North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 29 September 2021
9.45 am - 12.20 pm

Mercure Bolton Georgian House Hotel, Manchester Road, Blackrod, Bolton, BL6 5RU

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2122/68	Staff Story	09:45	Information	Interim Deputy CEO/Director of Strategy, Partnerships & Transformation	
INTRODUCTION					
BOD/2122/69	Apologies for Absence	10:00	Information	Chairman	
BOD/2122/70	Declarations of Interest	10:00	Decision	Chairman	
BOD/2122/71	Minutes of Previous Meeting	10:00	Decision	Chairman	3 - 14
BOD/2122/72	Board Action Log	10:05	Assurance	Chairman	15 - 16
BOD/2122/73	Committee Attendance	10:10	Information	Chairman	17 - 18
BOD/2122/74	Register of Interest	10:10	Assurance	Chairman	19 - 20
STRATEGY					
BOD/2122/75	Chairman & Non-Executives' Update	10:15	Information	Chairman	
BOD/2122/76	Chief Executive's Report	10:20	Assurance	Chief Executive Officer	21 - 34
BOD/2122/77	Strategic Planning Review and Recommendations	10:30	Decision	Interim Deputy CEO/Director of Strategy, Partnerships & Transformation	35 - 46
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/78	Memorandum of Understanding: Division of Responsibilities between the Chair of the Trust Board and Chief Executive Officer	10:40	Decision	Director of Corporate Affairs	47 - 54
BOD/2122/79	Deloitte Developmental Well Led Actions - Update	10:50	Assurance	Director of Corporate Affairs	55 - 62
QUALITY AND PERFORMANCE					
BOD/2122/80	Integrated Performance Report	11:00	Assurance	Director of Quality, Innovation and Improvement	63 - 112
BOD/2122/81	Lessons Learnt from Deaths Q1 2021/22	11:10	Assurance	Medical Director	113 - 124

BOD/2122/82	IPC Annual Report 2020/21	11:20	Assurance	Director of Quality, Innovation and Improvement	125 - 188
BOD/2122/83	Quality and Performance Committee Chairs Assurance Report - from the meeting held on 26th July 2021	11:30	Assurance	Prof A Chambers, Chair, Quality & Performance Committee	189 - 198
BOD/2122/84	Resources Committee Chairs Assurance Report - from the meeting held on 24th September 2021	11:40	Assurance	Mr R Groome, Chair, Resources Committee	199 - 214
WORKFORCE					
BOD/2122/85	Workforce Equality Update - Race, Disability, Gender	11:50	Decision	Director of People	215 - 234
BOD/2122/86	Flu Assurance Report 2021/22	12:00	Assurance	Director of People	235 - 248
COMMUNICATIONS AND ENGAGEMENT					
BOD/2122/87	Partnerships and Integration Progress Update	12:10	Assurance	Interim Deputy CEO/Director of Strategy, Partnerships & Transformation	249 - 270
CLOSING					
BOD/2122/88	Any Other Business Notified Prior to the Meeting	12:15	Decision	Chair	
BOD/2122/89	Items for Inclusion on the BAF	12:20	Decision	Chair	

Date and Time of Next Meeting 9.45 am Wednesday, 24 November 2021 - Venue to be confirmed

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

Minutes
Board of Directors

Details: Wednesday 28th July 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
	Dr D Hanley	Non-Executive Director
	Mr D Mochrie	Chief Executive Officer
	Prof M Power	Director of Quality, Innovation and Improvement
	Mr D Rawsthorn	Non-Executive Director
	Prof R Thomson	Associate Non-Executive Director
	Ms A Wetton	Director of Corporate Affairs
	Ms C Wood	Director of Finance/Interim Deputy Chief Executive Officer

In attendance:

Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)
Ms L McConnell	Deputy Director of People

Minute Ref:

BOD/2122/45 Patient Story

The Director of Strategy, Partnerships and Transformation presented a film narrated by the Fundraising and Business Development Manager of the Deafway Charity based in Preston. The film included an interview with a Deafway service user and provided a short awareness course on the communication needs and barriers faced by members of the community with a hearing impairment.

The Director of Strategy, Partnerships and Transformation advised that lessons had been learnt by NWAS following a Trust event, which included a film, without subtitles. He reported developments identified by Deafway had been implemented across the Trust and included an increased number of BSL interpreters and signs included on ambulance tablets. He added that NWAS were extremely grateful for the input from the Deafway organisation.

He highlighted that PPE requirements, during the Covid-19 pandemic, had restricted communication to deaf people and highlighted the need for the Trust to consider communication barriers for all sectors across the community, particularly in times of need and distress.

The Chairman supported the developments and lessons learnt from collaboration with Deafway and was encouraged that the organisation had responded to the feedback. He acknowledged there was still work to do; particularly in cases of deaf people who had English as a second language. He also recognised the importance of basic deaf awareness training for the benefit of patients.

Prof A Chambers supported the Chairman and stated that the introduction of basic hand signals on tablets; to support staff training was a good option and a helpful tool for colleagues.

The Board of Directors:

- Noted the content of the Patient Story and the progress related to the implementation of communication tools for deaf people.

BOD/2122/46 Apologies for Absence

Apologies were received from Ms G Singh, Associate Non-Executive Director and Ms L Ward, Director of People.

BOD/2122/47 Declarations of Interest

There were no declarations of interest to note.

BOD/2122/48 Minutes of Previous Meeting held on 26th May and 30th June 2021

The minutes of the previous meetings held on 26th May 2021 and 30th June 2021 were agreed as true and accurate records of the meetings.

BOD/2122/49 Board Action Log

The Board of Directors noted the action log.

BOD/2122/50 Committee Attendance

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

BOD/2122/51 Register of Interest

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

BOD/2122/52 Chairman and Non-Executive Directors Update

The Chairman reported attendance at a variety of meetings related to the ICS arrangements and acknowledged that Cheshire and Mersey were yet to appoint a CEO to the ICS.

He stated the Trust's recent performance highlighted the extreme pressures experienced by NWAS and all ambulance sectors across the country. He stressed that NWAS was operating during unprecedented levels of demand and conveyed his gratitude to all members of staff; including volunteers who supported the organisation.

The Board of Directors:-

- Noted the update from the Chairman.

BOD/2122/53 Chief Executive's Report

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

- The unprecedented and sustained pressure in the Paramedic Emergency (999) and the NHS 111 services and advised that the Director of Operations and teams were implementing a number of initiatives, with national work ongoing across the ambulance sector, to address the issues. He stated the Trust was doing everything possible to keep staff and patients safe.
- A recent clinical shift from Blackpool station and a visit to Blackpool Victoria Hospital to see the Electronic Patient Record (EPR) in operation and thanks for the hard work involved in rolling out the EPR during the current operational pressures.
- Following the Trust's Culture Audit, he reported that the Trust had already refreshed its approach to leadership recruitment to ensure that inclusive and compassionate leadership was at the heart of recruitment. He added that a refreshed leadership development programme was underway to ensure leaders were equipped with the tools they needed.
- Short term national funding, recently announced to address suicide prevention, had come at a critical time faced by the ambulance sector; he outlined communication initiatives underway with AACE and other health colleagues.
- The recent Trust Team Talk Live events had produced good challenges from the staff.
- Newly proposed national standards for urgent and emergency care following a clinically led review and consultation with clinicians and the public.
- Recently appointed Partnership & Integration Managers would be responsible for supporting the Trust during the transition to Integrated Care Systems (ICS).
- Finally, he paid tribute and conveyed sincere condolences on behalf of the Trust to the families and friends of Michelle Clark and Ken Hyde.

The Chairman requested an update for Board members on the plans related to the progress of the Suicide prevention work and referred to the recent Ambulance Learning Forum Presentation and supported the revised standards urgent and emergency care. The Director of Quality, Innovation and Improvement advised that the Integrated Performance Report would include progress against the standards.

The Board of Directors:

- Received and noted the contents of the Chief Executive's report.
- Noted a future update to Board of Directors of the progress of the Suicide Prevention work.

BOD/2122/54 Board Assurance Framework Q1 Review

The Director of Corporate Affairs presented the closing position following the Q1 Board Assurance Framework (BAF) review.

A reduction in risk score of 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, from 20 to 15, was proposed based on the following rationale:

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.

The Director of Corporate Affairs also explained that following consideration by the Executive Leadership Committee (ELC), it was proposed that the remaining originally identified strategic risks (from Q4 2020/21) should be added to the BAF from 01 July 2021:

Strategic 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, Partnerships & Transformation
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

Dr D Hanley referred to the strategic risk related to legislative changes and partnership working and queried if the risk would include consideration of capacity requirements and the increased level of partnership working required by the Trust. The Director of Strategy, Partnerships and Transformation confirmed that the risk reflected all those elements and some corporate risks would likely sit below. The Chief Executive also advised that the ICS considered NWAS to be a key partner as the ICS continued to develop.

The Director of Corporate Affairs advised that there had been discussion at ELC regarding the inclusion of a digital strategic risk and the meeting had concluded that a digital risk was not a standalone strategic risk but various elements of risks relating to the digital agenda were included within the corporate risk register and aligned either to SR01 or SR02.

The Director of Quality, Innovation and Improvement expanded on the discussions at ELC and reminded Directors that the Resources Committee received a digital assurance report, which included an update on the Trust's digital risks. She confirmed that the IT platforms used to support delivery of safe patient care directly aligned to SR01 and this had been discussed at the Quality & Performance Committee earlier in the month.

Mr D Rawsthorn acknowledged that a number of Non-Executive Directors had previously discussed their concern regarding the absence of a dedicated digital strategic risk. He added that although the digital team had carried out a tremendous amount of work, he believed there was still a significant digital risk that threatened delivery of the Trust's corporate strategic objectives. He advised that he would not support the decision to not include a standalone strategic digital risk.

The Director of Quality, Innovation and Improvement thanked Mr D Rawsthorn for his continued support in relation to the digital agenda and associated risk.

Prof A Chambers advised that the Quality and Performance Committee had discussed the alignment of the digital risks to SR01 acknowledging the impact on patient safety.

Dr D Hanley supported the challenge in relation to a standalone digital risk and recognised the potential impact of digital risk on patient care. He added digital risk was an ever-developing situation, which included the ongoing capacity to respond to challenges.

The Director of Strategy, Partnerships and Transformation supported the healthy debate and discussion at Board and reminded the Board that it was important strategic risks provided a clear risk to delivering the Trust's strategic priorities and ELC did not believe digital presented such a risk. The Chairman asked whether he therefore believed that digital was not a strategic risk and it was confirmed that he did not.

Mr R Groome advised that the Resources Committee had received moderate assurance in relation to the Digital update and noted that issues had been complex with cross cutting actions and included urgent maintenance of IT services. He supported a standalone BAF risk to encompass the complexity of the risk.

The Chairman recognised the significance of the digital risk, which was complex and posed a realistic threat to systems that supported the Trust, however, he confirmed that based upon the discussion he did not agree that a digital risk should be added to the Board at this point but he requested that the Director of Quality, Innovation & Improvement and the Director of Corporate Affairs meet with Mr D Rawsthorn to discuss further. He requested that Non-Executive Board members are involved in the next review of the strategic BAF risks.

The Board of Directors -

- Agreed the reduction in risk score for SR02 from 20 to 15
- Agreed the 2021/22 Q1 position of the Board Assurance Framework.
- Agreed the recommendation to include the additional originally identified strategic risks on the BAF from 1st July 2021
- Requested that the Director of Quality, Innovation & Improvement and the Director of Corporate Affairs meet with Mr D Rawsthorn to discuss digital risk further.
- Noted that Non-Executive Board members would be involved in the next review of the strategic BAF risks.

BOD/2122/55 Freedom to Speak Up Annual Report 2020/21

The Freedom to Speak Up Guardian presented the Freedom to Speak Up (FTSU) Annual Report 2020/21. She reported that the Trust had received 228 cases during 2020/21 and provided an overview of the activity within the reporting period.

Dr D Hanley, in his capacity as Non-Executive lead for FTSU, advised that Freedom to Speak Up provided an effective route for staff to speak up and from his perspective there was no evidence of systemic failure.

The Director of Finance referred to the category referred to as 'other' and requested that for transparency further details be given.

The Chairman acknowledged that whilst the Covid-19 pressures continued, the Trust would expect to see an escalation in FTSU cases. He stated it was important to

recognise that staff were feeling the pressures and important that the Board kept the number of cases in context

He thanked Dr Hanley for his input and assurance, with the aim of the process to support patient and staff safety.

The Board of Directors -

- Noted the work of the Guardian.
- Supported the provision of the Trust's Freedom to Speak Up strategy.
- Robustly supported the Freedom to Speak Up principles.
- Supported the development of the Freedom to Speak Up training plan and that this aligned to the NGO's recommendations
- Supported embedding learning from concerns across the Trust.
- Considered any risks and further actions for the Trust.
- Noted that future reports would include pie charts with a breakdown of the concerns referred to as "other".

BOD/2122/56 Audit Committee Chairs Assurance Report from the meetings held on 11th June 2021 and 16th July 2021

Mr D Rawsthorn presented the Chairs Assurance Reports from the meetings held on 11th June and 16th July 2021. He referred to the Committee's Self-Assessment, which had received moderate assurance in relation to the processes of the Audit Committee and how this linked with other assurance committees.

He advised that following a conversation with MIAA it was proposed that the Resources Committee Chair's Assurance Report be included on future Audit Committee agendas, however this hadn't been communicated to or discussed with the Director of Finance or the Director of Corporate Affairs, as Executive leads for the Audit Committee prior to the meeting and during the meeting held on 16th July both had expressed concerns that it appeared to duplicate the role of Board and the process of Board governance. It was therefore agreed that a conversation would be held outside the meeting.

The Board of Directors:

- Noted the content of the Audit Committee Chair's Assurance Reports.

BOD/2122/57 Auditors Annual Report 2020/21

The Director of Finance presented the Auditor's Annual Report 2020/21. She advised that the report confirmed the outcome of the audit of the financial statements undertaken by the Trust's external auditors.

Mr D Rawsthorn advised that the Audit Committee had considered the Annual Report and the Trust's external auditors had concluded that the report provided excellent assurance with no audit recommendations. He added this was an excellent achievement, which supported the reduction in the strategic risk score of SR02.

The Board of Directors:

- Noted the content of the Annual Audit Report.
- Noted the assurance provided.
- Noted the Annual Audit Report would be published on the trust's internet site.

BOD/2122/58 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report for June 2021. She advised that the ARP C4 performance standard had been omitted, for this month, due to a review being undertaken in partnership with NHSE/I.

She highlighted the report demonstrated the Trust's response to the system demand and the sickness metrics highlighted the effect on the system. She added there were some delays in closing complaints due to the pressures. Additionally, she noted the influx in the system had affected long waits and response times; however, serious incident investigation and reporting was managed effectively.

In response to Prof R Thomson's request for clarification on the number of complaints, the Director of Quality, Innovation and Improvement confirmed that the Trust received 146 complaints per month on average and 212 in June. She acknowledged the serious incident statistics, included in the same sentence in the report, caused confusion.

In relation to Patient Experience, the Director of Strategy, Partnerships and Transformation reported that PES and PTS had experienced an increase in returns and NHS 111 a reduction of 25%. He confirmed that work was ongoing to consider the timing and receipt of surveys.

In terms of future EDI reporting, he noted that some elements of the data would be available in the September 2021 IPR Board report.

The Director of Finance provided an overview of the financial position and advised that detailed discussion had taken place at Resources Committee in relation to agency staff expenditure. She reported that some agency staff had been transferred to fixed term contracts and the increase in 999 call handling staff resource had increased the Trust's agency spend, on a temporary basis.

She advised that in terms of H2, she expected to understand the financial position in September, with the expectation that the efficiency requirement would increase.

In terms of Patient Emergency Services, the Director of Operations reported that on 19th July 2021, the Trust took 6,500 calls, the busiest day for the service ever recorded. He advised the service was operating at REAP Level 4.

He stated that a recent deep dive into Category 1 and 2 calls had highlighted an increase in call activity for 0-9 year olds and over 75 year olds and call coding attributed predominantly to respiratory problems and Covid-19. He added that Covid-19 related staff abstractions had doubled in recent weeks; however, there was evidence of staff returning to work sooner and change in the return to work guidance. He highlighted the Trust had a tired workforce which resulted in a reduced uptake of overtime.

The Director of Operations reported the Trust had recruited additional call takers, transferred agency staff onto full time permanent contracts and enhanced payment for shift over time. He added the Trust had received £6.2m additional resource to increase call-taking resources in EOC plus resource to retain vehicles for the winter period. He added plans to increase the emergency fleet and workforce by utilising the PTS workforce had commenced and discussions with Trade Unions were positive. He added the Trust had also completed a military aid application, pending submission.

Prof A Chambers advised that the Quality and Performance Committee provided scrutiny of the mitigations in place to address the risks. She confirmed the measures

taken in response to the REAP 4 pressures were effective, in terms of the level of avoidable harm reported.

Prof R Thomson referred to the heat maps contained within the report and stated the Quality and Performance Committee would monitor for geographical trends, particularly in rural areas.

The Director of Operations reported an increase in NHS 111 service call activity, with particular surge in volume from 6pm in the evening. He added the increased call volume was a national problem and recovery plans were in place including improvements to the delivery of staff training, to reduce time and increase efficiencies. He added call-handling time was on average 5 minutes with call backs adding to call volume. He noted delays attributed to newly recruited staff and changes in advice associated to the Covid-19 variants.

In relation to PTS, the Director of Operations reported a recruitment drive to the service and praised the PTS staff for their outstanding efforts in supporting the PES service. The Chairman thanked PTS for their contribution and stated the Executive Directors had full support to act and allocate resources from the additional funding. He stated all staff deserved huge praise and gratitude for working tirelessly.

He encouraged the Chair of the Resources Committee to continue to monitor sickness absence rates and any underlying related issues, despite Covid-19.

The Board of Directors:

- Noted the content of the Integrated Performance Report.

BOD/2122/59 Lessons Learnt from Deaths Summary Report Q4 2020-21

The Medical Director presented the Learning from Deaths Summary Report for Q4 2020-21 and the Annual 2020-21 dashboards. He advised the report demonstrated and supported a promise to the public that the Trust would learn and promote good practice from the process.

The Medical Director advised that the report correlated with the Trust's serious investigations and the coronial process, which provided an investigative route to identify lessons learnt from deaths.

Prof A Esmail provided assurance that the Quality and Performance Committee discussed the report in detail and stated the process was an extremely important driver for change across the organisation.

The Chairman supported the importance of the process, particularly the triangulation of the learning. He thanked all involved for providing insight into lessons learnt.

The Board of Directors:

- Noted the progress and assurance from the Learning from Deaths Q4 report and annual 2020/21 dashboards.

BOD/2122/60 Health and Safety Annual Report 2020/21

The Director of Quality, Innovation and Improvement presented the Health, Safety and Security Annual Report 2020/21 and Forward plan. She reported it represented a significant year for the Trust and detailed the work completed during the pandemic.

She highlighted the increased level of RIDDOR reporting which demonstrated a high level of efficiency and a positive indicator of the team's achievements.

She advised of a significant piece of work to review buildings and vehicles through a process of risk assessment, audit and monitoring. The Director of Finance supported the work achieved, which had included input from the Trust's Estates Department.

The Director of Quality, Innovation and Improvement highlighted the team's forward plan for 2021/22, which built upon the foundations made during 2020/21.

The Chairman noted the extremely challenging year and thanked the staff for all their efforts and a comprehensive annual report.

The Board of Directors:

- Received and accepted the Annual Report 2020/21 in relation to regulatory and mandatory national requirements.
- Acknowledged and thanked the team for their commitment and hard work.
- Recognised the achievements made in the year.
- Noted and accepted the forward plan for 2021/22.

BOD/2122/61 IPC BAF Update

The Director of Quality, Innovation and Improvement presented the Infection Prevention and Control (IPC) Board Assurance Framework (BAF) update. She reported that the BAF provided assurance that policies, procedures, system processes and training were in place to minimise the risk of Covid-19 transmissions to service users, patients and staff. She added the framework identified gaps in assurance in relation to the IPC risks and included progress made against each of the mitigating actions. She stated the framework was organised in line with the 10 Key lines of enquiry (KLOEs) with a series of questions for each KLOE.

The Director of Quality, Innovation and Improvement reported that at the end of Q1 there were 15 active IPC risks on the BAF with 3 risks assigned a score 12 or above. She added the BAF highlighted effective management of the IPC risks.

Prof A Chambers advised that the Quality and Performance Committee had received robust assurance of efficient monitoring of risk through the IPC BAF.

The Board of Directors:

- Noted the assurance that IPC risks were being adequately identified against the Key Lines of Enquiry.
- Noted that IPC risks had been reviewed.
- Noted IPC improvements had been achieved and aligned with IPC risks and actions from the original IPC BAF and revised board guidance

BOD/2122/62 Quality & Performance Committee Chairs Assurance Report from the meeting held on 24th May 2021

Prof A Chambers presented the Quality and Performance Committee Chairs Assurance Report from the meeting held on 24th May 2021.

She advised that the Integrated Performance Report had received red rated assurance due to demand and pressure on the service. She recognised the timing of the interventions the Trust had made since the date of the meeting.

The Board of Directors:

- Received and noted the content of the Quality and Performance Chairs Assurance Report from the meeting held on 24th May 2021.

BOD/2122/63 Resources Committee Chairs Assurance Report from the meeting held on 23rd July 2021

Mr R Groome presented the Resources Committee Chairs Assurance Report from the meeting held on 23rd July 2021. He reported moderate assurance had been received in relation to the digital strategy update and specifically the outstanding maintenance work required to IT systems in the 111 sites.

The Committee had considered and supported business cases related to Preston and Blackpool sites.

In relation to the Workforce Indicators Assurance Report, he noted moderate assurance in relation to the challenges of sickness absence and the ongoing actions to address compliance levels related to mandatory training and appraisals.

He added that assurance reports from the Strategic Workforce Sub Committee and Diversity and Inclusion Sub Committee provided very positive examples of the work undertaken at operational level.

The Board of Directors:

- Received and noted the content of the Resources Committee Chairs Assurance Report from the meeting held on 23rd July 2021.

BOD/2122/64 Equality, Diversity and Inclusion Priorities

The Deputy Director of People presented the Equality, Diversion and Inclusion (EDI) Priorities. She reported that following Board approval of the EDI priorities, the Trust had developed action plans to support and align to the three EDI priorities. She advised that the action plans had been discussed and supported by the Diversity and Inclusion Sub Committee and the Resources Committee.

Prof A Esmail welcomed the recruitment and progression plans. He stated these were encouraging and ambitious, particularly in relation to health inequalities. He looked forward to understanding how action plans would be cascaded and reviewed through middle management within the Trust.

The Chairman supported future understanding and assurance regarding dissemination of the action plans.

Prof R Thomson confirmed that Public Health England had published a new report that would need to link into the plans concerning rural and coastal communities' and older members of the community. The Chairman requested Prof R Thomson and Director of People discussed the inclusion of the new report. The Chief Executive added that national and regional priorities would be included in the plans and he would discuss these with Prof R Thomson.

Dr D Hanley supported the action plans and reiterated the points highlighted by the earlier patient story and barriers for deaf people within the community. He queried whether activity on workplace adaptations, if captured, would assist in collating data.

The Chairman supported the suggestion made by Dr D Hanley and requested this be discussed further with the Director of People and the Resources Committee.

The Board of Directors:

- Approved the EDI action plans that underpinned the EDI priorities.
- Supported future assurance reporting on the dissemination and review of action plans within middle management across the organisation.
- Supported further discussion between Prof R Thomson, the Chief Executive Officer and Director of People regarding national and regional priorities for EDI priorities.

BOD/2122/65 Communications and Engagement Team Q1 Report

The Director of Strategy, Partnerships and Transformation presented the Communications and Engagement Team Dashboard Report for Q1 2021/22. He reported that the quarterly report presented the key outputs and highlights from the period April to June 2021.

In terms of patient and public engagement, he advised of 22 virtual community engagement opportunities, a 22% increase on the previous quarter.

He stated there were 15 new members recruited and inducted to the Patient and Public Panel (PPP) with 157 members in total. He added that two new priorities related to increasing youth representation and representation from diverse communities.

The Director of Strategy, Partnerships and Transformation reported media relations activity for the period and stated there had been positive and proactive media relations work. He added that overall volume had increased and attributed to media coverage related to the Manchester Arena Inquiry and the major incident at Heysham.

He added there had been a number of films and videos produced and included on the Trust's website, which provided an effective method of communication with Trust stakeholders.

He advised of the launch of new branding with cleaner contemporary clinical colours that now appeared on Trust communications. He added that new initiatives included Team Talk Live and an Ideas Room on the staff website.

In relation to Freedom of Information, the Trust had completed 56 requests in Q1 and 95% within the 20 working day target, against a national target of 90%.

The Chairman thanked the Communications and Engagement team for their hard work during the quarter and the Patient and Public Panel for their continued involvement and quality feedback.

The Board of Directors -

- Noted the Communications and Engagement Team Q1 update.

BOD/2122/66 Any other business notified prior to the meeting

There was no other business notified prior to the meeting.

The Chairman reiterated the current and difficult time for the Trust and thanked the Executive team and their teams for their ongoing hard work during the extreme pressures. He also expressed his thanks to the PPP members for their attendance at the meeting.

BOD/2122/67 Items for Inclusion in the BAF

There were no items identified for inclusion in the BAF.

Date and time of the next meeting – 9.45am on Wednesday, 29th September 2021

Signed _____ Date _____

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.	Director of Corporate Affairs	26.5.21	29.9.21	For submission to September Board of Directors meeting.	
56	28/07/21	2122/53	Chief Executive's Report	Progress update on Suicide Prevention Work	Chief Executive & Execs	29.9.21	29.9.21		
57	28/07/21	2122/54	Board Assurance Framework Strategic Risks Review	Further discussion on the rationale related to digital risk.	Director of Corporate Affairs & Director of Quality, Innovation and Improvement	29.9.21	29.9.21		
58	28/07/21	2122/54	Board Assurance Framework Strategic Risks Review	Non Executives to be involved in the next review of the BAF strategic risks.	Director of Corporate Affairs & Execs	24.11.21	24.11.21		
59	28/07/21	2122/55	Freedom to Speak Up Report	To include a breakdown of the pie chart segment referred to as "other" in future reports.	Director of Corporate Affairs	24.11.21	24.11.21		
60	28/07/21	2122/64	EDI Priorities / Action Plans	Further discussion on the new Public Health England national and regional priorities related to coastal and rural communities for inclusion in local EDI action plans.	Prof R Thomson, Chief Executive and Director of People	29.9.21	29.9.21		

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NWAS Board and Committee Attendance 2021/22

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

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

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

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

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

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

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

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

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NHS
North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 September 2021			
SUBJECT:	Chief Executive's Report			
PRESENTED BY:	Daren Mochrie, Chief Executive			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
	SR05	**SR06**	**SR07**	**SR08**
	☒	☒	☒	☒
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 28 July 2021. The highlights from this report are as follows: **Paramedic Emergency Services** • Call volumes have increased by 24% in August • Continued increase in C1 and C2 calls as a percentage of the total incident volume • A recruitment plan is in place to support call pick up and additional emergency ambulances over the winter months funded through additional monies **NHS 111** • Call demand far in excess of predicted and contract value • Additional funding received to support increased activity in August and September • Staffing continues to be a challenge **PTS** • Social distancing measures continue to impact utilisation of resource • Recruitment progressing to fill current vacancy gap • PTS Review Group established to focus on designing a new service model for PTS 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 suicide prevention, the staff burnout programme and working with other parts of the NHS system to highlight challenges, identify opportunities and take action to make improvements for staff and patients			

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:			

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 28 July 2021

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

The trust continues to see increased demand and call volumes have increased by 24% in August when compared to a similar pre-COVID period. Call pick up, whilst still challenged, has improved during July and August, we are still below the required standard but improvements are being made. A recruitment plan is in place to recruit over the funded establishment to support call pick up over the winter months. This is being funded by additional funding released to ambulance trusts.

There has been a small drop in incidents (4%) for the same period, this is driven through a change in dealing with lower acuity calls whereby patients are signposted to alternative pathways before being recorded as an incident. Of the remaining calls we have seen a continued increase in category one and two calls as a percentage of the total incident volume similar to that reported in the last Board report. To meet the increased acuity we are looking to increase our emergency ambulance fleet. A plan to over recruit is in place, plus agreements with the trade unions have been made to allow a more flexible approach to utilisation of certain staff groups.

Hospital turnaround times are an increasing risk to vehicle availability this is despite less attendances by ambulance. There has been a 4:59 increase in the mean arrival to hand-over time.

2.2 NHS 111

During July and August 2021, 111 has continued to experience call demand far in excess of the contract value. 111 performance against the IUC (Integrated Urgent Care) KPIs continues to be challenged, however we are not currently an outlier across the rest of the English 111 services.

The call demand profile, particularly in the early morning on week days has shifted. There is a lot of previously unseen demand and further work is ongoing with commissioners to understand opportunities to decrease this demand across the North West.

Extended patient call back times from Out of Hours (OOHs) services following a 111 referral continue to cause additional pressures in 111 as patients frequently call back. Work is ongoing with commissioners and out of hour providers to see what more can be done to support each other.

The current demand continues to be just over 30% greater than contract value (contract plus 111 First funding). This increase in activity presents a resource gap at some points in the day of up to 50%. At the beginning of August NW 111 commissioners received £2.65m to support ongoing funding of the 111 First activity (111 and CASs) plus additional monies to improve performance during August and September in lieu of the guidance and ICS allocations of the H2 monies being released.

111 Senior Leadership Team have worked with finance, HR and the medical directorate to identify best use of the monies.

The 111 Senior Leadership Team continues to drive efficiencies through staff support to optimise the AHT (average handling time) with particular focus on ACW (after call work), where it has been found that due to the constant call demand, some staff are taking extended time out at the end of the call prior to their next call.

111 staffing continues to be a challenge with absence remaining at 20%, and attrition growing to 40%. Audit of exit interviews has identified the key reasons being, stress of the job, rostering, getting annual leave and returning to pre-COVID role/starting university. The senior team have developed a Staff Health and Well-Being Plan, to support our teams and includes reviews of annual leave, rosters and our recruitment process.

The 111 team have been recruiting continuously from May 2021 to meet the attrition levels, with courses planned throughout the rest of the financial year. Following a recent review of demand versus resource with the finance team to inform the H2 funding discussions, the 111 teams are identifying further potential recruitment that can be delivered within 2021/22.

2.3 PTS

There remains circa 90 whole time equivalent vacancies across PTS and the service line is progressing with its recruitment plans to fill these positions by the end of the financial year. It should be noted that this may be impacted by further release of resources if PTS volunteer to undertake 'blue light' duties in line with the Trust's plans to increase the number of emergency ambulances over winter. Further proposals to adapt the current workforce profile to enable greater provision of double crewed non-emergency ambulances especially in Greater Manchester are progressing in discussion with Trade Union, HR and Finance colleagues. The rationale for this is resultant from the demand profile changing since the onset of COVID as a greater proportion of PTS activity is an ambulance category mobility and to enable support to PES via the transportation of lower acuity patients.

As previously reported, capacity challenges associated with social distancing measures continue to impact utilisation of resource. Whilst the current direction is that current IPC / social distancing measures will remain in place discussions continue with NHSE/I, and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively.

In addition to the above, the service line is a core member of an Operational Design Group (ODG) 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. A sub group to the ODG (PTS Review Group) and led by Commissioners has been established.

3. ISSUES TO NOTE

3.1 Local Issues

New Hospitals Programme

Lancashire and South Cumbria New Hospitals Programme is now entering an important new phase, including the publication of a list of possible solutions for hospital facilities in Preston, Lancaster and Barrow-in-Furness.

Over the last few months, the programme has been collecting information on everything from what future clinical and technological developments they might need to accommodate in new hospital facilities, to potential land availability and building specifications. Thousands of patients, staff and stakeholders have been involved in this conversation to start to build a picture of what they do (and don't) want from new hospitals facilities.

Birkdale Park Care Home

I was recently contacted by the manager of two care homes in Southport and invited to partake in Birkdale Park chip butty Friday. For the last 5 months they have run a growing service of Chip Butty Friday for all NWAS paramedics. They post on social media using the hashtags #aftertheclapshavestopped and #inthistogther and invite any ambulance crew who might be passing to stop and enjoy a chip butty. An amazing gesture of support for our crews

3.2 Regional issues

Update on pressures

During the months the trust has escalated and deescalated between REAP 3 and REAP 4

The decision to escalate or deescalate is taken after reviewing current operating pressures and considering several factors including demand for our services. It's important to remember that, whilst a de-escalation, REAP level 3 is still classed as major pressure – we continue to operate under challenging and uncertain circumstances and will always return to a higher REAP level as necessary.

We continue to take extra steps to help ensure we can deliver safe, quality and timely services to patients. We are in the process of recruiting and training a significant number of key personnel over the coming weeks and months, specifically EOC staff including emergency medical dispatchers (EMDs), paramedics, associate ambulance practitioners (AAPs), emergency medical technicians (EMTs), and health advisors within 111.

We continue to work with NHS England to explore all other suitable alternatives of maximining resources, including how we can maximise internal resources as we have done previously with patient transport services supporting PES, and also considering support from other public sector organisations. We continue to talk to trade union colleagues to ensure we have the best balance to support staff and respond to our patients.

We are also looking at ways corporate colleagues may be able to offer additional support to the frontline on welfare vehicles and in EOC, for example. We are continuing to use Volunteers and resources from third parties. Following a recent government funding announcement, we plan to increase our resources further to help us mitigate these stresses. We're looking to retain existing vehicles to expand our fleet, increase call handlers and clinical staff in EOC, and support operational resources through various other routes.

Manchester Arena Inquiry

The Manchester Arena Inquiry has moved into the next Chapter which will hear details about the circumstances and injuries of those who lost their lives. This will include witness accounts from people who were in contact with them, including our staff.

Revisiting the events of 22 May 2017 and talking about this to the inquiry will not be an easy task, and all colleagues who are being called as witnesses are being fully supported by a dedicated legal team and their senior managers.

We expect to see headlines in the press relating to the inquiry over the next few weeks, some of which will refer to NWAS and our response. We understand that when there is media attention about our team members who did their very best on that awful evening, the natural reaction is to want to support them. The trust fully supports the inquiry and respects the right of the families and the public to have an open, independent review, which will help all the authorities involved to understand if there is learning that could be applied in future major incident scenarios. For this reason, and on the advice of our legal team, we cannot publicly comment on proceedings before the inquiry has concluded.

Trust AGM

On Tuesday 14 September the trust held our Annual General Meeting (AGM), live via Microsoft Teams. I presented our performance and achievements from 2020/21, and Carolyn Wood, Director of Finance, discussed the financial accounts.

Around 50 attendees watched the event, and the Q & A session that followed produced a good range of questions answered by executive director colleagues. A short film showcasing our achievements from the past year was played.

Feedback on the virtual live event has been very positive from those attending as well as those involved. I would to thank the governance and communications teams for delivering a very professional and smooth-running event once again.

Patient and Public Panel – second anniversary

During September we celebrated the second anniversary of our Patient and Public Panel (PPP).

Despite the challenges of the pandemic, we now have more than 170 members involved in the work of the trust, supporting at learning forums, giving feedback on projects and providing their opinions on campaigns, new systems and strategies.

To mark this milestone, we have produced a PPP achievements publication to recognise and showcase the fantastic work our panel members have supported us with since it was first established in September 2019.

During the last year, panel members have supported the NHS 111 First initiative, provided feedback and ideas around the development of our new brand and even completed a mystery shopper exercise with our third-party PTS providers, to name a few.

3.3 National Issues

Afghanistan

We have a large number of veterans and reservists working as part of Team NWAS and we were aware that the news regarding the situation in Afghanistan had the

potential to be very distressing and have a significant impact on colleagues within our armed forces community.

The mayors of Greater Manchester and the Liverpool City Region welcomed refugees fleeing from Afghanistan and were in need of somewhere safe to stay; charities were overwhelmed with donations of items such as clothing and other essentials.

The first evacuation flights carrying British nationals and Afghans arrived in the UK on Sunday 15 August with other flights landing on the Tuesday and Wednesday. NWAS provided support to other agencies to ensure the safe arrival of the evacuation flights. This really reflects the kind-hearted nature of our North West communities, which we have seen come together to help others at times of crisis over and over again.

4. GENERAL

Public inquiry into the COVID-19 response

Prime Minister Boris Johnson announced an inquiry into the handling of the COVID-19 pandemic, likely to start next year, including the public sector's response. The purpose of the inquiry is not to determine civil or criminal liability, but to ensure transparency and that lessons are learned. As such, they have considerable evidence gathering powers.

We anticipate this will consider in detail the response of NHS England and NHS Improvement and providers of health and social care. Also that it will require the disclosure of a considerable number of records relating to key issues arising and decisions made before and during the pandemic.

It is not clear at this stage how individual organisations, like ours, will be involved. However, in anticipation of our potential involvement, we must retain all documents (reports, letters, notes, text messages, emails etc.) and all other information, which may relate to our response to the pandemic and critical decisions made as part of the recovery.
We are committed to fully cooperating with the inquiry openly and transparently.

Internal COVID-19 Audit

It has been announced that there will be an internal audit to review the mechanisms we used to identify and learn lessons from our response to the COVID-19 pandemic and how these lessons have translated into practice changes. The review will be led by Mersey Internal Audit Agency and will include both patient facing and corporate services.

Ambulance services key to NHS transformation and coping with COVID-19 long term

The Association of Ambulance Chief Executives recently published a joint report with NHS Providers which says ambulance services should play a pivotal role in helping the NHS pull through the pandemic, bear down on the care backlog and transform services for patients.

'Rapid response: The role of the ambulance sector in transforming services and coping with the long-term impact of COVID-19' sets out how the skills, scale and reach of ambulance services mean we can be key to planning and delivering high

quality care as close to home as possible: a central ambition of the NHS Long Term Plan.

Ambulance trusts are operating under incredible pressure and the health system owes a huge debt of gratitude to the staff who have maintained services and cared for patients – operating at the sharp end of the pandemic.

This report shows in practical ways how we have been adapting and, as the health and care system builds on learning and innovation from the pandemic, it highlights how the ambulance sector will play a key role in helping to reduce care backlogs and meet rising demand for services. This is a time of extraordinary pressure, but also a moment of opportunity to build on the strategic strengths of ambulance services.

Ambulance BBC documentary

2.7 million people across the country, tuned in to watch the first episode of the brand new series of BBC's Ambulance. This is the seventh series and was filmed in Merseyside, Cumbria & Lancashire and will run for 12 weeks. Filmed in early 2021, it highlights our challenges when dealing with an unprecedented volume of calls, and puts a spotlight on the strains the whole NHS feel.

I would like to thank everyone involved for allowing the public into staff's working life and for sharing their powerful, personal stories, as well as capturing the life affirming highs and the deep lows they encountered every day.

It was the most popular programme on the 9pm timeslot on launch day and the reaction on social media was phenomenal, with so many messages of support from the public.

Another episode featured the mental health triage car whose work in the community aims to reduce the number of mental health hospital admissions. At the time of filming temperatures plummeted to below zero and staff reflected on how loneliness had started to take over the thoughts of so many through lockdown. The series has helped shine a light on what the pandemic has really been like for those at the heart of it.

Emergency Services Day

On 9 September we marked Emergency Services Day, also known as 999 Day, with a flag-raising ceremony and two minutes' silence at our HQ in Bolton. The day is celebrated across the UK annually and is a chance to support the heroic men and women of the NHS and emergency services.

The day also gave us the opportunity to remember the #TeamNWAS members and all our colleagues across the emergency services who are sadly no longer with us. Along with myself, Director of Operations, Ged Blezard, was also present as well as colleagues who wanted to pay their respects. Other sites across the trust also raised their flags to support the day.

Suicide Prevention Day

Friday 10 September was Suicide Prevention Day and was the launch of our suicide prevention toolkit for staff. The toolkit has been designed to help, support and educate everyone in the organisation around the risks of suicide within the workplace, promoting good practice, and encouraging healthy conversations to remove the stigma often associated with mental health problems and suicide.

I am aware that work has been done recently within the ambulance sector to address this and support suicide prevention and postvention. 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. Our Suicide Prevention Lead, Craig Hayden, has been an integral part of this essential programme of work ensuring that we were key contributions in the national work being undertaken and recently joined a meeting with The Duke of Cambridge and other emergency responders at Kensington Palace to speak about how we can help to support suicide prevention within the emergency services community.

I am aware, that we were already leading the way in terms of suicide prevention before this national work was commissioned. As an organisation, we have had a Suicide Prevention Lead, a Suicide Prevention Steering Group and three year programme of work in place since January 2019, the main focus of this work has been not only supporting our patients who are suicidal but also working to support positive mental wellbeing in our workforce. I am delighted that the outcome of this latter work stream has been this valued and time critical Suicide Toolkit Prevention, Management and Postvention. My hope is that this will be a toolkit that will support the organisation to better support the mental health and wellbeing of our staff, volunteers and students.

World Patient Safety Day

Friday 17 September marked World Patient Safety Day, and this year's theme was safe maternal and newborn care. This is an area of work that is growing rapidly for us and I am pleased to have a dedicated maternity team in our organization, focused on strengthening the representation of the ambulance services as a critical provider of maternal and newborn emergency care.

In May of this year, we appointed our first ever Consultant Midwife, Dr Stephanie Heys. Stephanie is one of only three consultant midwives in the country to work within ambulance trusts. Stephanie and the team have been working hard on fantastic initiatives, including 'snuggle pods' for preterm babies, who are born too early for resuscitation so that they can travel to hospital with dignity, compassion and respect.

A huge well done to everyone involved for all this work.

Team Talk Live

Chairman Peter White and I held a Team Talk Live session after the last Board meeting to give updates and insights from the meeting and answer staff questions.

Peter shared his thoughts on the patient story, which was about our partnership with Deafway. The film provided useful, practical information about how we can do more to support patients who are deaf. Peter explained how we, as a Board, have committed to undertaking disability awareness training to improve our awareness and understanding of the some of the challenges faced by people with a disability.

I then gave an overview of the CEO report which I presented to the Board which included providing the position in terms of demand and how we are working together to manage it as well as how we're continuing to invest in and increase our operational resources across 999 and 111.

The amazing efforts of our volunteers is something else I highlighted, backed up by the amazing statistic that over the last year, our community first responders (CFRs) have given over 120,000 hours' worth of support.

Working with System Leaders

Members of the Executive Leadership Committee continue to work with other parts of the NHS system to highlight challenges, identify opportunities and take action to make improvements for staff and patients.

I meet regularly with the national NHS England/Improvement team, CQC, College of Paramedics and the Chief Allied Health Professions Officer. I have been discussing the pressure on the ambulance sector and what more we can do together. I also sit on several weekly regional NHS England and Improvement strategic meetings along with Integrated Care System leads, representatives from the larger NHS Providers in the region and senior leaders from NHS England and Improvement. I highlight the pressures on all aspects of our service and discuss what more we can do together.

Treat Me Right

One of my regular duties is to review the current anonymized Freedom To Speak Up cases, which I do every month. Freedom To Speak Up is the name we give to the process for raising concerns confidentially. A number of the issues I reviewed recently relate to dignity at work.

Staff feedback in previous surveys showed us that too many people experience bullying and harassment in the workplace. This is not acceptable and identified a key improvement goal. No one should feel harassed, bullied or abused in their place of work. A group was set up to tackle this. It recommended a campaign to reinforce and further embed our Dignity at Work Policy and highlight the importance of informal resolution and civility and respect at work.

The treat me right toolkit helps support staff and managers to feel empowered to seek early resolution and to encourage open communication.

Burnout Programme

The staff burnout programme hosted by Manchester Stress Institute presented an opportunity for staff to participate in a four week resilience recovery programme and some well-deserved relaxation. We all have very active, busy lives and sometimes it can be hard to remember to take some all-important time for yourself.

The sessions are taking place all month and have been teaching us the art of meditation, dealing with anxiety and switching off from negative thoughts. Feedback from the sessions has been very positive.

The Manchester Stress Institute will also be delivering a Manager's mental health and resilience programme throughout October and November. This bespoke four week programme is specifically aimed at managers and leaders and consists of weekly 1:1 30 minute coaching sessions.

Launch of new menopause policy and procedure

We recognise the importance of supporting staff who are experiencing symptoms associated with menopause or who are indirectly affected through a family member or work colleague. We want to provide an environment where staff feel able to engage in discussions about menopause and ask for support and adjustments at work without fear or embarrassment.

To provide further support, we have appointed a group of menopause champions from across all areas of the trust. The champions are fully trained and can be contacted via email should staff wish to talk or seek support.

NHS makes history with first female CEO

The NHS's first female chief executive replacing Sir Simon Stevens has commenced in role. Amanda Pritchard was NHS England's Chief Operating Officer and previously led Guy's and St Thomas' NHS Trust in London and was an adviser in Tony Blair's government.

Prime Minister Boris Johnson said her experience and expertise made her 'perfectly placed' to lead the NHS.

NHS Confederation, which supports and speaks for the whole healthcare system, including ambulance services, has set out what it believes Amanda's immediate priorities should be:

- The first priority should be to put forward the strongest argument possible for the NHS to get the funding it needs to get through the second half of this financial year and respond to coronavirus and its associated challenges.
- The second priority should be to put forward a watertight position for additional long-term funding for the NHS in the comprehensive spending review in the autumn.
- The third priority should be to help steer the Health and Care Bill through Parliament, given the support it largely has across the NHS already and to work to address the few elements of the legislation that do not have the NHS's backing.
- The fourth priority should be to lead the NHS workforce through the remainder of the pandemic and beyond in a way that makes them feel valued and supported to deliver their vital roles for their local communities.
- The final immediate priority should be to reduce micromanagement and control from NHS England to the service and support a culture that genuinely lets local leaders lead.

Random acts of kindness

In addition to our usual 999 day commemorations, we wanted to make this year a little bit more special.

500 random acts of kindness have been delivered across the trust to help spread a little positivity. Staff were chosen completely at random to receive a small gift, these included a £5 Costa voucher, a copy of The Happy Newspaper, a gratitude journal, a positivity mug and one lucky person from each service line received a winter survival kit.

Each gift was accompanied with a card asking you to pass on the positivity amongst your colleagues in small ways, such as making someone a cup of tea, checking in with a quick chat or dropping someone an email to say thank you.

This was part of a week of gratitude initiatives which also included the release of our COVID-19 thank you pin badges, for staff to keep in recognition of their support, kindness and exceptional service during the COVID-19 pandemic. These last 18 months have been the hardest and most tiring times in our service so far and we are still facing extreme pressure.

As a trust we know we have a long way to go in terms of recovering from this pandemic and we know we cannot do it without each and every one of our staff and volunteers. The week of positivity has been a reminder that everyone is doing a fantastic job and we as a Board are very grateful for what everyone does

Essential research

Research is essential to expanding the evidence base in health and social care to improve the current and future health of the population. All NHS trusts are subject to Care Quality Commission (CQC) inspection and under the 'Well-led Framework', are assessed on how well clinical research is integrated into their organization.

As an NHS organisation, we generate our own research income, some of which is dependent on the number of people who take part in the studies we support. The number of participants that have taken part in research with NWAS has increased over the last few years and we would like to see this growth continue and carry on attracting investment to help build our capacity and capability to host, deliver and develop research.

Three are currently 2 National Institute for Health Research (NIHR) studies which staff can participate in: For paramedics: AHP Perceptions of Research in the NHS and for all staff, patients and the public: Psychological Impact of COVID-19. The closing date for both research studies is 30 September 2021

Building a Net Zero NHS

In October 2020, NHS England and Improvement and the Greener NHS team released an ambitious plan to deliver a Net Zero carbon National Health Service by 2040. To achieve net zero, every NHS organisation needs to accelerate the implementation of low carbon and sustainable solutions at a rapid pace so that by 2040 the whole system has reduced the amount of carbon it has produced as far as is possible and also has systems in place to absorb carbon from the atmosphere, known as offsetting.

Awards

Our magazine Your Call and our #Inside999 campaign have been shortlisted for awards at the CIPR North West PRide Awards which recognise the talent, creativity and success of communications teams and individuals around the UK.

Your Call, has been shortlisted in the Best Publication category and has gone from strength to strength in the last year as readership has increased by a massive 957%. This is thanks to introducing a number of changes to the publication including staff, volunteers, patients and public getting involved and sharing their real-life, human interest stories and news articles, which are important and relatable to readers.

In the height of the pandemic, back in January 2021, the trust introduced a public education campaign that looked at how the ambulance service works by debunking common myths and misconceptions. Some of the messages shared on our social media platforms using #Inside999 helped spread key messages in a meaningful and engaging way as well as encouraging people to use our services sensibly.

#Inside999 has been shortlisted in the Best Healthcare Campaign category and winners of both categories will be announced in a virtual ceremony that takes place on the evening of 5 October 2021.

In addition the trust has been shortlisted for the 2021 HSJ Awards in the Patient Safety Award Category. Our Every Minute Matters hospital handover collaborative was selected based on ambition, visionary spirt and the demonstrable positive impact the team has had on both patient and staff experiences.

The winners of the HSJ Awards will be announced on 18 November

Death of staff members

It is with great sadness that I report on the death of Paul Scott, and former staff members Bernard O'Brien and Graham (Joe) Phipps

Paul sadly passed away suddenly. He joined NWAS as a CFR in February 2013 and went on to complete his eCFR training course in August 2015. He recently took up the role of CFR team leader for the Lancaster and Morecambe team and played a part in covering the welfare vehicles at Royal Lancaster Infirmary. Paul finally achieved his ambition to become an apprentice EMT and started his training with us just couple of months ago

Former staff members

Bernard O'Brien started in the service in 1992 and left in 2010. Bernard worked out of Fazackerly and was a well-liked member of the team.

Graham (Joe) Phipps worked for the service for around 24 years as an ambulance care assistant based at Southport and retired in 2018. Joe was a well-respected member of the team and a good friend to many.

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

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.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th September 2021			
SUBJECT:	Strategic Planning Review and Recommendations			
PRESENTED BY:	Salman Desai, Director of Strategy, Planning and Transformation			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
	SR05	**SR06**	**SR07**	**SR08**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision			

EXECUTIVE SUMMARY:

The strategic context within which NWAS is operating has changed significantly during Covid-19 and will be subject to further change as national policy and reform embed in legislation.

In Q2 2021/22, a strategic planning review was undertaken to establish whether our Corporate Strategy and Strategic Planning function, processes and outputs remain relevant and responsive within the changing strategic context.

The purpose of this paper is to outline the findings of the strategic planning review and the associated recommendations for improvement which Trust Board are asked to discuss and endorse.

Section 3 provides an overview of the Strategic Planning review scope and approach, and outlines a SWOT analysis of the findings. The key themes identified were; trust strategy, strategic priorities/objectives, culture, documentation/assurance and strategic planning function.

Section 4 outlines the recommendations for improvement informed by the review. Four recommendations are outlined for discussion and approval:

1. Undertake short-term Q3/Q4 planning which provides a balance between ongoing Covid-19 response, winter plans, restoration and recovery objectives and priority 'must-dos';
2. Initiate a Trust strategy redevelopment programme which aims to review the content of the Corporate strategy and associated strategic priorities and objectives to ensure the content provides clear strategic direction and alignment to changes in wider national/regional legislation;
3. Align review of Right Care strategy with the Corporate strategy review to ensure consistency in approach and content, whilst maximising opportunities to streamline engagement and capacity, and;

	4. Develop and implement a revised annual planning process for implementation from 2022/23 which replaces the existing IBP to provide more useful, iterative documentation which reduces duplication and silo working and increases oversight and accountability over delivery of strategic objectives Section 5 details the next steps and actions which will be undertaken to implement the recommendations outlined above following Trust Board approval.			
RECOMMENDATIONS:	The Trust Board of Directors are asked to consider the content of this report and in particular, note the outcomes of the Strategic Planning review summarised in section 3, consider and discuss the associated recommendations outlined in section 4 and endorse the over-arching workplan and associated next steps outlined in section 5. It is recommended that a follow up report is presented to ELC in October and Trust Board in November outlining a more detailed implementation plan and providing assurance on progress made to date.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	n/a			
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this paper is to provide Trust Board with an overview of the Strategic Planning review which was completed in Q2 of 2021/22, and outline the associated recommendations for discussion and approval.

2. BACKGROUND

2.1 Covid-19 response

Since the onset of the Covid-19 pandemic in March 2020, NWAS' approach to strategic planning has been adapted to enable the organisation to proactively respond to the iterative changes in national and regional policy, whilst maintaining safe patient care and operational performance during periods of extreme pressure.

During this time, NWAS undertook a light-touch review of the corporate Trust Strategy and IBP in Q4 2020/21 however, the Executive Leadership Committee and Trust Board of Directors agreed to stand down BAU strategic planning processes such as objective setting and quarterly IBP assurance reports, in order to prioritise the ongoing Covid-19 response as well as 'must-do' programmes of work that support service delivery and/or our strategic direction of travel.

2.2 National and regional context

National and regional BAU planning processes have also been temporarily replaced with interim solutions which most notably included the implementation of the Covid-19 financial regime and a move away from annual financial planning to half-year (H1/H2) financial plans. Annual contract negotiations with Lead Commissioners were also paused and temporary block contracts agreed alongside extensions to the 111 and PTS contract end dates.

Nationally, NHS England and the Department of Health and Social Care have published a series of reports outlining the legislative changes which will come into effect from April 2022 as informed by both the Long Term Plan and experience/learning throughout the Covid-19 pandemic and the long-term associated challenges.

The whole-system reform will see a focus on co-design, collaboration, partnership and integration through the implementation of Integrated Care Systems (ICS) which will take devolved responsibility for all NHS strategic planning and financial allocation decisions from April 2022.

The strategic context within which NWAS is operating has therefore changed significantly during Covid-19 and will be subject to further change as national policy and reform embed in legislation.

In Q1 2021/22 NWAS commissioned an external consultancy (4OC) to undertake a review into how NWAS can most effectively engage with ICS' and position itself as a key partner within an integrated health and care system. Following engagement with internal and external stakeholders, a consistent theme which emerged was the need for greater clarity and consistency when communicating the vision and strategic direction for NWAS.

In response, a strategic planning review was undertaken to establish whether our Corporate Strategy, Strategic Planning function, processes and outputs remain relevant and responsive within the changing strategic context. The remainder of this paper outlines the findings of the strategic planning review and the associated recommendations for improvement which Trust Board are asked to discuss and endorse.

3. STRATEGIC PLANNING REVIEW

3.1 Scope and approach

The Strategic Planning review was commissioned by the Director of Strategy, Partnerships and Transformation in Q2 of 2021/22 for completion by the end of September. The scope of the review included the Trust's corporate strategy, enabling strategies, strategic priorities, IBP, PAF, directorate objective setting and assurance processes.

The review comprised the following elements:

- 1:1 and group discussions with individuals representing all NWAS directorates (operational and corporate);
- Benchmarking and evaluation of Strategic Planning approaches utilised in other NHS organisations, with particular focus on organisations who have been rated Outstanding by CQC in Well-Led domain;
- Evaluation of the themes and recommendations included within the 4OC report regarding NWAS engagement with ICS'.

During engagement with key stakeholders, the following three questions were posed in order to focus initial discussions and enable thematic analysis of outputs:

1. **Strategy content -** Is our Trust Strategy (incl. enabling strategies and business plan) clear and fit for purpose, accounting for the changing strategic context due to Covid, ICS reform etc.?
2. **Strategic planning processes -** Which aspects of NWAS' existing strategic planning approach work well, and where might we improve?
3. **Strategic planning function and outputs -** How could the Strategic Planning function within NWAS add most value to the organisation, and how should it interact with other Trust directorates/departments?

3.2 Key themes from findings

The table below provides a high-level SWOT analysis based on the outputs from discussions with NWAS leaders, supplemented by learning from external benchmarking and 4OC recommendations.

A number of key themes were clearly identifiable throughout the review which are highlighted in bold within the table below, these include; trust strategy, strategic priorities & objectives, culture & leadership, documentation & assurance and the Strategic Planning function.

STRENGTHS	**WEAKNESSES**
- Staff relate to and identify with 'Right Care, Right Time, Right Place; Every Time' which offers good foundation to develop strategic narrative and objectives - Existing **enables strategies** have moved NWAS forward in defining our long term strategic ambitions (incl. UEC, Digital, People, Quality, Estates) - Learning and opportunities during Covid-19 to improve co-design and collaboration and expedite improvements - Valuable partnerships we can draw on to support strategy development (i.e. AACE, other organisations etc.) - Good practice established within directorate and committee **reporting** structures which could be scaled up across the organisation.	- Lack of clear vision- existing **trust strategy** does not provide 'true north' - One strategy per directorate approach can lead to silo working - Strategy content needs to reflect current context and outline how we will respond to changes - Fewer, more consistent '**strategic priorities**' and **objectives** to develop a clear 'golden thread' across the Trust - Improve focus on outcomes and benefits rather than outputs and deliverables - Some inconsistency in strategic narrative and **prioritisation** at senior **leadership** level (incl. ELC and Board) - Duplication within **documentation** and reporting processes - Lack of critical challenge, scrutiny and 'read across' during **objective setting**

OPPORTUNITIES	THREATS
- Timing with wider changes in national and regional changes to legislation and strategic planning approach - NWAS partners recognise the crucial role we play in an integrated health and care system and want us 'round the table' - ICS legislation places emphasis on co-design, collaboration and integration which aligns to NWAS existing strategic intensions to become and integrated U&EC provider - Alignment of Strategic Planning with Transformation enables review of core **function** and skillset needed to improve value added - ELC and Board development to ensure **senior leaders** able to respond to ICS requirements - Effective **strategic planning processes** will increase capability to monitor resource availability against projects and the trusts strategic priorities.	- **Culture** within NWAS too process driven and perceived lack of appetite to be radical or brave in strategy review - Existing **IBP** not fit for purpose, not effectively utilise to set objectives or scrutinise progress - Risk if we do nothing, ICS' will move at pace without NWAS involvement meaning we could be 'done to' - DX3531 is a risk identified by Corporate Programme Board re: NWAS unable to effectively prioritise resource and capacity to achieve strategic objectives alongside BAU - Ongoing threat of Covid-19 pandemic and its impact on ability to proactively plan – must account for Covid-19 response within plans

The following section (4) provides a more detailed appraisal of the outputs of the review to inform a number of recommendations.

Trust Board are asked to discuss each of the recommendations and provide endorsement and approval to proceed with the next steps outlined within section 5.

4. RECOMMENDATIONS FROM REVIEW

4.1 Recommendation 1: Short term planning for Q3/Q4

Where are we now?

- NWAS has identified a number of short-term priorities to improve operational performance under the Service Delivery Model Review and aligned to non-recurrent winter funding
- Regional winter planning templates already in distribution, submission deadline 30th September via ICS governance structures
- H2 planning guidance expected in early Q3
- Short term strategic objectives require further clarity and alignment with directorate objectives

What should we do?

- Establish interim planning approach for Q3/Q4 of 2021/22 which provides a balance between ongoing Covid-19 response requirements, winter plan, restoration and recovery objectives and priority 'must dos'
- Subsequent directorate plans/objectives must align with organisational 'must do' priorities
- Agree prioritisation including what can be paused if required over winter
- Integrated Q3/Q4 plan to be signed off by ELC in October and Trust Board by November 2021

4.2 Recommendation 2: Trust strategy redevelopment

Where are we now?

- Feedback from strategic planning review highlights the need for greater clarity of Trust-level strategy, priorities and objectives
- Wider strategic context has changed since previous strategy published in 2019 (Covid-19, national strategic reform, ICS structures etc.)
- Opportunity to reset and reconfirm NWAS' strategic vision and transformation roadmap

What should we do?

- Complete full Trust strategy refresh/redevelopment programme by March 2022
- Series of strategy development workshops supported by consultation and engagement plan
- Strategy redevelopment programme to be designed and delivered through a series of stages:
    - **Stage 1: Frame** - Agree scope and mobilise (Board and ELC sponsorship, develop workplan)
    - **Stage 2: Diagnose** - Confirm current state, strategic context and intent (PESTLE, drivers, stakeholder mapping, governance, project plan)
    - **Stage 3: Design** - Agree 'true north', vision, priorities and strategic objectives (strategy driver diagram, enabling strategies, portfolio priorities, measures & outputs)
    - **Stage 4: Deliver** - Agree phasing of objectives, develop transformation roadmap, agree implementation approach (implementation planning aligned to annual business planning)
    - **Stage 5: Evaluate & evolve** - Approval and commence implementation (embed within strategic planning approach to measure and assure progress, identify triggers for review/refresh)
- Appendix 1 provides an indicative strategy redevelopment programme workplan and timeline to inform Trust Board discussions; further details around next steps are included within Section 5.

4.3 Recommendation 3: Enabling strategies

Where are we now?

- Feedback from strategic planning review suggests that NWAS have too many disparate enabling strategies which are not effectively aligned to the Trust strategy
- Lack of 'golden thread' between enabling strategies and with overarching strategic objectives; resulting in silo working
- Right Care strategy due for review and refresh by March 2022

What should we do?

- Incorporate Right Care strategy review and refresh within the wider Trust strategy redevelopment programme; consider appropriate timescales for engagement, strategy review and approval
- Align strategy engagement and consultation approach to maximise capacity and resource availability

- From 2022/23 (following approval of Trust strategy and Quality strategy), agree programme of wider enabling strategy review and refresh to ensure alignment with strategic objectives and priorities
- Recommendation would be to consolidate the number of enabling strategies and avoid a 'one strategy per directorate' approach

4.4 Recommendation 4: Strategic Planning Function & Approach

Where are we now?

- Feedback from strategic planning review suggests NWAS' Strategic Planning function could be improved to ensure value added
- Existing documentation and processes not well utilised or embedded (i.e. IBP)
- Before the onset of Covid, ELC and Trust Board approved a recommendation to move towards annual business planning approach
- Strategic Planning currently sits as an isolated function within the Strategy, Planning & Transformation directorate

What should we do?

- Agree to discontinue the existing Integrated Business Plan (IBP), PAF and objective setting processes
- Agree and embed an annual Strategic Planning approach which compliments the three-year strategic planning cycle by April 2022 (incl. annual trust plan, directorate business plans and measurement/assurance plans)
- Develop new processes, governance and documentation to streamline strategic planning requirements and remove duplication
- Review Strategic Planning team to ensure appropriate structure, skillsets and capacity that add value and bring together with Transformation into a single department (Strategic Planning & Transformation)

5. IMPLEMENTATIONS & NEXT STEPS

5.1 The recommendations outlined within section 4 represent a transition from how NWAS currently approaches Strategic Planning, to a proposed improved future state. The work required is complex and will need to be sequenced appropriately to ensure the outputs are achieved.

