North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 28 July 2021
9.45 am - 12.30 pm

Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2122/45	Patient Story	09:45	Information	Director of Strategy, Partnerships & Transformation	
INTRODUCTION					
BOD/2122/46	Apologies for Absence	10:00	Information	Chairman	
BOD/2122/47	Declarations of Interest	10:00	Decision	Chairman	
BOD/2122/48	Minutes of Previous Meetings held on 26th May 2021 and 30th June 2021	10:00	Decision	Chairman	3 - 18
BOD/2122/49	Board Action Log	10:05	Assurance	Chairman	19 - 20
BOD/2122/50	Committee Attendance	10:10	Information	Chairman	21 - 22
BOD/2122/51	Register of Interest	10:10	Assurance	Chairman	23 - 24
STRATEGY					
BOD/2122/52	Chairman & Non-Executives' Update	10:15	Information	Chairman	
BOD/2122/53	Chief Executive's Report	10:20	Assurance	Chief Executive Officer	25 - 38
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/54	Board Assurance Framework Q1 Review	10:30	Decision	Director of Corporate Affairs	39 - 66
BOD/2122/55	Freedom to Speak Up Annual Report 2020/21	10:40	Assurance	Freedom to Speak Up Guardian	67 - 78
BOD/2122/56	Audit Committee Chairs Assurance Report - from the meeting held on 11th June and 16th July 2021	10:50	Assurance	Mr D Rawsthorn, Chair, Audit Committee	79 - 88
BOD/2122/57	Auditors Annual Report 2020-21	11:00	Assurance	Director of Finance	89 - 108
QUALITY AND PERFORMANCE					
BOD/2122/58	Integrated Performance Report	11:10	Assurance	Director of Quality, Innovation and Improvement	109 - 158
BOD/2122/59	Lessons Learnt from Deaths - Summary Report and Q4 2020/21 and Annual	11:20	Assurance	Medical Director	159 - 172

	2020/21 Dashboards				
BOD/2122/60	Health & Safety Annual Report 2020/21	11:30	Assurance	Director of Quality, Innovation & Improvement	173 - 200
BOD/2122/61	IPC BAF Update	11:40	Assurance	Director of Quality, Innovation & Improvement	201 - 216
BOD/2122/62	Quality and Performance Committee Chairs Assurance Report - from the meeting held on 24th May 2021	11:50	Assurance	Prof A Chambers, Chair, Quality & Performance Committee	217 - 226
BOD/2122/63	Resources Committee Chairs Assurance Report - from the meeting held on 23rd July 2021	12:00	Assurance	Mr R Groome, Chair, Resources Committee	227 - 240
WORKFORCE					
BOD/2122/64	Equality, Diversity & Inclusion Priorities - Action Plans	12:10	Decision	Deputy Director of People	241 - 262
COMMUNICATIONS & ENGAGEMENT					
BOD/2122/65	Communications and Engagement Team - Q1 Report	12:20	Discussion	Director of Strategy, Partnerships & Transformation	263 - 274
CLOSING					
BOD/2122/66	Any Other Business Notified Prior to the Meeting	12:30	Decision	Chair	
BOD/2122/67	Items for Inclusion on the BAF	12:30	Decision	Chair	

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.

Date and Time of Next Meeting 9.45 am Wednesday, 29 September 2021 via Microsoft Teams

NHS North West Ambulance Service NHS Trust

Minutes
Board of Directors

Details: Wednesday 26th May 2021 9.45am
via Microsoft Teams

Present:		
	Mr P White	Chairman
	Mr G Blezard	Director of Operations
	Prof A Chambers	Non-Executive Director
	Mr S Desai	Director of Strategy, Partnerships and Transformation
	Prof A Esmail	Non-Executive Director
	Dr C Grant	Medical Director
	Mr R Groome	Non-Executive Director
	Mr D Mochrie	Chief Executive Officer
	Prof M Power	Director of Quality, Innovation and Improvement
	Mr D Rawsthorn	Non-Executive Director
	Ms G Singh	Associate Non-Executive Director
	Prof R Thomson	Associate Non-Executive Director
	Ms L Ward	Director of People
	Ms A Wetton	Director of Corporate Affairs
	Ms C Wood	Director of Finance/Interim Deputy Chief Executive Officer

In attendance:

Mrs P Harder	Head of Corporate Affairs
Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)

Minute Ref:

BOD/2122/16 Staff Story

The Director of Strategy and Planning presented a film entitled Introducing Electronic Patient Records (EPR) to NWAS and initial findings from the pilot in Blackpool.

The film featured an interview with Advanced Paramedic Michael Windever, who as clinical lead on the development of the EPR project, outlined the aims, challenges and learning discovered as the rollout of EPR progressed to other areas across the Trust. He also highlighted how some of that learning helped prepare the way for the larger more complex urban areas of the Trust footprint to incorporate EPR and go online such as recently across Merseyside and soon Greater Manchester.

The film highlighted i) how connectivity challenges were overcome in problematic areas such as Cumbria and Cheshire, ii) how the project team identified issues with Bluetooth connectivity with the LifePaks on ambulances during the very first staff training sessions and iii) how they worked to correct those. It demonstrated the challenges of engagement and buy in from NWAS clinicians to embrace the change to EPR, staff not as digitally aware and also hospital trust staff who had no choice

but to embrace this new way of working during the busiest months for the NHS due to the pandemic.

In relation to the roll out programme, he advised that following the success of the Blackpool pilot, EPR had been introduced across one emergency department at a time. Lancashire and Cumbria were live with Merseyside scheduled for 24th of May and finally Greater Manchester on 14th June 2021.

The Chief Executive stated that he had visited Blackpool hospital and spoken to digital staff, including consultants and nursing staff who had provided very positive feedback on the EPR system.

Mr R Groome stated he was delighted to see the implementation and progress made which was very exciting.

Prof A Chambers added it was good to hear the qualitative comments from staff that are experiencing the benefits of the EPR and Ms G Singh agreed it was encouraging to see that all staff had been supported with training in digital development.

The Medical Director advised that Trust Executives would be considering the next iteration of IPR to ensure the roll out developed and advanced in collaboration with the wider network.

The Chairman endorsed the implementation of EPR as a key system to improve patient care and manage Trust resources.

The Board of Directors:

- Noted the content of the Staff Story and the progress related to the EPR.

BOD/2122/17 Apologies for Absence

Apologies were received from Dr D Hanley, Non-Executive Director.

BOD/2122/18 Declarations of Interest

There were no declarations of interest to note.

BOD/2122/19 Minutes of Previous Meeting held on 31st March 2021 and 28th April 2021.

The minutes of the previous meetings held on 31st March 2021 and 28th April 2021 were agreed as true and accurate records of the meeting, subject to the amendment of minutes held on 31st March 2021 following comments from members of the Board.

BOD/2122/20 Action Log

The Board of Directors noted the updates against the action log. The Director of People referred to action 53, EDI Priorities Report and advised that although the EDI Annual Report was on the meeting agenda, public consultation was still in progress.

BOD/2122/21 Committee Attendance

The Board of Directors noted the Board and Committee Attendance Record.

BOD/2122/22 Register of Interest

The Board noted the 2021/22 register of interest presented for information.

BOD/2122/23 Chairman and Non-Executive Directors Update

The Chairman reported his attendance at ICS meetings in Cheshire and Merseyside and Lancashire and South Cumbria. He noted in particular attendance at Greater Manchester ICS Care Design workshop, which had been informative and had liaised with the Director of Strategy, Partnerships and Integration following the event. He noted two current and key issues being raised through the Chairs AACE meetings relating to retaining paramedics and ICS legislation.

He referred to the recent Board Development Session relating to Anti-Racism and requested Board members to respond to the Director of People's email relating to the next steps. He referred to a meeting held with the Director of Corporate Affairs and Director of People regarding future Board Development sessions and looked forward to future face-to-face sessions.

The Chairman reported that meetings to discuss ICS' and the development of the Trust's H1 Planning Submission had taken place between Non-Executive Director representatives and the Director of Strategy, Partnerships and Transformation.

He congratulated the Chief Executive Officer on his recent milestone of 30 years in the ambulance service.

The Board of Directors:-

- Noted the update from the Chairman.

BOD/2122/24 Chief Executive's Report

The Chief Executive presented the Chief Executive's report to provide members with information on a number of areas since the last report on 31st March 2021. He reported the Trust had experienced a busy period across all of the service lines and advised he had visited the Broughton Vaccination Hub to see staff and volunteers and noted it was fantastic to see the amount of vaccines administered.

He referred to the new Trust values launched in April 2021 and thanked staff for their contribution. He noted these continue to be embed across the organisation with accountability of leaders and managers across the Trust to uphold these values.

In terms of Regulatory Compliance, he referred to the backlogs caused by Covid-19 pressures in relation to closure of complaints, appraisals and mandatory training targets. He advised that training targets had been refreshed and discussed at length by the Trust's Executive Leadership Committee and Board of Directors, with robust action plans in place that would be monitored closely to ensure improvements are made.

The Chief Executive reported that work continued to review the Trust's Service Delivery Model, which included lessons learnt throughout the demands of the pandemic. He reported the Director of Operations had been appointed the Senior Responsible Officer to take this work forward and link into the clinical and operational leadership work being undertaken.

He noted it had been a busy period for the Association of Ambulance Chief Executives (AACE) nationally and locally with the fast-paced developments of ICS'. He added the recent Ambulance Learning Forum (ALF) was well attended with over 500 attendees at the virtual event.

He referred to the Executive portfolio changes following the departure of the Deputy CEO and the plans to thank staff for their incredible work during the pandemic.

Finally, he advised three NWAS vehicles had been dedicated to lost colleagues as a result of COVID-19. He noted with sadness the passing of three further staff members and expressed the Trust sincere condolences to the families.

Mr R Groome requested an update relating to the Northern Ambulance Alliance (NAA). The Chief Executive advised that the Chairs and Chief Executives of the individual ambulance trusts had discussed the need to refocus the purpose of the NAA, however as a result of COVID, trusts were heavily focused on their own recovery plans and learning from the pandemic and it had been considered that the NAA became a learning forum and network for sharing best practice. The Chairman supported this approach, particularly as ICS' would be key partners and the shift to a local focus on priorities.

Prof A Esmail referred to social distancing in PTS and whether any changes to the guidance was expected, to ease restrictions on resource. The Chief Executive advised the Trust continued to adhere to the national guidance and that a joint position around IPC was being reviewed through AACE.

Mr D Rawsthorn referred to the ICS related meetings and the ALF session and the pressures on executive capacity, within the ambulance sector, in dealing with multiple ICS'. The Chief Executive advised of the challenge to engage with multiple stakeholders and stated it was also important to have the capability and noted there were just over 3 ICS' however work had been undertaken to resolve this and felt confident the Trust had the capability which would be strengthened through additional resource. He highlighted the work undertaken by the Director of Strategy, Partnerships and Transformation would support the Trust.

The Chairman advised the Board of recent requests for Non-Executive Directors to attend local ICS meetings and advised that this pressure would continue. The Director of Strategy, Partnerships and Transformation offered his assistance to provide Non-Executive Directors with briefing material, prior to any meetings.

The Board of Directors:

- Received and noted the contents of the Chief Executive's report.

BOD/2122/25 Annual Self-Certifications: General Condition FT4 – Corporate Governance Declaration

The Director of Corporate Affairs presented the Annual Self-Certifications: General Condition FT4 – Corporate Governance Declaration.

She reported a review had been undertaken in relation to the Corporate Governance Statement and was based on the evidence presented in the current arrangements. She proposed that the Board made a positive declaration and declared 'Confirmed' to each clause and confirmed that no material risks had been identified.

The Board of Directors -

- Approved the 'Confirmed' declarations and confirmed that no material risks have been identified as described within this paper

BOD/2122/26 Annual Self-Certifications: General Condition 6 – Systems for Compliance with Licence Conditions

The Director of Corporate Affairs presented the General Condition 6 – Systems for Compliance with Licence Conditions. She reported that whilst NHS trusts were not issued with a provider licence, they were required to self-certify whether or not they

had complied with conditions equivalent to the licence that NHS Improvement had deemed appropriate.

She reported that a management review had been undertaken and confirmed compliance against General Condition 6 of the NHS Provider Licence (Appendix 1).

The Board of Directors -

- Approved the annual GC6 self-certification 2020/21.

BOD/2122/27 Charitable Funds Committee Chairs Assurance Report from the meeting held on 28th April 2021

Mr D Rawsthorn presented the Chairs Assurance Reports from the Charitable Funds Committee meetings held on 28th April 2021. He referred to the action tracker and advised a further meeting would be scheduled in Q3 to develop the future Charitable Funds Strategy to inform a future Board Development session.

He advised that the Committee also noted the Grant award received from NHS Charities Together of £687k for specific projects including CFR resources. Prof R Thomson emphasised the importance of communicating to the public the allocation of funding through social media and campaigns. The Director of Corporate Affairs advised on receipt of the funds the Trust featured this on social media and had already been published in the national press.

The Chairman supported funding for the Trust's CFRs and stressed how important their contribution had been during the pandemic.

The Board of Directors:

- Noted the content of the Charitable Funds Committee Chairs Assurance Reports from the meetings held on 28th April 2021.

BOD/2122/28 Audit Committee Chairs Assurance Reports from the meetings held on 23rd April 2021 and 11th May 2021

Mr D Rawsthorn presented the Chairs Assurance Reports from the Audit Committee meetings held on 23rd April 2021 and 11th May 2021. He referred to the amber moderate assurance relating to MIAA follow up recommendations for Freedom To Speak Up where 2 recommendations were partially implemented, with completion due December 2021.

He referred to the Annual Review of Declarations and Gifts & Hospitality and noted the description in the register was not as full as it should have been and noted he had requested the Director of Corporate Affairs to make it clear to the Executive Leadership Committee that full and clear reasons should be included in the register when any travel or accommodation was accepted.

The Chairman supported the recommendation and was grateful for the scrutiny of the Audit Committee.

The Board of Directors:

- Noted the assurances provided in the Audit Committee Chairs Assurance Reports for meetings held on 23rd April 2021 and 11th May 2021.

BOD/2122/29 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report for May 2021, which showed performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during April 2021.

She referred to the high level summary provided within the report and noted this was strengthened by narrative for each section.

Mr P White requested an update in relation to the Ambulance Clinical Quality Indicators (ACQIs). The Medical Director advised that the Trust's performance against the Ambulance Quality Indicators (AQI's) related to period up to December 2020 and NWAS appeared nationally in the top half of the rankings. He advised that the Trust had a direct influence in relation to pre-hospital ROSC however cardiac outcomes ranked lower due to outcomes within the hospital environment. He added plans were in place prior to COVID-19 to develop Centres of Excellence to drive up care.

Mr P White noted his interest in relation to elements within the Trust's control and queried whether Prof A Esmail was comfortable around the scrutiny and development of measures. Prof A Esmail confirmed this was the case and that future deep dives at the Quality and Performance Committee would allow the Board to understand this further. However, it was clear that the North West region was significantly challenged with improved cardiac outcomes required and dependent on preventative strategies. He added it was clear that care bundles were effective and evidenced by the care package outcomes.

The Medical Director confirmed that the Trust were committed to health inequalities, particularly cardiac arrest outcomes, with deprivation and ethnicity factors part of the 2021/22 work plan.

The Chief Executive added that the EPR would provide much more information to enable an understanding of what was adding value to improve clinical outcomes as opposed to a retrospective review of data. He advised that the Medical Director would focus on ACQIs and clinical structure to see what was adding value to the Trust and the outcomes from those interventions.

In response to Mr P White's query relating to the plans to improve performance, the Director of Operations reported that in March and April the Patient Emergency Service (PES) activity had increased towards the end of the month due to lock down release. He stated that the Trust continued to implement the Patient Safety Plan to focus on the C2 stack and reduce impacts of C4, with a focus on the high acuity patients. He added that increased activity had resulted in escalating to REAP Level 4 as the Trust was under severe pressure.

He reported that in terms the service delivery model, broad themes had been identified from the remodelling work completed by ORH and these would be used to inform the future model of operational resource and practices including identifying efficiencies. He noted the Trust identified a significant funding gap that widened due to COVID-19 and from an operational perspective looking at what can change to make the service more effective. Prof A Chambers assured the Board that the Quality and Performance Committee continued to scrutinise the Integrated Performance Report and recognised the ongoing issue of demand vs capacity. She added the Committee recognised the need to deliver improvements in performance and would continue to monitor long waits in C3 and C4, which were unsustainable moving forwards.

The Medical Director advised that when the Trust experienced a surge in demand the C2 call bundle, control centres reassessed the patients waiting, and the Clinical Co-ordination Desk repeatedly reviewed markers for areas of concern. Prof A Esmail agreed that C2 was of critical focus during surges of demand and through discussions at Quality and Performance Committee, he was confident this was being monitored. Prof R Thomson confirmed that long waits would be a priority for future scrutiny and discussion at the Quality and Performance Committee

In relation to the 111 service, the Director of Operations reported that there had been a significant increase in calls related to Covid-19 vaccination safety concerns. He advised the service had experienced a change in call profile with a peak in calls at 9am in the morning on weekdays attributed to unmet demand from primary care and recognised as a national trend. He added the Trust had implemented changes to NHS pathways to deal with vaccination related calls and that the 111 service across the country was experiencing the same change in demand profile.

Prof A Chambers advised that the Quality and Performance Committee scrutinised 111 performance with focus on long waits and call back times.

In relation to the Patient Transport Service (PTS), the Director of Operations noted a reduction in capacity of 29% below contract baselines, whilst year to date position was performing at 37% below baseline due to Covid-19. The Chairman expressed his gratitude to the PTS staff and the flexibility the service demonstrated throughout the pressures of the pandemic.

In relation to Finance, the Director of Finance, confirmed that as at month 1 the trust was reporting a breakeven position in line with the H1 financial plan and spending remained in line with the previous financial year. She advised that the Covid-19 financial framework remained in place for H1, 1st April 2021 to 30th September 2021 and the Trust had received confirmation of Covid-19 funding that was discussed in detail by the Resources Committee. She stated that future resource requirements would be dependent on the Trust's review of the service model and work on productivity and efficiency gains continued.

The Chairman emphasised the importance of input from all Board members at Board Assurance Committees to ensure a continued focus on patient safety.

The Board of Directors:

- Noted the content of the Integrated Performance Report.

BOD/2122/30 Safeguarding Annual Report 2020/21

The Director of Quality, Innovation and Improvement presented the Safeguarding Annual Report 2020/21 detailing safeguarding activity during 2020/21.

She advised that safeguarding activity had continued to rise across the Trust during 2020/21 and that work had been undertaken to understand this. She added Mersey Internal Audit Agency had inspected safeguarding activity within the Trust and received substantial assurance.

The Director of Quality, Innovation and Improvement confirmed that the Safeguarding team continued to be involved in serious case reviews, safeguarding adult reviews and domestic homicide reviews. She added that NWAS had particular learning in relation to concealed and denied pregnancy, which had been incorporated into the level 3 safeguarding training.

She advised that there had been 103 safeguarding flags placed on addresses of vulnerable patients in the ERISS system to improve information exchange and the

Trust had been involved in 21 LADO notifications with multi agencies. She added that the team continued to progress Project Emerald, a safeguarding innovation project that would introduce a new safeguarding platform for recording safeguarding concerns and would replace the current ERISS system.

Mr P White commended the progress made in relation to the safeguarding agenda.

The Board of Directors:

- Took assurance from the information provided within the Safeguarding Annual Report 2020/21.
- Approved the onward progression of the assurance report to publication.

BOD/2122/31 Senior Information Risk Owner Annual Report 2020/21

The Director of Quality, Innovation and Improvement presented the Senior Information Risk Owner Report 2020/21. She reported the key headlines that included a significant piece of work to deliver the Data Security and Protection Tool kit (DSPT), which the Trust is required to submit by the end of June 2021. She added that MIAA internal audit had completed a readiness audit in order to provide assurance of the intended June submission and confirmed that the Trust was on track to achieve all mandatory assertions except for the requirement for 95% of staff to complete the data and security awareness training. She advised that work was ongoing to increase the percentage before submission.

In relation to Data Protection Impact Assessments (DPIA), the Director of Quality, Innovation and Improvement noted the creation of a simplified DPIA developed for use with urgent data protection/IT developments during COVID-19. Finally, she advised the Information Governance Team had reviewed and processed 4 information sharing agreements, 19 agreements had been reviewed and processed for the GP connect program, with 11 received for the EPR project and highlighted this may increase as ICS' develop

Ms G Singh referred to staff reporting data breaches, which she considered to be positive for the organisation however queried the communicational channels in place to share learning outcomes across the organisation. The Director of Quality, Innovation and Improvement advised a thematic analysis was being carried out by the team for future reporting. She advised that the Information Governance team worked with the Trust's communications team to generate staff bulletins to increase awareness of cyber security but there was a need for staff to share learning through local forums.

Mr D Rawsthorn welcomed the inclusion of a thematic analysis in the 2021/22 Annual Report.

The Chairman thanked the team for their hard work and efforts during 2020/21.

The Board of Directors:

- Took assurance that the Trust had effective systems and processes in place to maintain the security of information.
- Took assurance that an audit would take place to ensure the readiness for the DSPT submission at the end of June 2021.

BOD/2122/32 Complaints Update and Annual Report

The Director of Quality, Innovation and Improvement presented the Complaints Update and Annual Report from 1st April 2020 to 31st March 2021.

She advised that comparison data from the same dates within 2019/20, had shown that there had been a decrease from an average of 168 complaints per month. In terms of closure of complaints, from 1st April 2020 until 31st March 2021, the team had closed an average of 111 complaints per month, which had supported the reduction of a backlog that had previously developed.

She stated there were 214 complaints open, which was an increase from 201 open complaints in September 2020. Of the 214 current open complaints, 80 (37%) are past their due date for closure and are in the backlog. Since January 2021, significant work had gone into reducing the significant complaints backlog that had accrued.

The Director of Quality, Innovation and Improvement confirmed the aim was to return to business as usual by the end of Q1. Prof A Chambers noted assurance was provided to the Quality and Performance Committee that a robust action plan was in place to reduce the backlog.

Mr P White acknowledged the progress made in respect of the backlog however queried the closure of the Level 4 and 5 complaints. The Director of Quality, Innovation and Improvement confirmed there was a requirement to complete a more detailed investigation, which involved multiple people including operational staff, who were not always able to respond within the 60 day timeframe due to operational pressures. She noted a review of the data would provide a better sense of how long cases have been open and would be presented to the Quality and Performance Committee.

The Board of Directors:

- Noted the content of the Complaints Update and Annual Report 2020/21.

BOD/2122/33 Medicines Management Annual Report 2020/21 including the Controlled Drugs Annual Report

The Medical Director presented the Medicines Management Annual Report 2020/21 including the Controlled Drugs Annual Report. He reported the Medicines Team had been at the forefront of the pandemic response and had continued to deliver against the agreed Medicines Optimisation Strategy, responded to the rapid need to change controlled drug supplier and been integral to the management and delivery of the Covid-19 vaccine.

In terms of Patient Group Directives (PGDs), he confirmed that new PGD training assessment and declaration had been agreed with multiple PGDs and e-learning packages implemented; including a Covid-19 vaccine handling package and a general PGD management package. He added that the team had received excellence assurance regarding paramedic use of PGDs.

The Medical Director added that the Trust had transferred to a new CD supplier and the team had facilitated the development and approval of the business case to secure a CD Home Office Licence.

He reported that Medicines Management Quality Indicators (MMQIs) for vehicles highlighted some lack of compliance with daily checks; however, SafeCheck would provide the operational leads with the ability to monitor this. He highlighted the importance of the digital agenda in relation to barcoding and the ability to track drugs, with the digital solution implemented within a year, using either SafeCheck or a specific bar code system.

The Medical Director advised that pledges and goals for the medicines management team during 2021/22 with quarterly objectives had been included in the report.

The Chairman referred to the delays in full implementation of the barcoding system due to the Covid-19 pandemic and stressed the importance of the project. He requested the Resources Committee to monitor progress of implementation moving forward.

The Board of Directors:

- Noted the achievements and assurances provided in the Medicines Management Annual Report including the Controlled Drugs Annual Report 2020/21.
- Noted the forward plan for 2021/22

BOD/2122/34 Quality and Performance Chairs Assurance Report from the meeting held on 26th April 2021

Prof A Chambers presented the Chairs Assurance Report from the meeting held on 26th April 2021. She advised the Committee had received assurance from the agenda items discussed, with the exception of the Integrated Performance Report and ARP response times in relation to C3 and C4 long waits.

The Chairman referred to discussion on the Integrated Performance Report, earlier in the meeting and requested ongoing scrutiny by the Quality and Performance Committee.

The Board of Directors:-

- Received and noted the assurances in Quality and Performance Chairs Assurance Report from the meeting held on 26th April 2021.

BOD/2122/35 Resources Committee Chairs Assurance Report from the meeting held on 21st May 2021

Mr R Groome presented the Chairs Assurance Report from the meeting held on 21st May 2021. He referred to the moderate assurance relating to the deep dive into staff survey results and culture audit plans, which was due to the lack of time on the agenda to discuss the issues in full. He also advised the Committee would continue to monitor the backlog in HR caseload.

He reported that the NWAS People Plan and Equality, Diversity and Inclusion Annual Report had been well received, along with a very comprehensive digital strategy update from the Chief of Digital and Innovation.

The Director of People advised that she had shared detail of the HR caseload backlog with the Resources Committee and processes were ongoing to reduce and improve timeliness to close cases and promote earlier resolution with welfare support for staff concerned. She added that she would continue to provide updates for scrutiny by the Resources Committee for onward reporting to the Board of Directors.

The Board of Directors:

- Received and noted the assurances in the Resources Committee Chairs Assurance Report from the meeting held on 21st May 2021.

BOD/2122/36 EDI Annual Report 2020/21

The Director of People presented the Board of Directors with the Annual Equality, Diversity and Inclusion Annual Report 2020/21 for approval and noted the report demonstrates compliance against the Public Sector Equality Duty.

She highlighted the report included the work completed over the last 12 months in support of the equality, diversity and inclusion agenda. She referred to the work undertaken relating to community/patient engagement which had continued throughout the pandemic.
Ms G Singh referred to the level of work and engagement undertaken during the pandemic and highlighted this was admirable. She welcomed Executive leads as sponsors and congratulated the team for their hard work.

Prof A Esmail added the EDI Annual Report was very thorough and clearly a large piece of work. He supported widening the diversity of the patient and public representation to reflect the region.

Prof A Chambers commented that the report was very comprehensive, showed excellent progress and underpinned recent Board Development conversations.

The Chairman referred to the recent Board development session on anti-racism and advised that the EDI priorities provided context, focus and visibility for the organisation. He added that the Director of People was considering future closer engagement between Board and patient and public members.

The Board of Directors -

- Approved the Equality, Diversity and Inclusion Annual Report for publication.
- Took assurance on the progress of the equality, diversity and inclusion agenda.

BOD/2122/37 NWAS People Plan

The Director of People presented the Board of Directors with the refreshed 3 year NWAS People Plan for approval, together with assurance relating to 1 year work plans to implement the People Plan.

She reported that the NWAS People Plan was an enabling strategy, which supported and underpinned the wider Trust strategies and aims to develop the culture and leadership environment to facilitate the delivery of the overall organisational goals.

The Chairman welcomed the refreshed NWAS People Plan and the one-year implementation plan for 2021/22.

The Board of Directors:-

- Approved the refreshed NWAS People Plan.
- Took assurance from the robust one year implementation plan, which underpinned the People Plan through the identification of objectives and measures of success.

BOD/2122/38 Communications & Engagement Team Dashboard Report - Q4 2020/21

The Director of Strategy, Partnerships and Transformation presented the Communications and Engagement Team Dashboard Report for Q4. He advised that patient and public engagement activity had continued through the pandemic and virtual community engagement opportunities had been well attended.

In terms of Patient and Public Panel activity, he confirmed that 17 new panel members had been confirmed and inducted to the trust and noted the intention to increase the representation of panel members during 2021/22.

He reported that Q4 media activity had involved a number of incident check calls and highlighted pro-active media relations work during the quarter. He added that proactive interviews continued to be limited due to Covid-19, in line with NHS England guidance. In relation to Freedom of Information (FOI), he confirmed that the Trust had received fewer requests during Q4 than the previous quarter and the team had maintained a performance rate of 96%, against the national target of 90%.

Ms G Singh referred to the use of internal communications to share information relating to actions taken following the staff survey. The Director of Strategy, Partnerships and Transformation confirmed that the use of social media, throughout the year would be used to engage with staff. The Director of People added that directorates would be responsible for demonstrating how their own people plans had been delivered to engage with their teams.

The Chairman referred to the Trust's first Team Talk Live session that he would host together with the Chief Executive to provide staff with a live update on strategic news, Board priorities and the opportunity to ask questions.

The Board of Directors:

- Noted the content of the Communications and Engagement Team Dashboard Report for Q4 2020/21.

BOD/2122/39 Any other business notified prior to the meeting

There was no other business notified prior to the meeting.

BOD/2122/40 Items for Inclusion in the BAF

There were no items for inclusion in the BAF.

Date, time and venue of the next meeting:

The next meeting of the Board of Directors will be held at 9.45am on Wednesday, 28th July 2021 via Microsoft Teams.

Signed: _____

Date: _____

Minutes
Board of Directors

Details: Wednesday 30th June 2021 9.15am
via Microsoft Teams

Present:		
	Mr P White	Chairman
	Mr G Blezard	Director of Operations
	Mr S Desai	Director of Strategy, Partnerships and Transformation
	Prof A Esmail	Non-Executive Director
	Dr C Grant	Medical Director
	Mr R Groome	Non-Executive Director
	Mr D Mochrie	Chief Executive Officer
	Mr D Rawsthorn	Non-Executive Director
	Ms G Singh	Associate Non-Executive Director
	Prof R Thomson	Associate Non-Executive Director
	Ms L Ward	Director of People
	Ms A Wetton	Director of Corporate Affairs
	Ms C Wood	Director of Finance/Interim Deputy Chief Executive Officer
	Dr D Hanley	Non-Executive Director

In attendance:

Mr N Barnes	Deputy Director of Quality
Mrs P Harder	Head of Corporate Affairs
Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)

Minute Ref:

BOD/2122/41 Apologies for Absence

Apologies were received from Prof A Chambers, Non-Executive Director and Prof M Power, Director of Quality, Innovation and Improvement

BOD/2122/42 Declarations of Interest

There were no declarations of interest to note.

BOD/2122/43 Final 2020/21 Quality Account

The Deputy Director of Quality presented the Trust's 2020/21 Annual Quality Account and noted it had been reviewed by the Executive Leadership Committee on 23rd June 2021.

He advised that initially, the Trust had received communication via NHS national bodies that indicated the Quality Account deadline would be later in the year to allow

NHS organisations to return to business as usual and recover from the Covid-19 pandemic. However, NWAS received communication early May 2021 that the Department of Health and Social Care would not be extending the Quality Account timeline and consequently the Quality Account had to be produced and signed off by the 30th June 2021.

Due to the tight timelines, the Deputy Director of Quality advised that the Quality Account had not been reviewed by the Q&P Committee but had been sent to the Chair of the Committee for review. Due to the tight timescales, he reported the Trust had not been required to consult with lead commissioners, Health Watch and other public bodies; however, had undertaken consultation with lead commissioners. The Deputy Director of Quality advised that it was the intention to publish the Quality Account by close of business on 30th June 2021 to meet the required deadline.

Prof R Thomson advised that s7.4 of the report related to Effectiveness could be more robust to reflect the increased focus the Trust has placed on the effectiveness of services during 2020/21. The Medical Director advised that he would review this section with the Deputy Director of Quality to emphasis the strength and positivity throughout the year prior to publication.

The Chairman thanked the Deputy Director of Quality and the team for their hard work in the production of the Quality Account within the tight timeframe.

The Board:

- Approved the 2020/21 Quality Account.

BOD/2122/44 Any Other Business

The Chairman reported two key points related to Covid-19 that had been discussed at a recent NHSE/I meeting and related to staff sickness rates to look after children and low rates of self-testing.

The Director of People advised that the Trust had seen a rise in Covid-19 related abstractions and self-isolation due to household infection in the recent weeks but there was no specific observations related to staff abstractions due to caring for children.

The Deputy Director of Quality advised he would seek confirmation of the current rate related to self-testing from the IPC team and confirm to the Chairman following the meeting. He added that the IPC cell and IPC BAF implementation plan, managed at sub committee level, reviewed operational IPC related matters and he had not observed any specific issues regarding self-testing, but had observed a rise in staff abstractions.

The Chairman thanked colleagues for the updates and the current percentage rate of self-testing following the meeting.

Date and time of the next meeting –

9.45 am on Wednesday, 28th July 2021 via Microsoft Teams.

Signed _____ Dated _____

This page is intentionally left blank

Status:	
Complete & for removal	
In progress	
Overdue	
Included in meeting agenda	

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
55	28/04/21	2122/6	FT Code of Governance Compliance Declaration	Review of the Memorandum of Understanding relating to the division of responsibilities between the Chairperson and Chief Executive Officer during Q12021/22.	AW	26.5.21	29.9.21	For submission to Board of Directors meeting.	

This page is intentionally left blank

NWAS Board and Committee Attendance 2021/22

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

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

Resources Committee						
	21st May	23rd July	24th September	26th November	21st January	25th March
Ged Blezard	✔	x				
Salman Desai	✔	✔				
Richard Groome (Chair)	✔	✔				
Dr David Hanley	✔	✔				
Prof Maxine Power	✔	✔				
David Rawsthorn	✔	✔				
Gillian Singh	✔	x				
Lisa Ward	✔	x				
Carolyn Wood	✔	✔				

ality and Performance Committee							
	26th April	24th May	28th June	26th July	27th September	25th October	28th March
Ged Blezard	✔	✔	Cancelled				
Prof Alison Chambers (Chair)	✔	✔					
Prof Aneez Esmail	✔	✔					
Dr Chris Grant	✔	✔					
Dr David Hanley	✔	✔					
Prof Maxine Power	✔	✔					
Prof Rod Thomson	✔	✔					
Lisa Ward	x	✔					
Carolyn Wood	x	✔					

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

Nomination & Remuneration Committee						
	30th June	28th July	29th September	24th November	26th January	30th March
Prof Alison Chambers	x					
Prof Aneez Esmail	✔					
Richard Groome	✔					
Dr David Hanley	✔					
David Rawsthorn	✔					
Gillian Singh	✔					
Prof Rod Thomson	✔					
Peter White (Chair)	✔					

This page is intentionally left blank

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

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

This page is intentionally left blank

NHS
North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 July 2021			
SUBJECT:	Chief Executive's Report			
PRESENTED BY:	Daren Mochrie, Chief Executive			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
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 CEO's report to the Trust Board on 26 May 2021. The highlights from this report are as follows: **Paramedic Emergency Services** • Activity has increased to similar levels to pre-Covid • Cat 1 activity increased from 8-9% to 14-15% of total volume • The Trust escalated to REAP 4 • Additional funding has been announced to support ambulance trusts **NHS 111** • Current demand is approximately 30% greater than baseline funding plus 111 First activity • 14 Health Advisors commenced training in Liverpool in May with more courses planned in the lead up to winter • Work has begun to optimise Average call Handling Time within 111 **PTS** • Overall activity is below contracted baseline • All areas are experiencing gradual increases in activity • A recruitment drive is underway The paper also provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as electronic patient records (EPR), the single primary triage platform and building a better culture			
RECOMMENDATION:	The Board is requested to receive and note the contents of the report			

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Not applicable			
	Date:			
	Outcome:			

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 26 May 2021

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

May and June continue to be very challenging for operations and this has continued into July with unprecedented levels of 999 calls. Throughout the past 19 months of Covid our Emergency Operations Centres (EOCs) have consistently performed well with 999 call answering, with small numbers of over 2 minutes delays reported by BT. In fact NWAS has been able to support a number of other Ambulance Trusts with their 999 calls. Given the recent pressures we have seen a significant rise in over 2 minute 999 call delays. Activity is now higher than a normal summer period pre Covid.

The main drivers for the challenging response times are the increasing acuity of patients. Category 1 patients usually account for 8-9% of our call volume, this is currently 14-15%. Similarly category 2 call volume has risen from around 52% to 56%. That equates to 70% of our activity being in the highest 2 categories. That impacts on the resources required to attend these incidents as they all require an emergency ambulance attendance as opposed to category 3 and 4 calls where Urgent Care/third party resources can attend. Increasing staff abstractions and easing of lockdown, whilst continuing with infection prevention control procedures, has led to a really challenging summer so far. In response, the trust has escalated to REAP Level 4, postponed mandatory training (to be re-instated in August subject to capacity) and Operations are doing all they can to increase call handling and emergency ambulance cover. We have also reviewed our Patient Safety Plan to enable us to prioritise patients with the highest clinical need.

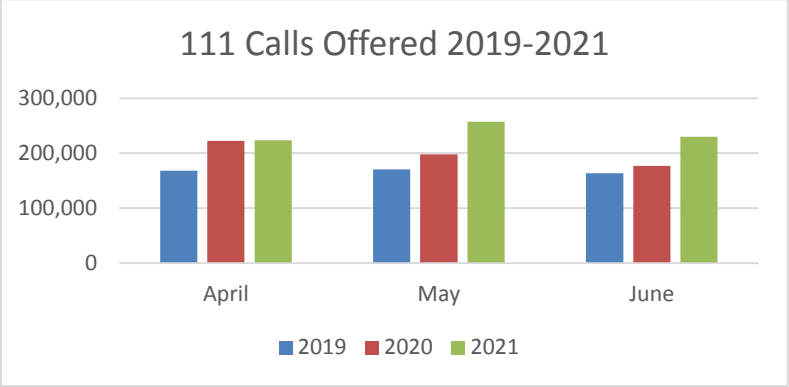
Given this is not unique to NWAS, all Ambulance Trusts have been working with NHS England/Improvement Nationally to address the challenges. When we compare NWAS to other trusts we are in the pack for C1 and C2 performance but we are at the back of the pack for C3 and C4, 7 other ambulance trusts are at REAP 4 with the remainder at REAP 3

During this period we have also had further periods of relaxation of the lockdown rules, warm weather and dealt with the Euro 2020 finals.

Some additional funding has been announced to support ambulance trusts and we are working on the best use of the money to support patient safety and staff welfare.

2.2 NHS 111

During May and June 2021, 111 was no different to PES, and has experienced the most calls offered/demand experienced over the length of the contract. The current demand is approximately 30% greater than baseline funding plus 111 First activity; if no funding for 111 First activity is secured prior to the end of July, then August's activity is predicted to be 45-55% over contract value.



The 111 Senior Leadership Team are continuing to work with the NW Commissioners to support Primary and Urgent Care Services to work with 111 to ensure clinically safe services that ensure best use of limited resource.

Increases in AHT (Average Handling Time)

In the last Board report it was identified that nationally across all 111 services there was an increase in AHT. The causes of this increase include changes to NHS Pathways questions during Covid and increased direct booking of patient appointments into Primary Care and Emergency Departments lengthening the call. However, using the NWAS call data, the 111 team has identified some potential areas of efficiency within our service delivery.

Work began in July within 111 to optimise AHT with 3 key areas of focus:

- Operational Processes
- Digital solutions to long call waits (GP Connect, DoS, PDS look up)
- Management of Mental Health Calls

Staff

Following the past 18 months of Covid-19 and the continuous growing demand on the 111 service, we have experienced a rise in staff absence (currently 20% including Covid isolation) and staff attrition (approximately 30%).

A course of 14 Health Advisors commenced training in Liverpool in May, with more courses at Bolton planned for July, August, September and October to ensure maximum staffing going into the winter period.

2.3 PTS

Due to timetable issues PTS will always report a month behind other operational areas. The narrative below was shared during May.

Overall activity during May 2021 was 37% below contract baselines with Cumbria at 43%, Greater Manchester at 32%, Lancashire 44% and Merseyside 27% below contract baselines. For the year-to-date position (contract year July 2020 - May 2021) PTS is performing at 37% (530, 042 journeys) below baseline.

Within these overall figures year to date, Cumbria is at 45%, Greater Manchester 31%, Lancashire 44% and Merseyside 26% below baseline. It should be noted that the majority of the reduction in activity is in the low acuity (walking) mobility category whilst ambulance category activity is approximately 7% lower than pre Covid levels meaning that ambulance capacity is challenged when set against the capacity issues associated with social distancing and IPC measures (e.g. additional cleaning).

As previously reported, the service line has commenced a recruitment drive to recruit to the vacancies left as a result of repurposing staff into PES. The recruitment plan has been accelerated with the aim now being to recruit to full establishment by the end of the financial year. Further proposals to adapt the current workforce profile to enable greater provision of double crewed non-emergency ambulances, increase the funded establishment and associated supervision are being drafted in conjunction with Finance colleagues and will be submitted to ELC in August 2021.

As alluded to above, capacity challenges associated with social distancing measures continues to impact utilisation of resources and, in collaboration with senior colleagues from other ambulance Trusts, the Head of Service has met with the chair of the national IPC cell to discuss the operational and systems challenges these measures present. Whilst the current direction is that current IPC / social distancing measures will remain in place we are also working with NHSE/I, and commissioners locally to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively.

In addition to the above, the service line will be a core member of an Operational Design Group which comprises senior NWAS, commissioner and partner Trust leadership. The purpose of the group is to support the redesign of service delivery models in such a way that provides an improved patient transport service and works towards the development of an integrated model of delivery that utilises PTS resources more broadly to enhance the paramedic emergency service offer.

3. ISSUES TO NOTE

3.1 Local Issues

Observation Shift

At the beginning of June I undertook a clinical shift out of Blackpool and visited Blackpool Victoria Hospital to see the Electronic Patient Record (EPR) in action and meet some of the people involved and to express my thanks for the hard work involved in rolling out EPR.

Euros 2020

I worked an operational clinical shift on the evening of the Euro final to support our command team with our plans for the match. I joined the strategic commander update chaired by Gene Quinn, Head of Service for Cumbria & Lancashire and Strategic Commander, and was able to hear about the plans we had in place to deal with the Euros final. I then spent time in Parkway EOC thanking the staff for all they are doing during this very busy time, before joining Advanced Paramedic John Carrie on shift to respond to a number of patients.

I know it will have been a challenging shift for many who worked; thank you to all the staff and volunteers who supported us.

3.2 Regional Issues

REAP level

Once again the trust had to increase its REAP level from Level 3 (major pressure) to Level 4 (extreme pressure). This change in REAP level is due to increased pressure

being experienced across our services as outlined above, this is system wide and is being experienced nationally.

Managing Demand

Our service is continuing to feel the pressure of high demand. Hospital trusts across the region and ambulance services in other parts of the country are also reporting very busy periods.

We're handling approximately 20% more category 1 incidents and 8.5% more category 2 incidents compared to the same time last year.

As an Executive Leadership Team, we are constantly looking at what we can do to improve this situation, across 999, NHS 111 and PTS to support staff and ensure patient safety.

We are continuing to invest and increase our operational resources across the trust, including more 999 or NHS 111 call handers and more emergency ambulances to meet this demand and we are working with our key partners to see what more they can do to help reduce the pressures on us. Focusing specifically on handover delays at emergency departments, opening up access to alternative pathways and reducing inappropriate demand.

Thank you to our volunteers

We have more than one thousand active volunteers performing essential roles across three areas:

- Community first responders
- Volunteer car drivers
- Patient and Public Panel members

It is incredibly heart-warming to see hundreds of people volunteering their time and expertise ultimately to help others and support our services. Over the last year, our CFRs have given over 120,000 hours' worth of support.

We have currently more than 160 active volunteer car drivers working in PTS, some of whom are working every day, clocking up thousands of miles every month helping patients to a variety of medical appointments. I know that for our regular patients, the relationship they form with their driver is very important to them.

Despite only being active for 18 months, we have over 150 members of the Patient and Public Panel. The engagement we have with the public is incredibly important. In the last year and a half, these volunteers have attended dozens of meetings and discussion groups to tell us how we can develop better care for our patients

Electronic Patient Records (EPR)

The final phase of the EPR roll out commenced in GM on 14 June. EPR offers significant benefits to us, our patients and our healthcare partners and allows us to pass clinical incident information to our receiving locations digitally. With future modification EPR will be instrumental in reducing avoidable conveyance due to improvement in accessing a patient's medical history.

The project team have done a fantastic job to deliver this huge piece of work in amongst Covid and extreme pressures and my thanks goes to them and all staff who

have embraced this new way of working. Feedback from colleagues across the region has been very positive

New triage system

In 2019 a full review of our contact centres took place in line with the Urgent and Emergency Care Strategy. This review was undertaken to find potential areas for improvement and opportunities for closer working between our emergency operations centres (EOCs), NHS 111 and patient transport service (PTS) control, ultimately improving patient experience.

During the review, it was found that aligning primary triage platforms across 111 and 999 has the potential to significantly benefit patients, contact centre staff and the wider organisation. A full business case was developed and reviewed by the Executive Leadership Team and, following this, it was agreed that NHS Pathways would be implemented across all EOCs.

Since then, a dedicated project team has been established with lots of work going on behind the scenes to make sure that this will be a smooth transition, including visits to other ambulance services already using NHS Pathways.

This is a large-scale project which will impact not only those working in EOC, but many of the wider workforce including frontline responders. The actual rollout however has been delayed to allow our contact centre teams to focus on delivering safe and quality patient care during the current pressures, whilst we handle more emergency calls than ever. The trust is committed to ensuring our primary triage systems for 999 and 111 calls are aligned in order to standardise outcomes for patients and the project will be overseen by the Corporate Programme Board.

Work & Wellbeing Passport

The trust has launched the new Work & Wellbeing Passport which everyone has access to. The tool has been piloted and developed to help any staff member who feels that they may need some additional support at work, whether that's a disability, long term health condition or have caring responsibilities for a relative with a disability or long term health condition. Completion of the passport is voluntary and all information provided in strict confidence.

Building a Better Culture

The health, wellbeing and culture audit was an opportunity for all staff to tell us what we are getting right and what we need to improve, and a chance for us to listen to their views and experiences and learn from them.

Zeal Solutions, who we commissioned to conduct the audit, has now evaluated the responses and given us an analysis into how staff's experience of work influences our health and wellbeing. Zeal has also produced four bitesize video clips about the key findings

Plans have already been developed focused on making long-term improvements to the staff experience of work. Many of these are reflected in the NWAS People Plan which has been refreshed to take account of the outcomes from the audit.

The key areas of focus for the year ahead are:

- **Just culture -** we are reviewing our approach to investigations, incident management and formal processes. Our aim is to focus on early resolution of issues, make our use of learning more effective, improve the support for staff

affected by formal processes, improve timeliness and overall to assure staff they will be treated fairly when things go wrong.

- **Leadership support** - we have already refreshed our approach to leadership recruitment to put inclusive and compassionate leadership at the heart of our processes. We are also refreshing our leadership development to ensure we are equipping our leaders with the tools they need to succeed.

- **Wellbeing** - we will focus on ensuring wellbeing conversations become part of normal practice so we can proactively identify and support staff who are struggling. We aim to improve accessibility for wellbeing offers so that it is easier for staff to navigate and access support when needed and for managers to be able to signpost to support. We are also encouraging local ownership of wellbeing plans using the staff survey and culture and wellbeing audit for teams to identify what they can do differently to improve wellbeing.

- **Values** - we launched the new values and the supporting behaviors in April. We will continue to work to embed these through policies, leadership development and our recruitment and progression processes so that they become a reality for the way we do business

As we move forward and reflect on the findings of the audit, Zeal will be working with our senior teams to share the results in more detail and support us to take action to address the findings. This will help us further understand how we can embed the recommendations of the audit into our organisational culture and make further improvements.

Covid-19 guidance

As restrictions are eased in many settings, NHS England and Public Health England, announced the guidance for both staff and patients in relation to healthcare settings will continue to apply. For us, this means there will be no change to the mask wearing and social distancing guidance. We will continue to follow the 'hands, face, space and ventilate' advice and encourage all staff to make use of lateral flow or LAMP testing twice a week; our responsibility to protect each other and our patients, as well as our own families and friends, remains.

The same applies for those using the NHS – patients will still be expected to follow the guidance and should wear masks when we attend to them. We will be using our public communications channels, including social media networks, to reinforce this message, which has been promoted by NHS England nationally; whilst cases are on the rise again we have to play our part in continuing to control the spread of the virus and consider those who may be vulnerable.

NHS England funding announcement for ambulance services

It has been confirmed that NHS England will be giving ambulance trusts a share of £55 million funding to help increase resources ahead of the winter.

For us, this means approximately £6.2m additional funding. Plans will now be developed to ensure we make the most of that money to maximise our available resources to see us through the winter months and reduce waiting times for patients.

In June, we took more than 155,000 emergency calls – 48,000 more than the same period last year and 23,000 more than 2019. Other ambulance trusts up and down the country are experiencing the same high levels of demand, so this funding comes at a crucial time.

Nursing and Midwifery forum

I recently attended the NWAS nursing and midwifery forum, chaired by our Assistant Director of Nursing, Lynsey Yeomans.

Guest speaker, Andrea Sutcliffe CBE, who is CEO of the Nursing and Midwifery Council, discussed how valued nurses and midwives are, even more so in Covid times, and talked about the future of the NMC, including the vision to update the NMC Code in 2025.

NWAS' Consultant Midwife, Stephanie Heys, updated the forum on her work so far on improving maternity care pre-hospital and the progress already made on developing the trust's first maternity strategy.

3.3 National Issues

Ambulance services come together to stop abuse

Ambulance services across the country are working with NHS England on the first-ever national campaign to tackle violence and aggression, which will launch in the autumn.

Every ambulance service is invited to participate in a virtual focus group over Teams where colleagues from across the country will chat informally about their experiences. The informal chat will help those working on the project gather background information to shape the campaign.

News programmes are always interested in this subject. I recently spoke about this issue on Channel 5 news in my role as Chair of the Association of Ambulance Chief Executives. Sky News aired a feature on body worn cameras with Paramedic Ian, who responds on the bike in Manchester city centre.

The trust takes a zero-tolerance stance. It's not part of the job and the trust will support any staff member to report the crime and follow through the process

Northern Ambulance teams work together

I recently met with the chief executives from the services in the Northern Ambulance Alliance (NWAS, NEAS, YAS and EMAS). We have seen huge benefits in working together, so we are extending this to some teams within our organisations.

We are establishing staff networks in digital, HR, quality improvement, fleet, strategy and those working on change programmes. The networks will share learning and work together to get the best value on specific projects.

Preventing suicide in the ambulance workforce

A shocking statistic from the Office of National Statistics indicated that male paramedics are 75% more likely to take their own life than any other health care professional. To help address the issue, Chief Allied Health Professions Officer for England, Suzanne Rastrick, commissioned a programme of work and established an ambulance sector suicide prevention and wellbeing advisory group.

AACE, together with Suzanne, launched three publications:

- 'Working Together to Prevent Suicide in the Ambulance Service – A National Consensus Statement for England',
- 'Prevention of Suicide in the Ambulance Service – What we Know'

- ‘Working Together to prevent suicide in the Ambulance Service – next Steps’

As well as the publications a lot of supporting work is going on in the background. A toolkit will be published to support the implementation of the recommendations in the documents. An advice pack for family and friends is also being created. We hope that we start to see a difference and that this work helps to address the tragic link between suicide and working in the ambulance service.

4. GENERAL

Team talk live

Following the last Board Meeting, our Chairman and I hosted the very first post- board Team Talk Live. More than 100 staff tuned in to hear the latest updates and announcements straight after the Board meeting and took the opportunity to ask questions. Talking points included: increased demand for 111, 999 and PTS; Equality Diversity and Inclusion; Manchester Arena Inquiry, EOC0001 Procedure/40 minute ruling and Paramedic Prescribing

Pride month

June was Pride month and was the perfect time to take stock of how far we've come and how much more there is to do to make our service inclusive for all.

LGBT people face inequalities in terms of access to services, clinical outcomes and experience, according to NHS England. The same applies to the NHS workforce - our staff survey results show that LGBT staff are more likely to have experienced abuse, harassment and physical violence from patients.

Our LGBT Network is open to all staff and focuses on improving the staff and patient experience for the LGBT community. The network has achieved great things over the last few years, including updating the procedure for supporting trans staff in the workplace, hosting the National Ambulance LGBT conference in Manchester in 2018, participating in the development of a CPD resource regarding the experiences of HIV positive patients and the development of our policy for supporting trans and Non-binary staff.

Well done to everyone involved for developing this vital area of work.

Armed Forces Week

Armed Forces Week also took place in June and the trust celebrated the contribution of all our veterans, reservists and cadet force adult volunteers.

It’s a shame that we couldn’t have our usual Reservists Day celebration at Ladybridge Hall this year. However we still raised the Armed Forces flag and celebrated through our normal communications channels.

A huge thank you to all of our armed forces staff for their essential contribution to the armed forces and the unique mix of skills and experience they bring to their roles with us.

New care standards for urgent and emergency care

A bundle of new access standards for urgent and emergency care has been proposed following a clinically-led review and consultation with clinicians and the public.

The 10 proposed standards would replace the four-hour target, which has only ever focused on one part of a complex range of services for patients. The proposed measures track activity across urgent and emergency care, rather than a single element of care, to help people understand what to expect at each stage and drive improvements.

The proposed standards are:

- Response times for ambulances
- Reducing avoidable trips (conveyance rates) to emergency departments by 999 ambulances
- Proportion of contacts via NHS 111 that receive clinical input
- Percentage of ambulance handovers within 15 minutes
- Time to initial assessment - percentage within 15 minutes
- Average (mean) time in department - non-admitted patients
- Average (mean) time in department - admitted patients
- Clinically ready to proceed
- Percentage of patients spending more than 12 hours in A&E
- Critical time standards

The NHS worked with many acute hospital trusts and consulted with clinical and patient representatives to develop and test the standards in practice.

I welcome these new standards which I believe could significantly improve the way patients experience healthcare from the NHS, both in terms of speed and clinical quality, and crucially through the elimination of handover delays at hospital emergency departments, which is a significant problem.

Ambulance services already play a vital role in offering the most clinically appropriate response to patients, including telephone advice or treatment at scene. These new changes could now see further improvements in wider urgent and emergency care provision, drawing on what has been learned during the Covid-19 pandemic and making the whole experience better for patients.

LAMP testing

All contact centre staff have access to Loop-mediated Isothermal Amplification (LAMP) tests, these are more accurate and quicker than the lateral flow tests and will be rolled out to more places as soon as possible. This one initiative is part of a range of measures to deal with Covid.

EU Settlement Scheme

The EU Settlement Scheme allows staff and their family members to get the immigration status needed to continue to live, work and study in the UK beyond the end of June 2021.

The confirmed status means staff can continue to be eligible for public services such as healthcare and schools, public funds and pensions and British citizenship if the relevant requirements are met.

New Partnership & Integration Managers

Linsey Hall and Nathan Hearn have recently been appointed as the new partnership and integration managers. As part of their new roles they will be responsible for

enhancing our engagement, collaboration and integration in the developing healthcare structure of Integrated Care systems (ICS)

NWAS' new look

As part of a branding refresh project by the Comms Team, our identity has had a makeover, including letterheads and presentations. To celebrate our unique role as the only ambulance service in the North West we have adapted our well-established NHS brand to play to our strengths and make us stand out.

Eid

Eid al-Adha is an important Islamic holy four day festival period for Muslims. Often abbreviated to Eid, the first day of the festival celebrated by Muslim communities across the North West was Tuesday 20 July.

Muslims celebrate the prophet Ibrahim's (Abraham) complete obedience to the will of God during Eid-al-Adha. They remind themselves of the importance of sacrifice to follow God's commands. It also marks the end of the annual Hajj pilgrimage to Mecca in Saudi Arabia. The pilgrimage took place this year, for a very limited number of people due to the Covid-19 pandemic restrictions.

On this day, Muslims will dress in smart attire and attend an early morning 'Eid Namaz' prayer service at their local mosque. They will also give money to charities that feed and or donate to the poor at this time. The greeting used on this day is known as 'Eid Mubarak'.

We would like to wish all our Muslim staff a very warm and heartfelt 'Eid Mubarak'.

Death of staff members

It is with great sadness that I report on the death of our friend and colleague: Michelle Clark

Michelle passed away after a battle with cancer. She joined the service in December 2017 as a PTS Controller/Planner and then progressed to duty manager in PTS control at Estuary Point

Also the death of our former friend and colleague Ken Hyde

Ken joined the service in 2002 as a PTS ambulance care assistant based at Blackpool ambulance station and later retired from the trust in 2014. Ken was highly respected and well liked amongst his friends, colleagues and patients alike. Ken's son is employed as a Community Resuscitation Development Officer based at Broughton

The trust sends sincere condolences to the families and friends of Michelle and Ken.

5. LEGAL IMPLICATIONS

There are no legal implication contained within this report

6. RECOMMENDATIONS

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

This page is intentionally left blank

NHS North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 28 July 2021		
SUBJECT:	Q1 Board Assurance Framework Review		
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs		
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.	☒
	SR02	There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements and infrastructure.	☒
	SR03	There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care.	☒
	SR04	There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services.	☒
PURPOSE OF PAPER:	For Decision		
EXECUTIVE SUMMARY:	The Corporate Risk Register can be seen in Appendix 1 and the proposed Q1 (as at 30 June 2021) of the Board Assurance Framework (BAF) with the associated Corporate Risk Register (CRR) risks scored ≥15 can be viewed in Appendix 2. The BAF Heat Maps for 2021/22 year to date can be viewed in Appendix 3. The Executive Leadership Committee (ELC) recommends the following Q1 change (s4): • SR02: Reduction in risk score from 20 to 15. ELC recommendations for additional risks to be included on the BAF from 1st July onwards can be seen in s5.		
RECOMMENDATION:	The Board of Directors are requested to: • Agree the reduction in risk score for SR02 from 20 to 15 • Agree the 2021/22 Q1 position of the Board Assurance Framework. • Agree the recommendation to include the additional four original strategic risks on the BAF from 1st July 2021 • Agree the recommendation from ELC that there is no requirement for a digital strategic risk on the BAF		
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability ☐
PREVIOUSLY CONSIDERED BY:	Assurance Committees, ELC and Audit Committee		
	Date:	Throughout Q1	
	Outcome:	For Assurance	

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

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

This paper provides an opportunity for the Board of Directors to review the 2021/22 Q1 position of the Board Assurance Framework (BAF) along with the Corporate Risk Register (CRR) risks scored 15 and above that are aligned to each BAF risk.

2. ASSURANCE PROCESS

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

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

3. REVIEW OF THE CORPORATE RISK REGISTER

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

4. REVIEW OF THE Q1 BAF POSITION

The Executive Leadership Committee has reviewed the Q1 position and recommends the following change to Board for approval:

SR02: There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure

- Reduction in current risk score for Q1 from 20 to 15

Opening Score 01.04.2021	Q1 Risk Score	Exec Lead
20 5x4 CxL	**15** 5x3 CxL	Ms C Wood

This risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. The Trust has agreed H1 plan and year to date position for Month 2 is on plan

2. The 2021/22 Capital Plan has been approved by NWAS Board of Directors and by the Lancashire and South Cumbria ICS Board, which included our CDEL requirement for 2021/22
3. The refreshed NWAS Financial Plans have been approved by the NWAS Board of Directors to cover H1 period in line with national guidance and system financial settlements
4. NWAS still awaits H2 Planning Guidance from NHSE/I.

5. 2021/22 BAF STRATEGIC RISKS Q2 ONWARDS

Initial work for the BAF identified potential strategic risks (see below), however, on 31 March 2021, the Board of Directors agreed a core set of four strategic risks to be carried into Q1 whilst awaiting planning guidance with an expectation that this would be reviewed for Q2.

The legislation changes are moving forwards and following recent Board strategic sessions on the risks around the proposed changes, the Executive Leadership Committee recommends to the Board of Directors that the following two original strategic risks are included on the BAF from 01 July 2021.

