North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 31 March 2021
9.00 am - 12.30 pm

via Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2021/138	Patient Story	09:00	Information	Director of Strategy and Planning	
INTRODUCTION					
BOD/2021/139	Apologies for Absence	09:00	Information	Chairman	
BOD/2021/140	Declarations of Interest	09:00	Decision	Chairman	
BOD/2021/141	Minutes of Previous Meeting	09:00	Decision	Chairman	3 - 18
BOD/2021/142	Board Action Log	09:05	Assurance	Chairman	19 - 20
BOD/2021/143	Committee Attendance	09:10	Information	Chairman	21 - 22
BOD/2021/144	Register of Interest	09:15	Assurance	Chairman	23 - 24
STRATEGY					
BOD/2021/145	Chairman & Non-Executives' Update	09:20	Information	Chairman	
BOD/2021/146	Chief Executive's Report	09:30	Assurance	Chief Executive Officer	25 - 40
BOD/2021/147	Northern Ambulance Alliance Progress Report	09:40	For Discussion	Chief Executive Officer	41 - 46
BOD/2021/148	UEC Strategy Refresh	09:50	Decision	Deputy Chief Executive Officer	47 - 98
BOD/2021/149	Digital Strategy Refresh	10:00	Decision	Director of Quality, Innovation and Improvement	99 - 172
GOVERNANCE AND RISK MANAGEMENT					
BOD/2021/150	Board Assurance Framework (BAF) Risks 2021/22	10:10	Decision	Director of Corporate Affairs	173 - 178
BOD/2021/151	Risk Appetite Statement 2021/22	10:20	Decision	Director of Corporate Affairs	179 - 184
BOD/2021/152	Governance Structure - Trust Board, Assurance Committees	10:30	Assurance	Director of Corporate Affairs	185 - 192
BOD/2021/153	Chairman's Annual Fit and Proper Persons' Declaration	10:40	Assurance	Director of People	193 - 198
BOD/2021/154	Non-Executive Directors - Terms of Office 2021/22	10:50	Assurance	Director of Corporate Affairs	199 - 202
QUALITY AND PERFORMANCE					
BOD/2021/155	Integrated Performance Report	11:00	Assurance	Director of Quality,	203 -

				Innovation and Improvement	258
BOD/2021/156	CQC Regulation Update	11:15	Assurance	Director of Quality, Innovation and Improvement	259 - 268
BOD/2021/157	Learning from Deaths: Quarter 3 2020/21	11:25	Assurance	Medical Director	269 - 278
BOD/2021/158	Quality and Performance Committee Assurance Report - from the meeting held on 15th February 2021 and 15th March 2021	11:35	Assurance	Prof A Chambers, Non-Executive Director	279 - 294
BOD/2021/159	Resources Committee Chairs Assurance Report - from the meeting held on 26th March 2021	11:45	Assurance	Mr M O'Connor, Non-Executive Director	295 - 306
FINANCE					
BOD/2021/160	Green Plan Review	11:55	Decision	Director of Finance	307 - 346
BOD/2021/161	Modern Slavery Act 2015 Statement	12:05	Decision	Director of Finance	347 - 354
COMMUNICATIONS AND ENGAGEMENT					
BOD/2021/162	Communications and Engagement Report - Q3 2020-21	12:15	For Discussion	Director of Strategy and Planning	355 - 364
CLOSING					
BOD/2021/163	Any Other Business Notified Prior to the Meeting	12:25	Decision	Chairman	
BOD/2021/164	Items for Inclusion on the BAF	12:30	Decision	Chairman	

Date and Time of Next Meeting 11.00am on 28th April 2021 via Microsoft Teams

NHS North West Ambulance Service NHS Trust

Minutes
Board of Directors

Details: Wednesday 27th January 2021 9.45am
Microsoft Teams

Present:

Mr P White	Chairman
Prof A Chambers	Non-Executive Director
Dr D Hanley	Non-Executive Director
Mr M O'Connor	Non-Executive Director
Mr D Rawsthorn	Non-Executive Director
Mr M O'Connor	Non-Executive Director
Prof R Thomson	Associate Non-Executive Director (Clinical)
Mr D Mochrie	Chief Executive
Mr M Forrest	Deputy Chief Executive
Mr G Blezard	Director of Operations
Dr C Grant	Medical Director
Ms C Wood	Director of Finance
Ms L Ward	Director of People
Ms A Wetton	Director of Corporate Affairs
Mr S Desai	Director of Strategy & Planning
Prof M Power	Director of Quality, Innovation and Improvement

In attendance:

Ms V Davies	Deputy Chair / Non-Executive Director, St Helens & Knowsley Teaching Hospitals NHS Trust (Observer)
Ms J Pritpal	CQC (Observer)
Mr A Wood	Operational Governance & Risk Manager (Observer)
Mrs S White	Risk and Assurance Officer (Observer)
Mrs P Harder	Head of Corporate Affairs
Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)

Minute Ref:

BOD/2021/114 Apologies for Absence

There were no apologies for absence.

B0D/2021/115 Declarations of Interest

There were no declarations of interest to note.

BOD/2021/116 Minutes of Previous Meeting held on 25th November 2020 and 16th December 2020

The minutes of the previous meeting held on 25th November 2020 and 16th December 2020 were agreed as a true and accurate record.

BOD/2021/117 Action Log

The Board noted that the action number 52 regarding serious incidents reporting was embedded in the Quality and Performance Committee Work Plan and reported to Board of Directors via the Chairs Assurance Report.

The Board of Directors noted the update to the action log.

BOD/2021/118 Committee Attendance

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

BOD/2021/119 Register of Interest

The Board noted the 2020/21 register of interest presented for information and agreed it was a true and accurate record.

BOD/2021/120 Chairman and Non-Executive Directors Update

The Chairman reported that he continued to represent the Trust via online meetings both at regional and local level to discuss strategic and operational delivery of services.

He added there was a focus on the Integrated Care Systems and the NHS as a whole feeling the pressure amidst the third wave of the Covid-19 pandemic. He acknowledged a recent letter from Mr Bill McCarthy, North West Regional Director, NHSE/I regarding reducing the governance burden and that Regional and National meetings with Chairs and CEOs across the ambulance services had continued.

He reported that latest communications with NHSE/I had involved a great deal of discussion on the preparation and administration of the Covid-19 vaccination and noted that the forthcoming removal of lock down restrictions would have an impact on infection rates across the North West over the Christmas period; to add to winter pressures.

He noted that the key focus for the Board continued to be the delivery of the best service possible, to ensure patients were safe and received quality services.

The Board:

- Noted the update from the Chairman.

BOD/2021/121 Chief Executive's Report

The Chief Executive presented a report to provide members with information on a number of areas since the last report presented to the Trust Board on 25th November 2020.

He highlighted that the Paramedic Emergency Services (PES) continued to deal with the pressure of a global pandemic and that the delivery of the winter/festive plan had ensured the Trust managed the Christmas and New Year pressures. He reported

that NWAS continued to maximise resources and support staff and volunteers to deal with the pressures.

In terms of the NHS 111 service, a call pick up rate of 74.83% was achieved through December and a new telephony system went live, successfully, on 12th January 2021.

He explained that a significant amount of work to recruit additional staff and refine the clinical advice queue had been undertaken within Cleric, to allow more efficient management of the queue.

The Chief Executive reported that the Trust had continued to recruit staff for the new National NHS 111 First programme to support ED activity demand and he thanked the team, new staff and the technology teams for their hard work.

Prof A Chambers, Non-Executive Director observed and supported the hard work of staff in the NHS 111 service and congratulated colleagues on the recruitment of staff and implementation and launch of the new telephony system.

The Chief Executive further advised that the Trust had successfully implemented the Covid-19 vaccination programme and thanked the Director of People, her teams and NWAS volunteers for their efforts and the progress made.

He added there had been extensive engagement between Ambulance Service Chief Executives and Chairs through the Covid-19 winter pandemic, including attendance on the NHSE/I North West Leadership Group and at Regional Incident meetings.

In response to significant high demand the Chief Executive advised that the Trust moved to the highest REAP level on 12th January due to significant high demand and has remained at level 4 since this date.

The Chief Executive advised that a live launch of the Race Equality Network took place yesterday with a future update to the Board.

He reported that the Trust continued to work with the Care Quality Commission (CQC) and NWAS had completed a second transitional monitoring approach (TMA) interview with the local inspector on 19th January 2021 following submission of a comprehensive assurance document covering all aspects of regulatory compliance and governance across the Trust; which had been confirmed as very good assurance.

The Chief Executive announced that NWAS received the Ambulance Service of the Year Award in the prestigious Health Business Awards. He explained that the Award went to the Trust that had embraced change and demonstrated a decrease in response times with the ability to provide treatment at the scene of an accident and the provision of outpatient services. The award predominantly related to the collaborative work carried out by an NWAS paramedic and occupational therapist who responded to non-life threatening calls for falls, so that patients could be treated at home or referred to a community service, without having to go to hospital. He acknowledged and congratulated the two members of staff and their teams.

In relation to the Manchester Arena Inquiry Proceedings, the Chief Executive confirmed that the Inquiry resumed on 18th January 2021 and the Trust continued to prepare for proceedings.

He sadly reported the deaths staff and colleagues during the last and paid tribute to Ian Fawcett, Peter Sargeant, Ryan Booth, Bill Delaney and Bill McKenna

Mr D Rawsthorn referred to the Integrated Care System Consultation and option 2 in the Chief Executive's report. The Chief Executive advised that NWAS and the Association of Ambulance Chief Executives (AACE) with the support of Bill McCarthy, Regional Director had submitted an initial response to the consultation and NWAS were engaged with the Regional Director for Yorkshire and Humber Region.

Prof R Thomson referred to Cleric and management of the clinical advice queue. The Chief Executive confirmed the unified telephony platform that went live in January 2021 provided the foundations for an integrated model and the functionality was working well. He added that the team were ensuring the Trust had the ability to integrate NHS 111, emergency departments and other services.

Mr M O'Connor, Non-Executive Director recognised the Trusts ambitious digital agenda and referred to call passing capabilities during the pressures.

The Chief Executive explained that devolved administrations across AACE had ensured the service worked collaboratively in relation to 999 calls and that NWAS had increased resources significantly to absorb 999 calls to enable them to take 200-300 additional 999 calls without an impact on quality whilst also supporting the ambulance service in Scotland.

At this point in the meeting, the Director of Strategy and Planning referred to questions raised by the Public and Patient Panel as follows:

I see the Transformation of Urgent and Emergency Care: a model of care and measurement consultation period is due to end in February. In the Chief Executive's report, he mentions "standards should measure what matters most to patients". Will there be a future role for the PPP in assisting in this?

In response, the Deputy Chief Executive advised that the consultation is open to patients, clinicians and members of the public and I would encourage the PPP to share their views or concerns if they have any. If the PPP would like to submit their feedback, I am happy to get Jenna and Fran to facilitate a virtual discussion to support you. As and when the measures are agreed and implemented, we will of course look to the PPP to tell us how it is going.

Has NWAS experienced any initial supply problems this month, since we left the EU?

In response, the Director of Finance reported that since leaving the EU on 31 December 2020, the Trust has not experienced any problems with the supply chain. The situation continued to be closely monitored by the Procurement Team.

What % of NWAS staff has now received vaccinations against COVID19?

In response, the Director of People advised that as at 26th January, a minimum of 55% (3919) of substantive and bank staff have been vaccinated, with vaccinations ongoing.

The Chairman recognised the outstanding performance of the Trust on behalf of the Board and stated that NWAS continued to operate in very challenging times. He added that the teams had delivered not only operationally but also in technology and through the launch of NHS 111 First.

He also congratulated the teams on the successful launch of the Race Equality Network.

He added that escalation to REAP Level 4 had meant delays in delivery of mandatory training and appraisal activity, however recognised and supported the action taken

by the service to support other ambulance trusts during a time of significant pressure. He added that NWAS had contributed positively to the NHS to meet demands during a National pandemic.

In relation to the Manchester Arena Inquiry, the Chairman recognised the emotional demands on staff and their families.

He congratulated the Trust on the Ambulance Service of the Year Award, which was significant to the Trust's ambition to become the Best Ambulance Service in the UK.

Finally, the Chairman paid tribute to the tragic loss of NWAS staff, detailed in the Chief Executive's Report. He recognised these times were increasingly difficult and support for families, friends, colleagues was paramount.

The Board:

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

BOD/2021/122 Northern Ambulance Alliance Update

The Chief Executive presented a report that provided an overview of Northern Ambulance Alliance (NAA) key work stream progress.

He reported that Appendix 1 provided an update on the various projects and that although there had been positive progress across a number of work streams, some projects had slowed down due to the impact of Covid-19.

Mr D Rawsthorn reported that he had set up email communication links with Audit Chairs from the NAA in order to share best practice and discuss issues and developments. The Chief Executive thanked Mr D Rawsthorn and highlighted that the NAA Legal networks and partnerships were a positive step but required further clarity.

The Board:

- Noted the content of the report, the current position and plans for the NAA work streams.

BOD/2021/123 Q3 Board Assurance Framework Review & Corporate Risk Register (CRR)

The Director of Corporate Affairs presented the proposed Q3 position as at 31st December 2021 of the Board Assurance Framework (BAF) with the associated Corporate Risk Register risks scored 15 and above.

She reported that in total there were 23 risks that scored 15 or above and aligned to the strategic risks in the BAF. She added 21 actions had been completed during Q3 with no actions yet to be commenced or completed late. As part of the Q3 review, with Executive Director leads, no proposed changes to the BAF had been identified.

The Director of Corporate Affairs confirmed that the Trust's Executive Leadership Committee reviewed the risks on the Corporate Risk Register on a monthly basis. She reported an amendment to s5 in the report reference strategic risk SR01 that stated 21 actions were to be completed, which should read 14 actions to be completed.

The Director of Corporate Affairs advised that due to the current operational pressures, the Trust's Executive Leadership Committee would consider the Strategic

Risks for 2021/22 in March, followed by a dedicated session with Non-Executive Directors on the strategic risks and risk appetite.

She confirmed the Strategic Risks for 2021/22 would be presented to the Board of Directors for final approval on 31st March 2021.

Dr D Hanley referred to page 59 and the risk of paramedic shortfalls.

The Director of People advised that the Trust had a focus on the training programme for paramedics and particularly the issue of internal progression. She added that the Trust were working hard to make the programmes flexible and actions completed by the Trust in Q4 would ensure the supply of qualified paramedics was maintained.
The Chairman referred to the BAF Strategic Risk SR07 relating to the Digital agenda and the actions with a January 2021 completion date.

Mr M O'Connor explained that the Resources Committee had received a comprehensive update at their meeting on 22nd January 2021 from the Chief of Digital and Innovation and confirmed that action to mitigate risks were being delivered well.

In relation to SR07, the Director of Quality, Innovation and Improvement confirmed that the implementation of the IT 24/7 support model would be extended into 2021/22 as implementation had proved logistically challenging during the pandemic.

The Board of Directors:

- Approved the Q3 position of the Board Assurance Framework.

BOD/2021/124 Corporate Calendar 2021/22

The Director of Corporate Affairs presented the Corporate Calendar for 2021/22, which proposed the Board and Committee meeting dates. She advised that the Audit Committee dates would be finalised by email following the meeting.

The Chairman stated it was commendable that the Board members had continued Board Assurance Committee meetings during the pandemic and thanked the teams for their hard work. He added the Trust should continue to do everything possible to continue the work of the Assurance Committees to promote strong governance through challenging times.

The Chief Executive thanked the Director of Corporate Affairs for ensuring the Calendar facilitated members commitments.

The Board –

- Approved the Trust's Corporate Calendar for 2021/22.

BOD/2021/125 Risk Management Policy 2021/22

The Director of Corporate Affairs presented the Trust's Risk Management Policy, following a full review and refresh.

She advised that the Board of Directors had approved the Risk Management Strategy in November 2020 and subsequently the Risk Management Policy had been revised

to define the approach taken by the organisation in applying risk management practices in a consistent manner across the Trust.

The Director of Corporate Affairs confirmed that Risk Management is a statutory requirement and an indispensable element of good governance.

Mr D Rawsthorn endorsed the Risk Management Policy 2021/22 and recommended the Non-Executive induction programme should include the Policy.

The Board -

- Approved the Risk Management Policy for 2021/22.

BOD/2021/126 Anti-Fraud, Bribery and Corruption Policy

The Director of Finance presented the Anti-Fraud, Bribery and Corruption Policy, which had been jointly reviewed and updated by the Anti-Fraud Specialist and Deputy Director of Finance. She reported that the aim of the Policy was to provide a guide for employees as to what fraud is in the NHS and to emphasise that it is everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it.

She highlighted the three key updates in the Policy, which included i. ensuring that four key principles of tackling fraud in the NHS were clear ii. compliance with the NHS Counter Fraud Authority's standards and iii. the roles and responsibilities section provided further clarity for all relevant parties, including additions for the Fraud Champion and Freedom to Speak Up Guardians.

The Director of Finance advised that the Audit Committee had approved the final version of the Policy for adoption by the Trust Board.

Mr D Rawsthorn noted that although the Policy does not have a specific section for theft, there is a link and reference to the Trust's Policy on theft.

The Board:

- Approved the Anti-Fraud, Bribery and Corruption Policy.

BOD/2021/127 Audit Committee Chair's Assurance Report from meeting held on 15th January 2021

Mr D Rawsthorn presented the Chairs Assurance Report from the Audit Committee meeting held on 15th January 2021.

He advised the Committee had received assurance from the Head of Digital Intelligence in relation to the step change relating to data quality processes and confirmed that internal audits had recommenced, with internal auditors complimentary about the engagement and management of audits.

The Audit Committee also reviewed the National Audit Office Check list and compared this with the work of the internal audit team and he confirmed that NWAS had covered the basics.

Mr D Rawsthorn advised of a new code of Audit Practice for external audit for 2021 with new outputs and value for money arrangements with an auditor required to produce an annual report.

The Chairman added that he had observed the Audit Committee meeting, which had been well chaired and productive, with many actions recommended from audits including completion dates.

He stated he felt confident that actions were completed and engagement between the external auditors, the Director of Finance and the Deputy Director of Finance provided prominence with the Committee and they were holding accountability.

The Director of Finance supported the Chairman and advised that the teams had proactively addressed outstanding actions across the Trust.

The Chairman thanked the Chair, the Directors and their teams for their hard work.

The Board:

- Noted the content of the Audit Committee Chair's Assurance Report from 15th January 2021.

BOD/2021/128 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report for January 2021, which reported the Trust's performance on Quality, Effectiveness, Finance and Operational Performance and Organisational Health during December 2020.

She highlighted that focused work continued to manage the complaints backlog caused by the pressures on operational staff not being able to close investigations in the required timeframe.

She reported the Trust had a robust process for learning from serious events via a review panel, chaired by the Medical Director. She added that findings were inputted into a data system that picked up alerts and recurring themes. She advised that operational groups and the Board were identifying themes and learning from complaints and incidents.

The Chairman advised that whilst there was a backlog in fully closing complaints, the work to review and obtain the themes at the earliest opportunity was robust and ongoing. He stated that in part 2 of the Board meeting there was time dedicated for robust discussion on safeguarding and serious incidents to provide the Board with the required assurance.

Prof R Thomson confirmed that quarterly reviews with Non-Executive Directors were also held and fed into the audit process.

The Director of Operations reported operational performance and explained that December had been a challenging month for the 999 service due to Covid-19 related staff abstractions and delays caused by donning of PPE.

He advised that the Trust's Winter Plan and December festive plans had been delivered successfully across the 2 week holiday period.

He reported that hospital handover delays had reduced capacity and that the Director of Quality, Innovation and Improvement and her team were working collaboratively with acute trusts and regionally to improve the situation.

Dr D Hanley referred to the impact on patients whilst waiting in ambulances. The Director of Quality, Innovation and Improvement advised that the Trust had implemented measures to deal with the delays which included action cards for staff

to ensure support from crews and patient safety. She further advised that joint working with hospital colleagues was actively ongoing at Executive Director level but stated that the amount of pressure on the health care service had been unprecedented. She added that more alternative pathways for patients were monitored daily.

She reported that the Trust had networked into the Regional Improvement Team and National Handover at Work team, on the basis that every patient matters.

The Chief Executive added that hospital handover delays was on the agenda with NHSE via Regional Leadership Groups and the Regional Director was aware of the operational situation.

In terms of NHS 111, the Director of Operations confirmed that agency recruitment during wave 2 of the pandemic had been necessary and the Trust had responded successfully, to recruit the levels of staff required.

The Director of People confirmed that the Trust recruited the highest level of agency staff into EOCs and there was a clear plan to roll out fixed term and permanent contracts. She added that an agency exit strategy would be presented to the Resources Committee in March 2021.

The Director of Operations advised that there was a concern that the build-up of annual leave due to the pandemic pressures would have an impact in 2021/22. The Director of Finance reported that the impact of annual leave had been raised at Board level and the Trust awaited national guidance as to how this would be managed operationally.

The Medical Director reported that the Ambulance Quality Indicators (AQIs) had remained consistent and although the rankings changed from month to month in comparison to other trusts over all, there had been no significant change. The Chairman advised that considering the pressures it was extremely positive that the Trust's performance against the AQIs had remained consistent.

In relation to PTS, the Director of Operations confirmed that in order to reduce the burden on PES, the service were continuing to support PES in their work with the wider acute systems whilst delivering a discharge service to renal oncology patients.

In terms of organisational health, the Director of People reported that the overall staff appraisal completion rate was 69.87% against a revised trust target of 85%; lower than 95% due to the effect of Covid-19.

Mr M O'Connor confirmed that there had been robust debate regarding the revised target at Resources Committee and was included in his Chair's Assurance Report.

The Chief Executive confirmed that the Trust were not taking the challenges of the targets lightly and the trust were working to maintain good compliance and aspiring to the pre-pandemic high standard. However, he advised under the current pressures the Trust had held lengthy discussions regarding the revised target to ensure the target was realistic.

The Director of People added that the Trust's priority was the health and wellbeing of the staff who were tired. She added there was an extensive risk assessment process to enable the Trust to provide the relevant support and explained that management were holding the conversations with staff regarding their health and wellbeing during contact shifts and normal interactions with PES staff to spot early signs where support may be required.

Dr D Hanley referred to turnover figures and asked if an increase in turnover was anticipated post Covid-19. The Director of People advised that the department was maintaining a focus on retention work and learning from previous turnover rates. She advised that there was a current correlation between the recruitment market and the current pandemic situation.

The Deputy Chief Executive congratulated the Director of People and the vaccination team for their hard work in setting up the NWAS vaccination hub at Broughton.

The Director of Quality, Innovation and Improvement reported an error on page 214 of the report for C1 ranking, which should read 7th not 8th. She added that in relation to Covid-19 outbreaks, the Trust had now received clear guidance from Public Health England on the definition of an outbreak, which was 2 or more confirmed cases shown to be through a linked work experience.

She advised that in light of the guidance the NWAS Test Track and Trace Process had been reviewed and was reported monthly at the Quality and Performance Committee. She confirmed 27 new outbreaks in NWAS in December, which reflected the escalating position of cases in the region.

The Chairman thanked the Directors for their robust reporting and discussion and stated it was important the Board gave time to discuss patient safety and staff welfare.

He confirmed that the hospital handover time for patients at A&E departments was having a significant impact on the system and particularly the impact in the service's ability to attend to patients in the community. He added the pressure on the staff taking the calls was of equal concern.

The Chairman stressed the importance of working with partners to improve the handover situation and this was critical to patient safety and performance. He added that the situation would continue to be monitored by the Board through the Quality and Performance Committee.

The Board:

- Noted the content of the report.
- Noted the impact on performance of Covid-19 staff abstractions.
- Clarified the ongoing monitoring of hospital handover delays to Board through the Quality and Performance Committee.

BOD/2021/129 IPC Board Assurance Framework (BAF) Refresh

The Director of Quality, Innovation and Improvement presented the IPC Board Assurance Framework (BAF) which 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 that the BAF also identified gaps in assurance, IPC risks and mitigations. She reported that the Framework was organised under 10 Key lines of enquiry, each with a series of questions to be addressed.

The Director of Quality, Innovation and Improvement confirmed that the Executive Leadership Committee and Quality, and Performance Committee had approved the associated action plan and risk log. She also confirmed that the Trust had received an external assurance from NHSI who had visited the Trust and the BAF had also been shared with the Care Quality Commission. She advised that the paper detailed

the actions taken during Quarter 3 and provided the Board with an overview of the current position.

The Chairman referred to s9 of the report, which reported a risk of lack of audits and IPC support. The Director of Quality, Innovation and Improvement assured the Chairman that daily audits and the work plan to mitigate this risk were on track and the action rated green.

Prof A Chambers confirmed that the Quality and Performance Committee provided detailed scrutiny and time taken to consider the IPC BAF and she felt actions to mitigate risks were ongoing with hard work from the team.

The Chairman compared the report to a previous paper and stated that there had been a focused approach, which was critical with the high staff abstraction rates.

The Board:

- Noted the updated published revisions of the IPC Board Assurance Framework (BAF).
- Noted the updated risks and actions from the original IPC BAF and revised Board guidance.

BOD/2021/130 Complaints, Incidents and Investigations Policy

The Director of Quality, Innovation and Improvement presented the Trust's Complaints, Incidents and Investigations Policy. She reported that whilst a number of procedures exist within the Trust for the management and progression of complaints, incidents and serious incident investigations it was identified that there was no overarching policy to ensure consistency in line with National strategy and guidance.

The Chairman welcomed the Policy, which had been approved by the Trust's Executive Leadership Committee.

The Board:

- Supported approval of the Trust's Complaints, Incidents and Investigations Policy.

BOD/2021/131 Quality and Performance Committee Chairs Assurance Report – from the meeting held on 18th January 2021

Prof A Chambers presented the Chairs Assurance Report from the meeting held on 18th January 2021.

She advised there had been robust scrutiny of papers and Committee members had sought assurances relating to the areas of patient safety and Infection Prevention and Control.

She reported that the amber ratings in the Chairs Assurance Report related to the increasing demand on the emergency service and hospital handover delays, which was ongoing and the Committee would continue to monitor.

In terms of Learning from Deaths, she highlighted that the amber rating related to the resources available within the team for the auditing process, caused by the pandemic pressures. However, the Committee had held a robust discussion and felt assured that Learning from Deaths analysis involved two contrasting methodologies and the approach effectively triangulated evidence based learning.

She added that the audit team reported an increase in PPE time and further formal support was required for staff who repeatedly failed to wear PPE. The Committee had supported the proposal to implement Quality Improvement Plans over the next 6 months and the Committee continued to receive monthly updates on Covid-19 cases and outbreaks.

Prof A Chambers advised that the Trust's management groups met weekly and monthly, there was scrutiny, and frameworks that provided the operational oversight to the Quality and Performance Committee.

The Board:

- Received and noted the content of the Quality and Performance Committee Chairs Assurance report from 18th January 2021.

BOD/2021/132 Resources Committee Chairs Assurance Report – from the meeting held on 22nd January 2021

Mr M O'Connor presented the Chairs Assurance Report from the meeting held on 22nd January 2021.

He advised that although there had been a condensed agenda, due to the extreme pandemic pressures, the Committee had received assurance regarding the Trust's financial performance at 31st December 2020.

He reported that an appraisal process of waivers and tenders would be presented to a future Committee.

In terms of appraisals and mandatory training compliance, the Committee noted moderate assurances in relation to the reset targets and would continue to monitor future performance. The Committee also received an NWAS vaccination report from the Director of People, which provided assurance on implementation of the programme.

Mr M O'Connor reported that the Chief of Digital and Innovation had presented an in-depth review of the digital agenda, which had highlighted the extent of the work involved.

The Board:

- Received and noted the content of the Resources Committee Chairs Assurance report from 18th January 2021.

BOD/2021/133 Workforce Governance Structure

The Director of Corporate Affairs presented a proposed governance structure to strengthen the governance and assurance processes relating to workforce matters. She advised the proposal involved establishing a Strategic Workforce Management Group to provide assurance to the Resources Committee to ensure the Trust had appropriate and effective strategies and plans relating to workforce, education, organisational development and culture to enable the Trust to meet its Strategic Objectives.

She added that the Group would review and oversee the implementation of the key provisions in the NHS People Plan that relate to NWAS, other national strategic plans/guidance and the NWAS Workforce Strategy.

The Director of Corporate Affairs advised that the structure included the proposal to establish an Equality, Diversity and Inclusion Assurance Group would report jointly

to the Resources Committee on workforce and public engagement related matters and to the Quality and Performance Committee on patient related matters.

Prof A Chambers welcomed the workforce proposal and the scrutiny of patient related matters at the Quality and Performance Committee meetings.

The Chairman supported the proposed structure and advised that this closed a loop in sub committee assurance reporting to Board, ensured scrutiny of workforce issues and the impact on staff and patients.

The Board:

- Agreed the establishment of a Strategic Workforce Management Group reporting into the Resources Committee.
- Approved the establishment of an Equality, Diversity and Inclusion Assurance Group reporting into both Resources Committee and Quality & Performance Committee.
- Noted the intention to run the structure in shadow form for the remainder of the financial year before commencing formal reporting, with evaluation taking place during the first 12 months of operation.

BOD/2021/134 Equality, Diversity and Inclusion Report

The Director of People presented an EDI report, which provided an overview of the strategic reset of the Trust's Diversity and Inclusion approach. The paper provided discussion on the context and drivers for the reset, the work already undertaken and outlines the proposed priority areas for the Trust that aim to support the delivery of a step change in the experience of our staff and patients from protected groups.

She reported that although the Trust had made demonstrable progress in narrowing the gaps in staff experience for different protected groups and that inclusion is a key improvement goal within the Workforce Strategy, the Trust's staff survey results still highlighted differences in the experience of some of our protected groups, especially BAME and disabled staff.

The Director of People confirmed that the Trust's Executive Leadership Committee (ELC) had held lengthy debates on the areas of focus and the external demands and drivers.

She advised that the ELC had committed to the development and delivery of three key objectives, which the ELC believed to be critical to delivering a step change in the experience of our staff and patients. (i.) better representation in the workforce creating role models and visibility which changes the dynamic of discussion and diversity of thinking (ii.) the need to embed core values and challenge where those are not being lived, supported through education and a willingness to have the difficult conversations about discrimination, particularly in respect of race (iii.) the importance of staff and patient voice in driving real change

In relation to the second priority, regarding education, the Director of People confirmed that the Trust's Treat Me Right campaign launch in Q4 would develop leaders and enable challenging conversations. She added the Just Culture competencies would be interlinked to facilitate improved staff and patient outcomes.

Dr D Hanley stated he fully supported the key priorities, which he felt were much focused and welcome. He added that the workforce structure paper to strengthen governance and accountability around EDI with reporting to Quality & Performance

and Resources Committee provided a more robust focus and provided the platform for discussion that EDI deserved.

Mr M O'Connor welcomed the report and noted that work to reflect the communities NWAS served through accessing the talents of people from different backgrounds to support and encourage career developments.

The Director of Strategy and Planning supported the Board priorities and encouraged leadership through example involving the Board and BAME networks across the Trust.

The Chairman welcomed the EDI report and thanked the Deputy Chief Executive for his input in progressing the EDI agenda over the years.

He stated that a commitment at Board level and working through developed networks would be key. He added that NWAS work linked to the broader network with NHSE/I and the Health and Equalities in the North West.

The Board:

- Approved the diversity and inclusion key priorities for further work.
- Noted the work already undertaken to improve leadership and governance of diversity and inclusion.

BOD/2021/135 Organisational Values – Implementation Plan

The Director of People presented a report that outlined the approach taken by NWAS to introduce, embed and implement the refreshed organisational values across all service lines and into business as usual activity, in support of the People Plan, NHS England 2020 and the Workforce Strategy.

She advised that the organisational values had been refreshed based on feedback from staff on what is important to them at work towards providing the best possible patient care and supporting NWAS to become the best ambulance service nationally and were shared with the Board of Directors in December.

The Director of People reported that NWAS was now at a stage where the newly refreshed values were ready for organisation-wide implementation. However, given the current global pandemic context and related guidance with regard to maintaining social distancing and PPE vigilance, an implementation plan had been developed to accommodate the COVID-19 recovery environment.

She confirmed that the proposed formal launch of the values was planned for March 2021 or Quarter 1 2021/22 dependent on operational pressures, with ongoing activities forming part of the implementation plan over the following 12 months.

The Director of People noted that the report detailed the five approaches proposed to introduce and embed the organisational values. She confirmed that evaluation of the implementation process would be reported to the Board Resources Committee for assurance.

Dr D Hanley welcomed the evaluation process and acknowledged that such plans take several years to fully embed. He advised that a longer-term implementation plan would be welcomed to monitor the improvements.

The Director of People thanked Dr D Hanley for his input and acknowledged this would be identified as the team worked through the implementation approach.

The Chairman stated that the Organisational Values were very significant to the agenda for the Board and there was a responsibility on Board Executives to communicate the values to the organisation. He also acknowledged the current Covid-19 climate and the current restrictions, but stressed the need for the Board members to invest time to breathe life into the values as leaders of the organisation.

The Chief Executive commented that there were ongoing extensive conversations around how to adapt to communication styles, given Covid-19 and different options and mediums for communication which would be presented to a future Board.

The Board:

- Received assurance on the proposed approach taken to introduce, embed and implement the newly refreshed Organisational Values into the organisation.
- Supported a longer-term Organisational Values implementation plan.
- Welcomed a report on communication options for future working.

BOD/2021/136 Any Other Business Notified Prior to the Meeting

There was no items of other business.

BOD/2021/137 Items for Inclusion in the BAF

None.

Date, time and venue of the next meeting:

The next meeting of the Board of Directors will be held at 9.45am on Wednesday, 31st March 2021 via Microsoft Teams.

Signed: _____

Date: _____

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Status:	
Complete & for removal	
In progress	
Overdue	

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
52	25/11/20	2021/93	Integrated Performance Report	Supported a further scrutiny paper on the evaluation of serious incidents to Q&P Committee.	CG/MP	31.3.21	31.3.21	Evaluation of Serious Incidents included in the Q&P Work Plan and future assurance to Board via Q&P Chairs Assurance Report.	
53	27/01/21	2021/134	EDI Priorities Report	Future reporting to Board on the EDI priorities.	LW	26.5.21	26.5.21	For submission to Resources & Q&P Committees for presentation to the Board in May 2021.	
54	27/01/21	2021/135	Organisational Values Implementation Plan	Future reporting to Board on the Organisational Values including a long term implementation plan and future ways of working.	LW	31.3.21	31.3.21	Assurance through the new governance structure to Resources Committee and reported to Board via the Resources Committee Chairs Assurance Report.	

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Board and Committee Attendance 2020/21

Board of Directors																			
	3rd April	6th May	27th May		3rd June	17th June	29th June	29th July		26-Aug-20		25th November		16th December		27th January		24th February	31st March	
	Part 2	Part 2	Part 1	Part 2	Part 2	Part 2	Part 2	Part 1	Part 2	Part 2	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 2 only	Part 1	Part 2
Ged Blezard	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x		
Prof Alison Chambers	✔	✔	✔	✔	✔	x	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Salman Desai	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Mick Forrest	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔		
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔		
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔		
Dr David Hanley	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Daren Mochrie	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Michael O'Connor	✔	✔	✔	✔	✔	x	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔		
Prof Maxine Power	x	✔	✔	✔	✔	x	x	✔	✔	Attendance at external meeting	✔	✔	✔	✔	✔	✔	✔	✔		
David Rawsthorn	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Prof Rod Thomson	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	x	✔	✔	✔		
Clare Wade	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔									
Lisa Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔		
Angela Wetton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Peter White ©	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		

Audit Committee						
	17th April	22nd May	17th June	10th July	23rd October	15th January
Dr David Hanley	Cancelled due to COVID-19	✔	✔	✔	✔	✔
Michael O'Connor		✔	x	x	✔	✔
David Rawsthorn ©		✔	✔	✔	✔	✔
Prof Rod Thomson		✔	✔	✔	✔	✔

Resources Committee						
	18th May	24th July	25th September	20th November	22nd January	26th March
Ged Blezard	Cancelled due to COVID-19	x	✔	x	x	✔
Salman Desai		✔	✔	✔	✔	✔
Richard Groome		✔	✔	✔	✔	✔
Michael O'Connor ©		✔	✔	✔	✔	✔
Prof Maxine Power		✔	✔	✔	✔	x
David Rawsthorn		✔	✔	✔	✔	✔
Lisa Ward		✔	✔	✔	✔	✔
Clare Wade		✔	✔			
Carolyn Wood		✔	✔	✔	✔	✔

Quality and Performance Committee										
	20th April	18th May	15th June	20th July	21st September	19th October	16th November	18th January	15th February	15th March
Ged Blezard	✔	✔	✔	x	✔	✔	✔	✔	✔	✔
Prof Alison Chambers ©	✔	✔	x	✔	✔	✔	✔	✔	✔	✔
Michael Forrest	✔	✔	✔	✔	✔	✔	✔	x	x	✔
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	x	✔
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Dr David Hanley	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Prof Maxine Power	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Rod Thomson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Carolyn Wood	x	x								

Charitable Funds Committee			
	29th April	29th July	28th October
Ged Blezard	Cancelled due to COVID-19	✔	x
Salman Desai		✔	✔
Richard Groome		✔	x
Dr David Hanley		✔	✔
David Rawsthorn ©		✔	✔
Lisa Ward		✔	✔
Angela Wetton		✔	✔
Carolyn Wood		✔	✔

Nomination & Remuneration Committee							
	14th April	27th May	3rd July	29th July	30th September	13th November	16th December
Prof Alison Chambers	✔	✔	✔	✔	✔	✔	✔
Richard Groome	✔	x	x	✔	x	✔	✔
Dr David Hanley	x	✔	✔	✔	✔	x	✔
Michael O'Connor	✔	✔	x	✔	✔	✔	✔
David Rawsthorn	✔	✔	✔	✔	✔	✔	✔
Prof Rod Thomson	✔	✔	✔	✔	✔	✔	x
Clare Wade	x	x	✔	✔	✔		
Peter White ©	✔	✔	✔	✔	✔	✔	✔

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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		Apr-19	Mar-20	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision 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
Michael	Forrest	Deputy Chief Executive	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			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
			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
Michael	O'Connor	Non-Executive Director	Partner in Addleshaw Goddard LLP	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Trustee of Central Manchester Concert Hall Ltd (Bridgewater Hall) (Charity)				√	Position of Authority	Apr-19	Present	N/A
			Chair, Festival Medical Services		√			Position of Authority	Apr-19	Present	N/A
			Company Secretary of Cartwright Care Balmoral Management Ltd 38 Montpelier Grove Ltd	√				Position of Authority	Apr-20	Present	N/A
			Company Secretary of Talia Lipkin Connor Ltd	√				Position of Authority	Apr-20	Present	N/A
			Non Executive Director and Trustee of Factory Youth Zone (Harpurhey) Ltd				√	Position of Authority	Apr-19	Present	N/A
			Director, 16 Princess Road, NW1 8JJ Freehold Limited	√				Position of Authority	Sep-19	Present	N/A
			Director, Lucinda Byre Limited	√				Position of Authority	Jun-20	Present	N/A
			Company Secretary, Lucinda Byre Ltd				√	Position of Authority	Jun-20	Present	N/A
			Company Secretary, Taylia Byre Ltd				√	Position of Authority	Jun-20	Present	N/A
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Gillian	Singh	Associate Non-Executive Director (Digital)	Non-Executive Director - The Riverside Group	√				Position of Authority	Jan-20	Present	N/A
Rod	Thomson	Non-Executive Director	Visiting Professor at the Universities of Chester, Staffordshire and Liverpool John Moores University		√			Position of Authority	Sep-19	Present	No conflict
			Trustee of the mental health charity "listening ear". The charity is based in Merseyside and provides services in the NW region,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Volunteer at Severn Hospice, Shewsbury and do so as part of CPD requirements for NMC registration.		√			Volunteer	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governing Body Member, Royal College of Nursing		√			Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Locum Consultant in Public Health, Cheshire East Council	√				Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Fellow of the Royal College of Nursing and the Faculty of Public Health,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Clare	Wade	Associate Non-Executive Director (Digital) (Resigned 1/11/20)	Head of Patient Safety, Royal College of Physicians	√				Position of Authority	Jul-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Lisa	Ward	Interim Director of Organisational Development	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	Husband is Operations Director of The Senator Group who supply the NHS, amongst many others, with office and hospital furniture.				√	Other Interest	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of 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.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	31 March 2021
Subject:	Chief Executive's Report
Presented by:	Daren Mochrie, Chief Executive
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board on 27 January 2021. The highlights from this report are as follows: **Paramedic Emergency Services** • Military Support to Civilian Authorities (MACA), was deployed for the first time within NWAS. Approximately 120 military personnel were trained and supported both PES and PTS across the region • REAP level was escalated and subsequently de-escalated to meet demand/pressures • Following the government's announcement of the pathway exit from lockdown, the surge plan has been updated accordingly to reflect the exit plan **NHS 111** • 111 experienced a significant rise in COVID abstractions • Additional space at Middlebrook for call taking is due to go live prior to Easter • Enhanced Infection Prevention Control (IPC) continues to be embedded and enforced. **PTS** • PTS continues to support the delivery of the PES operation via the supply of staff and vehicles. • A cohort of military personnel joined PTS as part of the Trust wide arrangement with the military

	The paper provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as the vaccination programme, lateral flow testing, NHS 111 First and areas of regulatory compliance.
Recommendations, decisions or actions sought:	The Board is requested to receive and note the contents of the report

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

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☒	☒	☐	☒	☒	☒	☐	Closed	☒

Are there any Equality Related Impacts:	No
Previously Submitted to:	N/A
Date:	N/A
Outcome:	N/A

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1. PURPOSE

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 27 January 2021

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

The Trust escalated to REAP level 4 in the early part of January due to the pressures of increased COVID abstractions, increased activity and delays at hospitals. This allowed NWAS to enact a number of plans to improve patient safety and utilise a wider range of resources. Theses plan included requesting Military Support to Civilian Authorities (MACA), this was supported by NHSE and approximately 120 military personnel were trained and supported both PES and PTS. A number of initiatives were used to improve staffing.

The call answering for PES has maintained delivery of the national standards throughout January and February. This is against a background of picking up calls for a number of other ambulance services due to a number of pressures.

The PES service showed significant improvement through February. The Trust hit 3 of the national ARP standards and was very close to achieving the other 4. This is a direct result of the REAP 4 actions but also an improvement in the COVID abstractions is helping to improve our resourcing. We are now regularly deploying over 400 DCAs on a daily basis.

The COVID Surge Plan is still in operation however we now have an exit plan for the Military who will cease support from 21 March 2021. NWAS has now reduced its REAP level to L2 due to the improved and stabilised position.

Operations are putting together plans to maintain the resource levels as high as possible and to look at the forthcoming pressures of Easter and the road map and exit from lockdown.

NHS 111

During January and February 2021 111 experienced a significant rise in COVID abstractions,. At the time of writing this update this level of abstractions has now reduced significantly to a less concerning level with the service having had no related positive cases for 18 days.

Calls answered within 60 seconds in January delivered 68.57%, with a further improvement in February delivering 76.12%. The improvement seen in February correlates with the improving position in staff abstraction.

Demand throughout January and February remains stable, however intraday volatility is still apparent therefore making forecasting a challenge at present.

Following the successful recruitment to support 111 First the service is now focussing on the support roles required to enable all new staff to undertake call taking to the highest possible standard.

IPC (Infection, Prevention and Control) is now embedded and part of business as usual within the 111 call centres. Daily IPC checks and senior manager floor walks are carried out to challenge where appropriate and are now part of the normal working day in 111. New screens are now in situ and are designed to keep staff safe whilst taking calls, these have now been fitted on both floors at Middlebrook, with plans to install at Estuary Point in the near future.

Estates work is well underway at Middlebrook preparing the new section of the building. This is still on plan to be available for call taking prior to Easter, and will increase desk capacity by approx. 70 desks. The extra estate capacity will enable the staff employed on fully flexed rotas for 111 First to be utilised to maximum capacity.

PTS

The impact of COVID-19 has led to a significant change in the profile of PTS activity.

As at February 2021 the overall year to date provisional activity was 39% below contract baselines which is consistent with previous months. Cumbria is 47% below, Greater Manchester at 35% below, Lancashire at 47% below and Merseyside at 29% below contracted baseline. Whilst activity is significantly below contracted baselines, outpatient activity rose sharply between June and October 2020 when it plateaued to December.

A slight rise in January was halted in February 2021 when PTS worked collaboratively with commissioners, ICS Hospital Gold Cells and the acute healthcare system to temporarily suspend some non-critical outpatient journeys. This action provided resilience across the wider system in supporting the 999 response, ensured that there has been a good response to rapid discharge requests from hospitals to enable effective patient flow and protected services to the most vulnerable. As system pressures eased and this action was closed activity has sharply increased, particularly in Greater Manchester.

Like other parts of the Trust, PTS has had to adapt to new ways of working to offset the impact of social distancing on vehicles which, as activity increases, and focus on the Trust's ability to respond to on the day discharge requests intensifies, is becoming a greater challenge. PTS continues to support the delivery of the PES operation via the supply of staff and vehicles. Additional third party private ambulance resources have been sourced following a tender awarding the service for 6 months providing confidence to the providers to commit to the shifts. During February PTS also welcomed a cohort of military personnel into its ranks as part of the Trust wide arrangement, with personnel deployed alongside PTS staff in Greater Manchester, Lancashire and Cumbria.

PTS continues to Support the NW Nightingale Hospital with participation in daily strategic calls in addition to a PTS Manager being on site Monday to Friday 08:00 – 16:00. The 36 bed site is managing non-COVID-19 patients and has been set up to accommodate patients from Greater Manchester and Cheshire hospitals**.**

3 ISSUES TO NOTE

3.1 Local Issues

Nothing specific to report

3.2 Regional Issues

NHSE/I Regional Leadership Group (RLG)

Since summer 2020, I have been a member of the NHSE/I Regional Leadership Group. The focus of this group is around three broad headings: Prepare, Restore and Transform. Remarkable progress has been made and our collective work has enabled the region to cope with the third wave of COVID whilst protecting the most urgent non-COVID work, embedding innovation in the use of technology and rolling out the vaccination programme.

NHSE/I Incident Management Team (IMT)

Since the arrival of COVID 19 I have also been a member of the NHSE/I Incident Management Team (IMT). This team meets either once or twice a week as the incident has developed and has ensured that NWAS is able to contribute to the overall regional NHS response to the pandemic.

Managing Demand

The trust's COVID-19 command structure remains in place and the daily teleconferences and weekly meetings help ensure we are taking all the necessary and possible actions.

Over the last few weeks, these have included:

- Increasing 999 and 111 call handling capacity
- Cancellation of all non-essential meetings and training
- Redeployment of clinical colleagues working in other areas of the service into frontline roles
- Reallocation of resources in response to demand
- Increased use of private providers
- Continued support for 999 from Patient Transport Service (PTS) colleagues
- Continued collaborative working both locally and nationally to ensure adequate supply of personal protective equipment (PPE) is maintained
- Working with the integrated care systems (ICSs) to reduce the number of PTS outpatient journeys, creating more capacity to focus on discharges to improve hospital flow
- Working with volunteers and providing additional training to allow enhanced community first responders (ECFRs) to support with ongoing pressures
- National, regional and local engagement with partners to address hospital handover challenges including ambulances being held outside emergency departments
- Annual leave carry forward option made available where staff have been unable to take leave due to COVID-19 or were willing to cancel planned leave
- Increasing the number of vehicle cleaning stations outside emergency departments

Partnership with the Military and Fire & Rescue Service

NWAS engaged with the Military and Fire & Rescue services to increase the availability of resources. This is something which has been introduced in ambulance and hospital trusts in other parts of the country although NWAS were one of the last ambulance trusts to consider external mutual aid.

The military commenced their training at a number of sites across the region, and became operational from Monday 15 February. Military personnel worked alongside the PES & PTS operations assisting with lower acuity incidents, discharges and inter-facility transfers, helping to ease pressure not only from NWAS but the wider NHS system. Whilst this is a first for NWAS they were a huge asset whilst we managed the challenge of high demand on our services.

A number of firefighters from across the North West have been part trained to enable them to support NWAS in the future in the same way as we have deployed the military. Further work is required to complete driver training and these staff will then be held in reserve and be called upon at short notice should we be in a position to require mutual aid in the future. This is a national agreement with the National Fire Chiefs Council and the Association of Ambulance Chief Executives, and one that many other ambulance trusts have already put in place.

Initiatives such as this are a great example of public services working together to ensure patients get the response they need and expect when they are vulnerable, and we are extremely grateful for the military and the fire services for offering this support. The last shifts

for the military were on Saturday 21 March before they returned to barracks across the country. Feedback received showed that the military were proud of their involvement with NWAS.

REAP Level (Resource Escalation Action Plan)

Due to increased operational demand and wider healthcare system pressures, combined with the impact of COVID-19, in January, like several other ambulance trusts we escalated from REAP level 3 to level 4 to enable us to respond to, and address, the operational challenges we were facing.

Like all other ambulance trusts, we have since been able to de-escalate back to level 3 and now level 2. To achieve this we maximised all available resources with clinically trained staff responding in frontline roles, increased our 999 and 111 call handling capacity, cancelled all non-essential meetings and training, engaged with partners to improve hospital handover times and introduced welfare vehicles to support staff. It is important that the trust remains cautious and continues to focus on operational performance to ensure the best possible service for patients. The REAP process is dynamic and a return to a higher level is always possible and is something which will be escalated as and when required.

In-house Vaccination Hub

I am pleased to report that more than 79.12% of staff have received their first dose of the COVID-19 vaccine. Over the coming weeks staff should start to attend appointments for second doses at the same place they received their first dose.

Our in-house Broughton vaccination hub is on schedule to commence second doses from 29 March.

This is a significant achievement and again I pass on my thanks to the team co-ordinating the internal and external programmes.

There has been dozens of positive comments on Twitter and the official staff Facebook group about how well the hub is run, the brilliant efforts of the volunteers, and the warm welcome colleagues received when they attended to get their jab.

IPC compliance

I would like to recognise all the good work that has been done by the majority of staff with infection prevention and control (IPC) compliance, as it is so important to get this right to protect ourselves and each other.

Constantly wearing PPE and observing the strict rules can be difficult, but a number of instances of non-observance in non-clinical settings has been highlighted to us by external regulators

The 111 team at Middlebrook recently received two unannounced and unrelated visits from the Health and Safety Executive (HSE). The inspectors were looking for information about how staff are informed about infection prevention and control (IPC) and COVID-19 measures. After talking with managers and staff and having a tour of the contact centre, the inspectors were happy with the measures that have been put in place to help keep staff safe, including the installation of the permanent perspex screens, good social distancing and COVID-19 signage.

The team at 111 has been working very hard to implement IPC best practice and it’s fantastic to have this recognised during the external inspections

National Day of Reflection

Tuesday 23 March marked a year since the start of the first lockdown and along with many other emergency services, the trust are taking part in Marie Curie's National Day of Reflection

At 12 noon we took a minute to reflect for those who have died during the pandemic; including three of our own much loved green family members

CQC recognition

The CQC has praised the region's NHS 111 service. Calls to NHS 111 increased from around 5,000 a day to 12,000 (and a reported record 18,000 calls in one day) as national guidance pointed people to use the service during the pandemic. Dedicated lines for adult social care providers were also implemented after some providers reported problems accessing NHS 111.

Recognition well deserved, well done to all involved.

Positive feedback for 111 First

Since the soft launch of the 111 First service, followed by national roll out on 1 December 2020, our Patient Experience Team has been surveying patients who have accessed the service to determine levels of satisfaction.

Of the 252 returns, over 95% said their needs were met by calling 111 First, and over 92% described their overall experience as being good/very good. 156 patients were given hospital ED arrival times, the remaining referred to alternative care.

This is really positive and useful feedback and I am sure the service will continue to progress to meet our patients' need in the future.

Meeting with Bill Esterson MP

In my role I quite often get the opportunity to meet with Members of Parliament (MPs) from across the North West. Recently I met (virtually) with Bill Esterson, MP for Sefton Central and Shadow Minister for International Trade.

Gene Quinn, Head of Service for Cheshire and Mersey, also attended the meeting and it was a chance for us to update Mr Esterson on everything that the service as a whole, and the local teams in Mersey, have been doing to support the community.

This included an overview of our response to COVID-19 and a chat about local schemes and partnership working, for example the mental health car initiative with Mersey Care NHS Foundation Trust. I was also able to share positive news about our improving ambulance response times and very good Hear & Treat and See & Treat rates, highlighting our commitment to delivering the right care for patients.

Mr Esterson asked me to pass on his sincere thanks to all NWAS staff and volunteers for everything they do, in particular everyone's incredible efforts throughout the pandemic.

Prince of Wales sends video message to Ambulance Workers

It's with great honour that I can reveal that The Prince of Wales has recorded a video message thanking all ambulance staff in the country for their tireless work during the pandemic. In the message, His Royal Highness pays tribute to the sheer professionalism and commitment to duty shown by ambulance colleagues over the past year

I know, after what has been an unrelenting period for all our colleagues across the country, this recognition will mean a lot, not just on the frontline, but in our whole operation. Of course I would echo all that His Royal Highness has to say, and I am extremely proud of the incredible team work that continues to provide high levels of service to our patients in their time of need.

Captain Sir Tom Moore

I was sad to hear the news that Captain Sir Tom Moore passed away; the former British Army officer was made famous for his efforts to raise money for charity in the run-up to his 100th birthday during the coronavirus pandemic.

In April 2020, at the age of 99, he began to walk around his garden in aid of NHS Charities Together with the goal of raising £1,000 by his 100th birthday on 30 April. He raised in excess of £30m, which is an astonishing achievement and some of the proceeds have benefited NWAS.

Winifred Page

I was also very sad to hear the news that Winfred Page had also passed away. Win, inspired by Captain Sir Tom Moore, raised an incredible £19,000 for our charity by walking 100 laps of her garden before her 100th birthday. We were overwhelmed by Win's fundraising efforts which gave our staff a huge morale boost at a time when they needed it the most.

EPR roll out

The beginning of March saw the continued roll out of the electronic patient record (EPR) which will transform the way we work. The roll out of EPR began in East Lancashire, followed by the rest of region in a phased approach through until June.

The hospitals, acute visiting services and other receiving locations that have signed up to EPR will be able to view real time data from our clinicians at scene before they arrive on site, as well as vital incident data such as ECGs and pictures from accident scenes to give them more time to prepare. In time, EPR will provide invaluable data for the health audit teams that we will be able to share with healthcare partners and research colleagues.

I'd like to congratulate the EPR project team led by Brian Mayor, Yvonne Cutler and Mike Hynes who have been working hard to ensure the transition from paper records to electronic is as smooth as possible.

The EPR team operational leads are supporting its integration into each area, so those using it will have plenty of help while getting used to the system. Feedback from the staff and our partners already using the EPR from the pilot stage is very positive.

Body Worn Cameras

As part of an NHS England pilot aimed at reducing acts of violence and aggression against staff and to aid in prosecutions of offenders following an attack, a number of ambulance trusts have been selected to take part in a pilot.

NWAS are involved in the pilot and lots of work has been taking place behind the scenes to source the cameras and put processes in place. We're looking forward to starting our pilot, with 230 cameras due to be deployed to 27 stations across three sectors: Cheshire and Merseyside North, Greater Manchester Central and Cumbria and Lancashire East.

We're pleased to be working with NHS England on this pilot and hope it will be effective in reducing violence and aggression - something that we will never tolerate against any of our staff.

NHS Charities Together Funding

NHS Charities Together has allocated £7m across all the ambulance services in England, Wales, Scotland and Northern Ireland, including funding for 60,000 additional volunteers and other community focused projects.

I'm pleased to report that the Trust's Grant application for £687k to NHS Charities Together was approved on 25th March 2021 by their Board of Trustees. This funding will go towards vital projects to assist our Community First Responders whose contribution saves lives, reduces pain, prevents/reduces hospital stays and provides reassurance to those requiring emergency care. Additional projects have been identified support the role of CFRs, ensure communities have access to vital lifesaving equipment and to enhance existing work of the Trust. All projects are intrinsically linked with the aim of improving patient care and engagement across different communities served by the Trust.

Below is a summary of the projects:

- CFRs will be provided the opportunity to enhance their skills and provide enhanced patient care through the provision of an emergency lifting cushion to provide early assistance to a patient who has experienced a non-injury fall.
- Purchase 1000 licences of the JRCALC CFR Plus App for active Community First Responders
- 125 Community Public Access Defibrillators (CPADs) to be installed across the North West
- To appoint 3 x Community Engagement Officers in hard to reach communities to develop CFR Schemes and to undertake wider community engagement, education and training for a 2 year period
- To increase youth education in relation to the ambulance service and live-saving skills through two specific projects i) increasing youth representation in the Patient and Public Panel and ii) to develop an online youth zone.

New Appointments

We are pleased to announce the appointment of a new Assistant Director of Nursing and Quality. Lynsey Yeoman will join us on a 12 month secondment from NHS England and Improvement, where she is currently the Head of Infection Prevention and Control (IPC). Lynsey is due to commence in role at the start of April.

The trust has also recruited our first ever consultant midwife. Dr Stephanie Heys will take up the role in May and will work with the different maternity systems across the North West, enhancing care pathways and identifying training opportunities.

Dr Heys is a senior lecturer in midwifery at the University of Central Lancashire, and works as a midwife at East Lancashire Hospitals NHS Trust. This will be only the third appointment made into this role in any ambulance trust across the country, and is part of a national agenda to bring additional maternity expertise into ambulance services.

3.3 **National Issues**

AACE Update

In my role as Association of Ambulance Chief Executive's (AACE) Chair, I have had regular monthly meetings with Ciaran Sundstrem, NHSE/I Urgent & Emergency Care Director and

Suzanne Rastrick who is Chief Allied Health Professions Officer. This is to discuss how AACE and NHSE/I work together on a variety of strategic priorities.

I have also had an introductory meeting with Alan Howson, Chair of the Independent Ambulance Association (IAA). The IAA is the first not-for-profit trade association for independent ambulance services in England and have associate members in Scotland, Wales and Northern Ireland. I have had regular catch up meetings with Martin Flaherty, as Managing Director of AACE and Anthony Marsh who is the former AACE Chair and NHSE/I Ambulance Strategic Advisor.

In addition a number of Integrated Care System (ICS) consultation meetings have taken place around the Ambulance Sector engagement with future ICS's and these meetings will continue with the NHSE/I team. ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

In addition I recently attended a CQC Prioritising Safety Workshop to discuss their strategy and thinking for the future. I have also had a couple of meetings with Dr Cathy Winfield, Community & Primary Care Commissioning Director for NHSE/I re Primary Care Networks (PCN's). AACE has been advocating for a number of years the introduction of rotational models that seek to benefit patients, paramedics and systems alike. A number of ambulance services have been involved in very successful rotational pilot schemes which we very much hope to learn from and build upon as a sector in the future.

The first AACE Strategy Oversight Board Meeting took place to scope out Terms of Reference, membership and priorities to shape a revised future AACEG agenda aligned more to our new strategic priorities for the year ahead.

Plans are underway for the virtual Ambulance Leadership forum on 18 May. The ALF brings together the senior leadership teams of ambulance services from across the UK along with key stakeholders, policy makers, and guests from overseas. This annual event has become established as an excellent forum for the sharing of ideas and at the most senior level.

GENERAL

Manchester Arena Inquiry Proceedings

The Manchester Arena Inquiry is currently hearing evidence relating to the emergency services response to the incident. So far this has included witness accounts from Greater Manchester Fire & Rescue Service (GMRFS) and British Transport Police (BTP)

From 15 March, the Inquiry heard from GMP and NWAS colleagues who responded to the incident, including Paramedic Emergency Services and the Hazardous Area Response Team (HART) members who were among the first on-scene.

The Inquiry is an independent, open process to investigate the deaths of those who sadly lost their lives in the 2017 attack and is a significant milestone for the families of those who died, the survivors and everyone involved, or effected by the terrible event. As a trust we are fully supporting the Inquiry and further evidence will be heard from NWAS over the coming months.

Race Equality Network launch

I was pleased to join the virtual launch of the Race Equality Network. It was great to see more than 60 colleagues join us online for the event.

It was an important day for us as a trust and shows our wholehearted commitment to ensuring NWAS is a more inclusive and diverse place to work, which will also positively impact on our delivery of even better patient care.

Network co-chairs Wes Proverbs and Asha Blake did a fantastic job hosting the event and we were joined by two very interesting and thought-provoking guest speakers, Dr Peggy Walker and Professor Anton Emmanuel.

I now look forward to seeing the network develop further and fulfil its purpose to provide a collective and influential voice on behalf of staff from different racial backgrounds.

Apprenticeship Week

Early February was National Apprenticeship Week, and we marked the occasion by showcasing a number of case studies; an EMD, an EMT and a business and administration graduate, to talk about their apprenticeship journeys and to promote how we have successfully embedded apprenticeship schemes within our organisation.

2020 saw 60 new apprentices complete their end point assessments and I would like to pass on my congratulations to every one of them.

The trust has teamed up with the University of Cumbria to offer England's first paramedic apprenticeship. The BSc (Hons) Paramedic Science (Apprenticeship) Degree is a two-year pathway for our existing emergency medical technicians (EMTs) to progress to become a fully registered paramedic.

We have a cohort of around 120 staff all ready to start over the next month and another cohort of 40 scheduled to begin in October.

The apprenticeship is a new and exciting route to professional registration which is focused on work-based learning, with practice educators supporting learners in the pre-hospital setting.

It's a really brilliant opportunity for us to support and develop the fantastic skills we have within the workforce and I wish all the learners getting started this month the best of luck with their studies

LGBT+ History Month

February was LGBT+ History Month. At NWAS we have a well-established and active LGBT+ network which has supported gay and trans colleagues and acted as champions for well over a decade.

The network helps the trust focus on and improve the staff and patient experience for the LGBT+ community. Network chair and paramedic, Adam Williams, also sits on the National Ambulance LGBT network, ensuring that NWAS is helping to shape and lead innovation and policy change in relation to LGBT+ rights.

It's been really positive to read people's stories in the bulletin and on our Twitter and Facebook pages. Adam's heartfelt comment about HIV awareness, which mentioned the recent Channel 4 series 'It's a Sin', seemed to really hit home, attracting many likes and shares, including one from a cast member of the television show. It is great to see our LGBT+ network getting really strong recognition both within the organisation and from the public too

Thank you to Adam Williams, Chair of our LGBT+ network, and everyone who shared their personal stories and icons.

International Women's Day

8 March marked International Women's Day 2021 – a globally recognised day to celebrate the achievements of women, raise awareness of bias and take action for equality. As an organisation, we have made great progress in taking action for equality over recent years and it's something that continues to be important to us.

This gave us another opportunity to reflect and say thank you to the incredible women of Team NWAS for everything they do.

Public and Patient Panel

Following the launch of our Public and Patient Panel (PPP) 18 months ago, we have a cohort of 134 individuals involved in helping the trust with various levels of support.

Now the PPP is well established, we have strengthened the value of it by involving members in more high profile work. For example, the opportunity to assess scores for each proposal submitted to our Executive Team, involvement in the PTS eligibility criteria review with NHSE, involvement in the EPR project and exploring ways to see how we can use their input in our digital developments.

Our NHS People

Following the publication of the NHS People Plan last year, a national 'big conversation' has been launched to gather feedback on the vision for the future of human resources (HR) and organisational development (OD).

HR and OD colleagues play a hugely important role every day in NHS organisations, including our own. Headed up by Director of People Lisa Ward, our entire HR, learning and development team has been pivotal in our COVID-19 response. They have supported a large amount of extra recruitment and redeployment of staff, delivered additional education and training, provided health and wellbeing support and kept on top of the ever-changing government guidance to be able to assist NWAS managers in particular – and those are just a few examples!

Staff Survey

The results of the 2020 staff survey have now been released by the Staff Survey Coordination Centre. We appreciate the time taken to provide valuable feedback of staff experience of working for the trust, especially considering the survey was conducted at the height of the second wave of the pandemic.

The key areas for development highlighted by the report are not unknown and reflect the need for us to continue to focus on leadership and culture as the key areas of improvement. There is a lot to do and the People Directorate will be working with the management teams to review the local data so they can develop their own local plans of how they can make changes to support their teams

At an organisational level we are already planning some changes over the coming months such as:

- Launch of our new Trust values and behaviours
- Launch a new anti-bullying and harassment campaign
- Review and refresh of the Workforce Strategy
- Continue with the 'Just Culture' work and review of investigation processes
- Help to strengthen equality and diversity networks

Facebook Live

Chair, Peter White, and I held a Facebook Live session to answer some staff questions. We covered a range of topics including thoughts on the COVID-19 vaccination, the importance of following IPC measures to protect ourselves and patients and how staff across the organisation have been helping the COVID-19 response. The video has been viewed over 1000 times by staff.

Goodbye and Good Luck

The month of March saw the departure of key members of staff.

Kevin Mulcahy - The team at Estuary Point led the week's celebrations and recognised the 40 years that Kevin has dedicated to the organisation, staff and patients alike. The EOC senior team celebrated Kevin's achievements with more gifts, cards and his favourite thing, cake!

John Moorhouse – After over 30 years in service, Burnley Operations Manager retired from the trust. Beginning his ambulance career in Wiltshire John joined Lancashire Ambulance Service in 1996 starting as a technician then progressing to become a paramedic and later Operations Manager. John has been the Burnley Commander at Burnley FC since 2004 overseeing medical provision on match day and was presented by a signed shirt by the Club to mark the occasion.

Michael O'Connor's term of office as a Non-Executive Director concludes at the end of March after six years in office. Mike qualified as a lawyer in 1989 and has been a partner in international law firm Addleshaw Goddard since 1996 where he leads the Infrastructure Projects and Energy team. Mike specialises in health transactions for the NHS advising at board level and on infrastructure projects particularly in the transport and regeneration sectors. Mike has a long and diverse experience of non-executive posts in public services including at Willow Park Housing Association, the Factory Youth Zone Harpurhey and Festival Medical Services.

Michael Forrest - Mick joined NWAS in January 2012 as Head of Organisational Development before being appointed as a Director in 2013, Deputy Chief Exec in 2015 and then Interim Chief Executive. Mick was a great advocate for ensuring opportunities for all, and was instrumental in establishing the Women in Leadership Programme; a successful working relationship with the Ministry of Defence to provide employment for ex-military personnel and leading the trust through its CQC visit in 2018 when we moved from 'requires improvement' to a 'good' rating. With a legacy as impressive as this, I am sure he will be greatly missed by all who have worked with him and I would particularly like to thank him for his support in assisting me when I joined the trust

I would like to take this opportunity to thank them all for their service to the Trust and the people of the North West and to wish them all well for their futures.

Death of Staff Members

It is with great sadness that I write to inform you of the death of our friends and colleagues: Ronnie Cowing, Lesley Scott, Peter Millington and David Smith

Ronnie, a PTS Controller/Planner passed away in the early hours of Tuesday 16 February 2021. Based in our Carlisle control room at Salkeld Hall, Ronnie joined the trust as a call handler for our contact centre in 2013 after a varied career that included a lengthy period as a television producer working for national and local networks. Ronnie was engaging, caring, personable, a popular member of the team and never short of amusing and interesting anecdotes from his life and time in the media.

Lesley, passed away on Saturday 27 February 2021 after a long illness, leaving her husband, four children and grandchildren. Lesley was an EMT1 based at Thornton ambulance station and joined the service in 2002.

Peter, aged 58, passed away after battling with COVID-19. Peter, has been a member of our green family for over 34 years. During his career, Peter worked as a paramedic at Wigan Ambulance Station and as an operational trainer. His passion and skill for computers eventually led to him to move into the information field as a capacity manager firstly at Broughton EOC then moving to Parkway working in the ROCC, part of the Regional Planning Team. Peter leaves behind his two children, Alex, who works in Broughton EOC, and Sophie.

David was a student paramedic, who began his studies at Edge Hill University in September 2018 on the BSc (Hons) Paramedic Practice programme. He worked with crews in Lancaster and in South Lancashire, helping us in our response to COVID-19, and volunteering not only with PES but also supporting welfare vehicles. He was in his final year of study at Edge Hill and was due to graduate later this year. He was a valued and popular member of the team, and had a promising career ahead of him.

The trust sends sincere condolences to the families and friends of Ronnie, Lesley, Peter and David

5 LEGAL IMPLICATIONS

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

6. RECOMMENDATION(S)

6.1 The Board of Directors is recommended to:

- Receive and note the contents of the report.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	31 March 2021			
Subject:	Northern Ambulance Alliance (NAA) programme update			
Presented by:	Daren Mochrie, Chief Executive			
Purpose of Paper:	For Discussion			
Executive Summary:	The paper provides the North West Ambulance Service (NWAS) Trust Board with an overview of Northern Ambulance Alliance (NAA) key work stream progress. The NAA consists of 4 Trusts: East Midlands Ambulance Service NHS Trust; North East Ambulance Service NHS Foundation Trust; North West Ambulance Service NHS Trust; and, Yorkshire Ambulance Service NHS Trust.			
Recommendations, decisions or actions sought:	It is recommended that the NWAS Trust Board note the content of the report and plans outlined regarding the current position and plans to progress the work programme and future NAA development.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☒	☐	☐	☐	☒	☐	☐	☐	☐

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

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1.0 PURPOSE

The paper provides the North West Ambulance Service (NWAS) Trust Board with an overview of Northern Ambulance Alliance (NAA) key work stream progress.

2.0 BACKGROUND, CURRENT CONTEXT & PROGRESS

The NAA Board meets bi-monthly and last met on 11 March 2021. This paper provides an update on actions and progress since the last NWAS Board paper on 27 January 2021.

2.1

Summary Update

- There has been continued positive progress across a number of work streams. The position up to the last reporting period is provided in Appendix 1. We continue to deliver on what can progress and contingency plans for other areas with adjusted timelines and understanding of risk and mitigation.
- There has been positive progress on the CAD project, with an initial Industry Day on 20 January followed by Industry Events on 17 and 18 March 2021 which were well attended by both potential providers and a range of key users and stakeholders across the member Trusts.
- There has been positive progress on completing the TRANMAN project with proposals presented to NAA Board to ensure full benefit realisation once in Business As Usual (BAU).
- The QI work recommenced on 22 March 2021 after a Covid pause.
- A review of ESR opportunities was undertaken with actions for the NAA HRDs to gather feedback from teams who attended seven workshops, and to co-develop opportunities to reciprocally share and learn. This will feed into the NAA future plans.
- An initial workshop to scope out Robotic Process Automation (RPA) opportunities took place on 2 March 2021. The 'art of the possible' RPA examples discussed will feed into the future NAA strategy development work.
- The proposal to develop a longer term NAA strategy and plan, aligned with the learning from work to date and complementing member trusts' transformation and business plans was discussed at the NAA Board workshop in March and is being further developed with the CEOs. This will be socialised in Q1.

3.0 NEXT STEPS

The plans for the future NAA are being developed with a view to socialising with senior leadership teams in Q1.

4.0 LEGAL and/or GOVERNANCE IMPLICATIONS

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

5.0 RECOMMENDATIONS

It is recommended that the NWAS Trust Board note the content of the report and plans outlined regarding the current position and plans to progress the work programme and future NAA development.

Appendix 1:

Table 1: NAA Progress on a Page Report - February 2021

Project on track	
Project progressing but minor/moderate risk or issues identified and affecting delivery	
Project off track with major risks/issues that require escalation	
NB-RAG status amended from November 2020 to include red, amber and green	FORECAST

PROJECT	ELEMENTS	CURRENT SUMMARY	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
QUALITY IMPROVEMENT	OVERALL STATUS	Forecast reflects Covid impact. Last two meetings cancelled due to increased operational demand across the Trusts. Next meeting 22.03.21	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER
	TIME	Capacity to meet regularly is limited due to Covid response	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER
	SCOPE	No current issues	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Capacity to meet regularly is limited due to Covid response	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER
TRANMAN	OVERALL STATUS	Change due to risk of delivery of 2 interfaces by 31.03.21 and withdrawal of PM impact on delivery & work required for project closure/ BAU transition	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER
	TIME	Extraordinary PB meeting scheduled 18.03.21 to consider outstanding interface delivery - BAU or project delivery extended	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER
	SCOPE	Project within original scope	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Full risk review undertaken Feb 2021 PB-no risks requiring escalation to DPB however risk to delivery of all the interfaces by end Mar 2021	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER
TELECARE DECISION SUPPORT TOOL	OVERALL STATUS	Work has recommenced. Aim is for new plan with NWAS, TSA & telecare providers to complete newly agreed desktop pilot-timeline TBC	RED	GREEN	RED	RED	RED	AMBER	AMBER
	TIME	Slippage against key milestones due to Covid and pause; timeline TBC	RED	GREEN	RED	RED	RED	RED	RED
	SCOPE	Tasks out of original scope. Project re-scoped	RED	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Significant risk-will not achieve objectives. Absence of lead/NWAS REAP 4 and further Covid	RED	GREEN	RED	RED	RED	RED	RED
AVOIDABLE CONVEYANCE	OVERALL STATUS	To be re-scoped now NWAS out of REAP 4	RED	GREEN	RED	RED	RED	RED	RED
	TIME	Slippage against key milestones due to Covid and current pause	RED	GREEN	RED	RED	RED	RED	RED
	SCOPE	Project within original scope	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Significant risk-will not achieve the objectives. Forecast reflects absence of lead/NWAS REAP 4 and further Covid delay.	RED	GREEN	RED	RED	RED	RED	RED
COMMON CAD	OVERALL STATUS	Good progress, on track. Resource/expertise from Mason Advisory in place to support achieving planned timescales/objectives	GREEN	RED	AMBER	AMBER	GREEN	GREEN	GREEN
	TIME	User Group availability enabling progress as planned with Mason Advisory	GREEN	RED	AMBER	AMBER	GREEN	GREEN	GREEN
	SCOPE	Project within original scope	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

	RISKS & ISSUES	**Major/strategic risks escalated to DPB incl. resource/SME availability. New risk identified relating to potential for reduced availability of capital funding within the future ICS structure which will be revisited in Q1 when further detail should be available**	**RED**	**RED**	**RED**	**RED**	**RED**	**RED**	**RED**

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North West Ambulance Service NHS Trust

REPORT

	Board of Directors
Date:	31st March 2021
Subject:	Urgent and Emergency Care; Strategy Refresh
Presented by:	Michael Forrest, Deputy Chief Executive
Purpose of Paper:	For Decision
Executive Summary:	**Purpose** The purpose of this report is to provide Trust Board with an overview of the Urgent and Emergency Care (UEC) strategy refresh which has been undertaken one year into strategy implementation. The report also provides assurance against the delivery of UEC Transformation objectives up to Q4 2020/21 and an overview of the delivery roadmap from 2021/22 onwards. **Background** In March 2019, Trust Board approved the UEC strategy which outlines how NWAS will develop an integrated urgent and emergency care model, to support our vision to be the best ambulance service in the UK; delivering the right care, at the right time, in the right place, every time. On approval of the UEC strategy, Trust Board requested a review and refresh of the strategy to be completed one year into strategy implementation in September 2020. It is important to note that upon submission of the UEC Strategy refresh to ELC in October 2020, further amends were requested to strengthen the Emergency care section within the strategy and include reference to the operational service delivery model which was being scoped at the time in partnership with the Association of Ambulance Chief Executives. This revised UEC Strategy was approved by ELC in January 2021, however submission to Q&P Committee was delayed from January to March due to escalation to REAP Level 4. Quality and Performance Committee approved the strategy refresh on 15/03/21. The scope of the UEC strategy review, did not include a re-write of our five-year strategic ambitions, however it does provide an updated position against previously agreed objectives and where necessary, provides a greater level of detail regarding progress, prioritisation and next steps. It is therefore important to note that the two fundamental aims of the UEC Strategy remain unchanged as follows:

1. For those people with urgent but non-life threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.
2. For those people with more serious of life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

Strategy refresh

Learning from Covid-19

The UEC strategy refresh acknowledges the changes to normal activity profiles caused by Covid-19, and the requirement for system-wide collaboration and responsiveness as we progressed through second and third waves alongside normal winter pressures. The strategy now also reflects the clear need to undertake a thorough systematic review of the Operational Service Delivery Model in conjunction with AACE and external demand and capacity review consultants.