The programme of work comprising the four recommendations will be managed by the Interim Head of Strategic Planning & Transformation with resource capacity provided by the Transformation Team.

The table below summarises the implementation actions and next steps which will be initiated following Trust Board approval of the recommendations outlined above.

Recommendation	Work area	Next step	Timescales
1. Q3/Q4 planning	Winter planning	- Regional winter planning template circulated to A&E Deliver Boards. - Regional winter plans submitted via ICS governance structures.	End Sept 2021
	Q3/Q4 prioritisation	- Finalise ELC prioritisation of Trust-level 'must do' objectives	End Oct 2021

		- Directorate Q3/Q4 objective developed and aligned to Trust-level 'must dos' - Q3/Q4 objectives presented to ELC (Oct) and Resources Committee (Nov)	
2. Trust strategy redevelopment	Programme initiation	- Commence 'diagnose stage' of programme with ELC & Board sponsorship	1st Oct 2021
	Implementation plan	- Develop detailed implementation plan for strategy development programme for ELC sign off	Mid Oct 2021
	Engagement strategy	- Develop detailed engagement strategy for strategy development programme for inclusion in implementation plan - Arrange NED briefing sessions for input and oversight - Commence engagement	Mid Oct 2021
	Delivery resource	- Utilise recent Transformation vacancies to fund fixed term programme resource	End Oct 2021
3. Enabling strategies	Right care strategy engagement	- Align RC Strategy refresh to strategy development programme - Align implementation and engagement plans - Commence engagement	Mid Oct 2021
4. Strategic planning function and approach	Function and team structure	- NED briefing regarding proposal for aligned Strategic Planning & Transformation function - Agree substantive team structure	End Nov 2021
	Annual planning approach	- Develop recommendations for annual business planning approach for approval at ELC and Trust Board	End Nov 2021
	2022/23 plans	- Utilise revised planning approach to develop plans for 2022/23 - Sign off 2022/23 plans	End Jan 2022

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

6.1 There are no immediate legal concerns associated with the Strategic Planning review or recommended next steps.

It is considered effective governance for NWAS to regularly review and refresh our strategic plans in order to effectively triangulate strategy, risk management and assurance through the Board Assurance Framework.

Full appraisal of the risk implications the Strategic Planning work programme will be considered alongside the next steps outlined above.

7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

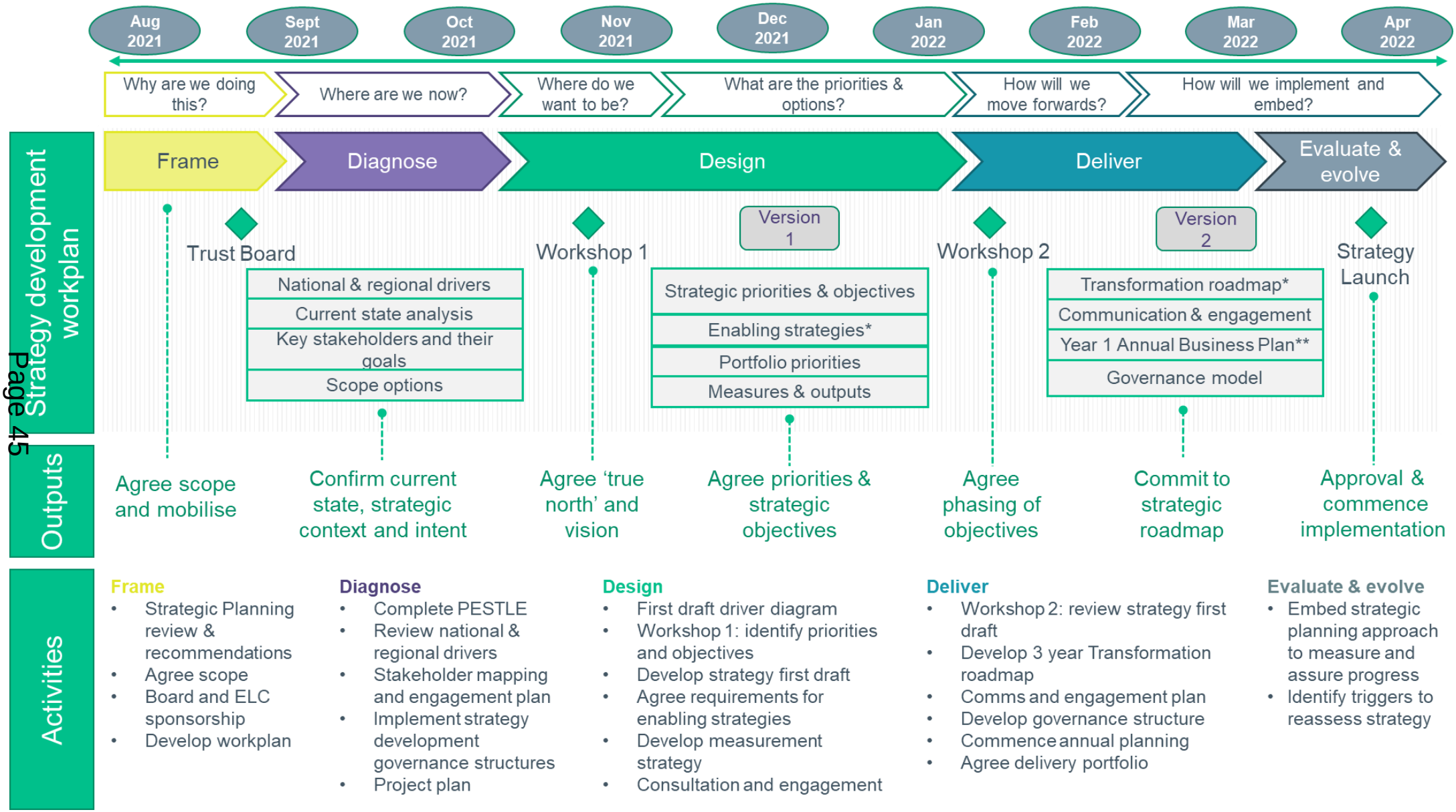
7.1 The equality and sustainability implications of each recommendation will be fully appraised and considered as part of next steps following Board approval to proceed. The implementation plan which will be presented to ELC will provide more detail regarding how equality and sustainability impact assessments will be incorporated within the programme.

8. RECOMMENDATIONS FOR BOARD

The Trust Board of Directors are asked to consider the content of this report and in particular, note the outcomes of the Strategic Planning review summarised in section 3, consider and discuss the associated recommendations outlined in section 4 and endorse the over-arching workplan and associated next steps outlined in section 5.

It is recommended that a follow up report is presented to ELC in October and Trust Board in November outlining a more detailed implementation plan and providing assurance on progress made to date.

Appendix 1: Indicative Strategy Redevelopment Workplan



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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	**29th September 2021**			
SUBJECT:	**MOU: Division of Responsibilities between the Chair of the Trust Board and the Chief Executive Officer**			
PRESENTED BY:	**Angela Wetton, Director of Corporate Affairs**			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☒	☐	☐
PURPOSE OF PAPER:	For Decision			
EXECUTIVE SUMMARY:	Whilst not a Foundation Trust, the North West Ambulance Service NHS Trust seeks to adhere to the Code of Governance where applicable. Clause A.2.1 of Monitor's Code of Governance recommends: "*that there should be a division of responsibilities between the chairing of the Boards of Directors and the executive responsibility for the running of the NHS Foundation Trust affairs. No one individual should have unfettered powers of decision. The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors.*" The clarification of the roles can be seen in the document attached.			
RECOMMENDATIONS:	The Board of Directors is recommended: • To approve the Memorandum of Understanding and ask the Director of Corporate Affairs to maintain a signed copy on corporate record.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:	N/A		
	Outcome:	N/A		

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1. PURPOSE

This Memorandum of Understanding between the Chair and Chief Executive of the North West Ambulance Service NHS Trust sets out their differing and complementary leadership roles.

2. BACKGROUND

At the broadest level the Chair's role is to lead the Board of Directors to ensure that the organisation has the vision, strategy and resource in place to deliver the objectives of the Trust and to create the conditions for good governance. It is acknowledged that the Chair's role is not an executive one and therefore does not require becoming involved in the day-to-day running of the organisation.

The Chief Executive's role is to lead the executive team and ultimately ensure that the Board's vision and strategy is achieved and that all risks are effectively managed. (These duties are expanded on in the Accounting Officer Memorandum.)

There is a shared role in communicating with external audiences, including NHSEI, but the Chief Executive will take the lead in communicating with external parties about performance issues in the Trust.

The Board is the ultimate decision-making body in the Trust, whilst at the same time the Chief Executive in their capacity as Accounting Officer has a personal responsibility to Parliament for the overall performance and conduct of the organisation.

Further clarification of each of these roles is provided in the document attached which has been drafted drawing on best practice including guidance contained in Monitor's NHS Foundation Trust Code of Governance (2013) and the Chartered Governance Institute.

It is important to understand that whilst roles can be clarified and allocated, in practice there can be a blurring of boundaries as particular situations and needs arise, therefore it is recognised that ongoing discussions about and seeking feedback from Board colleagues from time-to-time, including regularly reflecting on the extent to which each operate consistently with the role specifications outlined in this Memorandum.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

Whilst not a Foundation Trust, the North West Ambulance Service NHS Trust seeks to adhere to the Code of Governance where applicable.

Clause A.2.1 of Monitor's Code of Governance recommends: "*that there should be a division of responsibilities between the chairing of the Boards of Directors and the executive responsibility for the running of the NHS Foundation Trust affairs. No one*

individual should have unfettered powers of decision. The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors."

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

No implications identified.

5. RECOMMENDATIONS

The Board of Directors is recommended:

- To approve the Memorandum of Understanding and ask the Director of Corporate Affairs to maintain a signed copy on corporate record.

ROLE OF THE CHAIR OF THE TRUST

The Chair is responsible for:

Board of Directors

- Chairing meetings of the Board of Directors and the Nominations & Remuneration Committee.
- Managing the Board and ensuring its effectiveness in all aspects of its role, including regularity and frequency of meetings and that in all respects it functions as a unitary Board.
- Setting the Board agenda, taking into account the issues and concerns of all directors. The agenda should be forward looking, concentrating on strategic matters and taking into account the important matters facing the Trust.
- Ensuring there is appropriate delegation of authority from the Board to the Executive Team.
- Ensuring the effective implementation of Board decisions.
- Ensuring that directors receive accurate, timely and clear information, including that on the Trust's current performance, to enable the Board to take sound decisions, monitor and scrutinise effectively and provide advice to promote the success and sustainability of the Trust.
- Managing the Board to allow enough time for discussion of complex or contentious issues. The Chair should ensure that directors (particularly non-executive directors) have sufficient time to consider critical issues and obtain answers to any questions or concerns they may have and are not faced with unrealistic deadlines for decision making.
- Ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.
- Building an effective, complementary and unitary Board.

Directors

- Facilitating the effective contribution of directors and encouraging active engagement by all members of the Board.
- Promoting effective relationships and open communication between executive and non-executive directors, both inside and outside the boardroom, ensuring an appropriate balance of skills and experience.
- Holding meetings with the non-executive directors without the executive directors being present.
- Establishing a close relationship of trust with the Chief Executive providing support and advice whilst respecting executive responsibility.
- Overseeing the application of the Board of Directors' Code of Conduct and if in the Chair's opinion an individual director has failed to observe any part of the code take such action as may be deemed immediately necessary until the matter is investigated or resolved.

Induction, development and performance evaluation

- Ensuring that all new non-executive directors participate in a full, formal and tailored induction programme.
- Ensuring that the development needs of directors (in particular non-executive directors) are identified and met. (Members of the Board should be able continually to update their skills

and the knowledge and familiarity with the Trust as required to fulfil their role on the Board and its sub-committees).

- Regularly evaluating the performance of the Chief Executive.
- Identifying the development needs of the Board as a whole to enhance its overall effectiveness as a team.
- Ensuring the performance of the Board, its sub-committees and individual directors (in particular the Chief Executive and the non-executive directors) are evaluated at least once a year; acting on the result of such evaluation by recognising the strengths and addressing the weaknesses of the Board.
- Where appropriate through the Nominations & Remuneration Committee, proposing that new members of the Board are appointed to the Board or overseeing the resignation of others.
- Reporting on the outcome of the appraisal of the non-executive directors to NHSEI.

Governance

- Upholding the highest standards of integrity and probity
- Setting the agenda style and tone of Board of Directors to promote effective decision making and constructive debate.
- Ensuring a clear structure for, and the effective running of, Board and sub-committees.
- With the assistance of the Company Secretary, promote the highest standards of corporate governance, seeking full compliance with the Code of Governance.
- Ensuring respective compliance with the Board of Directors approved procedures.
- The Chair's direct reports are the Chief Executive, the non-executive directors and the Company Secretary. Other than the Chief Executive no executive director will report directly to the Chair. The Chair reports to the Board of Directors and the Secretary of State via NHSEI.

……	**……..**
Peter White	**Daren Mochrie**
Chairman	**Chief Executive Officer**

ROLE OF THE CHIEF EXECUTIVE

Within the authority limits delegated by the Board, and not to the exclusion of any duty detailed in the Accounting Officer Memorandum, the Chief Executive is responsible for:

Business Strategy and Management

- Developing the Trust's objectives and strategy having regard to its responsibilities to service users, carers, staff, partners and other stakeholders.
- The successful achievement of objectives and execution of strategy following presentation to and approval by the Board of Directors.
- Recommending to the Board an annual budget and forward plan and ensuring their achievement following Board approval.
- Optimising as far as is reasonably possible use of the Trust's resources.

Investment and Financing

- Examining all major capital expenditure proposed and the recommendation to the Board of Directors of those which are material either by nature or cost.
- Identifying and executing acquisitions and disposals, approving major proposals or bids.
- Identifying and executing new business opportunities.

Risk Management and Controls

- Managing the Trust's risk profile in line with the extent and categories of risk identified as acceptable by the Board.
- Ensuring appropriate internal controls are in place.

Board Sub-committees

- Making recommendations to the Nominations & Remuneration Committee on remuneration policy, executive remuneration and terms of employment of the executive directors.
- Making recommendations to the Nominations & Remuneration Committee on the role and capabilities required in respect of the appointment of executive directors.

Communication

- Providing a means for timely and accurate disclosure of information, including an escalation route

Human Resources

- Setting Trust HR policies, including management development and succession planning for the Executive Team and approving the appointment and termination of employment of members of that team in conjunction with the Nominations & Remuneration Committee.
  The duties which derive from these responsibilities include:
    - Leading the executive directors in the day-to-day running of the Trust's business, including chairing the Executive Team meetings and communicating decisions / recommendations to the Board.
    - Ensuring effective implementation of Board decisions.
    - Regularly reviewing operational performance and the strategic direction of the Trust's business.

- Regularly reviewing the Trust's organisational structure and recommending changes as appropriate.
- Formalising the roles and responsibilities of the Executive Team, including clear delegation of authority.
- Ensuring that all policies and procedures are followed and conform to the highest standards.
- Together with the Chair of the Trust, providing coherent leadership of the Trust, including representing the Trust and ensuring there is effective communication in place with service users, carers, staff, regulators, partners, stakeholders, commissioners, community and the public.
- Keeping the Chair of the Trust informed on all important, complex, contentious or sensitive matters.
- Ensuring that the Executive Team provides accurate, timely and clear information to the Board of Directors.
- Ensuring the development needs of the executive directors are identified and met, including a properly constructed induction programme and appraisal process.
- Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance.
- The Chief Executive's direct reports are the executive directors and the Company Secretary.
- The Chief Executive reports to the Chair of the Trust and the Board of Directors directly

……	……..
Peter White	**Daren Mochrie**
Chairman	**Chief Executive Officer**

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	**29th September 2021**			
SUBJECT:	**Deloitte Developmental Well Led Actions Update**			
PRESENTED BY:	**Angela Wetton, Director of Corporate Affairs**			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
	SR05	**SR06**	**SR07**	**SR08**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The report from Deloitte in Q4 2019/20 made 19 recommendations for areas of improvement across all the Well-Led KLOEs. Since the last report to Board in Q4 of 2020/21, a further four actions have been closed down, leaving eight actions still in progress, however the majority of these will be closed by the end of Q3. (see appendix 1)			
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the progress made against the actions despite the challenges of the covid response since Q4 2019/20. • Note the forecast closure date for the remaining actions			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee			
	Date:	11th August 2021		
	Outcome:	• Noted progress against the actions despite the challenges of the covid response since Q4 2019/20. • Noted the forecast closure date for the remaining actions		

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1. PURPOSE

This paper seeks to update the Board of Directors on the progress made against the recommendations and actions arising from the Deloitte Developmental Well Led Review since the last report in Q4 2020/21.

2. BACKGROUND

The report from Deloitte in Q4 2019/20 made nineteen recommendations for areas of improvement across all the Well-Led KLOEs.

Since the last report to ELC in Q4 of 2020/21, a further four actions have been closed down, leaving eight actions still in progress, however the majority of these will be closed by the end of Q3 (see appendix 1) - the updates are highlighted in purple.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

NHS providers are currently obliged to have developmental well led reviews carried out by independent organisations on a three-yearly basis.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

5. RECOMMENDATIONS

The Board of Directors is asked to:

- Note the progress made against the actions despite the challenges of the covid response since Q4 2019/20.
- Note the forecast closure date for the remaining actions

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No	KLOE	RECOMMENDATION	LEAD	ACTION/RESPONSE	FORECAST COMPLETION DATE	STATUS
1	1	Schedule time on the Board development programme for sessions focussing on Board dynamics and future operating principles to debate matters such as: how disagreements should be effectively managed; ways in which concerns can be raised outside of formal meetings; and how to get the best out of each other's individual working styles and preferences.	Chairman	Board Development Sessions were paused in March 2020 due to the Covid-19 pandemic. The plan was to restart them during Q3, however Covid-19 wave 2 arrived and a planned session held in October 2020 was revised to focus on critical operational and strategic updates. This will be factored into the plan for 2021/22. 3 x ½ day additional Board sessions identified and held in diaries. Procurement process commenced with appointment expected by end Oct.	October 2021	
2	1	As part of the planned introduction of a programme of executive team development, spend time reflecting on the perceptions raised within this report regarding a need to improve executive team cohesion. This will be particularly important in light of the ongoing restructure.	CEO	Work started on this with a facilitated session for the Executive team on 4th March 2020 but further development work stopped during wave 1 of Covid-19 and has not yet restarted. This will be factored into the plan for 2021/22. Individual appraisal discussions and half year reviews have given the opportunity to discuss team and individual issues. Director of People & Director of Corporate Affairs formulating a plan to share with CEO.	October 2021	
5	3	Use the ongoing culture perceptions audit to more fully understand the context and background for perceptions relating to: a) disconnect between Service Delivery teams and corporate functions and any required future ways of working to address this; and b) the ongoing prominence of the three legacy organisations over a more consistent 'NWAS culture'. Seek to identify the relative strengths from each area, so that good practice can be built upon and to encourage buy-in to any required changes. Operational staff will need to be fully engaged in this work, which is also likely to require input and facilitation from the Organisational Development (OD) team.	Director of People	The ZEAL survey took place during Q2 2020/21. Data was presented to ELC Q1 2021. Feedback to Board scheduled for October Board Development Session.	December 2021	
6	3	Agree the process by which staff who raise concerns (both formally and informally) will receive feedback. Themes from concerns raised, and actions taken as a result, should also be shared in Trust communications, to assure staff that feedback is valuable and acted upon consistently.	ALL	There is a Freedom to Speak Up (Raising Concerns) Policy and process in place. There are several avenues for staff to raise concerns – FTSU where feedback is received from the Guardian; directly to line managers where feedback should be received from line managers; directly to the Human Resources team where feedback should be received from the HR team and also incidents raised via Datix where feedback should also be given by managers and this is the route whereby staff generally feel they don't get feedback. The process for feedback from incidents should be included within an incident management policy/framework. Part of the new Datix upgrade will feature automated feedback sent to the employee reporting the incident, following review/ investigation from the appropriate manage. Themes from concerns raised are shared across the Trust from the via bulletins and newsletters.	Completed	
7	3	Develop a culture and leadership dashboard to support the triangulation and analysis of key people priorities across the Trust. Metrics selected may arise from the ongoing culture perceptions audit, and should be concise enough to	Director of People	Key workforce metrics are already included in the IPR and routinely reported to Resources Committee. HR case management data	Completed	

		focus on key areas to drive change. This should be reviewed by the Board, executive team and ideally also service line and directorate level.		reported regularly to ELC. Triangulation of FTSU hotspots undertaken for Q2 Board report. The organisational well being dashboard which will include FTSU data has been developed and completed and was presented at ELC during August 2021.		
9	4	As part of the planned review of service line governance, issue guidance to service line leaders, clarifying the essential topics to be covered and reported on within service line governance structures, to ensure a degree of consistency.	Director of Corporate Affairs/ Director of Operations	A standardised Agenda was agreed for the meetings during 2019/20. A new meeting structure had been agreed from 1 April 2020 but was paused due to the C-19 incident management. The review is in progress, advised to wait and see the outcome of the SDMR as things may change. Therefore, we are looking at reviewing what is currently in place and then see what enhancements can be made	March 2022	
11	5	Ensure that, as Accountability Review meetings develop and embed, the tone of meetings is appropriately balanced between challenge and two-way support between senior leaders and executive directors.	CEO	CEO Accountability Reviews were stood down during the 1st wave of Covid-19 and have not been re-established. The format and purpose will be considered prior to the start of 2021/22. The ongoing response to the Covid pandemic and the demand placed on all Trust services operating at REAP level 4 and with interim HoS in place, a pragmatic decision to keep these reviews on hold was taken. The intention is re-establish these meetings from 1 April 2022 once the operating model and any resulting workforce structural changes have been refreshed. The intention is to 'rate' areas in a similar way to CQC and the rating will determine the level of oversight needed. Meanwhile work to be undertaken around the design of the dashboard that will be used to format the meetings, engaging with BI to ensure the data is available at the level required.	April 2022	
13	5	Operational risks need to be reviewed on a more timely basis to ensure that effective service to board escalation processes are in place. Service line governance arrangements should be revised to ensure that risk management processes are sufficiently embedded across the organisation.	Director of Corporate Affairs/ Director of Operations	Operational risks are discussed at Directorate SMT, L4, L3 ; Risk Moderation Meetings for PES/ EOC; NHS 111 – SLT; PTS talk about them in meetings and they hold a PTS risk group every month also Not all of these meetings have been taking place on a regular basis during Q1 2021/22 due to REAP 4. A full review and update of the operational risks has taken place with support from the corporate risk team.	Completed	
15	6	Seek to refine the content of the IPR to focus on a smaller number of key metrics which are accompanied by more in-depth analysis of the variations and underlying trends behind the overall trust performance.	Director of Quality, Innovation & Improvement	Review of the IPR as part of the review of our compliance with the Oversight Framework guidance published last month. AH is leading this work with JS and this gives us an opportunity to: 1. Review our existing measures and their presentation 2. Review to proposed system oversight metrics in the NHSI document 3. Build the data collection into our data warehousing plans 4. Build the data display into our power BI plans moving forward 5. Consult with executives about the narrative descriptions they provide each month 6. Consult with the NEDS to get their views	November 2021	

				7. Develop our training plans for the year 8. Bring together the operational leads The plan is to have those revisions in place by the November Board		
17	6	Continue to work with the authors of reports in order to more clearly develop an understanding of the role and purpose of committee papers along with the levels of assurance required. This should include regular feedback and discussion on the impact of papers in practice.	ALL	Continue to work with the authors of reports in order to more clearly develop an understanding of the role and purpose of committee papers along with the levels of assurance required. This should include regular feedback and discussion on the impact of papers in practice. The Director of Corporate Affairs planned a development session delivered by NHS Providers on 30th March 2021, attended by 17 senior leaders. A further session was delivered 9th September to another 17 senior leaders. The session covered the key principles of report writing and presentation of data ▪ Understanding the ask ▪ Tailoring for the audience ▪ How good reports support good decision making ▪ Future as well as historical focus/balance ▪ Cover sheets. ▪ How to present data to generate the correct conversation. ▪ Impact of reports on the efficiency of meetings ▪ Push vs pull of assurance ▪ Principles of effective communication ▪ The importance of executive summaries ▪ What are the barriers to writing effective reports?	Completed	
18	7	Following the restructure of the executive team, a stakeholder mapping exercise should be undertaken to ensure that key relationships are clearly defined and the most impactful external forums are identified and prioritised for executive attendance.	Director of Strategy & Planning	A mapping exercise was conducted in December 2019 to gauge the level of involvement with external stakeholders. This exercise was shared with ELC in Feb 2020. This is now out of date and plans are in place to update this by the end of August 2021 In order to close the recommendation from the Deloitte Review, be ready for the new ICS structures, and also to improve our external engagement with key stakeholders and partners, a new structure was proposed and agreed by ELC in June/ July 2020. The new Partnerships and Integration Team is made up of three Partnerships and Integration Managers (PIMs) and a Partnership and Integration Officer. The full structure has been in place since 13 September 2021. The PIMs will work across all directorates to coordinate the right messages and also ensure the appropriate representation at the right level across all three areas, enabling the trust to be at the forefront of the discussions, debates, dialogue and decision making going forward with external partners A full external stakeholder mapping exercise was conducted to:	September 2021	

				• Find out the level of engagement across each Executives and senior managers externally • To then ensure the right representation, with the right expertise, delivering the right message at the right meeting • To ensure the important meetings are prioritised across the region This has been completed and is currently being analysed for headline information. A list of key critical meetings will be identified and shared, as structures evolve with ICs and other meetings come on line this will be added to. The critical part is to ensure we have the right expertise at the right meeting sharing the right offer and message. Work has progressed with the "Knowledge Vault" which will aid the new way of engagement externally allowing for timely, accurate and consistent information to be shared externally, as well as progressing actions which come back to the Trust through the managers and directorates. The Knowledge Vault is currently being tested in CAM area from 23 August to 27 September, at which time a review of the test will be completed and a potential roll out plan for the other areas put in place. Work is also ongoing to have System profiles for each of the ICS areas the trust works with covering all the key health statistics for each area.		
19	8	There is scope to rationalise the range of forums in place to look at learning and innovation in order to simplify the structure and to more readily facilitate the sharing of learning across the organisation. This should be supported by greater analysis of data to consider themes and trends arising, as well as consideration of moving all of these aspects under one executive portfolio area to enable greater oversight.	Director of Quality, Innovation & Improvement	The frequency, scope and effectiveness of the learning forums will be reviewed as part of the work of the Patient Safety Specialist (PSS) who commenced with the Trust on 1st December 2020. The focus on integrated learning will be overseen by the patient safety specialist but supported by all directorates. Pilot work has already commenced on the integration of learning from FTSU, complaints and workforce data and was presented to board in November 2021. This work will be ongoing through Q4 2020-21 and Q1 2021-22. The findings will be presented to ELC, quality and performance by the PSS for review and any recommendations which can be actioned during 2021-22 will be completed. Any significant changes will be articulated in the refresh of the quality strategy which will be in preparation and published in Q4 2021-22. **05/08/21** – The PSS, who had been assigned this piece of work was initially delayed in commencing this work due to the requirements of the Trust's COVID response and then left the Trust in June 21. Although a replacement PSS has been recruited, they do not start with the Trust until October 21. Realistically, the scoping of this review (*the frequency, scope and effectiveness of the learning forums*) will now not take place until Q4 of 2021/22, at the earliest, with an aim of completing this work during 2022/23.	Revised to 2022/23	

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th September 2021			
SUBJECT:	Integrated Performance Report			
PRESENTED BY:	Prof M Power, Director of Quality, Innovation and Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Integrated Performance Report for September 2021 shows performance on Quality, Effectiveness, Finance Operational Performance and Organisational Health during **August 2021** unless otherwise stated. **Quality** • 202 complaints were received, against a 12 month average of 162 per month. • 65% of complaints risk scored 1-3 and 67% 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 152 in January 2021 to 65 by late May but then rose to 168 at the end Of August. • 4 Serious Incidents (SIs) were reported in June. Three of the four of the SI reports due were submitted within the 60-day timescale. • There were 7 new safety alerts. Two safety alerts are currently applicable and are being managed by an accountable executive. **Effectiveness** • **Patient experience:** PES has seen a decrease in returns (8%) with PTS and NHS 111 have seen an increase in returns (6% and 51% respectively). PES and PTS and 11 have all seen an increase satisfaction levels compared to last month (3.7%, 1.8% and 1.7% respectively) 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, which shows an both an increase in responses and satisfaction in August compared to July. • **ACQIs:** Overall, we see limited change from month to month in the ambulance clinical quality indicators. The			

lag in data (from April) makes it difficult to understand the impact of any recent work to improve in these areas. Recent results (up until April 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 17mins; the Trust's performance was 2h 31mins.
- Mean call to hospital time for patients suffering a hyper acute stroke was the same as national mean of 1h 13mins;
- The stroke care bundle was not reported for April as consistent with the NHS England schedule
- **H&T, S&T, S&C:** The proportion of incidents with Hear and Treat is 9.3% for the month of August 2021. See & Treat has increased to 31.8% (which is higher than pre-covid levels) in total, there was an aggregate non-conveyance of 40.1%.

Finance

- The year-to-date expenditure on agency is £1.790m which is £0.415m above the 19/20 ceiling of £0.1.296m
- 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 August 2021, the Trust received 141,607 calls of which 93,354 became incidents. Compared with August 2019, we have seen a 22% increase in calls and a 4% decrease in incidents.
- **Call Pick Up** performance was 72%, with the data signalling special cause with call pick up (above the upper control limit in July) and Call Pick up within in 5 seconds being below the lower control limit in July). This is directly caused by increased activity for calls and the increase in turnaround times, lockdown easing and lower levels of uptake for overtime in EOC.

ARP Performance

	Standard	Actual
C1 (Mean)	7:00	8:42
C1 (90th)	15:00	14:52
C2 (Mean)	18:00	49:05
C2 (90th)	40:00	1:45:47
C3 (Mean)	1:00:00	3:14:19
C3 (90th)	2:00:00	8:06:09

- 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 times standards is a mismatch between demand and resource levels. Although we are seeing the benefit of a reduction in COVID 19 abstractions we are seeing a rise in sick absence. We are also seeing an increase in average turnaround time and both the frequency and length of time of delayed admissions. This is being seen within the hospitals in the north west and other ambulance trusts nationally. The Trust is also 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 the trust is above the required standard. 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 from the end of March which then peaks on WC 19th July and then improves until WC 23 August. This coincides with the end of military support (22nd March) and the end of shift enhancements, lower take up of overtime due to the Flowers Case. This has meant less resources are 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 35:06. This is the third consecutive month the trust has been above the standard and the 4th time since January. 3,796 attendances (7.7%) had a turnaround time of over 1 hour, with 203 of those taking more than 3 hours. 1,066 hours were lost to delayed admissions in June up from 806 in July.

NHS 111

	Standard	Actual
Calls Within 60s	95%	32.62%
Average Time to answer		6m 23s
Abandoned Calls	<5%	22.31%
Call back Within 10 min	75%	4.84%
Average Call Back		1hour 44min
Warm Transfer to Nurse	75%	0.80%

- Staff Attrition is causing significant pressures, with call volume remaining high. The gap between activity and resource is sometimes as high as 50%.
- Call profile is also shifting which impacts upon forecasting.
- 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 July for the Trust was 23% below contract baselines, whilst the year to date position (July 2021 – July 2021) is performing at 23% below baseline. This is due to Covid-19.

Organisational Health

- **Sickness**: The overall sickness absence rate for the latest reporting month (July 2021) was 9.33% including COVID related sickness of 1.3%.
- **Turnover** was 9.77%.
- **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 1.4% in August.
- **Vacancy**: Positions across the trust are under establishment by 2.03%. This is mainly as a result of establishment changes in 111 and vacancies in PTS.
- **Appraisal:** The overall appraisal completion rate was 60.72% against a revised trust target of 75% by March 2022 for the service lines and to 85% by March 2022 for Corporate and band 8a and above. 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

<table>
<tr><td></td><td colspan="4">against the agreed ELC target of 85% for service lines and 95% Corporate services by March 2022.
COVID 19
• There have been 97 instances of staff that have tested positive for Covid-19 in August 2021 with 1,981 instances since July 2020. As at the end of August there were 8 open outbreaks on Trust sites with 17 staff who tested positive and 29 staff isolating..</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">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</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☒</td><td>Sustainability</td><td>☒</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">27/09/2021</td></tr>
<tr><td>Outcome:</td><td colspan="3">Not known at time of submission</td></tr>
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1. PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month **of August 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. BACKGROUND

A new Single Oversight Framework has been published and work is ongoing to refresh the IPR with a new suite of measures aligned to the new requirements which place more emphasis on whole system metrics.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

The data in this report are presented at an aggregate level for the trust and so any issues related to equality and diversity are not highlighted. 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.

5. 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.

Q1 COMPLAINTS

Figure Q1.1

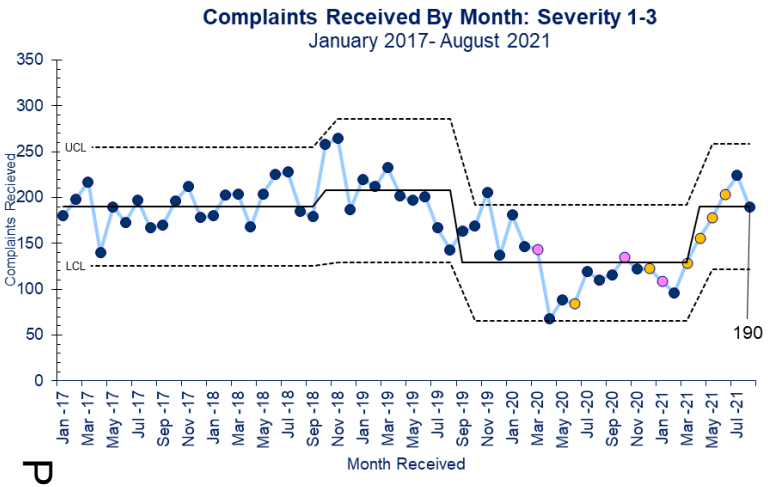


Figure Q1.2

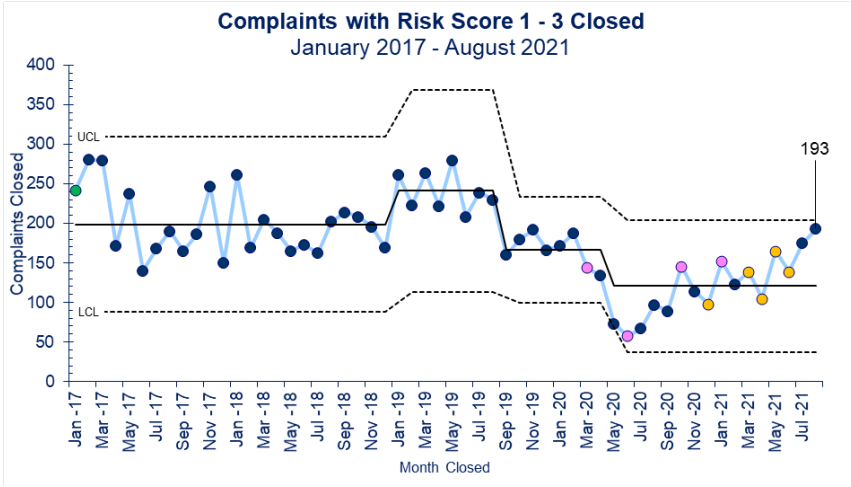


Figure Q1.3

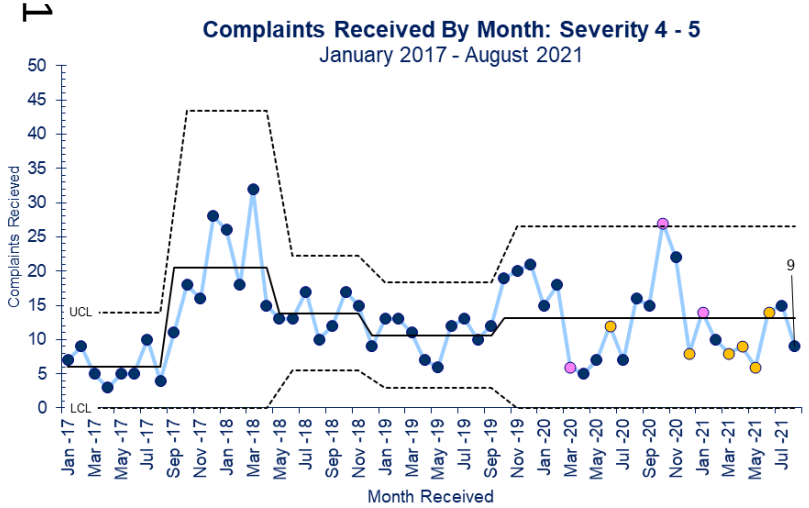
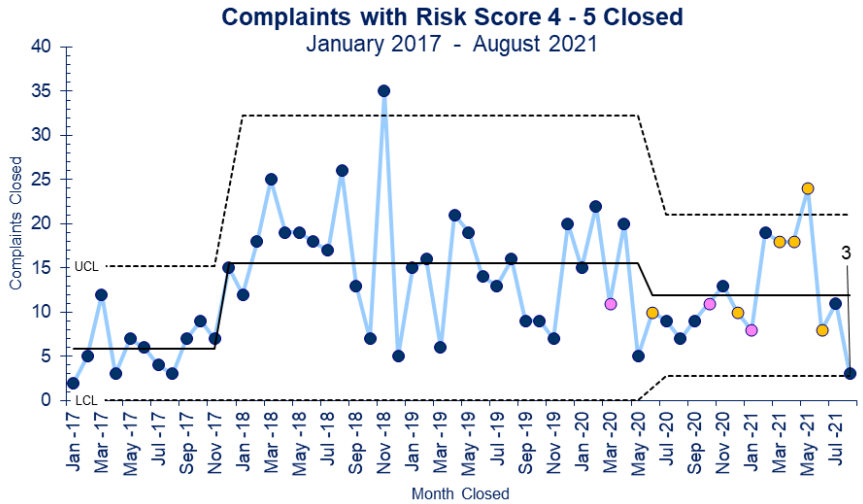


Figure Q1.4



* *Lockdown* *Easing of Restrictions*

Complaints & Compliments

In August, 202 **complaints** were received (figures Q1.1 & Q1.3) against a 12-month average of **162** per month.

75 compliments were received this month. This numbers is lower than previous months and has been impacted by the move to a new reporting system.

The rate of complaints in August 2021 was **32 per 1000 WTE**. The average for the fiscal year (1 April 2021 – 30 April 2022) is **32** per 1000 WTE. The rate for both the month of August and 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 5 consecutive months with a decrease in August (Q1.1). The data for August is **199** complaints.

A total of **196** complaints were closed in August 2021 (**193** were risk scored 1-3 Q1.2 and **3** 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. This is now being addressed as part of the recovery plan.

Figure Q1.5

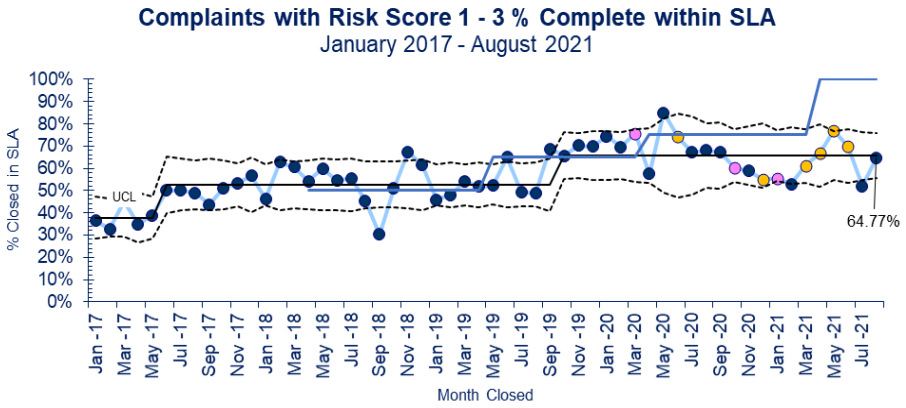


Figure Q1.6

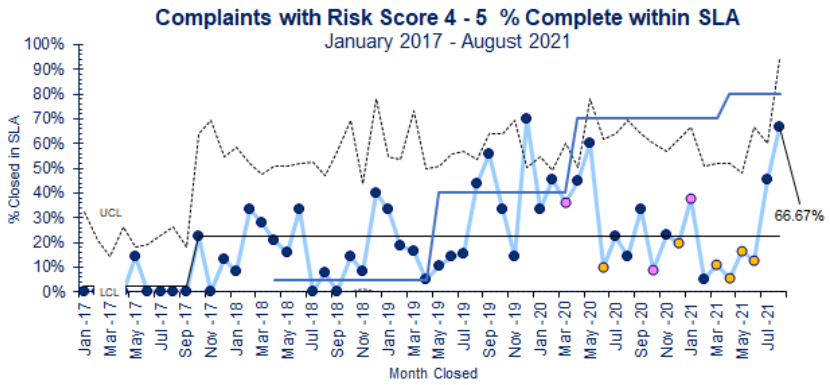
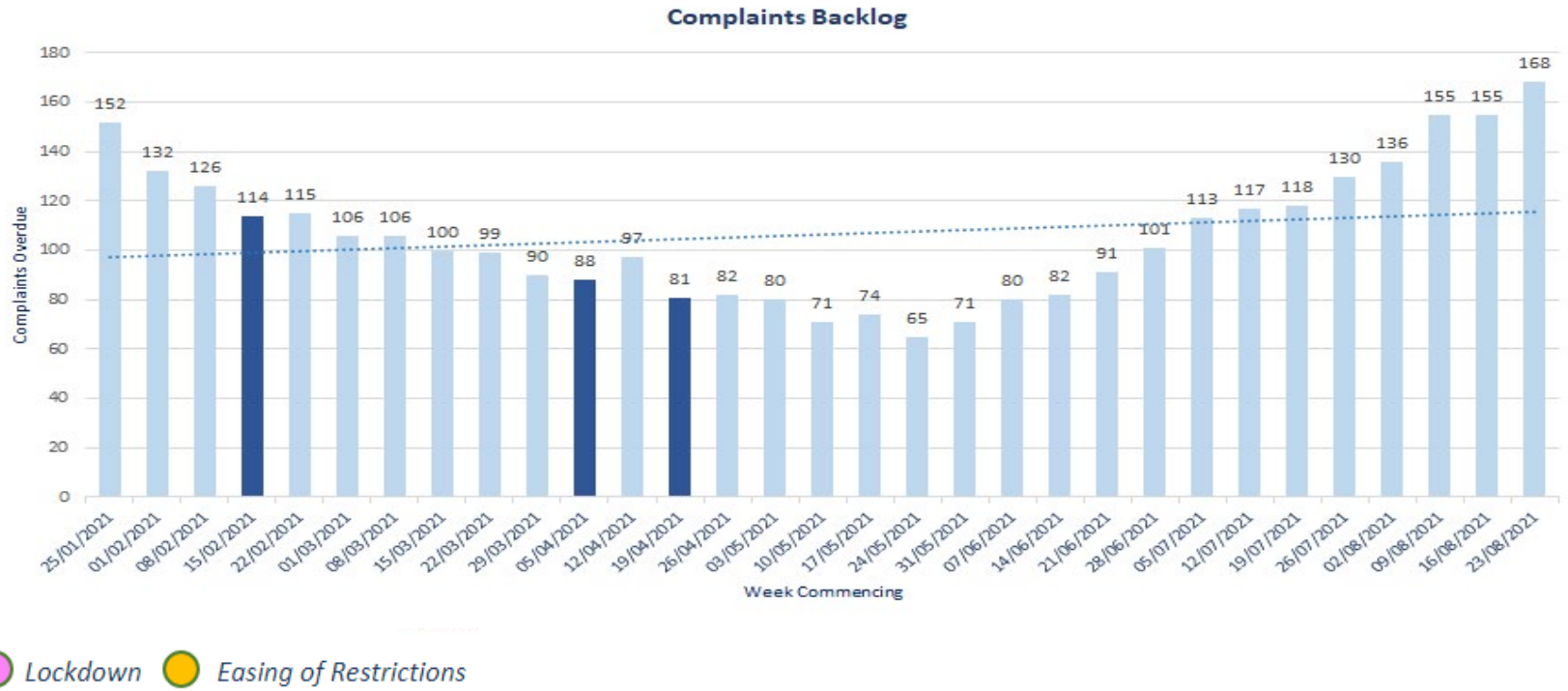


Figure Q1.7



* Lockdown Easing of Restrictions

Complaints Closure

Overall, **65%** 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.

67% 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 had fallen from **152** in January to **65** by late May, since then this has risen to **168** by the end of August. The backlog has started to increase since the introduction of REAP 4 (Q1.7).

Overall the backlog has increased to c62% of the total volume of complaints. A trajectory and improvement plan has been agreed with the Executive Leadership Team where the backlog will be back to low levels by the end of November.

Q2 INCIDENTS

Figure Q2.1

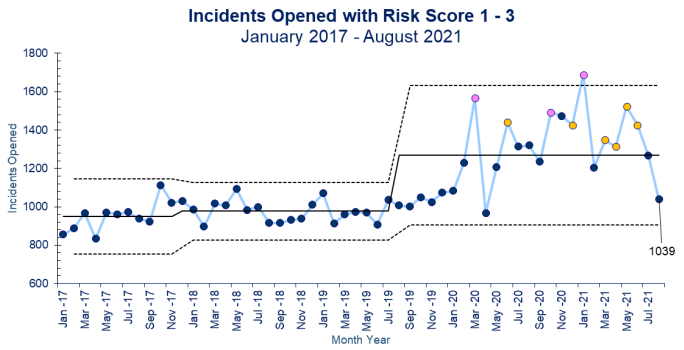


Figure Q2.3 - Highest number of incidents May 2021 by subcategory are from 111

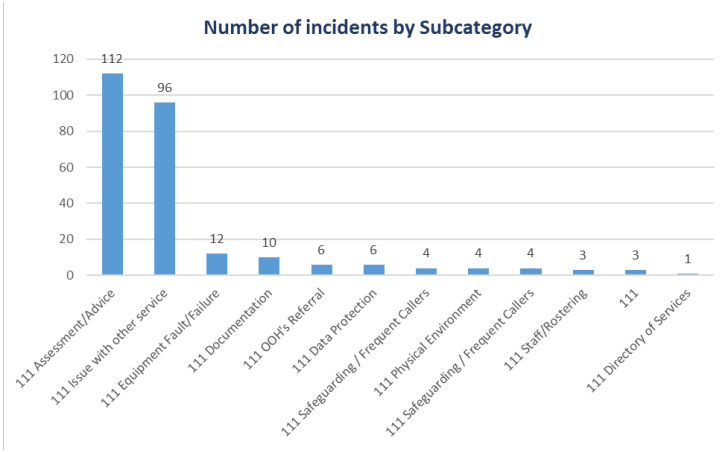


Figure Q2.4 - Second highest number of incidents May 2021 by subcategory are staff welfare

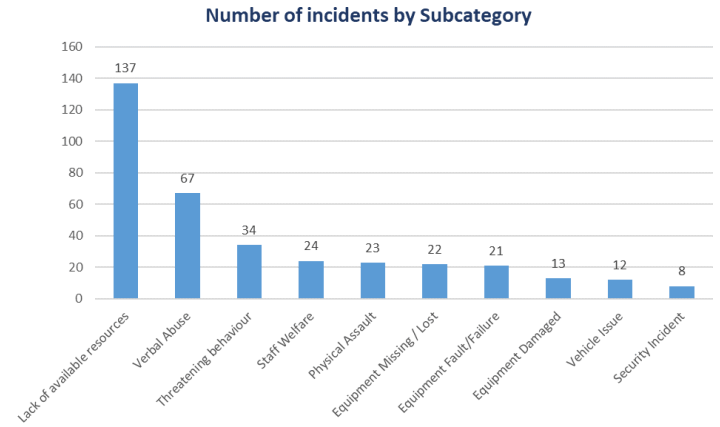
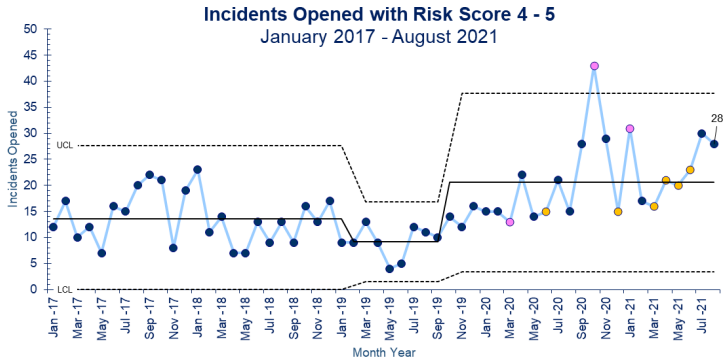


Figure Q2.2



* Lockdown Easing of Restrictions

Reporting: In August 2021, **1079** internal and external incidents were opened (Q2.1 and Q2.2) against a 12-month average of **1,429**, with an additional **156** still to be scored. High levels of reporting are important and considered a marker of a positive culture where staff feel able to speak up.

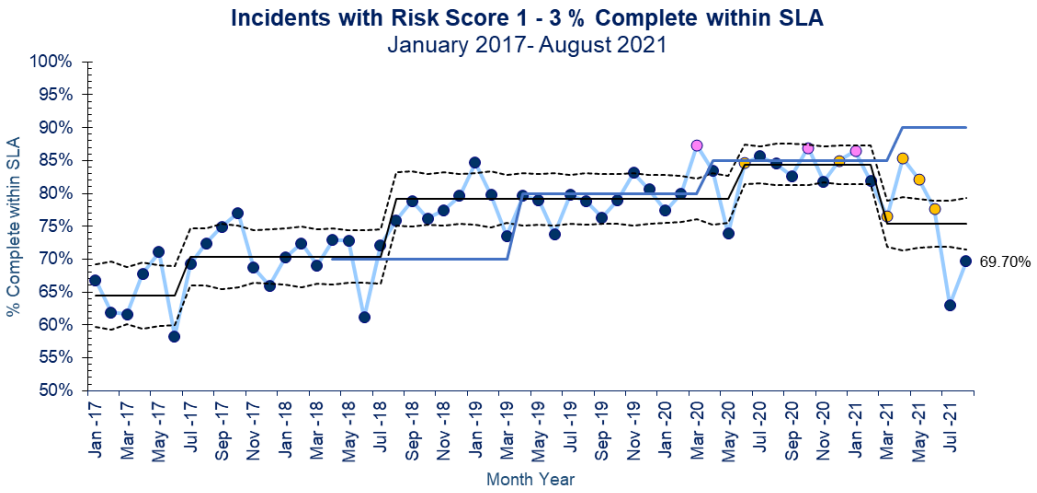
Unscored Incidents (RCS): In July, **16** incidents were unscored which is below the end of year Right Care Strategy goal of **25** unscored incidents in the previous month reported in the IPR. The scoring and management of incidents in a timely way is monitored via the clinical effectiveness and operation 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 (**261** incidents from **223,949** 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=**1125**), for documentation or data protection issues (**n=10+6**) or for out of hours referrals (n=**6**). Around **15% -20%** of Incidents raised within 111 can be resolved locally and do not relate to patient safety.

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

Figure Q2.5

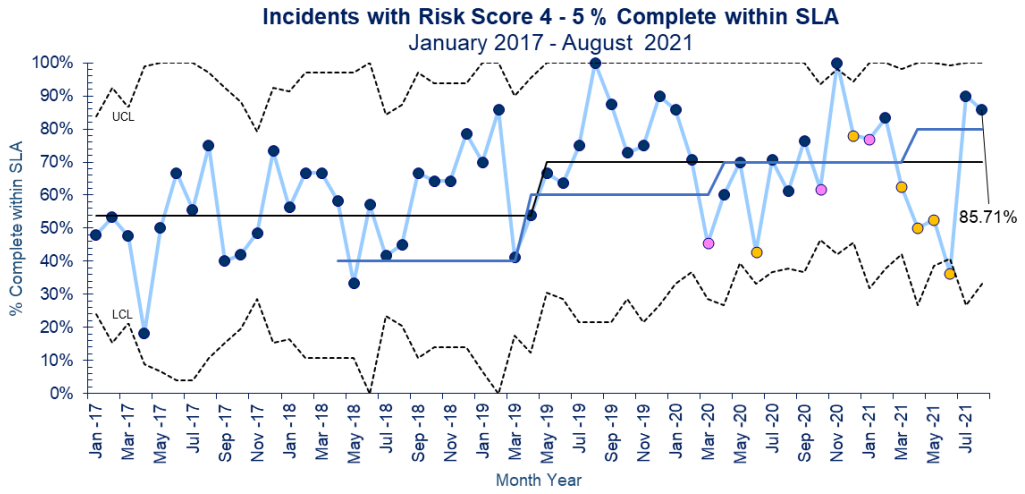


SLAs are calculated using the following measures/ targets.

No exceptions are taken into account:

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

Figure Q2.6



* Lockdown Easing of Restrictions

Incidents Closure

In total, **1070** incidents (level 1-5) were closed during August 2021.

70% level 1-3 were closed within agreed standard (Q2.5) which is currently showing as special cause variation and below the right care strategy goal of 90%.

86% 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

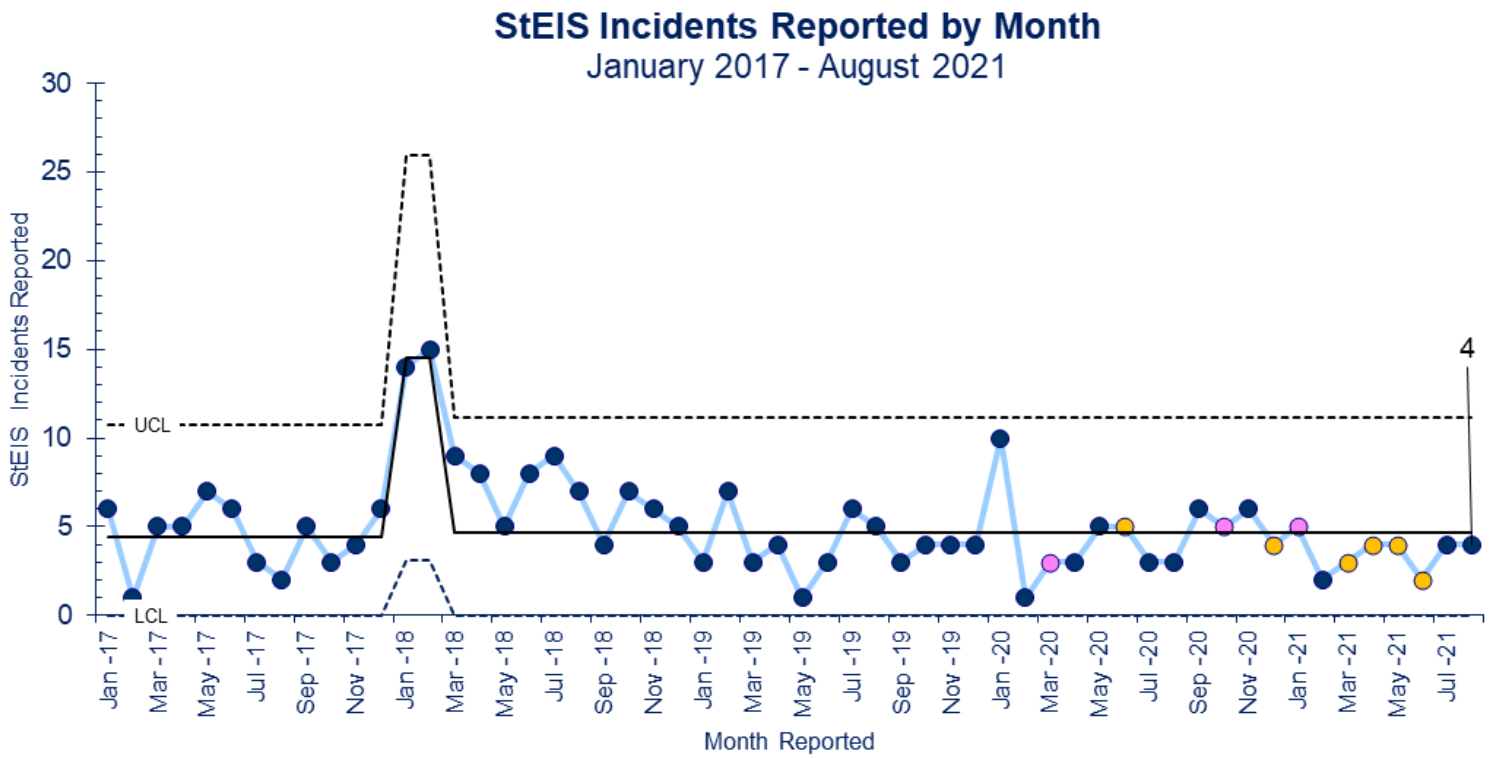
Both have been affected by periods of REAP Level 4 which impacts on the ability of the front line to produce the required statements and investigation reports, in a timely manner, to close off these incidents. The Patient Safety team are supporting this as much as they can during periods of REAP level 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 was established but is currently suspended due to REAP4 .

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

Q3 SERIOUS INCIDENTS

Figure Q3.1



* Lockdown Easing of Restrictions

Serious Incidents

4 Serious Incidents (SIs) were reported in August 2021.

4 SI reports were due with the commissioners in August 2021. **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, the last 7 months has seen the number of serious incidents being above the average. 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 Sept 20 – Aug 21)	Number of Alerts Applicable (Sept 20 – Aug 21)	Number of Open Alerts	Notes
CAS/ NHS Improvement	19	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 (Sept 20 – Aug 21)	Number of Alerts Applicable (Sept 20 – Aug 21)	Number of Open Alerts	Notes
MHRA – Medical Equipment	15	0	0	

Safety Alerts	Number of Alerts Received (Sept 20 – Aug 21)	Number of Alerts Applicable (Sept 20 – Aug 21)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	49	0	0	

Safety Alerts	Number of Alerts Received (Sept 20 – Aug 21)	Number of Alerts Applicable (Sept 20 – Aug 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 **7** new safety alerts in August 2021.

The total number of CAS/NHS Improvement alerts received between September 2020 and August 2021 is **19**, with **1** alert that is applicable.

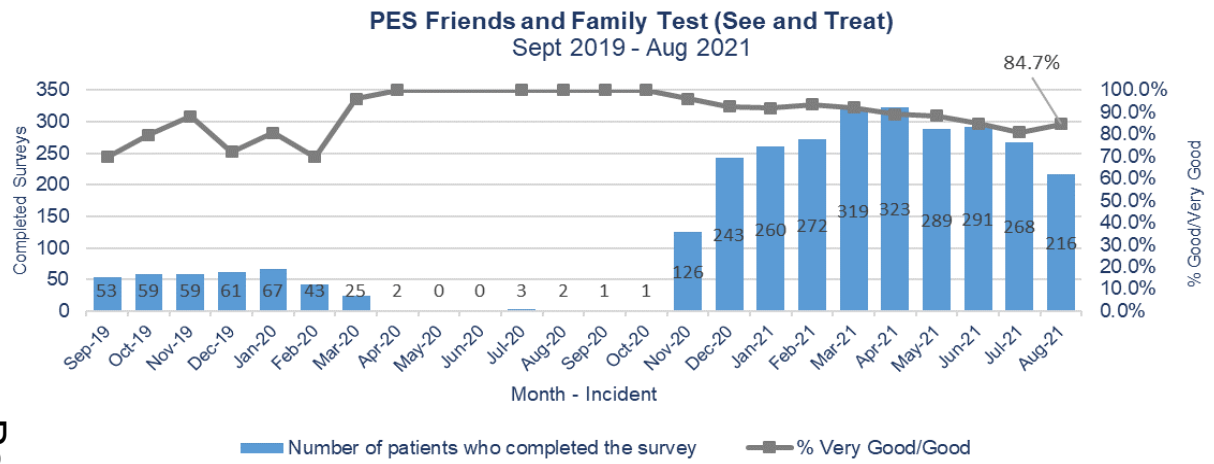
15 MHRA Medical Equipment Alerts have been received with no alerts applicable.

49 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 **268** return for July 2021 is **7.9%** lower than the **291** in June, with comments also seeing a drop of **11.6%**; (175 for July and 198 for June). The **216** return for August 2021 is **19.4%** lower than the **268** for July, with comments also seeing a drop of **10.36%;** (157 for August and 175 for July). This is a continuation of a decrease in returns (May 289).

On overall experience of the service, the **81.0%** patient satisfaction level for July 2021 has also reduced by **3.9%** when compared with **84.9%** for June 2021. The overall experience for August of **84.7%** is an increase of **3.7%** compared to the previous month of July of **81.0%** but marginally less than that recorded in June and a continuation of the decrease (88.2% in May) which may be attributed to the reduction in performance due to higher levels of demand.

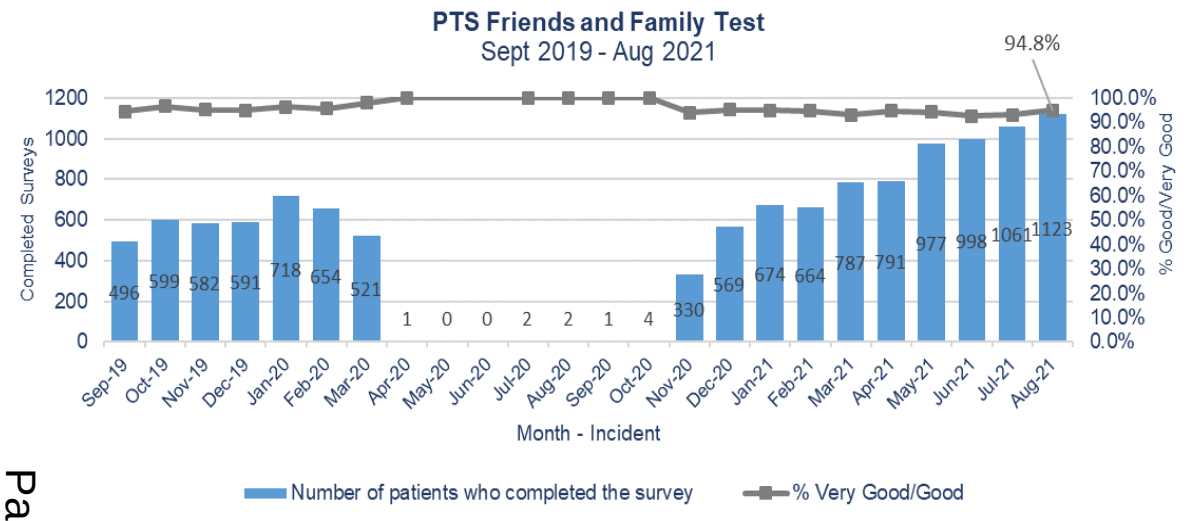
Where respondents indicated **'very good/good'**, the corresponding themes were around speed of response, reassurance provided both on the phone and by the paramedics, being treated with kindness; dignity and respect, the empathy, and professionalism of the paramedics and an explanation of what was being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

- *"Very fast response, 8 min for paramedics to arrive, my child had wonderful help from paramedics and good advice for the future! Amazing! Thank you so much."*
- *"The 2 gentlemen treated us with kindness and sensitivity. They were very professional."*
- *"The crew was very professional and respectful of my mum's wishes and treated the family and my mum with the most dignity one of the hardest times in our lives."*

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

- *"7 hours wait despite patients deteriorating condition, poor communication from call centre"*
- *"Waited over two days for an ambulance."*
- *"Initial call was good however the follow up call by the paramedics was very insulting and contradictory, the actual paramedics who turned up were very rude."*

Figure E1.2



Patient Experience (PTS)

The **1,061** return for July 2021 is **6.3%** higher than the **998** in June, with comments also seeing an increase of **10.1%**; (876 for July and 795 for June). The return of **1,123** for August is **5.8%** higher than the **1,061** for July, with comments also seeing a marginal increase of **1.0%**; (885 for August and 876 for July).