Risk Description	Exec Director Lead
There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint.	Director of Strategy & Planning
[sensitive part2 risk]	Director of Strategy and Planning

The Executive Leadership Committee has considered the remaining originally identified strategic risks and recommends to the Board of Directors that the following strategic risks should be added to the BAF from 01 July 2021:

Risk Description	Exec Director Lead
There is a risk that the required organisational cultural change does not sufficiently develop to support the organisational changes and improvements required to meet the changing demands on the service, resulting in poor quality services.	Director of People
There is a risk that non-compliance with legislative and regulatory standards could result in staff and/or patient harm.	Director of Quality Innovation & Improvement

Finally, the Executive Leadership Committee considered the feedback that the absence of a digital strategic risk was a potential gap for the organisation and should be considered for inclusion on the 2021/22 BAF. The Executive Leadership Committee following a frank discussion does not believe that digital is a key strategic risk to the Trust achieving its strategic objectives. It does agree that there are operational digital risks, however, these risks are sitting beneath SR01 and SR02 – aligning to patient safety and infrastructure. Therefore, the recommendation from the Executive Leadership Committee to the Board of Directors is that a digital strategic risk is not required on the Board Assurance Framework for 21/22.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

7. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the reduction in risk score for SR02 from 20 to 15
- Agree the 2021/22 Q1 position of the Board Assurance Framework.
- Agree the recommendation to include the additional four original strategic risks on the BAF from 1st July 2021
- Agree the recommendation from ELC that there is no requirement for a digital strategic risk on the BAF

This page is intentionally left blank

Appendix 1: Corporate Risk Register

Extracted from Datix on 08 July 2021

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (Initial)	Risk Treatment	Key Controls in Place	Likelihood (current)	Consequence (current)	Rating (current)	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
2507	01/02/18	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	Approved Risks	Operational	Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	Strategic Meal Break Guidance. NWAS Meal & Rest Break Management Working Arrangements Procedure. Strategic Meal Break Dining Instructions. Meal Break Policy. Return to base procedure/ guidance. Effective Meal Break Management of Operational Resources within Meal Break Window memorandum. Establishment of Meal Break Review Group to review current practices including review of the Policy. Terms of Reference for Meal Break review group. Paper presented to Workforce Committee in August 18 (07.08.18) and then October 18 (23.10.18) for further review re update on current meal break review. NWAS Strategic meetings taken place re Meal Break Management. (May 19 & 23 July 19). MB Workshop took place (8th July), led by Strategic Head of EOC to discuss SMB etc. Paper to be developed and presented back to Strategic Group by end of September 19 (DA). Additional focus in C&M EOC re adherence to the meal break policy to take place for a four week period throughout December 19. Rota Review which may support meal break management due to stagger times implemented in GM and C&L. Additional focus from the Covid-19 command cell re meal break management compliance (currently at 70%).	4	4	16	Review and Implement new Meal Break Policy - GB - March 21.	Meal Break Policy/Procedures. Meal Break Reports submitted to SD SMT. ORH and ACE to support NWAS model with recommendations made Links with Trade Unions and have their agreement Interim Head of Service for Cheshire & Merseyside reviewing Demand and Capacity Daily measurement of meal break compliance.	MIA Reporting re Meal Break Management.	4	02/06/21	14/07/21
2568	26/03/18	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	Approved Risks	Operational	Emergency Preparedness	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	NWAS action cards updated. NWAS Major Incident Response Plan/National Decision Making Model/JESIP ethos embedded across NWAS. Ballistic Personal Protective Equipment issued to trained staff with spare stores held on ISUs. All HART staff trained. 63 Uplift staff trained with further training planned. All Gx Sx Bx Commanders and APs attended training. Numerous multi agency `live` and `table top` exercises conducted. Cadre of specially trained Ambulance Intervention Team Commanders available. All Tactical Advisors and National Interagency Liaison Officers (NILOs) have been trained. Specialist medical equipment procured. Mutual Aid available from adjacent Trusts under the national mutual aid procedure. Trained Commanders identify themselves to Support Centre when on call. Operational uplift staff on duty identified on C3 and PROCLUS twice daily. Random sampling of trained staff on duty. Refresher training for Commanders, HART and uplift staff on continually rolling programme. NARU suggestion that NWAS can uplift their number of MTFA trained staff. 2 courses scheduled with GMP for 28 NWAS operational staff. 1 course delivered for 14 staff to increase required numbers.	3	5	15	Outcome of national decision re MTFA capability. There is a lack of staff trained in MTA who cover the Lancashire & Cumbria area	01.Approved Policies and Procedures. 02.Workforce Committee re reporting of staff trained. 03.National Capabilities Audit to NARU/NHSE. 04.Service Delivery SMT. 07. The deployment of resources into the hot and warm zones may include both specialist and non-specialist multi-agency responders with the correct PPE. 08.Commanders should decide when and how their responders are deployed (informed by the attack methodology). 09.The intention to deploy should be to minimise the risk to the public (including the injured) whilst maximising the safety of responders. 06.Agreed SORT uplift as agreed nationally – funding agreed (option 12) and roll out of SORT uplift in 2021 10. Substantive Training Manager has been appointed. 11. Funding has been approved to accommodate the backfill of staff for training 12. Project workstream is being developed to ensure compliance. 05.Approval of Option 12 has been given and commissioned and funded from April 2021 13. SORT Enhancement Project commenced May 2021.	01. National decision re MTFA funding. 03. Receipt of additional funding. 02. Ability to recruit 290 staff by 31/03/2022.	5	02/06/21	14/07/21
2867	22/02/19	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	Approved Risks	Operational	Digital and Innovation	te and Commercially Sensitive Risk Register	Maxine Power	16	mplement controls and mitigating actions to reduce the risk.	Change Control process to ensure the change is robust, widely communicated and contingency plans are in place where possible. Supplier engagement on high impact service changes Key programmes have PMO support and individual risks Corporate programme Board Project support for Digital projects (SPMS) and aligned with key projects CIO Role in post Continuous reviews of plans	4	4	16	Multiple training programmes being delivered symultaneously on and offsite Multiple projects running at same time -UCP, embedding SPMS, 111 First, ESMCP, infrastructure work Lack of detailed scoping of interdepndacies between changes to critical systems	CPB and DOF oversight - minutes System resilience measures MIAA business continuity audit	Detailed mapping of interdepndanices and resource Clear exec prioritisation of projects	8	19/05/21	30/07/21

						Corpora			Treat - I	Structure review for additional resources to support projects agreed and progressing										
										Increased VDI infrastructure										
3027	03/07/19	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	20	Treat - Implement controls and mitigating actions to reduce the risk.	Increased numbers for direct entry and in-service conversion programmes for 2019/2020 starts. 2019/20 in-service conversion rescheduled to maximise staff availability over winter periods (2019 and 2020) Active recruitment EMT approved 3 year transition to new skill mix July 2019 EMT approved increase in internal progression to 170 in July 2019, 165 starts. Paramedic apprenticeship preferred supplier in place and contract award approved by Board. Turnover remains stable. Plans agreed with HEIs to prevent COVID from delaying completion of programmes HCPC approval of U of C apprenticeship programme. HEE funding secured for rotational working pilots and recruitment to infrastructure posts commenced ELC approved key decisions for Paramedic apprenticeship, including supporting posts, cohort size and pay and conditions Paper approved for application of sponsor licence. Assessments completed for paramedic apprenticeship and offers made Adverts opened for paramedic pilots Paramedic apprenticeship programme commenced	4	4	16	01. Local Paramedic supply insufficient to meet potential demand 02. Impact of GP reform on retention unclear 03. Change in GP contract to band 7 funding for Paramedic posts. Further proposal also suggest Band 8A might be added to the ARRS. 04. Delay to rotational pilots as a result of COVID-19 05. PCN recruitment plans unclear	01. EMT1 AAP CPD Bridging Programme expansion, with over 250 EMT1s on track to achieve the AAP qualification. 02. AACE and HRD oversight of impact of GP reforms 03. Prevoius paper to EMT approving over-establishment of paramedics and increases in provision 04. EMT paper July 2019 - agreed 3 year transition to increased skill mix 05. Agreed ToR and project plan for rotational working groups 06. ELC approval of Paramedic apprenticeship supplier - January 2020 07. Confirmation of HCPC validation of apprenticeship course. 08. Contract for apprenticeship awarded. 09. POC case to ELC 19/08/20 which identifies Pilot Schemes. 10. Develop trust offer for rotational paramedic working both internal and externally - model in place and advanced discussions. 11. Pilot Schemes identified 12. ELC report Nov 20, confirmed continuation of two pilot scheme 13. ELC report Nov 2020, assurance on Paramedic apprenticeship progress and key decision milestones 14. Resources Committee, assurance on Paramedic	STP/ICS oversight of paramedic demand outside of ambulance trust Clear understanding about how the healthcare system is proposing to use paramedics to fill staffing gaps	4	25/05/21	25/06/21
3177	28/11/19	There is a risk that patient safety may be compromised due to the updated operation of the triage system (AMPDS ProQa) within the 999 environment. This is due to the updated program utilizing an electronic business continuity model rather than the manual card sets previously in place.	Approved Risks	Operational	Safety	Corporate and Commercially	Ged Blezard	12	Treat - Implement controls and	Priority Dispatch made aware of the issues EOC management aware of the risk to operations if PC's are unavailable VW meeting with the MIS to review process. Card-sets have been removed from EOC. Table Top BCS exercise in May 2021.	4	4	16	AMPDS manual card sets are not licensed for use Multiple evidenced failures of the backup ProQA system. iPads for each position within EOC. Standalone PRoQA doesn`t function as designed	Electronic version of ProQA which is a more advanced version of the card-sets available to each P.C. and will work independently of the CAD should that fail.	I.T. Investigating the incidents. Cardsets being issued in EOCs for use only when both ProQA and Standalone fail, and there is no other EMD to transfer the call to. iPads not being supplied to EOC.	4	02/06/21	14/07/21
3254	24/04/20	There is a risk that operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19 which may result in delayed patient response times and delivery of national ARP standards.	Approved Risks	Operational	Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	Maximum abstraction rates. Option to carry some leave over into the next financial year. Introduction of the NWAS annual leave buy back scheme. (8.47% of staff within PES took up the offer). NHS Employers guidance re annual leave carry forward provision (2 years). NWAS Operational Performance Calls. Operational, Tactical and Strategic Management. Performance Management Framework. Overtime opportunities. Use of Third Party Providers and VAS. Increase scope of Third Party Providers and VAS. NWAS Patient Safety Plan. NWAS Communications and use of Social Media Clinical Leadership Model. ROCC Tactical and Strategic Commanders. Deferring of Mandatory training. PTS resources used in PES Support work. Implementation of National Pandemic Card 36. NWAS COVID-19 Response Plan. Agreed additional funding to increase PES workforce establishment. Issue of taking carried over leave in Q1 of 2021 raised with ELC again on the 16 Dec 2020 and awaiting a decision - Q1 is likely to see continued high demand. ELC have agreed to extend the period of time in which annual leave can be taken (up to 20 days carried forward in line with National recommendation). Resources from MACA and eCFRs Annual leave to be taken across the leave period 1 April 2021 - 31 March 2022.	4	5	20	Number of operational staff opting to utilise the annual leave buy back scheme. Use of Overtime and impact on Trust Financial position Increased use of PAS/VAS impacting on Trust financial position Sustainability of using non-PES clinical resources Timescale of staff vaccination programme Subsequent COVID-19 peaks/waves Changing regional teir system and national/local lockdown restrictions. Evolving guidance on higher risk individuals who should be shielding Feedback on National ARP Standards. Funding for additional resources.	01.Abstraction Reports. 02.NWAS Annual Leave Buy Back Scheme. 09. Return to Work process in place for those who have been shielding. 10. Confirmation on the amount of annual leave that can be carried over from HR. 03.National Performance Data 04.ORH Modelling Report 05.NWAS Integrated Performance Report 06.NWAS Performance Reporting to Commissioners 07.NWAS Performance Reporting to NHSE/I 08.NWAS Workforce Indicators Report	Adherence to abstraction rates on abstraction reporting. Mandatory Training deferred until February 2021 Sustainability of using University Students for PES Support PTS Uplift staff working in PES Support roles There will be additional impact due to staff have been provided with an additional days annual leave across 2021/22.	5	02/06/21	14/07/21
3320	14/05/20	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	20	Treat - Implement controls and mitigating actions to reduce the risk.	Any suspensions that were in place at the start of the pandemic are still in place and being regularly reviewed. A small number of more serious cases have continued to be brought to conclusion. A risk assessment process has been developed to flag a priority order when resuming investigations / hearings. HRBP Team are looking at ways in whih cases can be expediated by reviewing and suggesting a temporary adjustment to the Scheme of Delegation. Principles regards employee relations cases agreed with Trade Unions to recommence March 21. Prioritisation process in place to clear back log	3	5	15	01. ET application responses from the Trust being delayed due to postal service delays and home working arrangements within the Team. 02. Lack of Operational and Clinical resources to pursue cases resulting in very lengthly investigations and potentially adverse impact on individual staff members. 03. The impact of the current situation with regards the Trusts strategic intentions around Just and Learning Culture and the associated review of the Disciplinary Procedure. 04. Further pause to hearings agreed Jan 13 2021	01. Temporary Scheme of delegation approved by ELC. 02. SPF document issued to Trusts to pause until 30/09 unless agreements reached. 03. Principles for managing ER cases agreed with local trade Unions. 04. HR Team prioritising cases in line with agreed principles. 05. ER tracker with ER cases now reported on a monthly basis to ELC. 06. Workforce indicators report Resources Committee March 2021		5	25/05/21	25/06/21

3433	26/10/20	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond.	Approved Risks	Financial	Value for Money/ Efficiency	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	16	Treat - Implement controls and mitigating actions to reduce the risk.	The Director of Finance presented a paper to the Regional Leadership Group on 14th October, which outlined the 2020/21 and recurrent funding required. 2020/21 funding was agreed but there has been no agreement yet on recurrent funding. NHSE/I, commissioners and the Regional Leadership Group are all aware of the recurrent financial impact for NWAS. Ongoing dialogue between Finance and 111 Operations to minimise the recurrent impact as possible without impacting on service provision. 111 Operations, Finance and HR are in regular dialogue regarding the trajectory of recruitment to mitigate the recurrent impact. Confirmation of funding within the H1 plan, which is going to Resources Committee and Trust Board for approval in May, of £1.300m national SDF for Q1 and £1.822m regional system funding for H1. National funding for 2021/22 Q2 and beyond will be dependent on the conclusions drawn from the full 111 First programme evaluation which will occur during Q1. NHSI also have an interim evaluation that should be completed imminently which may give some insight of what we can expect in the full evaluation. NWAS has submitted the 2021/22 staff in post trajectory to the NHSEI UEC Team which is anticipated to form part of the funding evaluation for the remainder of 2021/22.	4	4	16	No confirmed recurrent funding information available. The Phase 3 financial regime covered 1st October 2020 to 31st March 2021 only and NHSE/I have confirmed that the national SDF will currently cover 2021/22 Q1 only, pending the outcome of a programme evaluation and workforce trajectories.	Reported to the Regional Leadership Group on 14th October Continued dialogue with regional NHSEI on the funding requirements Continued engagement with the NHS 111 First Operational Delivery Group	NHSE/I have confirmed that the current financial framework will roll over into 2021/22 H1, however national funding has only been confirmed for Q1 and no further information has been received relating to recurrent values.	4	18/05/21	30/06/21
3447	17/11/20	There is a risk that due to increasing operational demands and call volumes across NWAS, the health and wellbeing of our workforce may deteriorate leading to sickness and absenteeism which may impact on staff safety	Approved Risks	Operational	Workforce	Corporate and Commercially	Ged Blezard	16	Treat - Implement controls and	Local Health and Wellbeing Plans Organisational Policies and Procedures Self-Referral Schemes Health & Wellbeing initiatives Occupational Health HR Business Partnering Team	4	4	16	01. Outcome of internal service delivery model review	01. Demand levels have seen a recent decrease 02. Reinforcement of local level engagement and partnership with Trade Unions 03. Sickness and Data Officer position created to manage sickness. 04. Return to Work procedures taking place for those	None	4	02/06/21	14/07/21
3452	17/11/20	There is a risk that with the existing operating model for NWAS, this may be ineffective due to insufficient workforce, vehicles & processes due to increases in operational demand and patient acuity across PES. This may impact on our ability to achieve our ARP standards with limited resources for effective and efficient utilisation across the region which could result in delayed patient response.	Approved Risks	Operational	Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	25	Treat - Implement controls and mitigating actions to reduce the risk.	01.Shared learning via AACE and other NHS Ambulance Trusts 02.Preparatory workforce planning including overtime and recruitment opportunities 03. Senior operational representation at National level 04. NWAS representation on monthly conference calls 05. Implemented Pre-Determined Attendance (PDAs) part of ARP v2.3 and frequent reviews of PDAs 06. Implemented clinical leadership across all EOCs and Trauma cells 07. Implementation of Demand Management Plan 08. Auto-allocation 09.Management of IFT/ HCP activity 10. DCA, RRV and ORH Modelling Review Building & Better Rota's Project 11. Fleet Replacement Programme 12. Operational Policies & Procedures and Operational Guidance 13. Operational, tactical and Strategic Management 14. Performance Management Framework 15. Additional resources utilised to support performance, e.g. use of Third Party Providers with increased scope of practice, use of CFRs and PTS supporting PES work 16. NWAS Communications; use of social media 17. Clinical Leadership Model 18. NWAS Operational Performance Calls 19. ROCC Tactical Commanders & Strategic Commanders 20. Cancellation of mandatory training & appraisals 21. Implementation of National Pandemic Card 36 22. NWAS Winter Plan 23. Engagement with System Leaders & Acute Hospitals 24. Engagement with NHSE/I 25. Engagement with NWAS Lead Commissioner 26.Temporary suspension of Mandatory Training and Clinical supervision 27.Initiated Actions for REAP 3 and REAP 4 as agreed by EL 28.Weekly review of strategic intentions in connection with increases in pressures.	5	5	25	04. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 01.Additional Finances from Commissioner 02.Delivery of Urgent and Emergency Care Strategy 03.Workforce Planning	09.NWAS REAP levels reduced to level 2 in March 2021. 10. National Hospital Handover Performance Data 11. NWAS Hospital Handover Performance Data to Commissioners 12. NWAS Hospital Handover Performance Data to NW NHSE/I 13. NWAS Integrated Performance Report 14. Hospital Handover Project Documentation 15. Every Minute Matters Project Documentation 16. DATIX reports have seen a measured reduction in the number of vehicles being delayed outside of hospitals. 17. PES abstraction rates are reducing 18. Right Care Closer to Home` allocated to SPTLs. 19. Improvement of turnaround times for ambulances of 28 mins (set against 30 mins). 01.National Performance Data 02.National ARP Data 03.ORH Modelling Report 04.NWAS Integrated Performance Report 05.NWAS Performance Reports to Commissioners 06.NWAS Performance Reports to NHSE/I 07.NWAS Business Cases for Fleet Replacement 08.NWAS Workforce Indicators Report	01. AACE to simplfy the operating model. 02. Continued hospital pressures	5	02/06/21	14/07/21
						ster			uce the risk.	Operational, Tactical and Strategic Management Performance Management Framework Overtime opportunities Recruitment opportunities Use of Third Party Providers Increased scope of practice for Third Party Providers								

3455	17/11/20	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Regis	Ged Blezard	20	Treat - Implement controls and mitigating actions to redu	Additional resources utilised to support performance NWAS Demand Management Plan NWAS Communications; use of social media Clinical Leadership Model Trauma Cell in EOCs Utilisation of CFRs NWAS Operational Performance Calls ROCC Tactical Commanders & Strategic Commanders Cancellation of mandatory training & appraisals PTS Resources being utilised for PES Support Work Implementation of National Pandemic Card 36 NWAS COVID-19 Response Plan NWAS Winter Plan ORJ Modelling Review Engagement with System Leaders & Acute Hospitals Engagement with NHSE/I Engagement with NWAS Lead Commissioner BT Scripts for COVID-19 Calls into NWAS Agreed additional funding to increase PES workforce establishment	3	5	15	01. Continued high abstraction rates of staff and limited resources.	01. Weekly monitoring of resources 02.Military assests provide limited resources. 03. Reduction in NWAS REAP Levels to Level 2 in March 2021 04. Weekly Strategic Delivery and Performance Cell meeting reduced to bi-weekly meetings until week 2 April 2021.	01. Inability to cover all abstractions 02. External pressures have increased Trust REAP Levels to Level 3	5	02/06/21	14/07/21
3456	17/11/20	There is a risk that due to increasing numbers and acuity of 999 calls to NWAS EOCs, call pick up delays may be experienced by callers which could impact on our ability to achieve operational performance standards and patient`s ability to access emergency care. This is also affected by the pressures experienced by other National Ambulance Controls and requests from the BT to take 999 calls.	Approved Risks	Operational	Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Agreed increase in EMD establishment 02. Agreed implementation of EMD Support Staff 03. Performance Management Framework 04. Call Pick Performance Data 05. Wallboards in EOCs 06. Implementation of BT Scripts for screening COVID-19 Calls 07. Implementation of National Pandemic Card 36 08. NWAS Demand Management Plan 09. EMD Recruitment 10. EMD Training and Mentoring 11. Additional EMDs and EMD Support Staff recruited & operational 12. Reduction in duplicate calls 13. Additional workforce resources for EOCs being managed via NHSE/I 14. HI reporting enables planning for Building Better Rota's 15. Agreement to increase staffing levels in EOCs 16. Use of agency staff	4	5	20	01.Additional recruitment supported by NHSE/I 02.Buddy Support for other NHS Ambulance Services during periods of high demand 03. Increased activity from members of the public due to follow-up calls 04. Increased pressures on the workforce 05. Increased acuity - Cat 2 increased by 60% 06. Increase in call demand/ follow-up calls	Continued recruitment of ECH`s. A number of Agency EHCs have been given fixed term NWAS contracts until end September 2021 National Performance Data NWAS Integrated Performance Report NWAS Performance Data to Commissioners Performance Management Framework Incident Report Forms	No gaps.	5	14/06/21	14/07/21
3459	19/11/20	There is a risk that due to the increasing operational demands, call volumes and numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards and this may also affect the wellbeing of our workforce leading to sickness and further absenteeism.	Approved Risks	Operational	Workforce	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce	01. BCM in place across Service Delivery areas 02. Access to Occupational Health 03. Organisational Policies and Procedures 04. Alternative Duties 05. HR Business Partnering Team for Advice & Support 06. Military assets are being utilised to support PES and PTS with low acuity calls (February 2021 - March 2021). 07. Local Health and Wellbeing Plans & initiatives 08. Self-Referral Schemes	4	4	16	01. The military assets are unable to back fill the vacancies by 100% of the current abstractions. 02. Outcome of internal service delivery model review	01. Military assests are able to provide a level of support to PES and PTS. 02. Staff abstraction rates have reduced; 03. Sickness and Data Officer position created to manage sickness. 04. Reinforcement of local level engagement and partnership with Trade Unions	01. Waitng confirmation from Heads of Service across Service Delivery.	4	02/06/21	14/07/21
3487	27/01/21	There is a risk that the Trust will not meet compliance with the Data Security and Protection Standards for health and care, due to the low compliance with the Mandatory Training Data Security Awareness Module, which may result in non-compliance with regulatory standards	Approved Risks	Operational	Information Governance	Corporate and Commercially Sensitive	Maxine Power	12	Treat - Implement controls and mitigating	Data Security Awareness Training Module in MyESR Compliance with Mandatory Training discussed at Local Meetings & IMG Mail Merge completed from MyESR to all non-compliant staff Communication Bulletin	5	3	15	Lack of awareness of compliance with Data Security Awareness Training Lack of timescales for completion of Mandatory Training across the Trust Monitoring of compliance by Local Managers Operational pressures of the Trust Compliance of 95% for Data Secruity Awareness Training	Mandatory Training Compliance Spreadsheets Workforce Indicators Assurance Report to Resources Cttee Information Governance Key Performance Indicators Report to IMG MIAA DSPT Readiness Audit	Local Level Mandatory Training Compliance Trust-wide Mandatory Training Compliance Completed MIAA Audit on DSPT	3	19/05/21	23/07/21
3514	31/03/21	There is a risk that we are not fulfilling our contractual responsibility to pay section 2 staff correctly when they are on annual leave or a period of absence that attracts unsocial hours pay, resulting in underpayments of salary. This affects only staff who have transferred from Annex 5 to Section 2 and are within their first 12 months of the transfer date and relates to ESR system limitation.	Approved Risks	Operational	Workforce	Corporate and Commercially Sensitive Risk Register	Lisa Ward	15	Treat - Implement controls and mitigating actions to reduce the	Meeting with national ESR along with payroll to explore solution options Meeting with TU leads to highlight difficulty and explore solution options. Staff affected identified by payroll. HRBP team aware of the problem.	5	3	15		01. Suggestions put forward by payroll and TU leads are being worked through to identify a suitable solution that is unlikely to result in detriment to affected staff. 02. Discussions with payroll about potential to pay a 5% payment in first 12 months. further discussion with People SMT and TU's. If agreed Payroll have confirmed could be during Q1 of 21/22.		6	25/05/21	25/06/21
3519	14/04/21	There is a risk that the NWAS IT infrastructure at GMP Headquarters is inadequate for the needs of NWAS and could severely compromise a multi-agency response to a large, critical or major incident	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially	Maxine Power	16	Treat - Implement controls and	Wifi provided by GMP (very limited) NWAS Infrastructure currently permits one user with limited or no access to systems other than email. GMP, HEADQUARTERS,4 NORTHAMPTON ROAD,, M40 5BR is due to get a network link upgrade to 50mb as part of WAN upgrade	4	4	16	Resilient NWAS IT infrastructure for multiple user access to NWAS systems across the 4 pods at GMP HQ – IT Request in place Resilient WIFI Systems as a backup for NWAS systems	Debrief Reports Incident Logs Incident Reporting	No design of requirements has been submitted and that C3 can only run on a sub 7ms latency network. Connectivity Report	3	17/06/21	14/07/21
3520	20/04/21	There is a risk that due to additional use of third party providers (private ambulance and taxi providers), which has resulted from increases in activity, and continued social distancing measures, this places in increased financial risk on PTS. This may lead to the service becoming financially unsustainable.	Approved Risks	Financial	Performance	Corporate and ommercially Sensitive	Ged Blezard	20	Treat - Implement ontrols and mitigating	Third party resources are procured utilising a procurement framework in line with the NHS Contract and Procurement Regulation to ensure value for money. Third party resources are utilised based on demand. Existing procurement arrangements are in place for the 1st half of the year.	5	4	20	Staff are still absent due to shielding and are unable to return to fact-to-face duties. 100+ staff are currently working within the PES service line with no know return date. Currently no changes in the social distancing guidance which impacts on vehicle capacity. The level of out-patient restoration is currently unknown	Discussed at Level 3 meeting Discussed at Service Delivery SMT Discussed with Finance Department	Currently no independent assurance available	4	02/06/21	14/07/21

						Cl			Cc	Discussed at ELC and SPTB				unknown.					
3532	13/05/21	There is a risk that NWAS records are not managed appropriately due to a lack of a robust records management framework, policy and procedures, resulting in poor decisions based on inadequate information, financial loss, reputational damage, failure to handle confidential information with the required level of security and protect information	Approved Risks	Operational	Compliance and Regulation	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the risk.	Records management policy agreed	4	4	16	Records management policy not enacted No resources to support records management Control not full enacted against the records policy for sharepoint		No audit of records management No centralised oversight and governance of records management No resource to enact the records management policy	4	13/05/21	31/08/21
3536	16/06/21	There is a risk that the H1 draft planned financial deficit is not achieved because of the Covid-19 outbreak which may increase the Trust financial pressure, and further compromise achievement of Trust statutory financial duties and requirements.	Approved Risks	Financial	Value for Money/ Efficiency	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. Projected £24m additional costs based on the resources put in place for Covid-19 response last year, plus forecast increased social distancing costs required for recovering PTS activity. To date £22.8m income has confirmed from L&SC Covid-19 allocation Phase 1 final financial plans have been submitted to ICS (5th May 2021) which identify a projected deficit of £2m, with the following included:- 02. £3.6m efficiencies have been included in the plan, based on run rate savings identified in H2 03. NHSE/I have continued the Monthly Block Contract arrangements based on which has been £0.9m financial uplift, £2.3m 111 core contract increase, and £2.5m national top up, which has been reconciled and agreed by Finance 04. Quarter 1 national 111F SDF incomed confirmed £1.3m, with the committed H1 6 month expenditure driving the £2m overall deficit. This is whilst nation evaluation of the 111F scheme is underway, with monthly reviews/allocations being confirmed whilst this is being finalised. 05. Cash flow will continue to be closely monitored to ensure there is no negative impact on the Trust due to this new NHS finance regime 06. Monthly finance reporting to ELC, and Resources Committee detailing achievement to date and forecast achievement of plan, indicating necessary action to be taken if/when required.	3	5	15	Efficiency and Productivity Oversight group are yet to meet formally	• Achievement of plan to date (M2), reported to NHSE/I and ELC	Awaiting formal confirmation of future 111F national SDF allocations	10		16/07/21
1181	30/01/14	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.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the risk.	Robust National 999 Network Constantly monitored by National Operator Centre Full Business Continuity plans developed in partnership with all telecom providers. Resilient telephone system and network design including diverse routing. NWAS operate a virtual regional network 24/7 specialist support from NWAS staff and Third party suppliers There is constant liaison with the core provider 999 liaison teams who will monitor and advise of any threat that may interrupt the service. SMT Team meetings to review system updates/ outages Change request process in place and meets weekly as part of a formal CAB A back up voicemail server is being purchased to enable a swap out in the event of failure, greatly reducing downtime. Unified Communications Programme has submitted a business case to replace all telephony and the voicemail solution which will eliminate this risk. Unified Communications Business case approved and work underway.	3	5	15	Current telephony systems are end of life and are no longer supported by Avaya with only limited support from BT available. Full Business Continuity plans need to be reviewed and tested in partnership with the providers and EOC Avaya are no longer providing any security patching or updates after April 19 The Voicemail server is end of life ,vulnerable to cyber attack and sits on the NWAS LAN, any outages would result in no messages being heard and dropped call rates Due to increased capacity of home workers due to COVID-19 the CISCO infrastructure may exceed capacity	BT providing interim maintenance and support Any system downtime reported to ICT SMT meetings Changes to telephony are strictly monitored and controlled via CAB	Report from third party to show preventative maintenance outcome	5	29/03/21	30/06/21

This page is intentionally left blank

North West Ambulance Service NHS Trust

APPENDIX 2

Board Assurance Framework 2021/22

BOARD OF DIRECTORS

WEDNESDAY 28 JULY 2021

nwas.nhs.uk

Q1 2021/22 Reporting Timescales:

Quality & Performance Cttee:	26/07/2021
Resources Cttee:	23/07/2021
Executive Leadership Cttee:	21/07/2021
Audit Cttee:	16/07/2021
Board of Directors:	28/07/2021

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

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

Board Assurance Framework Legend

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

OUR STRATEGY AT A GLANCE

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

Values:

WORKING TOGETHER.

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

BEING AT OUR BEST.

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

MAKING A DIFFERENCE.

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

Priorities:

Urgent and Emergency Care

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

Quality

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

Digital

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

Business and Commercial Development

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

Workforce

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

Stakeholder relationships

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

Infrastructure

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

Environment

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

Supporting strategies:

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

BOARD ASSURANCE FRAMEWORK DASHBOARD 2021/22

BAF Risk	Committee	Exec Lead	01.04.21	Q1	Q2	Q3	Q4	2021/22 Target	Final Target
SR01: There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure	**Resources**	**DoF**	**20** 5x4 CxL	**15** 5x4 CxL				**15** 5x3 CxL	**5** 5x1 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**20** **5x4** **CxL**				**15** 5x3 CxL	**5** 5x1 CxL
SR04: There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**8** 4x2 CxL	**4** 4x1 CxL

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR01:
There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Strategic Priority: Quality

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 of this BAF risk has maintained a scored of a 15 due to the continuing impact of COVID-19 on response times. SR03 directly correlates with delays in the delivery of care which affects quality, safety, and patient experience. There have been significant improvements in quality, however work is required to recover, maintain, and improve quality to deliver our strategic intentions to be the best ambulance service in the context of COVID-19 recovery. The pandemic has highlighted the importance of having the right clinical leadership structure, particularly preventing harm while waiting, ensuring clinical best practice, and learning when things g wrong. The biggest risk for 2021/22 is the resource required to fund the proposed leadership model for both operations and corporate is yet to be secured due to the prolonged pause in financial planning. The ongoing focus will include delivering the milestones in the Right Care Strategy, refreshing the strategy, and delivering on the requirements of the new regulatory regime.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report	Reported to BoD (BOD/ 2122/29) Reported to BoD (BOD/ 2122/11)
Clincial Audit	**Level 2:** Clinical Audit Plan 2021/22	Reported to Q&P Cttee (Q&PC/ 2122/15)
Quality Surveillance	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2021/219)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 20122/35)
CQC Transitonal Monitoring	**Level 2:** CQC Assurance Report & Action Plans	Reported to Q&P Cttee (Q&PC/ 2122/34)
Quality Systems and Process	**Level 2:** MIAA Quality Audit Plans	Reported to Audit Cttee (AC/ 2122/12)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (Q&PC/ 2021/171)
DIGITAL		
Digital Strategy	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2122/23)
Data Security and Quality	**Level 3:** Data Secruty Protection Toolkit **Level 3:** MIAA Digital Audit Plans	Reported to Audit Cttee (AC/ 2122/10)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Complaints & Incident Management	Develop and deliver a new operating model	Prof M Power	Q2	Q&P Cttee	In Progress
Midwifery Strategic Plan	Develop and deliver the Midwifery Strategic Plan	Dr C Grant	Q3	Q&P Cttee	In Progress

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

Operational Risks Scored 15+ Aligned to BAF Risk: SR01

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
1181	Operational/ Digital & Innovation	There is a risk that the 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	⇔	5 Moderate
2867	Operational/ Digital & Innovation	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	16 Significant	16 Significant	⇔	8 High
3177	Operational/ Safety	There is a risk that patient safety may be compromised due to the updated operation of the triage system (AMPDS ProQa) within the 999 environment. This is due to the updated program utilizing an electronic business continuity model rather than the manual card sets previously in place.	12 High	16 Significant	↑	4 Moderate
3455	Operational/ Patient Safety	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	20 Significant	15 Significant	⇔	5 Moderate
3456	Operational /Performance	There is a risk that due to increasing numbers and acuity of 999 calls to NWAS EOCs, call pick up delays may be experienced by callers which could impact on our ability to achieve operational performance standards and patient`s ability to access emergency care. This is also affected by the pressures experienced by other National Ambulance Controls and requests from the BT to take 999 calls.	20 Significant	20 Significant	↑	5 Moderate
3466	Operational/ Safety	There is a risk that there is currently no consistent approach, across the Trust, to the reporting and management of level 1 to 3 internal and external incidents, which will result in missed opportunities for managing identified harm for staff and patients, potentially identifying higher levels of harm, learning and the prevention of reoccurrence.	15 Significant	15 Significant	⇔	3 Low
3487	Operational/ Information Governance	There is a risk that the Trust will not meet compliance with the Data Security and Protection Standards for health and care, due to the low compliance with the Mandatory Training Data Security Awareness Module, which may result in non-compliance with regulatory standards	12 High	15 Significant	↑	3 Low
3519	Operational/ Emergency Preparedness	There is a risk that the NWAS IT infrastructure at GMP Headquarters is inadequate for the needs of NWAS and could severely compromise a multi-agency response to a large, critical or major incident.	16 Significant	16 Significant	⇔	3 Low
3532	Operational/ Compliance & Regulation	There is a risk that NWAS records are not managed appropriately due to a lack of a robust records management framework, policy and procedures, resulting in poor decisions based on inadequate information, financial loss, reputational damage, failure to handle confidential information with the required level of security and protect information.	20 Significant	16 Significant	⇔	4 Moderate

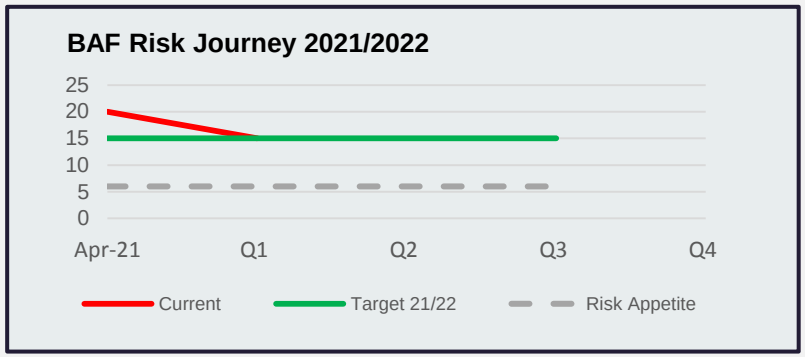
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR02:
There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q1 of this BAF risk has decreased in risk score to a 15 due to the Trust having an agreed H1 plan and the year to date position for Month 2 being on plan. The 2021/22 Capital Plan has been approved by the NWAS Board of Directors and by the Lancashire and South Cumbria ICS Board, which included our CDEL requirement for 2021/22. The refreshed NWAS Financial Plans were approved by the NWAS Board of Directors to cover the H1 period in line with the national guidance and system financial settlements. NWAS still awaits H2 Planning Guidance from NHSE/I.

CONTROLS	ASSURANCES	EVIDENCE
Financial Plans	**Level 2:** 2021/22 Financial Plans	Reported to BoD (BOD 2122/15)
Financial Controls	**Level 3:** MIAA Internal Audit – Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Significant Change Projects	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB
2021/22 Capital Plan	**Level 2:** 2021/22 Captial Plan **Level 3:** NWAS 2021/22 Captial Plan	Reported to BoD (BOD/2122/15) Reported to Lancashire & South Cumbria ICS Board

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
2021/22 Capital Plan	Approved 2021/22 Captial Plan	Ms C Wood	July 2021	Resources Cttee	Completed
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	July 2021	Resources Cttee	In Progress
H2 Planning Guidance	Receipt of H2 Planning Guidance from NHSI	Ms C Wood	July 2021	Resources Cttee	Not Commenced
2021/22 H2 Revenue Financial Plan	Approved 2021/22 H2 Revenue Financial Plan	Ms C Wood	September 2021	Resources Cttee	Not Commenced
2021/22 H2 Efficiencies	Delivery of 2021/22 H2 Efficiency Savings	Ms C Wood	September 2021	Resources Cttee	Not Commenced
Funding for Digital Strategy Delivery	To source alternative funding models (ICS/ National)	Prof M Power	September 2021	Resources Cttee	In Progress
Funding for key risk mitigation within the Digital portfolio	Develop proposal to mitigate data quality, clinical records governance, records management and development support	Prof M Power	September 2021	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3433	Financial/Value for Money/Efficiency	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond.	16 Significant	16 Significant	⇔	4 Moderate
3514	Operational/ Workforce	There is a risk that we are not fulfilling our contractual responsibility to pay section 2 staff correctly when they are on annual leave or a period of absence that attracts unsocial hours pay, resulting in underpayments of salary. This affects only staff who have transferred from Annex 5 to Section 2 and are within their first 12 months of the transfer date and relates to ESR system limitation.	15 Significant	15 Significant	⇔	6 Moderate
3520	Financial/ Performance	There is a risk that due to additional use of third party providers (private ambulance and taxi providers), which has resulted from increases in activity, and continued social distancing measures, this places in increased financial risk on PTS. This may lead to the service becoming financially unsustainable.	20 Significant	20 Significant	⇔	4
3536	Financial/ Value for Money/ Efficiency	There is a risk that the H1 draft planned financial deficit is not achieved because of the Covid-19 outbreak which may increase the Trust financial pressure, and further compromise achievement of Trust statutory financial duties and requirements.	15 Significant	15 Significant	⇔	10 High

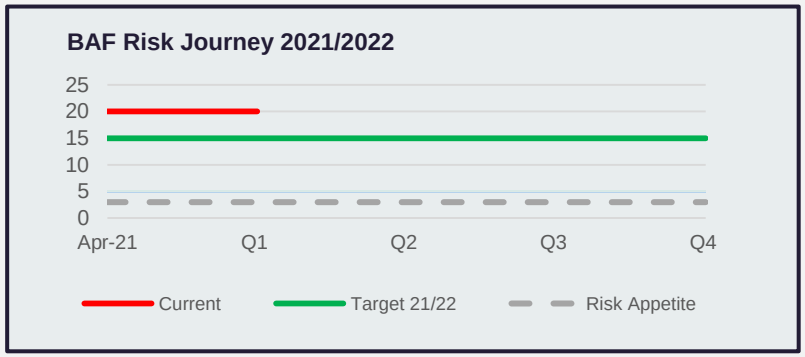
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR03:
There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care

Strategic Priority: Urgent & Emergency Care

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 of this BAF risk has maintained a scored of a 20 due to increased operational pressures the Trust has seen across 999 and NHS 111 during Q1., resulting in an increase to REAP Level 4 at the beginning of June 2021. The Trust continues to apply appropriate mitigating measures in place to assist with pressures, including use of third-party providers, shift enhancements and PTS providing support to PES. ETA scripts have been introduced within Q1 to minimise the number of duplicate 999 calls. The Trust continues working with AACE and ORH with the initial findings from the Demand and Capacity Review.

CONTROLS	ASSURANCES	EVIDENCE
Optima Independent Review of NWAS Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&P Cttee (Q&PC 2021/145)
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BOD/ 2122/29)

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

Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	↑	4 Moderate
3177	Operational/ Safety	There is a risk that patient safety may be compromised due to the updated operation of the triage system (AMPDS ProQa) within the 999 environment. This is due to the updated program utilizing an electronic business continuity model rather than the manual card sets previously in place.	12 High	16 Significant	↑	4 Moderate
2568	Operational/ Emergency Preparedness	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	20 Significant	15 Significant	⇔	5 Moderate
3254	Operational/ Performance	There is a risk that operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19 which may result in delayed patient response times and delivery of national ARP standards.	20 Significant	20 Significant	↑	5 Moderate
3447	Operational/ Workforce	There is a risk that due to increasing operational demands and call volumes across NWAS, the health and wellbeing of our workforce may deteriorate leading to sickness and absenteeism which may impact on staff safety	16 Significant	16 Significant	⇔	4 Moderate
3455	Operational/ Patient Safety	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	20 Significant	15 Significant	⇔	5 Moderate
3456	Operational/ Performance	There is a risk that due to increasing numbers and acuity of 999 calls to NWAS EOCs, call pick up delays may be experienced by callers which could impact on our ability to achieve operational performance standards and patient`s ability to access emergency care. This is also affected by the pressures experienced by other National Ambulance Controls and requests from the BT to take 999 calls.	20 Significant	20 Significant	↑	5 Moderate
3452	Operational/ Performance	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being in place currently which may impact on our ability to achieve our ARP standards.	25 Significant	25 Significant	↑	5 Moderate
3459	Operational/ Workforce	There is a risk that due to the increasing operational demands, call volumes and numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards and this may also affect the wellbeing of our workforce leading to sickness and further absenteeism.	16 Significant	16 Significant	⇔	4 Moderate

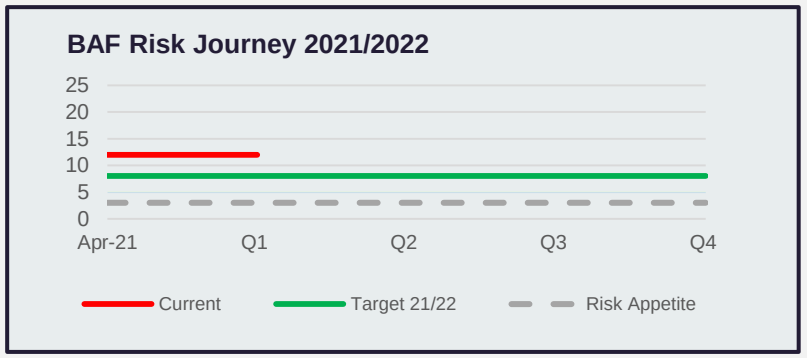
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR04:
There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 of this BAF risk has maintained a scored of a 12 due to improvements in abstractions and mobilisation of high-volume recruitment. The return of turnover to pre-COVID levels is being seen but risks of high turnover related to PCN recruitment has not materialised in Q1. Overall vacancy position remains good except for PTS where plans are in place. Recovery arrangements for key indictors demonstrated good progress, although impacted by REAP level 4 and pause for frontline operations in June 2021, plans are being refreshed. Planned culture and inclusion work has progressed including the launch of the refreshed Trust values and 'Treat Me Right' campaign, sharing of culture audit outcomes at senior level and incorporation of actions into the NWAS People Plan. Some evidence of impact on morale of frontline staff from extended pandemic and current activity levels.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to BoD (BOD/ 2122/37)
Strategic Workforce Plan	**Level 2:** H1 Planning Submission	Reported to BoD (BOD/ 2122/10)
Diversity & Inclusion Plans	**Level 2:** Diversity & Inclusion Assurance Report	Reported to Resources Cttee (RC/ 2122/22)
People Metric Surveillance	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Report **Level 2:** Staff Survey and Culture Audit Deep Dive	Reported to BoD (BOD/ 2122/29) Reported to Resources Cttee (RC/ 2122/20) Reported to Resources Cttee (RC/ 2122/07)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Workforce Plans	Development of Operating Plan and Sign Off	Ms L Ward	May 2021	Resources Cttee	Completed
Staff Survey & Culture Audit Results	Implementation of action plans and monitoring of impact	Ms L Ward	May 2021	Resources Cttee	Completed
HR Casework Backlog	Implementation of action plan to reduce backlog of casework	Ms L Ward	July 2021	Resources Cttee	In Progress
Recruitment Plans	Confirmation of Q2 recruitment plans	Ms L Ward	July 2021	Resources Cttee	In Progress
Freedom to Speak Up	Complete actions identified by MIAA Internal Audit	Ms L Ward/ Ms A Wetton	September 2021	Resources Cttee	In Progress
Mandatory Training Compliance	Refresh recovery plans for mandatory training resulting from Q1 pause	Ms L Ward	September 2021	Resources Cttee	In Progress
Vaccination	Develop plans for Flu and COVID booster roll out	Ms L Ward	September 2021	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3027	Operational People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	20 Significant	16 Significant	⇔	4 Moderate
3320	Operational People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care.	20 Significant	15 Significant	⇔	5 Moderate
3459	Operational/ Workforce	There is a risk that due to the increasing operational demands, call volumes and numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards and this may also affect the wellbeing of our workforce leading to sickness and further absenteeism.	16 Significant	16 Significant	⇔	4 Moderate

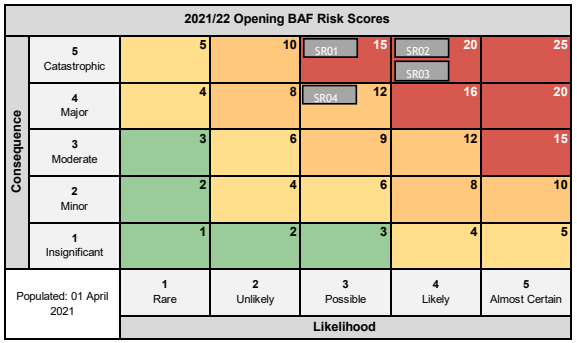
This page is intentionally left blank

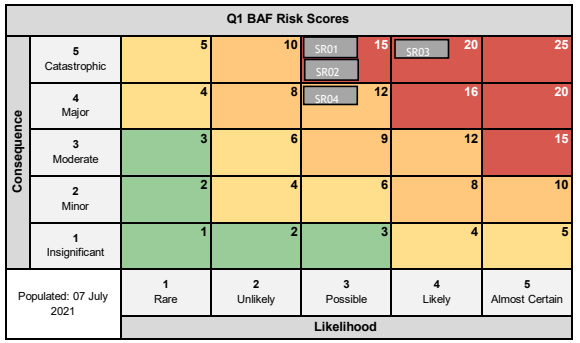
Appendix 3:

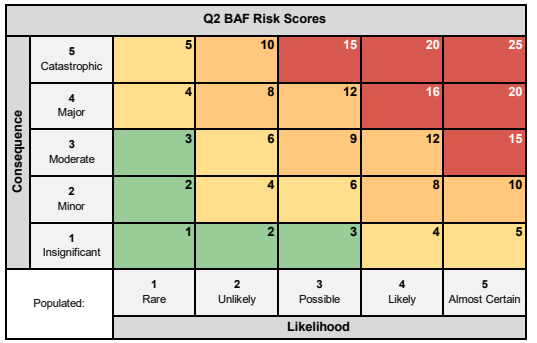
2021/22 Board Assurance Framework (BAF) Heat Maps

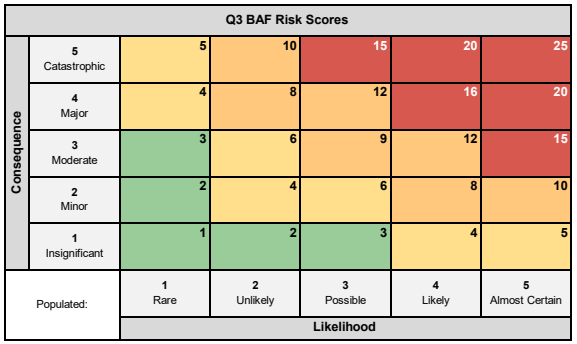
Quarter 1 Position

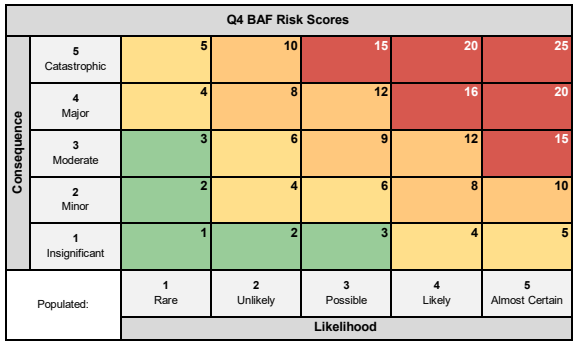
NHS North West Ambulance Service NHS Trust

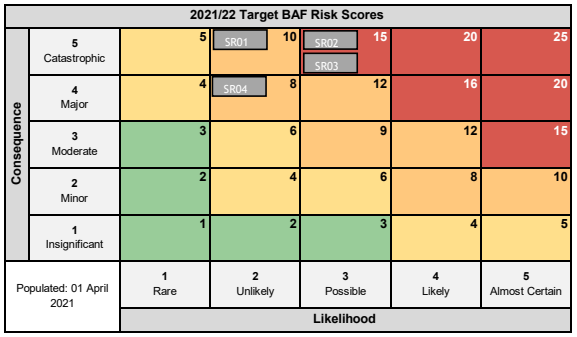


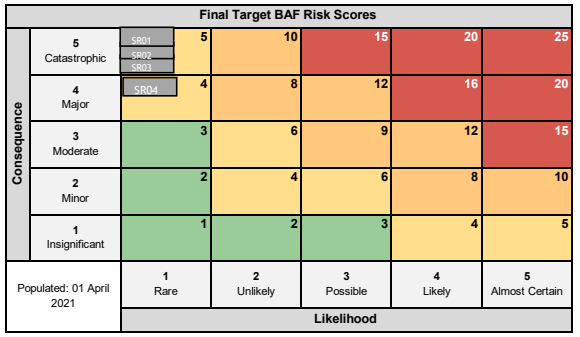












This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 28 July 2021			
SUBJECT:	Freedom to Speak Up Annual Report 2020/21			
PRESENTED BY:	Ms Rachael Foot, Freedom to Speak Up Guardian			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	2020/21 Freedom to Speak Up National Guardians Office statistics show the cases raised for the year under the 5 categories monitored: • Number of Cases: 228 • Raised Anonymously: 7 • Patient Safety: 20 • Unacceptable Behaviours: 72 • Staff Detriment : 5			
RECOMMENDATION:	The Board is asked to: • Note the work of the Guardian • Support the provision of the Trust's Freedom to Speak Up strategy • Actively promote and robustly support the Freedom to Speak Up principles • Support the development of the Freedom to Speak Up training plan that is aligned to the NGO's recommendations • Support 'embedding any learning from concerns being raised across the Trust' • Consider any risks and further actions for the Trust			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

- THIS PAGE IS INTENTIONALLY BLANK -

1 PURPOSE

This report provides the Board with an Annual Summary of 2020-21.

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

- Improving and protecting patient safety
- Improving and supporting staff experience
- Visually promoting learning cultures that embrace continual improvement.

This annual report details the progress the Trust has made during 2020–21 to ensure that everyone in the Trust works together to develop a culture that welcomes speaking up, and where action is taken to address anything that is an obstacle to providing great care. To speak up and be heard not only improves the quality and safety of patient care, but also, in tackling bullying and discrimination.

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

2 BACKGROUND

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

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

When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that we all feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we should feel able to say something and should expect that our suggestion is listened to and used as an opportunity for improvement.

National Guardian's Office (2021)

3 Concerns Raised During 2020/2021

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

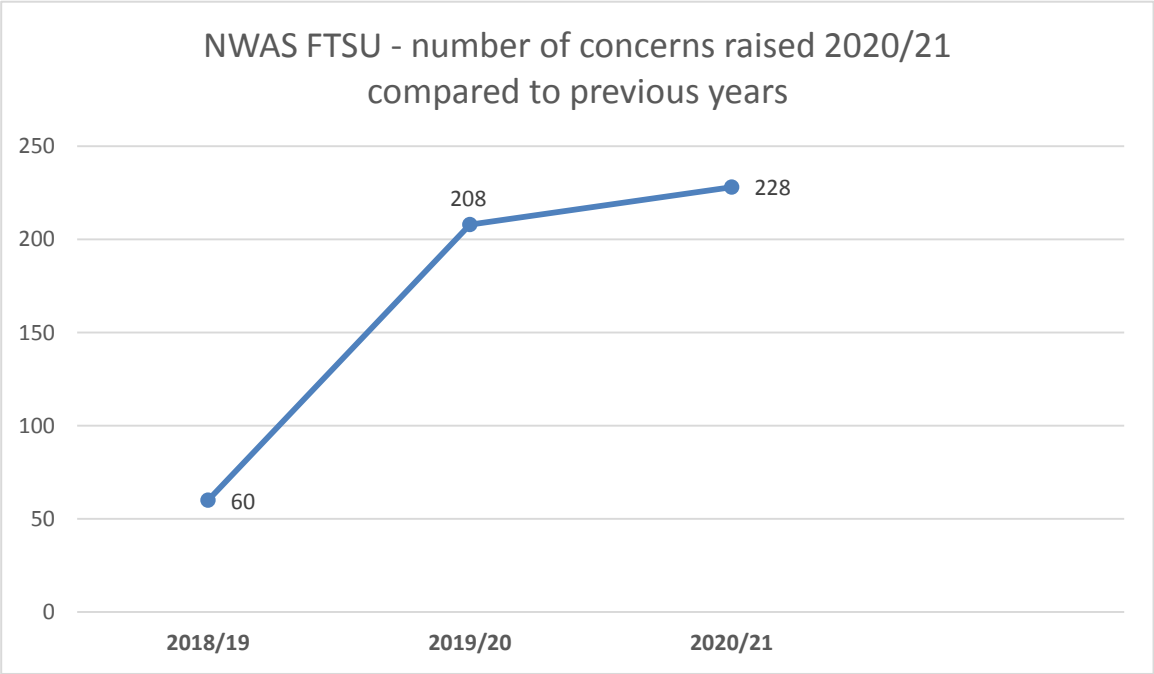
It is the responsibility of the FTSU Guardian to record and monitor all concerns raised and report them to the Trust's Board of Directors on a bi-annual basis and the National Guardian's Office on a quarterly basis.

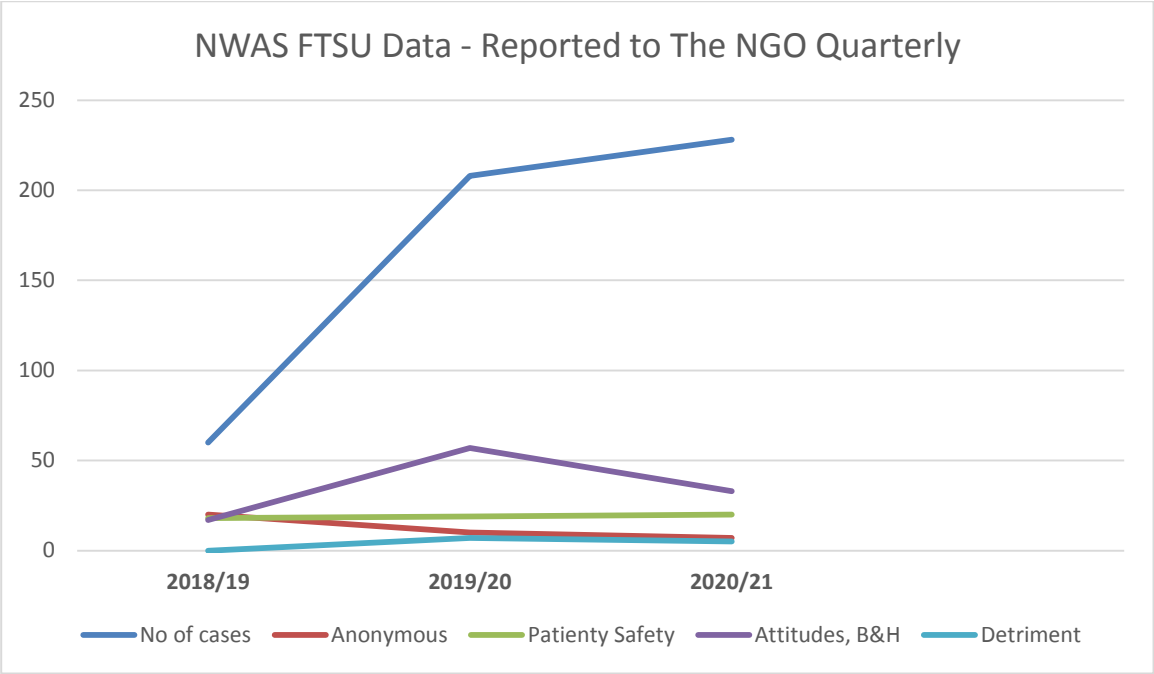
Throughout the year 228 cases were reported by the Freedom to Speak Up (FTSU) Guardian or Champions. This is a slight increase on the previous year (2019/20) where 208 cases were raised.

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

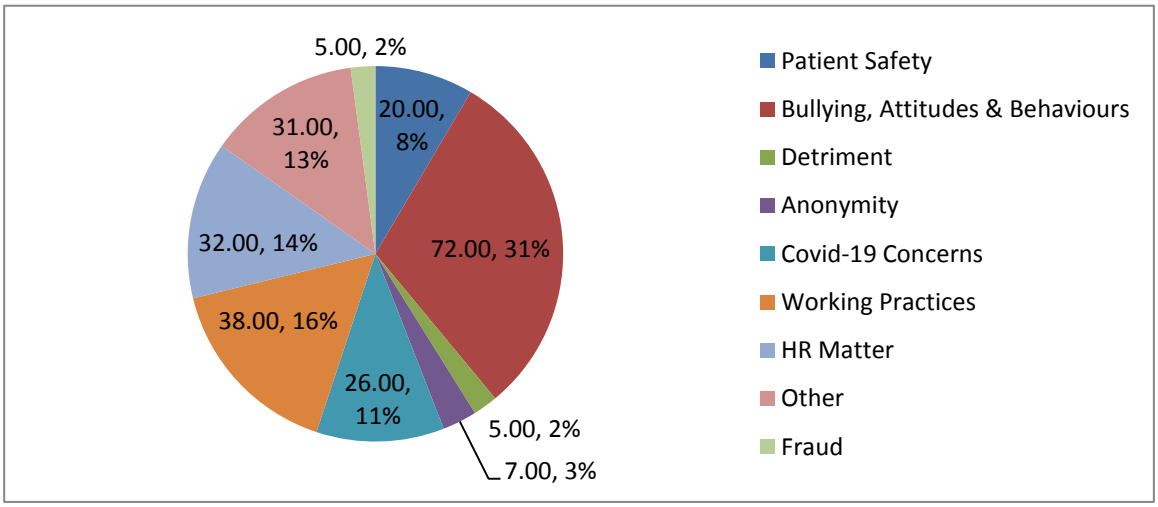
Freedom to Speak Up Concerns raised during 2020-21 Per Quarter

	Q1	Q2	Q3	Q4	**Total**
Total number of concerns raised	84	51	42	51	**228**
Number of cases raised anonymously	3	1	1	2	**7**
Patient safety concerns	6	1	8	5	**20**
Cases related to bullying and harassment including behaviours and attitudes	25	26	8	13	**72**
Where people indicate that they are suffering detriment as a result of speaking up	1	3	1	0	**5**

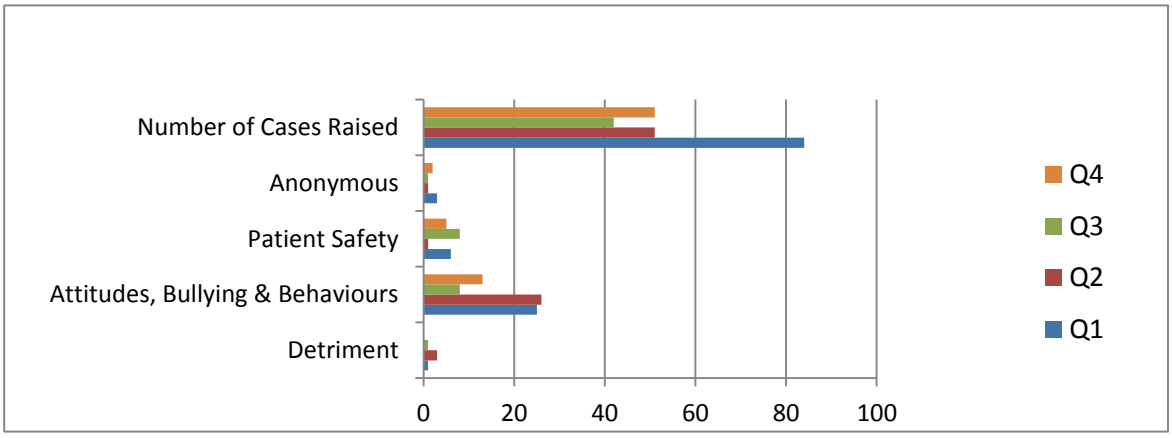




Details of Concerns 2020-21

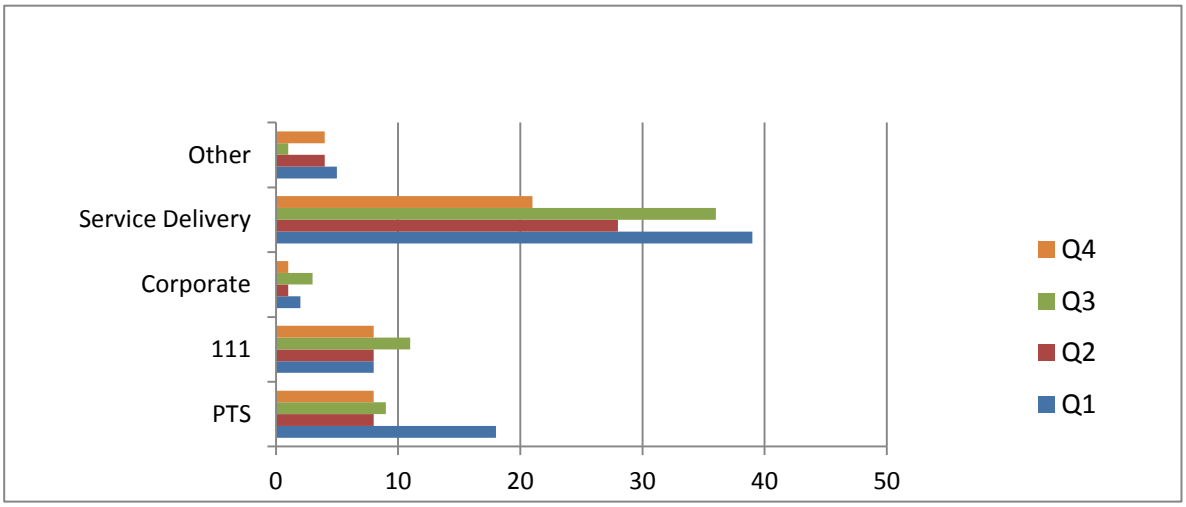


2020-21 Concerns by Reporting Category



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

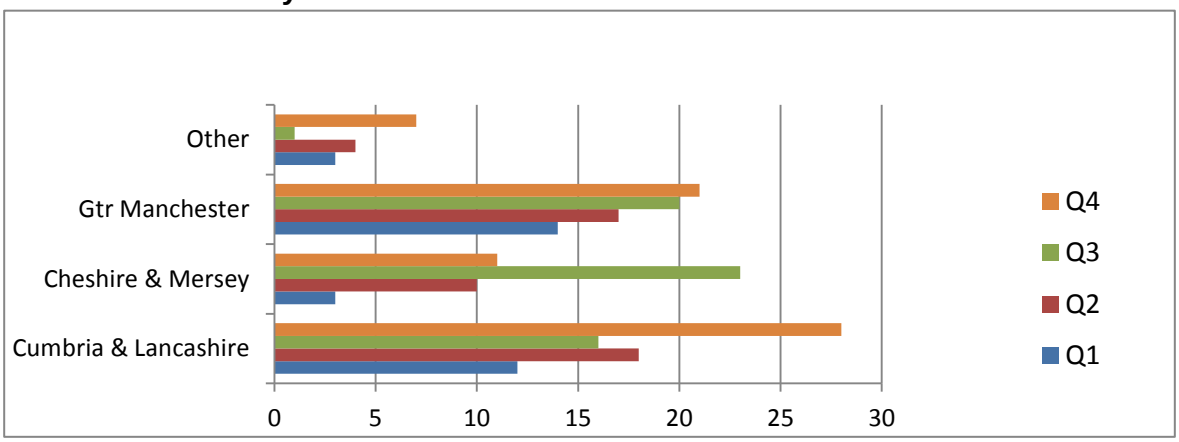
2020-21 Concerns By Service Line:



Please note – Service Delivery includes EOC.