Section 3 driver diagram

The driver diagram has been updated in the refreshed strategy to align with the current portfolio of UEC Transformation programmes/projects and offer more specific, measurable and achievable objectives.

The driver diagram outlines four strategic priorities:

- **Emergency care** - NWAS' statutory obligations to deliver highly responsive emergency and urgent care in full compliance with APR remain unchanged (including the proposed review).
- **UEC service delivery** - The primary aim under this priority is to undertake a review of the U&EC clinical and operational leadership structures to provide an effective balance between clinical leadership and operational management.
- **Integrated response model (IRM)** - The fundamental principle underpinning priority 3, is a 'one service' approach, meaning PES, PTS and NHS 111 operate in a more integrated way to provide a single, integrated response model.
- **Reducing avoidable conveyance (RAC)-** Successful implementation of our UEC strategic objectives is primarily underpinned by an ability to reduce avoidable conveyance to Emergency Departments through increased H&T, S&T and conveyance to alternative services.

UEC integration roadmap

The UEC integration roadmap (see appendix B) has been developed as a way of visualising the implementation of key deliverables within the UEC Transformation portfolio. The roadmap has been developed alongside PMO and Digital and therefore outlines critical interdependencies and timelines across NWAS' wider project portfolio.

Next steps

The UEC Oversight Forum had commissioned a refresh of the UEC implementation plan in order to focus on year 2 and 3 objectives. The updated implementation plan will now incorporate the service delivery model review and incorporate the lessons identified within year one of strategy

	implementation and during COVID-19 and will align to the strategic objectives articulated within the UEC strategy. Alongside the implementation plan the UEC Oversight Forum will also develop a measurement strategy to demonstrate the impact the deliverables outlined in the plan have in supporting the Trust to become the best ambulance service in the UK.
Recommendations, decisions or actions sought:	Trust Board are asked to note the changes made to the UEC strategy, alongside the delivery progress up to Q4 2020/21 and priorities for 2021/22 onwards.

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

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR 03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☒	☐	☒	☐	☐	☐	☒

Are there any Equality Related Impacts:	The UEC Strategy EIA will be reviewed and updated following approval of the refreshed strategy.
Previously Submitted to:	Quality & Performance Committee
Date:	15th March 2021
Outcome:	Approved

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1. PURPOSE

1.1 The purpose of this paper is to provide Trust Board with an overview of the Urgent and Emergency Care (UEC) strategy review which was completed one year into strategy implementation. The report also provides assurance against the delivery of UEC Transformation objectives up to Q4 2020/21 and an overview of the delivery roadmap from 2021/22 onwards.

2. BACKGROUND

2.1 In March 2019, Trust Board approved the UEC strategy which outlines how NWAS will develop an integrated urgent and emergency care model, to support our vision to be the best ambulance service in the UK; delivering the right care, at the right time, in the right place, every time.

2.2 On approval of the UEC strategy, Trust Board requested a review and refresh of the strategy to be completed one year into strategy implementation in September 2020.

2.3 The UEC strategy review was completed in October 2020 based on the following key considerations:

- Year 1 achievements, outputs and lessons learned
- Covid-19 specific learning, opportunities and risks
- New or emerging changes at a national, regional and local level
- Implementation priorities from year 2 onwards
- Required review of Operational Service Delivery Model

2.4 It is important to note that upon submission of the UEC Strategy refresh to ELC in October 2020, further amends were requested to strengthen the Emergency care section within the strategy and include reference to the operational service delivery model which was being scoped at the time in partnership with the Association of Ambulance Chief Executives.

This revised UEC Strategy was approved by ELC in January 2021, however submission to Q&P Committee was delayed from January to March due to escalation to REAP Level 4. Quality and Performance Committee approved the strategy refresh on 15/03/21.

2.5 The scope of the UEC strategy review did not include a re-write of our five-year strategic ambitions, however it does provide an updated position against previously agreed objectives and where necessary, provides a greater level of detail regarding progress, prioritisation and next steps.

2.6 It is therefore important to note that the two fundamental aims of the UEC Strategy remain unchanged as follows:

1. For those people with urgent but non-life threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.
2. For those people with more serious of life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

2.7 The infographic found in section 3 of the strategy document provides a visual representation of our five-year strategic ambition and has also informed the driver diagram which outlines our approach to achieving this vision. The remaining sections of this paper summarise the outputs

of the UEC strategy review, including progress against objectives, any changes made to the UEC strategy content and the associated next steps for ongoing implementation.

3. SUMMARY OF STRATEGY REFRESH

3.1 Sections 1 and 2 of the UEC strategy provide an overview of the background and strategic context to position the ambition and objectives summarised within Section 3. These sections remain largely unchanged, with the exception of an additional sub-section which summarises the context of the 2020 strategy refresh, specifically the implications and learning from the Covid-19 pandemic.

3.2 Learning from Covid-19

The UEC strategy refresh acknowledges the changes in activity profile caused by Covid-19, particularly within NHS 111, and NHS 111 First, and the requirement for system-wide collaboration and responsiveness as we work through the second and third waves alongside winter pressures.

As the Trust refocused on responding to the Covid-19 pandemic many pieces of UEC Transformation work were paused, however others were accelerated and generated the following useful learning which has informed the refresh process:

- The Covid-19 response resulted in more frequent and greater levels of communication, shared timely decision making, and strengthened partnership working, both internally across NWAS service lines and externally with partners across the health and care system.
- The Trust has had to employ new ways of working to manage capacity during Covid-19 by introducing more flexible, integrated working practices. For example, remote and home working has been essential to alleviate seating capacity within contact centres to increase the number of call handlers and clinicians.
- Patient Transport Service (PTS) volunteers were trained and teamed up with paramedic emergency service staff to support frontline operations which demonstrated how PTS skill mix could be used to effectively increase capacity and deliver the right care.
- NWAS established more integrated ways of working, both internally and externally to help manage demand and direct patients to the right care for their needs.

3.3 Section 3 driver diagram

Section 3 of the UEC strategy outlines how we will achieve our aims and is structured around the driver diagram (see Appendix A). Within the first year of UEC strategy implementation, the primary objectives across the majority of UEC Transformation projects were to undertake thorough reviews, followed by options appraisals to inform objectives and priorities within the UEC transformation roadmap.

The driver diagram has been updated for this strategy refresh to align with the current portfolio of UEC Transformation programmes/projects and offer more specific, measurable and achievable objectives.

The refreshed driver diagram now outlines four strategic priorities, instead of the previous three:

- Emergency care
- UEC service delivery model
- Integrated response model (IRM)

- Reducing avoidable conveyance (RAC)

The UEC strategy executive summary provides an overview of each priority and the associated strategic objectives.

3.4 Priority 1- Emergency Care

NWAS' statutory obligations to deliver highly responsive emergency and urgent care in full compliance with APR remain unchanged. The objectives under priority 1 within the UEC strategy outline our ongoing commitment to:

- Delivering the requirements of the National Ambulance Commissioning Framework and 999 Service Specification throughout the term of this strategy.
- Systematic and Comprehensive Review of the Operational Service Delivery Model.
- Sustainably achieving and maintaining all ambulance response standards and become the best performing Trust by 2023.
- Sustainably achieving all national response standards for HCP/IFT requests.
- Ensuring workforce rosters are initially reviewed and implemented by the end of 2020/21 to inform regular review in line with operational requirements.

Within year 1 of UEC strategy implementation, the roster review has been undertaken and implemented across all operational sectors, with the exception of EOCs which are forecast to be completed by the end of 2020/21.

During the first peak of the Covid-19 pandemic, we achieved all 999 performance standards for the first time since ARP was introduced. This was partially attributed to an overall reduction in 999 activity, combined with increased see and treat and hear and treat, but also highlighted the importance of increased levels of frontline resources.

Therefore, in 2021/22 the primary objective under this priority is to undertake a systematic and comprehensive review of the operational service delivery model which will be underpinned by updated ORH modelling, to determine the optimum configuration of NWAS' urgent and emergency care functions to deliver ARP standards.

The review will focus on three key areas; operational resources, workforce and contact centres and will be underpinned by the ORH modelling to understand how each area contributes to the delivery of ARP standards.

The review will also include a financial evaluation of the current and proposed future service delivery model to determine the most cost effective use of resources, identifying potential cash releasing productivity gains and associated affordability analysis.

We will use the outputs of the service delivery model review and ORH modelling to compile recommendations within an implementation plan by the end of Q1 2021/22. This plan will outline the roadmap to achieve sustainable performance improvement including the short, medium and long term implementation objectives, associated benefits and an overall financial affordability and efficiency plan.

3.5 Priority 2- Service Delivery Structures

The primary aim under this priority is to undertake a review of the U&EC clinical and operational leadership structures to provide an effective balance between clinical leadership and operational management.

The refreshed strategy articulates the key leadership principles which were developed in year 1 of strategy implementation which will underpin the full leadership review.

The UEC leadership review commenced in 2019/20 but was delayed due to the review of the Executive Director's portfolio and then subsequently during Covid-19.

The objectives under priority 2 have therefore been updated within the refreshed strategy to reflect the amended delivery timescales. These now read:

- By the end of Q1 2021/22 we will complete the full review of U&EC clinical and operational leadership structures to ensure alignment to the Trust's strategic direction of travel and UEC leadership principles.
- Within the first two years of this strategy we will restructure service delivery functions in way that delivers an effective balance between clinical and operational leadership.

3.6 Priority 3- Integrated Response Models

The fundamental principle underpinning priority 3, is a 'one service' approach, meaning PES, PTS and NHS 111 operate in a more integrated way to provide a single, integrated response model.

Within year one of the strategy a number of key deliverables were completed to support the delivery of the IRM objectives. These include:

- Undertaking a review of current state contact centres, with input from all service lines to identify opportunities for improvement and inform the IRM implementation roadmap. This review scoped the organisational benefits associated with moving to a single primary triage across 999 and 111.
- The development of a full business case recommending a move from MPDS to NHS Pathways in 999 which was approved in principle by Resources Committee and Trust Board, subject to the re-prioritisation of funding commitments for 2021/22 and ongoing review of achievability within the recommended timescales in light of COVID-19.
- The development of strategic principles for a future state operational contact centre estate that will enable an integrated response model.
- Working in partnership with GM Health and Social Care Partnership to pilot the GM clinical assessment service.
- Scoping a Non-Emergency Transport Solution (NETS) which was subsequently tested as part of NWAS' Covid-19 response.
- Developing and implementing a new single patient management system (SPMS) that is used across NHS 111 and the Clinical Hub.

During the Covid-19 pandemic, we also saw national strategic priorities change to reflect the increasing value which the NHS 111 service offers through effective triage and signposting of patients away from Emergency Departments into a range of alternative services. This resulted in NWAS' involvement in the 'NHS 111 First' programme which will have important learning for the future expansion of NWAS' CAS offer.

In addition, following the renewal of the NHS 111 contract, the strategic intentions of NWAS' regional Commissioners have been more clearly articulated. These include a requirement for improved integration internally across NWAS service lines and with external partners, during the three-year extended contract term.

As a result of our year 1 outputs and learning alongside Covid-19 specific opportunities and changing national/regional drivers, the objectives under priority 3 have been updated to provide a greater level of detail regarding prioritisation and next steps.

Within years 2 and 3 of strategy implementation our overall focus will be to design and deliver the underlying technological and estates infrastructure to support the implementation of an IRM. Without these foundations, NWAS will be unable to realise the benefits of harnessing collective expertise and capacity both internally and externally. The year 2 & 3 objectives specifically read:

- We commit to aligning the primary triage systems within NHS 111 and 999 in order to increase flexibility of workforce and reduce variation; resulting in greater consistency in the quality of triage outcomes.
- We will develop a high level specification for a proposed operational contact centre estates which aligns to the Integrated Response Model which will be used to scope the options for a future contact centre estate business case.
- We will evaluate and review existing CAS arrangements, with particular focus on developing NWAS' offer to complement the system-wide CAS and LCAS arrangements, including opportunities to further develop technical solutions such as video triage.
- We will maximise opportunities for internal integration across NWAS' clinical assessment and triage functions following the implementation of the Single Patient Management System (SPMS)
- We will build on the learning during Covid-19 and embed recommendations to develop and implement a sustainable Non-Emergency Transport Solution.

The UEC Transformation roadmap included in section 4 below, provides an overview of the prioritisation and sequencing of the objectives above.

3.7 Priority 4- Reducing Avoidable Conveyance

This priority comprises three core themes; 1) rotational working, 2) reducing avoidable conveyance and 3) health promotion and prevention.

Rotational working

The UEC Strategy outlines the importance of developing highly skilled, flexible clinicians who can work across traditional practice boundaries and within multi-disciplinary teams, in order to deliver the requirements of an integrated UEC model.

During the first year of strategy implementation, national GP contract reforms significantly influenced NWAS' objectives and an external rotational working group focused on the development of a formal rotational primary care offer in response to the additional roles reimbursement scheme.

The refreshed UEC strategy acknowledges that developing rotational working models in partnership with PCNs and system providers, through early adopter sites, will seek to mitigate the risks of paramedic attrition and enable the Trust to respond quickly to subsequent approaches from PCNs across the region.

The rotational working project was paused at the onset of Covid-19, therefore the objectives under rotational working have been updated within the refreshed strategy to increase the level of priority and reflect the amended delivery timescales. These now read:

- We will develop, run and evaluate a series of rotational working pilots to establish NWAS' offer to the wider system by the end of 2021/22.
- We will continue to engage with partners across the North West to ensure we have an effective, joined-up approach to managing rotational working.

Reducing avoidable conveyance

Successful implementation of our UEC strategic objectives is primarily underpinned by an ability to reduce avoidable conveyance to Emergency Departments through increased H&T, S&T and conveyance to alternative services.

Each of the priorities detailed above should contribute to this outcome measure by equipping our workforce with the right knowledge, skills, infrastructure and clinical expertise to assess, treat and refer patients across a range of urgent and emergency care settings.

In the first year of strategy implementation, we have established a reducing avoidable conveyance programme. The programme is made up of three key workstreams, each containing several smaller pieces of work. The refreshed strategy has been updated to provide specific detail under each of the three workstreams, 1) clinical assessment and triage, 2) clinical treatment and referral and 3) clinical support.

The objectives associated with each workstream are more specific and measurable to demonstrate progress towards our overall strategic aim and now read:

- We will deliver a programme of work which focuses on enhancing clinical assessment and triage, treatment and referral to alternative pathways and clinical supervision and support.
- We will work collaboratively with frontline operational clinicians and managers to achieve the objectives of the Reducing Avoidable Conveyance programme, utilising appropriate methodologies to foster collaboration, engagement and learning both internally and externally.
- We will deliver and sustain improvements in key associated metrics, including See & Treat. Hear & Treat and See & Convey to ED alternatives.

Health promotion and prevention

This section with the strategy articulates NWAS' role in managing activity 'before the contact' through a focus on preventative care for high intensity users. The overall strategic objectives remain largely unchanged, although limited progress was made during year 1 of strategy implementation and was subsequently paused during Covid-19.

The strategy refresh acknowledges that during the Covid-19 pandemic, we saw an increased focus on the importance of utilising demographic data to identify patients who are at higher risk of serious illness such as the BAME population, as well as those high-intensity users who may be more likely to require support from one of NWAS' service lines.

It is therefore more important than ever, for us to work with partner organisations across the North West to more appropriately support patients within the community in order to prevent the need for a more urgent or emergency care response.

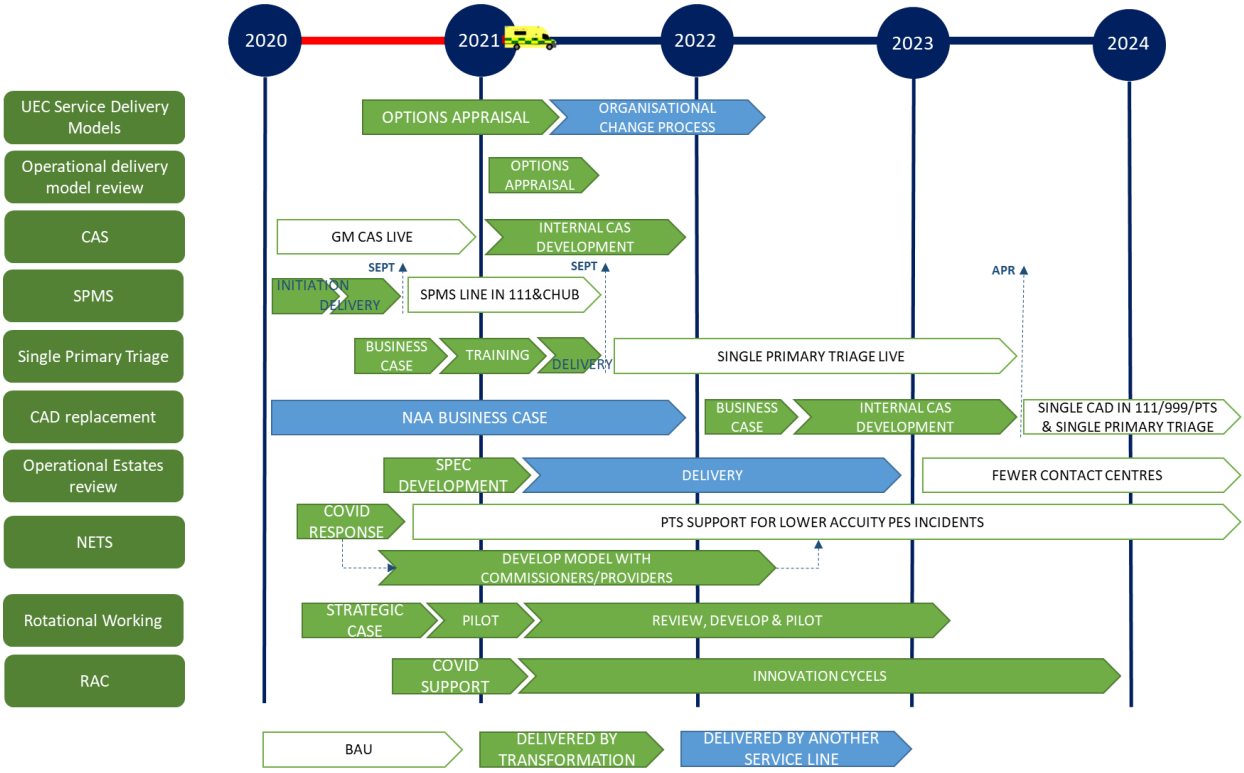
The strategic objectives under this priority have therefore been updated and read as follows:

- We will engage with commissioners, ICSs and providers to ensure that we are a key partner in delivering integrated urgent care solutions which align to population demography and healthcare needs.
- In particular, we will draw on population data and learning from Covid-19 in relation to higher-risk, high-intensity service users in order to improve NWAS' approach to prevention.

4. UEC INTEGRATION ROADMAP

4.1 The UEC Oversight Forum is currently refreshing the UEC implementation plan to refocus on year 2 and 3 objectives. The UEC integration roadmap below has been developed as a way of visualising the implementation of key deliverables within the UEC Transformation portfolio. The roadmap has been developed alongside PMO and Digital and therefore outlines critical interdependencies and timelines across NWAS' wider project portfolio.

4.2



*See Appendix B for more detailed version.

4.3 The UEC Transformation portfolio reports via the UEC Oversight Forum into the Corporate Programme Board. This enables the appropriate prioritisation of projects across the Trust's portfolio whilst also managing the critical interdependencies, risks and benefits which exist across strategic objectives and deliverables.

5. NEXT STEPS & RECOMMENDATIONS

5.1 Next steps:

U&EC Implementation Plan - The UEC Oversight Forum has commissioned a refresh of the UEC implementation plan in order to focus on year 2 and 3 objectives. The updated implementation plan will incorporate the lessons identified within year one of strategy implementation and during COVID-19 and will align to the strategic objectives articulated within the UEC strategy.

The implementation plan will clearly identify the structures required to deliver the portfolio of work, and the key deliverables for each project or working group within the portfolio.

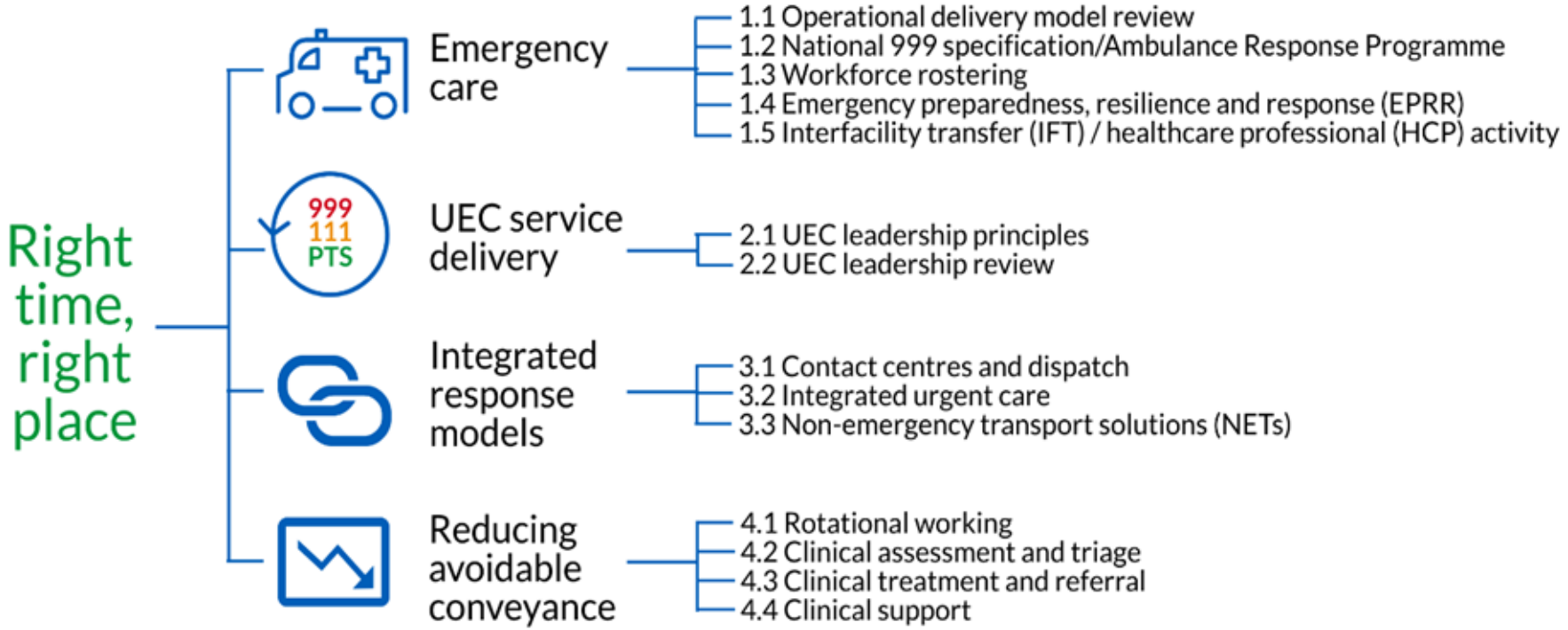
Measurement strategy - Alongside the implementation plan the UEC Oversight Forum will develop a measurement strategy to demonstrate the impact the deliverables outlined in the plan have in supporting the Trust to become the best ambulance service in the UK.

The measurement strategy will be developed into a dashboard and will be regularly reviewed by the UEC Oversight Forum to ensure the portfolio is prioritising work that provides the greatest benefit to the organisation in delivering both Urgent and Emergency care.

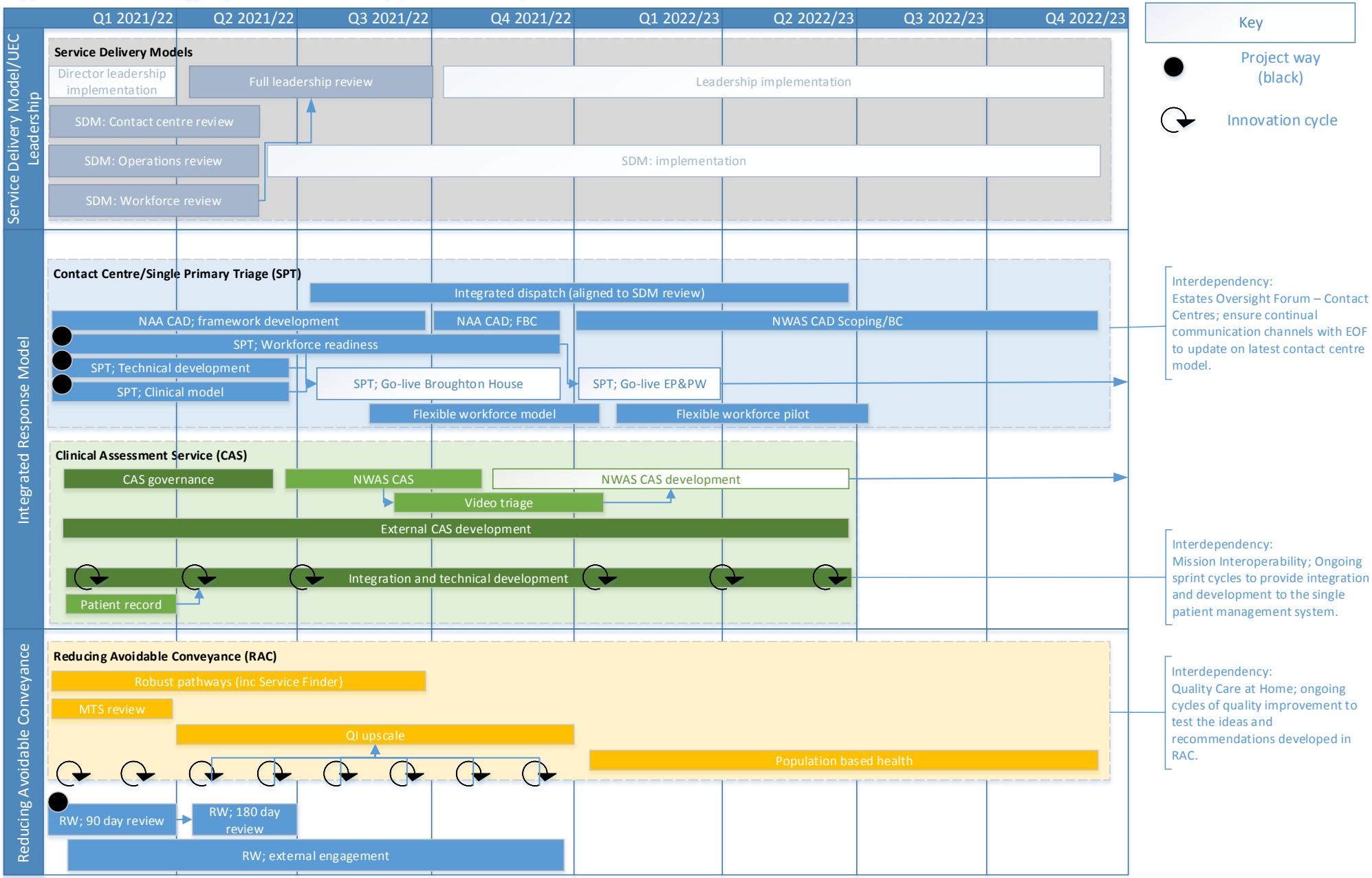
5.2 Recommendations:

Trust Board are asked to approve the changes made to the UEC strategy, alongside the delivery progress up to Q4 2020/21 and priorities for 2021/22 onwards.

Appendix A- UEC Strategy Driver Diagram



Appendix B- UEC Strategy Implementation Roadmap (detailed version)



NORTH WEST AMBULANCE SERVICE NHS TRUST

STRATEGY FOR THE DELIVERY OF URGENT AND EMERGENCY CARE

(Right Time, Right Place)

2019/20-2023/24

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

Recommended by	Executive Management Team
Approved by	Board of Directors
Approval date	January 2021
Version number	2.0
Review date	January 2022
Responsible Director	Deputy Chief Executive
Responsible Manager (Sponsor)	Associate Director of Transformation and Integration
For use by	All Staff, Commissioners, Stakeholders

Record of Document Development			
Date	**Change**	**By Whom**	**Reason**
31/8/2018	Document Creation	M Newton	Document Creation
11/9/2018	Document Revision	M Newton/D Ratcliffe	Revised Structure
13/9/2018	Document Revision	M Newton	Content Update
5/10/2018	Document Revision	M Newton	Content Update
17/10/2018	Document Revision	M Newton/M Wynne	Digital Update
20/10/2018	Document Revision	M Newton	Content Update EOC
6/11/2018	Document Revision	M Newton/S Latham	Consultation with Director of Operations
12/11/2018	Document Revision	M Newton	Structural Update
29/11/2018	Document Revision	S Latham	Preparation for EMT review on 5/12/18
2/12/2018	Document Amendments	M Newton/S Latham	Following review by EMT
29/1/2019	Document Revision	M Newton	Board of Directors Approval of Intentions
18/2/2019	Document Revision	M Newton/S Latham	Post consultation with Dr Ops/Dep Dr Ops
20/2/2019	Document Revision	M Newton	SD Business Planning Update
28/2/2019	Document Revision	M Newton	Feedback from Sector Managers
1/3/2019	Document Revision	M Newton	Feedback/Additional Section:Business Planning CH
3/3/2019	Document Amendments	M Newton/D Ratcliffe	Feedback from Medical Director and CPs.
18/3/2019	Document Update	M Newton/S Latham/ C Hall/ L Ward	Document update following EMT submission
19/3/2019	Document Update	M Newton/S Latham/ C Hall	Final formatting and proof
20/3/2019	Document Finalised	M Newton/D Ratcliffe/ M Power	Final Exec Review
1/09/2020	Document reviewed	M Newton/ S Latham/S Scholes/ Review Group	Year 1 strategy review and refresh
October-January 20/21	Document Reviewed and Updated	M Newton/S Latham/S Scholes/G Blezard	Update to reflect AACE supported Delivery Model Review

CONTENTS

EXECUTIVE SUMMARY

We have stated our ambition to be the best ambulance service in the UK; delivering the right care, at the right time, in the right place; every time. This ambition is built on the understanding that delivering patient care at the right time in the right place is reliant on the delivery of an integrated urgent and emergency care model.

We have also stated our ambition to be in the top three performing ambulance trusts by the end of 2021/22, and to be the best ambulance service in the UK by 2023. This Urgent and Emergency Care (right time, right place) Strategy describes how we will deliver effective urgent and emergency care for every patient by adopting a system wide integrated response model. The strategy also recognises the importance of delivering outstanding patient outcomes and should be viewed in conjunction with our Right Care Strategy.

Our primary objective is always to ensure that patients presenting with serious or life-threatening emergencies receive timely high-quality care in order to maximise their chances of survival and recovery. We continue to aim to achieve ambulance response standards consistently and sustainably by working in collaboration with the wider health care system to develop a range of integrated urgent and emergency care solutions. This will ensure that emergency resources are able to provide a timely response; every time.

Whilst we maintain our position as the core provider of pre-hospital emergency care in the North West, we will also position NWAS firmly at the centre of a whole system integrated response model (IRM). We recognise that we are ideally placed to provide high-quality patient-centred care closer to home, in order to treat more patients, by telephone, at scene, and in community settings; thereby reducing unnecessary conveyance to hospital.

In recent years, our ability to provide a timely response to emergency patients has often been challenged by: growing demand from patients with urgent care needs; delays caused by increased hospital handover times; and system reconfigurations, all of which need to be delivered within a nationally-recognised restricted financial envelope.

In considering these challenges and the learning from the COVI 19 Pandemic, our response continues to be based on the implementation of a fully integrated urgent and emergency care (UEC) model which will enable us to achieve the following core aims of this strategy:

1. For those people with urgent but non-life-threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in, or as close to, people's homes as possible minimising disruption and inconvenience for patients and their families.

2. For those people with more serious of life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

We will achieve our aims through a focus on the following three strategic priorities which are underpinned by key objectives:

STRATEGIC PRIORITIES	OBJECTIVES
1. Emergency Care	✓ We are committed to delivering the requirements of the National Ambulance Commissioning Framework and the 999 Service Specification throughout the term of this strategy. ✓ We are committed to sustainably achieving and maintaining all ambulance response standards and become the best performing Ambulance Trust by 2023. ✓ We will have completed a full roster review and implementation by the end of 2020/21. ✓ We are committed to sustainably achieving all national response standards for HCP and IFT requests within the term of this strategy, in order to provide a fair and equitable response to all patients, every time. ✓ We are committed to undertaking a systematic and comprehensive review of the operational service delivery model during 2021, in order to determine where improvements can be made, and whether the service delivery model can be rationalised in terms of more cost efficient resource utilisation, and to inform future investment decisions.
2. Service Delivery Structure	✓ By the end of Q1 2021/22 we will complete the review of U&EC clinical and operational leadership structures to ensure alignment to the Trust's strategic direction of travel and UEC leadership principles. ✓ Within the first two years of this strategy we will restructure service delivery functions in way that delivers an effective balance between clinical and operational leadership.
3. Integrated Response Model	Contact centres: ✓ We will review and reconfigure our existing EOC and contact centre functions within the term of this strategy to ensure that we provide an efficient, appropriately resourced and resilient service at all times. ✓ We commit to aligning the primary triage systems within NHS 111 and 999 in order to increase flexibility of workforce and reduce variation; resulting in greater consistency in the quality of triage outcomes. ✓ We will develop a high level specification for a proposed operational contact centre estates which aligns to the Integrated Response Model. Integrated Urgent Care: ✓ We commit to working with partner organisations to implement a fully integrated Clinical Assessment Service across the North West within the first three years of this strategy. ✓ We will review existing CAS arrangements, with particular focus on developing NWAS' offer to a system-wide CAS.

	✓ We will maximise opportunities for internal integration across NWAS clinical assessment and triage functions following the implementation of a Single Patient Management System (SPMS) ✓ We will also maximise opportunities to improve external integration with system partners to increase access to patient information to improve clinical assessment and triage. Non-Emergency Transport Solutions: ✓ We will build on the learning during Covid-19 and embed recommendations to develop and implement a sustainable Non-Emergency Transport Solution.
4. Reducing Avoidable Conveyance	Rotational Working ✓ We will develop, run and evaluate a series of rotational working pilots to establish NWAS' offer to the wider system by the end of 2021/22. ✓ We will continue to engage with partners across the North West to ensure we have an effective, joined-up approach to managing rotational working. Reducing Avoidable Conveyance ✓ We will deliver a programme of work which focuses on enhancing clinical assessment and triage, treatment and referral to alternative pathways and clinical supervision and support. ✓ We will work collaboratively with frontline operational clinicians and managers to achieve the objectives of the Reducing Avoidable Conveyance programme, utilising appropriate methodologies to foster collaboration, engagement and learning both internally and externally. ✓ We will deliver and sustain improvements in key associated metrics, including See & Treat. Hear & Treat and See & Convey to ED alternatives. Health Promotion and Prevention ✓ We will engage with commissioners, ICSs and providers to ensure that we are a key partner in delivering integrated urgent care solutions which align to population demography and healthcare needs. ✓ In particular, we will draw on population data and learning from Covid-19 in relation to higher-risk, high-intensity service users in order to improve NWAS' approach to prevention.

The integrated response model approach will ensure that we functionally integrate our 999, 111, and PTS services, whilst harnessing capacity across the whole economy for the purposes of seamless patient care, in which needless waiting is eliminated.

In short, we are committing to a significant organisational change process which will position NWAS as the lead provider for both emergency and urgent care.

1. INTRODUCTION

Background

Across England and the UK, the ambulance sector has experienced increases in activity, year on year, with little indication of a slowdown in the rate of growth. Funding for those services has not kept pace with rising demand and continued financial pressure is likely. In 2019/20 NWAS provided a response to more than 1.3m incidents. In addition, we managed over 1.7m calls through NHS 111, and over 2m patient transport contacts. In the same year we also lost over 70,000 ambulance hours due to delays in ambulance turnaround at hospitals.

In 2017, we embarked on a two-year transformation programme known as 'Transforming Patient Care' (TPC). The programme was designed to ensure that patients could be managed without transportation to emergency departments (ED) whenever clinically appropriate, increasing the number of patients managed by telephone advice, see and treat, or by using pathways of care other than ED attendance.

The transformation programme adopted the principles outlined within our five-stage patient journey model which is still reflected in the 999 National Ambulance Commissioning Framework specification. The core aim of the model is to reduce needless waiting and to provide clinical advice and intervention at the earliest opportunity within the patient journey.

Throughout the period of the Transforming Patient Care Programme we saw a sizeable reduction in the number of patients conveyed to ED and this reduced level of conveyance has been sustained throughout 2019/20 and 2020/21. The basic principle of early clinical navigation and intervention allows us to identify the most appropriate pathways of care, delivering the right care, at the right time, in the right place; every time. As a result we have seen outstanding performance in delivery of care provided by 'hear and treat'. It is crucial that we improve the number of patients accessing alternative pathways from scene and this will remain a priority during the remaining term of this strategy as part of the reducing avoidable conveyance programme.

More effective management of patients will maximise our ability to respond to higher acuity patients, helping to improve our performance against Ambulance Response Programme (ARP) standards.

2020 strategy refresh and learning from COVID 19

As we enter the second year of UEC strategy implementation we have been faced with significant challenges associated with the global COVID-19 pandemic and it would be remiss of us if we did not consider the potential implications and learning within our 2020 strategy refresh.

The NHS declared a Level 4 National Incident on 30 January 2020 in response to the COVID-19 pandemic, and the UK government subsequently introduced a series of measures to reduce the spread across the country, including the issuing of clear guidance on self-isolation, household

isolation and social distancing. In March 2020 the National Incident Response Board (NIRB) agreed that ambulance services would move to a single command and control structure in response to the pandemic, coordinated through the National Ambulance Coordination Centre (NACC).

At this time, steps were taken to improve national readiness and protect the 999 critical national infrastructure and staffing across ambulance services. This included the introduction of specific pandemic protocols within primary triage systems, development of clinical pathways for operational use, national interoperability links between ambulance emergency operations centres (EOCs) to support call handling, and a process at BT exchange level to ensure patients requiring COVID-19 specific advice are transferred to NHS 111.

Ambulance Services in England have been affected by the changing demand profiles caused by COVID-19 during 2020 and into the start of 2021. During the past year the NHS has undertaken an unprecedented rearrangement of its resources, with specific measures including the postponing of non-urgent elective procedures, video-triaging patients for referral to hospital services and is now beginning to rollout COVID-19 vaccinations. Ambulance Services have adapted to the COVID-19 pandemic through increased use of remote / home working technologies, digital systems and temporary increases in workforce numbers. Clinical care has also responded through the use of specific clinical pathways, pandemic specific call handling protocols, care closer to home models and clinical decision support tools, all with the intention of ensuring patients are afforded care in the right place and as early as possible in the Ambulance journey. Some of this adaptation was undertaken at great speed and we must learn from all of these changes if we are to deliver a sustainable urgent and emergency care service during 2021 and beyond.

Following easing of the first phase of lockdown measures, activity began to return to pre-lockdown levels in both clinical nature and volume. Emerging evidence has shown that ED attendances during the lockdown period reduced by 53% nationally, with one study reporting that decreases were most noticeable in those <65 years of age, those arriving by their own means and an approximate 64% reduction in injuries presenting to the ED. The evidence suggests that public behaviours in response to COVID-19 may have contributed to this (e.g. delayed attendance or ED avoidance) or these patients have been seen through additional capacity within primary and urgent care services (e.g. extended hours practice, virtual consultation). Further analysis of the subsequent lockdowns involving a newer COVID-19 variant remains necessary.

Ambulance response times have painted a starker picture of the impact of COVID-19, initially with extreme pressure on Category 2 incidents throughout March 2020. Conversely, during April, activity fell, resources were strengthened, and changes to triage processes led to full compliance with ARP standards through April, May, and much of June. This trend has not continued during a second tiered lockdown in autumn 2020 and the current new-year national lockdown. England remains one of the worst countries affected by the COVID-19 virus with over 82,000 deaths to date being related to COVID-19.

Within NWAS, as well as across the wider health and social care system, there is a real determination to learn from the experience of our response, and to preserve the very best practices that have manifested from some of the regional and national readiness measures. Many of the changes were already identified as objectives within our UEC Strategy and most of them comprised solutions that are not just about ambulance operations, but co-designed, integrated models working with partner providers in the NHS and in other sectors. We have taken the opportunity to reflect on events over the course of 2020, and have continued to work with other

UK Ambulance Trusts, NHS England & NHS Improvement and the Association of Ambulance Chief Executives to share those elements of COVID-19 response that worked well or not so well.

Whilst our long-term strategic objectives remain unchanged, our ability to maintain and sustain the benefits identified through COVID-19 will demand a new level of system wide collaboration and responsiveness and one in which key areas of work will need to be expedited. We now intend to build on the strategic objectives and learning from COVID-19 by undertaking a comprehensive systematic review of our operational service delivery model that will allow us to provide a service for urgent and emergency care that is sustainable and resilient, with equity of access for the whole population.

What is Urgent and Emergency Care?

Urgent care

Involves a range of services that are available for the public to access where there is an urgent actual or perceived need for intervention by a health or social care professional. In practice this will mean that people, whatever their urgent care need, wherever the location, get the right care, from the right person, in the right place, at the right time; every time.

Emergency Care

Is an immediate response to a time critical health need. A small number of people suffer from serious illness or have a major injury which requires rapid access to highly skilled, specialist care to give them the best chance of survival and recovery.

We believe that outstanding provision of urgent and emergency care will be defined as:

- ✓ Patient-focused
- ✓ Based on good clinical outcomes
- ✓ Timely
- ✓ Right the first time
- ✓ Available 24/7 to the same standard wherever possible

National Strategy and Policy Drivers

In developing our original strategy, we considered national and local policies that were current at the time. For example, NHS England's Five Year Forward View (5YFV) was the pivotal document in outlining requirements for change, specifically relating to demand management, operational efficiencies, and funding.

The 5YFV also called for ambulance services to provide an enhanced clinical decision-making role with paramedics supporting the delivery of safe care closer to home and within community services. This has now been further highlighted by more recent policy changes such as GP contract reform and evolving roles of primary care networks (PCNs) which place the role of the paramedic as a central requirement of a primary care system.

Our refreshed strategic objectives continue to reflect the principle of the Urgent and Emergency Care Review (UECR), Commissioning Standards for Integrated Urgent Care (Sept 2015), Clinical

Models for Ambulance Services (Nov 2015), and more recently Guidance on the Implementation of a Clinical Hub (July 2016).

Transforming Urgent & Emergency Care Services in England (Safer, Faster, Better) endorses that "Ambulance services play a central role in the provision of urgent and emergency care". Ambulance services and their commissioners should work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital". This document can be accessed at: **https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf**

The national policy context also offers us a unique opportunity to position the organisation as the primary provider of urgent and emergency care provision in the North West. We are the existing provider of 999, NHS 111, and patient transport services and will always seek to ensure patients are managed in adherence with the principles of the Urgent and Emergency Care Review.

Lord Carter Review

The publication of Lord Carter's review highlighted a number of key areas of required improvement in operational delivery. These are:

1. Workforce
2. Digital
3. Fleet

This strategy recognises the need for our workforce to be more flexible, receive enhanced managerial and clinical support, and be rostered effectively to meet the profile of activity demand more effectively. Lord Carter's report also stressed the importance of addressing challenges to productivity such as hospital handover delays, a reduction in conveyance to ED, and the use of alternative pathways of care such as urgent treatment centres.

It is not the intention of this strategy to provide detailed overviews of support service strategies such as fleet, workforce, finance, and others, but in determining our direction of travel for the delivery of core urgent and emergency care services, organisational strategies must be aligned to the core principles of right care, right time, right place; every time. We will set clear aspiration targets for the achievement of reducing ED conveyance by managing patients before the call, or by hear and treat or see and treat methods whenever clinically appropriate.

The NHS Long Term Plan (LTP)

Pre-hospital urgent care is a vital component of the NHS LTP. Sections 1.27 states

> 1.27. Ambulance services are at the heart of the urgent and emergency care system. We will work with commissioners to put in place timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter's recent report on operational productivity and performance in ambulance trusts, ensuring that **ambulance services** are able to offer the most clinically and operationally effective response. We will continue to work with ambulance services to eliminate hospital handover delays. We will also increase specialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.

Building on the work started by the 5YFV, the LTP highlights a number of key areas of strategic change relating to the reduction of pressure on emergency hospital services. There is clear intent to support patients to navigate the optimal service 'channel'. The LTP commits to embedding a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20.

1.25. **To support patients to navigate the optimal service 'channel', we will embed a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20.** This will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers. Access to medical records will enable better care. The CAS will also support health professionals working outside hospital settings, staff within care homes, paramedics at the scene of an incident and other community-based clinicians to make the best possible decision about how to support patients closer to home and potentially avoid unnecessary trips to A&E. This includes using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for an urgent response from community health services using the new model described

This vision of an effective integrated urgent and emergency care model will also be designed to support a wide range of healthcare professionals to manage patients closer to home, including an ambulance clinician at the scene of an incident.

Regional Drivers

The NHS and local councils in England have formed partnerships to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.

STPs will build upon collaborative work to support implementation of an integrated response model, which outlines a number of areas in which changes to urgent and emergency care are needed. More recently, the emergence of same day emergency care (SDEC) models, including changes in provision of ambulatory care and urgent treatment centres, as well as improved access to primary care will support patients to be treated in urgent, community, and primary care settings and to stay healthy with improved prevention measures complementing integrated care.

Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

The implementation of NHS 111 means that NWAS is now the 'gateway' for over three million unscheduled care contacts each year. The need to provide enhanced triage through effective, clinically focused, decision making in our contact centres is crucial in the context of fulfilling the requirements of the national policies and local commissioning intentions.

Every year, we visit the homes of approximately 2 million patients requiring planned hospital transport. These are often the more frail and vulnerable patients within the North West. This provides a superb opportunity for prevention and health promotion opportunities to improve care and manage demand.

Foremost amongst the causes of urgent and emergency care system pressure is the ageing population. By 2030 the North West will be classified as having a super-ageing population, with more than 20% of the population aged over 65 years. National targets for managing patients away

from traditional EDs do not always consider the specific population health challenges of the North West such as frailty, cardiovascular disease, respiratory disease, obesity, and mental health.

Reconfiguration and transformation schemes such as Devolution Manchester, Cumbria Success Regime, Healthier Liverpool, and others, further emphasise the need that a 'one size fits all' service is not sustainable, rather we must focus on delivering a service that can be both regionally and locally implemented depending on the needs of individual areas.

2. WHAT ARE WE TRYING TO ACHIEVE?

We have stated our ambition to be the best ambulance service in the UK; delivering the right care at the right time in the right place, every time. This ambition is built on the understanding that delivering patient care at the **right time** in the **right place** is reliant on the delivery of an integrated urgent and emergency care model.

Our primary objective is always to ensure that patients with serious or life-threatening emergency needs receive timely high-quality care in order to maximise their chances of survival and recovery. We aim to achieve ambulance response standards consistently and sustainably by working in collaboration with the wider health care system to develop a range of integrated urgent and emergency care solutions. This will ensure that emergency resources are able to provide a timely response; every time.

Whilst we maintain our position as the core provider of pre-hospital emergency care in the North West, we will also position NWAS firmly at the centre of a whole system integrated urgent care (IUC) model. We recognise that we are ideally placed to provide high-quality patient-centred care closer to home, in order to treat more patients, by telephone, at scene, and in community settings; thereby reducing unnecessary conveyance to hospital.

What are our challenges?

In recent years, our ability to provide a timely response to emergency patients has often been challenged by: growing demand from patients with urgent care needs; delays caused by increased hospital handover times; and system reconfigurations, all of which need to be delivered within a nationally-recognised restricted financial envelope. These challenges are further exacerbated by the need to improve our digital solutions.

Operational delivery and performance/national standards

We recognise that our approach to delivery of urgent and emergency care services must adapt if we are to meet the national ambulance response standards on a sustainable basis. We have an evolving operational model but acknowledge that we have not always been as effective as we would like in our response to changes in urgent and emergency care. The need to deliver sustainable ambulance response standards has often limited our capacity to achieve large scale organisational change.

Whilst we can demonstrate our ability to be innovative, and significant improvements have been made, we recognise that we must translate this innovation and improvement into sustainably delivered quality, performance, and service standards.

Demand Growth

Using incident activity* as a measure of activity growth, 999 activity has risen from a 2011/12 out-turn of 968,720 incidents to 1,311,630 incidents in 2019/20. It must be acknowledged that operational budgets have not kept pace with activity growth and therefore alternative methods of delivering care have been employed to allow the trust to maintain operational capability.

*Patient incidents requiring a telephone or face to face response.

Total Incidents (hear and treat + see and treat + see and convey)									
Year	2011/12	2012/13	2013/14	2014/15**	2015/16	2016/17	2017/18	2018/19	2019/20
Incidents	968,720	1,000,187	1,001,594	1,041,040	1,163,287	1,210,228	1,240,152	1,257,147	1,311,630
Annual Growth		31,467	1,407	39,446	122,247	46,941	29,924	16,995	54,483
Percentage Growth		3.25%	0.14%	3.94%	11.74%	4.04%	2.47%	1.37%	4.33%

** Includes 111-999 activity from 2014/15

As well as incident growth, the five-year call demand trend of c. 5.6% has been above the all-England average of 5.2%. We expect to see a further 38% in call growth over the next ten years (Carter 2018) and must therefore adapt our working practices to manage these exceptional levels of activity within restrictive financial budgets. In doing so, and to manage demand across all categories of urgent and emergency care, including healthcare professional activity, we must develop integrated working practices that bring together providers from the wider health system as the lead provider and primary coordinator.

Whilst activity growth from 2003 onwards has predominantly been concentrated in patients with urgent care needs, over the last few years we have also seen a significant rise in patients presenting with high acuity conditions, and increased journey times associated with service reconfigurations. Whilst much of the growth has been mitigated by using community services, those patients being conveyed to ED are at a much higher risk of admission to hospital. This places pressure on EDs whose 'major' patients often need more complex investigations and interventions.

We are committed to working with the wider system to harness capacity within community-based services for patient groups who can be cared for in more effective ways. We intend to work hard on improving the quality of care for all patients, but will be focusing on several patient groups for whom bespoke pathways of care can be beneficial to the clinical outcomes and patient experience.

Hospital Handover

In England, over 500,000 hours of time critical ambulance response capacity was lost in 2017/18 due to delays in handing over patients to ED. In the North West alone, we lost over 70,000 hours of resource time during the year. The impact on our ability to respond to seriously ill or injured patients seriously compromises the quality of care that we aim to provide.

There are a number of significant factors that impact on handover times, such as blockages with the hospital system itself, delays in ED, inappropriate conveyance to hospital, and timely access into community services.

During 2018/19 we have worked extensively to address the resource loss through excessive hospital turnaround times. Whilst we have seen some improvements in trusts with historical turnaround challenges, improvements across the whole acute trust sector have not been sustainably delivered.

Digital

We are aware that our digital capabilities require improvement. 999, NHS 111, and patient transport services operate on disparate systems that do not currently allow us to harness the potential utility of our workforce, estates, and business intelligence in the most efficient way. Whilst we have taken steps to introduce an Electronic Patient Record (ePR) the process has been slower than we anticipated. Integrated software is in need of further development, and our ability to access and shared patient information has been compromised as a result. The need for urgent and emergency care services to be supported by our new digital strategy has never been more apparent.

Within year one of the strategy NWAS have focused on using digital technology to integrate 999, NHS 111 and patient transport services. A single patient management system has been implemented across NHS 111 and the Clinical Hub which will enable a single clinical environment for 999 and 111 calls to undergo a secondary triage and be referred to appropriate providers.

Finances

Our ability to provide a sustainable, efficient service will be reliant upon receipt of sufficient funding. In the future the contract framework will need to be more flexible and sophisticated to support the delivery of integrated service models.

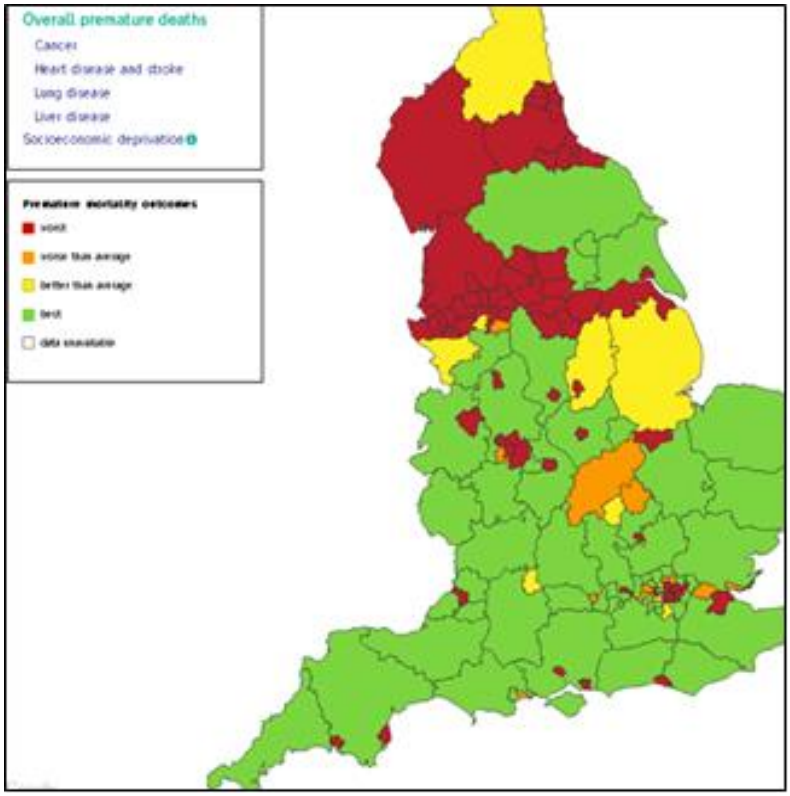
Population

We believe that understanding the needs of our population is crucial in delivering effective urgent and emergency care. Our service traverses a diverse geographical footprint, with an ever-increasing complexity within the patient demography. Male and female life expectancy are both below the all England average, there are high levels of social deprivation, with a significant number of local authority areas falling within the most deprived 10-20% in England. Nine of the top 20 most deprived local authority areas are in the North West. (NAO 2015 Index of Multiple Deprivation)

We have consistently been under enormous pressure to convey fewer patients to EDs across the North West. Whilst significant progress has been made, especially in management of low acuity patients by telephone advice, the number of patients managed on scene is lower than the all-England average.

The patient demographic of the North West is one of the biggest single challenges in maximising opportunities for pre-hospital management. High levels of social deprivation, especially in the Greater Manchester and Mersey conurbations, as well as specific condition presentations, create an environment in which health inequality with the rest of the UK is widening. While people in the more affluent local authority areas experience better than average health, the reverse is true

in the areas with the highest levels of deprivation, where health is generally worse than the England average.



Neighbourhood poverty is linked to poor long-term physical and mental health, as well as an increased prevalence of cardiovascular risk factors such as obesity and diabetes. Indeed, in the North West there is a 1.6-1.8 times likelihood of childhood obesity than the national average, and levels of alcohol and smoking related illness continue to be higher than in most areas of the UK. Despite improvements in population risk factors in recent years and reductions in mortality from coronary heart disease (CHD) socioeconomic gradients in health status have persisted or worsened. In the context of the extremely tight fiscal climate, these inequalities are expected to worsen further.

We are expecting high levels of incident growth over the next ten years. Evidence suggests that growth will also come with increasing levels of complex medical conditions in a super-ageing population. The baseline characteristics of neighbourhood poverty also strongly suggest higher levels of hypertension, smoking, diabetes, obesity, high cholesterol, statin use, and mental health related conditions.

The North West has a diverse population, wide variation in distribution of wealth, and while life is not 'grim up north' the stark truth is that on average because of poorer health, people in the North West suffer shorter lifetimes and suffer more years of ill-heath than in the South.

In the North West, premature mortality outcomes for the biggest causes of early death (under the age of 75) are among the worst in the UK. The impact on the ambulance service is significant with a proportionately higher number of patients presenting with cardiovascular and respiratory presentations than those in the South.

Whilst we enjoy a hugely diverse population, this diversity tends to be concentrated in urban, and often deprived areas. There are health inequalities and high instances of certain types of conditions in different diverse groups which can have a significant effect on our models of care. In our region, 18% of men and 31% of women, who are of working age, are not in employment. This is above the national average.

System Engagement

We are jointly commissioned by 31 Clinical Commissioning Groups (CCGs) to provide urgent and emergency care services across the North West of England. There are four Sustainability and

Transformation Partnerships (STPs) whose role is to bring together local health and care leaders to deliver system-wide transformation which meet the needs of local communities.

We therefore operate across a highly complex geographical location with growing expectations to meet the urgent and emergency care needs of its population through greater integration and collaboration with health and care partners across the North West.

Integration with local health and social care systems necessitates a review of the internal managerial and clinical leadership structures within NWAS. This strategy will make clear recommendations and commitments towards a restructured operational model that will enable us to provide highly effective clinically led services over the next five years and beyond.

Our Response

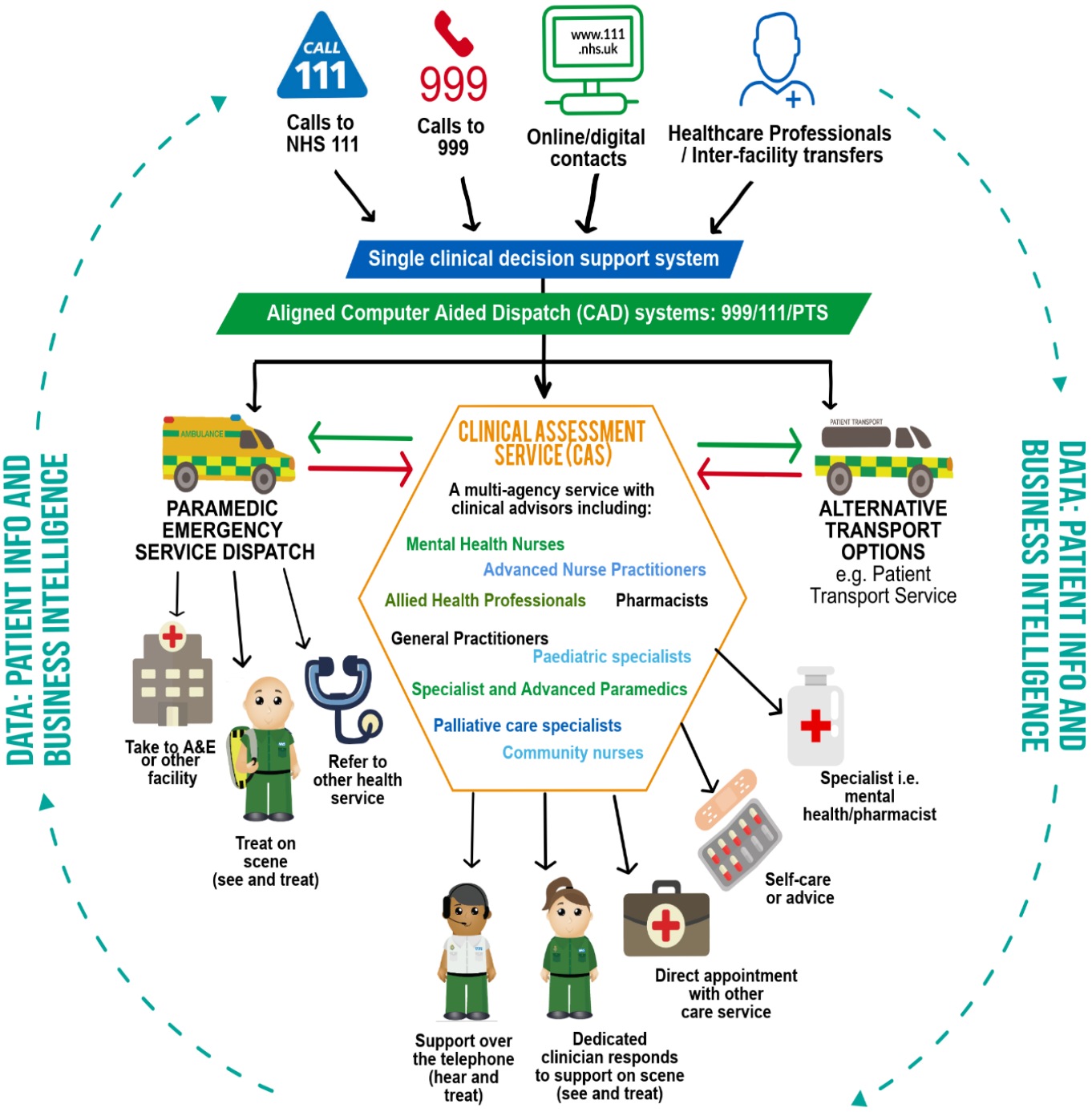
In considering these challenges and the context in which we operate, our response is to implement a fully integrated urgent and emergency care model which will enable us to achieve the following core aims of this strategy:

1. **For those people with urgent but non-life-threatening needs we must provide highly responsive effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.**

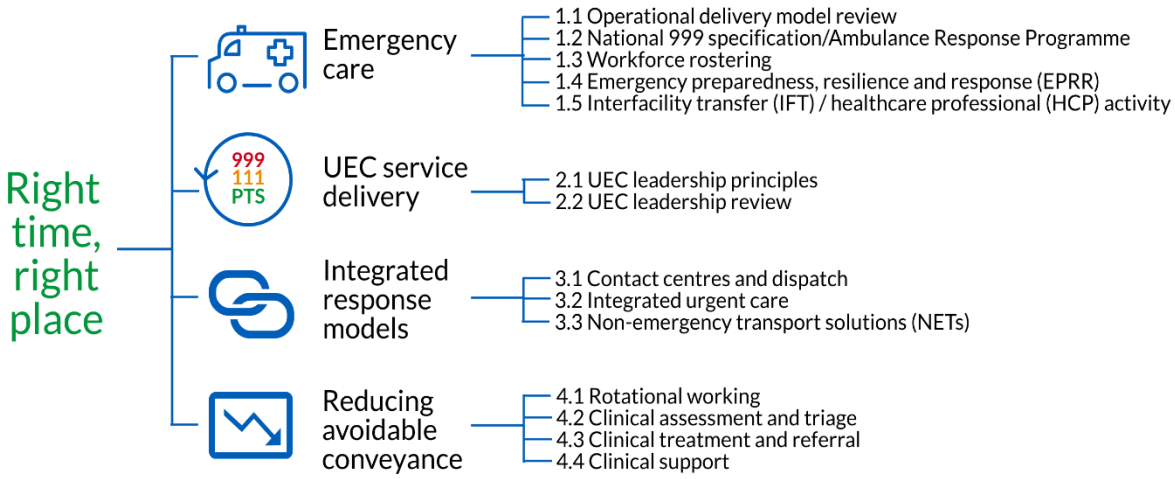
2. **For those people with more serious of life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.**

3. HOW WILL WE ACHIEVE OUR AIMS?

The infographic below provides a visual representation of how our urgent and emergency care service will look in five years' time:



The following driver diagram illustrates our approach to achieving this five-year strategic vision:



We have identified four strategic priorities:

- Emergency care
- UEC service delivery model
- Integrated response model
- Reducing avoidable conveyance

These are further explained within the remaining sections of this strategy including the underpinning objectives for each.

Priority 1: Emergency Care

1.1 Performance standards

Ambulance Response Programme (ARP)

The development of the combined Urgent and Emergency Care Strategy recognises our commitment to the principles of national, regional, and local drivers, but also that we must continue to provide a highly responsive and sustainable emergency response to those patients requiring immediate assessment and treatment. The document describes our commitment to delivering full ARP standards and how we will ensure that resources are used effectively through efficient use of emergency dispatch functions and control.

We have statutory obligations to deliver emergency responses in full compliance with ARP. Following the largest clinical ambulance trials in the world, NHS England announced a new set of measures for ambulance services. The changes focus on making sure the best, high quality, most appropriate response is provided for each patient first time. This includes providing call handlers with more time to assess 999 calls that are not immediately life-threatening, enabling them to identify patients' needs more efficiently, and identify the most appropriate response.

Categories of call are as follows:

Category	Response	Average response time
Category 1	For calls to people with immediately life-threatening and time critical injuries and illnesses.	These will be responded to in a mean average time of **seven minutes** and at least 9 out of 10 times before **15 minutes.**
Category 2	For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time.	These will be responded to in a mean average time of **18 minutes** and at least 9 out of 10 times before **40 minutes**.
Category 3	For urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes	These types of calls will be responded to at least 9 out of 10 times before **120 minutes.**
Category 4	For less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist.	These less urgent calls will be responded to at least 9 out of 10 times before **180 minutes**

The Trust recognises that achieving ARP standards whilst maintaining delivery of Paramedic Emergency Services in full compliance of the National Ambulance Commissioning Network 999 specification will continue to require a model of urgent and emergency care that harnesses the operational benefits of reduced avoidable conveyance, digital improvements, and innovative workforce solutions. However, throughout 2020 our response to the COVID 19 Pandemic has highlighted a need for core frontline resources to be increased to modelled baseline levels in order to deliver ARP standards and provide resilience in the event of surges in activity.

As part of our Urgent and Emergency Care Strategy, we will undertake a systematic and comprehensive review of the existing operational model in order to determine where improvements can be made, whether the service delivery model can be rationalised in terms of more cost efficient resource utilisation, and to inform future investment decisions.

NWAS is currently working with external consultants in order to finalise a Demand and Capacity Review that is designed to accurately determine the front-line resource capacity required to achieve predicted 999 demand as far forward as March 2022. This follows a previous review by ORH in 2017/18 which recommended a sizeable increase in operational staffing levels, together with the delivery of a number of service wide efficiency measures.

The Trust did see initial improvements in performance standards, but must acknowledge that we have experienced ongoing difficulties in maintaining the required improvements in ARP performance.

Updated resource modelling suggests if we maintain our current operating model, a considerable increase in vehicle hours will be required by 2022 to deliver core performance in a sustainable manner. This equates to significant increases in Emergency Ambulance resources against the current plan, with a corresponding reduction in non-conveying resources. The cost of achieving these additional vehicle hours is estimated to be in the region of £30.6m.

At the time of writing, potential funding availability is yet to be determined and the Trust must proceed on the basis that post COVID funding is unlikely to fulfil longer term operational budget requirements in their totality.

We continue to recognise that partnership working will be essential to improve care for our patients. In the years ahead we will support STPs to realise their vision for healthcare improvements. We know that the STPs have differing needs and priorities and we will ensure we support them to deliver their individual aims.

Managing demand is a complex process. It relies on changing attitudes amongst the public and changing system wide processes or customs that have long been established. We have a key role to play in working proactively with STPs to support the delivery of an integrated response model, and associated demand management initiatives.

The revised standards can be accessed at:

www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators

1.2 Delivery of National Ambulance Commissioning Framework

We are contracted under the NHS Standard Contract which is the mandated form of contract for ambulance services. This can be accessed at https://www.england.nhs.uk/nhs-standard-contract/.

Within the National Ambulance Commissioning Framework for commissioning of ambulance services, the new National Urgent and Emergency Ambulance Service 999 Specification incorporates the core elements for delivery of urgent and emergency ambulance services.

1.3 Workforce Rostering

Provision of a high-performing, safe and effective 999 services can be mapped to the domains within the NHS Outcomes Framework. We recognised that roster patterns did not always reflect current or emerging demand patterns. Whilst we committed to a robust Performance Improvement Plan (PIP) during 2018/19, a full review of our roster patterns was required across all operational areas (including contact centres). During the first twelve months of this strategy we worked with external consultants to ensure that our rosters are profiled against demand and that staff and resources are efficiently managed. Further, continuous review of working patterns will ensure that staff and vehicle resources are optimised at all times and that there remains a dialogue with staff over effective working patterns to support work life balance and retention of staff.

Effective rostering will be supported by our digital strategy which will review all digital and interoperability solutions across service delivery and support services such as human resources, central recruitment, fleet, finance and procurement. It is imperative that rosters recognise the newly configured fleet profile, maximising the use of emergency ambulances to improve efficiency and reduce responses per incident.

1.4 Emergency Preparedness, Resilience and Response

All ambulance services hold a number of responsibilities in respect of EPRR. The requirements for ambulance services are also listed within the NHS England EPRR Framework **https://www.england.nhs.uk/ourwork/eprr/gf/**

We will continue to provide services, planning and service capability to deliver our obligations as a Category 1 responder as laid down in the Civil Contingencies Act 2004 and in line with the requirements of the Department of Health's Emergency Planning Guidance (2005).

We will work cooperatively with the other emergency services and other Category 1 and 2 responders, including but not limited to participating in the planning and exercise testing processes, and will continue to work cooperatively with the Home Office National Interoperability programme.

Full statutory responsibilities for ambulance services are detailed within the Civil Contingencies Act (2004) and are available via the following links:

https://www.gov.uk/government/publications/emergency-preparedness

https://www.gov.uk/government/publications/emergency-response-and-recovery

1.5 IFT/HCP Activity

We manage over 175,000 calls from healthcare professionals and hospitals each year. This activity ranges from emergency admission requests from general practitioners, community nurses etc. to the movement of patients between hospital sites. The Association of Ambulance Chief Executives (AACE) has produced a standardised policy for the effective management of this activity. The resulting framework has now been incorporated into the new 999 specification which came into effect on the 1 April 2018.

The purpose of the framework is to support system leaders in reducing unwarranted variation in the way ambulance services are provided and commissioned, in which the IFT/HCP frameworks determine how ambulance services manage HCP/IFT requests in a way that:

- Ensures equity of access for all serious ill or injured patients.
- Recognises that in certain situations, a healthcare professional may require immediate clinical assistance in order to make a life-saving intervention, in addition to ambulance transportation.
- Provides consistent definitions for high acuity healthcare professional responses that are established and mapped to Ambulance Response Programme (ARP) Category 1 and Category 2 response priorities.
- Offers opportunities for local innovation and acknowledgement of different contractual and commissioning arrangements for non-emergency healthcare professional requests.
- Allows responses to healthcare incidents to be measured separately to other 999 activity

The process also provided an auditable benchmark for us to evaluate and monitor the appropriateness of booking trends by healthcare professional users.

We understand that it is vital that booking healthcare professionals are well orientated with the frameworks and are thoroughly familiar with the defined response options contained therein. Information on the national frameworks and how to use our services is available on the NWAS website: **http://www.nwas.nhs.uk/professionals**

NWAS has been selected as one of two English pilot sites. The pilot will allow us to refine the proposed frameworks, ensuring the right technical and assessment systems are in place.

Whilst a variety of processes were previously being employed across the pilot sites, a single HCP/IFT algorithm is now being used. Evaluation of the pilots will be coordinated through NHS England/Improvement.

Priority 1 Objectives:

- ✓ We are committed to delivering the requirements of the National Ambulance Commissioning Framework and the 999 Service Specification throughout the term of this strategy.
- ✓ We are committed to sustainably achieving and maintaining all ambulance response standards and become the best performing Ambulance Trust by 2023.
- ✓ We will have completed a full roster review and implementation by the end of 2020/21 to inform regular review in line with operational requirements.
- ✓ We are committed to sustainably achieving all national response standards for HCP and IFT requests within the term of this strategy, in order to provide a fair and equitable response to all patients, every time.
- ✓ We are committed to undertaking a systematic and comprehensive review of the operational service delivery model during 2021, in order to determine where improvements can be made, and whether the service delivery model can be rationalised in terms of more cost efficient resource utilisation, and to inform future investment decisions.

Priority 2: UEC service delivery models

2.1 UEC Leadership Principles

The ability to sustainably deliver this strategy will be almost entirely dependent on an organisation structure that is designed around the strategic direction of the trust and which provides a more effective balance between operational and clinical performance and leadership.

The service delivery structure will continue to incorporate the vital components of both clinical leadership and operational management which better align with a service that delivers both urgent and emergency care. This reflects the need for maintaining high quality leadership in all operational areas, dedicated management of logistics (resources and assets), and detailed knowledge and expertise which may already be available within existing and emerging integrated urgent care partnerships.