On overall experience of the service, the **93.0%** patient satisfaction levels for July 2021 sees a slight increase of **0.5%** when compared with the **92.5%** from June. The overall experience for August of **94.8%** continues the small upward trend, with an increase of **1.8%** compared to the previous month of July of **93.0%**.

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

- *"She came to the door to make sure I got onto the ambulance OK. She made sure I was safely in the seat and all secure, she talked to me all the way there to make sure I was OK. I hadn't been to the department at Bolton RBH before so she made sure I was safely checked in at the department before she left me with them. That's what I call fantastic service. Door to door."*
- *"Ambulance staff were so lovely to my mum who is 93. Also very professional, making mum safe at all times. First class staff, could not have been more pleasant and friendly. They are assets to your organisation!"*
- *"Booking person passed on the appropriate details to the transport drivers who took care to provide a skilled, caring professional and empathetic service."*

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

- *"Transport arrived after my appointment time at hospital despite me ringing the taxi company several times, driver didn't think he should apologise as he's self-employed.*
- *"The transport that took me to the Hospital was very safe driver had her mask on plus there was plastic protection which was very good but the transport, that picked me up from the Hospital was not. I felt unsafe, he had no mask, no plastic divided and driver was coughing the entire journey."*

Figure E1.3

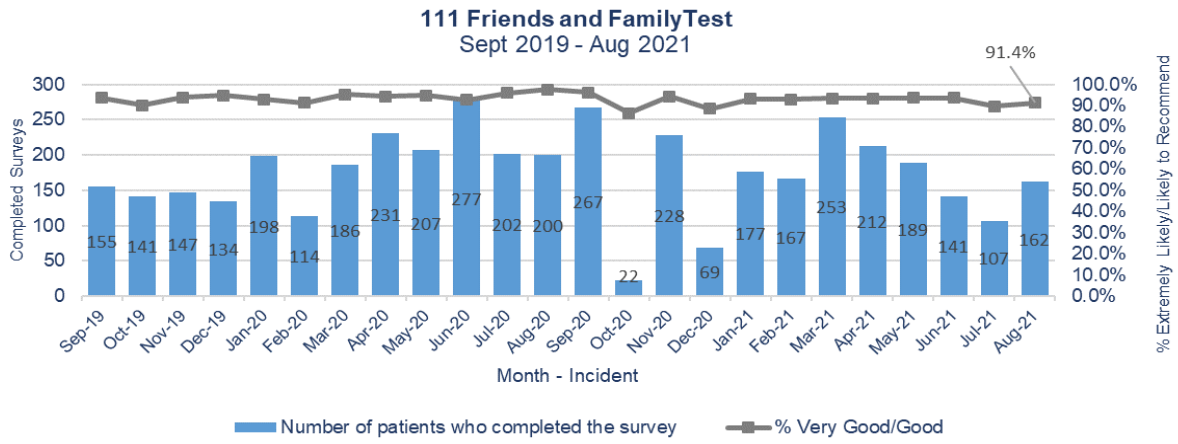
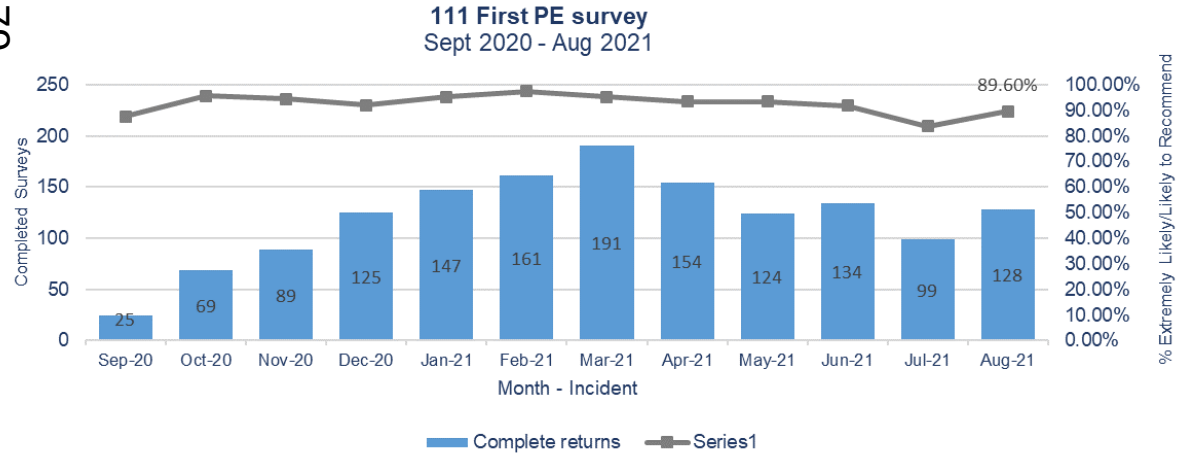


Figure E1.4



Patient Experience (NHS 111)

The **107** return for July 2021 is **24.1%** lower than the **141** in June. August 2021 saw returns of **162** which is **51.4%** higher than the **107** received in July.

In July, **89.7%** indicated the likelihood of recommending the service, a drop of **3.9%** when compared with the **93.6%** from June 2021. August brought a **91.4%** likelihood of recommending the service, which is an increase of **1.7%** compared to the previous month of July of **89.7%**.

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

- *"Good customer service, clear instructions during a worrying time. Took pressure off myself by having phone call doctor appointment made for me by operator."*
- *"I liked how I was referred to a paediatric specialist about my 6 year old son's headache and fever. This put me at more ease."*
- *"Outstanding advice and efficient follow up call, although it took 22 minutes for the call to be answered."*
- *"Quick to sort everything out and very professional."*

NHS 111 First

The return for July 2021 (**99**) is **26.1%** lower than the **134** in June. August 2021 saw a return of **128** which is **29.2%** higher than the **99** in July.

Whilst overall patient satisfaction has reduced from **91.79%** in June to **83.67%** in July it has increased to **89.60%** in August. Cumulatively since the service commenced in August 2020, **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

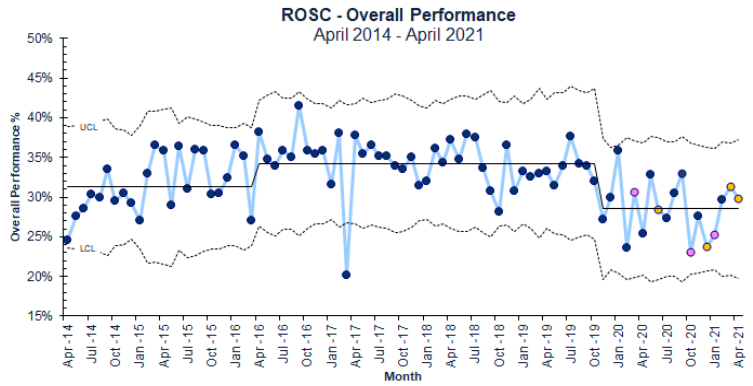
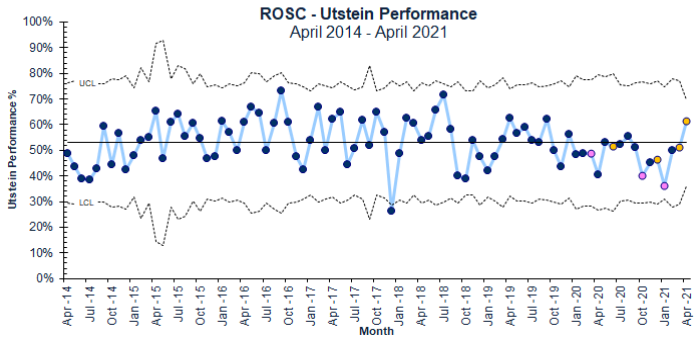


Figure E2.2



* Lockdown Easing of Restrictions

Figure E2.3

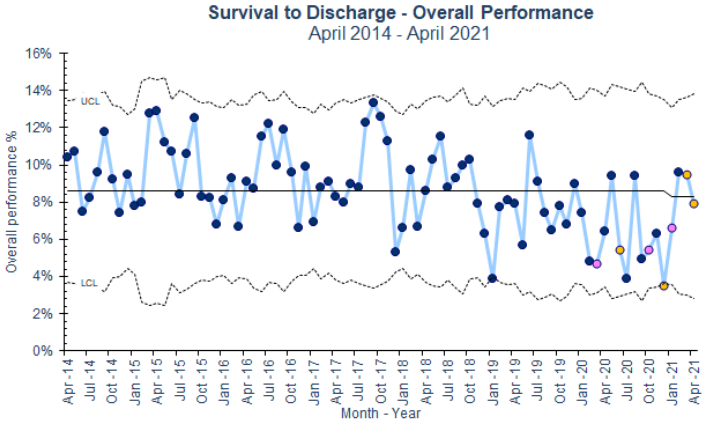
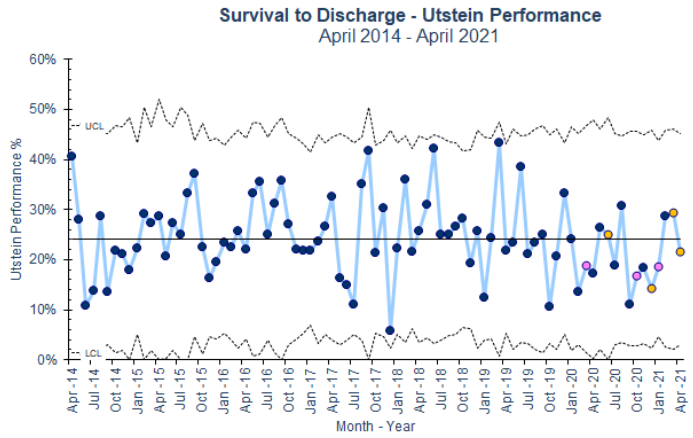


Figure E2.4



ACQIs (Last data point: February 2021)

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

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

Results for April 2021 show performance close to the Trust's mean performance for the ROSC overall measure and ahead of the mean for ROSC Utstein. There was a marginal decrease in ROSC overall and an increase in ROSC Utstein performance over the previous data point. Performance was ranked fifth nationally for ROSC – Overall and third for ROSC Utstein.

The ROSC achieved for the Utstein group was **52.4%** (national mean **50.3%**), For the overall group the rate was **29.8%** (national mean **27.2%**). 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 April 2021 were lower than the previous month at **7.9%**. Although the data remain within control limits and so this does not represent a significant improvement.

In February **21.6%** of patients in the Utstein group survived to hospital discharge, again lower than the previous month and the national mean at **29.2%** 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

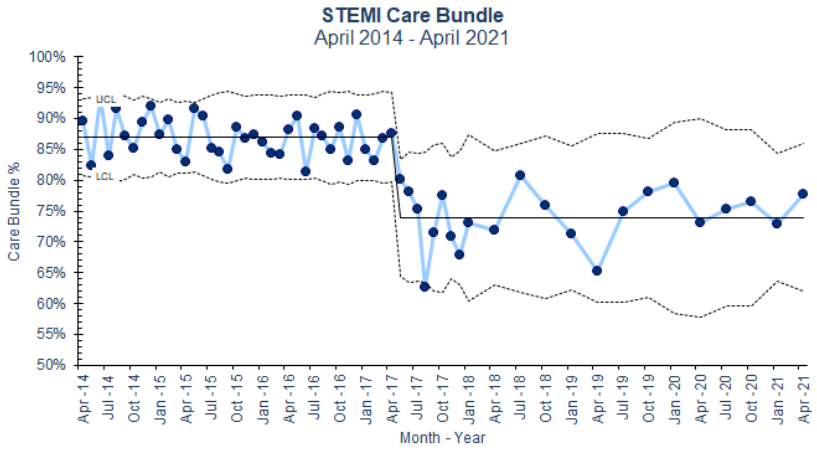
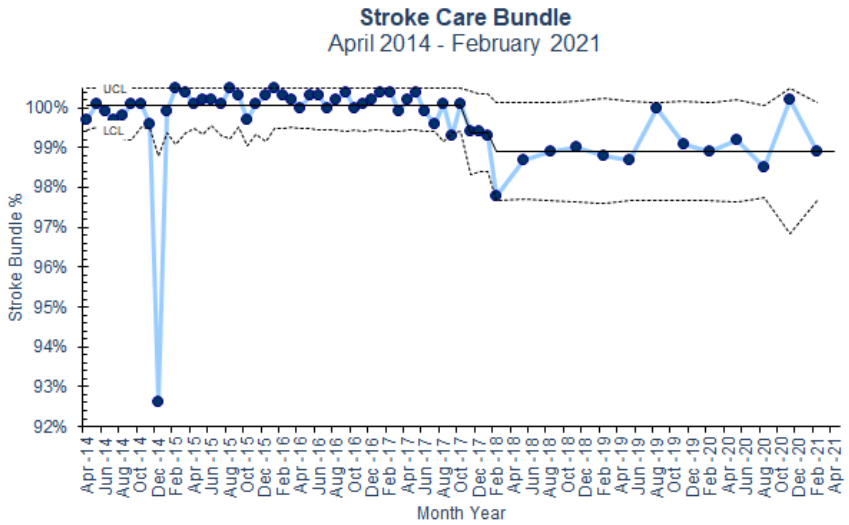


Figure E2.6



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 for April 2021 was **77.7%** (national mean **77.4%**), ranking sixth nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of **2h 17mins**; the Trust's performance was **2h 31mins.**

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 not reported for April 2021 as is consistent with the NHSE schedule.

Mean call to hospital arrival for stroke was 1h:13min in April 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

F1 FINANCIAL SCORE

Figure F1.1

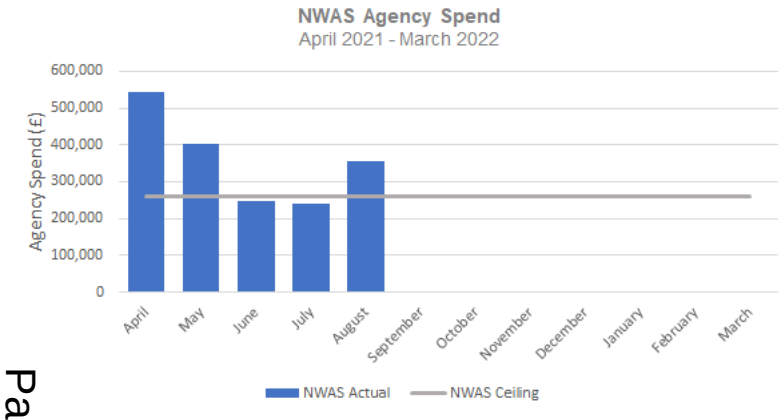


Figure F1.2

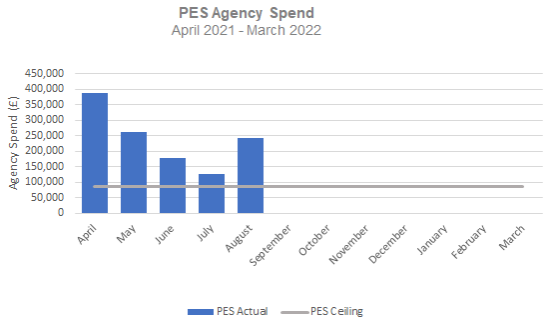


Figure F1.3

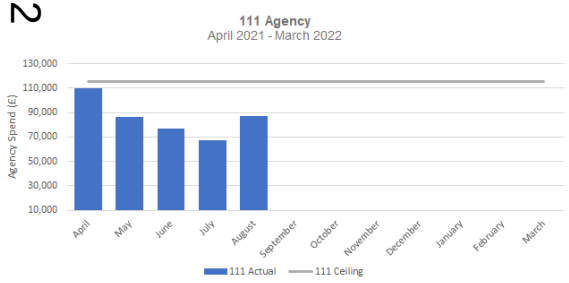


Figure F1.4

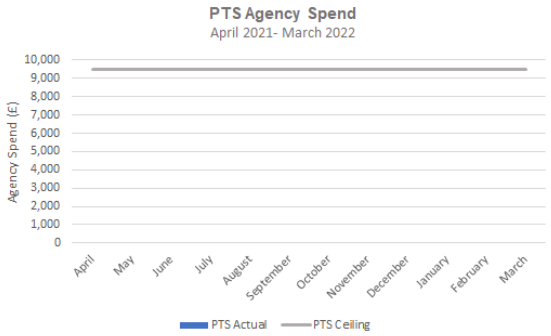


Figure F1.5

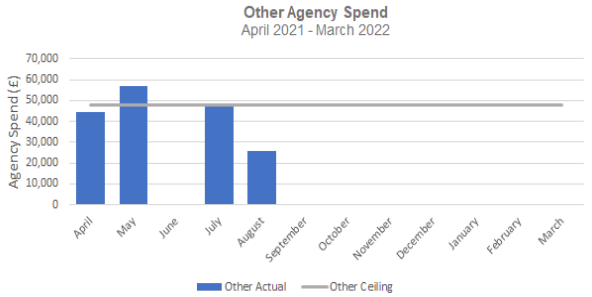
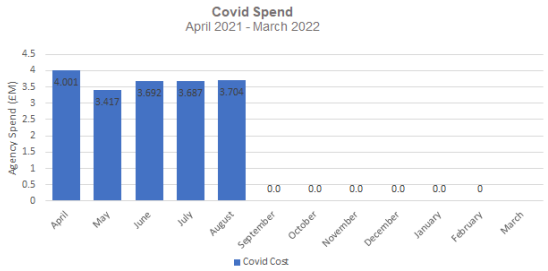


Figure F1.6



Finance Position

Month 5 Finance Position

As at month 5 the trust is reporting a small surplus position which is an improvement on the financial plan, due to additional national income being announced for the NHS 111 service. 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 £1.790m which is £0.415m above the year-to-date ceiling of £1.296m.

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.

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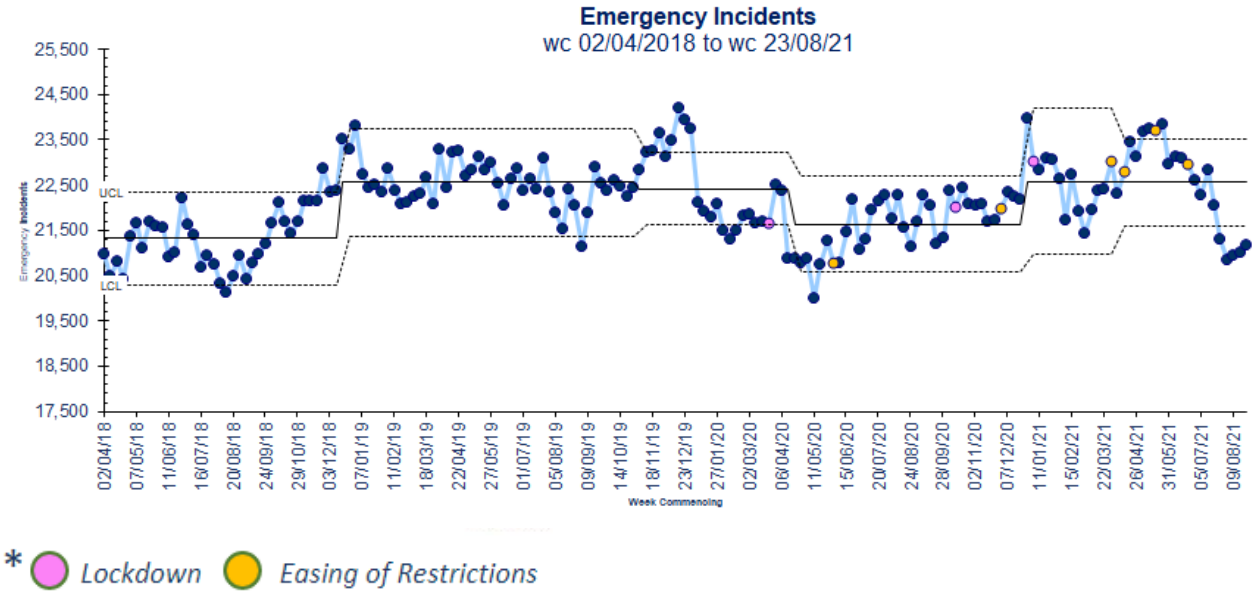
E3 ACTIVITY & OUTCOMES

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

Figure E3.2



* Lockdown Easing of Restrictions

Activity:
In August 2021 the Trust received **141,607** calls of which **93,354** became incidents. Compared with June 2019, we have seen a **24%** increase and **4%** decrease in calls and incidents respectively.

This is largely driven through an operational process change in Cat 3-5 calls, whereby we now provide an estimated wait time for responses. Meaning some callers subsequently cancel the ambulance or make their own way to an ED.

Aug	Calls	% Change from 2019	Incidents	% Change from 2019
2019	115,867		97,656	
2020	116,022	0%	96,134	-2%
2021	141,607	22%	93,354	-4%

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 **8.3%** for the month of August 2021. See & Treat (E3.5) has seen a small increase to **31.8%** (which is similar to pre-covid levels) in total, there was an aggregate non-conveyance of **40.1%** (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 11th in August. For See and Treat have moved from 9th in November to May to 6th in August.

Figure E3.4

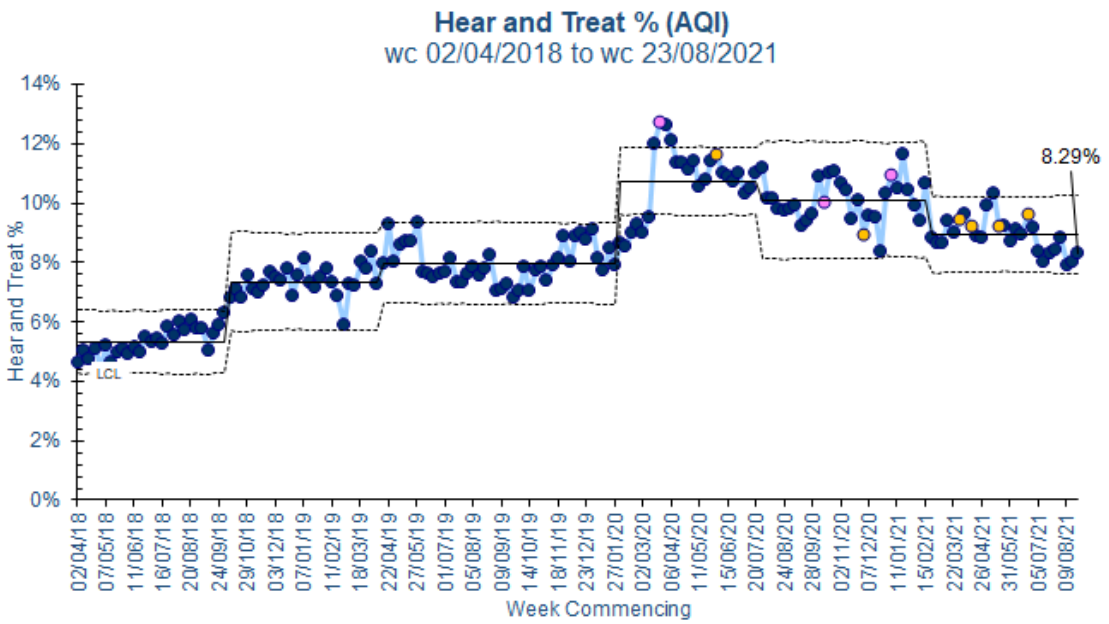


Figure E3.5

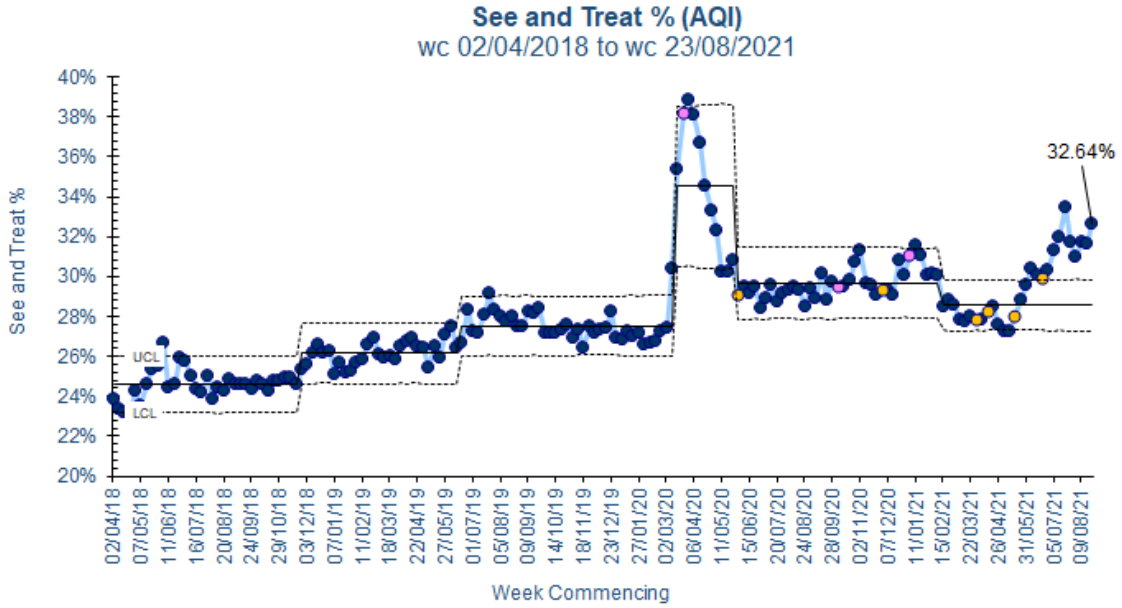
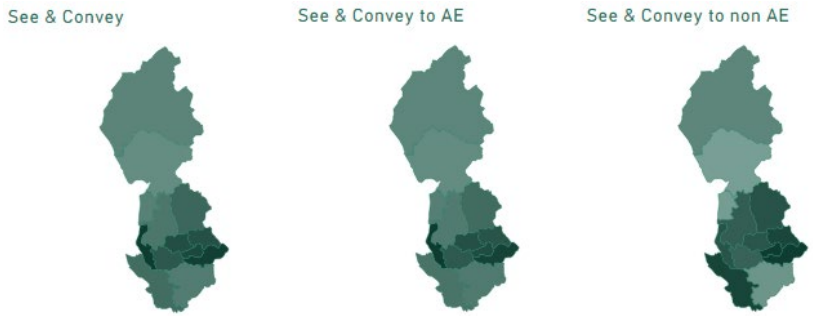


Figure E3.6



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

- **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
West Midlands	15.4%
London	15.3%
South Central	12.3%
Yorkshire	11.3%
North East	11.2%
East Midlands	11.0%
Isle of Wight	10.8%
South Western	10.1%
East of England	9.7%
South East Coast	9.0%
North West	8.3%

11/11

FigureE3.8

Provider	See & Treat
South Western	38.3%
South Central	34.2%
East of England	32.7%
South East Coast	32.1%
East Midlands	32.0%
North West	31.8%
West Midlands	31.7%
London	30.8%
Isle of Wight	30.7%
Yorkshire	28.3%
North East	26.6%

6/11

Figure E3.9

Provider	See & Convey
South Western	51.7%
West Midlands	52.9%
South Central	53.5%
London	53.9%
East Midlands	56.9%
East of England	57.6%
Isle of Wight	58.5%
South East Coast	58.9%
North West	59.9%
Yorkshire	60.4%
North East	62.2%

9/11

- **HEAR & TREAT**: Since January 2018 we have seen our Hear and Treat ranking improve from **8th** to **1st**, however, since November 2020 we have seen other Trusts figures improve significantly moving NWAS to **11th** place. Due to the increase in C1 and C2 incidents and the need to implement risk mitigation measures, clinicians within our clinical hub have improved focus on patient safety rather than improving hear and treat performance. The trust is working closely with clinical assessment service providers to increase the number of calls closed through the clinical assessment service and this is likely to improve H&T throughout Q3. As part of the winter initiatives we are also increasing the number of clinicians within contact centres.

- **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 remained in that position moving to **7th** in June and July then moving to **6th** in August.

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

O1 CALL PICK UP

Figure O1.1

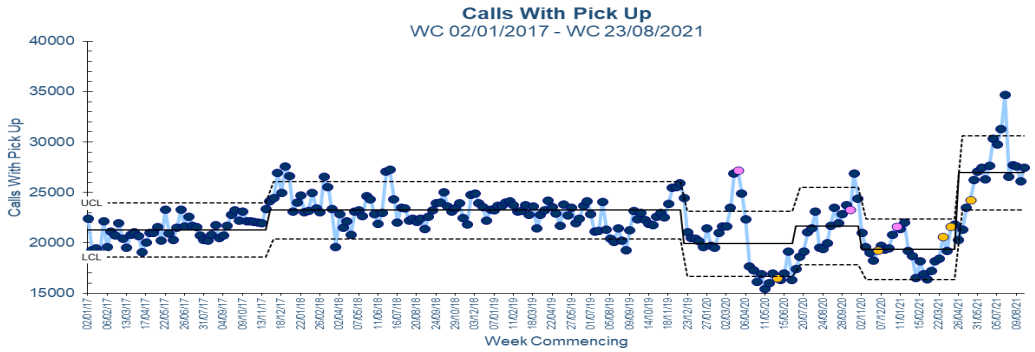
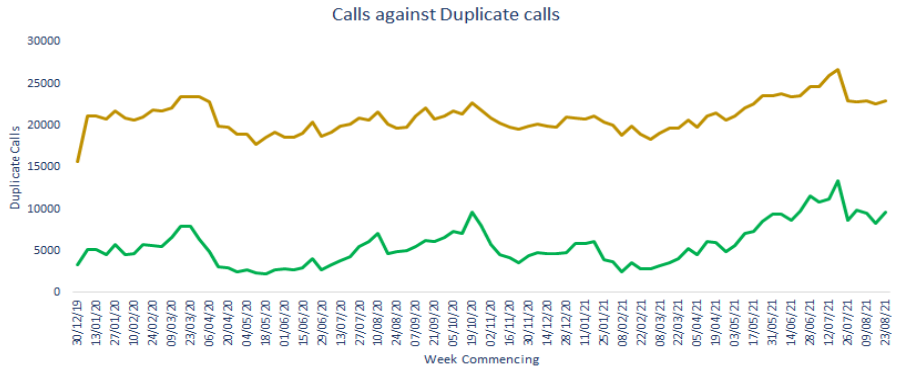
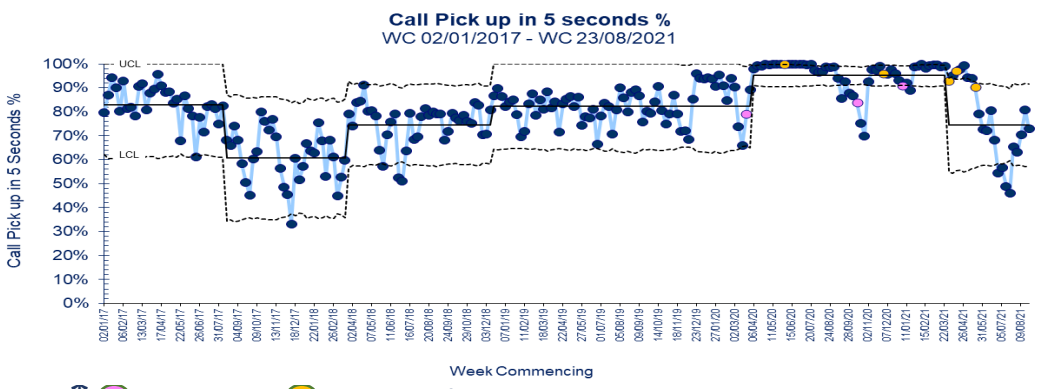


Figure O1.2



Figure



Call Pick Up

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

Performance: Call pick up performance has improved for August 21 when compared to the previous month of July 21. (Q1.3)

Mean call answer **29** seconds (improvement of 22 seconds vs July 21)
95th centile call answer **2 minutes 29 seconds** (improvement of 44 seconds vs July 21)
Percentage of calls answered within 5 seconds **72.83%** (improvement 21% vs July 21).

Despite the improvement, CPU is still well below the expected targets across all measures. This is true both for trust and the sector overall. Despite the challenges and poor performance, the trust remains within the top three for CPU performance.

Figure 01.1 reflects the stepped increase in demand that has been experienced over the past few months. Whilst call volume has decreased in August vs July, the activity is still well above the normal levels and represents the one of the busiest months on record. It is also of note that the profile of demand has shifted with more activity arriving earlier in the day.

Figure O1.2 reflects the current challenge managing the volume of duplicate calls. Duplicate calls have been on the increase since February and despite a reduction vs July still remain very high. For August, an average of **1354** duplicate calls were managed per day.

The call volume is the primary challenge for NWAS at this stage. It should be noted that abstractions are increasing the challenge and they continue to increase. Sickness levels are high with the majority relating to stress and anxiety. There is a robust recruitment plan in place which is scheduled to deliver an additional **140 EMDs** by the peak of Winter. These staff will be deployed throughout the next few months, with circa **30 EMD** being live in September. The EOC have ETA scripts in place for callers and these are reducing the incident volume and potentially duplicate calls. On average for August around **2,500** calls per week were closed following signposting advice.

O2 A&E TURNAROUND

Figure O2.1

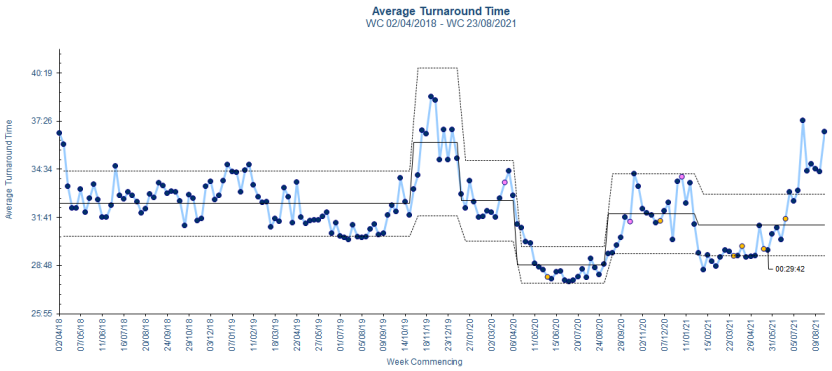


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
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	57,212	29:56	18:46	11:17
June-21	52,324	31:20	20:11	11:24
July-21	51,396	34:16	23:12	11:20
Aug-21	49,377	35:06	23:45	11:32

Figure O2.2

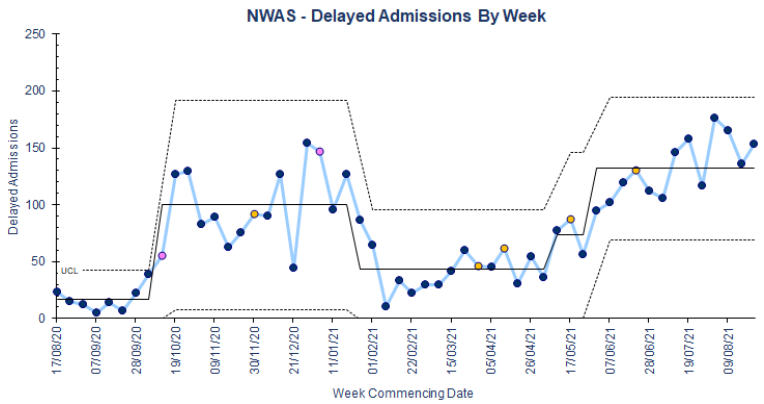


Table O2.2

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

*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 **35:06** (Table O2.1). This is the third consecutive month that the trust has not met the standard of 30 minutes and the 4th since January and the 7th 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 **23:45** in August (Table O2.1)

3,796 attendances (7.7%) had a turnaround time of over 1 hour, with **203** of those taking more than 3 hours. This has seen an increase with comparison to and June and Julys figures (**3,701** and **2,367** respectively). In August, **674** cases of delayed admissions were reported - higher than the **585** reported in July (Table O2.2). In August we lost **1,066** to delayed admissions - up from **806** hours in July.

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

Royal Oldham – **00:36:14**
Whiston – **00:34:42**
North Manchester General - **00:29:14**
Royal Albert Edward – **00:28:55**
Royal Preston – **00:27:51**

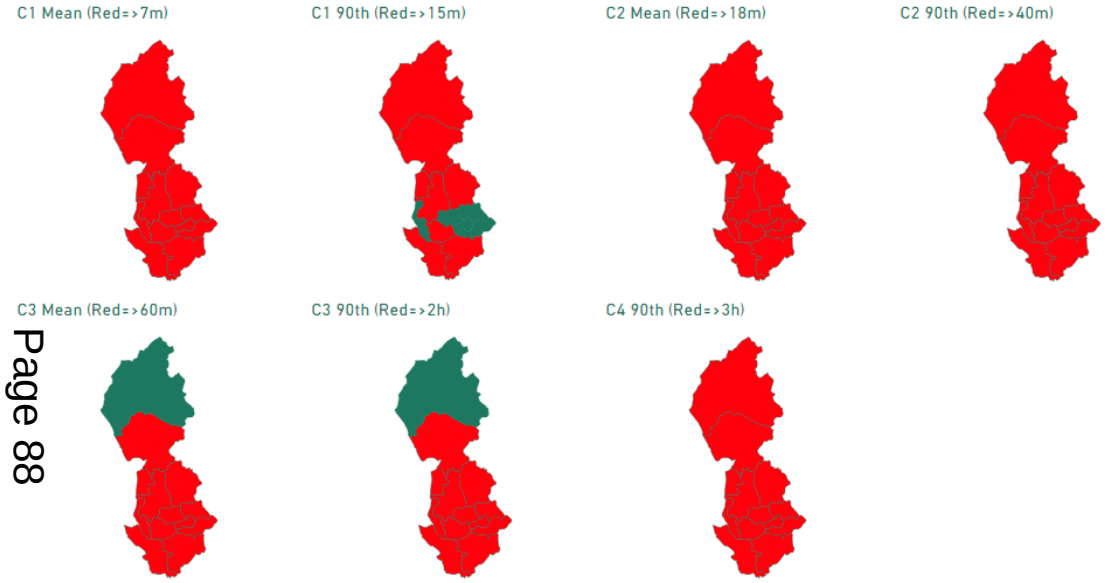
Over the last three months we have seen overall turnaround time exceed the standard of 30 minutes (Table O2.1) and this has increased each month. This is challenging for the trust but the results remain consistent within a tight distribution.

The number of delayed admissions is deteriorating month by month with **674** delayed admissions in August (Table O2.2). Delayed admissions are increasing in both frequency and length. There are currently a small number of sites where the delayed admissions have become a serious problem. At the sites waits of between four and six hours are common.

The trust continues to work with the most challenged trusts and is also ensuring a focus on patient safety while the system is challenged. Whilst performance for turnaround is outside the standard we are seeing similar performance around the country for other ambulance trusts.

O3 ARP RESPONSE TIMES

August 2021



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

1. **C1 mean: No** sector met the standards for C1 mean
2. **C1 90th: Five** sectors (Mersey North, , Manchester West, Manchester East, Manchester Central and Manchester South) met the standards
3. **C2 Mean: No** sector met the standard
4. **C2 90th: No** sector met the standard
5. **C3 Mean: One** sector met the standard (North Cumbria)
6. **C3 90th: One** sector met the standard (North Cumbria)
7. **C4 90th: No** sector met the standard

measures are meeting standard

measures are below standard

Activity: ARP Response Times

For August, response time targets were met for C1 90th only. For all categories of calls a new phase started on WC 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.

There are a number of reasons for worsening performance:

- A significant increase in delayed admissions with average turnaround time up by 20%
- Staffing shortages – due to increases in sickness and low uptake of shift enhancements (explained by easing of restriction and payments resulting from the flowers case)
- Although we have not seen an increase in incidents, we have seen a significant increase in the proportion of incidents which are higher acuity - C1 and C2.
- Overall call volume has also risen, which has partly been driven through an increase in duplicate calls.

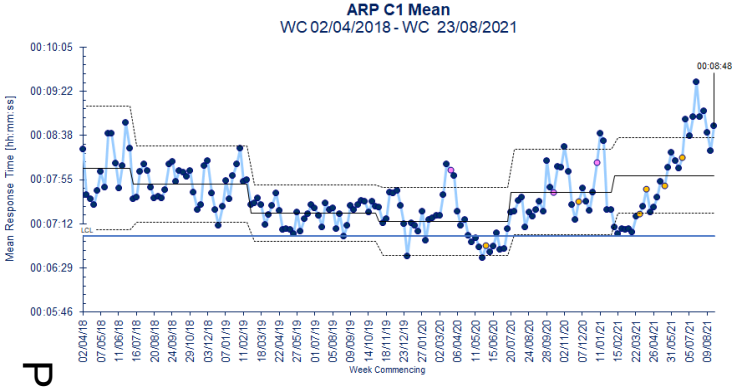
The trust has taken several measures to improve performance, including:

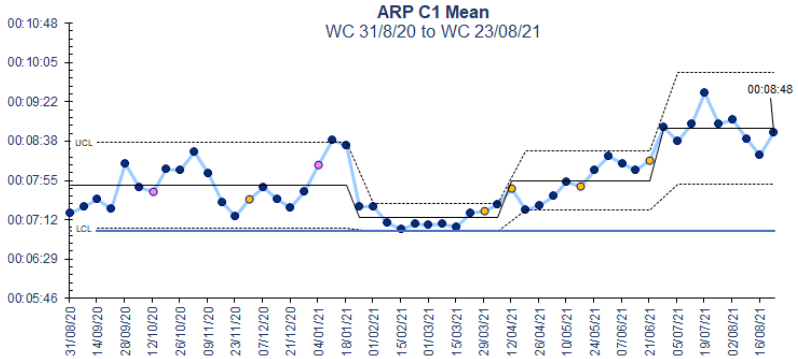
- An increase in third party support from Private Providers including St John's Ambulance
- Enhanced overtime payments on certain days
- Increased agency staff within the Clinical Hub
- A focus on reducing other abstractions and unavailability reasons
- Ongoing work to define and agree the NWAS winter plan in readiness
- £6.2M for increase for winter to be used for
    - Increase in 999 call handlers
    - Expanded capacity for crews on the road
    - Additional clinical support
    - Extended HALO (Hospital Ambulance Liaison Officer) cover
    - Retention of Emergency Ambulances to increase the fleet for winter

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. We have not seen an increase in serious incidents reports (section Q3).

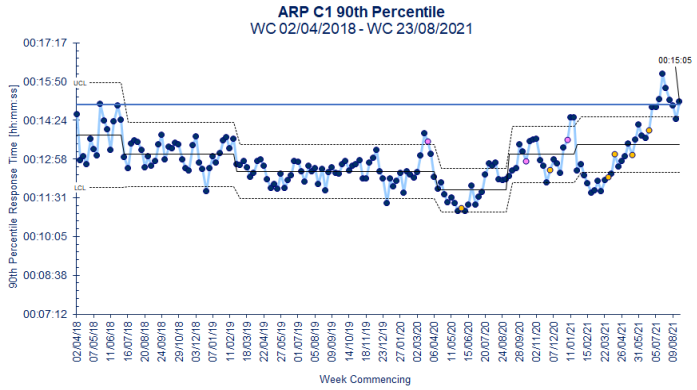
Figure O3.1

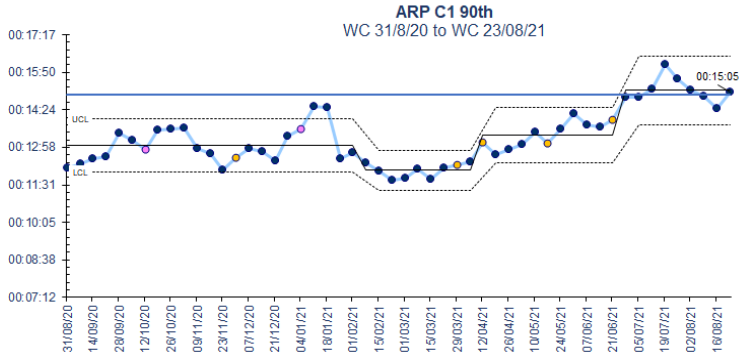




Green sectors

Figure O3.2





Green sectors

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

* Lockdown Easing of Restrictions

C1 Performance

C1 Mean

Target: **7 minutes**

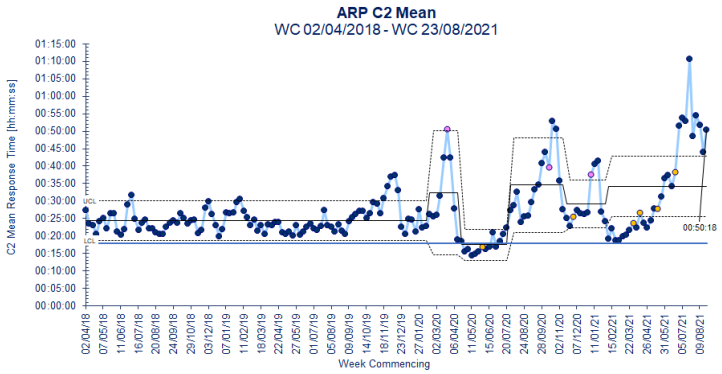
NWAS
August 2021: **8:42**
YTD: **8:21**

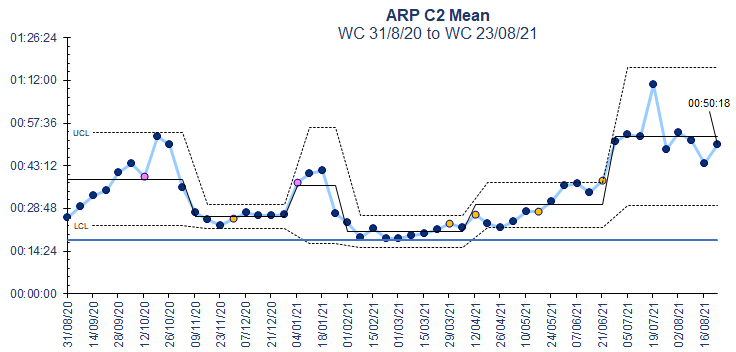
C1 mean performance is showing a general worsening of performance between March and the week commencing the 19th Of July with a general improvement since that date, This is a reflection of the increase in acuity - the percentage of C1 incidents has increased from under **10%** to **13.5%** in August (down from **14.4%** in July. The change is larger when looking on a daily basis.

C1 90th Percentile

Target: **15 Minutes**
NWAS
August 2021: **14:52**
YTD: **14:12**

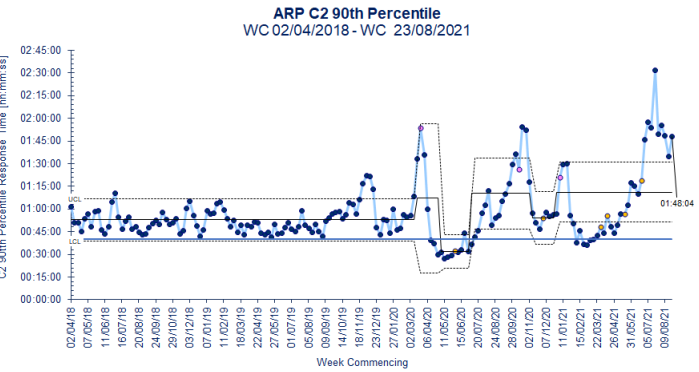
Figure O3.3

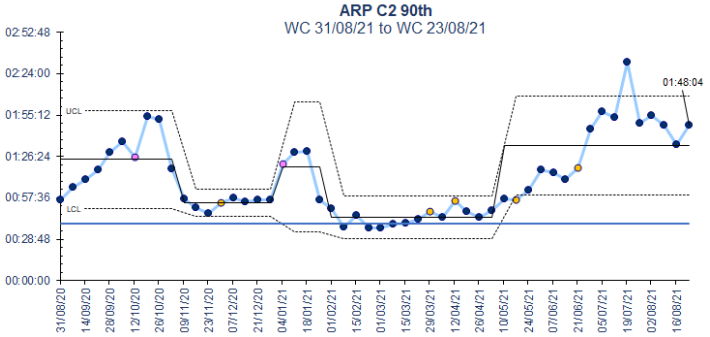




Green sectors

Figure O3.4





Green sectors

C2 Performance

C2 Mean

Target: **18 minutes**

NWAS:
August 2021: **49:05**
YTD: **39:02**

C2 performance is following a similar pattern as C1 with increases in acuity from below **50%** to just above **56%-57%** in June to August. This is in addition to the increase in C1 as a proportion. We are also seeing a drop in resources, this is due to a reduction in the uptake of overtime for a number of reasons:

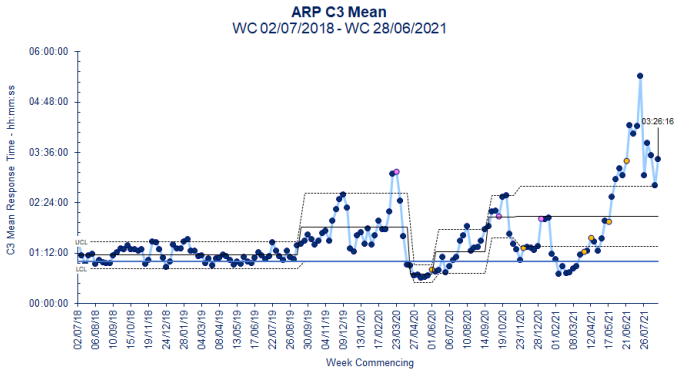
Additional focus is being placed on long waits ensuring incidents are responded to in order of acuity, ensuring we minimise any patient harm.

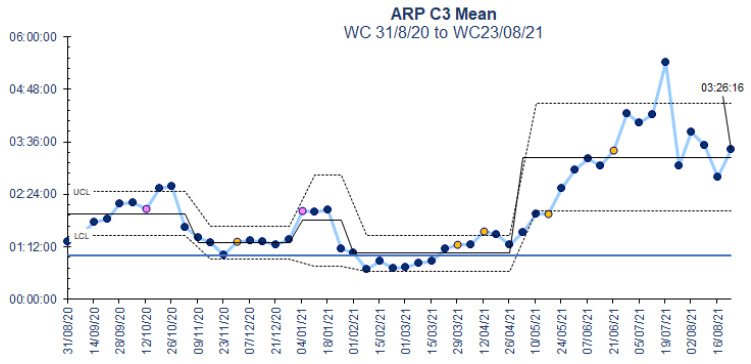
C2 90th Percentile

Target: **40 Minutes**

NWAS
August 2021: **1:45:47**
YTD: **1:22:21**

Figure O3.5





Green sectors
CL North Cumbria

C3 Performance

C3 Mean

Target: **1 Hour**

NWAS:
August 2021: **3:14:19**
YTD: **2:37:46**

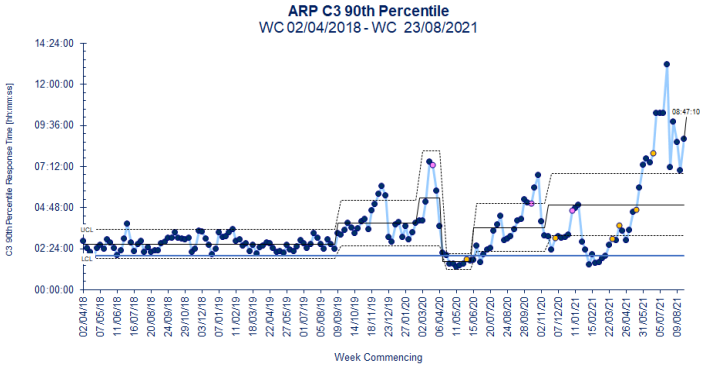
C3 follows the same pattern as C1 and C2 for both the mean and the 90th percentile.

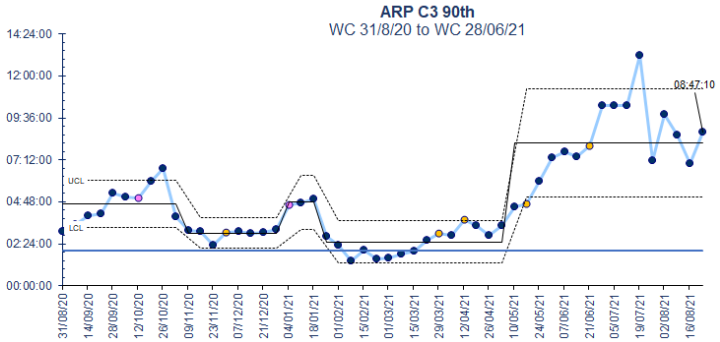
C3 90th Percentile

Target: **2 Hours**

NWAS
August 2021: **8:06:09**
YTD: **6:24:43**

Figure O3.6





Green sectors
Bay CL North Cumbria

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 August. Reporting will recommence in the next report.

Figure O3.8

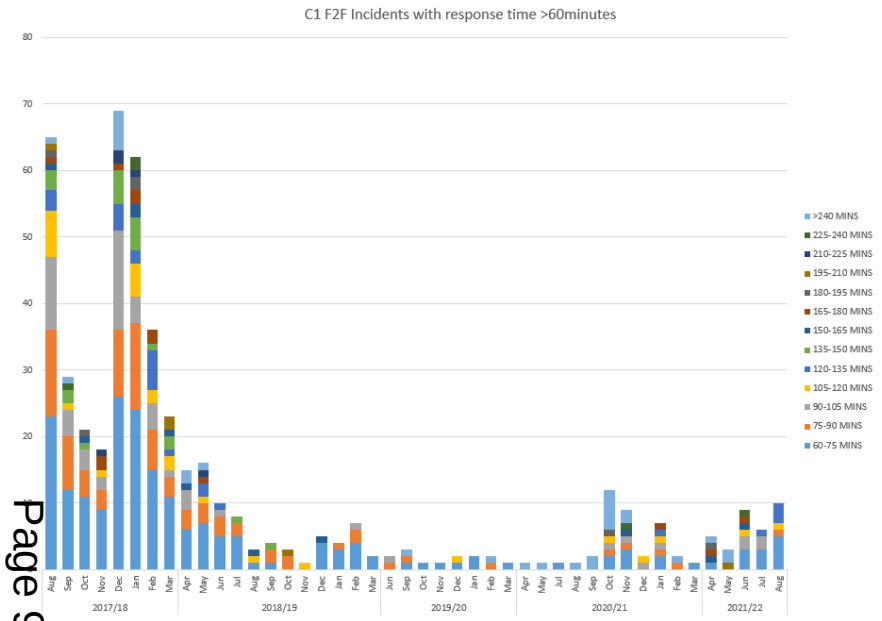


Figure O3.9

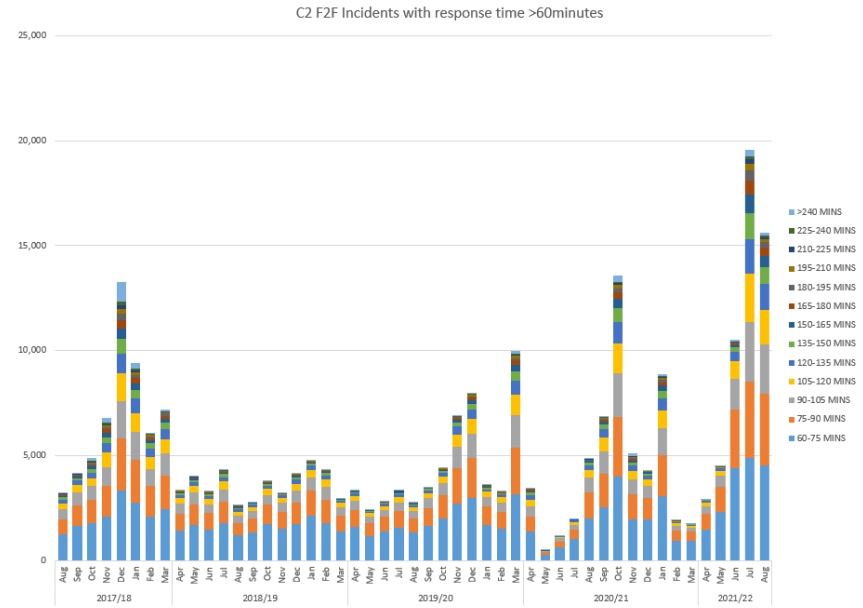


Figure O3.10

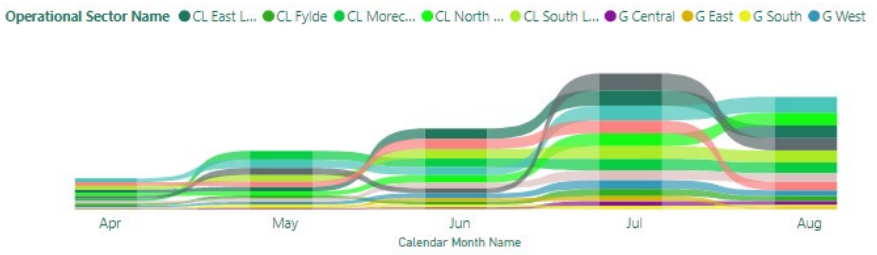
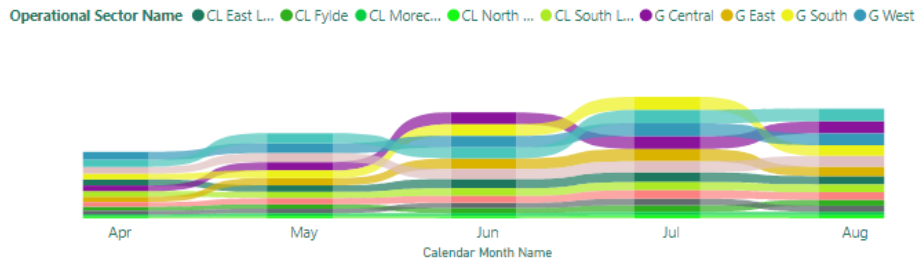


Figure O3.11



C1 & C2 Long Waits

There is a sustained level of 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 and July we have seen the rate of increase in the number of C2 long waits grow. This is a major patient safety concern and there are measures in place to review patients through the clinical control desk which are helping but not eliminating the risk.

Internal reporting has suggested that some of these patients may have come to harm, despite having multiple clinical reviews form the Clinical Co-ordination Desk.

