in the month. Unscored incidents are reviewed by the Clinical Safety Team and feedback is provided to the incident reporters on the importance of early review and scoring. They are also reported and monitored at Area Learning Forums. In total, 1043 incidents (level 1-5) were closed during October 2019. Of these, 79% level 1-3 and 80% level 4-5 incidents were closed within the agreed standard. Consistent performance have been achieved over time to remain on track with the performance goal to close incidents risk scored 1-3 within the agreed timeframes, with the average monthly rate in 2019/20 hitting 78%, and the rate not falling below 76% in any one month. However, no months so far have managed to dip over the target of 80%, and this has not happened since January 2019. Improvements have been made since April 2019 to realise the same goal for Incidents Risk Scored 4-5, with 80% closed within SLA in October 19, and a fiscal year monthly average of 75%. This is above and beyond the target set for 2019/20 (60%), and consistency should help accomplish the goal. The increased closure rate of level 1 to 5 incidents within agreed timeframes is attributed to the continual weekly reviews of all open incidents by the Clinical Safety Team. Any delays to closure are pre-empted and escalated early.

Q3 - Serious Incidents (SIs)

4 Serious Incidents (SIs) were reported this month, whilst 4 reports were submitted to Commissioners for closure. All Serious Incidents are reported within 2 working days of the ROSE meeting determining that they are StEIS reportable. Since the backlog of Serious Incidents ceased in July 2019, reports have largely been submitted within 60 working days. Any delays are due to the quality of reports that are submitted and the number of amendments that are required, as well as delays in the approvals process. These aspects of SI management are now the main focus of improvement.

Q4 – Staff Experience – Care/Treatment

No new data available for this month. New data available from December 2019.

Q5 - Safety Alerts and Health and Safety

There have been no new alerts in October 2019. The total number of CAS/NHS Improvement alerts received between November 2018 and October 2019 is 12, with 2 alerts applicable. 44 MHRA Medicine Equipment Alerts have been received with 1 alert applicable. 36 MHRA Medicine alerts have been received, with 1 alert applicable. 0 IPC alerts have been received, with 0 alerts applicable.

2.2 Effectiveness

E1 - Patient Experience

PES FFT returns and satisfaction ratings have increased this month but remain within our planned control limits. The 50% improvement goal in terms of returns set in Q1 was exceeded in Q2 and is being maintained going into Q3. PTS FFT returns and satisfaction ratings have also increased in October and also remain within our planned control limits. The number of NHS 111 FFT returns and satisfaction ratings decrease in October but they remain within our control limits. Following a programme of community events, patient and public feedback has identified low levels of understanding and awareness of the 111 service. As a result a 111 publicity campaign is currently underway.

E2 – ACQIS

In June, the rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 59.1% (national mean 54.2%), ranking the Trust 3rd nationally. For the overall group, the rate was 33.6% (national mean 31.6%) ranking the Trust 5th nationally. 10.6% of patients suffering an out of hospital cardiac arrest survived to hospital discharge in June (national mean 10.9%). The figure for the Utstein sub-group was 33.3% (national mean 33.8%). This performance saw the Trust ranked 4th and 5th respectively for English ambulance trusts. Mean call to door time for patients suffering a hyper acute stroke was 1h 22min marginally inside of the national mean (1h 23min). The Sepsis care bundle score of 76.8% was again marginally outside of the national mean of 77.6%.

E3 - HT, ST & SC Outcomes

NWAS is continuing to demonstrate a steady reduction in conveyance, from 68.6 % to 65.41 % over the past 12 months. Hear & Treat Performance for October 2019 was 7.33 %, as Clinical Assessment Service (CAS) contribution to H&T Performance was impacted throughout October due to the suspension of service from 2 GM Providers, Bardoc and Mastercall. Throughout September and October there has been engagement with NWAS, GM Health & Social Care Partnership and the Out of Hours providers. S&T in October saw a reduction to 27.2%, There has been an increase of over 4000, in 999 activity. This may be attributed to a small increase of H&T but also to an increase in patient acuity. We are continuing delivering training in the application of the Manchester Triage System to the NQP2 paramedic cohorts in anticipation of their qualification. We have also clarified that the application of Pathfinder by NQPs, allows appropriate referral and see & treat opportunities, without onward referral to the NWAS clinical hub. All areas are continuing to implement their improvement plans for S&T with support from the Urgent Care Development Team.

2.3 Finance

F1 – Finance

The position for the Trust at Month 7 is a surplus of £1.133m this is £0.103m better than the planned surplus of £1.030m. Income is over recovered by £1.903m, pay is overspent by £2.221m and non-pay is underspent by £0.421m. The year to date expenditure on agency is £1.007m which is £0.806m below the year to date ceiling of £1.813m equivalent to 44% under which results in an agency financial metric of 1. The overall year to date actual and forecast financial risk score remains at a 1 for the Trust.

2.4 Operational

OP1 – Call Pick Up

For August 2019, call pick up performance was at 87.5%. 16,180 calls took longer than 5 seconds to pick up. CPU has improved across all key measure vs September 19. This includes mean and both centiles, even with the number of calls answered increasing significantly vs September 19 (16,276 calls increase). This demonstrates improved capacity within the call handling teams. Duplicate calls have increased and appear to driving some of the call volume increase. The EOC are reviewing the end of call scripts in an effort to reduce duplicates, which can fueled by extended response times.

OP2 – Hospital Turnaround

The average turnaround for October 2019 was 32 minutes 34 seconds across the North West. The 5 hospitals with the longest turnaround times during August 2019 were Royal Oldham (39:22), Royal Bolton (38:03), Whiston (37:36), Southport District General (36:38) and Royal Lancaster Infirmary (35:55). Visits with acute sites continue at Exec level and the re-introduction of the collaborative work with the 14 most challenged trusts is underway. Handover to clear has seen a steady decrease over time, with the average in the latest week falling below the lower control limit, signaling the Trusts lowest average H2C time within the charts time period (Since April 2018). Arrival to handover has displayed special cause variation twice in October, with hospital attendances being the highest number since May 2019.

OP3 – ARP Standards

	C1 Mean	C1 90th	C2 Mean	C2 90th	C3 Mean	C3 90th	C4 90th
Oct-19	00:07:30	00:12:43	00:26:17	00:55:55	01:29:16	03:33:05	03:23:17
Target	00:07:00	00:15:00	00:18:00	00:40:00	01:00:00	02:00:00	03:00:00
Rank	7/10	5/10	6/10	6/10	6/10	6/10	6/10

C1 performance remains within normal variation for both mean and 90th centile. This is despite a 23% increase in C1 activity over the equivalent period last year. C2 and C3 have seen some special cause variation/deterioration during October. This has been investigated and is linked to an increase in acuity as noted for C1. C2 has also seen a rise in comparison with last year. The rise in acuity for these categories means we utilise more resources per incident, which in turn reduces resources for lower acuity calls.

OP4 – 111

Calls answered within 60 seconds sits at 70.6% in October 2019, with a year to date figure of 80.3%, against a target of 95%. Whereas the call backs in under 10 minutes percentage is 26.6%, against a target of 75%. Performance has been exceptionally challenging for 111 over the past 4 months primarily, although not exclusively, due to controlling the budget overspend. At the end of 2018 and over the beginning of 2019 NWAS 111 utilised an outside organisation (Conduit) to provide additional capacity to support performance. This was being delivered at the cost of an overspend on the contracted budget. This ceased at the end of June 2019.

OP5 – PTS Activity

Overall activity during October 2019 was 7% above contract baselines, whilst the year to date position (July 2019 - October 2019) is performing at 1% above baseline. In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 29% and 9% above 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 in achieving contract KPI performance. Cumbria and Lancashire are 19% and 11% below baseline. Overall trend analysis shows Greater Manchester experienced an upward activity movement for the 12 months to October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also levelled out whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity. Aborted activity for planned patients averaged 6% during the month.

2.5 Workforce

OH1 – Sickness

The overall sickness absence rates for September 2019 were 5.86%, with the Trust overall displaying a slight decrease over the previous 3 months. The position is slightly higher than the same time last year which was 5.81% in September 2018. There are no special clause variations with regards to Service Lines positions. The Trust has an improvement goal to reduce sickness absence overall by 0.5%, but there are specific improvement targets for PTS to reduce sickness to 6% and also for 111 to reduce to 8%. The Trust has an improvement plan which is being overseen by NHSE/I. PTS have made excellent progress and are currently at 6.17% sickness and whilst 111 have reduced their sickness absence rates over a 2 month period, there is still further improvements to be made.

OH2 – Turnover

October 2019 turnover is 8.41%, with common cause variation. There are no special cause variation with regards to turnover in service lines, however 111 turnover is at the lower end of the control limit at 27.97% and work continues to improve the position. As part of the Ambulance Improvement Programme (AIP), the Trust is engaging with NHSE/I to develop a retention plan by 30th November 2019 with a particular focus on 111 retention. Turnover in EOC is reported at 11.49%, which shows a slight increase in turnover, however their overall staffing position is positive. Both PES and PTS turnover is stable and within control limits.

OH3 – Staff Recommend (Place to Work)

No new data available for this month. New data available from December 2019.

OH4 – Temporary Staffing

The Trust remains in a strong position regarding Agency costs. The position in October 2019 is at 0.3%, with the lowest agency cost spend within the 12 month period. The Trust is working with a new Agency, which went effective from 1 September 2019.

OH5 – Vacancy Gap

The changes resulting from the contract settlement and revisions to the ORH position have started to be included from Quarter 3 into the establishment, so the vacancy position partly reflects the new requirements but will be fully reflected at the end of Q4. The revised establishment for EOC has been implemented and places the EOCs in a strong position moving into the winter period at 1.33% above establishment. Work is ongoing with PES, PTS and 111 to ensure robust plans are in place to reach the current establishment and new establishment as soon as practicable but overall the position is stable. The PTS vacancy position is -5.52% in October 2019, showing a slight improvement from the previous vacancy position and a continuous improving trend.

OH6 – Appraisals

Appraisal compliance overall has been stable for several months with no variations at Trust level. The October 2019 position being 83% against a target of 95%. The improvement goal for these measures for 19/20 is to achieve 95% compliance. Special clause variation at OH6.2 relates to PTS due to a slightly decreasing trend over a 3 month period to 84.59%. Support and monitoring will be provided to PTS. Both EOC and 111 have also seen a slight reduction in compliance but still with control measures. These workforce indicators will be reported through the Resources Committee to ensure that assurances can be provided regarding progress.

OH7– Mandatory Training

2019 classroom training for PES is under trajectory at 93% against a target of 95% and PTS mandatory training is slightly over trajectory at 96%. For 2019 we have moved to competency based compliance reporting for Mandatory Training. The overall Trust position at the end of October 2019 is 89% compliance against a target of 95%. The NWAS overall competency compliance is 89% compliance against a target of 95%. The NWAS corporate position is 93% compliance against a target of 95%. 111 compliance has been fairly static over the last few months but they are currently completing mandatory systems training which will be added to figures following completion of the full programme.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

3.1 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.

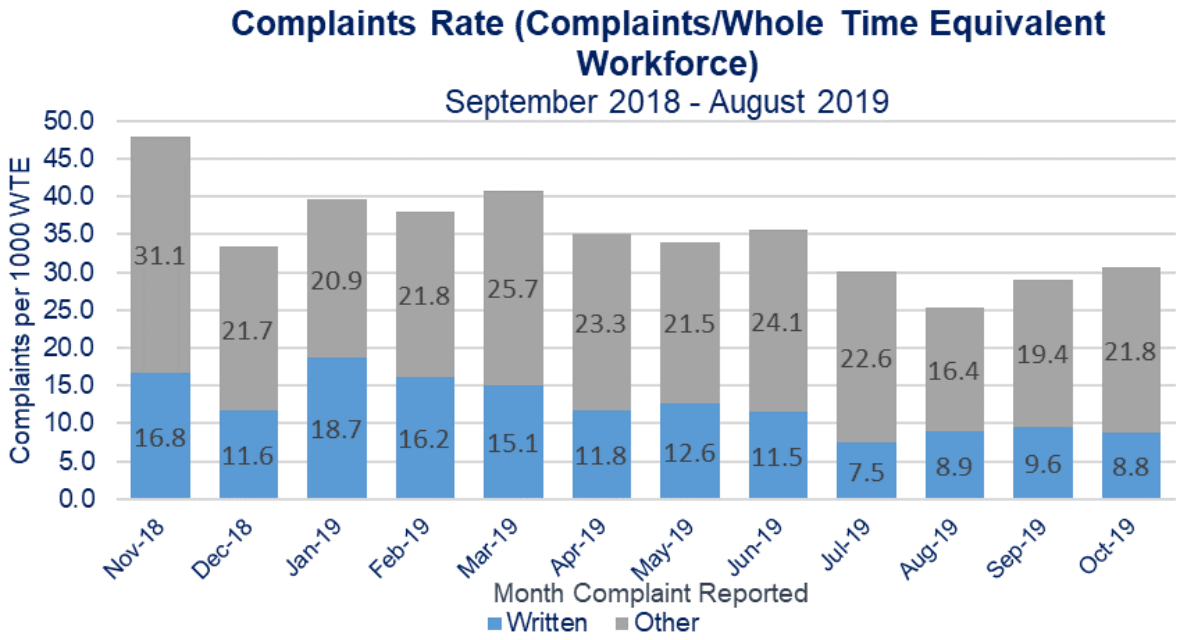
4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note the content of the report
- Clarify any items for further scrutiny through the appropriate assurance committee

Q1 COMPLAINTS

Figure Q1.1



Annual Average:
208 per month
35 per 1000 staff

Table Q1.1: Complaints Opened by Month

Severity	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
1. Minimum	45	36	27	21	36	45	39	32	17	13	15	9
2. Minor	184	123	158	160	172	140	133	150	125	109	132	143
3 Moderate	36	28	37	31	25	18	26	19	25	21	16	17
4 Major	12	7	6	7	8	3	3	9	11	10	9	14
5 Serious	3	1	5	6	2	3	2	3	3	0	3	5
Total	**280**	**195**	**233**	**225**	**243**	**209**	**203**	**213**	**181**	**153**	**175**	**188**
Compliments	121	127	103	109	122	113	109	35	135	112	127	146

Complaints & Compliments

In October 2019, 188 complaints were received, against a 12 month average of 208 per month.

146 compliments, the highest for 12 months, were received this month.

Complaints received in the month is currently showing common cause variation for both 1-3 and 4-5 risk scores.

Right Care Strategy Goals Performance:

1. Reduce the overall numbers of complaints per 1000 WTE staff by 10% (4) of the baseline (39) by 2019/20, achieving 35 per 1000 WTE staff.

NWAS is on track with the performance goal, with a fiscal year monthly average of 31 complaints per 1000 WTE staff for 2019/20, and 31 in October 2019.

Figure Q1.2

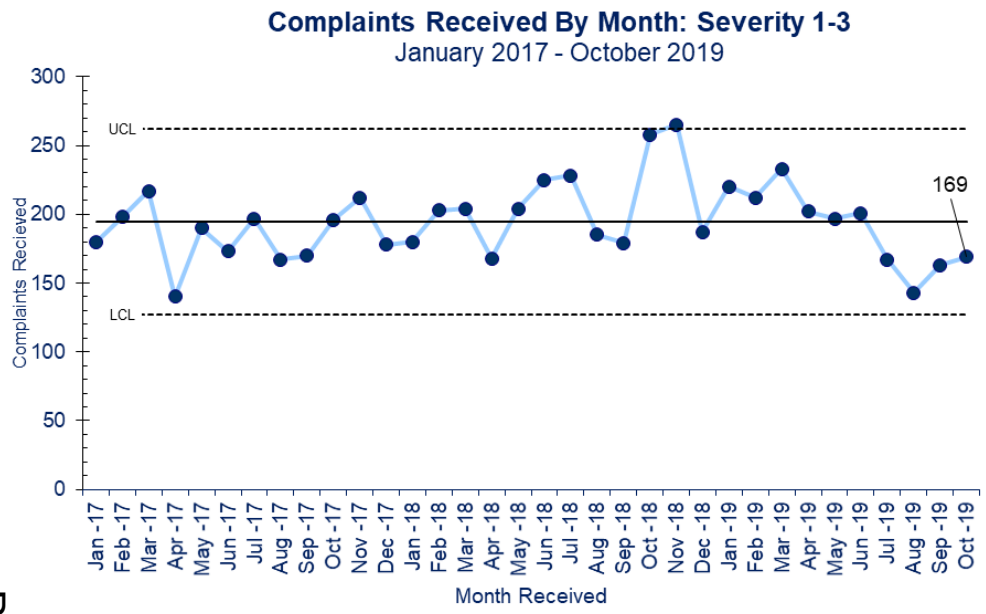


Figure Q1.3

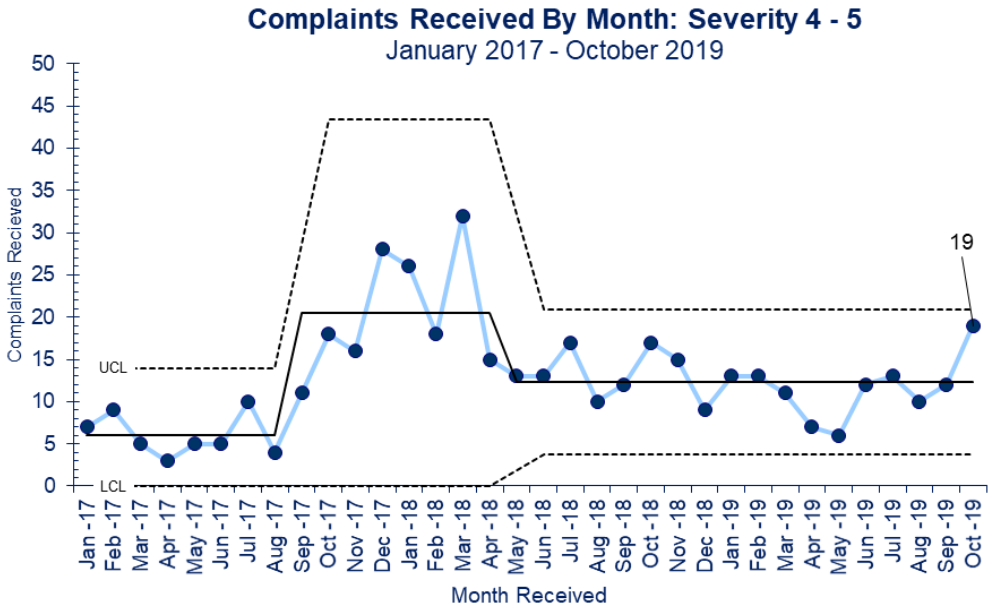


Figure Q1.4

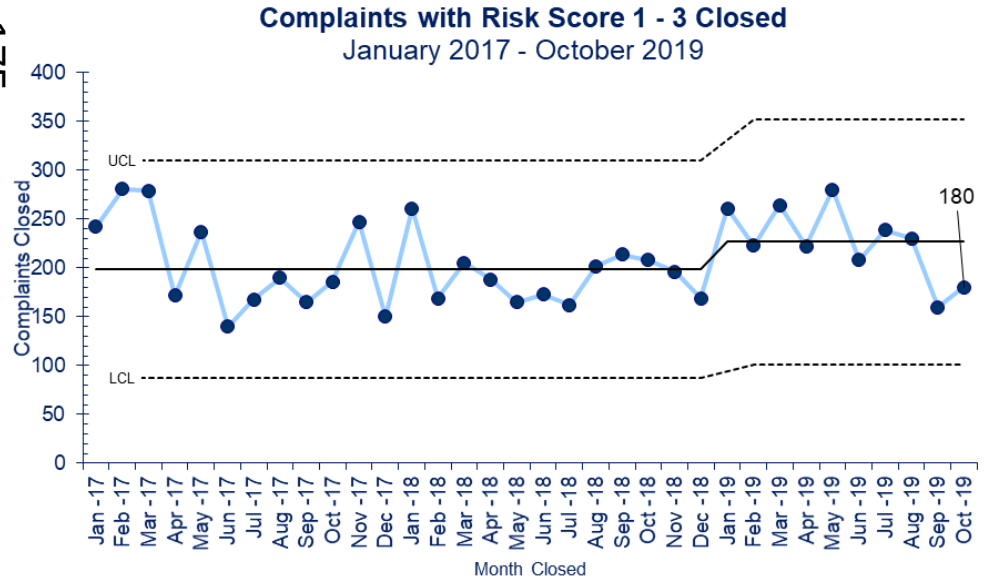


Figure Q1.5

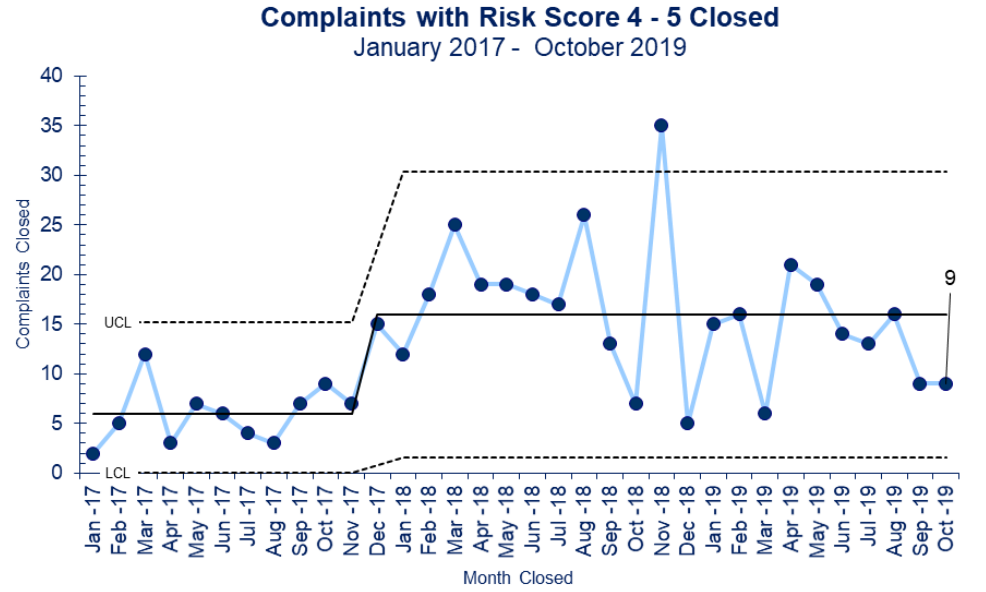


Figure Q1.6

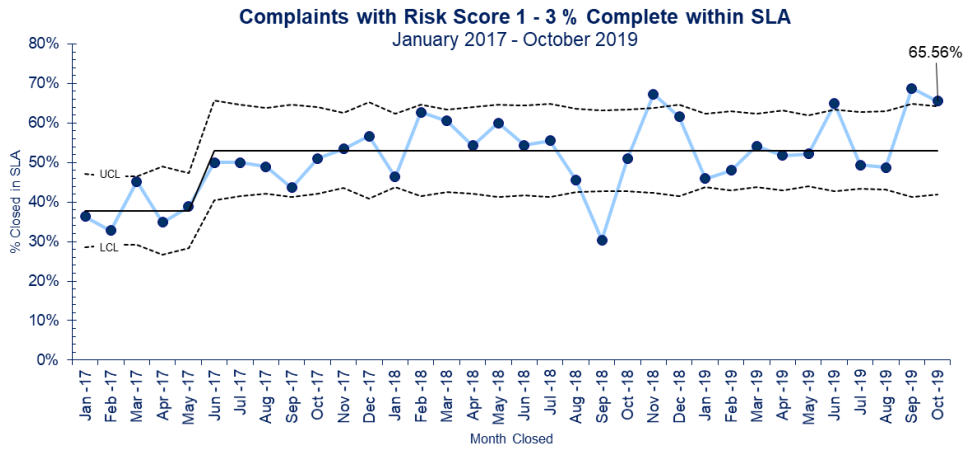
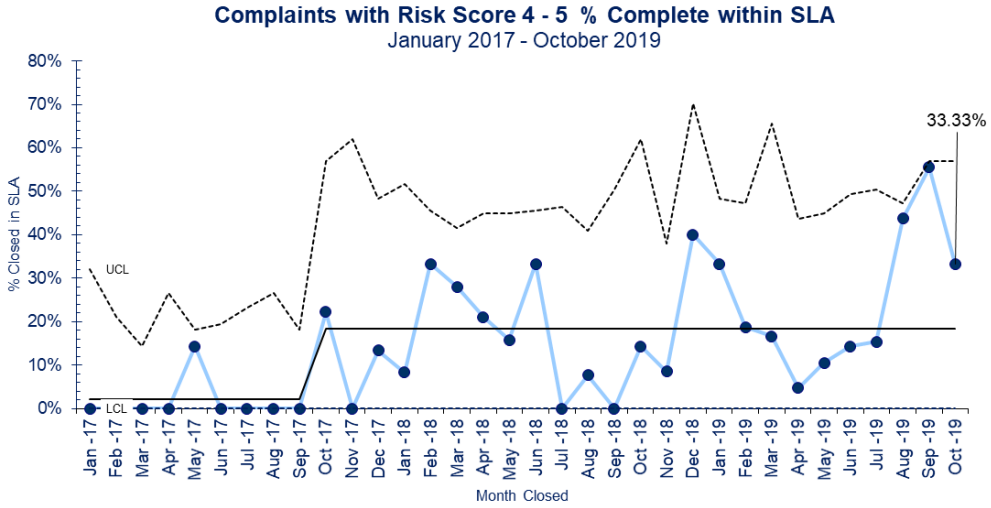


Figure Q1.7



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

Complaints Closure

A total of 189 complaints were closed in October 2019 (180 cases were risk scored 1-3 and 9 were risk scored 4-5).

Overall, 66% of level 1-3 and 33% of level 4-5 complaints were closed within agreed standard.

Q1.6 shows special cause variance with performance exceeding upper control limits. The reduction in backlog of cases has helped improve the closure within SLA.

Case management by individuals has been improved through adaptations of Datix dashboards and concise case assessment to reduce requests for specialist advice.

Given the number of new high risk complaints, ROSE has agreed to an alternative investigation strategy for high risk emergency response complaints, which is currently being tested.

Right Care Strategy Goals Performance:

1. 65% of complaints with a risk score of 1 to 3 will be closed within agreed timeframes by the end of 2019/20.

The Trust has been on track with this target for the last 2 months, as seen on Figure Q1.6, however the monthly average for the fiscal year so far reports 57% closed in SLA. Consistency is required to achieve this goal by the end of 2019/20.

2. 40% of complaints with a risk score of 4 to 5 will be closed within agreed timeframes by the end of 2019/20.

Special cause variation can be seen on Figure Q1.7, with a trend showing from April to August although this moved back to common cause variation in O. Whilst our closure rates for high risk complaints have improved in recent months, with August and September being over 40%, our monthly average in 2019/20 has been 24% closed in SLA.

BAF Risk: SR01 (Risk ID 2829)

Q2 INCIDENTS

Figure Q2.1

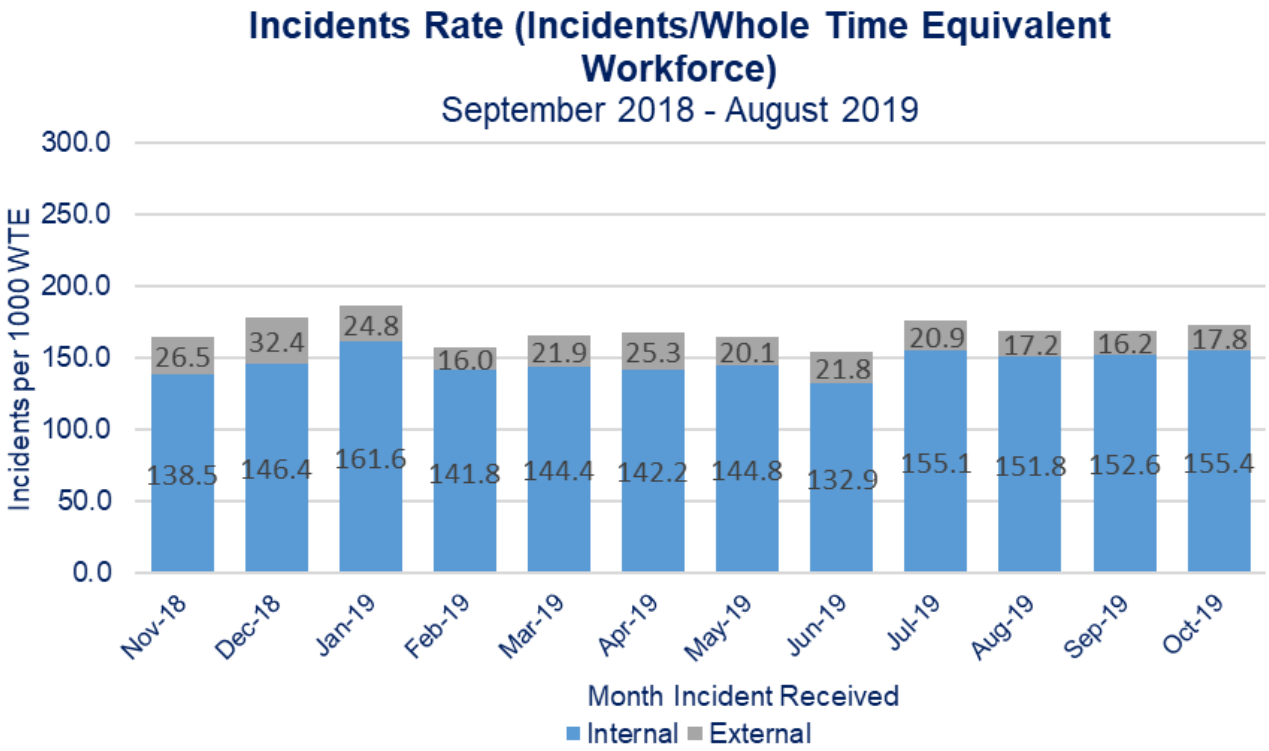


Table Q2.1

Severity	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
1. Insignificant	226	195	187	193	198	176	166	145	189	168	183	170
2. Minor	521	621	664	546	590	639	647	590	698	697	620	634
3. Moderate	189	193	218	174	169	155	151	165	141	132	172	149
4. Major	13	15	6	6	13	9	3	5	11	10	6	8
5. Catastrophic		2	3	3			1		1	1	3	7
Unscored	16	18	19	14	19	19	15	17	19	12	35	94
Total	**965**	**1044**	**1097**	**936**	**989**	**998**	**983**	**922**	**1059**	**1020**	**1019**	**1062**
Unscored %	1.66%	1.72%	1.73%	1.50%	1.92%	1.90%	1.53%	1.84%	1.79%	1.18%	3.43%	8.85%

Incidents

1062 internal and external incidents were opened in October 2019 at a rate of 173 incidents per 1000 WTE staff.

Incidents opened in October 2019 follow common cause variation on Figures Q2.2 and Q2.3

Right Care Strategy Goals:

1. Reduce reported unscored incidents in the IPR to 50 in previous reported month by 2019/20.

We measure the number of incidents for the reported month on the 5th working day of each new month to track our reduction goal. 94 'unscored' incidents were recorded at this stage for October 2019, which accounts for 8.9% of the total number of incidents opened in the month.

Unscored incidents are reviewed by the Clinical Safety Team and feedback is provided to the incident reporters on the importance of early review and scoring. They are also reported and monitored at Area Learning Forums.

Our progress can be tracked on Figure Q2.4 on the next page, which shows we have 21 more unscored incidents than our October 2019 trajectory target of 73.

Figure Q2.2

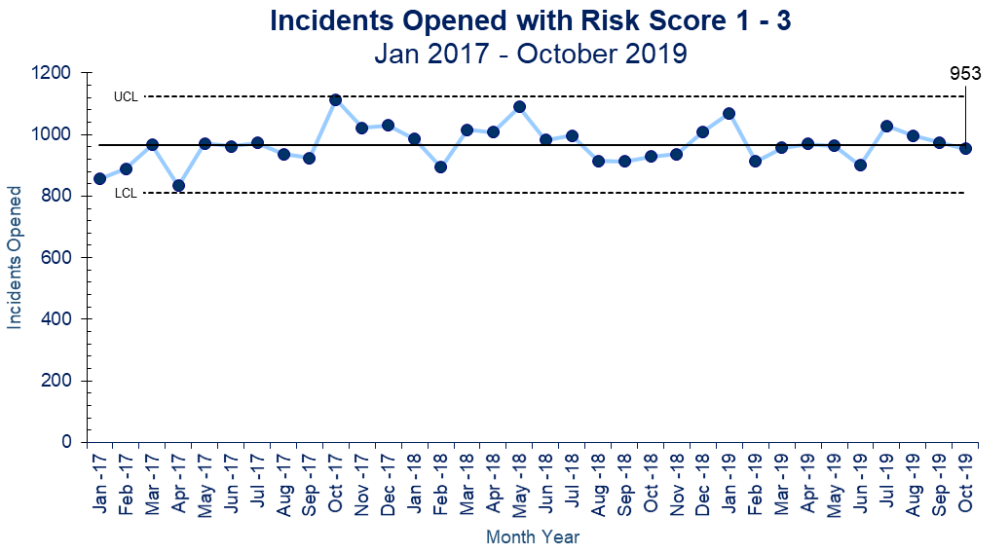


Figure Q2.3

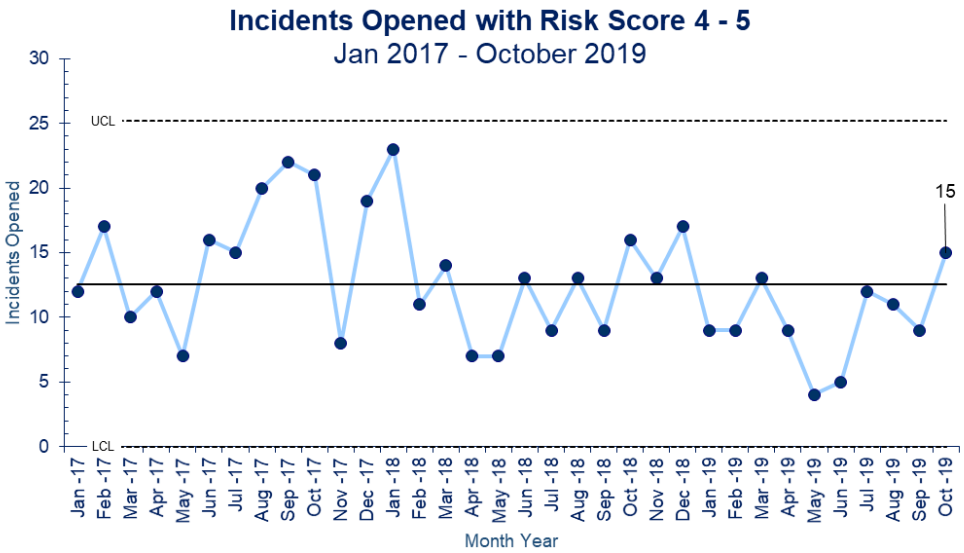


Table Q2.1 – Top 10 Incident Categories Opened in October 2019

Category	30/09/2019	07/10/2019	14/10/2019	21/10/2019	28/10/2019	Total
111 Assessment/Advice	17	27	24	25	24	**117**
Information	16	16	18	18	19	**87**
Verbal Abuse	17	12	13	11	10	**63**
Staff Welfare	16	12	11	7	12	**58**
Inappropriate Use of Service	7	12	11	10	13	**53**
Physical Assault	14	8	10	4	13	**49**
Equipment Missing / Lost	8	14	13	7	4	**46**
Communication	10	11	10	7	6	**44**
111 Issue with other service	8	7	8	8	13	**44**
Threatening behaviour	9	9	10	4	11	**43**

Figure Q2.4

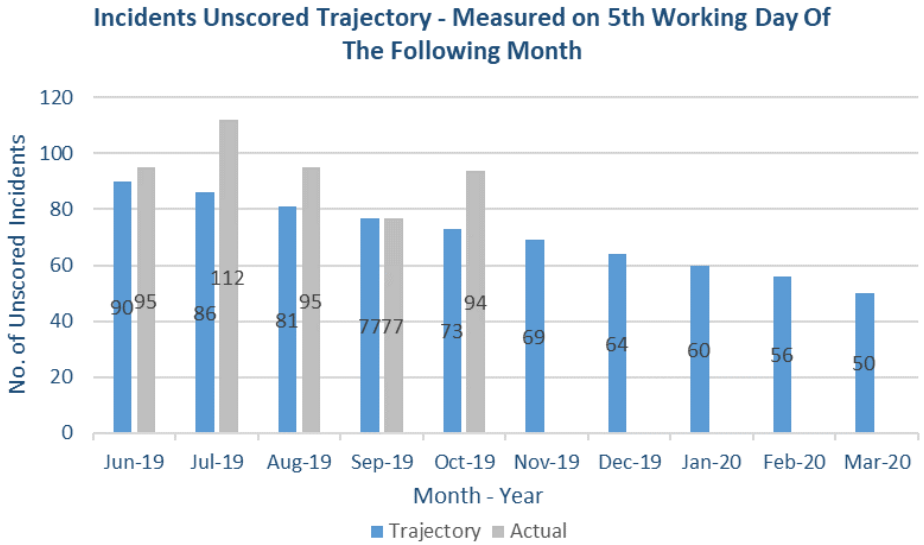


Figure Q2.5

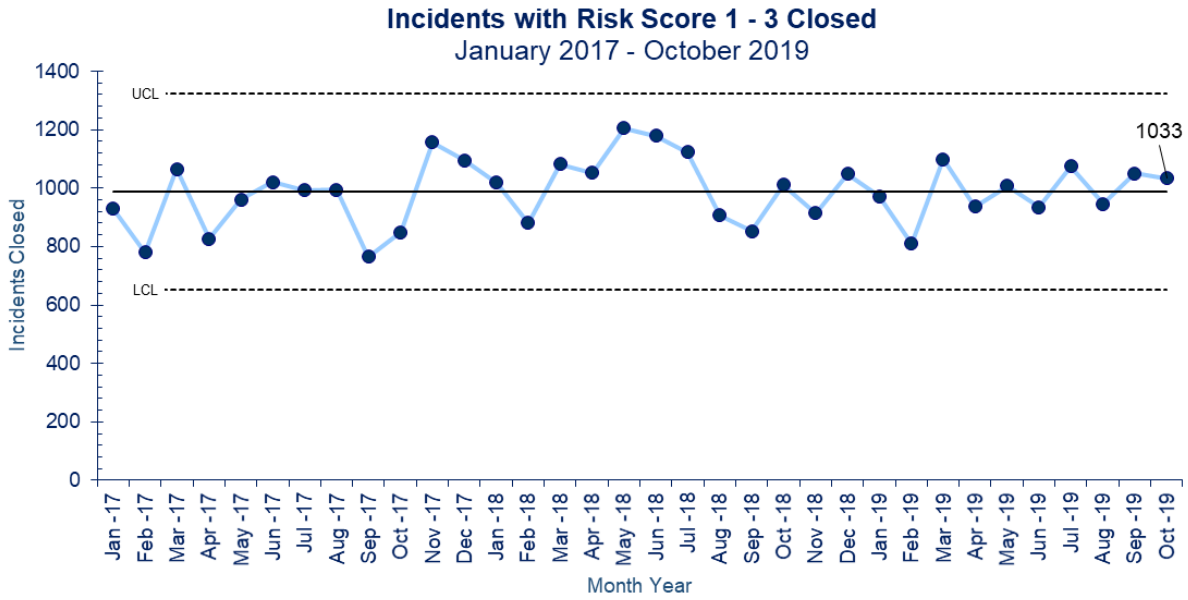
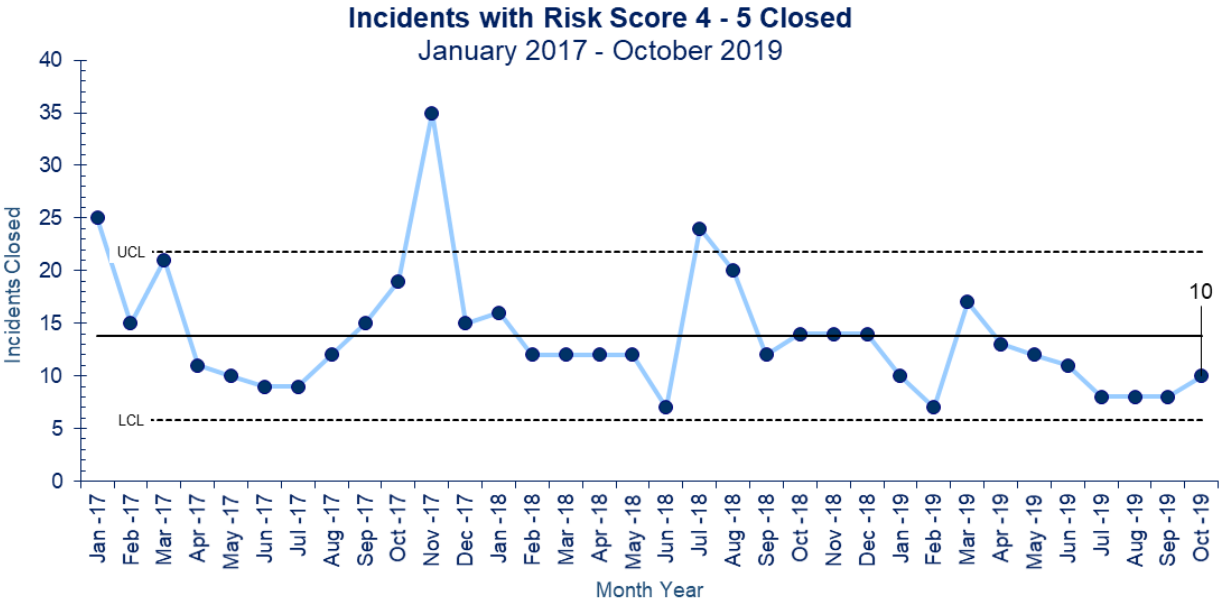


Figure Q2.6



Incidents Closure

In total, 1043 incidents (level 1-5) were closed during October 2019. Of these, 79% level 1-3 and 80% level 4-5 incidents were closed within the agreed standard.