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

2020-21 Concerns by Area:



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

Data

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

Covid-19

Covid-19 has had an impact on everybody's lives and the Trust recognises the impact this has had on colleagues. In these difficult circumstances, the Freedom to Speak Up Guardian and Champions have continued to listen and support colleagues to raise their concerns. During the peak of COVID-19, reports of behavioural issues such as bullying and harassment rose. Other concerns being raised relating to staff safety, including PPE, social distancing and risk assessments.

Feedback
Feedback is requested from staff who have raised concerns and monitored to assess any inequalities that require addressing and to identify any areas for improvement in the handling of the concerns. The Guardian has seen a slight increase in the amount of feedback being obtained verbally. This is in line with recommendations from the National Guardian's Office. The evaluation process has been widened to enable colleagues to provide feedback verbally instead of only in writing. The feedback received, demonstrates that the majority of colleagues giving the feedback 'would speak up again given their experience of doing so'. The Guardian also takes this opportunity, whilst obtaining verbal feedback to capture the demographics of the person raising the concern where possible.

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

The Guardian has been working with HR to review FTSU data to enable information to be correlated and triangulated allowing common themes can be identified.

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

- Handling of concerns – although there has been some improvement since the 2019-20 annual report, unfortunately there are still some discrepancies in the level of investigation warranted (proportionate to the concern) – This has created some issues around timeliness of the investigation and the consistency of the handling of the matter. The pandemic has also had a significant impact on this.
- Feedback - feedback must be provided in response to a concern having been raised, irrespective of the reporting method (i.e. Datix). This includes feedback on who is investigating the concern, where possible, the timescales and ultimately the outcome of the investigation. Feedback is essential to avoid misunderstandings (a sense that nothing happened or that it wasn't important enough causes unnecessary stress and anxiety) and helps create a positive learning culture. A Pro-Forma is currently in place to help address this matter.
- Attitudes and behaviours – including Issues around leadership at departmental level specifically where staff have spoken up to their Line Manager and no action has been taken.
- Managers attitudes and behaviours and lack of trust towards them.

National Freedom to Speak Up Month
October was National FTSU month. The Guardian raised the profile of Freedom to Speak Up by launching the FTSU icon on the staff App. The Guardian also interviewed the CEO and promoted the role of the Guardian and introduced a number of new Champions via social media through daily tweets using NWAS communications function. The Guardian also met virtually with fellow Guardians to share ideas and tips whilst offering peer support to one another during the busy speaking up period.

FTSU Champion Review 2020-21
The Freedom to Speak up role is ever evolving for the Guardian. As part of the process of evolution, the Guardian re-visited the role of the Champion. The Champion model has been refreshed to include a full application process and training. The Trust elected to have an open process which was advertised through internal communications inviting staff to

volunteer to become Freedom to Speak Up Champions. The Guardian looked to appoint Champions who are geographically spread out and diverse in terms of demographics, background and experience. By increasing the diversity of our Freedom to Speak Up networks, the needs of any group that may face particular barriers to speaking up, be that based on a protected characteristic, a working pattern, or other factors such as geographic isolation can be met.

The FTSU Champions' roles are to;

- To act as a local resource to support staff who raise concerns
- To ensure that any safety issues are raised appropriately and seek assurance that relevant/appropriate action has been taken and feedback is given to the member of staff who raised it
- To safeguard the interests of the individual raising a concern, ensuring that there are no repercussions for them either immediately or in the longer term, as appropriate.

Supporting Freedom to Speak Up

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

Staff Engagement

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

- EOC (walk rounds – FTSU Champions)
- Guardian attendance - Disability Forum
- Guardian attendance - BAME Forum
- Guardian attendance - LGBT Forum
- Non-Clinical Learning Forum
- SMT Meetings
- A FTSU intranet page on the Green room and staff app is in place. This includes details of the FTSU Guardian, FTSU champions and how to raise concerns
- Health and Wellbeing Team – The Guardian represents FTSU and supports the campaigns the H&WB team promote.

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

External Engagement

The NGO recommended that the Guardian hold regular engagement sessions with the CQC relationship holder for NWAS. The Guardian has met (virtually) with Pritpal Singh-Jagatia in March.

There are monthly sessions scheduled for the FTSU Guardians to come together as a support and learning network - Regional and NAN (ambulance sector)

National Guardians Office

2020/2021 saw the National Guardian's Office (NGO) update its branding from white lettering on a green background to the symbol of a tree, this is felt to be more reflective of the evolving activities of the NGO and the FTSU Guardians.

One of these activities is around culture, the term culture stems from the Latin 'cultivare' - to cultivate and grow, and the NGO has chosen to use a tree to symbolise both a strong supportive network and the culture they are seeking to embed within health.

"A culture where learning, growing, sharing and reaching out is business as usual"

NGO (2020)

The symbol of the tree also encapsulates the FTSU Guardian values:

- **Courage**: a tree stands strongly rooted in a storm
- **Impartiality**: trees welcome all within their branches without judgment
- **Empathy**: trees nurtures the lives which live within its branches
- **Learning**: a 'growth' mindset.

National Guardian

Freedom to Speak Up

To ensure that everyone has the tools to foster the '**speak up'** culture the NHS needs, the NGO has recently launched a new e-learning package, in association with Health Education England. The first module – '**Speak Up'** – available for all workers, no matter what their contract terms, was launched in October. The latest session, '**Listen Up'**, which is aimed at managers at all levels, focuses on listening and understanding the barriers to speaking up. A final module, '**Follow Up'**, aimed at senior leaders – including executive and non-executive directors, lay members and governors – will be launched later in the year.

Our FTSU Guardian can confirm both the **'speak up'** and **'listen up'** modules have been added to and are accessible on our e-learning platform for staff.

NGO case reviews, key publication and related reports in 2020/21

During 2020/21 the NGO updated its case review process reviewing how trusts have handled concerns and the treatment of people who have spoken up, where there is evidence

that good practice has not been followed. One NGO Case review report was published in 2020/21; Whittington Health NHS Trust[i]. The following also gives a sample of some of the other reviews and reports monitored during 2020/21 by the FTSU Guardian:

- National Guardian's Office Annual Report (2021)
- Care Quality Commission (2021) Protect, respect, connect – decisions about living and dying well during COVID-19[ii]
- Patterson enquiry report (2021)
- Survey of health and care staff for the Health and Care Women Leaders Network (2020)
- Association of Ambulance Chief Executives (AACE) Strategy 2020-2023
- NGO and WRES letter 15June
- Greenberg; Managing mental health challenges faced by healthcare workers during covid-19 pandemic (2020)

NGO Checking the Pulse of Speaking-Up Cultures

Part of the role of the National Guardian's Office is to challenge and support the healthcare system as a whole. There has been news stories during the pandemic about workers speaking up and not being listened to or, worse still, being victimised and actively discouraged from talking about these issues openly. In April 2020 the NGO launched pulse surveys asking Freedom to Speak Up guardians about the speaking up culture in their organisations during the pandemic and the types of cases they were handling.

Feedback was mixed. Some told the NGO that an established culture of speaking up made things easier. Others reported they were told there simply wasn't time to listen to everything workers were raising. There were also anecdotal reports of communications teams advising workers not to speak to the media or use their social media to post comments. With the CQC chief inspectors, Dr Henrietta Hughes wrote to all trust CEOs and chairs to remind them about how important it was to maintain safe speaking up channels for their workers.

Benchmarking

The National Guardian's Office collected data from Freedom to Speak Up Guardians in all Trusts and Foundation Trusts on cases raised with them in 2020/21. The Guardian compares all published NGO data and themes against internal data to identify any learning.

The annual NHS staff survey contains several questions that serve as helpful indicators of the speaking up culture. In the 2020 NHS National Staff Survey two new questions were introduced also relating to FTSU, these were:

- ***Q18e Feel safe in my work***
- ***Q18f Feel safe to speak up about anything that concerns me in this organisation***

Learning and Improvement

The Trust is committed to continuing to learn and improve its systems and processes for raising concerns.
This is done through:

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

Conclusion

The reporting period saw a slight increase in the number of concerns being raised via FTSU in comparison to the previous year. The majority of concerns raised are from clinical colleagues in various roles. The year on year annual increase in concerns being raised could suggest staff are becoming more aware and confident in raising concerns through the FTSU Service. Whilst there has been an increase in concerns being raised, the data shows there are fewer colleagues raising concerns truly anonymously which may suggest colleagues feel more able to raise concerns at North West Ambulance Service and access the FTSU Service in confidence and without fear of detriment.

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

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

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

3 LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4 EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

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

5 RECOMMENDATIONS

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

i

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	11th June 2021	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Mrs G Singh, Associate Non-Executive Director Prof R Thomson, Associate Non-Executive Director	**Key Members Not Present:**	All present

Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Audit Completion Report	The Committee received the Audit Completion Report from the External Auditors, Mazars LLP summarising the audit conclusions and the intention to issue an unqualified opinion.	Noted the contents of the report and positive outcome for the Trust	

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

Independent Auditor's Report	The Committee noted it was a standard document for inclusion within the Annual Report and Accounts.	Noted the contents of the report.	
Audited Annual Accounts 2020/21	The audited Annual Accounts 2020/21 were presented to the Committee for review prior to approval and adoption by the Board of Directors. The Committee noted the Trust had met all of its statutory duties, mainly: • Adjusted financial position is £41k surplus; • The Trust has underspent (allowed) against its External Financial Limit (EFL) by £15.664m; and • The Trust came on target against its Capital Resource Limit (CRL).	Recommended the audited Annual Accounts 2020/21 to the Board of Directors for approval.	
Annual Report 2020/21 including Annual Governance Statement	The Committee received the Annual Report 2020/21 for onward recommendation to the Board of Directors for approval. The Committee noted the Annual Report had been prepared in accordance with the Group Accounting Manual and had been reviewed by	Noted the contents of the report and compliance against the mandatory requirements set out in the DH Group Accounting Manual 2020/21 Recommended the Annual Report 2020/21 to the Board of Directors for approval.	

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

	external auditors. Specific statements had been included in the Annual Governance Statement related to COVID-19.		
Management Letter of Representation	The Director of Finance presented the Management Letter of Representation drafted by the External Auditors. It was noted the content of the letter attests to the accuracy of the financial statements and is largely driven by matters that the external auditors wish the Trust to confirm to support our compliance with accounting and auditing standards.	Confirmed agreement for the letter to be presented to the Board of Directors for signing.	

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

This page is intentionally left blank

i

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	16th July 2021	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Prof R Thomson, Associate Non-Executive Director	**Key Members Not Present:**	Mrs G Singh, Associate Non-Executive Director
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Clinical Governance-Quality and Performance Chair's Assurance Report and Clinical Audit Plan 2021/22	The Committee received assurance reports relating to Clinical Governance from the meeting held on 26th April 2021 and the Clinical Audit Plan 2021/22.	Noted the assurance provided within the reports.	

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

	The Deputy Director of Quality attended the meeting for this agenda item and provided clarification around specific items.		
Clinical Audit Q4 2020/21 Update	The Deputy Director of Quality presented the Clinical Audit Q4 2020/21 update to the Committee.	Noted the assurance provided.	
Chair's Assurance Report – Information Governance Sub Committee 13th April 2021	The Chief of Digital and Innovation attended the meeting to present the Chair's Assurance Report from the Information Governance Sub Committee meeting held on 13th April 2021.	Noted the assurance provided.	
Data Quality Update	The Chief of Digital and Innovation presented the Committee with an update report to improve Data Quality.	Noted the assurance provided relating to the progress of the data quality proposal.	
Critical and High Risk Recommendations	MIAA continued to follow up recommendations. It was noted 2 high risk recommendations remain outstanding and partially implemented relating to Freedom To Speak Up and one relating to Data Quality which is due for completion in March 2022.	Noted the update provided.	
Internal Audit Progress Report Q1 2021/22	The Committee noted the assurance review completed within Q1 relating to the Estates	Noted the assurance provided.	

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

	Strategy which delivered Substantial Assurance.		
Internal Audit Follow Up	The Committee noted the good progress within the reporting period and that 10 recommendations followed up during the period.	Noted the assurance provided.	
Anti-Fraud Annual Report 2020/21	The Committee received the Anti-Fraud Progress Report outlining the wide range of activities undertaken in relation to Strategic Governance; Inform and Involve; Prevent and Deter and Hold to Account since the last meeting. It was noted work had commenced on the review of the new Counter Fraud Functional Standards Return (CFFSR) and that 10 of the 12 components were rated as green and two rated as amber and noted the corrective actions in place to address these.	Noted the assurance provided.	
Anti-Fraud, Bribery and Corruption Policy	The AFS presented the Committee with the updated Anti-Fraud, Bribery and Corruption Policy. It was noted the policy had been updated to reference the change of AFS and the new Government Functional Standards.	Approved the Anti-Fraud, Bribery and Corruption Policy.	

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

Auditor's Annual Report	The Committee received the Auditor's Annual Report. This concluded the 2020/21audit. An unqualified opinion on the Trust's financial statements had previously been reported to the Committee and to the Board of Directors. Due to the new requirements of the National Audit Office to provide more detail around value money, the report provided commentary around the 3 areas of financial sustainability; governance; and improving economy, efficiency and effectiveness. The Committee noted there were no significant weaknesses identified and no recommendations arising.	Noted the assurances provided.	
Board Assurance Framework Q1 2021/22	The Committee received the updated BAF prior to submission to the Board of Directors for approval on 28th July 2021. It was noted that the Q1 position was incomplete and due for review by the Executive Leadership Committee. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurances provided.	
Waiver of Standing Orders Q1 2021/22	A total of seven waivers were approved during Q1 2021/22.	Noted the assurances provided.	

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

	The Committee noted the waiver template and process had been refined.		
Committee Self-Assessment	The Committee received a briefing note relating to the Committee self-assessment and noted whilst the outcomes of the checklist were positive, all actions from the previous year had been addressed with the exception of one issue relating to the committee formally considering how it integrates with other committees that are reviewing risk. It was proposed that the Committee received the Chair's Assurance Report from the Resources Committee.	Further discussion to be held between MIAA and the Director of Corporate Affairs.	

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

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 July 2021			
SUBJECT:	Auditor's Annual Report – 2020/21			
PRESENTED BY:	Director of Finance			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☒	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Auditor's Annual Report for the year ending 31 March 2021 confirms the outcome of the audit of the trust's financial statements undertaken by Mazars. In line with the National Audit Office's Code of Audit Practice the report covers the financial statements, including the regularity opinion, and also the value for money arrangements. There are no recommendations arising from the 2020/21 audit work. In line with reporting requirements, the Auditor's Annual Report will be published on the trust's internet site.			
RECOMMENDATION:	The Board of Directors are asked to: • Note the content of the Annual Audit Report • Note the assurance provided • Note the Annual Audit Report will be published on the trust's internet site			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Audit Committee			
	Date:	16 July 2021		
	Outcome:	Noted		

- THIS PAGE IS INTENTIONALLY BLANK -

Auditor's Annual Report

North West Ambulance Service NHS Trust – year ended 31 March 2021

July 2021

mazars

Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for North West Ambulance Service NHS Trust ('the Trust') for the year ended 31 March 2021. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements

We issued our audit report on 11 June 2021. Our opinion on the financial statements was unqualified.

Wider reporting responsibilities

In line with group audit instructions issued by the NAO, on 11 June 2021 we reported that the Trust's consolidation schedules were consistent with the audited financial statements.

Value for Money arrangements

In our audit report issued we reported that we had not completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not issued recommendations in relation to identified significant weaknesses in those arrangements at the time of reporting. Section 3 confirms that we have now completed this work and provides our commentary on the Trust's arrangements.

Following the completion of our work we have issued our audit certificate which formally closes the audit for the 2020/21 financial year.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2021 and of its financial performance for the year then ended. Our audit report, issued on 11 June 2021 gave an unqualified opinion on the financial statements for the year ended 31 March 2021.

Qualitative aspects of the Trust's accounting practices

We reviewed the Trust's accounting policies and disclosures and concluded they comply with Department of Health and Social Care Group Accounting Manual 2020/21, appropriately tailored to the Trust's circumstances.

Draft accounts were received from the Trust on 28th April 2021 and were of a good quality. Working papers were available in line with agreed timescales and the finance team responded promptly to our queries allowing for an efficient audit.

Significant matters discussed with management

During 2020/21 the Trust received £7.6m of consumables inventory which was centrally procured by DHSC to help the Trust manage the Covid-19 pandemic. The Trust elected to treat the whole amount as consumed in year and included the £7.6m in expenditure with an equal entry in income to recognise the donation of the inventory. The Trust concluded that any residual inventory unused at year end would not have a material impact on the year end inventories balance and therefore not included this on the Statement of Financial Position. Based on the values involved we are satisfied this does not create a material understatement of the Inventories balance as at the year end.

Due to the impact of the Covid-19 pandemic on the ability of staff to take annual leave, the Trust has received funding of £3.5m to mitigate the impact of the increase in the annual leave accrual. As this funding is based on management's estimate of the annual leave accrual, we completed a detailed review of the estimate and underlying methodology to confirm the calculation was reasonable and supported by appropriate evidence. Our review confirmed the annual leave accrual was supported by payroll records and staff returns breaking down the amount of leave carried over into the new financial year. This allowed for an accurate estimate to be made and included in the financial statements.

Significant difficulties during the audit

We did not encounter any significant difficulties during the course of the audit.

03

Section 03:

Commentary on VFM arrangements

3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements. Where we identify significant risks, we design a programme of work (risk-based procedures) to enable us to decide whether there is a significant weakness in arrangements. Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

The table below summarises the outcomes of our work against each reporting criteria. On the following pages we outline further detail of the work we have undertaken against each reporting criteria, including the judgements we have applied.

Reporting criteria	Commentary page reference	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability	9	No	No
Governance	11	No	No
Improving economy, efficiency and effectiveness	13	No	No

3. VFM arrangements - Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

Background to the NHS financing regime in 2020/21

Following the onset of the Covid-19 pandemic in March 2020, the original NHS Planning Guidance 2020-21 was suspended and a new financial regime was implemented. For the first half of the year (April to September 2020) all NHS trusts and NHS foundation trusts were moved to block contract payments 'on account' and the usual Payment by Results national tariff payment process was suspended. The Financial Recovery Fund was also suspended and NHS providers were able to claim for additional costs due to COVID-19. Whilst commissioner allocations for 2020-21 had already been notified, individual commissioner financial positions were kept under review and top-up payments were issued to commissioners to cover the difference between allocations and expected costs to pass on to providers.

For the second half of the year (October 2020 to March 2021) there was a move to "system envelopes" with funding allocations covering most NHS activity made at the system level, including resources to meet the additional costs of the Covid-19 pandemic. There were no further general retrospective top-up payments and all Covid-19 costs from that point were funded through the fixed Covid-19 funding allocation with a few exceptions.

Systems were expected to achieve financial balance within this envelope and individual organisations were able to deliver surplus or deficit positions by mutual agreement within the system. However, NHS trusts and foundation trusts were still required to meet statutory break-even duty and CCGs required to meet their resource limits.

The Trust's financial planning and monitoring arrangements

Based on the initial arrangements put in place by NHSI/E, the Board of Directors approved emergency budgets in May 2020 which provided for a break-even position. This enabled some iterative financial planning arrangements to be put in place for the second half of 2020/21. This involved NWAS working in partnership with other Trusts and CCGs within the North West through the Lancashire and South Cumbria Integrated Care System, and under the direction of the regional office of NHSI/E. The financial plans for the second half of 2020/21 were based upon forecasting requirements for the winter period, taking account of workforce plans, run rates from the first half of the year, continuation of COVID costs and cost pressures known to the Trust. Via agreement with ICS partners, NWAS was awarded income for the period of £205m with a projected deficit of £4.8m. We reviewed the assumptions underpinning the revised plan, the reports sent to the Board and the minutes of relevant meetings where the revised financial plan was considered. We confirmed that the assumptions made by management appeared reasonable, the reports were clear and concise, and adequate scrutiny was evident at the approval meeting.

The Trust has reported an adjusted outturn position at 31 March 2021 of £2.2m deficit, which equated to an adjusted financial surplus of £0.5m after allowing for the impact of revaluations, impairments and consumables donated by DHSC. We have considered the arrangements in place in respect of budget management as part of the Governance criteria on page 11.

During the year the Trust reported its financial position to the Resources Committee. We reviewed a sample of reports presented for 2020/21, which contain detail of performance by Directorate with explanations for any significant variances against budget. The Finance reports also identify risks to the financial position and mitigating actions being taken by the Trust to ensure delivery of the planned position..

The Trust's arrangements for the identification, management and monitoring of funding gaps and savings

In recent years, the Trust has delivered surpluses and operated within its financial performance measures including achievement of the breakeven duty. No financial savings were required to be delivered during H1, however financial planning for H2 required NWAS to deliver £1.2m (non-recurrent) efficiencies to enable it to achieve its £4.0m deficit requirement. These savings were reported on internally to the Resources Committee. The year end outturn confirmed the Trust has achieved the planned efficiencies.

The financial plan for 2021/22 includes a productivity target of £10.4m, which is a similar level to previous years at c. 2.9% of the Trust's turnover. The Trust has established an efficiency and productivity oversight group to develop programmes of work during Q1 of 2021/22. Schemes will require Quality Impact Assessments and will be signed off by the Director of Nursing and the Medical Director.

The Trust's arrangements and approach to 2021/22 financial planning

For the first half of 2021/22 the NHS funding regime will remain as it has for the second half of 2020/21. The arrangements will continue to include system funding envelopes, and block payments will remain in place for relationships between CCGs and NHS providers. NHS England and improvement (NHSE/I) have nationally calculated CCG and NHS provider organisational plans as default positions for systems and organisations to adopt and provide a starting point for budget management without the need to complete an extensive planning process.

3. VFM arrangements - Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria - continued

The requirement had been to submit plans for the first half of 2021/22. However, the Trust was keen to understand the full extent of financial pressures it faced and therefore developed plans to cover the full twelve month period 2020/21.

In March 2021, the Trust developed a baseline budget for 2021/22 based on a forecast breakeven position. The plan submitted by the Trust includes assumptions around staffing levels, pay awards and recurrent COVID-19 expenditure. It is based on block funding based on 2020/21 values adjusted for inflation. The baseline budget includes an efficiency and productivity target of £10.4m. This is based on the Trust's prudent assumptions of income levels known at the time of producing the annual plan, and in advance of receiving formal guidance on funding arrangements for the second half of the financial year. As discussed on the previous page the Trust has arrangements in place to develop schemes as part of the efficiency programme.

We have critically assessed the underlying assumptions used in the 2021/22 financial plan. We have also considered the Trust's achievement of financial targets in 2020/21 (and prior years) and we have reviewed the savings plans in place for 2021/22 and the Trust's wider plans for mitigation of these funding gaps, including its contribution to the performance monitoring of the wider system. It is clear that the Trust is closely monitoring progress against plan to date, is fully aware of where the gaps lie, and continues to identify mitigating actions to bridge the funding gap. Therefore, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to financial sustainability.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

The Trust's risk management and monitoring arrangements

Risk management at the Trust is guided by the Risk Appetite Statement which is reviewed by the Board on an annual basis. During 2020/21, NWAS completed a refresh of its Risk Management Strategy which defines the broad aims and principles of risk management across the Trust. This is supported by the Trust's Policy on Risk Management which details the risk management process used within the Trust.

The Policy on Risk Management defines several levels of risk register and sets clear responsibilities for period review of the register at each level. NWAS uses the Datix system to record its full range of organisational risks. The culmination of this is the corporate risk register reviewed by Board on a quarterly basis which is integrated into the Board Assurance Framework. The BAF outlines 11 strategic risks linked to the strategic priorities of the Trust. These are linked to the Trust's Risk Appetite Statement as appropriate. Any risk on the Corporate Risk Register with a score of 15 or more is reported in the BAF as part of regular reporting to the Board.

We have reviewed the minutes of the monthly SMT meetings within the Finance Directorate covering finance, procurement, fleet and estates. Detailed discussions take place on risks scored 12+ and risks due for regular review. Risks are reported on a monthly basis to the Resources Committee. We also reviewed the quarter 4 Corporate Risk Register and confirmed each risk identified is assigned a lead with overall responsibility for the risk. Each risk is scored on the basis of likelihood and consequence to provide an overall score and controls are identified which mitigate the level of risk. The register also identifies sources of assurance and gaps in controls/assurances as areas of focus for action. Regular review dates are in place and reported within the Corporate Risk Register.

In order to provide assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud, the Trust has appointed internal auditors and local counter fraud specialists. Work plans are agreed with management at the start of the financial year and are reviewed by Audit Committee prior to final approval.

We have reviewed the Internal Audit Plans for 2020/21 and 2021/22. We have confirmed the plan is developed in conjunction with management and covers the major operational areas of the Trust. The Audit Committee reviews and approves the plan at the start of each financial year providing oversight and assurance that the scope of the plan is appropriate for the Trust's needs. Progress reports are presented to each Audit Committee meeting including follow up reporting of recommendations not fully implemented by agreed due dates allowing those charged with governance to effectively hold management to account.

The work of internal audit culminates in the annual Head of Internal Audit Opinion which, for 2020/21, provides substantial assurance over the system of internal controls at the Trust.

The Trust's arrangements for budget setting and budgetary control

The Trust's budget setting process is based on national guidelines which sets out the assumptions and processes in place. The outcome of the Trust's baseline budget setting process is set out in the previous section.

Budgetary control guidelines are shared annually with all budget managers and formal sign off of the budget is obtained from the budget manager. We have reviewed a sample of budgets and confirmed the budget holder had signed off their budget as approved as part of the budget setting process.

Following consolidation of the individual operational budgets, the Trust-wide plan is taken through the Trust governance process including the Resources Committee and Board of Directors. Our review of minutes confirms this to be the case, with papers covering the Trust's I&E position, statement of financial position, forecast cash and capital expenditure, and links into the Trust's planned efficiencies.

Budgetary control is a continuous process at the Trust. The Trust is required to formally report its financial position and forecast outturn at each month end to NHSI/E. As part of these monthly returns, and annual planning rounds, the Trust is required to submit a triangulation file which reconciles activity, workforce and finance returns to ensure consistency. We have reviewed an example monthly return alongside the year-end return submitted to NHSI/E. In each case the return reconciles to the financial position reported to the Resources Committee.

As set out in the previous section the financial position is reported to the Resources Committee each month and includes sufficient detail to allow for effective review and challenge at the senior leadership level.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria continued

The Trust's decision making arrangements and control framework

The Trust has an established governance structure in place which is set out within its Annual Governance Statement. This is underpinned by the Trust's Core Governance Documents. Executive Directors have clear responsibilities linked to their roles and the Board Sub-Committee structure in place at the Trust allows for effective oversight of the Trust's operations and activity.

The Trust's Core Governance Documents are reviewed on an annual basis and updated in line with latest best practice. During 2020/21 the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation were subject to review by Executive Leadership Committee and Audit Committee prior to being approved by the Board of Directors. We have confirmed this through our review of Board and committee minutes and papers.

Financial investment decisions are supported by full business cases and are reviewed by Executive Leadership Committee (ELC). Business cases set out the strategic objectives of the project and include a full option appraisal analysis taking account of both financial and non-financial factors of all options including 'Do nothing'. Once approved by ELC, projects are taken to Resources Committee to allow for scrutiny prior to final Board sign off in line with the Trust's Scheme of Delegation.

We have reviewed a sample of business cases approved by the Trust Board of Directors and ELC and confirmed they included a comprehensive justification supporting the business case covering areas including strategic needs, commercial basis and a financial analysis. The business cases included a cost-benefit analysis and options appraisal. Sufficient information was included to allow for proper scrutiny. The cases had been through the appropriate approval process based on their relative values.

The Trust has a full suite of governance arrangements in place. These are set out in the Trust's Annual Report and Annual Governance Statement. We reviewed these documents as part of our audit and confirmed they were consistent with our understanding of the Trust's arrangements in place. This includes arrangements such as registers of interests being maintained and published and the Board completing an annual review of its compliance with the conditions of the NHS provider licence.

Based on the above considerations, we are satisfied there is not a significant weakness in the Trust's arrangements in relation to governance.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

The Trust's arrangements for assessing performance and evaluating service delivery

The Board of Directors received monthly integrated performance reports detailing the Trust's performance against key metrics ranging from the number of complaints to ambulance response times and levels of sickness absence. The data has been reported on a consistent basis and explanations provided for performance.

The Trust has been able to use performance data to adapt its ways of working in response to the COVID-19 pandemic. An example of this is the Trust's utilisation of patient transport service (PTS) staff to support emergency ambulance crews when PTS activity fell below baseline levels as a response to the reduction in outpatient appointments.

Given the Trust's wide geographical spread it is able to make use of data to identify areas of best practice and share these more widely. This is demonstrated in the Trust's review of Hear & Treat, See & Treat, and See & Convey outcomes across the region. The Trust is able to investigate better performing sectors and share learning through the Right Care at Home Collaborative.

The latest CQC inspections of the Trust's Emergency and Urgent Care Services, and the Emergency Operations Centre were undertaken in 2020. The Trust's services were rated as good overall, with its Emergency and Urgent Care service receiving an outstanding rating in the responsive domain. The Trust received 10 'should do' actions and no 'must do' actions from the reports. The Trust developed a detailed action plan in response to the recommendations, assigning an Executive Lead and Lead Officer for each action. Oversight of progress takes place through the Quality and Performance or Resources Committees as appropriate. Our review of Board minutes confirmed the overall progress had been reported to Board on a regular basis throughout the year. Actions were completed in line with agreed timescales and ongoing monitoring processes put in place to ensure continued compliance.

The Trust's arrangements for effective partnership working and stakeholder engagement

The Trust has historically demonstrated strong partnership working with key stakeholders across the North West. The Trust is a key member of the Northern Ambulance Alliance group which brings together four ambulance trusts with the aim of improving health outcomes and delivering greater benefits for the populations served by the Trusts. The Chief Executive and Chair of NWAS are members of the Northern Ambulance Alliance Board. Our review of minutes confirm progress against workstreams undertaken by the Northern Ambulance Alliance are reported to the NWAS Board on a regular basis.

NWAS has an extensive engagement strategy with multiple stakeholder groups. The Trust has an established patient and public panel comprising 139 members which meets on a regular basis and has continued to do so throughout the pandemic. Panel members are invited to get involved in the Trust's activities including opportunities to attend Board meetings, development sessions and Q&A sessions with the Executive.

Through our discussions with management and review of communications we have seen examples of effective engagement with stakeholders such as briefings to MPs, local authorities, CCGs and Trusts on the Trust's response to the pandemic, regular briefings shared with staff via the intranet and email, and engagement with the wider public through the Your Call magazine published on the Trust's website.

The Trust's arrangements for commissioning services

The procurement of all goods and services is governed by the NWAS Board approved standing financial instructions. These set the procurement involvement required based on law and best practice.

Procurements cannot commence unless there is an appropriate budget available or approved business case. Depending on value, pre-tendering approval is also required. Goods and services over £100k must be compliant with the Public Contract Regulations. Awards over £25k and below £500k are approved via ELC whereas awards over £500k must be taken through Resources Committee and approved at Board. We reviewed an example procurement approval process and confirmed it had been approved at the correct level in line with the Trust's Scheme of Delegation.

The Trust maintains a contracts database which is used to develop the workplan for the procurement team alongside capital regulations. A process of obtaining quotes, tenders or OJEU tenders is put into action depending on value and based on a comprehensive specification of requirements. Evaluations are undertaken by a panel of subject experts. Frameworks are used wherever possible, and often involve collaboration with other ambulance trusts to deliver economies of scale. For routine purchase of consumables, the NHS supply chain is used.

Procurement activity is reported to Resources Committee on a regular basis to allow for scrutiny and governance review. We have confirmed this is the case through our review of Resources Committee papers.

A full waiver process is in place whereby waivers are reviewed and signed off by the Head of Procurement. Director of Corporate Affairs, Director of Finance and Chief Executive. Waivers are reported to Audit Committee for scrutiny on a regular basis. Our attendance at Audit Committee confirms this to be the case. In addition we have selected a sample waiver and confirmed it had been appropriately completed and received the necessary approvals required.

Based on the above considerations we are satisfied there is not a significant weakness in the Trust's arrangements in relation to improving economy, efficiency and effectiveness.

04

Section 04:

Other reporting responsibilities and our fees

4. Other reporting responsibilities and our fees

Matters we report by exception

The Local Audit and Accountability Act 2014 provide auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest;
- make a referral to the Secretary of State; and
- Make a written recommendation to the Trust which must be responded to publicly.

We have not exercised any of these statutory reporting powers.

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

4. Other reporting responsibilities and our fees

Fees for work as the Trust's auditor

We reported our proposed fees for the delivery of our work under the Code of Audit Practice in our Audit Strategy Memorandum presented to the Audit Committee in January 2021. Having completed our work for the 2020/21 financial year, we can confirm that our fees are as follows:

Area of work	2020/21 fees
Planned fee in respect of our work under the Code of Audit Practice	£64,925
Total fees	**£64,925**

Fees for other work

We confirm that we have not undertaken any non-audit services for the Trust in the year.

Mazars
One St Peter’s Square
Manchester
M2 3DE

Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars’ integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

*where permitted under applicable country laws.

mazars

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th July 2021			
SUBJECT:	Integrated Performance Report			
PRESENTED BY:	Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
PURPOSE OF PAPER:	For Assurance			

EXECUTIVE SUMMARY:

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

The highlights from this report are as follows;

Quality

- 212 complaints were received, against a 12 month average of 146 per month.
- 70% of complaints risk scored 1-3 and 23% of level 4-5 complaints were closed within the agreed time frames.
- A plan is in place to address the complaints backlog which has fallen from 150 in January 2021 to 101 by the end of June.
- 2 Serious Incidents (SIs) were reported in June. All three of the SI reports due were submitted within the 60-day timescale.
- There were 9 new safety alerts. Three safety alerts are currently applicable and are being managed by an accountable executive.

Effectiveness

- **Patient experience:** Both PES and PTS have seen an increase in returns (1% and 2% respectively) with NHS 111 have seen a drop in returns of 25%. Both PES and PTS have seen a reduction in satisfaction levels compared to last month (3.3% and 1.7% respectively) whilst NHS 111 has seen a small increase of 0.3%. Positive and negative comments are provided for all service lines together with supporting narrative.
- This report also contains a high level summary regarding the experience of patients using the NHS 111 First service.
- **ACQIs:** Overall, we see limited change from month to month in the ambulance clinical quality indicators. The lag in data (from February) makes it difficult to

understand the impact of any recent work to improve in these areas. Recent results (up until February 2021) do signal an increase in the percentage of patients achieving ROSC and survival to discharge in this group from October 2020 compared with previous months but still below the mean. This is consistent with the national picture and pandemic influences and has been shared with the regional medical directors team. It will inform the regional mortality cell's learning about the impact of the COVID 19 pandemic.

- Mean call to PPCI time for patients suffering a myocardial infarction was slightly outside of the national mean of 2h 15mins; the Trust's performance was 2h 23mins.
- Mean call to hospital time for patients suffering a hyper acute stroke was within the national mean of 1h 12mins;
- The stroke care bundle was above the national mean at 98.4%
- **H&T, S&T, S&C:** The proportion of incidents with Hear and Treat is 9.1% for the month of June 2021. See & Treat has increased to 30% (which is similar to pre-covid levels) in total, there was an aggregate non-conveyance of 39.1%.

Finance

- The year-to-date expenditure on agency is £1.192m which is £0.415m above the 19/20 ceiling of £0.777m
- The COVID-19 financial framework remains in place for H1 (1 April 2021-30 September 2021) and the monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process..
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- **Activity:** In June 2021, the Trust received 143,008 calls of which 95,508 became incidents. Compared with June 2019, we have seen a 24% increase in calls and a 2% increase in incidents.
- **Call Pick Up** performance was 72%, with the data signalling special cause with call pick up in 5 seconds being above the upper control limit. This is directly caused by increased activity for both calls and incidents, lockdown easing and lower levels of uptake for overtime in EOC.

ARP Performance

	Standard	Actual
C1 (Mean)	7:00	8:19
C1 (90th)	15:00	14:03
C2 (Mean)	18:00	38:15
C2 (90th)	40:00	1:17:58
C3 (Mean)	1:00:00	3:18:28
C3 (90th)	2:00:00	7:53:55

- Response times for C4 90th are currently under review following discussion with NHSI/E and are not reported this month.
- Response time standards have been met for C1 90th. The primary reason for not reaching the other response time standards is a mismatch between demand and resource levels. The Trust is seeing an increase in the acuity of patients with a significant rise in the proportion of category 1 and 2s.
- For all categories of incidents apart from C1 90th there is special cause during week commencing 26th June. This follows on from earlier easing of lockdown measures and is something we see across most measures when the rules are eased. There is also a more general worsening trend which coincides with the end of military support (22nd March) and the end of shift enhancements. This has meant less resources are available. We are also seeing a lower uptake for overtime shifts which is impacting upon resources available.
- The trust has taken a number of measures to improve performance and maintain patient safety.

Handover

- Average turnaround time has moved above the National standard of 30:00 with a turnaround time of 31:20. This is the first time the trust has been above the standard since January. 2,367 attendances (4.5%) had a turnaround time of over 1 hour, with 65 of those taking more than 3 hours. 570 hours were lost to delayed admissions in June up from 289 in May.

NHS 111

	Standard	Actual
Calls Within 60s	95%	32.86%
Average Time to answer		5m 43s
Abandoned Calls	<5%	21.23%

Call back Within 10 min	75%	4.79%
Average Call Back		1hour 36min
Warm Transfer to Nurse	75%	0.79%

- Call volumes are 30% higher than the same time last year and as a consequence performance on the headline KPIs continues to challenge the service.
- Time taken for a call back continues to be well above the target. The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Safety measures are in place.

PTS

- Due to reporting timing issues PTS performance will be reported one month in arrears.
- Activity in May for the Trust was 37% below contract baselines, whilst the year to date position (July 2020 – April 2021) is performing at 37% below baseline. This is due to Covid-19.

Organisational Health

- **Sickness**: The overall sickness absence rate for the latest reporting month (May 2021) was 8.32% including COVID related sickness of 0.9%.
- **Turnover** was 9.1%.
- **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 1% in June.
- **Vacancy**: Positions across the trust are under establishment by 2.16%. This is mainly as a result of establishment changes in 111 and vacancies in PTS.
- **Appraisal:** The overall appraisal completion rate was 68.07% against a revised trust target of 75% by September 2021 this is lower than 95% due to the effect of Covid-19.
- **Mandatory Training:** The trust was 75% compliant in March for the 2020/21 financial year. A new cycle started in April with additional topics, this has pushed trust compliance down to 63%, this will build during the year and we are currently on target against the agreed ELC target of 69% in June.

COVID 19

- There have been 44 instances of staff that have tested positive for Covid-19 in June 2021 with 1,814 instances since July 2020. As at the end of June there were no open outbreaks on Trust sites.

RECOMMENDATION:

The Board of Directors is asked to:

- Note the content of the report
- Note the omission of reporting on C4 90th for June.
- Clarify any items for further scrutiny

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Q+P committee			
	Date:	26.7.21		
	Outcome:	Not know at time of submission		

- THIS PAGE IS INTENTIONALLY BLANK -

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 June 2021. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

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

2. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

3. EQUALITY OR SUSTAINABILITY IMPLICATIONS

The data in this report are presented at an aggregate level for the trust and so any issues related to equality and diversity are not highlighted. We have begun to explore equality, diversity and inclusion measures starting with analysing AQIs against these measures and adding measures into the complaints process. Data are being explored in relation to the friends and family test which will be presented to the next Committee.

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

4. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the content of the report
- Note the omission of reporting on C4 90th for June.
- Clarify any items for further scrutiny through the appropriate assurance committee.

This page is intentionally left blank

Q1 COMPLAINTS

Figure Q1.1

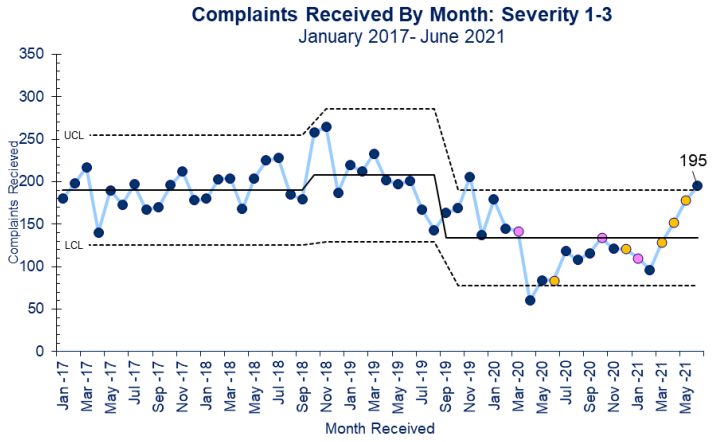


Figure Q1.2

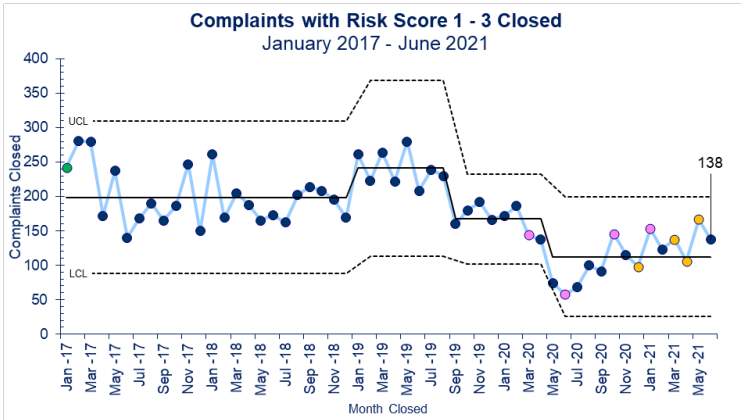


Figure Q1.3

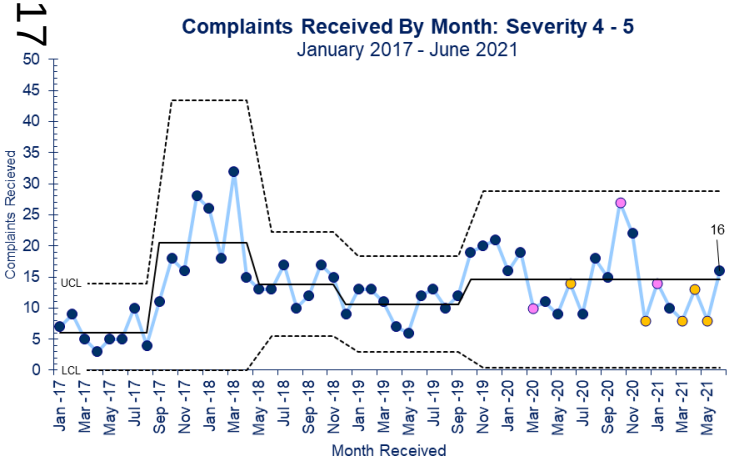
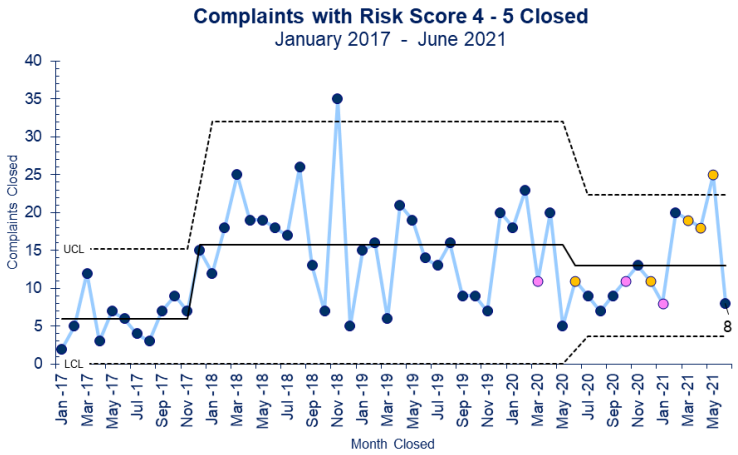


Figure Q1.4



* *Lockdown* *Easing of Restrictions*

Complaints & Compliments

In June, 212 **complaints** were received (figures Q1.1 & Q1.3) against a 12-month average of 146 per month.

128 compliments were received this month.

The rate of complaints in June 2021 was 34 per 1000 WTE. The average for the fiscal year (1 April 2021 – 30 April 2021) is 30 per 1000 WTE. The rate for both the month of June the year to date is above the strategy goal for 2021/22 of 27.

The number of complaints received with a score of 1-3 has increased for 4 consecutive month (Q1.1). The data for June at 195 complaints shows special cause variation with the number being above the upper control limit.

A total of 146 complaints were closed in June 2021 (138 were risk scored 1-3 Q1.2 and 8 were risk scored 4-5 Q1.4).

The fall in the number of 4-5's closed is due to the Trust being at REAP 4 and so therefore the amount of time that operations have to undertake investigations is limited.

Figure Q1.5

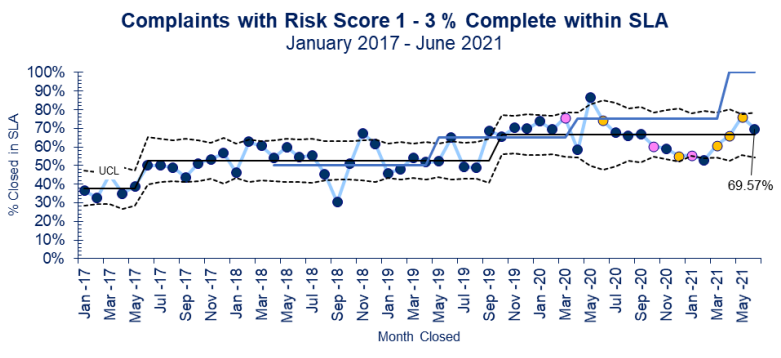


Figure Q1.6

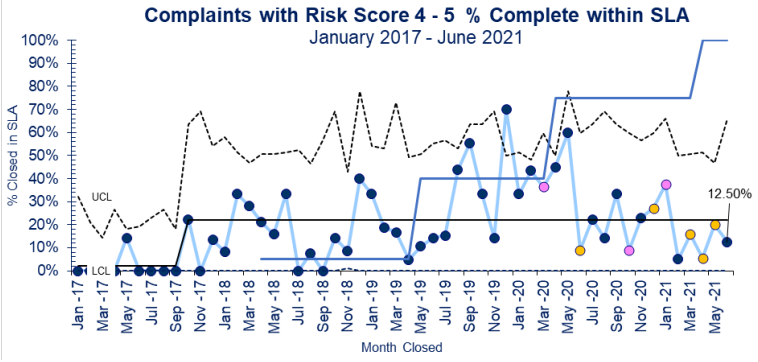
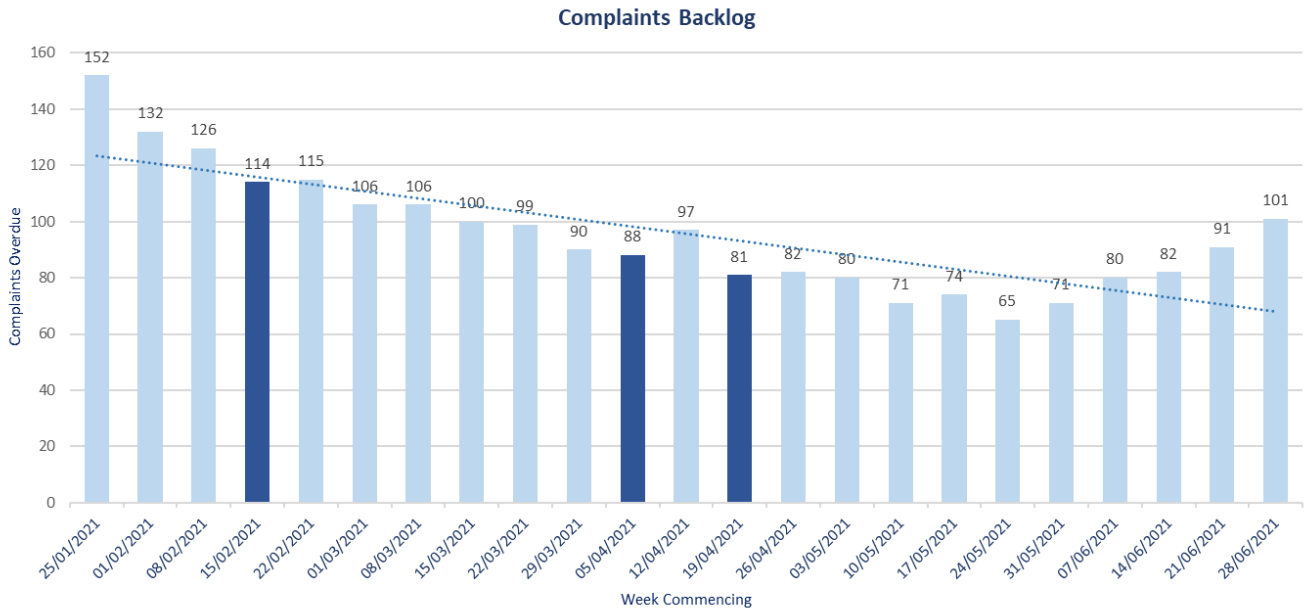


Figure Q1.7



* Lockdown Easing of Restrictions

Complaints Closure

Overall, 70% of cases risk scored 1-3 were closed within the agreed timescales (Q1.5) against a right care strategy goal of 85% for the end of 21/22. Thirteen percent of level 4-5 complaints were closed within agreed timescales (Q1.6) against a right care strategy goal of 70% by the end of 21/22. It is important to note that the strategy goals were set pre-pandemic. Incident management has been significantly affected by the COVID 19 pandemic and the prolonged periods in REAP 4 which stops production of the required statements and investigation reports.

The backlog of complaints has fallen from Just over 150 in January to 101 by the end of June. The backlog has started to increase since the introduction of REAP 4 (Q1.7). Overall the backlog remains at c30% of the total volume of complaints.

Q2 INCIDENTS

Figure Q2.1

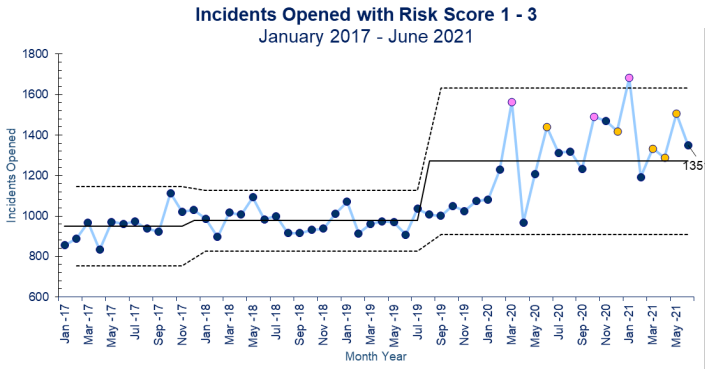


Figure Q2.3 - Highest number of incidents May 2021 by subcategory

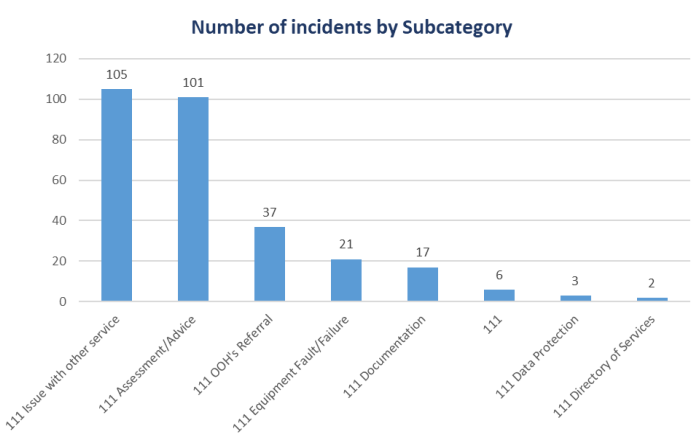


Figure Q2.2

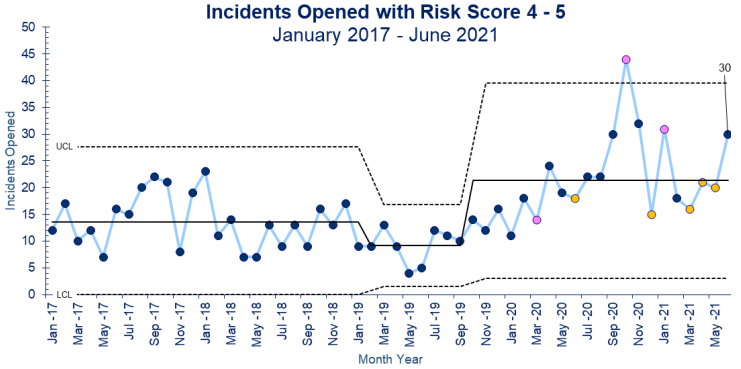
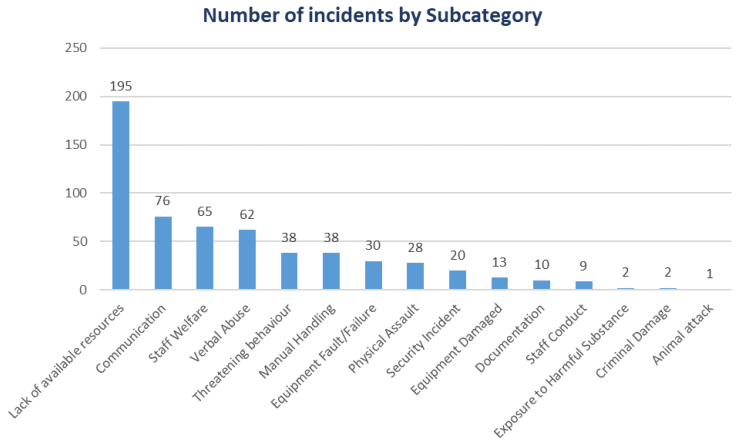


Figure Q2.4 - Second highest number of incidents May 2021 by subcategory



* Lockdown Easing of Restrictions

Reporting: In June, 2021, 1475 internal and external incidents were opened (Q2.1 and Q2.2) with an additional 94 still to be scored, against a 12-month average of 1443. High levels of reporting are important and considered a marker of a positive culture where staff feel able to speak up.

Unscored Incidents (RCS): In May, 45 incidents were unscored which is above the end of year Right Care Strategy goal of 25 unscored incidents in the previous month reported in the IPR. The scoring and management of incidents in a timely way is monitored via the clinical effectiveness and operation outstanding meetings and plans are in place to ensure the end of year target is achieved.

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

111: It is important to frame the total number of incidents in 111 against the total number of calls received (292 incidents from 255,552 calls). Many of these incidents are raised by healthcare professionals who want clarity on outcome decisions. All calls are audited and action taken where concerns are upheld. The majority of 111 incidents have been raised because of concerns about the assessment or advice given (n=110), because we have had issues with another NHS service (n=105), for documentation or data protection issues (n=17+3) or for out of hours referrals. Around 15% -20% of Incidents raised within 111 can be resolved locally and do not relate to patient safety.

Staff Welfare Incidents: The 2 most common reasons for reporting are violence and aggression towards staff, which includes threatening behaviour, verbal abuse and physical assault, and resource or equipment issues. The Trust has an active Violence and Aggression working group (a sub-group of the Health, Safety and Security sub-committee) with workstreams to reduce assaults on staff and to assist in increasing appropriate prosecutions. For example, the Body Worn Video Cameras project and the refreshment of existing and developed of new Policies and Procedures.

Figure Q2.5

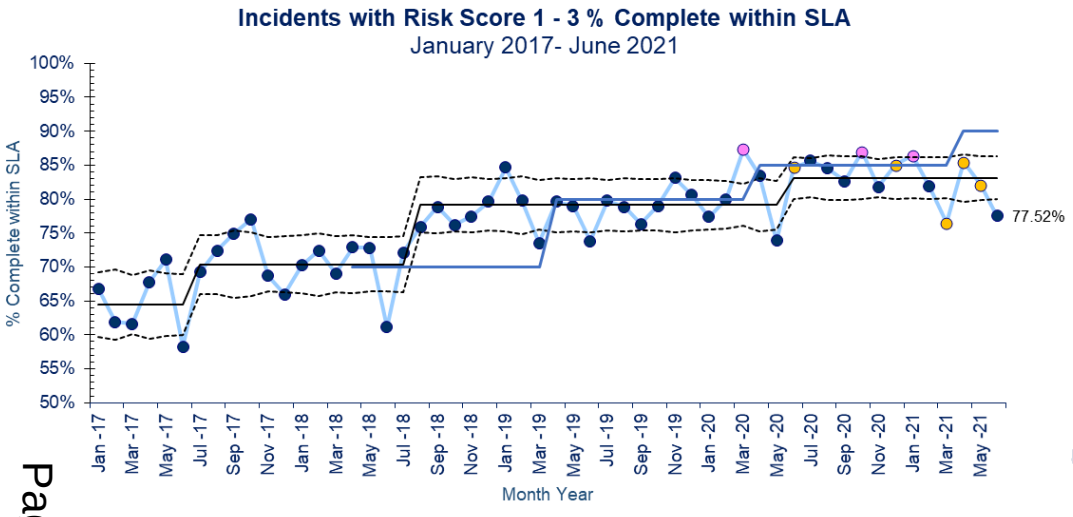
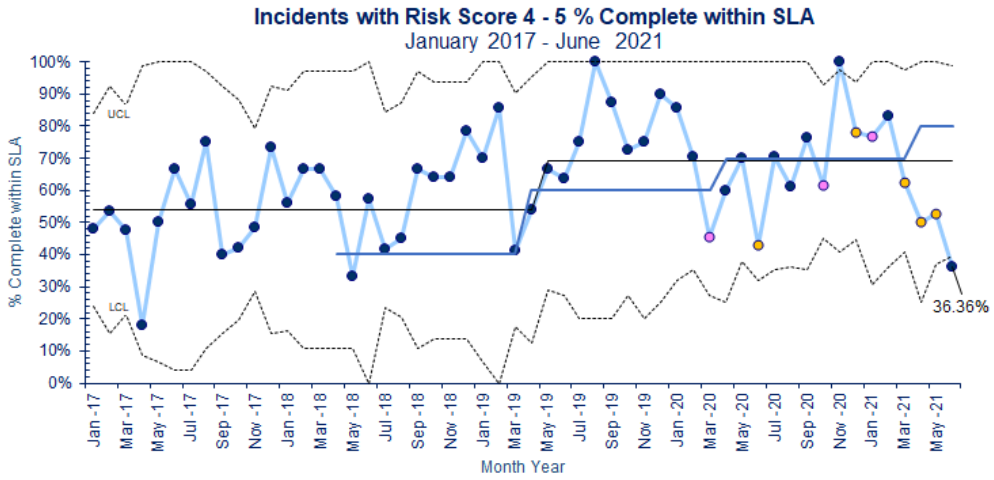


Figure Q2.6



* Lockdown Easing of Restrictions

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

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

Incidents Closure

In total, 1312 incidents (level 1-5) were closed during June 2021.