ARP Provider Comparison Figures May 2021

Figure O3.8

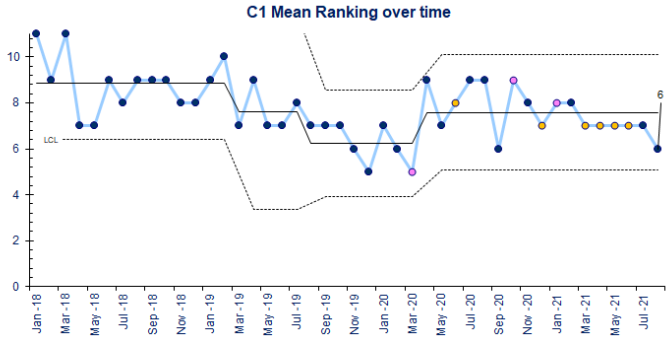


Figure O3.9

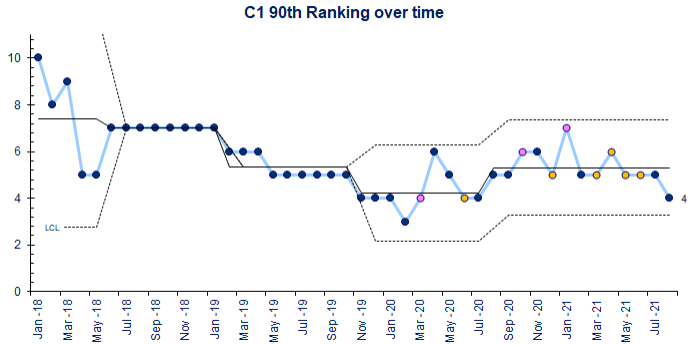


Figure O3.10

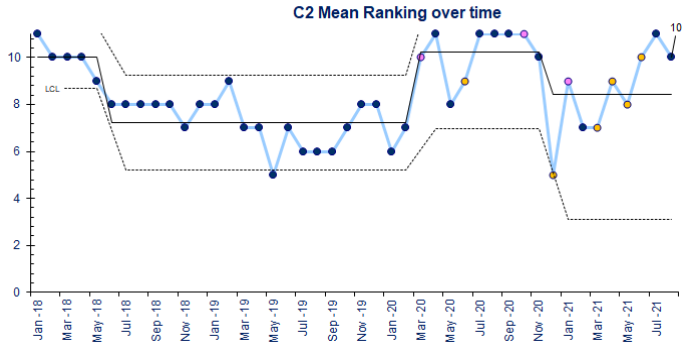
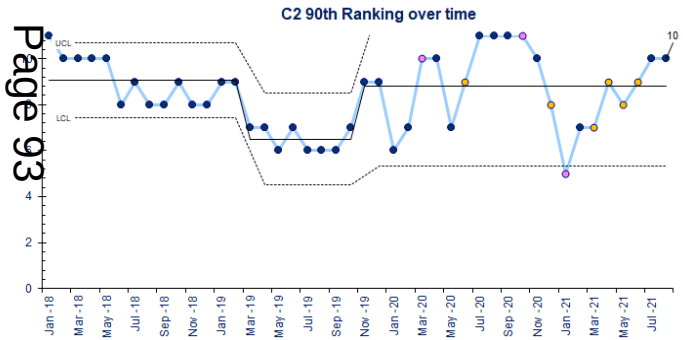


Figure O3.11



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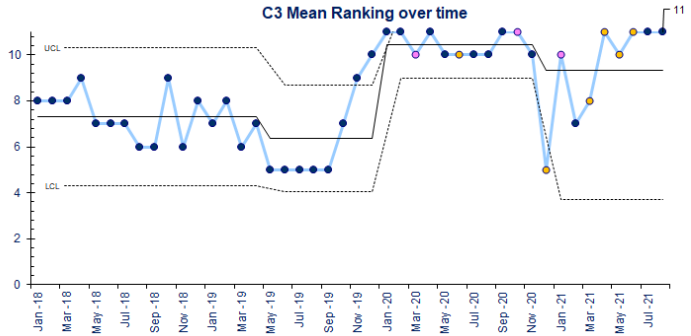
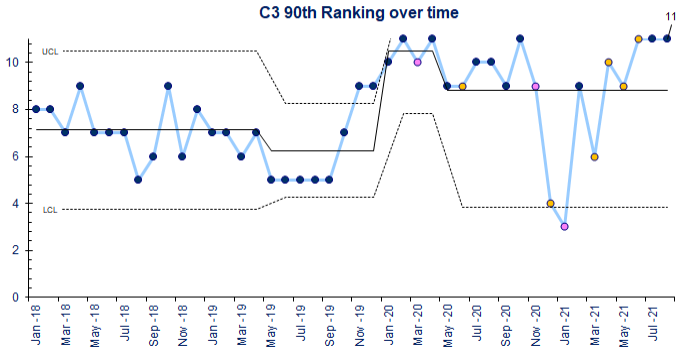


Figure O3.13



Provider	C1 Mean
London	06:58
North East	07:08
West Midlands	07:31
South Central	08:02
East Midlands	08:36
North West	08:42
South East Coast	08:45
Yorkshire	08:55
East of England	09:11
South Western	09:56
Isle of Wight	10:13

Provider	C1 90th
London	11:47
North East	12:20
West Midlands	13:17
North West	14:52
South Central	14:58
Yorkshire	15:23
East Midlands	15:35
South East Coast	16:04
East of England	17:13
South Western	18:32
Isle of Wight	19:28

Provider	C2 Mean
West Midlands	22:49
Isle of Wight	23:47
South Central	24:01
South East Coast	29:42
North East	36:57
Yorkshire	37:18
London	39:14
East of England	41:03
East Midlands	43:30
North West	49:05
South Western	53:52

Provider	C2 90th
Isle of Wight	0:47:54
South Central	0:48:35
South East Coast	0:58:53
West Midlands	1:02:45
North East	1:16:46
Yorkshire	1:21:16
London	1:24:35
East of England	1:28:05
East Midlands	1:33:08
North West	1:45:47
South Western	1:58:06

Provider	C3 Mean
Isle of Wight	01:06:40
London	01:43:05
South Central	01:43:39
West Midlands	01:53:02
North East	02:01:43
East of England	02:03:37
Yorkshire	02:04:35
East Midlands	02:40:10
South Western	02:40:52
South East Coast	02:45:22
North West	03:14:19

Provider	C3 90th
Isle of Wight	02:30:32
South Central	03:56:19
London	04:13:08
West Midlands	04:21:28
Yorkshire	04:52:55
North East	05:06:23
East of England	05:14:11
South East Coast	06:17:10
East Midlands	06:26:30
South Western	07:28:58
North West	08:06:09

O4 111 PERFORMANCE

Figure O4.1

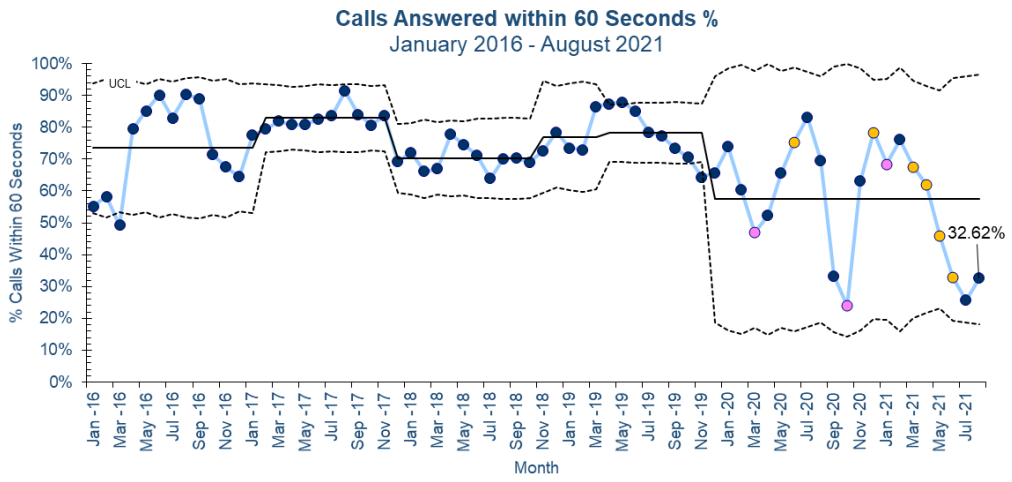
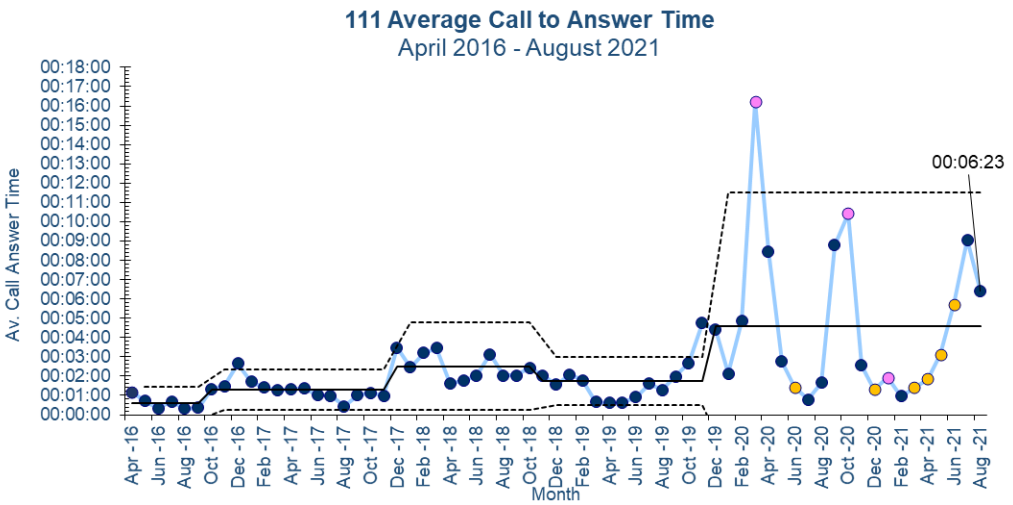


Figure O4.2



* Lockdown Easing of Restrictions

111 Performance

Calls Answered within 60 seconds %

Target:	**95%**
NWAS	
August 2021:	**32.62%**
YTD:	**40.84%**
National	**41.3%**

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).

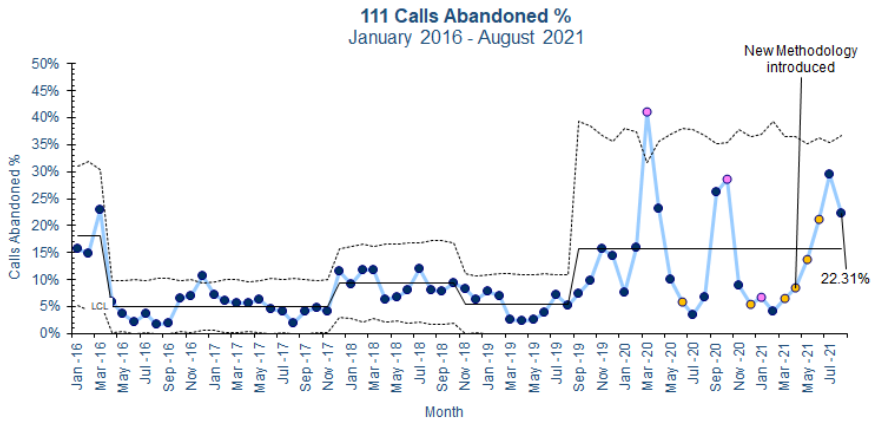
Staff attrition is causing significant pressures within the service. Usual levels of 30% per annum have now increased to around 45%. This is multifactorial and can be attributed to pressures of the role, pre covid employers now recruiting again and challenges staff are facing with annual leave. The senior team within 111 are working to support staff and are on track to deliver the Health and Wellbeing plan developed recently.

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

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 areas of pressure across the North West.

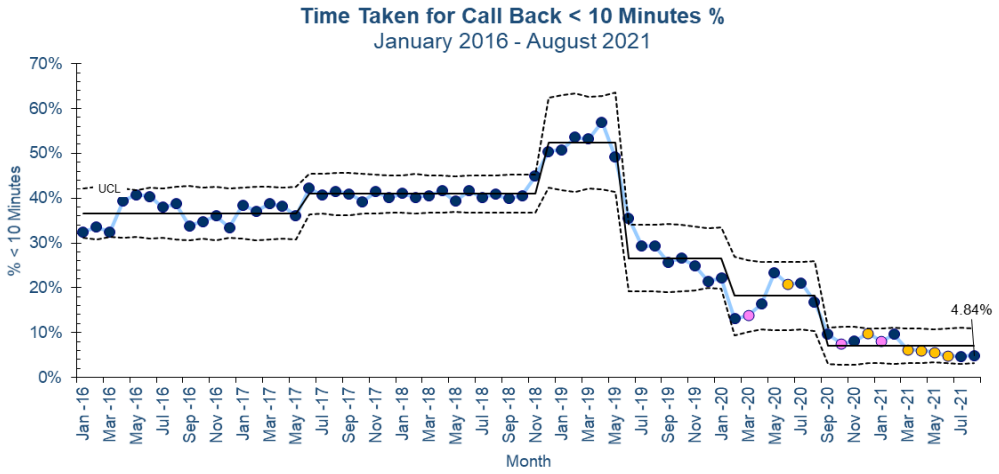
Call back times with Out of Hours (OOHs) services continue to present us with additional pressures as patients continue to call back into the service to chase their call. This has now been escalated to commissioners and conversations between CCGs and OOHs providers are now taking place. The service have agreed to continue to monitor this position.

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
August 21: **22.31%**
YTD: **17.42%**

National **19.9%**

Call Back < 10 Minutes %

Target: **75%**

NWAS
August 21: **4.84%**
YTD: **5.21%**

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

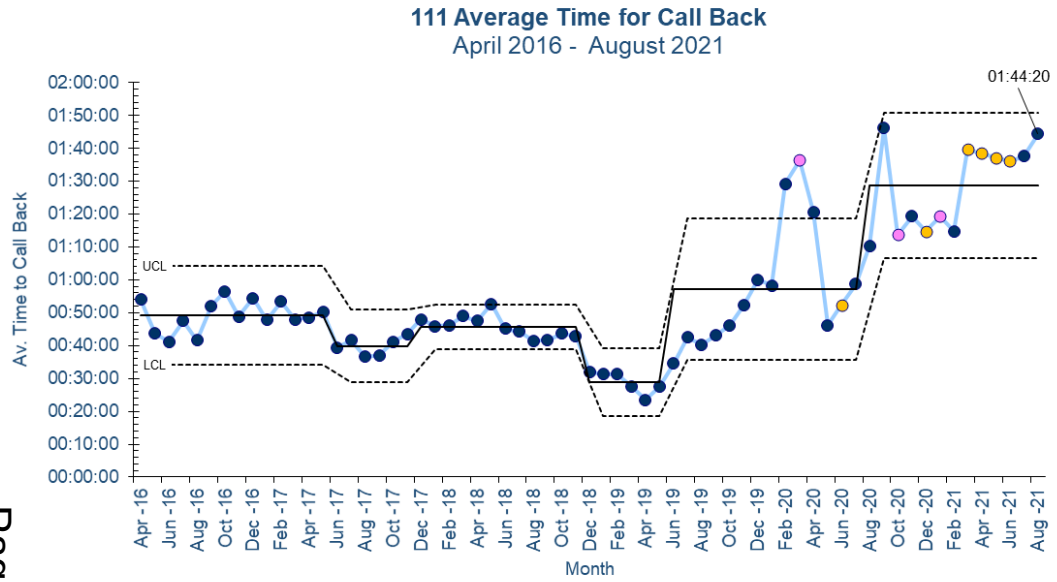
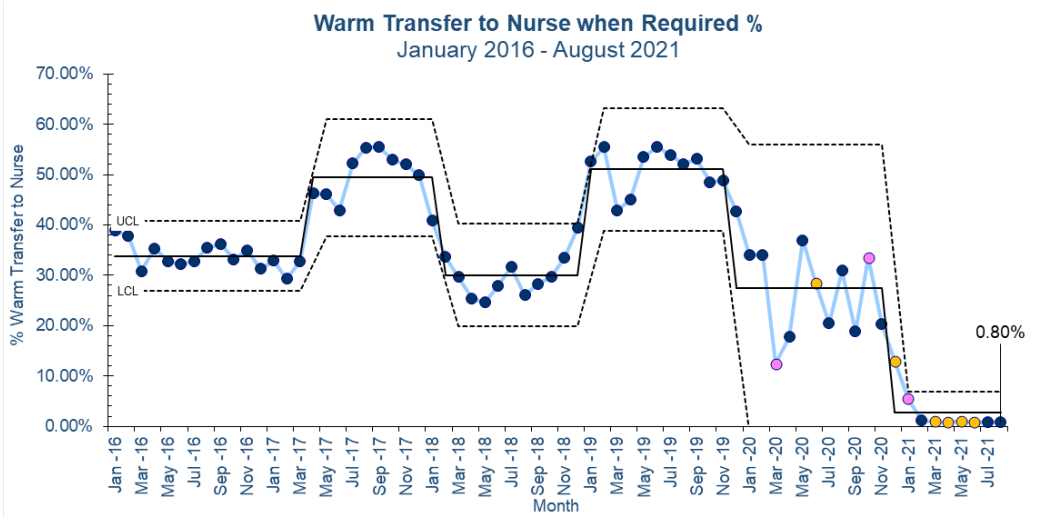


Figure O4.6



* Lockdown Easing of Restrictions

Warm Transfer to Nurse when Required%
Target: **75%**

NWAS
August 21: **0.80%**
YTD: **0.86%**

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										
	Current Month: July					Year to Date: July 2021 - July				
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	9,457	(4,567)	(33%)	14,024	9,457	(4,567)	(33%)
Greater Manchester	526,588	43,882	36,465	(7,417)	(17%)	43,882	36,465	(7,417)	(17%)
Lancashire	589,181	49,098	33,362	(15,736)	(32%)	49,098	33,362	(15,736)	(32%)
Merseyside	300,123	25,010	22,427	(2,583)	(10%)	25,010	22,427	(2,583)	(10%)
NWAS	1,584,182	132,015	101,711	(30,304)	(23%)	132,015	101,711	(30,304)	(23%)

UNPLANNED ACTIVITY										
	Current Month: July					Year to Date: July 2021 - July				
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	577	(670)	(54%)	1,247	577	(670)	(54%)
Greater Manchester	49,133	4,094	4,498	404	10%	4,094	4,498	404	10%
Lancashire	58,829	4,902	3,635	(1,267)	(26%)	4,902	3,635	(1,267)	(26%)
Merseyside	22,351	1,863	1,817	(46)	(2%)	1,863	1,817	(46)	(2%)
NWAS	145,282	12,107	10,527	(1,580)	(13%)	12,107	10,527	(1,580)	(13%)

ABORTED ACTIVITY									
	July								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	154	5,969	3%	38	567	7%	45	2,863	2%
Greater Manchester	1,580	16,240	10%	660	4,399	15%	1,028	15,405	7%
Lancashire	894	17,662	5%	511	3,565	14%	327	11,906	3%
Merseyside	504	8,960	6%	276	1,767	16%	456	11,523	4%
NWAS	3,132	48,831	6%	1,485	10,298	14%	1,856	41,697	4%

PTS Performance

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

Activity during July was **23%** below contract baselines with Lancashire **32%** below contract baselines whilst Merseyside is operating at -**10%** (-**2583**) Journeys below baseline. For the year-to-date position (July 2020 - July) PTS is performing at -**23%** (-**30304** journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 33% and 32% below baseline whilst Greater Manchester and Merseyside are operating at **17%** and **10%** below baseline respectively.
In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are **10%** (**404** journeys) and -**2%** (-**46** journeys) against baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges achieving contract KPI performance. Cumbria and Lancashire are -**54%** (**-670** journeys) and **-26%** (**-1267** journeys) below baseline. In terms of overall trend analysis, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas.

Aborted activity for planned patients averaged **6%** during July. Cumbria experienced **3%**, Greater Manchester experienced **10%** whilst Lancashire and Merseyside both experience **5%** & **6%** aborts respectively. There is a similar trend within EPS (renal and oncology) patients with a Trust average of **4%** aborts whereas Cumbria has **2%** and Greater Manchester **7%** Lancashire and Merseyside operate with **3%** and **4%** respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average **14%** (**1** in **6** patients) with variances of **7%** in Cumbria, **15%** in Greater Manchester, **14%** in Lancashire and **16%** Merseyside.

There remains circa **90** whole time equivalent vacancies across PTS and the service line is progressing with its recruitment plans to fill these positions by the end of the financial year. IT should be noted that this may be impacted by further release of resources if PTS volunteer to undertake 'blue light' duties in line with the Trust's plans to increase the number of emergency ambulances over winter. Further proposals to adapt the current workforce profile to enable greater provision of double crewed non-emergency ambulances especially in Greater Manchester are progressing in discussion with Trade Union, HR and Finance colleagues. The rationale for this is resultant from the demand profile changing since the onset of Covid as a greater proportion of PTS activity is an ambulance category mobility and to enable support to PES via the transportation of lower acuity patients.

As previously reported, capacity challenges associated with social distancing measures continue to impact utilisation of resource. Whilst the current direction is that current IPC / social distancing measures will remain in place discussions continue with NHSE/I, and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively.

In addition to the above, the service line is a core member of an Operational Design Group (ODG) 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. A sub group to the ODG (PTS Review Group) and led by Commissioners has been established. The group is set up to focus on designing a new service model(s) for PTS with a view to the procurement of a new service due to commence in April 2023. The group comprises commissioners, senior representatives from the Provider Collaborative (i.e. acute hospital trusts) and West Midlands Ambulance Service. Currently the outputs from this group will be discussed at the UEC Oversight Forum.

OH1 STAFF SICKNESS

Figure OH1.1

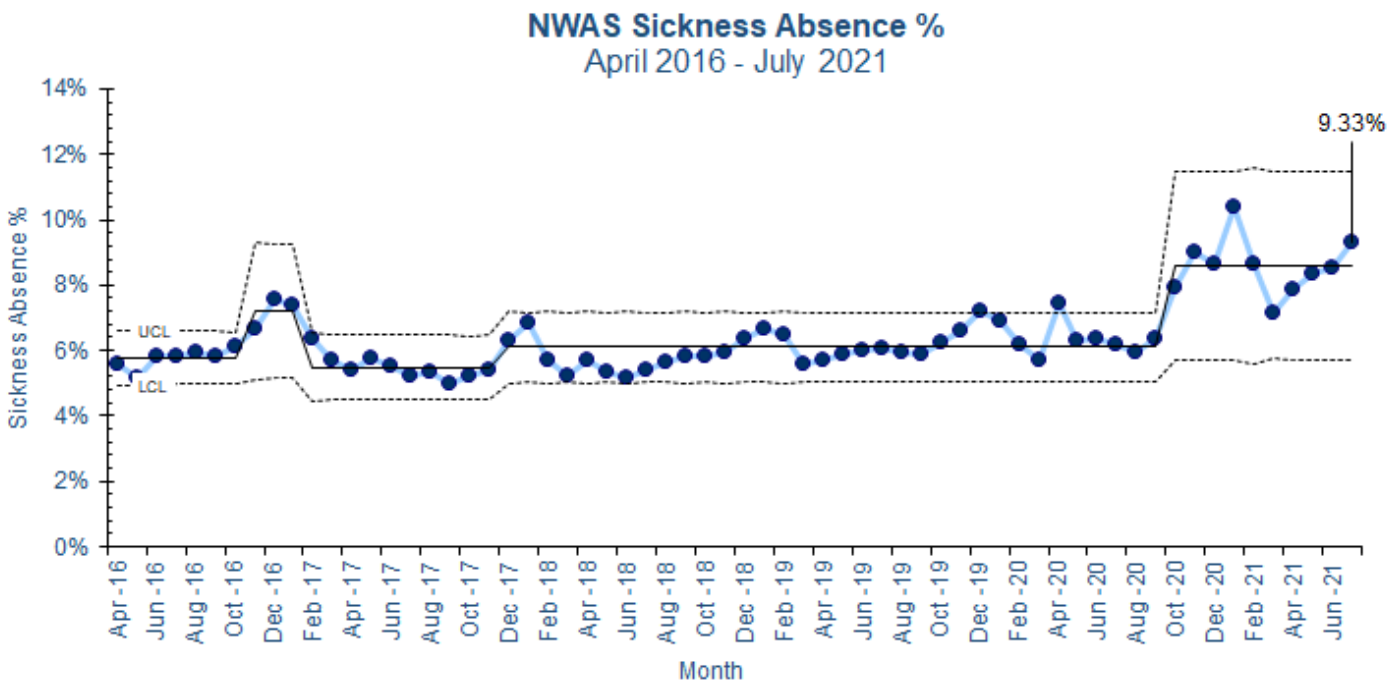


Table OH1.1

Sickness Absence	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
NWAS	5.96%	6.35%	7.94%	9.00%	8.66%	10.41%	8.65%	7.15%	7.90%	8.32%	8.55%	9.33%
Amb. National Average	5..24%	5.74%	6.10%	6.51%	6.75%	9.37%	7.03%	6.06%	6.36%			

Staff Sickness

The overall sickness rates for July 2021 were 9.33% (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 4 consecutive months. Data analysis shows the top 5 reasons for absence being Mental Health, Covid, Injury, MSK and Back problems. Short term sickness absence is broadly equal to long term sickness in PES and PTS however short-term sickness in 111 is high which is likely to be as a result of sustained demand on the service .

The impact of COVID related sickness has increased slightly to 1.35% (OH1.2). The underlying non-COVID position is 7.98 which is higher than the same period last year which was 6..18 % and above the 5.7% target.

In the July data, the impact of COVID absence is clearly reducing however, 111 remains the highest at 2.99% (OH1.6). All other Service Lines are slightly up on previous months at over 1%.

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

The People directorate have identified additional resources to establish a dedicated Team to focus on supporting operational teams to improve attendance management and wellbeing.

Figure OH1.2:

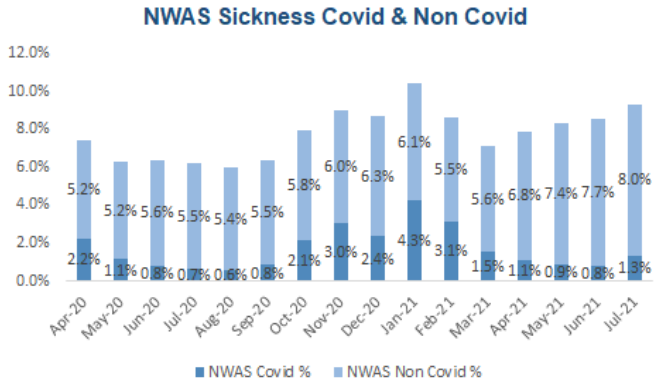


Figure OH1.3:

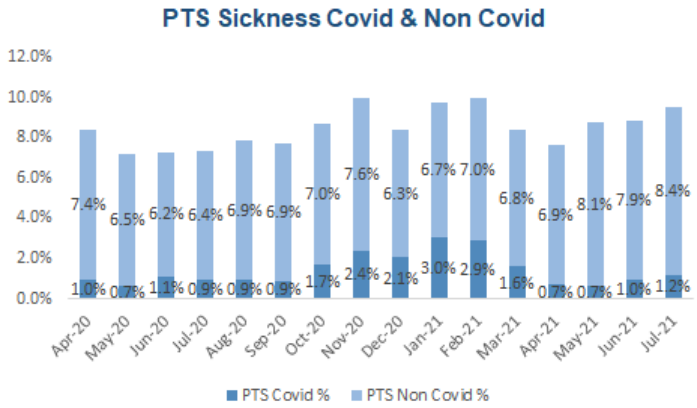


Figure OH1.4:

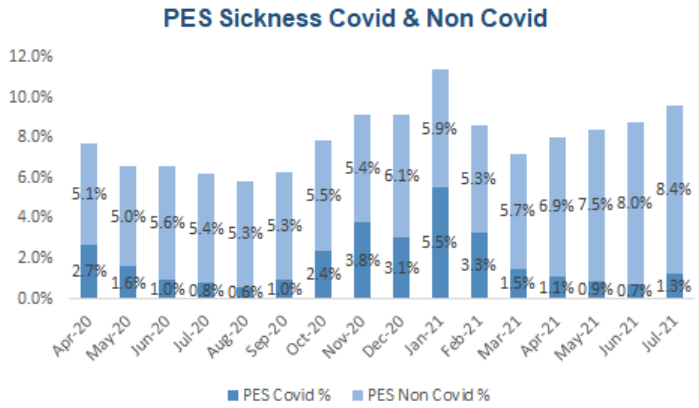


Figure OH1.5:

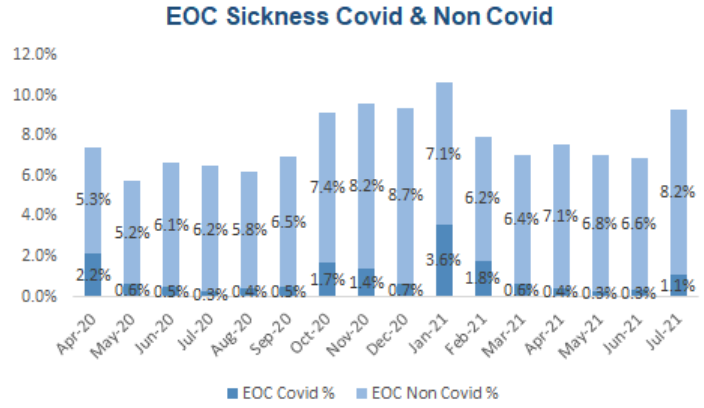


Figure OH1.6:

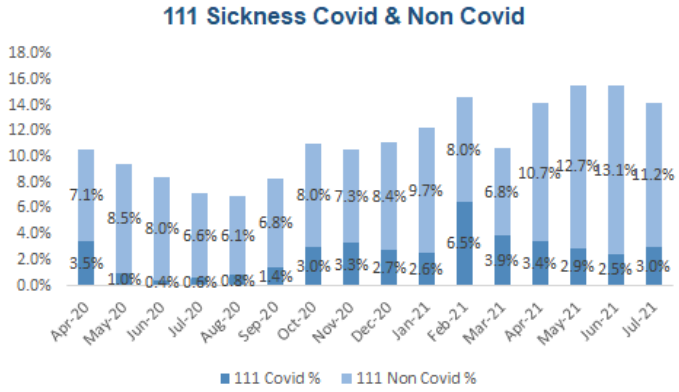
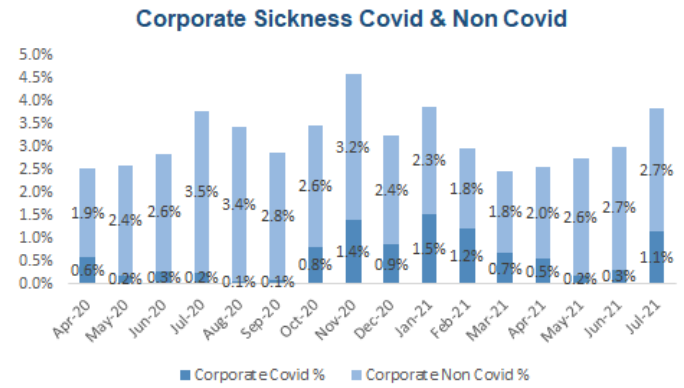


Figure OH1.7:



OH2 STAFF TURNOVER

Figure OH2.1

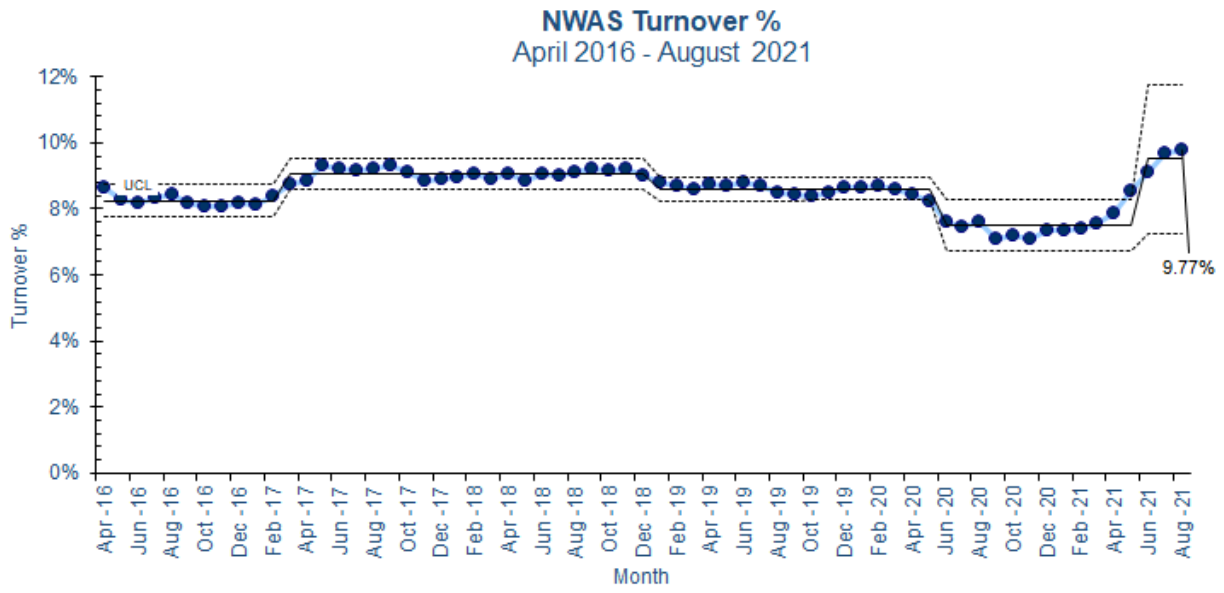


Table OH2.1

Turnover	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
NWAS	7.07%	7.19%	7.08%	7.35%	7.34%	7.41%	7.57%	7.87%	8.56%	9.10%	9.67%	9.77%
Amb. National Average	8.08%	7.95%	7.75%	7.67%	7.58%	7.41%	7.35%	7.57%	7.52%			

Staff Turnover

Staff turnover for June is 9.77%. 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 9 months. Aug 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 August data indicates turnover is now at 33.28% now above the upper control limit (OH2.5). Detailed analysis on leavers is ongoing but there is a spike in leavers within the first 12 months which is likely to indicate the pressure within the service .

EOC has also seen an increase with Aug turnover at 10.49% (OH2.4), it is slightly up on previous months. Some of this reflects the loss of fixed term staff seeking permanent positions. However EOC staffing position is stable moving into the winter period.

Both PES and PTS turnover are showing a small upward trend, however, overall the Trust has not seen the anticipated loss of Paramedics to PCNs in Q1 and Q2.

Figure OH2.2

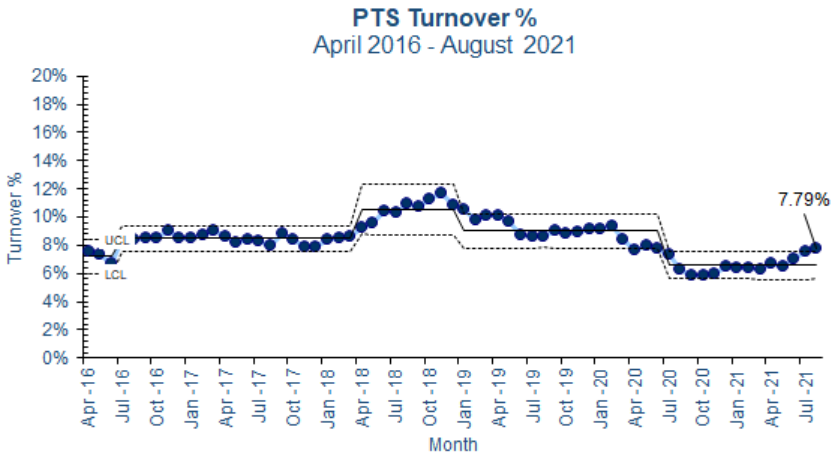


Figure OH2.3

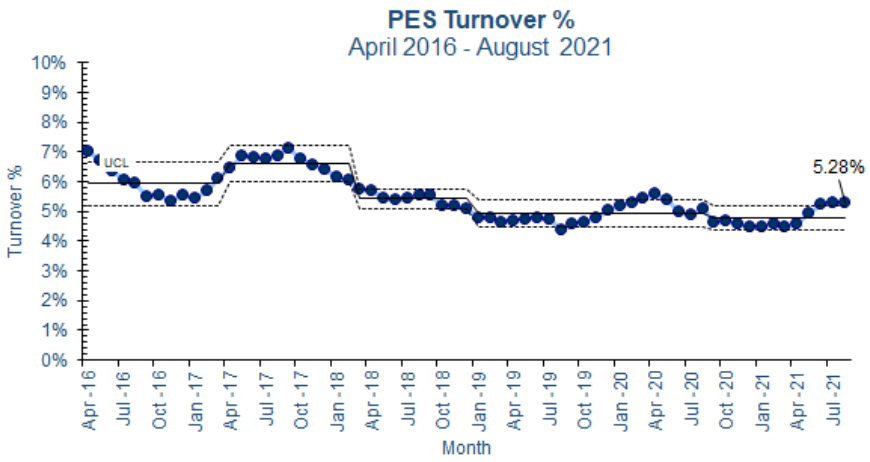


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Figure OH2.4

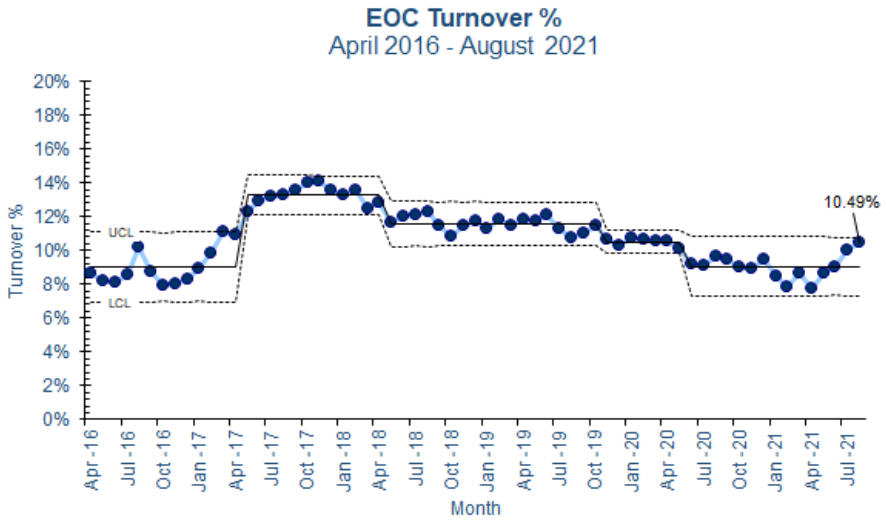
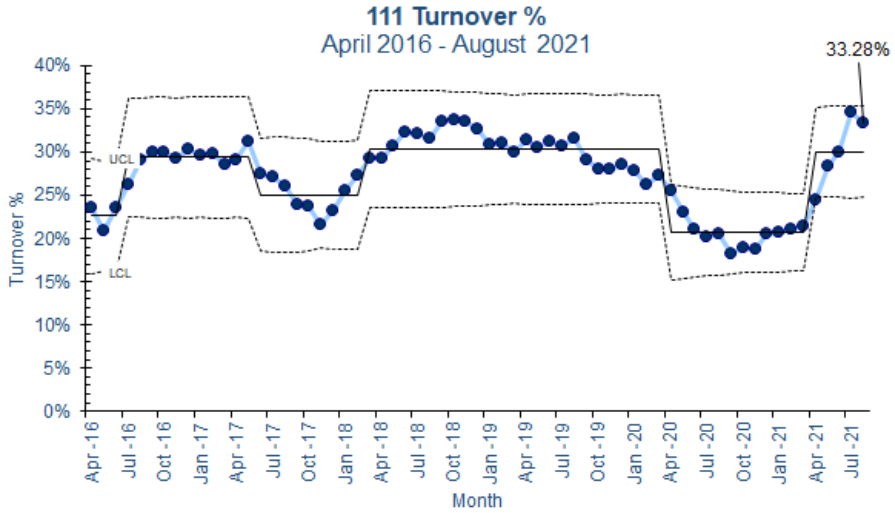
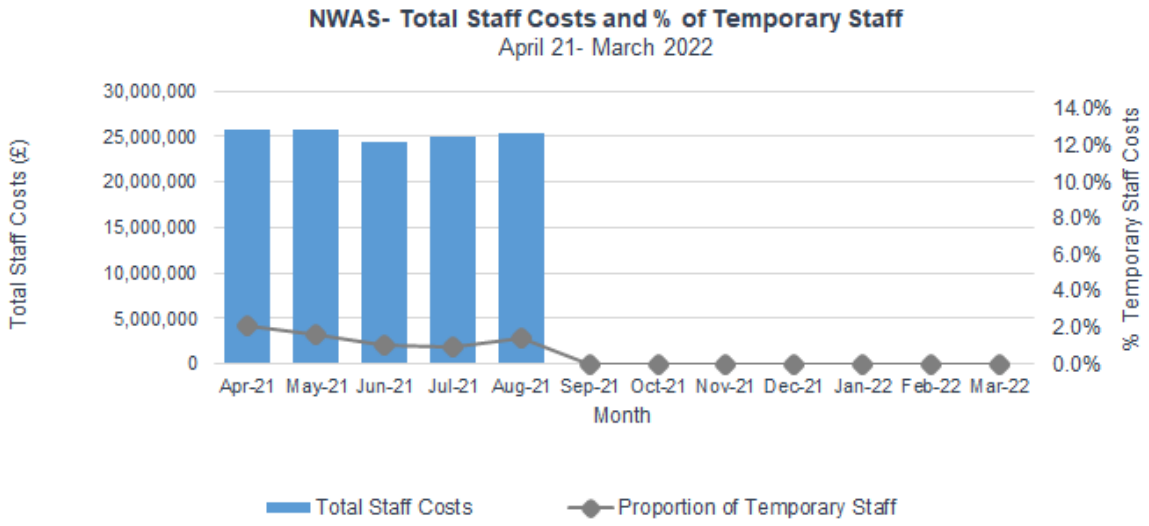


Figure OH2.5



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	Sep-20	Oct-20	Nov-19	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Agency Staff Costs (£)	466,727	386,841	502,967	541,395	636,447	478,564	647,483	541,873	404,321	245,748	241,475	356,466
Total Staff Costs (£)	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	24,909,469	25,379,411
Proportion of Temporary Staff %	1.2%	0.7%	1.7%	1.6%	2.5%	1.9%	1.3%	2.1%	1.6%	1.0%	1.0%	1.4%

Figure OH4.2:

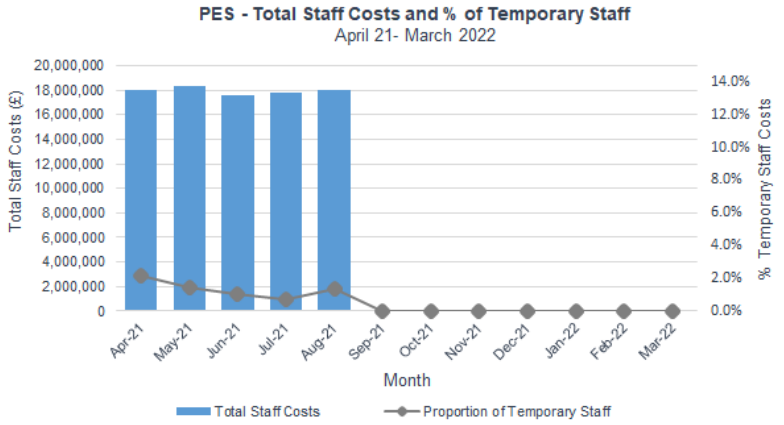


Figure OH4.3:

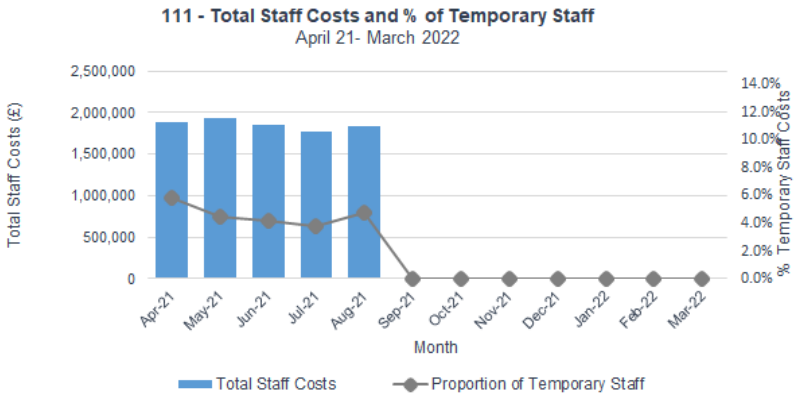


Figure OH4.4:

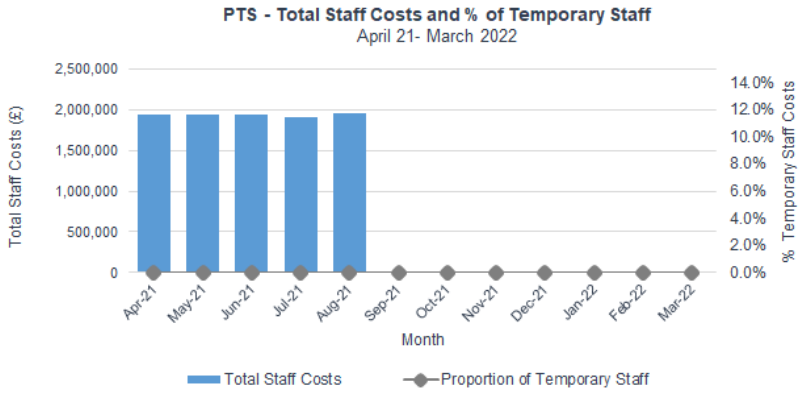
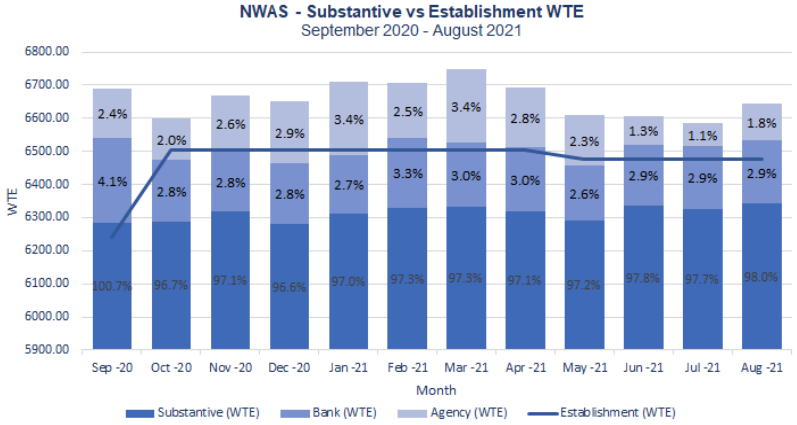


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

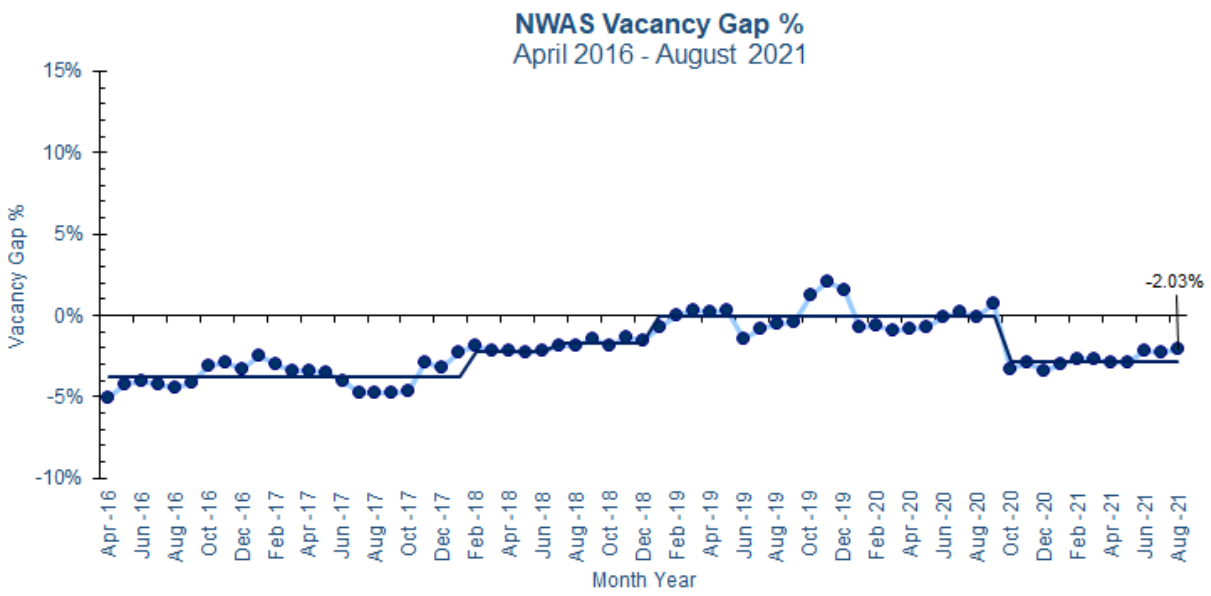


Table OH5.1

Vacancy Gap	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
NWAS	0.17%	-0.08%	0.69%	-3.31%	-2.88%	-3.44%	-2.97%	-2.68%	-2.67%	-2.86%	-2.85%	-2.16%	-2.30%	-2.03%

Vacancy Gap

Chart OH5.1 shows the vacancy gap at circa –2% reflecting overall a positive position.

Although recruitment plans for 111 are on track the establishment change now shows the current position against all the growth as a gap of 6.60% (OH5.5). The recruitment plan focuses on Clinical Advisors and recruiting to management posts. Health Advisors vacancies have been prioritised and are near establishment, although current turnover is a risk.

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 Q1. 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. EOC are 8.45% above establishment due to ELC approving the continued recruitment at risk to maintain and improve frontline staffing.

Figure OH5.2

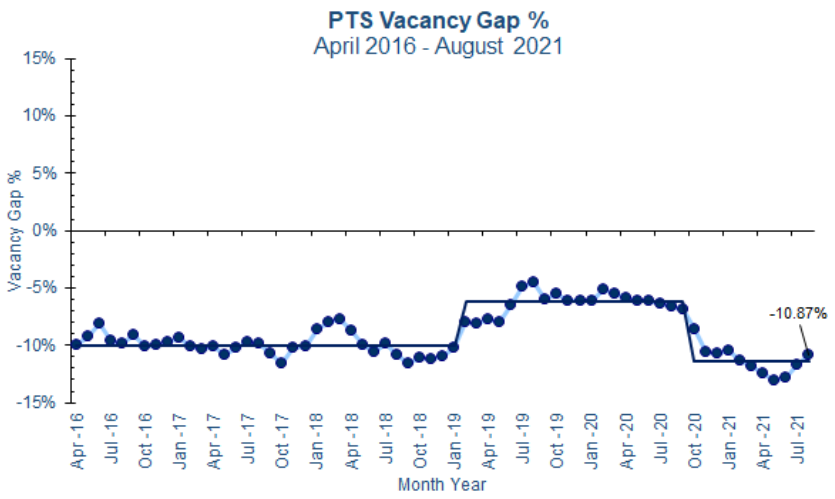


Figure OH5.3

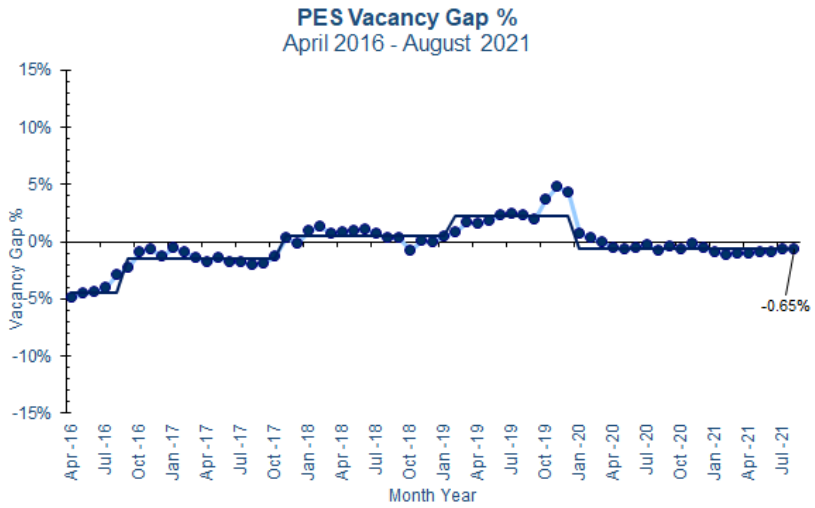


Figure OH5.4

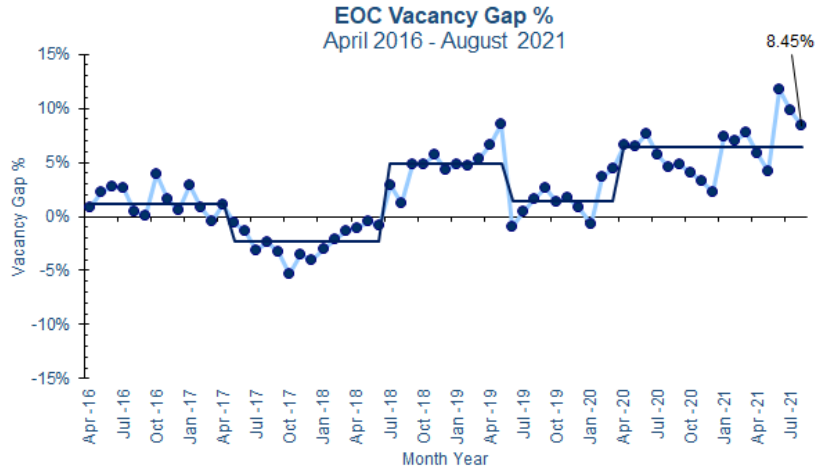
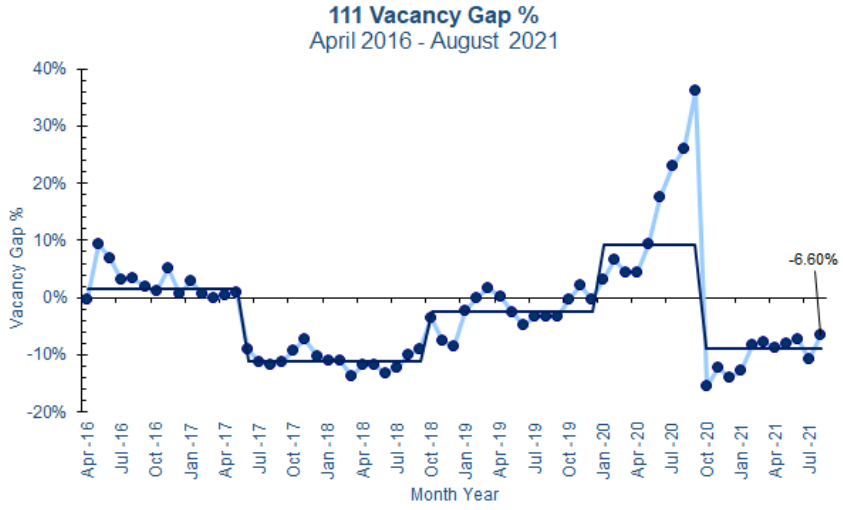


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

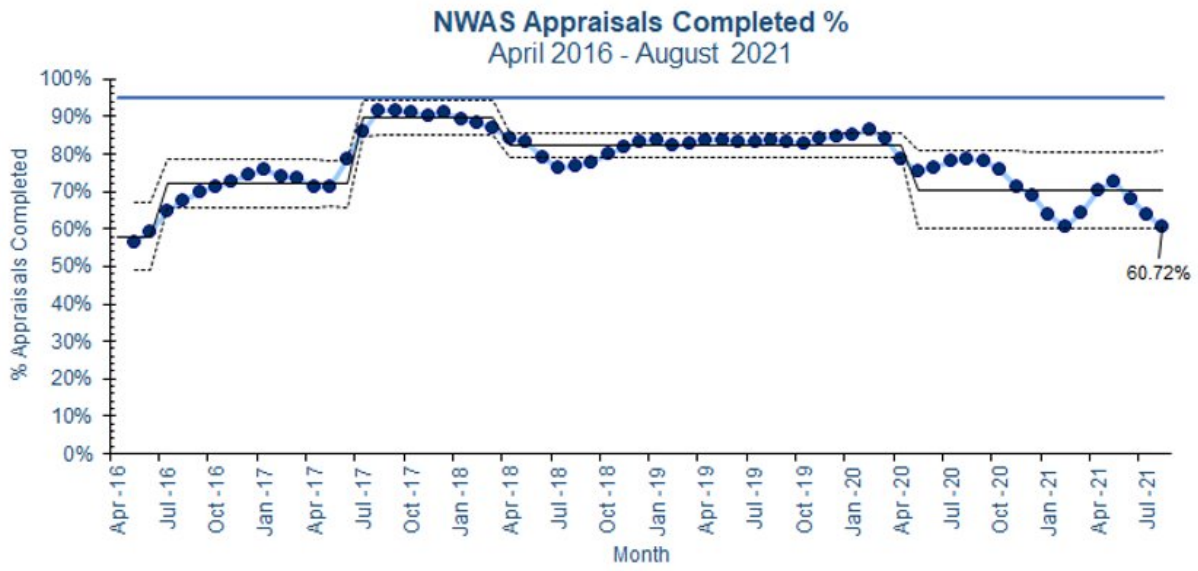


Table OH6.1

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

Appraisals

Appraisal completion rates are at 61% for August 21 (OH6.1). The impact of operational pressures since June and the move to Reap 4 has impacted on the good progress made towards the September target. ELC have now approved revised targets in light of operational pressures and demands on Service Lines.

The revised targets approved by ELC are:

75% by March 2022 – Service Lines

85% by March 2022 – Corporate and Band 8a and above

Most service lines are just within control limits apart from EOC where recovery work is required (OH6.4). PTS & PES have dropped compliance rates slightly due to REAP 4. Again, recovery plans will be required. The 111 data position has improved significantly with the data point above the upper control limit at 66%.

A revised process will set a minimum expectation for staff check-in conversations with a focus on

- Health, wellbeing, safety, and any support that may be needed
- Personal and professional resilience in the current operating environment, and
- Identification of any development needs that may arise out of the previous discussion points

Figure OH6.2

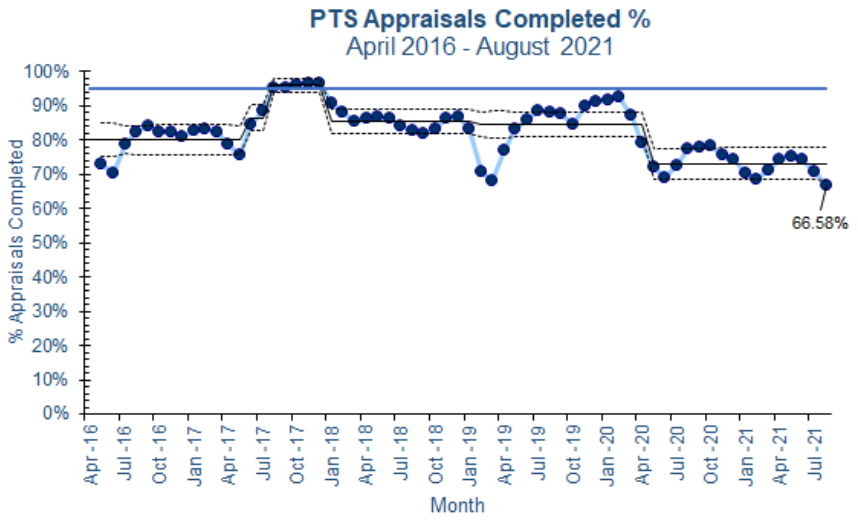


Figure OH6.3

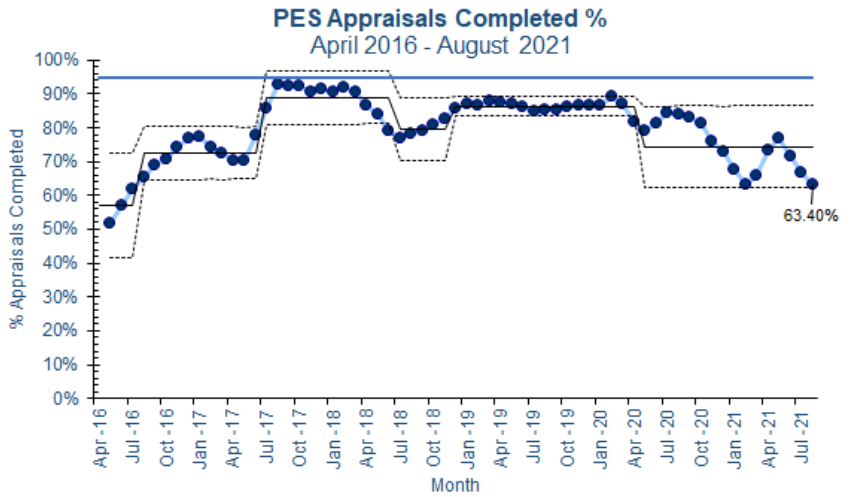


Figure OH6.4

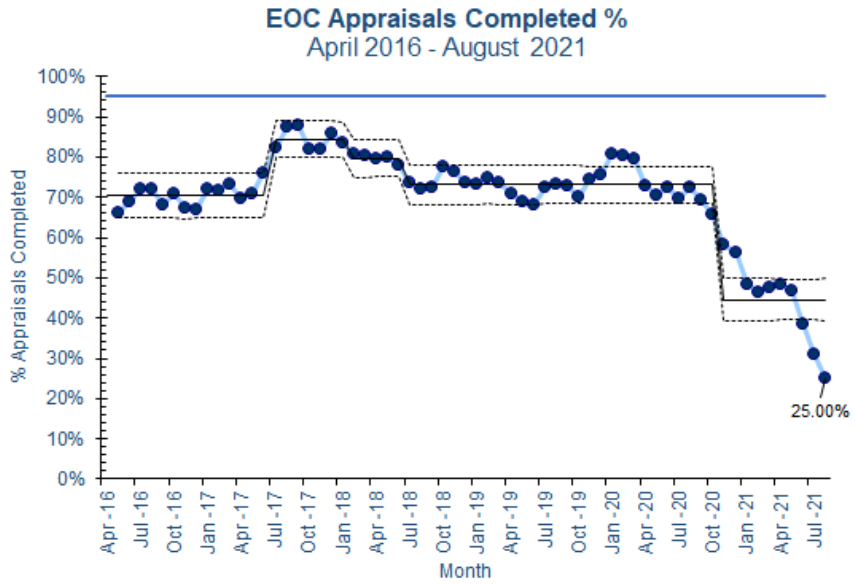
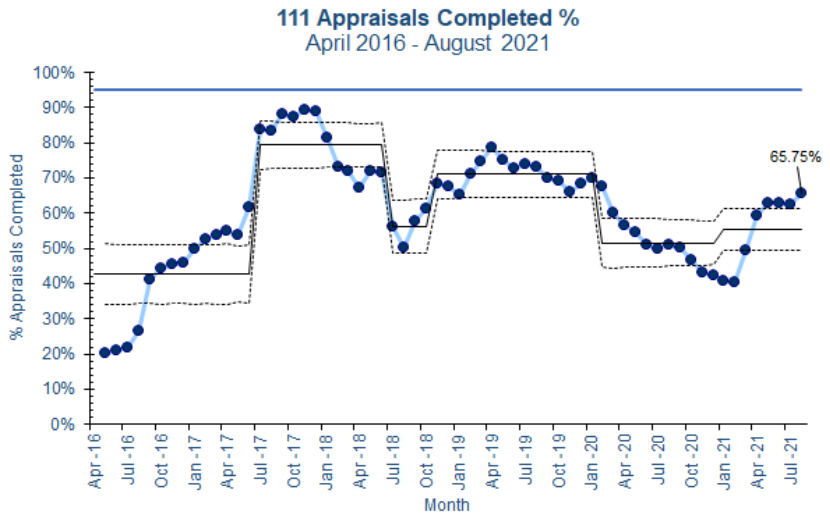


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

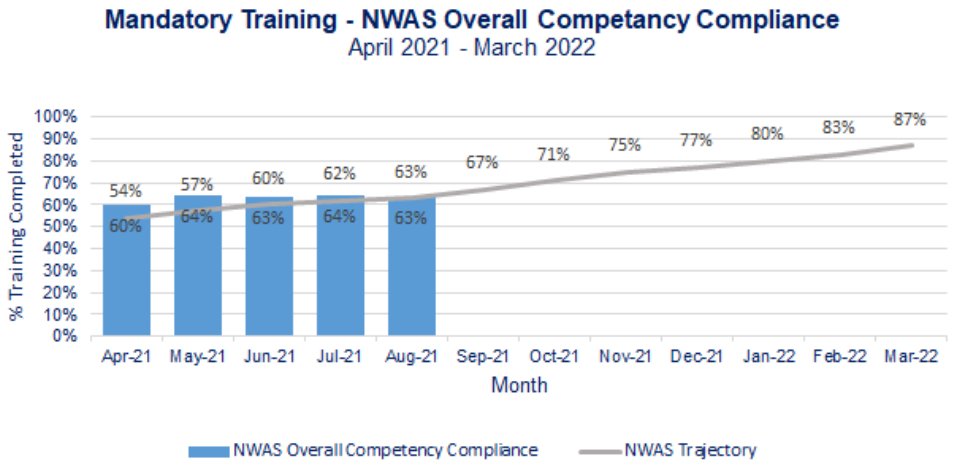
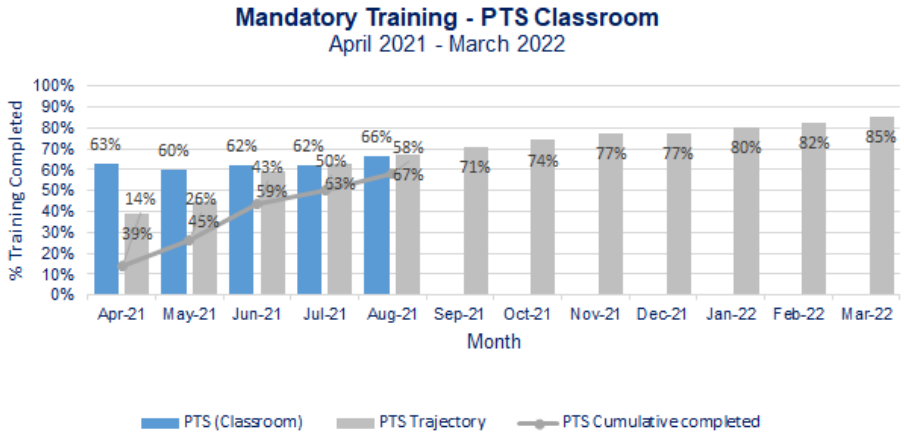


Figure OH7.2



Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and runs across the financial year. The target for 2021/22 was to achieve 95% compliance. However, as a result of REAP 4 , ELC have agreed a revised target of 85% compliance for all Service Lines apart from Corporate Services remaining at 95% compliance.