Since the introduction of ARP in 2017, it has become increasingly apparent that the critical 'emergency response' provided by paramedic emergency service (PES), requires dedicated focus through a bespoke, highly experienced leadership structure. Further, delivery of integrated urgent care, including low acuity 999 activity, current NHS 111 activity, and specialist see and treat and hear and treat functions similarly requires a thorough understanding and level of

expertise, and acknowledgement of scale, especially in developing the integrated collaborative solutions required by CCGs and devolved healthcare arrangements. This must include an ability to consider system wide business opportunities in order to maximise the potential for locally determined models of care and the associated funding and investment opportunities.

Patient transport services (PTS) must also be seen as, not only a planned care provider, but a service that can support urgent and emergency activity profiles at times when activity is high, or surges are experienced. We recognise the need to deliver its current PTS contractual obligations, but also understand that a 'one service' approach will be fundamental to our ability to manage demand from healthcare professionals and inter-facility transfer demands.

During the first year of UEC Strategy implementation, the Executive Director's portfolios were reviewed, the outcome being that PTS was aligned to PES and NHS 111 under the Executive Director of Operations.

The following UEC leadership principles were also developed to articulate the overall aims of the full UEC leadership review:

1. Increase capacity for leaders to engage at system-level
2. Functionally integrate NWAS service lines with dedicated leadership
3. Embed a shared vision and ownership of strategic objectives
4. Ensure parity of focus across quality and performance outcome measures
5. Provide effective clinical leadership and supervision across all service lines
6. Ensure staff are supported and developed to deliver high-quality, effective and safe patient care

2.2 UEC Leadership Review

The UEC leadership review commenced in 2019/20, but was temporarily paused during the COVID-19 pandemic. The review was remobilised in Q2 2020/21 and continues to be forecast for completion by Q4 2020/21.

The future UEC leadership structure must reflect the need for enhanced clinical leadership, dedicated operational management of resources and assets, alongside the required level of business knowledge and expertise.

The future UEC service delivery model must also enable the delivery of an integrated response model; in which, PES, PTS and NHS 111/future IUC model will operate in a more integrated way.

Effective leadership must also create an environment where clinically excellent patient-centred care can flourish, but where our services are delivered innovatively, effectively and with high levels of productivity.

The review of our UEC leadership models must aspire to and drive clinical excellence, whilst also enabling a dedicated focus on resource planning, staffing and efficient utilisation of resource.

Priority 2 Objectives:

- ✓ **By the end of 2020/21 we will undertake a full review of the U&EC clinical and operational leadership structures to ensure alignment to the Trust's strategic direction of travel and UEC leadership principles.**
- ✓ **Within the first two years of this strategy we will restructure service delivery functions in way that delivers an effective balance between clinical and operational leadership.**

Priority 3: Integrated Response Model

In order to deliver highly effective urgent and emergency care, there is a need for all existing business lines to work as 'one service'.

The basic principle of the integrated response model, therefore, is for PES, PTS, and NHS 111 to operate in a more integrated way to provide a single joined up response model. Whilst PTS and NHS 111 are commissioned separately and have existing contractual commitments, the use of resources must be harnessed collectively across the three services, leading to efficiencies in staffing, clinical workforce, estates, fleet, and other infrastructure.

The integrated response model must harness the expertise and capacity across primary, urgent, and emergency care to provide a multi-disciplinary response to patients presenting to the system via 111 or 999. Patients will receive a complete episode of care concluding with either advice, a prescription, or an appointment for further assessment or treatment.

3.1 Contact Centres

We operate three EOCs at Parkway (Greater Manchester), Broughton (Lancashire), and Estuary Point (Merseyside). Whilst the EOCs are predominantly responsible for answering calls in Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside respectively, they are able to work virtually to ensure robust business continuity and management of surges in activity by sharing the call and dispatch activity across all three EOCs. We also operate the North West NHS 111 service from a main site at Middlebrook in Bolton, two satellite sites at Estuary Point and Carlisle, and with a sub-contracted provider, Fylde Coast Medical Services, based in Blackpool.

Operational support is offered by a bespoke function based in Carlisle. The Carlisle Support Centre provides logistical support, coordination of clinical and safeguarding referrals, sickness management, and fleet issues. We know that our demand growth and associated need for support services to be robust is key.

In order to achieve our aim of greater integration between PES, IUC/111 and PTS, we will review and enhance the functions undertaken within the EOC and contact centres including the leadership and management structures.

We will ensure that call-handling functions operate as a single-entry point to NWAS' integrated response model, regardless of the route of access, to ensure prioritisation and streaming of patients is clinically robust and commensurate with patient needs.

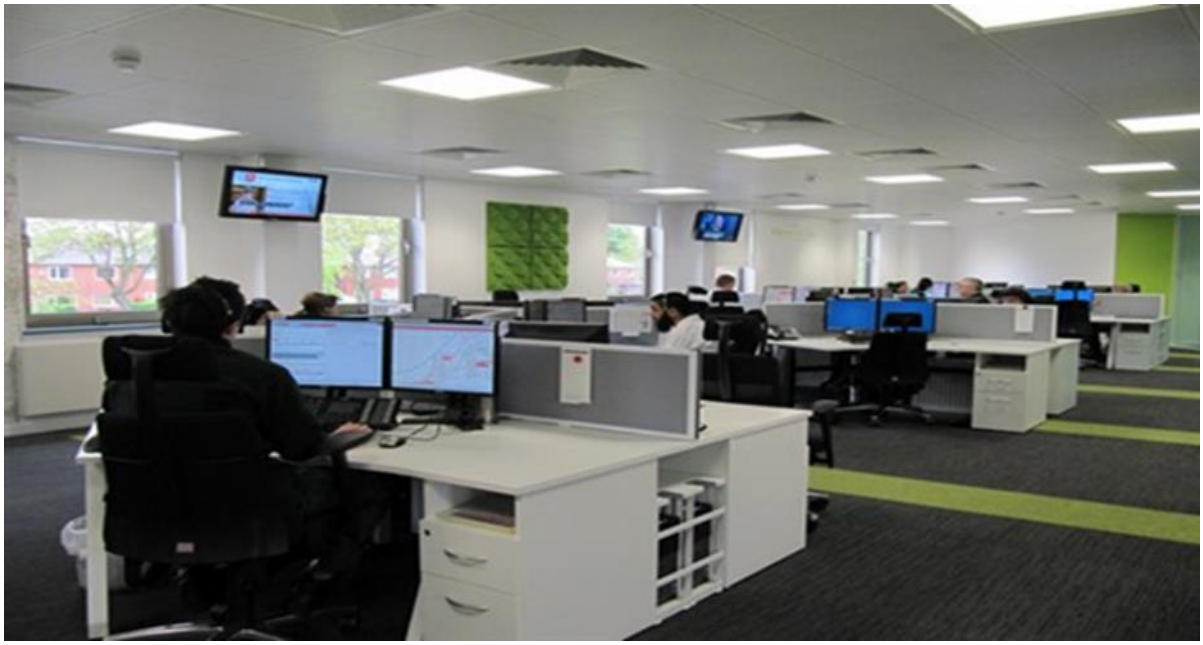
As IUC becomes embedded in the wider health system, a joined-up approach between 999 and NHS 111 is essential. The need to ensure that the first contact of every 999 and 111 call is managed effectively is essential as the impact on the wider health system, is often directly proportionate to decisions made during primary triage.

We will therefore utilise digital solutions to provide patients with a seamless journey and high-quality care which is bespoke to their individual needs, regardless of the point of contact.

We commit to aligning the primary triage systems within NHS 111 and 999 in order to increase flexibility of workforce and reduce variation; resulting in greater consistency in the quality of triage outcomes. Implementing a single primary triage platform across 111 and 999 is considered one of the fundamental changes required to develop an integrated response model and realise all of the benefits that come with the model, including;

- An increase in the functional integration of 111 and 999, allowing a call handler to work within both service lines to meet current demand.
- A seamless journey for patients with high quality care which is bespoke to their individual needs, regardless of the point of contact.
- A reduction in unwarranted variation; resulting in greater consistency and quality of triage outcomes.
- A joined-up approach between 999 and 111 is essential to ensure integrated urgent care is embedded within the wider health system.

The benefits of introducing an integrated response model includes opportunities to harness collective capacity across service lines and therefore reduce inefficiency in our workforce and estates utilisation. As a result, the contact centre estate infrastructure renewal roadmap must align to the UEC strategic direction of travel.



3.2 Integrated Urgent Care

Clinical Assessment Service (CAS)

In line with the national recommendations, we will implement a single multi-disciplinary Clinical Assessment Service (CAS) which will integrate our NHS 111 and 999 clinical hub service with wider health and care partners. In year one of the strategy NWAS migrated from Adastra to Cleric

which will enable a single clinical environment for the CAS to respond to patients and provide hear and treat.

A CAS will allow for a greater level of clinical expertise in assessing a patient that would normally be expected of a referring clinician. This expertise will be used to ensure that patients are directed efficiently and effectively into the most appropriate onward care pathway. The CAS will be staffed by multi-disciplinary healthcare professionals.

The CAS will utilise integrated digital solutions to provide patients with a seamless journey and high-quality care which is bespoke to their individual needs, regardless of the point of contact. We continue to work in partnership with commissioners and providers in order to evaluate the utility and clinical safety of CAS solutions as they emerge against the drive to minimise emergency department attendance.

In particular, we will undertake a full review of the computer aided dispatch (CAD) system in 999 to ensure that interoperability with the new NHS 111 Patient Management System and PTS delivers better integration and efficiencies. Interoperability means that systems can talk to each other, enabling information to be shared so that health and care professionals have access to the information they need to provide the right care, in the right time, at the right place. Further detail is outlined within the Digital and Business Intelligence Strategy.

Single Patient Management System

NHS England and NHS Improvement have recently committed to a programme to review the validation of 999 Category 3 & 4 cases across English ambulance services. The aim of this is to trial a nationally agreed set of evidence-based code sets and processes for clinical validation of appropriate codes prior to dispatch. This seeks to safely increase hear and treat responses whilst maintaining clinical safety and reducing the requirement for ambulance resources to be dispatched to an incident where alternative clinical pathways are available. We will monitor the outcomes of this pilot and seek to implement early clinical validation processes as part of our CAS offer.

NHS 111 First

NHS 111 First is a national programme which builds on the existing integrated urgent care (IUC) service accessed through NHS 111. It will encourage the use of the NHS 111 online and phone service to access a range of urgent care services including, for the first time, direct booking into EDs. Alongside this, processes will be developed to appropriately stream patients who present unannounced ED to the right service.

NHS 111 First places even more importance on our 111 service, recognising how valuable it is as a main point of contact for patients who need to access urgent care.

The **NHS 111 First** model also:

1. Enables patients appropriate for alternative management, such as GP or urgent treatment centre, to be **booked into a time slot wherever possible**.
2. **Makes best use of technology** to enable direct referrals and support remote consultations.

3. **Improves clinical outcomes** by increasing the volume of patients with an 'emergency treatment centre' disposition that are clinically validated by a local clinical assessment service (CAS).
4. **Aligns with the integrated urgent care ambition** through the development of local clinical assessment services offering patients access to clinicians, both experienced generalists and specialists (such as dental nurses, mental health nurses and palliative care nurses).

We are working closely with NHS England and local partner organisations across the health system to introduce the new approach in the North West and ensure the service our NHS 111 service is adequately supported and resourced to meet any additional demand.

Partnership Working

We are perfectly placed as a lead partner in managing patient flow through the whole healthcare system therefore, it is essential that we further develop and maintain effective partnerships across the North West. We understand that implementation of IUC is crucial to the whole health system but that delivery cannot be achieved in isolation.

We recognise that partnerships with STPs will become crucial to delivery of integrated urgent care. We already engage STPs and commissioners to develop innovative, system-wide integrated response model which aligns to population demography and healthcare needs. This strategy describes our ambition to exceed current expectations to position NWAS at the forefront of the out of hospital health and care system.

In order to deliver the requirements of an IUC specification, we will continue to work in partnership with providers across the North West, including pharmacists, dental, mental health, maternity, GPs, with links to social care and other community services further strengthening these at all levels (Board to frontline)

The commissioning arrangements for IUC will involve collaborative solutions between ambulance services, GP out of hours, and other community-based providers. Therefore, we will strengthen our existing engagement with commissioners and STPs to develop collaborative commissioning arrangements between the ambulance service, GP out of hours, and other community-based providers which will enable the implementation of a CAS.

3.3 Non-Emergency Transport Solutions

The aim of a non-emergency transport solution is to enhance the function of existing patient transport services to support all urgent and emergency activity when the patient's condition is commensurate with non-emergency transport. The non-emergency transports solution should offer a 'one service' approach which is fundamental to our ability to more effectively, and sustainably, deliver our strategic priorities and manage demand from across the urgent and emergency care system including healthcare professionals and inter-facility transfers.

Within the first year of UEC Strategy implementation, a dedicated programme has focused on developing a proposal which supports a non-emergency transport solution in line with the our organisations strategic vision.

The strategic principles underpinning a future PTS and non-emergency transport solution are as follows:

- Provide a patient transport service defined by the Department of Health as being typified by the non-urgent, planned transportation of patients, with a medical need for transport, to and from a premises providing NHS healthcare and between NHS healthcare providers.
- Provide an integrated, non-emergency transport service (NETS) that will respond to activity originating from 999 and 111 that is commensurate with that skill level.
- Be able to respond to a range of commercially tendered opportunities for non-emergency patient transport and integrated care services.

PTS Learning from Covid-19

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

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

The use of PTS staff and ambulance resource - in addition to increasing 999 responses by supporting PES colleagues on frontline emergency ambulances - augmented a range of non-emergency resources available to EOCs, such as urgent care service (UCS) voluntary aid resources (VAS) with the aim of assuring best use of resources and providing a response commensurate with patients' needs.

The use of non-emergency resources through COVID-19 offers a unique opportunity to create a legacy of career progression, developing motivated staff at all levels, demonstrating a clear pathway through the service for those who wish to progress, which over decades has diminished or appeared complex, to the point of demotivating, to achieve.

Priority 3 Objectives:

Contact centres:

- ✓ **We will review and reconfigure our existing EOC and contact centre functions within the term of this strategy to ensure that we provide an efficient, appropriately resourced and resilient service at all times.**
- ✓ **We commit to aligning the primary triage systems within NHS 111 and 999 in order to increase flexibility of workforce and reduce variation; resulting in greater consistency in the quality of triage outcomes.**
- ✓ **We will develop a high level specification for a proposed operational contact centre estates which aligns to the Integrated Response Model.**

Integrated Urgent Care:

- ✓ **We commit to working with partner organisations to implement a fully integrated Clinical Assessment Service across the North West within the first three years of this strategy.**
- ✓ **We will evaluate and scale up existing CAS arrangements, with particular focus on developing NWAS' offer to a system-wide CAS.**
- ✓ **We will maximise opportunities for internal integration across NWAS clinical assessment and triage functions following the implementation of a Single Patient Management System (SPMS)**
- ✓ **We will also maximise opportunities to improve external integration with system partners to increase access to patient information to improve clinical assessment and triage.**

Non-Emergency Transport Solutions:

- ✓ **We will build on the learning during Covid-19 and embed recommendations to develop and implement a sustainable Non-Emergency Transport Solution.**

Priority 4: Reducing Avoidable Conveyance

4.1 Rotational Working

The future delivery of an integrated urgent care approach relies on enhanced clinical assessment and treatment in pre-hospital and community-based settings. New models of care will require highly skilled, flexible clinicians who can work across traditional practice boundaries and within multi-disciplinary teams. Developing these clinical teams will require a more adaptable approach to clinical leadership in which, urgent care capability is recognised as essential in enabling delivery of emergency services.

In the context of a limited national resource pool, recruitment and retention is crucial to our future plans and as clinicians increase their knowledge and skills, we understand that to become an employer of choice, we must provide a rich experience for all staff, whatever their role. We must continue with our recruitment of a highly skilled and sustainable workforce as well as

deploying, across a range of settings, clinicians with specialist skillsets such as mental health, pharmacy, midwifery, occupational therapy, and physiotherapy.

This strategy builds on the success of early rotational working pilots, flexible and shared workforce models as key enablers to the delivery IUC and CAS models and will provide exciting roles plus development opportunities for NWAS clinicians. This aligns to the recommendations published in Lord Carter's review which states that rotational working models can reduce staff turnover, alleviate demand issues across the NHS, enable staff to develop a wider skill-set and ultimately provide better care for patients.

As part of our approach to workforce development we will work closely with system wide providers and academic partners in order to develop productive rotational working solutions.

NWAS' Estates Strategy is key to the delivery of innovation workforce models. This will support staff from NWAS and our partners to work remotely and more flexibly; providing the opportunity to flex staff availability during spikes in activity.

GP Contract Reform

In January 2019, the NHS announced a five-year deal to expand GP services as part of the NHS Long Term Plan (LTP) (NHS England, 2019a) implementation. The LTP sets out how PCNs will join up the delivery of urgent care within communities, which will also include a £300m fund by 2023 to deliver these changes at pace (NHS England, 2019b). The new GP contract is designed to facilitate delivery of commitments made in the NHS long term plan and PCNs will receive funding to employ additional staff under an additional roles reimbursement scheme (ARRS). PCNs are predicted to receive £1.8bn over five years for this purpose and there are five reimbursable roles, one of which being paramedics.

ARRS funding is not due to become available for paramedic recruitment until 2021/22 (NHS England, 2019c) and will be reimbursable up to an indicative Agenda for Change (AFC) Band 7 rate in June 2020, increased from the planned AFC band 6 rate in January 2020. The maximum reimbursable amount at Band 7/8a from contract amendment is not yet available.

The updated GP contract is clear that:

1. It is up to individual PCNs to decide the distribution of roles required.
2. Illustrative distribution by NHS England suggests that will be maximum of 2 WTE paramedics per PCN, funded by the ARRS.
3. PCNs are encouraged within the contract to engage with partner providers where they do not wish to directly employ paramedics or other reimbursable posts under the ARRS themselves.

We have subsequently identified a corporate risk that the trust will suffer a paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.

Therefore, if we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of our objectives'.

It has been acknowledged that developing rotational working models in partnership with PCNs and system providers, through early adopter sites, will seek to mitigate these risks and enable us to respond quickly to subsequent approaches from PCNs across the region.

Within the last 12 months, an external rotational working group has focused the development of a formal offer in response to the GP contract reforms and the additional roles reimbursement scheme (ARRS). This has included engagement with interested primary care networks (PCNs) sites and commissioners to understand barriers and facilitators to rotational working models and develop an initial offer to the system.

The transition from traditional paramedic employment within an ambulance service to rotational roles within primary care will result in knowledge, clinical skill set and clinical practice changes. This affords opportunities to paramedics to develop clinically, work at an enhanced level and bring forward clinical skills from primary care to benefit patients early into their frontline ambulance roles.

Ultimately, the development and testing of rotational models should aim to minimise the risk of system destabilisation by a desire of one sector/partner to strengthen themselves, which could easily leave a deficit in another (e.g. risks associated with paramedic attrition to primary care if there were no response from the trust to the reforms proposed). These risks are reflected in the Workforce Strategy and rotational working is identified as a key response to the GP contract reform.

4.2 Reducing Avoidable Conveyance

It is crucial to the delivery of our strategic aims, that we equip our workforce with the right knowledge, skills and clinical expertise to assess, treat, diagnose, supply and administer medicines, manage, discharge and refer patients across a range of urgent, emergency, critical or out of hospital settings.

Within the last 24 months there have been several national policy developments and publications that have emphasised the importance of ensuring that ambulance clinicians convey patients to an ED only if this is clinically appropriate for the patient's needs, or where no alternative community-based pathway of care exists for the patient's needs.

The NHS Long Term Plan (NHS England, 2019) includes the ambition to deliver the opportunities for safe reductions in avoidable conveyance highlighted in the Lord Carter Review (NHS Improvement, 2018). More recently, guidance has been issued in the Planning to Safely Reduce Avoidable Conveyance (NHS England and NHS Improvement, 2019) document. These documents have detailed the variation in conveyance to ED between ambulance services and methods by which commissioners, ambulance services and STP/ICSs can look to safely reduce avoidable conveyance by 2023.

Within the Planning to Safely Reduce Avoidable Conveyance (NHS England and NHS Improvement, 2019) document there are a number of areas which are seen as integral in safely reducing avoidable conveyance. These include for example:

- Building on opportunities to maximise hear and treat and see and treat where safe to do so by developing pathways with other organisations and systems.
- Increasing access to ED alternatives where patients are not suitable for community care pathways e.g. developing pathways into ambulatory emergency care (also known as same day emergency care) for use by clinicians.
- Improvements in digital maturity to support the delivery of hear and treat and see and treat e.g. access to summary care records and live access to the NHS Directory of Services (DoS).
- The development of effective pathways to support patients experiencing mental health crisis or falls.
- Development of differentiated responses that could be provided to nursing and care home residents to ensure pathways across the whole patient journey are accessed.
- Supporting improvements in the clinical skills of staff to optimise the response to the patient e.g. clinical skill improvements and rotational working.

In order to drive improvement, we have established a reducing avoidable conveyance programme. The programme is made up of three key workstreams, each containing several smaller pieces of work. The key pieces of work in each workstream are detailed below:

Clinical assessment and triage: evaluation of triage and clinical decision-making tools, alongside a review of the potential benefits of additional point of care testing.

Clinical treatment and referral: developing enhanced clinical skills and review the potential for an increased formulary; pathway development and Directory of Services (DoS) and onward referrals and alternatives to ED.

Clinical support: supporting clinicians to improve alternative pathway utilisation by providing effective clinical feedback and supervision, in order to improve see and treat decision making.

4.3 Health Promotion and Prevention

This strategy follows the principles of the NHS Constitution. We already engage with partner organisations such as Public Health England, Healthwatch, STPs, community services, and social care organisations in order to maximise our contribution to health promotion and prevention thus reducing demand on 999 services, EDs, and the wider health system.

We will manage activity 'before the contact' through education and management of known high intensity users; both individual patients and care establishments such as nursing home, residential homes and hospitals. We will support and engage in activities to assist initiatives that lead to better education and health management of the populations at regional or local level.

In line with our digital commitments to improve business intelligence, we will access and utilise high-quality data from a range of sources to identify areas of preventable demand and proactively manage our resources. We will also use historic data to target public health communication to promote preventative self-care.

During the Covid-19 pandemic, we saw an increased focus on the importance of utilising demographic data to identify patients who are at higher risk of serious illness such as BAME populations, as well as those high-intensity users who may be more likely to require support from one of NWAS' service lines.

It is therefore more important than ever, for us to work with partner organisations across the North West to more appropriately support patients within the community in order to prevent the need for a more urgent or emergency care response.

Priority 4 Objectives:

Rotational Working

- ✓ **We will develop, run and evaluate a series of rotational working pilots to establish NWAS' offer to the wider system by the end of 2021/22.**
- ✓ **We will continue to engage with partners across the North West to ensure we have an effective, joined-up approach to managing rotational working.**

Reducing Avoidable Conveyance

- ✓ **We will deliver a programme of work which focuses on enhancing clinical assessment and triage, treatment and referral to alternative pathways and clinical supervision and support.**
- ✓ **We will work collaboratively with frontline operational clinicians and managers to achieve the objectives of the Reducing Avoidable Conveyance programme, utilising appropriate methodologies to foster collaboration, engagement and learning both internally and externally.**
- ✓ **We will deliver and sustain improvements in key associated metrics, including See & Treat. Hear & Treat and See & Convey to ED alternatives.**

Health Promotion and Prevention

- ✓ **We will engage with commissioners, ICSs and providers to ensure that we are a key partner in delivering integrated urgent care solutions which align to population demography and healthcare needs.**
- ✓ **In particular, we will draw on population data and learning from Covid-19 in relation to higher-risk, high-intensity service users in order to improve NWAS' approach to prevention.**

4. HOW WILL WE DELIVER THIS STRATEGY?

Enabling Strategies

There are a number of strategies which are crucial to enable the delivery of this UEC Strategy. These include:

Digital and Business Intelligence Strategy

We recognise our ability to deliver the right care, in the right place at the right time relies on investment in new technological solutions and therefore the need for UEC services to be supported by a robust digital strategy has never been more apparent. The adoption of digital technology will enable organisational transformation by creating efficiencies within our internal processes, whilst also providing greater integration into the wider health system.

Our Digital and Business Intelligence Strategy complements the principles and commitments of urgent and emergency care delivery. Through the adoption of secure, integrated digital solutions and robust business intelligence, we will reduce variation across service provision to provide a reliable, patient-centred response every time for those with both emergency and urgent care needs.

Workforce

The purpose of the Workforce Strategy is to set how we will develop, engage and empower our workforce to deliver our vision to become the best ambulance in the UK. The strategy sets out our strategic workforce priorities and our approach to enabling the changes required in our workforce to support delivery of our strategic objectives.

Estates

The Estates Strategy is principally concerned with our utilisation of our estate and the capital investment over the next five years to ensure we can achieve its service objectives.

Fleet

The fleet is a vital part of resources and the future fleet requirements need to be considered within our planning of future resources. The Fleet Strategy aims to support the Trust strategy of becoming the best ambulance service by procuring a fleet which supports our current and developing operational models.

Communication and Engagement

Effective communication with public, patients, staff and partners will improve the services that we provide, strengthen our reputation and achieve mutual understanding of our goals and the needs of our patients and staff. We embrace a commitment to listening and involving communities, their representatives and others in the way we plan and provide our services.

In order to ensure that patients must be as informed as possible about their options for treatment, medications, and other aspects of the ambulance service and the wider system providing their journey of care, we are committed to working together with patients to improve the care they receive. We will embed this through the newly formed Patient and Public Panel and associated work plan of engagement and involvement activities.

Implementation Plan

Year 1 of UEC strategy implementation was supported by a robust implementation plan which centred on the creation of a shared vision. Responsibility for creating the shared vision started

with the Board of Directors, through the Executive Leadership Committee, and continued to every member within operational, corporate, and support services.

We adopted the following five-point framework for successful implementation:

1. Communicate and align

- ✓ We will clearly communicate our objectives, all of which will be driven by our organisational values and vision.
- ✓ We will have clear goals with a comprehensive list of business objectives that will become the foundation for improvement and change.
- ✓ We will align the strategic principles and commitments with the business planning of each of the trust's directorates to ensure that all work aligns to and is prioritised against trust goals.

2. Drive accountability

- ✓ The Chief Executive and Executive Leadership Committee will ensure that our goals and objectives are shared with teams and individual staff members to ensure that everyone is clear how their contribution impacts on the success of NWAS as the best ambulance service in the UK by 2023.
- ✓ Objectives will be assigned to responsible officers. We will ensure that each responsible officer has clear action plans and objectives, and that they will be accountable, through a robust governance framework, for delivering those objectives.

3. Create focus

- ✓ We will ensure that goals are realistic and achievable.
- ✓ We will develop a series of dashboards that will allow staff to monitor their progress and see how their work contributes to the rest of the strategy implementation.
- ✓ Regular and structured performance conversations will be established against each of the strategic principles, commitments and individual work-stream objectives.

4. Be action orientated

- ✓ We will ensure that appropriate actions are taken when goals or objectives are not being achieved.
- ✓ We will be supportive and proactive in action planning processes. Managers will focus on the specific tasks needed to move their objectives forward in line with the strategic vision.

5. Track progress

- ✓ A governance structure will be established in order to provide oversight and scrutiny and to allow each team to discuss progress against their implementation objectives.
- ✓ Assurance on the delivery of our objectives will be provided through the committee structure, reporting to the Board of Directors.

A subsequent Year 2 implementation plan will be developed to include a summary of objectives, deliverables, timescales, benefits and measures.

5. CONCLUSION

The purpose of this strategy refresh is to set an ambitious strategic direction for NWAS which informs and enables us to lead a robust response to regional, local, and national healthcare drivers.

We maintain our commitment to delivering the highest quality of care to those patients who present with time-critical illness or injury. Person-centered, outcome-focused care will be our top priority. We will support our staff and patients to make confident decisions at all stages of the patient journey.

Our workforce is key. Innovative workforce solutions will drive the high quality of care for which we strive. We will explore rotational working solutions within emergency and urgent care that harness the skills, expertise, and capacity of our workforce. Health promotion, prevention initiatives, and the channel shift to community-based care will be dependent on developing high caliber, versatile, and holistic practitioners.

Enhanced clinical leadership which empowers staff to be innovative, patient centered, and quality driven, will complement existing general management functions. The addition of business and commercially focused managerial support will create a tripartite approach to service delivery which will adopt a rich, forward thinking approach to STP/ICS engagement.

We must digitally enable our workforce in order to promote interoperability and shared decision making, whilst also employing creative solutions for 'before the contact' healthcare.

The integrated response model approach will ensure that we functionally integrate the 999, 111, and PTS businesses, whilst harnessing capacity across the whole economy for the purposes of seamless patient care, in which needless waiting is eliminated.

Our commitment to learn from the COVID 19 Pandemic and to undertake a comprehensive and systematic review of our operational service delivery model will ensure that we are fully equipped to deliver ARP standards through the term of this strategy and beyond.

In short, we are continuing to build upon the largest organisational change process since the merger of legacy Ambulance Trusts in the North West. The challenge is there, and we are committed to embracing that challenge.

Appendix 1- Glossary of Terms

GLOSSARY OF TERMS	
AACE	Association of Ambulance Chief Executives
A&E	Accident and Emergency
APAS	Acute Primary Assessment Service
ARP	Ambulance Response Programme
CAD	Computer Aided Dispatch
CAS	Clinical Assessment Service
CHD	Coronary Heart Disease
CSP	Community Specialist Paramedic
CVD	Cardiovascular Disease
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ePR	Electronic Patient Record
eTS	Electronic Triage System
EPRR	Emergency Preparedness, Resilience and Response
5YFV (FYFV)	Five Year forward View
GP OOH	General Practice Out of Hours
HART	Hazardous Area Rescue Team
HCP	Healthcare Professional
H&T	Hear and Treat
IFT	Interfacility Transfer
IUC	Integrated Urgent Care
IVCH	Integrated Virtual Clinical Hub
LTP	The NHS Long Term Plan
MDT	Multidisciplinary Team
MPDS	Medical Priority Dispatch System
MTS TTA	Manchester Triage System Telephone Triage and Advice
NAO	National Audit Office
NHSE	NHS England
NHSI	NHS Improvement
NWAS	North West Ambulance Service NHS Trust
PTS	Patient Transport Service
S&C	See & Convey
S&T	See & Treat
STP	Sustainability and Transformation Partnerships
TPC	Transforming Patient Care (Transformation Programme)
UCP	Urgent Care Practitioner
UECR	Urgent and Emergency Care Review

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	31st March 2021			
Subject:	Digital Strategy Refresh			
Presented by:	Director of Quality, Innovation and Improvement			
Purpose of Paper:	For Decision			
Executive Summary:	The North West Ambulance Service (NWAS) published its first Digital strategy on 29th May 2019. To ensure the strategy remains relevant we agreed on a process of yearly refresh. The delay in production and publication was agreed by the ELC to minimise pressures during the COVID response. An annual report summarising what we have achieved since the launch of the strategy, risks mitigated and remaining, finance implications and key next steps will be put forward May. The refresh of the strategy was overseen by the Digital Oversight Forum including representation from across the organisation and following a number of sessions with the Patient and Public Panel and external partners. The strategy has largely remained the same as the original version although a number of changes and additions have been made strengthening key areas. These are outlined in a table (appendix 1) with a version of the strategy with tracked changes and a final version (appendix 2 and 3).			
Recommendations, decisions or actions sought:	The Board of Directors are recommended to approve the refreshed digital strategy.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

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

Are there any Equality Related Impacts:	Yes, the strategy includes more emphasis on digital inclusion
Previously Submitted to:	• Executive Leadership Committee • Resources Committee
Date:	• 24th March • 26th March
Outcome:	• Approved • Approved with suggestions around strengthening support of our green goals and the data quality focus - now included

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1. PURPOSE

1.1 This paper outlines the changes that have been made to the digital strategy through the review process and asks for approval for the changes to be accepted.

2. BACKGROUND

2.1 The North West Ambulance Service (NWAS) published its first Digital strategy on 29th May 2019. To ensure the strategy remains relevant we agreed on a process of yearly refresh. The delay in production and publication was agreed by the ELC to minimise pressures during the COVID response.

2.2 A bi monthly update to give assurance on delivery of the digital strategy and highlight any key risks has been reported to the Resources Committee since the strategy was launched.

2.3 Since the strategy was published a leadership team has been put in place to lead the strategy implementation including the Chief of Digital and Innovation and CIO (July 19), our Chief Technical Officer (July 20) and the Head of Digital Intelligence and Analytics (December 20). We have also invested in new areas of the digital teams and PMO to support project delivery, cyber security, business intelligence and in house development of digital solutions.

2.4 Our Digital Oversight Forum, including representation from across NWAS service lines provides oversight of delivery of the strategy and has contributed to this report.

2.5 An annual report summarising what we have achieved since the launch of the strategy, risks mitigated and remaining, finance implications and key next steps will be put forward May.

3. STRATEGY REFRESH

3.1 The refresh of the strategy was overseen by the Digital Oversight Forum including representation from across the organisation and following a number of sessions with the Patient and Public Panel and external partners.

3.2 The strategy has largely remained the same as the original version although a number of relatively small changes and additions have been made. These include:

- A strengthened focus on digital inclusion which was highlighted in particular through our patient and public panel sessions
- More detail on evaluation with an increased focus on how we understand productivity and efficiencies linked to digital changes
- A re-focus of the objectives around avoidable deterioration in the digital pioneers section to set out how we will work in partnership on wearable tech and focus within NWAS on innovative technologies to support on scene physiological monitoring
- More focus on how we work together with PMO and transformation as a core part of our operating model
- An update of language to reflect the current context for example ICSs instead of STPs
- An update of governance and team structures
- A strengthened focus on how we will implement innovations that enable us to be an efficient and productive organisation including Smart technologies and supporting our

green agenda
- A strengthened focus on data quality

3.3 A table outlining every change can be seen in appendix 1. The strategy refresh including track changes in appendix 2 and the strategy refresh with changes accepted in appendix 3.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 There are no direct legal or governance implications.

5. RECOMMENDATIONS

5.1 The Board of Directors are recommended to approve the refreshed strategy.

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APPENDIX 1 Table of Changes

Reference	Change
Refresh of Foreward	Minor updates to reflect 2020/21 progress
Section 1.3 Patient experience	Addition of: 'We will ensure our services are designed to be digitally inclusive.' 'We will work in partnership with the Patient and Public Panel, using the co-design approaches to deliver key improvements.
Section 1.6 Listen, test and learn	Addition of: 'We will invest in evaluation and learning, creating an evaluation framework to support digital programmes so that we are able to understand the impact of our investments and work to deliver productivity and efficiency gains across the organisation and wider systems.'
Section 2.1 'Digital First Culture'	Addition of: Within the first 18 months of this strategy we developed and tested a digital confidence, capability and satisfaction survey and established a baseline from which we will measure improvement periodically. AND: 'This has been expedited due to the impact of the corana virus.'
Section 2.2 Leadership and Governance	Update to the section on how the digital portfolio is managed and where it reports to.
Section 2.3 Operating Model	Addition of: 'We will work in partnership with the PMO and transformation team to enable delivery of digital projects.' AND: 'We will work closely with finance, partners and the Board to enable the ongoing funding of the digital strategy. We will focus on four key areas: 1. Budget management and reinvestment of efficiencies in the digital budget 2. Enabling productivity and efficiencies in the organisation which if measures and released may be reinvested 3. Securing external funding from NHS central bodies and 4. A long term plan for investment and commercialisation of digital innovations.'
Section 3.2 Privacy and cyber security	Addition of: 'We will ensure we meet all regulatory requirements related to Information governance and cyber security.' AND: 'We will position Information Governance as enablers of change involved in the design of canges supporting asset owners via a digital asset register.'
Section 3.3 Cloud and Edge storage	'We will explore opportunities for the appropriate use of cloud hosting and data storage' replaced with: 'Where appropriate, we will use cloud services to store data and patient information safely and securely and reduce risk of data accessibility being affected by local hardware failure'
Section 3.5 Core business paltforms	Amendment to the timeframe of replacement of current telephony systems from 'within the life of this strategy' to 'by the end of 2021.
Section 4.2 Better access	Amendment to section on access to patient data from developing 'a Patient Information portal' to 'develop and implement solutions to enable access to patient data.' AND: Amendment to workforce information section from it being aaccessibale through a 'single staff index' to 'accessible thorugh the integration of key systems such as ESR and GRS'.

Section 4.5 Better operating procedures	Addition of 'we will implement data quality by design including software and focused data quality processes.'
Section 5.1 Preventing harm and deterioration	Removal of: We will also utilise unified communication channels within our contact centres to analyse data from wearable technology and proactively contact patients for preventative care. For example, we will explore utilisation of text messaging functionality and tele-health appointments.' AND addition of: 'We will explore the latest innovations to enable on scene physiological monitoring, working to share data with clinicians in other services and working together via video consultation on scene.
Section 5.3	ADDITION OF: We will develop an innovation fund to support our innovation pipeline
Section 5.4	ADDITION OF: 'We will focus on innovations that enable us to be an efficient and productive organisation, enabling us to be greener, cost effective, improve staff experience and wellbeing and provide the best possible care. This will include a focus on Smart technologies and supporting our 'green' agenda.'
Governance structure diagram	Update to governance structure diagram.
Digital leadership structure	Update to digital leadership structure diagram.
Digital Roadmap	Table replaced for full roadmap image
Draft measures table	Removed as final measures going in the annual report in May
Finance table	Removed as full update to be included in annual report in May
Appendix 1 Governance Structure	Updated to reflect current governance structure

North West Ambulance Service NHS Trust

Digital Strategy

Overview

2019-2024

Recommended by	Executive Management Team
Approved by	Board of Directors
Approval date	May 2019
Version number	2.0
Review date	1st March 2021
Responsible Director	Executive Director for Quality, Innovation and Improvement
Responsible Manager (Sponsor)	Chief of Digital and Innovation
For use by	All staff, Commissioners, stakeholders

Record of Document Development			
Date	**Change**	**By Whom**	**Reason**
14/01/2019	Document Creation	Sarah Latham/ Matt Wynne	Document creation
24/01/2019	Document Revision	Sarah Latham	Content update
30/01/2019	Document Revision	Matt Wynne	Digital strategy workshop comments
06/02/2019	Document Revision	Sarah Latham	Digital strategy development group comments
15/02/2019	Document Revision	Matt Wynne	Digital strategy working group comments
18/02/2019	Document Revision	Matt Wynne	Addition of digital infographics
20/02/2019	Document Restructure	Sarah Latham	Digital strategy workshop comments
25/02/2019	Document Revision	Sarah Latham	Comments from Interim Head of Informatics
27/02/2019	Document Revision	Matt Wynne	Comments from digital strategy development group
01/03/2019	Document Restructure and Update	Sarah Latham/ Matt Wynne	Following review by Digital Oversight Forum
06/03/2019	Document Revision	Sarah Latham/ Matt Wynne	PA Consultancy comments
12/03/2019	Document Revision	Sarah Latham	Comments from responsible Director
14/03/2019	Document Revision	Sarah Latham	Feedback from Joint Partnership Council
21/03/2019	Document Revision	Sarah Latham	Digital strategy development group comments
22/03/2019	Document Amendments	Sarah Latham	Following review by FIP
27/03/2019	Document Revision	Sarah Latham	Addition of digital roadmap
02/04/2019	Document Revision	Sarah Latham	Addition of measurement strategy
03/04/2019	Document Revision	Sarah Latham	Feedback from EOC governance group
09/04/2019	Document Restructure	Sarah Latham	PA Consultancy workshop comments
12/04/2019	First Draft Finalised	Sarah Latham	Full draft circulated to EMT for formal comments
25/04/2019	Document Update	Matt Wynne	Feedback from A&E consultative group
26/04/2019	Document Update	Sarah Latham	Following comments from Medical Director
29/04/2019	Document Update	Matt Wynne	Feedback from PTS Level 3 meeting
29/04/2019	Document Revision	Sarah Latham	Following comments from Digital Oversight Forum
30/04/2019	Document Update	Matt Wynne	Feedback from Greater Manchester QBQ
30/04/2019	Document Update	Sarah Latham	Following comments from EMT
03/05/2019	Document Update	Matt Wynne	Following comments from EMT
22/05/2019	Document Update	Matt Wynne	Document update following FIP submission
22/05/2019	Document Update	Sarah Latham/ Matt Wynne	Final formatting, addition of foreword and proof
30/05/19	Document Finalised	Sarah Latham	Final Trust Board review

25/08/20	Document refreshed	Carol Hall	To ensure the strategy remains up to date and relevant, reflecting the current environment and progress
01/03/2021	Document review and refresh	Abigail Harrison	To ensure strategy remains up to date and ensure key areas of work / focus included
11/03/2021	Document refresh Finalised	Abigail Harrison	For ELC, Resources Committee and Board approval

1. Foreword

In less than two decades the world we live in has changed beyond recognition. The birth of the internet paired with mobile computing has changed everything. If we look around now in any cafe, airport, sporting event or social occasion, the world is connected by cameras, social media platforms, applications and pocket sized devices. They sit by our sides in a way that seems completely normal. We tap them onto scanners to board planes and pay for coffee. We treat them as key assets and feel bereft if they are taken from us. Phones are mini computers, smart devices, with more capability than anyone could have dreamed. Even more exciting is the ability we now have to manage our lives through these devices. If we want to protect our children, secure our homes, set our heating, all of this is now possible. This next generation 'internet of things' is a burgeoning area of digital growth. Our NWAS digital strategy provides the foundations for us to operate in this context. Being the first ambulance service to become fully digitally enabled is our ambition. This is a bold statement given our current positioning and we know that. So, why do we think this is necessary and how will this be possible?

In simple terms the rationale for our ambition is that we have promised our patients that we will deliver the right care at the right time in the right place every time and without a progressive digital infrastructure this is simply not possible in today's world. Our patients expect to be able to interact with us through whatever device or platform is most convenient for them, be that email, phone web or application. They expect that we will know all about them because we have access to the best location software, health record and past interactions with us. They expect our clinicians to have the latest knowledge at their fingertips and to use this to advise and direct them to the choices available to them. They expect us to be able to provide immediate access to the right healthcare professional either in person or via video and they do not want to wait for treatment if it's possible to start that immediately in a safe way. Partnering in care in this way is not a luxury, it is the only way. This is what we heard when we conducted the focus groups to develop this strategy and it was a message that we cannot ignore.

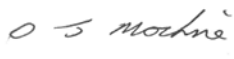
Our ambition is also fuelled by our commitment to our staff. To be the best ambulance service in the UK, we have a responsibility to ensure that our staff are happy and equipped to deliver services in the most effective and efficient way. Over the past decade, Ambulance Trusts led the way on developing their control room technology with virtual Command and Control and call answering. However, despite this,technology has moved on and historically, NWAS, like most NHS organisations, has continued to operate in a world of pen and paper in many other areas. For example, signing in at the entry to our buildings, requesting supplies, completing training, requesting leave, claiming expenses, recording patient information, completing audit or collating evidence of our personal development. These paper systems are slowly being replaced by digital solutions. This strategy makes a commitment to our staff to pursue these improvements at pace.

Most of the technology and applications we need already exist. Our job through the strategy is threefold: to build a stable and resilient platform which has the maintenance required to keep our digital information safe; to connect with WiFi seamlessly and to ensure that our data sharing agreements permit secure, seamless interoperability. Our ability to be able to connect to one another within NWAS, for example through a single telephone or computer system, is key. If we have this we can help one another succeed, breaking down some of the inevitable historical barriers between service lines and departments, sharing expertise and supporting demand. Our ability to be able to connect to other health partners and to patients directly is central to our ambition to lead urgent as well as emergency care. Our strategy addresses this directly.

It is well recognised that the adoption of digital solutions varies significantly from one person to the next, one team to the next and one organisation to the next. This variation exists within NWAS. We already have innovators using mobile computing to access patient records on scene, tap into knowledge repositories such as JRCalc and access Manchester Triage via the GeTac devices. We also have those who will need help with this change, waiting for proof that this will help them deliver better care. This strategy recognises both these opposing views and sets out an ambition in the first instance to simply 'get the basics right'. After all, if we can't even issue phones and computers on time how can we be trusted to do the rest? To deliver this ambition our IT, Business Intelligence, Information governance and clinical records team have come together under a single leadership. Our team, headed up by a Chief of Digital and Innovation will steer the strategy forward, working with us to build our confidence in these changes and our skills in using the equipment we have. This won't happen overnight for everyone but for some it will be long overdue. We recognise that our workforce will have different needs and have different capabilities and we are absolutely committed to leaving no one behind.

Digital is the opportunity to make NWAS an even greater place to work than it is today. Our people make our organisation outstanding. The systems they work in don't always marry up. Frustrations build and time is wasted trying to access buildings and cupboards with a plethora of keys and codes. For those of you who are bothered by this, help us build a safe single swipe solution for all buildings, cupboards and locked areas which also helps us log into our devices and applications. Help us install number plate recognition into access barriers and garages. Help us continually monitor tyre pressures and vehicle safety, removing the need for manual checks. Let's use our cameras as scanners to barcode our PIN numbers, stock levels, training records and timesheets. Let's upload rather than transport, let's Skype rather than ride. Let's connect and learn. Let's re- define what it means to be a modern and progressive ambulance service.

We hope you enjoy reading this strategy but we hope even more that you enjoy being part of our progressive and exciting digital future.



Daren Mochrie QAM
Chief Executive

Maxine Power, Executive Director of Quality, Innovation & Improvement

2. About this Strategy

This strategy guides the delivery of our digital ambition for a five year period. It is core to the delivery of reliable services 'every time' and is in service of the organisation's overall commitment to deliver the right care, at the right time, in the right place, every time. Our Digital strategy will sit alongside other core enabling strategies such as the Workforce, Fleet & Estates and Communications strategies to support the delivery of our overarching Trust ambition; to become the best Ambulance Service in the UK (see Appendix A).

The strategy will be dynamic and is refreshed on an annual basis with an annual report alongside it which summarises progress and any key changes made. This process ensures it remains relevant and reflects the key changes and challenges that affect the Trust. This strategy describes our commitment to developing our services with digital solutions, a digitally enabled workforce, secure joined up IT platforms, smarter decisions through improved insight and innovation throughout all of North West Ambulance Service.

Technology is increasingly important for safe, effective and efficient service provision from the frontline to the board. It is central to delivery of key performance standards and enhancing patient experience. Likewise the opportunities afforded by connected business intelligence systems and the insight they provide can reduce variation in management systems and deliver back office efficiencies. Our digital strategy is also critical to connecting with other health providers in the North West and with the strategic transformation partnerships regionally. Digital enables us to connect with other ambulance Trusts to provide a more effective response to national resilience, activity increases and mutually beneficial support arrangements.

The Digital Strategy within NWAS has been developed in three stages. This overview document describes our direction of travel, which wasfollowed with a detailed implementation plan as an integral part of our integrated business plan (IBP). The Annual report includes a detailed roadmap, set of objectives and dashboard of key measures aligned to this strategy and used to update the Trust's Integrated Business Plan.

Finally, each objective in the strategy is included in a bimonthly assurance report to the Digital Oversight Forum and Resources Committee to provide an update on progress, and from which the chair of Resources Committee provides a highlight report with key risks and mitigations to Board. Digital projects are also reported via the Digital Oversight Forum to the Corporate Programme Board.

3. Board Commitment

The Trust Board are committed to ensuring that the programme of work required to develop our digital ambitions is at the forefront of our integrated business planning. Ongoing resources are required to support the renewal of critical systems and ensure IT systems are securely maintained and that staff are cyber aware. Investment is still required for embedding these systems, ensuring long term stability and resilience. Similarly, investment decisions are required to balance improvements to the internal operating platform with our patient facing IT systems.

The Trust Board acknowledge that digital infrastructure is viewed as a priority to any service redesign and as a key enabler to improvement. We have prioritised those programmes that address risks to patient care, outcomes or information security. These commitments will continue to be delivered

recognising that our resources are limited and a continuous programme of efficiency improvement is required. To this end, the board are committed to partnering to access investment opportunities and adopting partnerships which support procurement efficiencies.

4. Our Vision

Our digital vision is to radically improve how we meet the needs of patients, staff and any partners every time they interact with our digital services. These benefits will be measured through a focus on aligning our digital development priorities to the Trust's strategic priorities and creating a 'digital first' culture from the board to the frontline.

Our Strategic Themes and Focus

Our five year plan is focused on delivery of five strategic themes as outlined below:

Our aim is to use digital solutions to radically improve how we meet the needs of patients and staff; every time.

Solve everyday problems

- 1.1 Getting the basics right
- 1.2 Staff experience
- 1.3 Patient experience
- 1.4 Personal safety
- 1.5 Digital skills
- 1.6 Listen, test and learn

Our digital journey

- 2.1 'Digital first' culture
- 2.2 Leadership and governance
- 2.3 Operating model
- 2.4 Integrated organisational approach
- 2.5 Digital partnerships

Secure and joined-up systems

- 3.1 System integration and interoperability
- 3.2 Privacy and cyber security
- 3.3 Cloud and Edge
- 3.4 Open standards
- 3.5 Core business platforms
- 3.6 Proactive risk and renewal

Smarter decisions

- 4.1 Better data
- 4.2 Better access
- 4.3 Better insight
- 4.4 Better collaboration
- 4.5 Better operating procedures

Digital pioneers

- 5.1 Preventing harm from deterioration
- 5.2 Innovation partnerships
- 5.3 Cultivating innovation
- 5.4 Rapid deployment of innovation

1. Solving Everyday Problems

When speaking with our staff and volunteers it is clear that one of their biggest challenges is not having the right digital equipment or skills, at the right time or in the right place to support them to do their jobs effectively. We also recognise that technology is changing public expectations for more immediate, joined-up and comprehensive care which can be accessed through the use of digital channels. Therefore, one of the fundamental aims of this strategy is to improve digital services and technological solutions so that they meet the needs of our staff and patients; every time. If we can improve the quality and resilience of our digital services, we will in turn make NWAS a more accessible service for our patients and a great place to work for our staff.

1.1 Getting the basics right	✓ Our ambition is that all NWAS staff, whether clinical, corporate or voluntary, will receive the right digital equipment required for their role, from the first day they join the Trust. ✓ We will provide a timely response when staff do encounter technical problems or require further support or training, minimising disruption to roles wherever possible. ✓ We will ensure that our workforce is digitally connected, through digital communication channels, access to emails and reliable Wi-Fi connections.
1.2 Staff experience	✓ We will work closely with teams to develop and implement digital solutions which are focused around the end user and business need. ✓ We will redesign our digital operating model to focus around staff experience with a continuous feedback loop between our digital services, and the staff using these on the frontline and in our corporate services. This will ensure we understand the experience of digital system users and work with them to design and implement improvements based on their experience. ✓ Where possible we will use technology to provide equity of access for everyone, removing barriers for staff with disabilities. ✓ We will digitise our workforce using single-sign on and smart unique identifiers to securely access our core business platforms (see section 3.5) as well as staff and patient information.
1.3 Patient experience	✓ Our services will be straightforward to access and use and will help patients and carers navigate their care pathway in a seamless, integrated way. ✓ We will offer patients several points of contact into our service; using digital channels to be a gateway to the wider urgent and emergency care system. ✓ We have developed unified communications platforms which enable the flow of patient information. For example,if a patient switches from NHS 111 online to calling 111, the information they have provided up to that point will not be lost. ✓ We will offer our patients more opportunities for self-service for example, to book, cancel and update Patient Transport Services (PTS). ✓ We will use digital solutions to minimise unnecessary waits or duplication such as using NHS numbers to reduce the need for patients to repeat personal information to different staff during their care pathway. ✓ We will use digital solutions to offer clinical advice and intervention at the earliest opportunity in the patient's journey and navigate patients through the most appropriate care pathway.

	✓ We will ensure our services are designed to be digitally inclusive. ✓ We will protect patient's privacy and adhere to all information governance standards. ✓ We will proactively gather feedback from patients through the Patient and Public Panel and use insights from the evaluation of patient and staff feedback to identify opportunities to improve. ✓ We will work in partnership with the Patient and Public Panel, using the co-design approaches to deliver key improvements.
1.4 Improving safety	✓ We will test the use of technological equipment and safety devices to continuously improve the personal safety of staff on the frontline. ✓ We will digitise our estate through the adoption of smart access technologies to maintain security for our staff, systems and patients. ✓ We will use routine and automated alerts from systems such as Gazetteer, to inform staff when they are entering a situation with a patient who is known to be challenging or who may threaten their personal safety. ✓ We will develop partnerships with other partners to share information which will improve the safety of our workforce. ✓ We will integrate our systems so that vital information collated in out of hospital settings can be shared to keep staff safe; for example, valuable information collected by PTS crews about patients with challenging or aggressive behaviour can be used by PES to support teams. ✓ We will also use digital solutions to keep our patients safe and reduce the number of serious incidents with technology or ICT identified as a root cause.
1.5 Digital skills	✓ We will enhance the digital skills and capability of every member of staff through robust and innovative approaches to training and support across all NWAS directorates. ✓ All staff will receive an overview of our digital strategy and culture during induction as well as specific training on how to use the equipment and systems required for their role. ✓ We will digitalise our learning and development offer where appropriate, using simulation training, online seminars e-learning, and electronic portfolio development to make training more accessible for staff ✓ We will design new digital solutions to be intuitive and user-friendly and where required training will be put in place to ensure smooth transition into business as usual. ✓ We will establish digital partnerships with other industries to provide expert coaching and an environment within which digital skills can be shared. ✓ We will undertake a full skills profiling exercise to baseline the current levels of digital capability across the organisation and adopt a channel shift approach to upskilling and developing our workforce.
1.6 Listen, test and learn	✓ We will listen to ideas from staff on how we can use digital solutions to solve every day problems and improve working practice (Topol Report, 2019). ✓ We will adopt an agile approach to digital innovation; using improvement cycles to continuously test staff ideas and learn from both success and failure before scaling up across the organisation.

	✓ We will develop criteria through which benefits from change ideas can be measured and aligned to Trust goals and prioritise the rollout of those initiatives with demonstrable improvements. ✓ We will invest in evaluation and learning, creating an evaluation framework to support digital programmes so that we are able to understand the impact of our investments and work to deliver productivity and efficiency gains across the organisation and wider systems.

2. Our Digital Journey

Digital is about more than just ICT, it is simply a way of doing things which can deliver benefits to patients, staff and the wider system through the use of technology[1]. Our ability to realise the benefits it brings will be influenced by how we approach and adopt digital solutions across the whole Trust. Our strategy therefore, is as much about people as it is systems and processes and therefore requires a culture change from 'board to floor' that embraces a digital first approach.

2.1 'Digital first' culture	✓ In order to embed a 'digital first' culture we will re-think how and why our organisation does things. ✓ We will utilise digital skills and technologies to unlock the capability of digital transformation across our organisation and help our staff to do their jobs more effectively. ✓ We will continue to work towards a paper-free patient experience by 2024 including a commitment to remove all clinical paper records. This will support clinicians to manage care more effectively, improve ease of data extraction and sharing and minimise waste and duplication within audit processes. ✓ We will continuously strive to improve our systems and processes using digital solutions, rather than simply digitising our current paper processes. ✓ Within the first 18 months of this strategy we developed and tested a digital confidence, capability and satisfaction survey and established a baseline from which we will measure improvement periodically. ✓ We will optimise our estates using digital solutions to enable remote and virtual working to reduce unnecessary travel and contribute to a reduction in emissions as part of our environmental targets. ✓ We will also use remote and virtual working to offer more flexibility and opportunity for rotational working between NWAS service lines and with external partners. This has been expedited due to the impact of the corona virus. ✓ We will digitise our fleet to improve vehicle maintenance and resource management as well as explore opportunities to improve connectivity across all geographic locations. For example, we will continue to engage with the Emergency Services Network programme, which aims to install dedicated networks within Ambulance vehicles which can be used for critical communications and information sharing.

[1] National Ambulance Digital Strategy (2018) NHS Digital and NHS England.

2.2 Leadership and governance	✓ We will develop clear structures through which our digital portfolio will be designed and implemented, with assurance provided both internally and externally. ✓ Our digital portfolio will be managed by our Digital Oversight Forum (DoF) who represent NWAS' digital strategic priorities. Digital projects, priorities and interdependencies are reported to and supported by the Corporate Programme Board, who ensure strategic alignment (see section 5). ✓ We will develop a Clinical roles to provide clinical leadership across our digital portfolio and a space to engage with clinical and operational colleagues through the Digital Design Forum. This will maintain focus on patient experience and outcomes.
2.3 Operating model	✓ We will continue to review our digital operating model to ensure we have sufficient capacity and capability within our digital structures to simultaneously deliver essential ICT systems management and business continuity, whilst releasing capacity for innovation and intelligent data analytics to drive future transformation. ✓ We will provide IT systems and services that will remain 'fit for purpose' for a minimum period of five years from the date of implementation, and that can be scaled to suit the needs of the Trust. ✓ We will establish clear roles and responsibilities within our ICT and Business Intelligence teams which will include ownership of this strategy and the implementation plan which follows. ✓ We will work in partnership with the PMO and transformation team to enable delivery of digital projects. ✓ We will clearly articulate within our operating model, the roles of data and asset owners across the organisation and educate these individuals so they fully understand and appreciate their responsibilities. ✓ We will work closely with finance, partners and the Board to enable the ongoing funding of the digital strategy. We will focus on four key areas: 1. Budget management and reinvestment of efficiencies in the digital budget 2. Enabling productivity and efficiencies in the organisation which if measures and released may be reinvested 3. Securing external funding from NHS central bodies and 4. A long term plan for investment and commercialisation of digital innovations

2.4 Integrated organisational approach	✓ We will adopt digital solutions to meet the aims outlined within the Urgent and Emergency Care strategy to have a single-service approach to delivery. ✓ We will ensure our internal systems are fully integrated to support a shift away from operating as three distinct service lines across 999, 111 and PTS and re-align under a single integrated urgent and emergency care model. ✓ We will review and optimise our core business platforms to ensure they provide our operational and corporate teams with the flexibility and interoperability required to deliver an integrated organisational approach. For example, we will move to a single primary triage system across our 111 and 999 call taking functions to improve integration of our workforce and manage demand more effectively. ✓ We will also ensure integration and interoperability with external partners within an Integrated Urgent Care environment to provide patients with seamless access to and navigation of the wider North West health system. For example, we will continue to work with partners to develop automated processes for referring and booking patients into alternative care pathways from an integrated Clinical Assessment Service (CAS).
2.5 Digital partnerships	✓ We will develop and sustain digital partnerships to ensure strategic alignment at a national and regional level. ✓ We will work closely with the four Strategic Transformation Partnerships across the NWAS region to ensure our plans are aligned with other providers in order to achieve maximum system benefit. ✓ We will work with colleagues across the ambulance sector i.e. the Northern Ambulance Alliance, to champion the delivery of shared ICT systems and services to support wholescale efficiencies and resilience and learn from others. ✓ We commit to ongoing collaboration with national bodies such as NHS England, NHS Digital and NHS Improvement to ensure continued alignment with national strategic drivers whilst also maximising opportunities for collaboration, learning and innovation at scale with other providers and digital partners. ✓ We will continue to work in partnership with Commissioners to ensure that we can co-design and implement digital transformation with our system and our patients in mind.

3. Secure and Joined-Up Systems

Our technological systems must be secure, resilient and effective to maintain business continuity and high quality patient care; therefore, our priority will always be to provide essential system maintenance and improvement to maintain business continuity. At the same time, we want to create the capacity within our digital structures for ongoing innovation through increased system interoperability and more intelligent data analytics.

3.1 System integration and interoperability	✓ We will ensure that NWAS' systems are integrated and interoperable, both internally and externally, meaning systems can talk to each other. ✓ We will use interoperable systems to ensure that clinicians have access to the information they need to provide the right care, in the right place at the right time. ✓ We will develop interoperable systems to achieve our strategic ambition to act as a gateway to the wider urgent and emergency care system across the North West. For example, without system interoperability, we will be unable to pass information or patient incidents between our service lines (i.e. 111 to 999) or electronically refer a patient out from our Clinical Assessment Service into alternative providers. ✓ We will continue to work collaboratively with ICSs to increase interoperability with acute services, primary care, secondary care and social care pathways to improve the seamless coordination of patient care. ✓ We will also improve interoperability between our internal corporate systems to offer a single point of entry to input and collate consistent staff information and facilitate single sign-on functionality to access multiple systems through one device.
3.2 Privacy and cyber security	✓ We will continue to adopt the best cyber security standards and adhere to mandated frameworks around privacy and data sharing in order to maintain public trust in how we store, share and use data. ✓ We will develop and implement a programme of work which aims to continuously improve the levels of protection to cyber threats. ✓ We will ensure our systems and data infrastructure is safe and secure in order to protect our patients, staff, business continuity and resilience. ✓ We will proactively renew and update the software and networks which support our systems to create a secure digital environment. ✓ We will ensure we meet all regulatory requirements related to Information Governance and Cyber security. ✓ We will position Information Governance as enablers of change involved in the design of changes supporting asset owner via a digital asset register
3.3 'Cloud' and 'Edge' storage	✓ ✓ Where appropriate, we will use cloud services to store data and patient information safely and securely and reduce risk of data accessibility being affected by local hardware failure ✓ We will ensure that when procuring or reviewing our digital services that the benefits of cloud hosting and storage are included within the business case process.

	✓ We will adhere to national guidance to ensure any uses of cloud solutions are safe, secure and effectively managed.
3.4 Open standards	✓ We will comply with national open standards for integration and communication to allow our systems to become interoperable and talk to other systems. ✓ We will design our systems to enable reliable data sharing across care settings and organisations. ✓ When procuring new systems, or reviewing our current technological infrastructure, we will ensure that we invest in the best value for money technological solutions which comply with open standards and enable us to connect with the wider healthcare system.
3.5 Core business platforms	✓ We will ensure that our core business platforms are secure, resilient and fit for purpose to support our staff to do their jobs effectively. ✓ We will continuously review our core business platforms to identify opportunities for improvement and efficiencies, especially for those systems approaching 'end of life'. ✓ We will replace our current telephony systems with a fully unified communication platform by the end of 2021 . ✓ We will remove all clinical paper records by implementing an electronic patient record which will deliver a paper-free patient experience by 2024. ✓ We will review and optimise our core operational platforms to enable integration and resilience across service lines and with external partners. For example, we will undertake a full review of the current CAD platform used within 999 alongside the patient information platforms used within 111 and PTS and scope a new optimum system configuration to deliver Integrated Urgent and Emergency Care. ✓ We will optimise our core clinical platforms to provide high quality, patient-centred care which is seamlessly joined up internally and externally. For example, we will develop and implement a single electronic secondary triage system within our contact centres and by staff on the road. ✓ We will develop a core patient information platform to provide a single source of patient data to support clinical decision making in our contact centres and on the road whilst also providing spine look-up functionality allowing us to obtain patient NHS numbers at scene. ✓ We will integrate a core platform for workforce management and corporate systems to enable seamless management of staff through a master staff index.
3.6 Proactive risk and renewal	✓ We will take a proactive approach to internal system management and renewal; working closely with suppliers to clearly outline system requirements and support expectations. ✓ We will maintain robust digital roadmaps to understand when systems are coming towards 'end of life' whereby either software, system or network support will cease and follow the appropriate steps to review associated risks and implement mitigating actions to address these. ✓ We will ensure that financial investment in replacement systems and services is aligned to the wider business objectives of the Trust, and that where

	appropriate, cost avoidance is realised through investment in alternative technologies. ✓ We will ensure that our operational model supports ongoing system management and proactive risk and renewal to reduce unplanned critical system downtime and support business continuity.

4. Smarter Decisions

NWAS holds a unique position in the North West health and care system due to our geographical scale and amount of patient contacts each year; this means we have substantial knowledge and information about our patients, the wider population and the services available to support patient navigation.

We must share our data securely and consume data from across primary, secondary, community and other public health services in a more intelligent way. In particular, this information will help to inform clinical decision making; intelligently manage patient demand and resource allocation; predict and prevent deterioration in patients who are known to us as a service and; identify opportunities for innovation to improve service delivery.

4.1 Better data	✓ We will ensure that the data we capture, share and consume is high-quality, validated and stored within a central warehouse to provide a single source of truth. ✓ We will gather high quality data from a range of internal and external systems to inform real-time decision making and retrospective analysis. ✓ We will adhere to robust information governance standards as a means of providing assurance that all information, particularly person-identifiable information, is managed securely and appropriately in accordance with relevant legislation.
4.2 Better access	✓ We will ensure that our staff, and where appropriate, our patients and partners, will be able to appropriately access and gain insight from the data we hold. ✓ We will continue to develop and implement solutions to enable access to patient data to allow clinicians, in control functions and on the frontline, to access relevant patient information to support decision making and patient journey management. ✓ We will introduce an Electronic Patient Record that will provide NHS Spine look-up functionality which will increase utilisation of NHS numbers. ✓ We will also develop our self-service functionality to enable staff to generate automated reports and dashboards within a self-service portal. ✓ We will present data through clear, visual outputs which are user-friendly and offer opportunities for intelligent interactivity and drill-down functionality. ✓ We will increase the automation of data extraction to release capacity within our Business Intelligence function for more advanced analytics to inform service delivery and digital innovation across the organisation. ✓ We will ensure that all workforce information will be accessible through integration of key systems such as ESR and GRS enabling opportunities

	to use data to support workforce management, including HR, training and staff rostering.
4.3 Better insight	✓ We will develop an intelligent learning system within NWAS which proactively sources data and translates this into information which can be used to inform decision making and innovation. ✓ We will enhance our use of advanced analytics to gather insight from high quality data to support integrated urgent and emergency care, including better prevention and management 'before the call'. ✓ Demand management: we will analyse data captured from our interactions with our patients to gain insight into demand patterns and enable proactive resource management. ✓ Performance management: we will use data to measure performance against statutory measures (i.e. ARP) as well as the quality of care we provide. ✓ Patient communication: we will use historic data and digital communication channels to target public health communication to promote preventative self-care for example we will work closely with the Patient and Public Panel to drive intelligence-based improvements. ✓ Clinical decision-making: we will improve use of patient outcome data to inform staff training and development and improve competence and confidence in decision making. ✓ Master navigation: We will use data to strengthen our position as the master navigator of urgent and emergency care in the North West in order to effectively signpost and refer patients to the most appropriate care pathways for their needs. ✓ System-wide improvement: we will use data to continuously improve the safety and effectiveness of our delivery models.
4.4 Better collaboration	✓ We will bring together multi-disciplinary partners to contextualise data and identify opportunities for improvement. ✓ We will use data to proactively test hypotheses to drive insight, solve problems and implement changes in working practice. ✓ We will foster collaboration between our Business Intelligence teams and staff across the organisation to drive innovation using data to develop insight, test hypotheses and implement change. ✓ We will work in collaboration with partners to share and consume data from integrated sources to co-create and transform service delivery across the system. ✓ We will use data to inform opportunities for research and development in partnership with digital and innovation partners.
4.5 Better Operating Procedures	✓ We will improve our operating procedures to encode findings from data analytics in practice. ✓ We will establish data owners who will be responsible for using data to inform decision making and to take improvement action. ✓ We will work with data owners to establish guidelines and responsibilities for the management of data quality. ✓ We will implement data quality by design including software and focused data quality processes.

	✓ We will ensure that the results and intelligence gained from data analytics is used to improve clinical and corporate practice which in turn, will improve patient care and operational performance.

5. Digital Pioneers

Our ultimate aim is to create a culture of continuous improvement and innovation which supports the delivery of our strategic ambitions outlined within the Right Care and UEC strategies. We therefore see digital, business intelligence and innovation as wholly interdependent. Embedding digital capabilities and culture alongside robust technological solutions and intelligent data analysis should enable us to prioritise vital work on 'getting the basics right' whilst at the same time, continuing to move in pursuit of partnership working to drive innovation and digital transformation.

We aim to become leading pioneers across the Ambulance sector at preventing harm from avoidable deterioration and will develop, test and implement digital solutions which will help us to achieve this ambition. We will also develop innovation partnerships with academic and commercial organisations to drive innovation at pace and scale across the North West whilst also exploring opportunities for funding, resource and learning. Our approach to innovation at NWAS will be agile and fast-paced, putting the needs of our staff and patients first and using their ideas to identify opportunities to challenge the status quo, and adopt digital solutions to radically improve outcomes and experience.

5.1 Preventing harm from deterioration	✓ We will work closely with partners across integrated urgent and emergency care settings to target admission avoidance and support safe care closer to home. ✓ We will use ongoing research and development to test the use of digital solutions to provide enhanced physiological monitoring to detect deterioration in known patients, taking action to intervene at the earliest opportunity. ✓ We will explore the latest innovations to enable on scene physiological monitoring, working to share data with clinicians in other services and working together via video consultation on scene. ✓ We will use intelligence to make accurate predictions around health prevalence using demographic analysis to identify areas of health deprivation to identify at-risk patients or population groups before they reach crisis point and proactively manage their care. ✓ We will also drive innovation across our Patient Transport Services by testing sensor technology assessments and monitoring for the frail and elderly to identify at-risk patients before they require an emergency response.
5.2 Innovation partnerships	✓ We will continue to work collaboratively with Ambulance Trusts across the North West to develop innovative cross-organisational initiatives, which will improve quality, performance and resilience. ✓ We will develop a more proactive approach to collaborative working with other regional and national partners to maximise opportunities for system-wide innovation and change and access to resource, funding and support. ✓ We will establish innovation partnerships with academia to harness the knowledge required to drive innovation whilst also seeking opportunities to collaborate and learn from organisations that have previously piloted or implemented digital solutions to complex problems.

	✓ We will utilise the knowledge and experience of commercial organisations that have developed digital solutions and identify opportunities for external funding and investment to support innovation. ✓ We will work closely with STP partners and other providers to identify innovation opportunities which will have system-wide impact.
5.3 Cultivating innovation	✓ We will harness innovation by developing the people, processes and digital infrastructure required to surface and share ideas for innovation in a structured way. ✓ We will harvest bottom up idea generation using an agile approach to test ideas at pace (see section 1.6). ✓ We will create an innovation pipeline where ideas can be prioritised and incorporated into innovation cycles or Sprints. ✓ We will establish clear structures for ongoing horizon scanning and to identify opportunities for business or commercial development. ✓ We will explore further opportunities to join national pilots or partner with organisations such as Global Digital Exemplars to become early adopters. For example, within the first year of this pilot we will join the NHS Identity pilot to develop a national approach to two-factor authentication and replace the need for Smartcards. ✓ We will develop an innovation fund to support our innovation pipeline
5.4 Rapid deployment of innovation	✓ We will ensure our innovation roadmap is aligned with strategic ambitions to improve patient care and deliver a more integrated approach to urgent and emergency care. ✓ We will review our digital operational model to include innovation architecture which supports continuous rapid identification and prioritisation of opportunities, swift delivery of solutions and measurement of organisational impact. ✓ We will develop an innovation pipeline which provides a transparent process for prioritising and piloting innovative ideas and rolling out successful innovations into business as usual. ✓ We will also develop a blueprint through which we can share innovation and learning both internally across service delivery functions, and externally with digital partners to improve care across the system. ✓ We will focus on innovations that enable us to be an efficient and productive organisation, enabling us to be greener, cost effective, improve staff experience and wellbeing and provide the best possible care. This will include a focus on Smart technologies and supporting our 'green' agenda.

5. Strategy Implementation

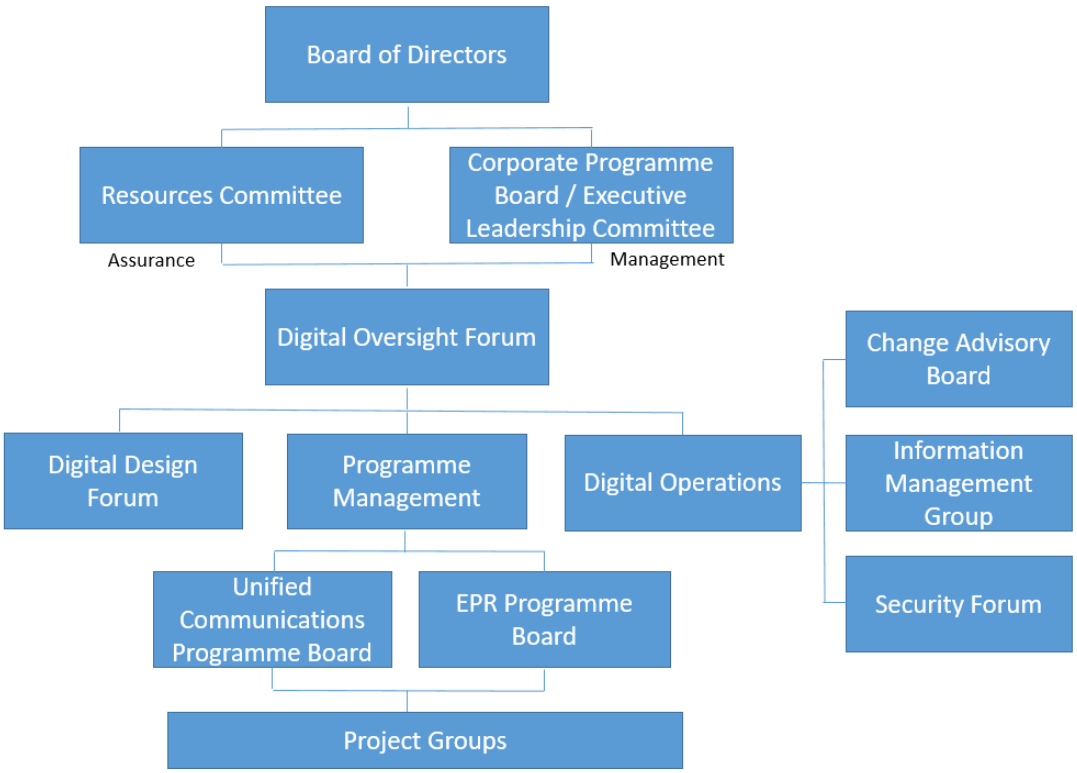
How will we approach delivery?