The number of complaints being closed on Figures Q2.5 and Q2.6 show common cause variation although only one more point is required below the mean to show special cause for Q2.6.

Right Care Strategy Goals Performance:

1. Increase closure within agreed timeframes to 80% by 2019/20 for severity 1-3 (Figure Q2.7).

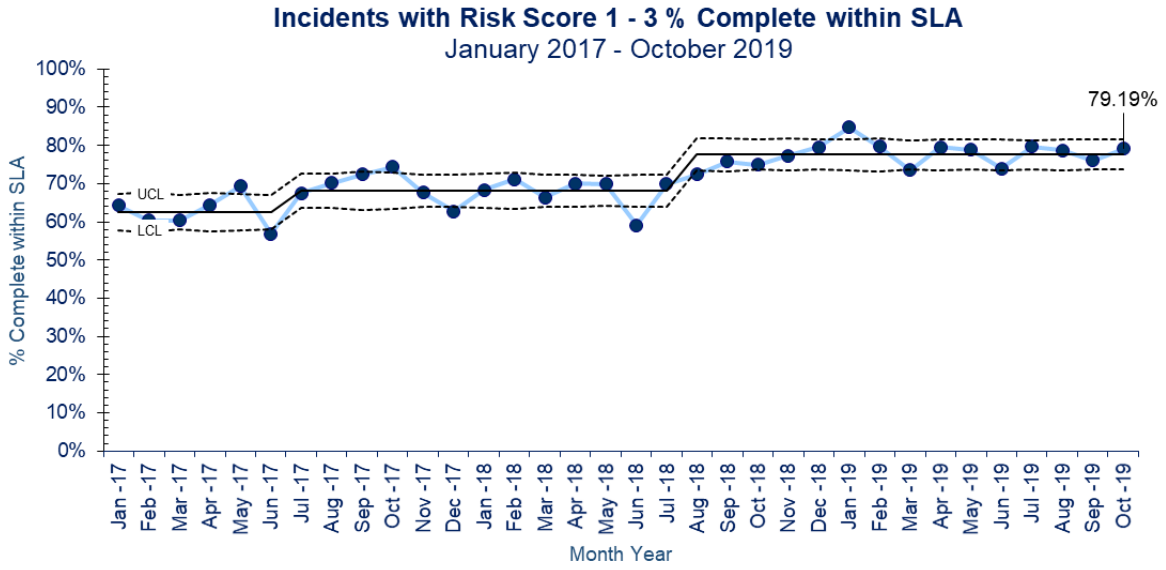
Consistent performance have been achieved over time to remain on track with this performance goal, with the average monthly rate in 2019/20 hitting 78%, and the rate not falling below 76% in any one month. However, no months so far have managed to dip over the target of 80%, and this has not happened since January 2019.

2. Increase closure within agreed timeframes to 60% by 2019/20 for severity 4-5 (Figure Q2.8).

80% were closed within SLA in October 19 with a fiscal year monthly average of 75%. Two more points are needed above the mean to demonstrate a shift beyond the improvement goal.

The increased closure rate of level 1 to 5 incidents within agreed timeframes is attributed to the continual weekly reviews of all open incidents by the Clinical Safety Team. Any delays to closure are pre-empted and escalated early.

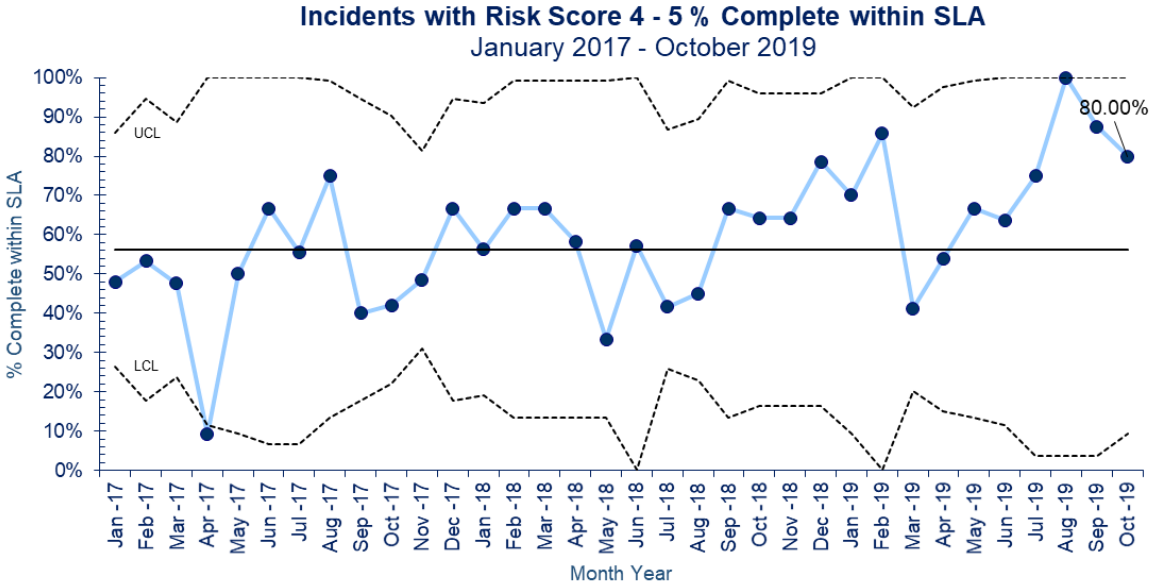
Figure Q2.7



SLAs are calculated using the following measures/targets:

Risk Score	Target Days
1	20
2	20
3	40
4	60
5	60

Figure Q2.8



Q3 SERIOUS INCIDENTS

Figure Q3.1:

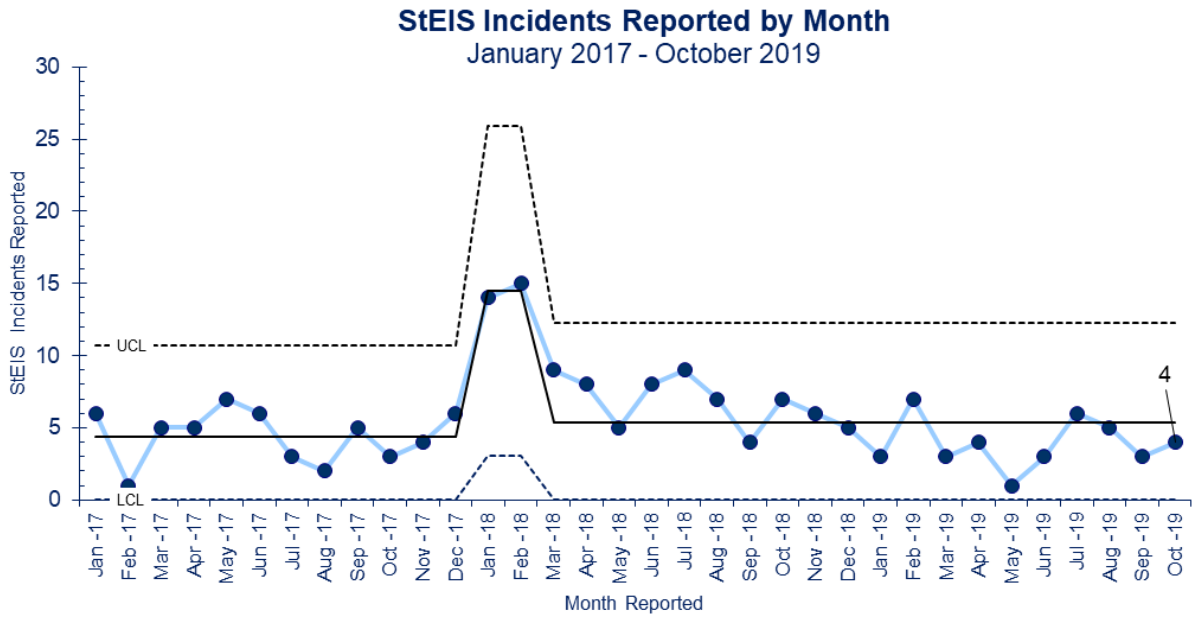


Table Q3.1: StEIS Incidents Opened in October 2019 by Source

Source	SD – Emergency Operations Centre	Total
Complaint/StEIS	2	**2**
IRF/StEIS	2	**2**
Total	**4**	**4**

Serious Incidents

4 Serious Incidents (SIs) were reported in October 2019.

4 reports were submitted to Commissioners for closure.

All Serious Incidents are reported within 2 working days of the ROSE meeting determining that they are StEIS reportable.

Since the backlog of Serious Incidents ceased in July 2019, reports have largely been submitted within 60 working days.

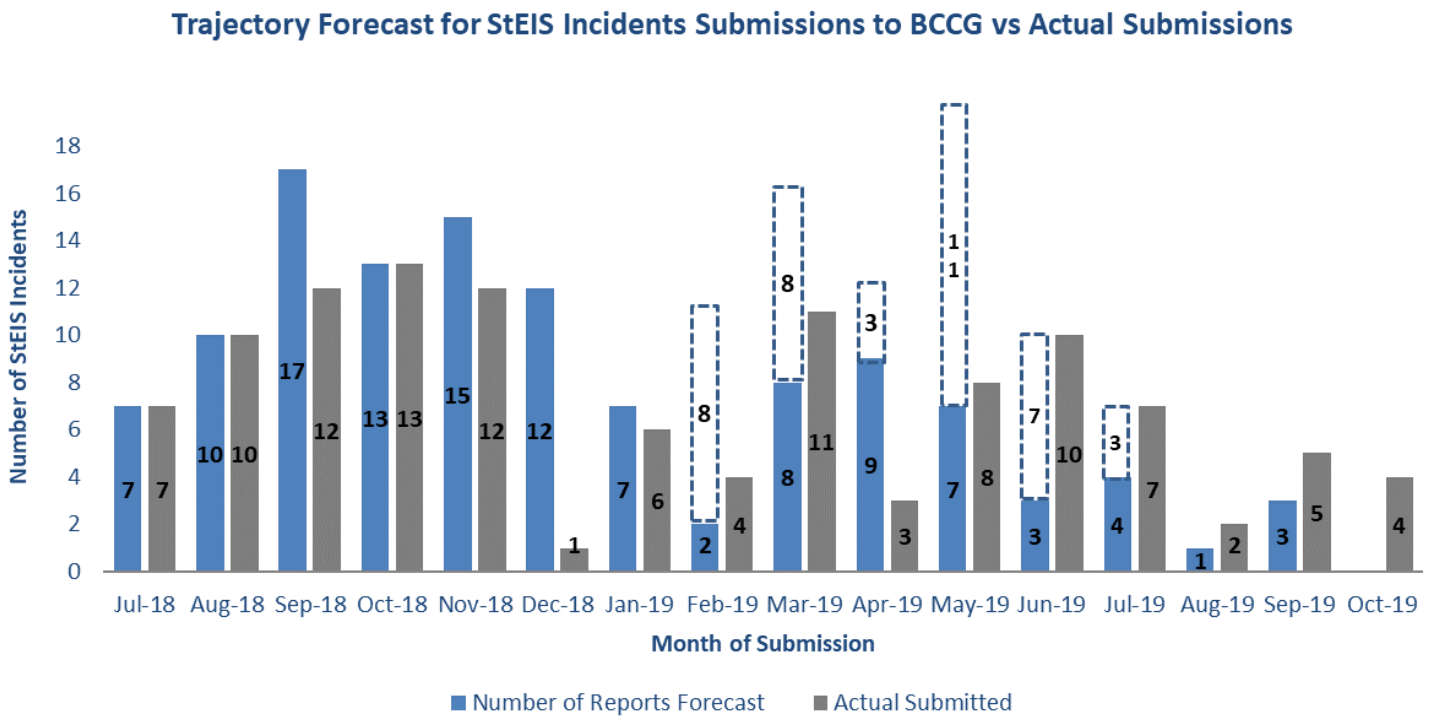
Any delays are due to the quality of reports that are submitted and the number of amendments that are required, as well as delays in the approvals process. These aspects of SI management are now the main focus of improvement.

Right Care Strategy Goals:

1. Increase the proportion of cases where the notify-to-confirm interval is within the agreed timeframes.
2. Increase the proportion of cases where the confirmation to report interval is within the agreed 60 day timeframe

BAF Risk: SR01.

Figure Q3.2: Current trajectory of StEIS submissions to BCCG per month vs actual submissions in the month.



Q5 SAFETY ALERT COMPLIANCE

Safety Alerts	Number of Alerts Received (Nov 18 – Oct 19)	Number of Alerts Applicable (Nov 18 – Oct 19)	Number of Open Alerts
CAS/ NHS Improvement	12	2	0
MHRA – Medical Equipment	44	1	0
MHRA - Medicine Alerts	36	1	0
IPC	0	0	0

Figure Q4.1:

CAS – Alerts Applicable

1. **Risk of harm from inappropriate placement of pulse oximeter probes**.
   Action: Clinical bulletin sent out by Chief Consultant Paramedic number CL648
   Action date: 08/01/2019, alert closed.

2. **Fire risk from personal rechargeable electronic devices**.
   Action: Health & Safety Bulletin sent out by Head of Safety & Patient Experience number HS033
   Action Date: 14/01/2019, alert closed.

Medical Equipment – Alerts Applicable

1. Professional use monitor/defibrillator: LIFEPAK 15 at risk of device failure during patient treatment. Action: Urgent Operation bulletin OI670 sent out and follow up bulletin OI671 by Director of Operations. The software upgrade has been successful and the rectification programme is close. Action date: June 2019

Medicines – Alerts Applicable

1. **Glucose 10% 500ml infusion bags** - Company led drug recall for certain batches issued 07/05/2019.
   Actions: Not general NWAS stock but stock was located on the DoH Mass Casualty Vehicles held in HART. Current stocks checked for affected batches and all found have been removed and replaced with non-affected stock. Disposed of affected stocks.
   Action Date: All actions completed by 05/06/2019. Alert now closed.

NWAS Response

There have been no new safety alerts in October 2019.

The total number of CAS/NHS Improvement alerts received between November 2018 and October 2019 is 12, with 2 alerts applicable.

44 MHRA Medicine Equipment Alerts have been received with 1 alert applicable.

36 MHRA Medicine alerts have been received, with 1 alert applicable.

0 IPC alerts have been received, with 0 alerts applicable.

BAF Risk: SR01.

E1 PATIENT EXPERIENCE

Figure E1.1

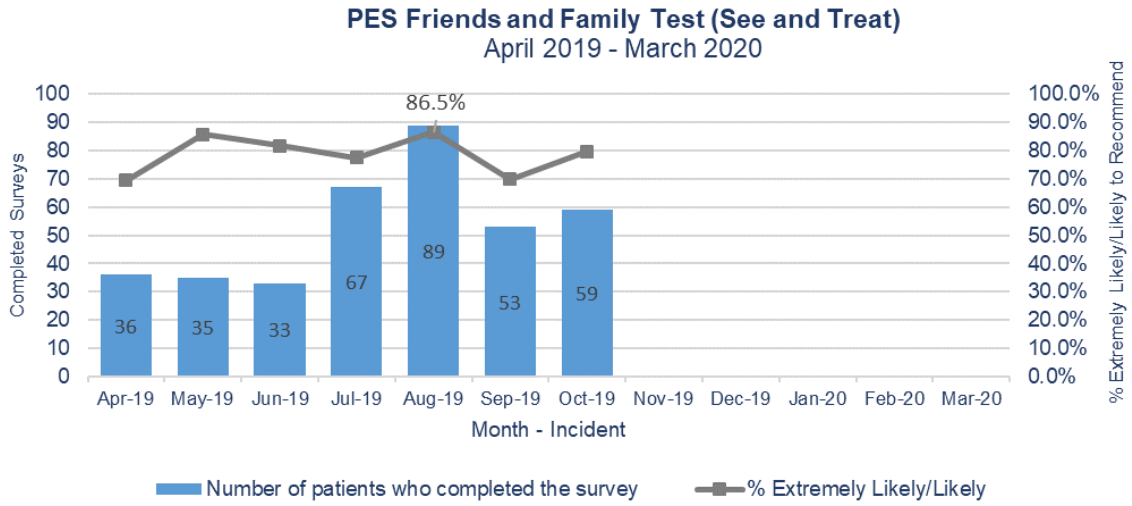


Table E1.1 National PES See and Treat FFT – September 2019

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	**242**	**89%**	**8%**
SOUTH WESTERN AMBULANCE SERVICE	7	100%	0%
NORTH EAST AMBULANCE SERVICE	104	99%	1%
EAST OF ENGLAND AMBULANCE SERVICE	42	95%	2%
EAST MIDLANDS AMBULANCE SERVICE	9	89%	11%
WEST MIDLANDS AMBULANCE SERVICE	9	89%	11%
SOUTH CENTRAL AMBULANCE SERVICE	13	77%	8%
NORTH WEST AMBULANCE SERVICE	53	70%	25%
LONDON AMBULANCE SERVICE	2	*	*
YORKSHIRE AMBULANCE SERVICE	3	*	*
ISLE OF WIGHT	0	NA	NA

Patient Experience (PES)

This month has seen an increase of 11.3% (from 53 to 59) for PES FFT returns, along with an increase of 9.9% in satisfaction rating from 69.8% to 79.7%.

The 50% improvement goal in terms of returns set in Q1 was exceeded in Q2 and is being maintained going into Q3. Work continues with an internal staff campaign to increase the awareness of the importance of handing out FFT cards.

National guidance on the submission of the PES (see and treat) FFT responses is that from Apr 2020 ambulance services will be able to stop collecting FFT response, if they so wish.

Figure E1.2

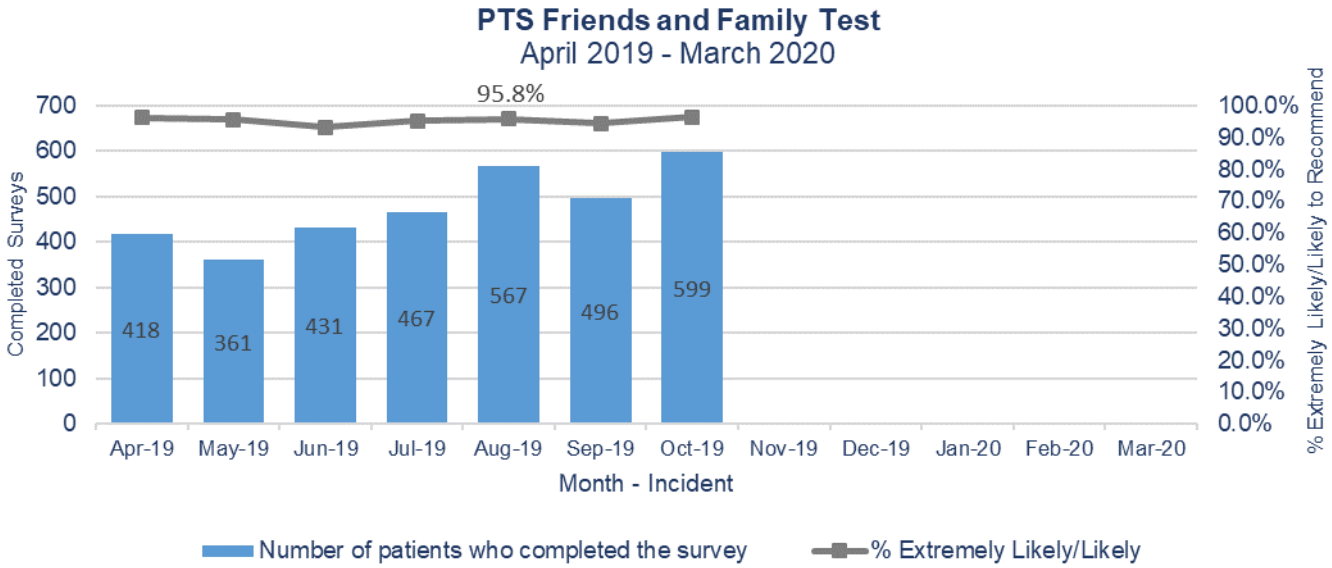


Table E1.2 National PTS FFT – September 2019

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	2,086	86%	7%
NORTH EAST AMBULANCE SERVICE	19	100%	0%
EAST MIDLANDS AMBULANCE SERVICE	29	100%	0%
ISLE OF WIGHT	9	100%	0%
NORTH WEST AMBULANCE SERVICE	496	94%	4%
EAST OF ENGLAND AMBULANCE SERVICE	115	90%	5%
GUY'S AND ST THOMAS'	1043	87%	5%
WEST MIDLANDS AMBULANCE SERVICE	7	86%	0%
UNIVERSITY COLLEGE LONDON HOSPITALS	249	80%	11%
IMPERIAL COLLEGE HEALTHCARE	108	44%	31%
SOUTH CENTRAL AMBULANCE SERVICE	8	38%	50%
YORKSHIRE AMBULANCE SERVICE	3	*	*

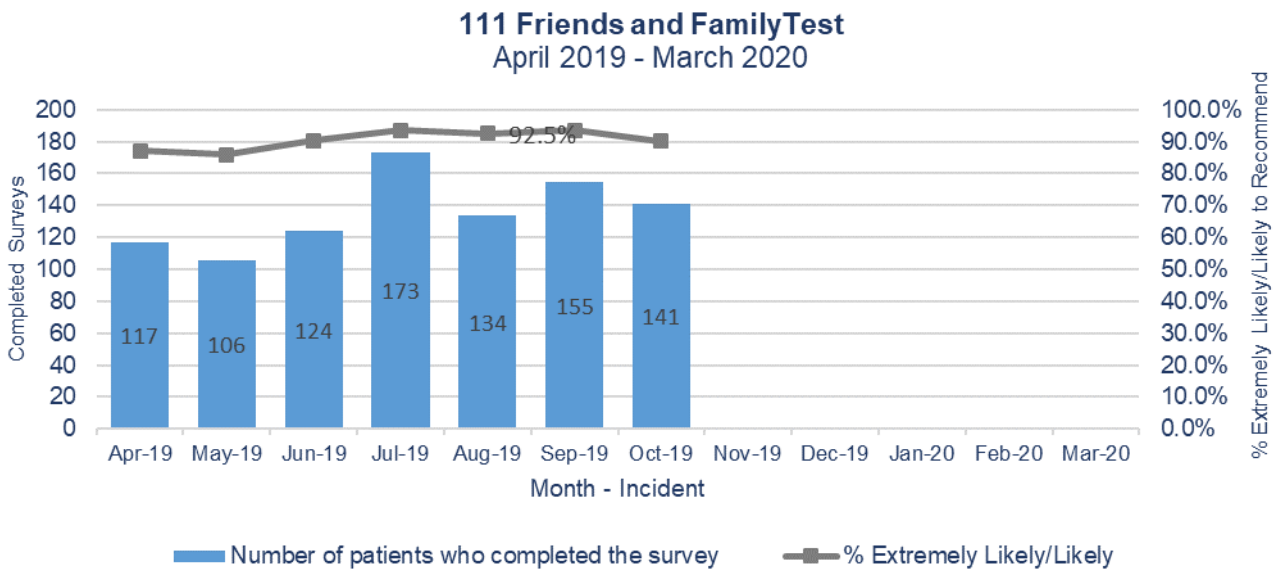
Patient Experience (PTS)

The number of patients who completed the FFT has increased from 496 in September to 599 in October (an increase of 20.8%), with the satisfaction rate also seeing an increase of 2.1% for the same period (94.4% to 96.5%).

Nationally the trust continues to hold the second highest spot in terms of number of responses, same as the previous month, as well as 2nd spot in terms of satisfaction levels, but dropping from 1st spot from the previous month (September 19 data).

There is still the requirement for national submissions for PTS FFT responses.

Figure E1.3



Patient Experience (111)

The number of NHS 111 FFT responses saw a drop from 155 in September to 141 in October, (9.9% reduction)

We also see a drop of 3.4% in satisfaction levels from 93.5% in September to 90.1% in October.

Following a programme of community events, patient and public feedback has identified low levels of understanding and awareness of the 111 service. As a result a 111 publicity campaign is currently underway. This will be followed up with a further programme of education and awareness activities developed and agreed with the trust's 111 service, together with national colleagues, as required. It is also intended to review our patient experience survey and other methods for capturing patient experience and learning from it

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Table E2.1: ACQI June 2019

ACQI Indicator		YTD Performance (%)	Sample Size (Current Month)	June 19 Performance (% / hrs: mins)	May 19 Performance (%)*	June 19 Rank position	Rank movement	Performance Range % / hrs: mins (national mean)
Cardiac Arrest ROSC	Overall	32.9%	250	33.6%	31.5%	5	↔	22.5-35.9 (31.6)
	Utstein	59.6%	44	59.1%	56.8%	3	↑	31.0-66.7 (54.2)
	Resus Care Bundle	63.4%	N/A	N/A	N/A	N/A	N/A	N/A
Cardiac Arrest Survival to Discharge	Overall	9.3%	235	10.6%	5.7%	4	↑	8.3-16.5 (10.9)
	Utstein	29.1%	36	33.3%	23.5%	5	↑	24.1-44.1 (33.8)
Acute STEMI	PPCI (mean call to PPCI time)	N/A	119	2hrs 13 mins	2hrs 20 mins	6	↑	2hr 02 mins - 2hr 27 mins (2hr 12 mins)
	Care Bundle	70.8%	N/A	N/A	N/A	N/A	N/A	N/A
Stroke	Hyper acute (mean call to door time)	N/A	334	1hr 22 mins	1hr 19 mins	8	↓	1hr 10 mins - 1hr 43 mins (1hr 23 mins)
	Care Bundle	98.2%	901	N/A	98.2%	N/A	N/A	N/A
Sepsis	Care Bundle	N/A	547	76.8%	N/A	6	N/A	53.9-89.9 (77.6)

ACQIs – June 2019

In June, the rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 59.1% (national mean 54.2%), ranking the Trust 3rd nationally. For the overall group the rate was 33.6% (national mean 31.6%) ranking the Trust 5th nationally.

10.6% of patients suffering an out of hospital cardiac arrest survived to hospital discharge in June (national mean 10.9%). The figure for the Utstein sub-group was 33.3% (national mean 33.8%). This performance saw the Trust ranked 4th and 5th respectively for English ambulance trusts.

Mean call to PPCI time for patients suffering a myocardial infarction was marginally outside of the national mean of 2h 12mins; the Trust's performance was 2h 13mins for these patients. Mean call to door time for patients suffering a hyper acute stroke was 1h 22min marginally inside of the national mean (1h 23min).

The Sepsis care bundle score of 76.8% was again marginally outside of the national mean of 77.6%.

Cardiac Outcomes over time (SPC)

Figure E2.1

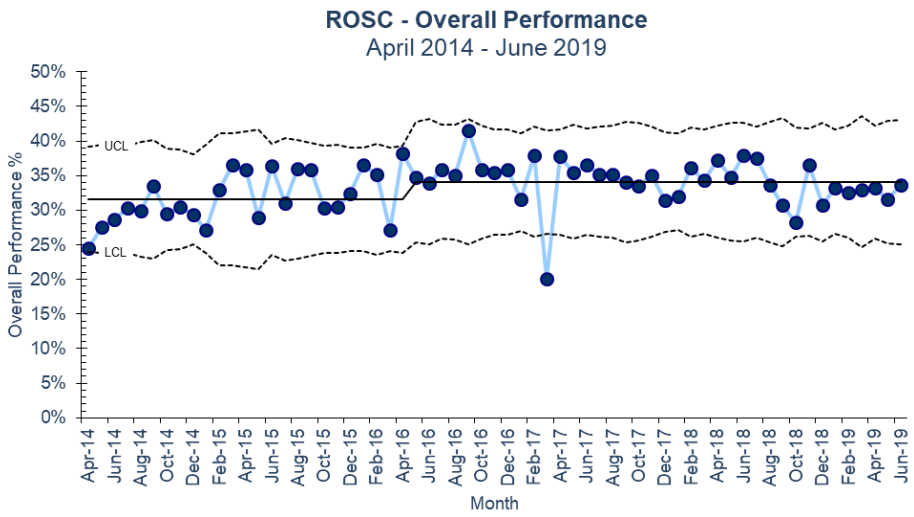


Figure E2.2

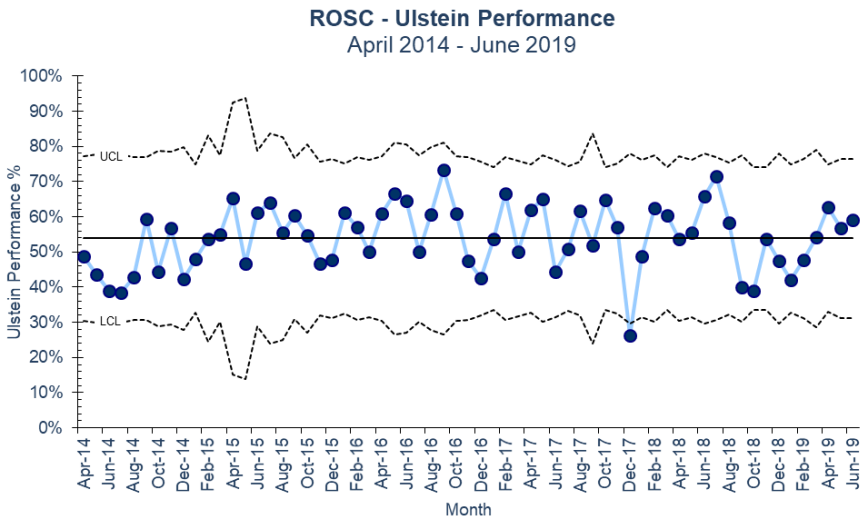


Figure E2.3

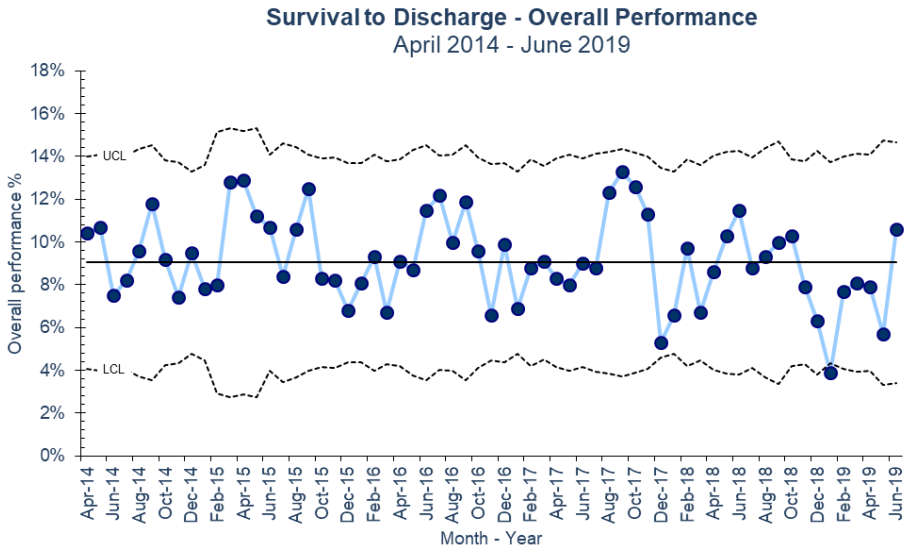
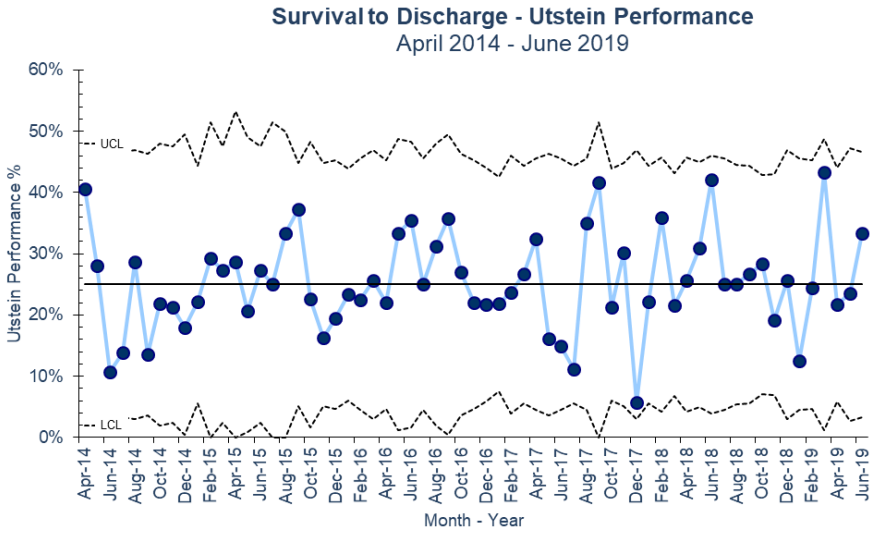


Figure E2.4



Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

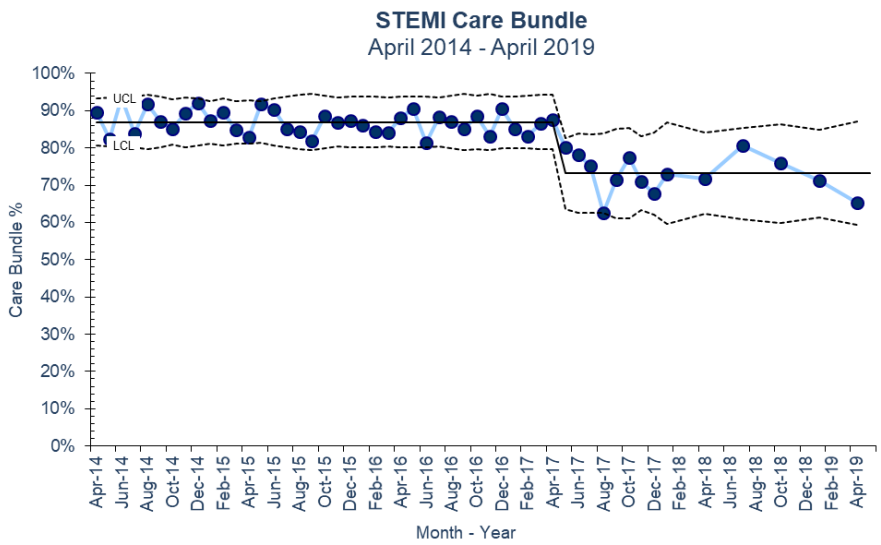
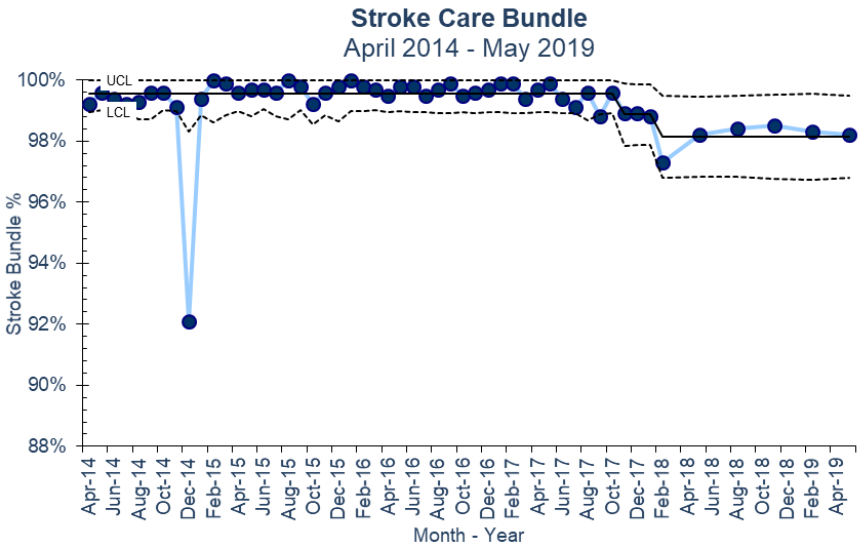


Figure E2.6



N.B. Stroke CB data now published nationally 1 month in 3: February, May, August and November (data produced internally on monthly basis).
STEMI CB now published nationally 1 month in 3: January, April, July and October (data produced internally on monthly basis).

E3 H&T, S&T, S&C OUTCOMES

Figure E3.1

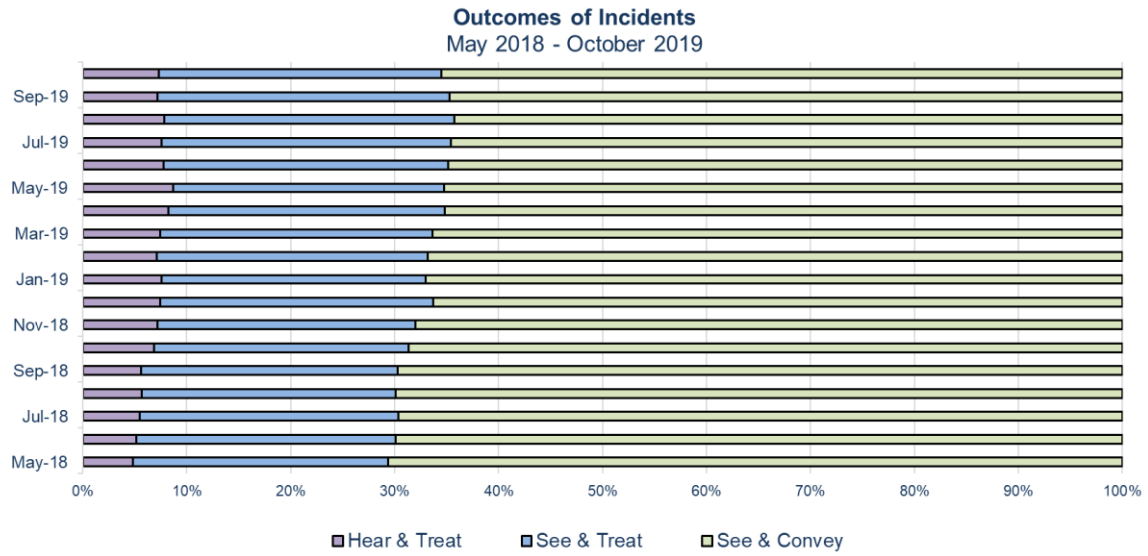


Table E3.1

Month/Yr	Incidents with no face to face response	Hear and Treat %	F2F Incidents with no transport	See & Treat %	F2F Incidents with transport	See & Convey %
Nov-18	6,837	7.2%	23,627	24.8%	64,668	68.0%
Dec-18	7,559	7.5%	26,608	26.2%	67,248	66.3%
Jan-19	7,641	7.6%	25,653	25.4%	67,595	67.0%
Feb-19	6,381	7.1%	23,296	26.0%	59,798	66.8%
Mar-19	7,349	7.4%	25,936	26.2%	65,672	66.4%
Apr-19	8,120	8.2%	26,244	26.6%	64,455	65.2%
May-19	8,741	8.7%	26,394	26.1%	65,844	65.2%
Jun-19	7,503	7.7%	26,554	27.4%	62,889	64.9%
Jul-19	7,565	7.6%	27,849	27.9%	64,554	64.6%
Aug-19	7,640	7.8%	27,280	27.9%	62,729	64.2%
Sep-19	6,782	7.1%	26,711	28.1%	61,423	64.7%
Oct-19	7,249	7.3%	26,863	27.2%	64,792	65.5%

Outcomes

Following the continued implementation of enhanced working practices in the EOC/Clinical Hub environments, we are continuing to demonstrate a steady reduction in conveyance, from 68.6 % to 65.41 % over the past 12 months. Hear & Treat Performance for October 2019 was 7.33 % and the number of incidents with no face to face response being 7248. This is a 0.5 % increase in performance in comparison to October 2018. Clinical Assessment Service (CAS) contribution to H&T Performance was impacted throughout October due to the suspension of service from 2 GM Providers, Bardoc and Mastercall.

Throughout September and October there has been engagement with NWAS, GM Health & Social Care Partnership and the Out of Hours providers. Following this GM CAS extended code set for all 9 out or 10 CCGs in GM is in place from 7th November 2019 and has positively impacted on H&T performance for November.

Crew advice calls into Clinical Hub have risen by 468% since its inception. This valuable functions supports crews on scene and they can call in for specialist advice from the Chubs Multi-Disciplinary Team, whilst also obtaining MTS triage to enable onward referral pathways for non-paramedic crews. This has a positive impact on S&T Performance.
Due to the rise in demand it has resulted in CHub Clinicians being deflected from H&T duties to Crew Advice calls.

Actions have been put in place to mitigate the impact on H&T and with the support of Operational Heads of Service training is being rolled out to SPTLS to deliver this function.