Additional mandatory topics have been introduced for 2021/22. The introduction of new modules not previously completed has reduced overall compliance to 63% in August . This will build up across the remainder of the year with targets as detailed above.

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

PTS classroom are in line with the plan 58% against a target of 58% for the end of August. However as a result of REAP 4, PES classroom training was paused June until August.

ELC have approved a revised programme of 1 day training, which will still deliver the main learning outcomes through a smaller staff to trainer ratio allowing condensing of content. Classroom training has recommenced in September and profiled training should deliver the 85% target. Further work is also being undertaken to recover Level 3 Safeguarding training for those missing classroom training last year, this will move to online.

Figure OH7.3

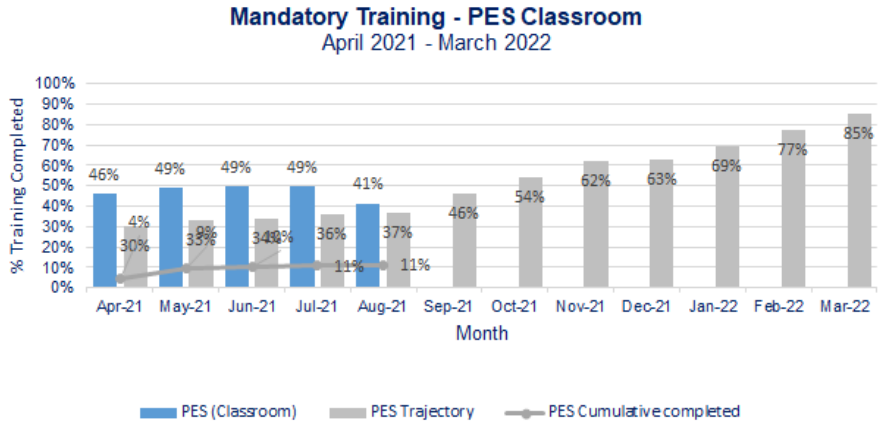


Figure OH7.4

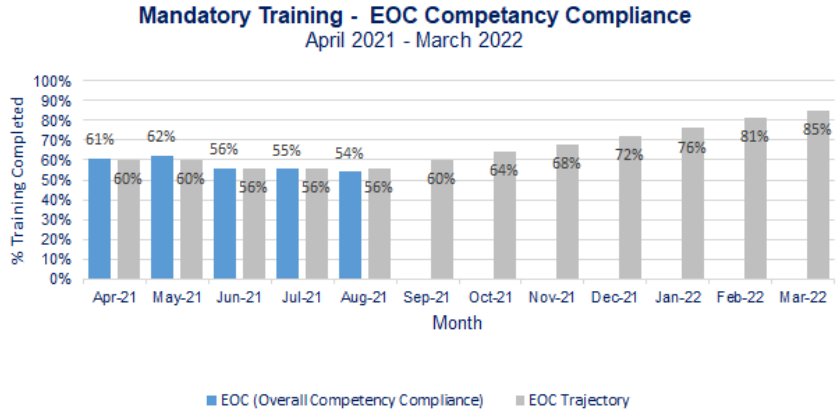


Figure OH7.5

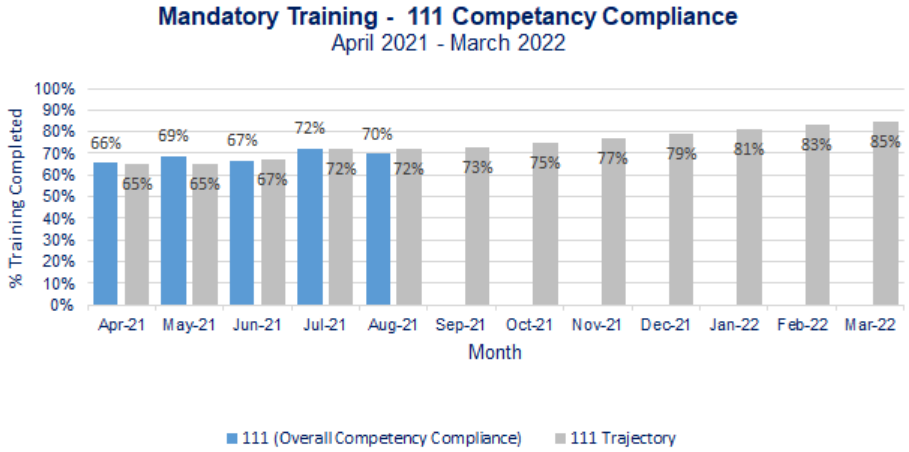
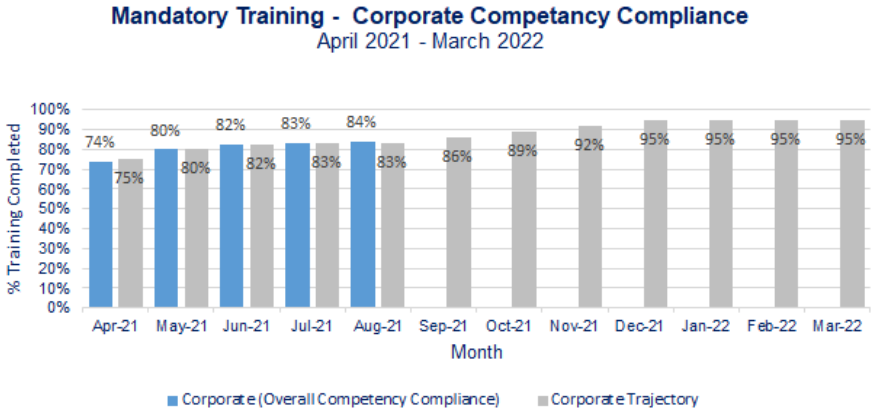


Figure OH7.6



OH8 CASE MANAGEMENT

Employee Relation Dashboard @ 31 Aug 2021

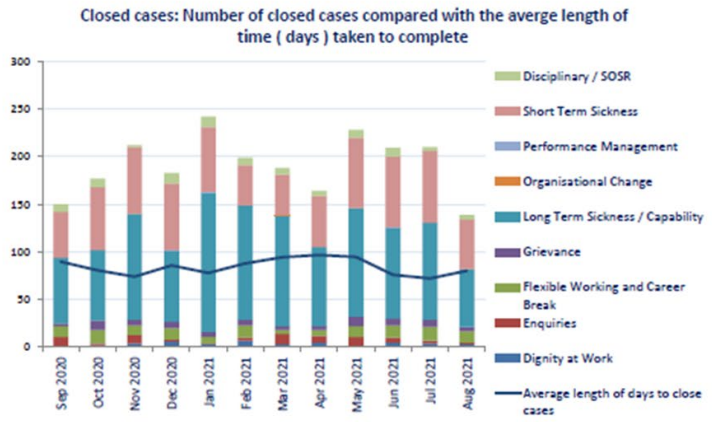
NWAS Summary

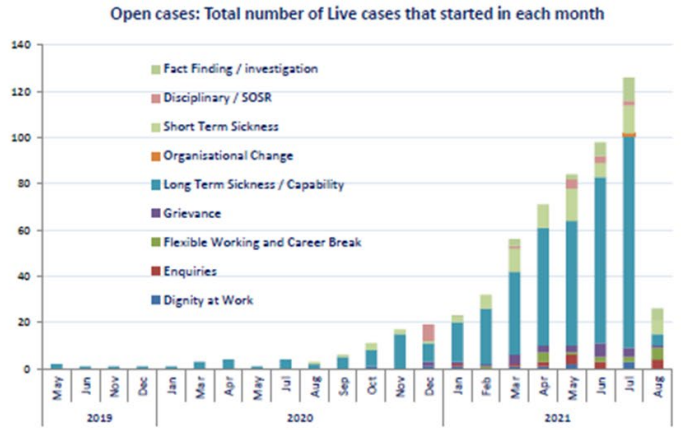
Service Line	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	388	1161	12.56
Operations ~ EOC	28	177	13.80
Operations ~ Resilience	1	10	11.09
Operations ~ 111	85	497	8.77
Operations ~ PTS	61	376	12.75
Corporate	15	62	21.06
Other*	12	29	13.75
NWAS Summary	590	2312	11.97

* 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

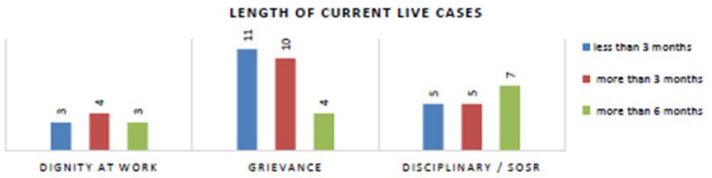
Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	10	44	12.51
Disciplinary	17	87	25.88
Enquiries	15	65	12.82
Flexible Working and Career Break	15	127	6.38
Grievance	25	74	17.76
Long Term Sickness / Capability	406	1165	14.77
Organisational Change	1	1	18.71
Performance Management	0	3	17.24
Short Term Sickness	74	735	6.09
Fact Finding	27	11	15.39
Case Summary	590	2312	11.97





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	3	4	3	0
Grievance	11	10	4	0
Disciplinary / SOSR	5	5	7	0
Case Total	19	19	14	0



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
- There has been 6 pre-investigation review panels considering over 40 cases ensuring appropriateness of entry into formal process, welfare support and resources required for investigation. This is reducing the number of cases entering formal processes.
- Improvement of data visibility and fitness for purpose

COVID 19

Covid-19

There have been 97 instances of staff that have tested positive for Covid-19 in August 2021 with 1,981 instances since July 2020.

As at the end of August 2021 there were 8 outbreaks on trust sites. This covered 17 staff who tested positive and 29 staff isolating.

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	08-Feb	84
27-Jul	3	15-Feb	24
03-Aug	1	22-Feb	9
10-Aug	7	01-Mar	9
17-Aug	3	08-Mar	3
24-Aug	5	15-Mar	6
31-Aug	2	22-Mar	4
07-Sep	6	29-Mar	1
14-Sep	22	05-Apr	2
21-Sep	34	12-Apr	0
28-Sep	53	19-Apr	0
05-Oct	54	26-Apr	1
12-Oct	71	03-May	4
19-Oct	96	10-May	2
26-Oct	101	17-May	8
02-Nov	83	24-May	4
09-Nov	99	31-May	5
16-Nov	87	07-Jun	7
23-Nov	42	14-Jun	4
30-Nov	28	21-Jun	17
07-Dec	24	28-Jun	28
14-Dec	34	05-Jul	24
21-Dec	52	12-Jul	29
28-Dec	75	19-Jul	26
04-Jan	144	26-Jul	17
11-Jan	168	02-Aug	26
18-Jan	113	09-Aug	21
25-Jan	72	16-Aug	19
01-Feb	83	23-Aug	20

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th September 2021			
SUBJECT:	Learning from Deaths summary report and dashboard Q1 2021/22			
PRESENTED BY:	Dr C Grant, Medical Director			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts, a quarterly and then an annual summary of learning; this is the fourth quarterly report to be published. The Q1 dashboard (appendix A) describes the opportunities to learn from deaths. In summary, the contributory factors to patient deaths, where identified, were attributed to problems with EOC procedures (specifically calls being incorrectly categorised) 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, Manchester Triage System (MTS) being used inappropriately, and/or lack of a comprehensive PRF. The peer review identified areas of good practice. This included recognition of patients approaching end of life where no End of Life Care package or DNACPR was in place. Another example was organising and engaging with MDTs comprised of carers/GP/family members and external providers to ensure best interests of the patient were met. A further area of good practice was exemplary behaviour when treating a patient who had self-harmed, ensuring they were thoroughly safety-netted with safeguarding, the police, the patient's GP and the Emergency Duty Team. A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums and individual frontline staff. In addition, the Datix Cloud IQ (DCIQ) Mortality Module is current undergoing secondary testing with the intention to go live in November 2021.			

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

• Support the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the developing formal process of learning from deaths.
• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
• Acknowledge the good practice identified including:
○ Recognising when a patient is approaching end of life and liaising with the patient and family to ensure their best interests are met
○ Thorough safety-netting of mental health self-harm patients through multiple agencies
○ Thorough safety-netting of patients at risk of dying who refuse conveyance and/or are violent.
• Support the dissemination process as described in 3.4.
• Note the progress in developing the DCIQ Mortality module.
• Note the progress in identifying a Patient and Public Panel member.</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee
Clinical Effectiveness Sub Committee</td></tr>
<tr><td>Date:</td><td colspan="3">27th September 2021
7th September 2021</td></tr>
<tr><td>Outcome:</td><td colspan="3">Received assurance</td></tr>
</table>

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q1 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 30th September 2021 in accordance with the national framework and trust policy. The Q1 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q1. The learning from the panels is discussed later in this paper.

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

It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2021/22 progresses.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3. LEARNING FROM DEATHS DASHBOARD Q4 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 68 (23 Datix incidents and 45 sampled - *table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 23 patient deaths;

- 16 patients were identified through the Incidents module
- Six (6) patients were identified through the Patient Experience module
- And a further one (1) patient was identified as having records on both the Incidents and the Patient Experience module.

3.2.1 ***Incident Module: Tables 2 and 3, figures 2 and 3***

Of the 16 patients, seven were reviewed and closed. In just one patient death, the investigation concluded the Trust had contributed in some way to that patient death.

- Problems in communication were cited as the main contributing factor to the patient's death

3.2.2 *Patient Experience Module: Tables 4 and 5 and figure 4*

Of the six patients reported, three are still in the early stages of review. For the three cases that have been closed, none of those deaths was considered to have been caused by the incident. The content of the reviews so far suggest the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures
    - Call incorrectly categorised with a missed opportunity to manually upgrade the call
    - Significant delay in responding to a suspected stroke patient due to demand outstripping resources
    - Significant delay in responding to a patient with chest pains due to demand outstripping resources
- Relative/external health professional concern raised
    - Relative concerned that clinicians lacked appropriate equipment to deal with incident (specifically a defibrillator)
    - HCP concerned that a patient was incorrectly conveyed to an Urgent Care Centre instead of Emergency Department

Positive Feedback:
PES Staff diagnosed a potential Cervical Spine injury in a patient presenting with a medical cause for condition not traumatic. The staff challenged the ED consultant to investigate the potential C-Spine injury and it was later confirmed that the patient had indeed injured their Cervical Spine. The practice shown by the PES Staff ensured no further injury or harm was caused to the patient.

3.2.3 *Investigation and Patient Experience Modules: Tables 6 and 7 and figure 5.*

One (1) patient death was recorded on both modules. The incident investigation has been closed with the investigation determining that the death was considered to have been caused by the incident. The main theme for learning was:

- EOC and EMD procedures:
    - EMD did not recall Sudden Silence Procedure, resulting in incorrect call categorisation for the incident

Sample Cohort Discussion: tables 8, 9 and fig 6.

Of the 45 patient deaths:

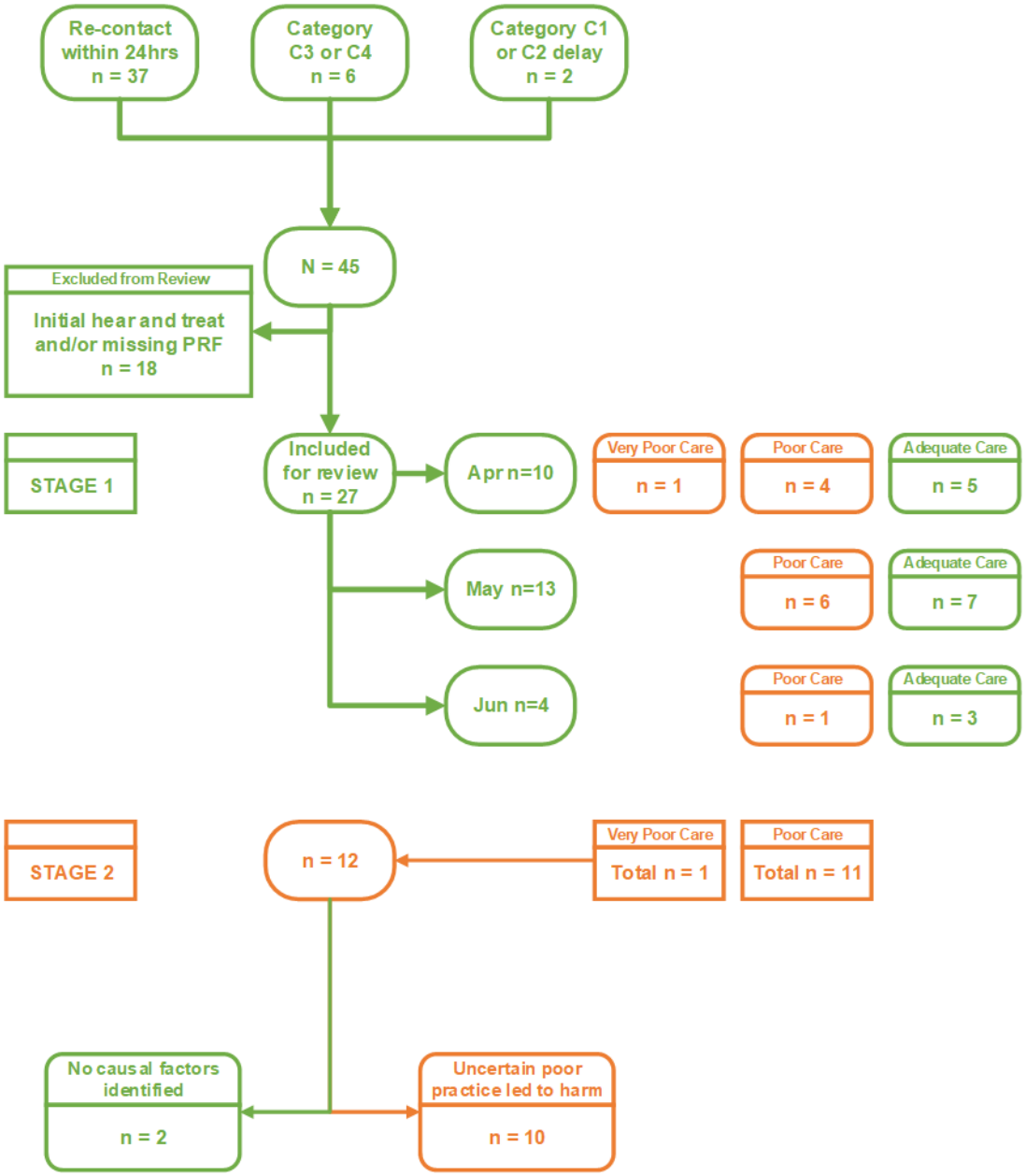
- 37 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- Six patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- Two deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long 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 of the cases identified were reviewed and how the numbers referred to in tables 8 and 9 and fig 6 of the Q4 dashboard change.

There are two reasons why the whole cohort identified are not reviewed:

1. Without a patient report form the review cannot be undertaken
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 the EOC Clinical Hub specialist.



Flow chart to describe sample cohort attrition and treatment Q1 2021/22

3.3.1 *Structured judgement review methodology*

The process requires the reviewing frontline staff to make explicit statements upon the 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.

3.3.2 *Outcome: Q1 Review: Stage 1.*

27 patient deaths were reviewed by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below.

Month	Very Poor	Poor	Adequate	Good	Very Good
Apr 21	1	4	5		
May 21		6	7		
Jun 21		1	3		

Moderation Panels held on 16/06/2021, 14/07/2021, & 18/08/2021

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

3.3.3 *Q1 Review: Stage 2.*

12 cases were identified as needing second stage review following Stage 1. It was identified that in two (2) cases no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect.

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

3.3.4 *Learning Outcomes: Tables 11 -12*

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Ensure SOS/red flag/worsening advice is given and recorded
- Make appropriate referrals to AVS, primary care or alternative providers when appropriate to have done so.
- Recording of discussions had with family and carers around a patient's condition
- Ensure safeguarding referrals are made when appropriate to do so

Other learning which was identified through the review but not leading automatically to a stage 2 review was the variable quality of the patient record itself in terms of legibility, its comprehensiveness and use of appropriate language – leading to the more specific learning identified above.

Escalation and Learning

The Consultant Paramedic, Medical Directorate has a responsibility to escalate incidents or concerns such as this through investigation and if appropriate to the review of serious events (ROSE) panel.

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

- Recognising when a patient was approaching end of life and liaising with the patient and their family to ensure their best interests were met
- PES staff showing exemplary behaviour and practice when treating a mental health self-harm patient, ensuring thorough safety-netting of the patient took place through safeguarding referrals, police liaison, referrals to the patient's GP, and the Emergency Duty Team.
- PES Staff showing exemplary behaviour and practice when treating a patient at risk of dying who refused conveyance and was violent.

3.4 ***Dissemination Process***

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and 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, Medical on a bi-annual basis. As such, the next set of learning will be disseminated following Q2 2021-2022.

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

3.5 ***Report Development***

DCIQ: Mortality Module

The project team for DCIQ is working with the Clinical Audit Team and Consultant Paramedic (Medical) to develop the structured judgement review process in Datix. The project continued testing in the first week of August with a final test phase to be completed in the Q2 2021-2022. The aim is to commute the current process into the Datix system by November 2021. This will bring all the elements of the Learning from Deaths review into a single system of data management.

3.6 ***Patient and Public Engagement***

The Learning from Deaths programme expects trusts to engage with family members and members of the public to add a personal and non-clinical dimension – a holistic perspective to the structured judgement reviews. The Consultant Paramedic and members of the Clinical Audit team have held two sessions with interested members of the Patient and Public Panel (PPP) in the expectation one of the PPP will attend and participate in the discussion at the SJRs. It is anticipated a PPP member will volunteer and attend SJR panel sessions by the end of Q3 2021/22.

4. RISKS

4.1 ***DX3408:*** *(risk score 12)* There is a risk that the lack of resource will mean the competing priorities to perform additional high risk defined audits (such as the Learning from Deaths audit) will not be undertaken in their entirety and this will have a negative impact upon the annual clinical audit plan resulting in a failure to provide assurance to the trust and regulatory bodies.

It is not possible to complete the 'call' element of the review without a dedicated EOC subject expert. Until this is resolved, all SJRs can only be 75% complete. Findings from each of the SJR panels held have highlighted this element as crucial towards identifying potential risks in practice.

DX3477: *(risk score 12)* There is a continued risk that NWAS will cease to be able to deliver the nationally mandated co-ordinated Learning from Deaths programme because of a failure to resource the co-ordinator position. Since 31st March 2021 cover has ceased and without a fully funded resource this will result in a failure to meet the national statutory requirement placed upon the trust going into 2021-2022.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

5.1 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.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

6.1 No equality or sustainability implications have been raised as a concern from this report.

7. RECOMMENDATION

The Board of Directors is recommended to:

- Support the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the developing formal process of learning from deaths.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
- Acknowledge the good practice identified including:
    - Recognising when a patient is approaching end of life and liaising with the patient and family to ensure their best interests are met
    - Thorough safety-netting of mental health self-harm patients through multiple agencies
    - Thorough safety-netting of patients at risk of dying who refuse conveyance and/or are violent.
- Support the dissemination process as described in 3.4.
- Note the progress in developing the DCIQ Mortality module.
- Note the progress in identifying a Patient and Public Panel member.

NWAS Learning From Deaths Dashboard Quarter 1 2021-2022 (April - June)

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

	Total Number of Deaths in scope (sample cohort and Datix incidents)*	Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	23	16	69.6%	6
May	27	16	59.3%	6
June	18	6	33.3%	2
This Quarter	68	38	55.9%	14
This Financial Year	68	38	55.9%	15

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality 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 inital 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 24/08/2021.

Learning from Deaths: Data over time

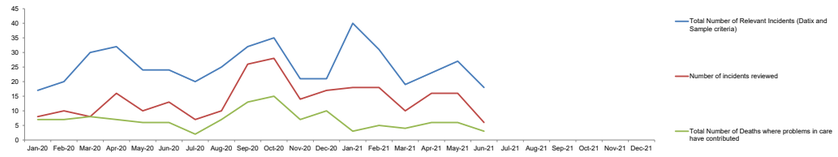


Figure 1.

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
April	5	4	1	0
May	8	2	4	2
June	3	0	0	3
Total	16	6	5	5

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
April	3	0	0
May	3	0	0
June	1	1	1
Total	7	1	1

Table 3.

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

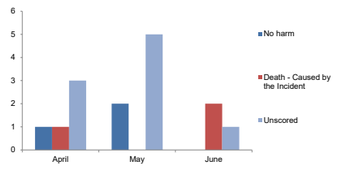


Figure 2.

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

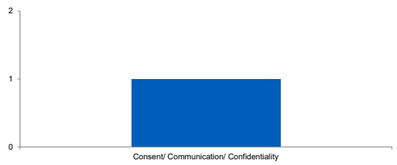


Figure 3.

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 28/07/2021. Last accessed 24/08/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
April	1	2	0
May	1	0	0
June	4	1	0
Total	6	3	0

Table 4.

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

Learning theme

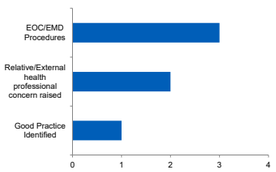


Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a suspected stroke patient	1	Reflection and/or feedback; demand outstripped resources; still under review
	Significant delay in responding to a chest pain patient	1	Reflection and/or feedback; demand outstripped resources; still under review
Relative/external health professional concern raised	Relative concerned clinicians lacked appropriate equipment (Defibrillator)	1	Still under review
	HCP concern patient was incorrectly conveyed to UCC instead of ED	1	Reflection and/or feedback; Crew acted appropriately as per GP instructions; still under review
Good Practice Identified	Diagnosis of potential C-Spine injury (later confirmed) in a patient presenting as medical cause not traumatic in nature	1	Positive feedback/commendation provided to crew; 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 28/07/2021. Last accessed 24/08/2021.

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
April	1	1	1
May	0	0	0
June	0	0	0
Total	1	1	1

Table 6.

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

Learning theme

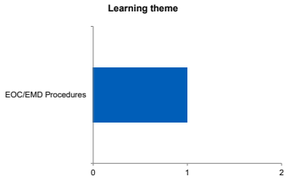


Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	ECH did not recall Sudden Silence Procedure, resulting in incorrect category for incident	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning 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 28/07/2021. Information recorded on these incidents: last accessed 24/08/2021. 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 28/07/2021. Last accessed 24/08/2021

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
April	16	10	5
May	18	13	6
June	11	4	1
Total	45	27	12

Table 8.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
April	0	3	13
May	1	1	16
June	1	2	8
Total	2	6	37

Table 9.

SJR Stage 1 Overall Care Assessment

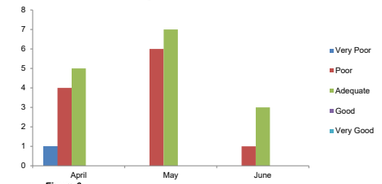


Figure 6.

	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	17	1	18 patients out of 27 patient cohort	67%
	Management Plan/Procedure Rating	9	15	3	18 patients out of 27 patient cohort	67%
Right Place	Patient Disposition Rating	7	20	0	20 patients out of 27 patient cohort	74%

Table 10.

† SJR Scoring Key:

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

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

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

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

Evidence of Poor/Very Poor Practice

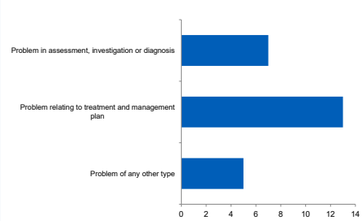


Figure 7.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	7
Problem relating to treatment and management plan	MTS/Pathfinder incorrectly/not used	7
	No SOS/red flag/worsening advice given	3
	No discussion with family members regarding patient's condition/DNACPR/EoLC	1
	No Safeguarding referral made when appropriate to do so	1
	No referral to AVS/GP/alternative providers when approriate to do so	1
Problem of any other type	Incomprehensive PRF	4
	By not making contact, crew did not establish whether patient was alive or not	1

Table 11.

Evidence of Good/Very Good Practice

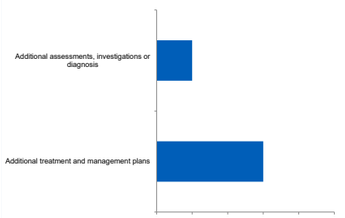


Figure 8.

Learning Theme	Learning Detail	Frequency (n=27 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice	1
Additional treatment and management plans	Crew made multiple attempts to encourage a patient to be treated and conveyed for a life-threatening condition, despite being met with violence/aggression by patient	1
	Patient recognised to be approaching EoL; crew liaised with patient and family members to ensure best interests were met	1
	Crew showed exemplary behviour and treatment towards a mental health self-harm patient, ensuring thorough safety-netting of the patient took place through safeguarding referrals, police liaison, referral to the patient's GP, and the Emergency Duty Team (EDT)	1

Table 12.

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 and a lack of EOC subject experts for the SJR process, 27 reviews took place, 13 less than the minimum random sample size of 40 required.

Data source: Informatics queries 994279, 1004018 & 1014348 last run on 05/07/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 24/08/2021.

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th September 2021			
SUBJECT:	Infection Prevention and Control Annual Report			
PRESENTED BY:	Prof M Power, Director of Quality, Innovation & Improvement			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The purpose of this paper is to introduce the Infection Prevention and Control Annual Report for 2020/2021. The trust has had a previous IPC Annual Report, however due to the COVID-19 pandemic, IPC has more than ever been the driver to achieve patient and staff safety in unprecedented times. This report is a summary of the efforts and challenges the Trust has faced and overcome during the pandemic, while maintaining the standard IPC controls. Assurance on delivery of IPC within the trust is monitored through the IPC Board Assurance Framework, which is presented to Quality and Performance Committee, as well as Board of Directors. The annual report aligns assurance and provides understanding of risks to the organisation during the reporting period. During the reporting period the Board of Director's are requested to acknowledge that there has been 2 different Directors of Infection Prevention and Control during the reporting period. Angela Hansen March 2020-February 2021. Deborah Bullock February 2021-March 2021. It also demonstrates the significant progress and achievements that have been made in delivering effective staff and patient safety during COVID-19 and responding to additional requirements many which expedited areas of the original IPC workplan: • Personal Protective Equipment (PPE) Improvements • Respiratory Protective Equipment (RPE) Improvements			

<table>
<tr><td></td><td colspan="4">

- The implementation of a COVID-19 vaccination hub
- Cleanliness and Estates Management
- COVID-19 Outbreak Management
- Staff Welfare and Communications
-
- A further summary report will be provided in June 22/23 summarising progress through 21/22.

</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors are asked to:
Note the content of the Report
Note the assurances it provides
Note the arrangements for ongoing monitoring via the IPC board assurance framework
Note the key risks and mitigations
Support the report for onward approval by board for publication on the Trist website</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☒</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">27th September 2021</td></tr>
<tr><td>Outcome:</td><td colspan="3">Pending</td></tr>
</table>

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1. PURPOSE

2. BACKGROUND

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

5. RECOMMENDATIONS

North West Ambulance Service NHS Trust

INFECTION PREVENTION and CONTROL ANNUAL REPORT

nwas.nhs.uk

3

1. Overview

This report summarises the management of Infection prevention and control (IPC) in the North West Ambulance Service (NWAS). The reporting period is 1st April 2020 until the 31st March 2021. During this time NWAS was both delivering its strategic ambitions with respect to IPC and also responding to the COVID-19 global pandemic. This report covers all aspects of IPC including our organisational response to the pandemic. Unlike previous IPC reports, which have focused predominantly on the work of the IPC team, the content in this report crosses multiple operational teams and corporate services who have been central to providing safe systems of work for staff and safe care for patients.

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

The NWAS green room hosts our IPC policy which is supplemented with a number of procedural documents for key areas of IPC practice. These policies are regularly reviewed and updated to ensure they are aligned to best practice guidance. In most cases this will happen annually, however, during the COVID-19 pandemic there has been a requirement to review and update staff in real time as guidance has changed. To ensure our staff have up to date guidance we also have robust internal communications via IPC bulletins which are distributed to all staff and discussed at operational meetings.

IPC forms part of the mandatory training programme for all clinical staff who complete 2 modules at recruitment and update annually via the mandatory training programme. During FY20-21 all staff have been re-trained in the donning and doffing of PPE and in the use of respiratory protective equipment (FFP3 face masks). The IPC team have focused on local training for staff in the workplace and are continually working on local training based on audit findings.

We monitor compliance to our policies, procedures and training via a series of audits which are carried out locally, by IPC specialist practitioners and also by external assessors (such as public health, environmental health, NHSI and NHSE). During 20-21 we have reviewed our audit systems to ensure they are meeting the enhanced requirements of the pandemic and have also developed more efficient systems for data collection and analysis. Key findings from the audit inform our improvement work and communications.

We also learn about IPC practices from when things go wrong. We log a high volume of incidents in relation to IPC each month with a peak of 429 incidents in January 2021 when we were at the peak of the second wave. Each of these incidents is managed by the local management team and is also reviewed by the IPC team. The themes from incidents are used, alongside audit data, to inform our intelligence about which systems need to be

improved, where additional training is required or where risk management systems need to be put in place.

We also receive valuable information about IPC practices from staff side colleagues and have active engagement from all trade unions. This has been vital during 2020-21, and partnership working has been strengthened through the establishment of a COVID-19 IPC cell within the command structure of NWAS. This cell met a minimum of twice weekly throughout the pandemic and was able to provide local intelligence and feedback on the effectiveness of IPC systems. The group were also instrumental in agreeing improvement priorities and actively worked with the IPC team on solutions.

The NWAS executive leadership team take joint responsibility for IPC oversight and have conducted leadership walk rounds throughout the year to ensure staff feel supported and key issues of PPE supply, compliance and the additional burden of continuous use of PPE are understood. During the height of the pandemic a number of outbreak sites were closed to external visits, however, the IPC team, DIPC, medical director and director of quality innovation and improvement continued to provide onsite and virtual support to teams.

IPC risks are identified from intelligence gathered from audit, incidents, site inspections, safety alerts, bulletins (internal and external) and risk assessments. Local risks are articulated, scored (using the trust risk matrix), logged onto our risk management system (Datix) and owned locally by managers. Corporate risks are generated through joint review of local risks and any significant risks which are not mitigated with available controls. IPC risks scoring 15 or above are included on the corporate risk register and board assurance framework (BAF). The risk management systems are overseen by IPC practitioners and reported to the IPC forum, executive leadership committee and quality and performance committee.

Board oversight of IPC is via the Quality and Performance Committee chairs assurance report and directly via bi-annual IPC reports which identify our compliance with standards, improvements made in the reporting period and any outstanding risks. On the 5th of May 2020 NHSE/I issued a Board Assurance Framework (BAF) guidance document to support IPC and the management of COVID-19-19. The framework presented an opportunity for us to align our IPC work to the requirements in the BAF. A number of additional risks were identified and added to the risk register. The BAF was included within the 2020/21 work plan for NWAS and is a corner stone of our IPC assurance. The BAF includes information about:

1. Our systems for managing and monitoring the prevention and control of infection
2. Our duty to provide and maintain a clean and appropriate environment
3. Our duty to ensure appropriate antimicrobial use, reduce the risk of adverse events and antimicrobial resistance
4. Our provision of suitable accurate information on infections to service users and any person concerned with providing further support or healthcare
5. Our 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 others

6. Our 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. Our duty to provide adequate isolation facilities
8. Our duty to provide adequate access to secure laboratory support
9. Our duty to have and adhere to policies, designed for the individual's care and other provider organisations
10. Our systems to manage the occupational health needs and obligations of staff in relation to infection

IPC compliance is also reported quarterly to the Q&P Committee against the 'Pillars of Quality' within the Right Care strategy update paper.

Progress Against BAF Key Lines of Enquiry (2020-21)

1.1 Systems to manage and monitor infection and risks of infection

IPC guidance was routinely revised and reissued throughout 2020/21 to ensure alignment with national emerging guidance, particularly related to the management of nosocomial infection, NWAS test, track and trace, outbreak management and working safely. External assurance was provided by peer review visits from the NHS England/Improvement regional IPC specialists. Covid-19 risk assessment processes were standardised and fully implemented across all stations, offices and control centres and were updated every 90 days (or after any Covid-19 outbreak).

1.2 Provide and maintain a clean environment

A review of organisational cleaning allocations was completed, and additional cleaning facilities and hours were introduced where indicated based on footfall, layouts and occupancy and to support outbreak management. Additional vehicle cleaning contracts were established across hospital sites upon patient handover at Emergency Departments. Safety check points were established at all sites, with hands free thermal imaging temperature check devices installed at high population sites such as Middlebrook and Estuary Point. IPC audits were reviewed, and the schedule enhanced to support outbreak management and continued IPC maintenance. Personal protective equipment storage facilities were also reviewed.

1.3 Provide suitable information on infections for staff and patients

Action cards were developed for crews managing infectious patients within vehicles and to support ventilation within vehicles. National guidance and local operating processes disseminated regularly to staff via bulletins, social media, internal intranet and the IPC cell. All training materials for staff and volunteers were reviewed and a 'fit testing' train the trainer programme has been developed. A routine data reporting system for outbreak data was designed and established utilising test, track and trace information to support outbreak management across sites.

1.4 Identification of people at risk of developing an infection and onward transmission

In Quarter 1, NWAS set up an in house Covid-19 testing service and via mutual aid ensured staff members could receive rapid access to a Covid-19 test if it was needed. Testing sites for NWAS crews were set up in Penrith and Dukinfield. 274 staff and household members accessed this service. This service was stood down at the end of Wave 1 as access to testing services matured across the UK.

The NWAS Test, Track and Trace service was established on 28th July 2020 to support staff members receiving notification of a positive Covid-19 diagnosis and to identify any staff or patients who may have been close contacts of the NWAS staff member. This service was established to run for 16 hours a day, seven days a week. By March 2021 1,707 staff members were tracked due to being Covid-19 positive during 2021 in a secure and confidential way. 569 staff were identified as close contacts of those staff members by the Test, Track and Trace team. Only two patients were identified as close contacts during this process and were asked to isolate.

Infection control measures to reduced transmission were introduced including protective screens and barriers across call centres, reduced occupancy of offices and home working where appropriate, ventilation reviews across buildings and fleet, social distancing within PTS vehicles and mask/hood wearing. These control measures were implemented in partnership with trade union colleagues and in line with national HSE Working Safely and CIBSE (Chartered Institution of Building Services Engineers) guidance. SafeCheck was used to provide information for staff to use with care homes to provide evidence of participation in a testing process.

1.5 Systems to ensure staff discharge their responsibilities for IPC

Weekly bulletins and guidance are regularly published for staff and available on the intranet. From late October 2021, NWAS staff were able to access asymptomatic testing and screening services and were asked to use lateral flow testing. More than 7,162 lateral flow tests were distributed, with over 47,400 test results reported. Secure and remote access information systems to support staff data collection and reporting were designed and established using SafeCheck.

Fit testing policies were updated, and respiratory protective equipment hoods were fully rolled out across the organisation via a respiratory protective equipment steering group. Compliance with the use of hoods and level 3 IPC protection was measured with a bespoke developed audit, which identified high compliance rates of 94% but challenges relating to full compliance with PPE in particular circumstances, such as rapid patient deterioration and with babies and children. Learning and enquiry approaches to support staff to protect themselves and to discharge their responsibilities in these circumstances have been put into place.

Uniform guidance was reviewed and issued and disposable bags to facilitate home laundering made readily available. Short educational donning and doffing and lateral flow videos for staff have been developed and distributed.

Increased IPC audits were scheduled and enacted to support compliance, and an IPC improvement module was developed to support sites and staff in improving their personal compliance with IPC protections and discharging their IPC responsibilities. A bespoke IPC training session was held for our third party ambulance providers.

1.6 Isolation facilities

Hospital handover action cards were developed and distributed in line with national guidance for patients delayed during handover on the back of a vehicle following national guidance from PHE. The cards supported staff to protect themselves and their patient whilst confined and isolated within the vehicle.

1.7 Access to laboratory support

Local access to laboratory support for Covid-19 testing was agreed via mutual aid with acute service providers. The growth in Pillar 2 provision of diagnostics from quarter 2 onwards ensured all staff had rapid access to PCR testing. During quarter 3, asymptomatic tests such as lateral flow were made available to all staff. The SafeCheck system was adapted and enhanced to securely and safely capture staff testing data, to identify risk areas, outbreaks and provide data to the national systems.

1.8 Policies and training to prevent and control infections

Public Health England, in conjunction with NHS England and Improvement (NHS E/I) supported all aspects of Health and Social Care by implementing supporting policies in which following review by the Ambulance Association of Chief Executive National IPC Group, were adopted and embedded into NWAS policies and procedures. Some guidance was already in existence and this was strengthened with in NWAS during the pandemic:

- COVID-19: Infection Prevention and Control Health and Care Guidance June 2020
- National Infection Prevention and Control Manuel: COVID-19 Addendum August 2020
- COVID-19 : IPC Guidance for Ambulance Trusts (Direct Patient Contact) August 2020
- AACE: Working Safely during COVID-19 in Ambulance Service non-clinical areas August 2020 updated February 2021
- NHS E/I :Key Actions: Infection Prevention and Control and Testing November 2020
- Ventilation Guidance ; HSE/CIBSE, November 2021
- Lateral Flow guidance November 2020
- COVID-19: Patient Transport Services December 2020
- NHS E/I :Checklist and Monitoring Tool for the management of COVID-19 – December 2020
- AACE: Ambulance Sector Level 2 PPE Donning and Doffing Guidance January 2021

- AACE: Ambulance Sector Level 3 PPE – FFP3/Eye Protection -Donning and Doffing Guidance January 2021
- AACE: Ambulance Sector Level 3 PPE –Powered Respirator Hood – Donning and Doffing January 2021
- AACE: IPC Precautions during hospital handover delays January 2021

NWAS also has responsibility to keep its internal policy and procedures up today and these were completed by the IPC Team with oversight from the DIPC. All policies that were required to manage IPC during the pandemic are compliant with national guidance and review dates.

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

1.9 Occupational health needs and obligations

All staff were risk assessed for vulnerabilities and shielding requirements and referred for occupational health advice and guidance. Alternative duties were put in place were required. Shielded and vulnerable staff were prioritised for vaccination provisions.

1.10 Specialist Resources

The Assistant Director of Nursing and Quality fulfils the role of Director of Infection Prevention and Control (DIPC), supported by the Head of Clinical Safety, Clinical Safety Manager, three Infection Prevention & Control Practitioners (IPCPs), and a Clinical Safety Co-ordinator. In addition, this year the team has benefited from agency support including an IPC Nurse Consultant, a Charge Nurse (who focussed on the set up of the Trust's vaccination pod), and a non-clinical generalist.

The IPC team is responsible for supporting staff to ensure they adopt best practice and provide expert advice on a safe environment and safe equipment and vehicles. The team supports the health and wellbeing of staff, patients and visitors by offering specialist advice. The IPCPs provide assurance for Infection Prevention and Control for the stations and vehicles through independent audits, as well as working with the wider Service Delivery teams to ensure goals and targets are met.

The Trust has a Consultant Paramedic within each county (5.0WTE) who work with a larger cohort of 70 Advanced Paramedics. These colleagues lead on clinical safety and IPC within service delivery and support the IPCPs in the development and implementation of new initiatives and improving standards.

2. Our IPC Improvement Aims for 2019-20

NWAS is committed to ensuring the highest standards of IPC for its patients and staff. Our achievements in recent years have been maintained and the right care strategy (2018-22) placed a focus on personal protective equipment, hand hygiene, cannulation and standardisation of IPC products and procedures. We also committed to deliver new standards of vehicle and station cleanliness through our quality visits programme. The goals for FY 2020-21 were set at the beginning of the programme and refined in 2019 with the onset of the pandemic. These included:

2.1 Goal 1: Increase the percentage of vehicle deeps cleaned within the 6-week standard .

Performance targets have been achieved despite COVID-19 challenges. Average Trust performance across the last 12 months has evidenced 93.8% of vehicles cleaned within 7 days of their scheduled 6 weekly clean, surpassing the target of 90%.

2.3 Goal 2: IPC audits on stations and vehicles reviewed & compliance standards implemented via operational manager

IPC audit questions have been reviewed and converted into an automated online tool, which was implemented in May 2020. IPC data is captured via an online portal, with performance data for the percentage of fully compliant emergency vehicles during 2020/21 evidencing vehicle cleanliness as 99.4%.

2.4 Goal 3: IPC standards on stations and vehicles checked via quality visits

Trust wide Quality Assurance Visits (QAV) were completed throughout the year – 100% of Trust Sites visited using agreed criteria, which provides impartial audit data conducted in a standardised format.

2.5 Goal 4: Compliance with the World Health Organisation (WHO) 5 moments of hand hygiene.

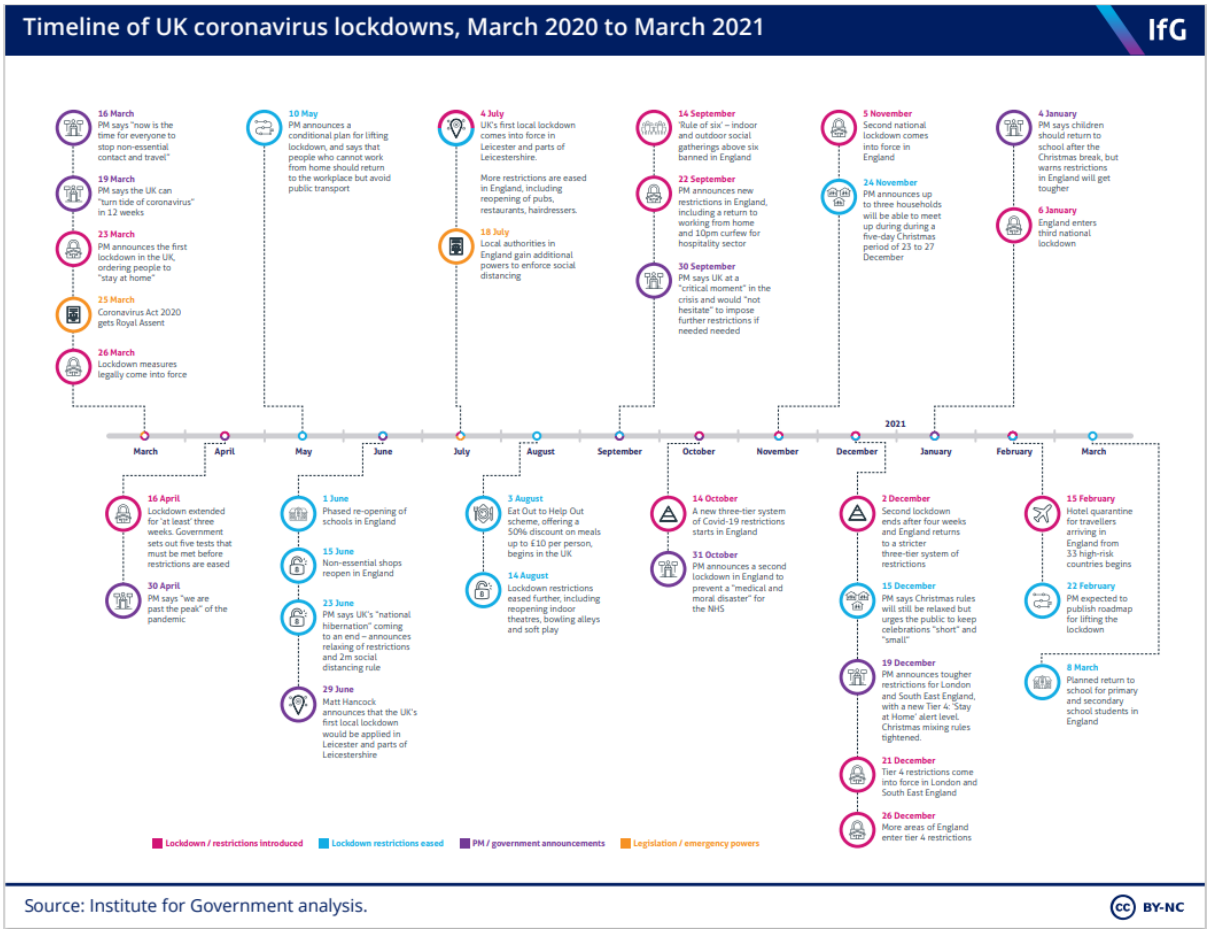
Audits continued throughout the year and overall compliance is high at 99.3% (in year target 100%). Hand wipes are available for staff to effectively clean their hands when no soap/water is available. Throughout the year the Trust has promoted its standards of hand hygiene during the global Covid-19 pandemic and the trust has further embedded national guidance on staff being Bare Below the Elbow (BBE).

2.6 Goal 5: Compliance with cannulation policy & procedure guidance

The IV Cannulation Policy has been approved and whilst work on auditing compliance against the policy was halted with the onset of the Covid-19 pandemic, plans are in place to resume this work. The team have developed the cannulation audit tool to measure compliance against the policy and a Cannulation Training Video has been created and published by the team.

3. COVID-19

On the 31st January 2020 the first two cases of coronavirus (2019-nCoV) in the United Kingdom were confirmed. On 5th March 2020 the first death from coronavirus in the UK was confirmed and the number of cases exceeded 100, with a total of 115 people having tested positive. England's Chief Medical Officer, Chris Whitty, told MPs that the UK had moved to the second stage of dealing with COVID-19 – from "containment" to the "delay" phase. In a televised address on 23rd March 2020, Boris Johnson announced a UK-wide lockdown, to contain the spread of the virus easing only on the 15th June 2020. A system of local 'tiers' was introduced in an attempt to contain the virus, however, the pressures of winter 2020 resulted in a second lockdown on 5th November 2020 and a third on 6th January 2021 which remained in place until June 2021.



https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

NWAS has been at the forefront of the pandemic response and details of our key deliverables are described in detail in our Annual Report (2020-21). Of relevance to the IPC narrative is:

- In February 2020 our HART team were responsible for the repatriation of UK citizens from Wuhan Province in China to isolation facilities at Arrowe Park Hospital on the Wirral. These transfers were coordinated by a dedicated command structure who worked with the PHE and MOD to ensure a safe transit.
- In March 2020 our HART team responded to the first community cases of COVID-19 and were instrumental in ensuring containment of the virus.
- From March 2020 onwards our emergency operations and patient transport staff were responding to patients with suspected and confirmed COVID-19 and have been since that time.

3.1 Impact of the Pandemic on IPC within NWAS

The pandemic has impacted significantly on NWAS and our focus during 2020-21 has been to keep our patients and staff as safe as possible. This year has been one that has required us to move at pace to deliver our pandemic response. This annual report details the contribution of countless staff and volunteers from across NWAS and beyond. We are, and will continue to be, eternally grateful for their commitment and selflessness. Without them our efforts would have been significantly hampered.

During the 2020/21 pandemic we did not have effective recording processes in place for recording positive cases in NWAS. We recognised this as an area that required urgent improvement and we were able to commission the support of the Mersey Internal Audit (MIAA) Team who started recording cases for us from the 19th July 2020 in a more effective manner. 1707 positive cases were identified July 2020-March 2021 of COVID-19 in our workforce. For a small number of colleagues there were inpatient stays. As we describe our IPC successes and challenges, our thoughts are with all our NWAS colleagues and their families, particularly those who lost their lives during the pandemic.

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

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

  - safe management of blood and body fluids
  - safe disposal of waste (including sharps)
  - occupational safety: prevention and exposure management
  - maintaining social/physical distancing (new SICP for COVID-19)
- Escalating levels of personal protective equipment (level 2 and level 3) based on the assessment of each individual case and /or procedure being performed.
- Clear protocols for staff participating in high risk procedures (known as Aerosol Generating Procedures –AGP's) to increase their levels of PPE to include FFP3 mask as the primary respiratory protection.
- Work with senior managers and the trade unions to develop regular IPC bulletins which describe how national policy is being put into practice within the workplace.

3.2 Supervision & Specialist Advice

To provide appropriate supervision within operations, the Trust already has in place a robust clinical leadership structure with Senior Paramedic Team Leaders (SPTL) responsible for the leadership and supervision of set numbers of operational staff. That clinical leadership structure is further enhanced with a 24/7 Advanced Paramedic (AP) capability working both operationally alongside staff but also based in each of the Emergency Operations Centres (EOC) as a point of contact for clinical or IPC enquiries. The IPC specialist team were available seven days per week to support teams during the height of the pandemic.

4. Personal Protective Equipment (PPE)

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

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

PPE Levels according to risk:

Level One	**Standard Infection Control Precautions (SICPs)** • Disposable apron • Disposable gloves	**Scenario:** No suspected or known infectious agent. Anticipated exposure to blood and/or other body fluids.

Level Two	**Direct or Indirect Contact Precautions** • disposable gloves • disposable apron • fluid resistant surgical mask (Type IIR) (FRSM) • eye protection/face shield (if risk of splashing and for all suspected/confirmed COVID-19 patients)	**Scenario:** i. Suspected or confirmed infectious agent spread by **DIRECT/INDIRECT CONTACT**, ii Suspected or confirmed infectious agent spread by the **DROPLET** route OR suspected or confirmed infectious agent spread by the **AIRBORNE** route
Level Three	**Enhanced Precautions** • disposable gloves • fluid repellent coveralls/long sleeved apron/gown • FFP3 or powered respirator hood • eye protection/face shield (not required with a powered respirator)	Scenario: All aerosol generating procedures AND for suspected or confirmed Infectious Diseases of High Consequence (IDHC) e.g. Ebola virus, SARS, MERs

4.1 PPE stock ordering and distribution

NWAS procurement team have full responsibility for the ordering and supply of PPE in NWAS. During FY 20-21 they worked tirelessly to ensure that essential PPE supplies were always available. This required us to work within new systems for stock distribution from NHS Supplies who adopted a 'push' system. In practice this meant that NWAS was sent the available PPE not the PPE that we needed to replenish our depleted stocks, for example we may be running low on aprons but the stock supplies may be gloves or surgical masks. Our procurement team actively participated in NHS exchange schemes to balance supplies between NHS providers and were constantly monitoring stock levels to ensure constant supply. At no point did NWAS run out of supply of any PPE stocks, a remarkable achievement in the circumstances.

4.2 PPE Contingency Plans

NWAS Procurement and designated leads reviewed available alternative options for PPE if stocks of the preferred PPE were unavailable. PPE stock levels were examined daily, and low stock levels are escalated to the National Supply Disruption Response (NSDR). In addition, mutual aid was able to be accessed from partnering Trusts via the NHS England North West Incident Co-Ordination Centre. A robust contingency plan is in place including via NW PPE Cell: - maximising the preferred PPE items through national and local supply - mutual aid system partners - assessment of the use of alternative PPE. The contingency plan was designed to support the significant risk to national supply routes and to ensure

staff and patient safety is maintained. The volumes required by all NHS organisations put a significant strain on the supply chain meaning that security and visibility of future deliveries of PPE stock was only on a 24 hour basis. This made planning for surges in activity and for recovery of services extremely challenging. The reliability on national supply routes was a significant risk to NWAS.

On 10 May 2020 the Government announced innovative collaborations with a number of organisations and establishment of a British manufacturing base for PPE to support future requirements.

4.3 PPE Hubs

It was essential that the supply of PPE was rapidly distributed to local teams. To achieve this the procurement and operational teams established PPE hubs in each county led by a senior operational manager. The hubs managed the local stock systems and packed PPE into L2 and L3 packs for easy access by crews. The hubs were coordinated by staff on light duties, community first responders and volunteers who donated their time to support PPE distribution. Each day procurement staff and volunteer drivers distributed 1000's of items of PPE to local areas, stocked ambulances and office buildings to ensure that PPE was readily available to all staff.

4.4 PPE Donations

During the pandemic we were inundated with offers of PPE from the public who were making face masks and volunteering their personal stocks, for example of non-latex gloves. These donations were welcomed in the spirit they were offered, however, it was essential that we provided quality controls on all PPE used by NWAS staff. All PPE used by NWAS staff during the pandemic was supplied by the PPE hubs and met the regulatory standards set by HSE or conformed to the agreed government exemptions.

4.5 PPE recalls and safety alerts

NWAS only received one PPE recall which was applicable to our procured stock. The Tiger Eye Protector Products were immediately recalled at the time of the Chief Medical Officer (CMO) alert (CEM/CMO/2020/021) on 9 May 2020. These products were added to the national pandemic preparedness programme stock in 2009 and testing by the HSE identified the product did not meet the current British or European safety standard for protective eyewear. NWAS used its incident logs to document and investigate the historical use of this product. We were able to provide a good level of assurance that none of these goggles had been used as part of our routine level 3 PPE use.

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 provided 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

4.6 Guidelines and Guideline Updates

During the early months of the pandemic there were numerous updates to the PHE guidelines for the prevention and control of infection. The responsibility for ensuring NWAS was updating their guidelines in a timely way was overseen by the executive command cell who met daily and were updated by the Director of Quality, Innovation and Improvement who led the regulatory compliance sub cell. Throughout the pandemic we used clinical and operational bulletins to clarify new guidance which were then cascaded through the operational command cells.

We have produced clear infection prevention and control (IPC) guidelines for staff on personal protective equipment (PPE) which can be located by accessing the Green Room (the Trust's internal website). This includes clear guidance on what level of PPE is required for each response and the importance of adhering to Public Health England (PHE) guidance. The Green Room also contains links to all the PHE and government websites to direct staff to further information and evidence pertaining to the risks associated with COVID-19. This also includes guidance that is in place to mitigate these risks. All staff have access to the JRCALC PLUS application on their phones which contains the latest regional and local guidance from the joint Royal Colleges Ambulance Liaison Committee.

4.7 Bulletins, message and live questions

We have produced bulletins and notices to staff for issues relating to COVID-19 including procedures to follow, PPE, donning and doffing and cleaning since the outbreak started. Frequently asked question bulletins in response to issues raised by staff, together with up to date information and changes in national guidance have been produced and issued. To date this equates to over 40 bulletins specifically relating to guidance for staff on COVID-19, for example covering PPE and IPC procedures. Updates are placed on the noticeboards of each station. There is also a Staff Facebook group with over 2500 members which staff

use to raise questions or queries to the Trust and a series of Facebook Live presentations have been delivered.

4.8 Training in IPC and PPE Use

IPC is a core component of mandatory training. To augment our mandatory training programme during the COVID-19 pandemic we have developed bespoke training materials on key aspects of IPC. A bespoke training video was produced in line with PHE guidance on the safe donning and doffing of PPE (including FFP3 masks) in response to the COVID-19 pandemic. This was loaded onto the staff central learning management system and to the bespoke NWAS learning platform. Time to watch the video was incorporated into the face fit testing programme and documented evidence of completion maintained on the staff training record on My ESR. At the height of the pandemic, daily reports of FFP3 mask testing were produced to monitor compliance. There was a strict version control system applied to the video based on the dated release of the corrected versions of the public health guidance. As part of the upskilling of our external and internal resources, the video was also shown to learners in class. It was contained in the tutor guidance produced for this purpose. Dynamic Operational Risk Assessment (DORA), which is an integral component of the trusts Mandatory Training (MT) was reiterated as part of this upskilling.

4.9 PPE/Clinical Waste Disposal

Our clinical waste disposal contract with Stericycle is managed by our Fleet Logistics department. During the early months of the pandemic there was a large increase in waste as all PPE disposals were being transferred through our station clinical waste streams. This increase in line with all other acute facilities serviced by Stericycle put the clinical waste network under considerable strain. Through effective contract management we increased waste collections throughout many areas of our operational estate to ensure there was no subsequent build-up of waste. For additional ad – hoc collections that Stericycle could not reach at the height of the pandemic the Fleet Logistics department also assisted in waste collections and removal to Royal Preston Hospital facilities by local agreement for incineration as required. Clinical waste streams are now reviewed each month in contract management meetings and collections are now flexed according to volume by the Fleet team and Stericycle.

5. Respiratory Protective Equipment

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

Public Health England Guidance states:

An FFP3 respirator should be worn by frontline staff when carrying out a potentially infectious aerosol generating procedure. Where a patient is known/suspected to have an infection spread via the aerosol route or when caring for patients known/suspected to be infected with a newly identified respiratory virus.

It is a legal requirement that anybody who might be required to wear an FFP3 respirator be fit tested in order to check that an adequate seal can be achieved with each specific model. It is also important that the user carries out a fit check each time an FFP3 respirator is worn.

During 2020-21 the use of FFP3 respirators increased globally as it was recognised that COVID-19 transmission was predominantly via airborne droplets. The supply chain of FFP3 masks from NHS Supplies was in high demand and transitioned to a new system known as 'push stock' where masks were distributed on availability rather than as a specific make and model request from Trusts. In practice this meant that NWAS required a rolling programme of FFP3 FIT testing to ensure that every member of staff has a mask with the correct seal and that it is available on the vehicle that they are working on.

During 2020-21 we had to rapidly stand up FFP3 face fit testing at scale to meet the demands of the pandemic. This programme of FFP3 face fit testing was led by the Executive who set up a task and finish group and led daily sub cell meetings with leads from operations, human resources, finance and IPC. In March 2020, each area appointed a FIT testing coordinator who attended the operational cell and had day to day responsibility for ensuring that:

- They had adequate numbers of trained FIT testers in place to meet their requirements
- They had procedures in place locally to ensure a consistent approach was adopted
- Supplies of FIT testing kit and solutions were available in the right places
- Staff were stood down from operational duties to be FIT tested
- Staff who failed FIT testing were referred for portacount testing
- Sufficient portacount testing capacity was available
- Data on compliance was reported back to the FIT testing sub cell

Guidance was produced for any staff who failed a FIT test or who did not have the mask that they had passed the test on available on the vehicle. They were instructed to perform a dynamic risk assessment and NOT to participate in AGP's. Control were notified at the beginning of the shift if a member of the crew on any vehicle could not perform AGPs

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

5.1 Training FIT Testers

At the start of the pandemic the Director of Infection Prevention and Control and Clinical Safety Practitioners refreshed their FIT test training via supervision from an accredited assessor. They were then responsible for the training up competent FIT testers across NWAS which they did using a train the trainer approach. Standard Operating Protocols (SOPs) were written by the Director of Infection and Control which complied with PHE guidance. Over 200 staff were trained to FIT test using these SOPs in less than 2 weeks. Their training and competency assessments were recorded on ESR. Individual staff records were transferred from the FIT testing database onto ESR by the HR hub who uploaded the FIT test completion as a training record. My ESR is now the NWAS legal record of our completion of FFP3 face FIT testing. During FIT testing the participants also received training on 'donning and doffing' this was also recorded in the training record. Each participant was asked to check that following FFP3 FIT testing they had a training record which accurately represented the completion record and approved mask type.