78% level 1-3 were closed within agreed standard (Q2.3) which is currently showing as special cause variation and below the right care strategy goal of 90%.

36% of level 4-5 incidents were closed within the agreed standard (Q2.6) against a right care strategy goal of 80% for the end of 2021/22 and is also currently showing as special cause variation.

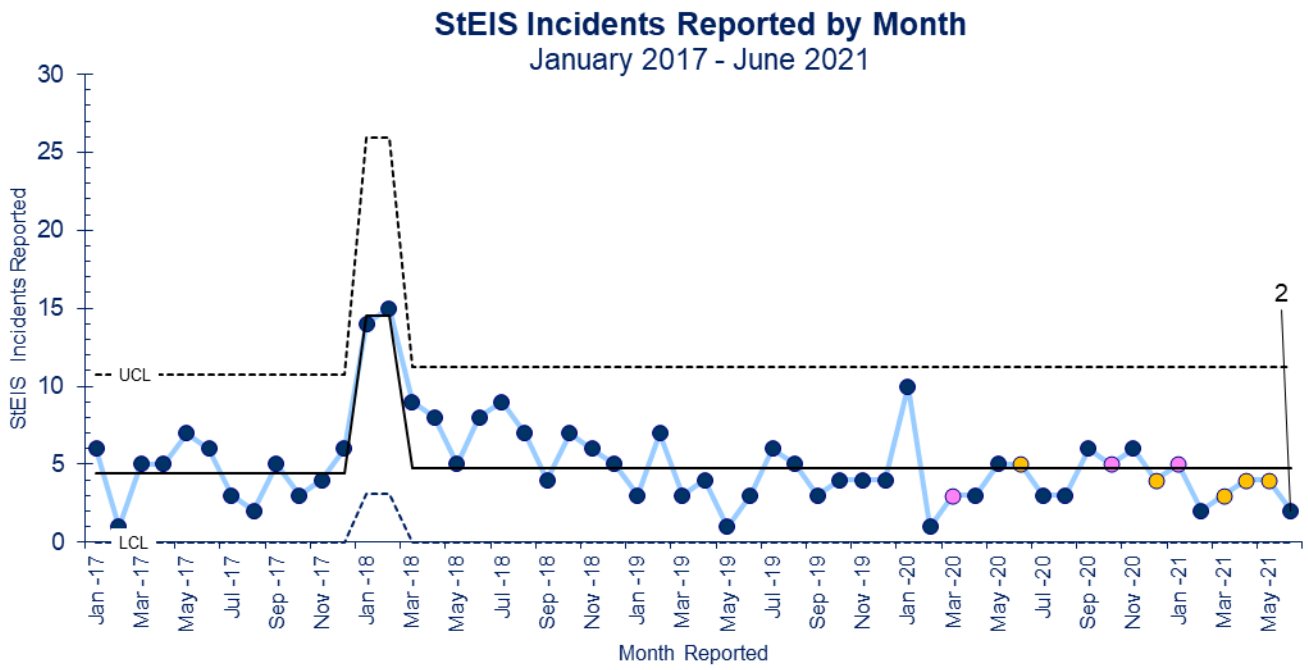
Both have been affected by the introduction of REAP Level 4 which impacts on the ability of the front line to produce the required statements and investigation reports, in a timely manner, to close off these incidents. The Patient Safety team are supporting this as much as they can during periods of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

The scoring, management and learning from incidents is a priority. Each area and head of service has a plan for recovery of their back log and a goal to get incidents scored and closed in a timely way. They report their progress at the clinical effectiveness sub-committee and as part of the operation outstanding meetings, which happen every alternate Friday (although some have been deferred due to REAP 4). A trust wide working group is in place under the leadership of the medical director and patient safety specialist, to review incidents, investigations & learning.

Due to the continuation of REAP level 4, we anticipate recovery will take until beyond the end of Q2. However, the closure of incidents in a timely way will remain a goal throughout the year and will be reported via Quarterly right care strategy updates to the Patient Safety Sub-Committee of the Quality and Performance Committee

Q3 SERIOUS INCIDENTS

Figure Q3.1



* Lockdown Easing of Restrictions

Serious Incidents

2 Serious Incidents (SIs) were reported in June 2021.

3 SI reports were due with the commissioners in June 2021. All 3 were submitted within the 60-day timescale.

Despite an increase in level 1-3 complaints recently, an increase in reported incidents since June 19 and performance pressures – there has not been an increase in the number of serious incidents. This is due the significant work undertaken to ensure quality and safety, learn from previous serious incidents and ensure clinical support within the EOC.

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

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received Jul 20 – June 21)	Number of Alerts Applicable (Jul 20 – Jun 21)	Number of Open Alerts	Notes
CAS/ NHS Improvement	28	1	0	Foreign body aspiration during intubation, advanced airway management or ventilation. A revised airway procedure is being developed by the Consultant Paramedics.

Safety Alerts	Number of Alerts Received (Jul 20 – Jun 21)	Number of Alerts Applicable (Jul 20 – Jun 21)	Number of Open Alerts	Notes
MHRA – Medical Equipment	4	1	0	

Safety Alerts	Number of Alerts Received (Jun 20 – May 21)	Number of Alerts Applicable (Jun 20 – May 21)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	53	0	0	

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

NWAS Response

There has been 9 new safety alerts in June 2021.

The total number of CAS/NHS Improvement alerts received between July 2020 and June 2021 is 28, with 1 alert that is applicable.

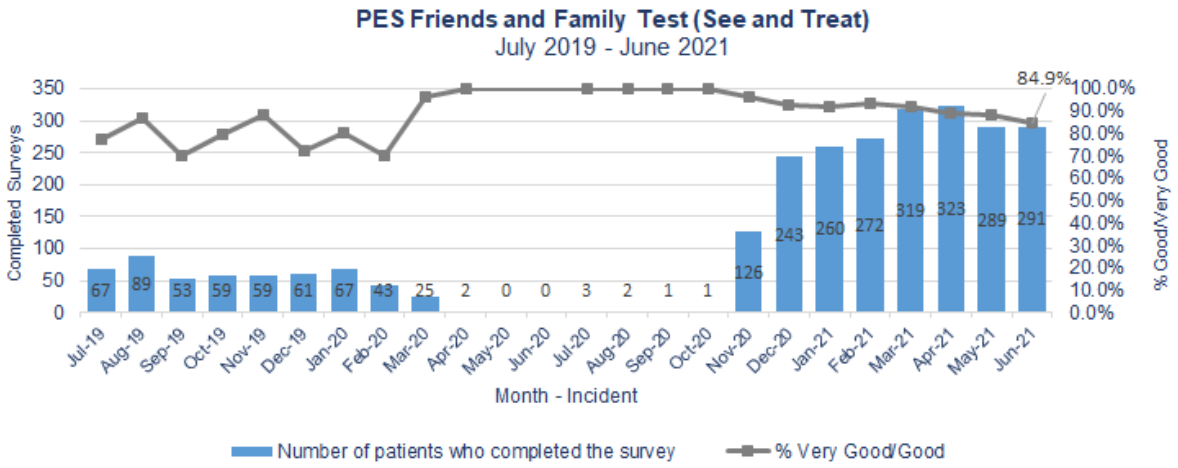
4 MHRA Medical Equipment Alerts have been received with 1 alert that is applicable.

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

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

E1 PATIENT EXPERIENCE

Figure E1.1



Patient Experience

The service line narratives and data below relates to all our patient respondents' feedback. We have started to explore any variation in the data related to equality, diversity and inclusion measures and more detail together with associated charts will be reported in future reports.

Patient Experience (PES)

The 291 return for June 2021 is in line with those for May 2021 (289), but with associated comments seeing a drop of 7.5%; 198 for June and 214 for May.

On overall experience of the service, the 84.9% patient satisfaction rate for June 2021 has reduced by 3.3% when compared with 88.2% in May 2021.

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

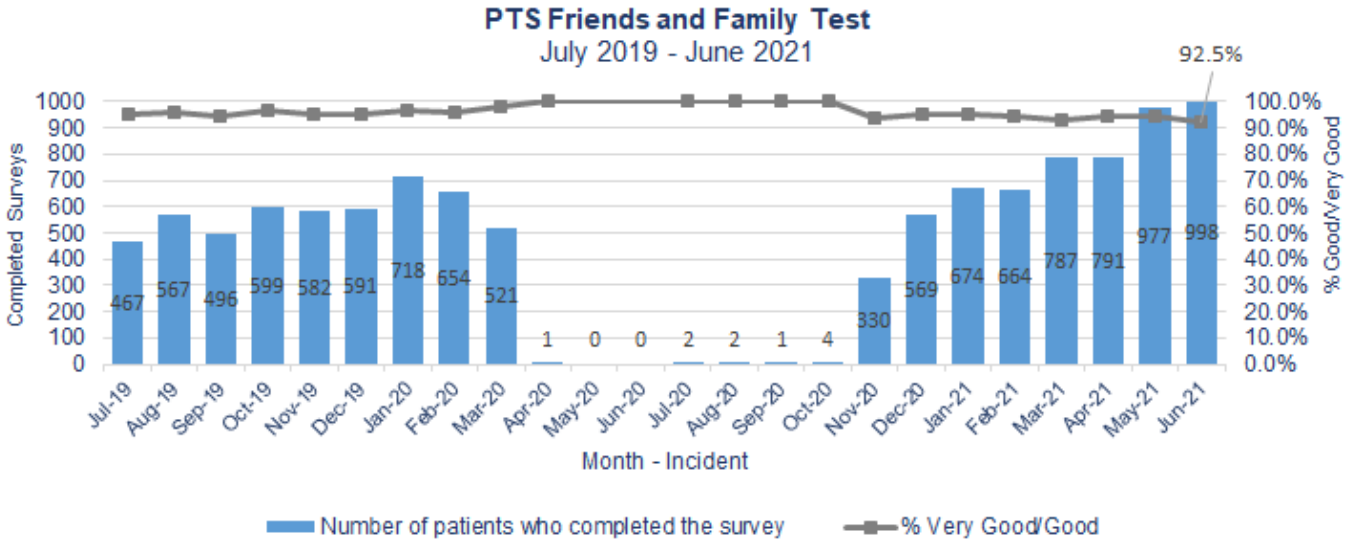
"Arrived quickly, efficient and caring approach, clear explanations, stayed to carry out checks over time, sensible advice offered."

- *"Efficient, respectful, treated with dignity at all times."*

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

- *"The ambulance didn't arrive until 12 hours later."*
- *"Because it took four 999 calls and twelve hours to get an ambulance to an 82 year old woman who, it transpired, had a fractured hip and a heart attack. At one point, when I explained that my mother couldn't move and needed to use the toilet, I was told that I should put something underneath her."*

Figure E1.2



Patient Experience (PTS)

The June 2021 return of 998 is almost on par with May at 977, a slight increase of 2.1%, with a similar slight increase in comments: 795 in June and 790 for May. For overall experience, the patient satisfaction rate has reduced by 1.7%, (92.5% in June compared to 94.2% in May).

Where respondents indicated '**very good/good**', the emerging themes were around friendly and helpful staff along with extra care shown, timely pick up; being treated with dignity and respect, patient comfort and safety, professionalism reinforced with an efficient and excellent service and good communication. Comments included:

- *"Driver was pleasant, helpful, made mum feel important and comfortable despite her condition. He went above and beyond.... only our 2nd time using the service and we were not aware of any cut off times for out of area hospital transport. This didn't matter, our driver went out of his way to collect us on this occasion. So helpful of him and put our minds at easy when it was brought to our attention that we may miss the window for a return home."*
- *"Both the ambulance crews both coming and going were very friendly and cheerful, explained what they were doing & treated me with respect."*

Where respondents indicated 'poor**/very poor**', the corresponding themes included: difficulty with booking transport, waiting time delays (inward and outward journeys); no transport and patient safety concerns. Comments included:

- *"I was told to ring back a week later as you only take bookings a week in advance, then when I did, I couldn't get through for 3 days (cut off after option 2) and tried 5 different numbers given by helpful hospital admissions staff. When eventually I got through I was treated terribly by woman at the other end who questioned my motives for using the service and was very sarcastic and rude."*
- *"Ambulance never turned up for first appointment, then second appointment on return didn't have right size seat belt extension then had to wait for next, when they come didn't have my nurse on job details or that oxygen was needed."*

Figure E1.3

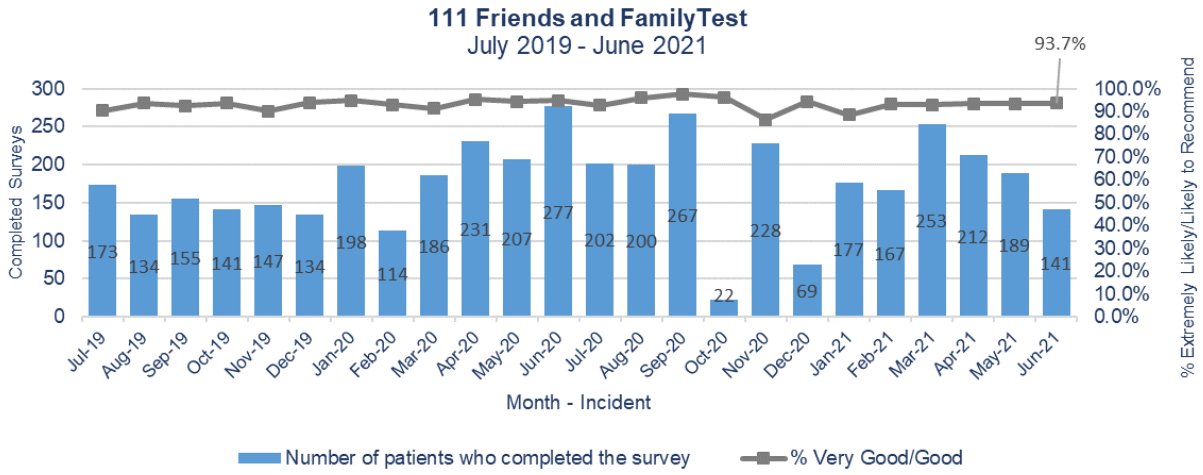
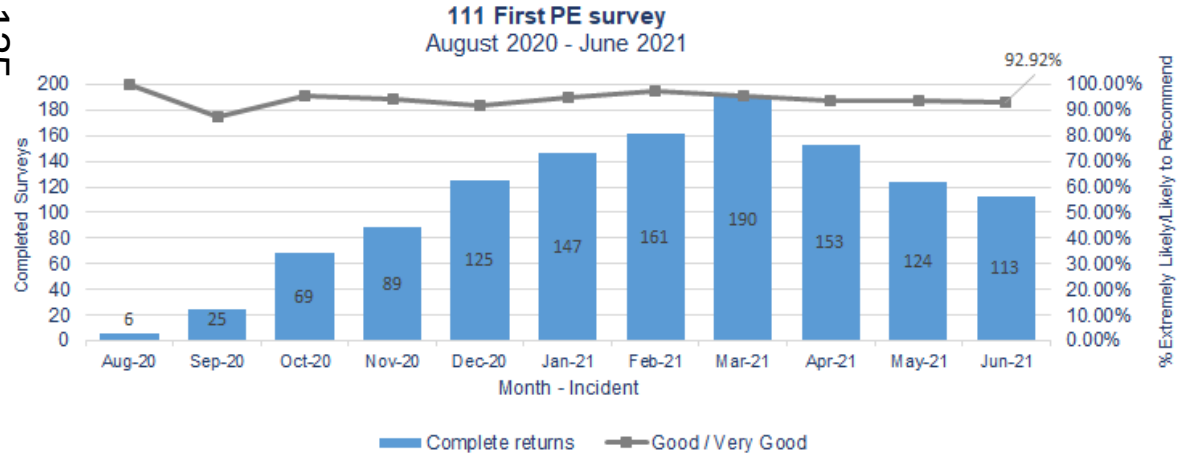


Figure E1.4



Patient Experience (NHS 111)

There were 141 surveys returned in June, a drop of 25.4% compared to the 189 seen in May. This return in June of 141, when compared to the monthly average of 150 for the last two quarters of 2019/2020, is lower. It is believed this is due to the fact that surveys take 1-2 weeks to be generated and posted out and a further 1-2 weeks to be returned, combined with changes in the submission window and frequency of reporting

In June we see the likelihood of recommending the service i.e. 'extremely likely/likely at 93.6%, almost matching that for May (93.7%).

Where respondents indicated an '**extremely likely/likely**' recommendation, themes emerging included**:** speed of response, professionalism; clear advice and helpfulness, reassurance and empathy, hospital/GP referral and booking process and access to prescription from pharmacies. Comments included:

- *"Efficiency and politeness of the chap I spoke to. He was calm and polite and helped the situation massively organised and efficient. We were on our way to A &d E urgent care centre in no time."*
- *"It is really good we have NHS 111 as doctor surgery has too many patients on books it is extremely difficult to get an appointment with them and after hours or weekend we would die if there was no NHS 111 as doctors' surgery are inaccessible."*

Where respondents indicated an '**unlikely/extremely unlikely**' recommendation (only 4) comments included:

- *"I spoke to 3 people over a 3 and a half hour period only to be referred to another number."*
- *"Spoke to 3 people on 111. An appointment was made for me at urgent care, where I sat for 2 hours and told when I saw the doctor he couldn't do anything for me. If problem got worse ring 111 get appointment with A and E why! When I was there. Total waste of time."*

NHS 111 First

Also reported is a high level summary table showing the number of returns, reasons for using the service, outcome and the levels of overall patient satisfaction. Cumulatively since the service commenced last August 94.38% of patients describe their experience as '**very good/good'** and 95.84% of patients felt their need for calling the service was met.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

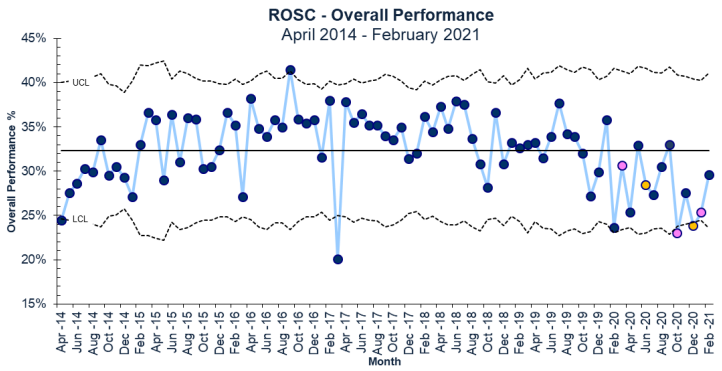
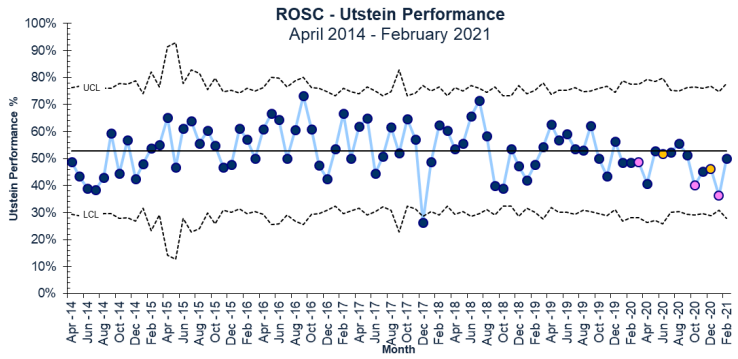


Figure E2.2



* Lockdown Easing of Restrictions

Figure E2.3

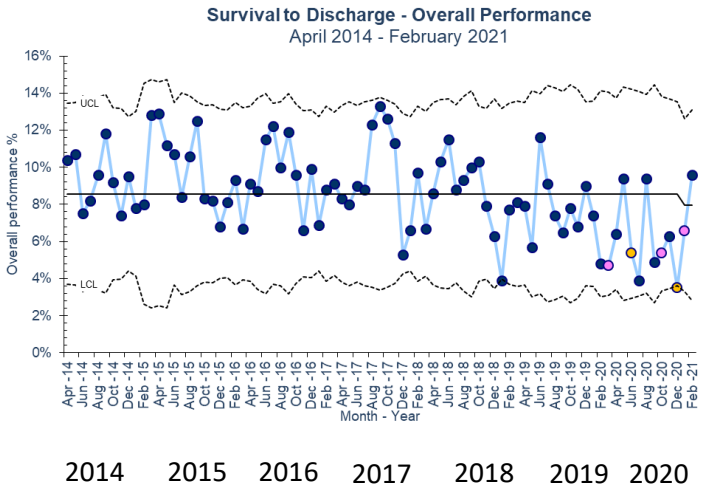
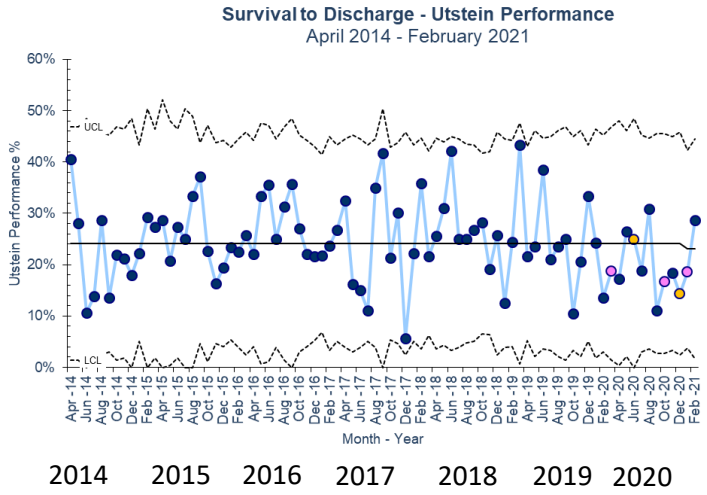


Figure E2.4



ACQIs (Last data point: February 2021)

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

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

Results for February 2021 show performance was closer to the Trust's mean performance in these measures. The previous months had seen a drop with special cause variation in the data. Performance was ranked second nationally for ROSC – Overall and seventh for ROSC Utstein.

The ROSC achieved for the Utstein group was 50% (national mean 51%), For the overall group the rate was 29.6% (national mean 24.2%). This indicator is predominantly influenced by pre-hospital factors.

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

Survival to Discharge rates in February 2021 were higher than the previous month at 9.6%. Although the data remain within control limits and so this does not represent a significant improvement.

In February 28.6% of patients in the Utstein group survived to hospital discharge, again higher than the previous month and the national mean at 26.7% but within the control limits.

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

Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

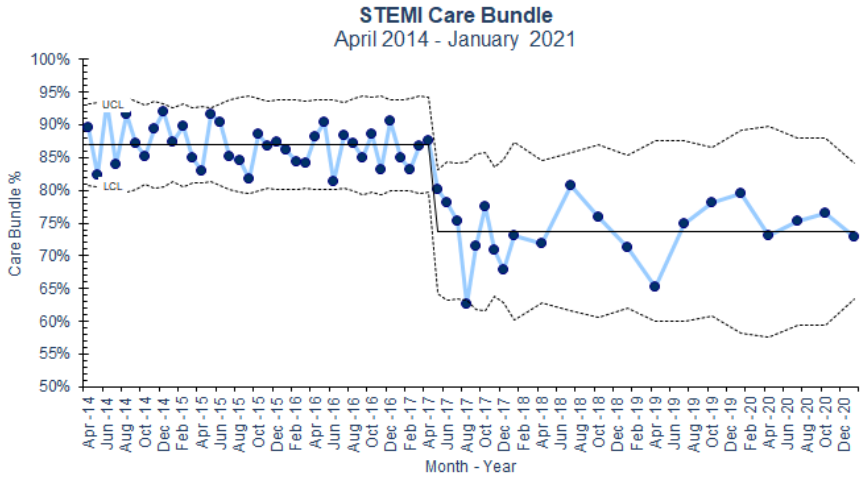
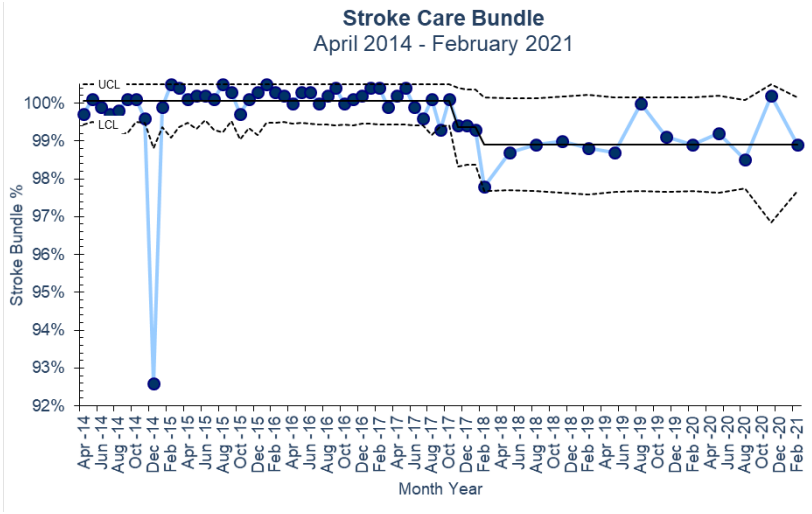


Figure E2.6



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).

Care Bundles

STEMI (2.5): STEMI care bundle performance was not reported for February 2021 as is consistent with the NHSE schedule.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 15mins; the Trust's performance was 2h 23mins.

Component of STEMI care bundle	Exceptions
Aspirin given	• Patient refusal • Contraindication to the drug • Cautions if clear reasons provided
Glyceryl trinitrate (GTN) given	• Patient refusal • Contraindication to the drug • No Chest Pain
Two pain scores recorded	• Patient refusal • Patient unable • Patient unconscious
Appropriate analgesia given –options available are Morphine, Entonox and Paracetamol	• Patient refusal • Patient not in pain • Contraindication to the drug(s) • Cautions if clear reasons provided

STROKE (2.6): Stoke care bundle performance was 98.4% for February 2021 ahead of the national mean of 97.8%.

Mean call to hospital arrival for stroke was 1h:12min in February 2021; the same time as the national mean.

Component of stroke diagnostic bundle	Exceptions
FAST assessment recorded	• Patient refusal • Patient unable
Blood glucose recorded	• Patient refusal
Systolic and diastolic blood pressure recorded	• Patient refusal

E3 ACTIVITY & OUTCOMES

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

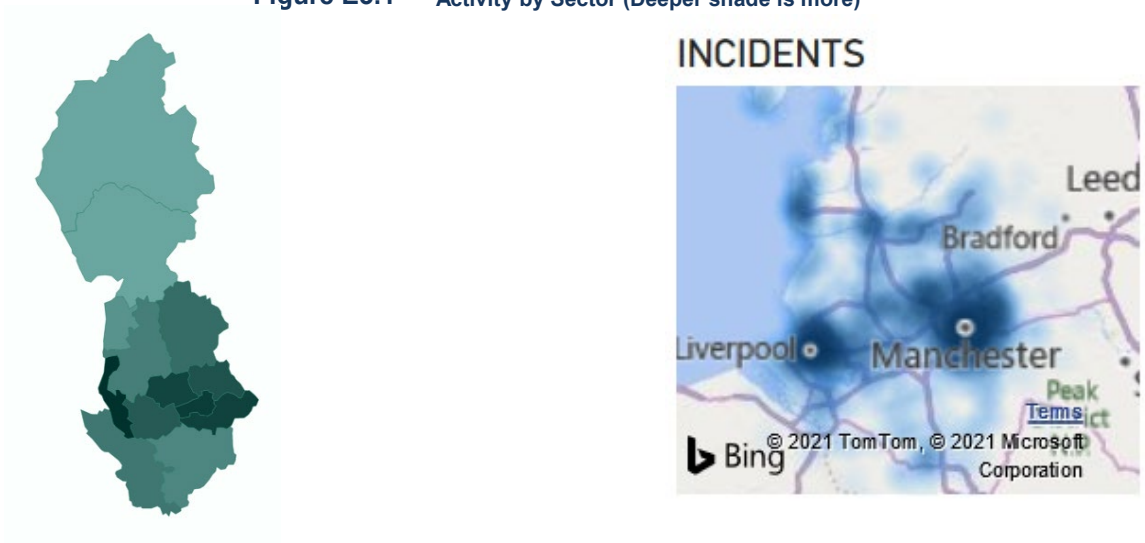
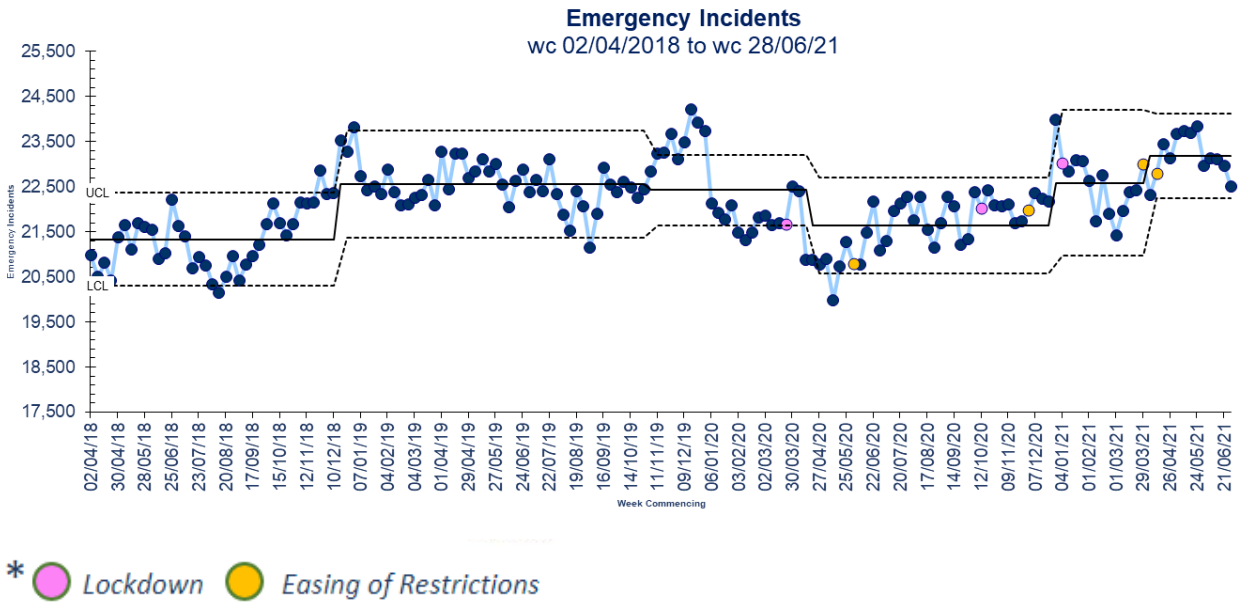


Figure E3.2



* Lockdown Easing of Restrictions

Activity:
In June 2021 the Trust received 143,008 calls of which 98,508 became incidents. Compared with June 2019, we have seen a 24% and 2% increase in calls and incidents respectively.

Jun	Calls	% Change from 2019	Incidents	% Change from 2019
2019	115,795		96,953	
2020	95,331	-18%	91,239	-6%
2021	143,008	24%	98,508	2%

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

H&T, S&T, S&C Outcomes
The proportion of incidents with Hear and Treat (E3.4) is 9.1% for the month of June 2021. See & Treat (E3.5) has seen a small increase to 30% (which is similar to pre-covid levels) in total, there was an aggregate non-conveyance of 39.1% (E3.6).

Our rankings since November have seen no change for See and Convey (E3.9), but for Hear and Treat have moved from 5th in May to 9th in June. For See and Treat have moved from 9th in November to May to 7th in June.

Figure E3.4

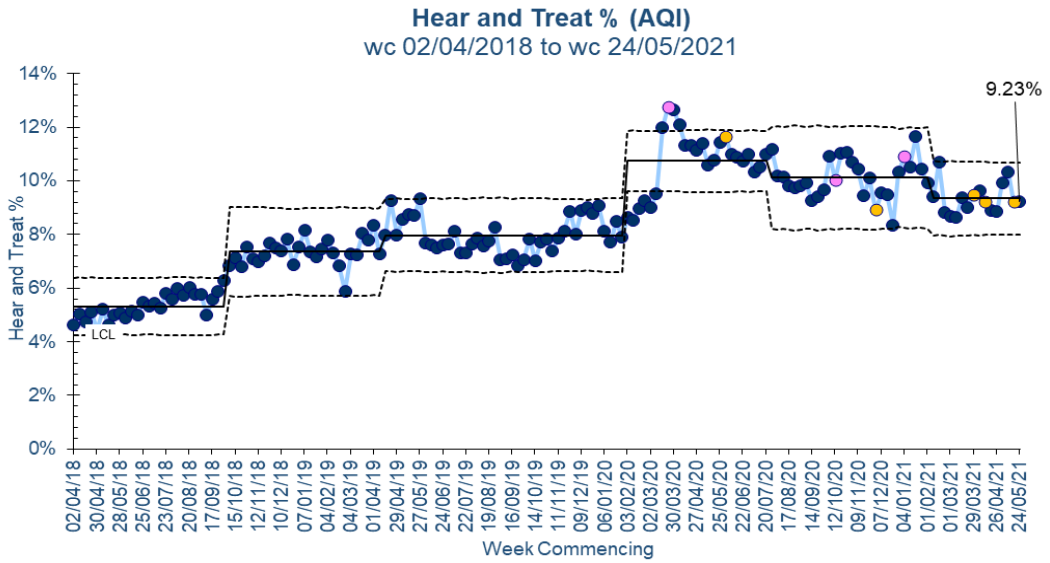


Figure E3.5

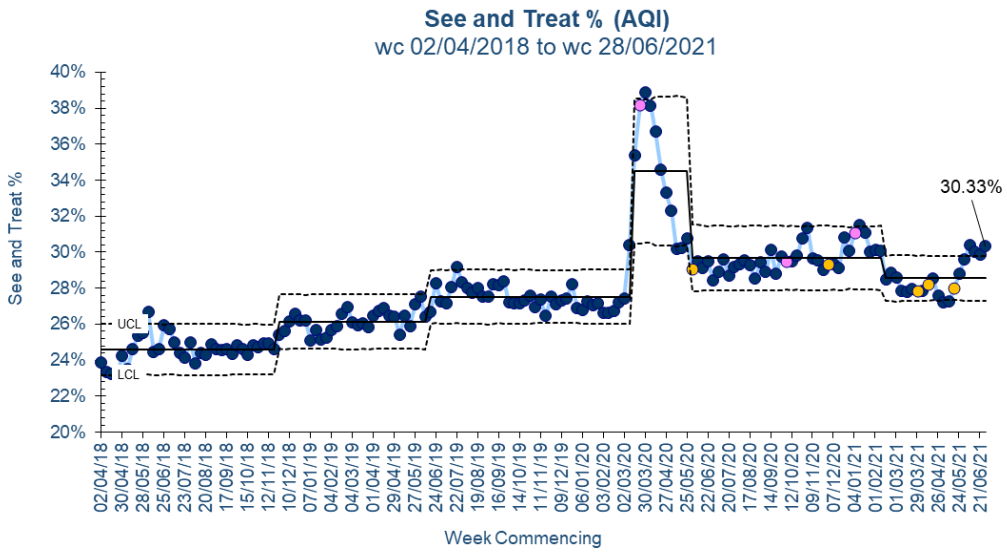
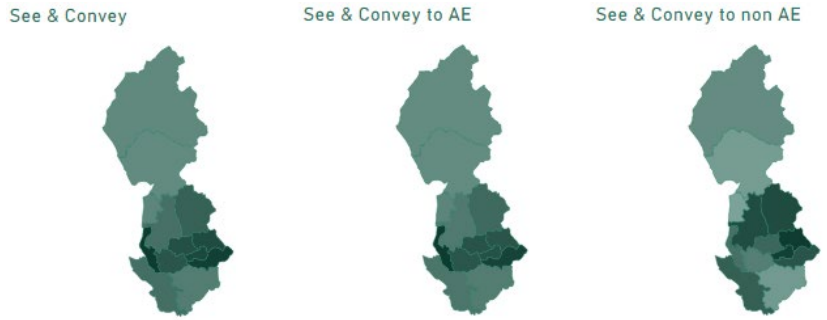


Figure E3.6



*the darker the colour the higher the level of activity

* Lockdown Easing of Restrictions

- **Hear and Treat rates** have stabilised since the increase in clinical workforce in March 20 due to staff realignment and home working enabled by COVID Pandemic. Clinical staff seconded to Clinical Hub have returned to Sector. It is encouraging to note that NWAS are consistently delivery about 9% H&T across the region. The variation through June is due to changes in acuity which means the Clinical Hub focus splits more between patient safety and Hear & Treat. As patient acuity increases this reduces the proportion of incidents that are suitable for Hear & Treat.

- **See and Treat rates** vary between sectors and are contingent on primary care and out of hospital commissioned services responding promptly to requests for clinical consultation. Where services aren't commissioned or aren't able to respond attempts to 'See and Treat' fail and the crew are left with no alternative than to transport the patient to hospital.

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

Outcome Provider Comparison Figures February 2021

Figure E3.7

Provider	Hear & Treat
London	14.8%
South Central	13.0%
East Midlands	11.7%
Isle of Wight	11.5%
Yorkshire	10.3%
North East	10.2%
East of England	10.1%
South East Coast	9.3%
North West	9.1%
South Western	7.9%
West Midlands	6.5%

9/11

FigureE3.8

Provider	See & Treat
South Western	38.5%
West Midlands	35.6%
South Central	33.3%
East of England	32.0%
South East Coast	31.3%
East Midlands	31.0%
North West	30.0%
Isle of Wight	29.6%
London	29.5%
North East	26.5%
Yorkshire	26.0%

7/11

Figure E3.9

Provider	See & Convey
South Central	53.7%
South Western	53.7%
London	55.7%
East Midlands	57.4%
East of England	57.8%
West Midlands	57.8%
Isle of Wight	58.9%
South East Coast	59.4%
North West	61.0%
Yorkshire	63.2%
North East	63.3%

9/11

- **HEAR & TREAT**: Since January 2018 we have seen our Hear and Treat ranking improve from 8th to first, however, since November 2020 we have seen other Trusts figures improve significantly moving NWAS to 9th place. NWAS has improved focus on Patient Safety within the waiting incidents, utilising the clinical resource in Clinical Hub to review the welfare of patients of concern. NWAS is still delivering above 9% H&T consistently.

- **SEE & TREAT:** During the height of wave one of the pandemic (March – June 2020) we ranked lowest of all Trusts on See and Treat rates despite seeing a sharp incline in S&T due to patient refusals. In July 2020 we moved up to 9th and have remained in that position until June where we moved to 7th.

- **SEE & CONVEY:** See and Convey rankings were steadily improving between Jan 2018 and September 2019 but since October 2019 we have been ranked 8th on average.

- **Note:** There are national pilots underway, with a view to improve see and treat and hear and treat rates. We are working closely to adopt the learning from these pilots.

F1 FINANCIAL SCORE

Figure F1.1

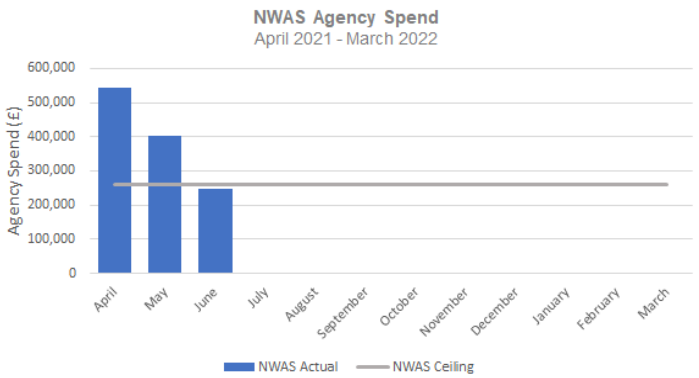


Figure F1.2

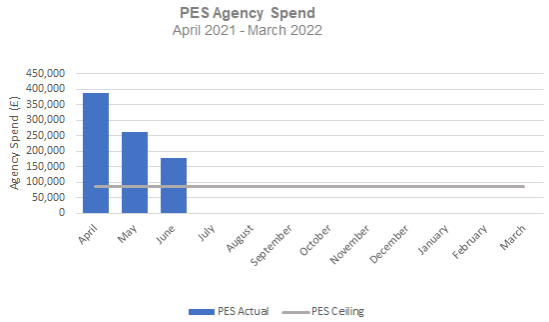


Figure F1.3

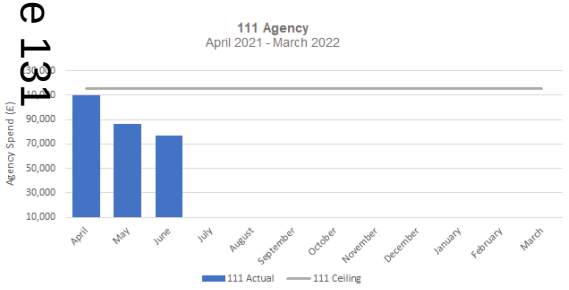


Figure F1.4

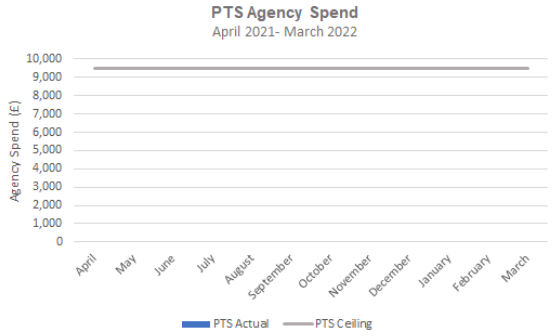


Figure F1.5

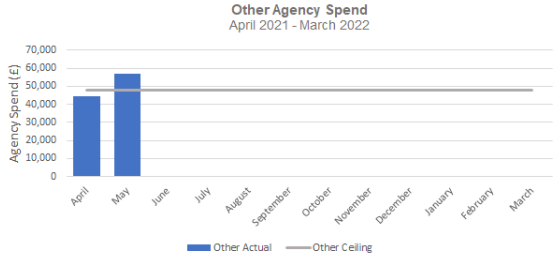
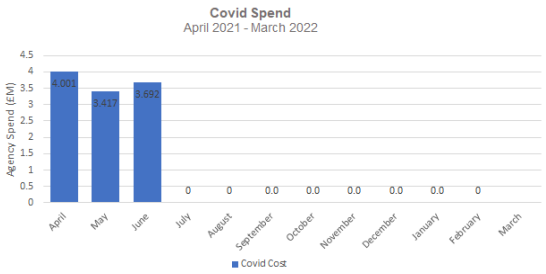


Figure F1.6



Finance Position

Month 3 Finance Position

As at month 3 the trust is reporting a breakeven position which is in line with the H1 financial plan. Spending remains in line with the previous financial year though increased costs are being experienced within PTS, as the NHS moves to restoration and recovery, whilst social distancing requirements remain in place for the service.

Agency Expenditure

The year-to-date expenditure on agency is £1.192m which is £0.415m above the year-to-date ceiling of £0.777m.

Please Note: The agency ceiling is based on 2019/20 ceiling figures and will be updated as soon as we have the information.

Risk Rating

The COVID-19 financial framework remains in place for H1 (1 April 2021-30 September 2021) and the monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process.

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

.

O1 CALL PICK UP

Figure O1.1

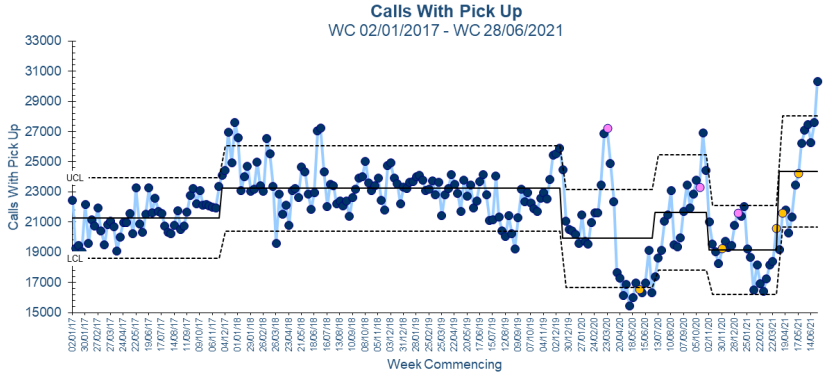


Figure O1.2

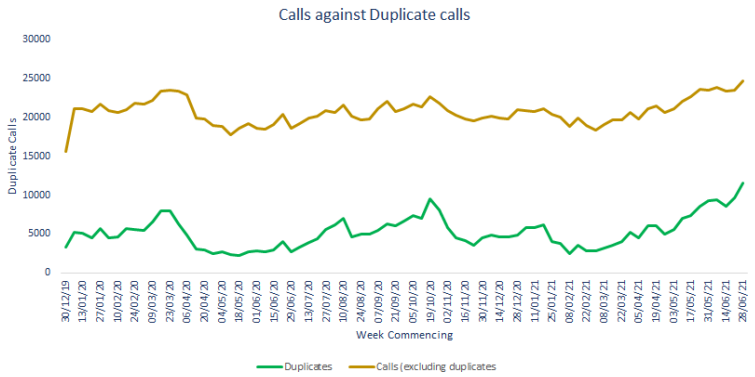
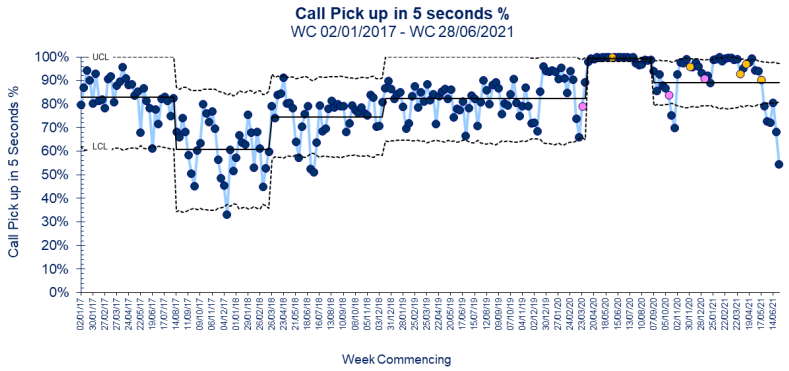


Figure O1.3



* *Lockdown* *Easing of Restrictions*

Call Pick Up

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

Performance: Call pick up performance in May had deteriorated when compared to previous months. This trend has continued into June. June's CPU has deteriorated from May's position (Q1.3)

Mean call answer 17 seconds.
95th centile call answer 1 minute 27 seconds.
Percentage of calls answered within 5 seconds 72%.

The primary challenge EOC face in respect to CPU performance is the volume of calls being presented. Call volume is currently higher than NWAS has experienced before (O1.1). The increase in calls can be attributed to increased demand across urgent/emergency care, a stepped increase in duplicate calls, increasing pressure born out of a more mobile population and enhanced night time economy. In addition the EOC has experienced pressure specific to the European Championships.

Figure O1.2 reflects the current challenge managing the volume of duplicate calls. Duplicate calls have been on the increase since February and continue to increase. Duplicate calls increase as response times to C2/3 specifically increase. Duplicates for June have averaged over 1400 per day.

As a result of increased demand and increased abstractions CPU has deteriorated. Abstractions have been increasing over the past few months. The EOC have observed stepped increases in abstractions due to COVID isolation and COVID positive results.

The EOC team have now introduced estimated times of arrival scripts (ETAs) for all C2 to 4. The ETAs provide an estimated response time to patients. This allows the patient to self-convey or access primary care / NHS online as well as managing patient expectations. It is hoped that by providing ETAs this will reduce the number of duplicate calls.

Further recruitment is planned across the next three months. This will increase call handling capacity and place NWAS in a stronger position moving into winter.

O2 A&E TURNAROUND

Figure O2.1

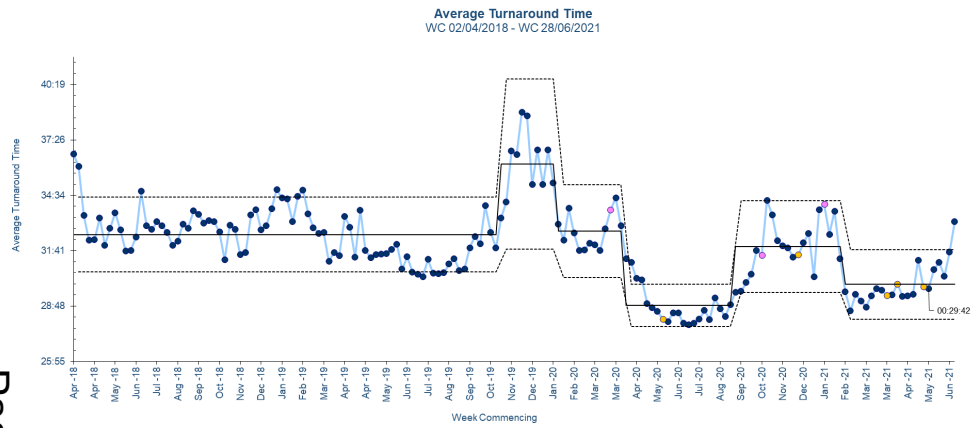


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Jul-20	52,551	28:05	16:44	11:10
Aug-20	52,059	28:33	17:28	10:52
Sep-20	49,946	29:37	18:45	10:53
Oct-20	51,452	32:32	21:47	11:04
Nov-20	49,885	31:49	20:31	11:08
Dec-20	53,723	31:54	20:56	10:56
Jan-21	53,179	33:00	21:58	11:08
Feb-21	47,620	29:09	17:47	11:17
Mar-21	54,174	29:25	17:57	11:42
Apr-21	53,552	29:26	18:14	11:18
May-21	57,211	29:56	18:46	11:17
June-21	52,325	31:20	20:11	11:24

Figure O2.2

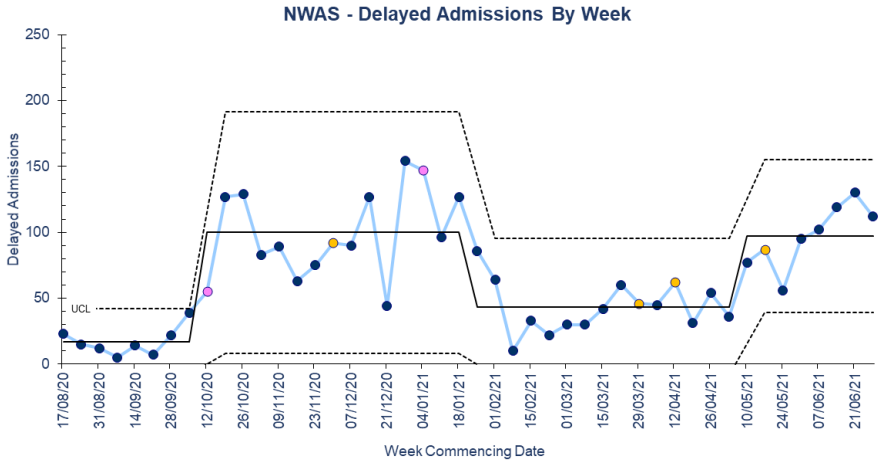


Table O2.2

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

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

A&E Turnaround Times

Average turnaround time was 31:20 (Table O2.1). This is the first month that the trust has not met the standard of 30 minutes since January and the 5th time in 12 months that the standard has not been met. The increase is primarily in the arrival to handover time which has increased from 18.46 in May to 20:11 in June (Table Q2.1)

2,367 attendances (4.5%) had a turnaround time of over 1 hour, with 65 of those taking more than 3 hours. This has seen an increase with comparison to and Aprils and Mays figures (1,458 and 1,937 respectively). In June, 491 cases of delayed admissions were reported - higher than the 282 reported in May (Table O2.2). June figures led to 570 lost hours - up from 289 hours in May.

The top five trusts with the highest Arrival to Handover time are:

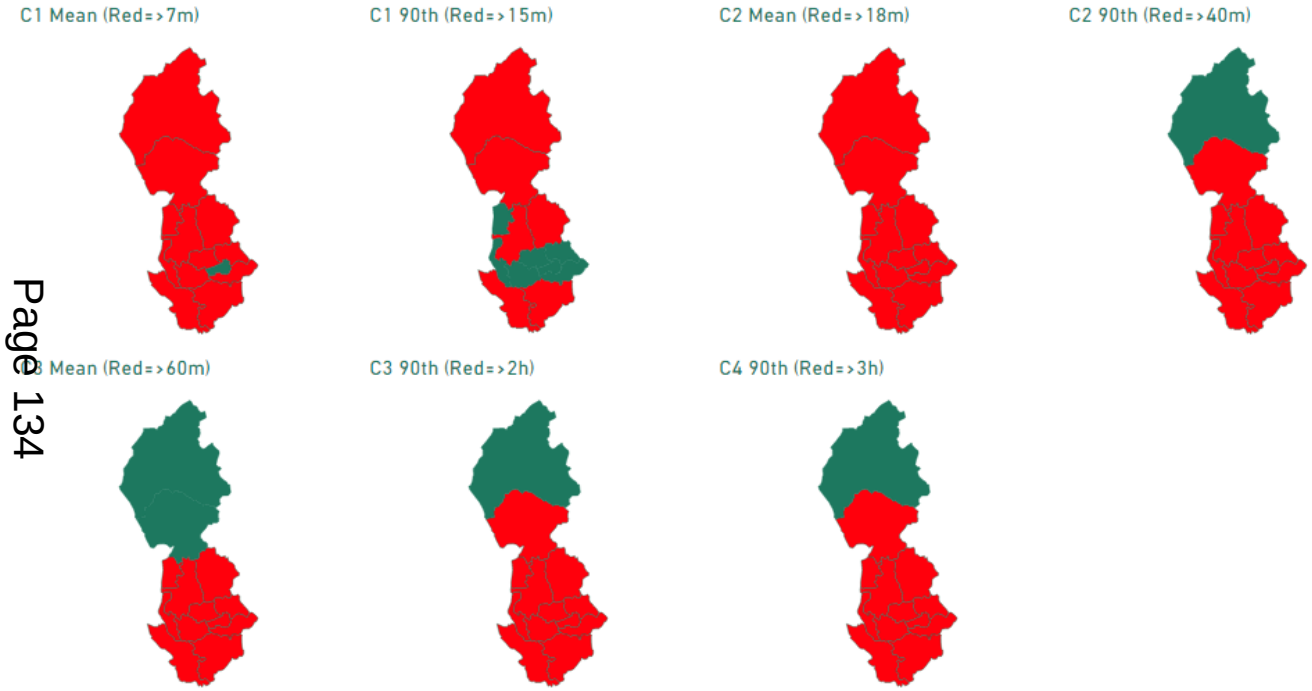
Royal Preston - 00:28:11
Royal Oldham – 00:25:21
Aintree - 00:24:43
Royal Lancaster - 00:23:11
Royal Albert Edward - 00:23:09

Even though overall turnaround times have increased this is largely being driven by a small number of acutes. the majority of acutes despite seeing increases in activity are continuing to meet the standard.

We are engaging with those trusts who have the highest turnaround times and expect to see similar improvements to those trusts that have been through the improvement process previously.

O3 ARP RESPONSE TIMES

June 2021



Activity: ARP Response Times

For June, response time targets were met for C1 90th. For all categories of calls apart from C1 90th there is special cause during week commencing 28th June . This is following on from the earlier easing of lockdown measures and something we see across most measures when the rules are eased. There is also a more general worsening trend which coincides with the end of military support (22nd March) and the end of shift enhancements. This has meant less resources were available. This trend is also being seen across the system with both Acute Hospitals in the NW and other ambulance trusts seeing increased activity. More recently we are seeing a significant increase in the proportion of incidents which are higher acuity - C1 and C2.

The trust has taken a number of measures to improve performance, including:

- An increase in third party support from Private Providers including St John's Ambulance
- Enhanced overtime payments on certain days
- Increased agency staff within the Clinical Hub
- Postponement of mandatory training to increase resources in the short term
- A focus on reducing other abstractions and unavailability reasons

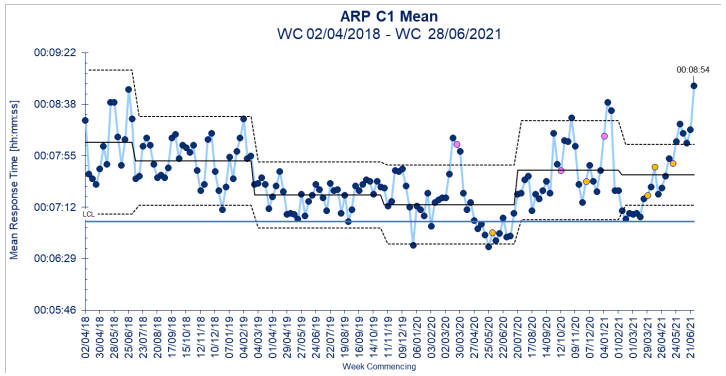
NWAS continues to progress the work with ORH and AACE to improve the operating model. Initial findings have been shared with the staff side representatives and a number of workstreams are progressing the work plans. Other avenues of increasing resources are being explored using the ORH modelling in relation to converting current resource hours to Emergency Ambulance resource hours.

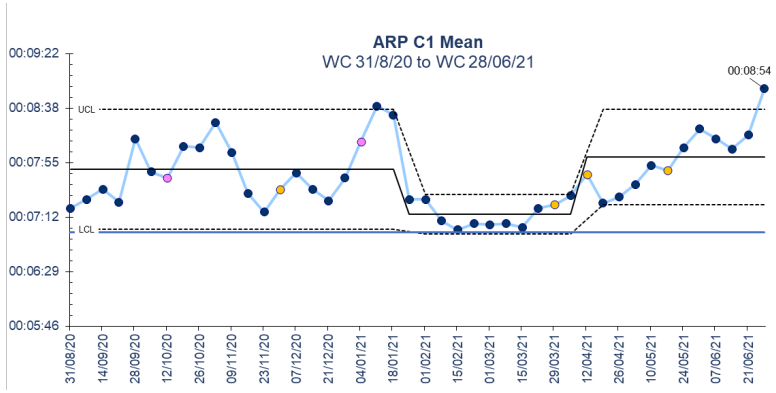
We continue to focus on patient safety with a particular focus on long waits to ensure we avoid patient harm.

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

1. **C1 mean:** One sector met the standards for C1 mean (GM Central)
2. **C1 90th: All But six** sectors (North Cumbria, Morecombe Bay, South Lancashire, East Lancashire, Manchester West and Manchester South) met the standards
3. **C2 Mean: No** sectors met the standard
4. **C2 90th: One** sector met the standard (North Cumbria)
5. **C3 Mean: Two** sectors met the standard (North Cumbria and Morecambe Bay)
6. **C3 90th: One** sector met the standard (North Cumbria)
7. **C4 90th: One** sector met the standard (North Cumbria)

Figure O3.1

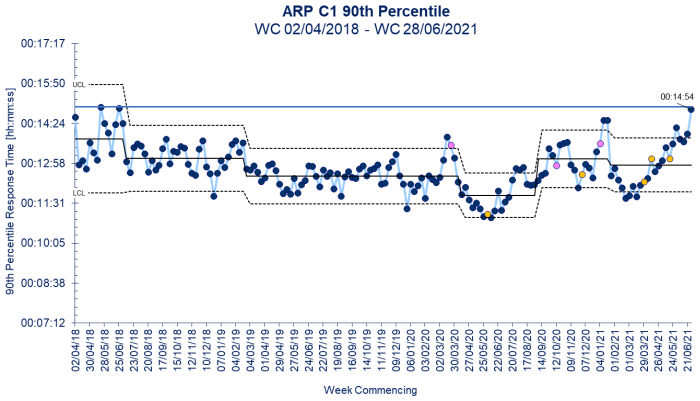


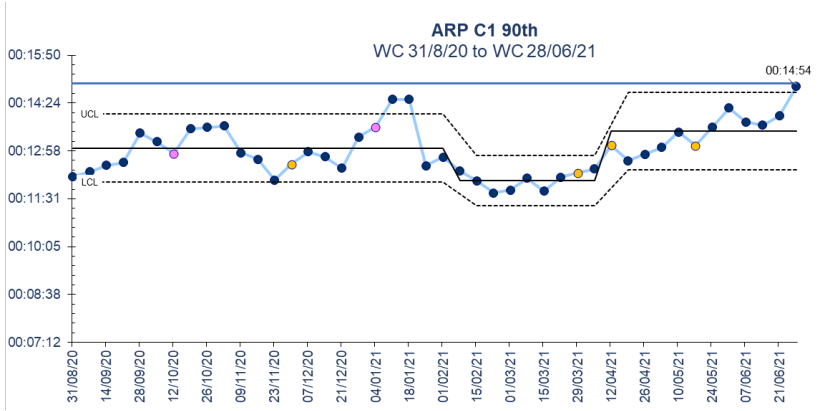


Green sectors

GM Central

Figure O3.2





Green sectors

CL Fylde, CL South Lancashire, M North, M East, M West, G West, G East, G Central, G South,

C1 Performance

C1 Mean

Target: 7 minutes

NWAS
June 2021: 8:19
YTD: 7:55

C1 mean performance shows one instance of special cause variation in June which is above the upper control limit. This is a reflection of the increase in acuity - the percentage of C1 incidents has increased from under 10% to 14% on some weeks. The change is larger when looking on a daily basis. On average this is an extra 90 incidents a day requiring an extra 145 emergency ambulance vehicles from a response ratio aspect. Activity has increased following a further release of lockdown on the 17th May. This has occurred after every release of locked down arrangements.