Figure E3.2

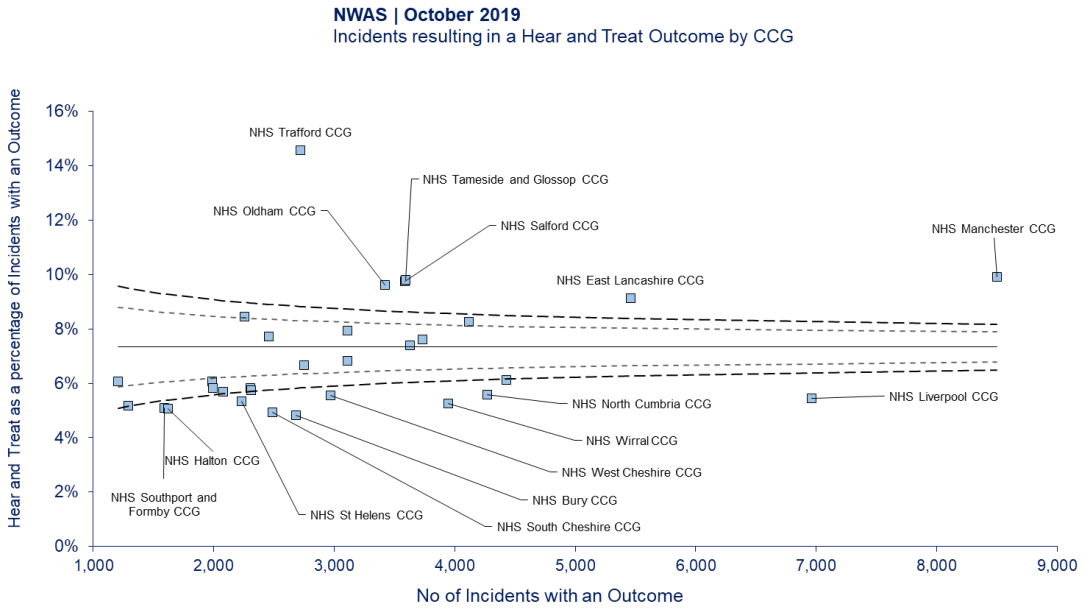
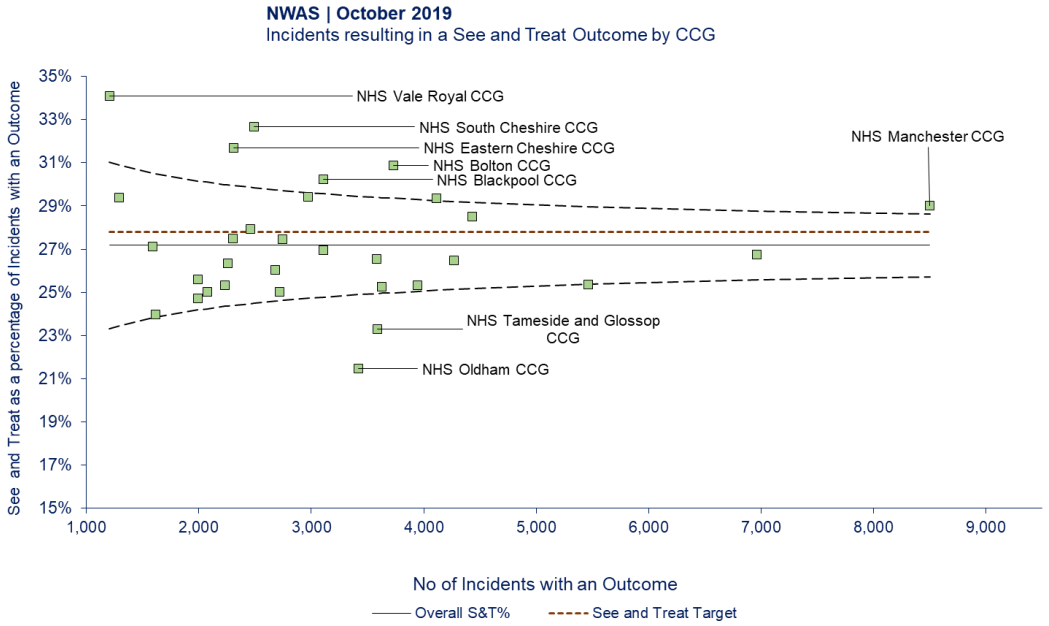


Figure E3.3



S&T in October saw a reduction to 27.2%, coupled with an increase of 0.8% in S&C to ED. There has been an increase of over 4000, in 999 activity. This may be attributed to a small increase of H&T but also to an increase in patient acuity. There has also been an increase in NQP workforce joining the Trust.

We are continuing delivering training in the application of the Manchester Triage System to the NQP2 paramedic cohorts in anticipation of their qualification. We have also clarified that the application of Pathfinder by NQPs, allows appropriate referral and see & treat opportunities, without onward referral to the NWAS clinical hub.

In the areas where Primary Care has had limited capacity, who have no AVS provision to receive referrals from NWAS clinicians, discussions have progressed and an alternative process has been agreed, in principle, with NWAS medical directorate. It is hoped that formal sign off, by all parties, will be completed before Christmas. This process will be evaluated and may influence the referral processes in future.

All areas are continuing to implement their improvement plans for S&T with support from the Urgent Care Development Team.

Figure E3.4

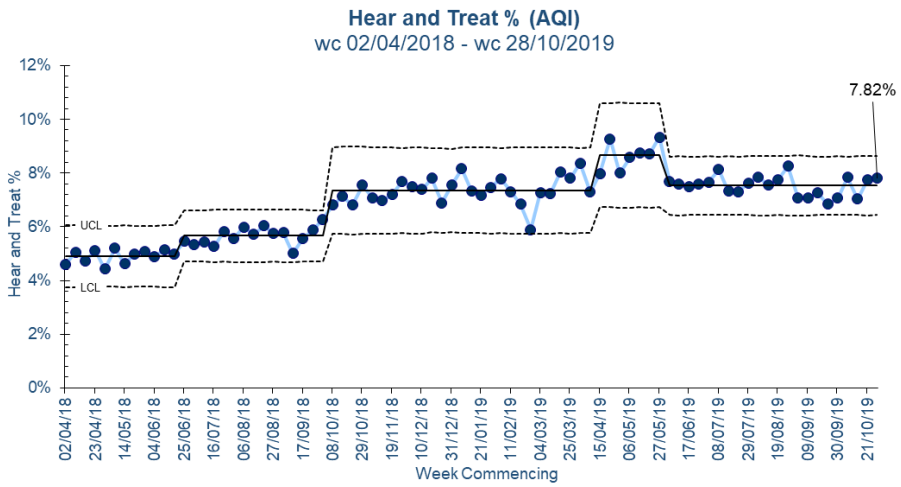


Figure E3.5

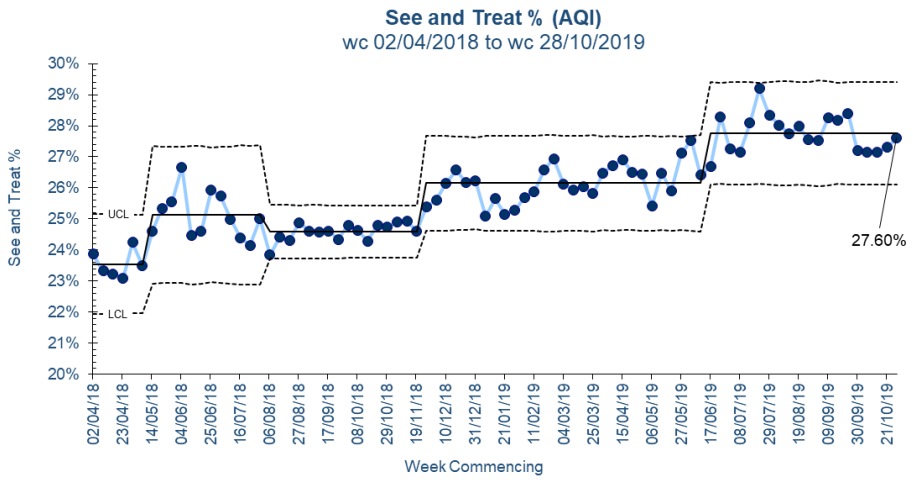
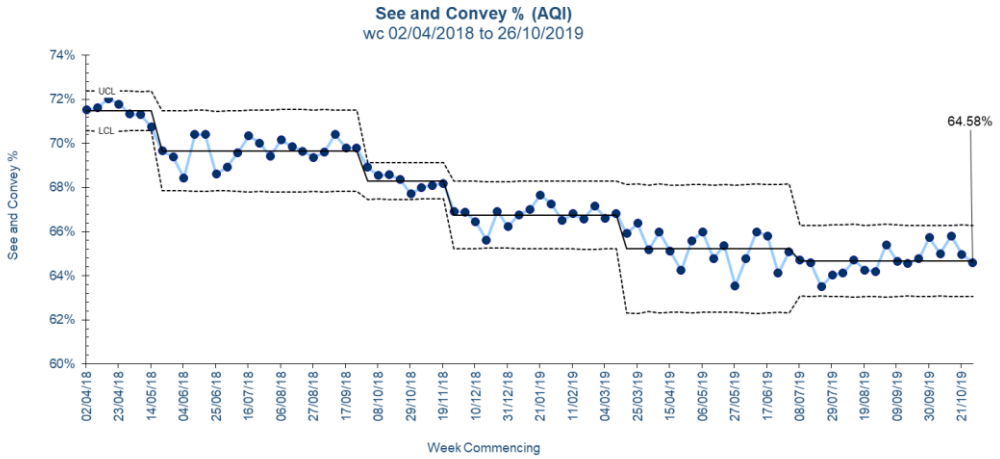


Figure E3.6

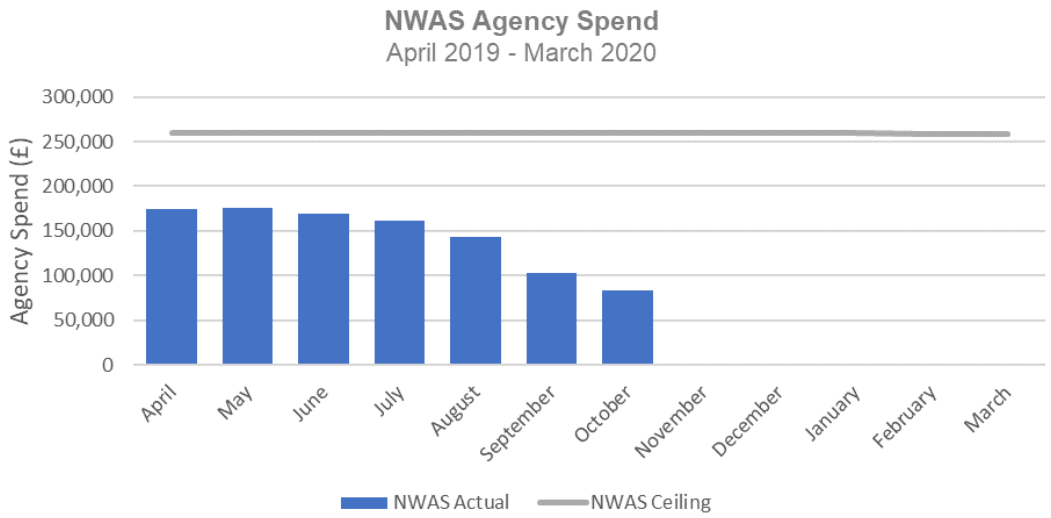


F1 FINANCIAL SCORE

Table F1.1 Financial Sustainability Risk Rating

Financial Metric	2019/20 YTD Score	Plan Score	Weight
Liquidity	1	1	0.2
Capital Servicing	1	1	0.2
I&E Margin	2	2	0.2
Distance from Plan	1	1	0.2
Agency	1	1	0.2
Overall Unrounded	1.2	1.2	
Rounded Score before override	1.2	1.2	
OVERALL SCORE AFTER OVERRIDE (Triggered if any of the score are 4)	1	1	

Figure F1.1



Finance Position – October 2019

Month 07 Finance Position:
The position for the Trust at Month 7 is a surplus of £1.133m this is £0.103m better than the planned surplus of £1.030m. Income is over recovered by £1.903m, pay is overspent by £2.221m and non-pay is underspent by £0.421m.

Agency Expenditure
The year to date expenditure on agency is £1.007m which is £0.806m below the year to date ceiling of £1.813m equivalent to 44% under which results in an agency financial metric of 1.

Risk Rating
The overall year to date actual and forecast financial risk score remains at a 1 for the Trust.

Figure F1.2

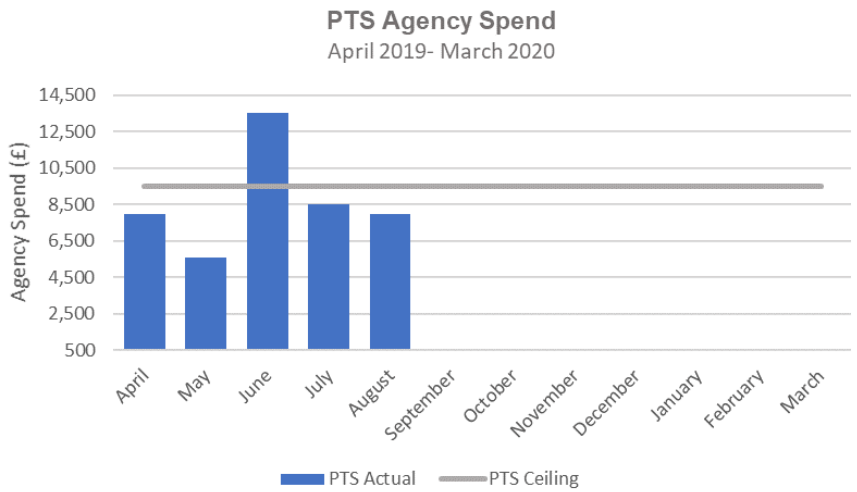


Figure F1.3

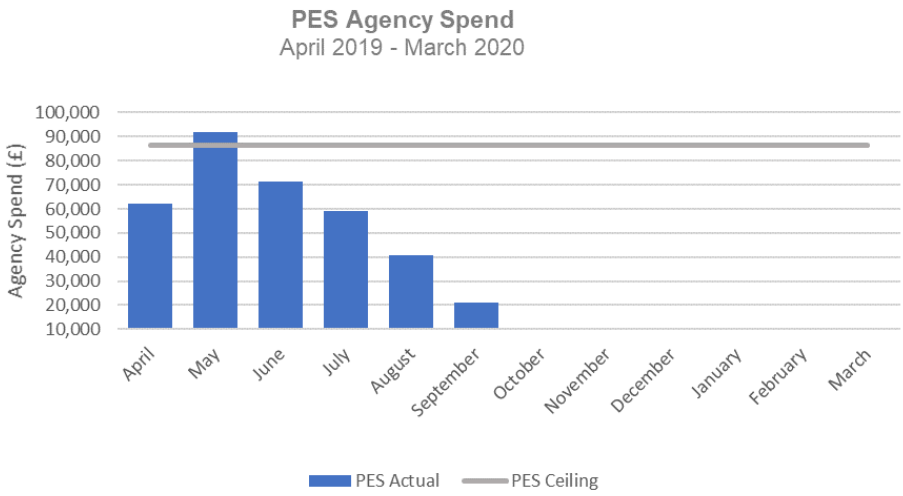


Figure F1.4

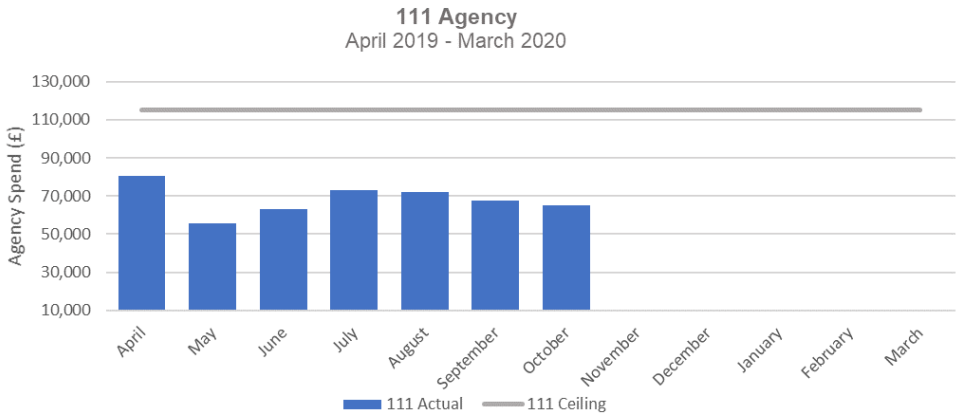
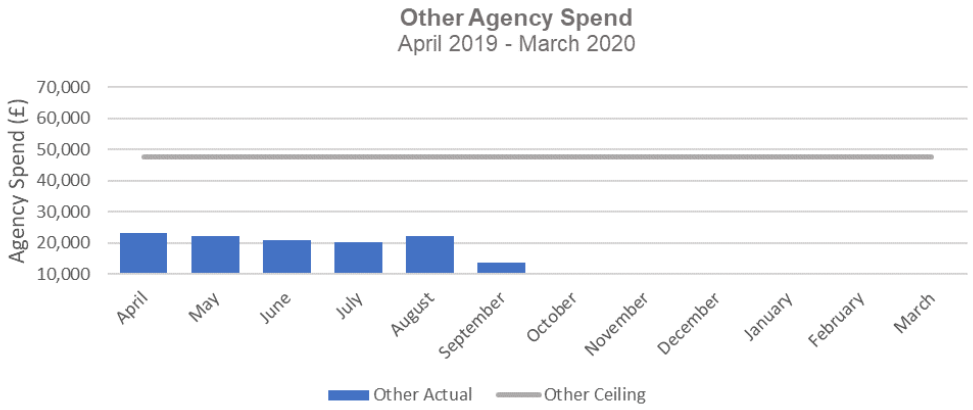


Figure F1.5



O1 CALL PICK UP

Figure O1.1:

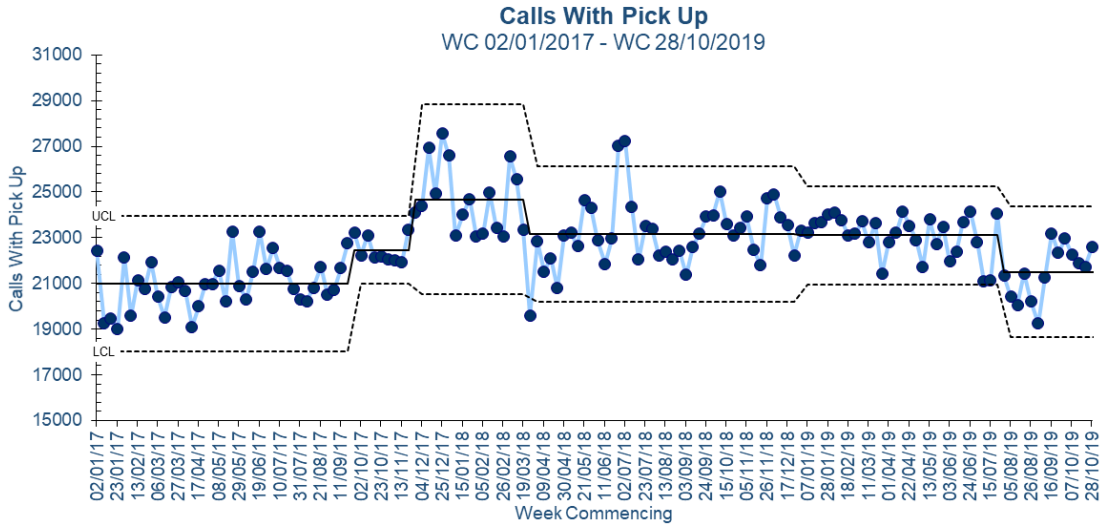


Figure O1.2:

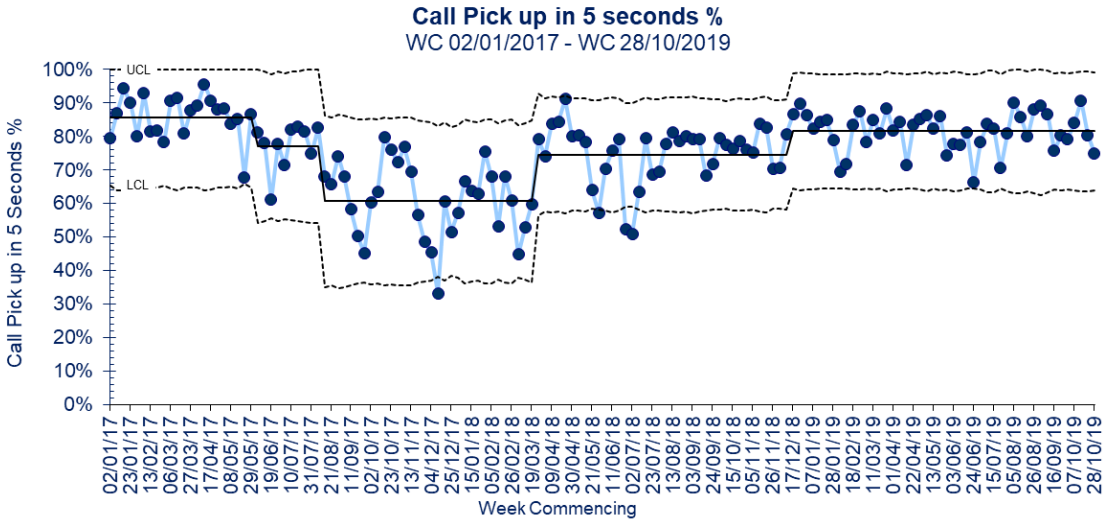


Figure O1.3: Source - CAD calls

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: For August 2019, call pick up performance was at 87.5%. 16,180 calls took longer than 5 seconds to pick up.

CPU has improved across all key measure vs September 19. This includes mean and both centiles. Calls answered has increased significantly vs September 19 (16276 calls increase). This demonstrates improved capacity within the call handling teams.

Duplicate calls have increased and appear to driving some of the call volume increase. The EOC are reviewing the end of call scripts in an effort to reduce duplicates, caused by extended response times.

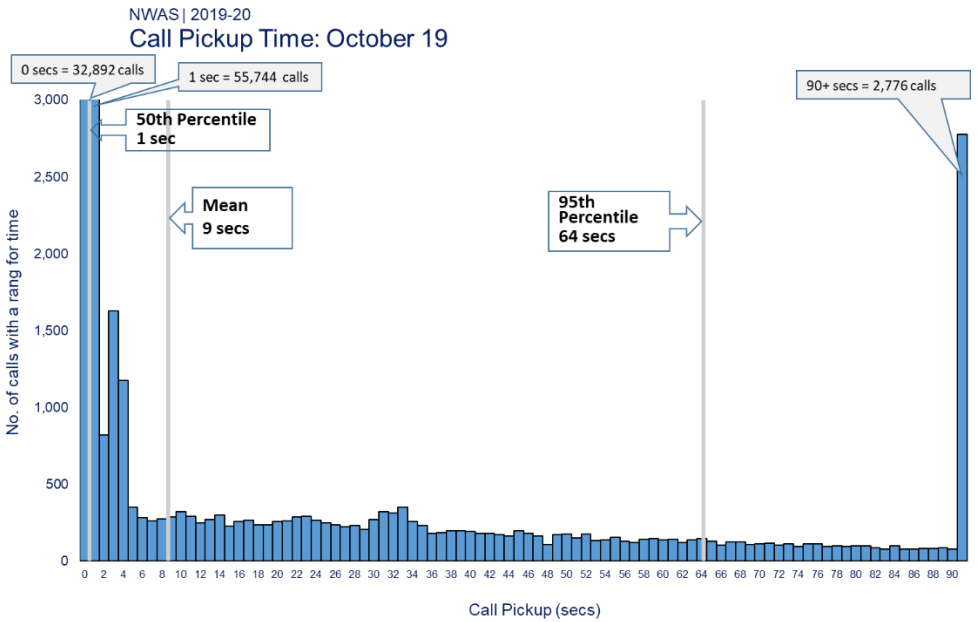


Table O1.1: Calls and Call Answer Times (Source – AQI)

			Call answer times (seconds)				
Month/Yr	Contact Count	Calls answered	Total	Mean (Switch)	Median (50th centile)	95th centile	99th centile
Nov-18	136,311	103,941	1,173,027	11	1	73	128
Dec-18	136,894	109,551	1,152,801	11	1	70	125
Jan-19	133,555	107,917	849,948	8	1	58	117
Feb-19	119,275	95,828	1,088,632	11	1	74	127
Mar-19	125,183	100,378	717,376	7	1	60	139
Apr-19	126,070	100,133	967,044	10	1	66	127
May-19	127,228	100,285	700,370	7	1	51	109
Jun - 19	127,636	103,571	1,423,103	14	1	85	141
Jul - 19	133,978	111,732	1,328,299	12	1	76	126
Aug - 19	129,170	106,821	962,210	9	1	62	120
Sep – 19	126,328	104,445	1,153,070	11	1	70	130
Oct - 19	134,676	120,721	1,120,257	9	1	64	120

Figure O2.1

A&E Turnaround Times

The average turnaround for October 2019 was 32 minutes 34 seconds across the North West.

The 5 hospitals with the longest turnaround times during August 2019 were:

Royal Oldham	39:22
Royal Bolton	38:03
Whiston	37:36
Southport District General	36:38
Royal Lancaster Infirmary	35:55

Visits with acute sites continue at Exec level and the re-introduction of the collaborative work with the 14 most challenged trusts is underway.

Handover to clear has seen a steady decrease over time, with the average in the latest week falling below the lower control limit, signalling the Trusts lowest average H2C time within the charts time period (Since April 2018).

Arrival to handover has displayed special cause variation twice in October, with hospital attendances being the highest number since May 2019.

O2 A&E TURNAROUND

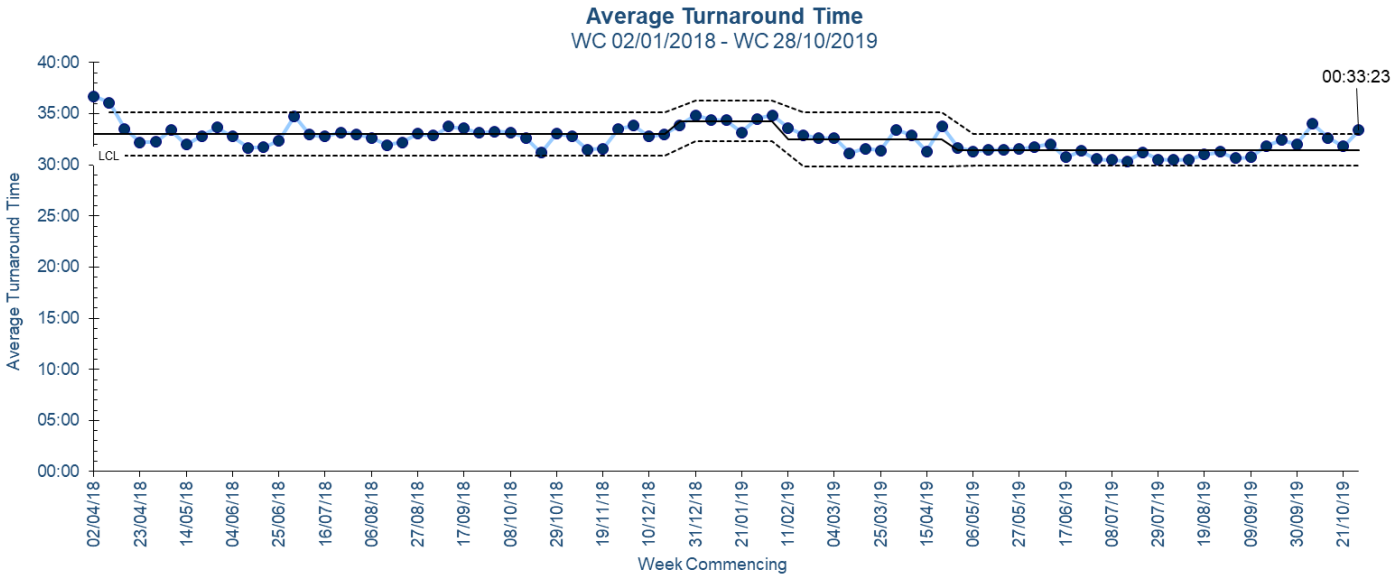


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Nov - 18	58,457	32:22	20:55	11:21
Dec – 18	61,139	33:25	22:02	11:16
Jan – 19	61,675	34:20	23:04	11:11
Feb - 19	54,255	33:37	22:18	11:12
Mar – 19	59,342	31:48	20:15	11:20
Apr – 19	58,214	32:55	21:25	11:13
May - 19	59,274	31:25	19:55	11:14
Jun - 19	56,635	31:26	20:03	11:09
Jul – 19	58,249	30:44	19:20	11:13
Aug - 19	56,602	30:44	19:18	11:10
Sep - 19	55,724	31:31	20:13	11:09
Oct - 19	58,933	32:34	21:31	11:03

Figure O2.2

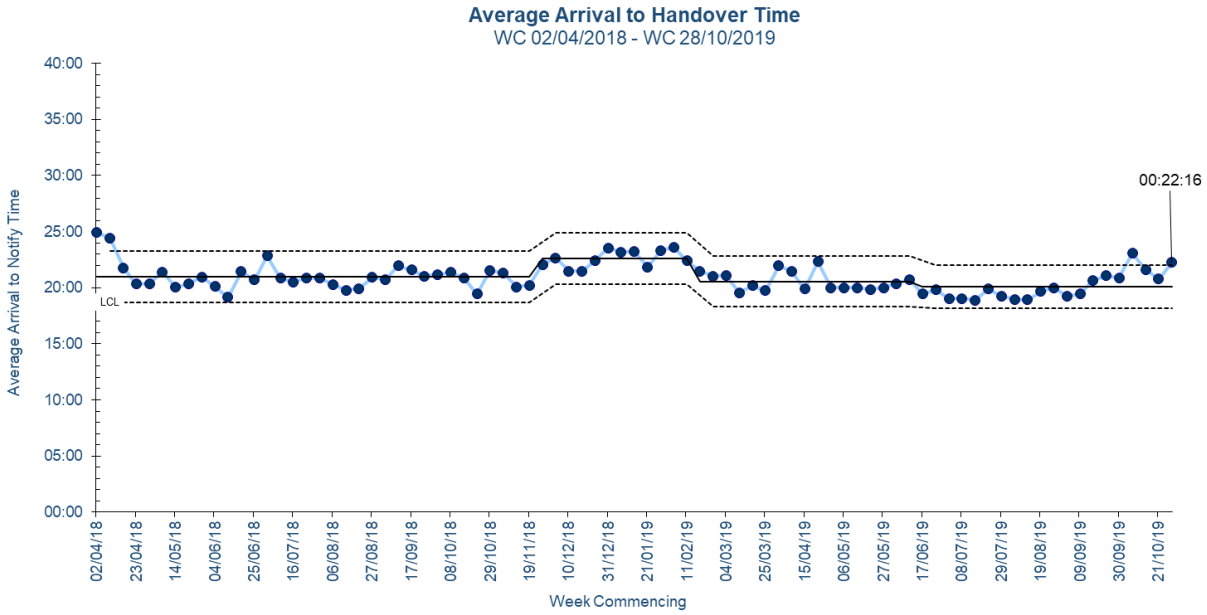
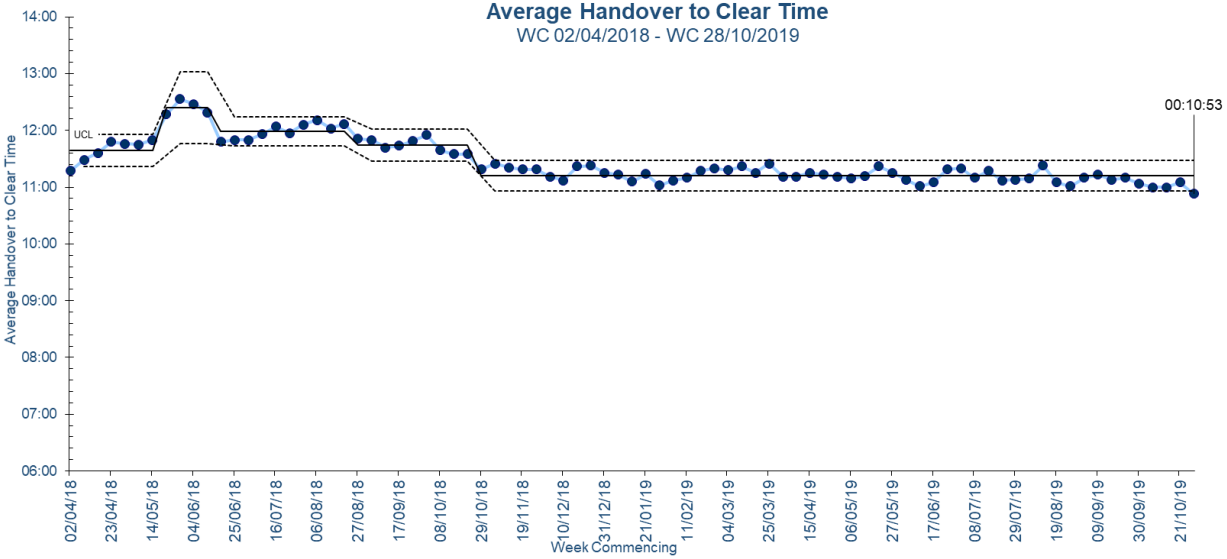

Average Arrival to Handover Time
WC 02/04/2018 - WC 28/10/2019
Average Arrival to Notify Time
40:00
35:00
30:00
25:00
20:00
15:00
10:00
05:00
00:00
LCL
00:22:16
02/04/18
23/04/18
14/05/18
04/06/18
25/06/18
16/07/18
06/08/18
27/08/18
17/09/18
08/10/18
29/10/18
19/11/18
10/12/18
31/12/18
21/01/19
11/02/19
04/03/19
25/03/19
15/04/19
06/05/19
27/05/19
17/06/19
08/07/19
29/07/19
19/08/19
09/09/19
30/09/19
21/10/19
Week Commencing

Figure O2.3

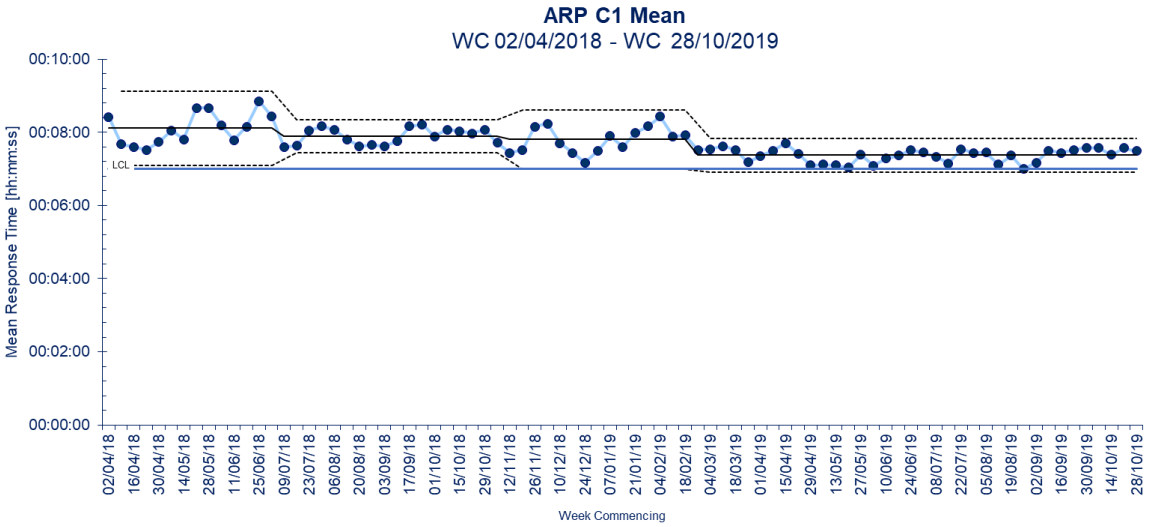

Average Handover to Clear Time
WC 02/04/2018 - WC 28/10/2019
Average Handover to Clear Time
14:00
13:00
12:00
11:00
10:00
09:00
08:00
07:00
06:00
UCL
00:10:53
02/04/18
23/04/18
14/05/18
04/06/18
25/06/18
16/07/18
06/08/18
27/08/18
17/09/18
08/10/18
29/10/18
19/11/18
10/12/18
31/12/18
21/01/19
11/02/19
04/03/19
25/03/19
15/04/19
06/05/19
27/05/19
17/06/19
08/07/19
29/07/19
19/08/19
09/09/19
30/09/19
21/10/19
Week Commencing

O3 ARP RESPONSE TIMES

Table O3.1 - Incidents with a response

Month/Yr	C1	C2	C3	C4
Nov-18	8,360	50,764	21,208	3,233
Dec-18	9,277	53,147	21,787	4,305
Jan-19	9,579	53,775	20,486	3,993
Feb-19	8,768	47,251	18,699	3,594
Mar-19	9,323	51,495	21,189	4,288
Apr-19	9,359	51,557	20,043	4,198
May-19	9,264	51,531	20,991	4,465
Jun-19	9,071	50,128	20,451	4,116
Jul-19	10,098	50,807	21,527	4,170
Aug-19	9,831	49,468	21,238	4,127
Sep-19	9,870	49,579	20,051	3,870
Oct-19	10,615	52,552	17,951	2,854

Figure O3.1



Activity

C1 performance remains within normal variation for both mean and 90th centile. This is despite a 23% increase in C1 activity over the equivalent period last year.

C2 and C3 has seen some special cause variation/deterioration during October. This has been investigated and is linked to an increase in acuity as noted for C1. C2 has also seen a rise in comparison with last year. The rises in acuity for these categories means we utilise more resources per incident which in turn reduces resources for lower acuity calls. A deep dive into the driver of this has highlighted that 3 MPDS codes has seen a significant rise. Chest Pain, Respiratory Problems and unconscious patients.

The rise is not unique to NWAS and is a national problem, when coupled with increasing hospital turnaround times we have a reduction in available resources. To combat this the Trust has moved to REAP level 3 in line with most ambulance trusts as an escalation to manage performance and patient safety. This will reviewed regularly with a view to de-escalating as soon as possible.