5.2 Learning from Incidents

During the FIT testing programme 3 incidents were reported associated with a change in respiratory status during or following FFP3 Face FIT testing. These incidents were reviewed by the Chief Nurse and the standard operating protocols were revised to include a consent and screening script which rules out staff with claustrophobia, asthma or respiratory disease.

5.3 Respiratory Hoods

On 26th February 2020, a business case was approved by NWAS board to purchase personal issue respiratory hoods (the unit of choice is the Sundstrom Safety SR700 Fan unit and the SR 520 Hood). This RPE solution comprises of a small motor unit that sits on an IPC compliant belt, in the small of the back. A corrugated hose runs up the wearers back to a hood. The motor unit sucks air in, via two filters, filter it, blows it up the hose and into the hood creating positive pressure. This enables staff with beards, stubble, spectacles and facial disfigurement to wear the equipment. There is no need for fit testing, however, the user does needs to be shown how to check, test, don, wear and clean the equipment.

By the end of March 2021 each locality within NWAS (C&M, C&L, GM) had produced a detailed plan for how they ensure that all staff are FFP3 face FIT tested; ii. Distribute and maintain respiratory hoods to ensure they are available to ALL staff and being used and maintained safely.

An Equality Impact Assessment (EqIA) identified issues with the FFP3 masks not being suitable for individuals with beards worn for religious reasons. These staff were prioritised for respiratory hoods if their beard was associated with a protected characteristic (BAME) or religious belief.

A number of students were employed by NWAS on a temporary basis in the urgent care service during the pandemic. The training team trained their own FIT testers and FIT tested

students prior to their deployment. Any student who was not FFP3 face Fit tested during their induction was tested by the area team on arrival at their deployment in the usual way.

5.4 Monitoring Compliance to RPE training and Standards

During 2020 we developed audit systems for monitoring operational compliance of our staff with our training and standards. This RPE audit was carried out by clinicians in the control room who would directly contact staff attending category one incidents to ascertain whether they had performed an AGP on the patient. If yes, the clinicians would go through a standard proforma to ask about respiratory protection. The responses were recorded and analysed by the clinical audit team who then reported the findings back to the executive leadership group and operational management team. The Chief consultant paramedic and deputy director of operations led the improvement work to drive up compliance which consistently measured 92-94%. The primary reasons for non-compliance were reported to the RPE cell and the ELC, along with the actions being taken.

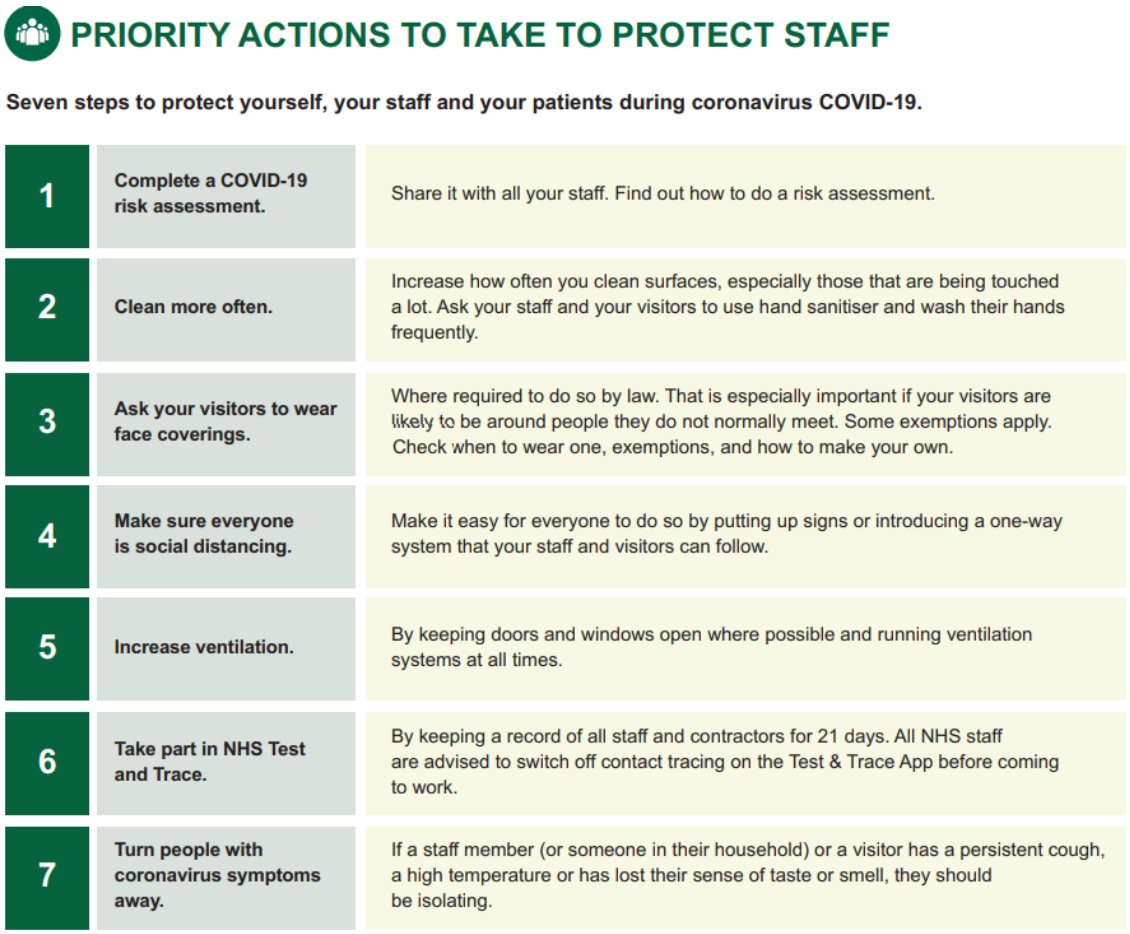
5.5 Governance

In order to ensure the ongoing requirements for respiratory protective equipment the Trust established an RPE steering group as a subgroup of the Safety Management Group. The steering group terms of reference were agreed by safety management group and included the oversight of the RPE action plan and the RPE audit. This is now an established feature of IPC governance.

The risk ownership for FFP3 face fit testing compliance transferred from the Director of Operations to the Director of Quality, Innovation and Improvement in May 2020 when a summary paper was presented to the Quality and Performance Committee. Associated risks, for example the adequacy of supply of equipment, remain with relevant directors as part of their portfolio of responsibilities. The risk environment for RPE is continuously monitored by the risk owners on an ongoing basis in line with the NWAS policy on risk management.

6. COVID-19 Security

In October 2020 the Association of Ambulance Chief Executives (AACE) published the first edition of the working safely in non-clinical areas guidance which described how ambulance trusts should implement the PHE IPC guidance for ambulance control rooms, training centres, general offices, ambulance premises and ambulance cabs. The guidance covered key areas which required focussed attention.



PRIORITY ACTIONS TO TAKE TO PROTECT STAFF

Seven steps to protect yourself, your staff and your patients during coronavirus COVID-19.

1	**Complete a COVID-19 risk assessment.**	Share it with all your staff. Find out how to do a risk assessment.
2	**Clean more often.**	Increase how often you clean surfaces, especially those that are being touched a lot. Ask your staff and your visitors to use hand sanitiser and wash their hands frequently.
3	**Ask your visitors to wear face coverings.**	Where required to do so by law. That is especially important if your visitors are likely to be around people they do not normally meet. Some exemptions apply. Check when to wear one, exemptions, and how to make your own.
4	**Make sure everyone is social distancing.**	Make it easy for everyone to do so by putting up signs or introducing a one-way system that your staff and visitors can follow.
5	**Increase ventilation.**	By keeping doors and windows open where possible and running ventilation systems at all times.
6	**Take part in NHS Test and Trace.**	By keeping a record of all staff and contractors for 21 days. All NHS staff are advised to switch off contact tracing on the Test & Trace App before coming to work.
7	**Turn people with coronavirus symptoms away.**	If a staff member (or someone in their household) or a visitor has a persistent cough, a high temperature or has lost their sense of taste or smell, they should be isolating.

In response to this guidance a working group was established to look at implementation. This response was led by the Head of Estates and Facilities Management with representation and support from across the organisation. The group moved quickly to:

- Develop a site-based risk assessment to ensure premises were COVID-19secure
- Developed safety checkpoints and kit of published notices, signs and vinyl that were then installed across the Trust with single standard of COVID-19 advice
- Tested the risk assessment in pilot sites, edited and rolled-out
- Scaled the implementation of the risk assessment to 100% of sites
- Develop a supplemental certification scheme as a visible assurance to staff

7. Staff Testing

6.1 Establishing Gram Probe Real Time Polymerase Chain Reaction (girt-PCR) Symptomatic Testing

As part of the response to the COVID-19 pandemic, the Trust established processes to ensure that staff who were self-isolating were able to gain access to a swab test to ascertain if they were positive for the virus. The testing was also offered to members of their household where appropriate. This service was set up on the 30 March 2020 before national testing was available.

In preparation for the COVID-19 pandemic a number of staff were trained to undertake grit-PCR swabbing. These staff included members of the IPC team and Community Specialist Paramedics (CSP). When the staff testing started, CSP were redeployed to undertake the testing role in the community. They worked 7 days a week and covered the North West footprint. Regional level agreements were made around laboratory capacity and which laboratories would provide testing kits and process results.

For NWAS staff and household members the gRT-PCR swabs were processed at Royal Oldham laboratory, following which the tested individuals were contacted with their result by wither an Advanced Paramedic, Senior Paramedic Team Leader or a member of the Education Team. It was important for these calls to be led by clinical practitioners. These staff were also redeployed to the staff testing cell from March to July 2020.

Results were made available to staff in most cases within 24 hours; and no-longer than 3 days. Staff were asked to contact the Carlisle Support Centre (CSC) to confirm they had their test result and the outcome of the result. If the result was negative the staff members would return to work. If a result was positive the affected staff member received a welfare call from either their operational team or HR and isolated for the recommended time period.

The responsibilities of the staff testing cell included:

- Understanding and accessing swab testing capacity at Royal Oldham laboratory
- Capturing and recording details of the staff and family members requiring a swab test (crucially including NHS number)
- Booking slots for the swab testing i.e., community, Dukinfield, national testing 'drive thru'
- Providing a community swab service
- All governance and assurance processes including:
    - Information governance (IG) i.e. DPIA, incident reporting
    - Risks management
    - Lessons learnt
- Reporting on tests undertaken, results received and staff abstraction
- Offering an expert resource to NWAS staff by keeping up to date with the latest clinical research and guidance relating to COVID- 19 i.e. when the loss of taste and smell was introduced as a symptom
- Monitoring the positive results obtained in order to identify possible hot spots which became known as outbreaks or clusters
- Delivering briefing sessions to operational managers
- Developing trust wide communications

3 weeks after the Trust established its staff testing process, a series of national drive thru testing facilities were established. The trust initially fully utilised the national service at Manchester Airport and subsequently Haydock racecourse. However, following a change in national process and associated poor service from the national testing, the trust decided to develop a NWAS drive thru based at Dukinfield based on the initial learning from the NWAS Penrith drive thru which was set up as initially there was limited testing in Cumbria.

The trust also had local arrangements with acute trusts to swab test staff. These services were provided at:

- Royal Blackburn Hospital
- Royal Preston Hospital
- Blackpool Teaching and Infirmary
- Furness General Hospital
- Royal Lancaster Infirmary
- Wirral University Hospital Trust
- Salford rugby stadium drive thru which was managed by the Northern Care Alliance
- Cumberland Infirmary
- West Cumberland Infirmary

The staff testing cell was stood down at the end of June 2020 and redeployed staff returned to their pre COVID-19 roles.

6.2 Asymptomatic testing

Following a request from NHS England the trust participated in a national piece of research looking at the prevalence of the COVID-19 staff in asymptomatic staff. At very short notice, the Trust established swab-testing facilities across the North West at 10 locations. Each location was resourced with swab-testing teams, comprised of a clinician swab tester, swab assistant and admin support. Booking staff provided support mainly focused on searching for and assigning the NHS Number for the staff to be tested. Approximately 100 staff were involved in this work – testing over 400 staff in one day.

As this was a national initiative, the laboratories at Royal Oldham hospital provided additional swabbing equipment and testing capacity for this specific period which was due to cover Friday 8 May 2020 until Sunday 10 May 2020.

Due to the short notice in the request to undertake the research, the Trust could not forecast the level of participation from its staff. Once it was apparent the interest was significant, the Trust contacted NHE England representative who confirmed that they required a maximum of 500 tests. Therefore, the decision was taken to cancel the planned testing on the Saturday and Sunday. Of the 412 swabs submitted – 3 tested positive.

6.3 Antibody Testing

Antibody testing arrived just as the Trust approved the shift from providing swab testing internally to recommending staff utilised the national testing sites or used a home testing kit. This allowed the staff testing cell to focus its attention on providing the opportunity for all our staff to access an antibody test within a specific six-week window. The national antibody testing programme comprised of several phases with the ambulance service required to offer antibody testing to all staff from the beginning of June 2020 until 12 July 2020.

NWAS was required to submit a trajectory for the uptake of the antibody test. This presented a challenge as numbers reported ranged from over 7300 to less than 6500. This was dependant on the inclusions of temporary and bank staff. This implied that the measure of

success would be in terms of the number of tests, rather than success being measured by demonstrating the opportunity to have test was available to all staff. The Trust was required to report the number of tests taken daily to the NACC (National Ambulance Command and Control) via the ROCC.

As an ambulance service, the Trust does not have permanent phlebotomy staff, neither does it have laboratories required to test the blood samples for the antibody. Therefore, a process had to be developed to allow access to these resources in order to achieve the testing aim. Offering the test to all staff involved all PES, PTS, 111 and corporate including Finance, Workforce, Quality, Transformation, PMO, Communication and Engagement, Fleet, Estates, and IT, totalled over 6500 staff dispersed across the North West. The acute trusts were geared up to provide this antibody test to their staff and some patients naturally, resulting in the processes being aligned to their workforce model – i.e., Static workforce at specific locations, utilising their own local laboratory systems and processes. Most of these acute trusts employed digital solutions to provide the laboratory testing and results reports; unfortunately, these IT systems were not consistent across the North West.

The different oversight processes within each of the areas (Cheshire & Mersey, Greater Manchester, and Cumbria and Lancashire) further compounded this complexity. Cheshire and Mersey had representatives from Mersey Internal Audit (MIAA) co-ordinating the processes, within Greater Manchester this was an item for the gold command meetings and within Cumbria there was less overarching oversight with processes managed at an individual organisation level. Support and oversight was also provided by NHSI.

5876 trust staff took the opportunity to have the antibody test during the six week period. This equated to approximately 89% of the workforce. The Trust was not informed of the results of the antibody tests and staff were not obliged to inform the Trust of the outcome. However the Cheshire and Mersey reporting process included the levels of positive results. Within Cheshire and Mersey positivity amongst staff was approximately 21.8% versus 16.7% across all the Cheshire and Mersey tests (staff and patients).

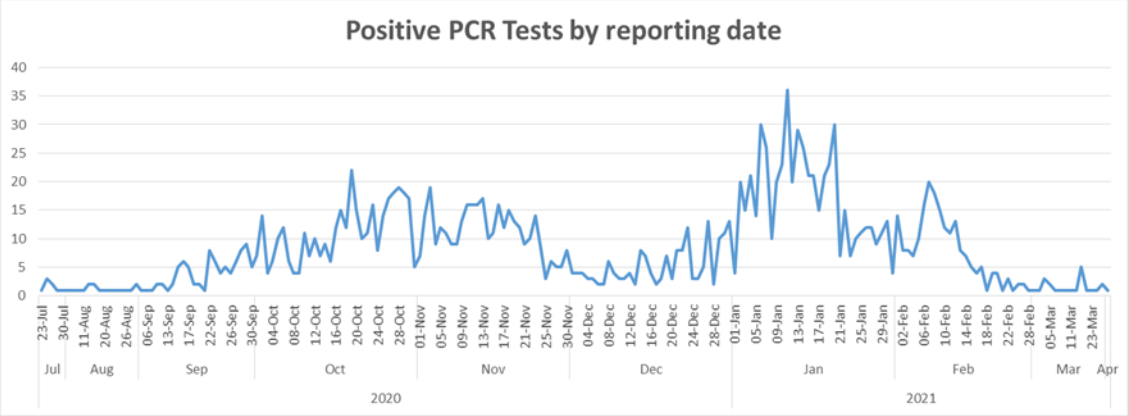
The breakdown of antibody tests by area is shown below:

- GM 2079
- CL 991
- CM 1744

6.4 Reporting results

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

This data was reviewed daily by the executive cell and regulatory and compliance cell to understand the impact of COVID-19 on the workforce and service delivery. The graph below captures the COVID-19 positive cases from when the changes to daily reporting started in line with the establishment of the Test, Track and trace team. The increase in COVID-19 positive cases reflected the national waves.



6.5 Test, Track and Trace Service

NWAS established a new Test, Track and Trace (TTT) service at the end of July 2020 to protect staff, partners and patients, in response to a mandated national request from NHS England/NHS Improvement. The NWAS TTT service is a supplemental service to the National Test Track and Trace system, which does not trace NHS staff at work.

NWAS TTT was designed using national guidance provided by AACE to complete a risk assessment where a positive COVID-19 PCR test is reported by an individual to NWAS. Financial resources were made available to recruit a Test, Track and Trace manager and project support officer to manage the team. Staff who were shielding or recovering from long COVID-19 were also offered alternative duties and worked as tracer. In extreme high demand situations, the QI team acted as resilience during these periods. Over 10 Standard Operating Procedures and internal processes were developed to ensure the TTT service could be established.

The service is offered 7 days a week 8am-7pm weekdays and 8am-5pm weekends. The staff work a rota and have a duty manager on weekdays. The service was also supported by the ROCC out of hours and operational managers.

The duties performed by the team include:

- Understanding the demand for the TTT services and escalating any capacity issues
- Checking the welfare of COVID-19 positive staff members and understanding there are any further workplace risks
- Tracing close contacts and recording accurate information about these cases
- All governance and assurance processes including:
- Information governance (IG) i.e. DPIA, incident reporting
- Risks management

- Lessons learnt
- Auditing the data to understand if there are any potential outbreaks or clusters for clinical review
- Implementing changes to Government policy i.e., isolation dates
- Holding drop-in sessions for managers
- Developing trust wide communications
- Point of contact for operational managers
- Developing and updating managers guidance
- Escalating issues of concern to senior leads

6.6 Lateral Flow testing

On the 9 November 2020, the Health Secretary, Matt Hancock, announced a plan to begin offering asymptomatic testing to all NHS staff twice a week to minimise the spread of the COVID-19 and keep NHS staff and patients safe. A national pilot for asymptomatic testing went live last at this time which included 34 trusts across the country. Three of these trusts were within the North West footprint at Oldham, Blackburn and Warrington. In response to a national requirement for all trusts to start piloting periodic asymptomatic staff testing by 20 November 2020, a short life asymptomatic testing cell was established to lead the pilot and roll out asymptomatic lateral flow testing of staff across NWAS as part of the wider test and trace element of the regulatory cell.

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

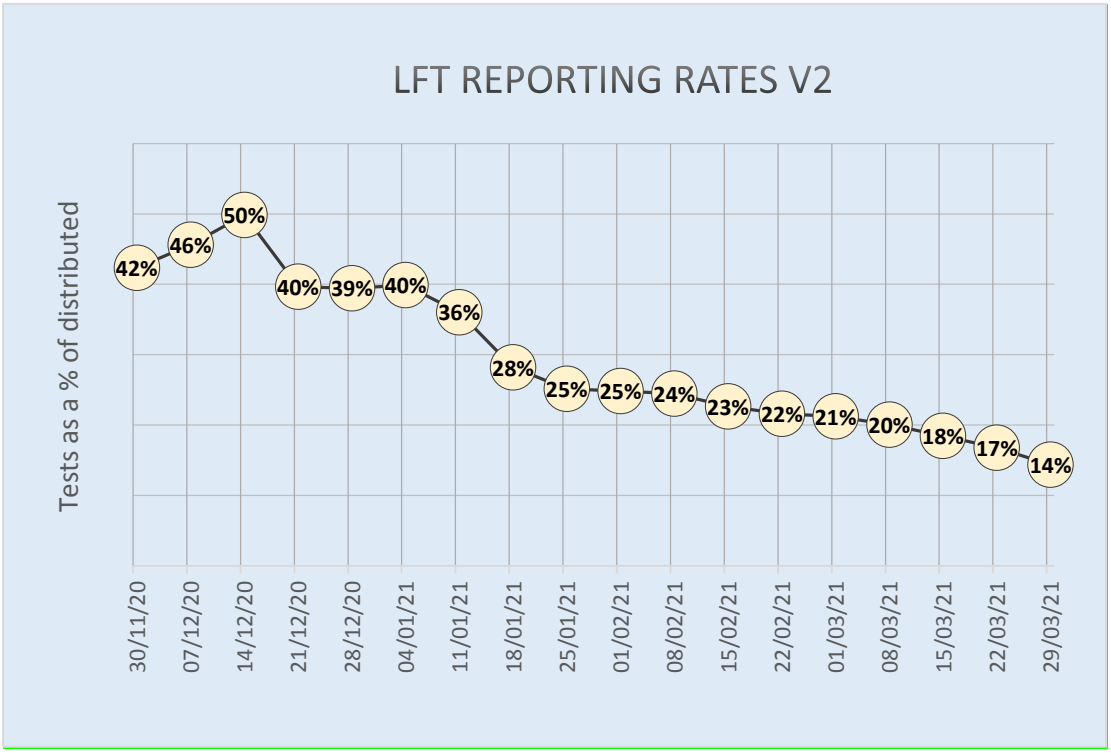
Lateral flow antigen testing detects the presence of the COVID-19 viral antigen from a swab sample. The test is administered by handheld devices producing results in 20-30 mins and can be self-administered. Lateral flow antigen testing has a lower sensitivity when compared to both qRT PCR and LAMP technology. However, studies to date suggest that, similar to LAMP, these tests are better at returning positive results for individuals who are infectious rather than individuals who may have had COVID-19 recently and are no longer infectious (qRT PCR will detect both).

The specificity of the test is 99%+. There is the possibility of some false positive results, therefore a confirmatory standard PCR swab test is required if a positive result is returned from an asymptomatic lateral flow test. Nationally it was expected that there would be a 2.% positivity rate from the asymptomatic lateral flow tests. The sensitivity of the asymptomatic lateral flow test is lower than the standard COVID-19 PCR swab test; therefore, there was a requirement for staff to carry our 2 tests per week to compensate for this. This is because carrying out 2 tests per week will result in a similar sensitivity rate as a standard COVID-19 PCR swab test.

Flu vaccine data was used to calculate how many asymptomatic lateral flow tests were needed for the trust. The test kits were delivered to trusts across England during the week commencing 16 November 2020. In total, 6,750 tests were delivered to NWAS and distributed across sites. The tests came in pre-packed boxes, comprising 25 individual tests and staff members will be issued with one box each.

A pilot commenced at Estuary Point on 20 November, as a test of change of key processes (e.g. training, kit distribution and result recording etc.). Estuary Point was chosen as a pilot for the start of the rollout due its staff numbers and ease of distribution of the kits. Middlebrook 111, HART, Fazakeley, Carlisle and Wigan were identified as the next sites within the roll out for the week commencing 22 November.

Reporting compliance for lateral flow testing was lower than expected. The graph below shows the amount of submitted results as a percentage of the expected number of results from the boxes NWAS has distributed to employees.



However, steps were put in place to increase lateral flow testing and included:

- Daily prompts when staff log on the NWAS IT systems to remind staff to undertake testing
- Weekly staff bulletins about testing compliance and open outbreaks at sites
- Training videos on how to undertake the Lateral Flow test and input the results
- Regular refresh of staff frequently asked questions bulletins
- Local manager engagement
- Promotion of testing via NWAS's 3 geographic area outbreak leads

- Promotion via social media i.e. Twitter and Facebook posts and videos
- Introduction of an IPC Quality Improvement programme and coaching
- Daily IPC checks are being undertaken
- Escalation process for sites who require more intensive IPC support has been implemented
- Working closely with the regional IPC leads
- Increased specialist IPC personnel

Staff reported all lateral flow test results via SafeCheck and reported a positive test result via Carlisle. A second roll out of test kits commenced in February 2021. A total of 7163 kits were issued between November 2020 and March 2021.

Systems were also established to ensure lateral flow positivity data could be reviewed by the test, track and trace team to ensure all positive staff members were traced swiftly.

6.7 LAMP testing

26th February 2021, in partnership with Lancashire and South Cumbria LAMP testing programme, Loop-mediated Isothermal AMPlification (LAMP) testing was introduced at some of the NWAS Critical Infrastructure Sites. Sites were identified based on high prevalence's of positive COVID-19 cases. LAMP testing is a way to deploy asymptomatic testing in an easy non-invasive approach. This process involves staff providing saliva samples which are sent to the laboratory for analysis and results are normally received within 24 hours. The saliva sample is highly accurate and more tolerable to weekly testing than undertaking lateral flow device testing.

Initially work started at the Middlebrook 111 site and was then rolled out to Broughton EOC. Once learning from the initial test sites was understood LAMP testing was rolled out to the NWAS Critical Infrastructure Sites. Operationally, Lancashire and parts of North Cumbria are able to participate in the LAMP testing programme with those NWAS teams able to drop off their sample at local hospitals. Lamp was also deployed to two other operational sectors in GM and C&M which were identified as being areas of concern in which Delta variant surge testing had been implemented.

LAMP testing sites include:

- 111- Middlebrook, Estuary point.
- EOC – Parkway, Estuary Point, Broughton
- PTS Contact Centres, Estuary Point, Oldham and Broughton.
- Support centre, Salkheld Hall
- Cumbria and Lancashire – North Cumbria Sector (East Stations)
- Cumbria and Lancashire – Fylde Coast Sector
- Cumbria and Lancashire – East Lancashire Sector
- Greater Manchester – West Sector
- Greater Manchester – Ladybridge Hall
- Cheshire and Mersey – Sefton Sector

From June 2021 onwards the process for registering for LAMP testing moved from a manual data inputting to using the NHS Digital 'HiPRES' app. The move to HiPRES has made the process of submitting saliva samples quicker. Results are then sent directly to staff via their email and mobile number. The app sends test results and reminders to undertake testing.

8. Facilities Management

7.1 Review of cleaning regimes across all sites

The Facilities Management (FM) team had begun some work to review the cleaning provision at all sites in early 2020. The aim was to develop an appropriate model which would provide equitable and consistent cleaning across all sites. The emerging pandemic halted this piece of work as the focus shifted to providing reactive responses to requests for increased cleaning as a whole.
Following the release of draft operating procedures from NHSE regarding the safe cleaning of patient and non-patient facing environments a new cleaning product, Bacticlean, which was currently being used for the ambulance deep cleaning, was introduced for premised cleaning, approved by IPC team in early April.

FM worked closely with the IPC leads to develop the internal procedures for cleaning of workstations. A procedure for colleagues to request decontamination of workstations was also developed and introduced, requests managed through the premises cleaning in-box. From the IPC procedures, FM developed a Decontamination - Standard Operating Procedure for the cleaning contractor, JPR to use during internal 'Tool Box Talks' to inform their staff on NWAS expectations for decontamination cleaning.

FM sought advice from NHSE following many requests into premises cleaning for operatives to clean desks before use. Advice provided by NHSE was to use a 'cleaning is everybody's responsibility' approach. The advice supported that colleagues clean their own workstations and areas they would use at break times before and after use using suitable and sufficient wipes and gel provided.
Further to the installation of social distancing measures and COVID-19Secure certificate installations, FM rolled out touch point cleaning adhesive vinyl to all sites for ease of identification of all touch points in communal areas.

In April 2020, following a number of concerns raised relating to the quality of cleaning provided by NHSPS at Parkway, FM issued the company with a notice to improve. To ensure consistency with standards at other sites, FM carried out a full review of provision, reset standards and established a monitoring schedule until the required standards were met.

7.2 Decontamination

Requests for decontamination cleaning began to escalate over the following months, this had an impact on the particular JPR staff who were also trained in the decontamination process, taking the focus away from regular cleaning duties. FM approved the appointment of a temporary mobile operative in September 2020, to deal with decontamination only, to relieve some of this pressure. Systems were also put into place, by arrangement with JPR, for colleagues to have access to the decontamination cleaning crews 12 hours over 7 days.

As we moved through the pandemic FM reached agreement with the cleaning contractor, JPR to increase the numbers of decontamination trained crew members to expedite requests.

7.3 Premises Cleaning and Increase to cleaning provision

From monitoring of the premises cleaning decontamination records it was found that high numbers of visits were being recorded from Sefton House during September. This information was shared with the Chief Nurse. The site subsequently moved to outbreak status, following confirmed linked cases. The site cleaning hours increased to 24/7 cleaning from 21 September 2020.

A further call centre, Parkway, moved to 24/7 cleaning from 27 October 2020 to combat increases in cases of Covid-19. Following a measure of the data from numbers of COVID-19cases v number of additional cleaning hours at the site. No positive impact was found, and the cleaning hours were scaled back, but with an enhancement on the original contract.

Analysis of the full decontamination records was undertaken by FM, the findings highlighted that the large stations and the contact centres were high risk sites with large numbers at outbreak status. A review of the cleaning hours was undertaken, and recommendation submitted to the Executive Oversight Coordinating Group on 24 November for immediate increases to cleaning provision at the large stations and contact centres. The decision was approved and ratified by the ELC at the meeting on 9 December 2020, these levels have been maintained at the sites in scope**.**

7.4 A&E Concierge Service

In March 2020, NWAS implemented a contract cleaning service at busy Emergency Departments (ED's) in the region, to provide enhanced ambulance cleaning (both non-AGP and AGP) during the handover of patients. By implementing the ED cleaning, NWAS hoped to both reduce the IPC risk to patients and staff from COVID-19, reduce delays in crews being available for incidents after handover and improve staff welfare.

The A&E 'concierge cleaning' or contract cleaning was delivered by JPR solutions, who already provide deep clean services for the Trust as a contract extension. It was implemented in three phases across 23 hospital ED sites between March 2020 and March 2021.

Group 1: 1st COVID-19Wave (Cleaning implemented between 06/04/2020 – 05/06/2020)	Group 2: Winter Pre-New Year (Cleaning implemented between 13/11/2020 – 30/12/2020)	Group 3: Winter Post-New Year (Cleaning implemented between 08/01/2021 – 11/03/2021)
Manchester Royal	Royal Bolton	Tameside Hospital
Salford Royal	Countess of Chester	Carlisle Hospital
Blackpool Victoria	Royal Oldham	Royal Liverpool
Leighton Hospital	Royal Lancaster	Bury Hospital
Royal Blackburn	Whiston Hospital	Southport Hospital
Arrowe Park Hospital	Royal Preston	Aintree Hospital
Stepping Hill Hospital	Warrington Hospital	North Manchester

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

A mixed-methods evaluation is in the process of being conducted to answer the following key questions:

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

A paper will go to our Executive Leadership Committee and findings will shape our forward plan for 21/22

9. Outbreak management

In May 2020 NHS England and Improvement released guidance on recording and monitoring COVID-19 outbreaks. Nosocomial patient outbreaks in our partner providers were monitored as well as staff related outbreaks. Public Health England then published COVID-19: Epidemiological definitions of outbreaks and clusters in particular settings which was national guidance on the 7th August 2020 took into consideration non-hospital settings. NWAS were required to report daily to NHS E/I initially via email submission daily and from December 2020 via the National Portal System.

Clusters or outbreaks of COVID-19 are declared by the Director of Infection Prevention and Control, the Head of Clinical Safety or an appointed deputy. A standard process of outbreak declaration and the appointment of an outbreak control team then triggers the NWAS cluster management and outbreak operating procedures. An outbreak of COVID-19 is where 2 or more cases of COVID-19 are linked in time or place. In the ambulance service this could be cases linked on specific stations, call centres or between crew members where the cases have occurred within 14 days of the first identified case (the index case). A cluster is two or more test-confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within a 14-day period. These are cases without direct linked exposure.

The NWAS Cluster and Outbreak Management Standard Operating Procedure COVID-19 was first approved by the Executive Leadership Committee in August 2020. This procedure ensures an effective and coordinated approach is taken to an outbreak of COVID-19 within NWAS, from initial detection to formal closure and review of lessons identified. It promotes a consistent approach across all levels of NWAS and includes a set of standards for an

outbreak response. This procedure is an aide to decision making for those who are involved in the management and response to an outbreak. Prompt appropriate actions are crucial, and the procedure ensures that all staff are timely and consistent with regards to decisions and actions undertaken.

8.1 Outbreak leadership

From September 2020 to March 2021 there were Outbreak coordination meetings which were set up by a designated Trust Outbreak Lead (TOL). The TOL worked with operational and corporate teams to establish outbreak cells which operated in all service lines (111, PES, emergency operations centres, resilience and PTS) and areas (Greater Manchester, Cheshire and Mersey, Cumbria and Lancashire). The role of the Trust Outbreak Lead was critical in ensuring procedural adherence, communication between teams and rapid adoption of learning.

In addition to the local meetings there were Executive Outbreak Meetings each week which were increased or reduced flexibly based on the number of outbreaks and the outstanding actions. These were chaired by the Executive Director of Quality, Innovation and Improvement. At the peak of the second and third lockdowns these meetings were held three times per week and were attended by nominated leads from corporate and operational teams who fed back on their local data, the management plans and any unmitigated risks. These risks were then reviewed and actions taken to address them locally and corporately.

8.2 Outbreak Reporting

There was a requirement for NWAS to report outbreaks and clusters to our regulators. At the outset of the reporting, we were reporting separately to NHSI, Public Health England (PHE) and CQC (Care Quality Commission). Outbreaks were also sometimes escalated to the Health and Safety Executive or had oversight from local environmental health teams. The higher the number of cases and longer the outbreak the more likely it was that multiple regulators would be involved. NWAS staff attended numerous online meetings with regulators, often at short notice and throughout the pandemic provided real time information to ensure all regulators were fully briefed.

For each new outbreak or cluster, a standard IIMARCH form was completed and sent to NHSI. These briefings were used to ensure that the appropriate actions were in place to control the outbreak and that any risks were identified. By January 2021, NWAS were providing daily updates on the number of live outbreaks to NHSI who acted as the meta regulator, coordinating the flow of information to other regulators. This approach worked well and enabled us to build strong working relationships with the regional IPC team, who completed a number of visits to the Trust to review IPC practice (see external partnerships).

8.3 Outbreak Escalation

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

where there was a growth in the frequency of positive COVID-19cases reported by staff, to a rate of more than 5 cases a week.

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

8.4 Outbreak Data

There were a total of 92 outbreaks across NWAS between 1st April 2020 and 31st March 2020. These were dispersed across the NWAS geographical footprint and were closely linked to the Public Health England rates of community prevalence, which were extremely high across the North West throughout the reporting period.

Our first outbreak occurred in August 2020 within 111, Middlebrook Site and then during the height of the second wave in October 2020 we saw 28 outbreaks recorded across all service lines. These reduced but a further spike took place in January 2021 where we recorded 22 outbreaks.

During this reporting period NWAS had significant outbreaks which affected our emergency operation centres, Middlebrook 111 as well as community prevalence clusters in GM West Sector and Cumbria.

8.5 Distington Cluster

Between the 13th April and 7th May 2020, 13 staff tested positive in a 25 day period in the Distington cluster of stations in West Cumbria: Egremont, Distington and Flimby. This was the first identified outbreak for NWAS and took place before NHS E/I Outbreak Guidance was put into place.

A pattern was identified by the NWAS Testing Team which identified that the cases were linked and it was during this period NWAS commenced asymptomatic testing for the first time and found that 7 staff had COVID-19but no symptoms.

Post-testing, NWAS conducted retrospective detailed tracing for the known positive staff and they had all worked together on an ambulance or on the same shift in the 7 days prior to developing symptoms/testing positive. This helped form the need for a Test Track and Trace service in the organisation.

8.6 Middlebrook 111

Middlebrook is situated at Sefton House in Bolton, Greater Manchester. It is our largest contact centre within the organisation and has 549 staff. Due to the nature of the service

these workers would not be able to provide their duties at home and required to continue to come to the centre. Where possible staff who could work from home were stood down and supported to do so.

On the 12th September 2020 during the beginning of the second wave, Bolton had a high rate of COVID-19 community prevalence. An outbreak occurred which had in total 79 staff members involved. A COVID-19 outbreak action plan was put in place to provide assurance and reduce the spread of the virus as the centre was unable to be closed and cleaned to break the cycle. Numerous changes to IPC management in call centres including, mask wearing at all times, improving IPC stations where staff had easier access to PPE and hand sanitiser. Safety Check stations were put in place to check staff's temperature pre their working day. Enhanced ventilation checks took place to minimise spread in the air conditioning/heating systems.

Middlebrook became the pilot site for installing Perspex screens, which was then replicated in other contact centres within NWAS. It also led the way in the improvements in high touch point cleaning regimes and increased site cleaning provisions. During this time NHS E/I attended to provide support and assurance to the region on measures taken and ongoing work with Bolton Council Public Health Department to implement asymptomatic testing on site.

A further outbreak took place 22nd February 2021 when Bolton were experiencing the highest rate of COVID-19in the country due to the 'Kent' variant. Reinforcing of the messaging was vital during this period at a time when staff pressure was high and compliance was dipping. . It was identified that most of the staff who had been positive had been asymptomatic, so work took place with NHS E/I and in a 24-hour turnaround Loop-Mediated Isothermal Amplification (LAMP) Testing was implemented with great success with the outbreak being closed within the 28 days Public Health England guidance.

8.7 Greater Manchester West Sector

In October and November 2020 along with high community prevalence in Bolton and Wigan, hospital admissions to Emergency Departments caused handover delays. This was a large contributing factor in a cluster of outbreaks that took place in Greater Manchester West Sector. Significant work was undertaken by the operational management team to follow the outbreak management process.

8.8 Emergency Operation Centres

At the height of the second wave COVID-19 outbreaks were also declared at all three Emergency Operation Centres. Like Middlebrook it highlighted the need to strengthen compliance in relation to Hands, Face, Space and also implement the learning around Perspex Screens and increased high tough point area cleaning regimes to protect the further spread of the virus.

Parkway 3 site had a further outbreak in February 2021, however like Middlebrook this was maintained and closed within the PHE 28 day guidance.

SITES	Outbreak 1	Outbreak 2
Parkway	10/10/2020	24/02/2021
Broughton	23/10/2020	
Estuary Point	04/10/2020	

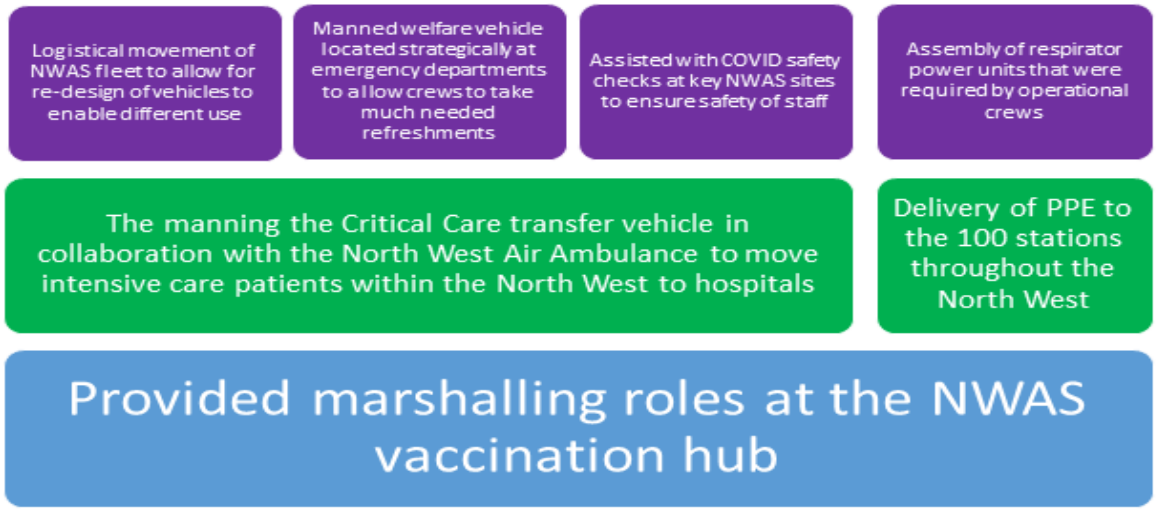
10. Volunteers

2020 and in to 2021, our volunteers have provided unwavering support to communities and added resilience to our service at NWAS. They have continued to respond to emergencies and the Trust has provided appropriate personal protective equipment for them to allow patients to be cared for and treated. Over 120000 hours' worth of volunteer support have been given to communities and the Trust responding to emergency calls by this group of volunteers for the period of 2020-21.

Over the past year, like all in the NHS we have faced unprecedented times dealing with the Pandemic, with challenges never experienced before. The support provided by our volunteers enabled NWAS operational crews to continue to deliver the best care to the people of the North West. We had over 300 volunteers offering to support us in various ways and this enabled resources to be directed to the areas of need that has equated to several thousand hours' worth of support. This was in addition to their normal roles for the Trust.

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

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



As numerous waves of the pandemic brought an increase in emergency calls, we requested additional support from our enhanced community first responders. This group of responders hold additional skills and knowledge to allow them to attend an increased number of emergencies. We placed 45 volunteers through an upskill course that enabled them to work on emergency ambulances with core staff. This increased the availability of ambulances for emergencies and is continuing through 2021-22.

11. Staff Welfare

Supporting staff and families

NWAS employs over 8,000 staff and volunteers. We value our staff and understand that they are our most important resource. The trust conducted one-to-one risk assessments with staff throughout the pandemic which have been fundamental to understanding individual difficulties and identifying appropriate support measures. Risk assessments were conducted initially with those identified as 'high risk' staff, i.e. those whose health condition(s) and/or age placed them at greater risk of serious ill health if they contracted COVID-19.

As the pandemic continued and we received further medical guidance, the process was rolled out to BAME staff and subsequently offered to all staff. The risk assessment itself evolved and the process prompted more focused discussion on an individual's mental health, exploring factors at work and at home, and the psychological impact the pandemic was having.

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

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

The risk assessment has recently been amended further and conducted with all staff who have been medically suspended and/or on alternative duties to re-assess their status and support their return to the workplace, where appropriate. This has enabled a further opportunity to reassess the mental health of those staff and identify appropriate support.

Regular welfare contact has been carried out with staff during periods of COVID-19 related absence, such as during medical stand down/ shielding, isolation periods and COVID-19 sickness. This enabled staff to maintain contact and inclusion with NWAS and ensure any support required is identified and accessible. In cases where staff have become seriously

unwell and hospitalised, regular contact has been maintained with the staff member's family and help and assistance provided wherever possible.

Counselling services provided through our OH provider, offered a remote service to our staff and we noted an increase in numbers accessing this. We also funded additional specialist therapeutic support such as Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) therapy which is an *interactive psychotherapy technique used to relieve psychological stress*.

10.1 Staff in Hospital and Bereavements

In the last year, 29 members of our NWAS family have been admitted to hospital, battling COVID-19 in intensive care and three have sadly lost their lives. We would like to extend our sincerest condolences to the friends and families of those who have lost their lives during this Pandemic.

12. Regulatory Compliance

11.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The Health and Safety Executive requires deaths and injuries to be reported only when:

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

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

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

NWAS were instrumental in supporting the practical application of this guidance in the ambulance sector leading this work via the quality directors group of the association of ambulance chief executives.

RIDDOR incident Reports are completed within 15 days of knowing about the incident, via DATIX. The target for 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, a performance of 53%**,** and therefore NWAS achieved the target of 50% This is a remarkable achievement given the growth in RIDDORS requiring reporting over 19/20 due to COVID19.

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

39 incidents were reported into Datix more than 15 days after the incident occurred.

11.2 Ventilation

Updated COVID-19-19 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.

11.3 H&S Inspections

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.

11.4 COVID-19Safety & HSE IPC Inquiries

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

11.5 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

11.6 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.

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.

11.7 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.

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.

13. Vaccination

In 2020/21 NWAS used the COVID-19 vaccine for the first time, along with the rest of the world as we all tried to support the fight against the pandemic. NWAS set up a COVID-19Vaccination Cell with support from Senior HR Lead as Chair and the Chief Pharmacist was vice chair. On Dec 18th NWAS expressed an interest to NHSE to receive stocks of the COVID19 Astra Zeneca vaccine (having ruled out using the Pfizer vaccine due to its characteristics). Stocks were received mid-January as NHSE entered the NWAS site as a part of the 'hospital hub' wave. This led to the set-up of a COVID-19Vaccination Hub at the Broughton Site, Preston, where NWAS staff could be vaccinated.

12.1 COVID-19VACCINE HANDLING

1. COVID-19Vaccination Hub

The Broughton site was chosen due to ease to set up as a hub (due to the pre-existing infrastructure) and geographical location in the NW. The team had 2 weeks to operationalise the site. There were three offices where staff had to be relocated from, plus a kitchen and dining area where a temporary facility had to be put in place for staff. Estates, facilities management, finance, procurement, HR and the medicines team worked together supported by the Transformation Team to set it up in time.

2. COVID-19Vaccination Hub Team

The Chair and Vice Chair of the COVID-19Vaccination Cell provided the leadership for the Hub with feedback to the Executive Director of People. A senior paramedic was tasked with overseeing all the vaccinators, ensuring they were trained and competent, rotas were filled. There was an operational lead who supported the operational running of the hub ensuring staffing, consumables, patient flow, site suitability. An admin team supported data input and the appointment booking system. The Medicines Team supported daily ensuring the provision of vaccine and accounting for all stocks, procuring more. The Chief Pharmacist oversaw the service clinically and escalated to a medical doctor as necessary, as well as handling all submissions to the regional team and Foundry. All internal communications were managed by the Communications Team. Four vaccinators could operate at any time, with support from a clinical lead and volunteers managing patient flow from the car park and in the waiting room.

Clinical queries often came in via email prior to booking in an appointment for a vaccine. These were dealt with by the Chief Pharmacist who provided advice, and where a plan was required this was documented so the Clinical Lead in the Vaccination Hub could understand what patients were coming that day and the treatment plan or concerns. When the concerns

regarding blood clots and the AZ vaccine were reported part way through the programme, there was an increased need for clinical input. This was handled by the Chief Pharmacist and a doctor who was specifically employed to support the vaccination hub. In some cases, patients were not able to progress to a second dose with the Astra Zeneca vaccine. One patient was referred to an immunologist for assessment and safely progressed to second vaccination.

3. Vaccines used and PGDs

During this vaccination programme one type of COVID-19vaccine was used, the COVID-19 Vaccine AstraZeneca, (ChAdOx1-S [recombinant])▼. The national patient group direction (PGD) was adopted for use. This was updated part way through the programme and a second version introduced and staff signed off to use. Two sizes of vials were used the 4ml and the 5ml, NWAS receiving whatever was available from the national supply chain at the time.

4. Vaccines Procured

Vaccines were procured via 'Immform' by the Medicines Team. A record of the stocks received is provided in table 1.

Table 1: NWAS Vaccine Orders and stock received.

Date Received	Qty Received	Qty Supplied
15/01/2021	4	0
16/01/2021	90	4
20/01/2021	100	0
25/01/2021	30	0
17/02/2021	40	0
29/03/2021	80	0
06/04/2021	50	0
08/04/2021	30	0
05/05/21	0	21
Total:	**424**	**25**

The initial stock of 4 vials of COVID-19vaccines were obtained via an NHS England mutual aid agreement with Lancashire & South Cumbria NHS Trust Ribble House Pharmacy department. Four vials from the NWAS order were then returned to them when the NWAS stock order arrived. The agreement allowed the NWAS vaccination hub to ensure stocks were available for the initial training and ensure vaccine availability for the first clinic whilst awaiting delivery confirmation of the NWAS vaccine orders.
399 vials were used during the NWAS vaccination campaign. This left a surplus stock of 21 vials which were transferred via mutual aid to Ribble House Pharmacy department. This ensured no vaccine waste occurred.

12.2 Vaccinator Training

A total of 83 staff completed the PGD training for the COVID-19vaccination delivery. However, following assessment and staff availability only 25 of these went on to become

active COVID-19vaccinators. The Vaccination Leads ensured all training records were successfully completed for all staff vaccinating. Of the 25 staff vaccinating in the Broughton Hub the vast majority were paramedics, one was a pharmacist and 2 were nurses.
Where possible national training courses were used via e-learning for health. There was no requirement to develop any new in-house training modules but face to face training on vaccine preparation (including ANTT) and intramuscular injection, was provided.

NWAS Covid Vaccinator Training

E-learning	Access	Comments
All of the below need to be completed, or proof of currency must be provided, BEFORE attending a Vaccination Session.		
General PGD Training	NWAS course, access via MyESR	Most staff will have already completed as already using PGDs.
Core Knowledge for COVID-19 Vaccinators	eLFH course, access via MyESR	
COVID-19 Vaccine AstraZeneca	eLFH course, access via MyESR	
Introduction to Anaphylaxis	eLFH course, access via MyESR	Paramedics do not need to complete this.
Recognising and Managing Anaphylaxis	eLFH course, access via MyESR	
Vaccine Administration	eLFH course, access via MyESR	
Vaccine Storage	eLFH course, access via MyESR	
Legal Aspects	eLFH course, access via MyESR	
Data Security Awareness Level 1*	NWAS course, access via MyESR	Most staff will have already completed.
Infection Prevention and Control Level 2*	NWAS course, access via MyESR	Most staff will have already completed.
Resuscitation Level 2+	eLFH course, access via MyESR	Most staff will have already completed.
Induction to the site including: Anaphylaxis and resus kits	***Video – not yet available***	
PGD: ***Must be completed BEFORE coming for a Vaccination Session***		
Signed the current version of the PGD	PGD will be sent to all vaccinators when available for sign off	
Assessment:		
COVID-19 vaccinator competency assessment tool	From the web link provided	Complete the self-assessment and bring to your first session at the hub for sign off.
ANTT assessment: Must be competent in the handling of the vaccine product and use of aseptic technique for drawing up the correct dose.	Included in the competency assessment on site. Training will be given.	
Must be competent in the intramuscular injection technique	Flag before attending a vaccination session if help/training needed.	

12.3 Cold Chain Management

All stock was delivered directly to the Broughton site and held at a location separate to the Vaccination Hub. This bulk stock was only accessible by the Medicines Team. Stock was transferred daily by the Medicines Team to the Vaccination Hub where there was a separate fridge the clinical lead vaccinator had access to for stocks during the day. If additional stocks were required, the Medicines Team would obtain them from the bulk supply.

Both fridges were monitored used a Promatica digital temperature monitor which monitored both the air and glycol encased probe. The latter is especially important as it provides a closer correlation to the temperature of the vaccine. These temperature monitors are new for NWAS and were invaluable to support accurate temperature monitoring but also remote temperature monitoring rather than relying on staff to manually check temperatures and all the inherent errors that can bring.

Any movement of stock to other sites, e.g.: when provided by mutual aid, was conducted using a portable vaccine fridge.

No excursions of temperatures of the vaccines stored occurred.

12.4 Anaphylaxis kits and other medicines

NWAS usual medicines and medicines pouches used on ambulances were provided to support the other equipment that the operations manager ensured was present. These kits were checked each day. There was also an anaphylaxis kit with adrenaline and syringes/needles provided.

12.5 Documentation

The following documents were in place:

- NHSE Vaccination Hub Readiness Checklist was signed off by the Regional Chief Pharmacist, Regional Quality Assurance Pharmacist and the NWAS Chief Pharmacist. This was reported to the Medicines Optimisation Group (MOG).
- NWAS Vaccination Proforma was developed by the Medicines Team and approved by the Chief Pharmacist and Chair of MOG and Executive Medical Director. This document was updated in light of changing information about the use of the unlicensed vaccine. Most notably the information regarding blood clots. The proforma was updated within 24hrs with staff trained and the new form in use.
- NHSE COVID-19vaccine handling and management policy was adopted by NWAS and approved by the Executive Leadership Committee and MOG.
- NWAS Training Requirements for Vaccinators – developed by the vaccination leads and the Chief Pharmacist based on national recommendations. Reported to MOG.

Table 2 : SOPs for vaccine handling
CV01: Ordering AZ COVID19 vaccine from PHE
CV02: Receipt, storage, stock control, temperature excursions, record keeping and security of AZ COVID19 vaccine
CV03 Covid-19 Vaccine Storage Conditions, Temperature Monitoring & Excursions
CV04 Issuing COVID-19vaccine from the primary fridge and stock reconciliation
CV05: Preparation of AZ COVID19 vaccine individual doses for patients
CV06: Administration of AZ COVID19 vaccine
CV07: Clinical Waste - Vaccination Hub
CVO8 – Spillages - COVID-19vaccine

Eight standard operating procedures were put in place to support vaccine handling. These were developed by the Medicines Team using the national templates where available. They were approved by the Chief Pharmacist and Chair of MOG and reported to MOG. They are detailed in table 2.

12.6 Vaccines administered

The Vaccination Hub opened for first doses from 15th Jan to 25th Feb and second doses from 29th Mar to 4th May. A total of 3829 doses were administered, 2030 first doses and 1799 second doses. The majority of NWAS staff received vaccination via other providers, e.g.: Hospital Hubs. Doses given by NWAS were recorded in the local NWAS COVMIS database and also the National Immunisation Vaccination System (NIVS) by the administrative staff.

Issues relating to missing NHS numbers caused delays in data being put onto the NIVS, not registered with a GP in England yet or patients having a Scottish/Welsh/Irish NHS numbers caused issues.

12.7 Stock Control

Stock control was tightly controlled by the Medicines Team. The bulk stock was receipted into a bound book (a repurposed controlled drug record book) and any issuing out of the vaccine from the bulk stock was recorded in the bound book and a running balance maintained. The stock that transferred to the Vaccination Hub fridge was recorded into their bound record book by both the Medicines Team (issuing the stock) and a vaccinator (receipting the stock). Every time the clinical lead issued a vial of the vaccine from the fridge it was signed out by the clinical lead and the vaccinator who was receiving the vial. Running balances were maintained. Each day after a clinic the Medicines Team cross correlated all the paperwork ensuring that each vial of vaccine used had patient records to evidence its use. Any concerns were escalated and dealt with, e.g. missing record sheets.

Information on vaccine use was submitted to the national team via the Foundry after each clinic by the Medicines Team.

No vials of vaccine were unaccounted for.

12.8 Incidents (vaccine related)

Two incidents related to the COVID-19vaccination program operated at Broughton Vaccination Hub were recorded on the Trust's incident reporting system. These were:

- Middlebrook 30th September 2020
- Four doses of vaccine wasted: A needle used to vaccinate felt blunt to vaccinator who was unable to advance into the muscle. The needle was then mistakenly reintroduced into the vial of vaccine in error. Resulted in 2.75ml wastage (4 doses) of COVID-19vaccine which was disposed of with a witness. (Ref: WEB98422). The blunt needles were reported via yellow card – see below.
- One instance of shoulder pain reported via incident form by the patient.

Two yellow cards were submitted, these were:

- Blunt needles: reported by separate vaccinators. This was escalated to the Regional Chief Pharmacist and Regional Quality Assurance Pharmacist on 15th April. It was reported by NWAS to MHRA using the yellow card system. It was also reported by NWAS to the National Vaccination Operations Centre (NVOC) via the Regional Vaccination Operations Centre (RVOC). Subsequently it appeared NWAS were not the only ones to report such issues and it was noted in a NHSE bulletin on 15th May.
- Rash/swelling soon after vaccination. This patient was escalated to the Occupational Health doctor who facilitated a consultation with an allergy specialist as per current guidance. The patient had a clinical plan put in place and came for second dose with a mild reaction only.

12.0 Medicines Oversight Group (MOG)

MOG provided oversight for the governance processes required for the handling of the COVID-19 vaccine at the Broughton Hub. In particular:

- The number of fridge temperature excursions
- Deployment of continuous digital temperature monitoring system with glycol encased probes
- Minimal waste of vaccine
- Excellent stock control and no unaccounted-for vaccines
- Excellent assurance around vaccinator training and competence
- Clinical oversight

14. IPC Improvement Module

13.1 Development

The Infection Prevention Control (IPC) module was developed in response to the high number of outbreaks across the Trust. The purpose of the module was to support Infection Prevention Control practices across NWAS and the module provides:

- Signposting to NWAS IPC training material
- Case study examples of how quality improvement models/methods can be used to identify IPC problem and ways to implement small tests of change
- Learning from COVID-19 and changes to IPC practices
- Assurances around IPC governance processes which is inherent to how NWAS will achieve 'Operation Outstanding' by March 2022

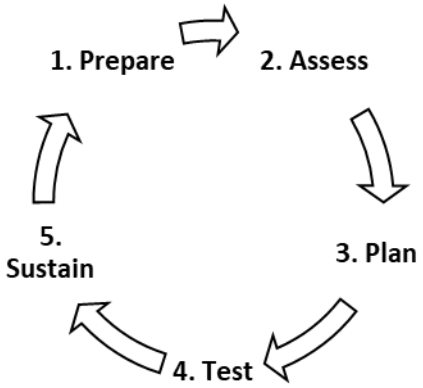
This module promotes the principles and implementation of a safe system of working for all staff throughout NWAS across all departments. This module is particularly important and relevant during the COVID-19 pandemic. This module can be used by any staff member managing an IPC issue. All the guidance in the module is underpinned by the most up-to-date evidence from Public Health England and the Association of Ambulance Chief Executives (AACE).

13.2 Content

The module has been designed to help team to:

- Understand where their IPC priorities are
- Use a Plan, Do, Study, Act cycle to implement small tests of change to improve Infection Prevention Control in working environments
- Have a standardised approach to manage IPC

The module uses a 5-step approach of:



Each of the steps are supported by narrative and case studies.

13.3 Delivery team

The delivery team comprised of a quality improvement lead and project support, IPC practitioners and an IPC consultant and leads from the 111 and PTS service who were testing the module. All the module material was approved by the IPC team. Initially leads were also approached from the Estates and Facilities Management team and HART team to test the module. Unfortunately, these teams didn't have capacity to undertake testing due to being involved in other COVID-19 and IPC related activities.

13.4 Testing Sites

The testing sites were from 111 Middlebrook and PTS Broughton. The leads attended weekly coaching sessions and benefitted from sharing ideas and learning within their services. The table below summarises the tests of change:

Site	**Middlebrook 111**	**PTS Broughton**	
Problem	• High numbers of staff traced from COVID-19positive cases at 111 Middlebrook	• Review of social distancing across Broughton (incorporating Broughton Ambulance Station, Patient Transport Services – Contact Centre & Broughton House)	• A review of staff compliance in wearing Personal Protective Equipment (PPE) during the COVID19 pandemic took place across the one site. • As government restrictions eased, a further survey was completed in June 2021 to see if this had changed staff's attitudes to wearing PPE.
What the team wanted to achieve	• To reduce the number of staff close contacts	• To understand what the current issues were	• Do staff have access to appropriate PPE?

	in a workplace setting	around social distancing • To understand how time of day may affect social distancing • To evaluate the impact of current measures	• Are staff using Personal Protective Equipment (PPE) effectively during the COVID-19 pandemic? • Reasons why staff are not wearing PPE
What the team did	• Introduced Perspex screens • Promoted the use of masks in the working environment and communication feeds on television screens • Piloted hands-free exit buttons at Estuary Point • Varied break times • Conducted asymptomatic and LAMP testing • Tested IPC Champions • Developed daily IPC 10 point checklist and ran multiple PDSA's • Checklist introduced across the trust and adapted for PES teams	• Random spot checks to ensure staff were able to adhere to social distancing measures in social areas / dining facilities took place over a week's period	• A survey took place in March 2021 during which time the country was in lockdown. • At the start of each shift staff were asked do you have: ❖ Eye Protection (either reusable goggles or personal issue visors). ❖ Face Masks (enough for the shift for both crew members and patients). ❖ Gloves (available in each size) ❖ Disposable Aprons (enough for the shift for both crew members) • Following the project and review in March 2021, Bulletin CV195 was reissued to all staff highlighting the guidelines for staff which is taken from Association of Ambulance Chief Executives (AACE).

The result	• Daily checklist being used across NWAS • Staff ownership • Question 4 on the checklist about desk logging was amended and staff came up with the idea of using the telephone as the desk audit process	• It was identified that whilst the maximum number of people per room was not exceeded, there were times (especially on Broughton Ambulance Station) when high footfall of people where on site • Staff were reminded that alternative space was available on the site, and the need to ensure that facemasks were worn when not eating / drinking • Collaborative working between PES and PTS management to address this has taken place with the look at alternative dedicated space for PTS staff to dine / socialise	• **March 2021** **Eye Protection** 100% compliance **Surgical Face Masks** 100% compliance **Gloves** 64% compliance 36% non-compliance* **Disposable Aprons** 100% compliance • **June 2021** **Eye Protection** 100% compliance **Surgical Face Masks** 100% compliance **Gloves** 100% compliance **Disposable Aprons** 100% compliance • Non-compliance was mainly due to staff having extra small / extra-large hands. Staff given own supply of gloves

13.5 Learning from testing

The table below describes the learning from the IPC module:

Test site	PDSA	Learning	Where learning was shared
Middlebrook 111	• Development joint governance between 111 contact centres around a daily 10 point checklist • Development of IPC champions	• Module provided a great framework to testing QI ideas • QI coaching was beneficial • Benefitted from peer networking and specialist support	• Operation Outstanding • QI Network

		• Learning was scalable • Case studies shared at various meetings	
PTS Broughton	• Social distancing compliance • PPE compliance		• IPC cell • L3 meetings

13.6 Roll Out

The module is available on ESR for staff to test. The module uses a step by step approach and has a narrative to complete the written training material. Alternatively, coaching can be provided by the QI team as required.

15. Innovation

14.1 SafeCheck

In October 2020 the SafeCheck system was developed to provide a Test, Track and Trace function. The first function to be released allowed for locations to be established within the system, for example an office space. A poster containing a QR code was then generated which would allow staff to 'check in' as they moved around the building, in order to assist with the track and trace requirements. In total 444 locations have been established within the system, with 5188 unique events where staff have checked in. This system was tested at Estuary Point and also with the training team. It was withdrawn at Estuary Point once alternative enhancements were put in place. However, the training team continue to use it for their courses and tracking which individuals have attended on a particular date.