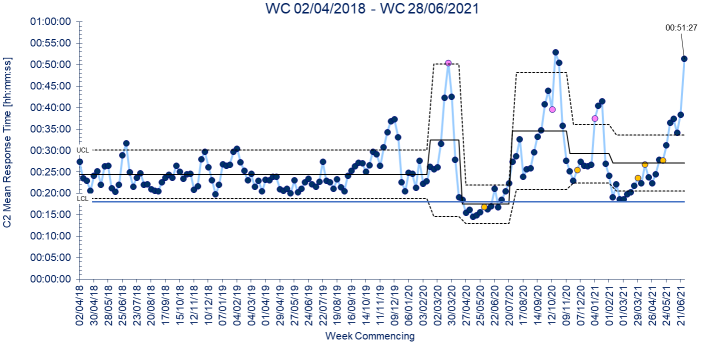
C1 90th Percentile

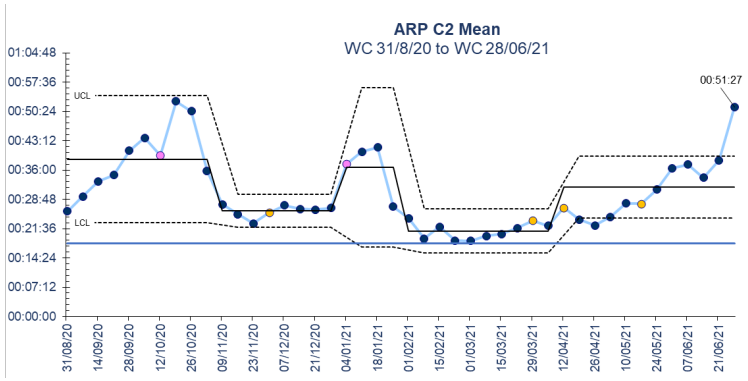
Target: 15 Minutes
NWAS
June 2021: 14:03
YTD: 13:25

C1 90th remains within standard but again there is a deteriorating trend developing.

* Lockdown Easing of Restrictions

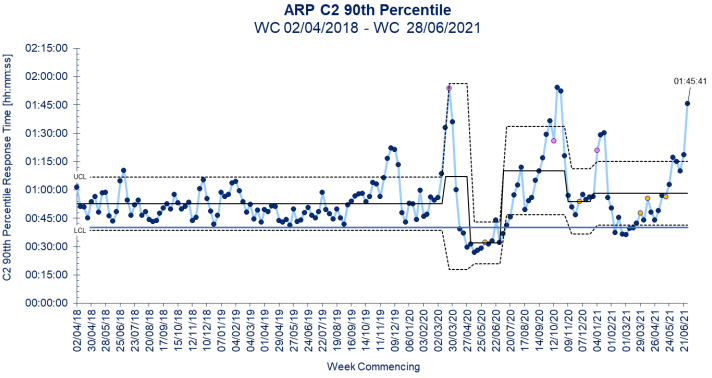
Figure O3.3

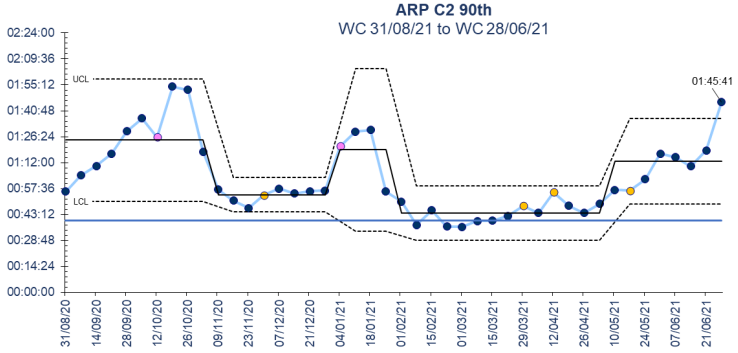




Green sectors

Figure O3.4





Green sectors
CL North Cumbria

C2 Performance

C2 Mean

Target: 18 minutes

NWAS:
June 2021: 38:15
YTD: 29:52

C2 performance is following a similar pattern as C1 with increases in acuity from below 60% to just above 70% in the last week of June. On average this is an additional 155 incidents per day which requires an extra 167 emergency ambulance vehicles due to the resource ratio. We are also seeing a drop in resources, this is due to a reduction in the uptake of overtime for a number of reasons: fatigue, increased social opportunities, bank holidays, school holidays and an increase in covid isolations and covid sickness.

There is special cause variation in the last week of June where the response time is above the upper control limit.

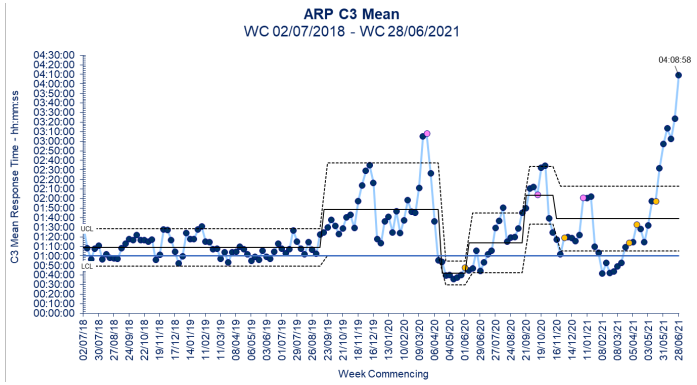
Additional focus is being placed on long waits ensuring incidents are responded to in order of acuity, ensuring we minimise any patient harm.

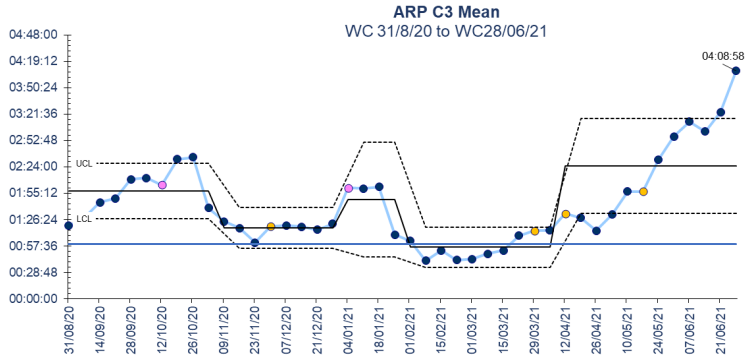
C2 90th Percentile

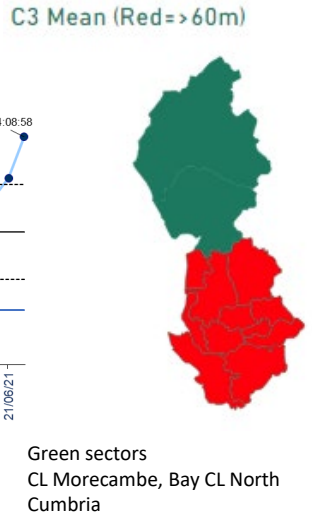
Target: 40 Minutes

NWAS
June 2021: 1:17:58
YTD: 1:00:50

Figure O3.5

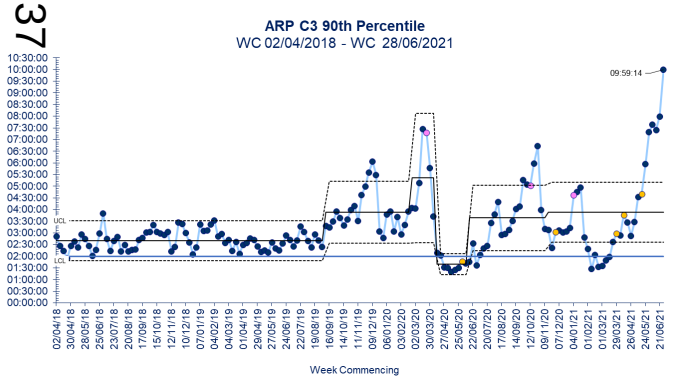


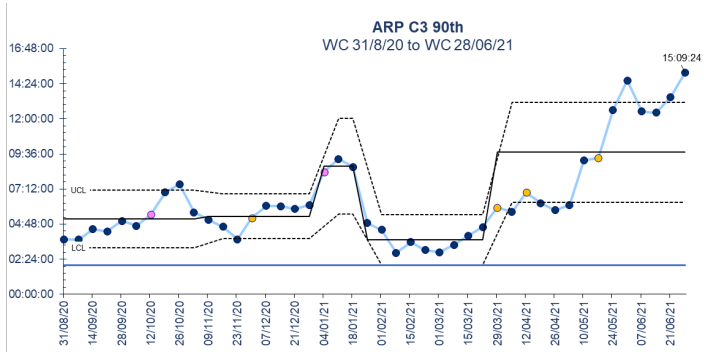




Green sectors
CL Morecambe, Bay CL North Cumbria

Figure O3.6





Green sectors
Bay CL North Cumbria

C3 Performance

C3 Mean

Target: 1 Hour

NWAS:
June 2021: 3:18:28
YTD: 2:05:18

C3 mean and 90th standards have deteriorated significantly throughout June, both standards have gone over the upper control limit in the last week of June. This is an impact of the focus on responding to C2 long waits as a higher proportion of total activity.

C3 90th Percentile

Target: 2 Hours

NWAS
June 2021: 7:53:55
YTD: 4:58:16

C4 Mean and 90th Percentile

Due to issues with the data these measures are not included in the report and were not submitted to NHS E/I for June. Reporting will recommence in the next report.

Figure O3.8

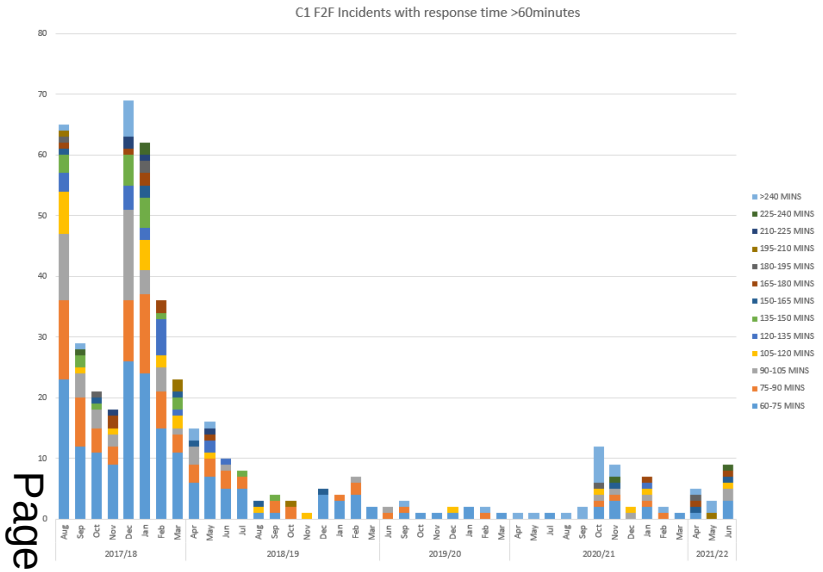


Figure O3.9

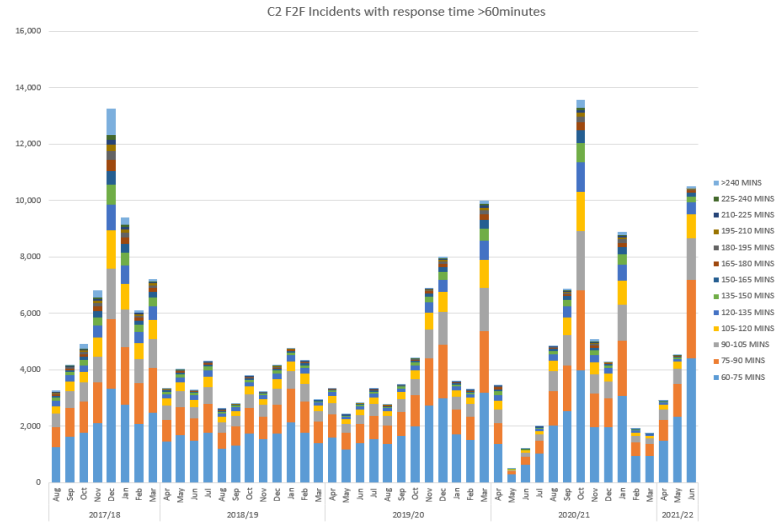


Figure O3.10

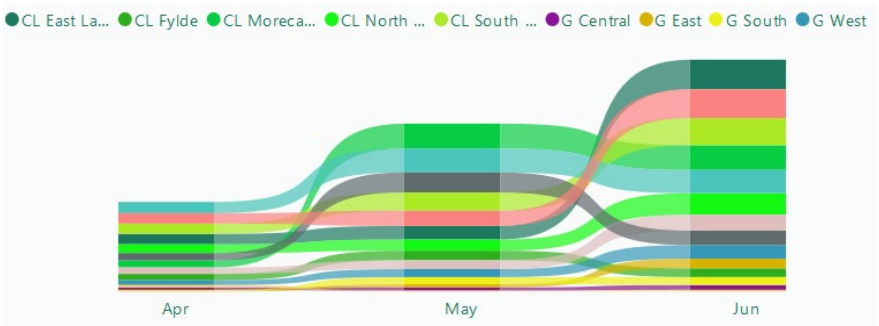
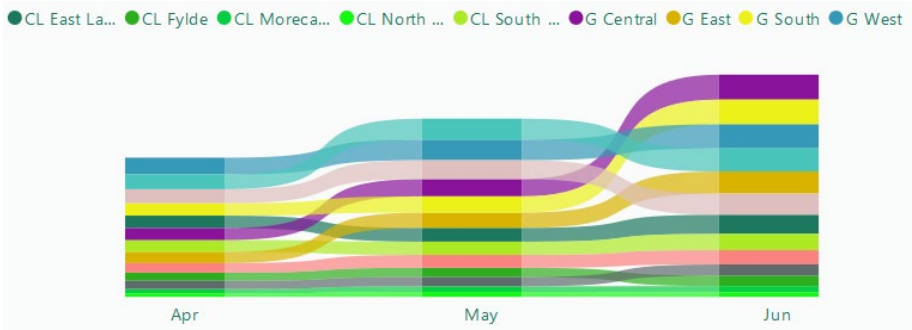


Figure O3.11



C1 & C2 Long Waits

There is an increase in the long waits for both C1 and C2. This corresponds with the overall increase in activity. As would be expected the increase is lower in C1 than C2. In June we have seen the rate of increase in the number of C2 long waits grow.

ARP Provider Comparison Figures May 2021

Figure O3.8

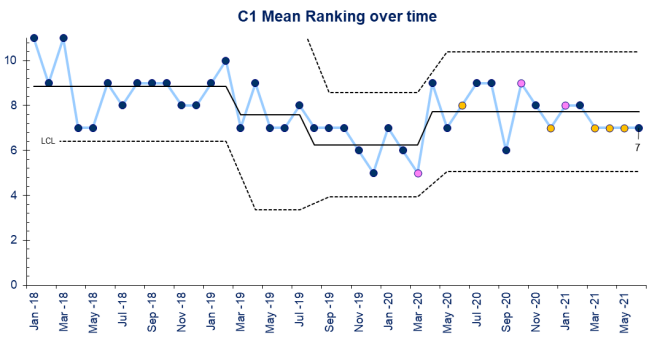


Figure O3.9

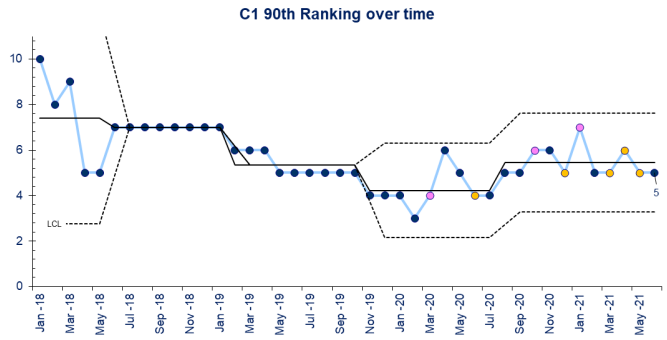


Figure O3.10

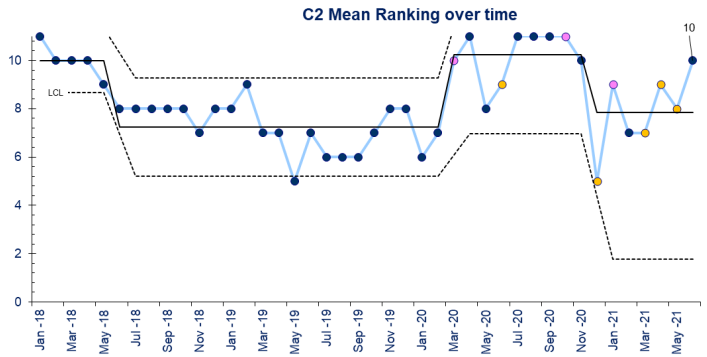


Figure O3.11

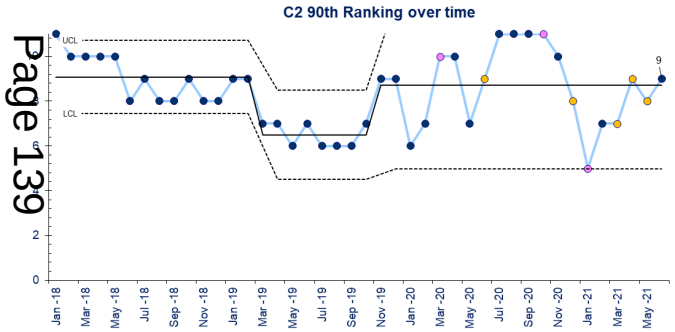


Figure O3.12

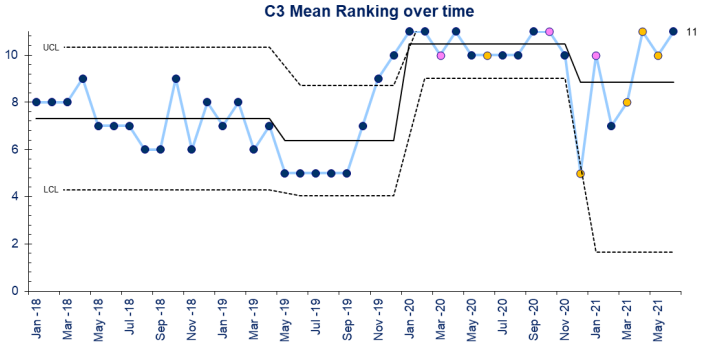
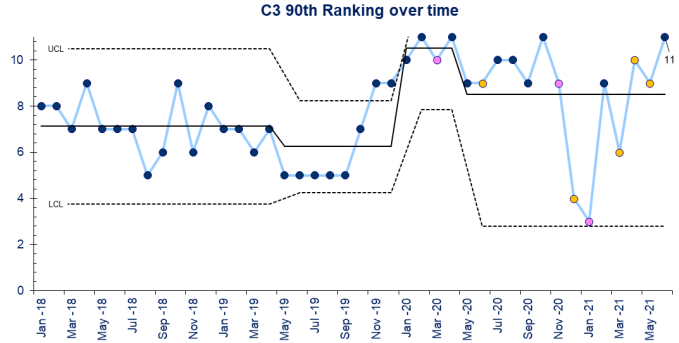


Figure O3.13



Provider	C1 Mean
London	06:34
North East	06:58
West Midlands	07:10
South Central	07:25
East of England	08:07
South East Coast	08:18
North West	08:19
East Midlands	08:21
Yorkshire	08:31
South Western	08:38
Isle of Wight	10:15

Provider	C1 90th
London	10:57
North East	12:27
West Midlands	12:33
South Central	13:50
North West	14:03
Yorkshire	14:24
East Midlands	14:46
South East Coast	15:08
East of England	15:15
South Western	16:23
Isle of Wight	18:57

Provider	C2 Mean
West Midlands	18:38
South Central	19:52
South East Coast	26:11
London	27:20
Isle of Wight	29:14
Yorkshire	30:04
East of England	32:03
North East	33:23
South Western	37:14
North West	38:15
East Midlands	41:26

Provider	C2 90th
West Midlands	0:37:26
South Central	0:39:34
South East Coast	0:50:55
London	0:58:18
Isle of Wight	1:03:38
Yorkshire	1:04:34
East of England	1:06:48
North East	1:07:39
North West	1:17:58
South Western	1:18:22
East Midlands	1:25:55

Provider	C3 Mean
South Central	01:20:36
London	01:25:07
West Midlands	01:29:42
Yorkshire	01:31:31
Isle of Wight	01:38:48
East of England	01:45:46
North East	01:53:41
South Western	02:04:35
East Midlands	02:31:32
South East Coast	02:35:06
North West	03:18:28

Provider	C3 90th
South Central	03:01:04
London	03:26:04
West Midlands	03:36:10
Yorkshire	03:37:30
Isle of Wight	03:39:46
East of England	04:37:58
North East	04:43:58
South Western	05:28:37
South East Coast	05:39:58
East Midlands	05:52:40
North West	07:53:55

O4 111 PERFORMANCE

Figure O4.1

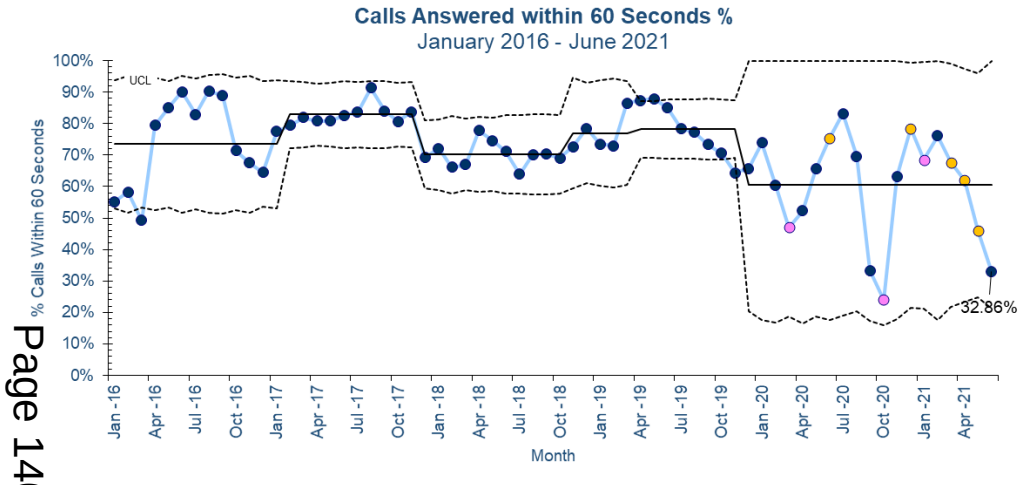
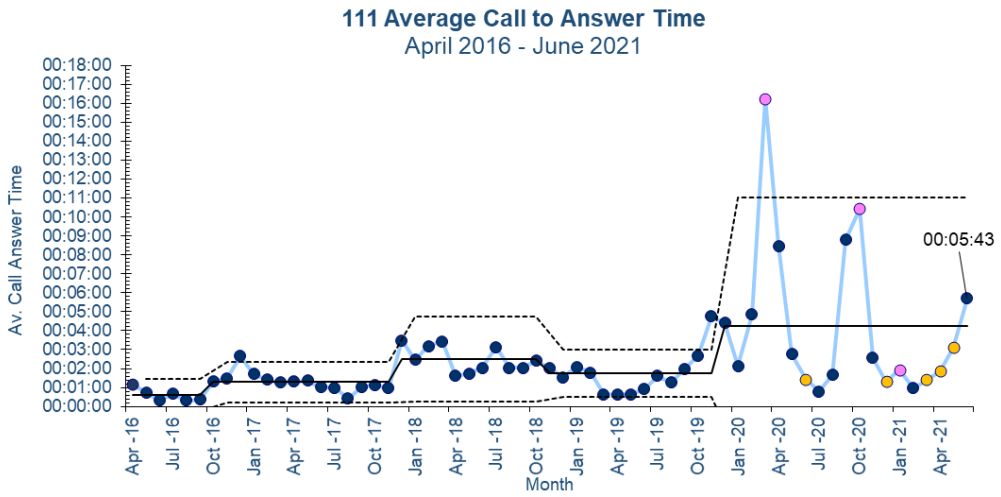


Figure O4.2



* Lockdown Easing of Restrictions

111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS
June 2021: 32.86%
YTD: 47.52%

National **50.2%**

Performance for the headline KPI continues to challenge the service. There are several causes for this at present.

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

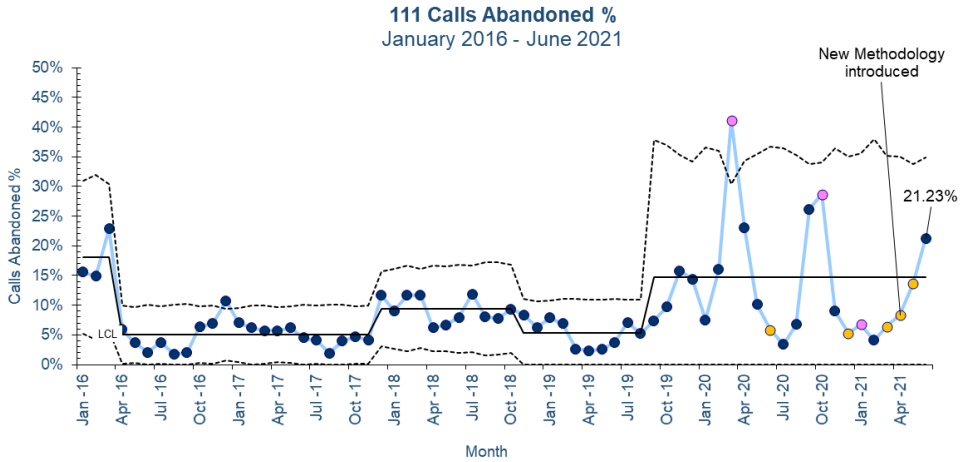
Call volumes remain high. Volume in June compared with June 2020 saw an increase of approximately 30%. This increase in activity is unfunded and presents a resource gap at some points in the day of about 50%. The additional volume is also variable in its profile with fairly significant swings causing significant pressures with forecasting.

Call profile, particularly in the early morning has also shifted. This suggests that availability within primary care is causing further demand into the 111 Service. Further work is ongoing with commissioners to understand particular areas of pressure across the North West.

Call back times with Out of Hours (OOHs) services continue to present us with additional pressures as patients continue to call back into the service to chase their call.

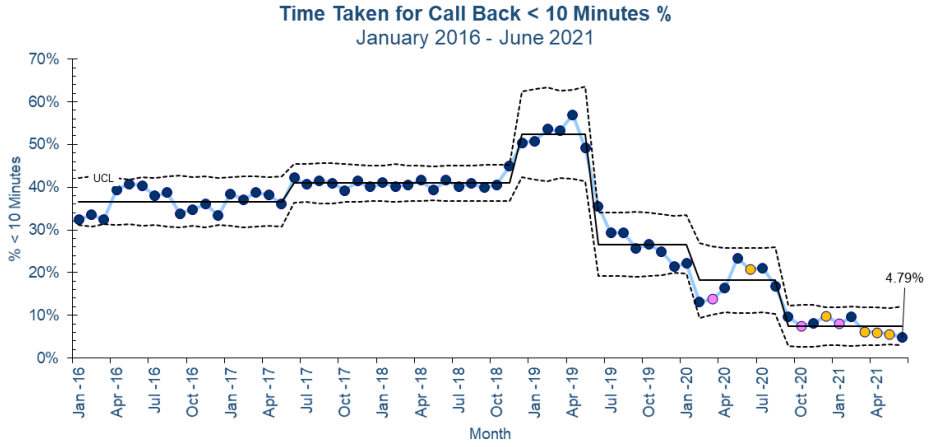
An increase in patients calling back following a referral to a CPCS Pharmacy has been seen, this again adds additional pressure to the already stretched service.

Figure O4.3:



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

Figure O4.4



* Lockdown Easing of Restrictions

Calls Abandoned %
Target: <5%

NWAS
June 21: 21.23%
YTD: 13.27%

National 15.2%

Call Back < 10 Minutes %
Target: 75%

NWAS
June 21: 4.79%
YTD: 5.49%

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

Time taken for a call back (10 mins). The increase in demand on the 111 service has directly impacted the size of the clinical advice queue. This has resulted in much larger queues and therefore fewer calls being called back within 10 minutes. The CAQ is managed 24/7 by the Clinical Duty Manager (CDM) and any calls of concerns are flagged for Clinicians to pick up as a priority.

All calls on the CAQ that have breached their disposition timeframe receive a comfort call from a Health Advisor. The Health Advisor will inform the patient that the service is experiencing a high level of demand and that they will receive a call back from a clinician as soon as possible. If the patient alert the HA that their symptoms have worsened, then the HA will re-triage the patient accordingly.

Figure O4.5

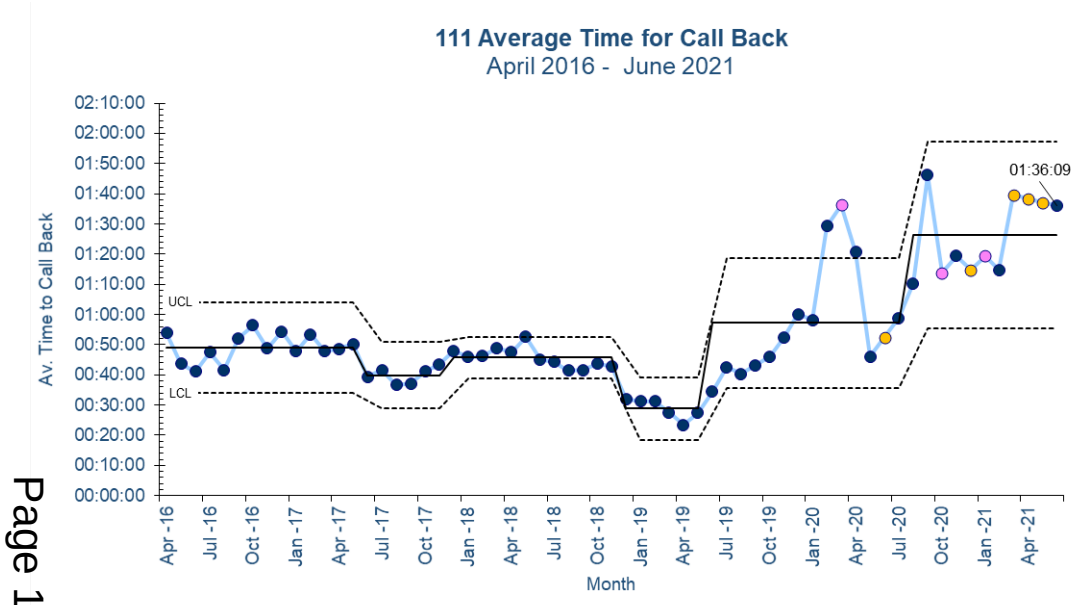
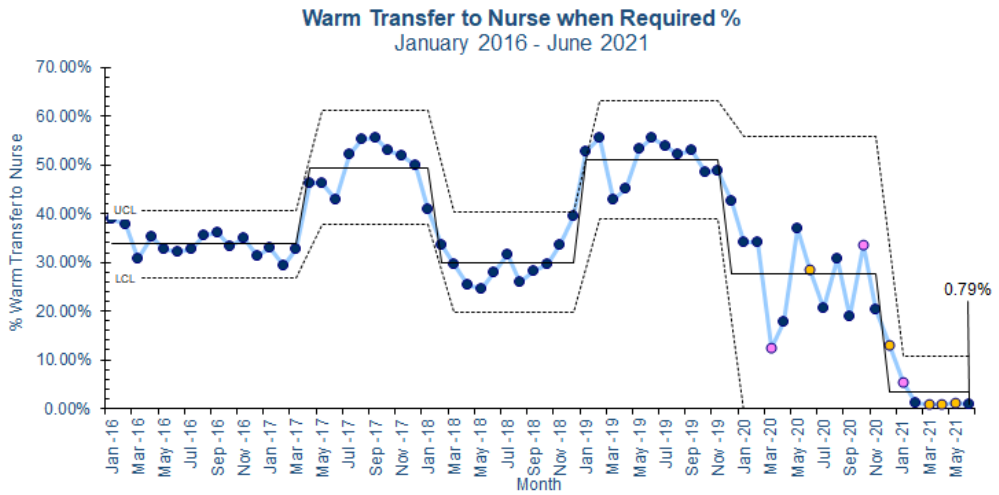


Figure O4.6



* Lockdown Easing of Restrictions

Warm Transfer to Nurse when Required%
Target: 75%

NWAS
June 21: 0.79%
YTD: 0.88%

As per previous commentary due to the increase in demand warm transfer to Clinicians has been affected.

This has resulted in a 'bottle neck' with health advisors being on hold for prolonged periods of time waiting to get through to the next available clinician.

Many of these calls are now checked with the Clinical Duty Manager and were appropriate are then placed on the Clinical advice queue to be called back.

This then releases the HA to take another incoming call. The CDM will monitor the CAQ and assign any calls of concern to a clinician to pick up as their next call.

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY

TOTAL ACTIVITY

Contract	Current Month: May 2021 Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date: July 2020 - May 2021 Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	7,970	(6,054)	(43%)	154,266	85,535	(68,731)	(45%)
Greater Manchester	526,588	43,882	29,806	(14,076)	(32%)	482,706	331,010	(151,696)	(31%)
Lancashire	589,181	49,098	27,509	(21,589)	(44%)	540,083	302,336	(237,747)	(44%)
Merseyside	300,123	25,010	18,184	(6,826)	(27%)	275,113	203,244	(71,869)	(26%)
NWAS	1,584,182	132,015	83,469	(48,546)	(37%)	1,452,167	922,125	(530,042)	(37%)

UNPLANNED ACTIVITY

Contract	Current Month: May 2021 Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date: July 2020 - May 2021 Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	433	(814)	(65%)	13,722	5,881	(7,841)	(57%)
Greater Manchester	49,133	4,094	4,043	(51)	(1%)	45,039	50,578	5,539	12%
Lancashire	58,829	4,902	3,174	(1,728)	(35%)	53,927	38,489	(15,438)	(29%)
Merseyside	22,351	1,863	1,489	(374)	(20%)	20,488	17,607	(2,881)	(14%)
NWAS	145,282	12,107	9,139	(2,968)	(25%)	133,175	112,555	(20,620)	(15%)

ABORTED ACTIVITY

Contract	May 2021 Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	163	5,488	3%	23	393	6%	41	2,824	1%
Greater Manchester	1,255	14,237	9%	768	4,677	16%	1,040	14,410	7%
Lancashire	709	15,512	5%	453	3,402	13%	307	11,117	3%
Merseyside	445	7,693	6%	210	1,503	14%	423	11,356	4%
NWAS	2,572	42,930	6%	1,454	9,975	15%	1,811	39,707	5%

PTS Performance

Due to timetable issues PTS will always report a month behind other operational areas.

Overall activity during May 2021 was 37% below contract baselines with Cumbria at 43%, Greater Manchester at 32%, Lancashire 44% and Merseyside 27% below contract baselines. For the year-to-date position (contract year July 2020 - May 2021) PTS is performing at 37% (530, 042 journeys) below baseline.
Within these overall figures year to date, Cumbria is at 45%, Greater Manchester is at 31%, Lancashire at 44% and Merseyside at 26% below baseline. It should be noted that the majority of the reduction in activity is in the low acuity (walking) mobility category whilst ambulance category activity is approximately 7% lower than pre Covid levels meaning that ambulance capacity is challenged when set against the capacity issues associated with social distancing and IPC measures (e.g. additional cleaning).

In terms of unplanned activity, cumulative positions within Greater Manchester are 12% (5,539 journeys) above baseline with Cumbria at 57% (7,841), Lancashire 29% (15,438) and Merseyside 14% (2,881) respectively, underactivity against contracted baselines. 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 for the reasons described above. It should also be noted that whilst under activity overall there is a general increasing trend of Unplanned activity regionally.

In terms of overall trend analysis activity, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas. Aborted (chargeable) activity for the Planned Service journeys averaged 6% during May 2021 with Cumbria reporting 3%, Greater Manchester 9%, Lancashire 5% and Merseyside 6%. There is a similar trend within EPS (renal and oncology) patients with an Trust average of 5% aborts with Cumbria reporting 1%, Greater Manchester 7%, Lancashire 3% and Merseyside 4% . Unplanned (on the day) activity experiences the greatest percentages of aborts with an average 15% overall (1 in 6 patients) with Cumbria reporting 6% in Cumbria, Greater Manchester 16%, Lancashire 13% and Merseyside 14%.

As previously reported, the service line has commenced a recruitment drive to recruit to the vacancies left as a result of repurposing staff into PES. The recruitment plan has been accelerated with the aim now being to recruit to full establishment by the end of the financial year. Further proposals to adapt the current workforce profile to enable greater provision of double crewed non-emergency ambulances, increase the funded establishment and associated supervision are being drafted in conjunction with Finance colleagues and will be submitted to ELC in August 2021.
As alluded to above, capacity challenges associated with social distancing measures continues to impact utilise of resources and, in collaboration with senior colleagues from other ambulance Trusts, the Head of Service has met with the chair the national IPC cell to discuss the operational and systems challenges these measures present. Whilst the current direction is that current IPC / social distancing measures will remain in place we are also working with NHSE/I, and commissioners locally to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively.

In addition to the above, the service line will be a core member of an Operational Design Group which comprises senior NWAS, commissioner and partner Trust leadership. The purpose of the group is support the redesign of service delivery models in such a way that provides an improved patient transport service and works towards the development of an integrated model of delivery that utilises PTS resources more broadly to enhance the paramedic emergency service offer.

OH1 STAFF SICKNESS

Figure OH1.1

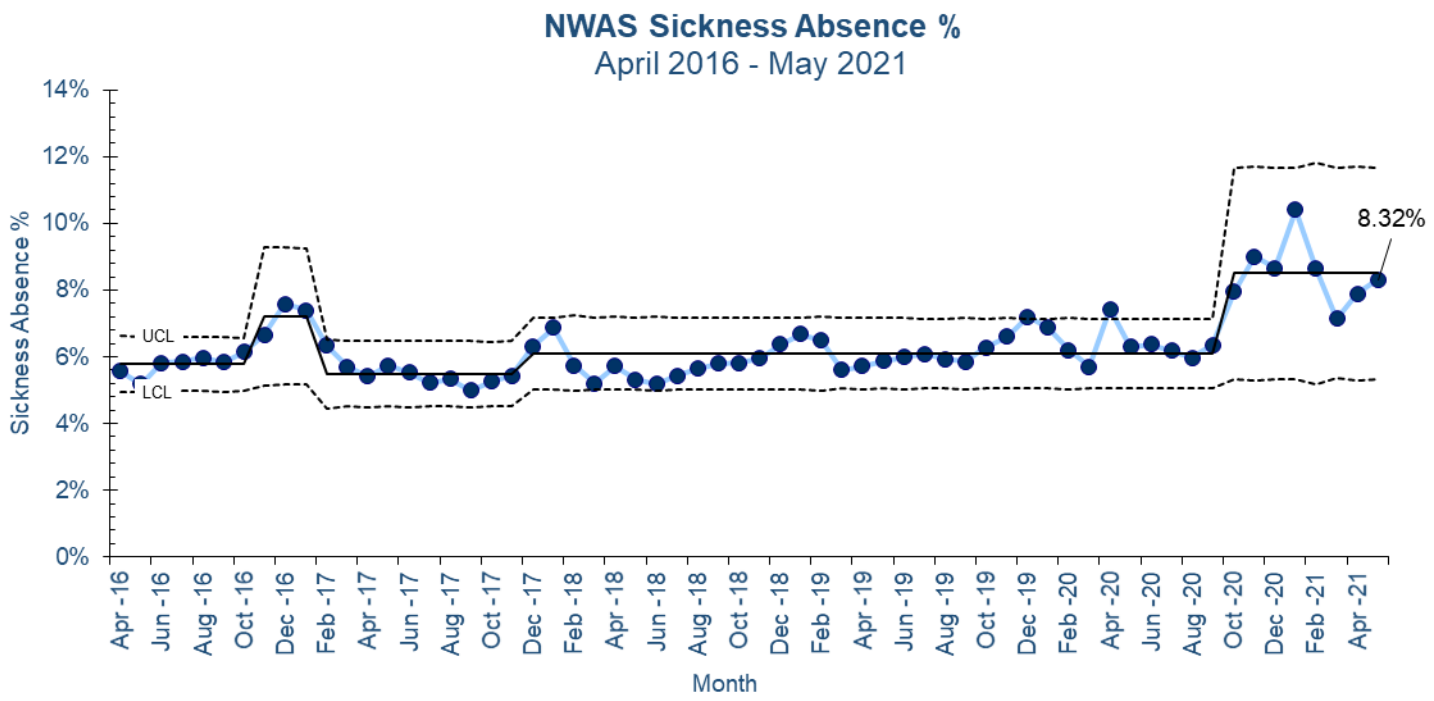


Table OH1.1

Sickness Absence	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
NWAS	6.38%	6.18%	5.96%	6.35%	7.94%	9.00%	8.66%	10.41%	8.65%	7.15%	7.90%	8.32%
Amb. National Average	4.65%	4.75%	5..24%	5.74%	6.10%	6.51%	6.75%	9.37%	7.03%			

Staff Sickness

The overall sickness rates for May 2021 were 8.32% (OH1.1). The current position being within the control limits but above the Trust target of 0.5% reduction on previous year which would be 5.7%. Sickness has continued to increase for 3 consecutive months and further data analysis is required to understand the underlying reasons but the current and sustained operational pressures are a factor. Short term sickness absence makes up 4.45% of the total absence with short term absence being higher than long term in both PTS and 111 Service Lines, whereby PES has a high level of long-term absence.

The impact of COVID related sickness has reduced to 0.9% (OH1.2). The underlying non-COVID position is 7.4% which is higher than the same period last year which was 6.30% and above the 5.7% target.

In the May data, the impact of COVID absence is clearly reducing however, 111 remains the highest at 2.9% (OH1.6). All other Service Lines are below1%.

In addition to sickness reported via ESR, COVID 19 self-isolating absences have been captured by GRS, Teliopi and Marval.

The People directorate will continue to work with service lines to ensure a targeted focus on improving attendance management and wellbeing.

Figure OH1.2:

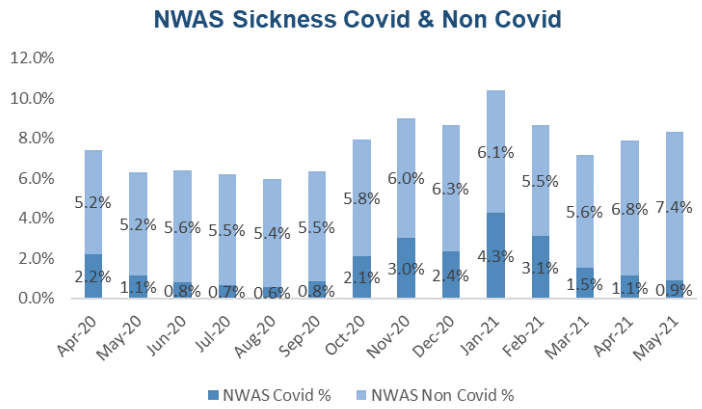


Figure OH1.3:

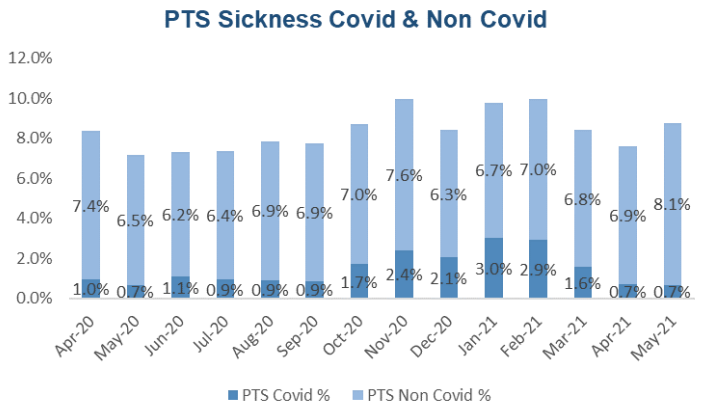


Figure OH1.4:

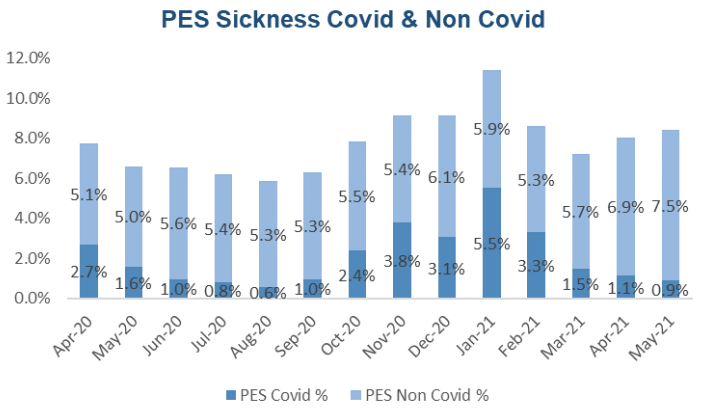


Figure OH1.5:

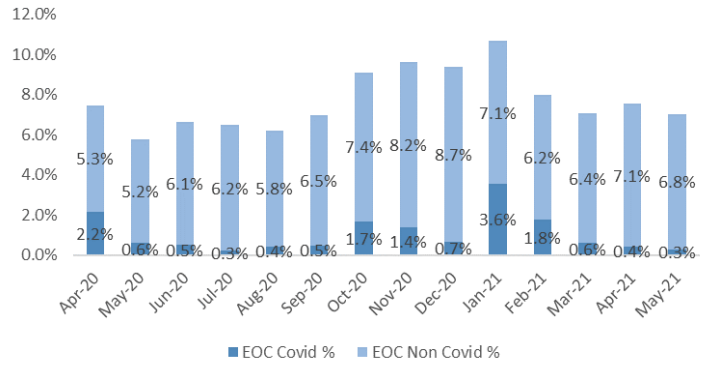


Figure OH1.6:

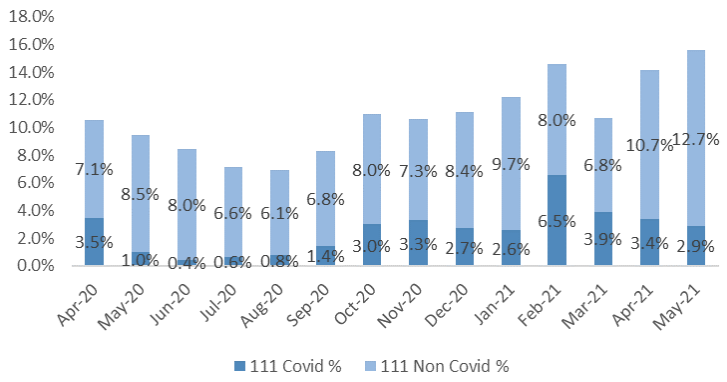
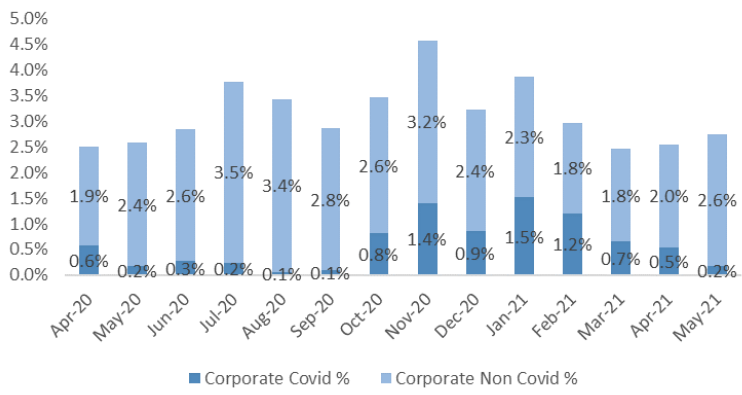


Figure OH1.7:



OH2 STAFF TURNOVER

Figure OH2.1

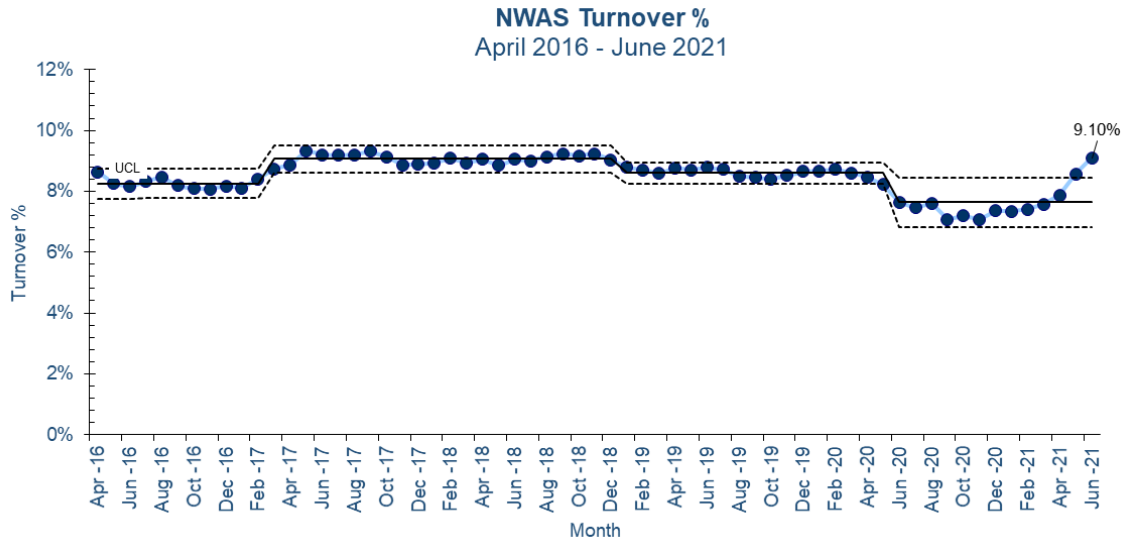


Table OH2.1

Turnover	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
NWAS	7.46%	7.60%	7.07%	7.19%	7.08%	7.35%	7.34%	7.41%	7.57%	7.87%	8.56%	9.10%
Amb. National Average	8.52%	8.21%	8.08%	7.95%	7.75%	7.67%	7.58%	7.41%	7.35%			

Staff Turnover

Staff turnover for June is 9.10%. This is calculated on a rolling year average.

Staff turnover has in the main been lower during the COVID-19 pandemic, likely as a result of the changed job market however, that position has changed with increases in turnover for the last 6 months. June shows an increase with the data point now above the upper control limit (OH2.1). This is mainly caused by 111 and corporate turnover.

Staff turnover in 111 had been stable since June 2020 but June's data indicates turnover is now at 29.99% now above the upper control limit (OH2.5). Some detailed analysis on leavers is being be undertaken to try to establish any underlying themes.

EOC remain in a strong position with April turnover at 9.01% (OH2.4) which will create stability as the Single Primary Triage Project is delivered. There has been a pause in the roll out plan for Broughton, with the 1st stage being moved to late 2021. However, the staffing position will be maintained over the winter period to provide additional staff to meet current demands.

PES turnover is showing a small upward trend, however, overall the Trust has not seen the anticipated loss of Paramedics to PCNs in Q1.

Figure OH2.2

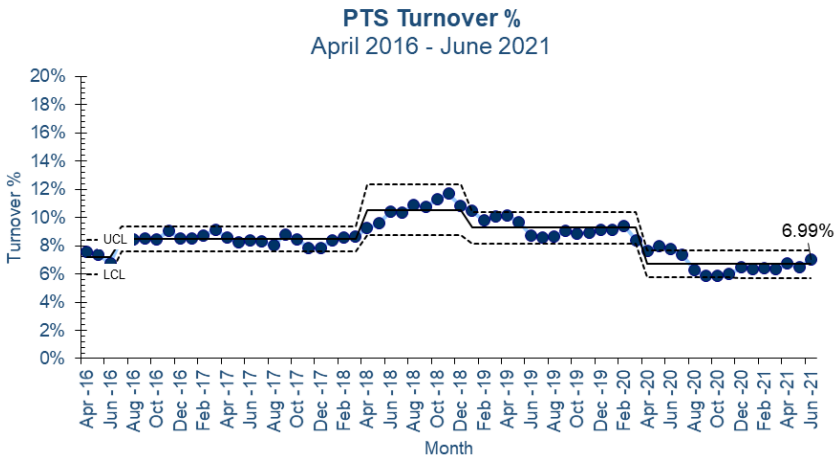


Figure OH2.3

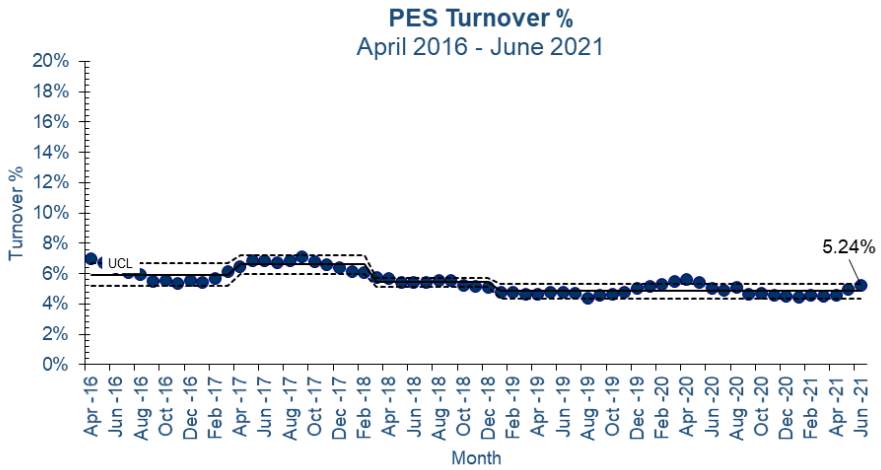


Figure OH2.4

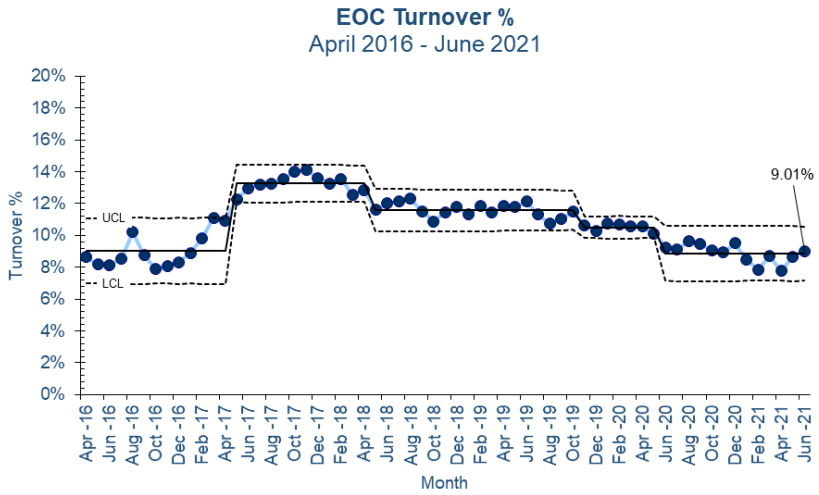
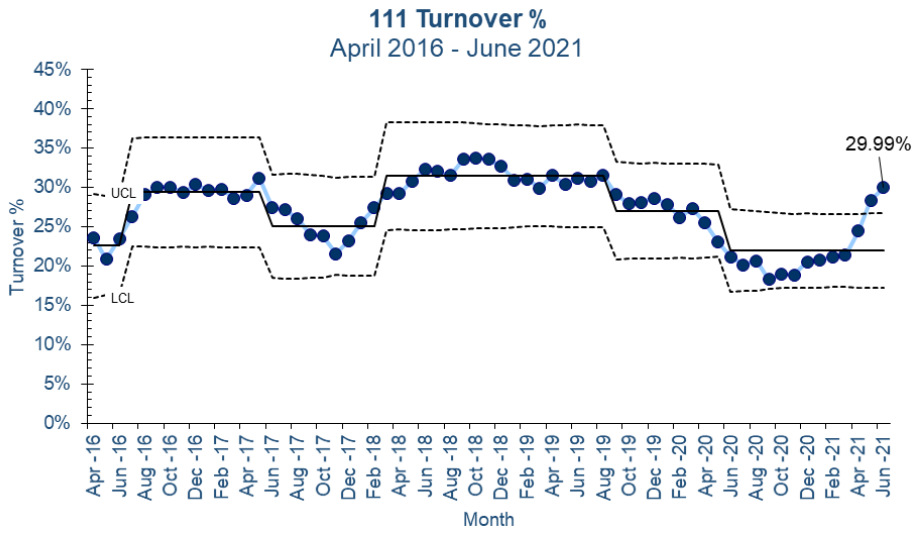
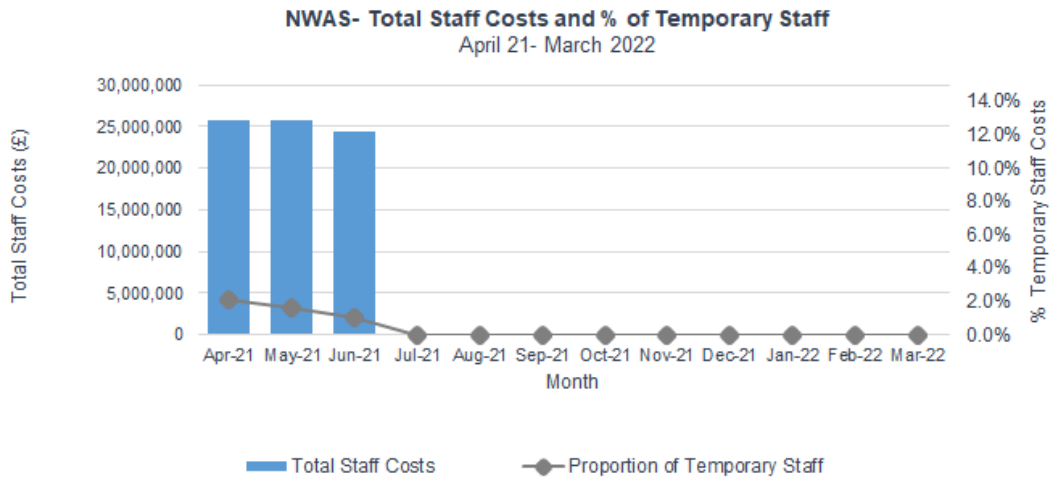


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

As a result of COVID-19 the Trust Agency usage and expenditure is projected to exceed the Agency ceiling, although this does not form part of the reporting under the emergency arrangements. The agency ceiling is a maximum amount of agency spend allowable.

Agency staff have continued to support the Contact Centre environment.

ELC have approved the continuation of Agency staff in EOC into 2021 as the emergency budget extends to Q2. The Trust delivered its initial plan to convert all Agency staff who started in Q4 2020/21 to fixed term appointments to support STP, however further Agency staff has now been approved to support the delivery of STP and current performance pressures and will remain on Agency for a 12 week period. Further Agency staff have also been approved for 111.