C1 Performance

C1 Mean

Target:	7 minutes
NWAS	
October 19:	7:30
YTD:	7:21
National:	
October 19:	7:25
Top three trusts:	
North East	6:40
South Western	7:02
West Midlands	7:02
NWAS Position	**7 / 10**

Figure O3.2

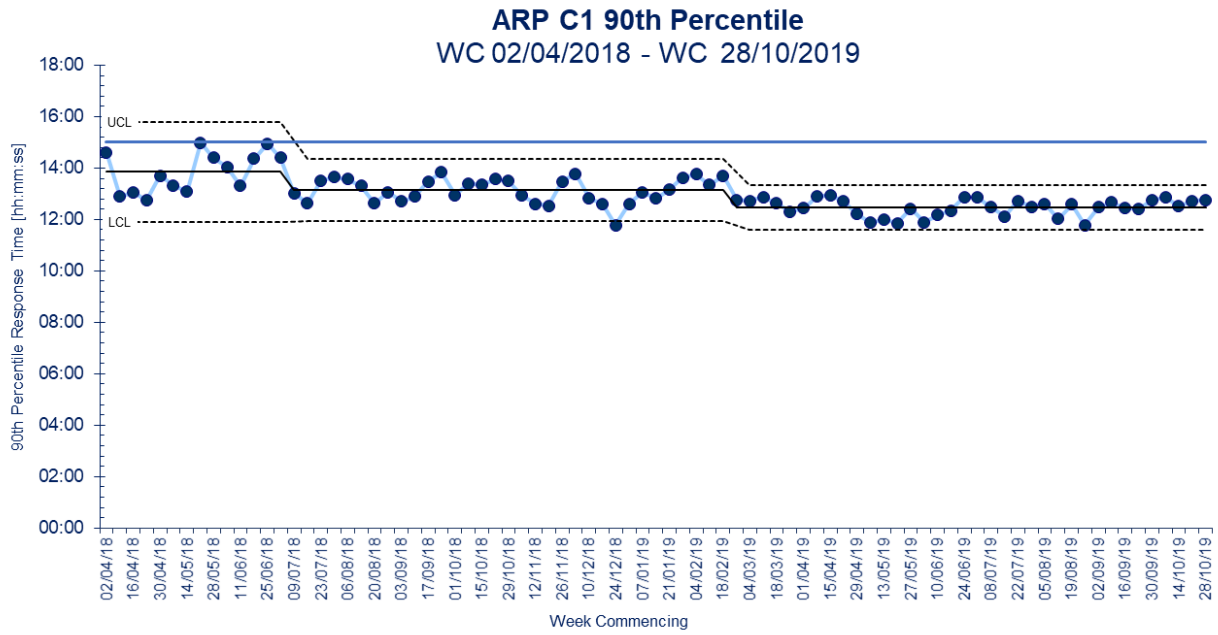
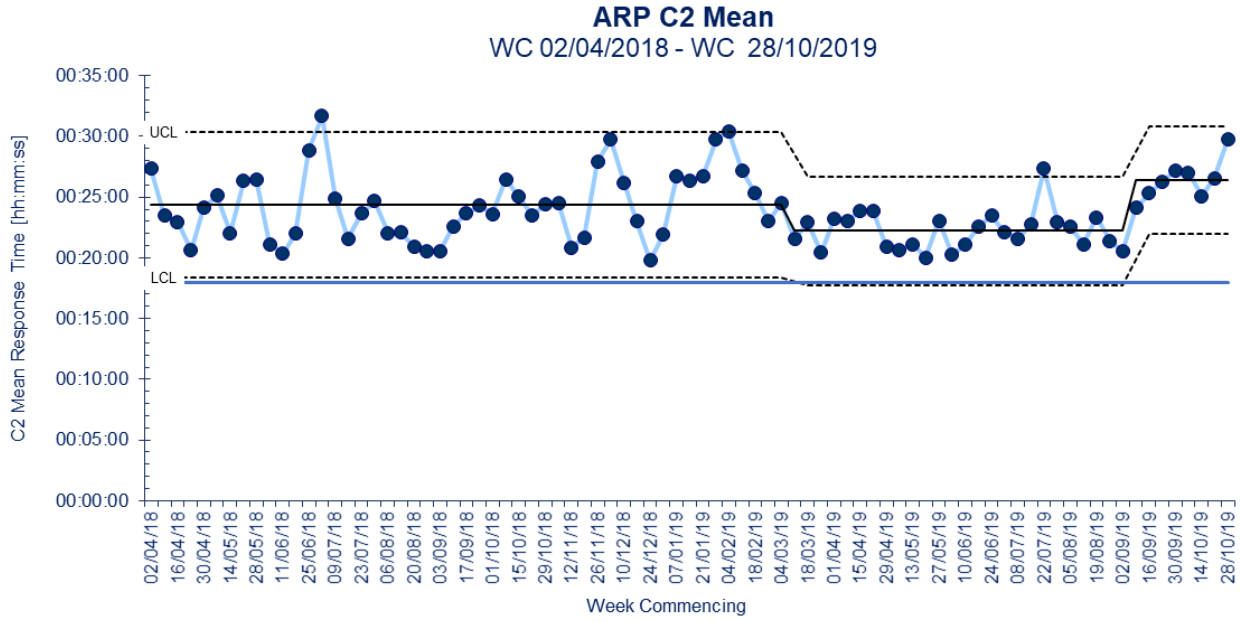


Figure O3.3



C1 90th Percentile

Target:	15 Minutes
NWAS	
October 19:	12:43
YTD:	12:27
National:	
October 19:	13:02
Top three trusts:	
North East	11:25
London	11:48
West Midlands	12:13
NWAS Position	**5 / 10**

C2 Performance

C2 Mean

Target:	18 minutes
NWAS:	
October 19:	26:17
YTD:	23:13
National:	
October 19:	23:50
Top three trusts:	
West Midlands	13:49
London	19:08
South Central	19:27
NWAS Position	**6 / 10**

Figure O3.4

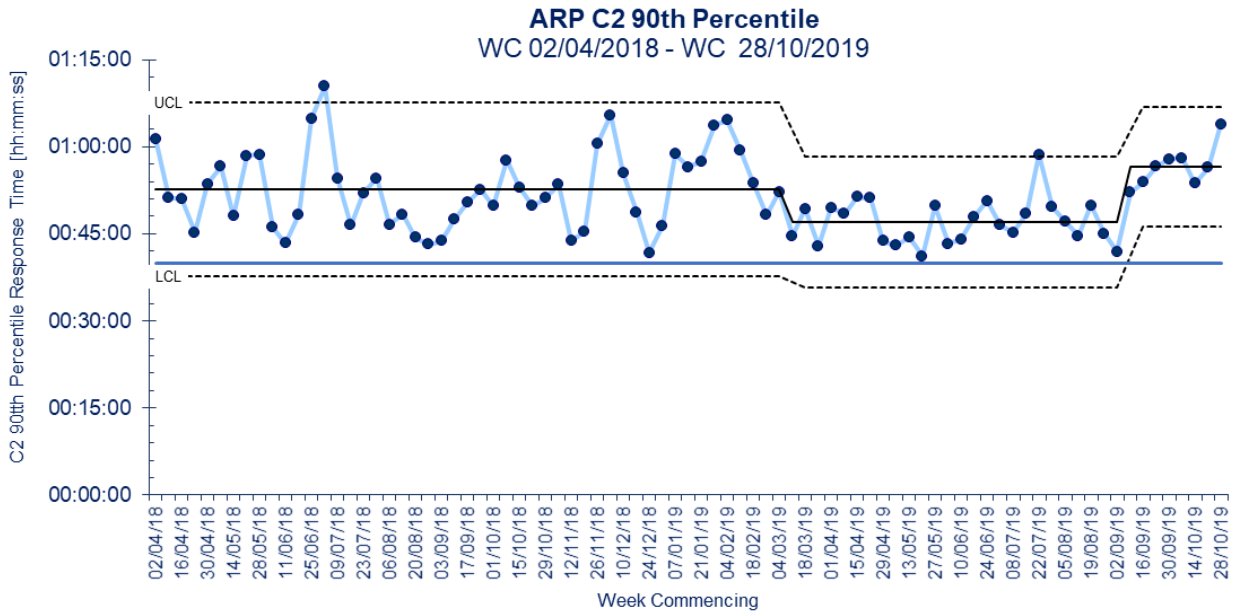
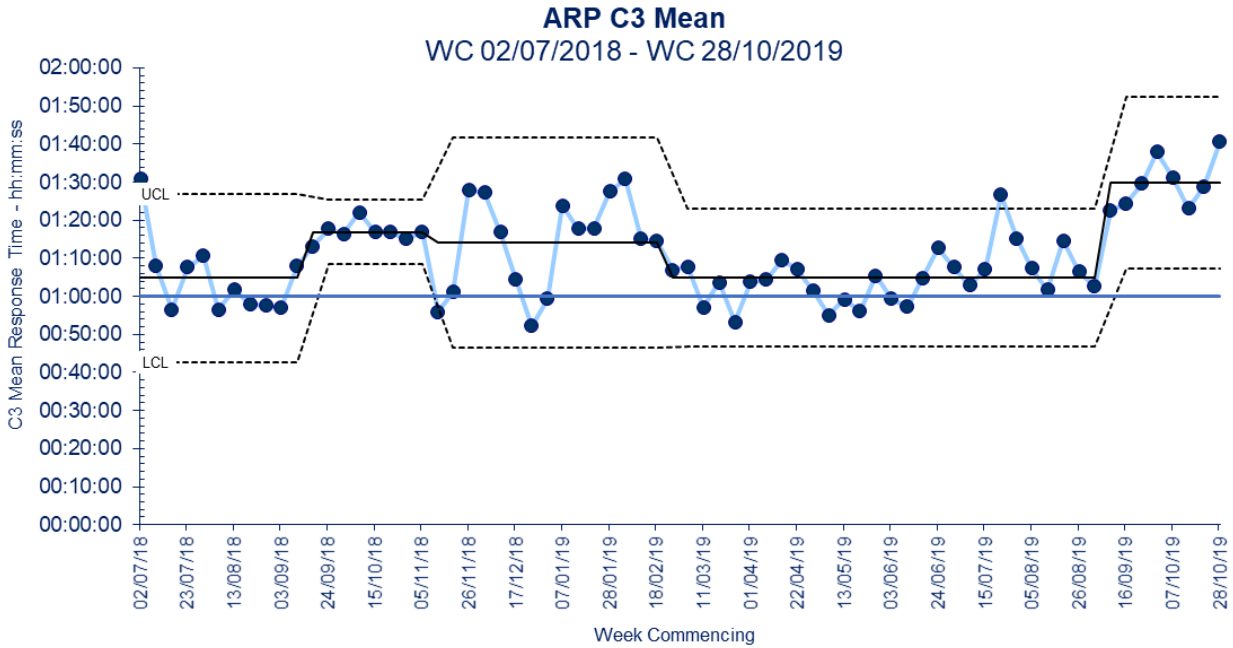


Figure O3.5



C2 90th Percentile

Target: 40 Minutes

NWAS	
October 19:	55:55
YTD:	49:31
National:	
October 19:	48:35
Top three trusts:	
West Midlands	25:21
South East Coast	38:01
London	38:36
NWAS Position	**6 / 10**

C3 Performance

C3 Mean

Target:	1 Hour
NWAS:	
October 19:	01:29:16
YTD:	01:10:47
National:	
October 19:	01:15:48
Top three trusts:	
Yorkshire	53:29
West Midlands	54:03
London	01:01:13
NWAS Position	**6 / 10**

Figure O3.6

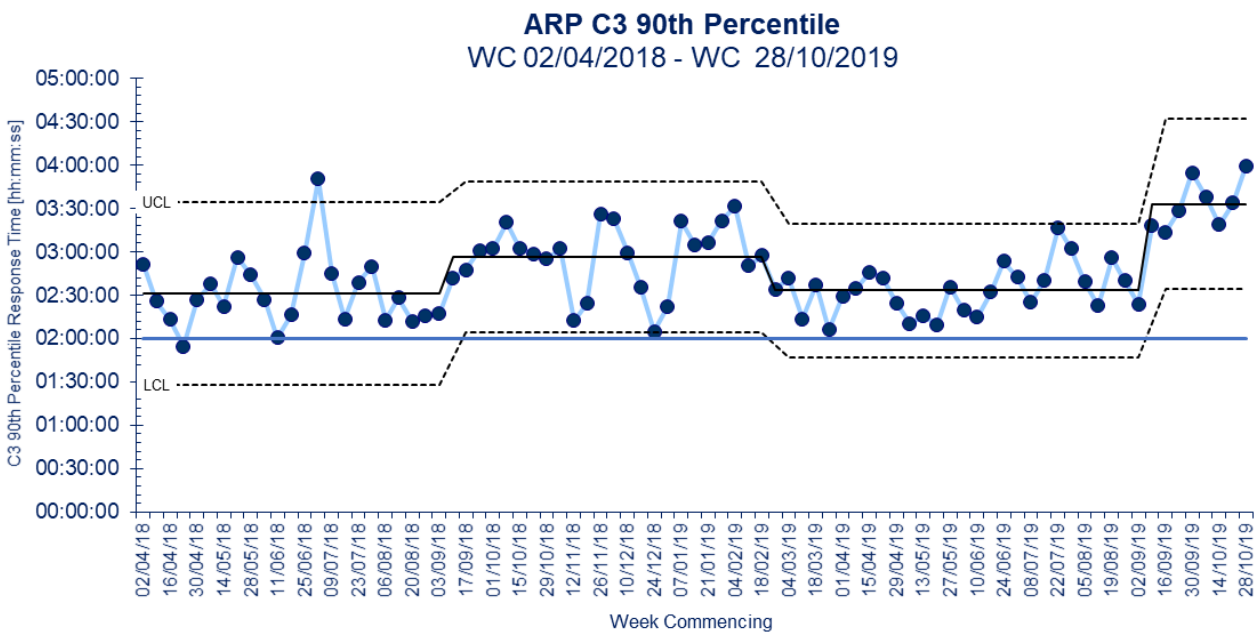
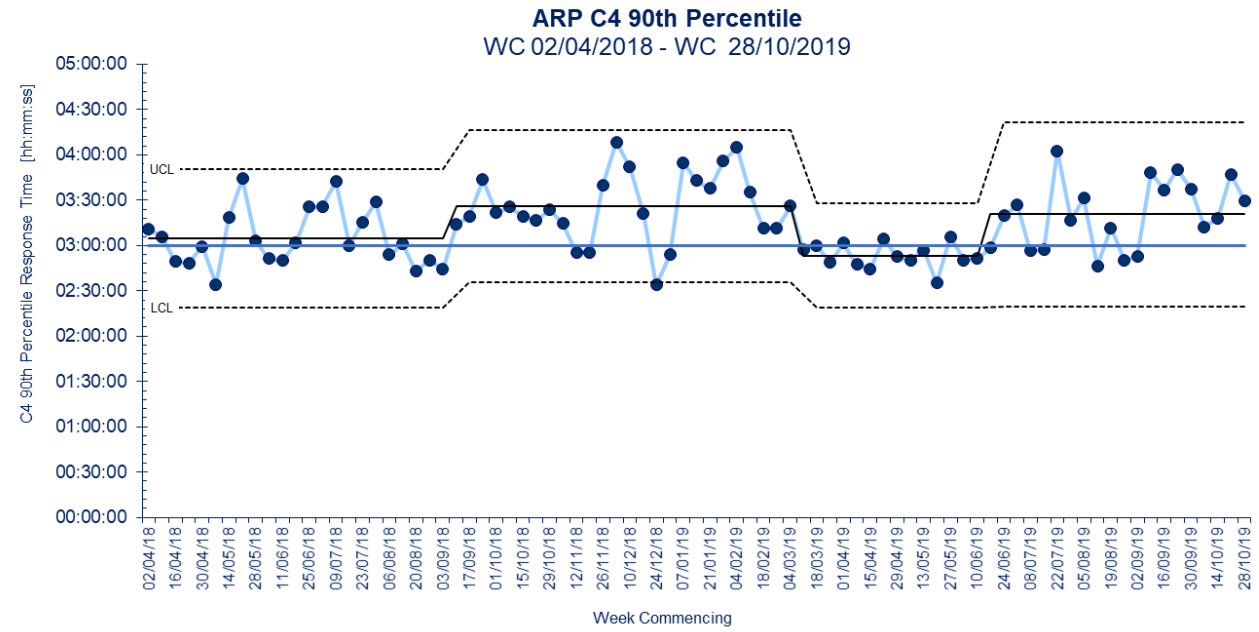


Figure O3.7



C3 90th Percentile

Target:	2 Hours
NWAS	
October 19:	03:33:05
YTD:	02:47:36
National	
October 19:	03:00:38
Top three trusts:	
West Midlands	02:01:43
Yorkshire	02:09:54
London	02:25:11
NWAS Position	**6 / 10**

C4 Performance

C4 90th Percentile

Target:	3 Hours
NWAS	
October 19:	03:23:17
YTD:	03:07:59
National	
October 19:	03:28:04
Top three trusts:	
Yorkshire	02:40:55
London	02:56:11
West Midlands	02:58:49
NWAS Position	**6 / 10**

Figure O3.8

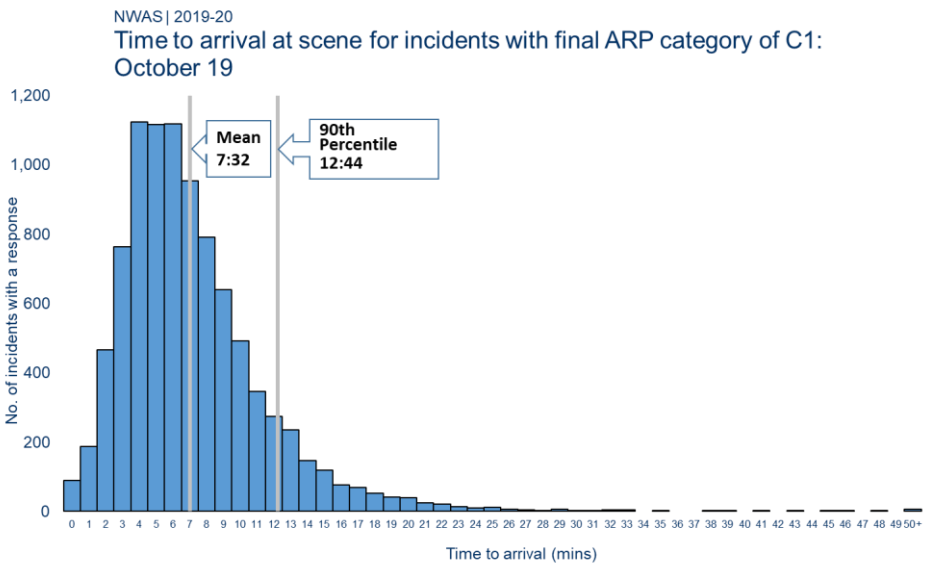


Figure O3.9

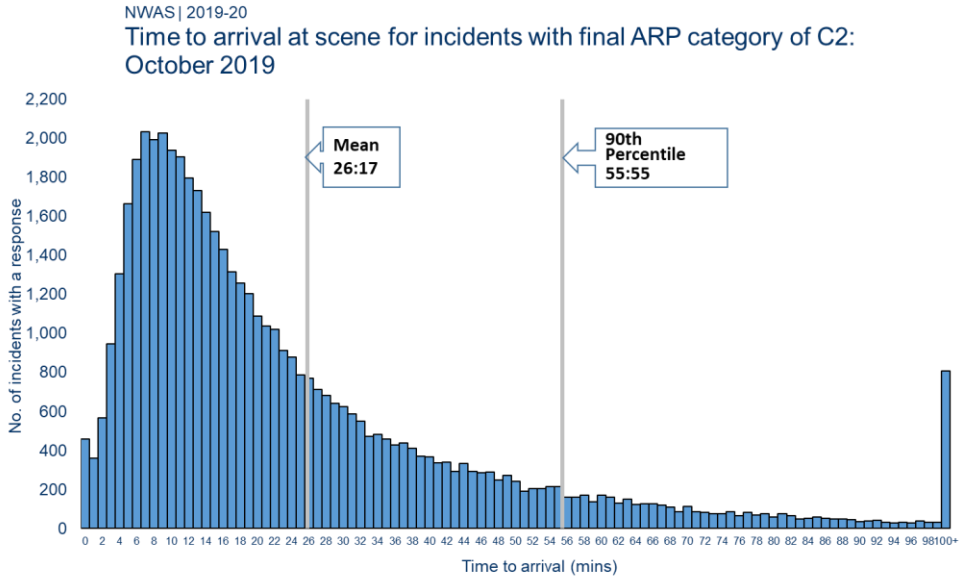


Figure O3.10

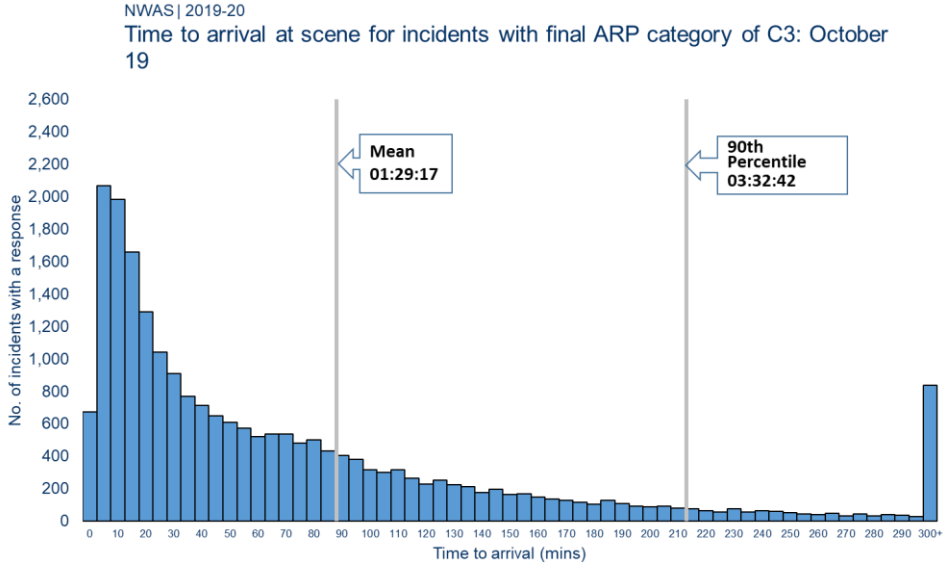
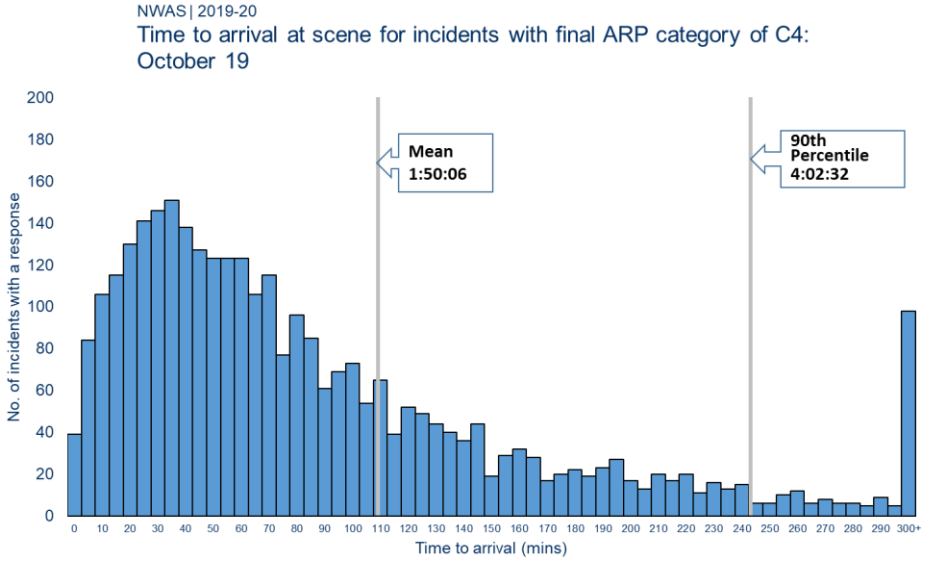


Figure O3.11



O4 111 PERFORMANCE

Figure O4.1:

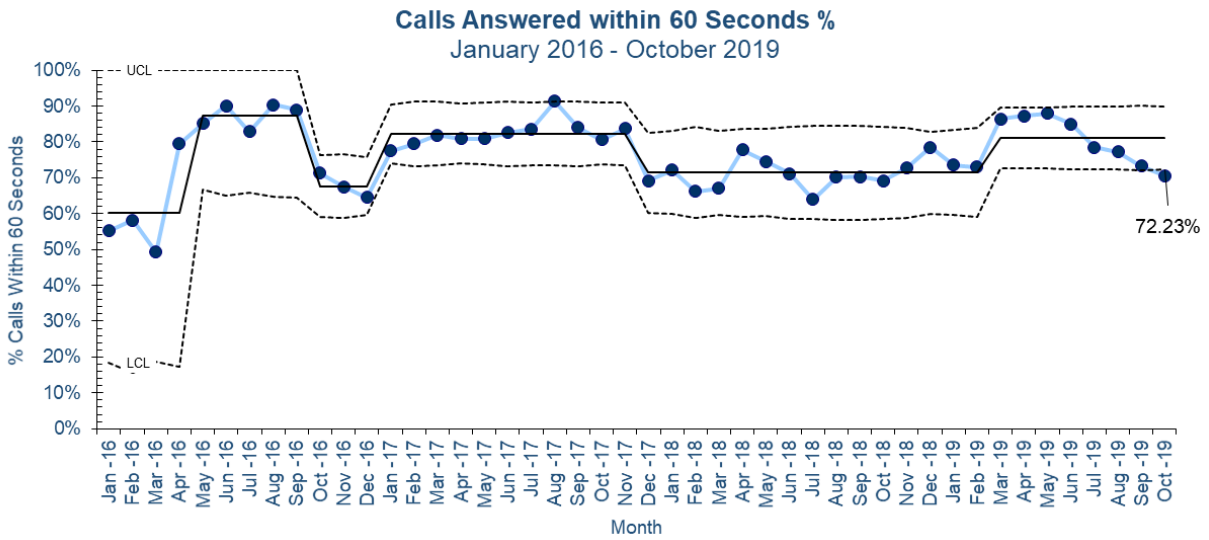
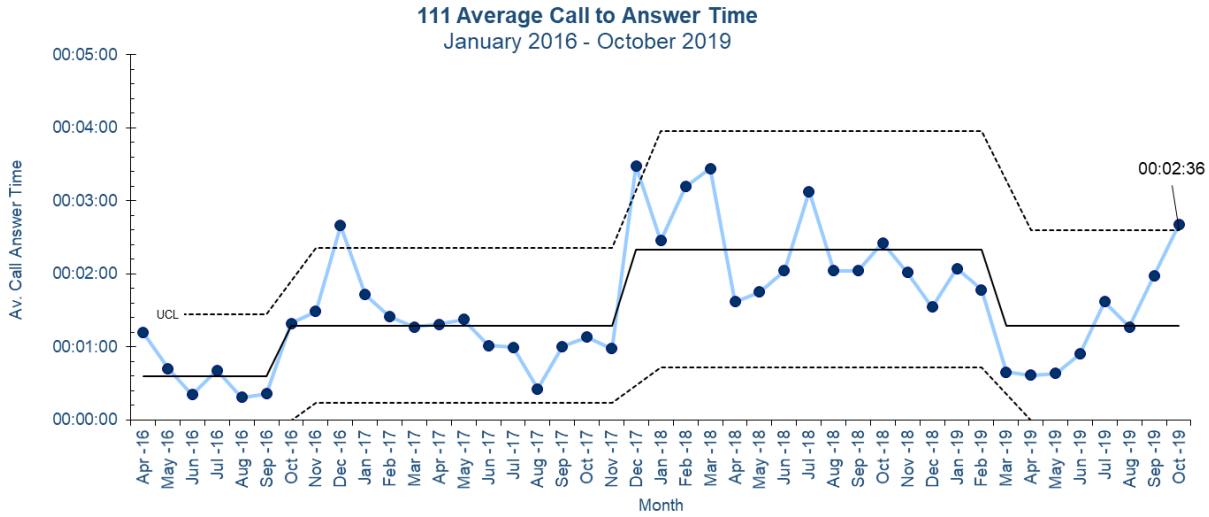


Figure O4.2:



111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS
October 19: 70.6%
YTD: 80.3%

National
October 19: 84.0%

Performance has been exceptionally challenging for 111 over the past 4 months primarily, although not exclusively, due to controlling the budget overspend. This has seen special cause variation, including a downward trend of 6 data points.

At the end of 2018 and over the beginning of 2019 NWAS 111 utilised an outside organisation (Conduit) to provide additional capacity to support performance. This was being delivered at the cost of an overspend on the contracted budget. This ceased at the end of June 2019 and 111 has experienced a drop in monthly performance of both KPIs in Fig O4.1 and O4.2.

An independent review of the current 111 demand against the current contract value by ORH has concluded the NWAS 111 service will deliver at optimum 76% performance for the calls to answer within 60 seconds KPI.

111 has recruited 60 additional staff in October and November in preparation for winter demand rises, which should support 76% performance delivery.

Figure O4.3:

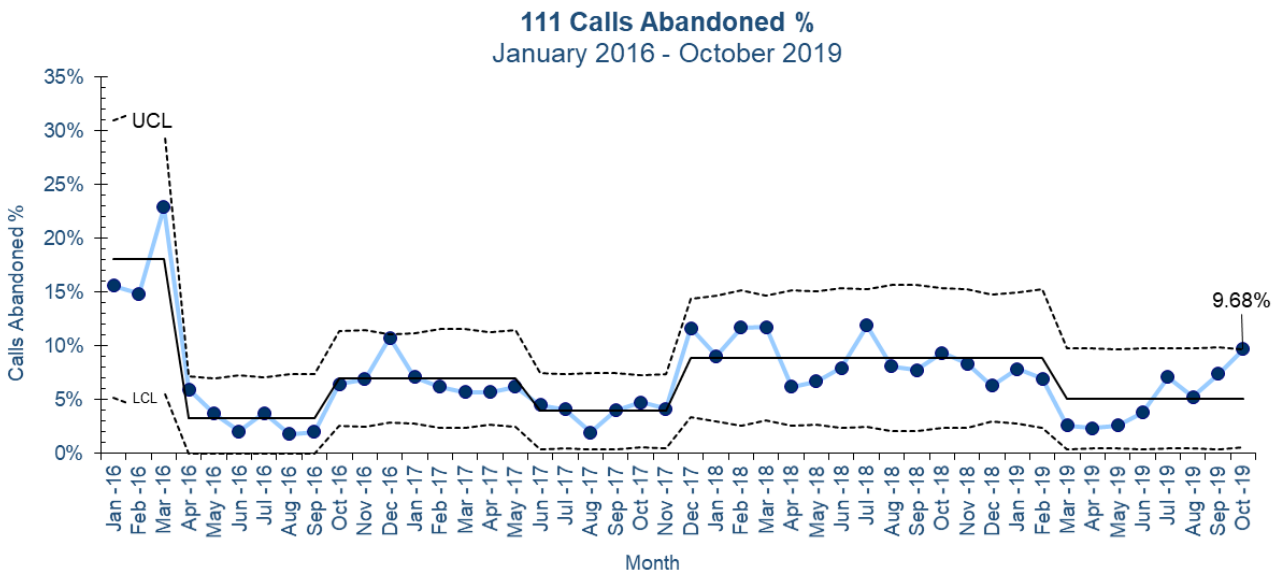
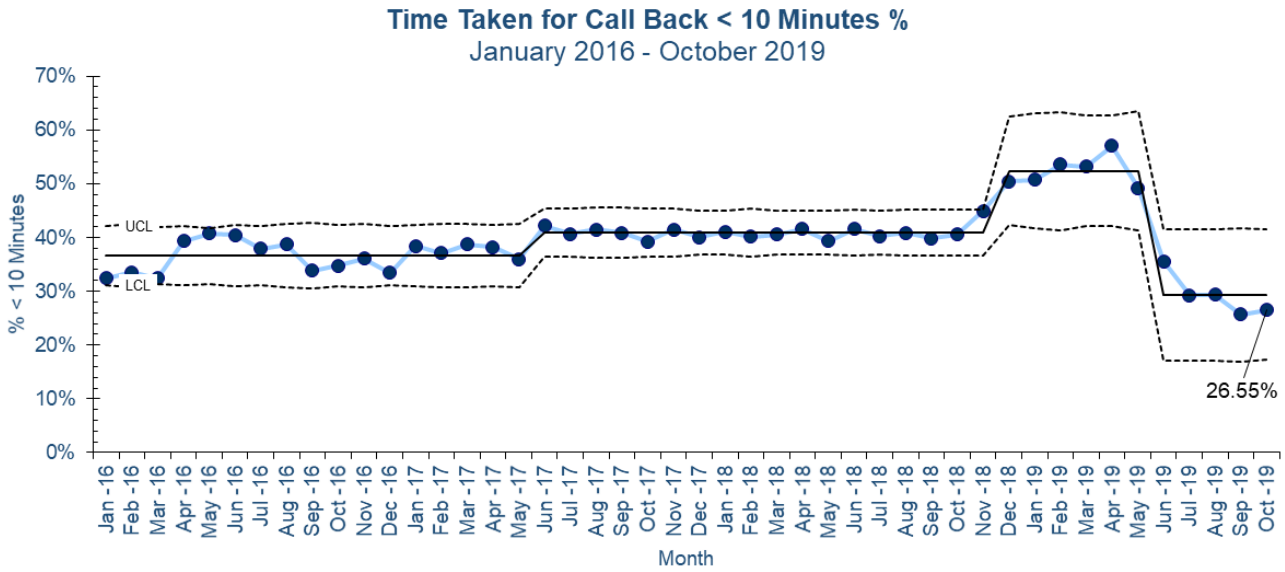


Figure O4.4:



Calls Abandoned %
Target: <5%

NWAS
October 19: 9.7%
YTD: 5.5%

National
October 19: 3.2 %

There is a direct correlation between poor call answering performance and abandoned calls.

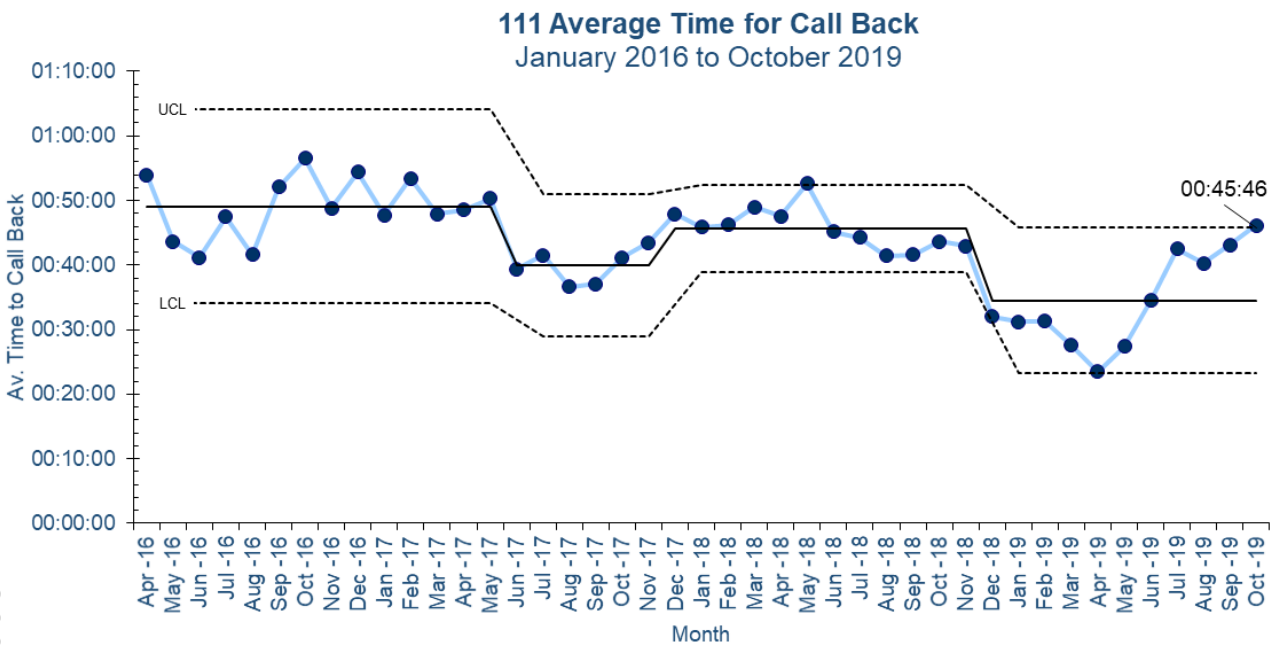
When we fail to answer in a reasonable timeframe patients hang up then call again later leading to a rise in abandoned calls.

Call Back < 10 Minutes %
Target: 75%

NWAS
October 19: 26.6%
YTD: 37.9%

National
October 19: 34.4%

Figure O4.5:



In Fig.O4.4 and Fig O4.5, over the past 4 months NWAS 111 has been consistently calling patients back in an average of 40-50 minutes.

There are 3 key reasons for this:

- rise in the number of patients on the clinical queue
- clinician resource shortfalls
- need for clinicians to do other duties e.g. front end call taking, clinical validation

111 Provider Comparison Figures – August 2019

Table O4.1

Provider	Of calls offered, abandoned after at least 30 seconds
Integrated Care 24	0.4%
Derbyshire Health United	1.2%
South Central Ambulance Service	1.3%
Yorkshire Ambulance Service	1.5%
Kernow Health	1.7%
Care UK	2.1%
Medvivo	2.2%
Vocare	2.2%
Herts Urgent Care	2.7%
South East Coast Ambulance Service	3.8%
North East Ambulance Service	4.8%
London Ambulance Service	4.8%
Isle of Wight NHS Trust	6.5%
London Central & West Unscheduled Care Collaborative	7.3%
Dorset Healthcare	7.4%
North West Ambulance Service	9.7%
Devon Doctors Ltd.	14.4%

Table O4.2

Provider	Of calls answered, calls answered in 60 seconds
Integrated Care 24	95.9%
Derbyshire Health United	94.0%
South Central Ambulance Service	90.3%
Kernow Health	89.7%
Medvivo	88.0%
Isle of Wight NHS Trust	87.5%
Herts Urgent Care	86.9%
Vocare	85.6%
Yorkshire Ambulance Service	81.7%
Care UK	81.1%
North East Ambulance Service6	81.1%
South East Coast Ambulance Service	78.3%
North West Ambulance Service	70.6%
London Central & West Unscheduled Care Collaborative	70.6%
Dorset Healthcare	70.2%
London Ambulance Service	69.9%
Devon Doctors Ltd.	68.6%

Table O4.3

Provider	Of call backs, call backs in 10 minutes	Provider	Of call backs, call backs in 10 minutes
Herts Urgent Care	55.7%	Devon Doctors Ltd.	26.8%
Isle of Wight NHS Trust	51.7%	North West Ambulance Service	26.5%
Vocare	47.3%	London Ambulance Service	26.3%
Medvivo	46.3%	Yorkshire Ambulance Service	25.2%
Kernow Health	45.2%	Integrated Care 24	23.8%
London Central & West Unscheduled Care Collaborative	38.9%	South Central Ambulance Service	23.2%
Dorset Healthcare	38.4%	South East Coast Ambulance Service	20.7%
Care UK	35.8%	North East Ambulance Service6	17.7%
Derbyshire Health United	26.9%		

O5 PTS ACTIVITY AND TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: October 2019					Year to Date: July 2019 - October 2019			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	14,577	553	4%	56,097	55,589	(508)	(1%)
Greater Manchester	526,588	43,882	48,978	5,096	12%	175,529	183,167	7,638	4%
Lancashire	589,181	49,098	47,476	(1,622)	(3%)	196,394	180,517	(15,877)	(8%)
Merseyside	300,123	25,010	29,743	4,733	19%	100,041	113,774	13,733	14%
NWAS	1,584,182	132,015	140,774	8,759	7%	528,061	533,047	4,986	1%

Table O5.2

UNPLANNED ACTIVITY									
	Current Month: October 2019					Year to Date: July 2019 - October 2019			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	1,003	(244)	(20%)	4,990	4,060	(930)	(19%)
Greater Manchester	39,178	3,265	4,575	1,310	40%	13,059	16,824	3,765	29%
Lancashire	56,132	4,678	4,537	(141)	(3%)	18,711	16,710	(2,001)	(11%)
Merseyside	22,351	1,863	2,053	190	10%	7,450	8,117	667	9%
NWAS	132,630	11,053	12,168	1,116	10%	44,210	45,711	1,501	3%

Table O5.3

ABORTED ACTIVITY									
	October 2019								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	275	9,601	3%	61	988	6%	59	3,914	2%
Greater Manchester	2,407	26,179	9%	955	5,343	18%	1,159	16,938	7%
Lancashire	1,243	27,716	4%	668	4,881	14%	438	14,527	3%
Merseyside	832	15,776	5%	264	2,022	13%	513	11,703	4%
NWAS	4,757	79,272	6%	1,948	13,234	15%	2,169	47,082	5%

PTS Performance

Overall activity during October 2019 was 7% (8,759) above contract baselines with Lancashire 3% (1,622) below contract baselines whilst Merseyside is operating at 19% (4,733) Journeys above baseline. For the year to date position (July 2019 - October 2019) PTS is performing at 1% (4,986 journeys) above baseline. Within these overall figures, Cumbria and Lancashire are operating at 1% and 8% below baseline whilst Greater Manchester and Merseyside are operating at 4% and 14% above baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 29% (3,765 journeys) and 9% (667 journeys) above 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 in achieving contract KPI performance. Cumbria and Lancashire are 19% (930 journeys) and 11% (2,001 journeys) below baseline.

In terms of overall trend analysis, Greater Manchester experienced an upward activity movement for the 12 months to October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also levelled out whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.

Aborted activity for planned patients averaged 6% during October 2019.

OH1 STAFF SICKNESS

Figure OH1.1

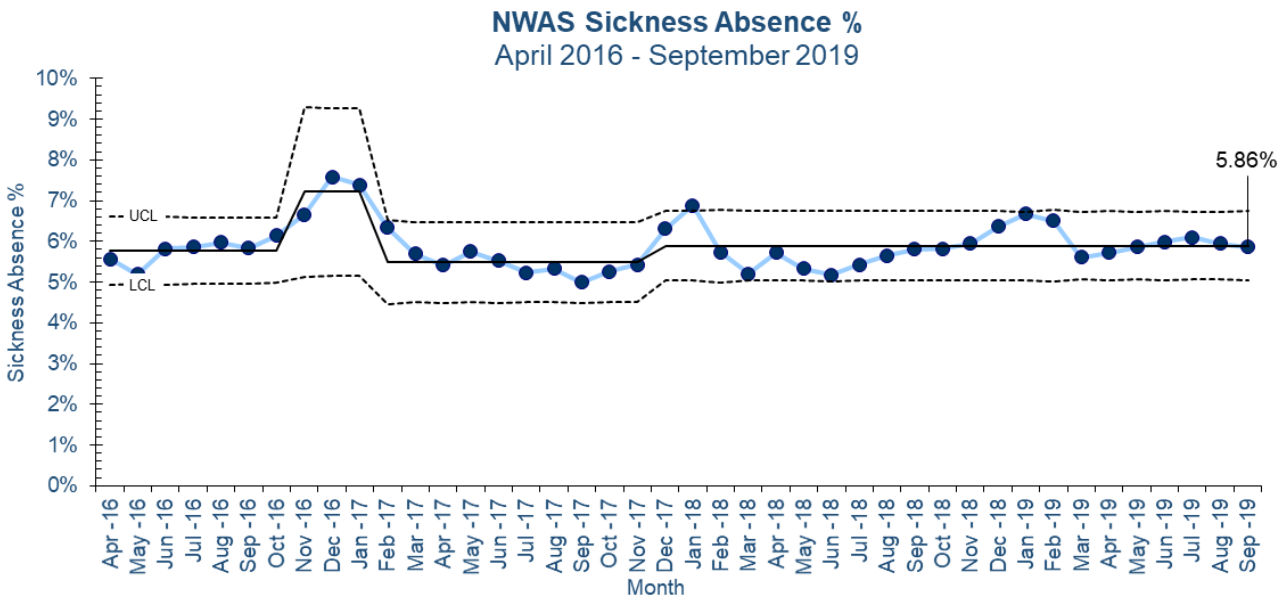


Table OH1.1

Sickness Absence	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
NWAS	5.82%	5.95%	6.37%	6.68%	6.50%	5.62%	5.72%	5.87%	5.99%	6.10%	5.94%	5.86%
Amb. National Average	5.40%	5.48%	5.87%	6.09%	5.77%	5.55%	5.52%	5.55%	5.50%			

Figure OH1.2:

Figure OH1.3:

Staff Sickness

The overall sickness absence rates for September 2019 were 5.86% with figure OH1.1 displaying a slight decrease over the previous 3 months. The position is slightly higher than the same time last year which was 5.81% in September 2018.