We recognise that the digital vision we have outlined in this strategy is ambitious and achievement of our goals over the next five years we will depend upon significant investment into getting the basics right, whilst prioritising future initiatives to drive digital transformation at pace and scale. The commitments outlined under each of our strategic intentions are subject to appropriate finance and resource. It is essential that as we move forward in pursuit of our strategic ambitions, we also remain focussed on the stabilisation and improvement of our existing technological foundations. These foundational systems will provide the infrastructure upon which future transformation can be developed whilst also maintaining resilience and business continuity.

A detailed implementation plan has been developed to outline how our digital portfolio is co-ordinated and delivered to ensure we can effectively balance the Trust's portfolio of activity and prioritise future projects. This implementation plan will be informed by NWAS' integrated business plan (IBP) to ensure the appropriate balance of resource, capacity, finances and capability to deliver a coherent portfolio of work across the organisation which aligns to the delivery of our overarching strategic aims. We wihave developed a robust communication and engagement plan which will ensure our objectives and progress are shared across the organisation and with partners.

How will we oversee delivery?

The governance structure below provides a proposal for how the implementation of our strategic intentions will be delivered; Appendix B provides details on the proposed function and outputs of each group.

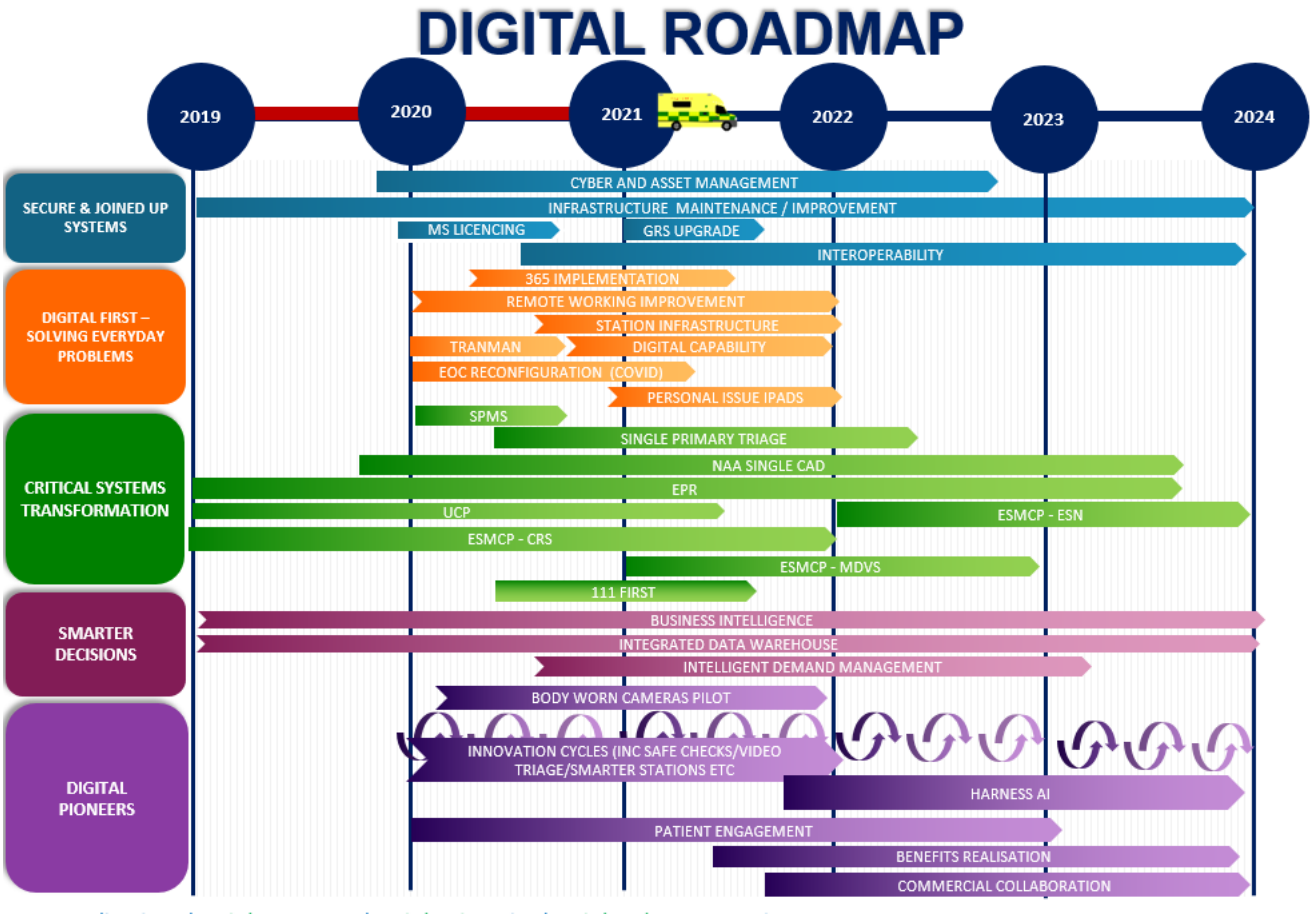


This governance structure aims to create a system with delegated oversight and ownership over our strategic aims and implementation plan. It is essential that we create a structure which enables engagement and involvement across all operational and corporate service lines as well as a process for the flow of information and assurance, including escalation of risks.

What is our roadmap for implementation?

Our roadmap for implementation is phased based on short, medium and long-term deliverables as outlined in our full roadmap.

A supporting risk and renewal roadmap is monitored through the asset management programme and is used to proactively identify systems which are approaching 'end of life' and take appropriate action to review, renew or replace as required.

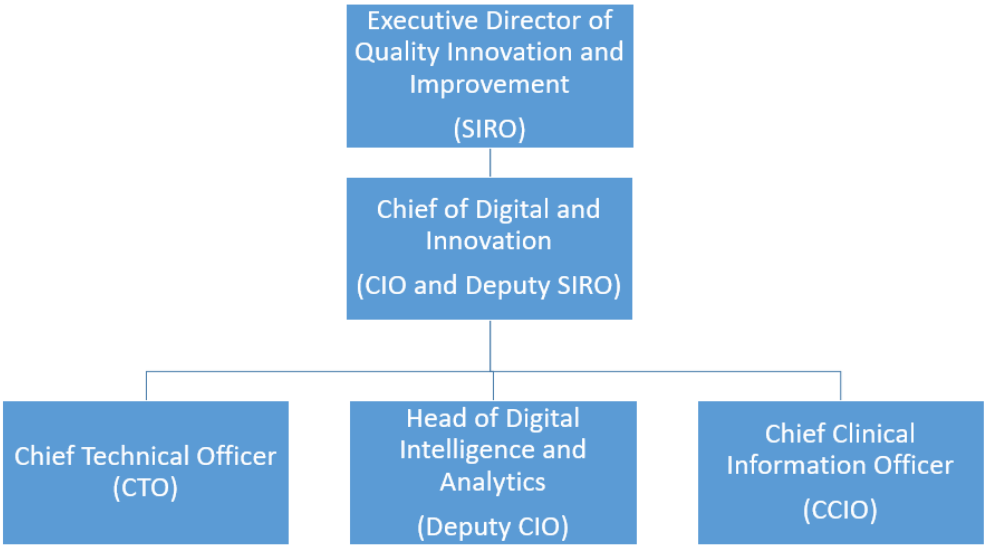


Digital leadership structure

In order to delivery high quality, effective digital services we will review our operating model to ensure we have sufficient capacity, capability and leadership within our digital structures to deliver

our strategic ambitions whilst also maintaining essential ICT systems management and business continuity.

We have reviewed the digital leadership requirements within NWAS and have developed the following high-level structure which was implemented during teh first 18 months of this strategy:



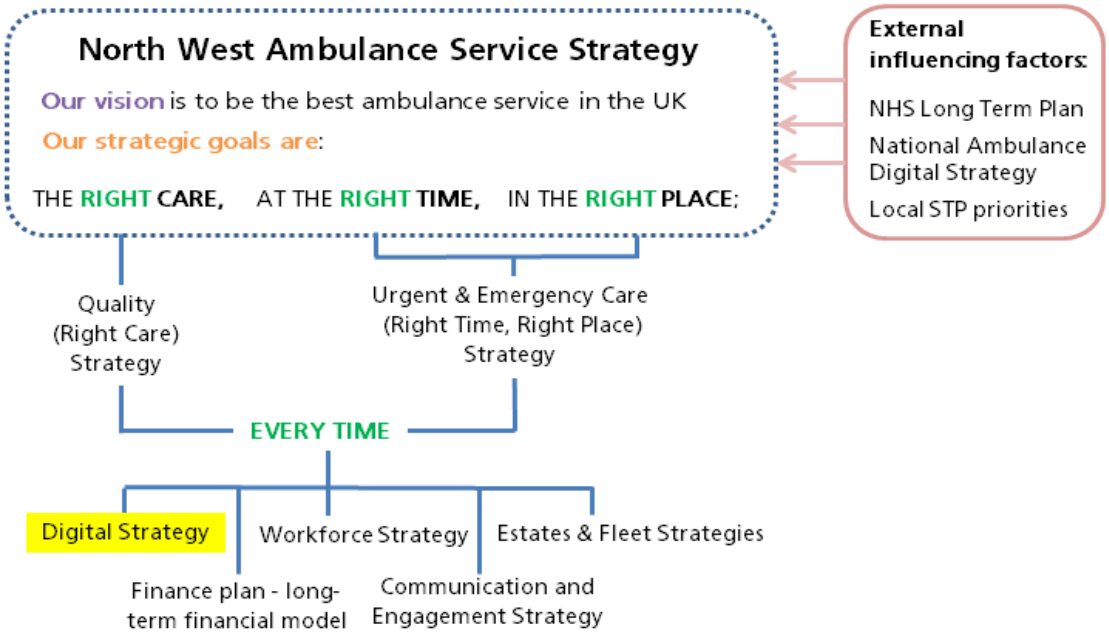
This leadership team works collaboratively with digital partners, both internally and externally, to ensure our digital services are fully integrated across all NWAS service lines and with partners across the wider system.

How will we measure improvement?

We have identified a number of core metrics which will be used to measure improvement over the next five years. Several measures had to be developed and a baseline gathered in the first 18 months of the strategy, The final set of measures and data over time will be included in the annual report May 2021.

		How much by when?					
	Goal	**Baseline**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Solving everyday problems	% of staff satisfied with digital services.	Collate baseline					95%
	% of patients satisfied with digital services.	Collate baseline					95%
Our digital journey	% of staff productively using digital systems.	Collate baseline					
	Number of digital partners established linked to delivering benefits.	Collate baseline					
Secure and joined up systems	Annual cyber security assessment shows no critical threats.						
	Reduction in unplanned down time.	Collate baseline					
	% of clinically relevant patient records accessed by Clinicians at scene and in contact centres.	0%	10%	30%	50%	70%	95%
Smarter decisions	Percentage of datasets in data warehouse.	20%	30%	45%	60%	75%	95%
	Number of unique logins to data warehouse.	0	100	250	500	800	1000
	10 hypothesis that use data to drive insight and changes ways of working.	0	10	20	30	40	50
Digital Pioneers	Number of patients with remote monitoring.	0					
	£ investment received to deliver innovative solutions	Collate baseline					

Appendix A- NWAS strategy portfolio



Appendix B- Governance Structure

Forum	Purpose
Trust Board	To support and oversee the Digital Strategy implementation plans, providing overarching investment decisions which balance improvements in core business platforms with ongoing innovation.
Resources Committee	To take assurance from the Digital Oversight Forum regarding delivery of Digital Strategy implementation plan and take decisions, based on submission of appropriate business cases, around investment in digital programmes. To ensure appropriate management of digital resource including staff, system management and funding. To support partnership opportunities to access investment both internally and externally.
Executive Leadership Team	To provide senior management support and oversight to the Digital strategy implementation plan; ensuring alignment of strategic intentions with wider operational and corporate priorities. To act as a point of escalation for emerging issues and risks and support mitigation actions.
Corporate Programme Board	To provide oversight and management support of the interdependencies between trust projects including digital, surfacing and managing associated risks.
Digital Oversight Forum	To act with delegated authority to manage the Digital Strategy implementation plan on behalf of Trust Board, FIP and EMT. To oversee the implementation of the digital services required to achieve strategic ambitions. To accept accountability for: 1) Ongoing development and delivery of digital services (including people, systems, training and culture) and drive NWAS' strategic direction and integrated planning from a digital perspective; 2) Digital innovation portfolio and delivery roadmap, acting as point of escalation for any operational or programme risks and issues; 3) Operational delivery of digital services, including system management, risk and renewal and the roadmap for improvement.
Information Management Group	To provide assurance and surface risks for all issues related to information governance and security. To provide a chairs report to the Resources Committee.
Business Intelligence Steering Group	To lead on the design of data services including alignment with strategic priorities and technical design of dashboard solutions. To ensure interoperability and integration between NWAS systems and manage the flow of information and data. To sign off all technical designs and system specifications; ensuring business readiness and strategic fit. To lead on horizon scanning to identify opportunities for business development and innovation.
Digital Design Forum	To find possible digital solutions to problems and test new innovative ideas. To work safely to test on a very small scale.
Digital Project Programme Boards	To lead on the delivery of all digital projects and programmes within the implementation plan. To oversee overall planning and investment in digital services and collate and maintain the roadmap for delivery. To provide delegated responsibility for digital projects including resource, delivery timelines, business change, operational impact, risk and mitigations. To report progress of project and programmes to the DOF including project status and exceptions (i.e. deviations from tolerances, risks, quality

	assurance etc.) To set the standards through which project will be managed (i.e. PMO framework, agile methodologies).
Digital Operations	To lead on operational delivery of digital services across NWAS including; proactive management of risk and renewal roadmap, capacity and planning, digital system capability and functionality, skills development and training, forward planning of work and modelling impact to business continuity, management of security (cyber and information) and information governance, disaster recovery planning and critical systems maintenance. Within Digital Operations key groups include the Cyber Security Forum and the Change Advisory Board.

Appendix C- Glossary of Terms

The glossary below should be used to provide definitions of key terms used within this strategy and supporting implementation plan documentation.

Term	Description
Access	The ability to utilise IT systems or view/edit data on IT systems
Access Control	An ACL is a table that tells a computer operating system which access rights each user has to a particular system object, such as a file directory or individual file. Each object has a security attribute that identifies its access control list.
Auditing	An examination of the management controls within an Information technology (IT) infrastructure. The evaluation of obtained evidence determines if the information systems are safeguarding assets, maintaining data integrity, and operating effectively to achieve the organisation's goals or objectives.
Authentication	The process of identifying an individual, usually based on a username and password. This is defined as single factor authentication. If another factor, such as a token or PIN, is required in addition to the first one this is defined as 2 factor authentication.
Authorisation	The process of granting or denying a user access to network resources once the user has been authenticated through the username and password.
CAD	Computer Aided Dispatch is the system used to dispatch Ambulances.
Cloud	A network of remote servers hosted on the Internet to store, manage, and process data, rather than a local server or a personal computer.
Cloud Security	A broad set of policies, technologies, and controls deployed to protect data, applications, and the associated infrastructure
Consumer	A system which consumes data using existing Open APIs.
Cyber Security	The body of technologies, processes and practices designed to protect networks, computers, programmes and data from attack, damage or unauthorised access.
Database	A structured set of data held in a computer, can be accessible in various ways
DAA	An agreement between two or more entities to allow access to data or information. Details the controls that are to be put in place to protect the data, including how the data will be used, stored, shared and disposed of.
DPA	Data Protection Act. The DPA (1998) is an act of the United Kingdom Parliament that defines the ways in which information about living people may be legally used and handled. The main intent is to protect individuals against misuse or abuse of information about them.
Encryption	The process of converting information or data into a code, especially to prevent unauthorised access.

Term	Description
EPR	An Electronic Patient Record is an electronic record of periodic health care of a single individual, provided mainly by one institution.
eTS	An electronic version of NWAS secondary Triage tool. Designed to provide clinicians with support in their decision making.
Firewall	A network security system that monitors and controls the incoming and outgoing network traffic based on predetermined security rules.
First of Type	The chosen recipient(s) to test the first deployment of the new capabilities.
Gateway	A hardware device that acts as a "gate" between two networks. It may be a router, firewall, server, or other device that enables traffic to flow in and out of the network
HSCI	Health and Social Care Integration. This integrates local health and social care services to improve coordination between local health and social care agencies, leading to improved experiences for people using these services.
Health and Social Care Network (HSCN)	HSCN is a Wide Area IP Network (WAN) connecting many different sites across the NHS within England & Scotland. It also connects to other networks via gateways, notably to the internet via the internet gateway
Identification	A logical entity used to identify a user on a software, system, website or within any generic IT environment. It is used within any IT enabled system to identify and distinguish between the users who access or use it. A user ID may also be termed as username or user identifier
Information Security	A set of strategies for managing the processes, tools and policies necessary to prevent, detect, document and counter threats to digital and non-digital information.
Internet	A network of global exchanges – including private, public, business, academic and government networks – connected by guided, wireless and fibre-optic technologies. The terms Internet and world wide web are often used interchangeably, but they are not exactly the same thing; the Internet refers to the global communication system, including hardware and infrastructure, while the web is one of the services communicated over the Internet.
MIG	The Medical Interoperability Gateway is a supplier lead interoperability solution provided by EMIS + Vision which allows third parties access to GP data.
N3	Now replaced by the Health and Social Care Network (HSCN).
Network	A group of computer systems and other computing hardware devices that are linked together through communication channels to facilitate communication and resource-sharing among a wide range of users.

Term	Description
NRLS	National Record Locator Service is a technical proof of concept acting as a national index to identify available records for patients and locate them across local and national care record solutions (such as SCR).
Open Source	Denotes software for which the original source code is made freely available and may be redistributed and modified.
Password (Protection)	A collection of letters/numbers/characters used in a security process that protects information accessible via computers that needs to be protected from certain users. Password protection allows only those with an authorised password to gain access to certain information.
PII	Personally Identifiable Information. Data that could potentially identify a specific individual. Any information that can be used to distinguish one person from another and can be used for de-anonymizing anonymous data can be considered PII.
Provider	An individual or an organisation that provides health care for a patient. Also a system which provides data by exposing Open APIs.
Proxy server	A server that acts as an intermediary for requests from clients seeking resources from other servers
Remote Access	The ability to access a computer from a remote location. This allows employees to work offsite, such as at home or in another location, while still having access to the office network. Remote access is usually set up using a virtual private network (VPN). Remote Access can also be known as remote login.
Security	The protection of information (digital and hardcopy), assets (physical and intangible) and personnel against internal and external, malicious and accidental threats. This protection includes detection, prevention and response to threats through the use of security policies, procedures, tools and services.
SCR (SCRa)	Summary Care Record. The SCR is intended to support patient care in urgent and emergency care settings. The SCR will store a defined set of key patient data for every patient in England except those who elect not to have one. This data will make a summary record created from information held on GP clinical systems. This summary record helps to ensure a continuity of care across a variety of care settings.
Spine	Spine is a collection of national applications, services and directories which support the health and social care sector in the exchange of information in national and local IT systems. A national, central service that underpins the NHS Care Records Service. It manages the patient's national Summary Care Records. Clinical information is held in the Personal Spine Information Service (PSIS) and demographic information is held in the

Term	Description
	Personal Demographics Service (PDS). The Spine also supports other systems and services such as the e-Referral Service and the Electronic Prescription Service.
SSO	Single Sign On. An authentication process that allows a user to access multiple applications with one set of login credentials. SSO is a common procedure in organisations, where a client accesses multiple resources connected to a local area network (LAN).
Validated NHS Number	A valid NHS Number is one that has the correct format and passes the number check digit calculation.
Verified NHS number	A verified NHS Number is one where the patient's identity has been cross-checked using demographic details on the Personal Demographics Service (PDS).
Virtual Private Network	A virtualised extension of a private network across a public network, such as the Internet. It enables users to send and receive data across shared or public networks as if their computing devices were directly connected to the private network. Applications running across the VPN may therefore benefit from the functionality, security, and management of the private network. A VPN allows employees to securely access an organisations intranet and other network resources while located outside the office. A VPN may also be used to securely connect geographically separated offices of an organisation, creating one cohesive network.
WAN	A network that exists over a large-scale geographical area. A WAN connects different smaller networks (LANs). This ensures that computers and users in one location can communicate with computers and users in other locations.
Wi-Fi	The standard wireless local area network (WLAN) technology for connecting computers and myriad electronic devices to each other and to the Internet. Wi-Fi is the wireless version of a wired network. Data is passed via radio waves broadcast to/from a Wi-Fi enabled devices that make up the WLAN (router, laptop, desktop, tablet, mobile phone, printer, etc.).
WPA	Wi-Fi Protected Access

North West Ambulance Service NHS Trust

Digital Strategy

Overview

2019-2024

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Approved by	Board of Directors
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Responsible Manager (Sponsor)	Chief of Digital and Innovation
For use by	All staff, Commissioners, stakeholders

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01/03/2021	Document review and refresh	Abigail Harrison	To ensure strategy remains up to date and ensure key areas of work / focus included
11/03/2021	Document refresh Finalised	Abigail Harrison	For ELC, Resources Committee and Board approval

1. Foreword

In less than two decades the world we live in has changed beyond recognition. The birth of the internet paired with mobile computing has changed everything. If we look around now in any cafe, airport, sporting event or social occasion, the world is connected by cameras, social media platforms, applications and pocket sized devices. They sit by our sides in a way that seems completely normal. We tap them onto scanners to board planes and pay for coffee. We treat them as key assets and feel bereft if they are taken from us. Phones are mini computers, smart devices, with more capability than anyone could have dreamed. Even more exciting is the ability we now have to manage our lives through these devices. If we want to protect our children, secure our homes, set our heating, all of this is now possible. This next generation 'internet of things' is a burgeoning area of digital growth. Our NWAS digital strategy provides the foundations for us to operate in this context. Being the first ambulance service to become fully digitally enabled is our ambition. This is a bold statement given our current positioning and we know that. So, why do we think this is necessary and how will this be possible?

In simple terms the rationale for our ambition is that we have promised our patients that we will deliver the right care at the right time in the right place every time and without a progressive digital infrastructure this is simply not possible in today's world. Our patients expect to be able to interact with us through whatever device or platform is most convenient for them, be that email, phone web or application. They expect that we will know all about them because we have access to the best location software, health record and past interactions with us. They expect our clinicians to have the latest knowledge at their fingertips and to use this to advise and direct them to the choices available to them. They expect us to be able to provide immediate access to the right healthcare professional either in person or via video and they do not want to wait for treatment if it's possible to start that immediately in a safe way. Partnering in care in this way is not a luxury, it is the only way. This is what we heard when we conducted the focus groups to develop this strategy and it was a message that we cannot ignore.

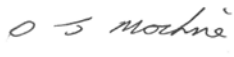
Our ambition is also fuelled by our commitment to our staff. To be the best ambulance service in the UK, we have a responsibility to ensure that our staff are happy and equipped to deliver services in the most effective and efficient way. Over the past decade, Ambulance Trusts led the way on developing their control room technology with virtual Command and Control and call answering. However, despite this,technology has moved on and historically, NWAS, like most NHS organisations, has continued to operate in a world of pen and paper in many other areas. For example, signing in at the entry to our buildings, requesting supplies, completing training, requesting leave, claiming expenses, recording patient information, completing audit or collating evidence of our personal development. These paper systems are slowly being replaced by digital solutions. This strategy makes a commitment to our staff to pursue these improvements at pace.

Most of the technology and applications we need already exist. Our job through the strategy is threefold: to build a stable and resilient platform which has the maintenance required to keep our digital information safe; to connect with WiFi seamlessly and to ensure that our data sharing agreements permit secure, seamless interoperability. Our ability to be able to connect to one another within NWAS, for example through a single telephone or computer system, is key. If we have this we can help one another succeed, breaking down some of the inevitable historical barriers between service lines and departments, sharing expertise and supporting demand. Our ability to be able to connect to other health partners and to patients directly is central to our ambition to lead urgent as well as emergency care. Our strategy addresses this directly.

It is well recognised that the adoption of digital solutions varies significantly from one person to the next, one team to the next and one organisation to the next. This variation exists within NWAS. We already have innovators using mobile computing to access patient records on scene, tap into knowledge repositories such as JRCalc and access Manchester Triage via the GeTac devices. We also have those who will need help with this change, waiting for proof that this will help them deliver better care. This strategy recognises both these opposing views and sets out an ambition in the first instance to simply 'get the basics right'. After all, if we can't even issue phones and computers on time how can we be trusted to do the rest? To deliver this ambition our IT, Business Intelligence, Information governance and clinical records team have come together under a single leadership. Our team, headed up by a Chief of Digital and Innovation will steer the strategy forward, working with us to build our confidence in these changes and our skills in using the equipment we have. This won't happen overnight for everyone but for some it will be long overdue. We recognise that our workforce will have different needs and have different capabilities and we are absolutely committed to leaving no one behind.

Digital is the opportunity to make NWAS an even greater place to work than it is today. Our people make our organisation outstanding. The systems they work in don't always marry up. Frustrations build and time is wasted trying to access buildings and cupboards with a plethora of keys and codes. For those of you who are bothered by this, help us build a safe single swipe solution for all buildings, cupboards and locked areas which also helps us log into our devices and applications. Help us install number plate recognition into access barriers and garages. Help us continually monitor tyre pressures and vehicle safety, removing the need for manual checks. Let's use our cameras as scanners to barcode our PIN numbers, stock levels, training records and timesheets. Let's upload rather than transport, let's Skype rather than ride. Let's connect and learn. Let's re- define what it means to be a modern and progressive ambulance service.

We hope you enjoy reading this strategy but we hope even more that you enjoy being part of our progressive and exciting digital future.



Daren Mochrie QAM
Chief Executive

Maxine Power, Executive Director of Quality, Innovation & Improvement

2. About this Strategy

This strategy guides the delivery of our digital ambition for a five year period. It is core to the delivery of reliable services 'every time' and is in service of the organisation's overall commitment to deliver the right care, at the right time, in the right place, every time. Our Digital strategy will sit alongside other core enabling strategies such as the Workforce, Fleet & Estates and Communications strategies to support the delivery of our overarching Trust ambition; to become the best Ambulance Service in the UK (see Appendix A).

The strategy will be dynamic and is refreshed on an annual basis with an annual report alongside it which summarises progress and any key changes made. This process ensures it remains relevant and reflects the key changes and challenges that affect the Trust. This strategy describes our commitment to developing our services with digital solutions, a digitally enabled workforce, secure joined up IT platforms, smarter decisions through improved insight and innovation throughout all of North West Ambulance Service.

Technology is increasingly important for safe, effective and efficient service provision from the frontline to the board. It is central to delivery of key performance standards and enhancing patient experience. Likewise the opportunities afforded by connected business intelligence systems and the insight they provide can reduce variation in management systems and deliver back office efficiencies. Our digital strategy is also critical to connecting with other health providers in the North West and with the strategic transformation partnerships regionally. Digital enables us to connect with other ambulance Trusts to provide a more effective response to national resilience, activity increases and mutually beneficial support arrangements.

The Digital Strategy within NWAS has been developed in three stages. This overview document describes our direction of travel, which wasfollowed with a detailed implementation plan as an integral part of our integrated business plan (IBP). The Annual report includes a detailed roadmap, set of objectives and dashboard of key measures aligned to this strategy and used to update the Trust's Integrated Business Plan.

Finally, each objective in the strategy is included in a bimonthly assurance report to the Digital Oversight Forum and Resources Committee to provide an update on progress, and from which the chair of Resources Committee provides a highlight report with key risks and mitigations to Board. Digital projects are also reported via the Digital Oversight Forum to the Corporate Programme Board.

3. Board Commitment

The Trust Board are committed to ensuring that the programme of work required to develop our digital ambitions is at the forefront of our integrated business planning. Ongoing resources are required to support the renewal of critical systems and ensure IT systems are securely maintained and that staff are cyber aware. Investment is still required for embedding these systems, ensuring long term stability and resilience. Similarly, investment decisions are required to balance improvements to the internal operating platform with our patient facing IT systems.

The Trust Board acknowledge that digital infrastructure is viewed as a priority to any service redesign and as a key enabler to improvement. We have prioritised those programmes that address risks to patient care, outcomes or information security. These commitments will continue to be delivered

recognising that our resources are limited and a continuous programme of efficiency improvement is required. To this end, the board are committed to partnering to access investment opportunities and adopting partnerships which support procurement efficiencies.

4. Our Vision

Our digital vision is to radically improve how we meet the needs of patients, staff and any partners every time they interact with our digital services. These benefits will be measured through a focus on aligning our digital development priorities to the Trust's strategic priorities and creating a 'digital first' culture from the board to the frontline.

Our Strategic Themes and Focus

Our five year plan is focused on delivery of five strategic themes as outlined below:

Our aim is to use digital solutions to radically improve how we meet the needs of patients and staff; every time.

Solve everyday problems

- 1.1 Getting the basics right
- 1.2 Staff experience
- 1.3 Patient experience
- 1.4 Personal safety
- 1.5 Digital skills
- 1.6 Listen, test and learn

Our digital journey

- 2.1 'Digital first' culture
- 2.2 Leadership and governance
- 2.3 Operating model
- 2.4 Integrated organisational approach
- 2.5 Digital partnerships

Secure and joined-up systems

- 3.1 System integration and interoperability
- 3.2 Privacy and cyber security
- 3.3 Cloud and Edge
- 3.4 Open standards
- 3.5 Core business platforms
- 3.6 Proactive risk and renewal

Smarter decisions

- 4.1 Better data
- 4.2 Better access
- 4.3 Better insight
- 4.4 Better collaboration
- 4.5 Better operating procedures

Digital pioneers

- 5.1 Preventing harm from deterioration
- 5.2 Innovation partnerships
- 5.3 Cultivating innovation
- 5.4 Rapid deployment of innovation

1. Solving Everyday Problems

When speaking with our staff and volunteers it is clear that one of their biggest challenges is not having the right digital equipment or skills, at the right time or in the right place to support them to do their jobs effectively. We also recognise that technology is changing public expectations for more immediate, joined-up and comprehensive care which can be accessed through the use of digital channels. Therefore, one of the fundamental aims of this strategy is to improve digital services and technological solutions so that they meet the needs of our staff and patients; every time. If we can improve the quality and resilience of our digital services, we will in turn make NWAS a more accessible service for our patients and a great place to work for our staff.

1.1 Getting the basics right	✓ Our ambition is that all NWAS staff, whether clinical, corporate or voluntary, will receive the right digital equipment required for their role, from the first day they join the Trust. ✓ We will provide a timely response when staff do encounter technical problems or require further support or training, minimising disruption to roles wherever possible. ✓ We will ensure that our workforce is digitally connected, through digital communication channels, access to emails and reliable Wi-Fi connections.
1.2 Staff experience	✓ We will work closely with teams to develop and implement digital solutions which are focused around the end user and business need. ✓ We will redesign our digital operating model to focus around staff experience with a continuous feedback loop between our digital services, and the staff using these on the frontline and in our corporate services. This will ensure we understand the experience of digital system users and work with them to design and implement improvements based on their experience. ✓ Where possible we will use technology to provide equity of access for everyone, removing barriers for staff with disabilities. ✓ We will digitise our workforce using single-sign on and smart unique identifiers to securely access our core business platforms (see section 3.5) as well as staff and patient information.
1.3 Patient experience	✓ Our services will be straightforward to access and use and will help patients and carers navigate their care pathway in a seamless, integrated way. ✓ We will offer patients several points of contact into our service; using digital channels to be a gateway to the wider urgent and emergency care system. ✓ We have developed unified communications platforms which enable the flow of patient information. For example,if a patient switches from NHS 111 online to calling 111, the information they have provided up to that point will not be lost. ✓ We will offer our patients more opportunities for self-service for example, to book, cancel and update Patient Transport Services (PTS). ✓ We will use digital solutions to minimise unnecessary waits or duplication such as using NHS numbers to reduce the need for patients to repeat personal information to different staff during their care pathway. ✓ We will use digital solutions to offer clinical advice and intervention at the earliest opportunity in the patient's journey and navigate patients through the most appropriate care pathway.

	✓ We will ensure our services are designed to be digitally inclusive. ✓ We will protect patient's privacy and adhere to all information governance standards. ✓ We will proactively gather feedback from patients through the Patient and Public Panel and use insights from the evaluation of patient and staff feedback to identify opportunities to improve. ✓ We will work in partnership with the Patient and Public Panel, using the co-design approaches to deliver key improvements.
1.4 Improving safety	✓ We will test the use of technological equipment and safety devices to continuously improve the personal safety of staff on the frontline. ✓ We will digitise our estate through the adoption of smart access technologies to maintain security for our staff, systems and patients. ✓ We will use routine and automated alerts from systems such as Gazetteer, to inform staff when they are entering a situation with a patient who is known to be challenging or who may threaten their personal safety. ✓ We will develop partnerships with other partners to share information which will improve the safety of our workforce. ✓ We will integrate our systems so that vital information collated in out of hospital settings can be shared to keep staff safe; for example, valuable information collected by PTS crews about patients with challenging or aggressive behaviour can be used by PES to support teams. ✓ We will also use digital solutions to keep our patients safe and reduce the number of serious incidents with technology or ICT identified as a root cause.
1.5 Digital skills	✓ We will enhance the digital skills and capability of every member of staff through robust and innovative approaches to training and support across all NWAS directorates. ✓ All staff will receive an overview of our digital strategy and culture during induction as well as specific training on how to use the equipment and systems required for their role. ✓ We will digitalise our learning and development offer where appropriate, using simulation training, online seminars e-learning, and electronic portfolio development to make training more accessible for staff ✓ We will design new digital solutions to be intuitive and user-friendly and where required training will be put in place to ensure smooth transition into business as usual. ✓ We will establish digital partnerships with other industries to provide expert coaching and an environment within which digital skills can be shared. ✓ We will undertake a full skills profiling exercise to baseline the current levels of digital capability across the organisation and adopt a channel shift approach to upskilling and developing our workforce.
1.6 Listen, test and learn	✓ We will listen to ideas from staff on how we can use digital solutions to solve every day problems and improve working practice (Topol Report, 2019). ✓ We will adopt an agile approach to digital innovation; using improvement cycles to continuously test staff ideas and learn from both success and failure before scaling up across the organisation.

	✓ We will develop criteria through which benefits from change ideas can be measured and aligned to Trust goals and prioritise the rollout of those initiatives with demonstrable improvements. ✓ We will invest in evaluation and learning, creating an evaluation framework to support digital programmes so that we are able to understand the impact of our investments and work to deliver productivity and efficiency gains across the organisation and wider systems.

2. Our Digital Journey

Digital is about more than just ICT, it is simply a way of doing things which can deliver benefits to patients, staff and the wider system through the use of technology[1]. Our ability to realise the benefits it brings will be influenced by how we approach and adopt digital solutions across the whole Trust. Our strategy therefore, is as much about people as it is systems and processes and therefore requires a culture change from 'board to floor' that embraces a digital first approach.

2.1 'Digital first' culture	✓ In order to embed a 'digital first' culture we will re-think how and why our organisation does things. ✓ We will utilise digital skills and technologies to unlock the capability of digital transformation across our organisation and help our staff to do their jobs more effectively. ✓ We will continue to work towards a paper-free patient experience by 2024 including a commitment to remove all clinical paper records. This will support clinicians to manage care more effectively, improve ease of data extraction and sharing and minimise waste and duplication within audit processes. ✓ We will continuously strive to improve our systems and processes using digital solutions, rather than simply digitising our current paper processes. ✓ Within the first 18 months of this strategy we developed and tested a digital confidence, capability and satisfaction survey and established a baseline from which we will measure improvement periodically. ✓ We will optimise our estates using digital solutions to enable remote and virtual working to reduce unnecessary travel and contribute to a reduction in emissions as part of our environmental targets. ✓ We will also use remote and virtual working to offer more flexibility and opportunity for rotational working between NWAS service lines and with external partners. This has been expedited due to the impact of the corona virus. ✓ We will digitise our fleet to improve vehicle maintenance and resource management as well as explore opportunities to improve connectivity across all geographic locations. For example, we will continue to engage with the Emergency Services Network programme, which aims to install dedicated networks within Ambulance vehicles which can be used for critical communications and information sharing.

[1] National Ambulance Digital Strategy (2018) NHS Digital and NHS England.

2.2 Leadership and governance	✓ We will develop clear structures through which our digital portfolio will be designed and implemented, with assurance provided both internally and externally. ✓ Our digital portfolio will be managed by our Digital Oversight Forum (DoF) who represent NWAS' digital strategic priorities. Digital projects, priorities and interdependencies are reported to and supported by the Corporate Programme Board, who ensure strategic alignment (see section 5). ✓ We will develop a Clinical roles to provide clinical leadership across our digital portfolio and a space to engage with clinical and operational colleagues through the Digital Design Forum. This will maintain focus on patient experience and outcomes.
2.3 Operating model	✓ We will continue to review our digital operating model to ensure we have sufficient capacity and capability within our digital structures to simultaneously deliver essential ICT systems management and business continuity, whilst releasing capacity for innovation and intelligent data analytics to drive future transformation. ✓ We will provide IT systems and services that will remain 'fit for purpose' for a minimum period of five years from the date of implementation, and that can be scaled to suit the needs of the Trust. ✓ We will establish clear roles and responsibilities within our ICT and Business Intelligence teams which will include ownership of this strategy and the implementation plan which follows. ✓ We will work in partnership with the PMO and transformation team to enable delivery of digital projects. ✓ We will clearly articulate within our operating model, the roles of data and asset owners across the organisation and educate these individuals so they fully understand and appreciate their responsibilities. ✓ We will work closely with finance, partners and the Board to enable the ongoing funding of the digital strategy. We will focus on four key areas: 1. Budget management and reinvestment of efficiencies in the digital budget 2. Enabling productivity and efficiencies in the organisation which if measures and released may be reinvested 3. Securing external funding from NHS central bodies and 4. A long term plan for investment and commercialisation of digital innovations

2.4 Integrated organisational approach	✓ We will adopt digital solutions to meet the aims outlined within the Urgent and Emergency Care strategy to have a single-service approach to delivery. ✓ We will ensure our internal systems are fully integrated to support a shift away from operating as three distinct service lines across 999, 111 and PTS and re-align under a single integrated urgent and emergency care model. ✓ We will review and optimise our core business platforms to ensure they provide our operational and corporate teams with the flexibility and interoperability required to deliver an integrated organisational approach. For example, we will move to a single primary triage system across our 111 and 999 call taking functions to improve integration of our workforce and manage demand more effectively. ✓ We will also ensure integration and interoperability with external partners within an Integrated Urgent Care environment to provide patients with seamless access to and navigation of the wider North West health system. For example, we will continue to work with partners to develop automated processes for referring and booking patients into alternative care pathways from an integrated Clinical Assessment Service (CAS).
2.5 Digital partnerships	✓ We will develop and sustain digital partnerships to ensure strategic alignment at a national and regional level. ✓ We will work closely with the four Strategic Transformation Partnerships across the NWAS region to ensure our plans are aligned with other providers in order to achieve maximum system benefit. ✓ We will work with colleagues across the ambulance sector i.e. the Northern Ambulance Alliance, to champion the delivery of shared ICT systems and services to support wholescale efficiencies and resilience and learn from others. ✓ We commit to ongoing collaboration with national bodies such as NHS England, NHS Digital and NHS Improvement to ensure continued alignment with national strategic drivers whilst also maximising opportunities for collaboration, learning and innovation at scale with other providers and digital partners. ✓ We will continue to work in partnership with Commissioners to ensure that we can co-design and implement digital transformation with our system and our patients in mind.

3. Secure and Joined-Up Systems

Our technological systems must be secure, resilient and effective to maintain business continuity and high quality patient care; therefore, our priority will always be to provide essential system maintenance and improvement to maintain business continuity. At the same time, we want to create the capacity within our digital structures for ongoing innovation through increased system interoperability and more intelligent data analytics.

3.1 System integration and interoperability	✓ We will ensure that NWAS' systems are integrated and interoperable, both internally and externally, meaning systems can talk to each other. ✓ We will use interoperable systems to ensure that clinicians have access to the information they need to provide the right care, in the right place at the right time. ✓ We will develop interoperable systems to achieve our strategic ambition to act as a gateway to the wider urgent and emergency care system across the North West. For example, without system interoperability, we will be unable to pass information or patient incidents between our service lines (i.e. 111 to 999) or electronically refer a patient out from our Clinical Assessment Service into alternative providers. ✓ We will continue to work collaboratively with ICSs to increase interoperability with acute services, primary care, secondary care and social care pathways to improve the seamless coordination of patient care. ✓ We will also improve interoperability between our internal corporate systems to offer a single point of entry to input and collate consistent staff information and facilitate single sign-on functionality to access multiple systems through one device.
3.2 Privacy and cyber security	✓ We will continue to adopt the best cyber security standards and adhere to mandated frameworks around privacy and data sharing in order to maintain public trust in how we store, share and use data. ✓ We will develop and implement a programme of work which aims to continuously improve the levels of protection to cyber threats. ✓ We will ensure our systems and data infrastructure is safe and secure in order to protect our patients, staff, business continuity and resilience. ✓ We will proactively renew and update the software and networks which support our systems to create a secure digital environment. ✓ We will ensure we meet all regulatory requirements related to Information Governance and Cyber security. ✓ We will position Information Governance as enablers of change involved in the design of changes supporting asset owner via a digital asset register
3.3 'Cloud' and 'Edge' storage	✓ ✓ Where appropriate, we will use cloud services to store data and patient information safely and securely and reduce risk of data accessibility being affected by local hardware failure ✓ We will ensure that when procuring or reviewing our digital services that the benefits of cloud hosting and storage are included within the business case process.

	✓ We will adhere to national guidance to ensure any uses of cloud solutions are safe, secure and effectively managed.
3.4 Open standards	✓ We will comply with national open standards for integration and communication to allow our systems to become interoperable and talk to other systems. ✓ We will design our systems to enable reliable data sharing across care settings and organisations. ✓ When procuring new systems, or reviewing our current technological infrastructure, we will ensure that we invest in the best value for money technological solutions which comply with open standards and enable us to connect with the wider healthcare system.
3.5 Core business platforms	✓ We will ensure that our core business platforms are secure, resilient and fit for purpose to support our staff to do their jobs effectively. ✓ We will continuously review our core business platforms to identify opportunities for improvement and efficiencies, especially for those systems approaching 'end of life'. ✓ We will replace our current telephony systems with a fully unified communication platform by the end of 2021 . ✓ We will remove all clinical paper records by implementing an electronic patient record which will deliver a paper-free patient experience by 2024. ✓ We will review and optimise our core operational platforms to enable integration and resilience across service lines and with external partners. For example, we will undertake a full review of the current CAD platform used within 999 alongside the patient information platforms used within 111 and PTS and scope a new optimum system configuration to deliver Integrated Urgent and Emergency Care. ✓ We will optimise our core clinical platforms to provide high quality, patient-centred care which is seamlessly joined up internally and externally. For example, we will develop and implement a single electronic secondary triage system within our contact centres and by staff on the road. ✓ We will develop a core patient information platform to provide a single source of patient data to support clinical decision making in our contact centres and on the road whilst also providing spine look-up functionality allowing us to obtain patient NHS numbers at scene. ✓ We will integrate a core platform for workforce management and corporate systems to enable seamless management of staff through a master staff index.
3.6 Proactive risk and renewal	✓ We will take a proactive approach to internal system management and renewal; working closely with suppliers to clearly outline system requirements and support expectations. ✓ We will maintain robust digital roadmaps to understand when systems are coming towards 'end of life' whereby either software, system or network support will cease and follow the appropriate steps to review associated risks and implement mitigating actions to address these. ✓ We will ensure that financial investment in replacement systems and services is aligned to the wider business objectives of the Trust, and that where

	appropriate, cost avoidance is realised through investment in alternative technologies. ✓ We will ensure that our operational model supports ongoing system management and proactive risk and renewal to reduce unplanned critical system downtime and support business continuity.

4. Smarter Decisions

NWAS holds a unique position in the North West health and care system due to our geographical scale and amount of patient contacts each year; this means we have substantial knowledge and information about our patients, the wider population and the services available to support patient navigation.

We must share our data securely and consume data from across primary, secondary, community and other public health services in a more intelligent way. In particular, this information will help to inform clinical decision making; intelligently manage patient demand and resource allocation; predict and prevent deterioration in patients who are known to us as a service and; identify opportunities for innovation to improve service delivery.

4.1 Better data	✓ We will ensure that the data we capture, share and consume is high-quality, validated and stored within a central warehouse to provide a single source of truth. ✓ We will gather high quality data from a range of internal and external systems to inform real-time decision making and retrospective analysis. ✓ We will adhere to robust information governance standards as a means of providing assurance that all information, particularly person-identifiable information, is managed securely and appropriately in accordance with relevant legislation.
4.2 Better access	✓ We will ensure that our staff, and where appropriate, our patients and partners, will be able to appropriately access and gain insight from the data we hold. ✓ We will continue to develop and implement solutions to enable access to patient data to allow clinicians, in control functions and on the frontline, to access relevant patient information to support decision making and patient journey management. ✓ We will introduce an Electronic Patient Record that will provide NHS Spine look-up functionality which will increase utilisation of NHS numbers. ✓ We will also develop our self-service functionality to enable staff to generate automated reports and dashboards within a self-service portal. ✓ We will present data through clear, visual outputs which are user-friendly and offer opportunities for intelligent interactivity and drill-down functionality. ✓ We will increase the automation of data extraction to release capacity within our Business Intelligence function for more advanced analytics to inform service delivery and digital innovation across the organisation. ✓ We will ensure that all workforce information will be accessible through integration of key systems such as ESR and GRS enabling opportunities to use data to support workforce management, including HR, training and staff rostering.
4.3 Better insight	✓ We will develop an intelligent learning system within NWAS which proactively sources data and translates this into information which can be used to inform decision making and innovation.

	✓ We will enhance our use of advanced analytics to gather insight from high quality data to support integrated urgent and emergency care, including better prevention and management 'before the call'. ✓ Demand management: we will analyse data captured from our interactions with our patients to gain insight into demand patterns and enable proactive resource management. ✓ Performance management: we will use data to measure performance against statutory measures (i.e. ARP) as well as the quality of care we provide. ✓ Patient communication: we will use historic data and digital communication channels to target public health communication to promote preventative self-care for example we will work closely with the Patient and Public Panel to drive intelligence-based improvements. ✓ Clinical decision-making: we will improve use of patient outcome data to inform staff training and development and improve competence and confidence in decision making. ✓ Master navigation: We will use data to strengthen our position as the master navigator of urgent and emergency care in the North West in order to effectively signpost and refer patients to the most appropriate care pathways for their needs. ✓ System-wide improvement: we will use data to continuously improve the safety and effectiveness of our delivery models.
4.4 Better collaboration	✓ We will bring together multi-disciplinary partners to contextualise data and identify opportunities for improvement. ✓ We will use data to proactively test hypotheses to drive insight, solve problems and implement changes in working practice. ✓ We will foster collaboration between our Business Intelligence teams and staff across the organisation to drive innovation using data to develop insight, test hypotheses and implement change. ✓ We will work in collaboration with partners to share and consume data from integrated sources to co-create and transform service delivery across the system. ✓ We will use data to inform opportunities for research and development in partnership with digital and innovation partners.
4.5 Better Operating Procedures	✓ We will improve our operating procedures to encode findings from data analytics in practice. ✓ We will establish data owners who will be responsible for using data to inform decision making and to take improvement action. ✓ We will work with data owners to establish guidelines and responsibilities for the management of data quality. ✓ We will implement data quality by design including software and focused data quality processes. ✓ We will ensure that the results and intelligence gained from data analytics is used to improve clinical and corporate practice which in turn, will improve patient care and operational performance.

5. Digital Pioneers

Our ultimate aim is to create a culture of continuous improvement and innovation which supports the delivery of our strategic ambitions outlined within the Right Care and UEC strategies. We therefore see digital, business intelligence and innovation as wholly interdependent. Embedding digital capabilities and culture alongside robust technological solutions and intelligent data analysis should enable us to prioritise vital work on 'getting the basics right' whilst at the same time, continuing to move in pursuit of partnership working to drive innovation and digital transformation.

We aim to become leading pioneers across the Ambulance sector at preventing harm from avoidable deterioration and will develop, test and implement digital solutions which will help us to achieve this ambition. We will also develop innovation partnerships with academic and commercial organisations to drive innovation at pace and scale across the North West whilst also exploring opportunities for funding, resource and learning. Our approach to innovation at NWAS will be agile and fast-paced, putting the needs of our staff and patients first and using their ideas to identify opportunities to challenge the status quo, and adopt digital solutions to radically improve outcomes and experience.

5.1 Preventing harm from deterioration	✓ We will work closely with partners across integrated urgent and emergency care settings to target admission avoidance and support safe care closer to home. ✓ We will use ongoing research and development to test the use of digital solutions to provide enhanced physiological monitoring to detect deterioration in known patients, taking action to intervene at the earliest opportunity. ✓ We will explore the latest innovations to enable on scene physiological monitoring, working to share data with clinicians in other services and working together via video consultation on scene. ✓ We will use intelligence to make accurate predictions around health prevalence using demographic analysis to identify areas of health deprivation to identify at-risk patients or population groups before they reach crisis point and proactively manage their care. ✓ We will also drive innovation across our Patient Transport Services by testing sensor technology assessments and monitoring for the frail and elderly to identify at-risk patients before they require an emergency response.
5.2 Innovation partnerships	✓ We will continue to work collaboratively with Ambulance Trusts across the North West to develop innovative cross-organisational initiatives, which will improve quality, performance and resilience. ✓ We will develop a more proactive approach to collaborative working with other regional and national partners to maximise opportunities for system-wide innovation and change and access to resource, funding and support. ✓ We will establish innovation partnerships with academia to harness the knowledge required to drive innovation whilst also seeking opportunities to collaborate and learn from organisations that have previously piloted or implemented digital solutions to complex problems.

	✓ We will utilise the knowledge and experience of commercial organisations that have developed digital solutions and identify opportunities for external funding and investment to support innovation. ✓ We will work closely with STP partners and other providers to identify innovation opportunities which will have system-wide impact.
5.3 Cultivating innovation	✓ We will harness innovation by developing the people, processes and digital infrastructure required to surface and share ideas for innovation in a structured way. ✓ We will harvest bottom up idea generation using an agile approach to test ideas at pace (see section 1.6). ✓ We will create an innovation pipeline where ideas can be prioritised and incorporated into innovation cycles or Sprints. ✓ We will establish clear structures for ongoing horizon scanning and to identify opportunities for business or commercial development. ✓ We will explore further opportunities to join national pilots or partner with organisations such as Global Digital Exemplars to become early adopters. For example, within the first year of this pilot we will join the NHS Identity pilot to develop a national approach to two-factor authentication and replace the need for Smartcards. ✓ We will develop an innovation fund to support our innovation pipeline
5.4 Rapid deployment of innovation	✓ We will ensure our innovation roadmap is aligned with strategic ambitions to improve patient care and deliver a more integrated approach to urgent and emergency care. ✓ We will review our digital operational model to include innovation architecture which supports continuous rapid identification and prioritisation of opportunities, swift delivery of solutions and measurement of organisational impact. ✓ We will develop an innovation pipeline which provides a transparent process for prioritising and piloting innovative ideas and rolling out successful innovations into business as usual. ✓ We will also develop a blueprint through which we can share innovation and learning both internally across service delivery functions, and externally with digital partners to improve care across the system. ✓ We will focus on innovations that enable us to be an efficient and productive organisation, enabling us to be greener, cost effective, improve staff experience and wellbeing and provide the best possible care. This will include a focus on Smart technologies and supporting our 'green' agenda.

5. Strategy Implementation

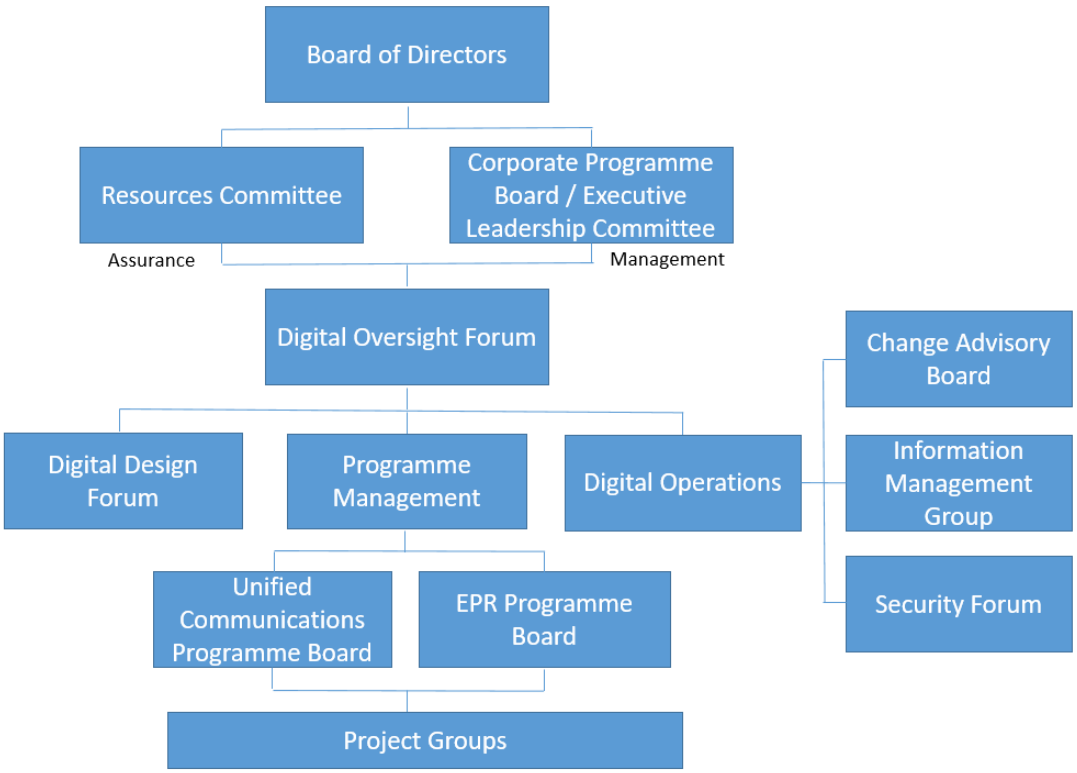
How will we approach delivery?

We recognise that the digital vision we have outlined in this strategy is ambitious and achievement of our goals over the next five years we will depend upon significant investment into getting the basics right, whilst prioritising future initiatives to drive digital transformation at pace and scale. The commitments outlined under each of our strategic intentions are subject to appropriate finance and resource. It is essential that as we move forward in pursuit of our strategic ambitions, we also remain focussed on the stabilisation and improvement of our existing technological foundations. These foundational systems will provide the infrastructure upon which future transformation can be developed whilst also maintaining resilience and business continuity.

A detailed implementation plan has been developed to outline how our digital portfolio is co-ordinated and delivered to ensure we can effectively balance the Trust's portfolio of activity and prioritise future projects. This implementation plan will be informed by NWAS' integrated business plan (IBP) to ensure the appropriate balance of resource, capacity, finances and capability to deliver a coherent portfolio of work across the organisation which aligns to the delivery of our overarching strategic aims. We have developed a robust communication and engagement plan which will ensure our objectives and progress are shared across the organisation and with partners.

How will we oversee delivery?

The governance structure below provides a proposal for how the implementation of our strategic intentions will be delivered; Appendix B provides details on the proposed function and outputs of each group.

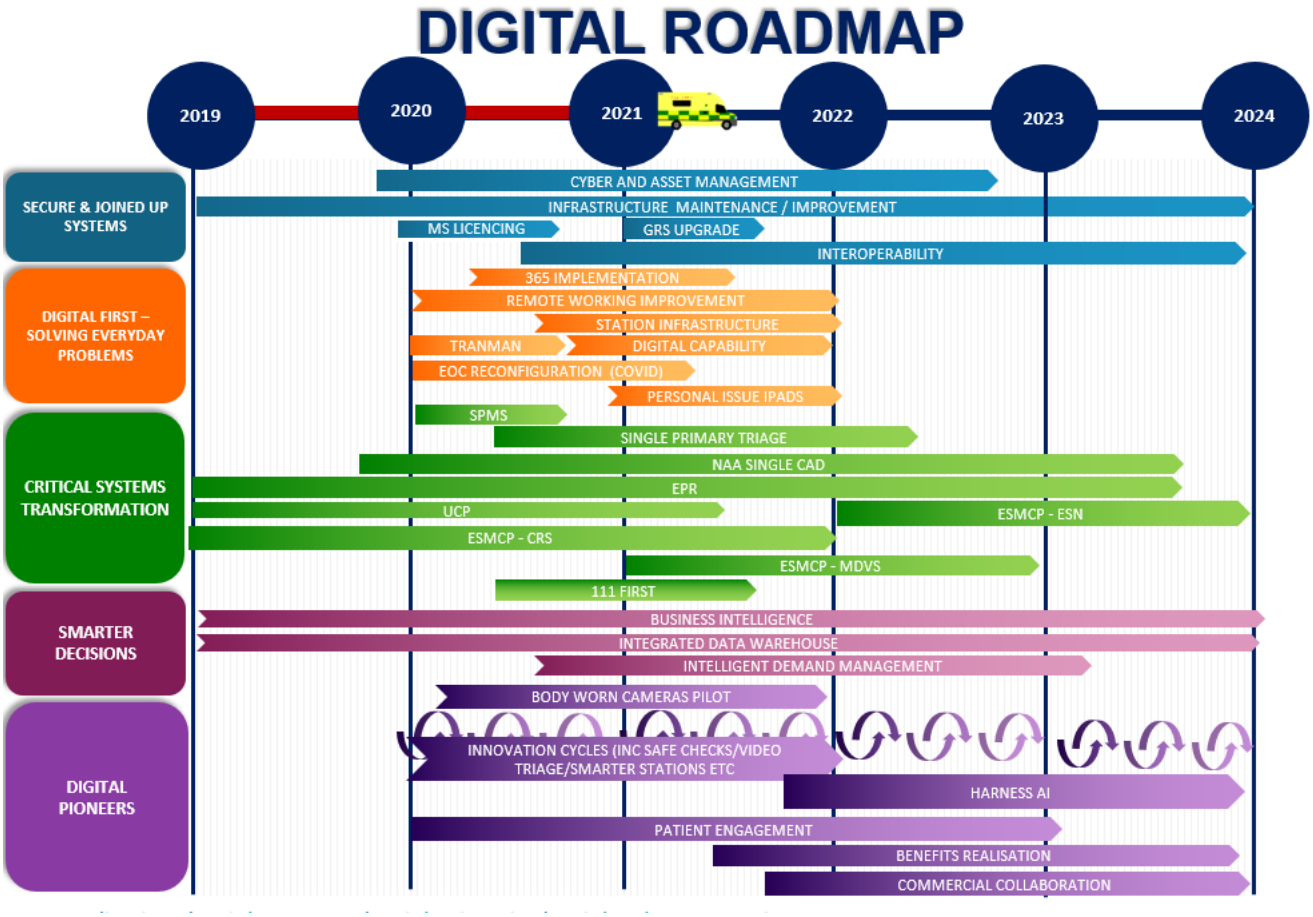


This governance structure aims to create a system with delegated oversight and ownership over our strategic aims and implementation plan. It is essential that we create a structure which enables engagement and involvement across all operational and corporate service lines as well as a process for the flow of information and assurance, including escalation of risks.

What is our roadmap for implementation?

Our roadmap for implementation is phased based on short, medium and long-term deliverables as outlined in our full roadmap.

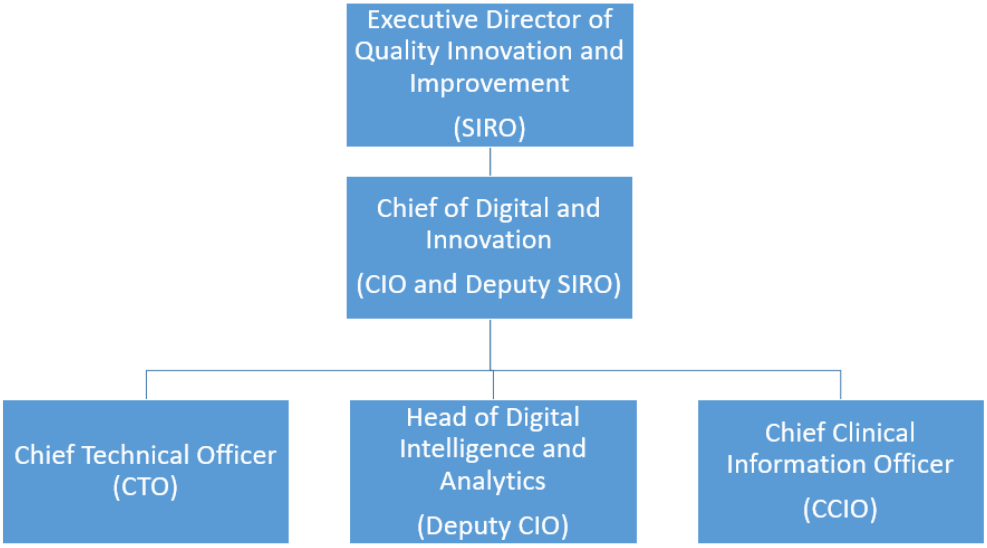
A supporting risk and renewal roadmap is monitored through the asset management programme and is used to proactively identify systems which are approaching 'end of life' and take appropriate action to review, renew or replace as required.



Digital leadership structure

In order to delivery high quality, effective digital services we will review our operating model to ensure we have sufficient capacity, capability and leadership within our digital structures to deliver our strategic ambitions whilst also maintaining essential ICT systems management and business continuity.

We have reviewed the digital leadership requirements within NWAS and have developed the following high-level structure which was implemented during teh first 18 months of this strategy:

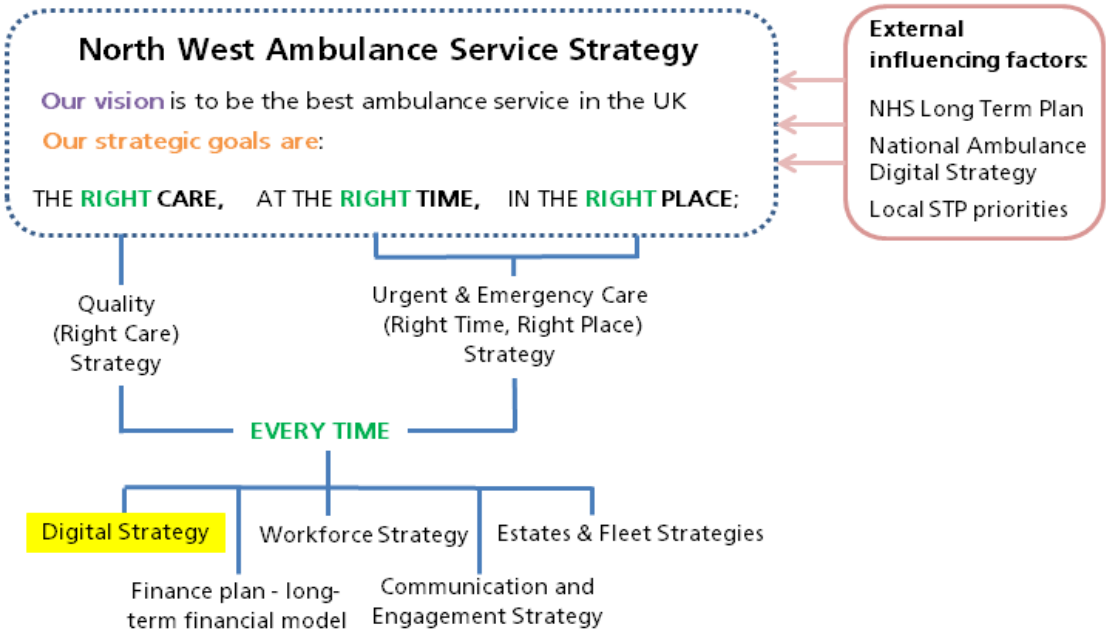


This leadership team works collaboratively with digital partners, both internally and externally, to ensure our digital services are fully integrated across all NWAS service lines and with partners across the wider system.

How will we measure improvement?

We have identified a number of core metrics which will be used to measure improvement over the next five years. Several measures had to be developed and a baseline gathered in the first 18 months of the strategy, The final set of measures and data over time will be included in the annual report May 2021.

Appendix A- NWAS strategy portfolio



Appendix B- Governance Structure

Forum	Purpose
Trust Board	To support and oversee the Digital Strategy implementation plans, providing overarching investment decisions which balance improvements in core business platforms with ongoing innovation.
Resources Committee	To take assurance from the Digital Oversight Forum regarding delivery of Digital Strategy implementation plan and take decisions, based on submission of appropriate business cases, around investment in digital programmes. To ensure appropriate management of digital resource including staff, system management and funding. To support partnership opportunities to access investment both internally and externally.
Executive Leadership Team	To provide senior management support and oversight to the Digital strategy implementation plan; ensuring alignment of strategic intentions with wider operational and corporate priorities. To act as a point of escalation for emerging issues and risks and support mitigation actions.
Corporate Programme Board	To provide oversight and management support of the interdependencies between trust projects including digital, surfacing and managing associated risks.
Digital Oversight Forum	To act with delegated authority to manage the Digital Strategy implementation plan on behalf of Trust Board, FIP and EMT. To oversee the implementation of the digital services required to achieve strategic ambitions. To accept accountability for: 1) Ongoing development and delivery of digital services (including people, systems, training and culture) and drive NWAS' strategic direction and integrated planning from a digital perspective; 2) Digital innovation portfolio and delivery roadmap, acting as point of escalation for any operational or programme risks and issues; 3) Operational delivery of digital services, including system management, risk and renewal and the roadmap for improvement.
Information Management Group	To provide assurance and surface risks for all issues related to information governance and security. To provide a chairs report to the Resources Committee.
Business Intelligence Steering Group	To lead on the design of data services including alignment with strategic priorities and technical design of dashboard solutions. To ensure interoperability and integration between NWAS systems and manage the flow of information and data. To sign off all technical designs and system specifications; ensuring business readiness and strategic fit. To lead on horizon scanning to identify opportunities for business development and innovation.
Digital Design Forum	To find possible digital solutions to problems and test new innovative ideas. To work safely to test on a very small scale.
Digital Project Programme Boards	To lead on the delivery of all digital projects and programmes within the implementation plan. To oversee overall planning and investment in digital services and collate and maintain the roadmap for delivery. To provide delegated responsibility for digital projects including resource, delivery timelines, business change, operational impact, risk and mitigations. To report progress of project and programmes to the DOF including project status and exceptions (i.e. deviations from tolerances, risks, quality assurance etc.) To set the standards through which project will be managed (i.e. PMO framework, agile methodologies).

Digital Operations	To lead on operational delivery of digital services across NWAS including; proactive management of risk and renewal roadmap, capacity and planning, digital system capability and functionality, skills development and training, forward planning of work and modelling impact to business continuity, management of security (cyber and information) and information governance, disaster recovery planning and critical systems maintenance. Within Digital Operations key groups include the Cyber Security Forum and the Change Advisory Board.

Appendix C- Glossary of Terms

The glossary below should be used to provide definitions of key terms used within this strategy and supporting implementation plan documentation.

Term	Description
Access	The ability to utilise IT systems or view/edit data on IT systems
Access Control	An ACL is a table that tells a computer operating system which access rights each user has to a particular system object, such as a file directory or individual file. Each object has a security attribute that identifies its access control list.
Auditing	An examination of the management controls within an Information technology (IT) infrastructure. The evaluation of obtained evidence determines if the information systems are safeguarding assets, maintaining data integrity, and operating effectively to achieve the organisation's goals or objectives.
Authentication	The process of identifying an individual, usually based on a username and password. This is defined as single factor authentication. If another factor, such as a token or PIN, is required in addition to the first one this is defined as 2 factor authentication.
Authorisation	The process of granting or denying a user access to network resources once the user has been authenticated through the username and password.
CAD	Computer Aided Dispatch is the system used to dispatch Ambulances.
Cloud	A network of remote servers hosted on the Internet to store, manage, and process data, rather than a local server or a personal computer.
Cloud Security	A broad set of policies, technologies, and controls deployed to protect data, applications, and the associated infrastructure
Consumer	A system which consumes data using existing Open APIs.
Cyber Security	The body of technologies, processes and practices designed to protect networks, computers, programmes and data from attack, damage or unauthorised access.
Database	A structured set of data held in a computer, can be accessible in various ways
DAA	An agreement between two or more entities to allow access to data or information. Details the controls that are to be put in place to protect the data, including how the data will be used, stored, shared and disposed of.
DPA	Data Protection Act. The DPA (1998) is an act of the United Kingdom Parliament that defines the ways in which information about living people may be legally used and handled. The main intent is to protect individuals against misuse or abuse of information about them.
Encryption	The process of converting information or data into a code, especially to prevent unauthorised access.

Term	Description
EPR	An Electronic Patient Record is an electronic record of periodic health care of a single individual, provided mainly by one institution.
eTS	An electronic version of NWAS secondary Triage tool. Designed to provide clinicians with support in their decision making.
Firewall	A network security system that monitors and controls the incoming and outgoing network traffic based on predetermined security rules.
First of Type	The chosen recipient(s) to test the first deployment of the new capabilities.
Gateway	A hardware device that acts as a "gate" between two networks. It may be a router, firewall, server, or other device that enables traffic to flow in and out of the network
HSCI	Health and Social Care Integration. This integrates local health and social care services to improve coordination between local health and social care agencies, leading to improved experiences for people using these services.
Health and Social Care Network (HSCN)	HSCN is a Wide Area IP Network (WAN) connecting many different sites across the NHS within England & Scotland. It also connects to other networks via gateways, notably to the internet via the internet gateway
Identification	A logical entity used to identify a user on a software, system, website or within any generic IT environment. It is used within any IT enabled system to identify and distinguish between the users who access or use it. A user ID may also be termed as username or user identifier
Information Security	A set of strategies for managing the processes, tools and policies necessary to prevent, detect, document and counter threats to digital and non-digital information.
Internet	A network of global exchanges – including private, public, business, academic and government networks – connected by guided, wireless and fibre-optic technologies. The terms Internet and world wide web are often used interchangeably, but they are not exactly the same thing; the Internet refers to the global communication system, including hardware and infrastructure, while the web is one of the services communicated over the Internet.
MIG	The Medical Interoperability Gateway is a supplier lead interoperability solution provided by EMIS + Vision which allows third parties access to GP data.
N3	Now replaced by the Health and Social Care Network (HSCN).
Network	A group of computer systems and other computing hardware devices that are linked together through communication channels to facilitate communication and resource-sharing among a wide range of users.

Term	Description
NRLS	National Record Locator Service is a technical proof of concept acting as a national index to identify available records for patients and locate them across local and national care record solutions (such as SCR).
Open Source	Denotes software for which the original source code is made freely available and may be redistributed and modified.
Password (Protection)	A collection of letters/numbers/characters used in a security process that protects information accessible via computers that needs to be protected from certain users. Password protection allows only those with an authorised password to gain access to certain information.
PII	Personally Identifiable Information. Data that could potentially identify a specific individual. Any information that can be used to distinguish one person from another and can be used for de-anonymizing anonymous data can be considered PII.
Provider	An individual or an organisation that provides health care for a patient. Also a system which provides data by exposing Open APIs.
Proxy server	A server that acts as an intermediary for requests from clients seeking resources from other servers
Remote Access	The ability to access a computer from a remote location. This allows employees to work offsite, such as at home or in another location, while still having access to the office network. Remote access is usually set up using a virtual private network (VPN). Remote Access can also be known as remote login.
Security	The protection of information (digital and hardcopy), assets (physical and intangible) and personnel against internal and external, malicious and accidental threats. This protection includes detection, prevention and response to threats through the use of security policies, procedures, tools and services.
SCR (SCRa)	Summary Care Record. The SCR is intended to support patient care in urgent and emergency care settings. The SCR will store a defined set of key patient data for every patient in England except those who elect not to have one. This data will make a summary record created from information held on GP clinical systems. This summary record helps to ensure a continuity of care across a variety of care settings.
Spine	Spine is a collection of national applications, services and directories which support the health and social care sector in the exchange of information in national and local IT systems. A national, central service that underpins the NHS Care Records Service. It manages the patient's national Summary Care Records. Clinical information is held in the Personal Spine Information Service (PSIS) and demographic information is held in the

Term	Description
	Personal Demographics Service (PDS). The Spine also supports other systems and services such as the e-Referral Service and the Electronic Prescription Service.
SSO	Single Sign On. An authentication process that allows a user to access multiple applications with one set of login credentials. SSO is a common procedure in organisations, where a client accesses multiple resources connected to a local area network (LAN).
Validated NHS Number	A valid NHS Number is one that has the correct format and passes the number check digit calculation.
Verified NHS number	A verified NHS Number is one where the patient's identity has been cross-checked using demographic details on the Personal Demographics Service (PDS).
Virtual Private Network	A virtualised extension of a private network across a public network, such as the Internet. It enables users to send and receive data across shared or public networks as if their computing devices were directly connected to the private network. Applications running across the VPN may therefore benefit from the functionality, security, and management of the private network. A VPN allows employees to securely access an organisations intranet and other network resources while located outside the office. A VPN may also be used to securely connect geographically separated offices of an organisation, creating one cohesive network.
WAN	A network that exists over a large-scale geographical area. A WAN connects different smaller networks (LANs). This ensures that computers and users in one location can communicate with computers and users in other locations.
Wi-Fi	The standard wireless local area network (WLAN) technology for connecting computers and myriad electronic devices to each other and to the Internet. Wi-Fi is the wireless version of a wired network. Data is passed via radio waves broadcast to/from a Wi-Fi enabled devices that make up the WLAN (router, laptop, desktop, tablet, mobile phone, printer, etc.).
WPA	Wi-Fi Protected Access

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	Wednesday 31 March 2021			
Subject:	Board Assurance Framework (BAF) Risks 2021/22			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Decision			
Executive Summary:	The planning guidance has just been issued and in light of that the proposal for the Board Assurance Framework during the first 2 months of 2021/22 is that it we have four strategic risks (see Appendix 1) • SR01:There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction • SR02:There is a risk that the Trust cannot evidence value for money and effectiveness in the use of the resources that could impact on its ability to invest improvements to infrastructure • SR03:There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care • SR04:There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services Following the planning process, the BAF will be reviewed and any Strategic Risks identified will be added for Board to approve.			
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Approve the current proposed BAF risks for 2021/22.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒

Are there any Equality Related Impacts:	None Identified

Previously Submitted to:	Executive Leadership Committee
Date:	Wednesday 24 March 2021
Outcome:	Supported onward reporting to the Board of Directors

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1. PURPOSE

This report provides the Board of Directors with an opportunity to agree the proposed Board Assurance Framework Risks for 2021/22.