The SafeCheck system was further developed in November 2020 to allow staff to upload their lateral flow testing results. The system was used for this purpose between 19/11/2020 and 12/07/2021. During this time 51,693 lateral flow results were logged within the system. The breakdown of test results can be seen in the table.

Lateral Flow (NWAS)	51693
Lateral Flow (Partners)	15299
LAMP Test (NWAS)	1785

The SafeCheck system was also designed to allow staff to state their preference with regards to the uptake of a vaccine. For NWAS staff, this was completed by 2591 individuals and for our partners, this was completed by 1243 individuals.

16. Assurance

The NWAS Board Assurance Framework includes a strategic risk related to the safe delivery of high-quality care which is articulated as follows: 'If we do not deliver appropriate safe,

effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety'. This is supported by the corporate risk register which includes a number of risks scoring 12 or more related to the pandemic including Risk ID 3435 added on 30th October 2020: *There is a risk that if the number of COVID-19related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.*

In addition to the overarching Board Assurance Framework there is a specific IPC Board Assurance Framework. The framework is structured around the 10 criteria set out in the 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. Risk is managed via a hierarchy of controls which are articulated in the assurance framework and risk register. The IPC board assurance framework was first presented to the board in January 2021, and it forms the basis of our six-monthly IPC reporting to the board.

15.1 CQC Assurance

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

On the 18th of August 2020, the Trust was asked to submit the IPC BAF for review by the CQC. The draft was shared with them pending approval by Board on 30th September 2020. The CQC conducted a 2-hour virtual review of NWAS IPC arrangements with the DIPC and Executive Director for Quality, Innovation and Improvement. The Trust's IPC Assessment Summary Record from the CQC was positive and the CQC's findings were reported through to trust Board, at the December 2020 meeting.

15.2 NHSI / E

Throughout the pandemic NWAS worked with the regional NHS North team to seek advice and assurance on IPC developments and standards. The NHS North IPC team carried out four onsite inspections at our critical infrastructure at Middlebrook 111, Parkway 3, Estuary Point and Broughton. There were also a series of observational audits which were carried out outside A&E departments by NHSI/E IPC specialists. These were followed up with a focus group with frontline staff which NHSI led to discuss IPC systems within NWAS. In each case the NHSI team carried out a debrief with the DIPC and where appropriate the Executive Director of Quality, Innovation, and Improvement. The learning from these visits was shared widely and was used to positively support the improvements made and to inform the risks which still required addressing.

1. Ventilation
2. Partition Screens
3. IPC compliance (face masks)
4. Exemptions

17. Risk management

During 2020/2021 risks in relation to COVID-19 have been identified and monitored as part of a specific COVID-19 IPC Board Assurance Framework (BAF) in addition to the Trusts standard risk registers and BAF.

This Board assurance Framework was developed to monitor NWAS standards against key healthcare criteria and provided evidence and assurance regarding the management of any risks identified within this criterion. At the peak of the second wave of the Pandemic there were 79 separate identified COVID-19 related risks.

Risks are continually monitored, and newly identified risks added to the Trust risk register. This BAF continues to be regularly reviewed and monitored through the Trusts Quality and Performance Committee and the Executive Leadership Committee:

16.1 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 by end of March 2021. All risks identified are in relation to area's highlighted in the report, including areas of improvement and additional assurance.

Risks Scoring >12

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. The organisation in 21/22 will be implementing an IPC Sub Committee to improve assurance to the Board of Directors and an IPC Specialist will be appointed in 21/22.

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. This has been addressed by the implementation of the RPE Steering Group attended by key NWAS staff and reported to Q&P: via a chair's assurance report.

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. A communications campaign has been reviewed throughout 20/21 to ensure that messaging is personable to each staff member and supports the NHS's message of Hands, Face, Space and ventilate. Campaigns have been led by the DIPC, DQII, Heads of Service's and HR.

Risks that improved during 2021:

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. This was improved by increased communications nationally and locally around PPE. This was supported by IPC Audits to review improved compliance.

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.

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

Risk 3306 (12 to 9) 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. This was improved by the implementation of competency-based training for staff members to roll out a better quality of fit testing.

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 COVID-19 absence data which is not fit for purpose and long term use due to some information governance concerns identified through a short Data Protection Impact Assessment (DPIA). This may result in the Trust not being to collect ongoing Test, Track and Trace data. This risk was improved by the implementation of SafeCheck.

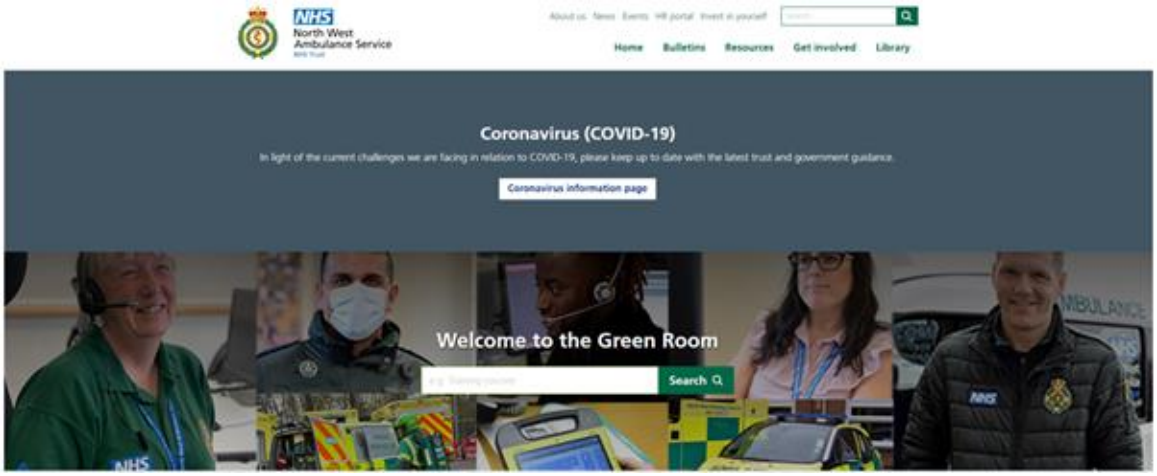
18. Communications

17.1 IPC Campaigns

NWAS ran a focused series of information and education campaigns during the entirety of the pandemic.

Hands, Face, Space

National campaign materials were distributed throughout NWAS property using the PHE messages on a NWAS corporate canvas. These were displayed in high touch areas within all NWAS estate. The responsibility for positioning, maintenance and replacement sat with operational management teams. The use of campaign materials was reviewed at every leadership walk round and during quality assurance visits by consultant paramedics, the IPC Team and Health and Safety Team.



The Communications Team supported IPC by setting up various platforms for messages and guidance to be accessed by all staff at any time. These were:

- A dedicated area on the intranet (Green Room), with direct access from home page.
- A COVID-19 daily briefing email sent to all staff with latest guidance, bulletins and items of note.
- A dedicated section on the staff app for all COVID-19 related communications and guidance.
- Creating posters for IPC ‘dos and don’ts’ and mask wearing guidance.

17.2 Continuous updating of government messaging

The Communications Team ensured that links to Government guidance on PPE were available on the dedicated section of the Green Room and were promoted throughout the

trust via use of the staff app, staff Facebook page and bulletins. Public messaging was also delivered via our trust social media accounts.

17.3 Bespoke NWAS internal communications and IPC Campaigns: My Brew Mate, My Crew Mate – more than just a colleague

The need to maintain robust IPC was supported with the development of different campaign ideas. Concepts were shared with staff focus groups who gave their thoughts on what resonated the most positively with them. As a result, the 'My Brew Mate, My Crew Mate' campaign was developed.

Real case studies, photos, and quotes from staff to highlight how those we work with are more than just colleagues, that they are our friends, the people who are there to give us support, and which is why it is so important to look out for each other. A variety of posters were produced alongside internal promotion on the staff private Facebook group to encourage everyone to protect their colleagues, as they do patients, by wearing the correct PPE, social distancing and hand hygiene.

Facebook live sessions

Director of Quality, Innovation and Improvement, Maxine Power, first took to Facebook with fellow Director, Angela Wetton, Director of Corporate Affairs in June. They answered questions from staff, some live and others submitted prior to the event, covering subjects including staff testing, antibody testing, electronic staff records (EPR) and self-isolating. Throughout the pandemic there were a further two live sessions discussing how to prevent the spread of COVID-19 in the workplace and infection control.

17.4 Beard off campaign

The Communications Team launched a 'Beard Off' campaign, which encouraged frontline male colleagues to consider reaching for the razor to remove their beards. This was supported by posters for sites, internal and social media promotion. The objective was to support the usage of correctly fitting FFP3 facemasks during the pandemic by wearing a clean-shaven face, allows the mask to form an effective seal to the face, therefore affording the optimum protection from the virus.

17.5 BBC 'Ambulance'

Despite the challenges brought about by the pandemic, the Trust committed to taking part in series 7 of the award-winning BBC series, 'Ambulance'. This series takes the viewer direct to the beating heart of the NHS. Each episode captured the real-time shifts of the

call-handlers and ambulance dispatchers in the highly pressurised environment of the control room. Cameras also followed the crews as they raced to save lives on the ground, witnessing the treatment patients received and giving them the opportunity to tell the real story of both the life affirming highs and the deep lows encountered by the ambulance service.

In order for the BBC to be present in NWAS during the pandemic, additional safety measures to provide assurance that by having film crews within our service lines, we were not at any point compromising on staff or patient safety. NWAS put in place a number of additional measures to protect staff and patients, to control any risk of spread of the virus. Asymptomatic testing of film crews was completed to ensure that the virus was not spread during filming. A robust risk assessment was also completed, which considered film crews entering NWAS buildings and fleet vehicles safely, as well ensuring that compliance with PPE was always taking place.

The Communications Team worked very closely with the producers to ensure all risks were minimised, for example COVID-19 lateral flow tests for their teams were agreed prior to entering any site during the filming period.

All footage taken to be aired is viewed by communications and senior operational colleagues to ensure content integrity, particularly during the height of the pandemic. A number IPC gaps were identified and some requests were made for footage to be edited out. However, the exposure and awareness of the service pressures the programme raises warranted some IPC gaps to remain in the programme.

19. External partnerships

18.1 Association of Ambulance Chief Executives (AACE)

During the pandemic the quality subgroup of AACE (QGARD) increased the frequency of meetings to ensure that the cascade of information from the national NHSE COVID-19cell. The meetings were attended by the Director of Quality, Innovation and Improvement. We worked closely with the QGARD to ensure we responded promptly to changes to policy and also were able to feed back to the national cell about the practicalities of implementation.

18.2 Chief Nurses Networks

The Director of Infection Prevention and Control and Chief Nurse was linked into the three Chief Nurse networks in Greater Manchester, Cumbria and Lancashire and Cheshire and Mersey. These networks were vital for us to sense check our IPC with the rest of the NHS and also to ensure that central alerts from the nursing directorate were acted on promptly. The DIPC was also actively involved with the regional IPC network meeting where peer supervision and system learning enhanced decision making within NWAS.

18.3 NHS England and Improvement

NHS England and Improvement in the North West during the pandemic set up 'cells' in order to support the full system in its emergency, preparedness, resilience and response (EPPR) to COVID-19. NWAS have been supported by the NW Incident Co-ordination Centre which worked 7am-9pm, 7 days a week and facilitated access to testing, mutual aid, death reporting, as well as being the centre for reporting relevant daily sitreps on the request of the national team. NWAS submitted SitReps daily with regards to PPE procurement and also accessed the service to support the need for fit testing training during the easter bank holiday weekend (10th April 2020) where support was provided by Blackpool Teaching Hospital.

NHS England IPC Cell supported NWAS with outbreak management and prevention with a particular focus on Middlebrook, Parkway, Estuary Point and Broughton. Visits from IPC Leads were arranged in order to provide expert advice and support in order to reduce the spread of the virus and reducing the risk to staff.

Visits took place as follows:

- Middlebrook 30th September 2020
- Middlebrook 28th January 2021
- Parkway 28th January 2021
- Estuary Point 3rd February 2021
- Broughton 26th February 2021

Written recommendations, as well as highlighting areas of good practice were provided following each visit and a MS Teams meeting was set up to provide support in order for us as a Trust to utilise the external expertise and improve. Following the support from the IPC Cell Team, NWAS were able to improve compliance and systematically begin closing active outbreaks.

NHS England Testing Cell supported NWAS with its access to antibody testing, PCR testing and asymptomatic testing. As NWAS are commissioned by Blackpool CCG and Blackpool Teaching Hospital were a pilot site for LAMP testing, the Testing Cell supported the introduction of LAMP into Middlebrook at speed in February 2021 when a large staff outbreak took place. This was an effective support to Middlebrook and allowed NWAS to break the cycle of COVID-19spread in the contact centre.

20. Forward Planning

It cannot be underestimated the disruption in which the COVID-19 pandemic has had upon all areas of our lives and the IPC requirements and workplans have been in the spotlight for most part. Our IPC team are a team of knowledgeable practitioners, they have responded to numerous day to day queries; been responsive in offering guidance, advice and importantly assurance; whilst being providing the basic IPC compliance assurances required in non-pandemic times.

19.1 Staffing

In order to maintain the momentum for IPC within NWAS it was recognised that further strengthening of knowledge and resource would be essential in 21/22.

It is our ambition to appoint IPC Specialist Clinician to provide strategic leadership and guidance to the Trust and also to support the DIPC in providing assurance in relation to the IPC BAF. This role will be at a band 8b, which matches system wide IPC specialists, and the successful individual will connect with the NW Regional IPC Network and the AACE National IPC Group.

This role will continue to be support by the IPC Team Manager (band 7) and IPC Practitioners (band 6) which we now have one linked to each Integrated Care Systems (ICS) in the NW.

The test, track and trace team will remain under the supervision of the IPC Manager for the duration it is required within the organisation, with the primary aim to maintain staff safety in relation to COVID-19.

19.2 IPC new and progressive activities for 2021/11 will include:

- Improving IPC assurance by implementing a formal IPC Sub-Committee to focus on the IPC Board assurance which will report directly to Quality and Performance Committee and Board of Directors
- Complete a training need analyse for the organisation to build on the educational foundations already in place
- Work on further digital solutions to support IPC Audits
- Agile working group to be established to keep staff safe as we return to corporate offices in the recovery phase of COVID-19
- Enhance our assurance and work with Health and Safety Team in relation to improving auditing and compliance with Respiratory Protective Equipment
- Improve compliance with level 2 and 3 PPE as we enter the recovery phase of COVID-19
- Implement findings from Ambulance Concierge Cleaning Evaluation
- Improving HealthCare associated Gram Negative Bloodstream Infections (GNBSI) and working with each local ICS in supporting this ongoing agenda
- Improving NWAS compliance with Aseptic Non-Touch Technique (ANTT)
- Continue to move towards the goals set within the Right Care strategy and the pillars of quality goals

20. Acknowledgments

During the period of this report the Infection Prevention and Control systems were overseen by two Directors of Infection prevention and control (DIPC). Special thanks must go to Angela Hansen, Chief Nurse and Deborah Bullock, Head of Clinical Safety who worked tirelessly to lead IPC corporately during this time as DIPC. Angela from April 20- January 2021 and Deb from February 2021 to the end of the reporting period. They were both

supported directly by the clinical safety practitioners, health and safety and improvement teams in their work without whom none of this would have happened.

It is clear, however, that the requirement to provide safe systems of work for patients and staff was never greater than during this last year. The achievements of NWAS were not solely down to the DIPC or the IPC core staff, but to the thousands of NWAS staff throughout the organisation who rallied to support. This report merely skims the surface of everything they did both in work time and in the precious time they gave, beyond their working hours to deliver our ambitious goal to stay safe.

We thank you all.

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	26th July 2021	**Chair:**	Prof A Chambers
Quorate:	Yes	**Executive Lead:**	Mr G Blezard, Director of Operations Dr C Grant, Medical Director Prof A Chambers, Director of Quality, Innovation & Improvement
Members Present:	Prof A Chambers Dr D Hanley Prof R Thomson Mr G Blezard Prof M Power Ms A Wetton Dr C Grant Prof A Esmail	**Key Members Not Present:**	None

Link to Board Assurance Framework (Strategic Risks):

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

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Q1 position of 2021/22 BAF presented awaiting approval by Board of Directors on 28th July 2021. • Noted extreme operational pressures with no risks related to avoidable harm reported in the period. • Acknowledged digital risks included in the BAF under SR01 due to the impact on patient safety and in the absence of a dedicated strategic digital risk. • Discussed Risk 3459 and the risks associated to extreme operational pressures effecting the wellbeing of staff leading to sickness and further absenteeism. Current risk score 16 but expected and confirmed to increase during Q2 reporting period. • Mitigating actions included £6.2m funding for additional resource. • Plans to utilise the funding included development of the NWAS PTS workforce.	• Received assurance from the Board Assurance Framework Report.	
Patient Safety Sign Posting and Call Handling Scripts – Updates to the Patient Safety Plan	• Received a presentation by the Medical Director on the Trust's Patient Safety Plan and updates to sign posting of patients and call handling scripts.	• Received assurance from the presentation and updated call handling scripts and signposting processes.	

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	• Noted the action to provide the estimated time of arrival to callers for transparency and management of patient expectations. • The processes associated to the Trust's REAP level and the impact on the Trust's Patient Safety Plan (PSP) were described and discussed. Noted the move from PSP to a Clinical Support Plan from 1st September 2021 across the ambulance sector to avoid discrepancies and promote standardisation. • Noted that management of C3 calls involved ongoing review and audits which enabled focus on C1 and C2 stacks. • Communication to the public would be considered once processes were embedded across the service. • Evaluation of signposting development to be presented to a future Committee meeting with geographical intelligence to understand trends.		
Quality & Performance Integrated Performance Report	• Received updates on 999 and 111 performance which highlighted significant high volumes of call activity with NWAS receiving 44% increase in 999 calls and 6.500 calls on 19th July	• Received assurance that risks to patient safety were being mitigated. • Received moderate assurance overall due to the unprecedented scale of demand and operational pressures.	

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	2021 and unprecedented in the history of the ambulance service. • Noted that the trend was consistent across the sector. • Additional funding for resource was reported to assist mitigate risks and plans were being prepared to utilise the funds, including development of the PTS resource. • Military aid application had been prepared but not yet submitted. • Staff abstractions had increased but expected that recent change in isolation guidance would see an improvement in this area. Pay incentives for overtime shifts had been introduced although acknowledged that the majority of the workforce were feeling fatigued with ongoing pressures. • In terms of 111, call takers experienced up to 50% increase in call volume and staff turnover had risen due to staff returning to jobs in the retail or hospitality sector. • Discussion highlighted the need to explore scope of selection and retention of call takers in the organisation.		

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	• Noted that career pathways would be introduced into Broughton site from October 2021. • Initiatives to explore the trends in 111 had been undertaken and revealed trends in relation to high volume calls from GP practices. • Acknowledged the ongoing work of the operational teams including PTS who continued to support the emergency service during REAP 4 pressures. • Noted that closure of complaints within required timeframe was ongoing and some progress had been made, however a limited clinical resource due to operational demands.		
Health, Safety and Security Annual Report	• Received the 2020/21 Report and highlighted that despite the impact of the pandemic all reasonable steps to ensure regulatory compliance and objectives within the Right Care Strategy were met. • 100% of NWAS sites had received a new Covid-19 secure risk assessment. • Good progress made with the Trust's Body Worn Cameras Project. • Forward Plan for 2021/22 for the team were noted and recognised the efforts and achievement of the team in	• Received assurance from the report for onward reporting to the Board of Directors.	

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	maintaining health, safety & security standards during the pandemic.		
IPC BAF Update Q1	• Acknowledged the IPC BAF represented the risks revised by the IPC Sub Committee and RPE Steering Group. • Reported that the risks aligned to the 10 Key Lines of Enquiry (KLOEs) for the reporting period January to June 2021 had reduced from 9 risks with a score of 12 or above to 3 risks. • Recognised the hard work of the IPC team and the work of the newly formed IPC Sub Committee with the responsibility to monitor and evaluate actions against operational risk. • IPC Specialist had been appointed to commence in October 2021 to support robust delivery of the IPC forward agenda. • Endorsed the IPC BAF Update for submission to the Trust Board.	• Received assurance from the IPC BAF Update for onward reporting to the Board of Directors.	
Medicines Management report 2021/22 Update	• Updates on the Medicines Optimisation Strategy pledges included a review undertaken in conjunction with Procurement and Digital Innovation teams of end to end medicines processes to ensure IT systems are meeting the needs of the service.	• Received assurance from the report.	

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	• Processes for delivering the Flu vaccination programme were being reviewed and the Trust's application for a Home Office Controlled Drug License was discussed. • Noted that a smart station had been developed to test digital processes in a controlled environment, with a focus on safety, prior to roll out across the Trust.		
Learning from Deaths Q4 and the 2020/21 overall dashboard	• Advised that the Trust had a requirement to publish annual summary of learning on the public website. • The report highlighted significant and robust learning from deaths with good practice highlighted through learning forums and frontline staff. • Recommendations for future report to the Committee were made including action logs and trend analysis over time. • Requested a timescale for the options to fill audit resource gap for the next meeting. • Acknowledged the huge amount of progress made by the team and passed on thanks to all involved for comprehensive report which provided a good level of assurance.	• Received assurance from the report.	

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	• Requested that dissemination of the good practice and achievements were shared throughout the organisation.		
Legal Services Assurance Report	• Received the first assurance report from the Head of Legal Services. • Noted a reduction in the number of claims during 2020/21 which was in line with the national picture. • Advised on the level of new HM Coroner's Requests and Legal Subject Access Requests. • Regulation 28 reporting provided assurance that incidents were investigated and actions for learning identified. • Further format of reporting discussed and requested that Executive Leads and the Head of Legal Services consider profiling and triangulation of learning alongside learning from deaths and IPR reporting.	• Received assurance from the report.	
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Acknowledged the assurances provided at the Clinical Effectiveness Sub Committee meeting held on 6th July, chaired by the Medical Director. • Area learning forums had not been held due to REAP Level 4 operational pressures.	• Received assurance from the Chairs Assurance Report.	

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	• Noted assurances from across the service lines including robust scrutiny of Learning from deaths report and learning.		
Patient Safety Sub Committee Chairs Assurance Report	• Received assurances from the Deputy Director of Quality, Chair of the Patient Safety Sub Committee. • Welcomed focus on Patient Safety Culture. • Noted that resource to close investigations in the required timeframe was restricted due to operational pressures.	• Received assurance from the Chairs Assurance Report.	
IPC Sub Committee Chairs Assurance Report	• Noted the assurance provided in relation to IPC risks and the transition of the IPC forum to sub committee. • Focus on improvement of IPC risks and noted that IPC Specialist had been appointed, to commence in October.	• Received assurance from the Chairs Assurance Report.	
Diversity & Inclusion Sub Committee Chairs Assurance Report	• Received a report from the Deputy Director of People, which highlighted robust discussion related to the EDI priorities and action plans. • Discussion regarding ambitious agenda for the sub committee and encouraged an in year review of EDI objectives and action plans.	• Received assurance from the Chairs Assurance Report.	

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NWAS Heat Wave Plan 2021	• Received the updated and approved NWAS Heat wave plan which had been published for internal use. • Noted that updates included factors related to Covid-19 and reflected the challenges faced by the operational service lines.	• Noted the assurances from the report.	
EPRR Sub Committee Chairs Assurance Report & Revised Terms of Reference / Work Plan	• Noted the assurances provided by the EPRR Sub Committee Chairs Assurance Report in terms of resilience assurance reporting. • Acknowledged that evidence of learning from training in EOC was required and would be reported to the September sub committee meeting. • Noted the robust membership of the committee and approved the revised terms of reference and work plan.	• Received assurance from the Chairs Assurance Report and revised Terms of Reference and Work Plan.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	24th September 2021	**Chair:**	Mr R Groome, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Mr R Groome Mr D Hanley Ms C Wood Ms L Ward Mr S Desai Prof M Power Ms A Wetton Mr G Blezard	**Key Members Not Present:**	Mr D Rawsthorn, Non-Executive Director

Link to Board Assurance Framework (Strategic Risks):

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

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Noted that 4 additional strategic risks had been approved in July and SR05,	• Received assurance from the Q1 BAF report.	

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	SR07 and SR08 were aligned to the Committee. • A new BAF risk SR09 related to the risk of cyber security resulting in partial or total loss of service and/or associated patient harm to be presented to Board of Directors in November. • SR02 risk related to productivity and efficiency discussed and noted that work would progress in Q3/Q4 and approved the rationale of the Q2 position. • Recognised the significant challenges in relation to SR04 with focused discussion in the meeting on the workforce indicators. • Noted that structures were developing in relation to future working within ICS' and the Trust had now appointed the area Partnership and Integration Managers.		
Finance Report – Month 5 2021/22	• Noted the financial position for the Trust to 31 August 2021 was a surplus of £0.368m. The year to date variance against the H1 plan reported as a favourable variance of £1.719m. • Income was over recovered by £0.737m, following confirmation of Q2 funding for 111.	• Received assurance from the Finance Report for Month 5 2021/22	

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	• The final H1 (April-September) financial plan, previously approved by the Board of Directors and submitted within Lancashire and South Cumbria (L&SC ICS) return to NHSE/I included an efficiency and productivity target of £3.620m. • Noted that plans were in place to achieve the target for H1, and actions had started to review which of these schemes would continue into H2 and also the recurrent values. • Reported that the Trust had notified CDEL of £15.278m from NHSE/I and the L&SC ICS Board approved the system capital envelopes for 2021/22, which included NWAS capital plan of £18.361m, an increase of £3.083m relating to the Blackpool estate business case. • Noted the latest capital forecast was £17.671m, a net reduction of £0.690m which had been declared back to L&SC ICS as in year slippage, which would be required as a first call on the system envelope in 2022/23. • Acknowledged the year to date gross capital expenditure was £2.497m with disposal of £0.340m, making net capital expenditure of £2.157m.		

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	• Highlighted that the Trust's cash and cash equivalents balance was £55.465m at 31st August 2021 and had achieved Better Payment Practice Code targets up to August 2021. • Noted that an increased efficiency requirement was expected but unable to assess how this would impact on the Trust.		
Patient Level Information and Costing Submission 2019/20	• Received an update on the National Costing Transformation Programme (CTP) and implementation of Patient Level Information and Costing Systems (PLICS). • Noted that PLICS provided the Trust with detailed information on how resources were used at patient (incident level). • Acknowledged that the first Ambulance Trust PLICS cost collection was submitted in January 2021, related to the 2019/20 financial year and the resultant National Cost Index (NCI) was recently published by NHSE/I for all Trusts. • Noted that in comparison with the corresponding NWAS Reference Cost Index for 2018/19, the NCI for the Trust had decreased from 92 to 89, with costs below the national average	• Noted the assurances provided in the report.	

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	of 100 and NWAS continued to have the third lowest NCI in England. • Recognised the benefits of PLICS in providing greater understanding of costs and allowed Trusts to facilitate benchmarking of costs across providers in each sector via a portal developed by NHSE/I. • An indication of the portal dashboard was provided to provide snapshot of comparison across other ambulance trusts with further validation required. • Noted the benchmarking information available on the NHS Ambulance Portal and the planned development of NWAS PLICS PowerBI dashboard and future plans to use the data for operational and business decision making. • Data collection and cost calculations were currently being finalised by the Financial Planning team, due for validation and submission on the 12 October 2021 and NHSEI advised that the Finance Director of each Trust would sign off the 2020/21 submission.		
Procurement Report	• Received an update on the procurement activity within the Trust. • Noted the progress made on the 68 projects on the procurement work plan	• Noted the assurances provided within the report.	

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	for 2021/22 including replacement contracts required during 2022. • Highlighted that 16 waivers would expire by the end of March 2022 and 7 of these were associated with the 999 CAD system part of the NAA project. • Noted that the procurement team had increased establishment from 9 to 11 and recruitment process underway. • No risks related to the expiry of forthcoming contracts.		
Sustainability (Green Plan) Update	• Noted progress against the Trust's Green Plan and associated environmental targets outlined in the new NHS Long Term Plan. • Key current projects identified to enhance sustainability commitment and progression included Blackpool ambulance hub, carbon literacy, healthcare without harm and race to zero, electric vehicles, solar PV, LED lighting and the Queens Green Canopy initiative. • Acknowledged that the Trust was a member of a number of National groups to expand learning and opportunities to access training. • Noted that although SDAT reporting had ceased, the team were still	• Noted the assurances provided within the report.	

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	collecting data, pending a new data collection regime.		
Draft Capital Programme 2022/23 Prioritisation	• Noted the draft capital programme for 2022/23 and investment required of £25.6m based on latest projections, which exceeds projected Capital Resource Limit of £16.9m. • Acknowledged that work underway through the Trust's Capital Management Group with a final capital plan to be presented to the Committee for Board approval in line with submission deadlines. • Discussed the projected gap in the capital programme for consideration in response to future business cases for 2022/23.	• Received assurance from the Draft Capital Programme 2022/23 Prioritisation report.	
PES Vehicle Replacement 2022/29	• In line with the Trust's Fleet Strategy, received a business case for a 7 year Duel Crew Ambulance (DCA) vehicle replacement programme which had been prepared following a robust option appraisal process. • Recommended for approval by Board of Directors.	• Recommended approval of the PES Vehicle Replacement Programme to Board of Directors.	
Digital Progress Report	• Received Digital Strategy Update on projects and risks. • Noted the recent recommendation by to create a Strategic BAF risk	• Received assurance from the Digital Progress update.	

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	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	specifically for cyber security, to be presented to the Board of Directors for approval in November 2021. • Highlighted that delay in unified telephony project due to lessons learnt from within the sector. Now planned for end of the month. • Risks associated to management of multiple projects and 24 hour / out of hour provision discussed. • Recognised investment had been secured for additional resource. • Challenges remained in relation to staffing in terms of annual leave and sickness. • Ongoing discussions related to EPR funding of phase 2 of the project and recognised funding pressures. • Report included detail of support desk developments and plans to improve onsite presence. • Acknowledged that digital projects were monitored by the Trust's Corporate Programme Board.		
Workforce Indicators Assurance Report	• Received an update on appraisal compliance with current performance at 61% due to extended REAP Level 4 operational pressures from June onwards.	• Received moderate assurance from the Workforce Indicators report.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	• PES rates at 56% and PTS at 67% with EOC having the most challenged rates at 19%. • Acknowledged that 111 had improved their positon in August at 63% and had delivered a consistent rise in compliance since February. • Noted the Executive Leadership Committee recently agreed a revised compliance target of 75% by March 2022 for Service lines and 85% compliance by Corporate and Band 8a and above. • Reported that Teams would be supported with recovery plans as the Trust moved out of current operational pressures. These to include a simplified process focusing on wellbeing and development. • In terms of Mandatory training, noted the new training cycle runs across the financial year and the Trust had reinstated the target of 95% compliance by March 2022. • Current overall compliance at 63% due to introduction of new online training modules. Noted that due to pressures the Executive Leadership Committee agreed a revised target of 85% for		

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	service lines and 95% compliance for corporate departments by March 2022. • In terms of Classroom training, PTS ahead of trajectory for completion at 58% at the end of August; with PES fallen behind as a result of pause in training due to pressures. • Noted, that PES classroom training had recommenced from September and profiled training should deliver 85% target with ELC agreed a revised programme for face to face delivery to one day to cover the main outcomes. Level 3 safeguarding training to move online. • In relation to sickness absence, reported an increase in July 2021 and above normal levels 9.33% for this time in the year and included Covid-19 sickness 1.35%. • Non Covid-related sickness higher than in previous years across frontline services, most pronounced in call centres; reflective of current pressures and unusual seasonal sickness trends. • Additional resources to establish a dedicated team to focus on supporting operational teams to improve attendance and management of		

Key		
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	wellbeing to be addressed through Strategic Workforce Sub Committee. • Reported that vacancy position was overall positive. • Discussed 111 position and plans to address staffing in relation to increased turn over. • PTS impacted due to transfer of staff to PES with a robust recruitment plan in place to recruit to EMT1 positions. • Overall Trust turnover rates higher than the sector average, noted 111 service experiencing an upward trend of 33.28% in August 2021 reflecting pre-COVID position. A review of recruitment strategies underway including the pace of integration. • Turnover amongst paramedic workforce not materialised but is expected in Q2 and Q3. • In relation to HR case management workload, noted 556 outstanding cases (an increase of 93 since last report), related to sickness absence casework. • Noted that progress being made with backlog with no new cases over 12 months old and 14 number of cases between 6-12 months old, all under 9 months.		

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	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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	• Covid-19 vaccination rate for the first dose stands at 87.7% for staff and 83% for second dose; arrangements and planning for booster vaccinations to be established over the coming weeks.		
Workforce Equality Update	• Provided with an overview of equality data along with year-end position in relation to three areas of workforce equality – race, gender and disability. • Data identified provided areas of focus for alignment with the Trust's EDI priorities. • Noted an increase in ethnically diverse staff within NWAS from 4.6% to 5.4%. • Overall positive improvement in most indicators with staff survey results showing particularly strong position with narrowing or elimination of gaps in staff experience for some key indicators. • Both disability and ethnic minority data highlighted that the likelihood of appointment from shortlisting had widened since last year however there had been a high number of appointments where the status was unknown because of the truncated recruitment processes in place.	• Noted the assurances provided within the report.	

Key		
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	Assured	No or minor impact on quality, operational, workforce or financial performance

	• 2020 staff survey results revealed that disabled staff were more likely to report incidents, however the overall experience of disabled staff was poorer; although results had improved since the 2019 survey with gaps in experience narrowing. • Noted that the work of the networks in supporting the development of action plans arising from the data. • In relation to gender equality, data showed an increase in the number of female staff from 48.91% to 50.41% overall. Representation in all the pay quartiles had improved but at a higher pace in the lower quartiles where most recruitment is carried out. This had impact adversely on the gender pay gap with the mean pay gap increasing to 10.89% and the median to 9.26%. • Acknowledged that further work to narrow the gender pay was required • Noted that the EDI priorities already set by Board combined with local EDI action plans should address key areas for improvement; with onward management and assurances via the Trust's Diversity & Inclusion Sub Committee.		

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

Flu Campaign 2020/21 Best Management Practice Checklist	• Reported that the DoH and Social Care have indicated a 100% offer with an 85% ambition of uptake amongst frontline healthcare workers for 2021/22. • The Trust achieved 78.3% in 2020/21 campaign, based on achieving a minimum of 75%. • Learning from last year's campaign included the need to review the delivery model, number of vaccinators and governance arrangements associated with the vaccine. • Learning from the Covid-19 Vaccination Hub programme had also been identified. • Recognised that an ideal delivery model would be a multi-site model with designated small number of roaming vaccinators, featured in previous Trust campaigns. • A proposal for the campaign to be run over an 8-week period between October and November to ensure a targeted approach was reported, with aim to conclude the campaign prior to December, to support the projected significant winter pressures with a full communications campaign.	• Noted the assurances provided within the report.	

Key		
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	• Discussed that the flu vaccination could not be administered along with the offer of Covid-19 booster vaccinations. The latter will be delivered via ICS provision with confirmation that NWAS features in ICS plans. • Noted the Trust was compliant with the HCW Flu Vaccination Best Practice Management Checklist with exception of incentives, which ELC had agreed, that in light of lack of clarity on the Covid-19 booster programme, an incentive scheme would be confusing and counterproductive for the Trust at this time.		
Strategic Workforce Sub Committee Chairs Assurance Report from the meeting held on 16th September 2021	• Received assurances from Education Assurance Management Group and Health, Wellbeing and Culture Management Group and Service line recruitment/workforce planning groups. • Noted service line updates and plans in relation to workforce health and wellbeing initiatives and progress. • Verbal assurances received from service lines due to operational pressures; however written reports requested to facilitate more robust scrutiny and discussion at the next meeting.	• Noted the assurances provided within the Sub Committee Chairs Assurance report.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 September 2021			
SUBJECT:	Workforce Equality update – race, disability, gender			
PRESENTED BY:	L Ward, Director of People			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☒
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Decision			
EXECUTIVE SUMMARY:	This paper provides an overview of the Trust's Equality data in relation to race, disability and gender which we are required to publish either statutorily or under regulatory requirements. The data has identified areas for focus over the next twelve months and the paper will consider how these actions align against the agreed ED&I priorities that were agreed by the Board in January 2021 along with any other actions or development. **WRES** The WRES data for summer 2021 is outlined in Appendix 1 and shows an increase in the number and percentage representation of ethnically diverse staff within NWAS from 4.6% to 5.4%. The data indicates a widened gap in terms of the likelihood of appointment from shortlisting however, the data for 2020-21 indicates a much higher proportion of data where candidates' ethnicity has not been captured in the recruitment process rising to 40% of appointments. This reflects truncated processes in use in 2020-21. An improvement has been seen in the likelihood of staff entering formal disciplinary processes but there is further work to do and the current review of the disciplinary policy will consider this data, with the pre-investigation panel process expecting to have a positive impact on future data. The 2020 Staff Survey data shows a strong picture. Whilst there is an increase in the percentage of ethnic minority staff suffering harassment, bullying from patients and public, this remains lower than for white counterparts. There are clear improvements over time in the other staff survey indicators with the experience of ethnic minority staff now being better than white staff in response to a number of questions.			

The Staff Survey results were shared with the Race Equality network when they were published earlier this year and discussions continue in relation to actions to improve staff experience.

WDES

The data shows an overall increase in the representation at all levels of the organisation. The increase in the percentages reported can be explained in part due to an internal communications campaign aimed at encouraging staff to record their disability status on My ESR, although we know there is a continuing disparity between those declaring and amending their status on ESR and those self-reporting in staff survey responses.

The data in relation to likelihood of appointment from shortlisting has widened since last year but the data has been affected in the same way as that for WRES with high numbers of appointments where status is unknown.

The 2020 Staff Survey results indicated that the experience of disabled staff was poorer on each factor than for non-disabled staff apart from the results showing disabled staff being more likely to report incidents. However, it is important to note that the results have improved across the board since the 2019 survey with the gaps in experience narrowing. The staff engagement score has increased for disabled staff, reducing the difference in experience when compared with staff who have not declared a disability. This is a positive indicator for the Trust.

The work for the Disability Forum will seek to continue to improve the experience for disabled staff and this should be supported further when the forum transitions into a Network later this year. Overall the results indicate that work to support the experience of disabled staff is progressing and there are further opportunities to support and engage with our disabled staff.

GENDER EQUALITY

The data shows an ongoing increase in the number of female staff from 48.91% to 50.41%. This means that for the first time women outnumber men within the workforce. The pay quartile information shows that female representation has also increased from 34.18% in 2019 to 37.23% in 2021 in the upper quartile of pay. This indicates a sustained level of improvement in addressing representation and progression in NWAS.

However, the pay gap using the mean calculation has increased from 8.79% to 10.89%. The pay gap using the median calculation has also increased from 7.2% to 9.26%. This reflects the fact that representation through direct recruitment has grown faster than representation in the middle and upper quartiles through progression. Last year's figures are significantly impacted by growth in call centre staffing where direct recruitment falls primarily within the lower quartiles of pay.

Although overall improvements in representation have been scene, we have to acknowledge that the Trust has not made

	progress in narrowing the gender pay gap. The ED&I action plan details activities to address this gap with actions to support internal progression. Activities such as this are long-term and are also dependent on staff turnover in senior roles but there is a need to redouble efforts to accelerate the impact of this work. Unlike the WRES and WDES metrics, the gender pay gap report only looks at where female staff work within an organisation. The data does not capture the experience of female staff as collated in the staff survey. From a high level perspective, the responses to key questions in the 2020 staff survey, do indicate that on the whole female experience on a range of wellbeing indicators is more positive than it is for men. The ED&I priorities agreed by the Board include some key areas of focus which align with the outcomes of the WRES, WDES and Gender pay gap data. In particular the focus on improving levels of representation from ethnic minority communities in the workforce and a focus on improving progression and reducing disparity ratios across the protected characteristics, using positive action where appropriate. In addition, the work around Just Culture and the current review of the disciplinary policy will incorporate a review of the experience of ethnic minority staff through the process. Engagement through our networks continues to drive improvements and work has commenced to develop and explore the opportunities for a Women's network through the two Executive Champions. Actions from the WRES, WDES and Gender pay gap data sets will be aligned and managed alongside the existing ED&I action plan. The ED&I Priorities action plan is managed by the ED&I subgroup with assurance on progress provided to the Resources Committee.			
RECOMMENDATIONS:	The Board of Directors are asked to: • Note progress on activity for WRES, WDES and gender work • Note the alignment of plans in response to this data with the EDI priorities • Approve publication of WRES, WDES and gender data.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee and Resources Committee			
	Date:	15 September 21 & 24 September 21		
	Outcome:	Recommended for publication by ELC acknowledgement of progress in most areas but focused debate on the gender pay gap and barriers to		

		progression/ Resources Committee update to be given verbally.

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1. PURPOSE

1.1 The purpose of this paper is to provide the Board of Directors with the most recent data in relation to race, disability and gender which is required to be published as a contractual and/or statutory requirement. Approval to publish the data is sought.

2. BACKGROUND

2.1 The Trust has a legal responsibility to publish its gender pay gap data on an annual basis. In addition, there is a contractual requirement under the NHS Contract to publish annual data in respect of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Working to address inequalities shows compliance with the Equality Act 2010 and the Public Sector Equality Duty.

2.2 This paper provides an overview of the data for 2020-21 along with an end of year position relating to these three areas of workforce equality – race, disability and gender.

2.3 The data has identified areas for focus over the next twelve months and the paper will consider how these actions align against the agreed ED&I priorities that were agreed by the Board in January 2021 along with any other actions or development.
The three priorities approved by Board are 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

2.4 The priorities are set over three years and have specific measures identified to monitor progress and form the basis of our statutory equality objectives.

2.5 The actions under the ED&I priorities support both the Trust's People Plan as well as aligning to the NHS People Plan published in 2020. The data identified in the WRES, WDES and gender pay gap submission will also contribute to actions and discussion that sit outside of the People Directorate. The work also supports the activity under the EDS2 framework, used to monitor progress on equality. Activities under the specific EDS2 goals are monitored via the ED&I sub-group and focuses on both workforce and patient experience developments.

2.6 In addition, the data will also be shared with the Staff Networks to enable discussions to inform the actions coming out of the data to ensure that actions are both relevant and take account of the voices of staff.

3. WORKFORCE RACE EQUALITY STANDARD (WRES)

3.1 The WRES data for summer 2021 is outlined in Appendix 1. The data relates to the period up until the end of March 2021 and was submitted to NHS England in August 21 in line with the nationally agreed timescales. As in previous years, the data includes the outcomes of the last national Staff Survey.

3.2 Overall the WRES data shows a mixed picture of results with some positive improvements in representation and staff experience but some areas for continued focus in recruitment, disciplinary processes and training.

3.3 The data shows an increase in the number and representation of ethnic minority staff within NWAS from 304 to 342 staff, which is a shift from 4.6% to 5.4%. There is a higher BAME representation in clinical roles than non-clinical. The Trust continues to seek to increase the overall BAME representation and as detailed in ED&I Priorities action plan (Appendix 4), the Trust aims to improve representation in the workforce from BAME communities to 8% by 2024. This represents an equivalent annual increase of 1% per year in representation and will require us to ensure 20% of our new recruits each year are from ethnically diverse backgrounds.

3.4 To support this ambition, plans are in place to support this target through the development of pre-employment programmes in PTS, which seek to focus on attracting applicants from ethnically diverse communities. Alongside this the Trust has an ED&I recruitment group which is developing several actions to attract and support ethnically diverse staff through the recruitment process. A future report will be presented back to the ED&I sub-committee to outline our progress towards this target.

3.5 Metric 2 assesses the likelihood of appointment from shortlisting. The results indicated that white staff are 1.51 time more likely than Ethnic minority candidates to be appointed from shortlisting. This is a worsening on last year's position which was 1.29. However, it is important note that the recruitment drives last year were impacted by COVID. Due to the pace of recruitment required to bring in Student Paramedics and ex-staff onto Bank contracts the campaigns were managed outside of normal processes. Whilst this was fully complaint with the national truncated approach to recruitment during the pandemic, it has resulted in a missed opportunity to collate ED&I data.

3.6 The data summarises that the number of staff who have not declared their ethnicity at appointment rose from 13% in 2020 to 40% in 2021. As such there are a significant number of shortlisted and successful applicants for whom we have not captured their ethnicity. As recruitment has come back into line with previous recruitment processes, this information will be captured at appointment moving forward. As outlined above the work from the ED&I recruitment group will include actions to improve recruitment processes and information for applicants. It is the intention that this in turn will provide applicants with the confidence to declare their ethnicity throughout the recruitment process.

3.7 The disciplinary metric shows a slight improvement 1.89 to 1.7 with 1 being the target indicating equal experience. Overall, this indicates that staff from ethnically diverse backgrounds are more likely to enter the formal disciplinary process, however, the numbers of staff affected remain relatively small with 8 BAME staff subject to formal

disciplinary processes. Given the small numbers, individual case reviews can be conducted to try to identify themes and ensure appropriateness of action. The Trust is also resuming its overall review of disciplinary procedure and the work around Just culture, both of which will seek to address any inequalities in the current process. The disparity in experience identified through WRES will form part of this review.

3.8 The Trust has also implemented a pre-investigation stage to formal proceedings. A senior panel now reviews cases following initial fact finding and determines whether a formal investigation is necessary. In addition, this panel is reviewing completed investigations to determine whether formal action is required. This is already impacting on the number of cases subject to formal action as it brings an objective and moderated view to cases which should impact on next year's figures. Diversity will be monitored in the outcomes of this panel.

3.9 The training metric shows a fairly static position towards a more equal experience in the likelihood of ethnically diverse staff and white staff accessing non-mandatory or CPD training. Overall total numbers accessing training have increased. This data is always impacted by the high proportion of CPD activity funded for registered professionals as this is a group where there is under-representation of ethnically diverse staff.

3.10 The 2020 Staff Survey data shows a strong picture in terms of improving staff experience. There is an increase in the percentage of ethnically diverse staff suffering harassment, bullying from patients and public, but it is important to note that this has improved by 8% over last 4 years and remains lower than for white counterparts.

3.11 However, there is consistently improved experience of ethnic minority staff within the workforce. Our ethnic minority staff now indicates that they are less likely than white staff to experience bullying and harassment or discrimination from colleagues or managers.

3.12 There is a clear improvement in staff experience in the fairness of career opportunities, rising from 57% to 63.2%. There remains a gap in terms of a belief in the fairness of career progression with white staff 13% more likely to consider processes to be fair than ethnic minority staff. However, this has narrowed by 6% over the last 12 months. A focus of the ED&I priorities is to seek a proactive approach to internal progression for staff, including the development of a talent management framework.

3.13 The Staff Survey results were shared with the Race Equality work when they were published earlier this year and discussions continue in relation to actions to improve staff experience.

4. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

4.1 This is the third year of reporting for WDES and Appendix 2 details the themes of the nationally set WDES metrics. This was submitted to NHS England in August 2021 and is based on data as at the end of March 2021.

4.2 The data shows an overall increase in the representation at all levels of the organisation. The increase in the percentages reported can be explained in part due to an internal communications campaign aimed at encouraging staff to record and update their disability status on My ESR. This work was driven by the Disability Forum and aims to

ensure that the Trust has an accurate record of staff representation. There remain 805 staff who have a 'null' or 'disability unknown' record in their ESR record. Work will continue to encourage staff to declare their status and to amend it when it alters, along with other protected characteristics that can be recorded in ESR. There remains a gap between declared status and self-reporting in the staff survey.

4.3 Data in relation to recruitment has shown a decrease in the raw number of disabled candidates appointed from shortlisting from the previous year. However, as the number of candidate's not declaring disability also increased, the likelihood calculation shows a slightly poorer experience for disabled candidates. As with the WRES data, the collection of protected characteristic information during the recruitment stage has been impacted by truncated recruitment processes used during the pandemic.

4.4 Further work to encourage candidates to declare their disability status is required and the work of the ED&I Recruitment group will also consider the experience of disabled staff.

4.5 Metric 3 looks at staff entering the formal performance process, this excludes sickness capability processes and focuses on performance management only. The figure indicates staff with disabilities are more likely to enter the formal performance process than staff who have not disclosed a disability. It should be noted that the overall number of staff who do enter this process is very small when reviewing the raw data and this impacts on the calculation. The data shows a significant improvement from last year but still indicates a disparity. The small numbers enable us to review individual cases to identify themes and areas for improvement.

4.6 Metrics 4 to 8 are staff survey scores and Metric 9 is an engagement score, calculated using several scores together. The 2020 Staff Survey results with have been shared with the Committee and Board earlier in 2021. The staff experience of disabled staff was poorer on each factor than for non-disabled staff apart from the results showing disabled staff being more likely to report incidents. However, it is important to note that in most cases the results have improved over the previous year (none have worsened) and the gap between disabled and non-disabled experience has narrowed.

4.7 The work for the Disability Forum will seek to continue to improve the experience for disabled staff. Later this year it is expected that the forum will complete its transition to a formal Network. The associated communications around this development are anticipated to raise the profile and it is also hoped that this will assure staff with disabilities that they are valued by the Trust.

4.8 Over the past 12 months the Disability Forum has been integral in the development of the Work and Wellbeing passport. The Passport provides employees and their line manager with the basis for discussions about reasonable adjustments that may be needed. The passport was launched earlier this year and will continue to be evaluated and developed,

4.9 The staff engagement score has increased for disabled staff, reducing the difference in experience when compared with staff who have not declared a disability. The gap between disabled and non-disabled experience has halved in the last two years. This is a positive indicator for the Trust.

4.10 Overall the results indicate that work to support the experience of disabled staff is progressing and there are further opportunities to support and engage with our disabled staff. The actions under the ED&I priorities seek to ensure improvement for all diverse groups and there will be continued work with the Disability Forum and the future Network to ensure that specific actions for our disabled staff are identified and addressed.

5. GENDER EQUALITY

5.1 Appendix 3 details the data collated for the gender pay gap submission. This data is collated as at 31st March 2021. The Trust has until March 2022 to publish this data to meet statutory requirements.

5.2 The data shows an ongoing increase in the number of female staff in the workforce from 48.91% to 50.41%. The pay quartile information shows that female representation has also increased in the upper quartile from 34.18% in 2019 to 37.23% in 2021. This indicates a sustained level of improvement in addressing representation in progression in NWAS. However, the data also shows that representation in the two lower quartiles of pay which is where most of our recruitment takes place has been growing at twice the rate of the upper two quartiles.

5.3 The data also includes an analysis against gender of the bonuses awards to staff on VSM contracts.

5.4 The pay gap using the mean calculation has increased from 8.79% to 10.89%. The pay gap using the median calculation has also increased from 7.2% to 9.26%. Whilst it is disappointing that the gap has increased since last year, it is important to try and ascertain the reasons for this change.

5.5 Appendix 3 details the gender split in each quartile and shows an increase in female representation in each quartile. However, the information also details that there have been significant increases in female representation in 111. Further analysis shows that the overall percentage of females in quartile 1 has risen significantly since 2020 and there is a significant rise within 111 from 71% to 78%. This has been one of the main areas of recruitment in the last year with the increased contract funding and whilst the representation improvements are positive, they are primarily reflected in the lower quartiles of pay. As such the increase in female representation in lower paid roles explains the widening of the pay gap. Whilst over time the overall improvement in representation in the workforce should work its way through to higher quartiles, it has had a negative impact on the gender pay gap over the last year.

5.6 The ED&I action plan details activities to address this gap with actions to support internal progression. Activities such as this are long-term and are also dependent on staff turnover in senior roles. The mean calculation will be impacted by efforts to increase representation at recruitment as many of our entry points are into lower graded roles. In addition over the last year a significant proportion of the Trust's recruitment has been to lower graded roles in contact centres and in PTS and EMT1 roles to support the requirement for increased resources during the pandemic.

5.7 Unlike the WRES and WDES metrics, the gender pay gap report only looks at where female staff work within an organisation. The data does not capture the experience of female staff as collated in the staff survey.

5.8 From a high level perspective, the responses to key questions in the 2020 staff survey, do indicate that on the whole female experience on a range of wellbeing indicators is more positive than it is for men:

Staff survey question	**Female (%)**	**Male (%)**
Opportunities for flexible working (satisfied & very satisfied)	41%	30%
The Trust acts fairly in respect of career progression	81%	69%
Experience of discrimination from manager	7%	12%
Recommend as a place to work	65%	56%
Satisfied to the extend the organisation values my work	38%	30%

5.9 Overall, the Trust acknowledges that whilst progress has been made in terms of equality of representation, this has not positively impacted on the gender pay data. The actions set out in the EDI priorities with a focus on development need to be accelerated to ensure that incremental improvement is seen in line with the three year lifetime of the ED&I priorities.

6. TRUST WIDE ACTIONS

6.1 Current work

6.1.1 For the WRES, WDES and gender pay gap data, it is important to reflect the ongoing work to support minority groups and address inequalities in the workplace.

6.1.2 As outlined above the Trust has set three equality and diversity priorities with supporting action plans. The first two of these are focused on workforce. Priority 1 focuses on improving the fairness of recruitment, improving overall representation in the workforce. Targets have been set both around representation but also on improving disparity ratios which measures representation at different levels of the organisation. It will also be critical that there remains a focus on the impact of management restructures over the course of the next 12 months to ensure fair application of organisational changes processes. These actions should improve the representation, gender pay and appointment from shortlisting data.

6.1.3 Priority 2 is focused on education and training and should continue to build on improvements in staff experience for ethnic minority and disabled staff. Moving forward, the Trust is developing a number of other initiatives including the introduction of Beyond Bias Training for managers and staff, aimed at identifying the types of bias that can exist in the workplace and how highlighting the impact that this can have.

6.1.4 This will build on work already undertaken. In April 2021 the Trust launched is new set of values and these are aimed at recognising the importance of a positive working environment and valuing inclusivity. During this year the Trust has also launched several

campaigns and toolkits aimed at support staff and addressing inequalities. The Treat Me Right campaign launched in May 2021 is aimed at supporting staff who experiences bullying and harassment and ensure that they and their managers have a clear overview of the Trust processes and support offers that are in place. This should impact on the bullying and harassment indicators in the staff survey.

6.1.5 The Mental Health toolkit also seeks to support staff who are suffering from mental health related issues and also seeks to provide a clear framework to support managers. In addition, the Trust has recently launched the Suicide Prevention toolkit which aims to support and educate staff and managers on the risks of suicide within the workplace, promoting good practice, and encouraging healthy conversation to remove the stigma often associated with mental health problems and suicide. Both of these should help to improve the experience of disabled staff in the workplace.

6.1.6 The ED&I priorities action plan seeks to put in place a three year plan to deliver the aspirations set out in the priorities in a sustainable way and will support areas identified in the WRES, WDES and Gender pay gap data sets. The actions include a requirement for organisations to overhaul their approach to recruitment and progression whilst increasing staff voice as a whole. The actions also seek to educated and develop our leadership cultural competence and confidence when dealing with discriminatory approaches at work.

6.1.7 Previously the Trust has operating individual working groups to address and monitor actions which fall out of each of the three equality data sets. A recent review has identified that efficiencies can be gained by bringing the actions together into a single working group, with a single plan that includes the ED&I priorities along with additional actions that have been identified throughout analysis of the data. A refreshed single working group is being developed and progress of actions will be monitored.

6.1.8 The ED&I Priorities action plan is monitored by the ED&I subgroup with assurance on progress provided to the Resources Committee.

7. LEGAL and/or GOVERNANCE IMPLICATIONS

7.1 As stated above, the WRES and WDES metrics and action plans are to be published in line with the commitments of the NHS Contract. The submission and publication of gender pay gap information is a legal requirement for an organisation of more than 250 staff.

7.2 This activity supports our commitment to ensure compliance with the Equality Act 2010 and with the Public Sector Equality Duty.

7.3 The work contributes to the Well Led domain of the CQC priorities, but the impact is felt across all areas.

8. RECOMMENDATIONS

8.1 The Board of Directors are asked to:

- Note progress on activity for WRES, WDES and gender work

- Note the alignment of plans in response to this data with the EDI priorities
- Approve publication of WRES, WDES and gender data.

Appendix 1 – WRES data summer 2021 collation

1 - Workforce data – percentage of staff BAME / White categories

	Data as at 31 March 2020	Data as at 31 March 2021
Total workforce	6211	6378
Number of BAME staff	304	342
% BAME staff in total workforce	4.8%	5.4%

2. Recruitment data

Likelihood of BAME staff being appointed from shortlisting is 1.51.

The target figure is 1.0 which would indicate no difference in experience in likelihood of being appointed.

3: Likelihood of BAME staff entering formal disciplinary process compared with White staff:

	2020	2021
Likelihood	1.89	1.70

4: Likelihood of BAME staff accessing non-mandatory training and CPD as compared with White staff:

	2020	2021
Likelihood	1.31	1.34

5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

	Staff survey 2018	Staff survey 2019	Staff survey 2020
White	47%	48%	43.5%
BAME	38%	35%	38.2%

6: Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months:

	Staff survey 2018	Staff survey 2019	Staff survey 2020
White	25.80%	24.5%	25.7%
BAME	27.50%	25%	24.2%

7: Percentage of staff believing that Trust provides equal opportunities for career progression or promotion

	Staff survey 2018	Staff survey 2019	Staff Survey 2020
White	74.30%	76%	76%
BAME	56.50%	57%	63.2%

8: Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues

	Staff survey 2018	Staff survey 2019	Staff Survey 2020
White	10.60%	11%	10%
BAME	12.80%	14%	9%

9: Percentage difference in board voting membership and overall workforce:

(This metric had previously collated data relating to the local population; it now looks at the current workforce).

	2019	2020	2021
White	-17.2%	-5.9%	-5.5%
BAME	3.2%	1.3%	1.3%
Ethnicity unknown/NULL as per ESR	14.0%	4.6%	4.6%

Appendix 2 – Workforce Disability Equality Standard Data as at 31st March 2021

For publication summer 2021

Metric 1 – Workforce information

	Percentage of disabled staff 2020	**Percentage of disabled staff 2021**
Non clinical staff – Cluster Bands 1 - 4	4.7%	6.7%
Non clinical staff – Cluster Bands 5-7	3.5%	5.8%
Non clinical staff – Cluster Bands 8a-8b	0%	0%
Non clinical staff – Cluster Bands 8c-9 and VSM	2.6%	5.1%
Clinical staff – Cluster Bands 1-4	3.65%	4.5%
Clinical staff – Cluster Bands 5-7	4.05%	4.5%
Clinical staff – Cluster Bands 8a-8b	3.70%	5.2%
Clinical staff – Cluster Bands 8c-9 and VSM	7.69%	13.3%

Metric 2 – Recruitment

Likelihood of 1.39 compared with 1.1 the previous year.

This metric looks specifically at the likelihood of being appointed from shortlisting. The outcome is a figure of 1.39 and means that disabled candidates are less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

Metric 3 – Formal Performance Process

Likelihood is 2.71

The figure for 2020 was 5.5. As for recruitment, a figure of 1.0 is desired as this would indicate staff with disclosed disabilities are no more or less likely to enter into a formal capability process with the Trust than staff without disclosed disabilities. Only the Performance policy is used by NWAS to calculate this figure, in line with the technical guidance; it does not include sickness capability processes.

Metric 4 – Staff Survey

This metric collates the data from four staff survey questions relating to bullying, harassment, abuse, discrimination and reporting such behaviours.

Metric 4 – This metric uses information from four separate staff survey questions on the theme of harassment and bullying.

The first question in this metric relates to the % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months.

	Staff survey 2018	**Staff survey 2019**	**Staff survey 2020**
Non-disabled	45.8%	45%	42%
Disabled	52.0%	56%	47%

The second question relates to the % of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	13.2%	12%	15%
Disabled	25.8%	23%	22%

The third question relates to the % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	15.6%	15%	16%
Disabled	26.5%	27%	23%

The final question which forms part of Metric 4 relates to the % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	38.3%	44%	43%
Disabled	40.1%	49%	49%

Metric 5 – Equal opportunities for career progression

The data from this metric also comes from the staff survey. It showed that 65% of disabled staff felt that the organisation provided equal opportunities for career progression compared with 77% of non-disabled staff feeling that there were equal opportunities.

	Staff survey 2018	Staff survey 2019	Staff Survey 2020
Non-disabled	76.5%	77%	77%
Disabled	61.4%	65%	67%

Metric 6 – Attending work

The staff survey question relating to this metric asks about staff feeling under pressure to come into work from their manager when they don't feel well enough to perform their duties.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	32.6%	31%	30%
Disabled	45.3%	44%	39%

Metric 7 – Feeling Valued

This question asks about staff feeling satisfied with the extent to which the organisation values their work. The data showed that 29% staff with a disability felt satisfied with the extent to which the organisation values their work; this compares to 40% of non-disabled staff.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	36.7%	40%	35%
Disabled	25.3%	29%	29%

Metric 8 – Reasonable Adjustments
This question asks staff with a disability to advise whether the organisation has made adequate adjustments to enable them to carry out their work.

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Disabled	60%	59%	71%

Metric 9 – Staff engagement
This metric provides an engagement score, calculated from 9 specific questions from the staff survey. There remains a gap between the engagement score for staff with and without disabilities in staff survey responses, but the gap has narrowed slightly according to these results.

Engagement score:

	Staff survey 2018	Staff survey 2019	Staff survey 2020
Non-disabled	6.5	6.5	6.4
Disabled	5.7	5.8	6.0

This metric also asks whether the organisation has taken action to facilitate the voices of disabled staff to be heard, to which NWAS has said 'Yes'.

Metric 10 – Board representation
The data again shows an overall underrepresentation of disabled people on the Board, voting membership and executive membership when compared with the overall workforce. This is due to no Board members having declared a disability which has been recorded on ESR; there are 4 Board members who have not advised of their disabled status.

Appendix 3 - Gender Pay Gap Data as at 31st March 2021

The NWAS Gender Pay Gap data is as follows:

Hourly wages gap

	2018	2019	2020	2021
Average hourly pay gap	7.9%	8.85%	8.79%	10.89%
Median hourly pay gap	6.9%	5.42%	7.2%	9.26%

The pay quartile information

	2019 Female %	2019 Male %	2020 Female %	2020 Male %	2021 Female %	2021 Male %
Lower pay quartile	54.85%	45.15%	55.26%	44.74%	60.95%	39.05%
Lower middle quartile	51.15%	48.85%	53.65%	46.35%	56.04%	43.96%
Upper middle quartile	47.13%	52.87%	46.81%	53.19%	47.43%	52.57%
Upper quartile	34.18%	65.82%	36.74%	63.26%	37.23%	62.77%

Bonus payments

Bonus payments are eligible to the Trusts staff on Very Senior Manager (VSM) contracts. Out of this group there are 8 eligible staff

Proportion of males and females who got bonus payments

Bonuses are only available to very senior roles.