There are no special clause variations with regards to Service Lines positions.

The Trust has an improvement goal to reduce sickness absence overall by 0.5% but there are specific improvement targets for PTS to reduce sickness to 6% and also for 111 to reduce to 8%. The Trust has an improvement plan which is being overseen by NHSE/I.

PTS have made excellent progress and are currently at 6.17% sickness and whilst 111 have reduced their sickness absence rates over a 2 month period there is still further improvements to be made.

BAF Risk: SR04.

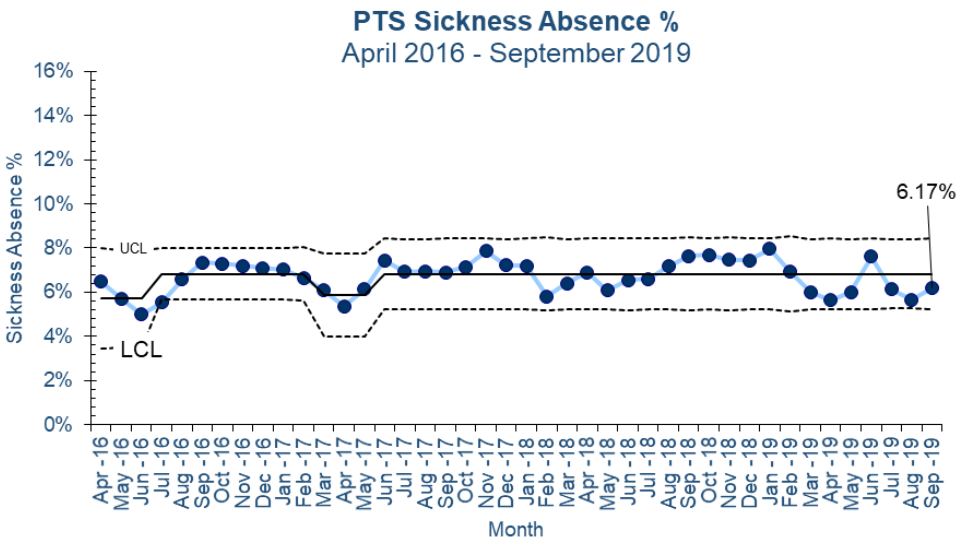


Figure OH1.4

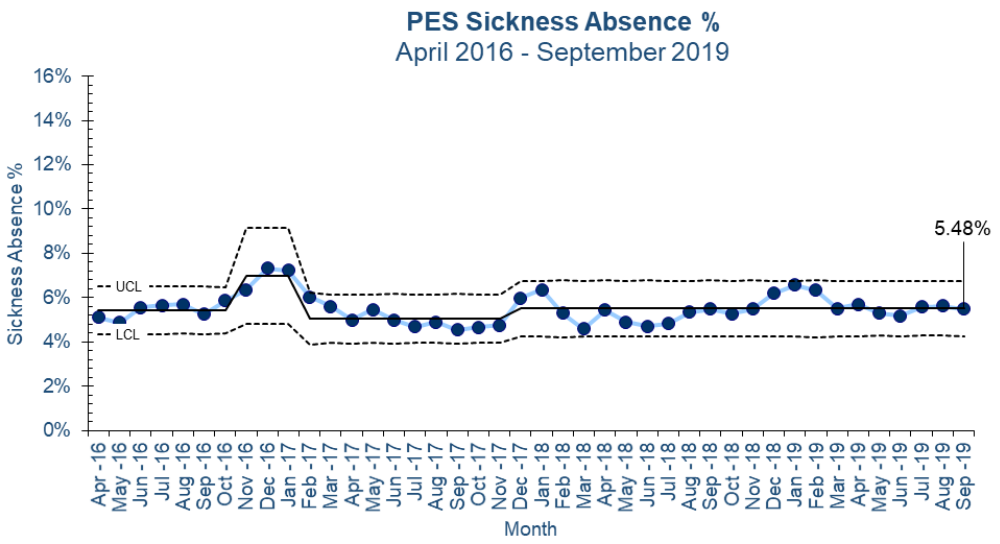
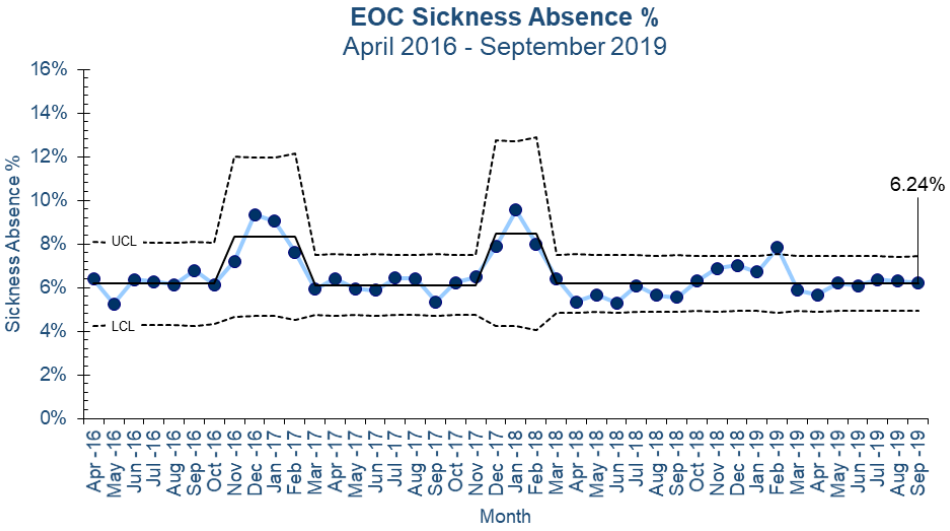
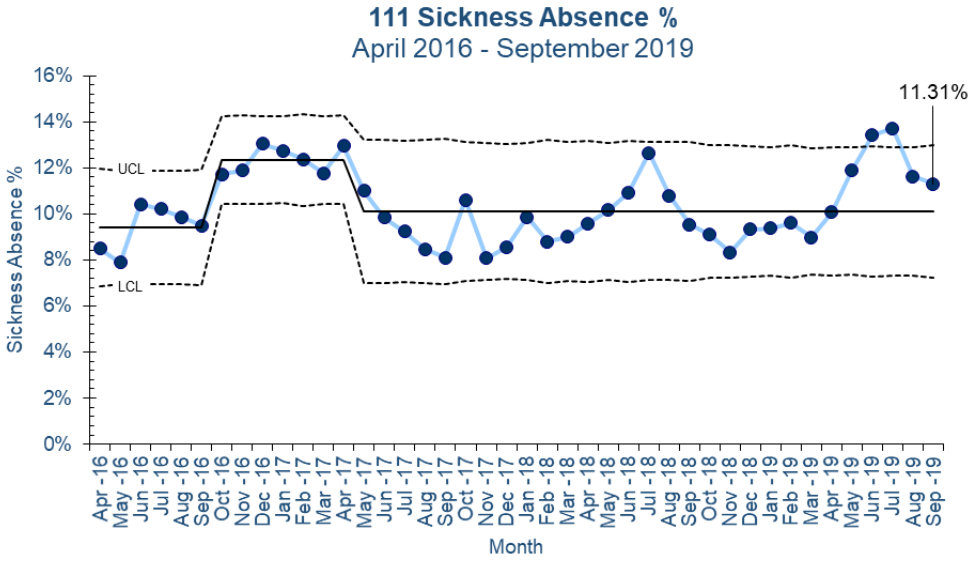


Figure OH1.5





OH2 STAFF TURNOVER

Figure OH2.1

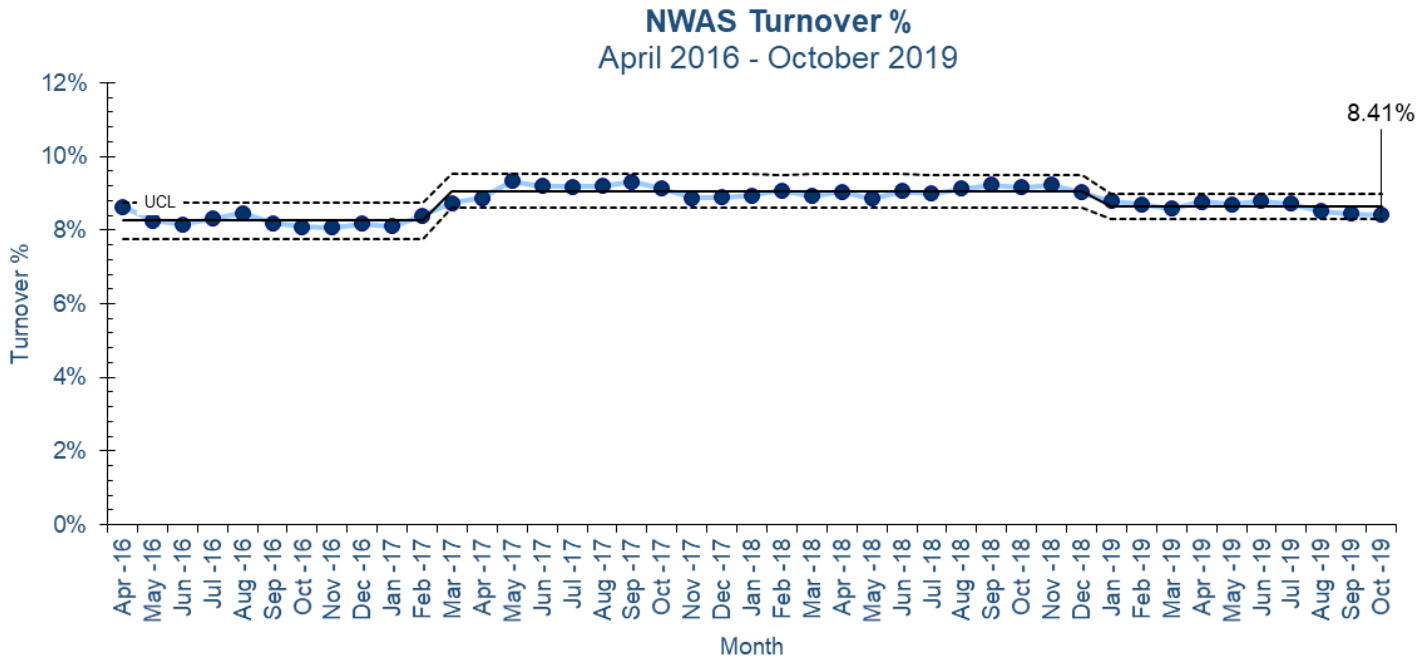


Table OH2.1

Turnover	Nov-18	Dec-18	Jan - 19	Feb - 19	Mar - 19	Apr - 19	May - 19	Jun - 19	Jul - 19	Aug - 19	Sep - 19	Oct - 19
NWAS	9.24%	9.03%	8.79%	8.69%	8.58%	8.77%	8.71%	8.79%	8.72%	8.51%	8.41%	8.41%
Amb. National Average	10.37%	10.30%	10.22%	9.98%	9.69%	9.57%	9.53%	9.39%	9.28%			

Staff Turnover

Turnover is calculated on a rolling year average and this does lead to some small variations between months with October 2019 turnover is 8.41% which continues a stable trend within narrow control limits.

There are no special cause variation with regards turnover, however 111 turnover is at the lower end of the control limit at 27.97% and work continues to improve the position.

As part of the Ambulance Improvement Programme (AIP), the Trust is engaging with NHSE/I to develop a retention plan by 30 November 2019 with a particular focus on 111 retention.

Turnover in EOC is reported at 11.49% which shows a slight increase in turnover however their overall staffing position is positive.

Both PES and PTS turnover is stable and within control limits.

BAF Risk: SR04.

Figure OH2.2

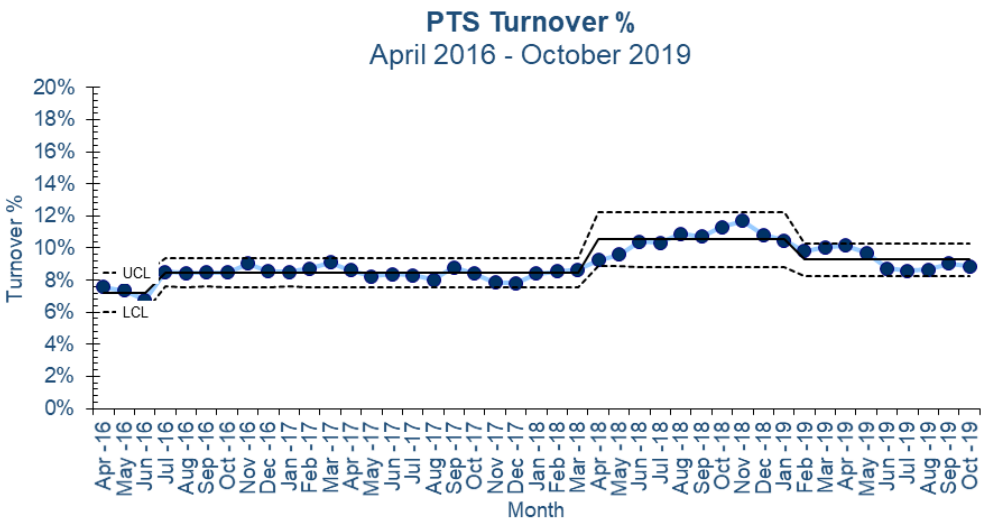


Figure OH2.3

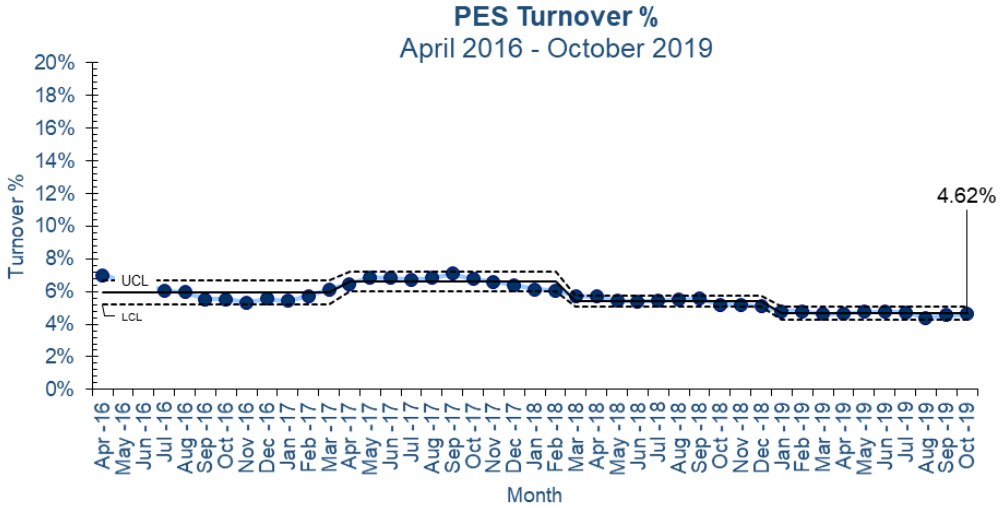


Figure OH2.4

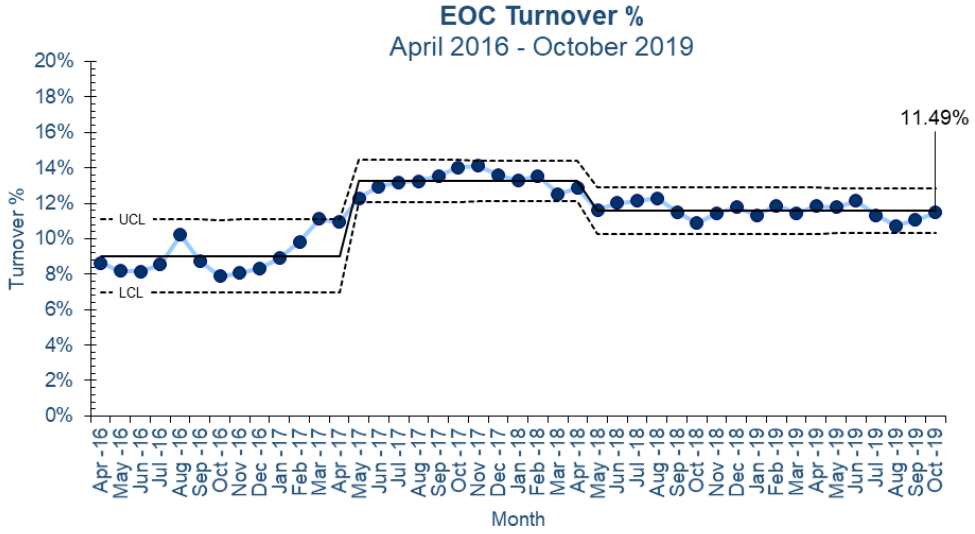
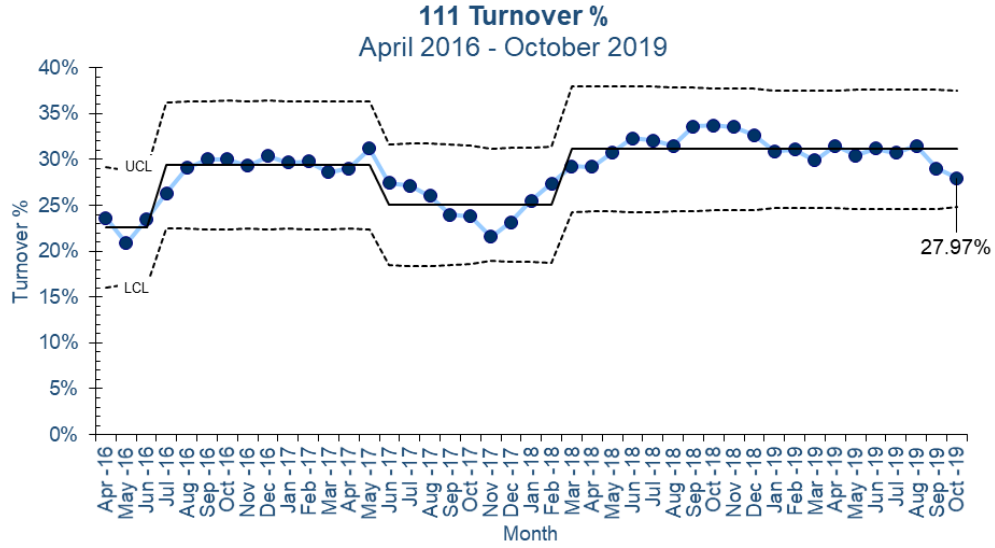
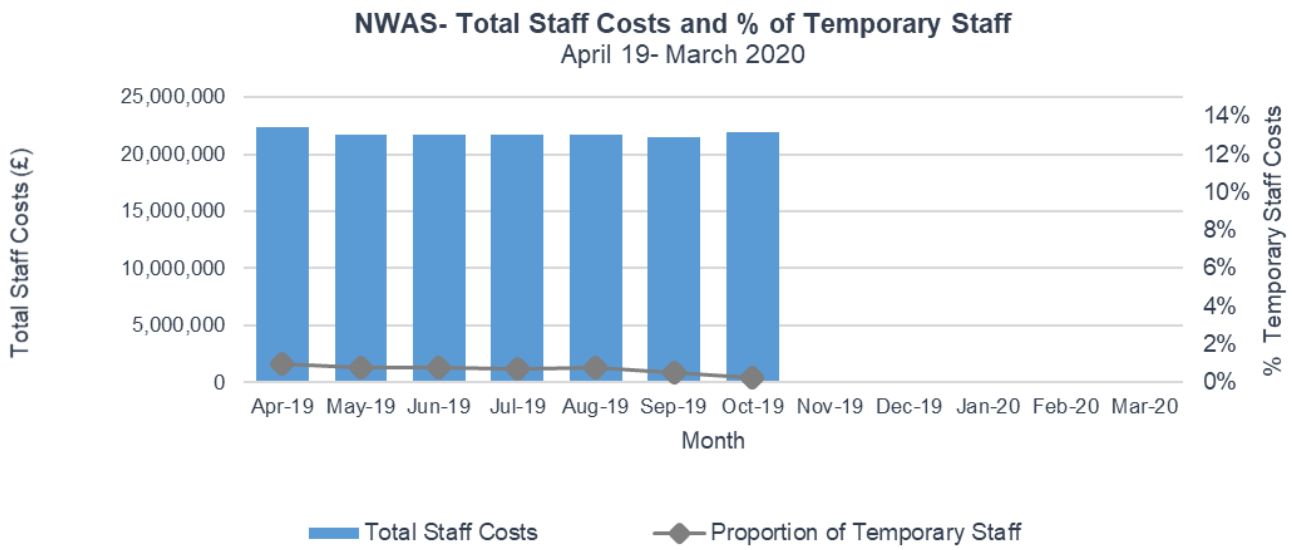


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

The Trust remains in a strong position regarding Agency costs. The position in October 2019 is at 0.3% as a proportion of staff costs.

The Trust is working within the new Agency, which were effective from 1 September 2019 and restrict the areas of the Trust where Agency staff can be used.

BAF Risk: SR04.

Table OH4.1

NWAS	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019
Agency Staff Costs (£)	212,061	173,766	191,843	180,676	203,421	173,834	175,326	169,134	161,001	142,550	102,471	83,441
Total Staff Costs (£)	20,394,454	20,058,775	20,169,610	20,354,432	22,621,645	22,342,157	21,671,356	21,667,396	21,686,448	21,692,684	21,460,515	21,982,878
Proportion of Temporary Staff %	2%	1%	2%	1%	1%	1%	1%	1%	1%	1%	1%	0.3%

Figure OH4.2:

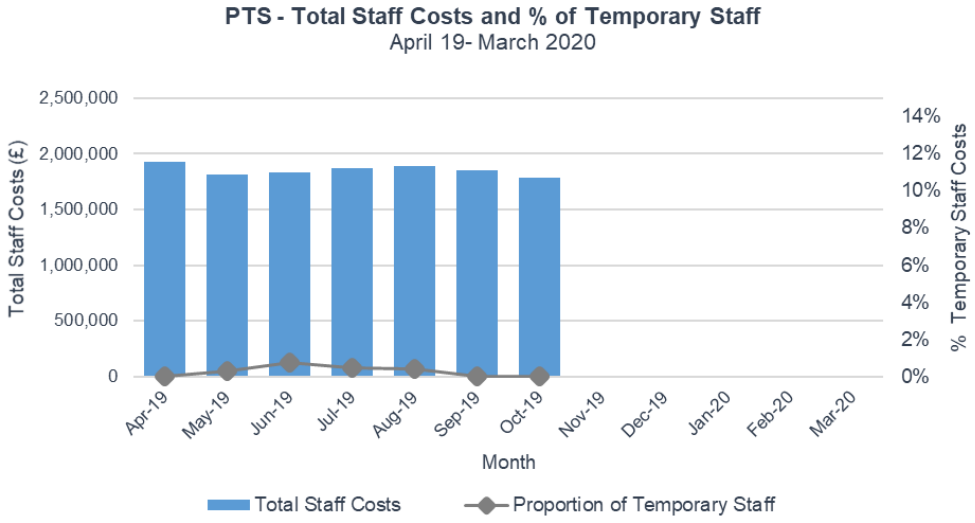
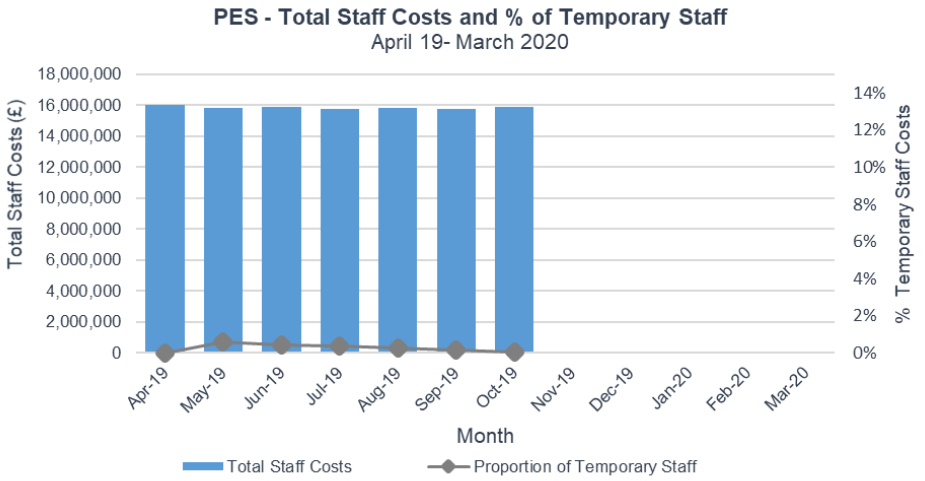


Figure OH4.3



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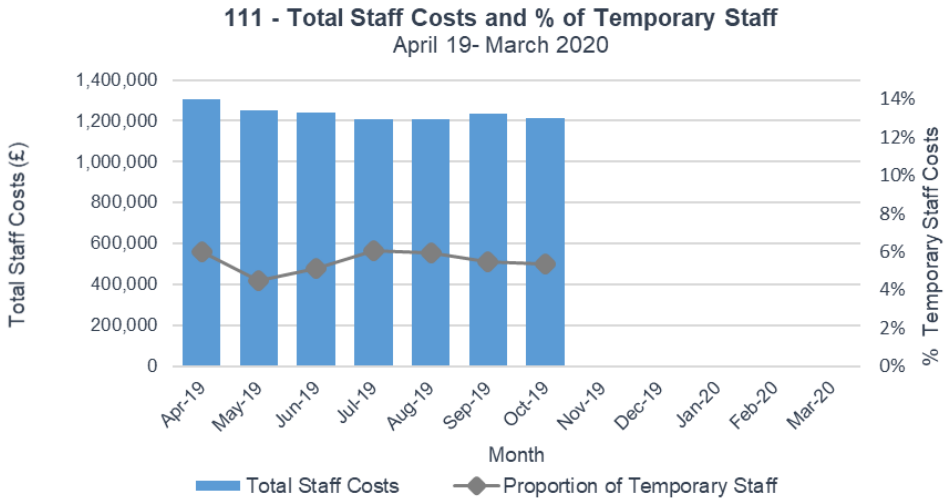
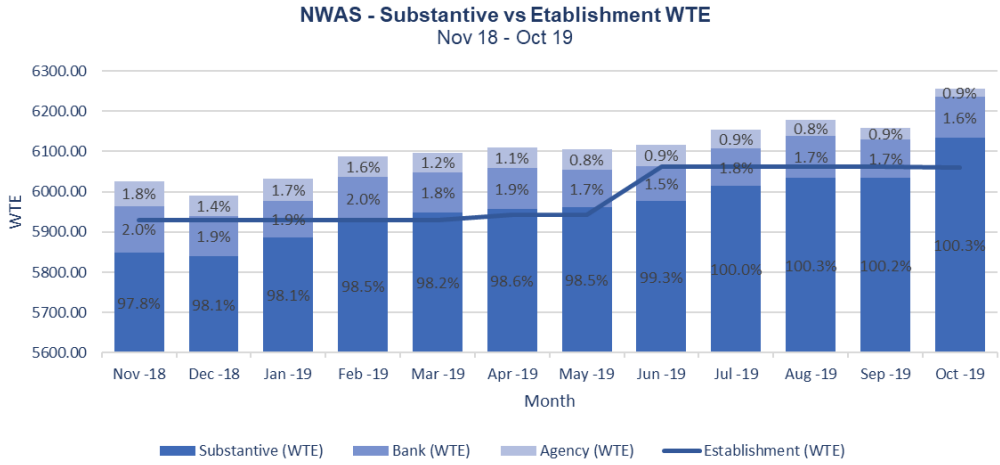


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

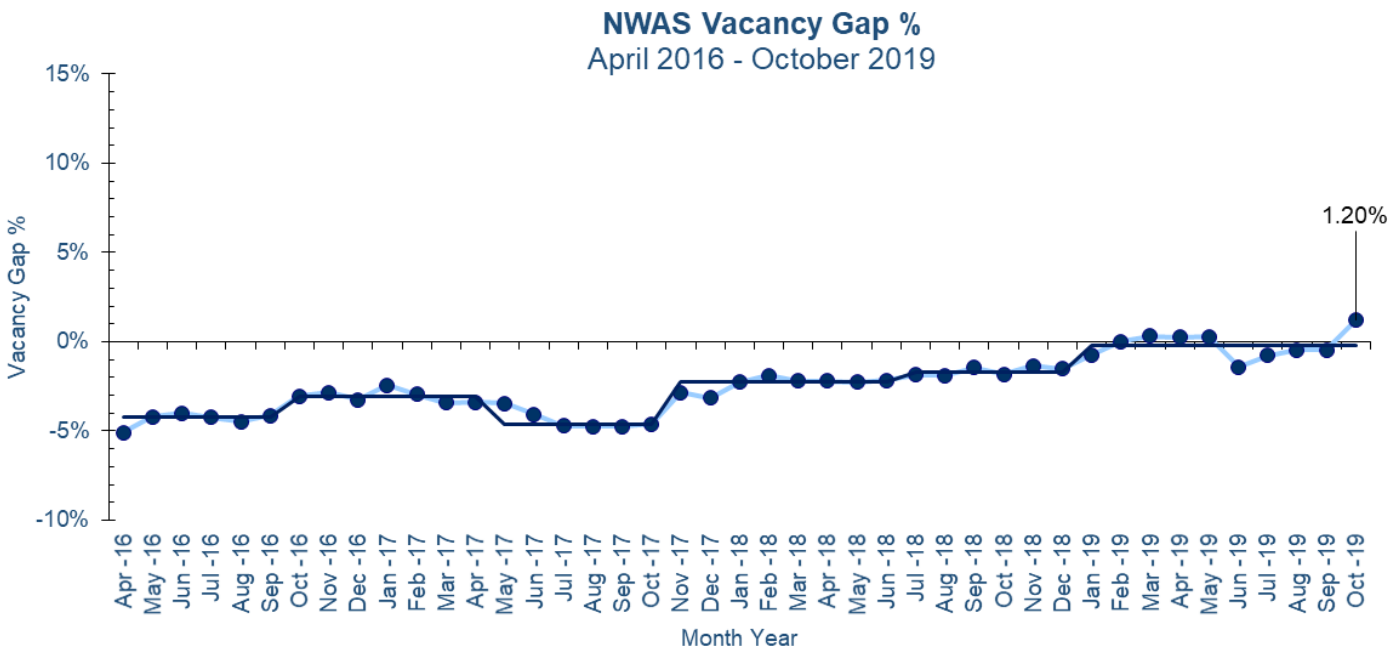


Table OH5.1

Vacancy Gap	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
NWAS	-1.35%	-1.52%	-0.74%	0.01%	0.33%	0.24%	0.29%	-1.42%	-0.79%	-0.47%	-0.45%	1.20%

Vacancy Gap

The changes resulting from the contract settlement and revisions to the ORH position have started to be included from Quarter 3 into the establishment, so the vacancy position partly reflects the new requirements but will be fully reflected at the end of Q4.

The revised establishment for EOC has been implemented (this can be seen in June 19 on the graph) and places the EOCs in a strong position moving into the winter period at 1.33% above establishment.

Work is ongoing with PES, PTS and 111 to ensure robust plans are in place to reach the current establishment and new establishment as soon as practicable but overall the position is stable.

The PTS vacancy position is -5.52% in October 2019 showing a slight improvement from the previous vacancy position and a continuing improving trend.

BAF Risk; SR04

Figure OH5.2

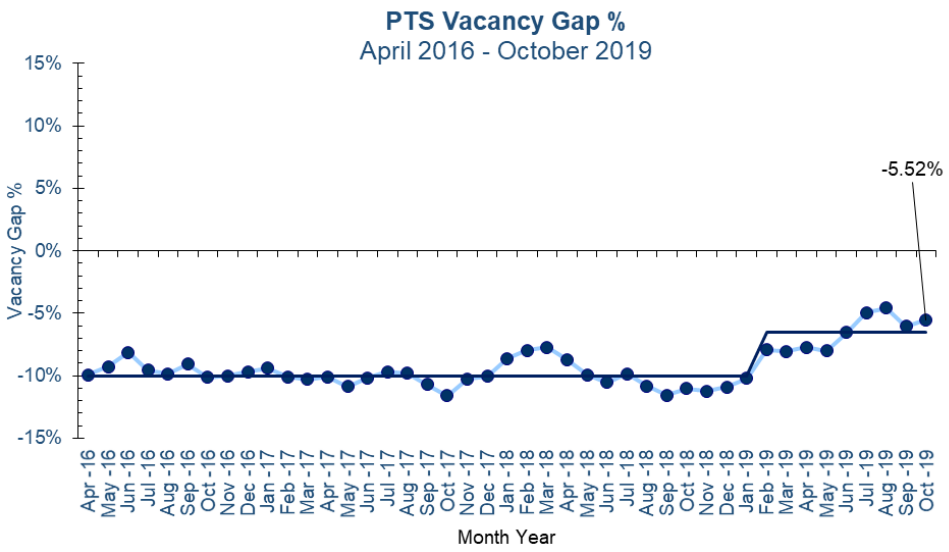


Figure OH5.3

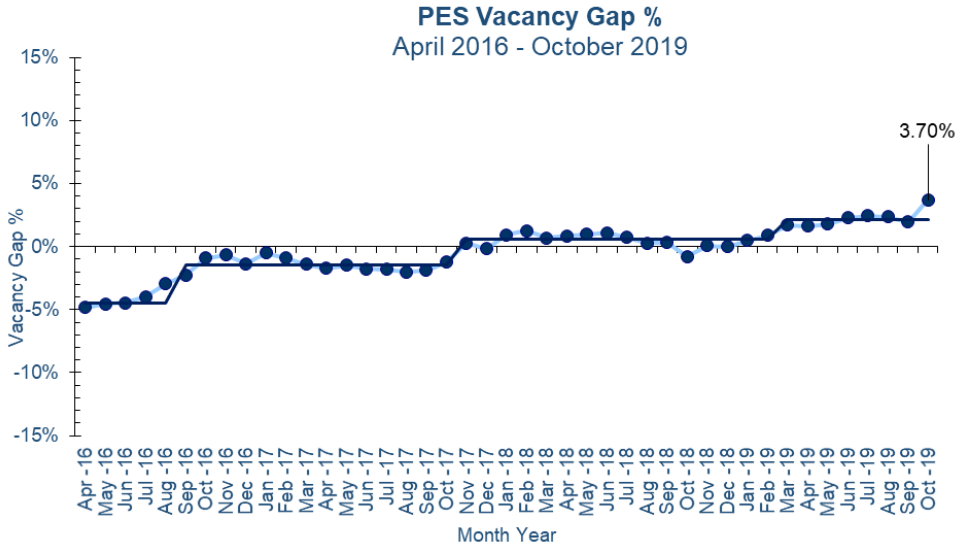


Figure OH5.4

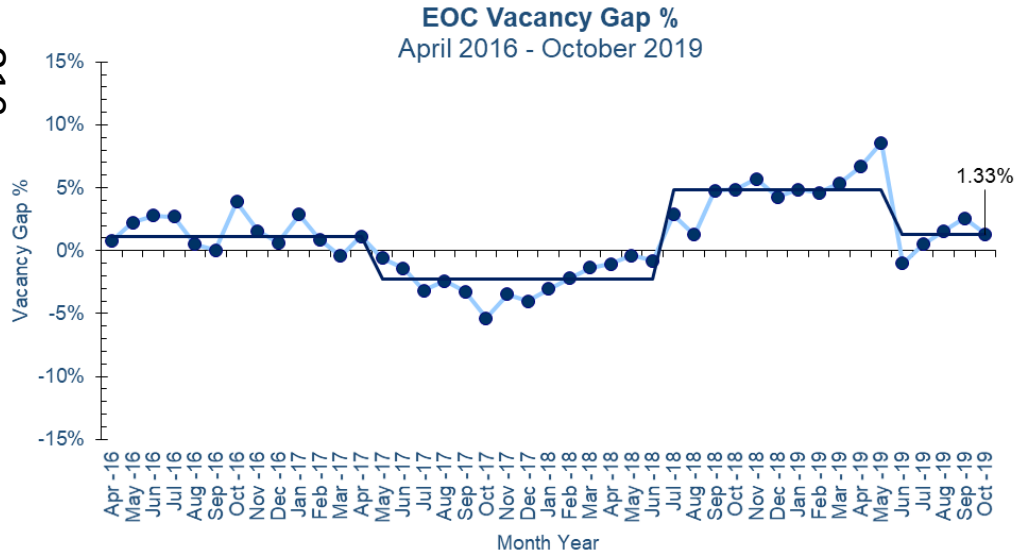
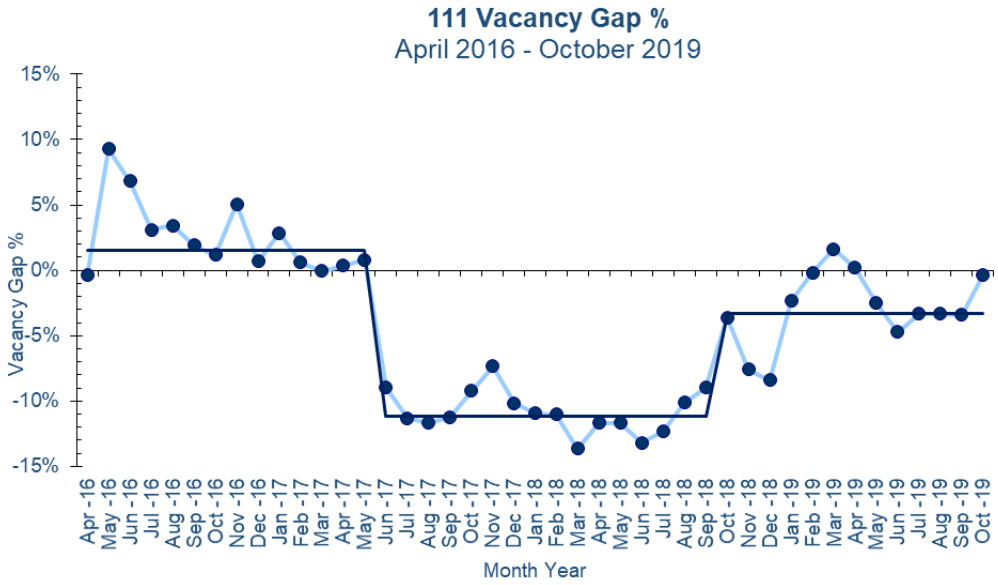


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

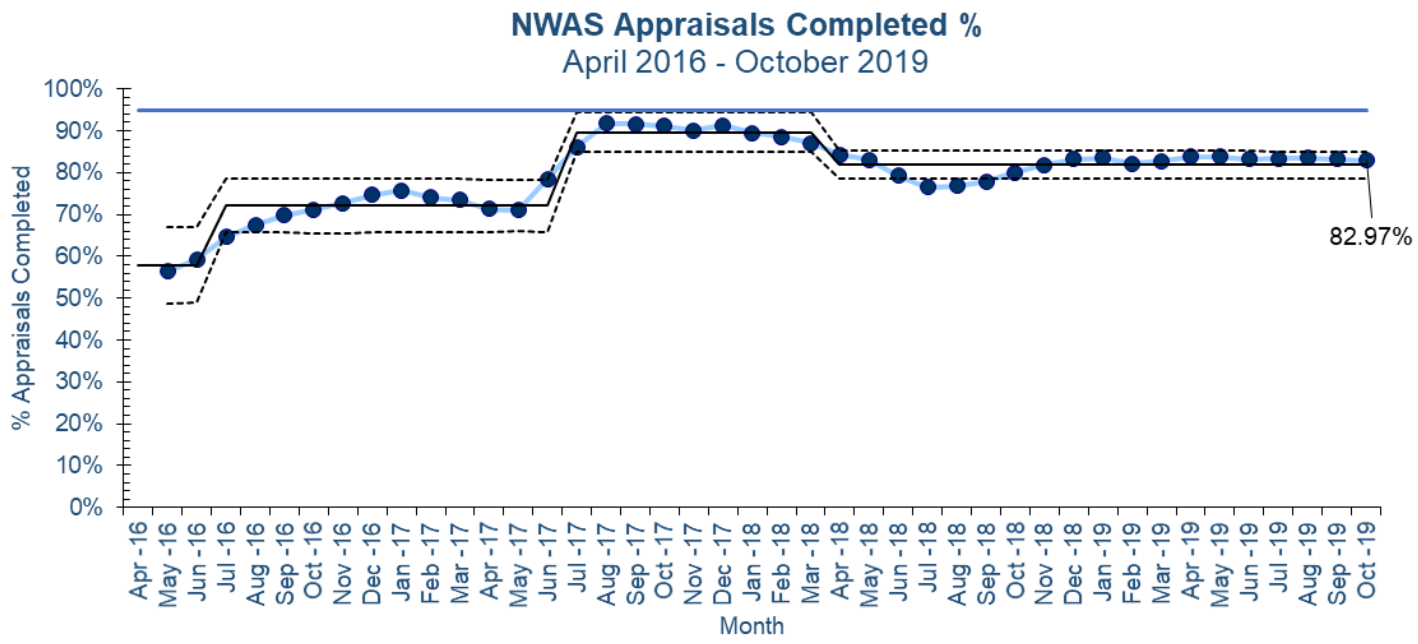


Table OH6.1

Appraisals	Nov-18	Dec18	Jan -19	Feb -19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
NWAS	82%	83%	84%	82%	83%	84%	84%	83%	83%	84%	83%	83%

Appraisals

Appraisal compliance overall has been stable for several months with no variations at Trust level. The October 2019 position being 83% against a target of 95%.

The improvement goal for these measures for 19/20 is to achieve 95% compliance.