2. BACKGROUND

Following discussions with both Executive and Non-Executive Directors nine strategic risks had been identified and agreed, however, following the release of the NHS Planning Guidance on 25th March 2021, the proposal is that the Board agrees four of those risks to be in place for the first two months of the year until the planning round has completed and the strategic plans and objectives of the Trust have been reviewed and potentially revised, at which point the remaining five risks will be revisited and either added to the Board Assurance Framework (if they remain relevant) or re-articulated if required.

The proposed BAF risks for 2021/22 can be viewed in **Appendix 1**.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the current proposed 2021/22 BAF risks.

North West Ambulance Service NHS Trust

PROPOSED 2021/22 BOARD ASSURANCE FRAMEWORK (BAF) RISKS

SR	Risk Description	Exec Director Lead
SR01	There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.	Medical Director
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.	Director of Finance
SR03	There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care.	Director of Operations
SR04	There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services.	Director of People

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	Wednesday 31 March 2021			
Subject:	Risk Appetite Statement (RAS) 2021/22			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Decision			
Executive Summary:	The Trust's Risk Appetite Statement underwent a full revision and refresh by the Board of Directors, during focused sessions in March 2021. The proposed Risk Appetite Statement for 2021/22 can be viewed in **Appendix 1** for review.			
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Approve the Risk Appetite Statement for 2021/22.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	Executive Leadership Committee
Date:	Wednesday 24 March 2021
Outcome:	Supported onward reporting to the Board of Directors

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1. PURPOSE

This report provides the Board the Directors with an opportunity to consider the Risk Appetite Statement for 2021/22.

2. BACKGROUND

The Trust's Risk Appetite Statement underwent a full revision and refresh by the Board of Directors during focused sessions in March 2021.

The proposed Risk Appetite Statement for 2021/22 can be viewed in **Appendix 1** for review.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

The Risk Appetite Statement forms part of the Trust's risk management arrangements and supports the Board in meeting its statutory duties.

4. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the Risk Appetite Statement for 2021/22.

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North West Ambulance Service NHS Trust

Risk Appetite Statement (RAS) 2021/22

North West Ambulance Service (NWAS) NHS Trust recognises as a healthcare provider that risks will inevitably occur in the course of providing care and treatment to patients, employing staff, owning, leasing and maintain premises and equipment, and managing finances.

As a result, NWAS endeavours to establish a positive risk culture within the organisation, where unsafe practice is not tolerated and where every member of staff feels committed and empowered to identify and correct and/or escalate system weakness.

The Board of Directors is committed to ensuring an effective risk management system is in place to manage risks from operational to Board level and where risk is identified, robust mitigating action plans are put in place.

NWAS recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff and volunteers, members of the public and strategic partners.

As such:

- NWAS has a low appetite to accept risks that could materially provide a negative impact on quality; including poor quality care, treatment or unacceptable clinical risk, non-compliance with standards of poor clinical or professional practice
- NWAS has a low appetite to accept any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies
- NWAS will take measured and considered risks that does not compromise the safety of our staff.

However, NWAS has a greater appetite to take considered risks in terms of their impact on organisational issues.

As such:

- NWAS has a moderate appetite to accept risks that impact on finance/ value for money, however, budgetary constraints will be exceeded when required to mitigate risks to patient or staff safety or quality of care
- NWAS has a moderate appetite regarding pursuit of commercial development, collaboration and partnerships. Although, the preference is for safe delivery options that have a low degree of inherent risk and may only have limited potential reward.

NWAS commits to actively utilise the Risk Appetite Statement during any decision-making process and to review its Risk Appetite Statement on an annual basis and/or following any significant changes or events.

Peter White
Chairman

Daren Mochrie
Chief Executive

North West Ambulance Service NHS Trust Risk Appetite			
Key Risk Category	**Risk Appetite Level**	**Risk Tolerance Score**	**Risk Appetite Statement**
Financial/ VfM	Moderate	4-6	We have a **MODERATE** appetite for measured risk taking to support growth whilst making best use of resources, delivering value for money whilst minimising the possibility of financial loss allowing the Trust to develop and provide highest standards of healthcare. We will not take any material financial risks which will have a negative impact on the overall sustainability of the Trust.
Compliance/ Regulatory	Low	1-3	We have a **LOW** appetite and we will not take any risks which will impact on our ability to meet our legislatory requirements.
Innovation	High	8-12	We have a **HIGH** appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities to improve patient outcomes, transform services and ensures value for money.
Quality Outcomes: *Safety* *Effectiveness* *Experience*	Low	1-3	We have a **LOW** appetite for risk taking in relation to Quality Outcomes. We will take measured and considered risks to improve and delivery quality outcomes where there is potential for long term benefit, however, we will not compromise the quality of care we provide or the safety of our staff, or patients in our care.
Reputation	Moderate	4-6	We have a **MODERATE** appetite for risk taking that will enhance our reputation to be an 'outstanding' organisation. We will not take any risks that will have a negative impact on the reputation of the Trust.

North West Ambulance Service NHS Trust

REPORT

Board of Directors					
Date:	31st March 2021				
Subject:	Integrated Governance Structure				
Presented by:	Angela Wetton, Director of Corporate Affairs				
Purpose of Paper:	For Assurance				
Executive Summary:	As part of the annual corporate governance processes whereby committee and management group effectiveness is evaluated, the supporting structure of the Board Assurance Committees has also been evaluated for effectiveness and efficiency. The following changes have been agreed with lead execs (see Appendix 1) subject to Terms of Reference and Work plans being presented to the relevant Board Assurance Committee during April 2021: ▪ Change of nomenclature for Board Assurance Committee immediate sub-structure from Management Group to Sub-Committee ▪ Separation of Health & Safety from Patient Safety resulting in: o Health, Safety & Security Sub-Committee o Patient Safety Sub-Committee ▪ Establishment of an IPC Sub-Committee ▪ Establishment of an EPRR Sub-Committee (agreed at Q&P Committee March 2021) ▪ Revised Clinical Effectiveness Sub-Committee remit to ensure no overlap/duplication with Patient Safety Sub-Committee ▪ Information Governance Sub-Committee – aligned to the Audit Committee's remit of governance; cyber security and data quality assurance				
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Note the refreshed integrated governance structure for 2021/22.				
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒	
	Right Place	☒	**Every Time**	☒	

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11

☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	Executive Leadership Committee ; Quality & Performance Committee
Date:	10th March 2021/ 15th March 2021
Outcome:	Supported Sub-Committee Structure

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1. PURPOSE

This paper provides the opportunity for the Board of Directors to review the proposed integrated governance structure.

2. BACKGROUND

As part of the annual corporate governance processes whereby committee and management group effectiveness is evaluated, the supporting structure of the Board Assurance Committees has also been evaluated for effectiveness and efficiency.

Consideration has also been given to any relevant findings from the Deloitte Review in January 2020.

3. REVIEW OF THE SUB-BOARD GOVERNANCE/ASSURANCE STRUCTURE

Following discussions with lead execs, the following is proposed, as can be seen in Appendix 1:

Changes

- Change of nomenclature for Board Assurance Committee immediate sub-structure from Management Group to Sub-Committee

Reporting Directly into Quality & Performance Committee via Chair's Assurance Report

- Separation of Health & Safety from Patient Safety resulting in:
    1. Refocusing of the Health, Safety & Security Sub-Committee
    2. Establishment of a Patient Safety Sub-Committee – aligned to the new NHS Patient Safety Strategy and guidance
- Establishment of an IPC Sub-Committee – aligned to the IPC BAF
- Establishment of an EPRR Sub-Committee – to allow greater oversight and to embed the learning from the Manchester Arena Inquiry.
- Revised Clinical Effectiveness Sub-Committee remit to ensure no overlap/duplication with Patient Safety Sub-Committee

Reporting Directly into Audit Committee via Chair's Assurance Report

- Information Governance Sub-Committee – aligned to the Audit Committee's remit of governance; cyber security and data quality assurance

By strengthening the sub-committee structure it should help reduce the burden on the Board Assurance Committees except for the papers they must see as they report onwards to Board.

There is an amount of work underway to ensure the terms of reference and workplans are in place ready for the start of the year and these will be presented to the relevant Board Assurance Committee during April.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

The revised and refocused structure will support the BAF and reduce Board level governance burden.

5. RECOMMENDATIONS

The Board of Directors are requested to:

- Note the refreshed integrated governance structure for 2021/22.

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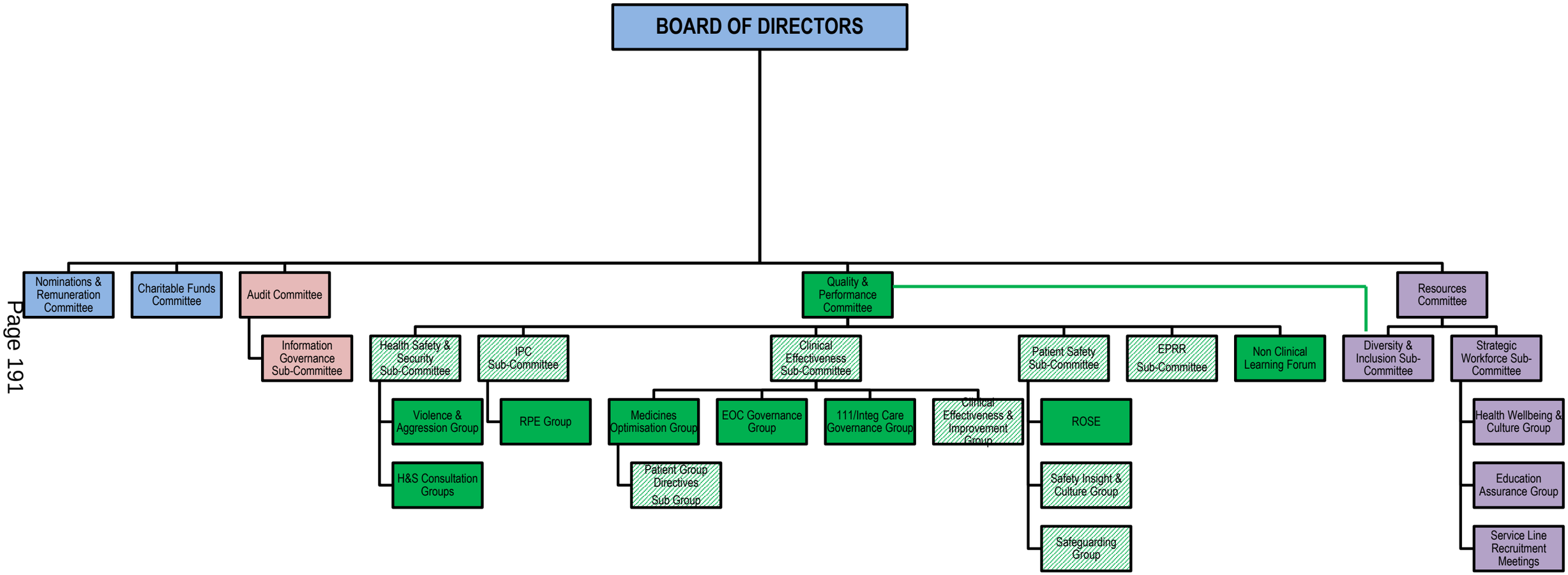
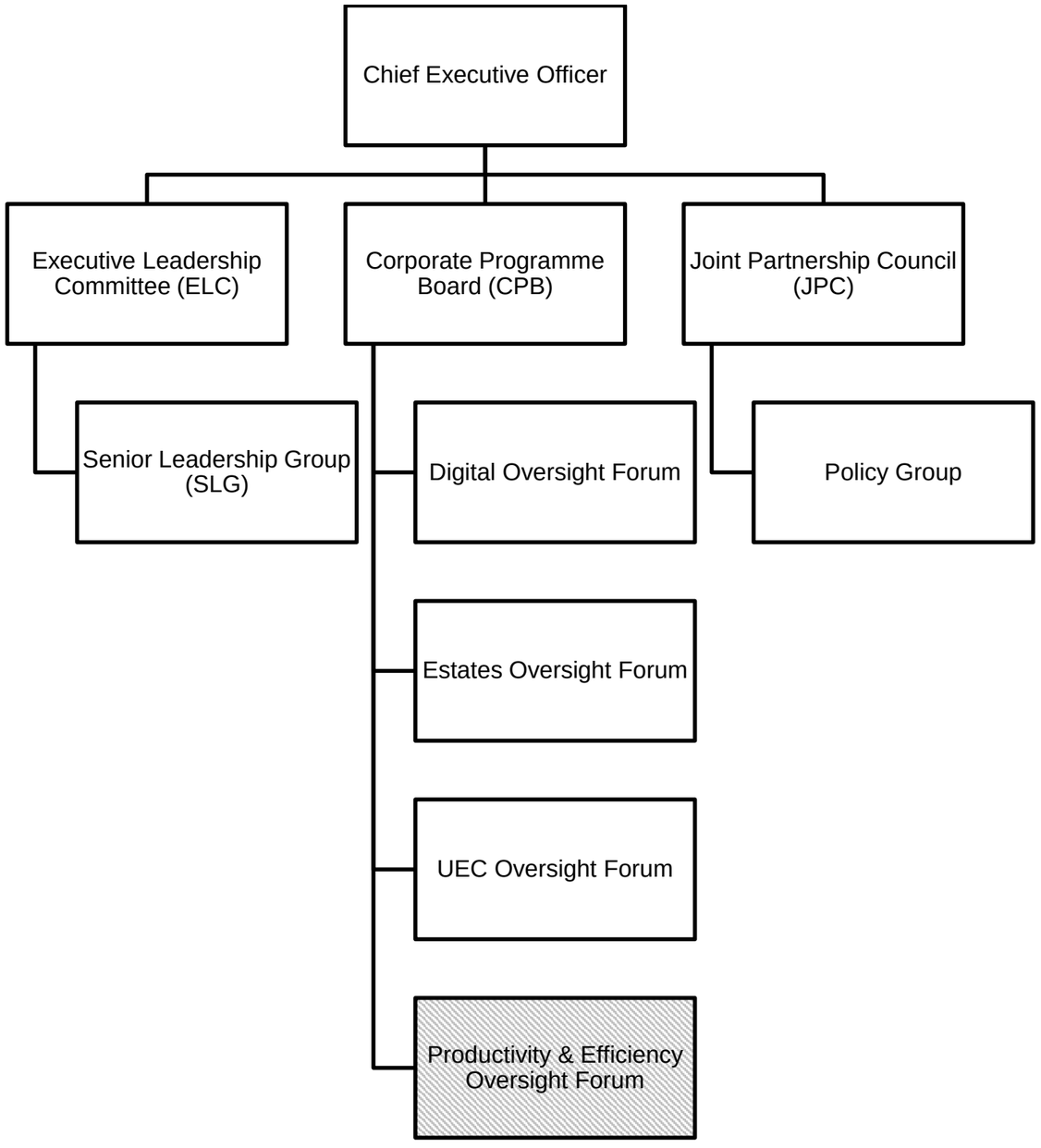
INTEGRATED GOVERNANCE STRUCTURE

ASSURANCE



INTEGRATED GOVERNANCE STRUCTURE

MANAGEMENT



North West Ambulance Service NHS Trust

REPORT

Board of Directors						
Date:	31 March 2021					
Subject:	Chairman's Annual Fit and Proper Persons' Declaration					
Presented by:	Lisa Ward, Director of People					
Purpose of Paper:	For Assurance					
Executive Summary:	In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5). The report sets out the Chair's annual declaration of compliance and has been informed by compliance with the agreed Board procedure; assurances from NHSI regarding non-executive directors; individual declarations of interest and an annual individual declaration of compliance with the regulations.					
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note the assurance given by the Chairman that he is confident the Trust is compliant with regulations and that the Board meets the Fit & Proper Persons criteria.					
Link to Strategic Goals:	**Right Care**	☐		**Right Time**	☐	
	Right Place	☐		**Every Time**	☒	

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☐	☒	☐	☐	☐	☐	☒	☐	☐

Are there any Equality Related Impacts:		The criteria is applied equally to all Directors and allowance is made in respect of reasonable adjustments to enable compliance with the regulations by disabled staff.
Previously Submitted to:		

Date:		
Outcome:		

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FIT AND PROPER PERSONS REQUIREMENTS: DIRECTORS AND NON-EXECUTIVE DIRECTORS

CHAIRMAN'S ANNUAL DECLARATION

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

The Fit and Proper Persons Test will apply to Directors (both executive and non-executive, whether existing, interim or permanent and whether voting or non-voting) and individuals *"performing the functions of, or functions equivalent or similar to the functions of a director".*

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience;
- is not physically and mentally fit (after adjustments) to perform their duties.

Regulation 5 also decrees that directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

These requirements play a major part in ensuring the accountability of Directors of NHS bodies and outline the requirements for robust recruitment and employment processes for Board level appointments. [In exceptional circumstances, Trusts may allow an individual to continue as Director without having met the requirements following approval of the Chairman and following an assessment of all elements of risk.

As Chairman of North West Ambulance Service NHS Trust, I confirm that all existing Executive and Non-Executive Directors (both permanent and interim) meet the requirements of the Fit & Proper Persons Test.

My declaration has been informed by:

The application of the Board approved Procedure on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:
    - Proof of identity
    - Disclosure and Barring Service check undertaken at a level relevant for the post
    - Occupational Health clearance
    - Evidence of the right to work in the UK
    - Proof of qualifications, where appropriate
    - Checks with relevant regulators, where appropriate
    - Appropriate references, covering at least the last three years of employment, including details of gaps in service.

- Additional checks for all Directors on the following appropriate registers:
    - Disqualified directors
    - Bankruptcy and insolvency

- Confirmation from the Chair of appointment panels of compliance with the checks process

- All new appointments for Non-Executive Director positions are undertaken in conjunction with NHS E/I. The pre-employment checks undertaken by NHS E/I checks are shared with the Trust so there is a retained record in the Trust of the individual's fitness to undertake their role as Non-Executive Director.
- A review of checks by NHS E/I in circumstances of the reappointment of Non-Executive Directors to ensure that they remain 'fit and proper'
- Assessment of the Ongoing Independence of Non-Executive Directors carried out by the Director of Corporate Affairs
- Annual and on-going Declarations of Interest for all Board members
- Annual Fit & Proper Persons Test self-declarations completed by all Executive and Non-Executive Directors.
- If there have been any individual concerns raised regarding Directors during the previous year, the outcome of any investigations is reviewed to provide continuing assurance that Directors remain 'Fit and Proper'.
- The retention of checks data on personal files.

PETER WHITE
CHAIR
March 2021

Relationships or circumstances which may be relevant to the Board's determination of the independence of Non-Executive Directors (The NHS FT Code of Governance, Monitor, July 14)									
	PW	RG	MOC	DH	DR	AC	Associate Non-Executive Directors		
							CW Ended 1/11/20	GS	RT
Has been an employee of the NHS Trust within the last five years	No	No	No	No	No	No	No	No	No
Has, or has had within the last three years, a material business relationship with the NHS Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS Trust	No	No	No	No	No	No	No	No	No
Has received or receives additional remuneration from the NHS Trust apart from a director's fee, participates in the NHS Trust's performance-related pay scheme, or is a member of the NHS Trust's pension scheme	No	No	No	No	No	No	No	No	No
Has close family ties with any of the NHS Trust's advisers, directors or senior employees	No	No	No	No	No	No	No	No	No
Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies (Cross-directorships are where: an executive director of organisation A serves as a NED in organisation B and, at the same time, an executive director of organisation B serves as a NED at organisation A.)	No	No	No	No	No	No	No	No	No
Has served on the board for more than six years from the date of their first appointment	7 years	6 years	7 years	2 years	2 years	2 years	1 year 5 months	<1 year	1 year 6 months
Is an appointed representative of the NHS Trust's university medical or dental school.	No	No	No	No	No	No	No	No	No

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	31st March 2021			
Subject:	Non-Executive Directors – Terms of Office 2021/22			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Assurance			
Executive Summary:	One Non-Executive Director whose term of office ends during Q1 2021/22 has already been reappointed by NHSEI for a further 2 year term. There are three Non-Executive Directors who reach the end of their current term of office during Q2 2021/22. Full details of Non-Executive Directors terms of office can be seen in s2.			
Recommendations, decisions or actions sought:	The Board of Directors is asked to receive the positive assurances that: • The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) • That the Board can continue to declare compliance with code provision B.7.1 of Monitor's Code of Governance with respect to Non-Executive Directors Terms of Office.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐

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

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1. PURPOSE

The purpose of this report is to provide assurance to the Board of Directors that:

1. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)
2. That the Board can continue to declare compliance with code provision B.7.1 of Monitor's Code of Governance with respect to Non-Executive Directors Terms of Office.

The paper also seeks to raise wider Board awareness of Non-Executive Director Terms of Office.

2. TERMS OF OFFICE

In a NHS Trust, Non-Executive Directors are appointed by NHSEI on behalf of the Secretary of State for Health for an initial term of office of 2 years and at the end of that 2 year period, consideration is given to extending their term of office with reappointment for a further 2 years.

The Trust, whilst not an FT, subscribes to the Code of Governance and Code provision B.7.1. suggests that Non-Executive Directors, to ensure independence, should not serve more than 6 years except in exceptional circumstances.

Terms of Office wef 1st April 2021 are shown below:

Name	Term of Office
Non-Executive Directors	
Peter White (Chairman)	01/02/19 – 31/01/23
Non-Executive Director Term of Office	Ended 31/1/19 30/04/18 – 30/04/20 01/05/16 – 30/04/18 01/05/14 – 30/04/16
David Hanley	Renewed 28/05/21 – 27/05/23 28/05/19 – 25/05/21
David Rawsthorn	Renewed 25/03/21 – 24/03/23 25/03/19 – 24/03/21
Alison Chambers	01/08/19 – 31/07/21
Richard Groome (Vice Chair)	08/08/19 – 05/08/21 05/08/17 – 05/08/19 06/08/15 – 05/08/17
Prof Aneez Esmail	01/04/21 - 31/03/23
Associate Non-Executive Directors	
Rod Thomson	01/09/19 – 31/08/21
Gillian Singh	01/03/21 – 28/02/23

3. LEGAL and/or GOVERNANCE IMPLICATIONS

In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended), the Trust is required to have five voting Non-Executive Directors plus a voting Non-Executive Chairman.

4. RECOMMENDATIONS

The Board of Directors is asked to receive the positive assurances that:

- The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)
- That the Board can continue to declare compliance with code provision B.7.1 of Monitor's Code of Governance with respect to Non-Executive Directors Terms of Office.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	31st March 2021
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for March 2021 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during February 2021 unless otherwise stated. The highlights from this **February** report are as follows; **Quality** • 106 complaints were received, against a 12 month average of 122 per month. The Trust is on track with its strategic goal of reducing complaints. 126 compliments were received. • 53% of complaints risk scored 1-3 and 5% of level 4-5 complaints were closed within SLA. This signals a reduction in the complaints completed within SLA from previous months even though we have seen a significant rise in those closed with a level 4-5. A plan is in place where there are three separate areas of focus new, existing and backlog. 1236 internal and external incidents were opened, against a 12 month average of 1392. Although the numbers of incidents has decreased we have seen a fall in the level 1-3 completed in SLA which is below the standard of 85%. We are still managing to close level 4-5 within the agreed standard though. (83% against a standard of 80%). • 2 Serious Incidents (Sis) were reported in February. Five of the six SI reports due were submitted within the 60-day timescale. • There were 6 new safety alerts of which 2 were applicable and are being managed by an accountable executive. **Effectiveness** • **Patient experience:** In November 2020, national collection of FFT data recommenced and the number of returns has increased across all service lines. These high return rates are due to use of an SMS service as opposed to reliance on postcard or postal survey returns. Satisfaction levels remain high. • **ACQIs:** Overall we are seeing no change in most measures for the clinical quality indicators. Rankings in comparison to other ambulance services change from month to month but overall there is no significant change (common cause variation). Data for the rates of the Return of Spontaneous Circulation (ROSC) overall performance signals a significant reduction and the Trust's Resuscitation Group is undertaking a review to understand causative factors. • **H&T, S&T, S&C:** The proportion of incidents with Hear and Treat is just under 10% (although within the control limits as common

cause variation) and is being sustained at high levels. See & Treat has also remained steady around 30% resulting in an aggregate non-conveyance of just under 40%.

Finance

- The year-to-date expenditure on agency is £5.319m which is £2.469m above the 19/20 ceiling of £2.850m which is due to be updated.
- 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)

- Call Pick Up performance was 99.05% , with the data signalling special cause to the good with call pick up in 5 seconds being on the upper control limit showing high levels of performance.

ARP Performance

	Standard	Actual
C1 (Mean)	7:00	7:11
C1 (90th)	15:00	12:34
C2 (Mean)	18:00	21:04
C2 (90th)	40:00	42:39
C3 (Mean)	1:00:00	49:51
C3 (90th)	2:00:00	1:50:48
C4 (90th)	3:00:00	3:30:12

- Response time targets have been met for C1 90th, C3 mean and C3 90th. The primary reason for not reaching targets is a mismatch between demand and resource levels although we are seeing the benefit of a reduction in COVID 19 abstractions.
- All ARP metrics are signalling a significant improvement with special cause to the good and data points below the lower control limit.

Handover

February saw significant improvement in average handover time hitting 29 minutes and 9 seconds versus a national standard of 30 minutes. 1,055 attendances (2.2%) had a turnaround time of over 1 hour, with 18 of those taking more than 3 hours. 134 hours were lost to delayed admissions in February down from 699 in January.

NHS 111

	Standard	Actual
Calls Within 60s	95%	76.12%
Average Time to answer		58s
Abandoned Calls	<5%	4.13%
Call back Within 10 min	75%	9.49%
Average Call Back		1hour 14min
Warm Transfer to Nurse	75%	9.49%

	• Performance throughout February is broadly in line with December and January for all measures. **PTS** • Activity in January for the trust was 40% below contract baselines, whilst the year to date position (July 2020 – February 2021) is performing at 39% below baseline. This is due to Covid-19. **Organisational Health** • **Sickness**: The overall sickness absence rate for the latest reporting month (January 2021) was 10.41% including COVID related sickness of 4.3%. • **Turnover** was 7.41%. • **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 1.9% in February. • **Vacancy**: Positions across the trust are under establishment by 2.68%. This is mainly as a result of establishment changes in 111 • **Appraisal:** The overall appraisal completion rate was 60.75% against a revised trust target of 75% by September 2021 this is lower than 95% due to the effect of Covid-19. • **Mandatory Training:** The trust is 75% compliant. This is due to the impact of Covid-19 and the addition of new topics for the current years cycle of training. ELC have agreed a revised target of 75% and this is currently being met. **COVID 19** There have been 200 instances of staff that have tested positive for Covid-19 in February 2021 with 1,685 instances since July 2020. There have been 91 outbreaks on trust sites from July until the end of February of which 68 are now closed. Outbreak management is a key objective and is overseen by a weekly executive management group.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the content of the report • Clarify any items for further scrutiny

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

Link to Board Assurance Framework (Strategic Risks):

SR01	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	☐
SR03	If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care	☐

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

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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 February 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. INTEGRATED PERFORMANCE SUMMARY

Quality

Q1 – Complaints and Compliments
In February 2021, 106 complaints were received, against a 12 month average of 122 per month. 126 compliments were received this month. The Trust is on track with its strategic goal of reducing complaints. The month average is 17 complaints per 1000 WTE staff, against a strategy goal of 31.

A total of 143 complaints were closed in February 2021 (123 cases were risk scored 1-3 and 20 were risk scored 4-5). Overall, 53% of cases risk scored 1-3 were closed within the agreed timescales against a right care strategy goal of 85% for the end of 20/21. 5% of level 4-5 complaints were closed within agreed timescales against a right care strategy goal of 75% by the end of 20/21.

The data signal a significant decrease in completion within SLA for 4-5 even though we have seen an increase in numbers completed in February. The data is also signalling a smaller but steady decline in those completed 1-3 with the data point on the lower control limit (special cause variation).

The reasons for the fall in completion rates within SLA are:

- Decrease in calls and activity in February
- The trust being at Reap Level 4 and therefore less availability within operational teams to support the investigation procedure.
- A significant backlog of those scored 4-5 closed , though not closed within SLA.

Clearing that backlog and the introduction of a plan which splits the team dealing with complaints into three to look at new, existing and backlog will enable to trust to work towards achieving the standard. In addition, the patient safety team are working closely with EOC to reduce their backlog quickly and a meeting is scheduled on the 24th March to develop a rapid response plan to reduce the operations backlog.

Q2 – Incidents
In February 2021 1236 internal and external incidents were opened, against a 12 month average of 1392. The number of opened incidents is back within the normal range having previously increased between October 2020 and January 2021. With the trust being at REAP 4 and then 3 this had impacted the availability of operational staff to support the investigation process.

In January, 34 incidents were unscored which is above the Right Care Strategy goal of 25 unscored incidents in the previous month reported in the IPR.

In total, 1335 incidents (level 1-5) were closed during February 2021 . There have been improvements in the incident closure rates of those scored 4-5 but a worsening for those scored 1-3 during February 2021.

81.93% level 1-3 were closed within agreed standard against the right care strategy goal of 85%. The data signal a significant change with special cause variation with February data point below the lower control limit.

88.33% of level 4-5 incidents were closed within the agreed standard against a right care strategy goal of 80% for the end of 20/21.

The data demonstrate that although the numbers of incidents opened has decreased we have seen a decrease for those scored 1-3 being closed and a decrease of them being closed within the agreed standard We have seen a decrease in incidents opened scored 4-5 but we have seen both an increase in those closed and those closed within the agreed standard.

Q3 - Serious Incidents (SIs)
2 Serious Incidents (SIs) were reported in February 2021. 6 SI reports were due with the commissioners in February 2021. Five of the six (83%) of the SI's reports due in February 2021 were submitted within the timescales which has pushed us bellow right care strategy goals which is 95% in the last quarter Despite this we are seeing the benefits of the introduction of the serious incident review panel and are continuing with the trial. Even though the number of incidents scored 4-5 in February remained the same as January we saw a fall in the number of those that were Sis.

Q5 - Safety Alerts and Health and Safety
There have been 6 new safety alerts in February 2021. The total number of CAS/NHS Improvement alerts received between March 2020 and February 2021 is 34, with 1 alert applicable. 12 MHRA Medical Equipment Alerts have been received with 0 alerts being applicable. 62 MHRA Medicine alerts have been received, with 0 alerts applicable. 1 IPC alerts have been received, with 1 alert applicable.

Effectiveness

E1 - Patient Experience
Because of the COVID-19 pandemic, NHS England suspended the FFT process at the end of Q4 2019/20, resulting in no submission of data from the April reporting window with submission recommencing in November.

Prior to this, the only responses received during 2020 in relation to FFT were through the trust's online digital surveys. These were introduced in the summer of 2020 and the lack of direct contact to individual patients receiving our services, reflect the low return rate.

Since November we have reinstated contacting patients to ask the FFT question via SMS text message– this allows us to contact those patients that we know have recently used the service directly to ask about their experience. Response levels tend to be much higher as patients receive this question directly to their mobile phones and it is tailored to only ask the question and follow up demographics. This has led to a large uptake in return rates since we have reinstated using this method.

Despite all the additional pressures that NWAS currently face - satisfaction levels remain high across all service lines.

It should also be noted that whilst postal surveys and face to face patient experience and engagement work have been mainly put on hold during the pandemic, the trust has continued to listen to and engage with patients, community groups and the public through its engagement framework implementation plan with these stakeholders in addition to its programme of work with the patient and public panel.

Quarterly updates on this work are provided to the Quality and Performance Committee and trust Board.

E2 – ACQIs

Effectiveness

Overall, we are seeing no change in our data for the clinical quality indicators. Rankings change from month to month but overall there is no significant change (common cause variation). The lag in data make it difficult to understand the impact of any recent work to improve in these areas and supplementary measures to give us a more recent picture are being explored.

In October, the rates of the Return of Spontaneous Circulation (ROSC) overall performance signals a significant change with the data point below the lower control limit (special cause variation). The Trust's Resuscitation Group is undertaking a review to understand any causative factors.

The ROSC achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 40% (national mean 42.8%), ranking us 7th nationally.

5.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge. The national mean is 7.9%. This performance ranked the Trust in 7th position.

The figure for the Utstein sub-group was 16.7% (national mean 20.5%) which saw the Trust ranked 8th for English ambulance trusts.

For the overall group, the rate was 23% (national mean 25.5%) ranking the Trust in 8th position nationally.

The STEMI care bundle result of 76.5% was fractionally ahead of the national mean of 76.4%. Care bundle data for stroke and sepsis was not published for October as is consistent with the NHSE reporting schedule.

E3 – H&T, S&T & S&C Outcomes

The Trust continued to deliver impressive levels of Hear & Treat throughout the first two months of the year. The regional response has provided some capacity with Clinical Assessment and Locality Clinical Assessment services that has helped to augment the Hear & Treat capability within the NWAS Clinical Hub. This means that H&T levels have consistently close to 10% throughout February. It is clear that the intense COVID activity has considered the need for patients to be managed away from ED whenever possible, helping to reduce nosocomial infections as much as possible. We continue to work with local providers to ensure that codesets are refined in a way that learns from COVID and maximises opportunities for patients to received early clinical input.

See & Treat for the period have stabilised at c 29.5% approximately 2% above the pre-COVID baseline. However, as the presentation profile of patients adjusts to pre-COVID levels, we have seen a marginal increase in the number of patients being managed by conveyance to a receiving unit. Those patients conveyed are often managed away from type 1 and 2 emergency departments with greater use of SDEC facilities emerging throughout quarter 1. Charts that H&T and S&T both tend to increase due to a higher emphasis in community based management. This was evident in wave 1 and again during peaks in November and January.

We are ranked 9th for See and Treat nationally and 9th for See and Convey which is the third highest in terms of patient conveyed. The See and Convey figure includes 53.48% convey to ED and 7.4% convey to non ED.

Finance

F1 – Finance
The year-to-date expenditure on agency is £5.319m which is £2.469m above the year-to-date ceiling of £2.850m. (Please Note: The agency ceiling is based on 2019/20 ceiling figures and will be updated as soon as we have the information). For the eleven months of the Covid-19 framework, the 2020/21 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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Operational

PES Activity

OP1 – Call Pick Up
Call handling performance continues to be excellent when appraised against all key metrics. The percentage of calls answered in 5 seconds was 99.05% for February 2021. 670 calls took longer than 5 seconds to pick up which is significantly lower than any month since July 2020. The mean, 90th centile and 95th centile are 1 second. The outstanding levels of call pick up are enabling improvements in both C1 and C2 response times. In addition, NWAS's EOCs have continued to support other Trusts, with frequent support being provided to Scotland.

Call pick up demonstrates a significant change with data points close to the lower control limit (special cause variation). This is a reflection of the reduction in calls being received by NWAS. This can be attributed to a reduction in incidents vs January and a reduction in duplicates calls due to improved response times, especially C2 and C3.

Call pick up in 5 seconds signals a significant change with data points on the upper control limit (special cause variation). This is due to the improved call pick up performance and consistency of call pick up. Abstractions have improved in February and continued into March. The increase in workforce metrics indicates the improved performance will be maintained.

OP3 – ARP Standards

	C1 Mean	C1 90th	C2 Mean	C2 90th	C3 Mean	C3 90th	C4 90th
Feb 2021	00:07:11	00:12:10	00:21:04	42:39	49:51	01:50:48	03:30:12
Target	00:07:00	00:15:00	00:18:00	40:00	01:00:00	02:00:00	03:00:00

For February, response time targets were met for C1 90th , C3 mean and C3 90th.

Modelling work has been commissioned from ORH to inform future commissioning.

The improvement in all ARP measures (as seen on the comparison between January and February) is as a result of a number of factors.

- Lower Abstractions due to COVID-19
- Increased performance for call pick up
- Lower call volume
- Lower Duplicates
- Decrease in COVID- 19 abstractions
- Increased DCA resource from PTS, VAS/PAS, Military (MACA) and up to 50 extra ECFRs
- Improvement in Hospital handover time
- Use of complimentary resources to increase clinical decision making on scene – through HART and SPTL structure
- Engagement locally, regionally and nationally regarding Hospital Handover challenges

Although not all targets have been met, all the data are signalling that performance is stabilising at a new lower mean time with data points on or close to the lower control limit in mid to late February (special cause variation). Should this continue then there will be a lower reset mean for the next report (fig O3.1 - O3.7).

During February we saw 8.7% of calls were C1.

OP2 – Hospital Turnaround

Average turnaround time shows a decrease for February with one of the last 4 data points being on, below or very close to the lower control limit (special cause variation). Average turnaround time was 29 minutes 09 seconds (Q2.1) and this is the first time since September that the trust has been within the national standard of 30 minutes. Even though we are meeting the standard as an average, there is significant variation within the aggregate performance. 1,055 attendances (2.2%) had a turnaround time of over 1 hour, with 18 of those taking more than 3 hours. This is a reduction from 2,910 in January. In February, 129 cases of delayed admissions were reported. This is significantly lower than the 528 in January.134 hours were lost to delayed admissions in February down from 699 in January.

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

Royal Oldham - 00:24:32
Warrington - 00:23:50
Macclesfield - 00:22:28
Tameside - 00:20:18
Royal Albert Edward - 00:20:00

Whilst the Every Minute Matters improvement collaborative has paused to support the pandemic response the Trust continue to work with NW NHSEI and acute hospital partners across the region to address the increase in hospital handover times and associated safety and patient experience risks. The ops team are working with the QI team to identify a number of EDs to trial the Patient Safety checklist. This will aid both the ED and NWAS in improving handover and will also support patient safety, those handed over and waiting for a NWAS response. It is worth noting that handover to clear has been consistently strong at 11 minutes 17 seconds for February.

OP4 – 111

In February, performance improved within 111 from January to February and to broadly similar levels to December. Demand throughout January and February remains stable, however intraday volatility is still apparent therefore making forecasting a challenge at present.

During January and February 2021 111 experienced a significant rise in Covid abstractions, peaking at circa 180 per day. At the time of writing this update this level of abstractions has now reduced significantly to a less concerning level with the service having had no related positive cases for 18 days.

Calls answered within 60 seconds in January delivered 68.57%, with a further improvement in February delivering 76.12%. The improvement seen in February correlates with the improving position in staff abstraction.

Following the successful recruitment to support 111 First the service is now focussing on the support roles required to enable all new staff to undertake call taking to the highest possible standard.

Despite the increase in staffing, performance at present is not fully optimised due to constraints with Estate and Telephony.

Estate - Work is underway preparing the additional estate within Middlebrook. The planned go live date for this is currently the end of March 2021. Call Handlers that have been recruited between December and March will be done so on fully flexible shift patterns until there is available estate to seat them in. Once Estate capacity is realised (circa 75 desks) call handlers will then be rostered to shift patterns to optimise performance.

OP5 – PTS Activity
Due to an issue with data extraction. PTS performance is reported to January 2021 instead of February 2021. Normal reporting will resume for the next board report.

Overall activity during January 2021 was 40% below contract baselines with Lancashire 47% below contract baselines whilst Merseyside is operating at 27% (6,826) Journeys below baseline. For the year to date position (July 2019 - January 2021) PTS is performing at 39% (359,744 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 47% and 46% below baseline whilst Greater Manchester and Merseyside are operating at 34% and 29% below baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside is 5% (1,118 journeys) above the baseline. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are 53% (4,607 journeys) and 34% (11,197 journeys) below baseline, with Merseyside also 13% (1,721) below baseline.

In terms of overall trend analysis, Greater Manchester has experiencing upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.
Aborted activity for planned patients averaged 6% during January 2021 however Cumbria experiences 3%, Greater Manchester operates with 9% whilst Lancashire and Merseyside both experience 5% aborts. There is a similar trend within EPS (renal and oncology) patients with an Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside both operate at 3% . Unplanned (on the day) activity experiences the largest percentages of aborts with an average 13% (1 in 6 patients) with variances of 7% in Cumbria, 13% in Greater Manchester, 14% in Lancashire and 15% Merseyside.

Workforce

OH1 – Sickness
The overall sickness absence rates for January 2021 were 10.41% with all service lines showing increases. This overall trust sickness rate includes COVID-19 related sickness of 4.3%. The underlying Non-COVID-19 sickness is slightly lower than the same time last year.

All service lines show sickness above 9% with PES, EOC and 111 all between 10.5% and 12.5%. PES/EOC and 111 have Covid related sickness at 5.5% and 2.6% respectively.

In addition to sickness reported via ESR, COVID-19 self-isolating absences have been captured by GRS, Teliopti and Marvel. This data is reported externally.

OH2 – Turnover
Turnover is calculated on a rolling year average and this does lend to some small variations between months with February 2021 turnover being 7.41% consistently lower than in previous years.

Staff turnover has in the main been positively affected by COVID-19 and the changed job market. 111 has seen the most significant reduction in turnover since COVID-19 although has had slight increase in February to 21.11% but overall the 111 turnover remains low compared to the historical position of over 30%.

OH4 – 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.

Agency staff have been used to support the Trust's response to the Pandemic and have been utilised primarily in the Contact Centre environment.

ELC approved the recruitment of an additional 123 Agency staff in EOC for the period up to the end of the financial year, so levels are expected to remain higher than previous years. An exit strategy to reduce agency levels through fixed and permanent contracts is in place to reduce this by the end of Q1, the start of the impact of the exit strategy can be seen in the February position of 1.9% down from January (2.5%).

The increase from November 2020 to January 2021 are impacted by Wave 2 & 3 of the Pandemic.

OH5 – Vacancy Gap

Chart OH5.1 shows a slightly improving vacancy position but this reflects the significant change in establishment for 111 as a result of the agreed contract extension and 111 First.

Although recruitment planned for 111 is on track the establishment change now shows the current position against all the growth requirements resulting in the current vacancy gap of 8.37%.

The PES position is positive and very stable. This excludes the continuing use of PTS staff. The increase in PTS vacancies reflect the permanent appointment of some of these staff onto the EMT1 apprenticeship. Plans are in place to address this shortfall.

EOC remains over established and supports the SPT roll out.

OH6 – Appraisals

As a result of the impact of COVID-19, appraisals were paused in March 2020 in line with national guidance. They were recommenced in June and improvement can be seen until the commencement of the second wave. The last 6 months have shown a worsening of the position. Appraisals were formally paused again for frontline staff on October 21st as a result of demand and high levels of abstractions. This has taken most service lines below the lower control limits.

As a result completion rates are currently 60.75% overall.

In January 2021, a revised recovery target has been set to deliver 75% compliance across all service lines by September, rising to 85% in March 2022 and 95% in March 2023.

Work is being undertaken to think innovatively about how we embed appraisals discussions in business-as-usual activities, and better use technology to support this going forwards. All corporate service lines and manages at Band 8a and above have been asked to deliver to the existing 85% target.

OH7– Mandatory Training

The pandemic has resulted in disruption to the planned mandatory training programme for 2020/21. The current position is that classroom training for this programme will not resume but targeted mandatory training activities are in place to continue with online module completions and to target areas of highest risk.

ELC have approved a revised target for 2020/21 of 75% and this target is currently being met. The overall compliance position in February 2021 is 75%.

It should be noted that PTS managed to maintain and deliver 95% classroom attendance by the original target date of December 2020 despite the pandemic.

Approval has been given to recommence a full cycle of mandatory training for 2021/22 from April. This will be targeted to deliver 95% compliance by March 2022, including recovery of Level 3 safeguarding training for Paramedics who did not attend classroom training this year.

Covid-19

There have been 200 instances of staff that have tested positive for Covid-19 in February 2021 with 1,685 instances since July 2020.

There have been 91 outbreaks on trust sites from July until the end of February with 68 of these now closed. The largest outbreak has been at Middlebrook where the call centre for 111 is based. The largest 5 outbreak sites account for 21% of confirmed covid cases. In February there were 5 new outbreaks.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

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

Q1 COMPLAINTS

Figure Q1.1

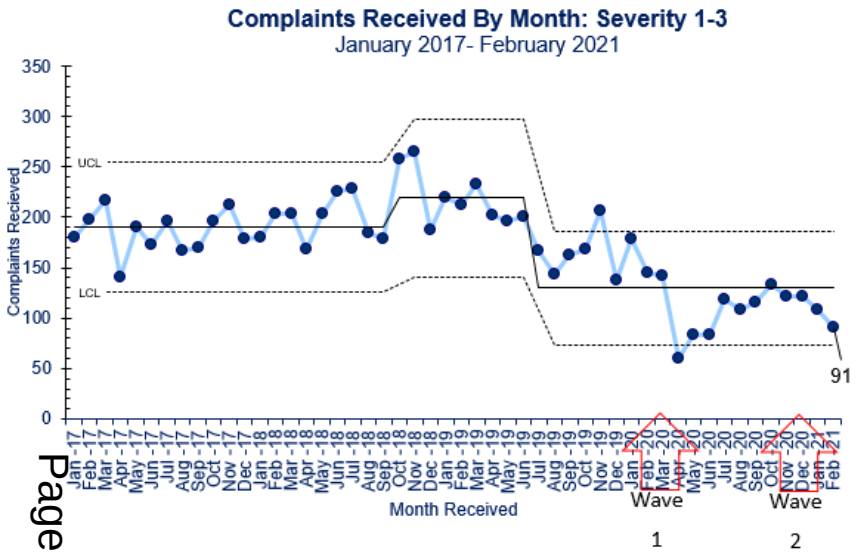


Figure Q1.2

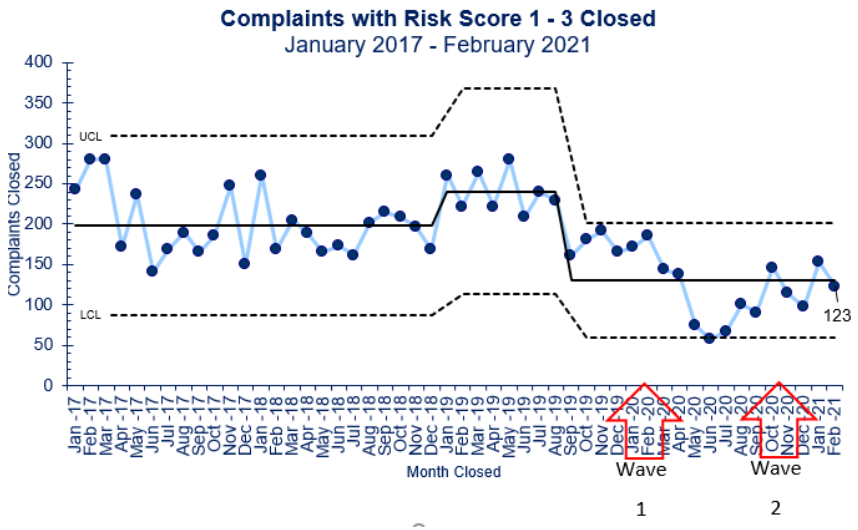


Figure Q1.3

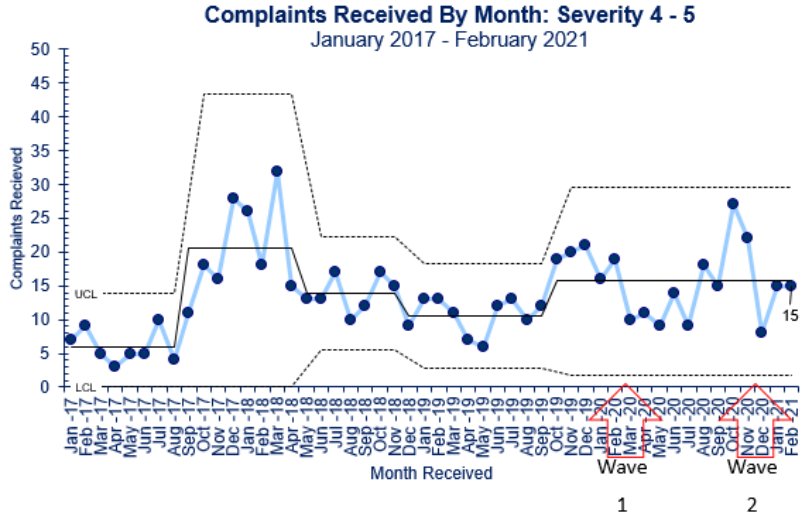
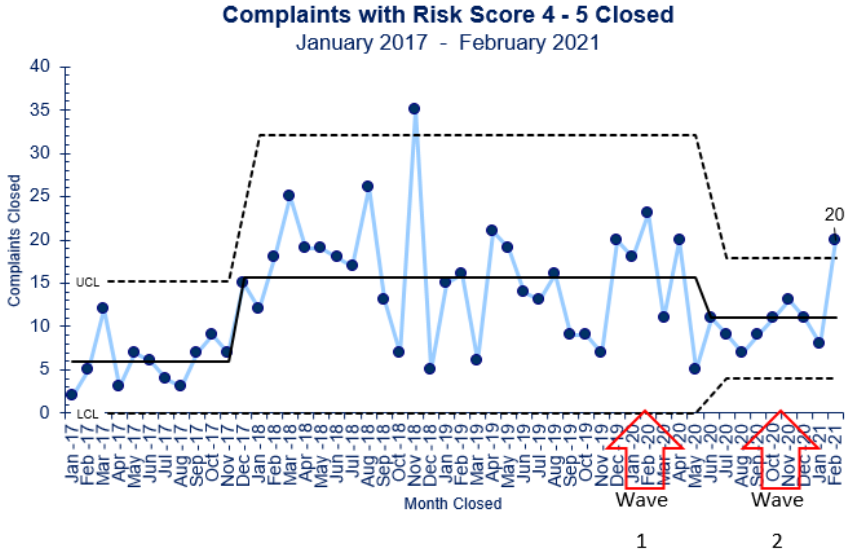


Figure Q1.4



Complaints & Compliments

In February 106 complaints (figures Q1.1 & Q1.3) were received against a 12 month average of 122 per month.

126 compliments were received this month.

The rate of complaints in February 2021 is 17 per 1000 WTE, which is below the strategy goal for 2020/21 of 31.

The average for the fiscal year (1 April 2020 – 31 February 2021) is 19.1 per 1000 WTE which is significantly below the target. This reduction in complaints is attributed to the current COVID-19 pandemic where we saw a reduction in lower-level complaints due to the following reasons:

- Improved performance in the early and mid stages of the first wave of COVID-19.
- Reduced PTS journeys which typically generate a high number of lower-level complaints
- More tolerance from the public for minor concerns.
- New plan in place which splits the team to focus on new, existing and backlog so that all three areas are being dealt with at the same time.
- The trust has moved out of REAP 4 this has allowed more operational focus to support the investigation and closing of complaints.

A total of 143 complaints were closed in February 2021 (123 were risk scored 1-3 Q1.2 and 20 were risk scored 4-5 Q1.4). Q1.4 signals a positive change with the number of complaints with a score of 4-5 closed above the upper control limit (special cause variation).

* baseline is the financial year 2017/18

Figure Q1.5

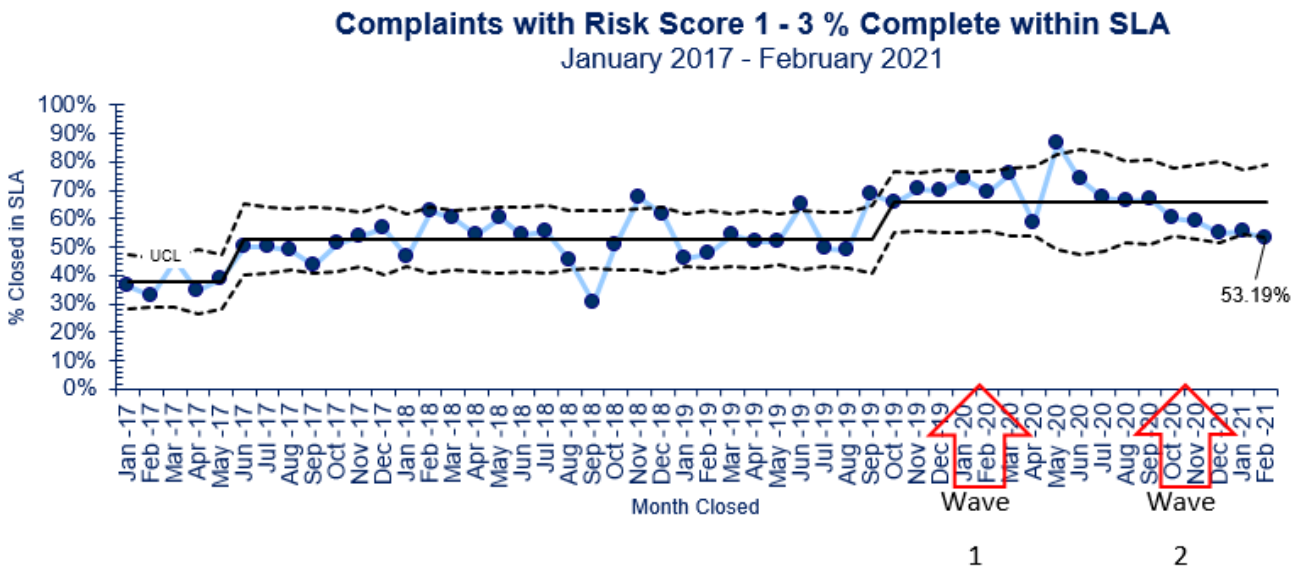
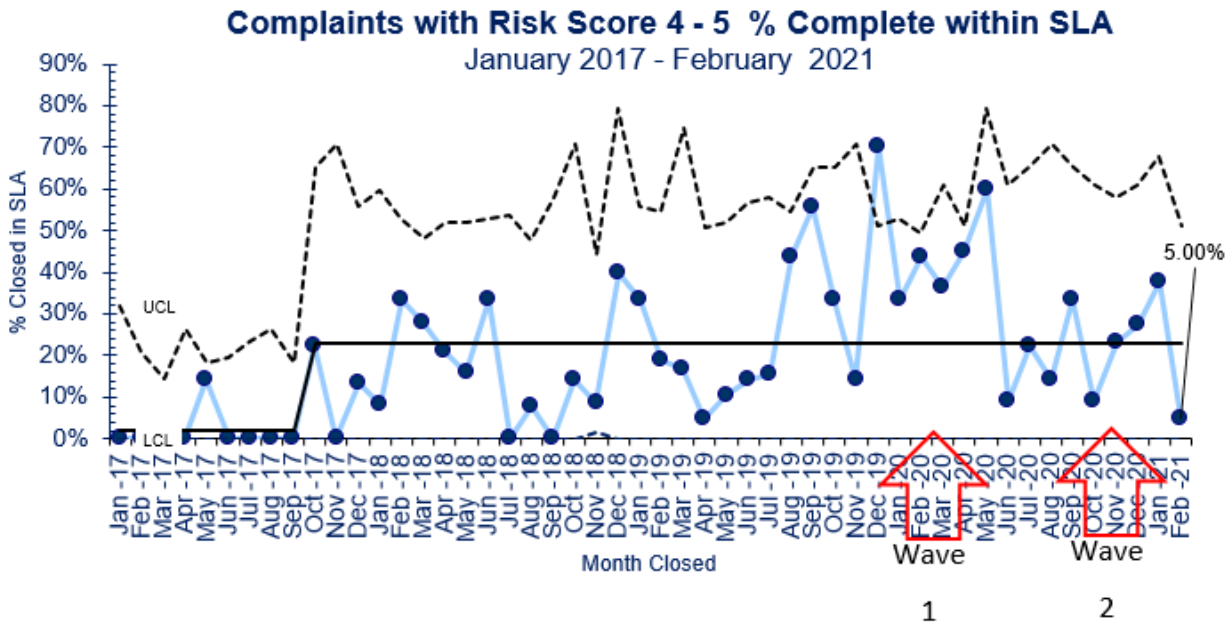


Figure Q1.6



Complaints Closure

Overall, 53% of cases risk scored 1-3 were completed within the agreed timescales (Q1.5) against a right care strategy goal of 85% for the end of 20/21.

5% of level 4-5 complaints were completed within agreed timescales (Q1.6) against a right care strategy goal of 75% by the end of 20/21.

The data signal a significant increase in completion within SLA in May (special cause can be seen with the data point above the upper control limit). This was due to the Ombudsman stopping lower level complaints between March to May.

Since June, the data signal that less complaints have been completed within SLA with December's data point in Q1.5 showing a significant change with this and subsequent data points on or near the lower control limit (special cause variation).

There are a number of reasons why we have seen a reduction, including:

•Operational pressures impacting on staff' ability to respond to complaints. The trust was at REAP level 4 and 3 during this time and experiencing extractions due to Covid-19.
•Parliamentary and Health Service Ombudsman (PHSO) have stopped the reporting of complaints during the first wave causing a backlog

Since January the 18th a plan was implemented to improve response times. Firstly to tackle backlog and this is shown in figure Q1.4 with high numbers of completion for those scored 4-5. Then splitting the team to look at three areas which are, backlog, existing and new complaints.

Q1.4 shows a higher number of complaints with a score of 4-5 closed though Q1.6 shows that in February only 5% 4-5's were complete within SLA. This is as several out of time complaints were completed within the month.

Q2 INCIDENTS

Figure Q2.1

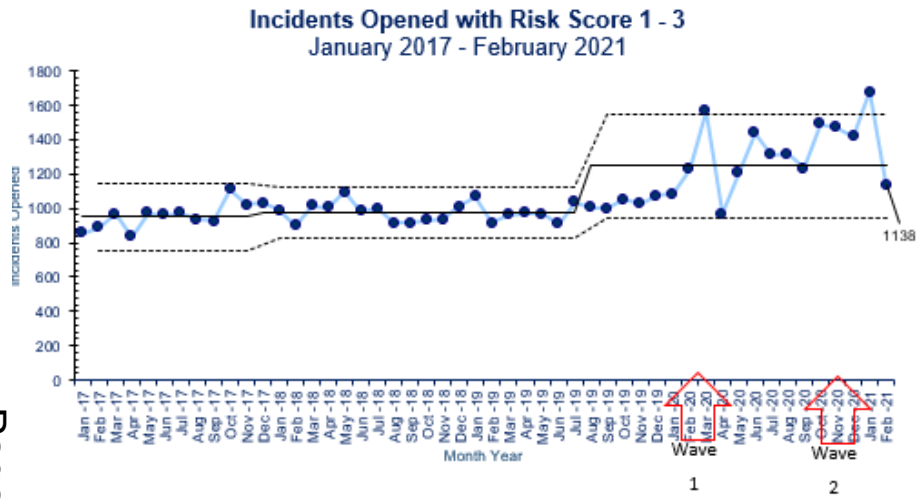


Figure Q2.2

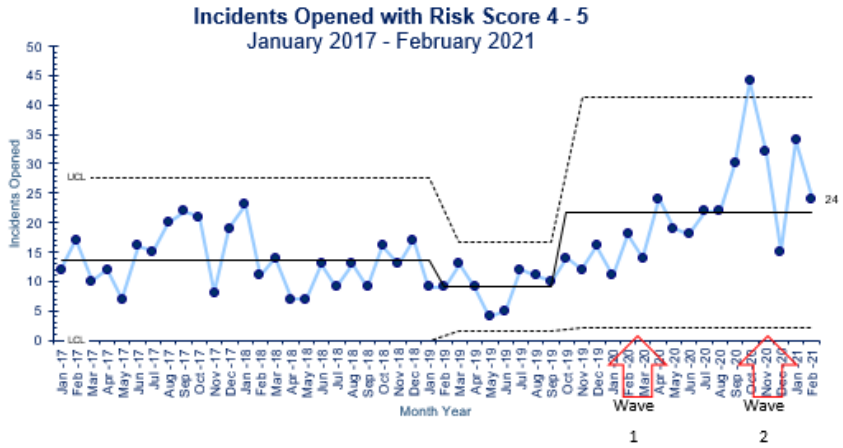


Figure Q2.3 - Highest number of incidents February 2021 by subcategory

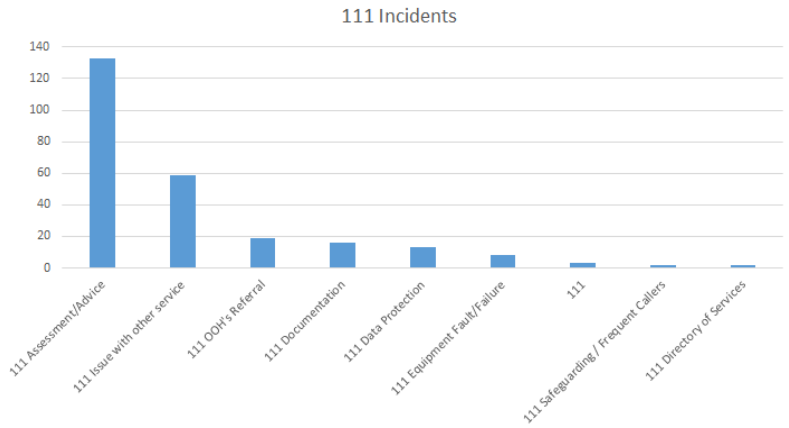
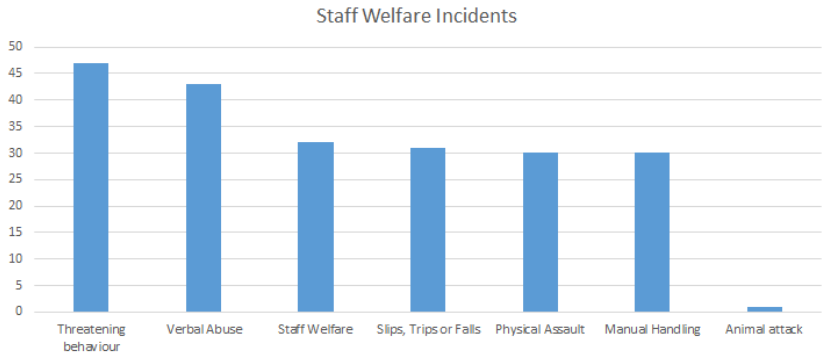


Figure Q2.4 - Second highest number of incidents February 2021 by subcategory



Incidents

In February 2021 1236 internal and external incidents were opened (Q2.1 and Q2.2), against a 12 month average of 1392.

In January 34 incidents were unscored which is above the Right Care Strategy goal of 25 unscored incidents in the previous month reported in the IPR.

In January there has been an increase in the number of incidents reported. The Clinical Safety Team continue to review covid-19 and IPC related incidents within each area. All incidents that the team review are risk scored and feedback is provided to the investigating officers.

Figures 2.3 and 2.4 are a breakdown of the top 2 reasons for incidents being reported which are 111 incidents and staff welfare. The charts show the subcategories within these top two categories.

For 111 incidents have been raised because of concerns about the assessment or advice given, because we have had issues with another NHS service, for documentation or data protection issues and also for vulnerable adults (safeguarding / frequent callers).

For staff welfare incidents the commonest reason for reporting is violence and aggression towards staff which includes threatening behaviour, verbal abuse and physical assault.

BAF Risk: SR01.

Figure Q2.5

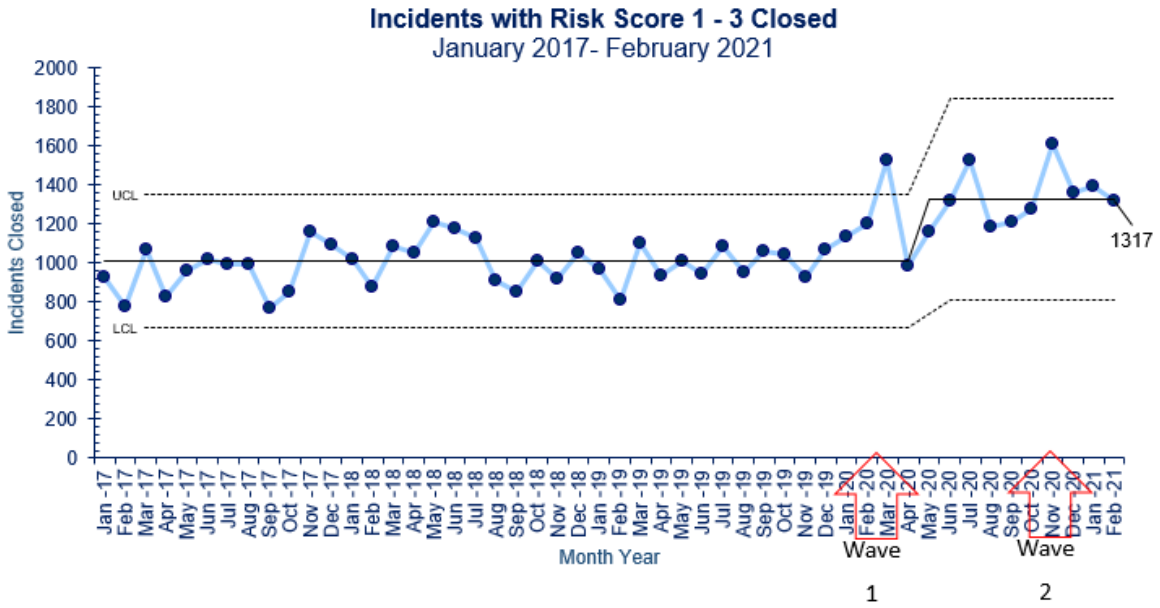
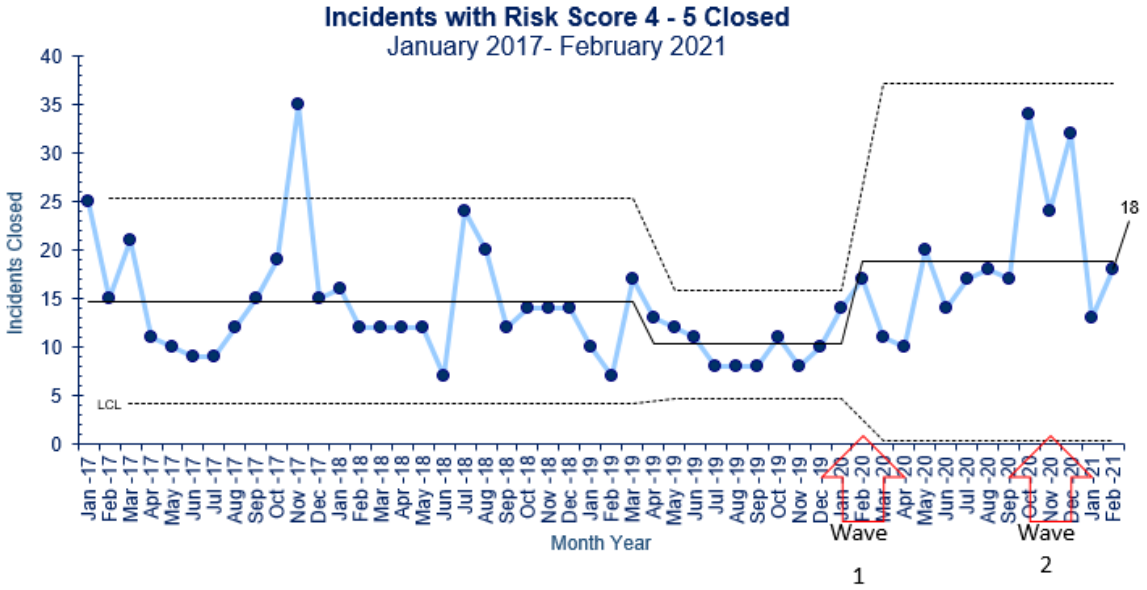


Figure Q2.6



Incidents Closure

In total, 1335 incidents (level 1-5) were closed during February 2021 (Q2.5 & 2.6)

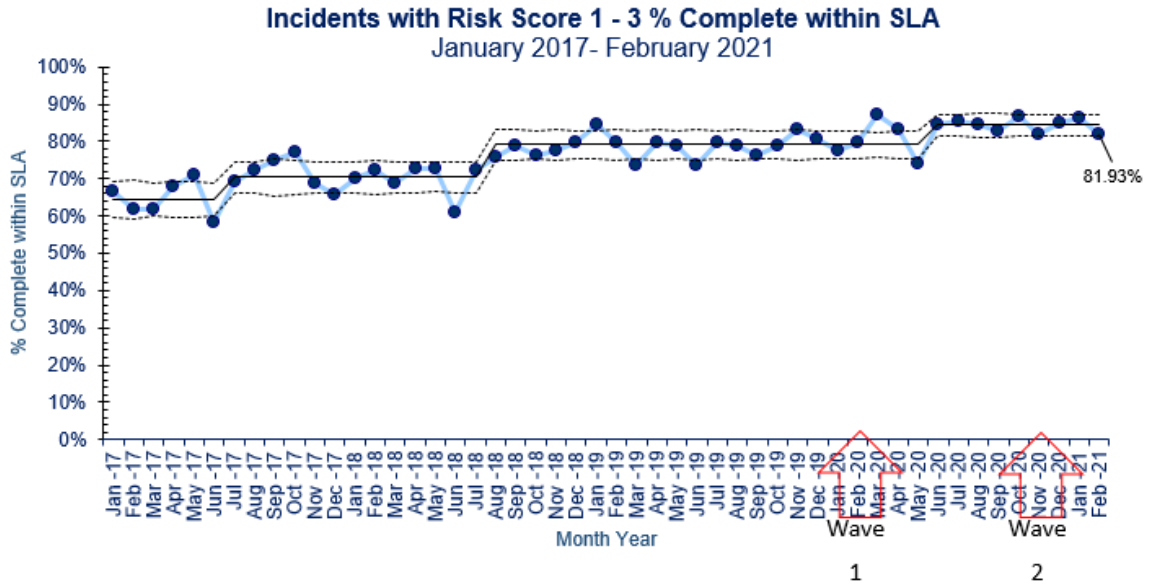
82% level 1-3 were closed within agreed standard (Q2.7) against the right care strategy goal of 85%.

83% of level 4-5 incidents were closed within the agreed standard (Q2.8) against a right care strategy goal of 80% for the end of 20/21.

During February 2021 the Trust has achieved the strategy goal of 80% of risk scored 4-5 incidents closed within the agreed timeframe for closure.

BAF Risk: SR01.

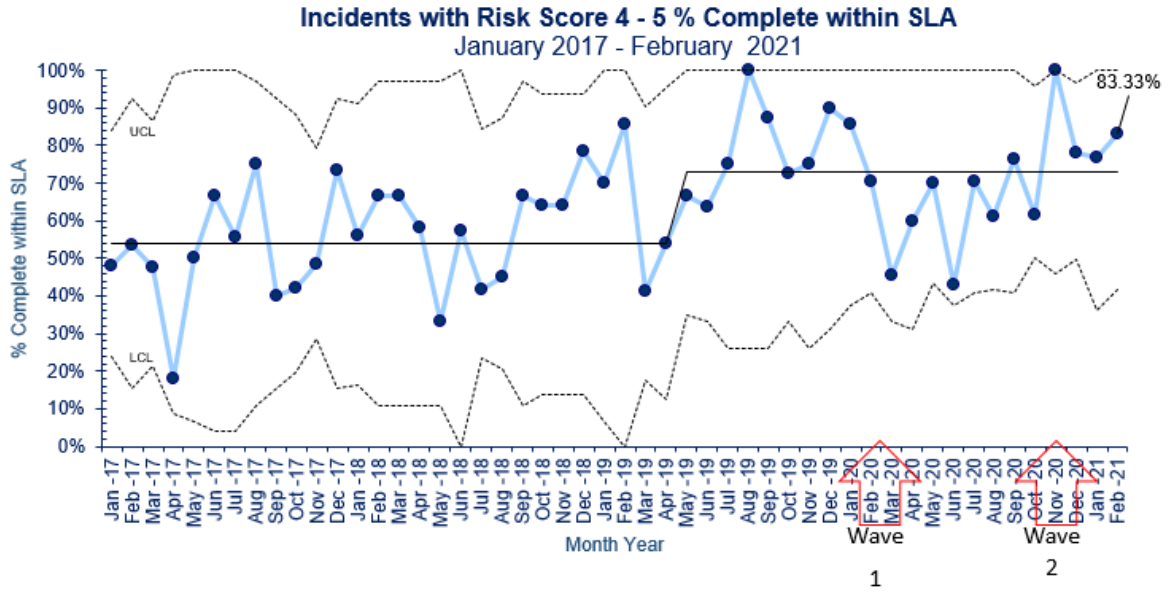
Figure Q2.7



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

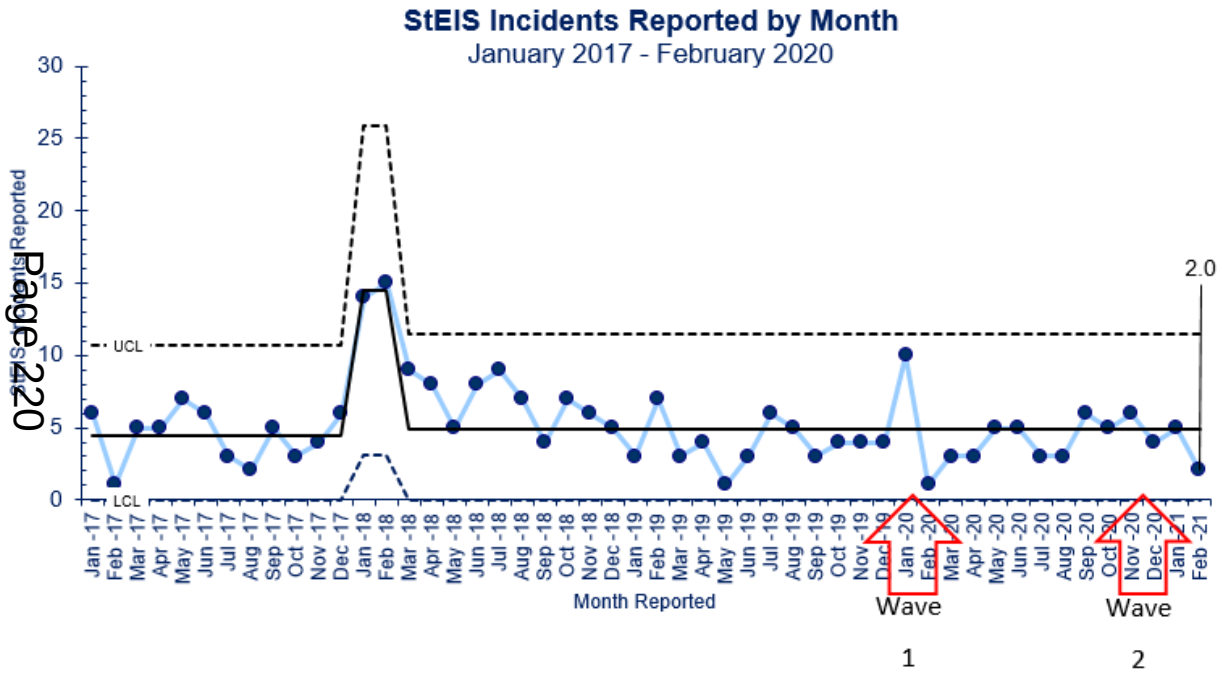
Risk Score	Target Days to Close Incident (From Date Received)
1	20
2	20
3	40
4	60
5	60

Figure Q2.8



Q3 SERIOUS INCIDENTS

Figure Q3.1



Serious Incidents

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

6 SI reports were due with the commissioners in February 2021. 5 were submitted within the 60-day timescale.

83% of the SI's reports due in December 2020 were submitted within the timescales which is below our right care strategy goal which is 95% for the Q4. However, we are seeing the benefits of the introduction of the serious incident review panel and are continuing with the trial.