0.03%% of eligible males received a bonus and 0.03% of eligible female received a bonus.

Mean gender pay gap in bonus payments

Mean amount of bonus pay for women is £3,284

Median gender pay gap in bonus payment

Median is the mid-point of the bonus payment.

Median bonus payment for men is £4079

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 September 2021			
SUBJECT:	Flu Campaign 2020/2021 - HCW Flu Vaccination Best Practice Management Checklist			
PRESENTED BY:	L Ward, Director of People			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☒
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The purpose of the paper is to provide the Board of Directors with an overview of the Flu campaign for 2021/22, taking account of the learning and outcomes from the Flu Campaign 2020/21. The paper will also outline potential implications of the COVID booster vaccination rollout in the Autumn. Last year's flu campaign was based on achieving a minimum of 75% uptake. The letter from the Department of Health and Social Care issued this year indicates a 100% offer with an 85% ambition of uptake amongst frontline health care workers. The last campaign was the best year to date with 78.3% frontline staff vaccinated. The paper outlines learning from last year's campaign and the need to review aspects such as the delivery model, the numbers of vaccinators trained and the governance associated with the management of the vaccine. A review of the 2020/21 flu campaign highlighted areas of improvement and lessons learnt for the forthcoming year. The most significant development since the last flu campaign is the learning that has also been identified from the creation of the Trusts' internal COVID-19 vaccination Hub. An ideal delivery model would be a multi-site model with a designated small number of roaming vaccinators that have featured in previous campaigns. However, this needs to be balanced with the needs of a peripatetic workforce. The approach being adopted, therefore, is the identification of some key sites that have rooms that can be used throughout the campaign supported by roaming vaccinators to improve vaccine management and IPC. A commitment has also been given to			

	provide light duties staff, where available to administer the vaccine so a dedicated team can be developed. The paper outlines that this year there is a project team in place which includes the Medicines Operational Manager and a clinical lead along with support from the Corporate HR team. The team will engage with local operational flu leads which will also help to improve the governance around the administration and management of the vaccines. The paper outlines the proposal for the campaign to be run over an 8-week period between October and November to ensure a targeted approach. The proposal is to aim to conclude the campaign prior to December, to support the projected significant winter pressures anticipated this year. The campaign will have a full communications campaign. Unlike previous years, there is a further consideration around how the flu vaccination should be administered along with the offer of the COVID booster vaccinations. For NWAS, the approach will be for staff to access the booster vaccinations via ICS provision either through hospital hubs or mass vaccination sites. Confirmation has been received that NWAS does feature in ICS plans, but these plans are still in the early planning stages, although expected to proceed at pace following recent announcements. The paper also includes the HCW Flu Vaccination Best Practice Management Checklist. The purpose of this is to demonstrate the Board's public commitment to the aim to achieve 100% offer of the vaccine to frontline healthcare workers, visible support for the programme and to provide assurance against plans and the communications campaign. The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. The only area where we are not completely compliant with the checklist is on the issue of incentives. Due to a lack of clarity around the COVID booster programme alongside the potential for the COVID vaccine to be mandated, ELC have taken the view that an incentive scheme could be confusing and counter-productive if applied this year.			
RECOMMENDATIONS:	The Board of Directors are recommended to: • Receive assurance on the approach to the Flu campaign for 2021/22 demonstrated through the completed Board Checklist • Provide Board commitment to offer all frontline staff a flu vaccination			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
	Executive Leadership Committee and Resources Committee			

PREVIOUSLY CONSIDERED BY:	**Date:**	15 September 21 & 24 September 21
	Outcome:	ELC approved approach/ Resources Committee to be provided verbally

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1. PURPOSE

1.1 The purpose of the paper is to provide the Board of Directors with an overview of the Flu campaign for 2021/22, taking account of the learning and outcomes from the Flu Campaign 2020/21. It provides assurance against the national checklist that we are required to present to Board in relation to the Flu campaign.

1.2 The paper will also outline implications of the COVID booster vaccination rollout in the Autumn.

2. BACKGROUND

2.1 Last year saw the roll out of the biggest NHS flu vaccination programme to date, with the aim of offering protection to as many eligible people as possible during the COVID-19 pandemic.

2.2 The Department of Health and Social Care issued its annual letter in July 2021 to announce the roll out of the flu immunisation programme for this year. In the letter it states that due to non-pharmaceutical interventions in place for COVID-19 (such as mask wearing, physical and social distancing, and restricted international travel) flu activity levels were extremely low globally in 2020 to 2021. The impact of this is that a lower level of population immunity against flu is expected in 2021 to 2022.

2.3 As social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal flu virus (and other respiratory viruses) will co-circulate alongside COVID-19. Seasonal flu and COVID-19 viruses have the potential to add substantially to the winter pressures usually faced by the NHS, particularly if infection waves from both viruses coincide. The timing and magnitude of potential flu and COVID-19 infection waves for winter 2021 to 2022 are currently unknown, but modelling indicates the 2021 to 2022 flu season in the UK could be up to 50% larger than typically seen and it is also possible that the 2021 to 2022 flu season will begin earlier than usual. Flu vaccination is therefore an important priority this coming autumn and one which the Trust needs to put appropriate steps in place to adequately prepare.

2.4 Last year's campaign was based on achieving a minimum of 75% uptake. The letter from the Department of Health and Social Care issued this year indicates a 100% offer with an 85% ambition of uptake amongst frontline health care workers.

3. OVERVIEW OF LAST YEAR'S CAMPAIGN

3.1 The total number of staff vaccinated within the 2020/2021 flu campaign was 4737 Healthcare Workers (HCW) with direct patient contact and 517 who are not involved with direct patient contact. Totalling 5254 staff vaccinated overall.

3.2 The Trust is required to submit their statistics to IMMFORM monthly. The table below illustrates IMMFORM submission over the past three years. The last campaign was the best year to date with 78.3% frontline staff vaccinated, which is our highest uptake to date.

3.3

Period From	IMMFORM SUBMISSION	2020	2019	2018	2017
October	November Submission	43.4%	38.7%	37.3%	34.6%
November	December Submission	72.2%	56.3%	53.8%	52.2%
December	January Submission	73.8%	61.6%	59.4%	57.9%
January	February Submission	78%	65.4%	62.1%	63.5%
February	March Submission	78.3%	67.3%	65.9%	67.2%

3.4 The overall Trust refusal rate has decreased over the past 4 years from 25.93% in 2017/2018, 23.4% in 2018/2019, 21.28% for 2019/20 to 21.8% for 20/21. However, refusal rates remained highest within PES frontline operations which averaged 23.4%.

3.5 Last year there was a focus on promoting the clinical evidence base for vaccination and a letter was also sent out from the Medical Director to staff who had actively declined to have a flu vaccine to consider the benefits of reviewing their decision.

3.6 The final figure for those who had not been targeted was 5.5% overall but the position in the frontline high-risk areas was much better than this:

3.7

Area	**Vaccinated**	**Declined**	**Not offered**
PES GM	72.1%	23.4%	1.9%
PES CL	78.6%	20.8%	0.1%
PES C&M	76%	23.5%	0%
EOC	73.8%	18%	8.0%
111	74.3%	25.6%	0.2%
PTS	65.6%	26.9%	7.1%

3.8 Whilst the figures reflect that PTS is a hard-to-reach group in comparison with PES, EOC and 111, the previous year's campaign showed that 54.41% of PTS were vaccinated, with 26.10% declining and 19.49% not being offered the vaccine. As such, last year's campaign reflected a significant improvement in the success of vaccinating PTS staff. The position in EOC also needs additional focus as the rate of staff not offered should be consistent with 111.

4. CAMPAIGN SUCCESSES

4.1 The campaign was co-ordinated slightly differently to previous years whereby flu leads took full control of their allocated area and permission was sought to grant access to the Flumis Reporting System. All flu leads viewed and ran their own local area reports to highlight staff who have not been vaccinated or declined. The data was used to provide target areas and updates were discussed weekly at the Flu Leads meetings.

4.2 To achieve the set targets, approval was also sought for flu vaccinators to claim overtime to support the flu campaign. This helped support the role of the vaccinators and ensured time was allocated for flu clinics.

4.3 Based on previous campaigns, there was an early focus to engage with PTS staff due to historical poor uptake. Designated vaccinators were assigned to cover PTS and they worked closely with PTS managers to ensure flu clinics were offered across all areas. PTS bases with separate crew sites, specifically in GM proved challenging but with GM PES continued support these rates improved.

4.4 Additional support was provided by the Education Training Team who supported with vaccinations and reporting. They were provided Flumis access and provided admin support for reporting specifically looking at those who had declined the vaccine during the 2020/2021 campaign but had received in previous years. These staff were targeted, and this really supported the decrease in refusal rates.

5. LESSONS LEARNT

5.1 With the additional pressures of COVID, there have been several issues that will require earlier intervention for the next Flu campaign. The following will outline each of the issues encountered and solutions for ensuring accountability/consistency throughout the next campaign.

5.2

1	**Training delayed due to PGD sign off.** The PGD needs to be completed much sooner but this is tied to the release of the national PGD
2	**A small number of vaccinators have been allowed to vaccinate when there is no record of completion of training.** Ensure there is a clear understanding of which clinician is responsible for approving vaccinators. They will need to check that all the requirements that need to be logged on ESR prior to vaccinating are all in place (as well as any other competency assessment, registration check and immunisation status check with all this documented) and there is written approval for them to vaccinate. Having a smaller cohort of vaccinators will make this more manageable.
3	**Flu equipment process.** Clear process to be agreed for 2021/22 Campaign.
4	**Issue of vaccines being held back by lead vaccinators impacting on the availability for PTS staff.** This year flu leads need to identify key vaccinators in pre planning and assign to PTS areas, so staff know who to contact for arranging vaccine.
5	**Improved guidance for vaccinators on using the Flumis system to record vaccinations**. Guidance to be reviewed.
6.	**Ensure adherence to IPC recommendations for the administering of the vaccine**. Static sites to be visited to identify their subtility
7.	**Closer governance around the management of the vaccine**. Last year 600 vaccines went unaccounted for.
8.	**A large number of vaccinators were trained but were not active** Review the number of vaccinators required.
9.	**Vaccinators not inputting the data into Flumis.** Ensure vaccinators are clear it is their responsibility to document the vaccinations they undertake on the same day into the FluMIS system with systems and processes are in place to support this.

10.	**Issue of the quality of data relation to vaccination records** There will be a weekly quality assurance of the data in FluMIS (ensure all fields completed correctly, only staff that are approved as vaccinators are vaccinating, etc) and correlation with stock levels with clarity as to who is to carry out this task.

6. FLU CAMPAIGN 20/21

6.1 Approach

6.1.1 A review of the 2020/21 flu campaign highlighted areas of improvement and lessons learnt for the forthcoming year. The most significant development since the last flu campaign is the learning that has also been identified from the creation of the Trusts' internal COVID-19 vaccination Hub. This was operational between January 2021 and May 2021.

6.1.2 The COVID vaccination hub programme was developed with specific workstreams covering areas such as Estates, IPC and workforce. One of the key areas of learning from the programme was the benefit of having lead clinicians in place to support areas such as workforce, training and clinical governance.

6.1.3 The vaccination hub operated from a static site at Broughton which had a fully fitted treatment area, clear SOPs in place, medical equipment and consumables, and clear duties of the vaccinators and lead clinician.

6.1.4 Since the COVID vaccination hub closed in May, discussions have taken place with those involved to understand the learning that can be taken to support this year's vaccination programme.

7. DELIVERY MODEL

7.1.1 The delivery model in previous years has operated with area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.

7.1.2 Taking account of the learning from the COVID vaccination Hub, discussions have been ongoing on whether a different delivery model would be more appropriate for this year. Consideration has been taken on whether a new model should be introduced with a small number of vaccination hubs to increase the accountability of vaccine and consumables management and assurance around IPC considerations. The proposal for this year is to have several static sites where there will be the ability to lock away the vaccines. Within the static sites there will be designated rooms set up in line with IPC regulations for vaccinations to take place. This will therefore resolve issues around the governance of the vaccines and IPC concerns relating to the conditions under which the vaccine is administered. This would also reduce the number of vaccinators required.

7.1.3 Discussions with Heads of Service around changing the model indicated that there was support for this model with the ability to have this in conjunction with a roaming model as this meets the needs of a peripatetic workforce.

7.1.4 Work has been undertaken to identify a small number of sites in each area, alongside areas offices, which could be used for vaccinations. This will allow for vaccination clinics to be held in designated rooms, which will be set up appropriately for administering the vaccine. This would then be supplemented by the flu leads identifying where and when there needs to be a roaming model based on the uptake of vaccine data.

7.1.5 The clear identification of key sites along with a small roaming model will reduce the need for vaccinators, reduce the number of fridges required at multiple sites and ensure a closer management of the vaccines. Thereby balancing the need to have greater accountability of vaccine stock, whilst still providing a flexible model to meet the needs of our workforce.

7.2 **Vaccinators**

7.2.1 Taking account of the learning from last year it was identified that out of 296 trained vaccinators only 28 administered 50 or more vaccines. Between them the 28 vaccinators accounted for more than half of all the vaccines administered throughout the campaign. Given the current operational pressures it is pragmatic that we focus on training a small number of core vaccinators to deliver the vaccine. This has been fully supported by the Heads of Service who are identifying potential vaccinators in the form of light duties staff who can be released as required to support the programme.

7.2.2 In addition, there are a small number of Bank Paramedics who supported the COVID vaccination programme and have been involved in the flu vaccination campaign previously. The costs would be met by the funding identified by Finance to support the overall flu campaign.

7.3 **Project Team**

7.3.1 The flu campaign has previously been led by the Corporate HR Team and they have overseen the coordination of area flu leads to manage the delivery of the vaccination programme. Learning from the COVID vaccination Hub identified the benefits from having key clinicians involved in a vaccination project.

For this year's flu campaign, a clinician within the People Directorate who was part of the COVID vaccination hub project group has been released to support the flu campaign. Their role will include:

7.3.2
- Overseeing all vaccinators to ensure that those who are administering vaccines are fully trained, HCPC / NMC registered and have the relevant immunisation status.
- Engagement with area flu leads
- Management of training and competence assessment for the vaccinators and sign off as approved to vaccinate
- Supporting the identification key sites for clinics
- Ensuring sites are adequately equipped
- Arranging consumables and clinical waste disposal
- IPC assessments
- Writing appropriate SOPs
- Trouble shooting issues throughout the campaign
- Engage with the Communication Team to help promote the flu campaign.

7.3.3 This role will ensure a closer engagement with operational colleagues with the ability to identify and resolve both operational and clinical issues appropriately.

7.3.4 The project team also includes the Medicines Operational Manager who have been key in the development of this year's operating model and will continue to support the ongoing training, medical management, and governance issues. They will also ensure that there is a formal reporting process into MOG for medicines approvals.

7.3.5 The Corporate HR Team remain involved in the project and will also take a lead in ensuring the fulfilment of national reporting requirements. Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.

7.3.6 Engagement with the areas flu leads commenced in early summer and weekly flu leads meetings are in place to ensure that delivery model is scoped out and developed, vaccinators have been identified and training is in place.

7.4 **Length of the campaign**

7.4.1 The flu vaccination campaign runs from October to February each year. However, as the data outlined in 3.2 demonstrates, most vaccinations occur within the first 8 weeks with a small percentage of vaccinations occurring through the rest of the campaign. The indication from the Department of Health and Social Care is to ensure that the campaign is progressed as quickly as possible. This will help to protect our staff throughout the winter period.

7.4.2 Taking this into account and given the anticipated pressures for this coming winter along with previous learning, the flu leads in each area are going to be given a remit to aim to complete their vaccinations within the first 8 weeks of the campaign. This will ensure a targeted approach that will conclude prior to December. A decision can be taken once the campaign has commenced on whether a small number of vaccinators continue to offer the vaccine over the remaining months of the campaign.

7.5 **Improved governance**

7.5.1 Learning from both the last flu campaign and the COVID vaccination hub has identified the need to tighten up on the governance of the campaign. As such the project team are putting measures into place to focus on the following areas:

7.5.2
- Improved accountability over vaccine stocks by having limited vaccinator access.
- Identified fridge lead to reduce the risk of wastage / unaccounted vaccines.
- Reduced commissioning of fridges used for vaccine storage to better control access to vaccines and to support reduced maintenance issues and costs.
- Clearer coordination of consumables
- Tamper evident anaphylaxis kits to be put in place.
- Route for supply and distribution of consumables to be identified.
- Digital stock management system for flu vaccines
- Digital remote temperature monitoring with automated alerts issued and out of hours monitoring via Support Centre.
- Ensure all vaccine queries are logged in a standard manner and responses are quality assured by a designated person/role before responding.

8. COMMUNICATION AND ENGAGEMENT

8.1 The communications team have developed a comprehensive communication and engagement plan which includes social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features.

8.2 One new feature will be the commencement of early communications encouraging individuals to register their consent online during September and to also give the opportunity to book into the static sites for vaccination. This will work in the same way as the COVID vaccinations at the Broughton Hub.

8.3 Trade Unions have also been asked to consider how they can support the flu vaccination and COVID booster campaigns. Given the additional risks of flu being highlighted this year, in light of the general lower immunity in the population and the risks of staff considering COVID vaccination to be more important than flu, a strong and consistent message on the importance of vaccination from Trade Union colleagues has been welcomed.

9. REPORTING SYSTEM

9.1 The Trust will continue to use the FLUMIS reporting system. This has been used in previous years and allows for the individual vaccination details of staff to be inputted on a secure system as opposed to have a local spreadsheets and forms. The same company provided the booking and reporting system used for the Trust COVID vaccination hub. The experience of using a similar system for the COVID vaccination hub identified the ability to manage and streamline the targeting strategy of the campaign.

The system has the ability for appointments in the static clinics to be pre booked. This allows vaccinators to be able to plan their time and also for staff to have a specific time slot as opposed to potentially queuing up for a vaccination as has occurred in previous years. The approach with the roaming vaccinators will not use a booking system and will be operated without the need to pre-book appointments.

9.2 However, to provide a more targeted approach and to ensure staff are not being offered the vaccine on numerous occasions unnecessarily, the Trust will be using the FLUMIS

system to contact staff. The system provides staff with the ability to complete their consent to receive or consent to decline the flu vaccination offer. Further details will be sent out in bulletins to staff about how this will work and how they can access this system. However, this should help to have an accurate status of each staff member's vaccination and to ensure that staff do not feel harassed through being asked to have the vaccine on multiple occasions.

9.3 Consent data and reporting procedures will be specified within a 'Standard Operating Procedures' (SOP) and guidelines to ensure accurate reporting and including the requirement for administration to be undertaken in a timely manner.

9.4 The system will be used to produce weekly reports to outline the uptake within service lines and teams and to ensure appropriate targeting of areas can be undertaken. In a change from previous campaign, the Trusts is required to upload vaccinations on a daily basis to the national NIVS database. This mirrors the national request made for the COVID vaccinations and as such the Trust is familiar with the ask. The FLUMIS system allows for a daily upload to the NIVS system, reducing the need to record vaccinations separately onto to NIVS as well as FLUMIS.

10. TRAINING

10.1 Meds Management will combine OH training requirements with NWAS specific procedures, which will then be placed on ESR. The training package is currently in development.

11. VACCINATIONS

11.1 The Trust has purchased vaccines directly from the supplier, rather than via Occupational Health, which proved cheaper. NWAS has already placed an order for 5500 vaccines of a single type, which is egg free and covers over 65s. Whilst some Trusts have had some indication of disruption of supply linked with the current shortage of HGV drivers, at present NWAS is still on track to receive the vaccines this month.

11.2 Flu Vaccination Best Practice Management Checklist

11.2.1 The Trust must complete a HCW Flu Vaccination Best Practice Management Checklist. The purpose of this is to demonstrate the Board's public commitment to the aim to achieve 100% offer of the vaccine to frontline healthcare workers. Whilst this does not have to be published nationally for public assurance until December 2021, Appendix A within this report illustrates how the checklist pointers are being met and provides assurance that the best practice recommendations have been adopted in the Trust's approach.

11.2.2 The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan. There are challenges in how the offer is presented and delivered to staff this year but the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates.

11.2.3 A risk register has been developed and placed on the risk register which currently scores at 12. This will be monitored throughout the campaign.

11.2.4 The Trust meets all elements of the checklist except one which relates to incentives. Last year the Trust offered a charity incentive which was well received but in light of the challenges in offering a flu and COVID booster this year through different processes, it was felt that an incentive would complicate matters.

12. FLU AND COVID-19 VACCINATION

12.1 Unlike previous years, there is a further consideration around how the flu vaccination should be administered along with the offer of the COVID booster vaccinations. The letter from the Department of Health and Social care indicates that at present, the Green Book chapter on the COVID-19 vaccine states that administration of the COVID-19 vaccine should ideally be scheduled with an interval of at least 7 days to another vaccination (including flu) in order to avoid incorrect attribution of potential adverse events but the recent announcement on boosters supports the delivery of both vaccines at the same time where appropriate.

12.2 However, for NWAS, there is currently no intention to stand up the internal COVID vaccination hub. The booster offered will be the Pfizer vaccination (or in some cases Moderna) and the Trust does not have the ability to store this particular vaccine in the conditions requires. Instead, the proposal would be to access the booster vaccinations from the mass vaccination sites and hospital hubs. NWAS does feature in ICS plans for the booster vaccination rollout and we are expecting more information on the offer to emerge shortly.

12.3 It is proposed that once booster vaccination plans are fully confirmed within ICS plans, the Trust will deliver in a similar way to the early stages of the original vaccination through coordinated local and central communication on where staff can access their booster. The communications plan for the flu programme will need to be carefully managed alongside the anticipated COVID booster campaign.

12.4 The key messages will need to be refined should there be a mandate for all health and social care staff to have the COVID vaccine, which is currently the subject of national discussions. This is currently subject to consultation. Planning on the approach and impact has already commenced with joint working at a national level on the approach with employees and review locally on the implications.

13. LEGAL and/or GOVERNANCE IMPLICATIONS

13.1 There are no legal implications from this report.

14. RECOMMENDATIONS

14.1 The Board of Directors are recommended to:

- Receive assurance on the approach to the Flu campaign for 2021/22 demonstrated through the completed Board Checklist

- Provide Board commitment to offer all frontline staff a flu vaccination

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 September 2021			
SUBJECT:	Partnerships and Integration Progress Update			
PRESENTED BY:	Director of Strategy, Partnerships and Transformation			
PURPOSE OF PAPER:	For Assurance			
LINK TO BOARD ASSURANCE FRAMEWORK	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☒	☒
EXECUTIVE SUMMARY:	The paper covers the formation of the Partnerships and Integration team (P&I), and the drivers for this. The North West will work with five ICS areas: • Greater Manchester • Lancashire and South Cumbria • Cheshire and Merseyside • Derbyshire (covering Glossop) • North East (covering North Cumbria ICP) The paper details progress within each ICS area. The governance and ICS executive teams are currently in the process of being formed and this will be completed by December 2021 for all ICS areas. The paper outlines how the system will fit together across the footprint, including an initial analysis of the external meetings per area, and per directorate. The paper also looks at the strategic meetings that are important for the trust to be represented at, although this will further evolve as the ICs structures develop further. The P&I team have identifiable objectives and deliverables for the remainder of 2021-22, as well as working with, and influencing the ICS developments these include: • Developing and strengthening relationships with ICS structures • External stakeholder mapping and analysis			

	• Design, develop, implement and maintain a Knowledge Vault • Developing system profiles for the ICS areas All of the above will enable the trust to use information and intelligence proactively and to ensure that the trust is central to the conversations going forward.			
RECOMMENDATIONS, DECISIONS OR ACTIONS SOUGHT:	The Board of Directors is asked to: • note the assurance and update provided in this paper • support work of the P&I team, in particular support the take up and roll out of the Knowledge Vault across the Trust • note that a presentation on the P&I work and ICS structures will be provided to non-executive directors in October			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality	☐	Sustainability	☐
PREVIOUSLY SUBMITTED TO:				
DATE:				
OUTCOME:				

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1. PURPOSE

The purpose of this paper is to inform the board of the new Integrated Care Systems, the progress to date within those systems and how the system in the North West will fit together. The paper will also detail the work being undertaken by the Partnerships and Integration Team (P&I) in relation to the new ICS structures.

2. BACKGROUND

The three Partnerships and Integration Managers (PIMs) will have lead responsibility for each of the three geographical areas of the Trust. Two PIMs took up post on 24 May 2021, and the third on 13 September 2021. The PIMs provide coverage across the trust as follows:

- Linsey Hall covering Cheshire and Merseyside
- Nathan Hearn covering Cumbria and Lancashire
- Paul Beech covering Greater Manchester

There is also dedicated managerial support for North Cumbria Integrated Care Partnership in order to ensure representation in that area, The Partnerships and Integration structure is shown in **Appendix 1** (page 3).

The Deloitte review in December 2019 highlighted the need for a responsive structure, stating:

- "several stakeholders expressed an appetite for more proactive communications from the Trust where possible"
- "It was felt that NWAS could be more proactive with working with external stakeholders to outline changes to service provision which other organisations should be undertaking as well as to work with external stakeholders in order to co-develop action plans…"
- "…the Trust should take greater steps to ensure it was adequately represented at key forums across the footprint…however, ensuring representation at aspects such as urgent care forums was considered to be vital"

The trust also had a strategic risk in 2020/21 which stated:

- "If we do not build and strengthen stakeholder relationships across systems, localities and neighbourhoods, this may impact on the trusts' ability to achieve our vision to be the best ambulance service in the UK"

The new structure allows the trust the opportunity to mitigate the above, as well as ensuring it is part of the developments and changes taking place across the wider NHS.

Integrated Care Systems (ICS) Update

ICSs across the UK will formally replace CCGs in April 2022, developments and changes are taking place within the North West ICS areas currently and these will gather pace as time evolves.

All ICS are developing plans in line with national guidance, as it becomes available. Further national guidance has been published in August 2021, "Working Together at Scale: Guidance on Provider Collaboratives" as well as guidance on Integrated Care Board functions and governance, the transfer of CCG staff and functions as well as Direct Commissioning.

Another set of guidance is expected in September on ICS digital and data, working with people and communities/ leadership and Thriving Places (place-based partnerships

The ICS system in the North West is made up of five ICS areas, with Glossop and North Cumbria covered by ICS' outside the North West footprint, namely Derbyshire ICS and North East ICS. Below is an update of progress in each ICS area.

Greater Manchester

- ICS Chair - Sir Richard Leese
- Executive Lead – Sarah Price

With having the Greater Manchester Health and Social Care Partnership already in place in previous years, Greater Manchester ICS are moving fast in putting structures in place around governance and working together arrangements. The expectation is that their executive level recruitment will be complete by October 2021.

Lancashire & South Cumbria (L&SC)

- ICS Chair – David Flory CBE
- Executive Lead – Andrew Bennett

Similar to Greater Manchester, L&SC have progressed quickly to begin executive level recruitment within their area, as well looking to put in place governance, reporting and collaborative arrangements

Non-Executive recruitment will start in October. The integrated care board expects to be operating in shadow form from January 2022. An ongoing review of place based partnerships is currently reviewing governance arrangements, reporting and collaborative working.

Cheshire and Merseyside

- ICS Chair – Alan Yates
- Executive Lead – Sheena Cuminskey

Cheshire and Merseyside ICS have recently started to move forward, given the lack of systems / personnel in place at the start, however, they are working with the North West regional team to bring process and structures in line with the rest of the North West.

Derbyshire (for Glossop)

- ICS Chair – John McDonald
- Executive Lead – Dr Chris Clayton

It was announced in July 2021Glossop would move from the Greater Manchester ICS into the Derbyshire ICS. Glossop local authority services are provided by Derbyshire County Council and High Peak Borough Council but has been part of the Manchester NHS system via Tameside and Glossop CCG.

The decision was taken based on a consideration of coterminous boundaries. The change will potentially give more opportunities for joined-up working with the local authority and the creation of joined-up plans for local people as well as greater alignment between community, mental health and ambulance service provision.

The decision will not impact patient's right to choose or use services outside of their ICS, and it is likely that Glossop patients will continue to use services provided by Greater Manchester ICS.

Work will be required with Derbyshire ICS where arrangements around Glossop have only recently been formalised.

North East (covering North Cumbria)

- ICS Chair – Sir Liam Donaldson
- Executive Lead – Alan Foster MBE

Specifically for North Cumbria Integrated Care Partnership:

- ICP Chair – Jon Rush
- Executive Lead – Lyn Simpson

Developments in North Cumbria has been fast moving and we have dedicated managerial support to service these meetings and to provide trust input into the structures going forward.

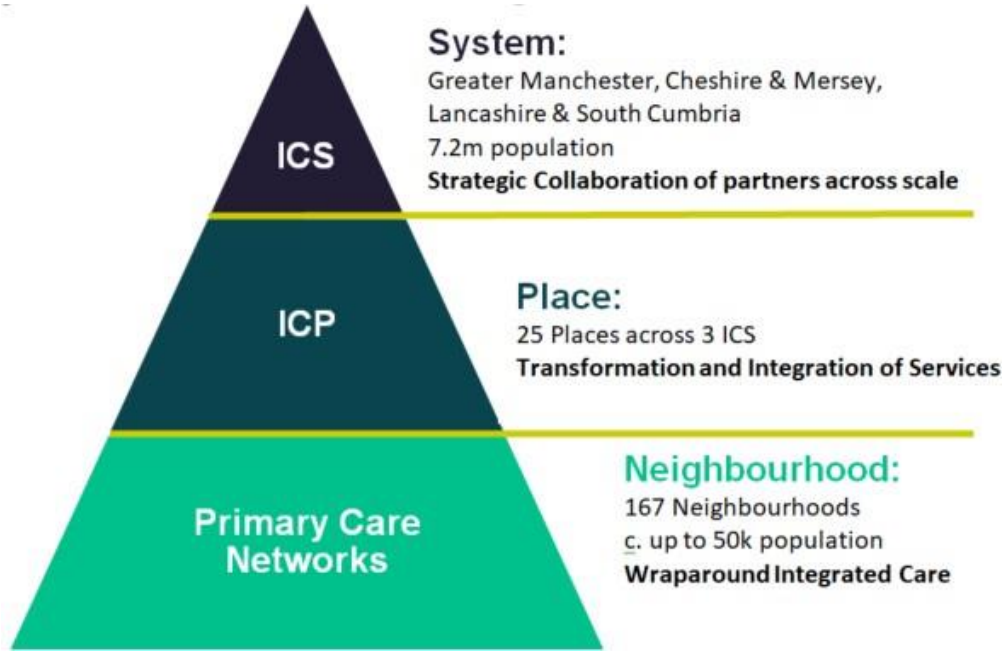
North Cumbria is currently reviewing potential governance structures, although the final arrangement is dependent on the authority delegated to them by the North East ICS. Consideration is also being given to the potential implications of local government reorganisation, which has also been discussed recently. The relationship with Local Authority partners, is a key consideration in the work at place based level in North Cumbria.

The main aims of all the ICS are to:

- Improving population health and healthcare outcomes
- Tackling inequality of outcome and access

- Enhancing productivity and value for money, and
- Helping the NHS to support broader social and economic development.

The graphic below shows how the main ICS system fits together in the North West.



The ICS areas are working at differing levels of scale and pace, both in terms of their governance structures and appointments to their executive teams. The trust has executive leads assigned to each of the ICS areas.

NHSEI have stated that the full executive teams for the North West ICS will be in place by December 2021.

The trust has been involved in the development phase of the ICS areas with NHSEI, taking part in the discussions and influencing some of the debates taking place.

3. PARTNERSHIP AND INTEGRATION PROGRESS UPDATE

Initial key areas have been identified for the P&I team for the remainder of 2021-22.

The Partnership and Integration Plan 2021-22, (shown in **Appendix 1**) gives more details around these key areas, these being:

- Partnerships
- Relationship Management
- Information Exchange

The following work is currently being undertaken:

- Developing and strengthening relationships with ICS structures

- Stakeholder Mapping and Analysis
- Designing, developing, implementing and maintain a Knowledge Vault (KV)
- Develop System Profiles for the ICS Areas

Developing and strengthening relationships with ICS structures

To develop and strengthen professional relationships with partners by being involved with the ICS structures and work together to improve services for patients and the public, by coordinating, managing, monitoring and reviewing actions to get things done.

The P&I team have started liaising with key contacts in the ICS areas in order to form relationships and be part of the discussions going forward. As stated earlier, ICS executive teams will be fully in place by December 2021, we will begin to gain a better picture of individuals and structures as they evolve. The trust is already involved in some of the early stage meetings with the individual ICS.

External Stakeholder Mapping and Analysis

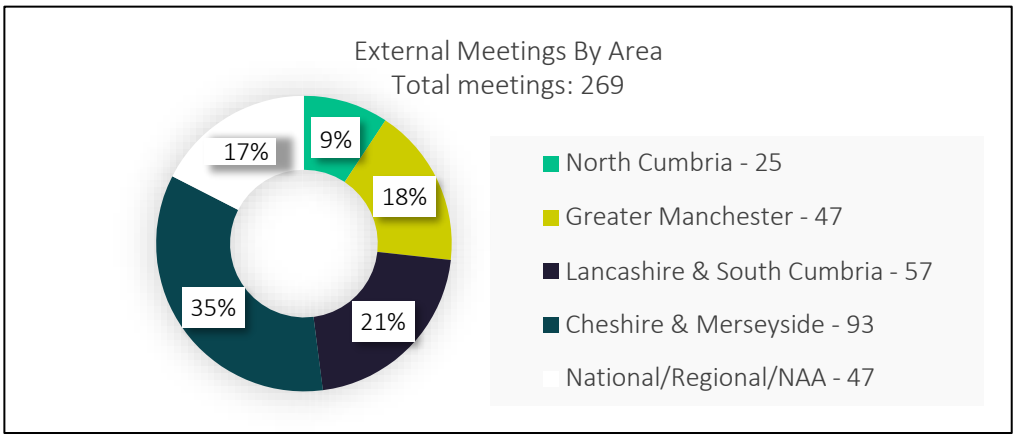
A mapping exercise of our external engagement across the region was conducted to get a snapshot of the external work taking place. All directorates were asked to forward their external engagement meetings to the P&I team to analyse the meetings/ current attendance. Not all managers responded to the request, of the ones that did, still some analysis can be drawn on the level of interaction per area and per directorate.

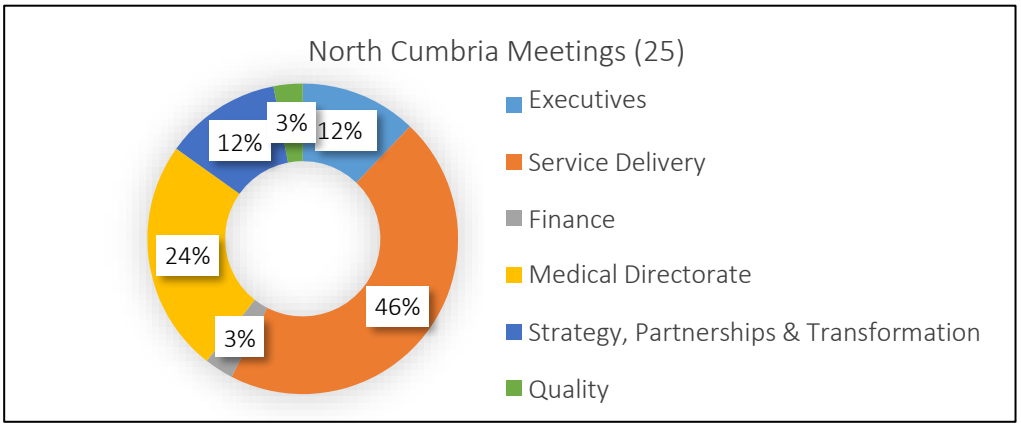
It is important that as the new structures develop that we have the right representation at the right meeting sharing the right message going forward.

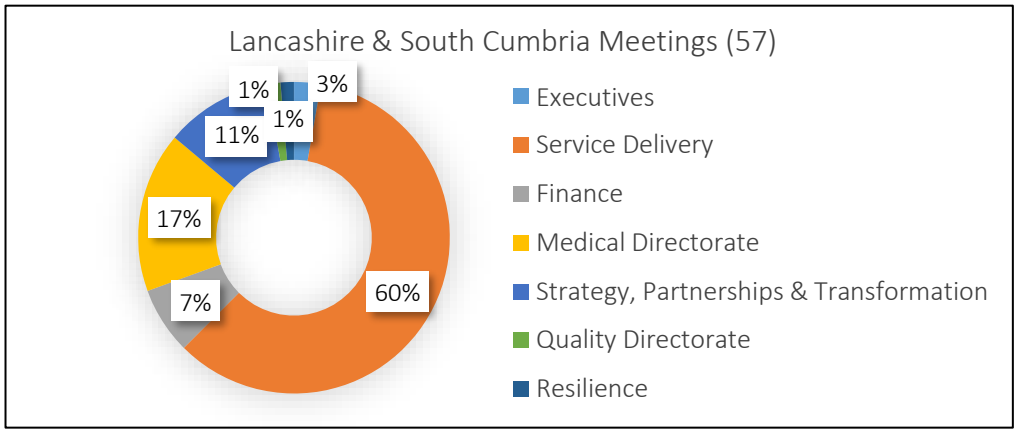
Although not exhaustive, the initial analysis charts below show the meetings taking place per area, and directorate representation.

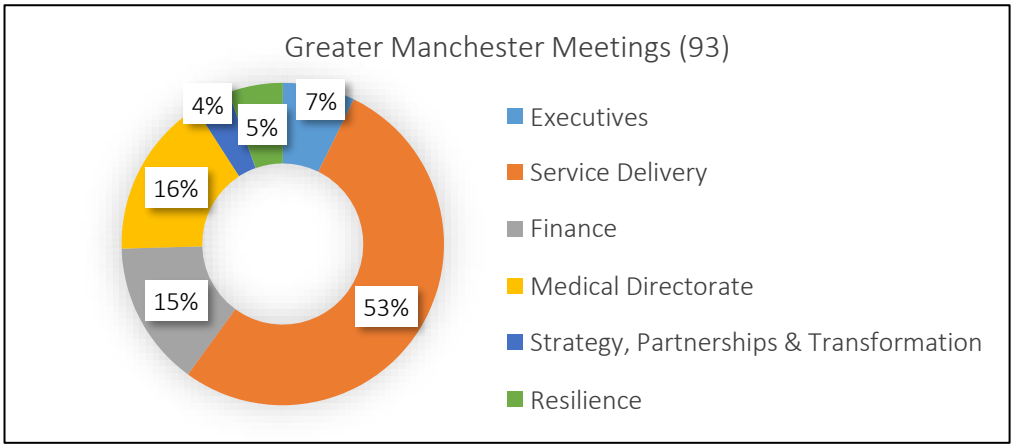
Work is currently progressing to determine which meetings are essential for attendance, which meetings the trust needs to be involved in / be kept informed of developments and finally which meetings the trust need to stay away from as they add little value to what we do or our plans.

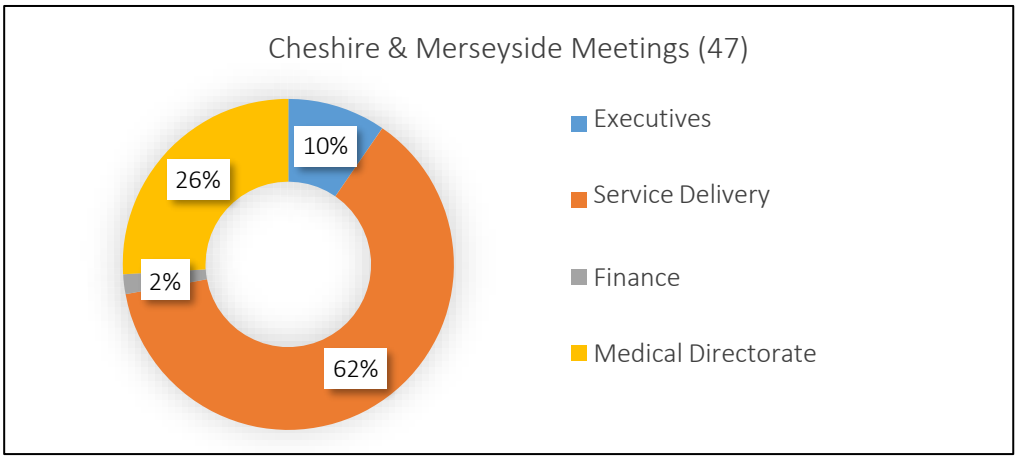
The first stage is to determine the essential meetings per area that require attendance and then ensure the right representation from the trust at those meetings.


External Meetings By Area
Total meetings: 269
9%
18%
21%
35%
17%
North Cumbria - 25
Greater Manchester - 47
Lancashire & South Cumbria - 57
Cheshire & Merseyside - 93
National/Regional/NAA - 47


North Cumbria Meetings (25)
12%
46%
3%
24%
12%
3%
Executives
Service Delivery
Finance
Medical Directorate
Strategy, Partnerships & Transformation
Quality


Lancashire & South Cumbria Meetings (57)
3%
60%
7%
17%
11%
1%
1%
Executives
Service Delivery
Finance
Medical Directorate
Strategy, Partnerships & Transformation
Quality Directorate
Resilience


Greater Manchester Meetings (93)
7%
53%
15%
16%
4%
5%
Executives
Service Delivery
Finance
Medical Directorate
Strategy, Partnerships & Transformation
Resilience



Early work has been done in identifying the important meetings across the areas that the trust should have representation at, this is shown in Appendix 2. As the ICS structures evolve this will be added to. Further work will be done on the mapping to look at further meetings that we may need to be involved in too.

Design, develop, implement and maintain a Knowledge Vault (KV)

This is a critical piece of work to ensure that we have information and intelligence that is utilised in the most appropriate way, to inform better information sharing and decision making. Leading on from the above mapping exercise, once the trust has the right representation at the right meeting, information and intelligence from external meetings can be uploaded into the KV and used in the most appropriate way.

It will show our ICS partners that managers attending external meetings across the footprint, are equipped with the authority, information, and the right narrative to make meaningful contributions to the discussions and debates taking place. This is about being fully involved in the discussions and debates rather than just an attendee at meetings.

The KV will include the following:

- ***Safe Space*** – A place where trust information, narrative and messaging, which has been quality assured and reviewed can be shared safely with partners. Also a document library to hold all national and regional papers.

- ***Capture of Information and Actions*** – Where managers can upload free text information and actions from external meetings remotely to the KV.

  Automated emails to managers to ensure actions are progressed internally to ensure they are completed in a timely manner.

- ***Drawdown of historical information*** – The ability to remotely drawdown information and history from previous meetings, including discussions and actions, enabling a richer consistent discussion with partners.

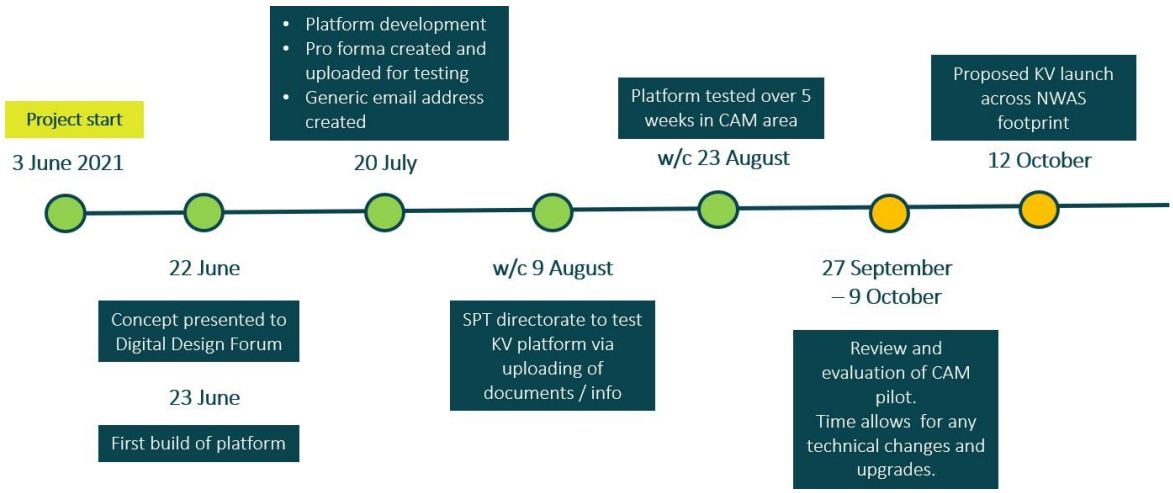
- ***Search Facility*** – A search facility based on Keywords, Area, Manager, Date, Name, Service line

There has been a significant investment of time between the P&I and Digital team to develop the KV and this is currently being piloted in Cheshire and Mersey area (Service Delivery only) until 27 September.

During this time work will be ongoing to ensure any issues that come up or any improvements that need to be made are put in place before a technical evaluation and potential roll out timeline to all areas.

The KV will only add value if utilised effectively by all managers. Work will take place with all areas / directorates to ensure awareness and use of the KV before a full planned roll-out.

The KV timeline is shown below in terms of progress and future planning.



Develop System Profiles for the ICS Areas

Work is in progressing well to develop ICS system profiles for the three main ICS areas as well as North Cumbria and Glossop.

It was hoped to have the profiles ready for this meeting, however, due to the information requirements from NHSEI this has not been possible. The profiles will go to Executive Leadership Committee in October followed by circulation to Board members.

The ICS system profiles will cover:

- Key system information
- Population overview
- Health statistics including co-morbidities (against national average)
- Pre-pandemic trends
- Index of deprivation in area
- Ethnicity
- Disability
- Who's who in the ICS, Acute and Local Authorities

The ICS system profiles will enable managers to have detail of each of the ICS areas and aid working together with key staff in each of the areas.

4. LEGAL, RISK and/or GOVERNANCE IMPLICATIONS

Work is ongoing with information governance as to whether a Data Protection Impact Assessment is required with regards to the Knowledge Vault.

On the board assurance framework for 2021-22 risks SR07 and SR08 apply, with the work currently being undertaken across the ICS areas these risks are being managed and mitigated.

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no equality or sustainability implications.

6. RECOMMENDATIONS

The Board are asked to:

- note the assurance and update provided in this paper
- support work of the P&I team in particular support the take up and roll out of the Knowledge Vault across the Trust
- note that a presentation on the P&I team and ICS structures will be provided to non-executive directors in October

Appendix 1

North West Ambulance Service NHS Trust

Integrated Care Systems

Partnerships and Integration Plan 2021-22

Partnerships and Integration Team

Integrated Care Systems
Partnerships and Integration Plan

Background

The following policy documents support the context of our Integrated Care Systems (ICS) Partnership and Integration Plan:

- NHS Long Term Plan
- Integrating care Next steps to building strong and effective integrated care systems across England
- Transformation of Urgent and Emergency Care (UEC) models of care and measurement
- Improving Health and Social Care for All, White Paper
- New NHS System Oversight Framework

Who we are – Partnerships and Integration Team

The Partnerships and Integration Team was established during 2021-22 and will work across the System, Place and Neighbourhoods taking shape across the region.

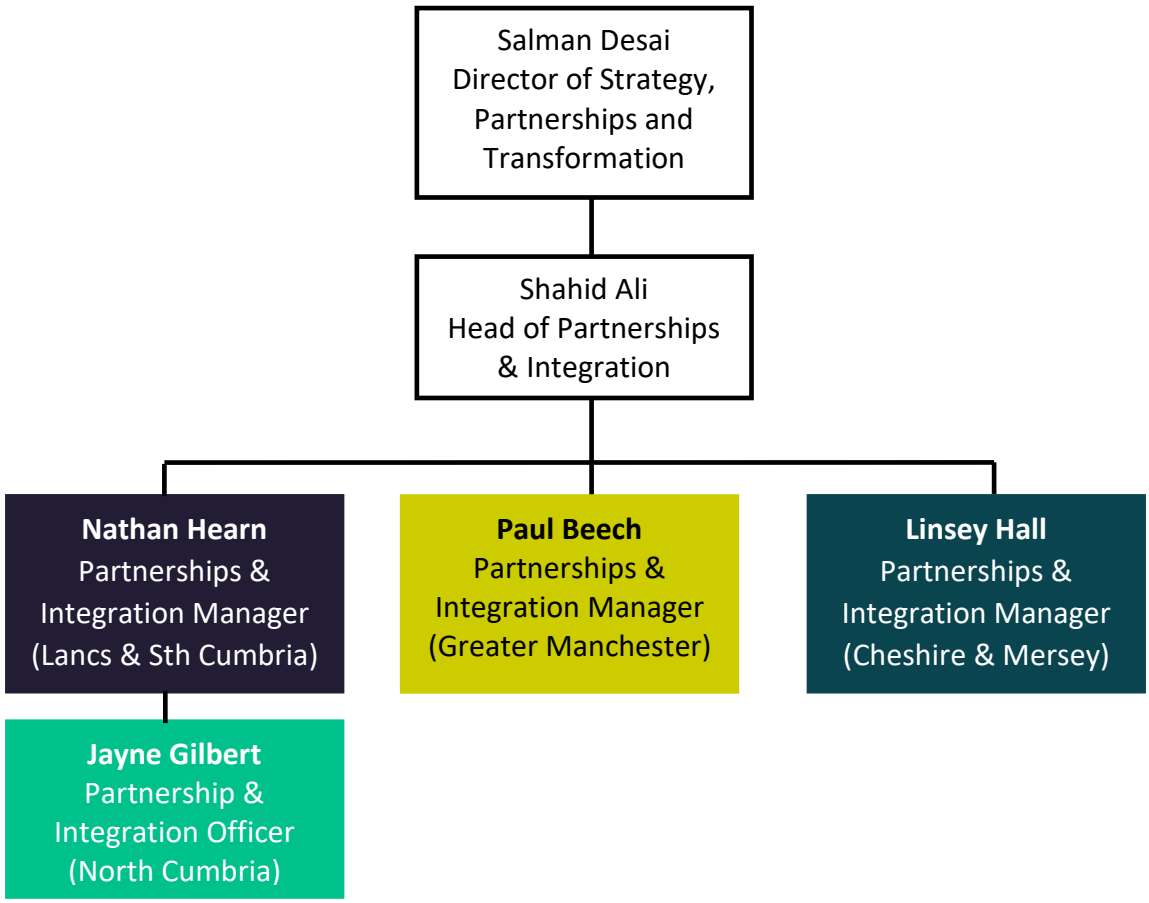
Building effective and efficient stakeholder relationships across the footprint, ensuring a working together approach between the trust and all external stakeholders and partners.

The team will work with across internal directorates and external partners to coordinate, manage, monitor and review actions through dialogue, debate, discussion and decision making with partners.

The team is embedded across the trust, and a lead partnerships and integration manager for each ICS area.

We will also build capability through a digital **Knowledge Vault** to ensure that actions agreed are progressed in a timely manner, equipping managers with the latest information and intelligence to share across the region to strengthen working together arrangements.

The team structure is as follows:



Current structure and system

As a regional provider North West Ambulance Service considers partnership and integration as an important an integral part of our work. We participate in the ambition of the Long Term Plan, and actively engage in its four core aims of

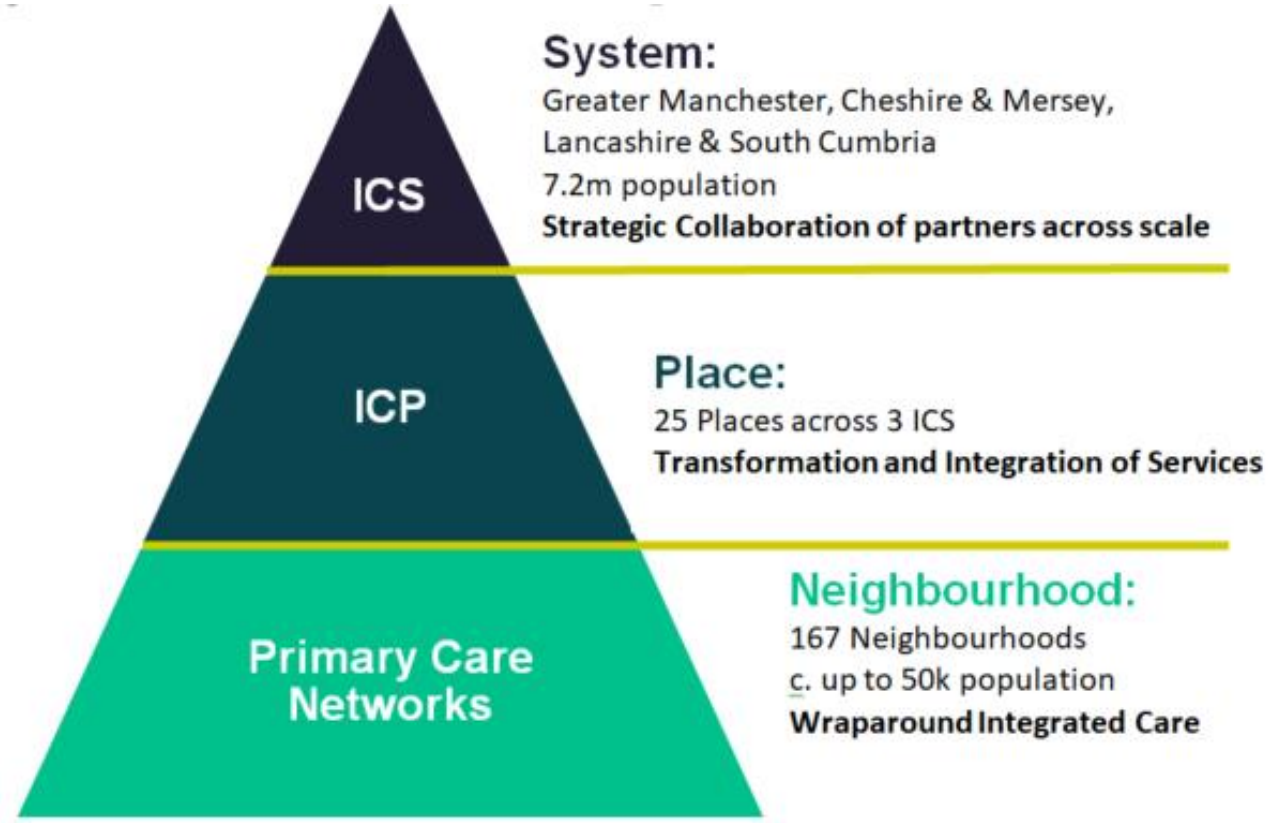
- Improving population health and healthcare outcomes
- Tackling inequality of outcome and access
- Enhancing productivity and value for money, and
- Helping the NHS to support broader social and economic development.

NWAS recognises that ambulance services provide both system and regional delivery platforms. We have an opportunity to enhance our role as a strategic and local partner, and to influence change going forward.

Our current assets engaged in ICS partnership working locally are:

- Clear senior relationships and representation from NWAS is delivered by executive directors and non-executive directors
- Executive directors are aligned with lead responsibility for an ICS area
- Partnerships and integration managers working with the ICS structures and external health partners
- Communications team support external engagement and ensure these align to stakeholders
- Head of Service support for local engagement for each area
- The Patient Engagement Team support engagement and collaboration with patients and the public

The system that the trust operates in is shown below, appointments are being made to the three ICS structures through September 2021.



Vision for Future - Partnerships and Integration

NWAS aims to be a trusted provider, an innovative collaborator, regional leader and influencer, and a positive employer.

As ICS develop and take shape over the short term and NWAS participates in developing local priorities new future structures will emerge. NWAS support and influence, especially in the arena of developing UEC pathways and pathways to avoid conveyance (and admissions) can share learning and good practice from within the region.

There is an opportunity to join with ICS partners and be involved in the key debates and decision making, to identify and reduce health inequalities by joining up our data, information and intelligence.

Key Objectives for 2021-22

The Partnerships and Integration team have a number of key short term objectives for the remainder of 2021-22 to ensure that the trust is in the best position possible to meet the new challenges.

Develop and strengthen stakeholder relationships with the ICS structures

Building long lasting, sustainable professional relationships with partners by being part of the ICS structures based on mutual respect, and a working together approach to improve services for patients and the public.

Working together with partners to coordinate, manage, monitor and review actions to get things done.

Stakeholder Mapping and Analysis

Map and analyse all trust external meetings across the ICS areas to ensure that the trust has the right level of expertise, at the right meeting, delivering the right message.

Ensuring consistency of message in relation to ask and offer across the region.

Develop, implement and maintain a Knowledge Vault (KV)

Design, develop and implement an online Knowledge Vault for use across the trust which enables a better way of using information and intelligence to inform decision making.

The KV will be the go to place for managers and include:

- ***Safe Space*** – A place where trust information, narrative and messaging, which has been quality assured and reviewed can be shared safely with partners and stakeholders.
- ***Capture of Information and Actions*** – Where free text information and actions from external meetings can be captured and uploaded remotely to the KV.
  Automated emails to managers to ensure actions are progressed internally to ensure they are completed in a timely manner.
- ***Drawdown of historical information*** – The ability to remotely drawdown information and history from previous meetings, including discussions and actions, enabling a richer consistent discussion.
- ***Search Facility*** – Based on Keyword, Area, Manager, Date, Name, Service line

System Profiles for the ICS areas

Compile system profiles for each of the ICS areas looking at key health data; demographics; population; key system information and contacts.

Partnerships and Integration 2021/22

Building effective stakeholder relationships through dialogue, debate, discussion and decision making with our partners.

We will achieve this by:

1. PARTNERSHIPS

Working together with partners to coordinate, manage, monitor and review actions to get things done.

OBJECTIVE

Consistency of: message, narrative, ask, offer and representation.

DELIVERABLES

1.1 Being clear on our ask and offer to partners

1.2 Integration of external services changes within the trust

2. RELATIONSHIP MANAGEMENT

Ensuring we have long lasting and effective relationships with organisations across the footprint which strengthen our working together arrangements.

OBJECTIVE

Ensuring we are central to decision making across the region and to develop and deliver services going forward.

DELIVERABLES

2.1 Engage with the new ICS/ICP structures, at the appropriate level

2.2 Stakeholder engagement mapping across the trust footprint

3. INFORMATION EXCHANGE

Establishing an online Knowledge Vault which will enable a better way of using information and intelligence with partners to inform decision making

OBJECTIVE

We will make appropriate and timely decisions through information and intelligence via the Knowledge Vault.

DELIVERABLES

3.1 Design and develop the Digital Knowledge Vault for use across the trust

3.2 Equipping directorates and managers to ensure they have the right information at the right time

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Appendix 2

STAKEHOLDER MAPPING AND ENGAGEMENT – EARLY ANALYSIS

National	
Name of meeting	**Attendance**
Joint Ambulance Improvement Board	Daren Mochrie
National Ambulance Directors of Finance	Carolyn Wood
Ambulance ICS Procurement Meeting	Daren Hopkinson
NDOG (Directors of Operations Group – National Ambulance Services)	Ged Blezard/Steve Hynes
HFMA Environmental Sustainability Special Interest Group	Paul Gilfoyle
National Ambulance Estates Group	Neil Maher
QGARD (Quality, Governance + Risk Directors)	Maxine Power
National Human Resources Development	Lisa Ward
National Ambulance Service Medical Directors (NASMeD) and Clinical Quality Group (NASCQG)	Chris Grant

Regional	
Name of meeting	**Attendance**
NW System Leaders Meeting	Daren Mochrie
NW Directors of Finance/CFOs	Carolyn Wood
Strategic Partnership Board/ODG	Executives
North West Human Resources Development	Lisa Ward
NAA Digitisation Board	Michelle Brooks, Ged Blezard, Dan Ainsworth
NAA Net Zero Group	Karen Aguilera

Cheshire and Merseyside	
Name of meeting	**Attendance**
Local Resilience Partnerships & Forums	Roger Jones
C&M Emergency Care Network	Roger Jones
Blue Light Executive Group	Dave Kitchin, Roger Jones, Maxine Power, Lisa Ward
Merseyside 111/NWAS Commissioning Meeting	Dave Kitchin, Ian Stringer, Linsey Hall
C&M Provider CEO Collaboration Meeting	Lisa Ward, Maxine Power
C&M Partnership Board	Maxine Power
ICS Development Advisory Group	Maxine Power, Linsey Hall
C&M ICS Sustainability	Karen Aguilera
Mid Mersey AEDB	Matt Calderbank, Linsey Hall
Southport & North Mersey AEDB	Dave Kitchin, Stuart Ryall, Linsey Hall
Wirral AEDB	Graham Dodd, Linsey Hall
West Cheshire AEDB	Val Davies, Linsey Hall
West Cheshire Health & Wellbeing Overview & Scrutiny Committee	Executive Lead, Roger Jones
East Cheshire AEDB	Tom Maloney, Linsey Hall
Central Cheshire AEDB	Val Davies, Linsey Hall

Greater Manchester	
Name of meeting	**Attendance**
GM Provider Federation Board	Daren Mochrie
GM Area Commissioning Meeting	Dan Smith/Ian Stringer/Nicola Hughes
UEC Board	Mark Newton
GM Directors of Finance/System Finance Group	Carolyn Wood
GMHSC Partnership Sustainability Leads	Karen Aguilera
GM Oversight & Scrutiny Committee	Dan Smith
GM Resilience Forum SCG	Dan Smith/Daren Mochrie
GM Community Coordination Group (out of hospital cell)	Mark Newton
GM NHS Gold Command Group	Dan Smith/Sam Molloy (PTS)
Wigan AEDB	Donna Hooley
Bolton AEDB	
Salford AEDB	
Tameside AEDB	Fran Dreniw
Stockport AEDB	

Cumbria and Lancashire	
Name of meeting	**Attendance**
North Cumbria ICP System Executive Group	Ged Blezard
Lancashire & South Cumbria System Leadership Executive	Daren Mochrie, Carolyn Wood
Provider Directors of Finance	Carolyn Wood/Michelle Brooks
North Cumbria ICP Leaders Board	Ged Blezard
North Cumbria AEDB	Rhonda Stanger, Jayne Gilbert
Cumbria Area Commissioning Meeting	Gene Quinn, Ian Stringer
Lancashire Area Commissioning Meeting	
Lancashire Local Resilience Forum	Gene Quinn
Cumbria Local Resilience Forum	Gene Quinn
Lancashire & South Cumbria Urgent & Emergency Network	Gene Quinn, Matt Dunn, Nathan Hearn
Lancashire & South Cumbria ICS Sustainability Collaborative Partnership	Paul Gilfoyle
Fylde AEDB	Jennie Peall
Morecambe Bay AEDB	Rick Shaw, Nathan Hearn
East Lancashire AEDB	David Dixon, Nathan Hearn
Central Lancashire ICP UEC System Delivery Board	Dave Suart, Nathan Hearn