Table OH4.1

NWAS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-19	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Agency Staff Costs (£)	465,485	407,651	466,727	386,841	502,967	541,395	636,447	478,564	647,483	541,873	404,321	245,748
Total Staff Costs (£)	24,737,935	24,176,859	24,352,743	24,669,105	24,985,757	24,466,230	25,444,774	25,353,362	48,192,045	25,673,168	25,780,966	24,317,963
Proportion of Temporary Staff %	0.2%	0.3%	1.2%	0.7%	1.7%	1.6%	2.5%	1.9%	1.3%	2.1%	1.6%	1.0%

Figure OH4.2:

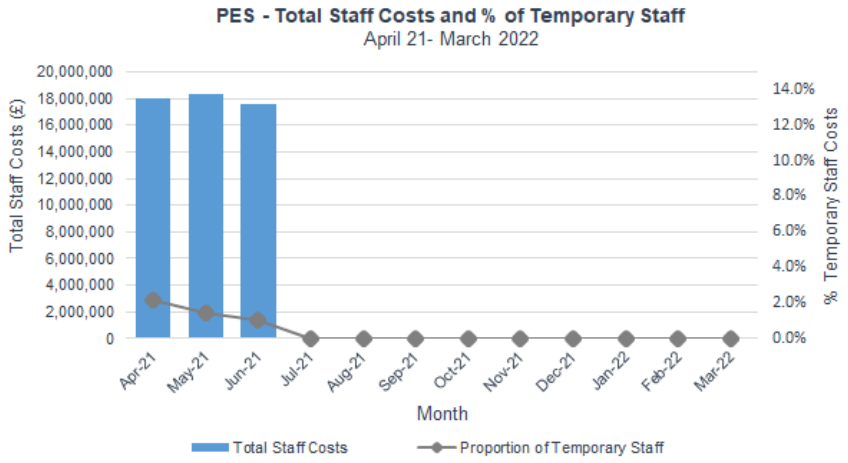


Figure OH4.3:

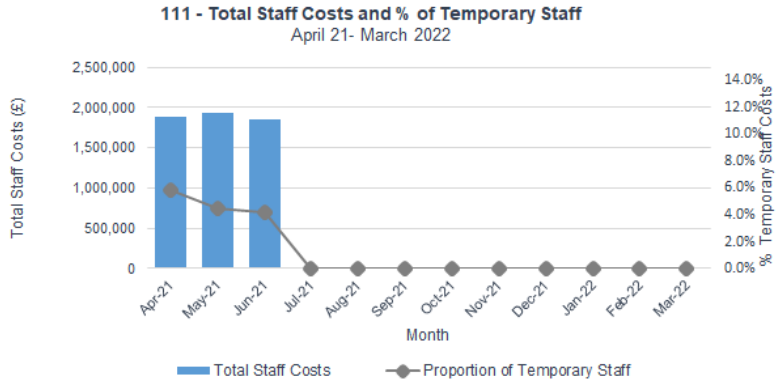


Figure OH4.4:

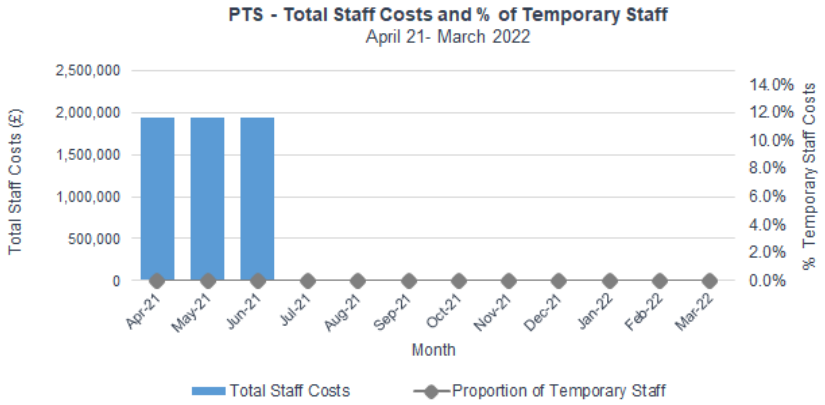
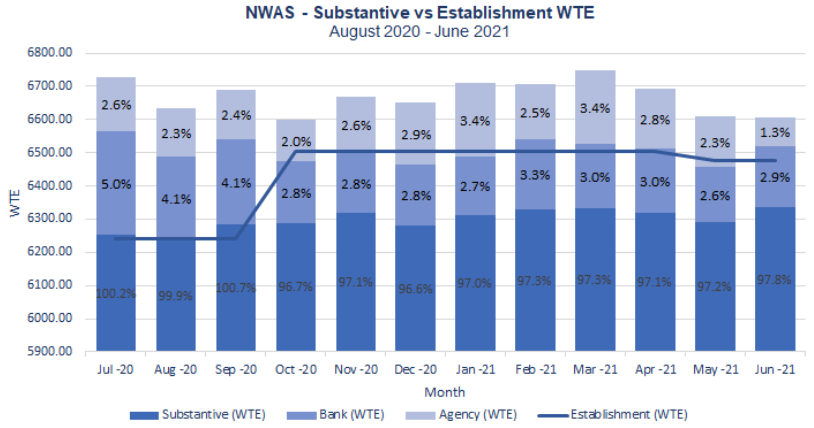


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

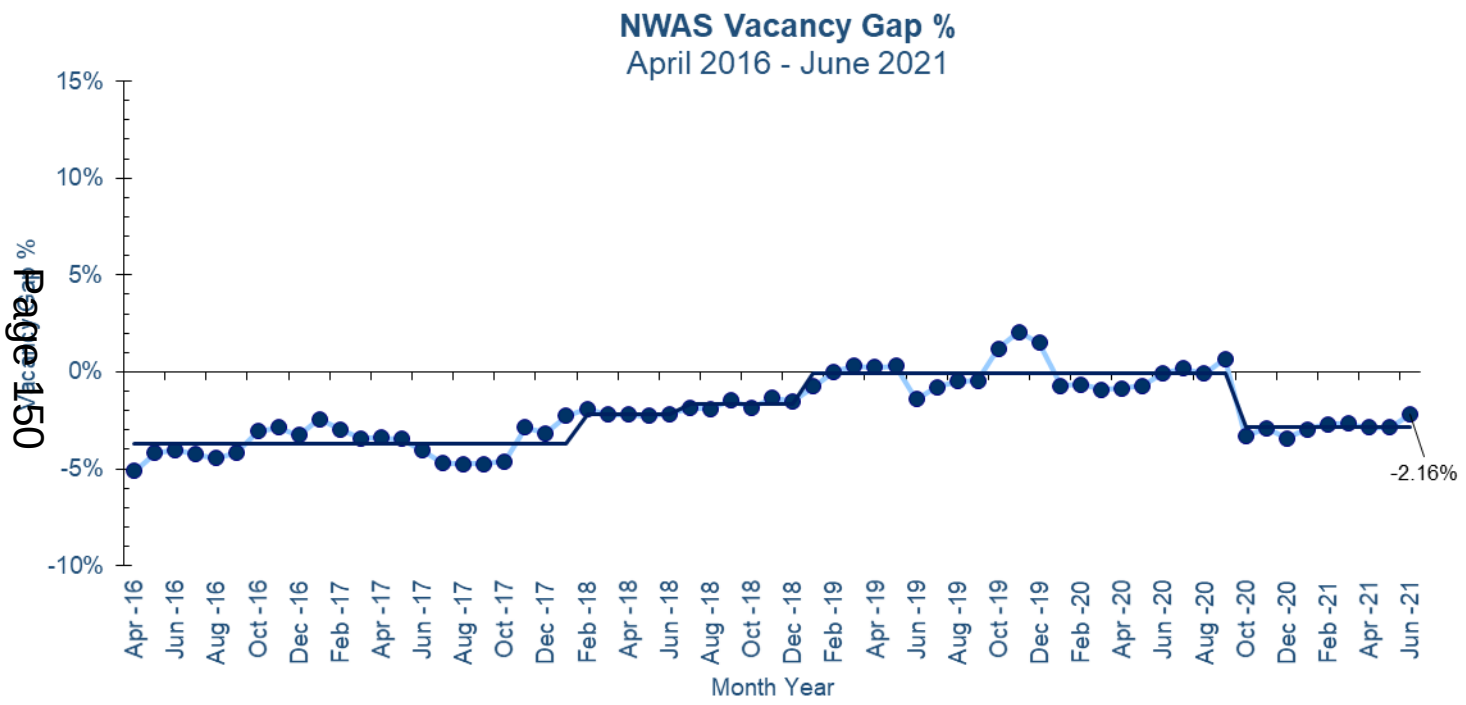


Table OH5.1

Vacancy Gap	May-20	Jun-20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
NWAS	-0.72%	-0.07%	0.17%	-0.08%	0.69%	-3.31%	-2.88%	-3.44%	-2.97%	-2.68%	-2.67%	-2.86%

Vacancy Gap

Chart OH5.1 shows the vacancy gap at circa –2% reflecting the significant establishment changes in 111.

Although recruitment plans for 111 are on track the establishment change now shows the current position against all the growth as a gap of 7.39% (OH5.5). The recruitment plan focuses on Clinical Advisors and recruiting to management posts. Health Advisors vacancies have been prioritised and are at establishment.

The increase in PTS vacancies (OH5.2) has been created due to a large number of PES upskill staff taking up apprentice EMT1 positions in April and May. There is a robust recruitment and training plan is place which will deliver an increase in staff with 12 PTS courses planned throughout the year. This plan has been revised to front load courses to ensure deployment Pre-Christmas with ongoing review in place.

The PES and EOC position remains very stable. ELC have approved continuing recruitment at risk to maintain and improve frontline staffing.

Figure OH5.2

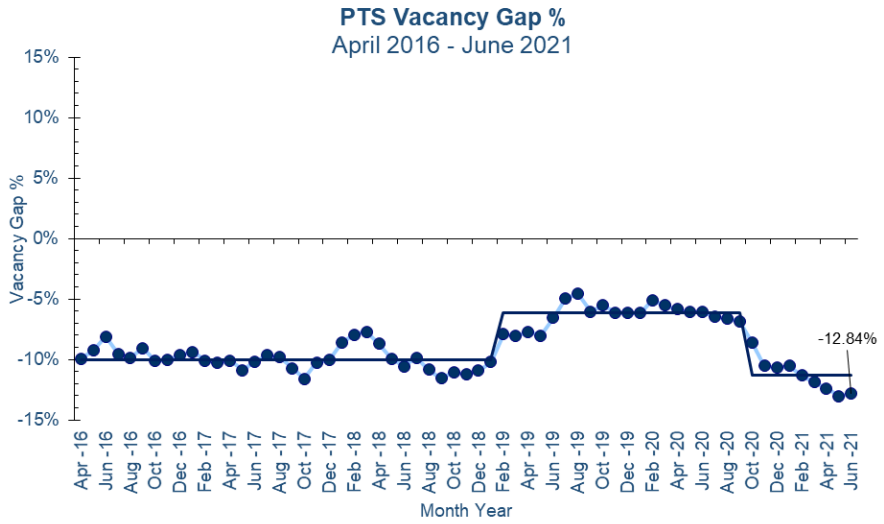


Figure OH5.3

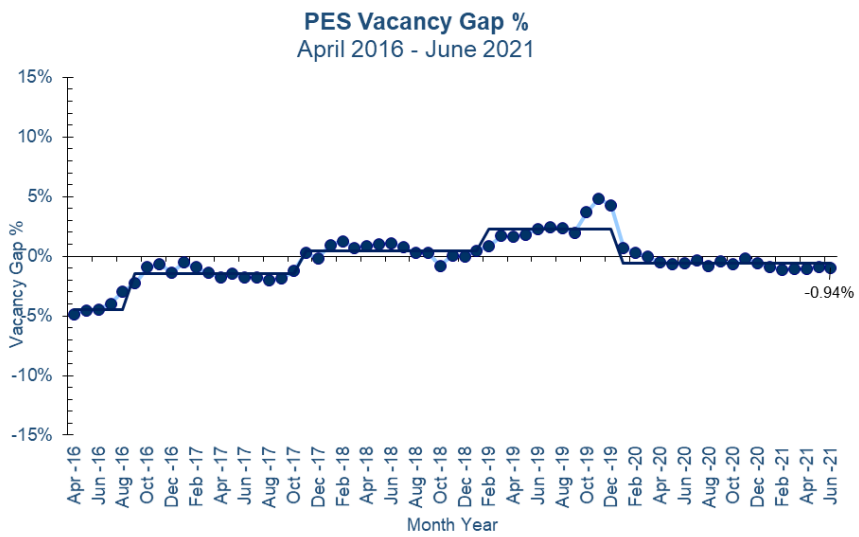


Figure OH5.4

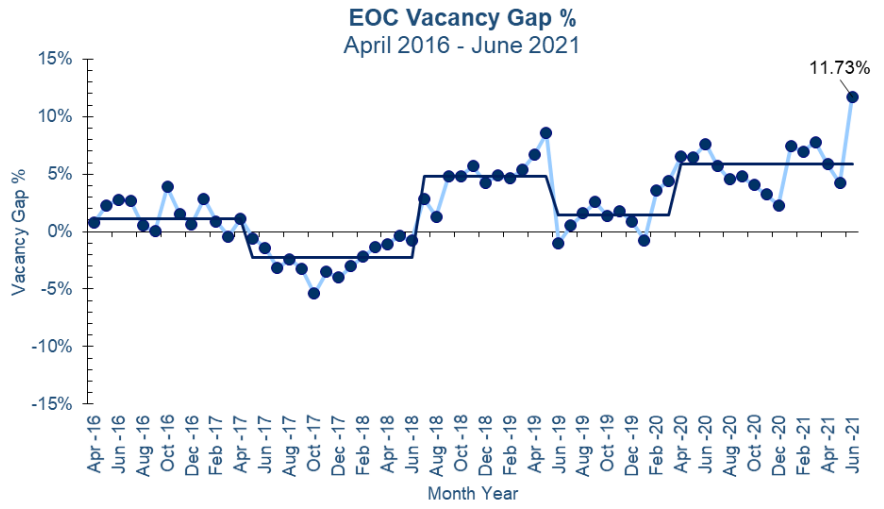
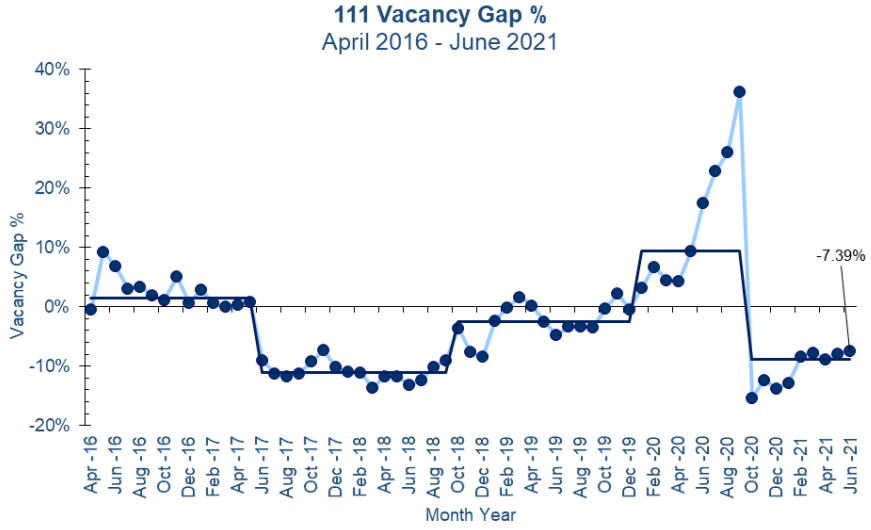


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

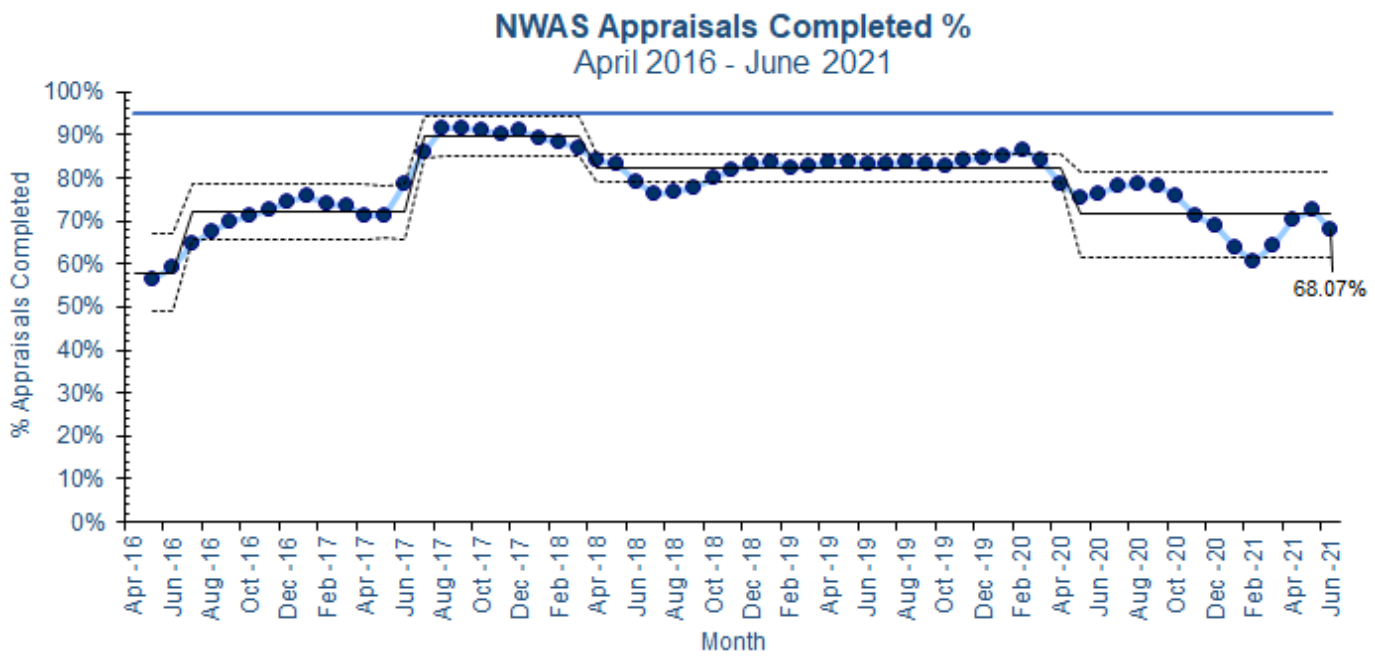


Table OH6.1

Appraisals	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
NWAS	78%	79%	78%	76%	71%%	69%	64%	61%	64%	70%	73%	68%

Appraisals

Appraisal completion rates are at 68% for June (OH6.1). The impact of operational pressures in June and the move to Reap 4 has impacted on the good progress made over the previous four months towards the September target.

The revised targets approved by ELC are:

75% by September 2021
85% by March 2022
95% by March 2023.

Most service lines are now back within control limits with the exception of EOC where recovery work is required (OH6.4). PTS & PES have made good progress towards the 75% target, with only a slight drop in completion rates from PES where the move to REAP 4 which will be starting to impact (OH 6.2 and OH6.3). The 111 data position has improved significantly with the data point above the upper control limit at 63%.

Work is being undertaken to think innovatively about how we embed appraisal discussions into business as usual, using technology to help support a sustainable approach for the future.

Figure OH6.2

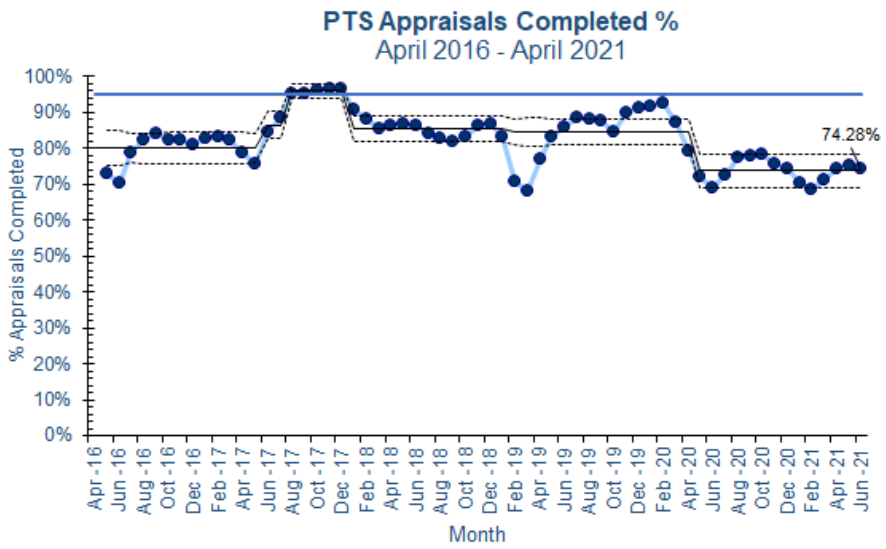


Figure OH6.3

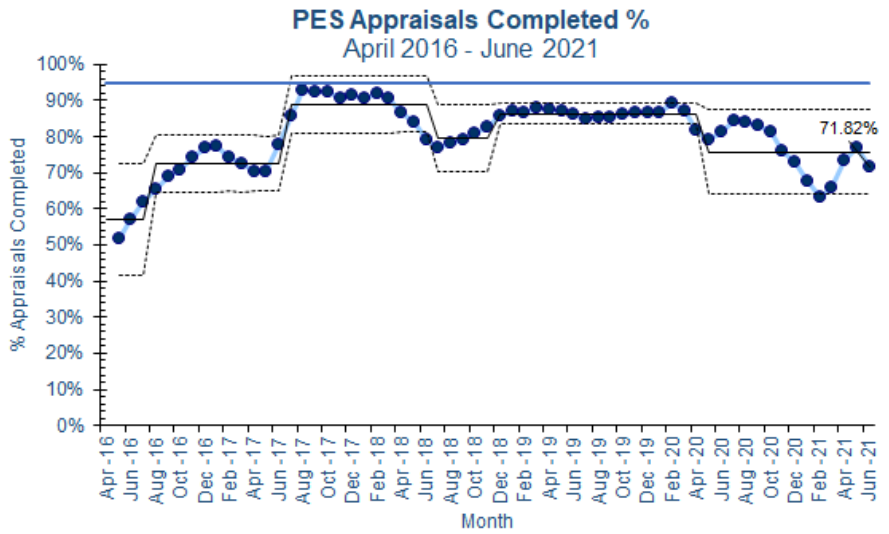


Figure OH6.4

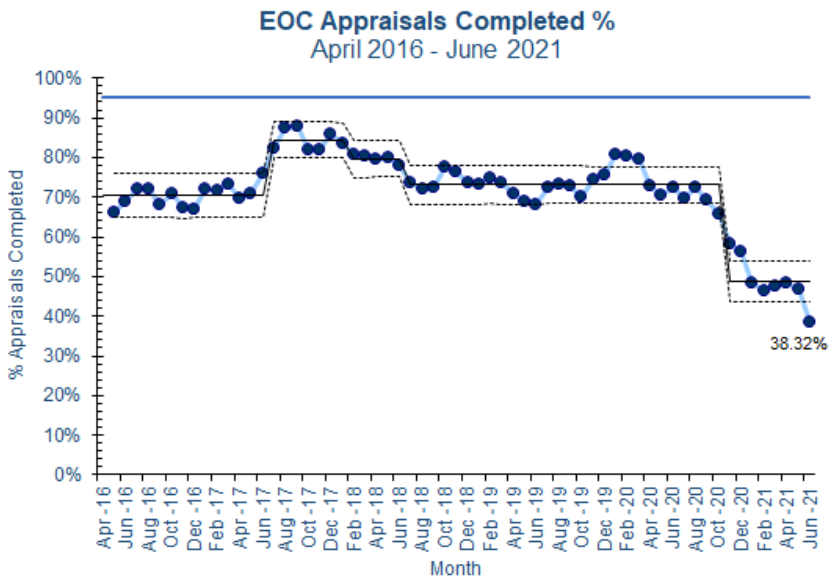
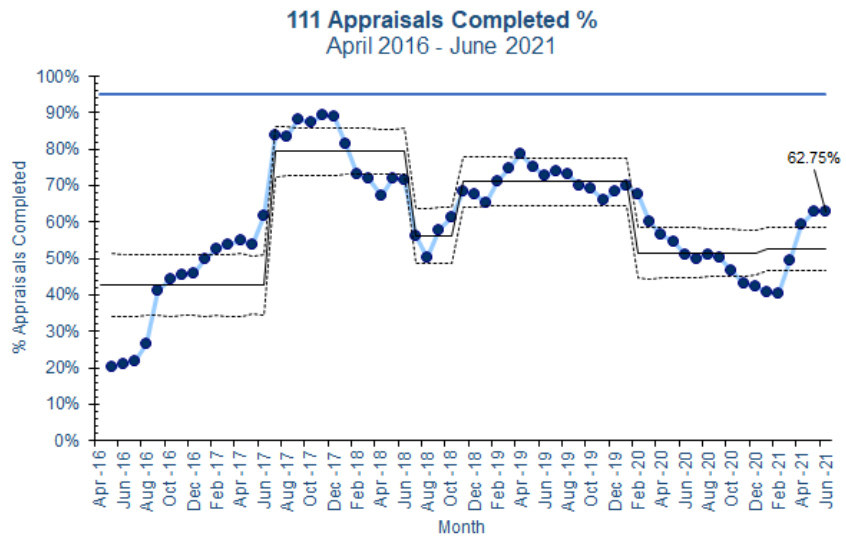


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

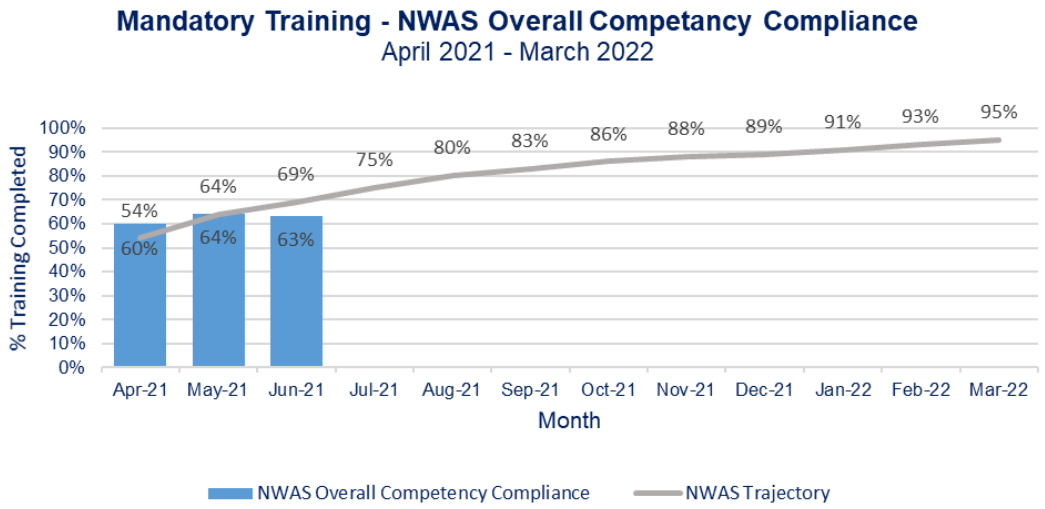
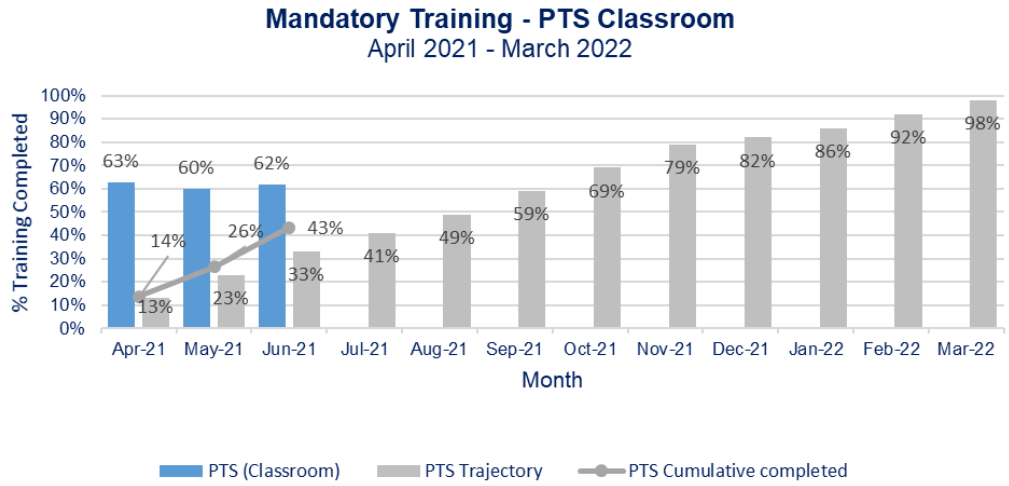


Figure OH7.2



Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and runs across the financial year. Although a revised target of 75% (agreed Jan 21) was in place and met by the trust in March 2021, the target for 2021/22 is to achieve 95% compliance.

A revised training needs analysis which includes additional mandatory topics has been introduced for 2021/22. The introduction of new modules not previously completed has reduced overall compliance to 63% in June. This will build up across the remainder of the year with a target of overall 95% compliance reinstated for March 2022.

The new cycle of classroom activity commenced on 12th April 2021 for PTS and PES with the emphasis on continued recovery of topics which could not be delivered face to face for some staff during the cessation of programme during the pandemic.

PTS classroom are ahead of plan at 43% against a target of 33% for the end of June. However as a result of REAP 4, PES classroom training was paused in June and continues to be paused for the month of July.

ELC have approved a revised programme of 1 day training, which will still deliver the main learning outcomes, with further work being undertaken to reprofile the delivery of the plan. However, the Trust is still expecting to achieve 95% compliance by March 2022.

Figure OH7.3

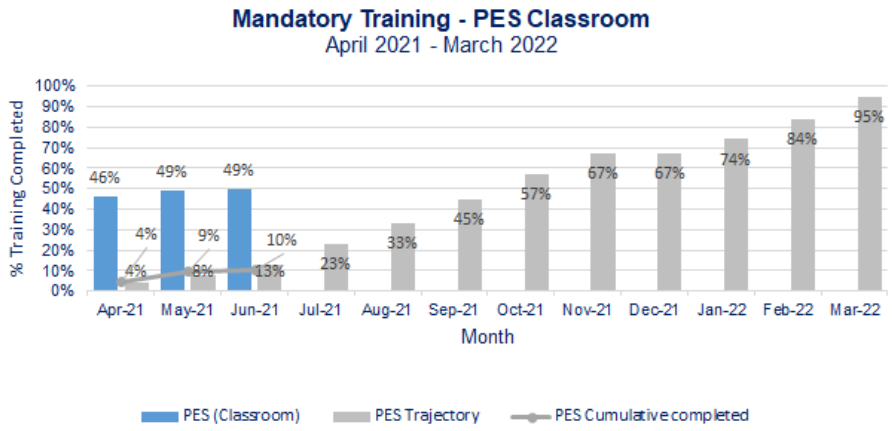


Figure OH7.4

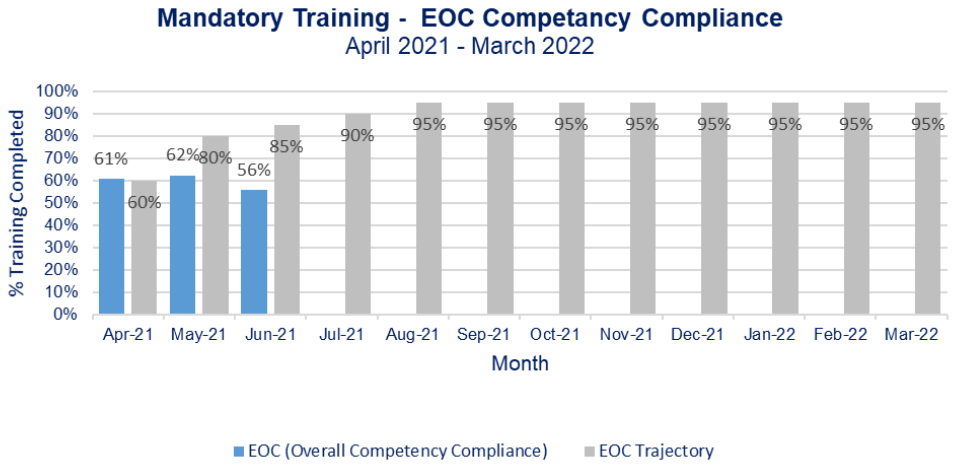


Figure OH7.5

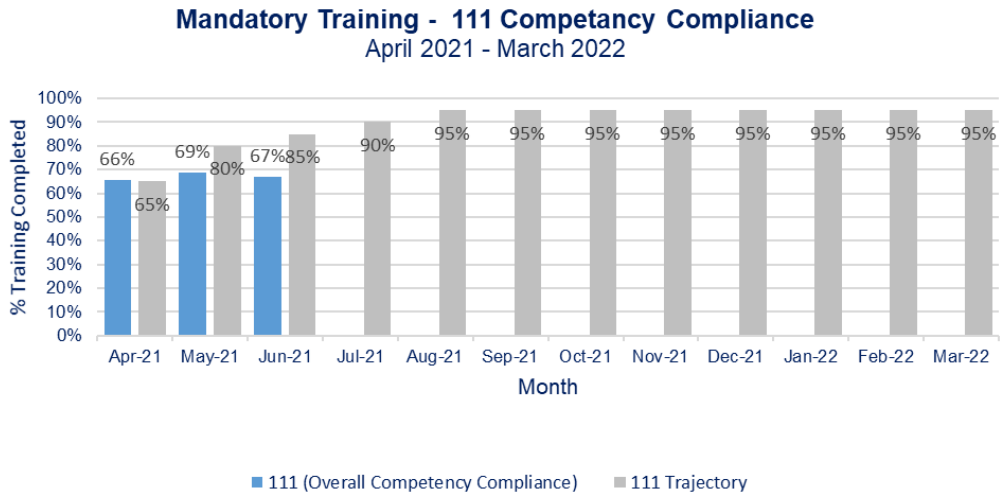
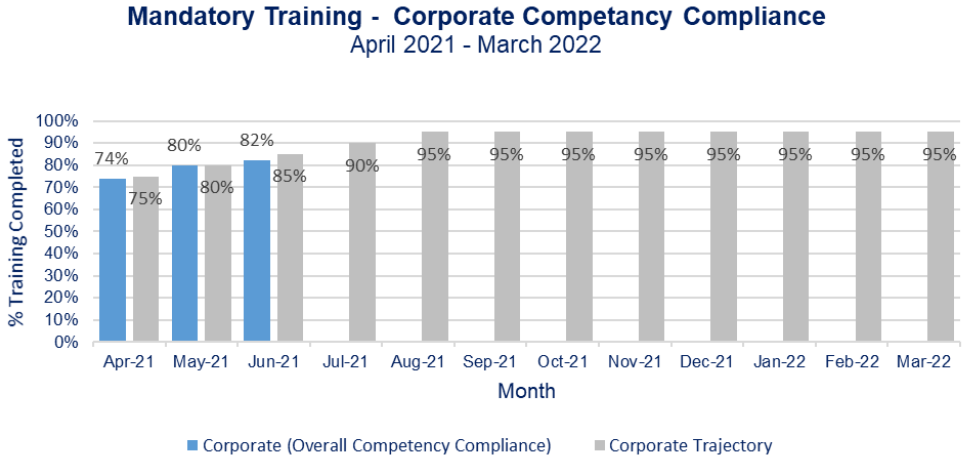


Figure OH7.6



OH8 CASE MANAGEMENT

Employee Relation Dashboard @ 30 June 2021

NWAS Summary

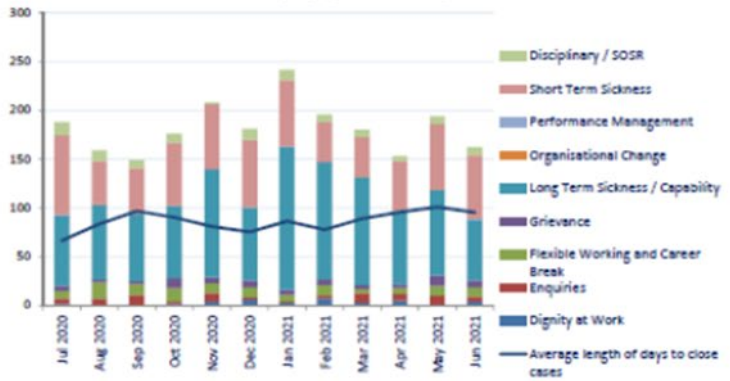
Service Line	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	350	1099	12.68
Operations ~ EOC	42	177	15.18
Operations ~ Resilience	3	8	12.64
Operations ~ 111	87	441	9.48
Operations ~ PTS	50	387	13.25
Corporate	22	56	17.61
Other*	14	25	12.56
NWAS Summary	568	2193	12.41

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

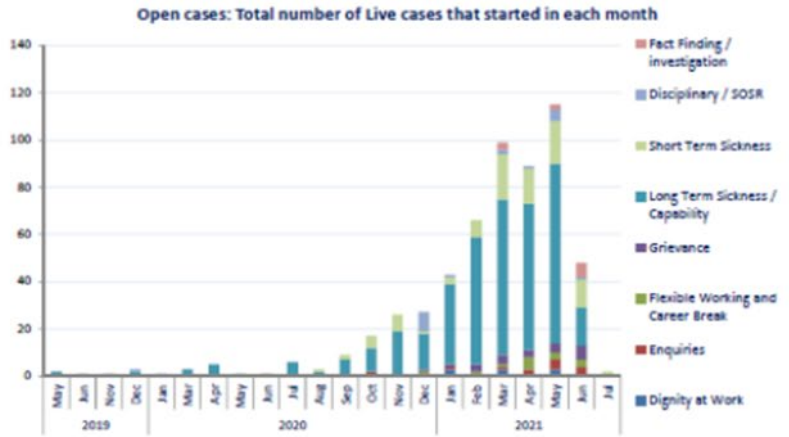
Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	13	38	14.95
Disciplinary	19	101	24.71
Enquiries	14	70	13.23
Flexible Working and Career Break	15	119	6.27
Grievance	22	71	18.68
Long Term Sickness / Capability	382	1077	15.13
Organisational Change	0	2	10.64
Performance Management	0	4	13.18
Short Term Sickness	92	706	6.61
Fact Finding	11	5	25.51
Case Summary	568	2193	12.41

Closed cases: Number of closed cases compared with the averge length of time (days) taken to complete



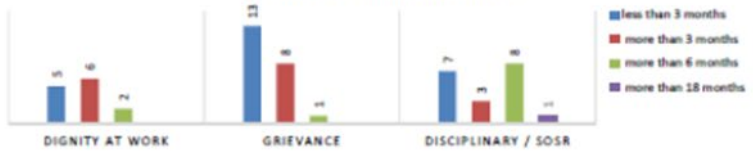
Open cases: Total number of Live cases that started in each month



Length of current live cases

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	5	6	2	0
Grievance	13	8	1	0
Disciplinary / SOSR	7	3	8	1
Case Total	25	17	11	1

LENGTH OF CURRENT LIVE CASES



Human Resources Case Management

The Trust is developing its data and oversight of case management. Details of casework are regularly reported to Resources Committee.

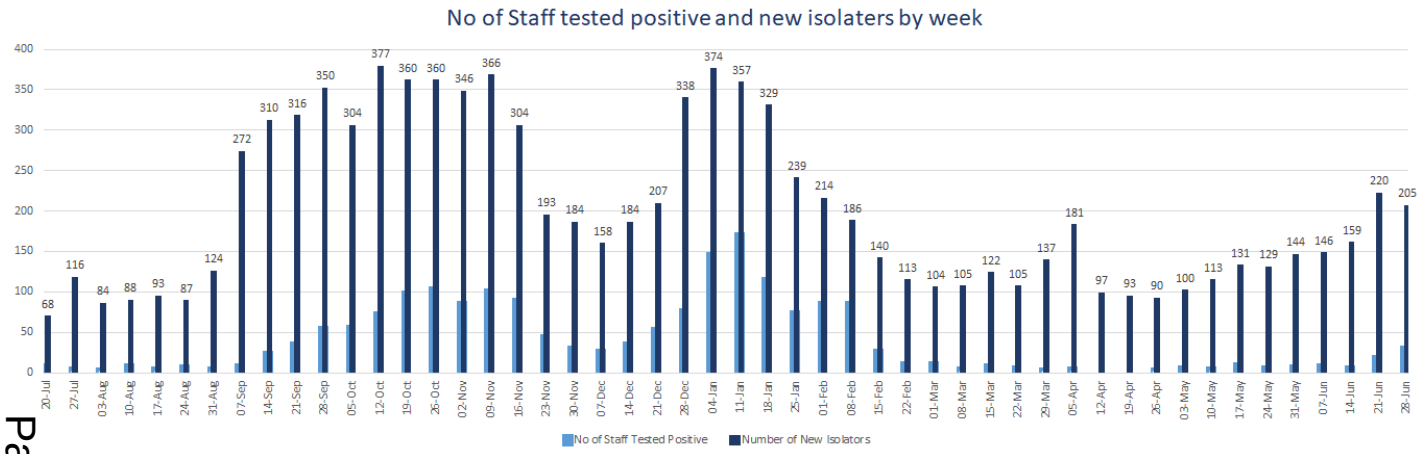
The overall number of open cases and timeliness has been impacted by COVID-19 with 8 out of the last 12 months affected by some type of limitation on progressing investigations and hearings. This has had a particular impact on the levels of sickness absence casework and on overall timeliness.

A recovery plan is in place to improve this position with immediate actions including:

- Review of all current non-sickness casework
- Structures for escalation of overdue casework being refreshed
- Introduction of pre-investigation review panel ensuring appropriateness of entry into formal process, welfare support and resources required for investigation
- Improvement of data visibility and fitness for purpose

COVID 19

Figure CV19.1 - Number of Staff tested positive and new isolators by week



Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	11-Jan	168
27-Jul	3	18-Jan	113
03-Aug	1	25-Jan	72
10-Aug	7	01-Feb	83
17-Aug	3	08-Feb	84
24-Aug	5	15-Feb	24
31-Aug	2	22-Feb	9
07-Sep	6	01-Mar	9
14-Sep	22	08-Mar	3
21-Sep	34	15-Mar	6
28-Sep	53	22-Mar	4
05-Oct	54	29-Mar	1
12-Oct	71	05-Apr	2
19-Oct	96	12-Apr	0
26-Oct	101	19-Apr	0
02-Nov	83	26-Apr	1
09-Nov	99	03-May	4
16-Nov	87	10-May	2
23-Nov	42	17-May	8
30-Nov	28	24-May	4
07-Dec	24	31-May	5
14-Dec	34	07-Jun	7
21-Dec	52	14-Jun	4
28-Dec	75	21-Jun	17
04-Jan	144	28-Jun	28

COVID-19

There have been 44 instances of staff that have tested positive for Covid-19 in April 2021 with 1,814 instances since July 2020.

As at the end of June 2021 there were no open outbreaks on trust sites.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 July 2021			
SUBJECT:	Learning from Deaths - Summary Report and Q4 2020/21 and Annual 2020/21 Dashboards			
PRESENTED BY:	Dr Chris Grant, Executive Medical Director			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then annual summary of Learning from Deaths; this is the fourth quarterly report to be published. The Q4 dashboard (Appendix A) describes the opportunities to learn. In summary, the contributory factors to patient deaths were predominantly attributed to problems in clinical assessment and lack of available resources. The peer review process identified most patients received appropriate care, but where failings occurred, these included the failure to record observations, failure to refer the patient to Acute Visiting Schemes/alternative providers and/or lack of a comprehensive Patient Report Form. The peer review identified areas of good practice such as recognition of patients approaching end of life, engaging with carers/GP/family members and external providers to ensure best interests of the patient were met, safety-netting a patient who had refused conveyance and organising respite support for family members. Disseminating and promoting good practice has been undertaken by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums and with individual frontline staff. The Learning from Deaths team will commend individuals who, through their care and professionalism, have supported families and patients to experience a good death. The Datix Cloud IQ Mortality Module is moving forward at pace. Initial testing was conducted through May and June 2021 with the intention to embed by Q2 2021/22			

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

• Agree the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement in the formal process of Learning from Deaths.
• Agree the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement in the formal process of Learning from Deaths.
• Acknowledge the impact of the Structured Judgement Review process in identifying opportunities for improving care and identification of Serious Incidents previously unidentified.
• Acknowledge the good practice identified including:
○ Organising respite support for family members, including support from District Nurses and bereavement support
○ Rapid deployment of End of Life Care packages where none were in place
○ Thorough safety-netting of patients and dependents
○ Thorough safety-netting of patients at risk of dying who refuse conveyance
• Support the dissemination process as described in Section 3.4
• Note the progress in developing the Datix Cloud IQ Mortality Module.</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Clinical Effectiveness Sub Committee
Quality and Performance Committee</td></tr>
<tr><td colspan="2">Date:</td><td colspan="2">06 July 2021
26 July 2021</td></tr>
<tr><td colspan="2">Outcome:</td><td colspan="2">Accepted</td></tr>
</table>

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

1.1 The purpose of this report is to meet the requirements of the national guidance for ambulance trusts on "Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care" as referenced in the Learning From Deaths Policy.

Appendix A is a summary dashboard of the Q4 2020/21 Learning from Deaths review. The 2020/21 Q4 dashboard includes output from moderation panels held following the Structured Judgement Reviews (SJR) for Q4.

Appendix B is a cumulative dashboard representing the overall activity from Learning from Deaths through 2020/21.

The next phase of dashboard development will require dedicated EOC subject experts to undertake the dispatch and triage review.

It is acknowledged the dashboard remains an iterative reporting process which will continue to become more sophisticated and informative throughout 2021/22.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement.

3. LEARNING FROM DEATHS DASHBOARD Q4 2020/21: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 90 (23 Datix incidents and 67 sampled - *Table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 23 patient deaths:

- 18 patients were identified through the Incidents Module
- 4 patients were identified through the Patient Experience module
- 1 patient was identified as having records on both the Incidents and the Patient Experience module.

3.3 ***Sample Cohort Discussion: Tables 8, 9 and Figure 6.***

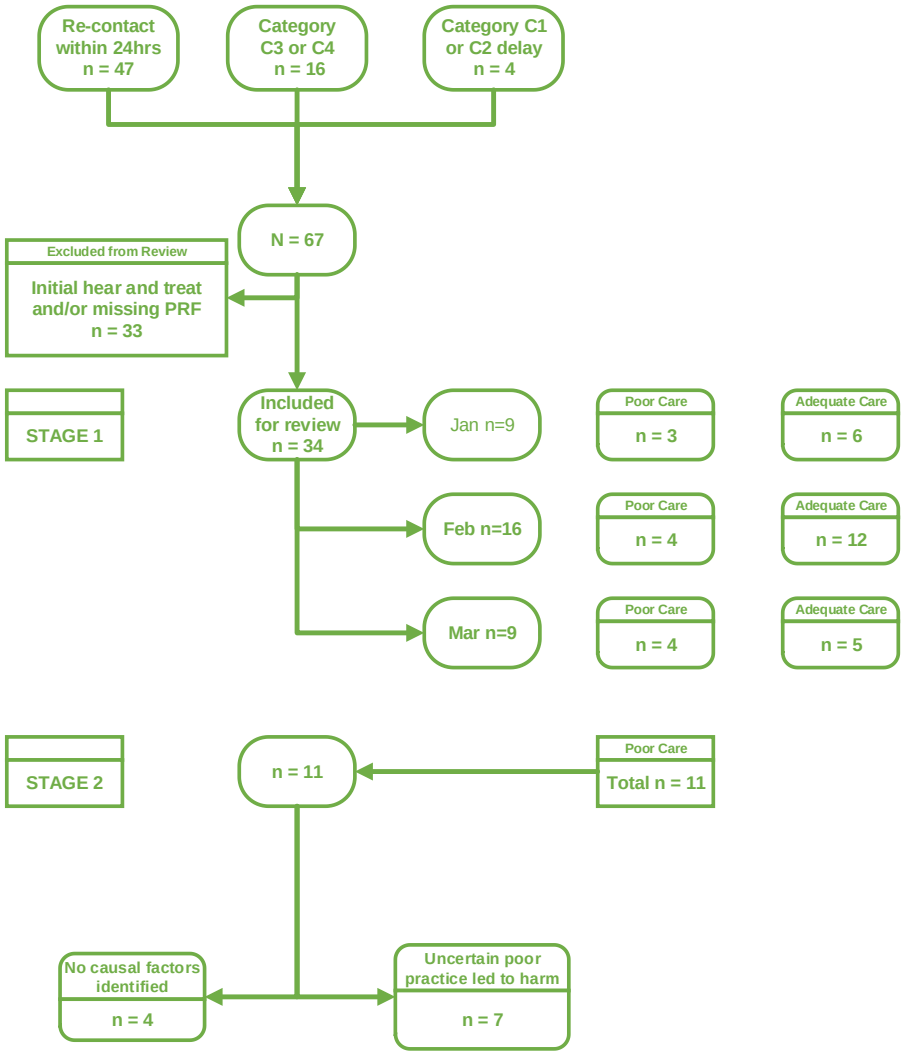
Of the 67 patient deaths:

- 47 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- 16 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- 4 deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait.

**The results should not be correlated to the results of the Safe Care Closer to Home audit due to significant differences in audit methodology.*

The flow chart below provides a summary of which cases were reviewed. There are two reasons why the whole cohort are not reviewed:

1. Absence of a patient report form
2. Where a 24hr re-contact incident is initiated as a 'hear and treat' and subsequently as a see and treat; the 'hear and treat' element review cannot be undertaken without an EOC Clinical Hub specialist.



Flow chart to describe sample cohort attrition and treatment Q4 2020/21

3.3.1 *Structured judgement review methodology*

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

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

The review comprises of Stage 1: review of clinical practice and call handling/ resource allocation. Where “less than adequate” overall care is identified, a Stage 2 review occurs to identify if any causal factors (systemic) have led to harm.

3.3.2 ***Outcome: Q4 Review; Stage 1.***

34 patient deaths were reviewed and following a moderation panel assurance process, review outcomes were determined as below:

Month	Very Poor	Poor	Adequate	Good	Very Good
Jan 21		3	6		
Feb 21		4	12		
Mar 21		4	5		

Moderation Panels held on 10/03/2021, 14/04/2021, 28/01/2021 & 12/05/2021

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

3.3.3 ***Q4 Review: Stage 2.***

11 cases were identified as needing Stage 2. In 4 cases, no other causal factors were identified as contributing to harm.

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

Poor Practice: Table 11 Figure 7.

The panel identified areas for improvement including:

- Increasing number of observations and/or investigations recorded
- Making appropriate referrals to AVS, primary care or alternative providers.
- Recording of discussions with family and/or carers around a patient’s condition.
- Applying and recording MTS/Pathway decisions
- Following Diagnosis of Death procedures correctly

Other learning identified was the variable quality of the PRF itself in terms of legibility, its comprehensiveness and use of appropriate language.

Escalation and Learning

The Consultant Paramedic (Medical Directorate) has the responsibility to escalate incidents or concerns whenever deemed appropriate to the Review of Serious Events (ROSE) Panel.

One such case was identified in Quarter 4. The subsequent detailed investigation did provide significant assurance in the preparation for a ROSE submission and the ROSE panel concluded this did not reach the threshold for declaration of an SI.

Hence, it can further be seen how the Learning from Deaths process contributes to identifying areas for improvement alongside current methodologies.

Good Practice: Table 12 fig 8.
The panel review identified numerous positive examples of practice over and above expected practice. This included:

- *Organising respite support for family members, including support from District Nurses and bereavement support*
- *Rapid deployment of End of Life Care packages where none were in place*
- *Thorough long-term safety-netting of patients and dependents*
- *Thorough safety-netting of patients at risk of dying who refuse conveyance*

3.4 ***Dissemination Process***
A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums (ALFs) and with individual frontline staff.

The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs by the Consultant Paramedic. A template to support dissemination has been developed and is attached as Appendix C.

There is an intention to commend individuals who, through their care and professionalism, have supported families and patients to experience a good death. This will be a key element of the Learning from Deaths communication plan.

3.5 ***Report Development*** DCIQ: Mortality Module

The project team for Datix Cloud IQ (DCIQ) is working with the Clinical Audit Team and Consultant Paramedic (Medical Directorate) to develop the SJR process in Datix. The aim is to embed the process into DCIQ by Q2 2021/22. This will bring all the elements of the Learning from Deaths review into a single system of data management.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

4.1 There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance to the Data Protection Act 2018.

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

5.1 No equality or sustainability implications have been identified.

6. RECOMMENDATIONS

6.1 The Trust Board is recommended to:

- Agree the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement in the formal process of Learning from Deaths.
- Agree the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement in the formal process of Learning from Deaths.
- Acknowledge the impact of the Structured Judgement Review process in identifying opportunities for improving care and identification of Serious Incidents previously unidentified.
- Acknowledge the good practice identified including:
    - Organising respite support for family members, including support from District Nurses and bereavement support
    - Rapid deployment of End of Life Care packages where none were in place
    - Thorough safety-netting of patients and dependents
    - Thorough safety-netting of patients at risk of dying who refuse conveyance
- Support the dissemination process as described in Section 3.4
- Note the progress in developing the Datix Cloud IQ Mortality module.

NWAS Learning From Deaths Dashboard Quarter 4 2020-2021 (January - March)

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

Total Number of Deaths in scope (sample cohort and Datix incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
January	40	18	45.0%	3
February	31	18	58.1%	5
March	19	10	52.6%	4
This Quarter	**90**	**46**	**51.1%**	**12**
This Financial Year	324	187	57.7%	85

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

Table 1.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 11/06/2021.

Learning from Deaths: Data over time

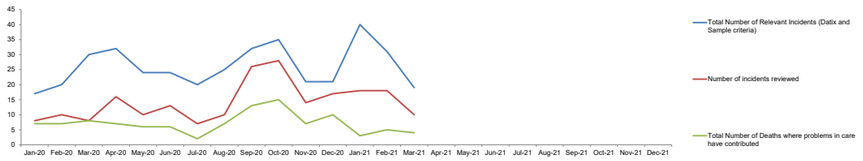


Figure 1.

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

Datix Cohort Breakdown

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

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
January	12	2	5	5
February	4	1	0	3
March	2	0	2	0
Total	**18**	**3**	**7**	**8**

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
January	7	0	0
February	2	1	1
March	1	0	0
Total	**10**	**1**	**1**

Table 3.

Datix Degree of Harm
(all in scope including those not yet closed)

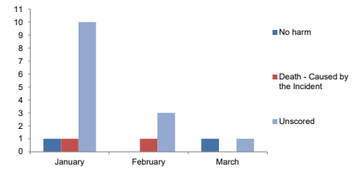


Figure 2.

Datix Category Type
(of those reviewed and death determined by the incident)

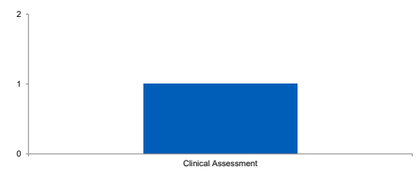


Figure 3.

Data source: Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 21/04/2021. Last accessed 11/06/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
January	2	2	0
February	1	0	0
March	1	0	0
Total	**4**	**2**	**0**

Table 4.

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

Learning theme

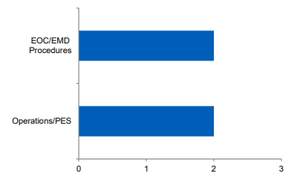


Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Extensive delay in emergency response for LeDer patient	1	Reflection and/or feedback; refresher training to be undertaken; learning forum to change training around chest pain recognition; still under review
	Extensive delay in emergency response for Mental Health patient	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Operations/PES	Concerns raised around treatment to paediatric patient	1	Reflection and/or feedback; Positive feedback for joint decision making; still under review
	Concerns raised around delayed extrication of bariatric patient	1	Reflection and/or feedback; still under review

Table 5.

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 21/04/2021. Last accesed 11/06/2021.

Incidents on both Patient Experience Module and Incidents Module

Month	Relevant incidents on both modules	Incidents Closed on both modules	Number closed and death considered caused by the incident
January	1	0	0
February	0	0	0
March	0	0	0
Total	**1**	**0**	**0**

Table 6.

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

Learning theme

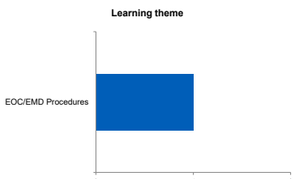


Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	Resource monitoring/management	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning review; commendation for EMD showing compassion/encouragement; still under review

Table 7.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter: last extracted 21/04/2021. Information recorded on these incidents: last accessed 11/06/2021. Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report': last extracted on 21/04/2021. Last accessed 11/06/2021

Sample Cohort Breakdown

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

Structured Judgement Review

Incidents used for the Sample criteria	Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
January	25	9	3
February	26	16	4
March	16	9	4
Total	**67**	**34**	**11**

Table 8.

SJR Stage 1 Overall Care Assessment

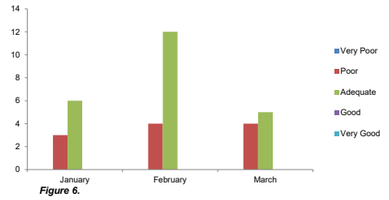


Figure 6.

Quarter 4 2020-2021 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
January	3	7	15
February	1	5	20
March	0	4	12
Total	4	16	47

Table 9.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	**N/A**	
Right Care	Patient Assessment Rating	9	25	0	**25 patients out of 34 patient cohort**	**74%**
	Management Plan/Procedure Rating	5	26	3	**29 patients out of 34 patient cohort**	**85%**
Right Place	Patient Disposition Rating	5	28	1	**29 patients out of 34 patient cohort**	**85%**

Table 10.

† SJR Scoring Key:

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

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

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

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 34 patients)

Evidence of Poor/Very Poor Practice

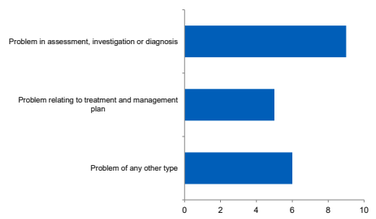


Figure 7.

Learning Theme	Learning Detail	Frequency (n=34 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	9
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	2
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
	Mismanagent of patient's symptoms/condition	1
	MTS/Pathfinder not used	1
Problem of any other type	Incomprehensive PRF	3
	Distress caused to patient's family	1
	DoD Procedure not followed correctly	1
	Crew behaviour/language used	1

Table 11.

Evidence of Good/Very Good Practice

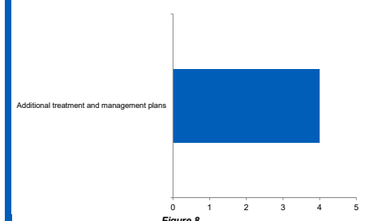


Figure 8.

Learning Theme	Learning Detail	Frequency (n=34 patients)
Additional treatment and management plans	Crew built enable rapid placement of EOLC package where one was absent as well as respite support for family members, including support from District Nurses and bereavement support	2
	Additional referrals/management plans put in place for long-term safety netting of both patient and dependents	1
	Crew made additional safeguarding referrals in a patient recognised as at risk of dying. Crew incredibly concerned to leave patient who refused to be conveyed despite risk of death	1

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. Due to PRFs being unavailable 34 reviews took place, six less than the minimum random sample size of 40 required.

Data source: Informatics queries 962543 & 988356 last run on 20/04/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 11/06/2021.

This page is intentionally left blank

NWAS Learning From Deaths Dashboard Annual 2020-2021 (April - March)

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

Total Number of Deaths in scope (sample cohort and Datix incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Q1	80	39	48.8%	19
Q2	77	43	55.8%	22
Q3	77	59	76.6%	33
Q4	90	44	48.9%	12
This Financial Year	324	187	57.7%	85

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

Table 1.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 11/06/2021.

Learning from Deaths: Data over time

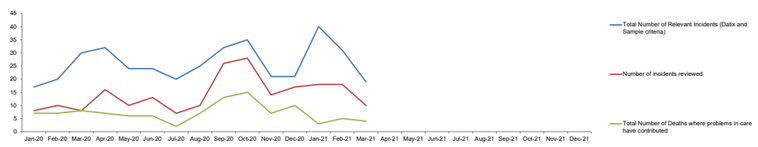


Figure 1.

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

Datix Cohort Breakdown

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

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
Q1	22	6	4	12
Q2	24	2	3	19
Q3	16	1	5	10
Q4	18	3	7	8
Total	**62**	**12**	**19**	**49**

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
Q1	21	11	4
Q2	21	15	7
Q3	16	10	4
Q4	10	1	1
Total	**58**	**36**	**15**

Table 3.

Datix Degree of Harm
(all in scope including those not yet closed)

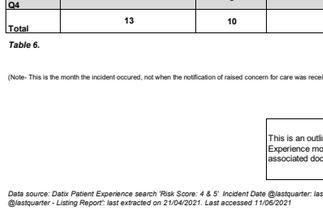


Figure 2.

Datix Category Type
(of those reviewed and death determined by the incident)

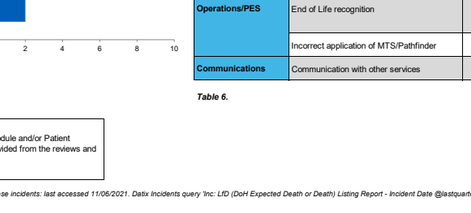


Figure 3.

Data source: Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 21/04/2021. Last accessed 11/06/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
Q1	13	13	3
Q2	6	5	2
Q3	6	4	3
Q4	4	0	0
Total	**25**	**22**	**8**

Table 4.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 21/04/2021. Last accessed 11/06/2021.

Learning theme

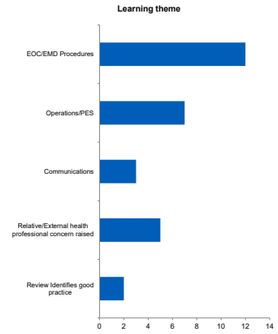


Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD Procedures	Procedure not adhered to	4	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Incorrect call categorisation	3	Reflection and/or feedback; re-training/re-reading procedures;
	Extensive delay in emergency response for vulnerable patients	2	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	EMD ineffective breathing recognition	2	Reflection and/or feedback; re-training/re-reading procedures;
Operations/PES	Lack of sufficient documentation	3	Reflection and/or feedback; improve documentation skills; emphasis of using CSH
	Concerns raised around delayed extrication of bariatric patient	1	Reflection and/or feedback
	Concerns raised around treatment of paediatric patient	1	Reflection and/or feedback; re-training/re-reading procedures
	Incorrect application of MTS/Pathfinder	1	Reflection and/or feedback; re-training/re-reading procedures
	Staff behaviour/attitude	1	Reflection and/or feedback
Communications	Internal communication messages	2	Reflection and/or feedbacl; re-training/re-reading procedures; new system configuration to avoid re-occurance
Relative/external health provider raised concern	Patient safety concern	6	Reflection and/or feedback; re-training/re-reading procedures
Review identified good practice	Reviewed as safe outcome	2	Reflection and/or feedback; commendation to EMD
	Good recognition of condition, treatment and interventions	1	Reflection and/or feedback

Table 5.