The data (Q3.1) does signal a decrease which demonstrates that although the number of incidents risk scored 4-5 has stayed the same as January (Q2.6) we have seen fewer serious incidents.

BAF Risk: SR01.

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Mar 20 – Feb 21)	Number of Alerts Applicable (Mar 20 – Feb 21)	Number of Open Alerts
CAS/ NHS Improvement	34	1	1
MHRA – Medical Equipment	12	0	0
MHRA - Medicine Alerts	62	0	0
IPC	1	1	0

Alerts Applicable

1. Coronavirus is a viral disease (Covid-19). Coronavirus has been spreading throughout the world therefore it has been declared as a national pandemic and is still ongoing. 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 via D Bullock (LEAD and DiPC) and the Executive Leadership Committee (ELC).
2. Foreign body aspiration during intubation, under review with Medical director.

NWAS Response

There have been 6 new safety alerts in February 2021.

The total number of CAS/NHS Improvement alerts received between March 2020 and February 2021 is 34, with 1 alert applicable.

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

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

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

BAF Risk: SR01.

E1 PATIENT EXPERIENCE

Figure E1.1

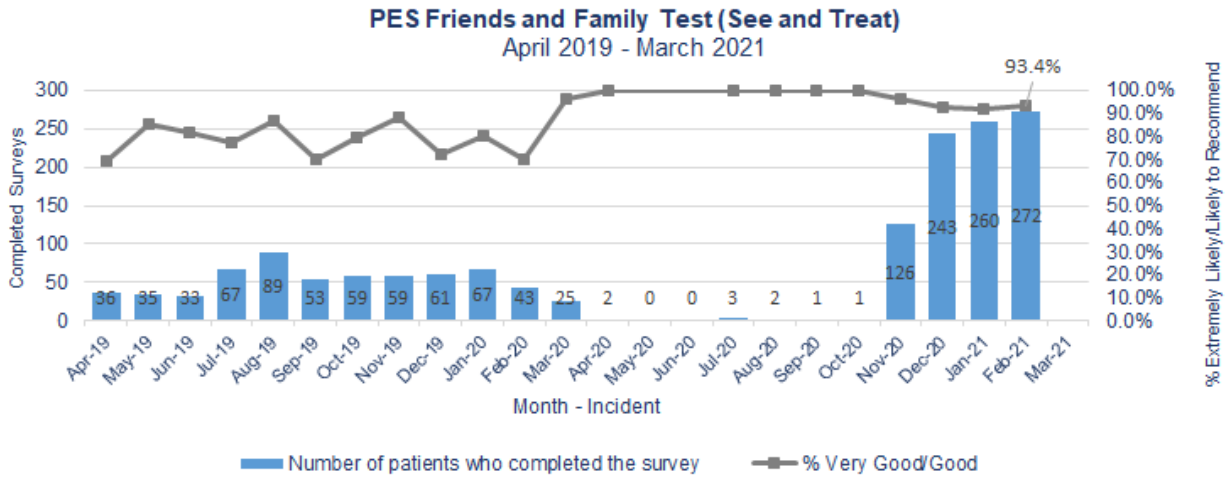
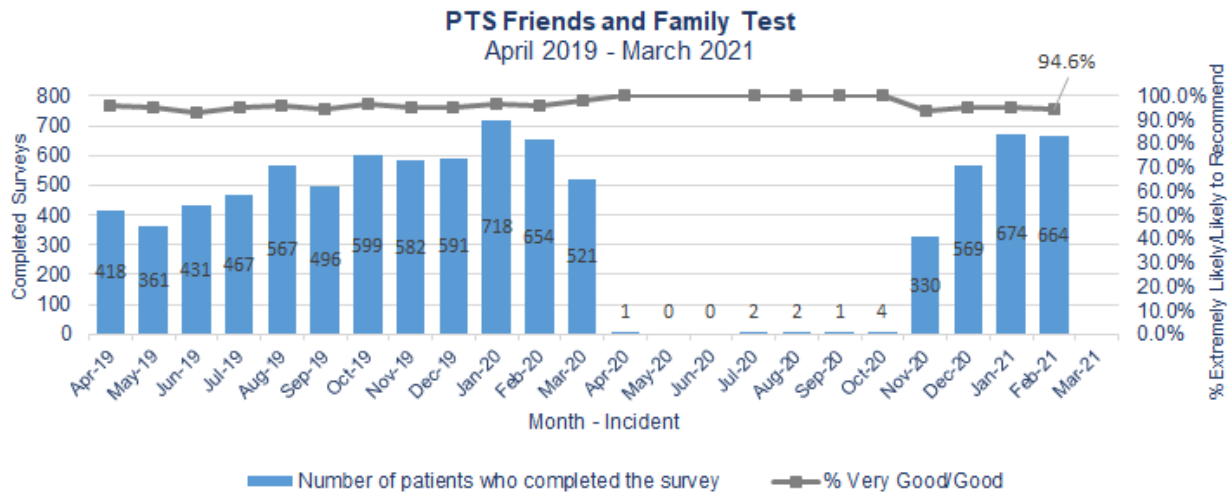


Figure E1.2



Patient Experience

Because of the COVID-19 pandemic, NHS England suspended the FFT process at the end of Q4 2019/20, resulting in no submission of data from the April reporting window with submission recommencing in November 2020. Due to a change in national guidance submission is no longer required for PES FFT feedback. Instead, ambulance trusts are required to undertake a piece of co-production work with patients. NWAS is working with its patient and public panel to deliver the co-production work but will continue to update the Board on the FFT returns it receives.

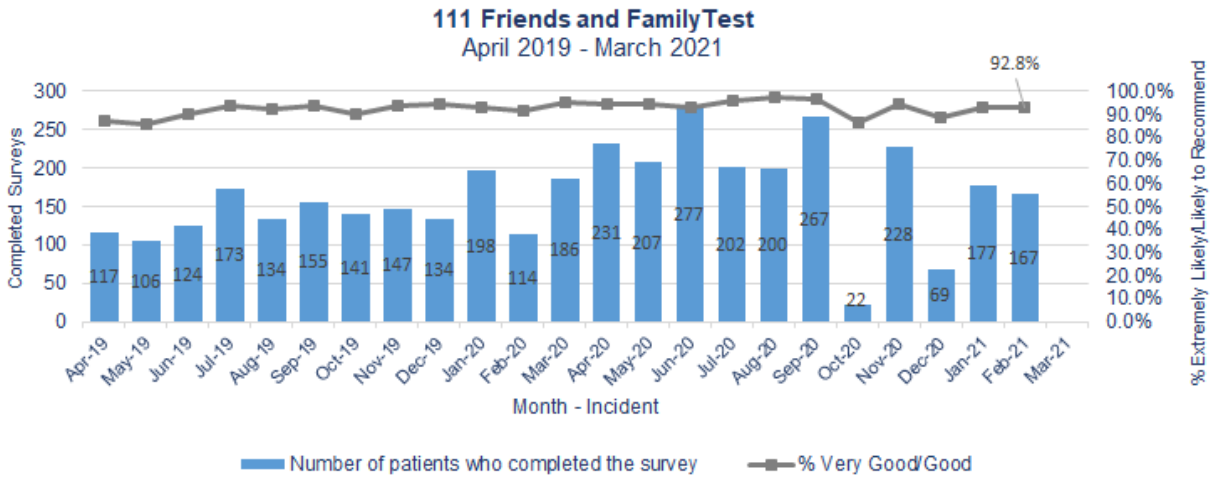
Patient Experience (PES)

In November 2020, we resumed the issue and collection of PES FFT feedback, via use of SMS, with the number of returns increasing above pre-suspension levels, (126 returns in November and 243 in December).

In January 2021, we saw 260 returns, (an increase of 6.9% from the previous month), with February bringing 272 returns (an increase of 4.6% on January).

An increase in returns has brought about some variance in the responses but satisfaction levels remain high, with an increase of 1.5% from January (91.9%) to 93.4% for February.

Figure E1.3



Patient Experience (PTS)

IIn November 2020, national collection of FFT PTS data was restarted and we saw a substantive increase in returns, surpassing levels prior to suspension, (with 330 returns in November and 569 in December).

In January 2021, we saw 674 returns, (an increase of 18.5% from the previous month), with February seeing 664 returns (a slight drop of 1.5% on January).

Satisfaction levels remain high, with a slight reduction of 0.4% from January (95.0%) to 94.6% for February.

PTS FFT returns are undertaken via SMS usage only at present.

Patient Experience (111)

The number of NHS 111 FFT returns decreased by 5.6% to 167 in February from 177 in January.

There was also a drop of 0.4% in satisfaction levels from 93.2% for January to 92.8% in February.

NHS 111 FFT returns are undertaken via use of the NHS 111 postal survey and not use of SMS which is currently used for PES and PTS FFT feedback purposes.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

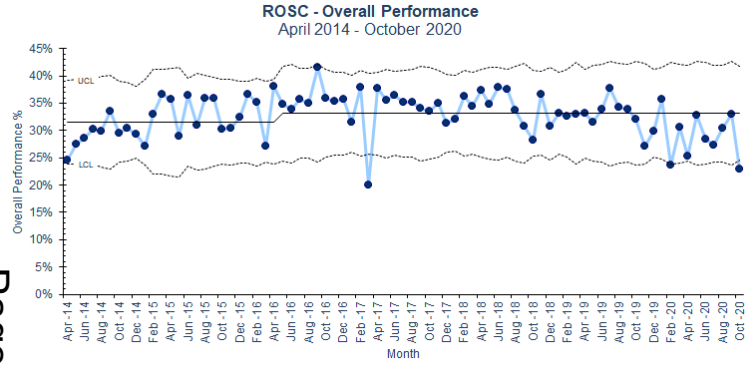


Figure E2.2

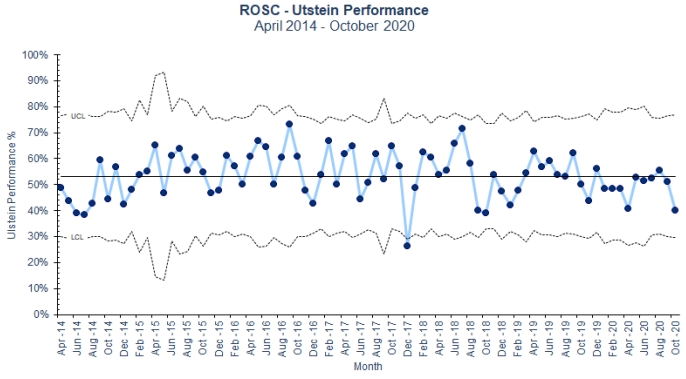


Figure E2.3

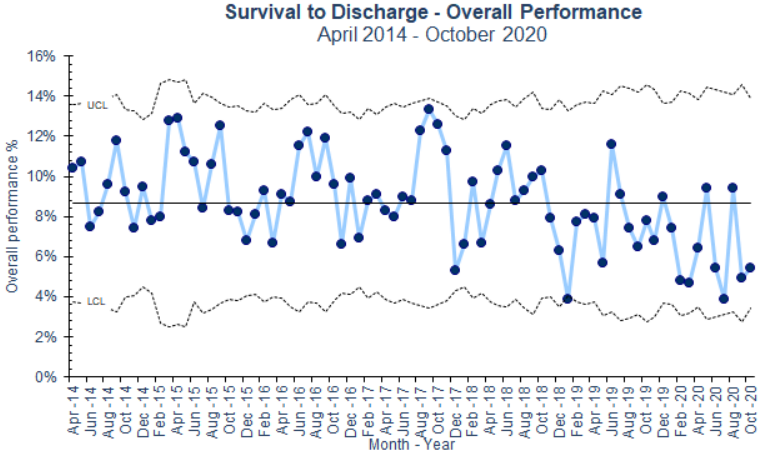
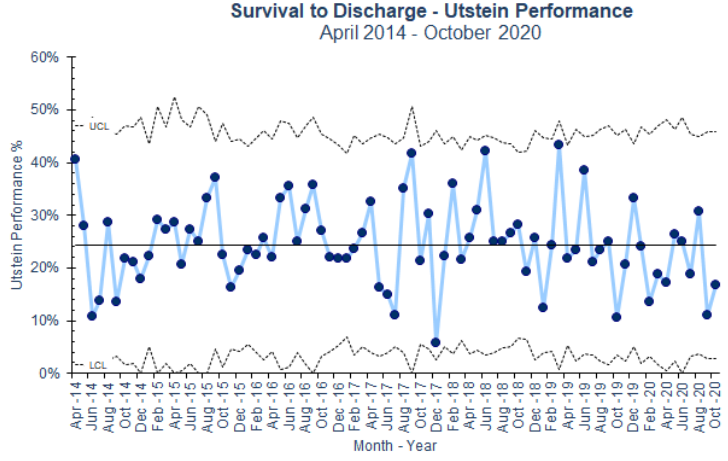


Figure E2.4



ACQIs (up to October 2020)

Overall, we are seeing no change in our data for the clinical quality indicators. (excluding E2.1 outlined below). Rankings change from month to month but overall there is no significant change (common cause variation). The lag in data make it difficult to understand the impact of any recent work to improve in these areas and supplementary measures to give us a more recent picture are being explored.

In October, the rates of the Return of Spontaneous Circulation (ROSC) overall performance (E2.1) signals a significant change with the data point below the lower control limit (special cause variation). The reasons for the performance level in October are multifactorial. For both DOA and TOR October saw the largest year on year increase except for March, with emergency incidents in October being 16% higher than the year to date average at that point. During October we also saw the impact of staff isolations due to Covid with cover at 97.1% and 95.1% on weekdays and weekends, respectively. The trust saw hospital turnaround of 32 mins 32 seconds with 55 incidents over an hour for total turnaround. Since October we have seen an improvement in turnaround time and less abstractions. Both these actions should improve our performance for ROSC.

The ROSC achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group (E2.2.) was 40% (national mean 42.8%), ranking us 7th nationally.

5.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (E2.3). The national mean is 7.9% This performance ranked the Trust in 7th position.

The figure for the Utstein sub-group (E2.4) was 16.7% (national mean 20.5%) which saw the Trust ranked 8th for English ambulance trusts.

For the overall group, the rate was 23% (national mean 25.5%) ranking the Trust in 8th position nationally.

The STEMI care bundle result of 76.5% was fractionally ahead of the national mean of 76.4%. Care bundle data for stroke and sepsis was not published for October as is consistent with the NHSE reporting schedule.

Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

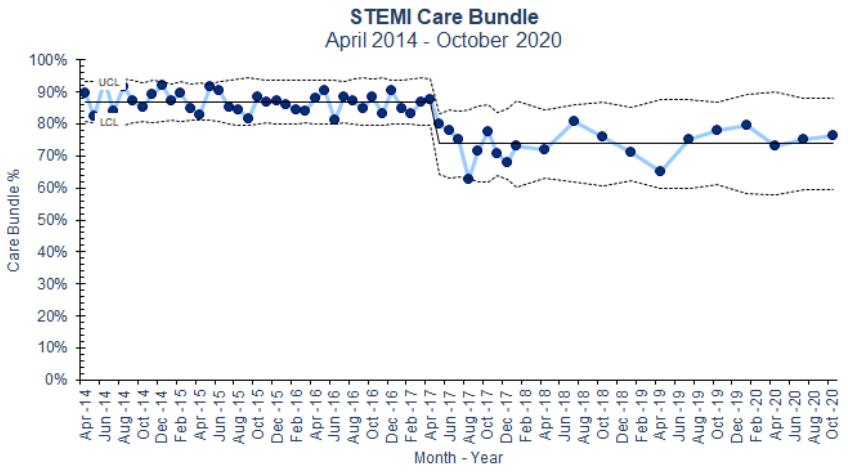
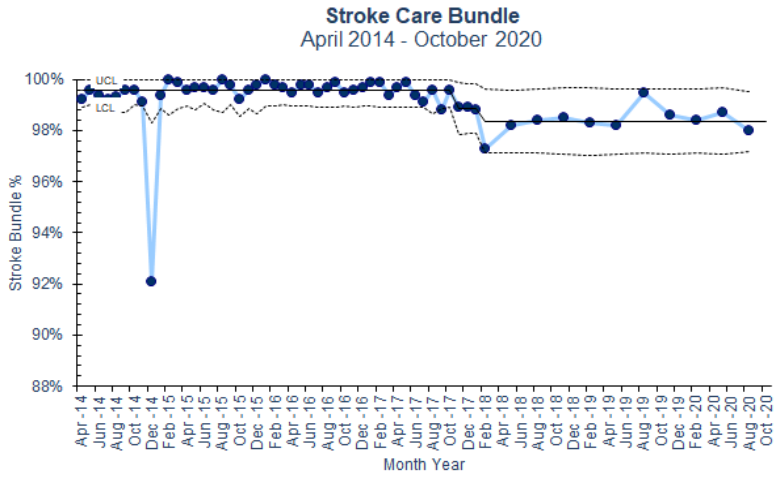


Figure E2.6



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).

Figure E2.7

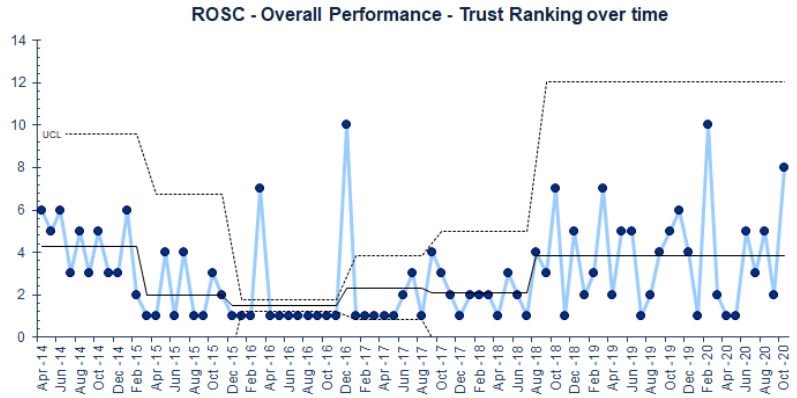
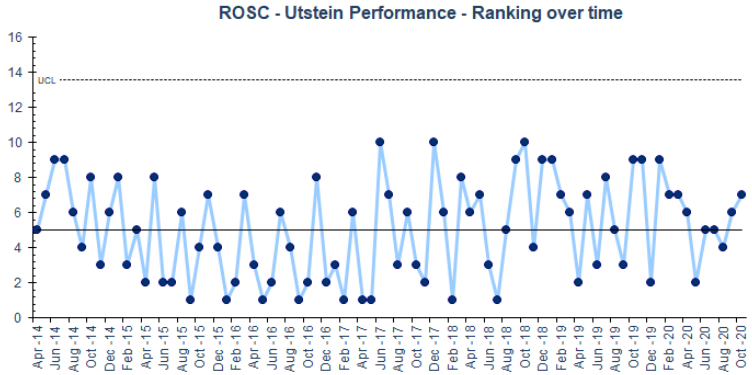


Figure E2.8



***NEW CHART** – this shows our change in the national ranking tables since June 14 on key metrics (1 is best, 10 is worst)

Figure E2.9

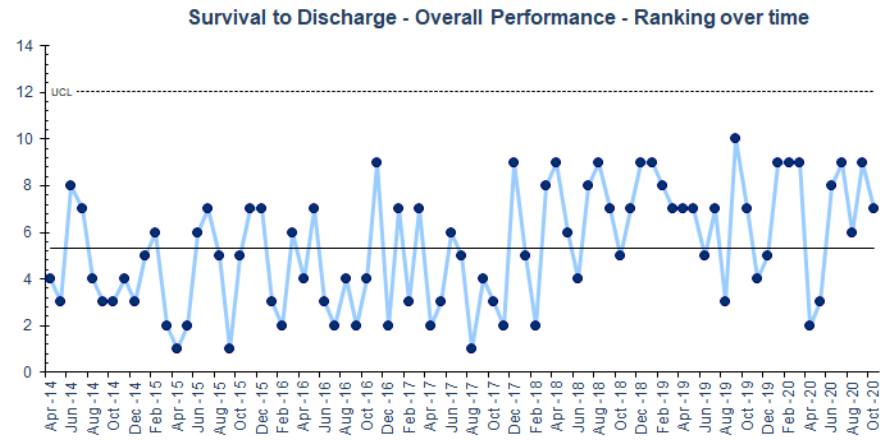


Figure E2.10

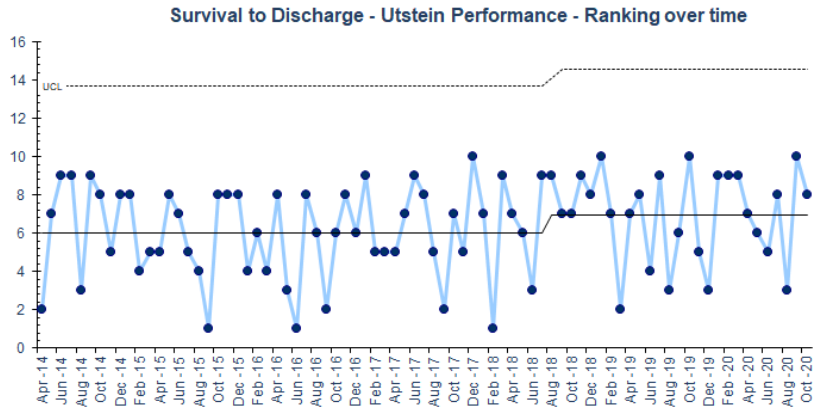


Figure E2.11

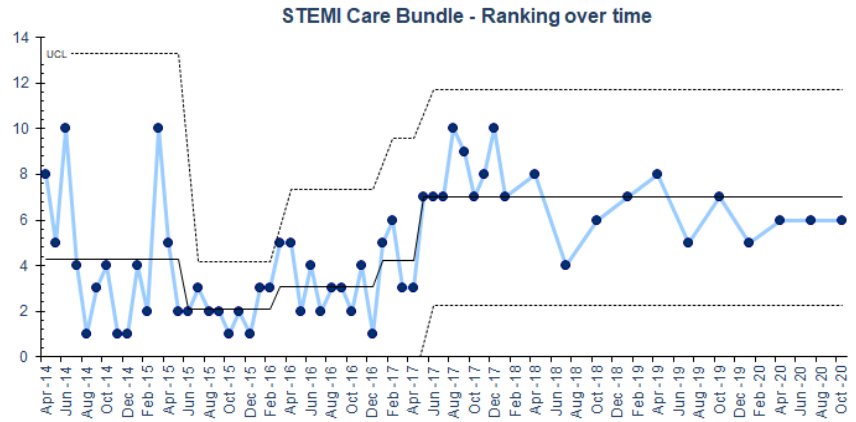
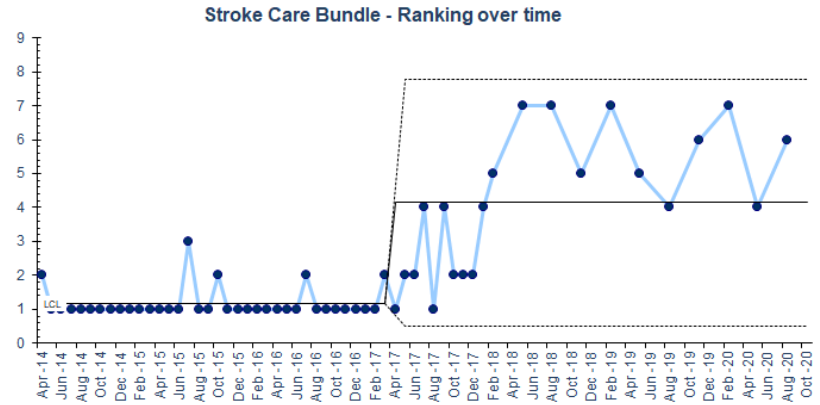
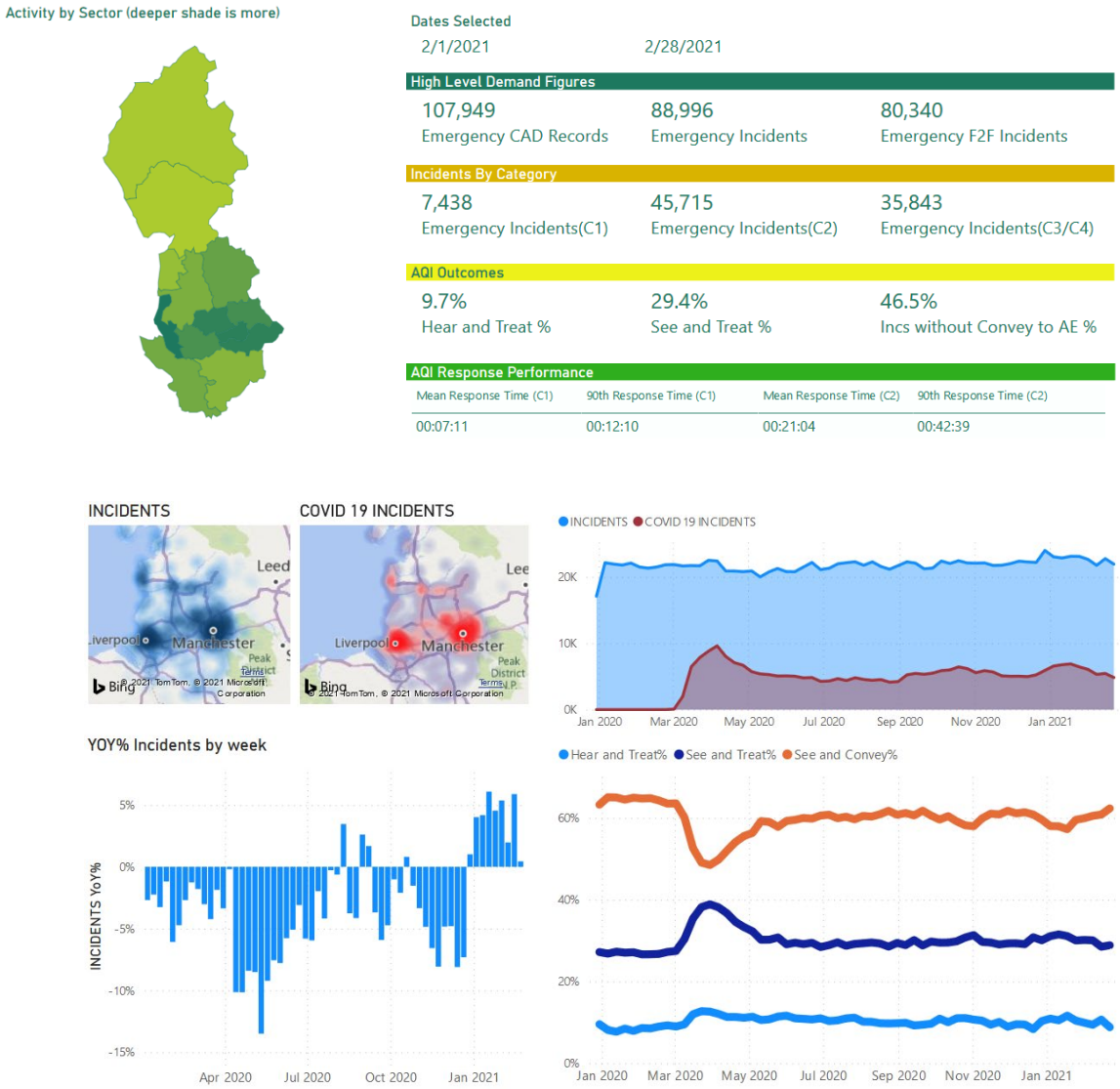


Figure E2.12



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

Figure E3.1



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

The Trust continued to deliver impressive levels of Hear & Treat throughout the first two months of the year. The regional response has provided some capacity with Clinical Assessment and Locality Clinical Assessment services that has helped to augment the Hear & Treat capability within the NWAS Clinical Hub. This means that H&T levels have consistently close to 10% throughout February. It is clear that the intense COVID activity has considered the need for patients to be managed away from ED whenever possible, helping to reduce nosocomial infections as much as possible. We continue to work with local providers to ensure that codesets are refined in a way that learns from COVID and maximises opportunities for patients to received early clinical input.

See & Treat for the period have stabilised at c 29.5% approximately 2% above the pre-COVID baseline. However, as the presentation profile of patients adjusts to pre-COVID levels, we have seen a marginal increase in the number of patients being managed by conveyance to a receiving unit. Those patients conveyed are often managed away from type 1 and 2 emergency departments with greater use of SDEC facilities emerging throughout quarter 1. Charts that H&T and S&T both tend to increase due to a higher emphasis in community based management. This was evident in wave 1 and again during peaks in November and January.

We are ranked 9th for See and Treat nationally and 9th for See and Convey which is the third highest in terms of patients conveyed.

The See and Convey figure includes 53.48% convey to ED and 7.4% convey to non ED.

Figure E3.4

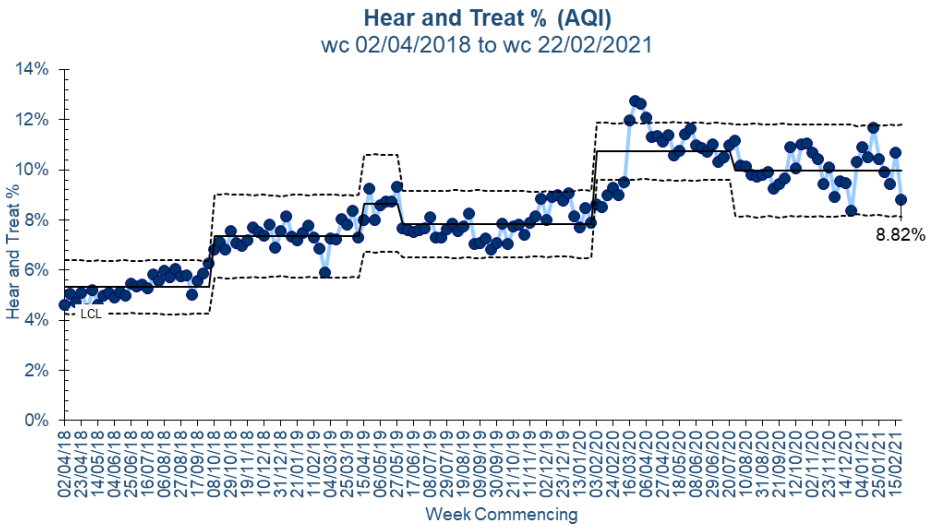


Figure E3.5

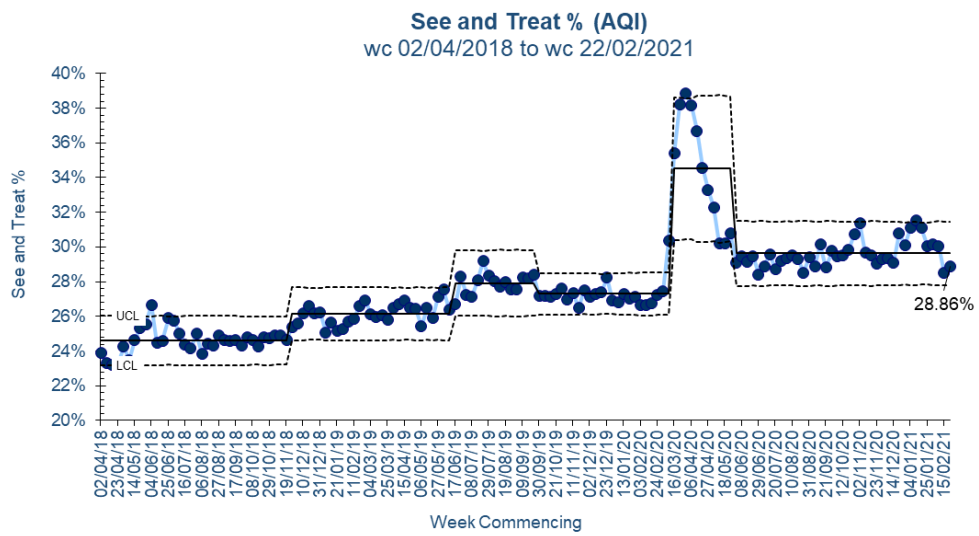


Figure E3.6

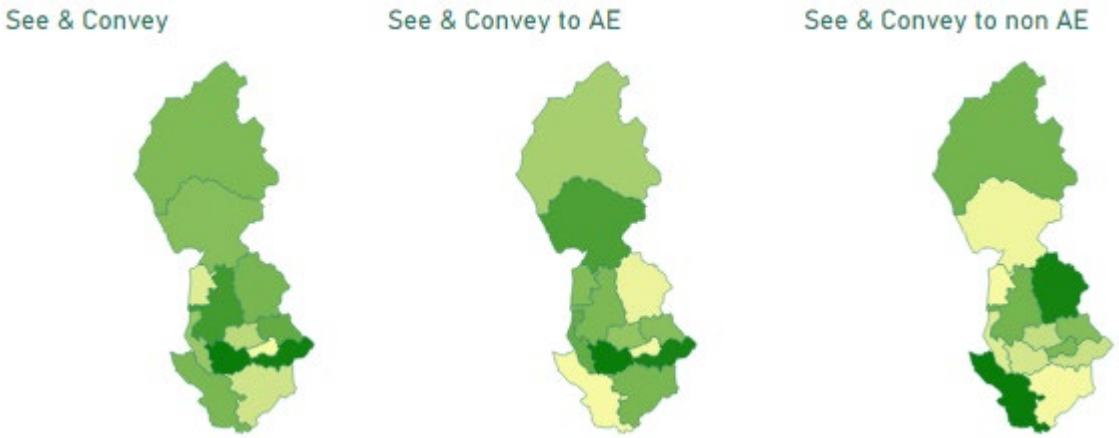
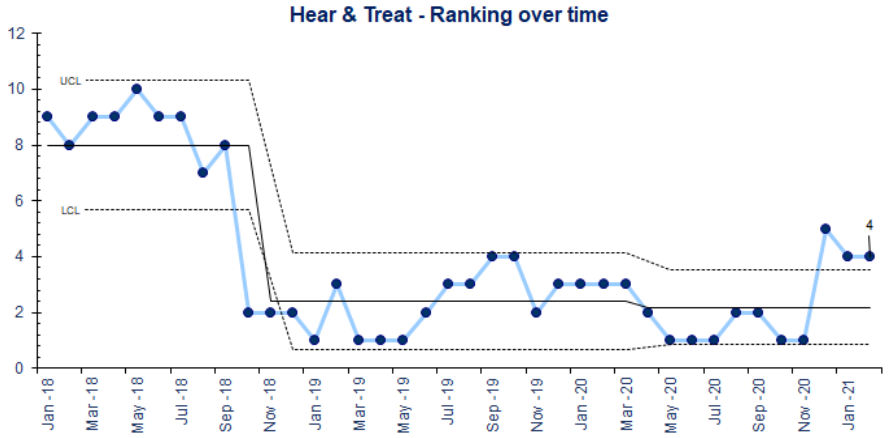
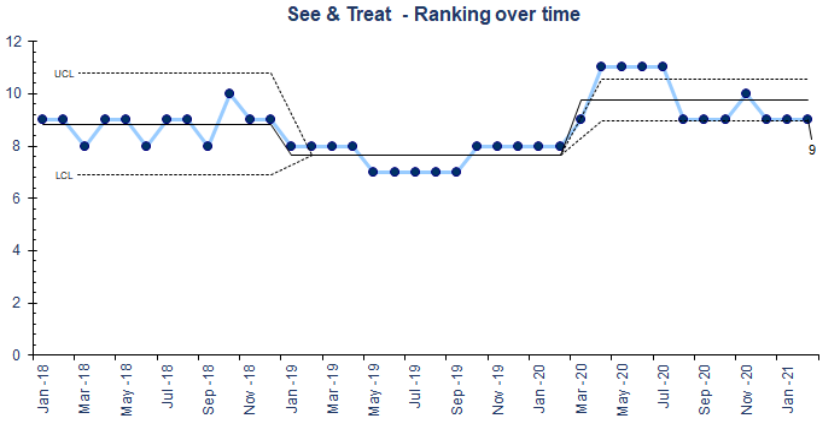


Figure E3.7



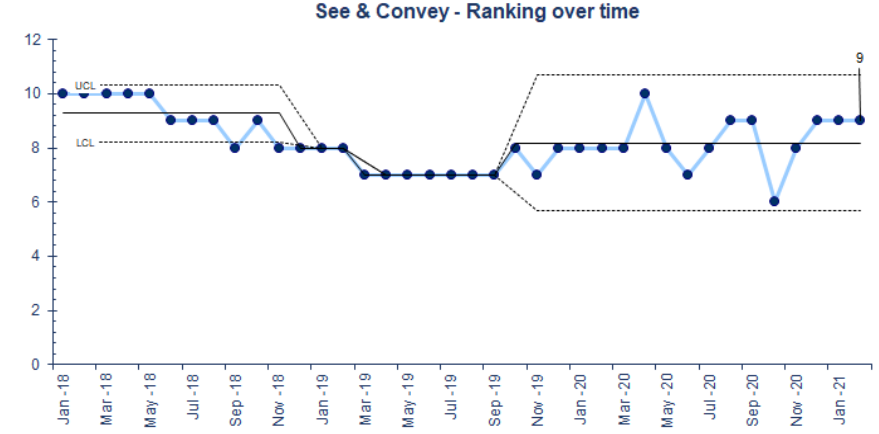
FigureE3.8

Provider	Hear & Treat
London	10.6%
South Central	9.9%
East of England	9.8%
North West	9.7%
Yorkshire	9.4%
East Midlands	8.9%
North East	8.9%
Isle of Wight	7.8%
South East Coast	6.1%
South Western	5.4%
West Midlands	4.7%



Provider	See & Treat
South Western	40.0%
West Midlands	39.4%
South Central	35.1%
South East Coast	35.1%
East of England	33.5%
East Midlands	33.3%
Isle of Wight	33.3%
London	32.5%
North West	29.4%
Yorkshire	28.8%
North East	27.5%

Figure E3.9



Provider	See & Convey
South Western	54.6%
South Central	55.0%
West Midlands	55.9%
East of England	56.7%
London	57.0%
East Midlands	57.8%
South East Coast	58.7%
Isle of Wight	58.9%
North West	60.9%
Yorkshire	61.8%
North East	63.6%

F1 FINANCIAL SCORE

Figure F1.1

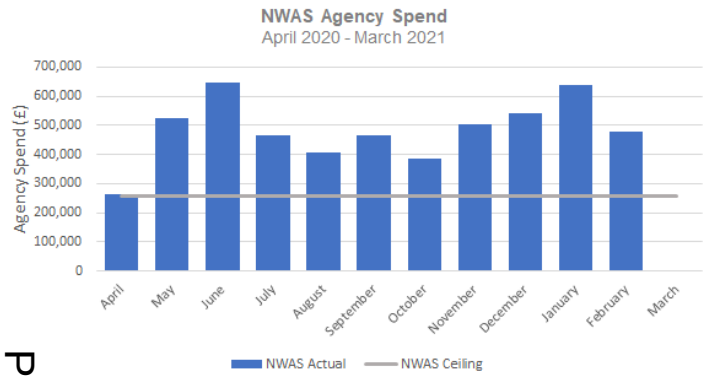


Figure F1.2

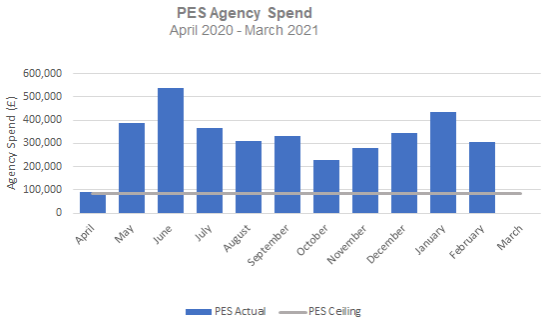


Figure F1.3

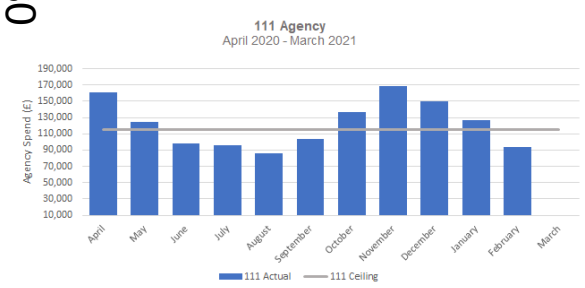


Figure F1.4

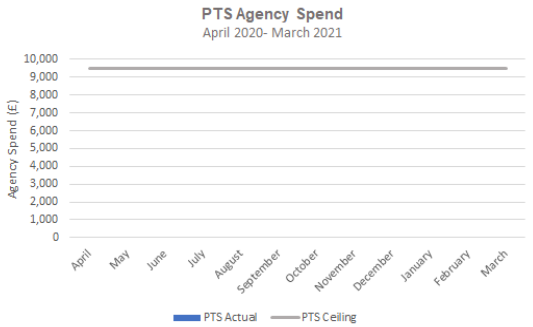


Figure F1.5

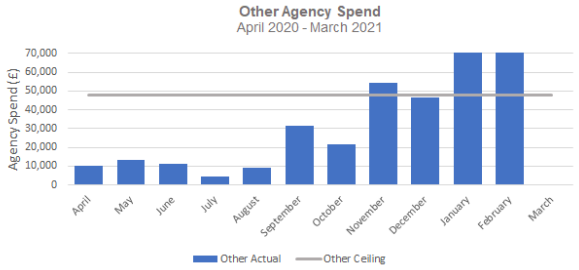
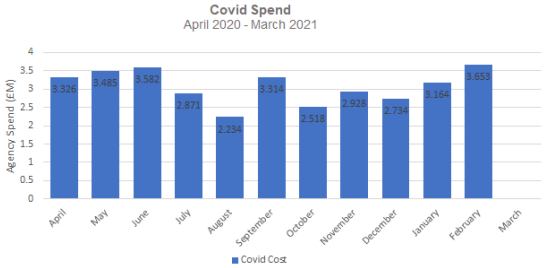


Figure F1.6



Finance Position – February 2021

Month 11 Finance Position:

Agency Expenditure

The year-to-date expenditure on agency is £5.319m which is £2.469m above the year-to-date ceiling of £2.850m.

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

For the eleven months of the Covid-19 framework, the 2020/21 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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O1 CALL PICK UP

Figure O1.1

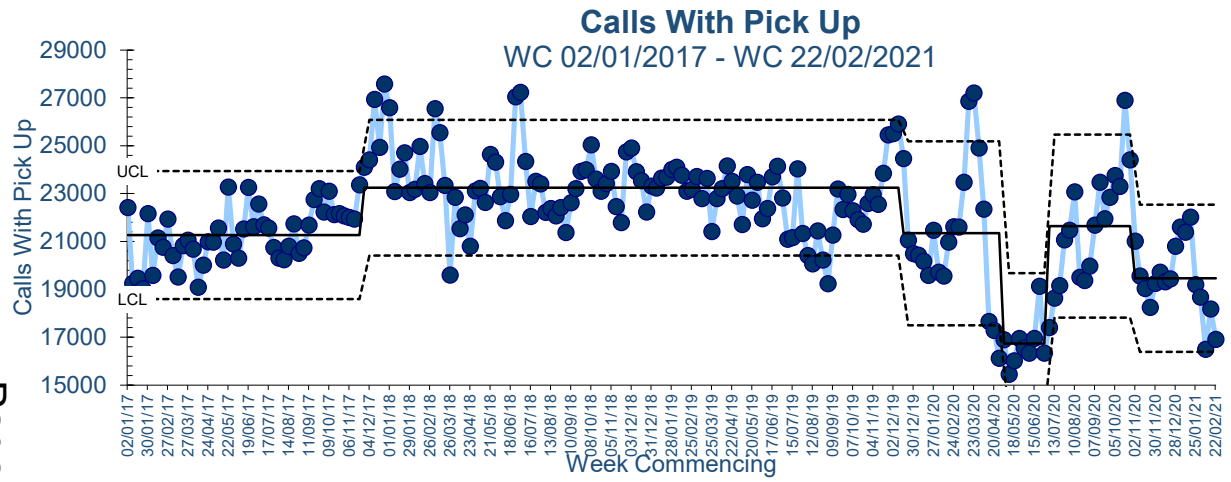
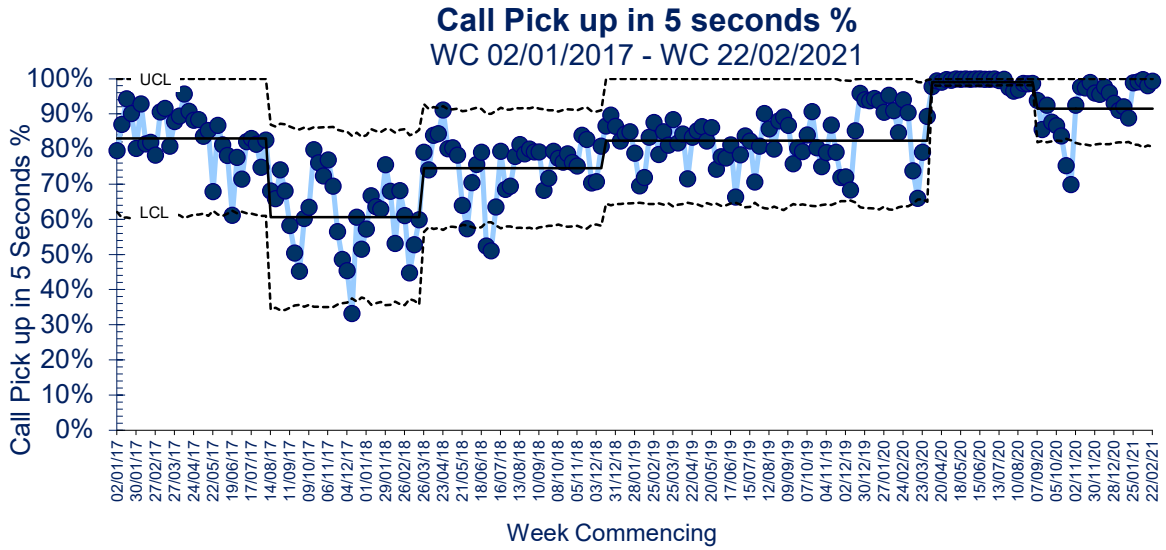


Figure O1.2



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 handling performance continues to be excellent when appraised against all key metrics. The percentage of calls answered in 5 seconds was 99.05% for February 2021. Mean, 90th centile and 95th centile are 1 second. The outstanding levels of call pick up are enabling improvements in both C1 and C2 response times. In addition, NWAS's EOCs have continued to support other Trusts, with frequent support being provided to Scotland.

Figure 01.1 demonstrates a significant change with data points close to the lower control limit (special cause variation). This is a reflection of the reduction in calls being received by NWAS. This can be attributed to a reduction in incidents vs January and a reduction in duplicates calls due to improved response times, especially C2 and C3.

Figure 01.2 signals a significant change with data points on the upper control limit (special cause variation). This is due to the improved call pick up performance and consistency of call pick up. Abstractions have improved in February and continued into March. The increase in workforce metrics indicates the improved performance will be maintained.

O2 A&E TURNAROUND

Figure O2.1

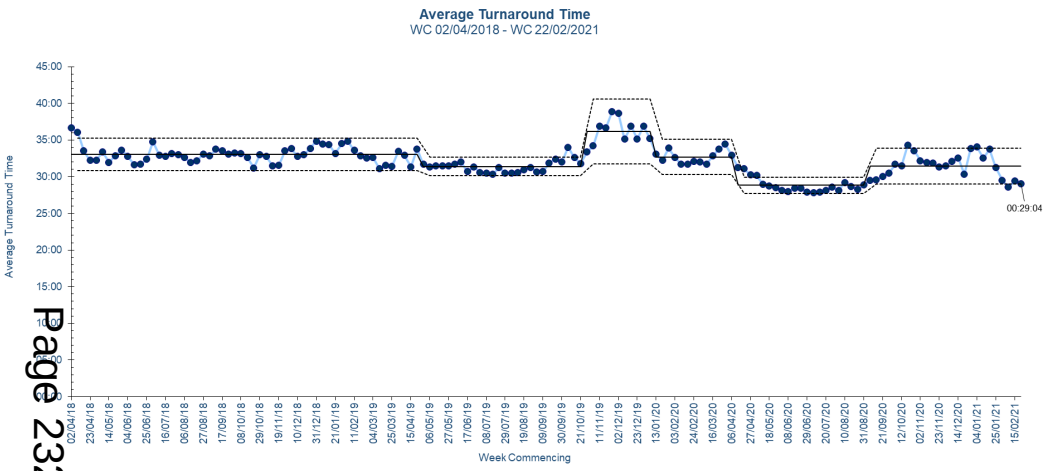


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Mar-20	49,419	32:37	20:54	11:26
Apr-20	41,267	31:58	19:45	12:06
May-20	47,637	29:10	17:08	11:47
Jun-20	49,207	28:14	16:43	11:21
Jul-20	52,551	28:05	16:44	11:10
Aug-20	52,059	28:33	17:28	10:52
Sep-20	49,946	29:37	18:45	10:53
Oct-20	51,452	32:32	21:47	11:04
Nov-20	49,885	31:49	20:31	11:08
Dec-20	53,723	31:54	20:56	10:56
Jan-21	53,179	33:00	21:58	11:08
Feb-21	47,579	29:09	17:33	11:17

Figure O2.2

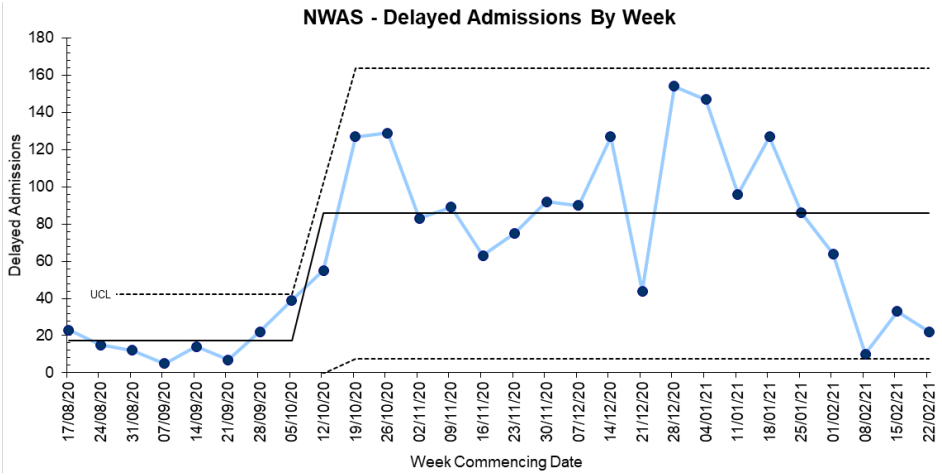


Table O2.2

Week Commencing	No. of Delayed Admissio	Week Commencing	No. of Delayed Admissio
17/08/2020	23	23/11/2020	75
24/08/2020	15	30/11/2020	92
31/08/2020	12	07/12/2020	90
07/09/2020	5	14/12/2020	127
14/09/2020	14	21/12/2020	44
21/09/2020	7	28/12/2020	154
28/09/2020	22	04/01/2021	147
05/10/2020	39	11/01/2021	96
12/10/2020	55	18/01/2021	127
19/10/2020	127	25/01/2021	86
26/10/2020	129	01/02/2021	64
02/11/2020	83	08/02/2021	10
09/11/2020	89	15/02/2021	33
16/11/2020	63	22/02/2021	22

A&E Turnaround Times

Average turnaround time shows a decrease for February with one of the last 4 data points being on, below or very close to the lower control limit (special cause variation). Average turnaround time was 29 minutes 09 seconds (Q2.1) and this is the first time since September that the trust has been within the national standard of 30 minutes. Even though we are meeting the standard as an average, there is significant variation within the aggregate performance. 1,055 attendances (2.2%) had a turnaround time of over 1 hour, with 18 of those taking more than 3 hours. This is a reduction from 2,910 in January. In February, 129 cases of delayed admissions were reported. This is significantly lower than the 528 in January.134 hours were lost to delayed admissions in February down from 699 in January.

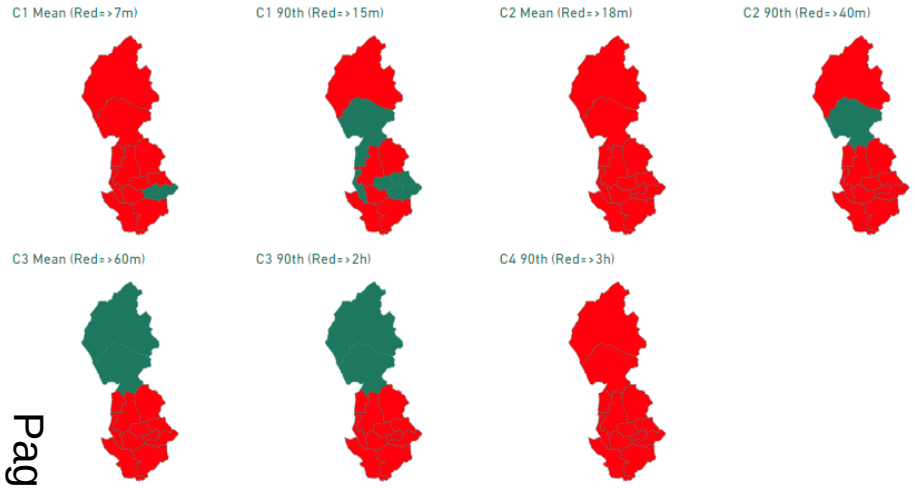
The top five trusts with the highest Arrival to Handover time are:

Royal Oldham - 00:24:32
Warrington - 00:23:50
Macclesfield - 00:22:28
Tameside - 00:20:18
Royal Albert Edward - 00:20:00

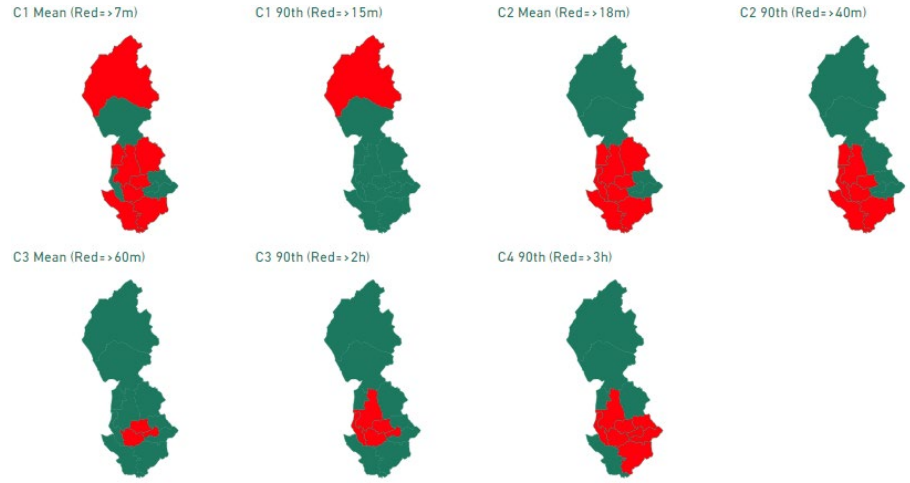
Whilst the Every Minute Matters improvement collaborative has paused to support the pandemic response the Trust continue to work with NW NHSEI and acute hospital partners across the region to address the increase in hospital handover times and associated safety and patient experience risks. The ops team are working with the QI team to identify a number of EDs to trial the Patient Safety checklist. This will aid both the ED and NWAS in improving handover and will also support patient safety, those handed over and waiting for a NWAS response. It is worth noting that handover to clear has been consistently strong at 11 minutes 17 seconds for February.

O3 ARP RESPONSE TIMES

January 2021



February 2021



measures are meeting standard

measures are below standard

Activity: ARP Response Times

For February, the response time targets were met for C1 90th , C3 mean and C3 90th.

Modelling work has been commissioned from ORH to inform future commissioning.

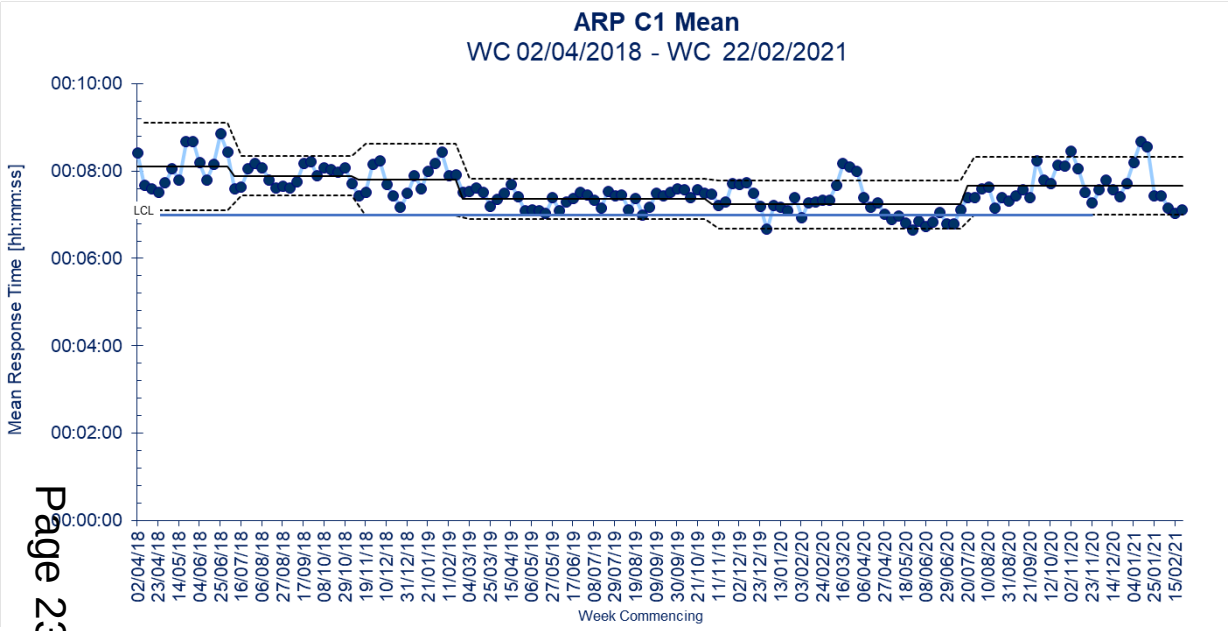
The improvement in all ARP measures (as seen on the comparison between January and February) is as a result of a number of factors.

- Lower Abstractions due to COVID-19
- Increased performance for call pick up
  - Lower call volume
  - Lower Duplicates
  - Decrease in COVID- 19 abstractions
- Increased DCA resource from PTS, VAS/PAS, Military (MACA) and up to 50 extra ECFRs
- Improvement in Hospital handover time
- Use of complimentary resources to increase clinical decision making on scene – through HART and SPTL structure
- Continue to engage locally, regionally and nationally regarding Hospital Handover challenges

Although not all targets have been met, all the data are signalling that performance is stabilising at a new lower mean time and all signalling a change with data points on or close to the lower control limit in mid to late February (special cause variation). Should this continue then there will be a lower reset mean for the next report (fig O3.1 - O3.7).

During February we saw 8.7% of calls were C1.

Figure O3.1



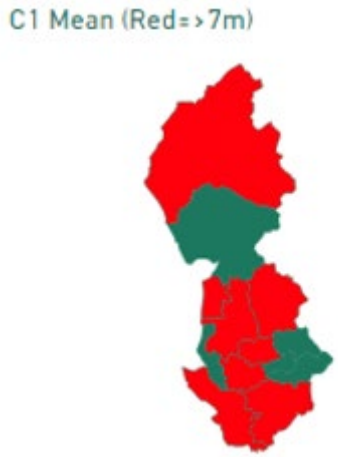
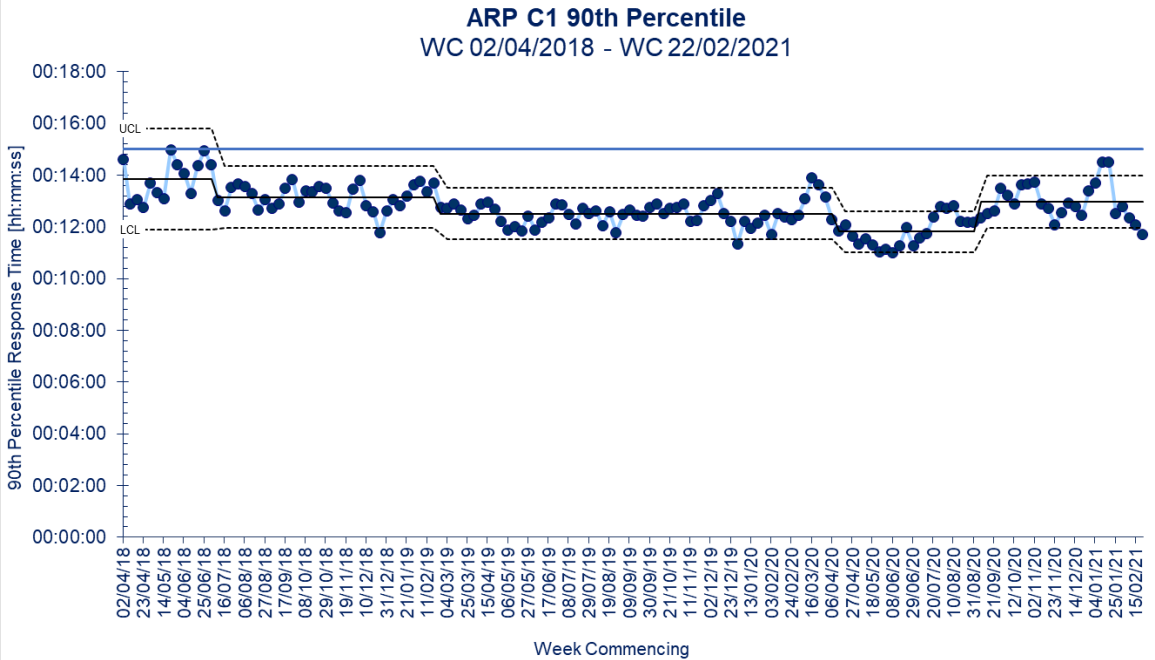


Figure O3.2



C1 Performance

C1 Mean

Target: 7 minutes

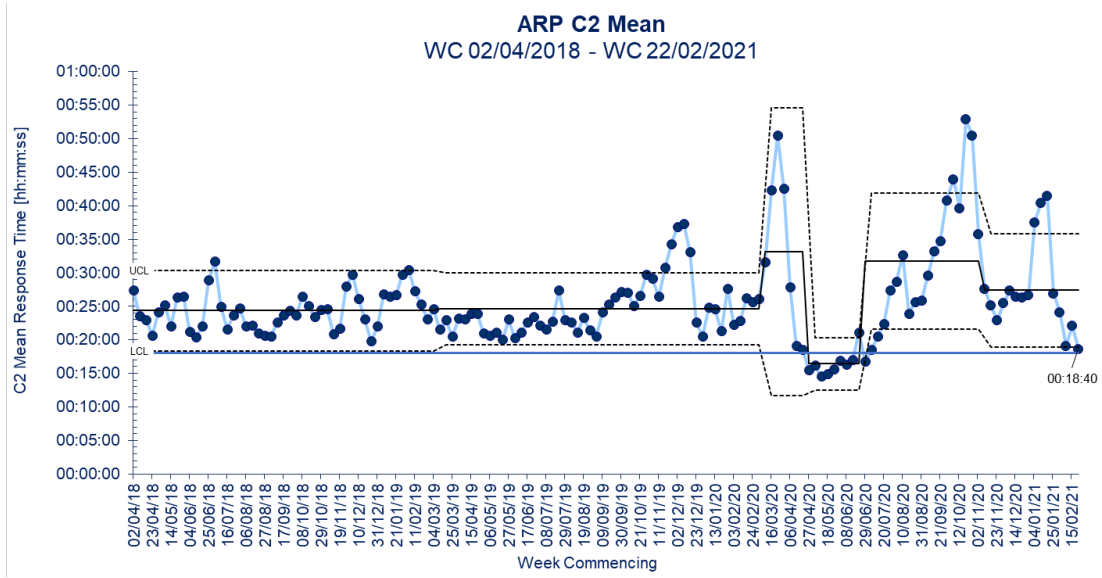
NWAS
February 2021: 7:11
YTD: 7:30

C1 90th Percentile

Target: 15 Minutes

NWAS
February 2021: 12:10
YTD: 12:34

Figure O3.3



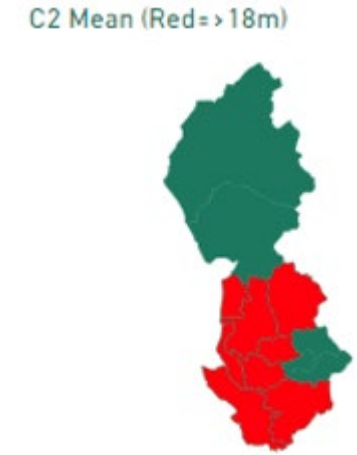
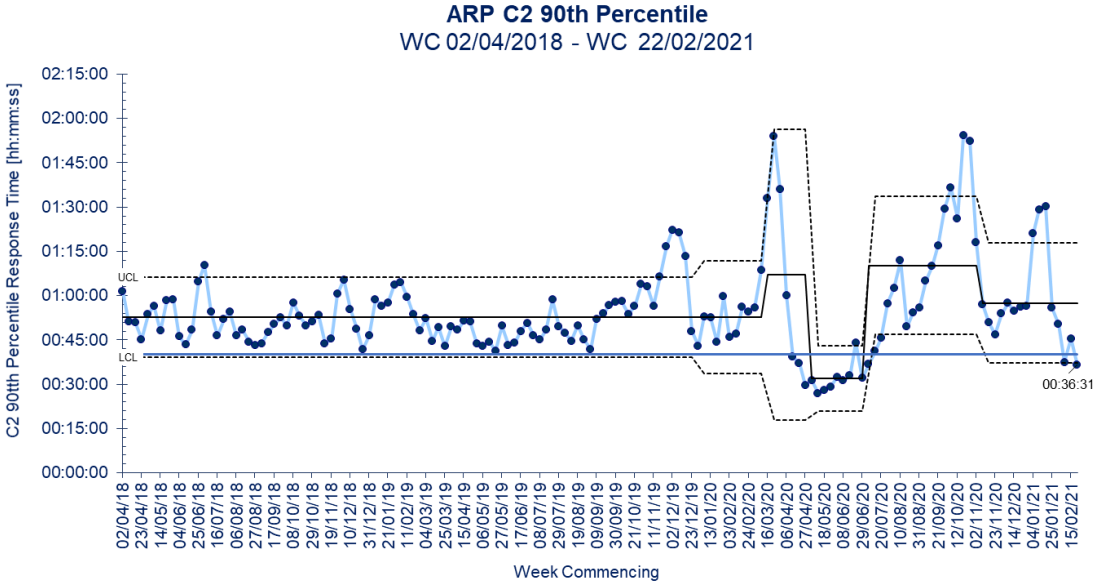


Figure O3.4



C2 Performance

C2 Mean

Target: 18 minutes

NWAS:
February 2021: 21:04
YTD: 27:28

C2 90th Percentile

Target: 40 Minutes

NWAS
February 2021: 42:39
YTD: 59:46

Figure O3.5

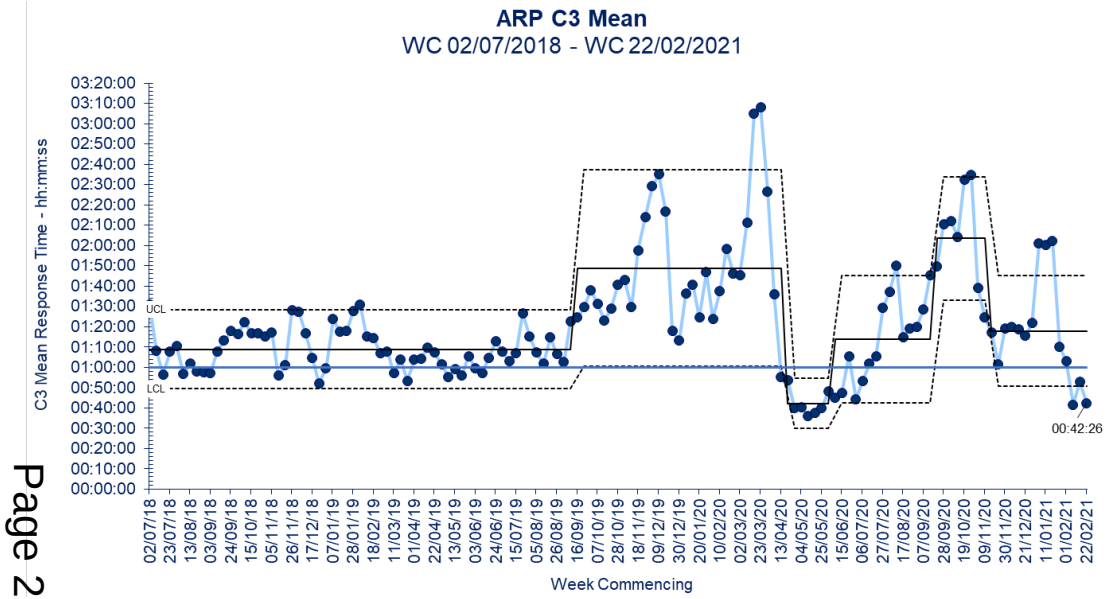
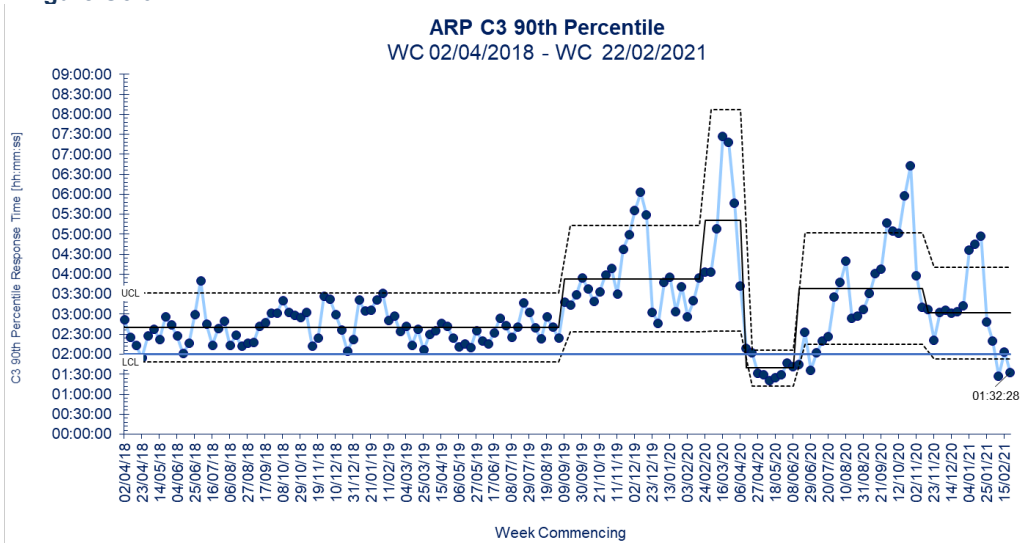


Figure O3.6



C3 Performance

C3 Mean

Target: 1 Hour

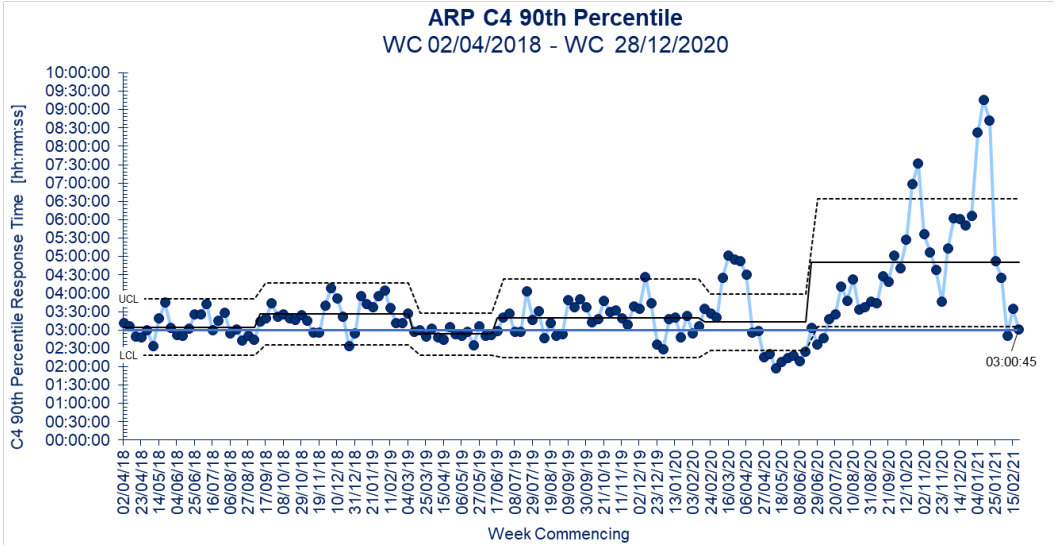
NWAS:
February 2021: 0:49:51
YTD: 1:18:22