Special clause variation at OH6.2 relates to PTS with the last six months being above the median albeit with a slight reduction in recent months to 84.59%. Support and monitoring will be provided to PTS.

Both EOC and 111 have also seen a slight reduction in compliance but still with control measures, although the position in 111is a cause for concern and work is ongoing to support improvement.

These workforce indicators will be reported through the Resources Committee to ensure that assurances can be provided regarding progress.

BAF Risk: SR04.

Figure OH6.2

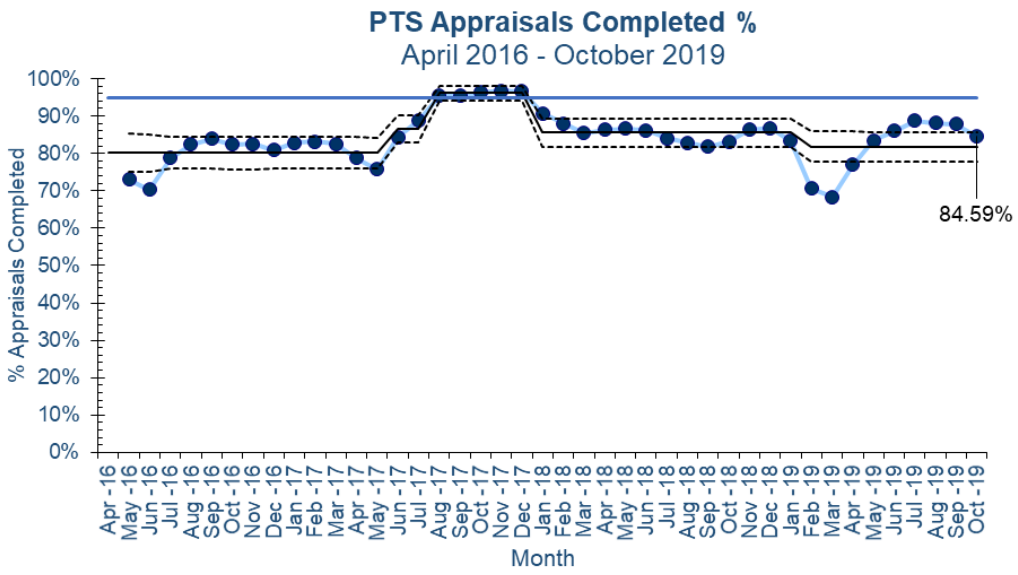


Figure OH6.3

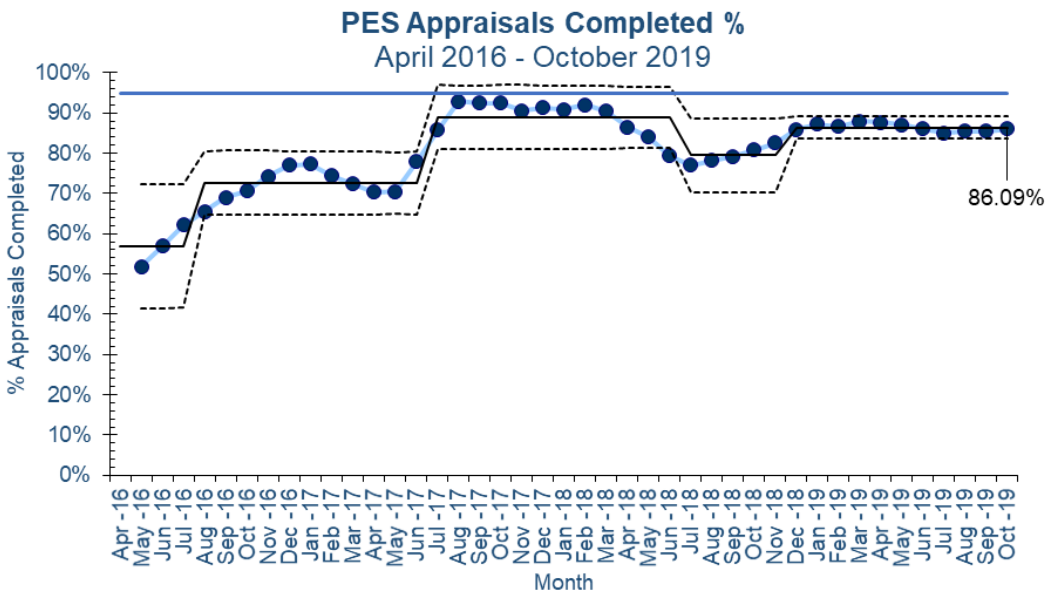


Figure OH6.4

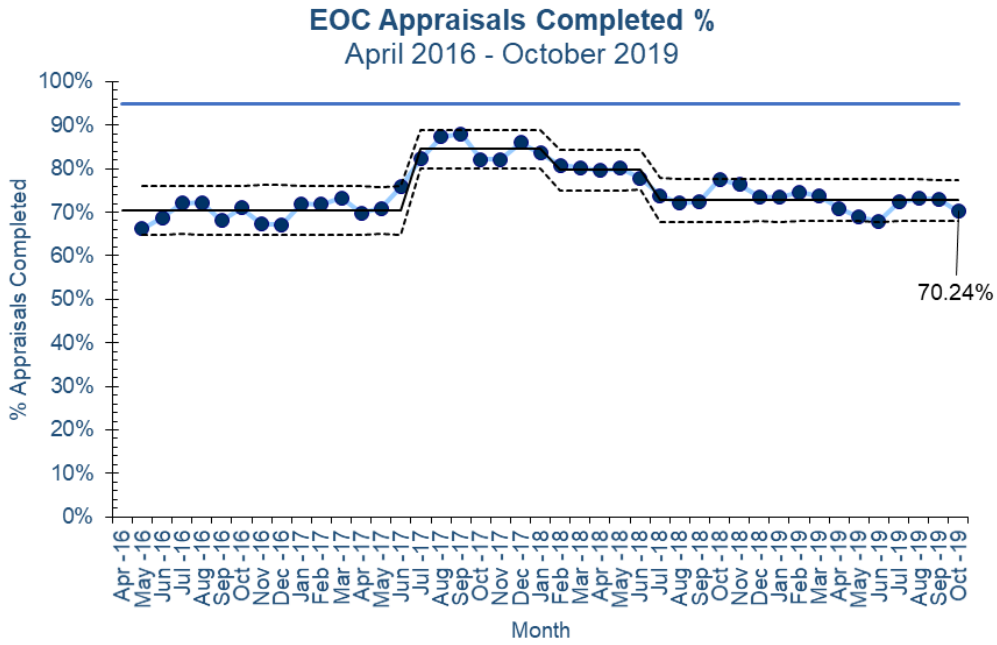
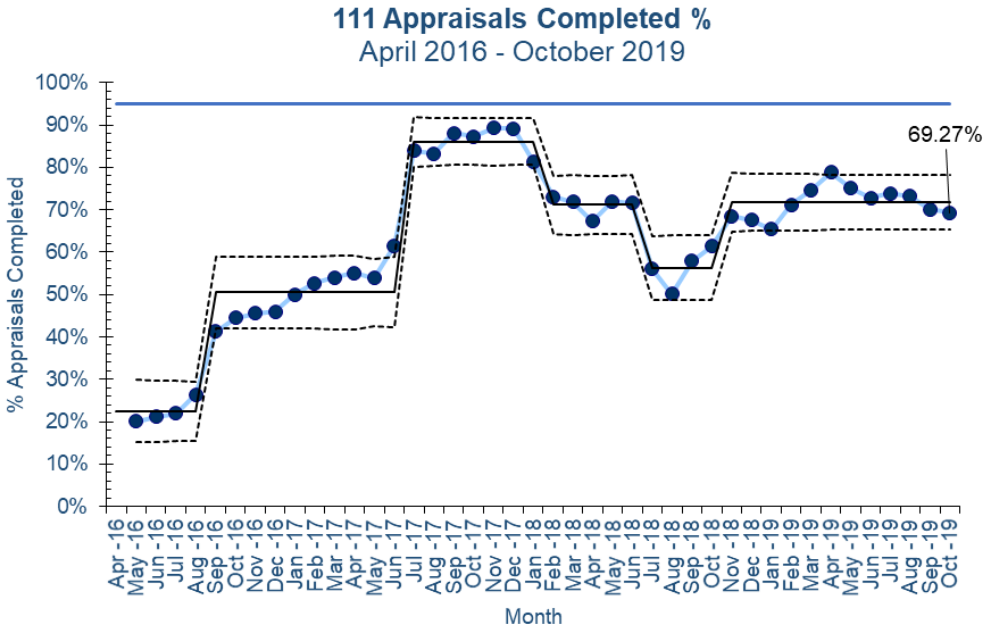


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

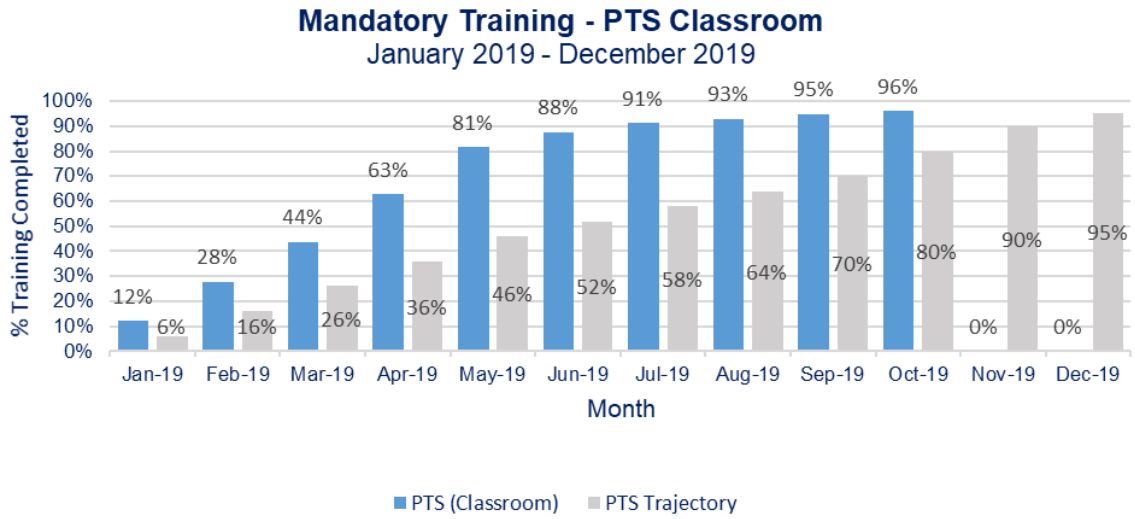
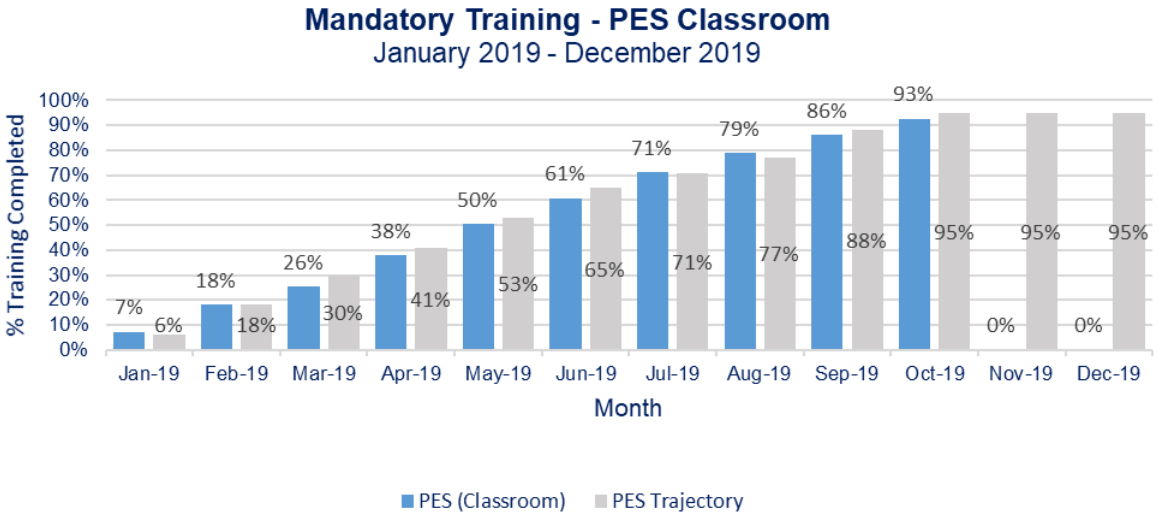


Figure OH7.2



Mandatory Training

The Trust has 2 main types of delivery of mandatory training, classroom based for staff who are clinical and who have patient contact and all staff have an element of on-line training via e-learning for everyone else.

For PES and PTS the mandatory training cycle runs from January to December each year.

2019 classroom training for PES is under trajectory at 93% against a target of 95% and PTS mandatory training is slightly over trajectory at 96%.

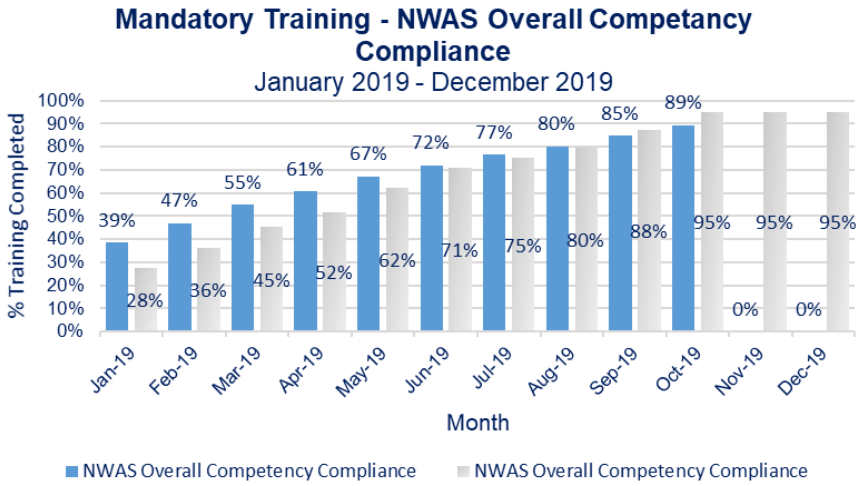
For 2019 we have moved to competency based compliance reporting for Mandatory Training. The overall Trust position at the end of October 2019 is 89% compliance against a target of 95%.

The NWAS corporate position is 93% compliance against a target of 95%.

111 compliance has been fairly static over the last few months but they are currently completing mandatory systems training which will be added to figures following completion of the full programme.

BAF Risk: SR04.

Figure OH7.3



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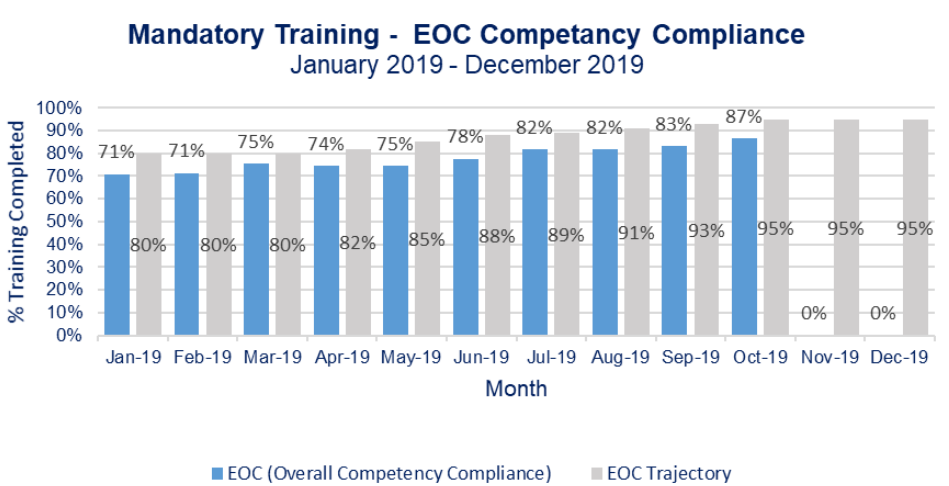


Figure OH7.5

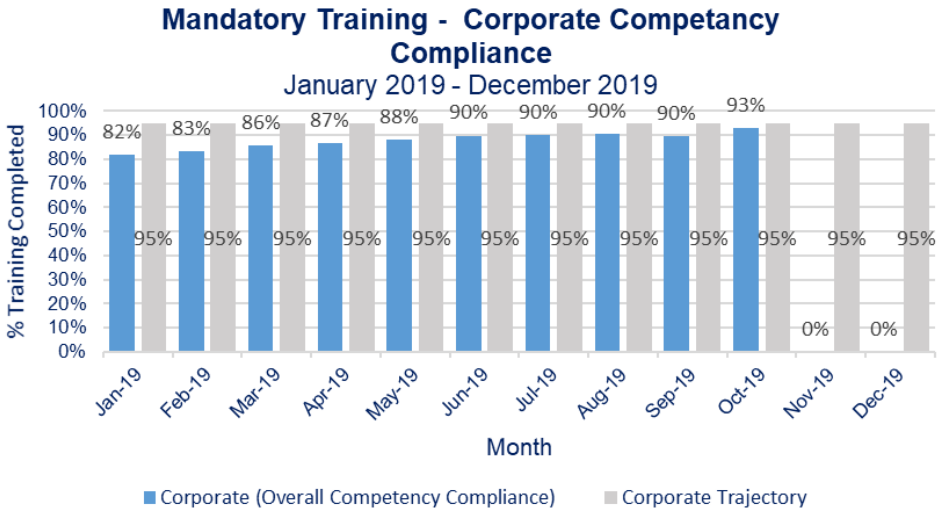
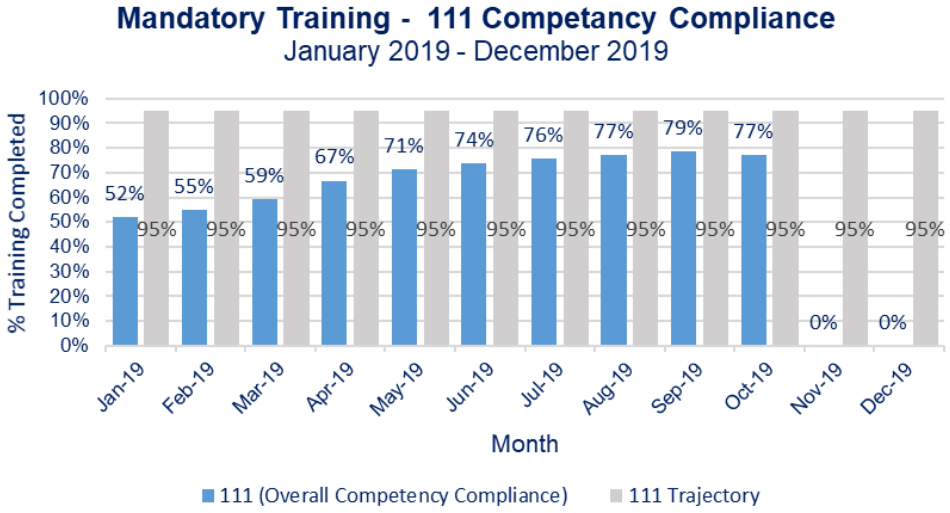


Figure OH7.6



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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 November 2019			
Subject:	EPRR Annual Assurance 2019/20			
Presented by:	Ged Blezard, Director of Operations			
Purpose of Paper:	For Assurance			
Executive Summary:	This paper describes NHS England 2019/20 Emergency Preparedness, Resilience and Response assurance process and presents the NWAS self-assessment results together with statements of compliance which have been signed by the Trust Accountable Emergency Officer. Blackpool CCG as Lead Commissioners have approved this submission as has the Lancashire Local Health Resilience Partnership a decision which has been further upheld by the North Regional Lead for EPRR from NHS England & Improvement as part of his aggregated report to the national Head of EPRR and ultimately the Secretary of State for Health. The overall ratings achieved for NWAS, NHS 111 and Interoperable Capabilities rest at 'Substantial Compliance' which indicates that the Trust as a whole is between 89-99% compliant with the standards it is expected to achieve which is the same position as 2018/19 but numerical improvements have improved the overall percentage ratings. An action plan has been generated for each of the elements which have been assessed as 'partially compliant' and this will inform the work plan to address each of these issue. Performance against this will be monitored periodically by the Lead Commissioner and NHS England & Improvement.			
Recommendations, decisions or actions sought:	That the Board considers the content of this paper and attached self-assessment templates and notes the Statements of Compliance. The Board is also requested to formally minute that assurances have been given to satisfy the prescribed requirements of the EPRR process.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):								
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**
☐	☐	☒	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**Executive Leadership Committee**
Date:	**20 November 2019**
Outcome:	

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1. PURPOSE

This paper describes NHS England 2019/20 Emergency Preparedness, Resilience and Response (EPRR) assurance process and presents the NWAS Action Plans together with Statements of Compliance which have been signed by the Trust Accountable Emergency Officer (AEO - Director of Operations). These statements were submitted to Blackpool CCG on 20 September together with the self-assessment documents for their own scrutiny and challenge before they were 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 severe weather, transport emergencies, industrial incidents/action, infrastructure failures, terrorist attacks or infectious disease outbreaks. 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.

For the 2019/20 EPRR assurance process, additional and completely separate sections have been retained in the checklist from previous years to reflect current concerns or heightened risks. Parts of these additional sections may be relevant to other acute providers but the majority of these new Core Standards only apply to the Ambulance Service.

In addition to the 49 general EPRR Core Standards applicable to NWAS, the 2019/20 document includes a separate set of 'Deep Dive' standards which do not contribute to the overall compliance calculations, but are used to inform the standards for the following year. The 'Deep Dive' questions for 2019/20 consisted of

15 concerning severe weather, 5 regarding long term climate adaptation and 15 standards for EOC resilience.

For NHS 111 there are a total of 42 general EPRR Core Standards which are also commensurate with the Trust core standards but specific assessment pertaining to the NHS111 Service is required. NHS 111 also have to complete a 'Deep Dive' section which has the same elements as the Trust core standards but without the EOC resilience section. In contrast to practice in some previous years, NW 111 have been requested to provide a separate Statement of Compliance and Action Plan.

There is a separate section of 163 Interoperable Capabilities standards (MTFA, HART, CBRN, Command & Control, Mass Casualties & JESIP) which are unique to ambulance services.

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 2019/20, 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 20 September 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 has been generated automatically by the self-assessment spreadsheet 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. (It should be noted that there is a known fault in the formulae in the spreadsheet that flags 'non-compliance' on the control page for the interoperable standards despite the overall rating calculation).

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 thus;

NW 111

Core Standards

Out of 42 applicable standards, NW111 have self-assessed full compliance with 40 and partial compliance with 2. This represents a compliance figure of 95% and therefore an overall rating of **'Substantially Compliant'**.

NWAS

Core Standards

Out of 49 applicable standards, NWAS have self-assessed full compliance with 48 and partial compliance with 1. This represents a compliance figure of 98% and therefore an overall rating of **'Substantially Compliant'**.

Interoperable Standards

Out of 163 applicable standards, NWAS have self-assessed full compliance with 155 and partial compliance with 08. This represents a compliance figure of 95% 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.

Initial discussions with the Lead Commissioning Team were undertaken following submission and no challenge to the self-assessment ratings or detail of available evidence have been received. Similarly there have been no challenges from NHS England & Improvement (Lancashire) nor from the NHS England & Improvement Regional Team. This acceptance of the NWAS return was minuted at the Lancashire Local Health Resilience Partnership meeting of 24 October 2019 when the agenda item was led by Paul Dickens, Regional Head of EPRR for NHS England & Improvement.

The attached action plans highlight the elements for each domain that require additional work to achieve compliance and activities are ongoing to achieve full compliance in these elements. For each line of assessment the final figures represent a slight improvement over the position last year. Progress against the Action Plans will be reviewed periodically by NHS England & Improvement as well as informing internal work plans.

The full self-assessment documents, Action Plans and Statements of Compliance are provided with this paper.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the CCA (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.

NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards which are revised annually.

4. RECOMMENDATIONS

That the Board of Directors note the contents of this paper and consider the evidence provided in support of the compliance ratings achieved. The Board is also requested to take assurance from the submissions to NHS England & Improvement and recognise the significant work conducted by the Resilience Team to achieve the levels of preparedness that they represent.

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Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

STATEMENT OF COMPLIANCE

North West Ambulance Service - Interoperable 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 2019-20 standards: **Substantial**

Compliance Level	Criteria
Full	The organisation is **100%** compliant with all core standards they are expected to achieve.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve.
Non-compliant	The organisation is complaint with **76%** or less of the core standards the organisation is expected to achieve.

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	0	08	155
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43** NWAS: **49/163*** NHS111:**42****			

**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

27/11/2019
Date of board / governing body meeting

17/09/2019
Date signed

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Overall assessment:										
Ref	**Domain**	**Standard**	**Detail**	**Evidence - examples listed below**	**Organisation 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**	**Comments**
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.	• EPRR Policy identifies resources required to fulfill 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	EPRR strategy part of Service Delivery annual Business Plan which outlines responsibilities for EPRR compliance. Formal Resilience Business Plan has been written which covers key Domain deails. It is implicit that the organisation is satisfied that the Resilience Team is appropriately resourced but the Resilince Business Plan as a stand alone doument has not yet been presented to the Board.	Partially compliant	Presentation to Board for formal review	Head of Contingency Planning	Nov-19	Capacity challenges have prevented final presentation through ELC and Board but basic workplan and obligations for Resilience are already part of wider Service Delivery Business Plan.
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Critical Infrastructure areas are temperature monitored,alarmed and mechanically cooled as part of essential operations.	Partially compliant	Adressed as part of new build to exploit design features which reduceneed for mechanical cooling .	AD Service Delivery Support	unknown	Architectural design features alone are unlikely to completely remove the need for mechanical cooling of server rooms and other critcial infrastructure equipment but will create passively cooled spaces overall.
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Modifications are applied as part of planned maintenance or as part of wider building resilience adaptation post flooding events. Vulnerable sites have been considered for relocation or wherer this isn't possible, mitigation measures installed. Much of the residual flood risks remain outside of NWAS' control but SUDs consideration is being added to the review of the Adaptation Plan.	Partially compliant	Add SUDs consideration to Adaptation Plan	AD Service Delivery Support	Dec-19	
4	**Ambulance Resilienc**	**EOC**	The trust can operate their control centres as autonomous centres with minimal disruption to user and patient experience / the Trusts ability to receive and respond to incidents during outages. These processes have been tested or exercised in the past 12 months	**Disaster Recovery:** • Processes in place which ensure staff are clear on the actions to take in the event of working locally • Spilt brain approach to rebuild post failure • Clear arrangements for passing calls between controls if dispatch required at remote control from where the call has been received **Business Continuity:** • Pre-plan arrangements with BT that ensure that in "local working" mode there is a reduction of cross control transferring of calls • Ability to switch between autonomous and virtual from the control room • Auditable staff refresher training • Evidence of exercise / practice scenarios	Virtualisation of EOC environment can be decoupled to allow most functions to operate autonomously. Telephony as in 1 above allows each EOC to operate singly and BT have separate lines into each so can also suport this. CAD resilience also supports this however, only 2 'instances' of C3 are opearated giving a primary system and the ability to switch to a back up secondary 'instance' when required and with minimal disruption. For full 'split brain' working a third 'instance' of C3 would need to be operated at significant cost and this would potentially reverse the operating model currently in place which has supported synergies between EOCs.	Partially compliant	Assessment of risk and consideration of contribution to resilience.	Strategic Head of EOCs	Unknown	Introducing a third 'instance' of C3 would be a significant departure from current working practice and would probably incur disproportionate costs to benefits. Nationally this may not be common practice for Trusts with multiple EOCs.
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.		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. That said, every effort is made to ensure 6 staff are available at all times including movement of staff from Training Team. Reliefs targeted to nights and weekends and active rota management.	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	Persistent issu	Only a change to Commissioning support and increas 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.

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.		NWAS Informatics maintain that it is still not possible to extract this data in a report format therefore compliance is being reported by exception. Failure to comply is reported via DATIX.	Partially compliant	Continue to request mechanism to be created to gather this information and exploit any opportunities to record this via other means.	Head of Special Operations	Jan-20	
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data		Additional equipment requirement has been agreed at NOG (National Operations Group) which is yet to be purchased.	Partially compliant	Business case required for capital spend on Thermal Imaging Cameras..	Head of Special Operations	Dec-19	Existing levels of equipment are fully compliant but current procurment process for newly identified and specified equipment is currently in process of being closed.
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		All HART staff are fit tested (using Portacount units) and have access to masks. Front line staff have FFP3 on the vehicles but stock is approaching use by date. Not all staff have had a recent fit test.	Partially compliant	Continue procurement of alternative product for all front line staff, specialists and on call Commanders with patient contact risk.	Director of Operations	Feb-20	In conjunction with Northern Ambulance Alliance, alternative products have been investigated and current option being tested is an over the head device (hood) which does not require the user to undergo a fit testing process. It will also negate any cultural or personal preference issues around facial
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		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. Gap in Forward Doctor Role	Partially compliant	Forward Doctor role paper written for EMT approval following identification of funding. Additional MERIT Doctors being recruited and BASICS an option but not absolutely guaranteed. Pilot courses for Safety Officer and Decontamination Officer completed and being rolled out wider to embed capability.	Head of Special Operations	Sep-20	
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).		Formal assessment process can now be set now that NARU National Commander Service Specification is implemented. Will require EMT/Board approval and discussion on need to retrospectively review and renew all applicable existing JDs and contracts (around 200) under 'Grandparent rights'.	Partially compliant	All new positions which have command duties implicit in their Job Descriptions, are subject to a competency assessment. The first of these has now been undertaken (Sept 19).	Head of Special Operations	Apr-20	Existing posts with Command roles need to be formally recognised as having 'Grandparent rights'. Commander competency is assessed by peer review and using NARU templates during exercise partcipation which adds to current requirement for individual Commanders to maintain CPD evidence to meet National Occupational Standards (NoS) requirements.
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).		All AMD trained and all MERIT Doctors competent but Forward Doctor role not yet fully established.	Partially compliant	Continuing devlopment of roles in conjunction with Medical Director and introduction of Forward Doctor position.	Head of Special Operations	Jan-20	Paper has been written for EMT but not yet on Agenda

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.		Role not yet established but work progressing to develop, train and test via exercise. Supporting template in place to support thiose alereadyin post to conduct the role if required.	Partially compliant	Continuing dvelopment of roles in conjunction with Medical Director and introduction of Forward Doctor position.	Head of Special Operations	Jan-20	Paper has been written for EMT but not yet on Agenda

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Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

STATEMENT OF COMPLIANCE

North West Ambulance Service - 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 2019-20 standards: **Substantial**

Compliance Level	Criteria
Full	The organisation is **100%** compliant with all core standards they are expected to achieve.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve.
Non-compliant	The organisation is complaint with **76%** or less of the core standards the organisation is expected to achieve.

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
42	0	02	40
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43** NWAS: **49/163*** NHS111:**42****			

**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.

E. A. Blezard

Signed by the organisation's Accountable Emergency Officer

27/11/2019
Date of board / governing body meeting

17/09/2019
Date signed

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Overall assessment:										
Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation 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.	Action to be taken	Lead	Timescale	Comments
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.	• EPRR Policy identifies resources required to fulfill 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	EPRR strategy part of Service Delivery annual Business Plan which outlines responsibilities for EPRR compliance. Formal Resilience Business Plan has been written which covers key Domain deails. It is implicit that the organisation is satisfied that the Resilience Team is appropriately resourced but the Resilince Business Plan as a stand alone doument has not yet been presented to the Board.	Partially compliant	Presentation to Board for formal review	Head of Contingency Planning	Nov-19	Capacity challenges have prevented final presentation through ELC and Board but basic workplan and obligations for Resilience are already part of wider Service Delivery Business Plan.
28	Training and exercisin	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	• Training records • Evidence of personal training and exercising portfolios for key staff	Strategic Commanders (who support 111) maintain NoS but 111 Clinical Managers do not have a specific NoS Profile as the national prescription does not translate appropriately. A bespoke CPD profile is being devised with assistance from the Resilience Team.	Partially compliant	Continue development of CPD profile based on NOS Standards.	Head of Service 111 & Head of Contingency Planning	Dec-19	
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Duty of Care of both Emergency and Patient Transport Staff extends to ensure that patients are not discharged into an unsafe enviromnent. Robust safeguarding arrangements are in place to maintain and report patient welfare.	Partially compliant	Review and reword policy and training to ensure standard can be fully met and evidenced. Issue staff communictions as required.	Head of Contingency Planning will coordinate with Directorate and Training Leads	Dec-19	
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higheracy.	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Critical Infrastructure areas are temperature monitored (and alarmed) and mechanically cooled as part of essential operations.	Partially compliant	Adressed as part of new build to exploit design features which reduceneed for mechanical cooling .	AD Service Delivery Support	unknown	Architectural design features alone are unlikely to completely remove the need for mechanical cooling of server rooms and other critcial infrastructure equipment but will create passively cooled spaces overall.
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Modifications are applied as part of planned maintenance or as part of wider building resilience adaptation post flooding events. Vulnerable sites have been considered for relocation or wherer this isn't possible, mitigation measures installed. Much of the residual flood risks remain outside of NWAS' control but SUDs consideration is being added to the review of the Adaptation Plan.	Partially compliant	Add SUDs consideration to Adaptation Plan	AD Service Delivery Support	Dec-19	

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Emergency Preparedness, Resilience and Response (EPRR) Assurance 2019-20

STATEMENT OF COMPLIANCE

North West Ambulance Service - Core 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 2019-20 standards: **Substantial**

Compliance Level	Criteria
Full	The organisation is **100%** compliant with all core standards they are expected to achieve.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve.
Non-compliant	The organisation is complaint with **76%** or less of the core standards the organisation is expected to achieve.

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
49	0	01	48
Acute providers: **64** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43** NWAS: **49/163*** NHS111:**42****			

**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.

C. A. Blezard.

Signed by the organisation's Accountable Emergency Officer

27/11/2019
Date of board / governing body meeting

17/09/2019
Date signed

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27/11/2019
Subject:	The NHS Patient Safety Strategy (July 2019)
Presented by:	Maxine Power. Director of Quality, Innovation and Improvement
Purpose of Paper:	For Discussion
Executive Summary:	NHS England and NHS Improvement have launched a new Patient Safety Strategy; "Safer culture, safer systems, safer patients". The Strategy outlines a vision for the NHS to continuously improve patient safety and the role of a safety culture to deliver it. It includes a series of recommendations built on two core pillars; **a patient safety culture** supported by **a patient safety system** and focuses on three main areas; • **Insight** - The utilisation of patient safety metrics to improve understanding of safety • **Involvement-** Involvement of patients, the public and the healthcare workforce and equip them with the skills to improve patient safety • **Improvement –** Programmes and initiatives designed to improve patient safety in focussed areas. This briefing has been collated to inform the Board of the content of the strategy, the principles on which it has been created, the areas of work identified as a priority and the developments and initiatives to be undertaken by the NHS and NWAS for successful implementation.
Recommendations, decisions or actions sought:	The Board of Directors are recommended to; • Be familiar with the content of the Patient Safety Strategy. • Approve a review of the Right Care (Quality) Strategy in alignment with this national strategy. • Be assured that; - Strategy accountability will sit with the Director of QI&I and Medical Director, supported by the Chief Nurse and Chief Consultant Paramedic. - Strategy implementation will be monitored via the Quality and Performance Committee and Safety & Effectiveness Management Groups. - Patient involvement in safety improvement to align with The Trust's patient and public involvement work led by the Director of Strategy

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☒	☐	☐	☐	☐	☐	☒	☐	☐

Are there any Equality Related Impacts:	**N/A**
Previously Submitted to:	Safety Management Group and Quality & Performance Committee
Date:	SMG on 03/09/19 & Q&P on 16/09/19
Outcome:	Information

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1. PURPOSE

The purpose of the paper is to inform the Board of Directors of the publication of the NHS Patient Safety Strategy published by NHS England and NHS Improvement in July 2019, including the alignment to existing strategies and oversight.

Key content from the National Safety strategy includes:

- An NHS where there is a relentless focus on continuously improving patient safety
- Built on two key foundations: a patient safety **culture** and patient safety **systems**

Three strategic aims:

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**insight**)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**involvement**)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

2. CONTENT

2.1 Insight

- Adopt and promote key safety measurement principles and use culture metrics to better measure how safe care is
- Use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system
- Introduce the Patient Safety Incident Response Framework to improve the response to, and investigation of, incidents
- Implement a new Medical Examiner system to scrutinise deaths
- Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee
- Share insight from litigation to prevent harm

2.2 Involvement

- Establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care
- Create the first system-wide and consistent patient safety curriculum, training and education framework for the NHS
- Establish Patient Safety Specialists to lead safety improvement across the system
- Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong
- Ensure the whole healthcare system is involved in the safety agenda.

2.3 Improvement

- Deliver the National Patient Safety Improvement Programme
- Deliver the Maternity and Neonatal Safety Improvement Programme
- Develop the Medication Safety Improvement Programme
- Deliver a Mental Health Safety Improvement Programme
- Continue efforts to prevent falls, pressure ulcers, venous thromboembolism and healthcare-associated infection
- Support safety improvement in priority areas such as safety of older people, safety of those with learning disabilities and the continuing threat of AMR.

3. IMPLICATIONS FOR NWAS

3.1 NWAS Right Care Strategy (2018-2023) is already closely aligned to the aims within the national strategy and therefore work is already progressing in all three strategic areas. For example, we have already highlighted the requirement to measure and improve safety culture and have started this work in our EOCs. We are already engaging with patients and service users through our patient and public engagement programme and we have an extensive programme of improvement focussed on the prevention of deterioration, maternity and neonatal care, medicines safety, mental health, frailty and infection prevention.

3.2 In addition to the Right Care Strategy, safety is embedded as a golden thread within all our organisational strategies. The strategy alignment table in appendix 1 highlights the requirements of the new national strategy (first column) and the read across to the NWAS strategy suite. As part of our ongoing strategy review process we will identify how (and where) our strategies align with the national strategy and identify if there are any gaps. These will be included in the updated strategy refresh documents.

3.3 Our Right Care (Quality) Strategy includes the express intention to build improvement skills and develop human factors and safety science as a core part of the continuous professional development for all staff. Goals have been set for the number of staff and our Right Care Strategy implementation update provides assurance against these goals.

3.4 Patient involvement in safety improvement is aligned with our patient and public involvement work led by the Director of Strategy

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 The Board retains overall responsibility for delivery of the national Patient Safety Strategy via the Quality & Performance Committee. The Quality and Performance Committee receive assurance from the management groups for Safety and Clinical Effectiveness chaired by the Chief Nurse and Medical Director respectively and, where necessary, from other assurance Committees/Management Groups.

4.2 Executive accountability sits with the DQII and the Medical Director, supported by the Chief Nurse and Chief Consultant Paramedic.

4.3 There are no known legal issues to report in relation to this Patient Safety Strategy.

5. REFERENCES

1.Institute of Medicine US (1999) To *Err is Human: Building a Safer Health System*

2. NHS England (2013) The Berwick Report *Improving the Safety of Patients in England National Advisory Group on the safety of Patients in England*

3. NHS England (2019) *The Long Term Plan*

4. NHS England and NHS Improvement (2019) *The NHS Patient Safety Strategy Safer culture, safer systems, safer patients*

5. NHS England Patient Safety Domain (2015) *Serious Incident Framework*

6. NWAS (2019-2024) *Digital and Business Intelligence Strategy*

7. NWAS (2019-2024*) Strategy For the Delivery of Urgent and Emergency Care*

8. NWAS (2018-2019) *Right Care Strategy, Safe Effective and Patient Centred Care, Every Time*

Appendix 1: Strategy Alignment Grid

Strategy: National Patient Safety Strategy	Right Care Strategy	Digital Health Strategy	Urgent & Emergency Care Strategy	HR & Workforce Strategy	Mental Health Strategic Plan	Communication and Engagement Strategy
Insight						
PSIRF (reporting)	✔	✔	✔	✔	✔	✔
Involvement						
Patient involvement	✔			✔	✔	✔
Patient Safety Partners (patients)			✔			✔
Patient Safety Specialists (staff)	✔			✔		✔
Patient Safety Syllabus (education) (NHSE/NHSI)	✔			✔		✔
Acute data Alignment (ADAPt)		✔	✔			
Sharing IT systems/ Electronic records	✔	✔	✔		✔	
Improvement						
Learning from deaths/ Medical examiner system	✔		✔		✔	
National Alerts	✔	✔	✔		✔	
National Patient Safety Improvement Programme:	✔		✔		✔	✔
Preventing deterioration (NEWS2) & Sepsis	✔					
Medicines Safety	✔		✔			
Maternal & neonatal Safety	✔		✔			
Mental Health	✔				✔	
Safety & Older People	✔		✔		✔	✔
Patients with Learning Disabilities	✔		✔		✔	
Antimicrobial Resistance and Healthcare Associated Infections	✔					
Openness and Transparency	✔	✔	✔	✔	✔	✔
Learning	✔	✔	✔	✔	✔	✔
Just Culture	✔	✔	✔	✔	✔	✔

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Chairs Assurance Report

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	18.11.19	**Quorate (yes/no):**	Yes
Chair:	Prof Alison Chambers	**Executive Lead:**	Ged Blezard, Director of Operations Chris Grant, Medical Director Maxine Power, Director of Quality, Innovation and Improvement
Members present:	Prof A Chambers, Non-Executive Director (Chair) Mr G Blezard, Director of Operations Dr C Grant, Medical Director Dr D Hanley, Non-Executive Director Prof R Thomson, Associate Non-Executive Director (via phone) Mr R Groome, Non-Executive Director Carolyn Wood, Director of Finance	**Key Members not present:**	Ms M Power, Director of Quality, Innovation and Improvement Mr M Forrest, Deputy Chief Executive
Board Assurance Risks Aligned to Committee:	**SR01 -** If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage **SR03** - If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.		