Incidents on both Patient Experience Module and Incidents Module

Month	Relevant incidents on both modules	Incidents Closed on both modules	Number closed and death considered caused by the incident
Q1	5	5	5
Q2	6	4	2
Q3	2	1	1
Q4	1	0	0
Total	**13**	**10**	**8**

Table 6.

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

Learning theme

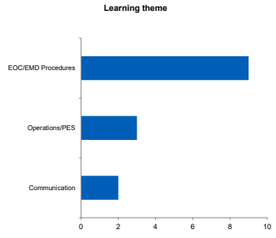


Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	EMD ineffective breathing recognition	3	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Procedure not adhered to	3	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	Resource monitoring/management	2	Reflection and/or feedback; re-training/re-reading procedures; staff to attend EOC learning forum
	EMD MPDS aspirin diagnostic instruction tool	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning review
Operations/PES	Lack of sufficient documentation	1	Reflection and/or feedback; re-training/re-reading procedures
	End of Life recognition	1	Reflection and/or feedback; re-training/re-reading procedures; staff to attend learning forum with EoLC Lead
	Incorrect application of MTS/Pathfinder	1	Reflection and/or feedback; re-training/re-reading procedures
Communications	Communication with other services	2	Development of new SOP around Police cancellations

Table 6.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter: last extracted 21/04/2021. Information recorded on these incidents: last accessed 11/06/2021. Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report': last extracted on 21/04/2021. Last accessed 11/06/2021

Sample Cohort Breakdown

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

Structured Judgement Review

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Q1	40	0	0
Q2	41	13	3
Q3	53	38	19
Q4	67	34	11
Total	**134**	**85**	**33**

Table 8.

SJR Stage 1 Overall Care Assessment

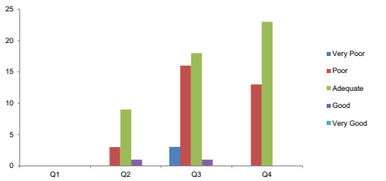


Figure 6.

Total 2020-2021 Sample Data Breakdown			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
Q1	3	17	20
Q2	4	11	26
Q3	9	16	28
Q4	4	16	47
Total	16	44	74

Table 9.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	23	58	4	62 patients out of 85 patient cohort	73%
	Management Plan/Procedure Rating	22	53	10	63 patients out of 85 patient cohort	74%
Right Place	Patient Disposition Rating	17	65	3	68 patients out of 85 patient cohort	80%

Table 10

† SJR Scoring Key:

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

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

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

Structured Judgement Review Highlighted Learning Themes from Stage 2 (Review of 85 patients)

Evidence of Poor/Very Poor Practice

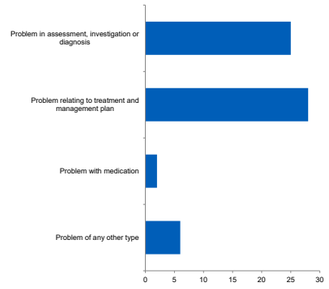


Figure 7.

Learning Theme	Learning Detail	Frequency (n=85 patients)
Problem in assessment, investigation or diagnosis	Lack of clinical observations and/or investigations performed	24
	No capacity, communication or consent assessments undertaken	1
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	12
	No SOS/red flag/worsening advice given	5
	No senior clinical advice sought	3
	No resuscitation attempted	2
	Delay in upgrading incident	2
	MTS/Pathfinder not used	2
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
Problem with medication	Incorrect use of medication	2
Problem of any other type	Incomprehensive PRF	2
	Distress caused to patient's family	2
	No LeDer referral made	1
	DoD procedure not followed correctly	1

Table 11.

Evidence of Good/Very Good Practice

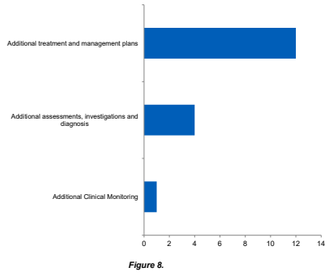


Figure 8.

Learning Theme	Learning Detail	Frequency (n=85 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additonal investigations and assessment beyond expected practice	4
Additional treatment and management plans	Additional referrals/management plans put in place for long-term safety-netting of both patients and dependents	4
	Crew built holistic picture of patient's condition for treatment and rapid placement of EoLC package/DNACPR in best interests of patient	3
	Crew decided not to resuscitate patient they recognised as EoL in absence of formal EoLC package/DNACPR in best interests of patient	2
	Appropriate application of the ReSPECT process in lieu of a formal DNACPR in place	1
	Crew engaged with MDT comprised of external providers, carers, GP and family to ensure best interests of patient were met	1
	Thorough knowledge of local community agencies with additional referrals made	1
Additonal clinical monitoring	NEWS2 monitoring in a non-septic patient to assess deteriorating status of patient	1

Table12.

Data source: Informatics queries 874893, 892664, 912009, 924638, 962543 & 988356 last run on 20/04/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 11/06/2021.

This page is intentionally left blank

NWAS LEARNING FROM DEATHS PROGRAMME

Key Learning Points
2020 | 21

NHS North West Ambulance Service NHS Trust

Areas for Improvement

01 Clinical Documentation

- Lack of clinical observations and/or investigations performed
- Incomprehensive PRF/lack of sufficient documentation
- No SOS/red flag/worsening advice given or documented

02 Safety Netting / Referrals

- Referrals not made to AVS/GP/alternative providers when appropriate to do so
- Incorrect/lack of use of MTS/Pathfinder

03 Clinical Escalation

- No senior clinical advice sought when appropriate to do so.

Sharing Excellence

End of life Care

Building a holistic picture of patient's conditions for treatment. Ensuring swift placement of EoLC packages/DNACPRs in the best interests of patients care.

Safety Netting

Additional referrals/management plans put in place for long-term safety-netting of both patients and vulnerable dependents, e.g. bereavement services

Patient Assessment

Assessment of patients with additional investigations beyond expected practice, e.g. use of NEWS2 in non-septic patients to identify deterioration

Resuscitation

Appropriate application of the ReSPECT process in lieu of formal DNACPRs in place.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th July 2021			
SUBJECT:	Health, Safety and Security Annual Report 2020/21 and Forward plan			
PRESENTED BY:	Executive Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Health and Safety at Work Act 1974 requires workplaces to provide: • adequate training of staff to ensure health and safety procedures are understood and adhered to, • adequate welfare provisions for staff at work, • a safe working environment that is properly maintained and where operations within it are conducted. The Health Safety and Security (HSS) annual report 2020/21 aims to provide assurance to the committee that despite the impact of the pandemic all reasonable steps to ensure regulatory compliance and objectives within the Right Care (Quality) strategy were met. The report describes the extraordinary HSS activity undertaken throughout the pandemic and celebrates success achieved despite the pandemic. The associated plan indicates the direction for the year ahead picking up on areas identified as needing focus and building on the foundations established in the past 12 months.			
RECOMMENDATION:	The Board of Directors is recommended to: • Receive and accept the annual report as assurance with regulatory and mandatory national requirements. • Acknowledge and thank the HSS team for their commitment to supporting staff to stay safe during 2020/21 • Recognise the achievements made in the year by the team. • Note and accept the content of the high level forward plan for 2021/22.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐

PREVIOUSLY CONSIDERED BY:	Health & Safety Sub Committee Executive Leadership Committee Quality and Performance (Q&P) Committee	
	Date:	6th July 2021 21st July 2021 26th July 2021
	Outcome:	Approved (pending approval from Q&P committee at the time of submission)

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

2. BACKGROUND

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

5. RECOMMENDATIONS

North West Ambulance Service NHS Trust

Health Safety and Security

Annual Report

2020 - 2021

Contents

1. INTRODUCTION

The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety. At NWAS we take the health, safety and security of our staff extremely seriously, whether patient facing, in a control centre or in an office. Our dedicated health, safety and security team (HSS) is responsible for making sure any risks to the security or welfare of staff are kept to a minimum.

The Health and Safety at Work Act 1974 requires workplaces to provide:

- Adequate training of staff to ensure health and safety procedures are understood and adhered to.
- Adequate welfare provisions for staff at work.
- A safe working environment that is properly maintained and where operations within it are conducted

This report provides a high level summary of the HSS activity carried out across the NWAS from 1st April 2020 to the 31st March 2021 and our compliance with the standards set out in the Health and Safety at Work Act 1974.

2. REGULATORY COMPLIANCE

Health Safety and Security systems within NHS Trusts are regulated by:

Health and Safety Executive (HSE): The HSE is the national independent regulator for health and safety in the workplace. This includes private or publicly owned health and social care settings in Great Britain. The HSE works in partnership with co-regulators in local authorities to inspect, investigate and where necessary take enforcement action.

Medicines and Healthcare products Regulatory Agency (MHRA): The MHRA is an executive agency of the Department of Health and Social Care; responsible for ensuring that medicines and medical devices work and are acceptably safe.

Care Quality Commission (CQC): The CQC is an executive non-departmental public body of the Department of Health and Social Care. It was established in 2009 to regulate and inspect health and social care services in England and works closely with the HSE with both regulators taking lead for certain issues across NHS trusts.

2.1 Consulting with staff

It is a regulatory duty employers consult with their employees about health and safety. The two sets of general regulations are:

- The Safety Representatives and Safety Committees Regulations 1977, and
- The Health and Safety (Consultation with Employees) Regulations 1996

NWAS works closely with Union colleagues to develop maintain and promote measures that ensure health and safety at work; and to act as 'critical friends' to check the effectiveness of

those measures. It should be noted that without Union colleagues significant contribution to the HSS agenda the achievements described in this annual report would not have been made.

3. HEALTH AND SAFETY EXECUTIVE

3.1 Reporting Of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses) against a clear set of guidelines.

Within NWAS the timely reporting of RIDDORs following an incident remains the responsibility of the HSS Team. Learning from RIDDOR reportable incidents is collated by the HSS team and reviewed locally at the learning forums. Thematic learning from RIDDOR reports is reviewed at the Safety Management Group and the Board of Directors receive a bi-monthly assurance update in the reportable events paper.

384 incidents were reported to the HSE under RIDDOR in 2020/21. Table 1 below summarises the RIDDORS by type. In 2020, new quidelines were issued by the HSE which required NHS Trusts to report workplace exposure to COVID 19 through the RIDDOR reporting system. 247 incidents were reported for reasonable evidence of COVID-19 occupational exposure predominantly within the first wave of the pandemic.

RIDDOR TYPE	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Total	*% of Total*
Infection Control - Covid-19	19	11	138	17	185	*48.2*
111 IPC Covid-19	No category in 111 Datix for IPC; number of incidents added as total overall.				62	*16.0*
Manual Handling	8	17	15	12	52	*13.5*
Slips, Trips or Falls	15	8	8	19	50	*13.0*
Physical Assault	4	3	7	2	16	*4.2*
Vehicle Issue	1	3	1	1	6	*1.6*
Sharps Injury/ Incident	1	1	1	0	3	*0.8*
Access/admission/transfer issue	2	0	0	0	2	*0.5*
Clinical Assessment	2	0	0	0	2	*0.5*
Equipment Fault/Failure	0	0	0	2	2	*0.5*
Exposure to Harmful Substance	0	0	2	0	2	*0.5*

RTC/ Vehicle	0	1	1	0	2	*0.5*
Equipment Damaged	0	1	0	0	1	*0.2*
Total	52	42	173	53	**384**	

Table 1. RIDDOR by incident type 2020/21 data source Datix last accessed May 2021

NWAS had an improvement goal to reduce the number of RIDDORs year on year. In the first two years this goal was achieved as we moved from a baseline of 33 per quarter (2018/19) to 27 per quarter (2019/20) a reduction of 20%. This safety improvement was to be achieved by focussing on what can be done to reduce the number of manual handling injuries experienced by NWAS. However, this reduction was not seen in the following two years. In the reporting year to 31 March 2020; 130 incidents were reported under RIDDOR to the HSE, in the year to 31 March 20201 (excepting for the 247 of COVID-19 related incidents) 138 incidents were reported. This represents a slight increase in RIDDOR reports.

The COVID-19 pandemic significantly inflated the number of RIDDOR incident reporting, and drew focus from the team to support the reporting process. The slight increase in the absolute numbers of RIDDOR reports is likely to reflect normal patterns of variation.

3.1.1 RIDDOR reporting rates in ambulance services

To fully understand the variation over time and between organisations, national RIDDOR reporting uses incidents per 1000 staff.

The information below indicates that the NWAS rate for RIDDORS per 1000 staff in post compares favourably with other ambulance trusts and is the third lowest in the country for those that have declared their full data set. The rate per number of journeys also compares favourably and is the second lowest for those that have declared a full data set.

Name of Ambulance Service	EEAS	EMAS	NWAS	NEAS	NIAS	SAS	SCAS	SWAS	YAS
Number of Staff Injury RIDDORS reported	126	67	118	67	73	114	98	93	20
Number of Staff employed as of 31/03/21	5611	4241	6778	2729		6735		4,853	5203
Total No of Journeys (PTS & PES combined)	1,337,684	1,231,991	1,902,964	618,376	306,348	1,128,175	982,659	434,081	1,465,893
Incident Rate (Injuries x 1000 ÷ No of Journeys) Staff injuries only	0.09	0.05	0.06	0.11	0.24	0.10	0.10	0.21	0.01
Incident Rate (Injuries x 1000 ÷ No of Employee) Staff injuries only	22.46	15.80	17.41	24.55		16.93		19.16	3.84

Table 2: National Ambulance Service statistics RIDDOR reporting rates 2020/2021

3.2 Non-clinical incident reporting

Table 3 below summarises the number of non-clinical incidents reported during 2020-21. There has been increase of 37% from 6,913 reported during 2019-20 to 9,504 in 2020 -21.

Non-clinical incidents by Directorate	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Total
Service Delivery Directorate (PES, EOC, UCS, PTS etc.)	2140	2166	2577	2363	9246
Medical Directorate	14	21	24	22	81
Finance Directorate (Finance/Fleet/Estates etc.)	4	13	45	16	78
Quality Directorate	16	13	9	5	43
People Directorate	3	4	12	12	31
Corporate Affairs Directorate	1	1	4	5	11
Strategy & Planning Directorate	0	1	2	6	9
Transformation Directorate	2	0	2	1	5
Total	2180	2219	2675	2430	9504

Table 3: Non-clinical incidents by Directorate 2020/21 data source Datix last accessed May 2021

3.3 Violence and aggression

Patient facing staff have reported over 1,300 incidents of violence and aggression in the 12 months to 31 March 2021. The top three categories of violence and aggression reported are:

- Physical Assault: 383 incidents
- Threatening Behaviour: 558 incidents
- Verbal Abuse:529 incidents

The Trust employs a full time security officer who reviews all incidents of violence and aggression against staff. The officer works with the operational management team to ensure that incidents are managed in a timely way to provide welfare to staff, and to advise on the appropriate management of the incident.

When a member of staff is assaulted an incident is reported in Datix, staff are asked to indicate extenuating circumstances such as alcohol, drugs, mental health etc. associated with the assault. Importantly the reporting process captures if a staff member is considering prosecution and if not, why not. NWAS has identified where a staff member indicates no intent

to pursue prosecution it is predominantly due to having sympathy for the patient and or relatives; or sanctions if imposed are considered too lenient.

NWAS staff who have experienced violence or aggression are encouraged to make a Community Impact Statement. This is supported by the Chief Executive and can be used by the Police and criminal justice system when a member of staff wishes to pursue a prosecution against an offender. The statement process encourages staff to describe the impact of the offense on themselves, the organisation and the public, and statements have been used by magistrates to assist in determining the sanctions to be imposed.

The security officer also oversees a standardised approach and set criteria for inputting both violence and cautionary markers on address flags. This is a crucial part of our safe system of work for frontline staff which allows them to be warned of a potential threat of violence or aggression at a particular location. A temporary marker is placed at staff request with an incident report form (IRF) to support the flag request. The flag may be extended for 12 months following a review of the incident report by the specialist safety officer, providing NWAS has a valid and accurate audit trail of why the address flags are placed, by whom and when they are due for review.

2,385 violence and aggression markers (address flags) have been recorded since August 2020. Of these 1,508 have been reviewed resulting in 966 being deleted and 542 updated. At time of writing 877 are waiting review; the risk is recorded and work is underway to address the backlog. It should be noted the pressures of Covid has at times contributed to the delay with this work.
Analysis of the violence and aggression markers have identified the top frequency markers as:

- Violence –person: 638 warning notes,
- Caution – verbally abusive: 336 warning notes
- Caution – Other: 313 warning notes
- Violence –weapons 285 warning notes
- Violence marker 47 warning notes

In the year to March 2021, there were 107 administrative sanctions and six successful prosecutions for violence and aggression.

3.3.1 Violence and aggression working group

The violence and aggression working group meets every two months under the leadership of the Head of Quality Compliance and Assurance. The group comprises of staff from control, health and safety, trade unions and operations. The primary objective of the group is to ensure a progressive approach to violence and aggression within NWAS. The work programme includes detailed review of incidents and is designed to address the learning from incidents. The programme can be broken down into 12 key areas:

Similarly the violence prevention and reduction standard (December 2020) has been reviewed and a gap analysis undertaken. The group will over the next 12 months as part of the forward plan move NWAS towards greater compliance with the standard which includes:

- Development of a comprehensive violence prevention and reduction policy
- Ensuring processes and procedures have clearly defined performance measures
- Ensuring the violence performance measures are specific, measureable achievable and relevant
- Provide assurance the performance monitoring and measurement is suitable and sufficient to support corrective and preventative action analysis
- Establishing an audit process to ensure violence prevention and reduction is effective and efficient.

3.4 Digital Surveillance

NWAS is committed to doing all it reasonably can for the protection of its staff, and is using digital surveillance to do this whilst ensuring patients receive appropriate and timely care. Footage from surveillance has been used in the police prosecution of an act of violence against members of staff. In support of the security work, the Head of Quality Compliance and Assurance held a Facebook live session answering questions about digital surveillance and security.

Body Worn Cameras

NWAS is participating as a national test site trialling the use of body worn cameras. If faced with an aggressive patient the member of staff informs the patient they are going to be recorded and their actions are being filmed. This can act as a deterrent in stopping undesirable behaviour from patients/others before it starts. The pilot is being run in eight sectors where we have observed high levels of violence and aggression. It will be evaluated through 2021 and, if found beneficial, rolled out to the remainder of NWAS.

3.5 HSS Training Programme

An induction programme for new staff in Paramedic Emergency Service, Patient Transportation Service and Emergency Operational Centres has been designed and made accessible on the electronic staff record (ESR) during 2020/21.The electronic induction programme complies with the requirements for NHS Health Education England – Competency Skills Training Framework (England) v1 for Health, Safety, and Welfare and Fire aspects. This approach has standardised the delivery of key and mandatory training skills and creates an auditable assurance trail for staff joining the service.

3.6 Ventilation

The COVID19 pandemic has impacted significantly on the risks to our staff (see section 8 for full details). There has been a requirement to review risk assessments and systems of work to ensure we are fulfilling our requirements as an employer under the Health and Safety at Work Act 1974. There has also been a requirement for us to respond to guidance issued by regulatory bodies such as Public Health England, Care Quality Commission and the HSE.

NWAS has issued multiple sets of guidance related to PPE which are reported through the 2020/21 Infection Prevention and Control annual report.

To support this a COVID-19 memo was issued in March 2021 reiterating the guidance NWAS expects its staff to follow in vehicles. The guidance CV196 explains heating and ventilation methods are different depending on vehicle type and advice given accordingly. The general guidance given is:

- Travel with the windows open
- When parked have the door open, where practical
- Where there is more than one person in the cab, both staff must wear a surgical mask
- In the salon the vents on the ceiling exchange system must be open at all times.

3.6.1 Vehicles

NWAS recognises good ventilation has proved to be an important aspect of reducing the concentration of the Covid-19 virus in the air and the risks from airborne transmission. During the pandemic, we need to do everything we can to ventilate our vehicles. NWAS has issued guidance for staff to follow in vehicles. The guidance explains the heating and ventilation methods are different depending on vehicle type and advice given accordingly and includes:

- Travel with the windows open
- When parked have the door open, where practical
- Where there is more than one person in the cab, both staff must wear a surgical mask
- In the salon the vents on the ceiling exchange system must be open at all times.

3.6.2 Buildings

Updated COVID -19 guidance was published in October 2020 by the Chartered Institute of Building Engineers version 4. The guidance serves to help building managers identify those areas in a building that my present risk to occupants and focussed on carbon dioxide concentrations as an indication of ventilation rates – a level above 1500ppm is indicative of poor ventilation.

Sites where NWAS experienced high levels of outbreaks were prioritised and remedial works undertaken to bring carbon dioxide levels down to 1000ppm. Eight NWAS sites were identified as requiring an audit.

- Three sites were found to have good levels of ventilation and no further action required.
- Four sites were outside of tolerance and remedial work and retesting took place to provide assurance the ventilation levels met the NWAS target.
- One site was assessed as satisfactory, and work will continue to bring this site to NWAS standards.

4. MHRA: CENTRAL ALERTING SYSTEM

The MHRA issues notice of safety alerts from the Central Alerting System (CAS). The NWAS Board of Directors are notified via the integrated performance report of safety alerts received. During 2020/21 NWAS has received 46 safety alerts through CAS (table 4 below). Two safety alerts required action:

- Foreign body aspiration during intubation, advanced airway management or ventilation
  Action: Revised airway procedure developed by Consultant paramedics, also tube come is a seal package.
- Masks: type IIR from Cardinal Health to destroy affected lots
  Action all PPE HUBS and procurement check for any masks, none been provide to NWAS

Safety Alerts Received	Number of Alerts Received (April – March 21)	Number of Alerts Applicable (April – March 21)
Central Alert System (CAS)/ NHSE/I	35	1
Medicines and Healthcare Products Regulation Agency (MHRA) – Medical Equipment	11	1

Table 4: Safety Alerts received 2020/21

5. REGULATORY REFORM (FIRE SAFETY) ORDER 2005 ASSURANCE

Fire safety risk assessments (FSAs) are undertaken at all properties under NWAS control and assurance sought that appropriate fire safety measures are in place at 24 shared sites where NWAS is a tenant of the property. The criteria for the frequency of an assessment is described in table 5 as is the number of FSAs conducted in year. The HSS team planned FSAs for 58

sites in 2020/21 and of these 41 (71%) received a FSA in year; as a result in part to the impact of the pandemic. A plan is under development to ensure the annual assessments will be completed for 2021/22 with some contingency to assess sites with adversely extended review times.

NWAS will ensure over a three year period FSAs are undertaken on at least one occasion at each of the 115 NWAS controlled sites. It should be noted a new FSA is conducted if there has been a fire incident or significant changes as the site.

Frequency	Fire Safety Assessment Criteria	Number of sites	No FSA Planned	Number FSA Undertaken
Annual	20 plus vehicles allocated, main offices, HART	18	18	8
2 years	10 to 20 vehicles allocated, workshops, HF hubs	37	20	13
3 years	Less than 10 vehicles allocated	60	20	20

Table 5: Fire Safety Assessments undertaken 2020/21

The associated risk assessment document is filed at station to be available should the enforcing authority and compliance auditor (Fire and Rescue Service) wish to inspect the fire safety provision in place. Copies of the assessments are shared with site managers and local estate managers where appropriate.

The HSS Practitioner determined overall fire prevention is taken seriously. The issue of hand sanitiser proved to be of concern in the early stages of the pandemic (as described in the common failings below) and both associated issues were rectified quickly, eliminating the risk.

Good practice:

- All fire extinguishers checking and alarm systems testing were carried out on the correct frequency and recorded appropriately.
- Fire doors and passageways in the main were free from obstructions.

Areas for improvement:

- Fire evacuation drills were not carried out on the correct frequency.
- It was found some staff had never experienced an evacuation drill; however most staff knew how to respond in case of fire and where the assembly point was.
- On a few occasions rubbish was found to have accumulated
- April 2020 the storage of hand sanitiser which is highly flammable was not appropriate with more than 50 litres stored inappropriately.
- Staff were also decanting from 5 litre containers into smaller bottles.

Three Fire related incidents were reported in 2020/21

- Two toaster related fires. Corrective actions: toasters to be emptied of crumbs frequently
- One microwave incident where a burning/smouldering smell was emanating from the unit. Corrective action: Microwave disposed and replaced.

6. RIGHT CARE STRATEGY ASSURANCE

The Right Care Strategy has the following Health Safety and Security pledge:
Fundamental standards of health, safety and security are continuously improved; we will educate to ensure advanced skills to deliver safe services. Support development of local policies and practices through Health, Safety and Security Practitioners. Conduct biannual reviews of all sites and an annual snapshot of health and safety on vehicles, including log books. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

6.1 Objective 1: RIDDOR Reporting

RIDDOR incident Reports are completed **within 15 days of knowing about the incident**, via DATIX. The target for 2020/21 was to achieve **50% within 15 days.**

384 RIDDOR incidents were reported in 2020/21.The overall aggregated performance has meant 203/384 were reported within 15 days of being notified – that is a **performance of 53%,** so the target was met in year. This is a remarkable achievement given the growth in RIDDORS requiring reporting over 19/20 due to COVID19. Over 200 more RIDDORS were processed and yet this was still met.

39 incidents were reported into Datix more than 15 days after the incident occurred.

Non- COVID-19 RIDDOR incidents: 138 in 2020/21

- 59% (n=82) were reported to the HSE within 15 days.

COVID-19 related RIDDOR incidents: 246 in 2020/21

- 44% (n=108) were reported to the HSE within 15 days.

6.2 Objective 2: Handling Injuries

The original objective was to ensure the proportion of incidents reported with confirmed harm from lifting and handling to be no more than 30% of total incidents reported in year. The aggregated performance for 2020/21 for patient and staff manual handling injuries is 12.6%. As individual incident types and as an aggregate, **the target has been met in year.**

The refreshed overall objective is to develop measures to allow for the monitoring of a reduction in lifting & handling incidents across NWAS. The 2020/21 objective was to establish baseline data for lifting and handling. Table 6 below provides a comparison of harm from lifting and handling for staff and patients.

YEAR	Total Manual Handling Patient Injuries	Total Patient Injuries	Proportion of Patient Manual Handling Injuries		Total Manual Handling Staff Injuries	Total Staff Injuries	Proportion of Staff Manual Handling Injuries
18/19	75	265	28%		339	1090	31%
19/20	73	294	25%		317	1202	26%
20/21	78	339	23%		300	2670	11%

Table 6: Handling Injuries as reported into Datix 2020/21

6.3 Objective 3: Health and Safety Competency Training

An advanced training programme for managers (Band 6 and above) has been designed and translated for MS Teams platform to support the ambitious objective set in the Right Care Strategy in improving the competence of mangers in NWAS.

- 50% of 480 frontline managers (Band 6 and above) offered advanced training in Health and Safety management.

The pandemic (Q1) and REAP levels (Q4) have reduced the opportunity to conduct training sessions; however 105 managers (Band 6 and above) have received advanced Health and Safety Management training. A further 79 are due to be trained by September 2021.

6.4 Objective 4: Rapid Health and Safety Review

100% sites receiving an annual rapid review of Health and Safety as part of the scheduled Quality Assurance Visits (QAVs).

At the end of Q4 NWAS had ensured a risk assessment was in place for 143 sites (100%), with the associated action plan in place and recorded centrally. The assessments were enhanced for Covid-19 in line with the HSE working safely guidance. The assessments include a revised risk assessment (within 7 days) for those premises where a confirmed outbreak was declared.

6.5 Objective 5: Vehicle Checks

The original overall objective was to provide assurance that at least 95% of vehicles using Safe Check are completing checks on a daily basis.

The Overall objective has been refreshed to develop measures to allow for the monitoring of Safe Check compliance and the 2020/21 in year target was to develop operational definitions and measurement frequency.

Previously daily vehicle check data was manually collected by staff working alternative duties.

Many improvements have been made with the collection of the daily vehicle check data which is captured on Safe Check. Action taken to increase daily vehicle checks include:

- Actively monitoring data and promoting the importance of vehicle check compliance via the PES Health and Safety group and
- The topic is a regular agenda item on the fortnightly Operation Outstanding meeting which operational leads attend.
- Working with the Safe Check development team and Informatics team around designing a Power BI reporting dashboard for health, safety and security.

As a result of the methodology changing the baseline data moving forward is that provided in Q4. Whilst a disappointing overall result of 49.81% (table 7), the ability to capture data in a robust way allows opportunity for improvement.

Vehicle check Q4 2020/21 Safe Check	**Vehicles**	**Vehicles with greater than 75% average daily checks recorded**	**Vehicles with between 45% and 75% average daily checks recorded**	**Vehicles with less than 45% average daily checks recorded**	**Sector Compliance**
CLA East	44	9	23	12	**56.80**
CLA Fylde	28	7	16	5	**61.03**
CLA Morecambe Bay	40	17	19	4	**67.67**
CLA North	44	13	20	11	**61.33**
CLA South	35	8	20	7	**58.32**
CMA East	51	4	13	34	**36.15**
CMA North	70	1	12	57	**26.02**
CMA South	43	1	15	27	**37.37**
CMA West	38	10	21	7	**61.36**
GMA Central	57	1	24	32	**39.70**
GMA East	54	7	26	21	**50.24**
GMA South	69	23	25	21	**57.32**
GMA West	57	0	22	35	**34.23**
TOTAL	**630**	**101**	**256**	**273**	**49.81**

Table 7: Safe Check summary vehicle check Q4 2020/21

7. GUIDANCE AND ADVICE ANNUAL SUMMARY REVIEW

7.1 Health Safety and Security Toolkit

The Health, Safety and Security A-Z Toolkit represents relevant legislation and or areas of risk to NWAS. It is a 'live' toolkit and subject to regular review. Each document is subject to review and consultation before approval. In 2020/21 the following procedures and guidance have been reviewed:

- Control of Substances Hazardous to Health Procedure
- Fire Safety Procedure
- Homeworker Assessment Guidance
- Medical Gases
- Newly Expectant Employee
- Noticeboard Guidance
- Observer Procedure
- Stress Management
- Working at Height Guidance
- Workplace Inspection Guidance

7.2 Risk Assessments

There are 18 generic risk assessments that cover the main activities across NWAS service lines. In 2020/21 the following generic risk assessments have undergone consultation and review:

- Ambulance Stations and Control Rooms Risk Assessment
- British Association for Immediate Care (BASCIS) NW Risk Assessment
- Community First Responders Risk Assessment
- COVID-19 Premises Risk Assessment (developed in year)
- Transport
- Volunteer Car Drivers
- Workshops

In some cases a generic risk assessment will not suffice and therefore non-generic specific risk assessments have been completed for:

- Ambulance Equipment Risk Assessments (various)
- COVID-19 Premises Site Specific Risk Assessments
- Emergency Ambulance Vehicle Risk Assessments
- Fire Risk Assessments
- PTS Vehicle Risk Assessments
- Task/Equipment Related Risk Assessments

8. COVID-19 SAFE SYSTEMS OF WORK: HSE INVESTIGATIONS

During 2020/21 two key items of primary legislation which contain emergency powers relating to coronavirus and health protection in England emerged and these are:

- Coronavirus Act 2020

- Public Health (Control of Disease) Act 1984

The HSE provided guidance 'Making your workplace COVID-secure during the coronavirus pandemic'. The HSS team used this to develop the COVID 19 Premises risk assessment amongst other systems of safe working.

During 2020/21 NWAS has responded to a number of HSE inquiries relating to safe systems of work. The NWAS response to each has satisfied the HSE concerns.

8.1 HSE FFP3 Face FIT Testing Inquiry: Pan - NWAS

The HSE contacted NWAS on 6th May 2020 following a concern raised by a member of staff about FFP3 face FIT testing. The assurance returned to the HSE on 15th May 2020 was:

- All staff will be FIT tested for FFP3 masks by 8th June 2020
- A process to ensure staff will have additional FIT tested for FFP3 as mask stock levels and availability fluctuate is in place.
- NWAS has a system in place for auditing aerosol generating procedures (AGPs) and for reporting incidents and acting on the learning from incidents
- NWAS has robust governance, leadership and action plan to provide safe systems of work for staff requiring RPE to carry out their duties

8.1.1 FFP3 mask face fit testing for non-clinical staff

The HSS team has assumed responsibility for ensuring that appropriate FFP3 mask face fit testing, for our non-clinical staff, is in place and compliant with the Regulations.

AREA	Passed	Failed
Blackburn	6	0
Blackpool	2	1
Broughton	7	0
Bolton	2	2
Bury	11	0
Cumbria Workshops	4	2
Regional Logistic Centre (Haydock)	17	1
Wallasey	2	0
Further Testing Required		**6**

Table 8: FFP3 mask face fit testing non-clinical staff

The numbers of staff tested and those that passed or failed is as described above and plans are in place to ensure that those staff that have failed are re-tested with a positive outcome.

8.2 HSE Respiratory Protective Equipment Inquiry: Carlisle

A staff member concern was referred to the HSE regarding the FFP3 mask available for use on site were marked as expired by the manufacturer:

- 3M 1863 expiry/shelf life date 30/11/19
- 3M 1873V expiry/shelf life date 31/10/19
- 3M 8833 expiry/shelf life date 31/3/20
- Cardinal Health RFP3FV expiry/shelf life date 08/2020

This prompted an inquiry from the HSE as to the safety of staff being asked to use this equipment.

Resolution:

The inquiry was resolved through the production of evidence from Public Health England who confirmed that each manufacturer 3M and Cardinal Health had confirmed a shelf life extension for the masks following the conclusion of testing using an approved and certified methodology. The HSE was satisfied with the evidence provided.

8.3 HSE COVID 19 RIDDOR Arrangements: NCLF

Staff who may have become unwell ill due to work exposure to illness must notify the HSE known as RIDDOR reporting. The extent of COVID19 exposure by staff through the pandemic created significant demand and workload on the HSS team, and so the RIDDOR process was redesigned to meet these demands:

- Identify is and how staff may have been exposed at work
- Aligning the process to national regulatory requirements to work related occupational exposure
- Additional questions into DATIX to support and guide managers
- From wave 2 triangulating data with Test, Track and Trace process
- New data collection process PPE batch number, manufacturer and serial numbers

8.4 HSE Personal Protective Equipment (PPE) Use and Storage Inquiry: Carlisle

A staff member concern was referred to the HSE regarding the storage of PPE stock. The reporter described the stock as being exposed in a garage environment.

Resolution:

The operational management team checked the area and found the stock was:

- Located in a ventilated garage used by Patient Transport Services only at the start and finish of the working day.
- Stored on pallets or within metal cages, or boxed within boxes and sealed and not affected by water ingress
- Baited traps on site as preventative measure – no current pest issues.
- In addition the stock was moved whilst a permanent, secure and specifically designed storage room was built in the garage area.

The HSE was satisfied with the evidence provided.

8.5 HSE Ventilator Product Inquiry: Liverpool

The HSE were notified of concerns regarding how the recording of checks and cleaning of respiratory Protective Equipment (RPE) was done, the cleaning regime, practical training,

quarantining of shared equipment, frequency of filter changes and assurance the filter types are suitable for medical use.

Resolution:

The inquiry was resolved by confirming:

- Records of cleaning checks are collected electronically through the use of Safe Check. Staff members are trained to include motor units are part of the vehicle checks and are cleaned at the beginning of shifts and decontaminated after use. In practice the units are cleaned after every patient contact in readiness for the next allocated response.
- A five day quarantine measure was established where units were used by more than one person and this was in place until each staff member could be allocated a personal issued hood. NWAS holds spare hoods if damages occur.
- The motor filters are suitable for medical provision as confirmed by Sundstrom and have extended expiry dates of 5 – 10 years. The expiry date forms part of the user checks (supported by a standard operating procedure).
- A competency check-list provides users with practical guidance for donning and doffing the hood and fan unit. Results are recorded through the workforce management system and a copy of the checklist was shared with the HSE.

The HSE was satisfied with the evidence provided.

8.6 HSE Spot Checks: Pan - NWAS

The HSE conducted a number of COVID secure spot checks on NWAS premises during the year. The HSE was satisfied on all occasions.

8.7 HSE External Review: HSS Practices

An independent review of HSS systems and processes was commissioned. The objective was to provide additional assurance to the NWAS Board that systems and processes comply with the Health and Safety at Work Act 1974. The assessment highlighted areas of good practice and recommended some areas of focus; and these recommendations form the local objectives for the year ahead, see annex 1 HSS Forward plan 2021/22.

9. DIRECTION FOR 2021/22

It cannot be understated what turbulence the Covid 19 pandemic has had upon all areas of our lives and the HSS team have been in the spotlight for most part. A strong team of experienced practitioners, they have responded to numerous day to day queries; been responsive and authoritative in offering guidance, advice and importantly assurance; whilst being providing the basic regulatory compliance assurances required in non-pandemic times.

In summary the team has:

- Reviewed and redesigned the RIDDOR review practice at the height of the pandemic creating a process which is robust and responsive.
- Developed and established the Covid 19 site assessment process which ensured all sites within NWAS are ‘Covid 19 safe’ places to work.

- Responded quickly and with appropriate evidence to the HSE inquiries whilst performing their general regulatory compliance.

The HSS team are committed to approaching 2021/22 with a renewed vigour and are seeking to embrace new challenges on improving assurance in the year ahead. There have been a number of developments for individuals within the HSS team including:

- The appointment of the Health Safety and Security Manager to Chair the National Ambulance Risk and Safety Forum. This provides NWAS with the opportunity to lead, set, promote and learn from others across the country about improving the industry response to safety at work; and
- The Head of Quality Compliance and Assurance, recruitment to an HSE panel which is a joint workshop with the Thomas Ashton institute from Manchester Business School at the university. The panel comprises 45 individuals from various organisations across the public and private sectors and aims to bring together cross-sector experiences, challenges and examples of best practice in addressing third party violence and aggression in the workplace.

9.1 Forward Plan: Regulatory Compliance

NWAS reiterates it will maintain its regulatory duty in maintain staff wellbeing and safety by ensuring the regulatory reporting and monitoring requirement of RIDDOR, Non-clinical incident reporting, violence and aggression and CAS alerts are met. Over the next 12 months the focus from the team will be to identify and promote learning and therefore improvement from these areas pan-NWAS.

9.2 Forward Plan: Right Care Strategy Objectives

It is the intention to review the objectives and set compliance targets as can be seen in the forward plan attached at annex 1. The objectives have been designed to support the mandatory health and safety regulatory compliance requirements for NWAS ensuring staff and patients are at reduced risk of harm. The team will use rigorous improvement approaches to support sustained actions within operational teams across the actions.

9.3 Forward Plan: Health, Safety and Security Team Activity

The HSS team new and progressive activities for 2021/22 will include:

- improving competence as evidence handlers for digital recording systems
- finalising the violence and aggression policy, meeting the new NHS security standard
- exploring the opportunity to enhance staff safety culture in the NHS alongside a strong patient safety culture
- developing new ways of working as Safecheck continues to develop
- Participate in the MIAA review of the HSS RIDDOR processes
- Improve on the areas of focus identified through the HSE review
- Continue to move towards the goals set within the Right Care strategy and the pillars of quality goals.

This page is intentionally left blank

NWAS HSS Forward Plan: 2021/22

REGULATORY COMPLIANCE: HEALTH AND SAFETY EXECUTIVE			
Simple Description	**Detailed Description**	**Frequency/ Due Date**	**Priority Level**
RIDDOR Reporting	Timely reporting of RIDDORs following notification remains the responsibility of the HSS team. Board of Directors will receive assurance update.	**Bi-Monthly**	**1**
Non-Clinical Incident Reporting	Reported into Datix and reported to the HSS Sub Committee	**Quarterly**	**1**
Violence and Aggression	Reported into Datix and received by the HSS Sub Committee	**Quarterly**	**1**
	Review Violence and Aggression Policy (new policy short time line review)	**Q4 2021/22**	
	Digital Evidence Handling: Train HSS staff and have supporting SOPs in place	**Q1 2021/22**	
HSS Training Programme	Training dates scheduled throughout the year for: • Induction of new staff • HSS Competency Training programme	**31 March 2022**	**1**
MHRA CAS	Update and monitor CAS on behalf of the Trust ensuring throughout the year pertinent alerts are acknowledged within the alert timeframe and holding responsible parties to account for review, assessment and if appropriate action.	**As informed**	**1**
	Report actionable alerts to the relevant committees	**At least twice a year**	
Fire Safety Assessments	Undertake the FSA at sites in accordance to the schedule: • 18 annual assessments • 2 year assessments (n= xxx) • 3 year assessments (n= xxx)	**31 March 2022**	**1**
	Undertake FSA at sites where • Significant changes to the site have taken place • Fire incident has occurred at site	**Within 1 month of incident**	

Key: Priority Level 1: Regulatory Requirement ***Priority Level 2: Trust Priority***

NWAS HSS Forward Plan: 2021/22

RIGHT CARE (QUALITY) STRATEGY ASSURANCE			
Simple Description	**Detailed Description**	**Frequency/ Due Date**	**Priority Level**
RIDDOR Reporting	Using improvement methodology ensure 70% RIDDOR incident Reports are completed within 15 days of knowing about the incident, via DATIX	**31 March 2022**	**2**
Manual Handling Injuries	Using the baseline identified in 2020/21 develop a methodology to robustly test data collection and monitoring processes (2 cycles of PDSA min)	**31 March 2022**	**2**
HSS Competency Training	Schedule and hold (virtual) advanced HSS training for Band 6 managers and above ensuring 50% of the cohort have received the offer to attend.	**31 March 2022**	**2**
Rapid HSS Site Review	Schedule and undertake at least one rapid HSS site review and improvement plan set for each NWAS site	**31 March 2022**	**2**
Monitoring Compliance	Using improvement methodology develop data collection, monitoring and dissemination processes (2 cycles of PDSA min) and report compliance	**At least twice a year**	**2**

HEALTH, SAFETY AND SECURITY TEAM ACTIVITY			
Simple Description	**Detailed Description**	**Frequency/ Due Date**	**Priority Level**
Independent HSS Review	Develop Incident Investigation and Risk Management Procedural Framework	**TBC**	**2**
	HSS Team role and function review	**Q3 2021/22**	
Digital Evidence	Develop and test the 'Evidence Handler' standard operating procedures for digital recording systems such as the body worn cameras	**Q2 2021/22**	**2**
Security	Review, assess and develop appropriate response to the NHSEI Security Standards	**Q2 2021/22**	**2**
	In-house 'Security' training programme for all members of the HSS team	**Q2 2021/22**	
	Develop new security questions for the QAVs/ Safe Check	**Q3 2021/22**	
Violence and Aggression	Finalise the Violence and Aggression policy and ensure FAQs are available on the Green Room	**Q3 2021/22**	**2**
Safety Culture	Explore the opportunity for zero RIDDOR events safety culture as in industry upon the NHS.	**31 March 2022**	**2**

Key: Priority Level 1: Regulatory Requirement ***Priority Level 2: Trust Priority***

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th July 2021			
SUBJECT:	Infection Prevention and Control Board Assurance Framework - Update			
PRESENTED BY:	Executive Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	NWAS IPC Board Assurance Framework (BAF) provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of COVID – 19 transmissions to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry, each with a series of questions which need to be addressed. The IPC BAF and accompanying action plan were last presented at Board of Directors in January 2021. The action plan, includes cross cutting actions for the whole trust and is monitored by the IPC team and reported via the newly formed IPC Sub Committee. Since January the IPC action plan has been reviewed at the following: 1. IPC Sub Committee 2. RPE Steering group (relevant parts) On presentation of the IPC BAF to Trust Board in September 2020 it was agreed that the IPC actions and risks should be presented to the Executive Leadership Committee (ELC) who provide assurance to the Board of Directors. This report provides the Board of Directors with a brief update on achievements and risks against the 10 KLOEs for the reporting period January– June 2021.			
RECOMMENDATION:	Board of Directors receive assurance that: 1. IPC risks are being adequately identified against key lines of enquiry. 2. IPC risks have been reviewed. 3. IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality: Equality Impact assessments have been completed for relevant issues	☒	Sustainability	☐

	including a review of the EQI for FFP3 face fit testing.			
PREVIOUSLY CONSIDERED BY:				
	Date:	N/A		
	Outcome:	N/A		

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

1.1 The purpose of this report is to update the Board of Directors with the current position as measured against the Infection Prevention and Control Board Assurance Framework (BAF) and to evidence the key controls which are in place to satisfy the 10 key lines of enquiry (KLOEs) which form the BAF.

2. BACKGROUND

2.1 The BAF was developed by NHSE/I to support providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance. The framework is used to identify gaps in assurance risks and evidence the corrective actions applied.

2.2 During 20/21, the trust enhanced and established many new processes and systems for IPC these were based on the development of the IPC board assurance framework focussing attention of the following 10 key lines of enquiry;

IPC BAF KLOEs	
1.	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7.	Provide or secure adequate isolation facilities
8.	Secure adequate access to laboratory support as appropriate
9.	Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections
10.	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.3 For each KLOE there is a requirement to provide evidence, identify any gaps in assurance and provide a high level overview of mitigating actions. This report provides an update against the achievements made and risk status against the initial 10 KLOEs.

2.4 The framework was initially presented and approved by the Trust Board on the 30th September 2020 with a quarterly update approved 18th January 2021. NHS E/I last published a revised version of the framework in 2020, however in July 2021 a new updated version of the IPC BAF has been issued and is being reviewed and incorporated into the IPC BAF.

2.5 The IPC BAF has been reviewed, evidenced and updated regularly. The documents used to monitor and document progress against the BAF include the Risk Register and the IPC Sub-Committee Action Log. These documents are appended and a summary of the key issues is provided in 3. Assurance.

3. ASSURANCE

3.1 **Risk Register**

There are currently 15 active risks that fall within the IPC remit. This includes risks attached to the Test, Track and Trace Team as this team sits within the IPC team. Of those 15 IPC risks, ***3*** have been assigned a rating of 12 or more.

Closed risks

Risk 3385 This centred on the resource to produce daily test, track and trace reports when managing absence and was closed on 30/06/2021.

Improved risks

At the time of writing this report and since the previous cyclical risk review, the risk register identified 9 risks as improving with a reduced risk rating. This includes 6 formerly 12+ risks as being re-categorised below 12, and 3 which were already rated below 12 which have improved further. This is due to more robust controls being in place to increase the assurance.

Risk 2715 (12 to 8) There is a risk that Infection, Prevention and Control Policy and Procedures surrounding Personal Protective Equipment are not followed leading to increased risk of splash injuries which could result in increased exposure to infection.

Comment

A series of key controls were implemented including IPC policies and processes, availability of PPE, training, and organisation-wide communications. Requisite monitoring evidences the effectiveness of these mechanisms, which are subject to ongoing review and sector quality visits.

Risk 3277 (20 to 8) There is a risk that operational staff may not have been face fit tested for FFP3 masks due to the lack of testing during the COVID-19 outbreak which may impact on our compliance with Health and Safety legislative requirements.

Comment

A series of key controls were implemented including revised IPC policy and procedures, updated Covid-19 PPE guidance, training, observational audits, identification of operational leads for FIT training, improved systems to report outcomes and incidents.

A FIT testing compliance report was produced for the IPC Sub-Committee on 14/06/2021. This evidenced that since April 2020 the Trust focussed efforts in ensuring almost 4,500 colleagues were FIT tested. As of 25/05/2021 just over 3,400 staff were FIT tested, with a further 564 tested and failed, and a further 525 yet to undergo testing.

Risk 3305 (12 to 9) There is a risk that the British Safety Industry Federation (BSIF) formal accreditation scheme is not utilised because of the competing timescales around fit testing across the organisation which may impact on regulatory compliance

Comment

Fit testing data is reported to Executive Leadership Committee (ELC), local data is reported via Strategic Governance Committee (SGC).

Risk 3306 (12 to 9) T

There is a risk that the Trust is unable to demonstrate quality assurance evidence for the fit testing process due to the programme pace. This may lead to an inability to evidence that the training meets the regulatory standards for fit testing.

Comment

Fit testing oversight is provided by Head of Service for each area. In addition, Trust monitoring and reporting of fit test figures is via the Respiratory Protective Equipment Steering Group, IPC cell and onward to ELC via the Director of quality, innovation and improvement weekly update.

Risk 3355 (16 to 8) There is a risk that due to the number of covid positive staff at sites across the trust clusters and outbreaks will occur at more sites which may lead to a shortage of operational resources across the Trust.

Comment
A series of key controls were implemented including accessing various platforms to disseminate new, updated and current guidance organisation-wide, revised IPC policies and procedures, availability of PPE, review of Test, Track and Trace internal reporting to increase integrity of data around clusters and outbreaks. This also supports opportunities around resilience planning.

We have recently witnessed an increase in clusters and saw two outbreaks declared at Estuary Point and Fazakerley Station. As part of our heightened IPC response practitioners were deployed to undertake audits and provide support to those outbreak sites. In addition, bulletins focusing on site-specific challenges have been issued and the situation continues to be monitored.

Risk 3381 (12 to 6) There is a risk that there is a lack of long term resilience with the Test, track and trace process due to the initial pragmatic use of the Marvel system to collect COVID19 absence data which is not fit for purpose and long term use due to a number of information governance concerns identified through a short DPIA. This may result in the Trust not being to collect ongoing Test Track and Trace data.

Comment
A series of key controls were implemented including investigation around the viability of other systems, reviewing Marvel risks to identify other areas of mitigation, introduction of a Data Protection Impact Assessment (DPIA) which is reviewed quarterly, increased collaboration between IT and IMT.

Current 12+ scored risks
The narrative below provides an overview of each risk rated **12+** (identified by risk number and rating), and the associated controls (identifies number of controls in place and a summary of main ones).

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

Comment
A series of key controls were implemented including revised Trust-wide and IPC policies and procedures, training, audits, Consultant Paramedic IPC leads identified, increased support from practitioners, sector quality visits incorporating IPC. Action cards were developed for crews managing infectious patients within vehicles and to support ventilation within vehicles. An IPC Specialist Role has been developed in the Quality Directorate. This has gone to advert and has been appointed to in July.

Gaps in assurance
- Evidence of audit improvements at local level. *This requires review by Operational Managers and at a local level.*
- More audits are required to ascertain correct compliance figures.
- Reporting structures not well established, resulting in infrequent reporting. *A new process is being established around self-serve reports for Operations.*
- Irregular updates from the consultant paramedics

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

Comment
A series of key controls were implemented including review of the RPE Equipment Cell to focus on delivering a programme of training across 2021, agreement on a schedule for joint IPC and H&S audits for 2021/22, FIT testing which is well underway and mentioned in 3277 above, AGP audits and risk assessments. All training materials for staff and volunteers have been reviewed and a 'fit testing' train the trainer programme has been developed.

Gaps in assurance
- System and Process Audit by independent body.

Risk 3517 (12) There is a risk that some staff are not wearing masks at sites and now compliance rates are decreasing leading to a potential of cross transmission of covid 19 from staff to staff which may result in staff absence.

Comment
A series of key controls were implemented including increased accessibility to PPE, improved working from home arrangements, increased virtual meetings, localised audits in EOC and contact centres, risk assessment follow-up at outbreak sites. The development and updating of the Escalation Policy approved by ELC in May 2021.

National guidance and local operating processes disseminated regularly to staff via bulletins, social media, internal intranet and the IPC cell.

Gaps in assurance
- Gaps in consistent communication with Heads of Services to assure key messages are delivered trust wide

3.2 **IPC Sub-Committee Action Tracker**

The IPC Sub-Committee action tracker reflects the operational detail linked to risks on the risk register. The closing of such actions therefore increases the assurance around its associated risk.

Since the last report, 16 actions have been closed on the action tracker. These include development of the IPC Sub-Committee Terms of Reference (ToR), appropriately representative membership, BAF action plan cyclical meetings scheduled.

Open actions are currently being reviewed to ensure RAG ratings and due dates reflect the integrity of the action.

3.3 **Context and Other Considerations**

We are on the cusp of a critical phase in our new Covid world following a protracted period having experienced 17 months of national restrictions. With such restrictions being lifted or reduced from 19/07/2021, consideration needs to be given to the following:

1. The impact on staff sickness/ organisation resilience with any increase in community transmission.
2. The increased challenges around implementing and monitoring adherence to IPC guidance in the workplace, most particularly when it conflicts with what is happening in the community.
3. As a direct consequence of 1 and 2, the potential increased workload for TTT and IPC colleagues, the impact on team resilience and team morale.
4. IPC Bulletins - During the initial stages of the pandemic there was a high volume of bulletins produced as the national guidance was changed regularly as more research and information was gathered about the virus. The number of bulletins has decreased during the first 6 months of this year as the situation has remained constant and the IPC Covid guidance has now become embedded into everyday practice for all staff, visitors and patients.

Below is a list of the bulletins that have been produced over the six months period;

- CV183- Guidance for ambulance services- Updated 21 January 2021
- CV190- Guidance for managers- mask wearing during COVID-19
- CV192- COVID-19 Outbreak and cluster management: important updates
- CV195 - Reminder of changes to Level 2 PPE
- CI860- disinfectant wipes for use on medical devices
- CV202- COVID-19- Working safely in non-clinical areas
- CV204 – Indian Variant and continuing IPC measures
- Amended - CV204 – Indian Variant and continuing IPC measures
- CV205 – Travelling abroad and quarantine arrangements during COVID-19 pandemic – updated advice
- CV201- Digitisation of LAMP testing
- CV208 – Personal Protective equipment and heat: risk of heat stress awareness
- CV210 – Estuary Point – Covid-19 Cluster Notification
- CV211- Important changes to our lateral flow testing
- CV212- PPE update- protecting ourselves and others
- CI843- Clinical and sharps waste
- CI860- Medical wipes for use on medical devices.

There has also been an IPC COVID Lessons Learnt Bulletin produced in May 2021

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

4.1 The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The framework has been structured around the existing 10 criteria set out in Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

4.2 The Health and Safety at Work Act 1974 places wide-ranging duties on NWAS, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

4.3 The management of the IPC Board Assurance Framework and action plan is the responsibility of the Director of Infection Prevention and Control (DIPC) and monitored through the following groups and committees:

- Infection Prevention and Control Sub Committee (Bi-Monthly)
- Quality and Performance Committee Bi- annually

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

5.1 Equality Impact assessments have been completed for relevant issues including a review of the EQI for FFP3 face fit testing.

6. RECOMMENDATIONS

6.1 Board of Directors receive assurance that:

- IPC risks are being adequately identified against key lines of enquiry.
- IPC risks have been reviewed.
- IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance.

Appendix 1.

IPC BAF KLOE	Questions	Risks Q3 (12 or above)	BRAGG
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users		2716 - Insufficient IPC audits and support – (12)	

KLOE 1: Q4 Achievements

- IPC guidance re-issued for adherence to national guidance, social distancing and the use of facemasks.
- Outbreak Escalation Policy reviewed and approved by ELC May 2021
- 256 IPC Tier 3 audits conducted at call centres and stations between January and June 2021.
- 3.0 WTE IPC practitioners working across ICS areas
- 2.0 WTE IPC specialist practitioners (agency) supported Trust till end of March 2021.
- 1:0 WTE IPC Specialist permanent post (8b) funding agreed and went to advert June 2021.
- IPC Practitioners have passed IPC Specialist Training Modules at Degree Level.
- External assurance peer review visits conducted by NW regional IPC specialists in January 2021.
- Risk assessment process standardised and fully implemented in all stations, offices and control centres
- Risk assessments reviewed after any outbreak and every 90 days.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections		2715 - Non-adherence to IPC Practices (8)	

KLOE 2: Q4 Achievements

- Internal study and evaluation of Ambulance Cleanliness and services commissioned by NWAS to seek outstanding vehicle cleanliness in progress.
- Continued review of cleaning to support outbreak management

- Competed review of organisational cleaning allocations
- Audit schedule revised and implemented

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance		No risks identified	

KLOE 3: Q4 Achievements

- N/A

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion		2715 - non-adherence to IPC practice (8)	

KLOE 4: Q4 Achievements

- Hospital handover guidance for staff with new action cards development has seen improvement.
- Continued liaison with hospitals on delays
- Robust IRF process in place with regular monitoring
- Updated national guidance disseminated to staff
- Reviewed training materials for staff and volunteers
- Porta count Train The Trainer Sessions implemented

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people		2715 non-adherence to IPC practice (8)	

KLOE 5: Q4 Achievements

- TTT service fully operational, however staff return to normal duties, DIPC and Head of Clinical Safety reviewing the internal resilience of the TTT service.
- Agile Working Group in place to look at improve transformation of corporate space
- All patients provided with appropriate masks

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection		3243 - lack of social distancing (12) 2716 - lack of audits and IPC support (12) 3326 - Workforce exposure to Covid (15)	

KLOE 6: Q4 Achievements

- Updated guidance regularly published on greenroom.
- Bulletins issues:
- CV183- Guidance for ambulance services- Updated 21 January 2021
- CV190- Guidance for managers- mask wearing during COVID-19
- CV192- COVID-19 Outbreak and cluster management: important updates
- CV195 - Reminder of changes to Level 2 PPE
- CI860- disinfectant wipes for use on medical devices
- CV202- COVID-19- Working safely in non-clinical areas
- CV204 – Indian Variant and continuing IPC measures
- Amended - CV204 – Indian Variant and continuing IPC measures
- CV205 – Travelling abroad and quarantine arrangements during COVID-19 pandemic – updated advice
- CV201- Digitisation of LAMP testing
- CV208 – Personal Protective equipment and heat: risk of heat stress awareness
- CV210 – Estuary Point – Covid-19 Cluster Notification
- CV211- Important changes to our lateral flow testing
- CV212- PPE update- protecting ourselves and others
- CI843- Clinical and sharps waste
- CI860- Medical wipes for use on medical devices
- LAMP testing introduced and mobile phone app to aide easier recording of sample and results.
- Lateral Flow Testing continues and moved to the government scheme to improve access for staff
- Lessons learnt- May 2021

7. Provide or secure adequate isolation facilities			
KLOE 7: Q4 Achievements • N/A			
8. Secure adequate access to laboratory support as appropriate		No risks above 12	
KLOE 8: Q4 Achievements • Asymptomatic Testing improved by the introduction of LAMP and continuation of LFT. • Safecheck logging system continues			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections		3315 - Pause of mandatory training (16) 3243 - lack of social distancing (12) 2716 - lack of audits and IPC support (12)	
KLOE 9: Q4 Achievements • Introduction of IPC Sub Committee (Parent Committee Q&P) to formalise assurance on IPC BAF, policies and Risk Management. • Updated guidance to reflect new national changes • Working safely continues with regular monitoring via IPC cell • Outbreak Escalation Policy and Management in place. • Risk Assessments in place for cluster and outbreak sites • Audits ongoing and action plans in place. • 3 IPC Practitioners in post and completed IPC Specialist Module.			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection		3342 - adherence to social distancing (12)	

		3242- risk to staff health if working safely not followed (12)	

KLOE 10: Q4 Achievements

- Alternative duties for staff as appropriate following risk assessment
- Vaccination Hub developed in January 2021
- Test, track and trace team ongoing
- LAMP testing introduced and LFT ongoing

Status:	
Work in progress	**WIP**
Completed on Time	
Completed Late	
Incomplete & Overdue	
On Current Agenda	

IPC SUB COMMITTEE - ACTION LOG

Ref	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Status/Outcome	Status
AT/21/27	11/05/21	IPC/21/33	IPC Subcommittee TOR - membership	MP to update LY in regards to members attending 5 out of 6 subcommittees per year.	LY/MP	25-May-21	29.6.21 - remain on action tracker until discussed at Exec. level.	
AT/21/28	29/06/21	IPC/21/42	Items of urgent business	Include locker provision & washing machine provision on the IPC BAF	LY/DS	14-Sep-21		
AT/21/29	29/06/21	IPC/21/45	IPC Verbal Updates	To follow up updates from EOC and PES.	LY/DS	14-Sep-21		
AT/21/31	29/06/21	IPC/21/45	IPC Verbal Updates	IPC Risks specific to smaller stations to be included in IPC BAF.	LY/DS	14-Sep-21		
AT/21/32	29/06/21	IPC/21/46	IPC BAF	Red rated RAG items on the IPC BAF to be discussed with risk owners.	LY/DS	14-Sep-21		
AT/21/33	29/06/21	IPC/21/47	IPC Training Requirements	Collate feedback for discussion at the next subcommittee meeting.	Clinical Leads	14-Sep-21		
AT/21/34	29/06/21	IPC/21/49	Sub Committee Work Programme	Work Plan items to include any lateral issues following discussion with MP.	LY/DS	14-Sep-21		

This page is intentionally left blank

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

QUALITY AND PERFORMANCE CHAIRS ASSURANCE REPORT			
Date of Meeting:	24th May 2021	**Chair:**	Prof Alison Chambers, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Dr C Grant, Prof M Power, Mr G Blezard
Members Present:	Prof A Esmail Dr D Hanley Prof R Thomson Mr G Blezard Prof M Power Ms A Wetton Dr C Grant Ms L Ward (part)	**Key Members Not Present:**	None

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04
☒	☐	☒	☐

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

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

Patient Story	• Received a patient story by the Senior Clinical Lead for EOC and the Advanced Nurse Practitioner. • Reported the outcome and learning from a serious case review, of a patient death by suicide, in December 2020. • Despite areas of learning from the incident, an audit of the category of the call revealed correct call coding by EOC. • Improvement to collaborative working with multi-agencies was recognised and a task and finish group established. • Excellent patient story with significant learning opportunities. • Recommended holding a central record of patient stories and sharing the patient story at Trust Board.	• Noted the assurances provided. • Recommend the Patient Story is shared at future Board of Directors meeting.	
Revised Terms of Reference	• Agreed the revised terms of reference following a change to Non-Executive director membership approved at Board of Directors meeting on 28th April 2021.	• Approved the revised Quality & Performance Committee Terms of Reference	

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

Board Assurance Framework (BAF)	• Received the Opening Position of the BAF Strategic Risks for Q1, 2021/22. • Further commentary and gaps in control with mitigations would be populated for the next meeting. • Noted the revised BAF report and the focus on assurances through sub committees with high level scrutiny of assurances at parent committees.	• Noted the assurance provided.	
Integrated Performance Report (IPR)	• For period April 2021, 999 had been challenged due to the easing of lockdown measures. • Call pick up performance 96.7% with call pick up in 5 seconds. • 111 noted a significant rise in activity in relation to the Covid-19 vaccination. • Reported a change in call volume trends from weekends to weekday pressures and peaks in calls at 9.00am, attributed to patients unable to obtain GP appointments. • Overall KPI performance continued to be challenging with time taken for a call back at 10mins. • The increase in demand had impacted on the size of the clinical advice queue. • Noted that safety measures had been put in place to mitigate risks.	• Noted the pressures on operational performance, particularly the 111 service.	