C3 90th Percentile

Target: 2 Hours

NWAS
February 2021: 1:50:48
YTD: 3:07:07

Figure O3.7

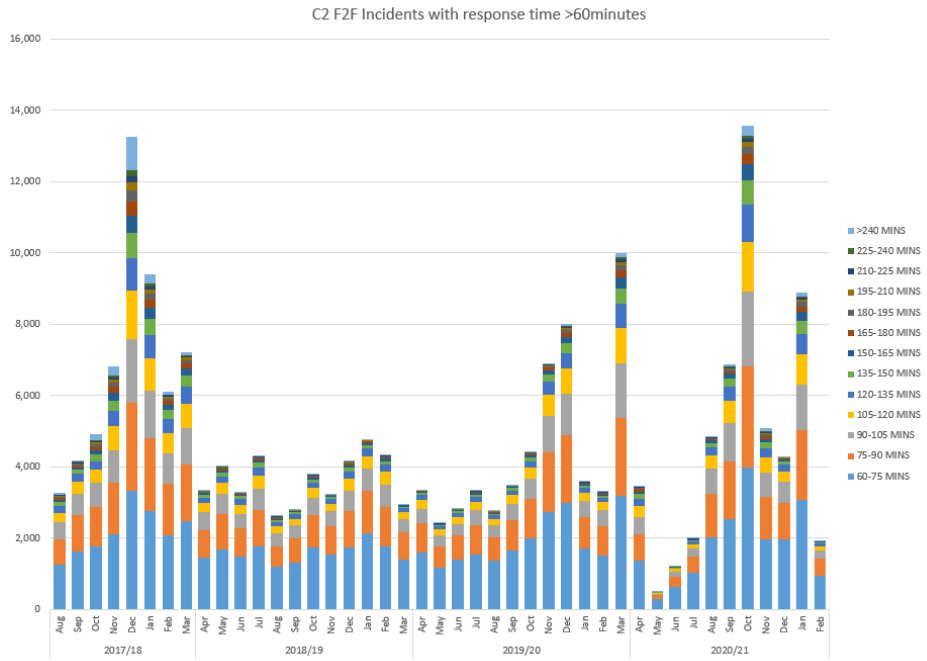


C4 Performance

C4 90th Percentile
Target: 3 Hours

NWAS
February 2021: 3:30:12
YTD: 4:07:00

Figure O3.8



C2 Long Waits

The data shows significant reduction in C2 long waits to the lowest level since June (Fig O3.8)

Figure O3.8

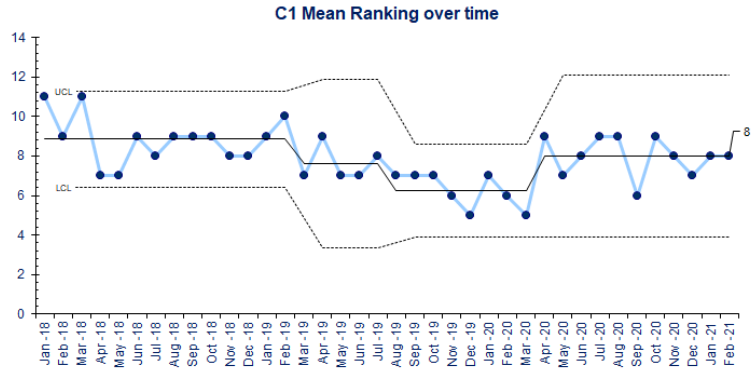


Figure O3.9

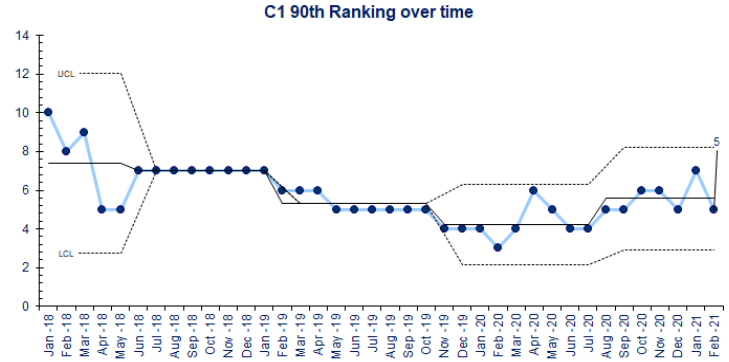


Figure O3.10

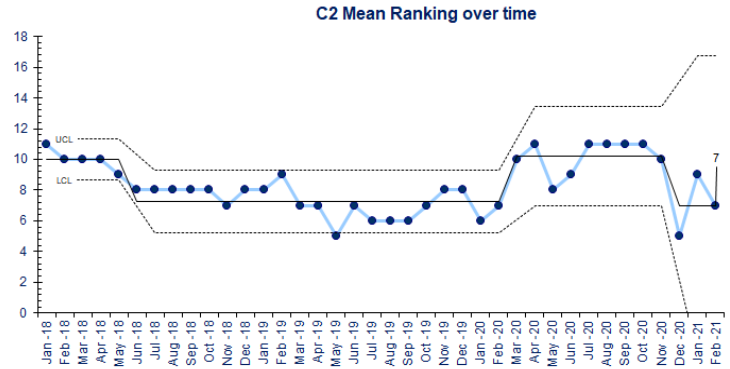


Figure O3.11

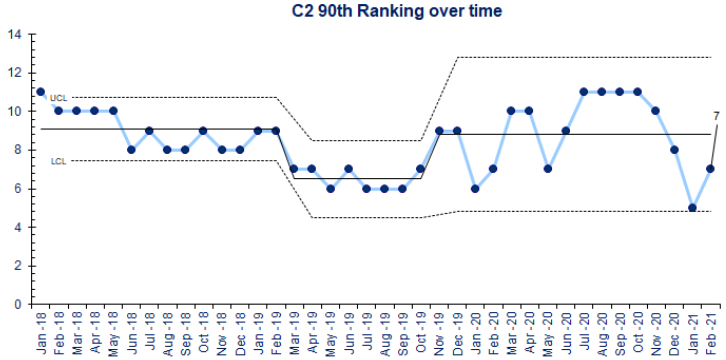


Figure O3.12

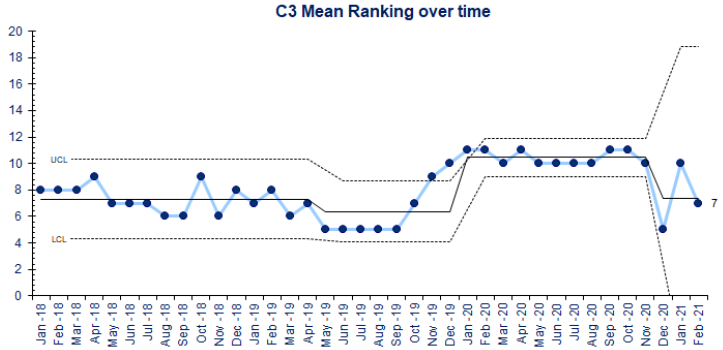


Figure O3.13

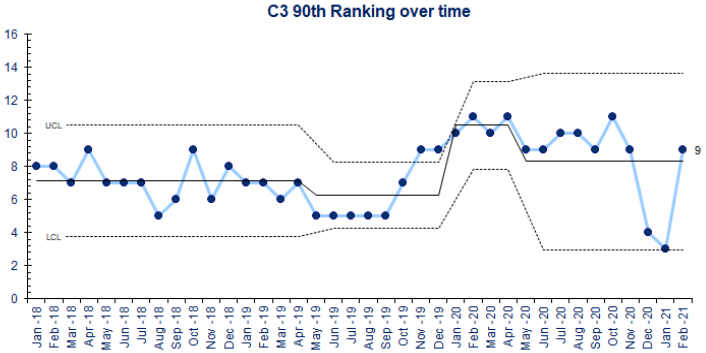
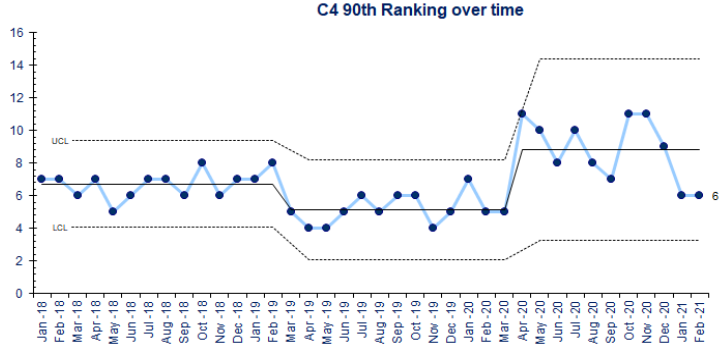


Figure O3.14



O4 111 PERFORMANCE

Figure O4.1

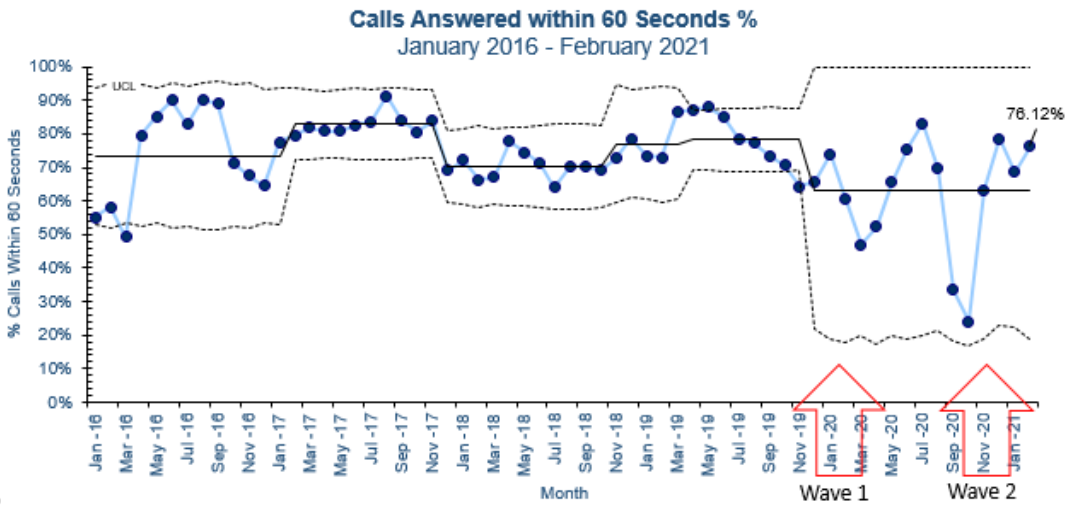
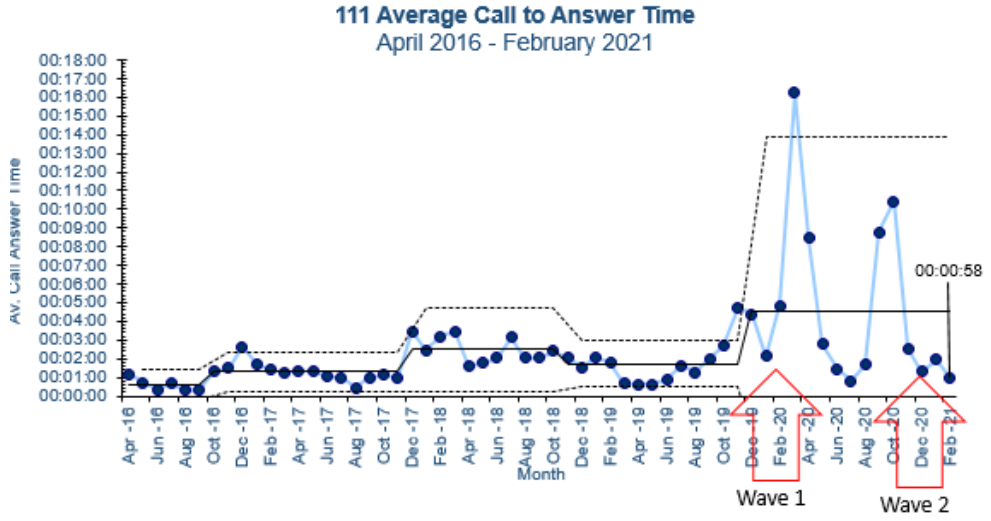


Figure O4.2



111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS
February 2021: 76.12%
YTD: 63.63%

National **86.0%**

Calls Answered within 60s directly relates to available resource.

Demand throughout January and February remains stable, however intraday volatility is still apparent therefore making forecasting a challenge at present.

During January and February 2021 111 experienced a significant rise in Covid abstractions, peaking at circa 180 per day. At the time of writing this update this level of abstractions has now reduced significantly to a less concerning level with the service having had no related positive cases for 18 days.

Calls answered within 60 seconds in January delivered 68.57%, with a further improvement in February delivering 76.12%. The improvement seen in February correlates with the improving position in staff abstraction.

Following the successful recruitment to support 111 First the service is now focussing on the support roles required to enable all new staff to undertake call taking to the highest possible standard.

Figure O4.3:

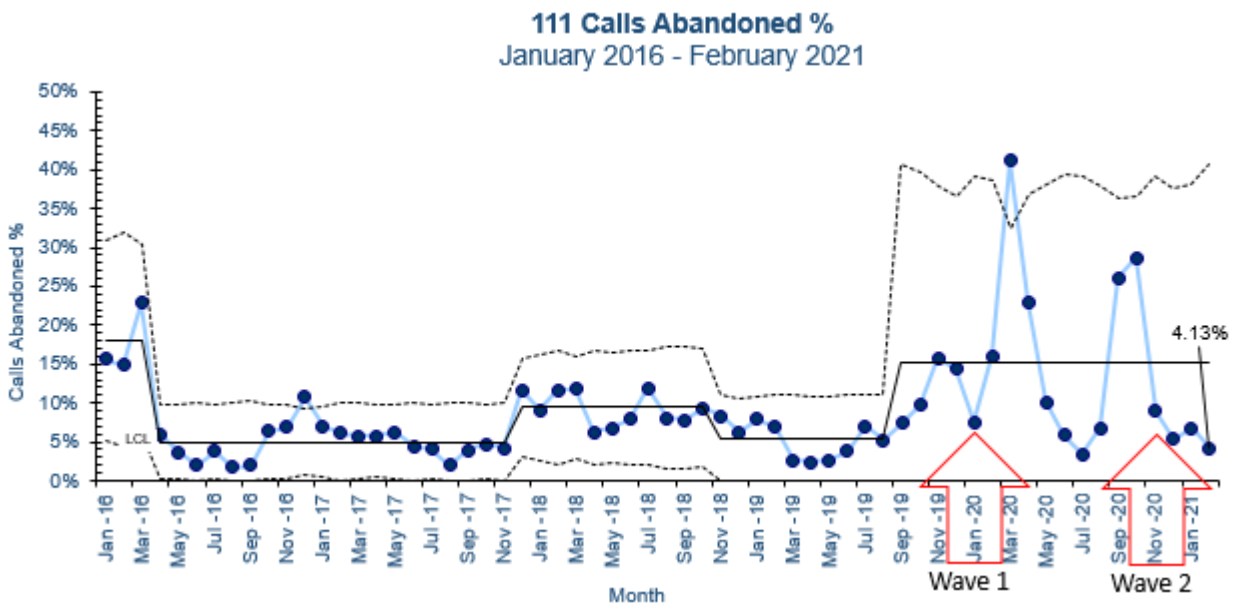
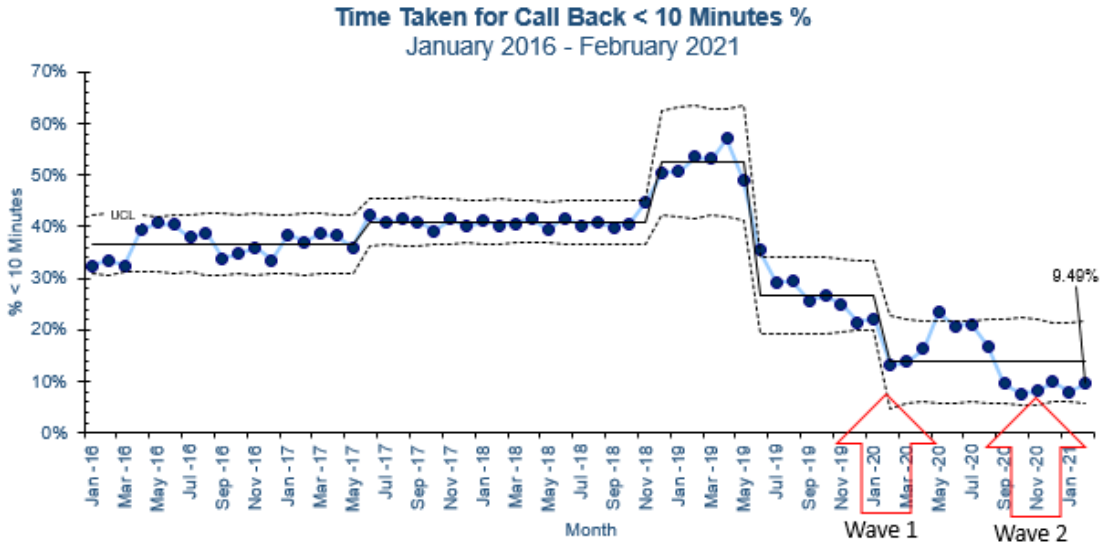


Figure O4.4



Calls Abandoned %
Target: <5%

NWAS
February 21: 4.13%
YTD: 12.59%

National 2.4%

Calls abandoned KPI directly relates to Calls answered in 60s, see previous narrative.

Call Back < 10 Minutes %
Target: 75%

NWAS
February 21: 9.49%
YTD: 13.55%

National 31.8%

Work is ongoing to identify what has caused the continual underperformance in call back in 10 KPI, the data suggests special cause variance and on further analysis this does correlate with the timing of the new SPMS Cleric being implemented. Initial findings suggest this may be linked to the counting of data to support this KPI, however this investigation is still in progress.

Figure O4.5

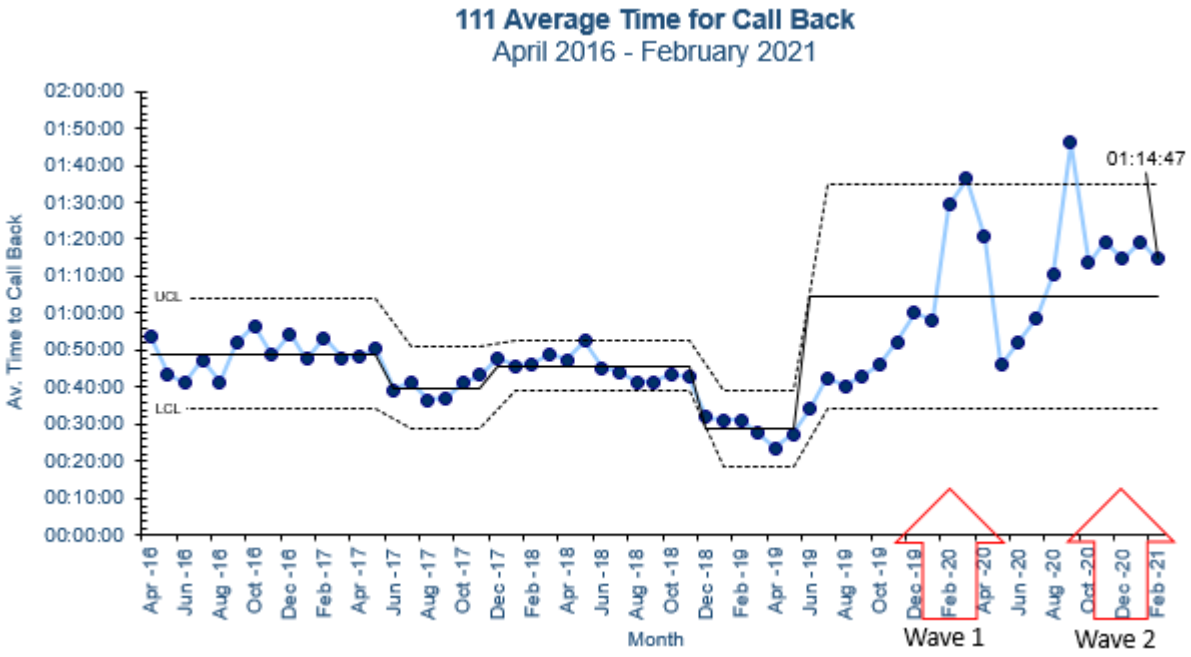
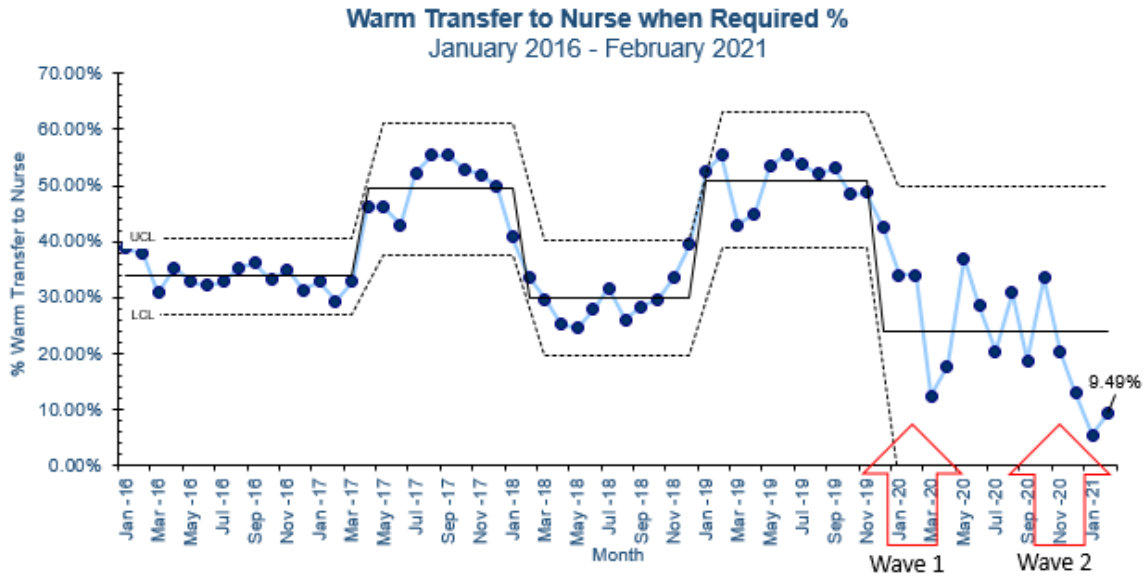


Figure O4.6



Warm Transfer to Nurse when Required%

Target: 75%

NWAS

December 20: 9.49%

YTD: 17.78%

This KPI relates to calls answered in 60s, see previous narrative.

***NEW CHART** – this shows our change in the national ranking tables since January 18 on key metrics (1 is best, 25 is worst)

Figure O4.7

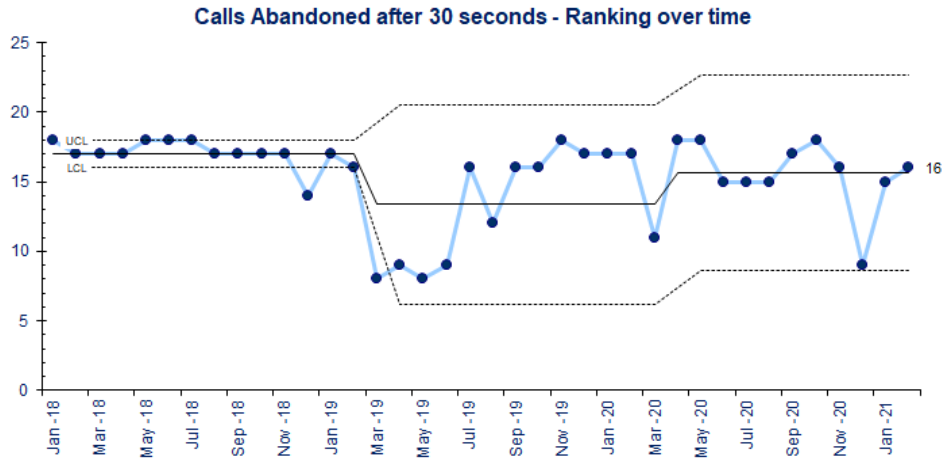


Figure O4.8

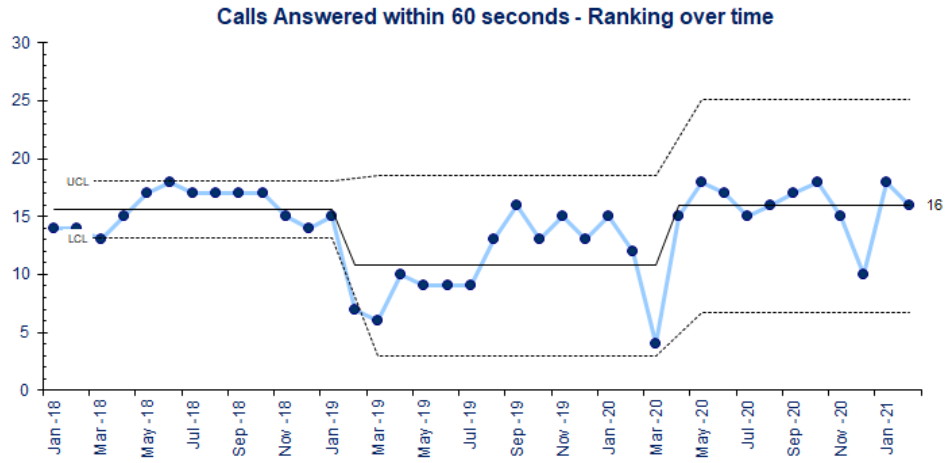
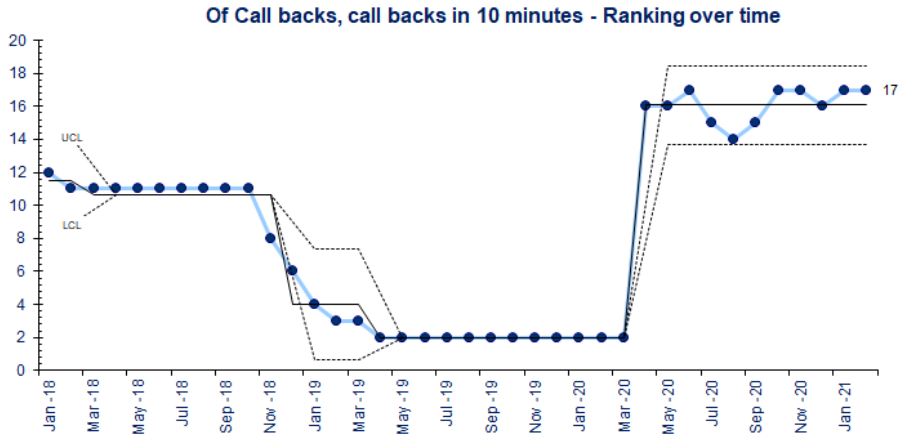


Figure O4.9



O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: January 2021					Year to Date: July 2019 - January 2021			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity	Current Month Activity	Year to Date Baseline	Year to Date Activity	Year to Date Activity	Year to Date Activity
Cumbria	168,291	14,024	6,439	(7,585)	(54%)	98,170	52,376	(45,794)	(47%)
Greater Manchester	526,588	43,882	29,126	(14,756)	(34%)	307,176	202,858	(104,318)	(34%)
Lancashire	589,180	49,098	26,093	(23,005)	(47%)	343,688	184,414	(159,274)	(46%)
Merseyside	300,123	25,010	18,184	(6,826)	(27%)	175,072	124,714	(50,358)	(29%)
NWAS	1,584,182	132,015	79,842	(52,173)	(40%)	924,106	564,362	(359,744)	(39%)

UNPLANNED ACTIVITY									
	Current Month: January 2021					Year to Date: July 2019 - January 2021			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity	Current Month Activity	Year to Date Baseline	Year to Date Activity	Year to Date Activity	Year to Date Activity
Cumbria	14,969	1,247	437	(810)	(65%)	8,732	4,125	(4,607)	(53%)
Greater Manchester	39,178	3,265	3,285	20	1%	22,854	23,972	1,118	5%
Lancashire	56,132	4,678	2,910	(1,768)	(38%)	32,744	21,547	(11,197)	(34%)
Merseyside	22,351	1,863	1,524	(339)	(18%)	13,038	11,317	(1,721)	(13%)
NWAS	132,630	11,053	8,156	(2,897)	(26%)	77,368	60,961	(16,407)	(21%)

ABORTED ACTIVITY									
	January 2021								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	85	3,195	3%	28	428	7%	30	3,023	1%
Greater Manchester	928	10,567	9%	639	4,756	13%	692	13,193	5%
Lancashire	539	11,543	5%	472	3,481	14%	356	10,836	3%
Merseyside	315	5,946	5%	190	1,488	15%	343	10,083	3%
NWAS	1,867	31,251	6%	1,329	10,153	13%	1,421	37,135	4%

PTS Performance

PTS reporting is for January due to system issues causing problems with the February data extraction

Overall activity during January 2021 was 40% below contract baselines with Lancashire 47% below contract baselines whilst Merseyside is operating at 27% (6,826) Journeys below baseline. For the year to date position (July 2019 - January 2021) PTS is performing at 39% (359,744 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 47% and 46% below baseline whilst Greater Manchester and Merseyside are operating at 34% and 29% below baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside is 5% (1,118 journeys) above the baseline. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are 53% (4,607 journeys) and 34% (11,197 journeys) below baseline, with Merseyside also 13% (1,721) below baseline.

In terms of overall trend analysis, Greater Manchester has experiencing upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity. Aborted activity for planned patients averaged 6% during January 2021 however Cumbria experiences 3%, Greater Manchester operates with 9% whilst Lancashire and Merseyside both experience 5% aborts. There is a similar trend within EPS (renal and oncology) patients with a Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside both operate at 3% . Unplanned (on the day) activity experiences the largest percentages of aborts with an average 13% (1 in 6 patients) with variances of 7% in Cumbria, 13% in Greater Manchester, 14% in Lancashire and 15% Merseyside.

OH1 STAFF SICKNESS

Figure OH1.1

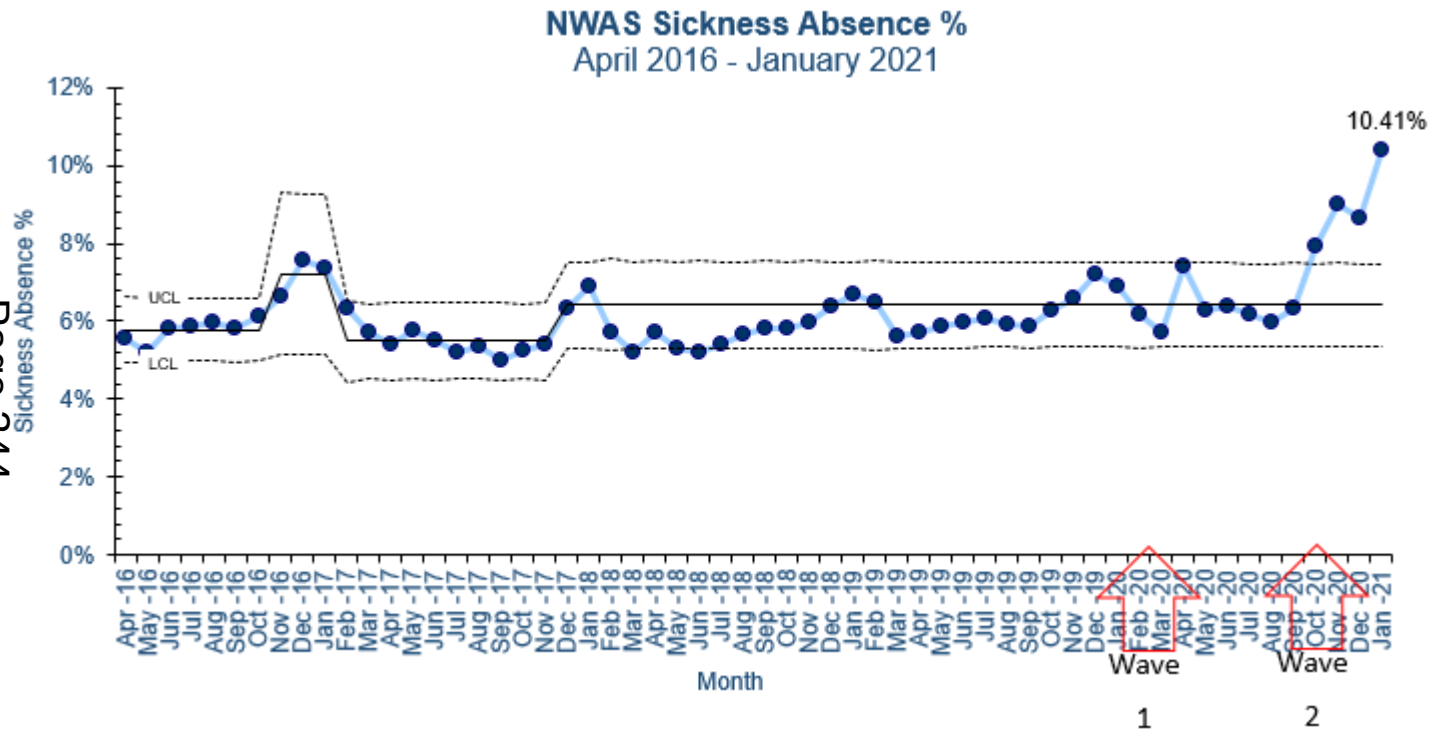


Table OH1.1

Sickness Absence	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
NWAS	6.20%	5.70%	7.42%	6.30%	6.38%	6.18%	5.96%	6.35%	7.94%	9.00%	8.66%	10.41%
Amb. National Average	5.93%	6.75%	7.40%	5.38%	4.65%	4.75%	5..24%	5.74%	6.10%			

Staff Sickness

The overall sickness rates for January 2021 were 10.41% with figure OH1.1 displaying an upward trend in sickness absence levels above the normal control parameters. The impact of COVID related sickness is significant with 4.27% being recorded as COVID sickness. The underlying non-COVID sickness rate at 6.14% is below the level for the same period in 2020.

In January the impact of COVID has been highest in PES/EOC, current rate of 11.42% overall of which 5.53% is COVID related. This compares with an average of 3% COVID sickness across PTS and 111.

A pause in formal sickness absence management during the 1st and most recent wave may be a contributory factor to underlying non-COVID sickness levels and plans are being developed to address the backlog and target improvements in underlying sickness. In particular in PTS, EOC and 111.

In addition to sickness reported via ESR, COVID19 self isolating absences have been captured by GRS, Teliopti and Marvel. This data is reported externally.

BAF Risk: SR04.

Figure OH1.2:

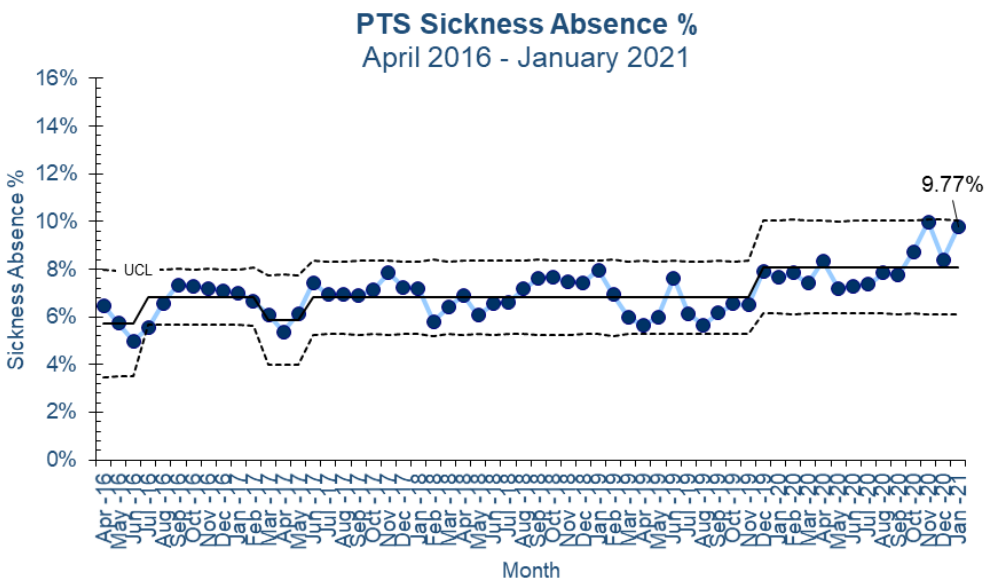


Figure OH1.3:

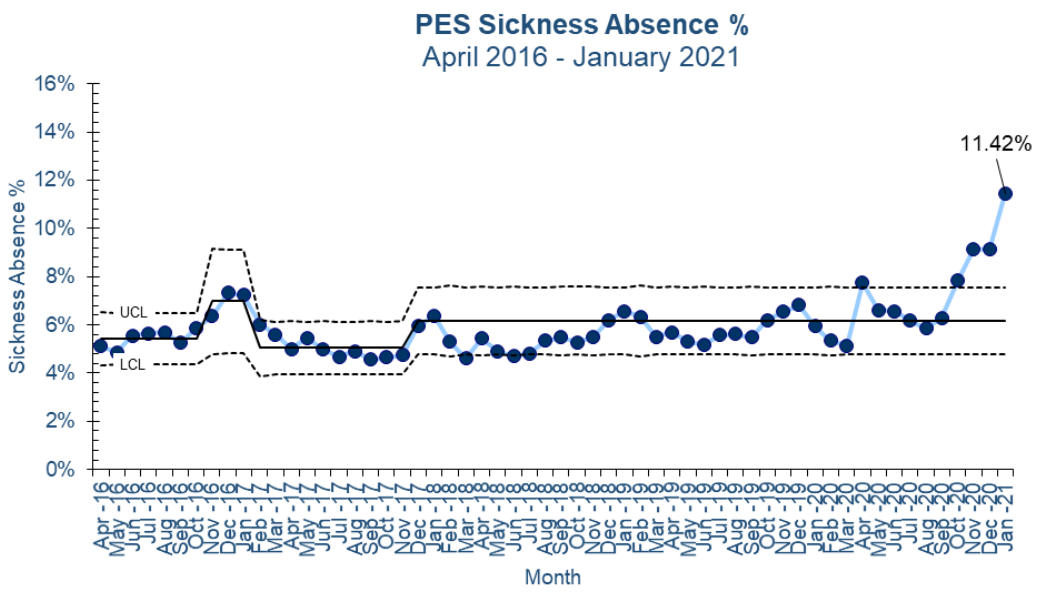


Figure OH1.4:

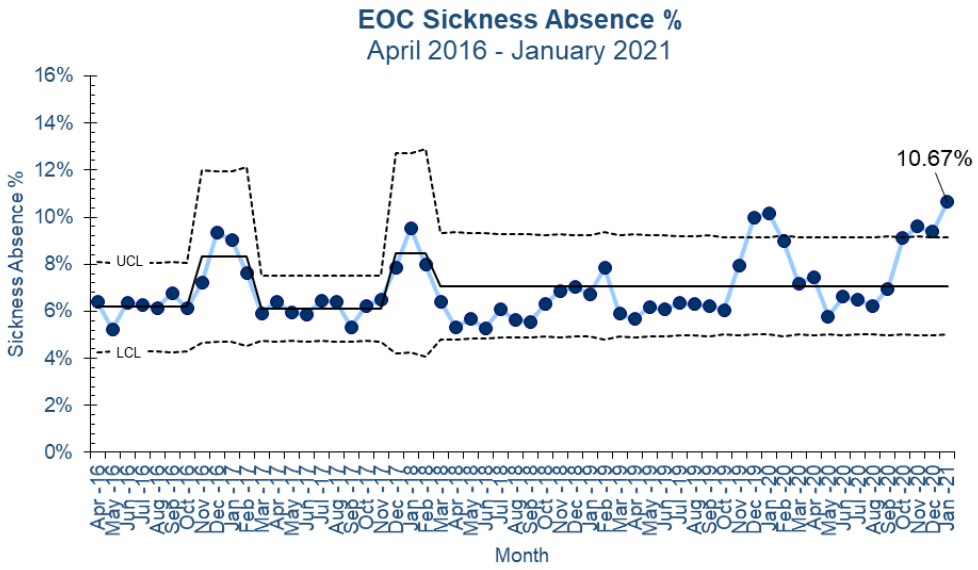


Figure OH1.5:

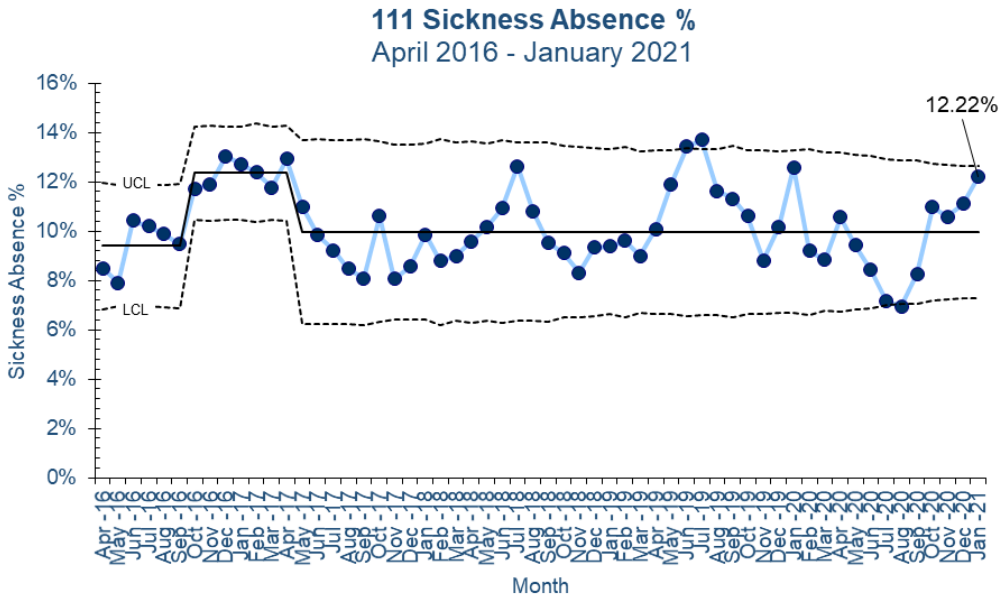


Figure OH1.6:

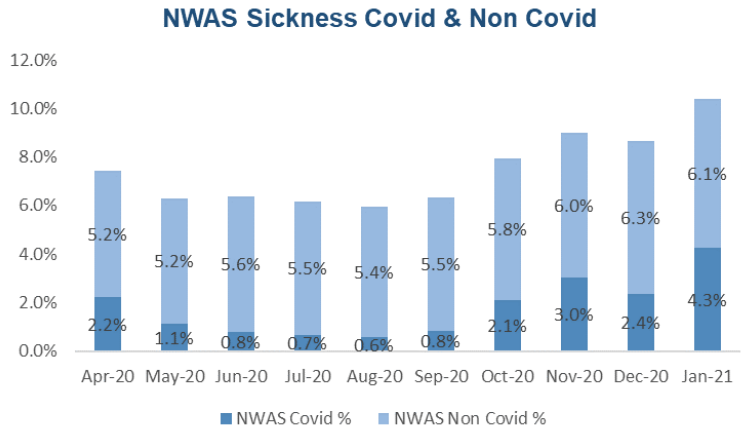


Figure OH1.7:

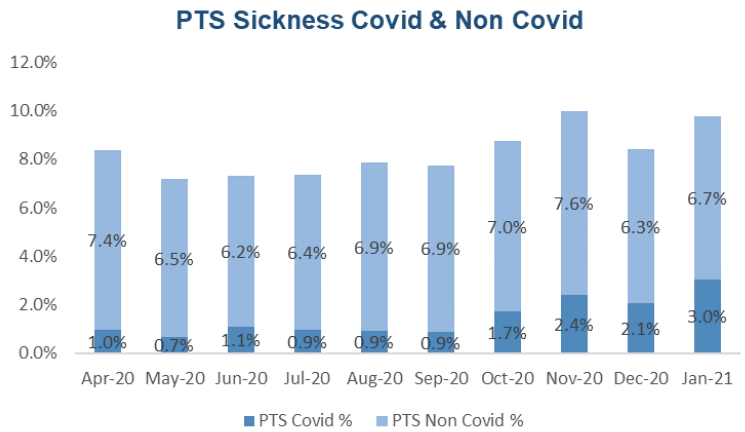


Figure OH1.8:

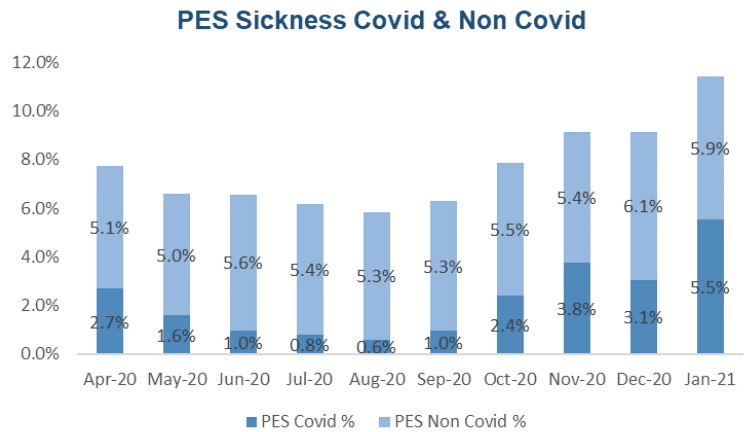
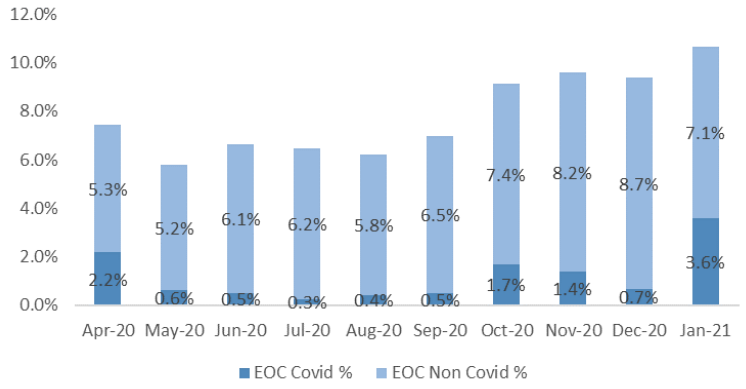


Figure OH1.9:



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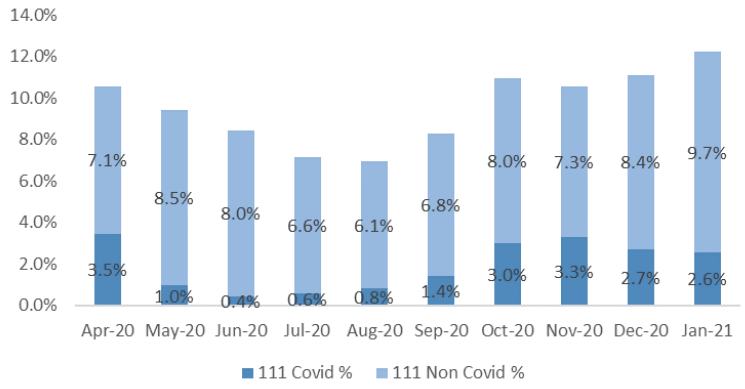
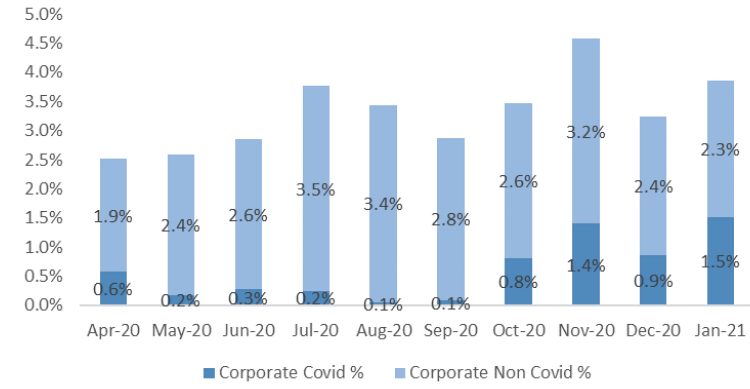


Figure OH1.11:



OH2 STAFF TURNOVER

Figure OH2.1

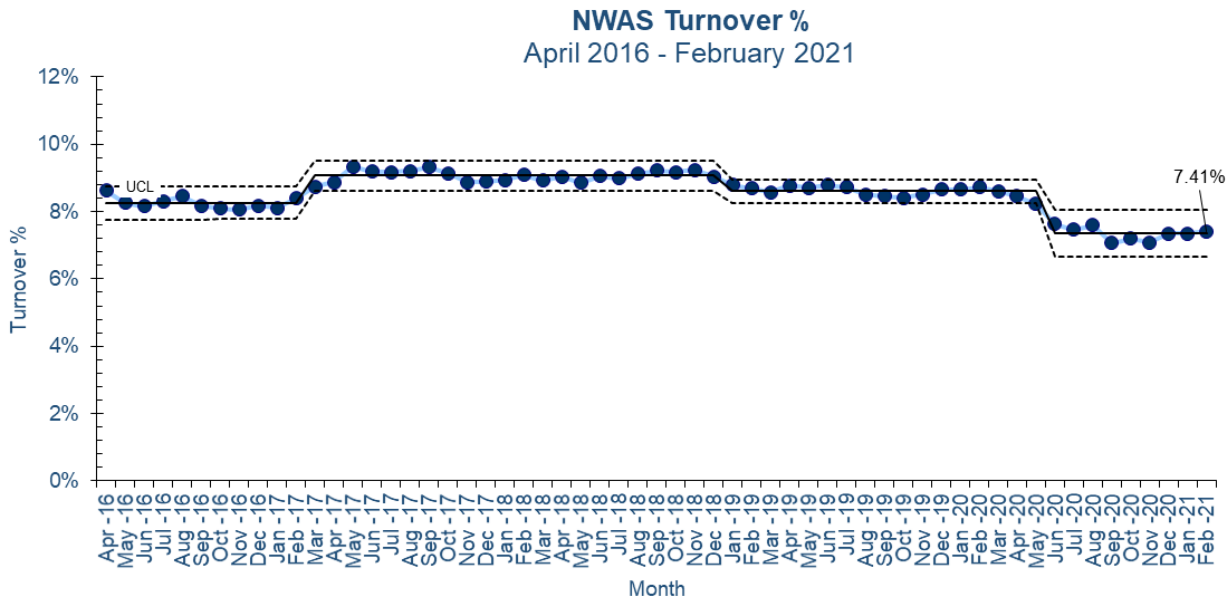


Table OH2.1

Turnover	Mar - 20	Apr - 20	May - 20	Jun - 20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
NWAS	8.60%	8.46%	8.22%	7.63%	7.46%	7.60%	7.07%	7.19%	7.08%	7.35%	7.34%	7.41%
Amb. National Average	9.12%	8.94%	8.98%	8.69%	8.52%	8.21%	8.08%	7.95%	7.75%			

Staff Turnover

Turnover is calculated on a rolling year average and this does lend to some small variations between months with February 2021 turnover being 7.41%

Staff turnover has in the main been positively affected by COVID-19 and the changed job market. 111 has seen the most significant reduction in turnover during COVID however, there is a slight upward trend with February figures being at 21.11%.

OH2.4 indicates a continuing downward trend with regards to EOC turnover with February 21 figures now being at 7.85% at the lower control limit. This presents a very positive position for EOC, creating stability as the Single Primary Triage Project is delivered.

BAF Risk: SR04

Figure OH2.2

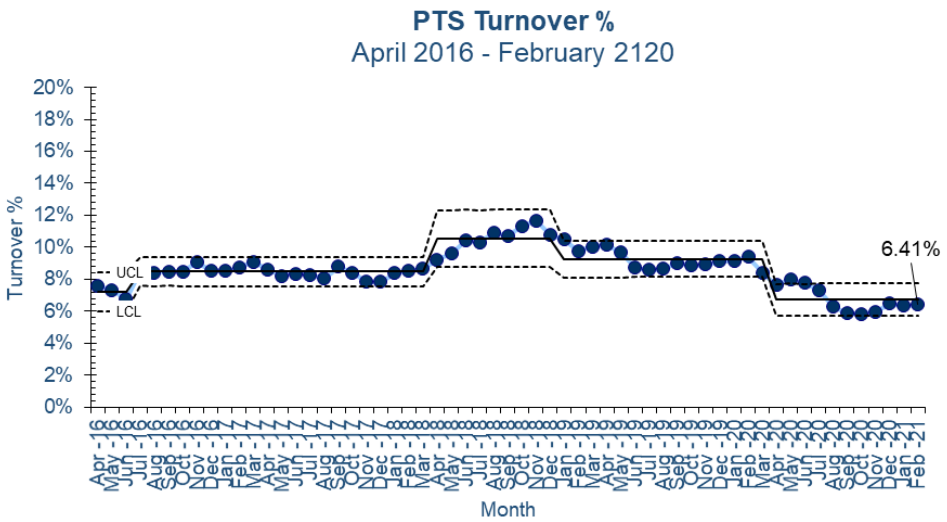


Figure OH2.3

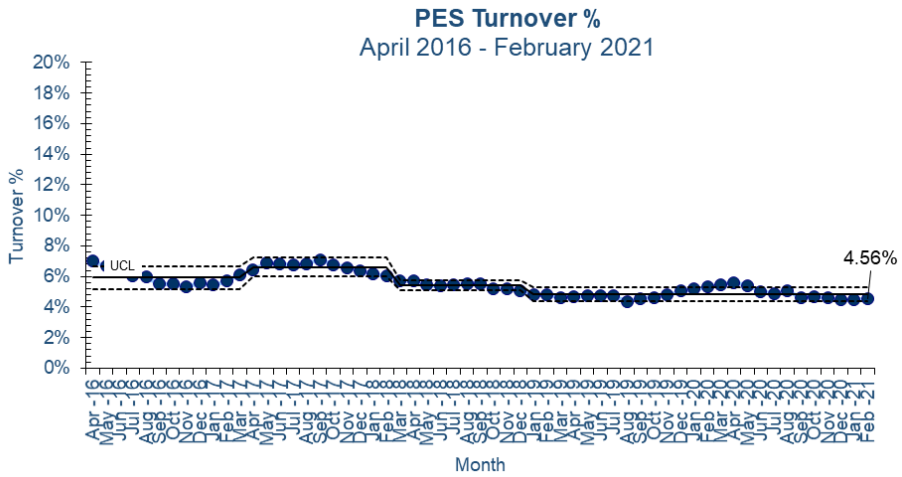


Figure OH2.4

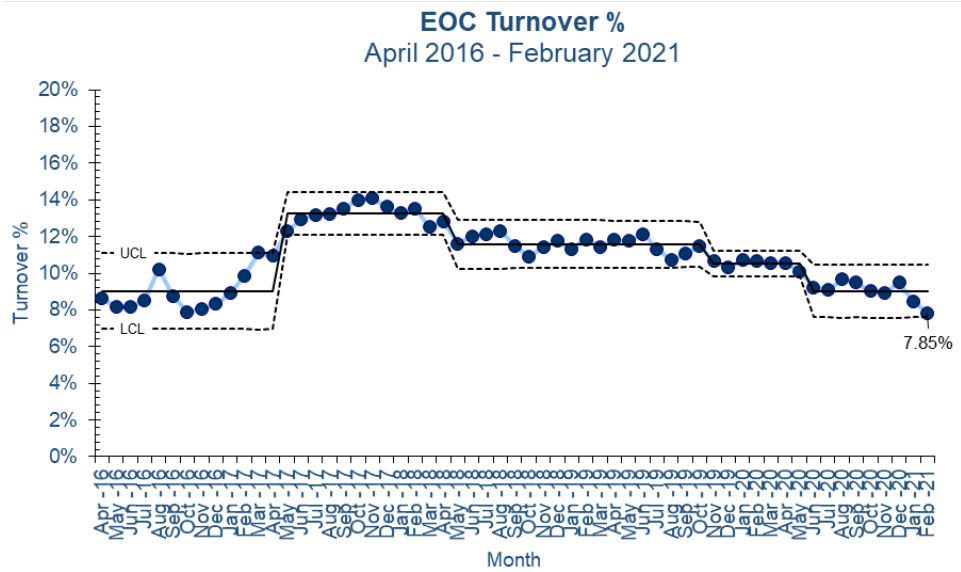
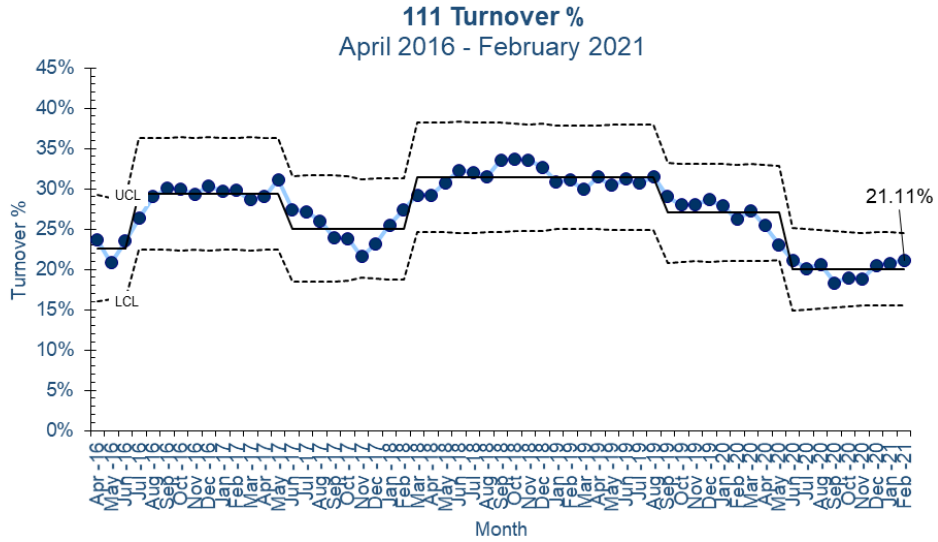
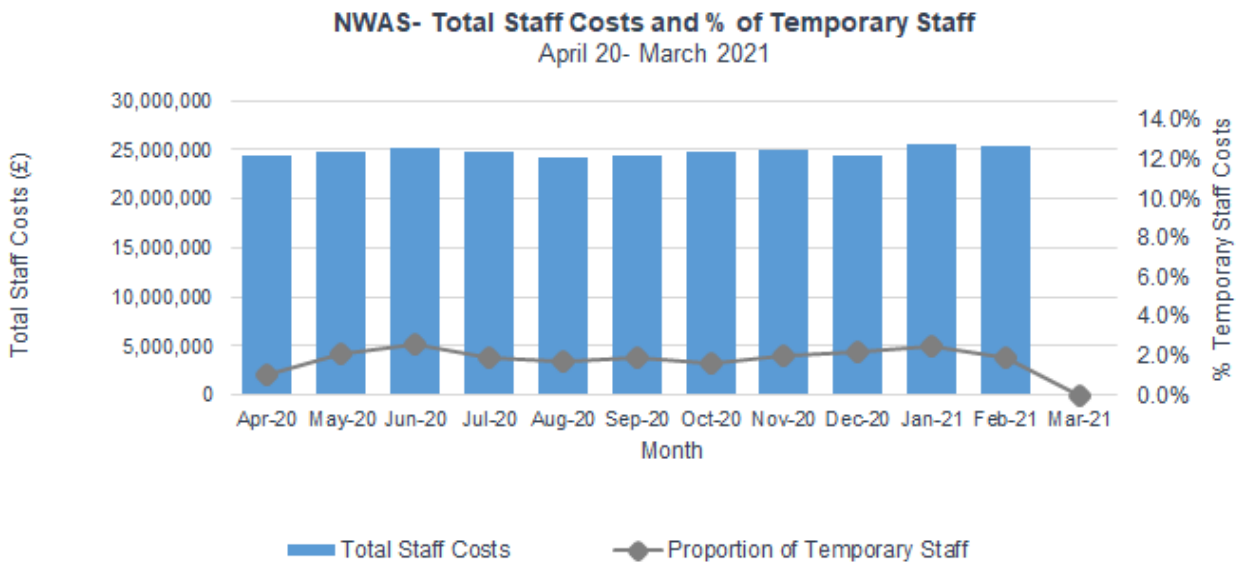


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

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

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 budgets extends to Q1. There is a clear exit strategy reported to Resources Committee in place to move agency into fixed term and permanent positions before the end of Q1. Some of the impact of that can be seen in February figures.

BAF Risk: SR04; SR11, SR02

Table OH4.1

NWAS	Mar-20	Apr-20	May-20	June-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-19	Dec-20	Jan-21	Feb-21
Agency Staff Costs (£)	153,153	261,425	523,449	647,832	465,485	407,651	466,727	386,841	502,967	541,395	636,447	478,564
Total Staff Costs (£)	21,904,103	24,361,995	24,812,375	25,181,809	24,737,935	24,176,859	24,352,743	24,669,105	24,985,757	24,466,230	25,444,774	25,353,362
Proportion of Temporary Staff %	0.4%	1.1%	0.4%	0.4%	0.2%	0.3%	1.2%	0.7%	1.7%	1.6%	2.5%	1.9%

Figure OH4.2:

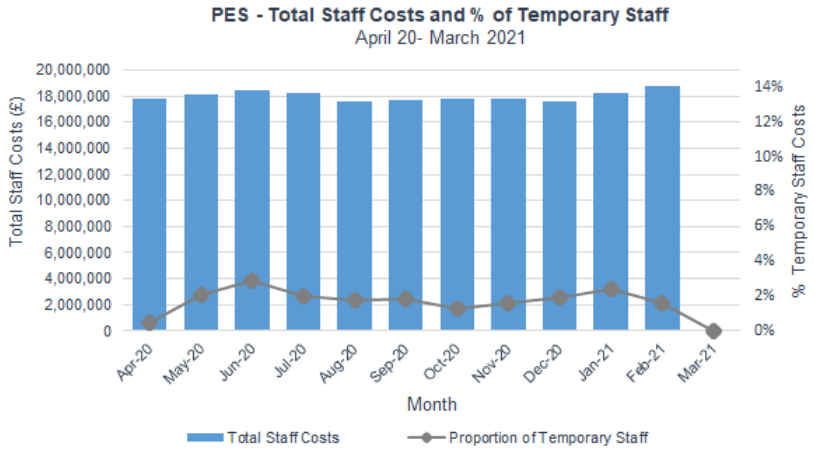
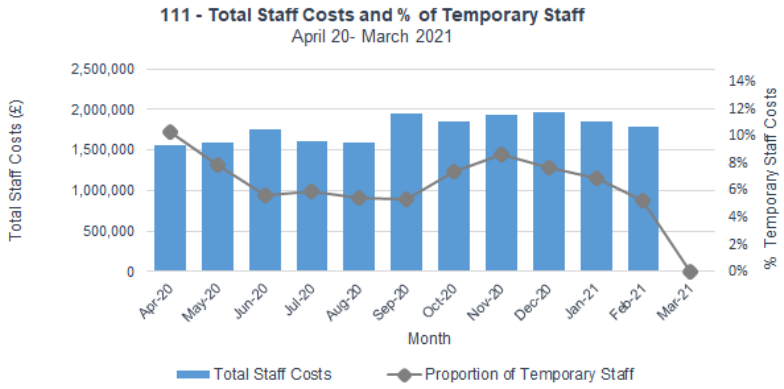


Figure OH4.3:



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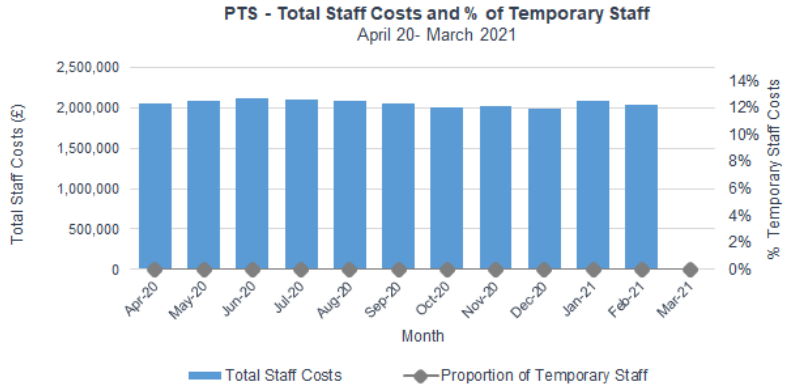
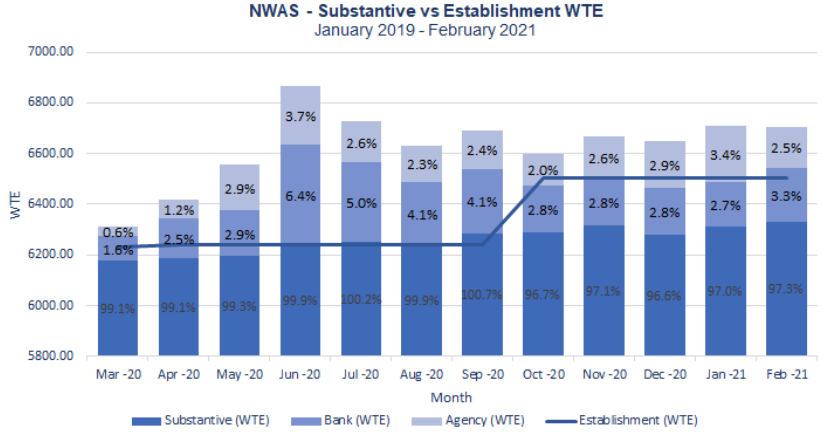


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

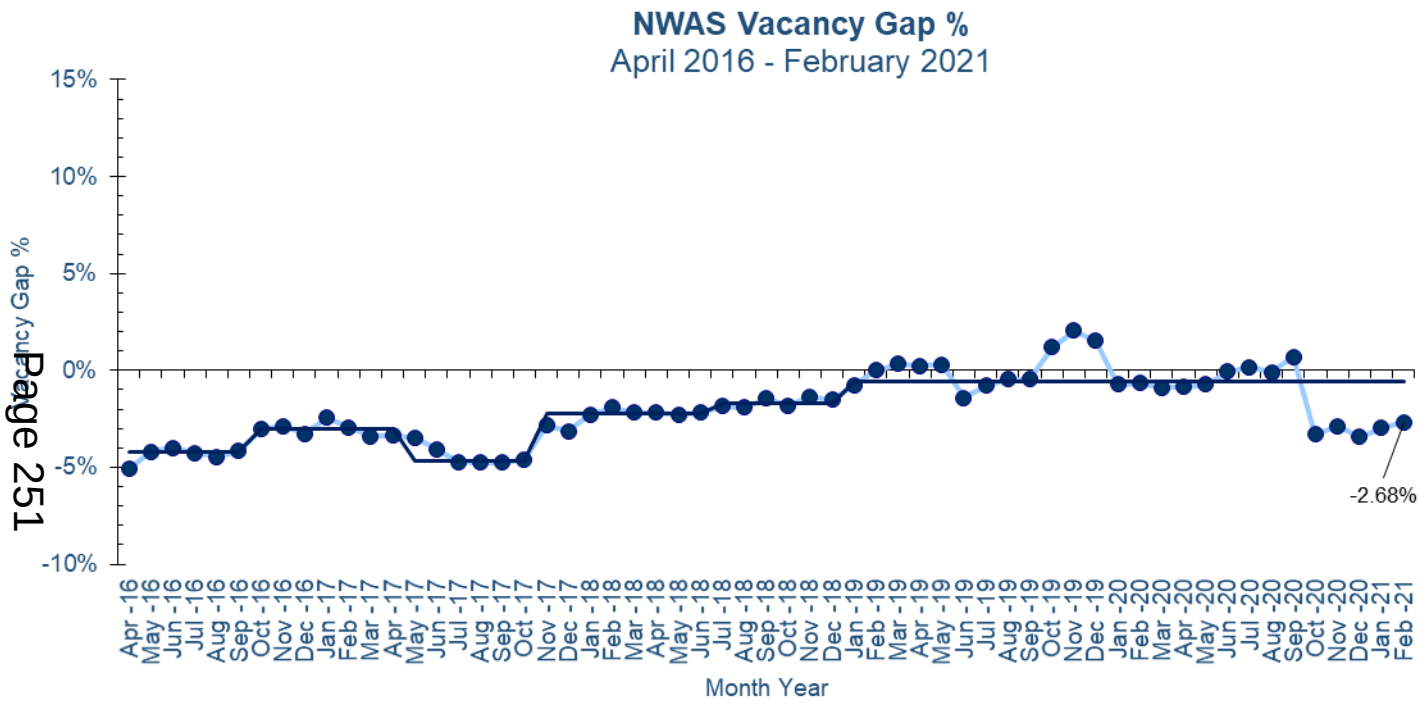


Table OH5.1

Vacancy Gap	Mar-20	Apr-20	May-20	Jun-20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
NWAS	-0.90%	-0.86%	-0.72%	-0.07%	0.17%	-0.08%	0.69%	-3.31%	-2.88%	-3.44%	-2.97%	-2.68%

Vacancy Gap

Chart OH5.1 shows a slightly improving vacancy position but this reflects the significant change in establishment for 111 as a result of the agreed contract extension and 111 First.

Although recruitment planned for 111 is on track the establishment change now shows the current position against all the growth requirements resulting in the current vacancy gap of 8.37%.

The PES position is positive and very stable. This excludes the continuing use of PTS staff. The increase in PTS vacancies reflect the permanent appointment of some of these staff onto the EMT1 apprenticeship. Plans are in place to address this shortfall.

EOC remains over established and supports the SPT roll out.