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		• Since the previous committee meeting, one risk had emerged – 3156 'Consistent high rates of sickness and absenteeism occur across the 111 service line could result in KPIs not being achieved.' • Zero risks had decreased in score. • Zero risks had been closed. • One risk had decreased in score – 2710 'Poor compliance of IPC across the Trust due to the lack of resources within the IPC team.	• Further work to be carried out in relation to gaps and control for SR03.
CQC Inspection Update		• One outstanding action in relation to the vehicle check book. Solution has been piloted and testing of 7 modules complete.	• Options for roll out being presented to the Executive Leadership Committee on 20th November 2019 for approval.
Right Care Strategy – Quarter 2 Update		• High level update presented in relation to the Right Care Strategy key deliverables. • The programme is developing well with work progressing for all the key deliverables. • In terms of complaints, changes to case assessments had been made to ensure new complaints are answered within the agreed timescales. However, further work is required to support 24 hour closure of risk score 1-2 complaints. • The culture of reporting incidents in the Emergency Operation Centres (EOC) is low and therefore, there is a need to raise awareness of incident reporting. It was noted that at the ROSE meeting, all complaints and serious incidents were reviewed and the meeting was attended by an EOC member of staff.	• Requested that the next report includes all trajectories, progress against them and details of any risk/mitigation.

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Chairs Assurance Report

Medicines Management – Quarter 2 Update		• Work is progressing in terms of the goals set out within the Right Care Strategy, to ensure what is being measured adds value. • MIAA conducted an audit in relation to managing medicines at events and partial assurance was received. • The single measure requiring improvement is the daily check of controlled drugs (metric CD5) on all vehicles. The Clinical Effectiveness Management Group and Medicines Effectiveness Group will continue to monitor progress against this measure.	• MIAA report and action plan to be presented to the Audit Committee on 17th January 2020. • Future reports to include more narrative in terms of performance against trajectory and mitigations in place.
Q2 Clinical Audit Progress Report		• The Trust has maintained its commitment to the national audit programme and is on schedule to meet the national requirements for the current year. • Three new local audits had been established (i) Basic step, (ii) SCCTH Deep Dive Cat 1, and (iii) Paediatric Triage Assurance. • A replacement audit tool has now been procured. • All outstanding projects are now completed.	• Reporting via the new audit tool will be in place by April 2020.
Learning from Deaths Policy		• NHS England and NHS Improvement (NHSE/I) has published national guidance to help NHS ambulance trusts in England improve the way they review and learn from the deaths of patients who had been under their care. • The Trust's Learning from Deaths Policy has been developed and has received extensive clinical input. • The policy was presented to and approved by the Clinical Effectiveness Management Group. • It was noted that the success of the policy will be measuring the change in practice. • Consideration required in relation to deaths in custody and whether this included prisons.	• The Learning from Deaths Policy will be presented to the Board of Directors for approval. • Following approval, an implementation plan will be developed, taking into account comments made by members.

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Chairs Assurance Report

		• Drug related deaths be captured within the implementation plan.	
Performance Update		• It was reported that activity saw a continued increase in October when compared to last year and commissioned levels. • There has been an increased in category 1 calls. • The Trust had moved to REAP level 3 and therefore staff could be released to respond to activity. • Approximately 2,500 hours lost in October due to hospital handover. • The APAS scheme has now been reinstated to respond to some category 3 and category 4 calls. • New business continuity software has been procured to improve reporting.	• Consideration is being given to reducing the REAP level.
111 Activity and Performance		• It was noted that the service had a challenging month during October 2019, with 'calls answered' in 60 seconds at 70.58% against a target of 95%. • Conduit were no longer supporting the service and therefore, performance had deteriorated. • V18 training would be completed by 28th November 2019 and a new set of codes would be introduced to manage the acuity of patients. • A number of GP surgeries closed for a period of time and the Trust were not advised. Therefore, demand for the service increased without additional resource. • Highlighted challenges in relation to recruitment and retention. • Significant increase in demand for the service is expected from St Helens area.	• Workforce Committee to review retention within the service including exit interviews. • Director of Operations and Senior Risk and Assurance Manager to review risks associated with the 111 service. • The Executive Leadership Committee to be made aware of concerns raised in relation to the 111 service.

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Chairs Assurance Report

		• The time in which the 111 service is in demand has changed and therefore a deep dive was being carried out to understand this. • Unseen risk, risk and quality were considered on a regularly basis within the service to identify risk and clinical safety. • Consideration to risks associated with the 111 service be included within the Board Assurance Framework.	
Urgent and Emergency Care Strategy		• The Urgent and Emergency Care Strategy was approved in March 2019 and the implementation plan in July 2019. • During quarter 2, work had been carried out to develop the governance and delivery processes. In addition, a recruitment campaign had been carried out and it is envisaged that the team will be in post by December 2019. • During quarter 3, work will be carried out to plot milestones and achievements and initiate further projects. • It was noted that the Integrated Response Model work stream is progressing well. • The UEC service delivery models work stream had commenced. • The rotational working work stream is progressing well. • Further work is required in relation to the clinical programme	• Milestones to be established and reports to include progress and narrative in relation to progress being made.
Emergency Preparedness Resilience and Response Submission		• In terms of 111, out of 42 standards the trust are fully compliant with 40 and partially compliant with 2. • Of the NWAS core 49 standards, the Trust were fully compliant with 48 and partially compliant with 1. • Of the 163 interoperable standards, the Trust were compliant with 155 and partially compliant with 8. • An action plan was in place in relation to the standards that the Trust was partially compliant with. It was noted	• The Emergency Preparedness Resilience and Response Submission be presented to the Board of Directors for approval. • Progress against the action plan to be presented to a

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Chairs Assurance Report

		that some of the standards would never be achieved as they did not relate to ambulance trusts.	future meeting of this committee.
Winter Plan		• The Strategic Winter Plan was presented to provide members with assurance of the Trust's plans to manage winter pressure. • Specific bespoke operational plans will be put in place for occasions such as Christmas and New Year. • Learning had been put in place since 2018 and planning for winter had commenced much earlier in the year. • Developments have been made in relation to 6 tactical plans for (i) PTS, (ii) 111, (iii) 999, and (iv) EOC. It was noted in the past one plan had been in place.	• Future reports to include learning that had been identified and embedded.
Assurance Report from the Clinical Effectiveness Management Group, Safety Management Group and Learning Forum.		• Assurance reports were presented from the Clinical Effectiveness Management Group, Safety Management Group and Learning Forum	• Assurance reports to be included amongst the assurance/discussion items within future agendas.

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Chairs Assurance Report

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	21.10.19	**Quorate (yes/no):**	Yes
Chair:	Prof Alison Chambers	**Executive Lead:**	Ged Blezard, Director of Operations Chris Grant, Medical Director Maxine Power, Director of Quality, Innovation and Improvement
Members present:	Prof A Chambers, Non-Executive Director (Chair) Mr G Blezard, Director of Operations Mr M Forrest, Deputy Chief Executive Dr C Grant, Medical Director Mr R Groome, Non-Executive Director Dr D Hanley, Non-Executive Director Ms M Power, Director of Quality, Innovation and Improvement Prof R Thomson, Associate Non-Executive Director	**Key Members not present:**	Carolyn Wood, Director of Finance
Board Assurance Risks Aligned to Committee:	**SR01 -** If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage **SR03** - If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.		

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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		• Since the previous committee meeting, zero risks had emerged and one risk had decreased in score – 3062 'EMDs failing to identify key words and phrases relating to the breathing status of a patient during a call resulting in potential incorrect call categorisation or delayed ambulance response'. • Assurance received in relation to risk 2710 – Infection, Prevention and Control and Safeguarding. It was noted a full risk assessment had been carried out and risk moderation was now complete.	• Noted and took assurance from the update, and • Gained assurance that each BAF risk was managed effectively.
CQC Inspection Update		• One outstanding action in relation to the vehicle check book. Solution was currently being piloted. • The service delivery meeting structure had been approved by the Audit Committee.	• A proposal to be presented to the Executive Leadership Committee and Quality and Performance Committee.
Performance Update		• It was reported that activity saw a continued increase in incident volume against commissioning plans (+3.8%). However noted the Trust were taking less patients to emergency departments (-1.4%) compared to the YTD position. • The APAS scheme is to be reinstated on 4th November 2019. • A mean and 90th centile standard will be introduced to measure call pick up performance. • EOC had seamlessly moved into Estuary Point. • Commended performance in relation to C1.	• Future reports to include actions that were being carried out to improve performance.
111 Activity and Performance		• It was noted that the service had a challenging month during September 2019, with 'calls answered' in 60 seconds at 73.3% against a target of 95%. • Conduit were no longer supporting the service and therefore, performance had deteriorated.	• Requested that the Resources Committee review in further details the recruitment and retention issues within 111.

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Chairs Assurance Report

		• Highlighted challenges in relation to recruitment and retention. • 111 had seamlessly moved into Estuary Point. • Mutual aid from West Midlands Ambulance trust had been requested – expected adverse impact on performance. • Significant increase in demand for the service is expected from St Helens area.	
Patient Transport Service		• Overall activity across the four PTS contracts during month 05 was 6,592 journeys below the contract baseline whilst the cumulative position was 454 journeys below baseline. It was added that call answering had achieved 75% against a target of 75% with an average waiting time of 28 seconds achieving the 60 second KPI target. • CQUIN was in place for winter preparedness with a focus on (i) a shift change of phone to online booking use, (ii) reducing aborts, and (iii) transferring unplanned activity to planned activity. • Current focus is being placed on aborted journeys and moving unplanned activity into planned activity.	• Noted the report.
Third Party Sub Contractor Management Framework		• Members expressed concern due to the content of the report that provided no assurance.	• It was requested that assurance around the management of third party providers providing patient transportation services operating on behalf of NWAS be presented to the Executive Leadership Committee and then the Quality and Performance Committee.
Ambulance Clinical Quality Indicators		• Performance against standards was presented but no narrative to explain the position.	• Requested that a sufficient executive summary was included within future reports

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			including a narrative to explain the performance position.
2018/19 Clinical Audit Annual Report		• Discussion ensued in relation to the status of a number of audits that were delayed, unknown and abandoned. • Members were advised that the revised Clinical Audit Policy would provide more rigour to the process.	• The Medical Director and Non-Executive Director to sign of future clinical audit plans.
Quality Impact Assessments		• Details of quality impact assessments for cost improvement schemes completed to date were presented. • Noted that an assessment for all current schemes and not yet been carried out.	• Requested that future reports include more narrative to provide the right level of assurance to members.

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Chairs Assurance Report

Name of Committee/Group:	**Audit Committee**	**Report to:**	**Board of Directors**
Date of Meeting:	**18th October 2019**	**Quorate (yes/no):**	**Yes**
Chair:	**David Rawsthorn, Non-Executive Director**	**Executive Lead:**	**Director of Finance / Director of Corporate Affairs**
Members present:	**Michael O'Connor, Senior Independent Director Rod Thompson, associate Non-Executive Director**	**Key Members not present:**	**David Hanley – Non-Executive Director**
Board Assurance Risks Aligned to Committee:	**No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.**		

Key Agenda Items	RAG	Key Points	Action/Decision
Risk Owner Presentation : PES		• Director of Operations presented the revised service delivery governance structure and explained the escalation of risk process aligned to this new structure. • The structure took into account feedback given during the previous presentation during 2018-19 • The structure also aligned to the Chief Exec Accountability Reviews in terms of the business discussed	The Committee was supportive of the new structure and process and explained the need to now embed.
Clinical Audit Q2 progress report 2019/20 and final report 2018/19		• Three new local audits had been established during Q2, one has been completed and two have	The committee only took partial assurance from the report. Further detail required in future reports as to

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Chairs Assurance Report

		slipped. • Forty three clinical audit projects were registered with the clinical audit team during 2018/19 and fifteen local clinical audit activity projects were undertaken.	why audits not undertaken or why audits have slipped. Exec lead to ensure Q&P Committee have sight of this report prior to Audit Committee.
Limited Assurance Reports Since the Last Meeting - Staff Responders Review Report 2019/20.		• Director of Operations attended to explain actions being taken to address the 3 high risk & 3 medium risk recommendations	An update to be presented to a future meeting of the Audit Committee
Critical and High Risk Recommendations Overdue: Serious Incidents 2017-18		• The Head of Safety & Patient Experience attended to update the Committee on progress against outstanding recommendations • An explanation was given on the purpose and work of the Review of Serious Events Group (ROSE) and how that Group reported assurance to the Quality & Performance Committee. • The learning loop from any incidents was closed via the Learning Forum. • A re-audit to be carried out in December 2019.	Implementation will be reported to the committee through the existing tracking process
Internal Audit Progress Report Q2 2019/20		The Committee received the update report from MIAA with the following highlighted: • Staff Responders – Limited Assurance (considered as separate item earlier on agenda) • Conflicts of Interest – Fully compliant in 2 areas, partially	

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		compliant in 3 areas • Quality Accounts – Substantial Assurance • Charitable Funds – High Assurance	
Anti-Fraud Service Progress Report Q2 2019/20		• 10 active investigations, 2 of which pending closure • 7 Anti-Fraud, Bribery and Corruption Awareness presentations to 71 members of staff delivered	
External Audit		1. The DHSC group accounting manual (GAM) 2019-2020 –main changes from the 2018/2019 version were: • The adoption of IFRIC23 which now applies in full • The inclusion of more information to confirm the deferral of IFRS16 • Additional detail around the treatment of investment property 2. The National Audit Committee (NAO) consulting on the draft text of the new Code of Audit Practice which would replace the previous version dated April 2015. Due to come into force no later than 1 April 2020.	Finance team will review the changes to the DHSC GAM from the previous version and discuss queries with external auditors ahead of the year-end. This is part of the usual liaison with the auditors.
Board Assurance Framework Q2 2019/20		• Further work had been done on SR01 to rearticulate the risk and the controls and assurances listed had been edited.	

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Chairs Assurance Report

		• The Committee members considered the report within the context of their role as Audit Committee and recognised the improvements made over the past two years.	
Losses & Compensation		• Losses and Compensations register as at 30th September 2019 totalled £494k for year to date.	The Committee requested that the next report contain more information about the top 10 value cases.
Legal Services Q2 2019/20		• 216 new HM Coroner's inquests: • 5 contentious (C) • 197 non-contentious (NC) • 14 potentially contentious (PC). • No findings of neglect • 21 new claims of which: • 9 Clinical Negligence claims (CN) • 8 Employer's Liability claims (EL) • 4 Public Liability claims (PL). • 241 SAR requests (up to 2 September 2019) • 23 requests for calls/records relating to care proceedings Committee's attention was drawn to the receipt of 4x Reg28 reports during the period which was highly unusual – the Trust normally only receives one or two per annum. All these inquests were instructed out and handled by a panel firm. The Director of Corporate Affairs has requested that the external firm review the handling of the cases to identify any learning.	Comparative previous year data to be included in future reports (provided separately outside the meeting)
FT Code of Governance		A summary of the Trust's corporate	

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Declaration Update		governance arrangements against the FT Code was provided for assurance and it was confirmed the Trust was able to declare compliance with all relevant clauses with the exception of clause D.1.4 which was partially compliant. Full compliance with this clause would not be possible given it would require retrospective application; however, it was applicable for all new Director contracts. This declaration would be included within the Annual Report & Accounts for the year.	
Waiver of Standing Orders Q2 2019/20		• 10 waivers had been received during Q2. • The Audit Committee Chair asked for further details on Waiver No 25/1920 which had been provided outside the meeting and shared with the Committee members.	Future reports to only include current quarter figures.
Review of meeting effectiveness		The meeting was considered to have been effective.	Risk owner presentations to continue Noted that wi-fi worked effectively- this was an improvement Mod Gov training to be provided

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Chairs Assurance Report

NHS North West Ambulance Service NHS Trust

Name of Committee/Group:	Resources Committee	**Report to:**	Board of Directors
Date of Meeting:	22.11.19	**Quorate (yes/no):**	Yes
Chair:	Mr M O'Connor	**Executive Lead:**	Carolyn Wood, Director of Finance Lisa Ward, Interim Director of Organisational Development Ms M Power, Director of Quality, Innovation and Improvement
Members present:	Mr M O'Connor, Non-Executive Director (Chair) Mr R Groome, Non-Executive Director Mr D Rawsthorn, Non-Executive Director Ms C Wade, Associate Non-Executive Director Ms C Wood, Director of Finance Ms L Ward, Interim Director of Organisational Development Prof M Power, Director of Quality, Innovation and Improvement Mr S Desai, Director of Strategy and Planning	**Key Members not present:**	Mr G Blezard, Director of Operations
Board Assurance Risks Aligned to Committee:	**SR02:** If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective. **SR04:** If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives. **SR05:** If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives.		

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	SR07: If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity**.**

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		• Zero risks had emerged, increased in score or decreased in score. • One risk has closed – 2221 'Trust unable to afford the additional car parking at Estuary Point'.	• Noted and received assurance from the update
CQC Inspection Update		• Both of the CQC should do recommendations pertaining to this committee had now been closed.	• Noted and received assurance from the update. • Welcomed future updates.
Digital Strategy Update		• Update received in relation to progress of delivery of the Digital Strategy. • Progress has been made to re license the SQL servers. Full business case to be presented in January 2020. • Full business case for office 365 to be presented in January 2020. • Progress is being made in relation to asset management. • DPST and ICO audits have now been completed. • Lightfoot system is now live. • EPR pilot due to start in February 2020. • The Patient Information Portal project has been re scoped. • Unified Communication Programme is making good progress.	• Noted and received assurance from the update. • Welcomed future updates. • Recognised the progress that has been made in relation to the Digital Strategy.

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MIAA Cyber Security Review		• NWAS ICT Cyber Security is in a reasonable position having obtained cyber essentials basic. • Some core areas are in need of attention in order to progress to cyber essential plus certification.	• Noted and received assurance from the update. • Welcomed future updates.
Financial Performance – Month 7		• The position for the Trust at Month 7 is a surplus of £1.133m, which is £0.103m better than the planned surplus of £1.030m. Income is over recovered by £1.903m, pay is overspent by £2.221m and non-pay is underspent by £0.421m. • The Trust continues to forecast delivery of the notified financial control total of £2.708m surplus. • The overall financial performance risk rating at 31st October 2019 is 1, in line with plan.	• Noted and received assurance from the update • Welcomed future updates.
Agency performance against ceiling		• The agency ceiling for 2019/20 is £3.109m and the year to date ceiling, as at the end of October, is £1.814m. The actual expenditure year to date is £1.007m, therefore the Trust is currently £0.807m below the agency ceiling. • In relation to the agency price cap, wage cap and approved supplier framework rules the trust has reported no breaches during 2019/20 on the monitoring returns which are submitted through to NHS Improvement/NHS England (NHSI/E)	• Noted and received assurance from the update. • Welcomed future updates.
CIP Progress Report – Month 7		• As at the 31 October 2019 (Month 7): • Year-to-date savings total £5.106m compared to the year-to-date plan of £4.594m, therefore £0.513m ahead of plan. • In relation to achieving the in-year target there has been an improvement of £3.815m in the forecast position compared to the opening plans, reducing the in-year gap from £5.777m down to £1.962m.	• Noted and received assurance from the update. • Welcomed future updates.

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		• Recurrent schemes are forecast to total £5.926m resulting in a recurrent gap of £1.957m against plan.	
Estates Update		• In terms of vehicle servicing and inspections, the Trust has achieved it target of 75% completion of planned maintenance. • The target to achieve 100% MOT tests has been achieved each month. • Each PES & PTS vehicle is scheduled to have a deep clean every 6 weeks +/- 7 days with a Trust agreed target of 85% completion. In August & September this year the Trust did not achieve target due to the operational need to maximize vehicle availability. • In terms of assurance, the Trust has a constant level of reportable accidents across the Trust, with both the frequency rate and average costs per claim below the average for ambulance trusts. The highest area of reportable accidents comes from hitting immobile property. • The Trust aims to achieve and maintain a 7 year replacement cycle of the PES Ambulance fleet. • A Sustainability Steering Group is in the process of being established to drive forward the SDMP's strategy in the aim of improving Trust performance towards target achievements. • Compliance within the estate is monitored and reviewed using a Statutory Compliance Audit Tool. • The Trust is actively involved and a key ambulance lead, with both the NHSI ERIC and NHSI Ambulance teams to develop ERIC and the model ambulance.	• Noted and received assurance from the update. • Welcomed future updates.
CQUIN Quarter 2 Update		• The total income earnable for the 2019/20 financial year is £4.017m. In relation to Quarter 1 and 2, progress reports have been submitted to the commissioners to demonstrate	• Noted and received assurance from the update • Welcomed future updates.

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

		the progress for the quarterly payments, and have been earned in full	
PES, PTS & RRV Vehicle Replacement Programme 2020/21		• Operations appraisal was presented to members.	• Recommendation to the Board of Directors for approval.
Long Term Plan Submission		• The Trust's final version of the LTP was submitted via L&SC ICS on the 15th November. • The following changes have been made to the LTP financial submission:- • Reduction in the financial control totals over the period, to an annual breakeven position, based on the letter received from NHSI/E on the 4th October 2019. • Increase in income and expenditure in relation to Mental Health investment included in the CCG baseline allocations that is to be invested in Mental Health within the ambulance sector. • Inclusion of Agenda for Change cost pressure for 2020/21 which is above the 2.9% guidance for pay inflation	• Noted and received assurance from the update. • Welcomed future updates.
Key Workforce Indicators		• Appraisal completion rates have remained stable at 83% overall with PES rates at 82% for 2 months running. This is impacted by 111 at 69%. PTS rates have shown a slight decrease to 87% following the previous improvement. • 2019 classroom training for PES is under trajectory at 92% against a target of 95% and PTS have achieved their classroom mandatory training target early and currently stand at 96% compliance. • Sickness has seen a slight decrease which overall is at 5.86% for September 19 • The vacancy position remains strong from frontline services and on track with workforce plans	• Noted and received assurance from the update. • Welcomed future updates. •

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

		• In terms of flu, at 8/11/19 frontline vaccination rates were 41% which is about 5% higher than the same period last year. • Apprentice progress is good as achievement rates are at 87% compared with a national average of 62%.	

Staff Survey Update and Health and Wellbeing Update		• The 2018 Staff Survey identified key areas of improvement around:
		  • Bullying and harassment;
		  • Leadership
		  • Organisational learning
		• Members received assurance that high level action plans are in place for each of the themes. In addition, they link to the Right Care Strategy and Workforce Strategy.
		• Work in relation to local people plans was being carried out.
		• Current staff survey response rate is 38.5%.
		• Use of therapy dogs is having a very positive impact amongst staff.
			• Noted and received assurance from the update.
			• Welcomed future updates.

Paramedic Upskilling		• The Trust met all milestones for 2018/19. • The 30th September 2019 milestone is for (i) Training plan implementation on track; (ii) all paramedic training requirements planned; and (iii) at least 80% of all identified training completed. • All of these milestones have been met with the milestone for delivery of identified training being met in July, with September compliance being 88%.	• Noted and received assurance from the update. • Welcomed future updates.

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

Chairs Assurance Report

Appraisal Assurance Report		• The appraisal compliance rate for the Trust at September 2019 is 83% against the agreed target of 95%. The key areas of challenge are in EOC, 111, PES Trust-wide and PES C&M. • Service lines were being held to account via the CEO Accountability Review.	• Noted and received assurance from the update. • Welcomed future updates.
Payroll Update		• Cumulative payroll performance year to date is 99.39% accuracy against a planned position of 99.5%. The position YTD shows that there have been 226 errors made by the Trust against 19 made by ELFS. • 247 errors made in terms of overpayments. • Work is ongoing to seek to identify the root cause of these issues and to improve the present position. • In March 2019 a review of the Electronic Staffing Records (ESR) was undertaken, providing substantial assurance. • In July 2019, the Trust had run the Pensions re-enrolment process. Learning had been identified and will be used to plan for the 2022 re-enrolment.	• Noted and received assurance from the update. • Welcomed future updates.

Workforce Strategy Progress Report		• Key areas of work have already been completed. Significant changes have been made to the approach to online mandatory training, over 300 EMT1s are on a progression route to Paramedic and our first fully electronic apprenticeship cohorts have been launched. • There has been a number of large scale projects being supported by the directorate including the rota review, review of the Partnership Agreement and the development of rotational working.	• Noted and received assurance from the update. • Welcomed future updates.

	No assurance – could have a significant impact on quality, operational or financial performance;
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		• Overall the part year measures show positive indicators of progress with mandatory training, apprenticeships achievement, WRES scores, retention and the recent positive Ofsted outcome showing good progress	
Carter Review Update		• Of the 50 actions overall, 26 actions sit specifically with NWAS and leads have been assigned to the actions. • NWAS has successfully completed 12 of the 26 actions from the action plan and tracker, with work ongoing on the remaining 14.	• Noted and received assurance from the update. • Welcomed future updates.
Integrated Business Plan Update		• During quarter 2, there were a total of 93 objectives. 4 had been completed, 3 were off plan, 8 were slightly behind plan, 66 were on track and 12 had not commenced.	• Noted and received assurance from the update. • Welcomed future updates.
Chairs Assurance Report from the Information Management Group held on 8th October 2019		• Received the assurance report from the Information Management Group held on 8th October 2019	• Noted and received assurance from the update. • Welcomed future updates.

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

North West Ambulance Service NHS Trust

REPORT

Board of Directors					
Date:	27th November 2019				
Subject:	Charitable Funds Annual Accounts 2018/19				
Presented by:	Carolyn Wood, Director of Finance				
Purpose of Paper:	For Decision				
Executive Summary:	The purpose of this paper is to present the audited Charitable Funds Annual Report and Accounts for 2018/19 to the Board of Directors for approval and adoption. These are attached at Appendix 1. Main points for noting: - Income amounted to £79k - Total expenditure was £179k, where main element was the planned purchase of medical equipment. - Overall funds have decreased by £100k				
Recommendations, decisions or actions sought:	The Board of Directors is asked to: - Approve and adopt the Charitable Funds Annual Report Annual Accounts for 2018/19.				
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☒	
	Right Place	☐	**Every Time**	☐	

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☐	☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**None**
Previously Submitted to:	**Charitable Funds Committee**
Date:	**30th October 2019**
Outcome:	**Recommended for approval**

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1. PURPOSE

The purpose of this paper is to present the audited Charitable Funds Annual Report and Accounts 2018/19 to the Board of Directors. These are attached at Appendix 1 and 2.

2. BACKGROUND

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

The attached Annual Report and Accounts were audited by the external auditors KPMG LLP. The audit was undertaken in August 2019.

The Charitable Funds Committee has reviewed the Accounts and Annual Report, Letter of Representation and Statement of Trustees Responsibilities for 2018/19 and is recommending it for approval. The deadline for submission of the Annual Report and Accounts to the Charity Commission is the 31st January 2020.

There are following appendices attached to this report:

Appendix 1 – Annual Accounts 2018/19

Appendix 2 – Annual Report 2018/19

Appendix 3 – Independent Auditors Report

Appendix 4 – Audit Highlights

Appendix 5 – Letter of Representation

Appendix 6 – Statement of Trustees Responsibilities

Appendix 7 – Letter of Independence

4. SUMMARY OF FINANCIAL PERFORMANCE

In summary the income of the charitable funds in 2018/19 amounted to £79k, out of which £32k was for unrestricted funds and the remaining £47k was for restricted funds.

Expenditure in 2018/19 amounted to £179k of which £60k was from unrestricted funds and £119k from restricted funds.

The overall available resource in 2018/19 has decreased by £100k where unrestricted funds decreased by £28k and restricted funds decreased by £72k.The largest element of expenditure was planned purchase of medical equipment, mainly defibrillators in line with donors wishes.

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

5. AUDIT

The audit of the Charitable Funds accounts for 2018/19 was undertaken by the external auditors KPMG in August 2019. An unqualified audit opinion was given to the accounts.

6. LEGAL and/or GOVERNANCE IMPLICATIONS

The are no legal and/or governance implications associated with this paper.

7. RECOMMENDATIONS

The Board of Directors is asked to approve and adopt the Annual Accounts 2018/19.

Appendix 3

CHARITABLE TRUST ACCOUNT - NORTH WEST AMBULANCE SERVICE NHS TRUST

Data entered below will be used throughout the workbook:

This year	2018-19
Last year	2017-19
This year ended	2019
Last year ended	2018
This year beginning	1 April 2018
This year name	31 March 2019
Last year name	31 March 2018

North West Ambulance Service NHS Trust Charitable Fund
Statement of Financial Activities and Income & Expenditure for the 12 months ended 31 March 2019

	Note	Unrestricted Funds £000	Restricted Funds £000	**12 months to 31 March 2019 Total Funds £000**	12 months to 31 March 2018 Total Funds £000
Income and Endowments					
Donation and Legacies	3	32	47	**79**	196
Total Income and Endowments		32	47 -	**79**	196
Expenditure					
Raising Funds	4	3	14	**17**	6
Expenditure on Charitable Activities	5, 6	57	105	**162**	102
		-	-	**-**	
Total Expenditure		60	119	**179**	108
Net Income/(Expenditure)		(28)	(72)	**(100)**	88
Net Movement in funds		(28)	(72)	**(100)**	88
Reconciliation of Funds					
Total Funds brought forward 1 April 2018		158	424	**582**	494
Total Funds carried forward 31 March 2019		130	352	**482**	582

North West Ambulance Service NHS Trust Charitable Fund
Balance Sheet as at 31 March 2019

	Notes	Unrestricted Funds	Restricted Funds	**Total Funds 31 March 2019**	Total Funds 31 March 2018
		£000	£000	**£000**	£000
Current Assets:					
Stock	8	-	2	**2**	2
Cash at bank and in hand		135	354	**489**	585
Total Current Assets		135	356	**491**	587
Creditors: Amounts falling due within one year	9	(5)	(4)	**(9)**	(5)
Net Current Assets		130	352	**482**	582
Total Assets less Current Liabilities		130	352	**482**	582
Total Net Assets		130	352	**482**	582
Funds of the Charity					
Restricted income funds	10		352	**352**	424
Unrestricted income funds		130		**130**	158
Total Charity Funds		130	352	**482**	582

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) issued on 16 July 2014 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 trustees consider that there are no material uncertainties about the Trust's ability to continue as a going concern.

(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 statutory audit 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 2019.

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 2019.

(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 2018/19 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 2019 Total £000**	12 months to 31 March 2018 Total £000
Donations from individuals and organisations	28	47	**75**	167
Legacies - General fund	4	-	**4**	29
	32	47	**79**	196

4 Expenditure on raising funds

	Unrestricted Funds	Restricted Funds	12 Months to 31 March 2019	12 Months to 31 March 2018
	£,000	£,000	Total	Total
Seeking donations	3	14	**17**	6
Total Expenditure on raising funds	**3**	**14**	**17**	**6**

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.

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 2019 Total £000	Allocated To Charitable Activities £000	Allocated to Governance £000	12 months to 31 March 2018 £000
Auditor's Remuneration	**4**		4	4
Administration	**28**	28		
Total	**32**	28	4	4

Auditor's remuneration costs are apportioned by prorata to total expenditure.

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 £000	Support Costs £000	**12 months to 31 March 2019 Total £000**	12 months to 31 March 2018 £000
Staff Education and Welfare	12	3	**15**	33
Purchase of New Equipment	117	29	**146**	60
Patient Education and Welfare	1	0	**1**	5
Total	130	32	**162**	**98**

7 Auditor's Remuneration

	12 months to 31 March 2019 Total £000	12 months to 31 March 2018 Total £000
Audit Remuneration	4	4
Total Cost	**4**	**4**

8 Analysis of current assets

(a) Stocks

	12 months to 31 March 2019 Total £000	12 months to 31 March 2018 £000
Raw materials and consumables	2	3
	2	3

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 2019 Total £000	12 months to 31 March 2018 £000
National Westminster Deposit Account	489	585
Total	**489**	585

9 Analysis of current liabilities and long term creditors

Creditors under 1 year

	31 March 2019 Total £000	31 March 2018 Total £000
Other creditors	**5**	5
Total	**5**	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

Type of Funds	**Balance 31 March 2019 c/fwd £000**	Balance 1 April 2018 b/fwd £000
Unrestricted - General Purpose Funds	**130**	158
Restricted - Designated Funds	**274**	338
Restricted - Other Funds	**78**	86
	482	582

(a) Restricted funds

	Balance 1 April 2018 b/fwd £000	Resources expended £000	Incoming resources £000	**Balance 31 March 2019 c/fwd £000**
Mayor of Wigan	18	(9)	0	9
First Responders Community Fund	1	0	0	1
Greater Mancheste First Responders	41	0	0	41
Lancashire First Responders	25	(1)	2	26
Legacy	230	(1)	3	232
Cardiac Smart	109	(108)	42	43
Grand Total	424	(119)	47	**352**

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.
Legacy Funds	The legacy 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 2019 £000	31 March 2018 £000
Nelson Ambulance Station	1	1
Cumbria- Penrith area	5	5
Cumbria area- for purchase of new equipment	65	65
Cumbria Ambulance Service	25	25
Runcorn Ambulance Station	133	133
Sedbergh Station	1	1
Flimby	1	
Warrington	1	
	232	230

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 2018 b/fwd £000	Resources expended £000	Incoming resources £000	**Balance 31 March 2019 c/fwd £000**
Unrestricted- General Purpose Funds	158	(60)	32	**130**
	158	(60)	32	130

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

Trustee's Annual Report &

Annual Accounts

For the Year to 31st March 2019

Registered Charity No. 1122470

Contents

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

Auditors:
KPMG
1 St Peter's Square
Manchester
M2 3AE

Foreword

The Corporate Trustee presents the Charitable Funds Report together with the Annual Accounts for the 12 months ended 31 March 2019. 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 (formerly the Trust Development Authority) 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:

Wyn Dignan	Chair (until 31/1/2019)
Peter White	Chair (from 1/2/2019)
	Non-Executive Director (until 31/1/2019)
Derek Cartwright	Chief Executive (until 30/6/2018)
Michael Forrest	Interim Chief Executive (from 1/7/2018)
	Director of Organisational Development (to 30/6/2018)
Tracy Ellery	Director of Finance (until 31/1/2019)
Michelle Brooks	Interim Director of Finance (from 1/2/2019)
David Ratcliffe	Medical Director
Ged Blezard	Director of Operations
Angela Wetton	Director of Corporate Affairs
Salman Desai	Director of Strategy & Planning
Maxine Power	Director Quality, Innovation & Improvement
Lisa Ward	Interim Director of Organisational Development (from 1/7/2018)
Michael O'Connor	Non-Executive Director
Mark Tattersall	Non-Executive Director (until 28/2/2019)
Richard Groome	Non-Executive Director
Maria Ahmed	Non-Executive Director

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 2019 were as follows:

Mark Tattersall	Non-Executive Director (Chair)
Richard Groome	Non-Executive Director
Tracey Ellery	Director of Finance
Michelle Brooks	Interim Director of Finance
Ged Blezard	Director of Operations

Angela Wetton	Director of Corporate Affairs
Salman Desai	Director of Strategy and Planning
Michael Forrest	Director of Organisational Development
Lisa Ward	Interim Director of Organisational Development

The Head of Technical Accounts and Charity Development Manager attended the meetings along with Independent auditors.

SCHEME OF DELEGATION

For the period up to the 31st March 2019 the Trust Scheme of Delegation and level of authorised expenditure is detailed below in table 1.

Table 1, Scheme of Delegation to 31 March 2019:

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 / 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 2019 the charity comprises of 8 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. Cardiac Smart Fund (regional)
7. 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:

- Maximising income to the Charitable Trust
- Supporting improvements in patient experience and engagement
- Provision of equipment for diagnosis and treatment outside of mandatory trust provision
- Supporting staff development and wellbeing
- Funding and provision of educational materials for schools

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 31"March 2019 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 2018-2019

The net assets of the Charitable Funds as of 31 March 2019 are £482k.

Overall net assets decreased by £100k being the excess of expenditure £179k over income £79k.

The general fund has received £32k in income, while restricted funds income came to £47k. (£79k total)

Total expenditure of £179k was spent as following:

- £132k was spent on direct charitable activity
- £30k spent on support costs
- £17k fund raising costs.

Direct charitable activity expenditure included:

- Purchase of new equipment £120k mainly defibrillators
- Staff Education and Welfare £11k
- Patient Education and welfare £1K

Projects Supported 2018-2019

The Charity continues to support and fund many projects authorised in line with the Scheme of Delegation. Projects supported during 2018/2019 included:

- 6,000 Rockwood Frailty cards for all operational trust personnel
- ALSi training equipment (Advanced Life Saving)
- c.120 AEDs & CPADs
- 4 Community Public Access Defibrillators placed in Decommissioned Telephone Boxes
- 24 Wooden trestle tables for the NWAS Museum
- 20 Foldable tables for NWAS CFR groups
- 400 Infrared thermometers for CFRs
- 400 Blood pressure monitors for CFRs
- £1,000 investment for 999ReUnite Tri-service dementia pilot scheme
- 5,000 NHS 50 Celebration cupcakes

- Advanced airway training mannequin
- Charity promotional items and collection tins/buckets
- CFR uniforms
- Chain of survival leaflets
- Social evening following a donation after a successful cardiac ROSC
- Cardiac Smart heart pin badges
- Training defibrillator for Patient Experience Team
- Charity Rugby trophy and medals
- CPD event catering

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

- 45 retirements with a combined service length of 1,405 years (average service of 31.2 years)
- 5 babies
- 5 bereavements/death in service

In more detail:

6,000 Rockwood Frailty Score cards for all operational trust personnel

Frailty is a common geriatric syndrome that embodies an elevated risk of catastrophic declines in health and function among older adults. The Rockwood Frailty score presented in these printed cards allows for quick identification of frailty in a patient based on patient assessment to enable greater care or appropriate pathways.

ALSi Training equipment (Advanced Life Saving)

ALSi allows Advance Patient Care Simulations and scenario based education to be delivered quickly, easily and intuitively. It is a hyper-flexible patient monitor simulator which uses 2 iPads connected wirelessly. The system includes an AED, sophisticated multi-parameter patient monitor and defibrillator can all be simulated using the touch screen of an iPad. It gives a greater depth to learning, ability to practice conditions or scenarios either encountered regularly, or more important rare occurrences.

AEDs & CPADs

The charity provided funding in total for the provision of c.120 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.

4 CPADS placed in Decommissioned Telephone Boxes

Alongside the defibrillators that we have placed in 2018-2019, the charity has also funded the supply and installation of 4 Community Public Access Defibrillators (CPADs) within decommissioned BT telephone boxes in more rural and remote areas in Cumbria. These boxes have been adopted by the local community and provide a recognisable and all weather placement for the CPADs in lieu of the more traditional locating methods.

Dementia Sufferers Safeguarding Pilot Scheme

The charity is supporting a tri-emergency service Dementia project in Blackpool, Wyre and Fylde where registered sufferers are issued with an NFC (Near Field Communication) chipped silicone wristband that displays a contact number and reference when presented to an NFC enabled Smartphone. This contact number might be a family member or care home and alleviates the need to call the emergency services when a person in distress or confusion is found either by the emergency services, council employees or a member of the public. All data is safeguarded and held by Lancashire Police.

Future Plans

A period of reflection and discussion will take place within the trust as to the best future for the charity.

A forward strategy for the charity does exist.

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 2018-2019 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 ……

Daren Mochrie

Chief Executive – North West Ambulance Service NHS Trust (From April 2019)

Independent auditor's report to the Trustees of North West Ambulance Service NHS Charitable Fund

Opinion

We have audited the financial statements of North West Ambulance Service NHS Charitable Fund ("the charity") for the year ended 31 March 2019 which comprise the statement of Financial Activities, the Balance Sheet and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2019 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*; and
- have been properly prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 149 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the charity in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

The impact of uncertainties due to the UK exiting the European Union on our audit

Uncertainties related to the effects of Brexit are relevant to understanding our audit of the financial statements. All audits assess and challenge the reasonableness of estimates made by the trustees, such as the valuation of investment properties and related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the group's future prospects and performance.

Brexit is one of the most significant economic events for the UK, and at the date of this report its effects are subject to unprecedented levels of uncertainty of outcomes, with the full range of possible effects unknown. We applied a standardised firm-wide approach in response to that uncertainty when assessing the charity's future prospects and performance. However, no audit should be expected to predict the unknowable factors or all possible future implications for a charity and this is particularly the case in relation to Brexit.

Going concern

The trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its

ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the trustees' conclusions, we considered the inherent risks to the charity's business model, including the impact of Brexit, and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the charity will continue in operation.

Other information

The trustees are responsible for the other information, which comprises the Trustees' Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

Trustees' responsibilities

As explained more fully in their statement set out on page [*number*], the trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the charity's trustees as a body, in accordance with section 149 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Timothy Cutler
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

Date:……..

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

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North West Ambulance Service NHS Trust Charitable Fund

Audit highlights memorandum (ISA260 report) for the year ended 31 March 2019

October 2019

Contents

Our objective is to use our knowledge of the Charity, gained during our routine audit work, to make useful comments and suggestions for you to consider. However, you will appreciate that our routine audit work is designed to enable us to form opinions on the Charity's financial statements and it should not be relied upon to disclose all irregularities that may exist, nor to disclose errors that are not material to the financial statements and contributions.