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

EPRR Sub Committee Chairs Assurance Report and NWAS Debrief Policy	• Noted the first meeting to consider terms of reference and work plan for 2021/22. • Agreed to widen the scope of the meeting. • EPPR actions were still being established pending outcomes of the MEN Enquiry. • Commander training competency framework being developed. • Ongoing quarterly reports to be presented to the Committee and an annual assurance report received by the Committee for onward approval to the Board of Directors.	• Noted the assurance provided.	
CQC Regulation Update	• Enquiries by CQC related to outstanding HR cases reported. • The Trust's response included the immediate action identified and timescales. • Commitment to close outstanding cases or have held hearings by June 2021. • Executive Leadership Committee monitoring progress of immediate actions set. • Noted the launch of the Trust's Treat Me Right Campaign and organisational values and work to promote early routes to resolution rather than use of formal processes. • An engagement meeting with CQC had been held between Executive Directors and the Trust's CQC relationship manager.	• Noted the assurance provided.	

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

Right Care Strategy Q4 Update	• Reported the Strategy was in its penultimate year with consultation on the strategy due to commence in 2021/22. • The Committee would be invited to contribute to the process, with an away day to identify key points and overarching objectives. • Timeline for consultation to be submitted to the next Committee meeting. • Assurance ratings for outstanding actions noted in relation to closing level 4-5 complaints, expired medicine pouches and completion of daily PES vehicle checks. • Noted the development of a mental health dashboard to facilitate conversations with commissioners and encourage co-production of the dashboard with a focus on priorities for multi-agency working.	• Noted the assurance provided.	
Quality Account 2020/21 arrangements	• Acknowledged the Trust had received the timeline for the publish of their Quality Accounts as per the Department of Health and Social Care (DHSC) NHS Regulations for which the Trust was required to produce Quality Accounts, on an annual basis. • Deadline noted as 30th June 2021. • The Quality Accounts would be shared with stakeholders and presented to Board of Directors for approval on 30th June 2021.	• Noted the timeline for the Quality Accounts 2020/21. • Recommended approval by the Board of Directors.	

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

Safeguarding Annual Report 2020/21	• Reported that safeguarding reporting had continued through the pandemic pressures in 2020/21. • A deep dive into under reporting in PTS had been undertaken with management training and an improved trajectory noted. • MIAA audit provided substantial assurance of safeguarding function in January 2021. • Welcomed the quality outcomes included within the annual report.	• Noted the assurance provided. • Recommended approval by the Board of Directors	
Complaints Update and Annual Report 2020/21.	• Received the Trust's annual complaint statistics and key highlights during 2020/21. • The Trust had received 112 complaints per month compared to 168 complaints per month during 2019/20. • The Complaints backlog was actively being managed and reduced with the aim to return to business as usual by the end of quarter 1 with a focus on closure of level 4-5 complaints. • The Annual Report included lessons learnt during the year and the system improvements made during 2020/21. • Noted that complaints during 2021/22 would be monitored by Patient Safety Sub Committee and reported quarterly to the Committee.	• Noted the assurance provided. • Recommended approval by the Board of Directors.	

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

ROSE Annual Report 2020/21	• Received the annual performance of ROSE from 1st April to 31st March 2021. • 457 cases had been considered with 50 cases deemed to reach the threshold for reporting as a serious incident. An increase on 47 cases in 2019/20. • Discussed the high amount of cases in Greater Manchester due to the higher volume of calls and location of the specialist hub. • Noted the higher volume of ROSE cases was indicative of the high demand in service during 2020/21. • Advised that ROSE meetings held weekly and chaired by the Medical Director of Chief Consultant Paramedic. • Key themes through ROSE included incorrect coding of calls and or a missed opportunity to deploy the relevant resource. • The report included remedial action taken as a result of reviews. • Discussed risks associated with long waits in the call stack. Noted that C2 stack contained higher risk and continued to be a priority during peaks of high demand.	• Noted the assurance provided.	
Medicines Management Annual Report 2020/21 - including the Controlled Drugs Annual Report	• Noted the key achievements of the Medicines Management Team who continued to deliver against the agreed	• Noted the assurance provided.	

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

	Medicines Optimisation Strategy during the pandemic. • Acknowledged the response to the urgent need to change Controlled Drug supplier and driven the change of the Covid-19 vaccination strategy across the Trust. • Three out of the four goals for medicines in the Right Care Strategy had been achieved with the exception of the goal to reduce the number of medicine pouches with expired drugs in circulation 1 week beyond their expiry date, to less than 1%. • The work undertaken was noted and risks mitigated. Highlighted that expired drugs did not include controlled drugs. • Acknowledged the significant work undertaken by the team and recent additional staffing resource in the team.		
Q4 Clinical Audit Progress Report 2020/21	• Reported that AQI submission had been made on time and in full with AGP audit data showing an overall compliance of 94% from June 2020 to 31st March 2021. • Noted that the Safer Care Closer to Home Audit had restarted following a break in collection during Covid-19 pressures. • Acknowledged that the Clinical Audit dashboard would be developed to support hospital collaboration projects over the	• Noted the assurance provided.	

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

	next 12 months, with support from the Trust's improvement team. • Implementation of the Apex audit tool had been delayed but prioritised with information governance colleagues to complete the roll out of EPR and the audit resource. • Noted that the Audit Committee received and scrutinised Clinical Audit Progress reports.		
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Noted the assurances related to risk documentation, recent clinical leadership recruitment in 111 and action take to speed up implementation of the Apex audit tool.	• Noted the assurance provided.	
Patient Safety Sub Committee Chairs Assurance Report	• Noted that the terms of reference and work plans had been considered by the wider team and required further amendment for presentation at next Committee meeting.	• Noted the assurance provided.	
Health, Safety and Security Sub Committee Chairs Assurance Report	• Noted that the terms of reference and work plans had been considered by the wider team and required further amendment for presentation at next Committee meeting.	• Noted the assurance provided.	
IPC Security Sub Committee Chairs Assurance Report	• Noted that the terms of reference and work plans had been considered by the wider team and required further amendment for presentation at next Committee meeting.	• Noted the assurance provided.	

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

Non-Clinical Learning Forum Sub Committee Chairs Assurance Report	• The revised terms of reference were approved. • Noted the annual lessons learnt newsletter was in progress and work plan discussed.	• Noted the assurance provided.	
Diversity & Inclusion Sub Committee Chairs Assurance Report	• Received the first report from the Trust's D&I sub committee, chaired by Deputy CEO. • EDI action plans in progress with future attendance extended. • Good level of discussion and engagement with future recommendations and progress reported quarterly to the Quality and Performance Committee and Resources Committee.	• Noted the assurance provided.	

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

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	23rd July 2021	**Chair:**	Mr Richard Groome
Quorate:	Yes	**Executive Lead:**	Ms C Wood
Members Present:	Mr R Groome (Chair) Dr D Hanley Mr D Rawsthorn Prof M Power Mr S Desai Ms C Wood Mr G Blezard Ms L McConnell, Deputy Director of People	**Key Members Not Present:**	Ms G Singh Ms L Ward

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04
☐	☒	☐	☒

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

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

Board Assurance Framework	• The Q1 position of the BAF included commentary for June and July 2021 provided by the Executive Leads for BAF risks SR02, SR04 and included risks pertaining to SR01 which related to resource. • Noted the actions taken in relation to SR02 and including risks associated to value for money for which assurance was endorsed by a recent MIAA Audit report that provided substantial assurance. • Risk 3459 related to operational pressures was acknowledged and reported that the BAF presented the position at June 2021. Discussion highlighted the risk would increase due to pressures and would be reflected in the next BAF report. • Noted updates to SR04 also covered in the Key workforce indicators report. • Assurances from the sub committees provided robust operational scrutiny.	• Noted and received assurance from the report.	
Digital Strategy Update	• The report presented the overarching measures set within the Digital Strategy and described work undertaken.	• Noted and received moderate assurance from the update.	

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

	• Noted the EPR Business Case Phase would be finalised for presentation to the Resources Committee and Board in September. • Recognised the outstanding incomplete maintenance work required at 111 in Broughton and Parkway which had been delayed. Acknowledged the operational pressures however members requested a date for the work to be scheduled and reported to the next meeting to ensure work was scheduled to be undertaken. • Discussed cyber security and the Trust's management of risks and mitigations via the Information Management Group chaired by the Director of Quality, Innovation and Improvement. Noted a dedicated full time resource to cyber security which involved comprehensive reports to the group to provide continual surveillance. • The DSPT was noted as the key tool for assessing the Trust's position in relation to cyber security and a recent		

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

	MIAA audit had provided strong assurance that the Trust were in a good position. • The challenges related to patching of critical systems was discussed and recognised the high risk related to downtime associated to the current operational pressures.		
Digital Strategy Summary Report 2019/20 and 2020/21	• Received an update on the Trust's Digital Strategy, which had been published in May 2019 and a refresh approved in March 2021. • Noted the first two years of the strategy had focused on securing digital infrastructure; responding in addition to Covid-19 requirements many of which had expedited areas of the strategy; collaboration with staff to respond to needs and solve problems; creating an environment for rapid implementation of digital solutions. • Acknowledged that the overarching digital Board Assurance Framework risk had reduced from 20 to 12 throughout the reporting period. • Noted that the report was not a regulatory requirement but was good	• Noted and received assurance from the report.	

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

	practice and would be shared on the Trust's public website.		
Financial Performance Month 3	• Received the financial performance of the Trust for the three months to 30 June 2021. • Noted the position for the Trust to 30 June 2021 is a surplus of £0.280m, with a year to date variance of £0.284m underspend, of which income is under recovered by £0.176m. Noted that pay is underspent by £0.314m and non-pay underspent by £0.146m. • Acknowledged that the final H1 (April-September) financial plan approved by the Board of Directors in May, and submitted within Lancashire and South Cumbria (L&SC ICS) return to NHSE/I on 6 May 2021 included an efficiency and productivity target of £3.620m. • In June the Executive Leadership Committee approved non-recurrent efficiency and productivity schemes of £2.877m leaving a shortfall of £0.743m which was still to be identified and managed within the H1 financial period.	• Noted and received assurance from the finance report for Month 3 2021/22.	

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

	• Noted that at 30 June 2021 the cash and cash equivalents balance was £55.507m and the Trust achieved the Better Payment Practice Code targets to June 2021.		
Agency Expenditure Update	• The agency expenditure update provided detail of the level of agency expenditure across the Trust up to end of June 2021 and since the last report in November 2020. • Reported that since the suspension of the NHS operational planning and contracting process and revised financial regime, due to the pandemic, the Trust had received no notification of any change to its annual agency ceiling and the ceiling was assumed to remain at the historical ceiling of £3.109m (from 2019/20). • In relation to 2021/22 the actual expenditure, to the end of June 2021 (Q1) is £1.192m, which is £0.415m above the year to date ceiling. • There had been no breaches in relation to the supplier framework rules and all agency staff had been procured	• Noted and received assurance from the report.	

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

	at or below the price caps and via approved framework agreements.		
Estates, Fleet and Facilities Management Assurance Report	• Received the assurance report that identified the key work areas in the Trusts Fleet and Estates strategies. • Noted that the target of 75% completion of planned maintenance on vehicles and 100% MOT tests completed had been achieved. • Deep cleaning of patient facing vehicles had been maintained with 97.38% compliance against 90% target. • A gradual increase in reportable accidents reported following a drop during lock down and in line with restrictions being relaxed. • The highest number of accidents related to immobile property. The Trust's Head of Fleet and Logistics Chaired a recently formed local accident reduction group to discuss and identify initiatives. • Noted the age profile of PES Ambulance Fleet had been impacted by the completion of Covid-19 delayed PES replacement program in June and	• Noted and received assurance from the report.	

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

	the removal of Covid-19 retained vehicles. Noted that 11% of the fleet was over 7 years old and a 12% decrease on the previous reporting period. • The Trust's Sustainability Steering Group (SSG) with progressing towards the previous targets set within the SDAT model until such time of the new model release.		
Contract Award - Staff Benefits - Salary Sacrifice Car Leasing Scheme (green car scheme) NWAS-TR-44-20	• Received the outcome of the procurement exercise undertaken to appoint a preferred supplier to provide an employee salary sacrifice car lease scheme.	• Noted and received assurance from the report and recommended for approval by the Board of Directors.	
Business Case – Blackpool Hub & Spoke	• Received the full business case for the Blackpool Hub and Spoke which had been developed in support of an investment by the Trust into the reconfiguration of the Blackpool estate in line with a hub and spoke operating model. • The model had been identified through the Estate Hub and Spoke SIP, the	• Noted and received assurance from the report and recommended approval by the Board of Directors.	

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

	Board approved Estates Strategy and subsequent feasibility studies. • Noted that the structure of the full business case was based on the HM Treasury Five Case Model. • Discussed the recommendation to proceed with the redevelopment of the Blackpool station site as a hub in line with the developed plans and 2nd stage tender costs. • The capital and revenue costs were currently being refined to consider value engineered options. • The Committee ratified approval of the Business case for onward approval by the Board of Directors.		
Business Case - Preston	• Received details of site acquisition at Bamber Bridge, Preston to provide accommodation for the PES service, which is currently leasing part of Preston Fire Station on an extended lease, which expires 30th September 2022.	• Noted and received assurance from the report and recommended approval by the Board of Directors.	
Key Workforce Indicators	• Received progress against the agreed recovery plan in relation to the revised appraisal target which was noted as	• Noted and received moderate assurance from the report.	

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

	68% against compliance target of 75% by September 2021. • Noted the slight reduction on the previous month following a consistent rise of 12% over the previous 3 months, caused by the current operational pressures and the move to Reap 4 at the start of June. • PES rates at 72% and PTS at 74% with EOC having the most challenged rates at 38%. 111 had maintained their positon in June at 63% and delivered a 23% rise in compliance since February. • Although support being given to staff teams noted that compliance target for September may be at risk. • In terms of mandatory training, noted a reinstated target of 95% compliance by March 2022. The current overall compliance was at 63% because of the introduction of new modules for this year's online training. Envisaged that compliance would increase across the year as these additional models are completed.		

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

	• Noted sickness levels and increase in May which was above normal levels for this time of year to 8.32%. • Figure included Covid-19 related sickness of 0.9%% which had improved from previous reports. • Discussed sickness reporting and run rates and requested a breakdown of sickness levels in each of the service lines for future reports. • The Board IPR report also provided further detail of sickness reporting for reference. • Vacancies in 111 services and turnover discussed and challenges regarding retaining staff now other sectors had reopened following easing of lockdown. • Initiatives to attract and retain call centre staff being explored by Trust Executives and their teams. • Received an update in relation to HR Caseload and noted 463 cases remained outstanding with a reduction in 54 cases. • A new investigation review panel had been implemented to provide an		

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

	effective route for review of potential investigations. • Reported 87.7% uptake rate of the Covid-19 vaccination.		
Equality, Diversity & Inclusion Priorities	• Received supporting action plans to support the Equality, Diversion and Inclusion (EDI) priorities agreed by the Board in January 2021. • The actions had been developed through analysis of supporting data and through engagement with networks. • Acknowledged that the plans had also been shared with the EDI Sub-Committee and Executive Leadership Committee and progression of the plans and targets had been guided by the Model Employer Framework and WRES team for parity in BAME representation. • Networks had supported the plans and had been integral to their development.	• Noted and received assurance from the report.	
Strategic Workforce Sub Committee Chairs Assurance Report	• Received assurances from the recent Strategic Workforce Sub committee meeting. • Assurances included reports from the Health, Wellbeing and Culture	• Noted and received assurance from the report.	

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

	Assurance Group and Education Management Group. • Evidence of scrutiny of the Key Workforce Indicators report by the Sub Committee prior to presentation to the Committee. • Risks identified and in relation to REAP level 4, mandatory training and appraisals. • Substantial assurance following MIAA Audit undertaken on ESR and Payroll controls.		
Diversity & Inclusion Sub Committee Chairs Assurance Report	• Meetings very well attended and now embedding the understanding and remit of the sub committee. • Robust discussion related to the EDI Priorities – action plans. • Representation ensured priorities are cascaded and developed within the directorates. • Deputising arrangements in place to allow effective representation at meetings.	• Noted and received assurance from the report.	

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

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 July 2021			
SUBJECT:	Equality, Diversity and Inclusion Priorities			
PRESENTED BY:	Lorraine McConnell, Deputy Director of People			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision			

EXECUTIVE SUMMARY:

The Board of Directors approved three Equality, Diversity and Inclusion (EDI) priorities in January 2021. The purpose of the paper is to confirm the supporting action plans for the EDI priorities. The actions have been developed through analysis of supporting data and through engagement with networks.

The priorities agreed were as follows:

- *We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.*
- *We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.*
- *We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities*

Following this approval Directors were remitted to develop supporting action plans and measures to enable these priorities to be delivered. This report provides an overview of those key actions with the detailed plans included at Appendix 1.

Plan have also taken account of best practice requirements set out in the Model Employer national document and the plans required to improve the Race Disparity ratios calculated from our WRES data. As far as possible these requirements have been aligned with our own strategic priorities to ensure consistency of approach and reporting to meet both local and national requirements.

The plans for recruitment and progression focus on improved attraction through where and how we advertise and through

	community work, pre-employment programmes, review of assessment processes and tracking of applicants. Similarly plans in support of progression will look at positive talent management, addressing fairness of informal development and continuing the assessment approach to leadership appointments. The second priority focuses on ensuring that ED&I is incorporated into the leadership and workforce education offer and is linked with the plans we already have around culture and embedding of the refreshed values. It will also reflect opportunities to use lived experience to inform decision making and development, combined with talent management, development of Board and reciprocal mentoring. In terms of health inequalities key areas for improvement will be set annually under this priority rather than for the full three years. This will enable an agile approach which can build on improved data analysis and patient engagement to inform the key improvement areas for later years. During the first year the focus will be on addressing differential 999 responses to mental health and understanding of variation in cardiac outcomes, combined with access issues linked with language and the use of EPR to support cultural sensitive clinical delivery. The attached action plans also indicate the method of measurement for each action. In the main these are output driven or we intend to use improvements in existing national measures such as WRES and WDES data. For recruitment overall the Trust is aiming for 20% of new starters (excluding paramedics) to be from a BAME background and for these targets to be disaggregated across key recruitment campaigns and service lines, to ensure ownership and support from managers in helping to engage. Over the course of 3 years this should lead to an improvement of around 3% in overall representation. From a progression perspective we have been guided by the Model Employer framework. Overall the WRES team advises for organisations like ourselves to seek to ensure parity of representation in Bands 6 and above compared with representation in the overall workforce. This provides us with a simple approach which can be applied across key protected groups. The data in report demonstrates that these targets will provide a challenge across our key protected groups. The ED&I priorities have been consulted through the networks who are supportive. Representatives from the REN already sit on the ED&I Recruitment group and have been supportive and integral to the development of actions with this group. The plans have also been shared with the EDI Sub-Committee and Executive Leadership Committee. Both of whom recommend the action plan for approval to Committee and Board.
RECOMMENDATION:	The Board of Directors is recommended to: • Approve EDI action plan underpinning the EDI priorities

ARE THERE ANY IMPACTS RELATING TO:	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Diversity and Inclusion Sub Committee Executive Leadership Committee Resources Committee			
	Date:	10 May 2021/ 9 July 2021 14 July 2021 23 July 2021		
	Outcome:	Approved – comments reflected in report		

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

1.1 The purpose of the report is to seek approval of the strategic action plans developed to enable delivery and measurement of the Equality, Diversity and Inclusion priorities approved by the Board of Directors in January 2021.

2. BACKGROUND

2.1 The case for creating an inclusive culture is compelling. Where staff feel valued and welcomed for the diverse lived experience they bring to their role and where the organisation around them reflects the diversity of the communities we serve, individuals will reach their potential and there will be a positive impact on the working environment, innovation and quality of patient care.

2.2 The disproportionate impact of COVID 19 on BAME communities and the Black Lives Matter movement has highlighted the disparity in the experience of BAME staff and the severe health inequalities experienced in BAME communities. This has prompted an increased focus at both a national and regional level on progress in reducing inequalities for BAME staff and patients.

2.3 Our staff survey results show a continuing disparity in the experiences of some of our staff from diverse groups, particularly those from BAME, disabled and LGBT backgrounds, and this is seen in their experiences of bullying and harassment, discrimination and their views of the fairness of career progression opportunities. Whilst performance indicators show continuing improvements in narrowing the gaps in areas such as recruitment and access to training, this does not adequately reflect in the day to day experiences of our staff and more drive is required to create a fully inclusive environment for our staff and patients.

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

2.5 Despite the pandemic, work has already been undertaken to start to improve leadership, governance and accountability across the agenda. In particular, in enhancing the infrastructure around networks, in the appointment of executive champions, improving governance and visibility and in Board development.

2.6 The responsibility of the Trust to make improvements in equality, diversity and inclusion is set out in law through the Equality Act and Public Sector Equality Duty and in the regulatory framework through the NHS contract (which required compliance with WRES, WDES and EDS) and CQC standards. The priorities previously approved by Board meet the Trusts requirements to commit to and publish equality objectives.

2.7 The Kings Fund research 'Making a Difference: Diversity and Inclusion in the NHS' identifies that the creation of a compelling vision and set of values, combined with clarity of objectives is critical to delivering sustained improvement in equality, diversity and inclusion. The report also identifies the value in focusing on a small number of fully resourced key priorities in what is a broad and challenging agenda.

2.8 The approach to ED&I is set within the context of the work already in progress to move the organisation towards a more compassionate and inclusive culture. This work will provide a critical foundation on which to build further work on diversity and inclusion. In particular, the work already being progressed through:

- *The Culture and Wellbeing Audit* – this will provide a more detailed understanding of the experience of staff, including those from underrepresented groups, helping to identify positive interventions which can build on the existing psychological capital within the organisation.
- *The Values refresh* – as previously shared with Board the revised values and underpinning behaviours will provide an opportunity to reset expectations of behaviour in the workplace with respect, dignity and inclusion fundamentally embedded within the desired behaviours
- *Just Culture* – with core processes and approaches to investigation and conduct being reviewed in the context of an agreed set of just culture principles
- *Leadership Framework* – The Be Think Do framework continues to provide a sound set of leadership principles linked to compassionate inclusive leadership.

2.9 As a result the following priorities were developed and approved in principle by the Board of Directors:

We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.

We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.

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

2.10 Following this approval Directors were remitted to develop supporting action plans and measures to enable these priorities to be delivered. This report provides an overview of those key actions with the detailed plans included at Appendix 1.

3. PLANS

3.1.1 The detailed action plan is attached but the following sections give a summary of the plans. Each of the priorities has strategic commitments and supporting action plans

and measures. Plans have been developed through analysis of current data and feedback, examples of best practices, national recommendations and in the case of recruitment, through a cross functional working group. They have been shared and consulted on with networks and with the EDI Sub-Committee who support the plans.

3.1.2 In the main these plans are focused on improvement across the full three years until 2024.

3.1.3 Plans have also taken account of best practice requirements set out in the Model Employer national document and the plans required to improve the Race Disparity ratios calculated from our WRES data. As far as possible these requirements have been aligned with our own strategic priorities to ensure consistency of approach and reporting to meet both local and national requirements.

3.2 Recruitment and Progression

3.2.1 In terms of recruitment there is a key focus on improving attraction, including where and how we recruit, how we present ourselves to and engage with different communities and how we build meaningful partnerships with EDI partners across our geography to achieve our ambition to be an employer of choice for all. We know from analysis of campaigns that applicants from ethnic minority backgrounds are not applying in the same numbers as other candidates and strategies to improve this will be crucial to deliver the targets set. In addition, the challenges around the paramedic intake to universities means that we will have to work in partnership to try and deliver improvement.

3.2.2 We also intend to look at how we can further support applicants through external recruitment campaigns. This will be through the expansion of pre-employment programmes which have proved successful, particularly in recruitment to PTS, but also through tracking of candidates to eliminate discrimination in the recruitment process and provide guidance, support and feedback where required.

3.2.3 There are then a number of actions looking at our approaches and processes themselves both for external recruitment but also for progression. Firstly looking to diversify the recruitment processes through better representation on selection panels and in recruitment assessment processes and also including improved training of recruiting managers. The importance of listening to staff and applicants is also recognised, particularly in terms of the perception of the fairness of internal progression processes and using this to drive change. The use of informal acting up and development to cover internal roles will be reviewed to ensure fair processes are in place for these appointments and this will be combined with the development of talent pipelines for managerial roles supported by positive action.

3.3 Leadership and Staff Development

3.3.1 NWAS has adopted the ‘leadership for inclusion’ agenda as a vehicle to drive positive action and anti-discriminatory practice to accelerate progress against the EDI priorities for the Trust. The leadership for inclusion agenda is focused on five focal priorities, to:

a) Educate our workforce to develop cultural competence and confidence in adopting anti-racist / ant - discriminatory approaches at work
b) Develop sustainable platforms for the voice of underrepresented groups to shape decision making
c) Develop inclusive Boards to optimise organisational EDI resilience
d) Improve experiences of care for underrepresented groups
e) Reward and recognise talent within underrepresented groups to facilitate positive action programmes for progression and promotion.

3.3.2 Each programme of work will seek to immerse EDI principles and practice into the Trust's mainstream courses, training, education programmes, development offers and learning spaces to enable a business as usual approach to leading for inclusion. The agenda will complement the Trust's inclusive recruitment efforts and underpin capability development for wider EDI initiatives.

3.4 Health Inequalities

3.4.1 NWAS has a critical role to play in closing the gap on healthcare inequalities experienced by underrepresented communities. Where national population health data draws on the relationship between inequities in disease prevalence and inequalities in access to care for underrepresented groups, global research has shone a light on the more stark realities of disparity in healthcare: BAME women are 5 times more likely to die as a result of complications in childbirth; BAME men are 4 times more likely to have their civil liberties revoked and detained under the Mental Health Act; BAME communities are less likely to be admitted to hospital despite qualifying clinical assessments in pre hospital care; BAME communities have disproportionate access to adequate pain management medication in emergency settings due to cultural bias. The current reconfiguration of healthcare around Integrated Care Systems places population health at the centre of planning and NWAS needs to both consider its own impact on health inequalities in this context but also to consider its role as partner.

3.4.2 NWAS recognises that it currently lacks good differential data to measure health inequalities in the pre-hospital environment, particularly in the context of direct clinical care as it is only just moving onto an electronic patient record which in time will enable a much more robust approach to identifying and targeting inequalities in the pre-hospital setting.

3.4.3 As a result of this position key areas for improvement will be set annually under this priority rather than for the full three years. This will enable an agile approach which can build on improved data analysis and patient engagement to inform the key improvement areas for later years. Future years will also be informed by the work being undertaken to develop a public health dashboard and the review of the Right Care Strategy.

3.4.4 In this first year the focus will be on known areas of clinical disparity:

- Addressing differential 999 response to patients presenting with mental health conditions

- Understanding and reducing variation in cardiac outcomes linked with deprivation

In addition, issues of access relating to English as a second language will be explored across 111 and EOC and work will continue to develop the Electronic Patient Record, particularly in expanding its capacity to support culturally competent clinical decision making.

4 TARGETS AND MEASUREMENT

4.1 The attached action plans also indicate the method of measurement for each action. In the main these are output driven or we intend to use improvements in existing national measures such as WRES and WDES data.

4.2 In the case of recruitment and progression we were challenged to improve our level of ambition. For recruitment although targets are the measures of success, they are also included as a key action in driving ownership and accountability across service lines. Overall the Trust is aiming for 20% of new starters (excluding paramedics) to be from a BAME background and for these targets to be disaggregated across key recruitment campaigns and service lines, to ensure ownership and support from managers in helping to engage. Over the course of 3 years this should lead to an improvement of around 3% in overall representation. In order to improve representation in the Paramedic cohorts we will need to work closely with HEIs and agree targets with them.

4.3 From a progression perspective we have been guided by the Model Employer framework. Overall this framework asks Trusts to seek to deliver 19% representation in the workforce of BAME staff. Clearly this would be a significant challenge to NWAS but for organisations like ourselves who are some way away from this target, the guidance from the WRES team is to seek to ensure parity of representation in Bands 6 and above compared with representation in the overall workforce. This provides us with a simple approach which can be applied across key protected groups.

4.4 The baseline position using 2020 WRES data (July 2020) is as follows:

Characteristic	Overall representation	Band 6+ representation
Race	4.7%	2.3%
Gender (female)	50%	40%
Sexual orientation	5.5%	4.1%
Disability	5%	4%

NB There is significant under reporting of disability in the workforce and further data cleanse work will be undertaken to seek to address this

4.5 The progression targets are seen as a first step in seeking to improve parity and will be kept under review so that when gaps close we can focus on continuing improvements in more senior representation.

4.6 The Trust will also use the WRES disparity ratios as a measure of progress across all the protected characteristics. The disparity ratios provide a measure of the comparative likelihood of individuals from protected groups progressing in the organisation.

5. FEEDBACK

5.1 The plans have previously been shared with the EDI Sub-Committee both as a draft and final version. The sub-Committee was supportive of the plans and targets. Plans have also been shared through the networks and the Race Equality Network has been embedded in the work group which is driving the recruitment plans.

5.2 The plans have also been shared at Executive Leadership Committee (ELC) who support recommendation to Board. ELC recognised that these were pragmatic plans in the current circumstances but asked for an annual review of progress and targets to ensure that these remained sufficiently ambitious. This would also enable us to ensure that the health inequalities objectives remain informed by the emerging population health work across systems.

5.3 ELC also recognised the commitments and responsibility of leaders across the organisation both to deliver on these priorities but also to continue to embed equality and inclusion in business as usual.

5.4 Resources Committee reviewed and agreed the plans on 23rd July 2021 and recommended approval to Trust Board.

5.5 Progress against plans will be monitored through Resources Committee and Quality and Performance Committee.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

6.1 The establishing and delivery of key priorities for Equality, Diversity and Inclusion will support the Trust in meeting its statutory and regulatory obligations under the Equality Act, Public Sector Equality Duty, NHS contract and CQC regulations.

7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

7.1 The plans presented aim to have a positive impact in representation and experience across protected characteristics and support the Trust to meet its statutory duties.

8. RECOMMENDATIONS

8.1 The Board of Directors is recommended to:

- Approve the EDI action plan underpinning the EDI priorities

Appendix 1: EDI Priorities

Key Improvement Goals	Year 1	Year 2	Year 3	Measures of success
We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.				
1. We will use targets to drive improvements in both recruitment and progression	Ensure 20% of our new recruits each year are from BAME backgrounds - review 2021/22 workforce plan and set individual targets for key mass recruitment campaigns: EOC PTS EMT1 111	Ensure 20% of our new recruits each year are from BAME backgrounds - review 2022/23 workforce plan and set individual targets for key mass recruitment campaigns: EOC PTS EMT1 111	Ensure 20% of our new recruits each year are from BAME backgrounds - review 2023/24 workforce plan and set individual targets for key mass recruitment campaigns: EOC PTS EMT1 111	The Trust aims to improve representation in the workforce from BAME communities to 8% by 2024. Improvement in WRES (Indicators 1 and 2)
	Move to representation in bands 6 and above should reflect the proportion who are in the workforce by 2025.	Move to representation in bands 6 and above should reflect the proportion who are in the workforce by 2025.	Move to representation in bands 6 and above should reflect the proportion who are in the workforce by 2025.	The percentage of staff in Band 6 and above are reflective of our overall workforce.
	Improve the attraction strategy of candidates	Review target % of BME applicants	Review target % of BME applicants	Review retention of BME staff.

2. We will proactively seek to attract candidates from under-represented groups	- Set target of % of BME applicants	Review impact of attraction improvements and seek feedback on continuous evolvement of attraction of candidates.	Review impact of attraction improvements and seek feedback on continuous evolvement of attraction of candidates.	Improved WRES metrics (Indicators 1 and 2)
	Revamp of external recruitment section on the website Refresh existing video / attraction materials Update PTS and PES videos. Review the content of the NWAS website	Review impact of the refreshed website.	Review and refresh website and video content.	Improved WRES metrics (Indicators 1 and 2)
	Review language in adverts and JD's to remove barriers to access	Review all band 8A and above JDs and PS essential and desirable criteria to remove barriers to applications from underrepresented groups	Refresh standardised template for JDs and PS with guidance notes based on lessons learnt	Mainstream JD and PS best practice
	Review engagement strategies with local communities. Map out	Review engagement throughout Trust footprint and identify	Continue to review engagement throughout	Improved WRES metrics (Indicators 1 and 2)

	areas throughout the NW where further engagement is required. Develop a toolkit for managers to use around how to partner and collaborate with local communities to support future recruitment.	any further areas that can be strengthened. Review impact of the toolkit and how it is working.	communities and impact on recruitment. Formal review and refresh of toolkit.	
3. We will support applicants who may face barriers in our recruitment process	Proactive pre-employment programmes to develop richer diverse talent pipelines at entry level roles level	Agree pre-employment schemes for 22/23 and review success and learning from 21/22	Agree pre-employment schemes for 23/24 and review success and learning from 22/23	Pre-employment schemes in place for a number of front line roles with measurable outputs Improvement in WRES (Indicator 1)
	Development of an application directory for those applicants from under-represented groups Candidates can then be tracked and supported at each stage of the recruitment process	Review how application directory is operating and success of supporting candidate		Robust process in place to support under-represented groups throughout the recruitment process. Improvement in WRES (Indicators 1 and 2)

4. We will diversify selection processes	Review of the current Recruitment and Selection HR Masterclass to address bias and underpin EDI best practice To be considered as part of ED&I T&F group with aim to: ○ Identify areas of improvement in the current training package ensuring that this seeks to address bias ○ Re-launch training to encompass both new and experienced managers	Review re-launched R&S masterclass Identify improvement and consider feedback	Refresh content of R&S masterclass	Ensure all new managers have gone through the refreshed programme. Improvement in WRES (Indicators 2 and 7)
	Develop mechanisms to facilitate inclusive selection in interview processes, ranging from diversifying selection panels to building inclusion capability within the various stages of assessment centre process.	Review assessment centre facilitator and interview panel diversity from 21/22 and seek to identify improvements.	Review assessment centre facilitator and interview panel diversity from 21/22 and seek to identify improvements.	Increase the diversity of assessment centre and interview panels. Improvement in WRES (Indicators 1, 2 and 7)
	Engagement with NW universities with an aim for them to understand and support our recruitment targets within their own student intake for Paramedic courses. Development of joint action	Review action plan and progress. Link in with BME students to understand their experience during	Review impact of actions and how this has improved diversity of intake on courses.	Improvement in WRES (Indicators 1 and 2)

5. We will work with partners to improve representation	plans with NW universities to improve the diversity of intake onto paramedic science courses. Look at approaches taken by non-NW universities.	the application process and what information they might wish to see from NWAS.		
	Launch sponsorship scheme for Paramedics	Review success of sponsorship scheme and if current annual numbers should be increased	Review success of sponsorship scheme and if current annual numbers should be increased	Review impact of sponsorship scheme in improving diversity amongst Paramedics Improvement in WRES (Indicators 1 and 2)
	Proactive approaches to internal progression of our staff – map out and agree process. Develop a talent management framework to identify and accelerate under-represented top talent progression and promotion into senior leadership roles at band 8A and above Agree roles that can be piloted.	Embed internal progress approach and review impact Commence talent spotting and pilot framework	Embed internal progress approach and review impact Review effectiveness and scale up best practice	Increase in the progress of BME staff Improvement in WRES (Indicator 7)

6. We will ensure our progression processes are fair for all				
	To end acting up and temporary appointments without a fair process. Review of current processes for short and medium term cover for supervisory and management posts with the aim of establishing talent based development pools. Create the ability to pause recruitment on grounds of equality performance	Embed changes, seeking feedback. Review processes in corporate teams	Evaluate changes and impact on perceptions of fairness.	Improvement in staff survey question relating to fairness of career progression
7. We will learn from the experience staff and applicants and make changes in response	Develop feedback mechanism for BME and female applicants to help improve process Review Recruitment and Selection Policy to reflect Trust ambition and provide clarity on process.	Embed an appropriate feedback mechanism for BME and female applicants. Have a clear understanding of key issues feedback form BME and female applicants and appropriate actions.	Review feedback and progress against actions to improve experience from BME / female applicants	Improvement in WRES (Indicator 7) Improvement in staff survey scores for the Trust provides equal opportunities for career progression or promotion

Key Improvement Goals	Year 1	Year 2	Year 3	Measures of success
We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.				
1. Educate: **We will educate our workforce to develop cultural competence and confidence in adopting anti-racist / anti - discriminatory approaches at work**	Review EDI core competencies for NHS compliance	Develop a pool of relevant learning materials to build awareness of EDI (including unconscious bias) matters across a range of mandatory subjects, in partnership with subject matter experts	Embed and mainstream EDI learning resources across mandatory training subjects	Mandatory training compliance rates for EDI training
	Embed reviewed EDI core competencies into 1) values based work programmes, including 1)staff induction and 2) mandatory training design and delivery			
	Integrate EDI lens into the design of the NWAS Leadership Programme 'Making Difference'	Develop an EDI maturity framework to map EDI capability requirements across leadership roles to inform EDI programme planning	Develop a suite of EDI positive action training resources/ programmes responsive to the maturity framework	Improved staff survey scores for leadership and management domains within staff survey
	Develop and offer 'Beyond Bias training programme to staff with leadership responsibilities			

	Build EDI education into key vehicles for people management including appraisals, recruitment and the Just culture programme	Audit EDI competence across the Just Culture Programme of work, drawing on staff experience and WRES / WDES data	Embed improvements for EDI competence into Just Culture Programme	Improvement in WRES / WDES performance
2. Culture: **We will develop sustainable platforms for the voice of underrepresented groups to shape decision making**	Support the development and growth of staff networks	Develop a sustainable infrastructure for staff network members to engage with the corporate EDI agenda as a part of the 'day job'	Enable staff network representation across all key strategic sub committees as agents of positive action	Staff network integration with NWAS governance structures Staff Network membership
	Identify executive leadership for EDI portfolios to support staff Network activity	Consolidate and mainstream Exec support for network led activity and programmes of work (Let's Talk about Race / AACE anti-racism programmes / positive action programmes) to	Provide continued leadership advocacy for scaling up and expanding sustainable EDI network led programmes	Improved staff survey scores

		scale up workforce engagement with EDI		
3. Leadership: **We will develop inclusive Boards for organisational resilience optimisation**	Develop a 12 month board development programme to engage visible leadership for inclusion	Adopt the Culture Web tool to frame Board leadership priorities for building inclusive cultures / services	Develop a suite of board led initiatives to showcase and drive an "inclusive 'employer" brand	Improvements in WRES / WDES
	Secure Board /and senior leadership advocacy / participation / engagement with the EDI Reciprocal mentoring initiative	Nurture, develop and amplify EDI led positive action outcomes drawn from the reciprocal mentoring programme	Mainstream and embed EDI change efforts into business as usual for long term sustainable EDI practice	Improvements in WRES / WDES
	Prioritise recruiting for EDI specialist competence for any forthcoming board positions within Exec / Non Exec vacancies	Build cognitive and demographic diversity into Board leadership to enable and facilitate strategic EDI leadership for improved staff / patient experience		Staff survey Patient feedback / complaints
4. Health Inequalities: **We will improve experiences of care for underrepresented groups**	Build EDI capability (robust EIAs) into service improvement methodology through Module 3 of MAD: Leadership of Services	Strengthen relationship between service improvement project planning and	Showcase EIA best practice to develop a best practice toolkit to undertake robust EIAs	EIA application

		Equality impact assessing		
	Undertake audit to understand and analyse complaints, patient experience and incident data to understand any disparities in the patient access / experience of care	Develop a strategy / action plan to respond to respond to any identified disparity trends	Progress and mature action plan that identifies disparity trends to develop maturity in service planning and delivery trends	Reduction in disparity trends
5. Reward and recognition **We will recognise and reward talent within underrepresented groups to facilitate positive action programmes for progression and promotion**	Develop a talent management programme for underrepresented groups operating at middle management level	Map diverse talent into succession for promotion and progression through agreed positive action pathways	Review and audit impact of programmes to scale up successful approaches on a Trustwide footprint	WRES / WDES data

Key Improvement Goals	Key actions	Year 1	Measures of success
We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities.			

Safety	We will deliver parity in 999 response times for patients with mental health conditions	Q1 - develop a power BI dashboard Q2 – share information with key stakeholders Q2 – develop improvement plan to reduce variation Q3 – test improvements Q4 – evaluation & future plans developed	Data demonstrates narrowing/elimination of response variation
Effectiveness	We aim to develop our understanding of the impact of deprivation on Cardiac outcomes and to deliver improvements	Q1 – examine the AQI data & produce dashboard Q2 – share information with key stakeholders Q2 – develop improvement plan to reduce variation Q3 – test improvements Q4 – evaluation & future plans developed	Data demonstrates narrowing/elimination of outcome variation
Experience	We will improve our understanding of the impact of English as a second language on access to 111 and EOC	Q1 – understand calls to 111 & EOC Q2 – examine barriers to communication Q3 – develop improvement ideas Q4 – test improvement and plan for 22-23	Feedback from patient groups with English as a second language 111/EOC patient satisfaction measures
Digital	We will develop the Electronic Patient Record to support the delivery of culturally competent care	Q1 – review the standard script for more information Q2 – ensure linkage to DOS for faith and cultural resources Q4 – ensure communication issues and support documented in EPR	Evaluation of usage Feedback from staff and patients

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 July 2021			
SUBJECT:	Communications and Engagement Team Dashboard Report – Q1 (April - June) 2021/22			
PRESENTED BY:	Salman Desai, Director of Strategy, Partnerships and Transformation			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
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 1 (Q1 – April - June 2021), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q1. It includes the number of virtual engagement opportunities attended, action we have taken from the feedback, and information about our patient surveys. For example, this quarter: • 22 virtual community engagement opportunities were attended or facilitated, 22% more than in Q4 2020/21. • Fewer patient surveys were returned this quarter, with low numbers for paramedic emergency service and patient transport service surveys especially. To address this, we are looking at the use of text messaging to prompt patients to fill in the surveys. • 92% were likely to recommend the service to friends and family, down 2% from Q4. • 92% were very or fairly satisfied with the overall service they received, down 3% from Q4. **Patient and public panel (PPP)** A summary of the Q1 activity for the PPP, including up-to-date figures for panel recruitment and information about events the PPP has been involved in over the last few months. For example, this quarter: • 15 new panel members confirmed and inducted to the trust • 157 panel members in total, a 10% increase from Q4 • 26 new expressions of interest in Q1 • 239 panel 'voices' to call on for a piece of work • 14 new requests for panel involvement in Q1			

This quarter, the report also includes two new panel priorities for the year ahead: increasing youth representation and ensuring we represent our diverse communities.

Press and public (patient) relations
A summary of our media relations activity for Q1. This includes the number of incident check calls and some highlights of the positive, pro-active media relations work that has been undertaken this quarter. In Q1:

- 461 incident check calls
- 30 proactive media stories/interviews, an increase from last quarter
- 18 statements prepared in response to press enquiries, a small decrease from Q4
- Highlights included positive news stories about award wins, new appointments, and the issue of snuggle pods, along with a Sky News interview about our body worn cameras pilot

The volume of press coverage reported this month has increased due to use of a new media monitoring tool. Themes from the media coverage include:

- 250 pieces about the Heysham gas explosion major incident
- 107 pieces relating to the Manchester Arena Inquiry and NWAS
- Approximately 40 pieces generated by positive or educational social media posts issued by the Communications Team, for example, posts asking people not to tailgate ambulances

FOI performance
An update on the FOI performance against the national target of 90% completion within 20 days. 56 FOIs were completed in Q1 and 95% were within the 20 working day target.

Stakeholder communications
A summary of stakeholder activity for Q1, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 3 stakeholder bulletins
- 4 stakeholder letters
- 6 MP letters

Social media: Facebook, Twitter and Instagram
A summary of our social media statistics for this quarter.

In Q1, we have been posting more demand-related posts than usual which has impacted our figures on different social media platforms. For example, on Facebook, these posts receive a lot of engagement which is positive as it helps us spread the message but we've also seen an increase in people 'unfollowing' the page, perhaps due to the repetitive nature of the content and move away from

our usual posts. On Twitter, we have still had a good amount of new followers but less engagement on the posts.

The most popular post on Facebook was a story about our tribute to colleagues who passed away with COVID, which reached more than 170,000 people. On Twitter and Instagram, the most popular posts were about inconsiderate parking in the Lake District restricting emergency vehicle access.

Website
A summary of statistics for the website, including page views and visitor numbers. In Q1, page views and visitors were down slightly on last quarter. This is likely to be because a popular job vacancy post (PTS care assistant) was shared in Q4 and drove traffic to the website, whereas there were no significant job vacancies to share in Q1.

External (public/patient facing) activity
Brief information about key external activity in Q1, including:

- Using social media to respond to staff concerns
- Inside 999
- Demand on services messaging
- Heysham gas explosion major incident

Internal projects and campaigns
Highlights and figures about the main internal communication projects and campaigns from Q1, including EPR, launch of the new trust values, service delivery model review, armed forces week, pride month, and the staff survey results.

Internal bulletins and the Staff App
Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q1:

- 8 CEO bulletins
- 20 Clinical bulletins
- 12 weekly bulletins
- 576 staff app downloads

Films produced in-house
A summary of in-house videography activity. 12 films were completed this quarter, the same amount as the previous quarter, with an average of four new films per month. They included: values film, treat me right campaign film, a violence and aggression Q&A, a message for 111 staff, a Facebook Live session and two Team Talk Live sessions.

Focus on…

- **Our new look -** introducing our refreshed NWAS brand
- **New ideas** – more information about two new staff communications and engagement ideas

	implemented in Q1: Team Talk Live and The Ideas Room.			
RECOMMENDATION:	For discussion, noting and the provision of any comments.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

- THIS PAGE IS INTENTIONALLY BLANK -

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 Q1 (April - June 2021).

2. BACKGROUND

The Communications and Engagement Team has created a dashboard providing high level statistical content and themes from Q1 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- 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

Each report also goes into more detail on some priority pieces of work. This quarter's dashboard provides an overview of our refreshed NWAS brand and two new staff communications and engagement ideas implemented in Q1: Team Talk Live and The Ideas Room.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.

NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

All of the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all.

5. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

This page is intentionally left blank

Communications and engagement dashboard

Q4 2021/22: April - June

NHS North West Ambulance Service NHS Trust

PATIENT AND PUBLIC ENGAGEMENT

22 virtual community engagement opportunities facilitated or attended. ▲ 22%

Including: Sandbach dementia cafe, Lancashire visual impairment forum, Wigan inequalities reference group and Healthwatch Trafford volunteers.

Feedback from groups included comments about the lack of face-to-face GP appointments during the pandemic and how this can cause difficulties for patients and carers and lead to people looking for help elsewhere – for example, calling 999.

We have been building up our connections with other patient engagement networks to learn and share best practice, including Lancashire and Cumbria Patient and Public Involvement network leads and a new National Ambulance Public Engagement network.

6,924 surveys sent

1,042 surveys returned ▼ 30%

The vast majority of the surveys returned were NHS 111 and 111 First surveys, and the results of these were:

92% were likely to recommend the service to friends and family ▼ 2%

92% of respondents were very or fairly satisfied with the overall service they recevied ▼ 3%

NOTES:

Response rates for paramedic emergency service (PES) and patient transport service (PTS) patient experience surveys were low this quarter, meaning the data is not representative. This is due to the surveys now being digital and a lack of 'prompt' to remind patients to complete them. To address this, we are exploring the use of text messaging to follow up and ask patients to complete the survey.

PATIENT AND PUBLIC PANEL (PPP)

26 new expressions of interest in Q1

15 new panel members in Q1

157 panel members now in total ▲ 10%

Some of the members are involved in two levels of participation meaning we have:

239 panel voices to call on for a piece of work

14 new requests for panel involvement in Q1

24 structured and/or task orientated involvement opportunities delivered

12 ad hoc opportunities (virtual only) offered for panel members in Q4

Including: area learning forums, suicide and self-harm prevention workstream meetings, high-intensity user management review group meetings, virtual 'tea and talk' mornings, development sessions on topics including dementia friends, CPR, race equality network, patient safety/complaints, green plan development.

Set priorities for the year ahead:

- Increasing youth representation – by the end of the year, our aim is to have 20% of our panel made up of young people (16-24 years old), having successfully bid for a grant from NHS England to help increase the youth representation
- Ensuring we represent our diverse communities – our target is to increase the representation of panel members from our diverse communities by 20% by end of this year.

PRESS AND PUBLIC (PATIENT) RELATIONS

Handled 461 'incident checks' through email

30 proactive media stories / interviews ▲ 11%

Prepared 18 statements in response to press enquiries ▼ 5%

Many of the press statements issued during Q1 were in response to reported disputes with trade unions, who issued several of their own press releases in this period.

As our demand continued to be high, we have also been asked to respond to news stories about delays in responding to patients.

We proactively shared positive news stories about: award wins, new appointments, an NHS 111 paediatric clinician pilot, the issue of snuggle pods, and many more. We also marked International Nurses Day, LGBTQ+ month and Reserves Day by sharing staff stories.

For the launch of body worn cameras, we set up a number of interviews to explain our pilot securing significant positive coverage, including Sky News.

NOTES:

Early in Q1, we started using a media monitoring tool to help us gather and analyse press coverage, particularly in relation to the Manchester Arena Inquiry. The system captures every mention of NWAS in the media, including articles 'syndicated' across every local area, resulting in a huge increase in coverage being logged. This has made it increasingly difficult to score the sentiment of articles as we have reported previously (positive/negative/neutral) however, some key themes are highlighted below.

1,554 pieces of media coverage

Many were reports of incidents including a mention of NWAS and, if they contacted the press office, some detail about what resources were there, number of patients and nature of injuries. This would be considered 'neutral' coverage.

250 about the Heysham gas explosion major incident

107 about the Manchester Arena Inquiry and NWAS

40 generated by our positive / educational social media posts i.e. asking people not to tailgate

FREEDOM OF INFORMATION (FOI)

56 FOIs completed ▼22%

95% within 20 working day target

95% year to date on 20 working day target

Topics included:

- Fleet lists
- ICT systems
- Agency staff
- Private ambulance calls
- Equipment contracts

NOTES:

FOIs: We have a statutory duty to reply to FOIs within 20 working days. The national target is 90% for this and we set an internal stretch target of 95%. After a busy end to 2020/21, there were fewer FOIs to manage in Q1 of 21/22 and we start the year on target.

Stakeholders: this group is external audiences such as MPs, commissioners, patient groups and other healthcare professionals / partner organisations.

STAKEHOLDER COMMUNICATIONS

3 stakeholder bulletins **4** stakeholder letters **6** MP letters

- 2 x Stakeholder News bulletins covering topics including: launch of new NWAS values, tackling racism in the NHS, operational service review, emergency operations centre (EOC) and association of ambulance chief executives (AACE) awards, youth representation plan, introduction to the new non-executive directors (NEDs) and launch of Treat Me Right. 1 other briefing about operational plans for the May bank holiday.
- Stakeholder letters: one to Oldham Council and faith leaders about a Talk Radio debate on alleged abuse of a paramedic; condolences to the Lord Lieutenants following the death of Prince Phillip; contact with overview and scrutiny committees to share Quality Account; a letter to West Midlands Ambulance Service following the death of a colleague.
- MP letters in response to queries about local resources, the Blackpool hub and a constituent's enquiry about a job application.

FACEBOOK

68,391 total followers

1,000 this quarter

▼ compared to the 2,615 new followers gained in Q4

4,969,509 reach ▲33%

314,537 engagements ▲10%

Top post:
Announcement of tribute to colleagues who passed away with COVID-19

367 shares

2,500 reactions

172,648 reach

TWITTER

56,019 total followers

1,239 this quarter

▲ compared to the 805 new followers gained in Q4

2,029,509 reach ▼23%

60,290 engagements ▼36%

Top post:
Notice about inconsiderate parking restricting access

111 retweets

125 likes

44,977 reach

INSTAGRAM

13,623 total followers

865 this quarter

▼ compared to the 995 new followers gained in Q4

35,021 engagements ▼16%

1,229,715 reach ▲6%

Top post:
Inconsiderate parking

1,253 likes

22,675 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: While Facebook enagement and reach is up on last quarter, our overall growth in followers has slowed. Q1 has been a very busy period for the service with high demand, resulting in more frequent posting of high demand messages replacing some of our normal content - this could be a reason for losing more followers than usual, who prefer not to see repeat posts about demand instead of our typical content.

That said, some of our demand messages do receive high levels of engagement and reach, which help us share important public messages about ambulance waits and educational messages such as advising the public only to call back if the condition worsens or they no longer need us.

TWITTER: We maintained a steady growth of new followers this quarter, but engagement and reach figures were down slightly. We have found that the repetitive nature of high demand posts on Twitter can result in fewer shares, which has led to us posting about this less frequently where possible and only when escalating to the highest patient safety plan (PSP) levels.

INSTAGRAM: Instagram figures have been growing steadily for some time now. After a peak in activity in Q3 2020/21 and good levels in Q4 20/21, we have seen a slight drop in the increase of new followers and engagement, but reach is up. Overall, it's a steady picture for Instagram which really increased in popularity for us last year to levels of reach and engagement that we hope to sustain for 2021/22.

WEBSITE: In Q4 2020/21, a PTS care assistant vacancy was promoted on social media and attracted a lot of attention and traffic to the website, particularly the careers page. There were no significant vacancy promotions in Q1 2021/22 and so figures have dropped slightly.

WEBSITE

378,103 page views ▼15%

116,383 total visitors ▼18%

Most visited page:
1 Careers/vacancies ▼ 91,147 views 36%

28,521 'news' views ▼5%

Top news story:
Poor parking obstructs emergency response

EXTERNAL (PUBLIC/PATIENT) ACTIVITY

- Staff concerns – we have been listening to staff feedback on certain issues and creating public social educational posts such as not tailgating ambulances and not hanging up emergency calls if the public find they no longer need us as, unless we get confirmation they don't, we still have to send help. These have gone down really well and are some of our best performing posts on social media. They have also been picked up in the press, making headlines in some local newspapers, helping us to share these important messages and respond to staff concerns even more effectively.
- Inside 999 campaign – Continuing to inform the public about what goes on behind the scenes at NWAS to support people during the pandemic, manage our demand, how staff are coping and how the public can support us.
- Demand on services – supporting level of demand through direct and indirect social media posts warning of delays, asking people to use 111 Online, and to only call back if a patient's condition worsens or to cancel an ambulance, for example.
- Heysham gas explosion major incident - on-call press support to strategic commander, Matt House, and multi-agency comms working during major incident

INTERNAL (STAFF) ACTIVITY

Values launch
- Worked with Learning and Organisational Development to develop new values and supporting materials inc: posters, toolkit, desktop background.
- Launched with CEO message and a film to showcase the values and supporting behaviours.

Electronic patient record (EPR)

The rollout of EPR was completed in May.
- Created news stories and social media posts which engaged and interested colleagues and the public.
- Sent thank you letters to frontline staff who helped implement the change.

Service delivery model review
- Issued bulletins and provided those involved in the working groups with key messages around the service delivery model review.

Staff survey
- The results of last year's staff survey were shared via a bulletin and video message from Director of People Lisa Ward explaining next steps.

Armed Forces Week
- Supported Armed Forces Week with news stories and social media posts involving our veterans and how the skills they learnt in the armed forces transferred to their job.

Pride Month
- As well as a flag-raising ceremony, we created social posts spotlighting some of our staff and what Pride month means to them and why they wear the rainbow badge.

Newsletters
- Supported the production of the third Race Equality Network newsletter.
- Gathered content for and produced the NHS 111 staff newsletter.

Staff Facebook group
- Continued to increase membership by sharing feel good news from the bulletins and encouraging people to post their own content directly onto the page.
- Responded to questions and comments posted.
- Membership is now 2,227.

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

8 CEO weekly bulletins
20 Clinical bulletins
12 Weekly Regional Bulletins
9 COVID-19 bulletins
16 Operational bulletins
10 Wellbeing Wednesday bulletins

plus 40 others, including Manchester Arena Inquiry, HR, 111, PTS, lessons learnt and staff bulletins

Topics included:
- EOC0001 updates
- Changes to lateral flow testing
- Manchester Arena Inquiry updates
- EPR going live in more areas
- REAP updates

9,196 total staff app downloads
+576 this quarter
Most popular pages: GRS and emails

FILMS

12 completed **8** underway
= to last quarter

- Our values
- Treat Me Right with an introduction from the CEO
- Ambulance Leadership Forum Awards nomination for Andrea Williamson
- Nurses day
- Facebook live Q&A with Lynsey and Erica for Nurses Day
- Violence and aggression Q&A film with Tony Carter and Gavin Price
- Staff story for Board on the EPR rollout
- Message to 111 staff from Head of Service, Jackie Bell
- 2 films to mark Armed Forces Week and Reserves Day
- 2 Team Talk lives with CEO and Chair, Lisa Ward and Chris Grant

NOTES:

Videos are filmed in-house using team skills and equipment.

Another 12 films were completed this quarter, averaging four new films per month.

FOCUS ON...our new look

We started the financial year with a fresh look for NWAS, thanks to a brand refresh and roll-out led by the Communications Team:

- Held a focus group with staff and patient representatives
- Worked with a creative agency to refresh our existing brand and focus on four Cs:

clean, contemporary, clinical, colour

- Agreed a new primary font and colour palette which reflects our services but maintains links to our NHS identity
- Updated our much-loved and well-used NWAS characters
- Developed a full set of brand guidelines to ensure all documents look professional and consistent
- Made suite of materials available in the new brand and shared templates on the Green Room, including: letterheads and compliment slips, bulletin templates, new-look weekly bulletin email, PowerPoint presentation template, MS Teams backgrounds, social media graphics

FOCUS ON...new ideas

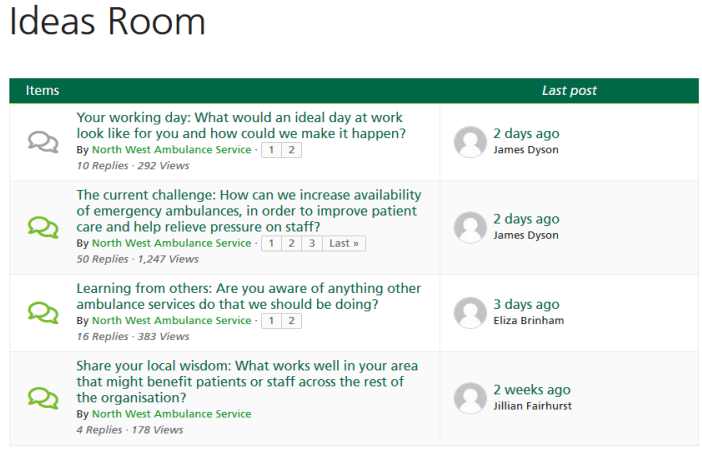
As a team, we are always looking for new ways to support effective communications and engagement across the organisation. During Q1, we launched two new staff platforms:

TEAM TALK LIVE

- Team Talk was a written bulletin emailed to all staff after each Board of Directors with key points from the meeting.
- We have been issuing this in the same format for years but had, many years ago, tried this as a face-to-face briefing.
- We decided to make the most of our new and well-used virtual channels to try a 'face-to-face' approach again for the Team Talk briefing.
- In Q1, we held our first 'Team Talk LIVE', on MS Teams, hosted by Daren Mochrie and Peter White following Board.
- The briefing had more than 100 viewers throughout the whole session and the recording was hosted on the Green Room for others to watch at a convenient time.

THE IDEAS ROOM

- As part of conversations about how to involve staff in organisational developments, particularly the service delivery model review, we suggested making use of a forum function on the Green Room.
- 'The Ideas Room' was launched in June for staff to share ideas, gather feedback and have discussions – as well as posting comments, colleagues can 'thumbs up' people's ideas to help us identify popular suggestions
- It is a tool for engaging the wider workforce and help people feel part of organisational change. It is an opportunity to listen and act on ideas.
- In the first few weeks, we've had hundreds of views and 84 suggestions put forward. These will be shared with relevant departments to identify those to take forward.



As these are embedded, they will be continually developed and evaluated to ensure they are working effectively.