This report is made solely to the Corporate Trustee of North West Ambulance Service NHS Trust Charitable Fund ('the Charity]'), in accordance with the terms of our engagement. It has been released to the Corporate Trustee on the basis that this report shall not be copied, referred to or disclosed, in whole (save for the Corporate Trustee's own internal purposes) or in part, without our prior written consent. Matters coming to our attention during our audit work have been considered so that we might state to the Corporate Trustee those matters we are required to state to the Corporate Trustee in this report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and its Corporate Trustee, for our work referable to this report, for this report, or for the opinions we have formed.

Please note that that this report is confidential between the Corporate Trustee and this firm. Any disclosure of this report beyond what is permitted above will prejudice this firm's commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If the Corporate Trustee receive a request for disclosure of this report under the Freedom of Information Act 2000, having regard to these actionable disclosure restrictions you must let us know and you must not make a disclosure in response to any such request without our prior written consent.

Summary

The purpose of this memorandum is to set out the significant issues that came to our attention during the course of the audit of North West Ambulance Service NHS Trust Charitable Fund for the year ended 31 March 2019.

Audit conclusions	
✓	We propose an unqualified audit opinion on the financial statements.
Accounting matters	
✓	No significant accounting issues arose during the course of our audit.
✓	The financial statements adopted appropriate accounting policies and are in accordance with disclosure requirements of relevant charities legislation, UK GAAP (FRS 102) and the Statement of Recommended Practice.
Auditing matters	
✓	No significant audit issues arose during the course of our audit.
Systems and controls	
✓	We identified no major weaknesses in the financial systems or controls in the current year.
Regulatory and tax matters	
✓	No significant regulatory or tax matters came to our attention during the course of our normal audit work.

Audit approach and findings

Overview of our audit approach

We adopt a risk based audit approach where we identify the key risks affecting North West Ambulance Service NHS Trust Charitable Fund based on our experience of the sector and our audit planning meetings with North West Ambulance Service NHS Trust Charitable Fund management and the Corporate Trustee.

Audit materiality limits

In accordance with auditing standard ISA 320 "Audit Materiality", we plan and perform our audit to be able to provide reasonable assurance that the financial statements are free of material misstatement and give a true and fair view. The assessment of what is material is a matter of professional judgment and includes consideration of both the amount (quantity) and nature (quality) of misstatements.

The level of materiality for the 2018/19 audit was £3,600 (2017/18; £2,000).

Audit materiality is both a quantitative and qualitative measure and the above figure is a guide only. The overriding objective is to preserve the true and fair view presented by the financial statements and we will consider any audit differences, individually and cumulatively, in that context.

We will report all uncorrected misstatements, other than those that we consider clearly trivial, to the Charitable Funds Committee in accordance with the requirements of ISA 260. In this respect we will accumulate differences that exceed our indicative posting threshold of £170 (2017/18 £100).

Your audit team

Your audit team has been drawn from our specialist public sector assurance department. It is the same team that is responsible for delivering the Trust's statutory audit.

Audit fee

Our audit fee this year is £3,700 (2017/18; £3,700) excluding VAT.

Audit approach and findings

We highlight significant findings in respect of the risks and other areas of focus for our audit identified in our discussion with you at the audit planning and strategy stage. We have dealt with them as set out in the right hand column.

Significant risks		Audit area	Proposed work	Our findings from the audit
Significant risk area required by ISA's	Fraud Risk from Revenue Recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.	For North West Ambulance Service Charitable Trust Account, we do not consider the fraud risk from revenue recognition to be a significant audit opinion risk as there is no management incentive.	Since we rebutted this presumed risk, there was no impact on our audit work and there are no matters arising that we need to bring to your attention.
Significant risk area required by ISA's	**Fraud risk from management override of controls**	Professional standards require us to communicate the fraud risk from management override of controls as significant. This is because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	We have considered management override of controls as a significant fraud risk. We have not identified any specific risk factors that increase the risk of management override. We will carry out specific testing over journals, judgements & estimates, and any significant or unusual transactions.	In line with our methodology, we carried out appropriate controls testing over journals and substantive procedures. There were no significant judgements or estimates. There were no significant transactions outside the normal course of business. We also considered the appropriateness of any related party transactions and their disclosure within the Charity financial statements. There are no matters arising from this work that we need to bring to your attention.

Appendices

1. Mandatory communications
2. Summary of audit differences
3. Auditor independence

Mandatory communications

We set out below details of the required communications to the Corporate Trustee.

Other information in documents containing audited financial statements	Our responsibility for other information in the Charity's Annual Report and Financial Statements does not extend beyond the financial information identified in our auditors' report. We have no obligation to perform any procedures to corroborate other information contained in those documents. However, prior to approval and signing we will continue to read the other information included in the Trustee's Report, and confirm that the information given, and the manner of its presentation, is materially consistent with the information, and its manner of presentation, with the consolidated financial statements.
Disagreement with management	There have been no disagreements with management on financial accounting and reporting matters that, if not satisfactorily resolved, would have caused a modification of our auditor's report on the financial statements.
Consultation with other accountants	To the best of our knowledge, management has not consulted with or obtained opinions, written or oral, from other independent accountants during the past year that were subject to the requirements of Statement 1.213 of the Institute of Chartered Accountants in England and Wales Guide of Professional Ethics.
Difficulties encountered in performing the audit	We encountered no difficulties in performing the audit.
Material written communications	In accordance with the communication requirements of International Standard on Auditing (UK and Ireland) 260, we provide the following written communications to the Trustee for their meeting on the 31 October 2019. — Report to the Charitable Funds Committee – This is the main body of this report; and — KPMG Independence communication – Appendix 3 to this report.
Management Representations	In accordance with ISA 580 *Written representations,* we request written representations from those charged with governance. Written representations are necessary information we require in connection with the audit. The draft written representations will be provided within the papers for the meeting on 31 October 2019.
Audit misstatements	Under the requirements of ISA 260 *Communication of audit matters with those charged with governance*, we are required to report any adjusted audit misstatements arising from our work. There has been no adjusted audit misstatements. This has been reported in Appendix 2. We are also required to report any unadjusted audit misstatements, other than those that are 'clearly trivial' (if there are any) to the Trustees. There have been no unadjusted audit misstatements. This has been reported in Appendix 2.

Summary of audit differences

Summary of uncorrected audit differences

We are required by ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance to communicate to the Committee all uncorrected misstatements, other than those that we believe are clearly trivial.

We are pleased to report that we have identified no uncorrected audit misstatements.

Summary of corrected audit differences

Under UK auditing standards (ISA UK and Ireland 260) we are required to provide the Committee with a summary of corrected audit differences identified during the course of our to assist the Committee in fulfilling its governance responsibilities.

We are pleased to report that there were no material or non material audit differences in the financial statements, other than presentational changes within the allocation and classification of expenses within the note 6.

Auditor independence

To the Charitable Fund Committee members,

Assessment of our objectivity and independence as auditor of North West Ambulance Service NHS Trust Charitable Funds (the Charity)

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

The conclusion of the audit engagement partner as to our compliance with the FRC Ethical Standard in relation to this audit engagement is subject to review by an engagement quality control reviewer, who is a partner not otherwise involved in your affairs.

We are satisfied that our general procedures support our independence and objectivity.

Summary of fees

We have considered the fees charged by us to the charity and its affiliates for professional services provided by us during the reporting period. We have detailed the fees charged by us to the charity and its related entities for significant professional services provided by us during the reporting period in the attached appendix, as well as the amounts of any future services which have been contracted or where a written proposal has been submitted. Total fees charged by us for the period ended 31 March 2019 can be analysed as follows:

	Current Year Continuing	Prior Year
	£	£
Fee for Charity	3,700	3,700
Total Fees	3,700	3,700

Independence and objectivity considerations relating to other matters

There are no other matters that, in our professional judgment, bear on our independence which need to be disclosed to the Charitable Fund Committee.

Auditor independence

Other Considerations

We confirm that we have not used the work of external experts engaged by KPMG.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Charitable Fund Committee of the charity and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so

Yours sincerely

KPMG

The contacts at KPMG in connection with this report are:

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Our services:
Emergency and urgent care
Non-emergency patient transport
NHS 111

NHS
North West
Ambulance Service
NHS Trust

Headquarters
Ladybridge Hall
399 Chorley New Road
Bolton
BL1 5DD

Tel: 01204 498400

www.nwas.nhs.uk

Timothy Cutler- Partner
KPMG LLP
1 St Peter's Square
Manchester
M2 3AE

27 November 2019

Dear Tim

This representation letter is provided in connection with your audit of the financial statements of North West Ambulance Service NHS Trust Charitable Fund ("the Charity"), for the year ended 31 March 2019, for the purpose of expressing an opinion:

i. as to whether these financial statements give a true and fair view of the state of the Charity's affairs as at *year end* and of its surplus or deficit for the financial *year* then ended;
ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)); and
iii. whether the financial statements have been prepared in accordance with the Charities Act 2011.

These financial statements comprise the Balance Sheet, the Statement of Financial Activities, and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Trustees confirm that the Charity is exempt from the requirement to also prepare consolidated financial statements.

The Trustees confirm that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Trustees confirm that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

Financial statements

1. The Trustees have fulfilled their responsibilities, as set out in the terms of the audit engagement dated *20th July 2019*, for the preparation of financial statements that:

    i. give a true and fair view of the state of the Charity's affairs as at the end of its financial year and of its surplus or deficit for that financial year;

ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice ("UK GAAP") (including Charities SORP FRS 102: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102));; and
iii. have been prepared in accordance with the Charities Act 2011.

The financial statements have been prepared on a going concern basis.

The Board of Trustees confirm that the Charity meets the definition of a qualifying entity and meets the criteria for applying the disclosure exemptions with Financial Reporting Standard 102.

2. Measurement methods and significant assumptions used by the Trustees in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Trustees have provided you with:

   - access to all information of which they are aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Trustees for the purpose of the audit; and
   - unrestricted access to persons within the Charity from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Trustees confirm the following:

   i) The Trustees have disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

   ii) The Trustees have disclosed to you all information in relation to:

      a) Fraud or suspected fraud that it is aware of and that affects the Charity and involves:
         - management;
         - employees who have significant roles in internal control; or
         - others where the fraud could have a material effect on the financial statements; and
      b) allegations of fraud, or suspected fraud, affecting the Charity's financial statements communicated by employees, former employees, analysts, regulators or others.

   In respect of the above, the Trustees acknowledge their responsibility for such internal control as they determines necessary for the preparation of financial statements that are free from material

misstatement, whether due to fraud or error. In particular, the Trustees acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Trustees have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Trustees have disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Trustees have disclosed to you the identity of the Charity's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102 .

10. The Trustees confirm that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the charity's ability to continue as a going concern as required to provide a true and fair view.
    b) No events or circumstances have been identified that may cast significant doubt on the ability of the Charity to continue as a going concern.

This letter was tabled and agreed at the meeting of the Trustees on 27 November 2019.

Yours faithfully

…… 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

Appendix to the Trustees' Representation Letter of North West Ambulance Service NHs Trust Charitable Fund: Definitions

- The Charity discloses in the notes to its financial statements:
    - A brief narrative summary of the disclosure exemptions adopted; and
    - The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained]

Financial Statements

A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- a Balance Sheet as at the end of the period;
- a Statement of Financial Activities for the period; and
- notes, comprising a summary of significant accounting policies and other explanatory information.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to “management” should be read as “management and, where appropriate, those charged with governance”.

Qualifying Entity

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

Related Party and Related Party Transaction

Related party:

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the “reporting entity”).

a) A person or a close member of that person’s family is related to a reporting entity if that person:
    i. has control or joint control over the reporting entity;
    ii. has significant influence over the reporting entity; or
    iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions apply:
    i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
    ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
    iii. Both entities are joint ventures of the same third party.
    iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
    v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
    vi. The entity is controlled, or jointly controlled by a person identified in (a).
    vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
    viii. The entity, or any member of a group of which is is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

Related party transaction:

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

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Statement of Trustees' responsibilities in respect of the Trustees' annual report and the financial statements

Under the trust deed and charity law, the trustees are responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations. The trustees have elected to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*]

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed [and rules], subject to any material departures disclosed and explained in the financial statements;] and
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

The trustees are required to act in accordance with the trust deed [and the rules] of the charity, within the framework of trust law. They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the financial and other information included on the charity's website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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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Private & confidential
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BL1 5DD

Your ref

Our ref JL/TC/1819NWASCF

Contact Jerri Lewis
(0161) 618 7359
Jerri.Lewis@kpmg.co.uk

31 July 2019

To the Charitable Funds Committee members

Assessment of our objectivity and independence as auditor of North West Ambulance Service NHS Trust Charitable Funds (the Charity)

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical

Standard. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

The conclusion of the audit engagement partner as to our compliance with the FRC Ethical Standard in relation to this audit engagement is subject to review by an engagement quality control reviewer, who is a partner not otherwise involved in your affairs.

We are satisfied that our general procedures support our independence and objectivity.

Summary of fees

We have considered the fees charged by us to the charity and its affiliates for professional services provided by us during the reporting period. We have detailed the fees charged by us to the charity and its related entities for significant professional services provided by us during the reporting period in the attached appendix, as well as the amounts of any future services which have been contracted or where a written proposal has been submitted. Total fees charged by us for the period ended 31 March 2019 can be analysed as follows:

	Current Year Continuing £	Prior Year £
Fee for Charity	**3,700**	**3,700**
Total Fees	**3,700**	**3,700**

Independence and objectivity considerations relating to other matters

There are no other matters that, in our professional judgment, bear on our independence which need to be disclosed to the Charitable Funds Committee.

Other Considerations

We confirm that we have not used the work of external experts engaged by KPMG.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Charitable Funds Committee of the charity and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours sincerely

Timothy Cutler
Partner, KPMG LLP

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th November 2019
Subject:	Flu Update
Presented by:	Lisa Ward – Interim Director of Organisational Development
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of the paper is to provide assurance to the Board of Directors in relation to the progress of the 2019/20 Flu Campaign and how we plan to ensure that all of our frontline staff are offered the vaccine and achieve the highest possible level of vaccine coverage this winter. The Trust has submitted the first set of data on 4th November 19, the total number of Health Care Workers (HCW) involved with direct patient care was 38.7% at the time of submission which is ahead of the same period last year. Public Health England have issued a management checklist which they have requested that all Trusts assess themselves against, prior to submission to Board. This enables Boards to assure themselves that best practice plans are in place and also to reconfirm their commitment to the Flu vaccination campaign. The completed checklist is included at Appendix 1 and the report provides a summary of key plans. Board have already demonstrated visible leadership through their own vaccinations which have been publicised as part of the campaign. The Flu coordinator job role has been redefined this year to clarify responsibility and accountability, especially across those service lines without clinical vaccinators, PTS and 111. The Trust has 276 embedded peer vaccinators who are running flexible regular clinics which are publicised through an extensive communications campaign. There are also designated vaccinators in the training team to ensure that new starters are being fully covered. Vaccination rates are ahead of last year at this stage of the campaign. Data is being circulated weekly both to local managers and flu leads, celebrating the good progress being made but also with a focus on refusal rates. Communications are also being targeted to reasons for refusal to try to ensure

	that this is reduced compared with 2018 when refusal was at 26%. Current rates are 8%.			
Recommendations, decisions or actions sought:	The Board of Directors is asked to note the plans and progress for the 2019/20 Flu Campaign.			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09
☐	☐	☐	☒	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	The vaccination is egg based and this can impact on uptake from some religions. Such staff are advised to arrange for special vaccination via their GP and will still have access to the voucher incentive on proof of vaccination.
Previously Submitted to:	Resources Committee (have received papers assessing 2018 campaign and plans for 2019)
Date:	23rd April 2019 & 26th July 2019
Outcome:	Approved

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1. PURPOSE

1.1 The purpose of the paper is to provide assurance to the Board of Directors in relation to the progress of the 2019/20 Flu Campaign and how we plan to ensure that all of our frontline staff are offered the vaccine and achieve the highest possible level of vaccine coverage this winter.

2. BACKGROUND

2.1 The vaccination of healthcare workers against flu is key to protect patients, staff and their families. Last year, North West Ambulance Service (NWAS) vaccinated 3830 frontline staff which was 336 more frontline staff than the previous year. The Trust achieved the 65% CQUIN threshold.

2.2 Based on the frontline total figure, last year's refusal rate was 26.9%. This refusal figure is slightly higher than the year before which was 25.93%. Overall, the offer rate was over 92%. The refusal rate is consistent with the efforts made to obtain all refusal data to capture potential target areas and provide better reporting. For the 2019/20 Flu Campaign the Trust will categorise data to correspond with the reasons for refusal set out by NHS England to ensure effective refusal reporting.

2.3 CQUIN funding has changed for 2019/20 meaning that the overarching aim is to reach over 80% uptake of the flu vaccine in frontline healthcare workers where CQUIN payment achieved is capped at 100%. As shown in the table below, should performance lie somewhere between 60% and 80% the Trust will be rewarded proportionately.

Table 1: CQUIN 2019/20

%	Value	Indicator	Requirement
0.25	£618,200	Flu	60-80%: Achieving an 80% uptake of Flu by frontline staff.

3. LATEST FLU DATA SUBMISSION

3.1 The Trust is required to submit flu vaccination data as a mandatory requirement to Public Health England. This submission will occur every month from October to February. The Trust has submitted the first set of data on 4th November 19, the total number of Health Care Workers (HCW) involved with direct patient care was 38.7% at the time of submission. This is ahead of the first submission in 2018.

4. FLU CAMPAIGN PLAN

4.1 The Trust is taking a multicomponent approach to achieve greater flu uptake in 2019/20. These range from bespoke PTS clinics, voucher incentives and board, senior management and trade union leadership to promote vaccination to staff via bulletins and social media.

4.2 Nationally we have been asked to review our plans against a checklist of best practice and to provide assurance to Board that all these key factors have been considered. Please refer to appendix 1 which is the completed management checklist for healthcare worker vaccination to provide assurance on planned activities. The following paragraphs provide greater explanation on progress to date.

Committed Leadership

4.3

4.3.1 The leadership teams have been instrumental on raising awareness of the importance of the flu vaccination. The Medical Director took part in a short film which was placed on the intranet. Other Directors have been visible on social media tweeting photos of them having the 'jab' leading by example. Vaccinators have been present at Board Development and the Joint Partnership Council with Trade Union leads and subsequent communication has been circulated.

4.3.2 Weekly flu reports are distributed to the Executive Leadership Committee and local managers to provide data on uptake, refusals and percentage to target.

4.3.3 Clinics are promoted via the bulletin the staff app and social media however this has been a challenge to date due to vaccines being delivered in three stages with the latter only received in November. This has been a national issue associated with Vaccine production. Therefore, clinics have been harder to schedule due to distribution constraints. However, future clinics will be more visible now the flu team can manage local stocks more effectively.

4.3.4 A Scope of Practice for the role of the Regional Flu Lead is shown in Appendix 2. This has been developed since last year to ensure greater clarity of accountability. It will ensure consistency of understanding of the responsibilities of Flu Leads and will provide local Flu Leads the flexibility to almost run mini Flu Campaigns in their own area. It is crucial that Regional Flu Leads from clinical service lines are responsible for providing appropriate vaccinator support to PTS and EOC in their areas to enable uptake. A vaccinator has been identified from the Education and Training Team to support with vaccinating new starters at inductions and support with administering flu vaccinations in the areas of low uptake alongside identified corporate vaccinators. The Flu Team comprises of representation from PES, EOC, PTS, 111, the Communications Team and Medicines Management. Corporate HR will lead the Trust's Flu Campaign with support from the Corporate HR Administrators. The flu team have met regularly since July to prepare for the launch.

Communication Plan

4.4

4.4.1 The communications team place a mixture of facts and myth busters in the weekly bulletin which are echoed via social media. Clinics are also placed in the bulletin as mentioned in 4.3.3 with leadership support playing a large part of the communication plan. A request for flu promotional banners have been placed on the footer of e-mails and there is a bespoke page on the intranet that provide information on the campaign for example, FAQs, myth busters and informative links to PHE.

The Trust is also using Greater Manchester Health and Social Care Partnership design and messaging for posters, hashtags and banners.

4.4.2

4.4.3 The Communications team are looking at targeting areas that have low uptake with an 'I will if you will' approach. Social media will be used to promote the benefits and bulletins articles will be used throughout the campaign.

4.4.4 Focus is also being provided to reasons for refusal with the aim of addressing the high refusal rates from 2018. Currently refusal rates are running at 8% which is an improvement on last year but these remain under weekly review and staff may be re-targeted as the campaign progresses.

Flexible Accessibility

4.5

4.5.1 The Trust has 276 trained peer vaccinators represented across the regions and service delivery areas. The focus now all vaccinations have arrived will be to place greater emphasis on co-ordinated clinics to make inoculations accessible as possible.

Incentives

4.6

4.6.1 The Trust is issuing a £20 voucher to each employee that has a flu vaccination. This also includes those who have the vaccine with a GP upon written proof. For the 2019/20 Flu Campaign, the issuing of E-CODE vouchers will be supplied by Love2Shop which has alleviated some of the administration burden previously experienced on historic campaigns.

5 RECOMMENDATIONS

5.1 The Board of Directors is asked to:

- Receive assurance on the plans and progress for the 2019/20 Flu Campaign.

Appendix 1 – Healthcare worker flu vaccination best practice management checklist - for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board is confirming commitment at 27 November meeting. Recording systems enable staff to record their reason for deciding against vaccination if they choose to do so.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers.	The Trust has ordered and received delivery of QIV vaccine. Over 65's have been written to in respect of advice regarding suitable vaccination.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.	Resources Committee received an evaluation 2018/19 flu programme, including lessons learned on 23 April 2019 and a report on 2019/20 plans on 26 July 2019.
A4	Agree on a board champion for flu campaign.	The Interim Director of Organisational Development is the Board Champion.
A5	All board members receive flu vaccination and publicise this.	All Board members have received their vaccination and this has been publicised.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	The flu team has full cross functional representation.
A7	Flu team to meet regularly from September 2019.	Flu team has been meeting regularly since July to plan and monitor campaign progress.
B	**Communications Plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions.	Regular mythbusting communications in place, endorsed by senior leaders and Joint Partnership Council.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Clinics and vaccinator availability widely publicised.
B3	Board and senior managers having their vaccinations to be publicised.	Board have received their vaccinators and this has been publicised.
B4	Flu vaccination programme and access to vaccination on induction programmes.	Designated vaccinators in training team in place to enable delivery on core induction.
B5	Programme to be publicised on screensavers, posters and social media.	Widespread communications campaign in place including bulletin, video, social media etc..
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Weekly feedback on uptake and refusals provided to local managers, flu team and ELC.
C	**Flexible Accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered.	276 trained peer vaccinators in place.
C2	Schedule for easy access drop in clinics agreed.	Schedule of clinics publicised regularly and ongoing.
C3	Schedule for 24 hour mobile vaccinations to be agreed.	Peer vaccinators available out of hours to support vaccinations as required.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this.	Incentives agreed in the form of Love2Shop voucher.
D2	Success to be celebrated weekly.	Communications to management teams and in Bulletin celebrate those areas doing well and support ongoing promotion of campaign on a weekly basis.

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Regional Flu Lead
Scope of Practice

Role Purpose
To be responsible and accountable for the Flu Campaign in their own area.

Overall Purpose
To drive and deliver on the Flu Campaign in their area and have full responsibility and accountability for delivery.

Location
There will be Regional Flu Leads appointed in the following areas across the Trust:

- GM
- CAM
- CAL
- PTS
- 111
- EOC

Accountable
The Regional Flu Leads will be accountable for the performance of the Flu Campaign in their own area at Level 2 or Level 3 meetings or appropriate Senior Management Team meetings within their own area.

The Regional Flu Leads will also be accountable to the Trust's Project Lead for the Flu Campaign within Corporate HR and will report regular progress updates throughout the Flu Campaign.

Regional Flu leads from clinical service lines will also be responsible for providing appropriate vaccinator support to PTS and EOC in their areas to enable uptake in these areas.

Main Responsibilities

- To be responsible and accountable for the Flu Campaign in their own area
- To drive and deliver on the Flu Campaign in their area
- To report performance of their Flu Campaign at the relevant Level 2 or Level 3 meetings or appropriate Senior Management Team meetings within their own area.
- To report performance and progress to the Trust's Project Lead for the Flu Campaign within Corporate HR who has overall responsibility for the Flu Campaign across the Trust
- To have the flexibility to run the Flu Campaign in their own way within their own area, which could include but is not limited to:
    - Different delivery methods (large team of vaccinators versus dedicated vaccinators)
    - Local prizes (should local budgets allow)
    - Organising flu clinics
    - Advertising and promoting the Flu Campaign
    - Engaging with those who refuse to have the Flu Vaccination
    - Sharing best practice and ideas across the Trust's Flu Team
- To be responsible for overseeing the use of the online Flu Reporting system with the Flu Vaccinators in their own area
- To promote and engage with staff in their area to encourage an increased flu vaccination uptake
- To be the point of contact in their area regarding the Flu Campaign.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 November 2019			
Subject:	Communications and Engagement Dashboard Report - Q2 2019-20			
Presented by:	Salman Desai, Director of Strategy and Planning			
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), statistical content and themes are provided on: • Patient and public engagement • Patient and public panel • Press and public (patient) relations • FOI performance • Publications • Stakeholder communications • External (public/patient facing) campaigns • Social media: Facebook, Twitter and Instagram • Website • Internal projects and campaigns • Internal communications including the Staff App • Films produced in-house • Other achievements Each report also goes into more detail on one or two priority pieces of work. This quarter's dashboard showcases the new website and gives more detail on five community events delivered by the team.			
Recommendations, decisions or actions sought:	For discussion, noting and the provision of any comments.			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):									
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**	**SR10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	
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 2019).

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
- Publications
- Stakeholder communications
- External (public/patient facing) campaigns
- Social media: Facebook, Twitter and Instagram
- Website
- Internal projects and campaigns
- Internal communications including the Staff App
- Films produced in-house
- Other achievements

Each quarter, the dashboard includes more detail on one or two priority pieces of work. This quarter's dashboard showcases the new website and gives more detail on five community events delivered by the team.

3. LEGAL and/or GOVERNANCE 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. 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 2019/20: July - Sept

NHS North West Ambulance Service NHS Trust

PATIENT AND PUBLIC ENGAGEMENT

24 community events attended, including:
freshers fairs; health events; emergency service open days; Manchester, Liverpool, Cumbria and Chester Pride.

2 public engagement events, including:
Alder Hey Patient and Family Forum and Bury 'Breathe Easy' group

3 NWAS hosted 'meet the ambulance' events
in Greater Manchester, Merseyside and Cumbria. Combined attendance of **171** people.

14,650 Patient surveys sent out ▲ 113%

2,835 (19.4%) returned ▲ 197%

92% of respondents said the overall service received was 'very good' or 'fairly good' ▼ 2%

93% were likely to recommend the service to friends and family ▲ 1%

95% agreed they were cared for appropriately with dignity, compassion and respect ▲ 1%

A review of Friends and Family Test (FFT) was conducted following new NHS England guidelines - approved by ELC.

NOTES

*At **community events**, we engage with the public about various topics. This quarter, these included: the patient and public panel, NHS 111 Online and appropriate use of 999.*

We also engage with specific public and patient groups.

This quarter, we held 3 of our 5 scheduled 'meet the ambulance' community events. There will be one in each county. The events give the public an opportunity to learn more about 111, 999 and PTS, provide their experience and ask questions as well as the chance to meet representatives from the service. Read more on page 4.

*For **patient surveys**, the increased sent and return rates in quarter 2 were a result of a catch up from quarter 1, when there was a late start in surveys being sent out.*

PATIENT AND PUBLIC PANEL (PPP)

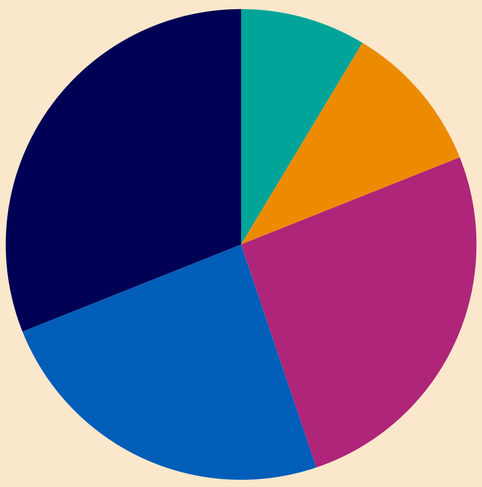
30 panel members confirmed and inducted to the trust

19 of which are involved in two levels of participation meaning we have...

49 panel voices to call on for a piece of work

27 Consult
16 Co-produce
6 Influence

116 expressions of interest



36 Merseyside
30 Greater Manchester
28 Lancashire
12 Cheshire
10 Cumbria

1 recruitment event held for prospective panel members

1 induction event held for new panel members

Plus:
- co-production training for panel members and comms team
- attendance at community events to promote the panel
- panel representation at the AGM

PRESS AND PUBLIC (PATIENT) RELATIONS

Handled **243** 'incident check' calls

50 proactive media stories / interviews ▲ 117%

Prepared **23** statements in response to press enquiries = TO Q1

142 pieces of media coverage:

74% incidents
15% positive
6% negative
5% neutral

Including:
- Manchester Evening News feature on life as frontline paramedic
- Cardiac arrest reunion with CFR who saved friend's life - coverage in multiple titles including The Mirror
- Specialist response team celebrates 10 years
- Chief of Nursing for England comes to visit
- Celebrating baby deliveries with stork badges

NOTES

***Incident coverage** is mostly neutral - NWAS is mentioned as attending an incident, with the press office confirming details. Sentiment for other coverage is based on how NWAS is represented in an article.*

Proactive media stories significantly increased this quarter as the whole team contributed to creating new website content. These good news stories are not always issued to the media but are published on the website to maintain fresh and engaging content. Read more about the new website on page 4.

FREEDOM OF INFORMATION (FOI)

83 FOIs completed

90% within 20 working day target

▼ 9%

16 requests came from the media

2 reviews on requests for operational fleet information

Topics included:

- Incidents involving electric scooters
- Call outs to warehouses
- Response times
- Hospital transfers

NOTES

***FOIs**: We have a statutory duty to reply to eligible FOIs within 20 working days and have a 95% target for this.*

The drop in FOI performance can be attributed to an unusually high number of delayed responses due to information not being received from internal departments. These have been escalated accordingly to highlight the importance of responding in a timely manner.

***Stakeholders**: this group is external audiences such as MPs, commissioners, patient groups and other healthcare professionals / partner organisations.*

PUBLICATIONS

1 Your Call magazine (summer edition)

STAKEHOLDER COMMUNICATIONS

1 bulletin issued

4 event invitations

10 MP letters / briefings

Stakeholder comms topics included:

- Pro-active letter to all MPs re: rota review project
- 2 x MP letters on PTS criteria and taxi use
- MP letters on local performance and delays
- Invitation to 'Sharing our Strategy' event
- Invitations to local community events
- Brexit briefing

FACEBOOK

41,664 total followers

3,824 this quarter

▲ **57%** growth in new followers

2,259,536 reach ▲ 49%

353,742 engagements ▲ 64%

Top post:
A post in memory of Winnie, a patient who featured on Ambulance

4,417 shares

23,523 reactions

872k reach

TWITTER

43,272 total followers

3,212 this quarter

▲ **405%** growth in new followers

1,771,156 reach ▼ 50%

61,422 engagements ▼ 56%

Top post:
A poll asking viewers of BBC Ambulance what they think hurts the most

36 retweets

62 likes

54,995 reach

INSTAGRAM

5,662 total followers

768 this quarter

▼ **36%** growth in new followers

76,276 reach ▼ 24%

5,629 engagements ▼ 30%

Top post:
#TeamNWAS takeover - collage of BBC Ambulance pictures

456 likes

5,209 reach

NOTES

*"**Reach**" is the number of people who may have seen our content.*

*"**Engagements**" is when someone engages with our content e.g. clicks on a link, reacts to it by clicking 'like', shares or retweets it.*

***FACEBOOK**: Growth in new followers, reach and engagement shot up this quarter thanks to a number of engaging posts and varied, high quality content. This included: a post dedicated to Winnie who was a patient from BBC Ambulance, a post promoting new EMT vacancies, and one about therapy dogs that have been visiting EOCs.*

***TWITTER**: Reach and engagement was down this quarter because Q1 had a very popular post which caused an unusual spike in figures. This was a post to mark the anniversary of the Manchester Arena incident.*

Despite this drop, the figures are still positive with more than three and a half million people reached and more than sixty thousand interactions with our content. Growth in new followers has increased this quarter following a quit quarter 1, in line with similar Facebook figures.

***INSTAGRAM**: The decline in Instagram figures this quarter reflects a number of factors, including a team focus on the other social media channels (which saw growth overall) and issues finding staff members to take part in #TeamNWAS. There are plans to focus on this area in quarter 3.*

***WEBSITE:** All website figures are up this quarter, which is to be expected with the launch of the new website. News views have increased significantly thanks to a team effort in producing regular, new content to keep the news pages current.*

WEBSITE

330,889 page views ▲ 13%

94,823 total visitors ▲ 8%

Most visited page:
Careers/vacancies
77,096 views

26,657 'news' views ▲ 73%

Top news story:
"Fancy a career in the ambulance service?"

EXTERNAL (PUBLIC/PATIENT) CAMPAIGNS

- **North West is Best** recruitment campaign aimed at paramedics which highlighted why they should live in the region and the opportunities NWAS provides for them to learn and develop
- **HART week** paramedics which showcasing the skills, equipment and work of the hazardous area response team
- **#NWASvoices** recruitment campaign for members of the new Patient and Public Panel
- **#Ambulance** supporting the airing of the BBC One documentary featuring our crews

INTERNAL (STAFF) PROJECTS / CAMPAIGNS

Rota Review

- Set up staff Facebook group and attracted more than **200** members
- **11** bulletins issued

Baby pin badges

- Launched recognition scheme for staff who have delivered babies (in person or on the phone)
- **85** pin badges given out

NHS 111

- **1** newsletter
- **7** bulletins
- **1** staff forum attended to gather insight for new 111 campaign (launched in Q3)

Topics included: call centre redesign, 111 nurse ambassadors, new Standard Operating Procedure (SOP)

Urgent and emergency care strategy

- Developed suite of materials to help communicate the strategy inc. presentations, plan on a page and UEC model graphic
- Issued first staff bulletin
- Started on supporting comms plans for each work-stream

Other priorities this quarter included:

- Preparation for campaigns including the staff survey, flu and Freedom to Speak Up month.
- CQC comms plan including updating the staff handbook to be tailored to NHS 111and PTS
- Updating Exec Director and NED posters
- Planning for trust strategy launch and refresh/update of trust strategy document

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

19 Clinical bulletins
11 CEO weekly bulletins
13 Weekly Regional Bulletins
8 Operational bulletins

plus **25** others, including Staff Communication, Rota Review, Health and Safety, and a PTS newsletter.

Topics included:
- Oxygen therapy
- Bunkered fuel
- New Facebook group for Rota Review
- Introduction to Urgent and Emergency Care Strategy
- JRCALC APP launch

In addition, letters were sent to all PTS staff with new reporting procedures.

FILMS

7 completed **3** underway
▲ 3 (75%)

Videos are filmed in-house using skills and equipment within the team

- Mental Health - 'Rising to Resilience'
- 2 x staff and patient stories for Board
- PTS and 111 website films
- 111 CQC info film
- GM senior leadership team animation

Ambulance producers Dragonfly also produced 10 short films for the BBC Bitesize careers website showcasing roles including: apprentice mechanic, press officer, mental health practitioner, HART paramedic and more.

STAFF APP

3,185 total downloads
386 this quarter

Most popular pages: email, GRS and ESR

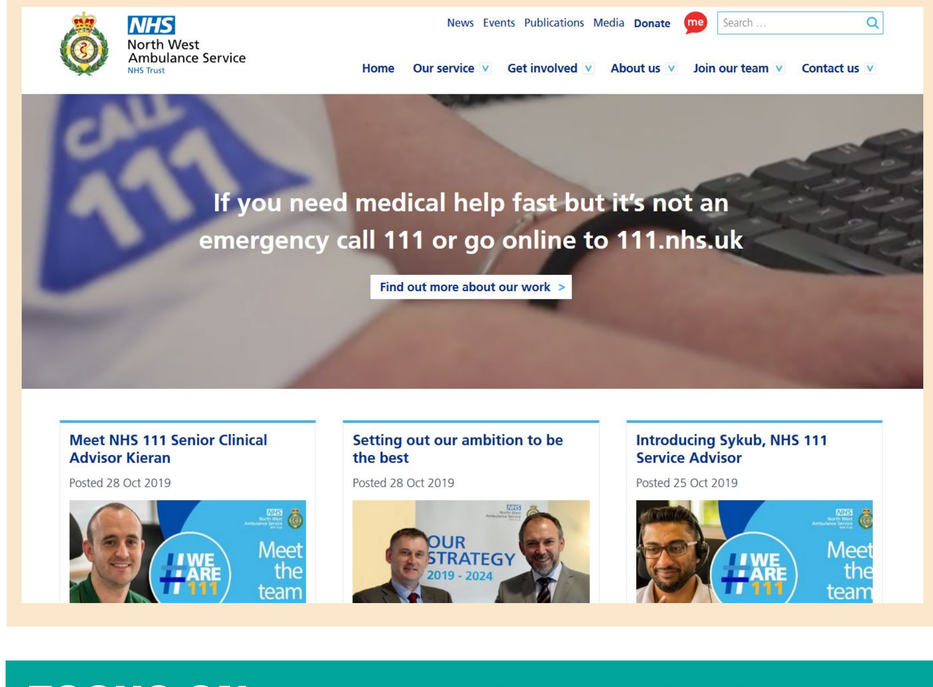
OTHER ACHIEVEMENTS

National social media training - the team produced a training package based on social media guidance for staff developed by national ambulance communications leads and medical directors. The package has been adopted by ambulance services across the country and is available on ESR.

NHS England adopts IFT materials - following an NWAS pilot of the new national IFT/HCP frameworks, NHS England has adopted communications materials produced by the comms team to share with other UK ambulance services.

Awards - The team was shortlisted for two awards: 'Outstanding in-house team' and 'low-budget campaign' in the Chartered Institute of Public Relations (CIPR) North West Pride Awards. Winners are announced in November.
- Ambulance was shortlisted for a TV Choice award and NWAS representatives attended the ceremony in September.

FOCUS ON... the new website



Each quarter we'll choose one or two priority pieces of work to showcase in more detail.

Following months of hard work from the project team, the new NWAS website went live on 1 July.

New features include:

- A bright, crisp design
- A homepage video to showcase an area of the service
- Prominent and regularly updated news stories with images
- An improved search function
- ReciteMe - a tool which improves accessibility by translating the page and helping people with sight or hearing impairments.

Since launch, the number of page views, visitors and news story views have increased.

FOCUS ON... 'meet the ambulance service' community events

In quarter 2, we held three of our five scheduled 'meet the ambulance service' community events. The remaining two were held early quarter 3. The events aimed to give the public an opportunity to learn more about 111, 999 and PTS, provide their experience and ask questions as well as the chance to meet representatives from the service.

The event format included 'meet the ambulance stars', 5 minute lightning talks by senior leads for each service line, followed by activities for each service, a Q&A session and event evaluation form.

248 people attended across five events, one in each county:

89 in Greater Manchester

59 in Merseyside

29 in Cumbria

36 in Cheshire

41 in Lancashire

118 different community organisations represented including:

St John Ambulance, air ambulance, coastguard, prison, cancer, rotary/lions, physical disability, employment, army, police, race, dementia, Healthwatch, religious, mental health, age, education, NHS trusts, CCGs, sensory disability, public health, nursing/carers, and community specific organisations.

Feedback themes from attendees:

- Low levels of awareness about our core services
- More understanding requested by the public about PES incident response times
- Perception that calling 999 means you will be seen quicker in the emergency department
- Low public awareness that an answering phone message may be played at very busy periods
- Public perception that ambulance crews have low levels of mental health knowledge
- Lack of understanding of NHS 111 - some unaware it's available 24/7 and is a free service
- Access concerns for the deaf community both with 999 and NHS 111
- Concerns with turnaround when accessing language translation services
- Uncertainty about who is eligible to use PTS

Learning from event planning:

- Support of our 999, EOC, 111, PTS colleagues is critical to the success of these events
- Community group stakeholder list needs regular updates to ensure all groups are invited
- Using a range of channels, inc social media, phone calls, emails and posters helps to enhance attendance
- Availability of frontline ambulance staff helps enhance networking opportunities
- Interactive sessions maximise opportunities for participation and feedback gathering
- Visual screen, BSL interpreters and hearing loops are required to ensure inclusivity
- Q&A sessions can be difficult for tracking time
- Choice of venue, buffet/refreshment provision and use of microphones help to stage a positive event

Recommendations:

- We are delivering three campaigns to raise further awareness of PES, PTS and 111. The NHS 111 trust and national winter campaign commenced on 21 Oct 2019
- The trust's mental health strategic plan website link has been shared with attendees
- Training to be sourced for staff to learn basic sign language required for patient care e.g. "hello, can you tell me what's happened?"
- Provide information to attendees on how people with disabilities can access 111