BAF Risk; SR04; SR11

Figure OH5.2

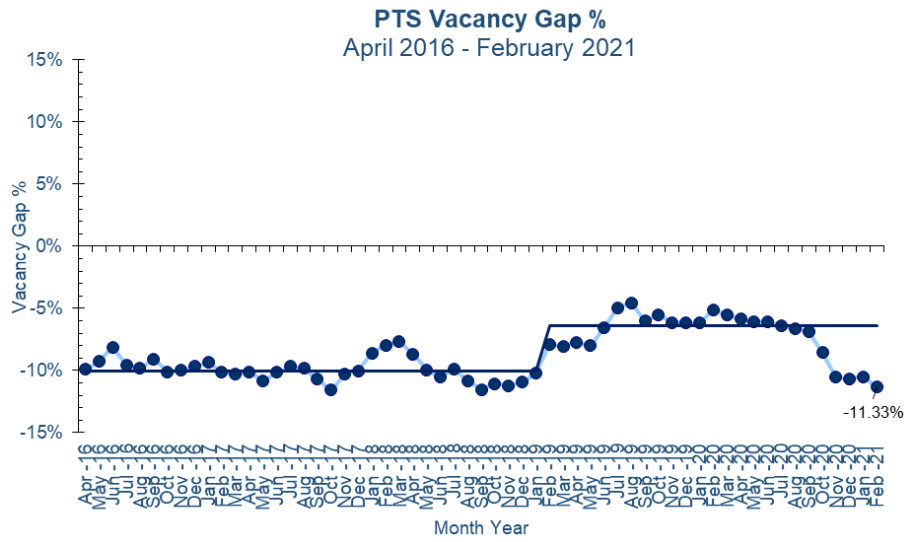


Figure OH5.3

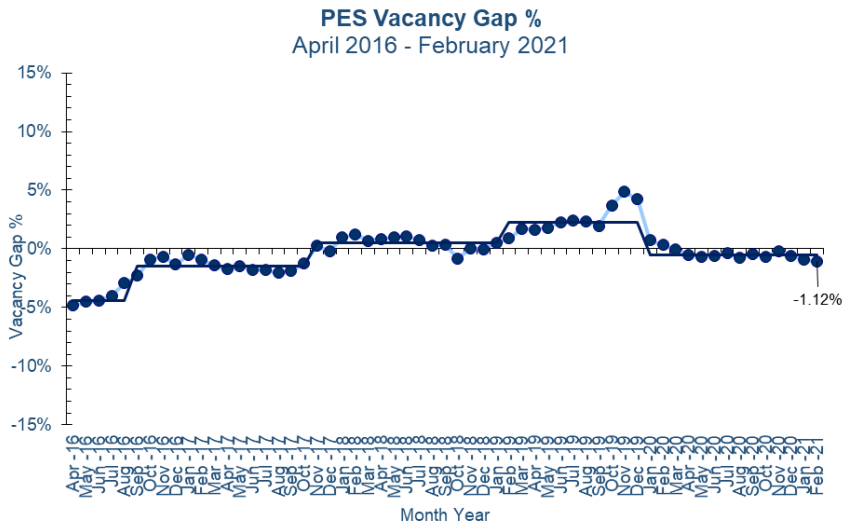


Figure OH5.4

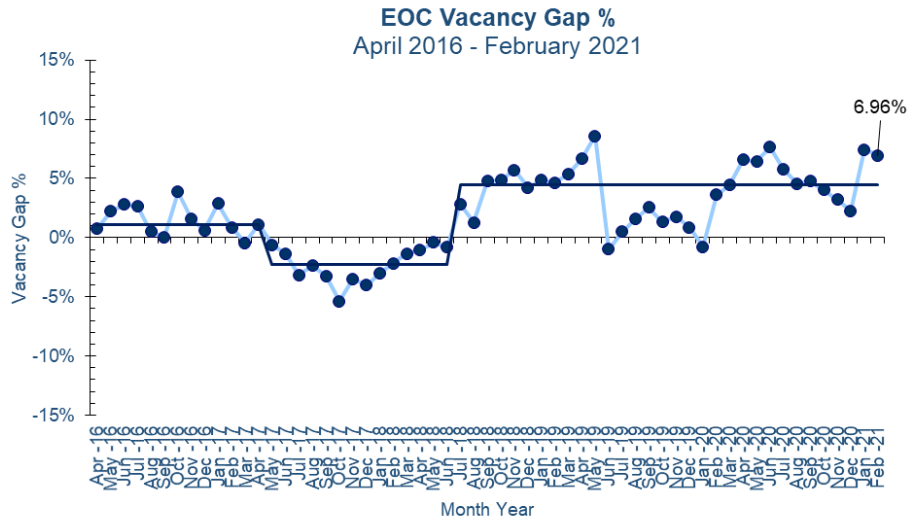
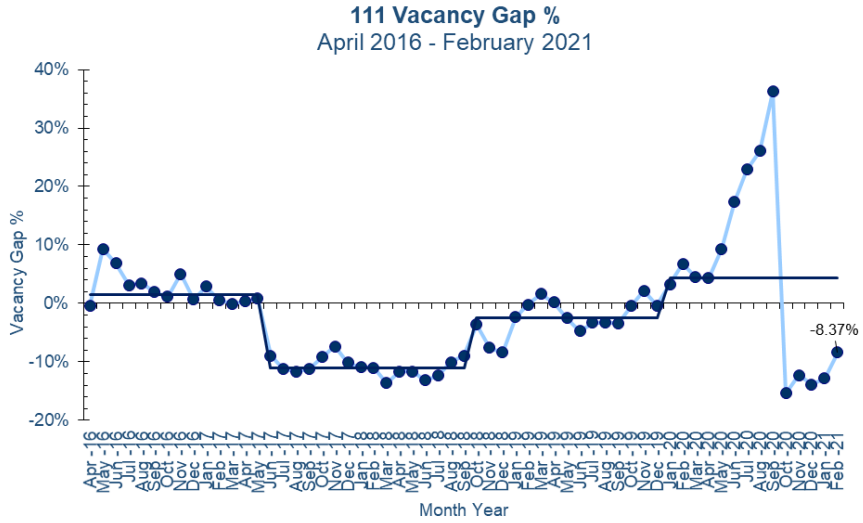


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

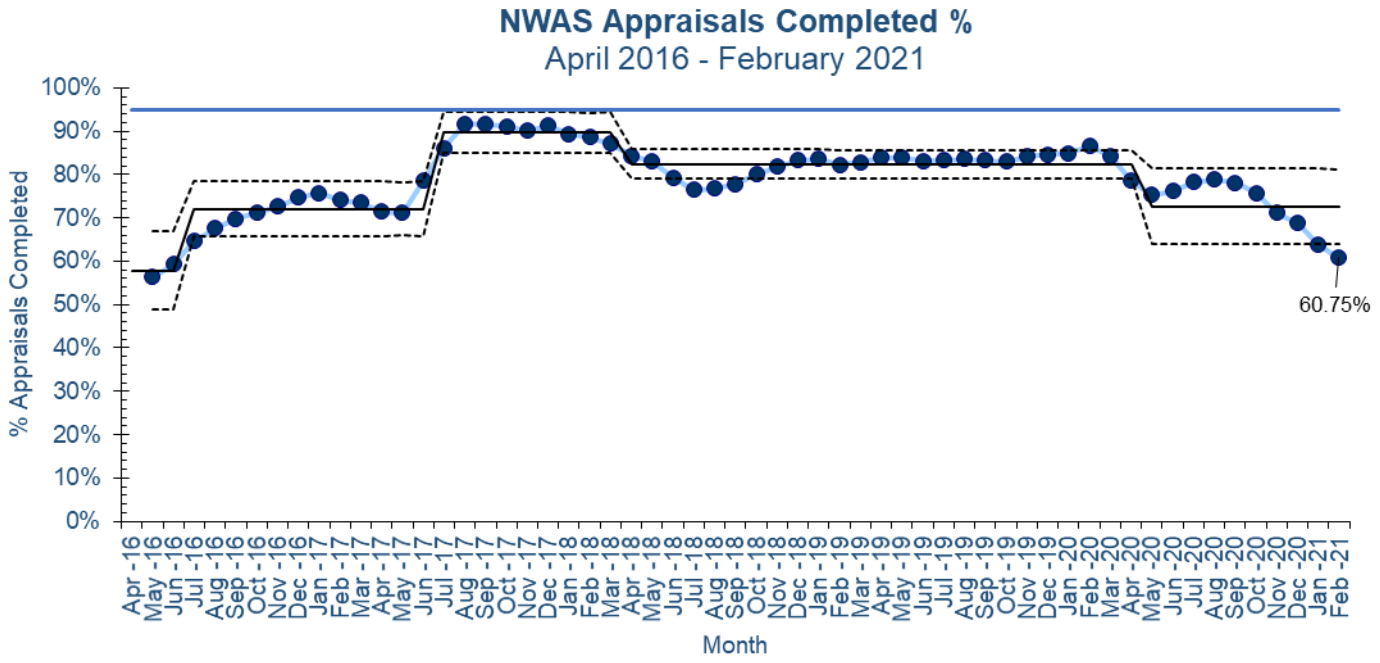


Table OH6.1

Appraisals	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
NWAS	84%	78%	75%	76%	78%	79%	78%	76%	71%%	69%	64%	61%

Appraisals

As a result of the impact of COVID-19, appraisals were paused in March 2020. They were recommenced in June but formally paused again for frontline staff in October 2020 as a result of demand and high levels of abstractions. This has taken most service lines outside of control limits.

As a result, completion rates are currently 60.75% overall.

PES rates are at 63.16% and PTS at 68.50%. EOC and 111 are at 46.56% and 40.30% respectively.

The revised targets approved by ELC are:

75% by September 2021

85% March 2022

95% March 2023

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

All Corporate Service Lines and Managers at Band 8a and above have been asked to deliver to the existing 85% target.

BAF Risk: SR04; SR11

Figure OH6.2

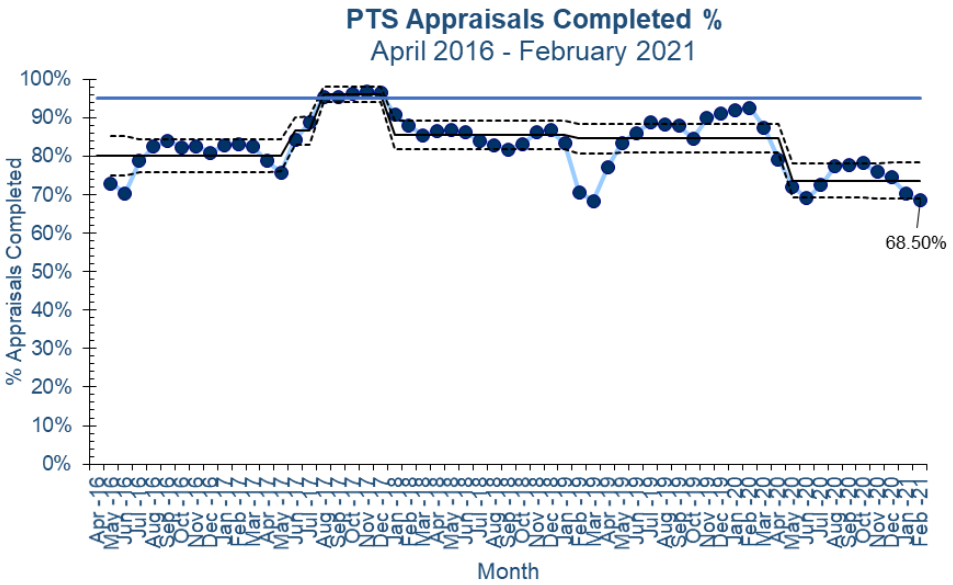


Figure OH6.3

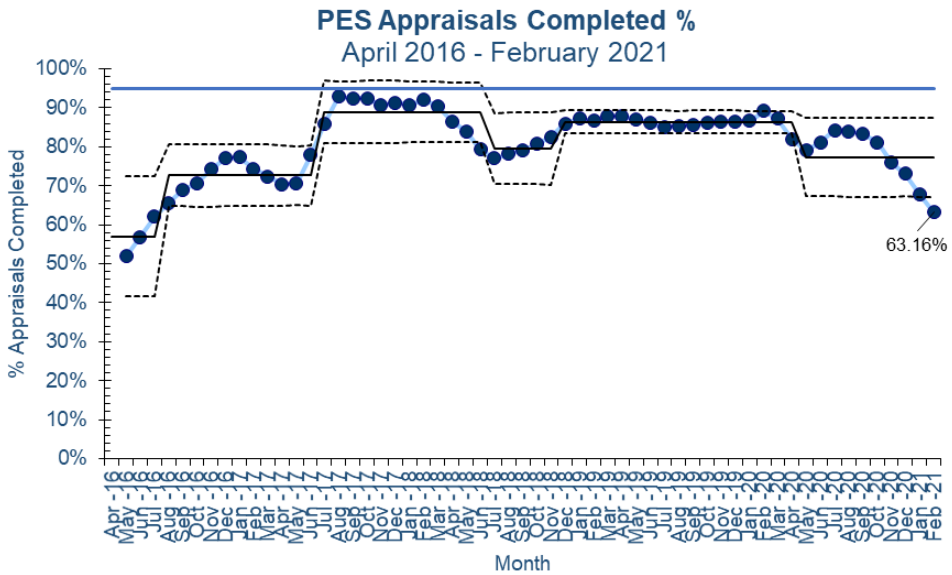


Figure OH6.4

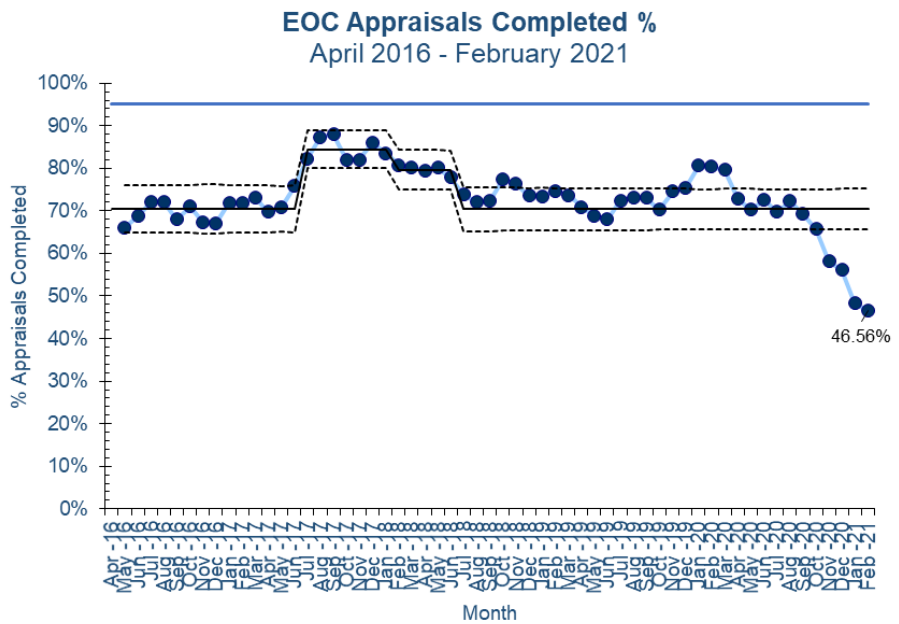
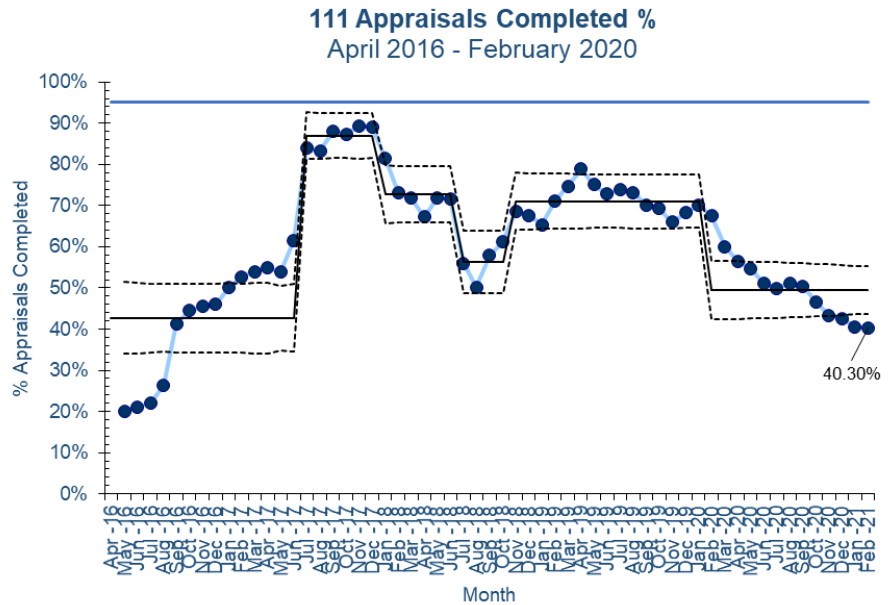


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

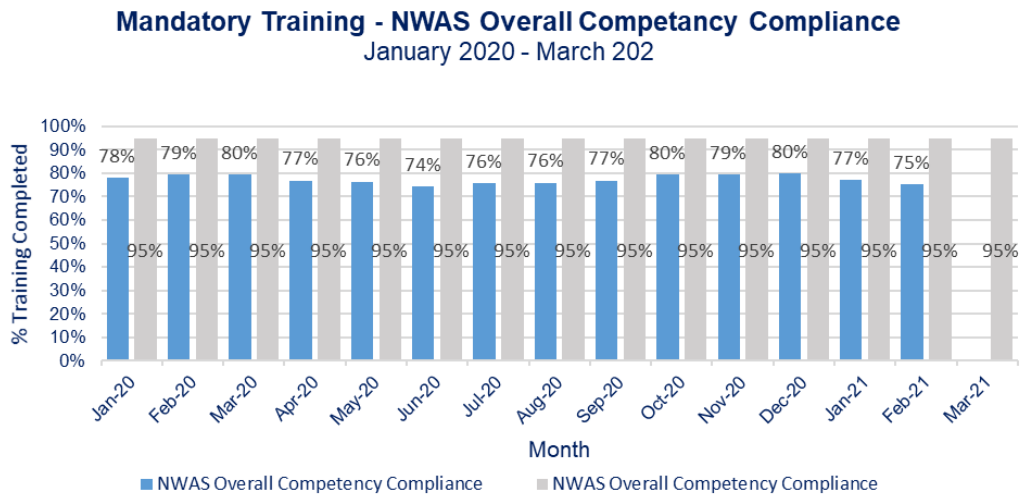
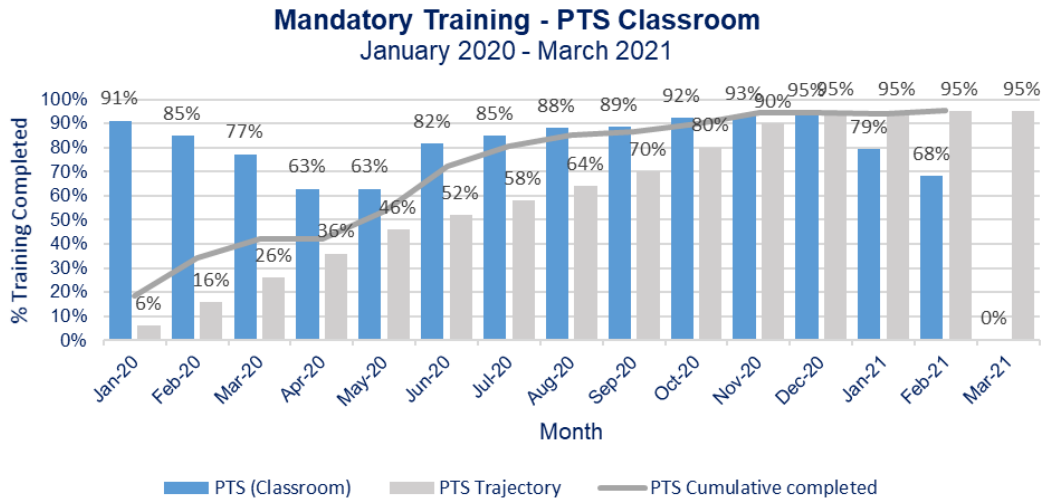


Figure OH7.2



Mandatory Training

The pandemic has resulted in disruption to the planned mandatory training programme for 2020/21. The current position is that classroom training for this programme will not resume but targeted mandatory training activities are in place to continue with online module completions and to target areas of highest risk.

ELC have approved a revised target for 2020/21 of 75% and this target is currently being met. The overall compliance position in February 2021 is 75%.

It should be noted that PTS managed to maintain and deliver 95% classroom attendance by the original target date of December 2020 despite the pandemic.

Approval has been given to recommence a full cycle of mandatory training for 2021/22 from April. This will be targeted to deliver 95% compliance by March 2022, including recovery of Level 3 safeguarding training for Paramedics who did not attend classroom training this year.

BAF Risk: SR04, SR11

Figure OH7.3

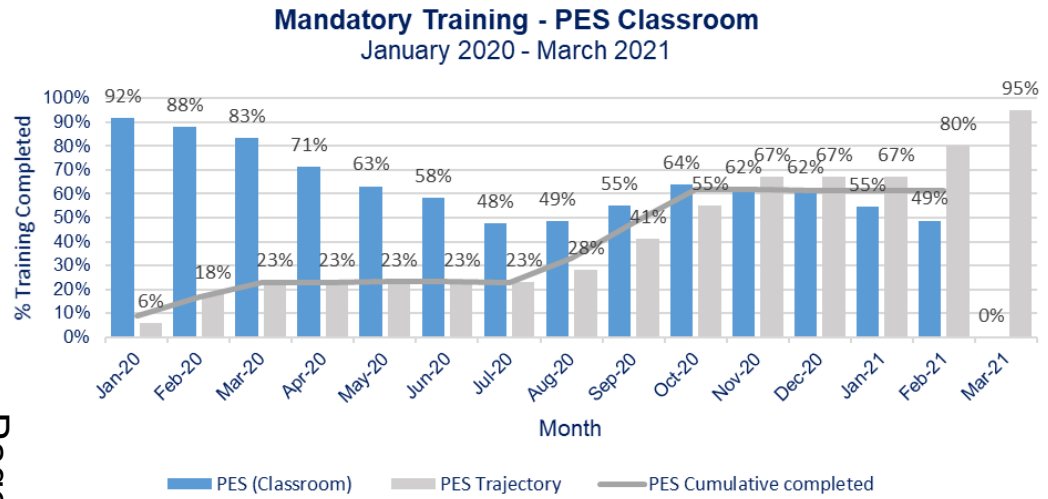


Figure OH7.4

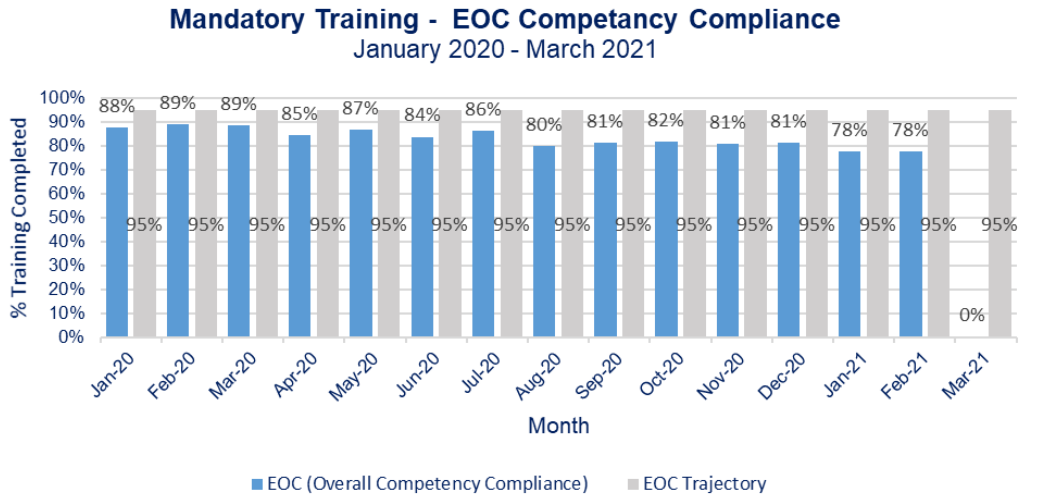


Figure OH7.5

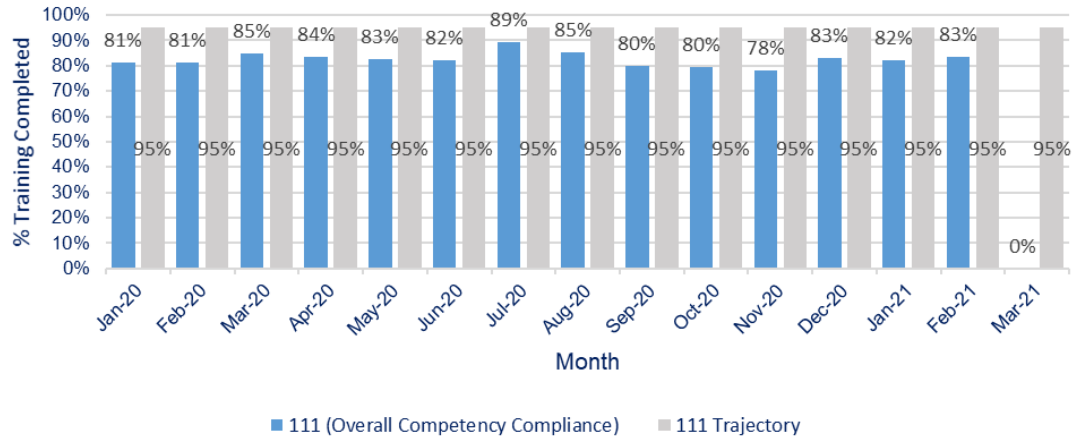
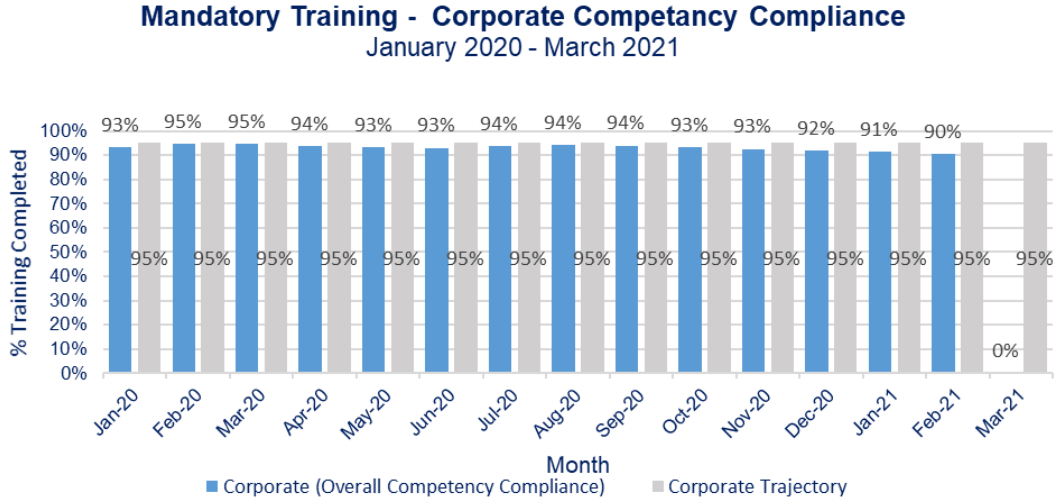


Figure OH7.6



COVID 19

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

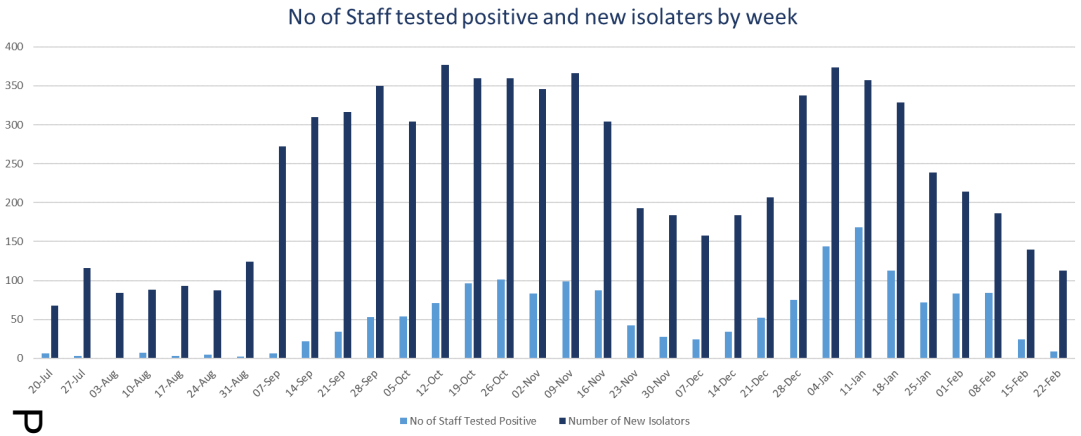
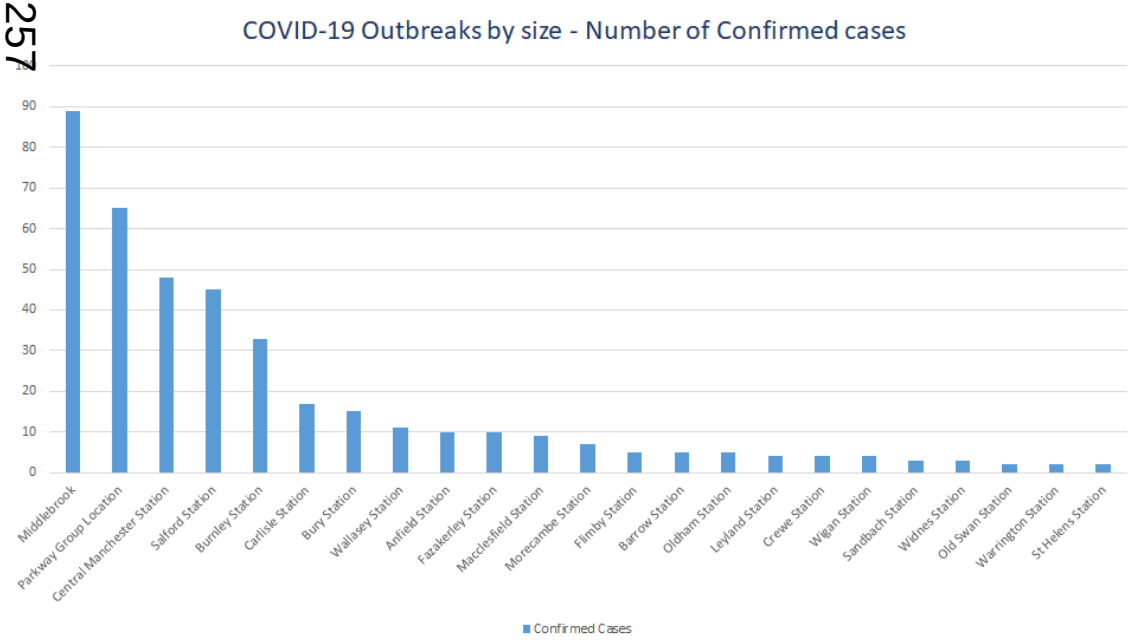


Figure CV19.2 - Outbreaks by size (number of confirmed cases)



COVID-19

There have been 200 instances of staff that have tested positive for Covid-19 in February 2021 with 1,685 instances since July 2020.

Three have been 91 outbreaks on trust sites from July until the end of February with 68 of these now closed. The largest outbreak has been at Middlebrook where the call centre for 111 is based. The largest 5 outbreak sites account for 21% of confirmed covid cases. In February there 5 new outbreaks.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	31 March 2021
Subject:	CQC 'Regulation' Update
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	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 24 August 2020, the Trust was required to develop an IPC Board Assurance Framework (BAF) for the CQC to review and provide a summary report of their findings. The Trust's IPC Assessment Summary Record from the CQC was very positive and the CQC's findings were reported through to Trust Board, at the December 2020 meeting. In November 2020, an application to add 'Surgical Procedures' as a CQC regulated activity was made and on 29 January 2021, the Trust were informed that the application was successful. On 17 December 2020, following the submission of a multi-directorate documented response to a series of questions asked of the Trust, a 'Winter Pressures' TMA interview took place. The outcome of this process was, once again, very positive. The Trust had a second 'regulatory compliance and governance' TMA interview on 19 January 2021, following the submission of a comprehensive assurance document. Again, a very positive outcome of this TMA was received and a number of follow-up questions were answered and addressed. The local CQC inspector re-iterated that they have no Regulatory concerns at the moment with NWAS. On 26 January the CQC launched a consultation process on their proposals for a more flexible and responsive regulation. Trusts were given until 23 March of the option to respond.

	The Executive Leadership Committee (ELC) considered the content of this paper at its meeting on 10 March 2021. The Quality & Performance Committee considered the content of this paper at its meeting on 15 March 2021. On 23 March, the Deputy Director of Quality, Innovation and Improvement, in conjunction with the ELC, submitted supportive feedback to the CQC, on behalf of the Trust.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to; • Note the assurances provided in this report

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

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	No more as a result of this report
Previously Submitted to:	EL Committee Q&P Committee
Date:	10/03/2021 15/03/2021
Outcome:	A formal and supportive response to the CQC's consultation on their proposals for a more flexible and responsive regulation was agreed by the ELC and forwarded to the CQC on 23/03/2021

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1. PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with an update of the most recent Care Quality Commission (CQC) related regulation activity and their proposals on changes for a more flexible and responsive regulation.

2. BACKGROUND

2.1 Although the Care Quality Commission has not routinely inspected services during the pandemic period and recovery phase, they 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), which is designed to look at the Trust in either a specific focused topic area or a more holistic way, via a multi-disciplinary documentation return and follow-up, virtual, interview.

2.2 However, Trust's should be aware that as a result of their risk based approach, the CQC will continue to conduct some focused 'on-site' inspections, where indicated.

2.3 As a result of the CQC's TRA, on the 24 August 2020, the Trust was required to develop an IPC Board Assurance Framework (BAF) for the CQC to review and provide a summary report of their findings. The Trust's IPC Assessment Summary Record from the CQC was very positive and the CQC's findings were reported through to Trust Board, at the December 2020 meeting.

2.4 In October 2020, the Trust reviewed its CQC Registrations for regulated activity which determined that, due to advancements in clinical practice, performed by the very senior clinicians and Doctors working on behalf of NWAS (in particular, for NWAA and BASCS), an application to add 'Surgical Procedures' as a CQC regulated activity was required.

2.5 On 29 January 2021, the Trust were informed that they are now CQC Registered for the activities of 'surgical procedures', 'diagnostic and screening procedures', 'transport services, triage and medical advice provided remotely' and 'treatment of disease, disorder or injury'.

2.6 The local CQC inspection team conducted a 'winter pressures' TMA interview on 17 December 2020, following the submission of a multi-directorate documented response to a series of questions asked of the Trust. The outcome of this process was, once again, very positive with a few follow-up questions that were resolved in a short space of time.

2.7 The Trust was informed, by the CQC that no formal documented feedback would be received as a result of any TMA.

2.8 The Trust had a second 'regulatory compliance and governance' TMA interview on 19 January 2021, following the submission of a comprehensive assurance document. Again, a positive outcome of this TMA was received and a number of follow-up questions were answered and addressed.

2.9 The local CQC inspector re-iterated that they had no regulatory concerns, at that time, with NWAS.

2.10 On 26 January the CQC launched a consultation process on their proposals for a more flexible and responsive regulation. Trusts were given until 23 March to respond.

2.11 The Trust was not aware of any requirement to respond to this consultation, as part of the wider ambulance sector, so the Executive Leadership Committee (ELC) colleagues were provided with the opportunity to respond as NWAS.

2.12 The ELC considered the content of this report at its meeting on 10 March 2021 and agreed to provide formal feedback to the CQC.

2.13 The Quality & Performance Committee considered the content of this paper at its meeting on 15 March 2021.

2.14 On 23 March, the Deputy Director of Quality, Innovation and Improvement, in conjunction with the ELC, submitted supportive feedback to the CQC, on behalf of the Trust, as described in s3 of this report.

3. CURRENT POSITION

3.1 Following on from the CQC's consultation on their new strategy and ambitions, launched in January, the CQC are now proposing some specific changes that will enable them to deal with ongoing challenges from the pandemic and move them towards their ambition to be a more dynamic, proportionate and flexible regulator.

3.2 The CQC's current inspection reports and ratings give a view of quality that is vital for the public, service providers and stakeholders. In this current consultation, the CQC are proposing some changes to allow them to assess and rate services more flexibly, so they can update their ratings more often in a more responsive and proportionate way. It is the intention of the CQC that the changes will make ratings easier to understand for everyone.

3.3 There were 2 main parts to this CQC consultation;

- ***Part 1 – "Our proposals for change"***
  - *Assessing and rating quality*
  - *Reviewing and updating ratings*
  - *Changing how we rate NHS Trusts*
  - *Measuring the impact on equality*
- ***Part 2 – "How we'll engage with you in the future"***

3.4. Part 1 – Our Proposals for Change

3.4.1 *Assessing and rating quality*

The CQC want to move away from using comprehensive, on-site inspections as the main way of updating ratings. Instead, they want to use wider sources of evidence, tools, and techniques to assess quality. This includes where they've gathered appropriate evidence following focused or targeted inspections, assessments without a site visit, and if we need to take significant enforcement action to protect people.

The CQC will still carry out an on-site inspection where they have information about significant risks to people's safety and to ensure the protection of the rights of vulnerable people.

The CQC's proposed change means that they will make more use of information that they hold to update ratings, and it won't be necessary to always carry out a site visit if they want to update a rating. If the CQC need to ask health and care providers for information before an inspection, the requests will be targeted and proportionate.

Question 1a; *To what extent do you support this approach?*

- *Recommendation provided to support this proposal*

Question 1b; *What impact do you think this proposal will have?*

- *Importance of CQC engagement*
- *Potential implications from limited third party feedback*
- *A more proportionate pre-inspection period*
- *A greater opportunity to consistently focus on outstanding practice*
- *Less requirement to arrange on-site visits*
- *Potentially added workload for Corporate/Support service functions*
- *Potentially less time spent with a wider range of NWAS staff*
- *Potentially less opportunities for a wider range of staff to showcase outstanding practice*

3.4.2 ***Reviewing and updating ratings***

The CQC want a less rigid approach that allows them to update ratings more often when they recognise changes in quality and to make their on-site inspections more targeted and flexible.

The changes that the CQC want to make mean they won't return to using the current inspection frequencies that are published on their website and the type of large inspections associated with this approach.

The CQC want to stop describing frequency of assessment in terms of 'inspection', and instead by how often they review quality and update ratings. This allows the CQC to focus on reviewing, confirming and changing ratings in a variety of ways, instead of this being limited to after a physical on-site inspection or a full assessment of quality. Being able to update ratings without an on-site inspection means the CQC will be able to use the expertise and professional judgement of their inspectors in a more flexible way.

Question 2a; *To what extent do you support this approach?*

- *Recommendation provided to support this proposal*

Question 2b; *What impact do you think this proposal will have?*

- *Ability to change ratings (up or down) quicker and more often*
- *Unsure of how this works, in practice*
- *Ability to put things right or share good practice in a more timely manner*
- *Reduce the potential of poor practice becoming embedded*

3.4.3 ***Changing how we rate NHS Trusts***

The CQC propose to simplify ratings for NHS trusts ***by publishing a single rating at the overall trust level, rather than multiple levels of complex, aggregated ratings***. This will enable them to focus on the culture and leadership of an organisation, as well as the services where people receive care.

This single rating will be based on the CQC's overall assessment of the organisation's performance against the well-led key questions, including findings from service-level assessments.

NWAS current well-led key questions position;

	Well-Led	Date of Outcome
E&UC	**Good**	**June 2020**
PTS	**Requires Improvement**	**January 2017**
EOC	**Good**	**June 2020**
Resilience	**Good**	**November 2018**
Overall	**Good**	**June 2020**

NHS 111	**Good**	**January 2017**
Overall	**Good**	**January 2017**

The CQC will continue to develop their approach to assessing the well-led key questions, at trust level*, to make sure that they look at the overall organisational performance on quality and safety effectively as part of that assessment.*

NWAS current other KLOE questions position;

	Safe	Effective	Caring	Responsive
E&UC	**Good**	**Good**	**Good**	**Outstanding**
PTS	**Good**	**Good**	**Good**	**Good**
EOC	**Good**	**Good**	**Good**	**Good**
Resilience	**Good**	**Good**	**Not Rated**	**Good**
Overall	**Good**	**Good**	**Good**	**Good**

NHS 111	**Good**	**Good**	**Good**	**Good**
Overall	**Good**	**Good**	**Good**	**Good**

If this approach is implemented then the CQC will ***no longer publish separate trust-level ratings for the safe, effective, caring and responsive key questions.*** However, the CQC will continue to publish those ratings at service and location level, which will provide a clear view of the quality of those services at the level that is relevant to people who use the service.

Questions 3a and b; ***Not relevant as they relate to GP Services***

Question 4a; ***To what extent do you support this approach?***

- *Recommendation would be to support this proposal, recognising the requirement of a greater focus on Well-led, Leadership and Culture*

Question 4b; ***What impact do you think this proposal will have?***

- *Potentially well-led visits to Trusts, will continue as they are now (on-site interviews, focus groups, documentation reviews etc)*
- *More 'in depth' assessment and 'enhanced' questioning*
- *Less 'tiles' to move from 'Good' to 'Outstanding'*
- *Potentially harder to move from 'Good' to 'Outstanding'*

3.4.4 ***Measuring the impact on equality***

The CQC need to consider equality and human rights in all their work, so they have produced a ***draft equality & human rights impact assessment*** (see Appendix 1), which identifies the opportunities and risks for doing this through their proposals. Importantly, it identifies the actions the CQC will take to minimise the risks and make positive change happen.

Question 5; ***We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our draft equality impact assessment. For example, you can tell us your thoughts on:***

- *Whether the proposals will have an impact on some groups of people more than others, such as people with a protected equality characteristic.*
- *Whether any impact would be positive or negative.*
- *How we could reduce or remove any negative impacts.*

3.5 **Part 2 – How we'll engage with you in the future**

The way the CQC currently consult and engage on any changes to their methods is a long process and means they can't implement changes and tell us about them quickly enough.

The CQC are changing the way they consult and engage with us on regulatory changes. To meet their statutory duties under the Health and Social Care Act 2008, the CQC will still publish a statement that explains how they'll assess the performance of health and care service providers.

However, going forward, the CQC will be able to hear people's views constantly through a range of ways, making it easier for them to design solutions together with all stakeholders, in real time, as they develop their future ways of regulating.

This means that we will see fewer large-scale formal consultations, but more on-going opportunities to contribute, as the CQC will start to engage in different ways.

The CQC will have more targeted conversations about things that affect NWAS, for example through focus groups and their online Citizen Lab platform.

This will help the CQC to respond more quickly to changes in health and care. Importantly, it will mean that the CQC will spend less time planning for formal consultations and more time listening to us.

In future, the guidance the CQC provide about how they regulate will be more focused on the key areas that service providers and the public need to know about. The CQC's engagement activity and the information they publish will be more accessible and easier to understand.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 The CQC is the independent regulator of health and adult social care in England to make sure that health and social care provide people with safe, effective, compassionate, high quality care.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to;

- Note the assurances provided in this report

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	31 March 2021
Subject:	Learning from Deaths: Quarter 3 2020/21
Presented by:	C Grant, Medical Director
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 third quarterly report to be published. The Q3 dashboard (appendix A) describes the opportunities to learn from deaths. In summary the contributory factors to patient deaths, where identified, were attributed to problems in clinical assessment and lack of available resources. The peer review process identified most patients received appropriate care, but where failings occurred these included the failure to record observations, referring the patient to AVS/alternative providers, and/or lack of SOS/red flag/worsening advice given. The peer review identified areas of good practice such as the recognition of patients approaching end of life where no formal arrangements were in place, organising and engaging with multi-disciplinary teams to ensure best interests of the patient were met. The peer review has identified three patient deaths for further review at ROSE and, at the time of writing, one of which is now classified as a serious incident which would not have been known to the trust if not for the learning from deaths review process. A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the learning forums and individual frontline staff. There is an intention to commend individuals who through their care and professionalism have supported families and patients to experience a good death. DCIQ Mortality module is moving forward at pace with the intention to be in test by 31 March 2021 and live by end of Q1 2021/22.
Recommendations, decisions or actions sought:	The Trust Board is recommended to: • Support the dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.

	• Acknowledge the impact of the SJR process in identifying opportunities for improving care and the identification of serious incidents previously unknown to the trust.
	• Acknowledge the good practice identified including:
	  ○ Clinicians building a holistic picture of the patient's condition
	  ○ Rapid replacement of EOLC packages where none were in place
	  ○ Excellent engagement with external care providers
	  ○ Thorough long-term safety-netting of patients
	• Note the progress in developing the mortality module in Datix

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

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**Clinical Effectiveness Management Group** **Quality and Performance Committee**
Date:	**2 March 2021** **15 March 2021**
Outcome:	**Approved**

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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' as referenced in the trust Learning From Deaths policy.

Appendix A is a summary dashboard of the Q3 2020/21 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st March 2021 in accordance with the national framework and trust policy. The 2020/21 Q3 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs). The learning from the panels is discussed later in this paper.

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

It is acknowledged the attached document remains an iterative reporting process which will become more sophisticated and informative as the year 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 nwasnt.clinicalaudit@nhs.net

3. LEARNING FROM DEATHS DASHBOARD Q3 2020/21: APPENDIX A

3.1 The number of patients whose deaths were identified as being in scope for this review was 77 (24 Datix incidents and 53 sampled - *table 1, Fig.1*).

3.2 *Datix Cohort Discussion*
Of the 24 patient deaths;

- 16 patients were identified through the Incidents module
- Six (6) patients were identified through the Patient Experience module
- And a further two (2) patients were identified as having records on both the Incidents and the Patient Experience module.

3.2.1 *Incident Module: Figures 2 and 3.*
Of the 16 patients, 11 patient deaths were reviewed and closed. In seven (7) patient deaths (64%) the investigations concluded the Trust had contributed in some way to that patient death:

- Problems with clinical assessment was cited as contributing to four (4) patient deaths;
- Lack of available resource was cited on two (2) occasions as contributing to patient death.

- Information issues was identified on one occasion.

3.2.2 *Patient Experience Module: table 4 and 5 and figure 4.*

Of the six (6) patients reported, all six are in the early stages of review and it is unknown at the time of writing if the care given was in line with best practice. The content of the reviews so far suggest the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures;
  - Recognition of ineffective breathing and
  - incorrect call categorisation
- Communications,
  - Internal/external communication messages for IFTs
- Operations/PES.
  - incorrect application of MTS
  - Staff behaviour/attitude

There was also one occasion where the behaviour/attitude of PES staff was raised as a concern by outside agencies.

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

Two (2) patient deaths were recorded on both modules – note these are different incidents from those referenced separately in the incident and patient experience modules. Of the two (2) patient deaths neither are closed at time of writing. The main learning themes are:

- Operational /PES
  - Incorrect application of MTS
- EOC/EMD procedures
  - Resource monitoring/management

Where noticeable practice has been identified this has been fed-back to the staff.

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

Of the 53 patient deaths:

- 28 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- 16 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- Nine (9) 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.*

3.3.1 *Structured judgement review methodology*

The process requires the reviewing clinicians to make explicit statements upon the practice under review using the ‘sequence of Events’ and ‘patient report form’ as the data source.

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

The review comprises of Stage1: review of clinical practice and call handling/ resource allocation. Where less than adequate overall care is identified a stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.

3.3.2 *Outcome: September Review: Stage 1.*

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

Month	Very Poor	Poor	Adequate	Good	Very Good
Oct 20	1	6	8	1	
Nov 20*	1	4	4		
Dec 20	1	6	5		

Moderation Panels held on 09/12/2020, 21/01/2021, 28/01/2021 & 10/02/2021

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'.

**November panel was cancelled by the Medical Director in response to REAP level 4. As a contingency the corporate team undertook the review and this was moderated by the reviewers on 24 February 2021 – therefore this data may change at the time of presenting the report.*

3.3.3 *Q3Review: Stage 2.*

19 patient death incidents were identified as needing second stage review. It was agreed that in four (4) deaths no other causal factors were identified as contributing to harm and 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 13 of the remaining patients remained as uncertain whether other factors added to poor practice leading to harm.

In two (2) cases is was determined that poor practice had led to harm of the patient

3.3.4 *Learning Outcomes: Tables 10 -12*

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase recording of patient observations and/or investigations recorded,
- Make appropriate referrals to AVS, primary care or alternative providers when appropriate to have do so. Ensure SOS/red flag/worsening advice is given and recorded
- Seek senior advice when you are unsure of what to next and have explored all reasonable options,
- Apply and record MTS/Pathway decisions
- Ensure all paperwork is signed by clinical staff attending the incident, and
- Make LeDeR referrals when appropriate to do so

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

Escalation

Through the stage 2 reviews, three (3) patient deaths were identified as requiring escalation to ROSE.

Outcome from ROSE:

- One patient death is now recognised as a serious incident and is being processed accordingly.
- One patient death has been downgraded to risk grade 3, and
- The third patient death is being prepared for ROSE at the time of writing this report.

In identifying three potential serious incidents previously unknown to the trust, the Learning from Deaths process clearly contributes to identifying areas for improvement.

Good Practice: Table 12 fig 8.

The panel review identified numerous positive examples of practice over and above expected practice. This included:

- clinicians building a holistic picture of the patient's condition,
- rapid placement of EOLC packages where none were in place,
- excellent engagement with external care providers, carers, GPs and family members to ensure the best interests are met for patients approaching end of life, and
- Thorough long-term safety-netting of patients.

3.4 *Dissemination Process*

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the learning forums 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 Learning Forums by the Consultant Paramedic, Medical. The development of a lessons learnt document would support dissemination. It is expected the Area Consultant Paramedics will use the document to feed into learning forums for discussion and action.

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 is anticipated to be in test by 31 March 2021 with a view to commuting the current process into the Datix system by end of Q1 2021/22. This will bring all elements of the Learning from Deaths review into a single system of data management.

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 aerosol generating procedure Audit, and Learning from Deaths audits) 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 has highlighted this element as crucial towards identifying potential risks in practice.

DX3477: *(risk score 12)* There is a 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 from 31 March 2021 when the current cover ceases which may result in a failure to meet the national statutory requirement placed upon the trust.

5. LEGAL and/or GOVERNANCE 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. RECOMMENDATIONS

6.1

- Support the dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.

- Acknowledge the impact of the SJR process in identifying opportunities for improving care and the identification of serious incidents previously unknown to the trust.

- Acknowledge the good practice identified including:
    - Clinicians building a holistic picture of the patient's condition
    - Rapid replacement of EOLC packages where none were in place
    - Excellent engagement with external care providers
    - Thorough long-term safety-netting of patients

- Note the progress in developing the mortality module in Datix

NWAS Learning From Deaths Dashboard Quarter 3 2020-2021 (October - December)

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
October	35	23	65.7%	12
November	21	12	57.1%	6
December	21	14	66.7%	8
This Quarter	77	49	63.6%	26
This Financial Year	234	93	39.7%	50

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

Table 1.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 12/02/2021.

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
October	11	1	2	8
November	2	0	2	0
December	3	0	1	2
Total	16	1	5	10

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
October	7	5	2
November	2	1	1
December	2	1	0
Total	11	7	3

Table 3.

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

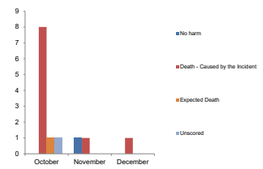

Figure 2.

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

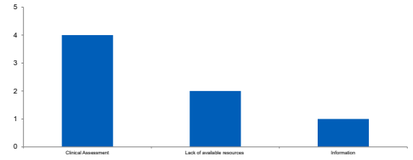

Figure 3.

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 01/02/2021.

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
October	1	0	0
November	3	0	0
December	2	0	0
Total	6	0	0

Table 4.

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

Learning theme

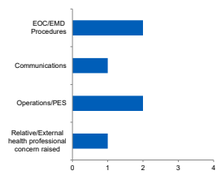

Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	EMD ineffective breathing recognition	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Incorrect call categorisation	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Communications	External/internal communication messages for IFTs	1	Reflection and/or feedback; invidicual and/or system learning with external HCPs
Operations/PES	Staff behaviour/attitude	1	Reflection and/or feedback; still under review
	Incorrect application of MTS	1	Reflection and/or feedback; re-training/re-reading procedures; still under review
Relative/External health professional concern raised	Patient safety concern	1	Reflection and/or feedback; re-training/re-reading procedures; 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 01/02/2021. Last accesed 12/02/2021.

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
October	1	0	0
November	0	0	0
December	1	0	0
Total	2	0	0

Table 6.

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

Learning theme

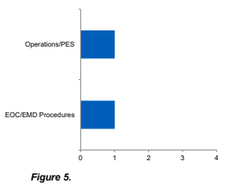

Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
Operations/PES	Incorrect application of MTS	1	Reflection and/or feedback; re-training/re-reading procedures; still under review
EOC/EMD Procedures	Resource monitoring/management	1	Reflection and/or feedback; re-training/re-reading procedures; still under review

Table 7.

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter: last extracted 01/02/2021. Information recorded on these incidents: last accessed 12/02/2021. 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 01/02/2021.

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
October	22	16	7
November	16	10	5
December	15	12	7
Total	53	38	19

Table 8.

SJR Stage 1 Overall Care Assessment

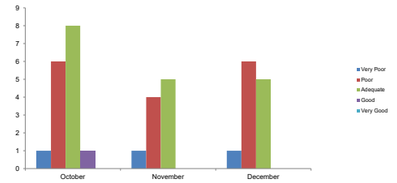

Figure 6.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
October	7	7	8
November	1	4	11
December	1	5	9
Total	9	16	28

Table 9.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	N/A	
Right Care	Patient Assessment Rating	12	25	1	26 patients out of 38 patient cohort	68%
	Management Plan/Procedure Rating	15	19	4	23 patients out of 38 patient cohort	61%
Right Place	Patient Disposition Rating	11	26	1	27 patients out of 38 patient cohort	71%

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 38 patients)

Evidence of Poor/Very Poor Practice

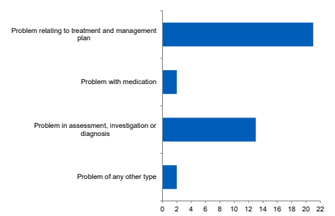

Figure 7.

Learning Theme	Learning Detail	Frequency (n=38 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	13
Problem relating to treatment and management plan	No referral to AVS/GP/alternative providers when appropriate to do so	8
	No SOS/red flag/worsening advice given	5
	No senior clinical advice sought	3
	No resuscitation attempted	2
	Delay in upgrading incident	2
	MTS/Pathfinder not used	1
Problem with medication	Incorrect use of medication	2
Problem of any other type	Lack of clinician signature on paperwork	1
	No LeDer referral made	1

Table 11.

Evidence of Good/Very Good Practice

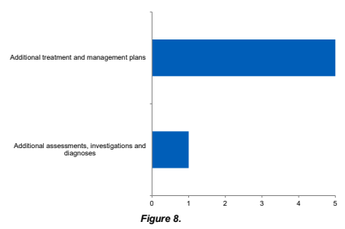

Figure 8.

Learning Theme	Learning Detail	Frequency (n=38 patients)
Additional treatment and management plans	Crew decided not to resuscitate patient they recognised as EOL in absence of formal EOLC package/DNACPR. Acted in best interest of patient.	2
	Additional referrals/management plans put in place for long-term safety netting of both patient and dependents	1
	Crew built holistic picture of patient's condition for treatment and rapid placement of EOLC package where one was absent	1
	Crew engaged with MDT comprised of external providers/carer/GP/family to ensure best interests of patient were met	1
Additional assessments, investigations and diagnoses	Crew recognised that patient was coming to the end of their life despite no EOLC/DNACPR being in place	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 staff absence/sickness 38 reviews took place, two less than the minimum random sample size of 40 required.

Data source: Informatics query 924638 last run on 07/01/2021, . SJR data souce: Learning from Deaths SJR Database, last accessed on 12/02/2021.

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Quality and Performance Committee

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	15th February 2021	**Quorate (yes/no):**	Yes
Chair:	Prof A Chambers	**Executive Lead:**	Dr C Grant, Medical Director Prof M Power, Director of Quality, Innovation and Improvement Mr G Blezard, Director of Operations
Members present:	Prof A Chambers (Chair) Mr R Groome, Non-Executive Director Prof R Thomson, Associate Non-Executive Director Dr D Hanley, Non-Executive Director Mr G Blezard, Director of Operations Prof M Power, Director of Quality, Innovation and Improvement	**Key Members not present:**	Dr C Grant, Medical Director Mr M Forrest, Deputy Chief Executive Officer
Board Assurance Risks Aligned to Committee:	**SR01:** 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. **SR03:** If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care		

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

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance framework		Since the previous Committee: • 10 new risks had been identified; 1 risk had increased in risk score, 1 risk had decreased in risk score and 9 risks had been closed. • The full root and branch review of the service delivery risks had been completed and consolidated. • 16 outstanding mitigating actions for completion by 2020/21 aligned to the Committee. • Risk 3451 relating to NWAS commanders not fulfilling their National Occupational Standards noted. Covid-19 impacted on live training sessions. Actions in place to complete training. Future reports requested to the Committee. • Noted that gaps in controls/assurances relating to ORH model, medical pouches and closure of complaints were unlikely to be completed by the end of 2020/21 due to Covid-19 pressures.	Gained assurance that each BAF risk was reported and managed effectively.
BAF Risk SR01 & SR03 Integrated Performance Report		• PES - call pick up in 5 seconds signals significant changes in the last two data points in January. • There had been a strong corporate performance across the Trust throughout the month of January 2021, which included supporting and picking up a number of calls for other ambulance service trusts. • ARP performance had been an improving picture, including IPC tables and the Trust had recently achieved 4 out of the 7 performance standards on a daily basis. • NHS 111 – 70% performance from November to December. • Received an Item of Urgent Business relating to a significant Covid-19 outbreak at Middlebrook resulting in significant staff abstractions.	Received moderate assurance from the IPR report.

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Chairs Assurance Report

		• The trust had completed IPC actions with regulators and twice daily LAMP testing had been introduced and monitored on a daily basis. • Increased promotion of Covid-19 vaccine for recently recruited 111 staff. • In terms of Quality, the remedial plans to address the backlog of closure of complaints continued, with complaints aligned to the Patient Safety Specialist Team continued. • Increased cases of violence and aggression towards NWAS staff (38 incidents of threatening behaviour and 28 cases of physical assaults) in January 2021. • Violence and Aggression Group addressing the issues and a Violence and Aggression Policy to be developed to capture the current V&A processes in place. • Q&P Committee to continue to monitor the cases via the Q&P Dashboard monthly reports.	
BAF Risk SR03: CFR Performance Update Q3		• A presentation on the CFR performance for Q3 highlighted the significant contribution of Trust volunteers during the pandemic. • 8529 responders had been signed up from November 2020 to February 2021 averaging 34,116 hours and 1,442 days per month during the same period. • Ongoing CFR support to the NWAS TTT service and assistance at the Trust's vaccination hub. • Ongoing training and development of the volunteer workforce. • Recruitment initiatives discussed to promote CFR role within BAME communities including NHS Charities bid for Engagement Officer.	Noted the assurance provided.

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Chairs Assurance Report

BAF Risk SR03: EOC Call Taking Assurance Summary		• A presentation on the methodologies for categorising calls aligning NHSE determinants against ARP categories. • The Single Primary Triage Project would involve developing the NHS Pathways described.	Noted the assurance provided.
BAF Risk SR03: Single Primary Triage Project (SPT) Update		• Since Board approval of the SPT project the Executive Leadership Committee had approved progress to Gateway 2 of the project - the ability to release trainers and commence technical development. • ELC also approved progress onto decision Gateway 3, the ability to release super users. • The update included details of continued progress, despite Covid-19 pressures, to implement NHS Pathways as the primary triage platform from September 2021.	Noted the assurance provided.
BAF Risk SR03: Third Party Assurances – Audit Committee Report		• The Audit Committee had recommended third party assurances were sought by Q&P Committee from third party providers of Private Ambulance services and FCMS (NHS 111) on an annual basis. • The third party assurances would be added to the Q&P work plan for 2021/22.	Noted the assurance provided.
BAF Risk SR01: Right Care Strategy – Q3 Progress Update		• Received the Q3 position on performance against the high level deliverables of the Right Care Strategy. • Noted that ELC had reviewed the Trust's performance indicators and agreed must do objectives for Q3 and Q4. • RAG ratings noted against the must do objectives with plans in place to address mitigating actions.	Noted the assurance provided.
BAF Risk SR01: Covid-19 NWAS Test, Track and Trace Project		• An update on the NWAS TTT service highlighted that 556 staff tested positive for Covid-19 during January 2021. • 198 staff identified as close contact cases. • 165 isolated as a result of the TTT risk assessment.	Received moderate assurance.

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Chairs Assurance Report

		• Some staff IPC non-compliance factors regarding mask wearing and social contact. • TTT service responded to the recent outbreak at NHS 111 Middlebrook.	
BAF Risk SR01: Hospital Handover Improvement Project		• Received an update on the Hospital Handover Improvement Project and a patient story to highlight the safety risks associated with hospital handover delays and patients waiting in ambulances. • Reported that despite efforts by the trust and participation in the Every Minute Matters Hospital Handover Collaborative there had been 1,721 delayed admissions since August 2020 and 2,112 NWAS ambulance service hours lost. • BAF risks 3445 – hospital handover delays and 3446 – risk to patients being held on ambulances continued to remain a significant risk score and on the service delivery risk register. • There was a significant concern that waiting ambulances will become business as usual across the region and the risks required escalation to the NWAS trust board to consider a trust board level approach to the risks including commissioners.	Escalated the Hospital Handover Delays and risks to patients waiting in ambulances to the Board of Directors.
BAF Risk SR01: Patient Safety Specialist – 60 Days reflections and forward thinking (Presentation)		• The committee noted the work of the newly appointed Patient Safety Specialist. • Forward plans for the role and the Patient Safety Team included - – Future restructure of the Patient Safety team – Learning disseminated from Board to front line – Datix Cloud IQ to be used as the platform for data collection – Themes, innovation and improvements from analysis of complaints data	Received assurance from the future plans of the Patient Safety Specialist.

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Chairs Assurance Report

		– National and regional comparisons and benchmarking – Involvement in the Hospital Handover Delay Improvement project through monitoring complaint and patient safety activity.	

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Quality and Performance Committee

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	15th March 2021	**Quorate (yes/no):**	Yes
Chair:	Prof A Chambers	**Executive Lead:**	Dr C Grant, Medical Director Prof M Power, Director of Quality, Innovation and Improvement Mr G Blezard, Director of Operations
Members present:	Prof A Chambers (Chair) Mr R Groome, Non-Executive Director Prof R Thomson, Associate Non-Executive Director Dr D Hanley, Non-Executive Director Mr G Blezard, Director of Operations Prof M Power, Director of Quality, Innovation and Improvement Dr C Grant, Medical Director Mr M Forrest, Deputy Chief Executive	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**SR01:** 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. **SR03:** If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care		

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		Since the previous Committee: • 16 actions outstanding mitigating actions aligned to the Committee for completion by the end of the financial year. • 1 brand new risk scoring 15 relating to IPC risks and 1 new Corporate Risk scoring 15 aligned to SR01 regarding AGP audit resource following disestablishment of the Covid-19 cell. • 1 risk had been removed from the Corporate Risk Register and 1 closed. • Action plans in place to address mitigating actions for completion by end of the financial year. • Noted the re-modelling of the NWAS resource model which would roll over into Q2 21/22.	Gained assurance that each BAF risk was reported and managed effectively.
BAF Risk SR01 & SR03 Integrated Performance Report		• PES – Call Pickup in 5 seconds during February and remained consistently above 98% with most weeks over 99%. • Service supported other ambulance services. • In relation to the data signal, the service had seen continuation of previous improvement in all ARP response times in February and NWAS were now meeting performance standards for C1 90th Percentile, C3 and C3 90th Percentile. • Noted that military aid to NWAS would cease by 21.3.21. • NHS 111 – achieved 76.1% with continual improvement towards the latter end of the month due to reduced number of Covid-19 staff abstractions. • The expansion of the Sefton House estate would be completed by the end of the March 2021 to provide an opportunity to recruit further call taking staff.	Received moderate assurance from the IPR report.

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Chairs Assurance Report

		• Call back under 10 minutes had not been achieved due to the utilisation of clinicians at the front end of the emergency service during Covid-19 pressures, with reduced capacity within the NHS 111 service. • Noted the position had recently improved as pandemic pressures had eased. • Monitoring and scrutiny of 111 performance, particularly the data points under the mean performance measure would continue to be monitored by the Committee. • PTS - continued to be managed in line with national command and control arrangements with priorities to support delivery of the 999 service through the provision of staff and fleet, maintenance of service provision to priority patients such as those travelling for haemodialysis and cancer treatment (including those who are considered to be clinically extremely vulnerable) and to respond to rapid discharge requirements to ensure effective flow through hospitals and the wider system. • Noted that the Trust were developing delivery plans to manage demands of Easter holiday, Euro Football finals and easing of lock down measures. • Quality performance highlighted the closure rates of complaints continued to be outside of the required standard with resources restructured within the Patient Safety team aligned to manage the backlog.	
BAF Risk SR03: UEC Strategy Refresh		• Received an update on the Urgent and Emergency Care Strategy and progress against delivery of UEC Transformation objectives up to Q4 2020/21. • Received a detailed overview of the delivery roadmap from 2021/22 onwards including the need to review	Noted the assurance provided.

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Chairs Assurance Report

		structures to identify integrated response model to include PTS and the 111 service. • Future assurance regarding the resources to deliver the implementation plan would be reported via a measurement strategy to demonstrate impact of the actions in the strategy. • Discussed the benefits of video conferencing in the care home sector and future consideration would be included in the UEC implementation agenda.	
BAF Risk SR03: Mandatory Commander Training (including HART)		• The NWAS Mandatory Commander Training position regarding compliance against the national standards was presented for 2020. • Specifically the attendance rate on annual command refresher training and Hazardous Area Response Team (HART) mandatory recertification. • 17 out of 18 NWAS Strategic Commanders had attended training. With 100% compliance in attendance of Tactical and Operational commander mandatory training. • In relation to HART mandatory recertification, the practical training of all staff had been delayed due to social distancing restrictions, however an adequate number of staff had been trained to maintain deployable capability post April 2021.	Noted the assurance provided.
BAF Risk SR03: Emergency, Planning, Resilience and Response (EPRR) Sub Committee Terms of Reference		• Following restructure of the Board Sub Committees an EPRR sub-committee has been established to provide assurance in relation to the Trust's preparation for an emergency situation. • Noted that under the Civil Contingencies Act 2004, the Trust is required to plan for major incidents to ensure appropriate strategies are embedded throughout the organisation in order to return to business as usual.	Noted the assurance provided and approved the Terms of Reference for the EPRR Sub Committee.

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Chairs Assurance Report

		• The Sub Committee to commence during 21/22 and meet on a quarterly basis and provide assurance reporting to the Quality and Performance Committee via a Chairs Assurance Report.	
BAF Risk SR03: Performance Challenge/Sustainability		• A briefing paper detailed the forthcoming challenges presented to the Trust in the coming months, including withdrawal of military support, the lifting of lockdown restrictions and upcoming Easter holidays; plus the Euro Football Championships. • Discussions recognised that specific plans were being developed but had not been confirmed.	Received moderate assurance.
BAF Risk SR01: Covid-19 Outbreaks Update		• At the time of reporting there were 17 outbreaks of Covid-19 open within the Trust. • Acknowledged that many of which were small with only two members of staff connected in time and place. • There were 2 escalation sites, NHS 111 Middlebrook and Warrington ambulance station. • Improved IPC compliance was reported and peer to peer role models were acknowledged as good practice. • However, compliance rate for the Covid-19 staff vaccination programme was noted as 79.12% and further NHS guidance to be considered by Executive Directors on managing the risks associated with staff who declined the vaccine.	Received moderate assurance.
BAF Risk SR01: Quality Assurance Visits (QAVs) Update		• A presentation from the Internal Accreditation and Quality Assurance Manager provided an overview of the current position relating to the Trust's Quality Assurance Visits (QAVs) and the ongoing improvement work to replace QAVs with an internal accreditation programme by the end of Q2 2021/22.	Noted the assurance provided.

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Chairs Assurance Report

		• The internal accreditation programme would be a structured measurement system with outcome ratings aligned to the CQC Inspection Framework. • Action plans to deliver against outcomes of the QAVs had been devolved to the teams however a future report to provide an overview of the themes and outcomes following the action taken to be presented to a future committee to complete triangulation of assurance.	
BAF Risk SR01: CQC Regulation Update		• A CQC Regulation Update reported that the CQC had launched a consultation process on the 26th January 2021 on their proposals for a more flexible and responsive regulation regime and the Trust had prepared a response for submission by 23rd March 2021. • Assurance provided that following a transitional monitoring inspection approach, taken by the CQC during December 2020 and January 2021, there had been no regulatory concerns reported to the Trust. • CQC inspection regime would be continued focus on the Well Led KLOEs which would include gathering information and intelligence from the wider public and NHS sector.	Noted the assurance provided.
BAF Risk SR01: ROSE Review of Learning		• An annual thematic learning of Review of Serious Events (ROSE) identified that 50 serious event investigations had been closed during the year to date. • The 10 most frequent areas of learning were presented and the number 1 theme for NWAS and across the ambulance services within the NHS related to ineffective breathing descriptors. • A dedicated Task and Finish Group had been established to address the learning outcomes including full engagement with the Medical Priority Dispatch System to ascertain a clear definition and application.	Received moderate assurance.

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Chairs Assurance Report

		• Staff bulletins and specific briefs issued throughout the year and NWAS work with National Coding Group was in progress to drive further improvements in the National system. • Noted that each SI identified had an action plan and the Clinical Effectiveness Management Group continued to provide assurance on the monitoring of the action plans to Q&P Committee through the Chairs Assurance Report.	
BAF Risk SR01: Learning from Deaths Quarter 3 2020/21		• Noted the risk relating to the lack of a dedicated EOC subject expert to conduct the high tier end to end audits. • Advised the team were currently using existing resources with a gap in EOC call handling resource. • The Trusts' Executive Leadership Committee to consider options to mitigate the risks associated with audit resource.	Received moderate assurance.
BAF Risk SR01: Okenden Review of Maternity Services		• Received an annual update on the Trust's action taken in response to the Okenden Review of Maternity Services published in December 2020. • Noted NWAS were not a commissioned maternity service however were a commissioned provider of urgency and emergency care. • Advised that the Trust was compliant against 6 out of the 7 Immediate and Essential Actions identified by the Okenden review with remedial action taken relating to informed consent. • The Committee welcomed the Trust's actions to address the recommendation regarding urgent transfer from an immediate area to an alternative provider with specialised facilities. • Reported that a newly appointed Consultant Midwife had been appointed by the Trust, to commence on 1st May 2021.	Noted the assurance provided.

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

BAF Risk SR01: Chairs Assurance Report from the Clinical Effectiveness Management Group (CEMG) held on 2nd March 2021		• Members received moderate assurance in the areas of ➢ The Group's annual self-assessment in relation to actions to address changes required to the Terms of reference and the format of governance reporting. ➢ Clinical audit and AQIs pending work completed by a new Clinical Audit and Improvement Group to include MIAA assurance reporting. ➢ Clinical Governance assurance for 111 service in relation to recruitment to quality assurance posts, team manager and clinical auditor positions, but good progress had been made in relation to complaints and emerging themes.	Received moderate assurance.
BAF Risk SR01: Chairs Assurance Report from the Non Clinical Learning Forum held on 8th February 2021		• Members received moderate assurance in relation to the Forum's annual self-assessment of learning trackers which required completion on a more regular basis with more frequent updates. • Acknowledged that the learning tracker process was in place for the membership to promptly identify and record learning.	Received moderate assurance.
BAF Risk SR01: Chairs Assurance Report from the Safety Management Group held on 2nd March 2021		• The Committee were informed of a significant increase in complaints received during Q3 which had challenged the Trust's resource to meet the demand. • Resulted in a delay in achieving the safety related pillars of quality goals set out in the Right Care Strategy during Q3, specifically the closure of complaints within a required timeframe. • Action plans in place to mitigate the backlog and led by the Patient Safety Specialist.	Noted that a significant increase in complaints during Q3 (Sept-Dec 2020) had challenged available resource to close complaints within the required timeframes. A progress update to be presented to the next Committee

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Chairs Assurance Report

		• The complaints team has been restructured to streamline processes. • Noted that a patient story presented by a service user from an NWAS patient had provided members with insight into mental health recovery and interactions with the service and other NHS organisations.	meeting and a deep dive into Trust Complaints.

	No assurance – could have a significant impact on quality, operational or financial performance;
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	Assured – no or minor impact on quality, operational or financial performance

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Chairs Assurance Report

Name of Committee/Group:	Resources Committee	**Report to:**	Board of Directors
Date of Meeting:	26th March 2021	**Quorate (yes/no):**	Yes
Chair:	Mr M O'Connor	**Executive Lead:**	Carolyn Wood, Director of Finance Lisa Ward, Director of People Prof M Power, Director of Quality, Innovation and Improvement
Members present:	Mr M O'Connor, Non-Executive Director (Chair) Mr R Groome, Non-Executive Director Mr D Rawsthorn, Non-Executive Director Ms G Singh, Associate Non-Executive Director Ms C Wood, Director of Finance Ms L Ward, Director of People Mr S Desai, Director of Strategy and Planning Mr G Blezard, Director of Operations	**Key Members not present:**	Prof M Power, Director of Quality, Innovation and Improvement
Board Assurance Risks Aligned to Committee:	**SR02:** If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective. **SR04:** If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives. **SR05:** If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives. **SR07:** If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity. **SR08:** If the Trust does not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to complete and gain business and commercial opportunities that will generate income and protect our core services.		

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Chairs Assurance Report

Key Agenda Items		Key Points	Action/Decision
Board Assurance Framework		• 6 new risks had emerged relating to SR04. • 1 risk had increased in score relating to the lease of premises. • 3 risks had decreased in current risk score 3170 – MEN Enquiry 3437 – Risk that H2 draft planned financial deficit was not achieved due to Covid-19 outbreak. 3372 – Segregation of healthcare waste on vehicles. • 3 risks had been closed 2920 – insufficient workforce resources not in place across the NHS 111 service 3187 – poorly located sites due to the Trust not planning effectively for the future configuration of its estate 3318 – impact of Covid-19 on the delivery of planned October 2020 paramedic cohort • Currently 26 mitigating actions for completion by the end of the financial year. • Discussion regarding the representation of the digital agenda in the Trust's 2021/22 Strategic Risks for discussion and approval by the Board of Directors.	• Noted and received assurance from the report.
BAF RISK SR02: Finance Report to 28th February 2021 (month 11 2020/21)		• The financial position for the Trust at 28th February 2021 (month 11) reported a surplus of £0.232m, which is £2.900m better than the planned deficit of £2.668m. Income is over recovered by £18.889m, pay is overspent by £8.168m and non-pay is overspent by £7.821m. • The financial plans for the period October 2020 to March 2021 (H2) were resubmitted to NHSE/I on the 18th of November. • Noted that the latest forecast outturn position is a deficit of £2.5m. The key movements from the H2 planned £4.0m deficit were due to additional system funding from the ICS; interim payment received from NHSE/I to cover the loss of	• Noted the Month 11 2020/21 reported financial position.

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

		non -NHS income; a reduction in the Trust's forecast expenditure position for the year; an increase in the forecast annual leave to be carried forward, compared to the value included in the H2 plans. • In terms of capital expenditure, the YTD capital expenditure was reported as £9.227m against the Trust's latest forecast charge against CRL for the year of £22.025m. The Trust currently has a notified CRL of £21.655m therefore a shortfall of £0.550m, which is due to be transacted by DHSC.	
BAF Risk SR02: Draft Estates Revaluation Report		• The Committee were informed of the impact of the 2020/21 draft estates revaluation and the subsequent impairments in response to an annual desk top valuation undertaken by Deloitte LLP. • The value of Trust's estates had reduced from £38.4m to £36.3m; a decrease of £2.1m with an upward revaluation of £0.4m against properties increasing the respective revaluation reserve and £2.5m has been charged against Trust's income and expenditure position as an impairment. The charge was noted as technical in nature and did not affect the Trust's ability to achieve its financial duties. • The main decrease in value was attributed to capital Spend, due to ongoing maintenance and repair at the properties and weakening sentiment in the office accommodation market.	• Noted and received assurance from the report.
BAF Risk SR02: Draft 2021/22 Financial Plans		• The Committee were presented with the 2021/22 draft revenue financial plans, including efficiency and productivity targets, and the draft opening capital programme for 2021/22 for onward reporting to the Board of Directors for approval. • The annual national financial and operational planning guidance for 2021/22 was delayed, and in response the	• Noted and received assurance from the report. • Approved for onward reporting to the Board of Directors.

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		current emergency financial regime, put in place as a response to the pandemic, would remain in place for at least Quarter 1 of 2021/22 but more likely this will be for a H1 (April-September) period. • Reported that the draft baseline financial plans currently exclude expenditure budgets, or corresponding income budgets, required to continue with the initiatives established during 2020/21 in relation with responding to the Covid19 pandemic. These would be included within an updated financial plan once national guidance and financial envelopes have been received. • The draft baseline financial plans for 2021/22 had been established with a breakeven position with the income budgets set at £384.923m, the expenditure budgets for pay and non-pay at £285.072m and £99.851m respectively. • The draft capital programme for 2021/22 was forecast at £21.564m, funded by internal resources of £15.278m depreciation (CDEL) and £0.500m from the sale of assets, leaving a shortfall of £5.786m. • Noted that the Trust would continue reviewing and prioritising the programme and once the final proposal had been determined seek additional CDEL from other sources, either via the ICS or other nationally funded capital. • The Committee noted that the draft financial plans would be reviewed and updated in April/May 21 following the issue of the system financial envelopes and the publication of national planning guidance for 2021/22 from NHSE/I.	
BAF Risk SR02: C1 Driver Training		• Received the outcome of the procurement exercise undertaken to appoint a supplier to provide a full C1 Driver Training Programme.	• Approved the contract award for C1 Driver Training. • Recommended approval to the Board of Directors.

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BAF Risk SR02: Conflict Resolution Training – Contract Award		• Received the outcome of the procurement exercise undertaken to appoint a preferred supplier to provide Conflict Resolution Train the Trainer Training.	• Approved the contract award for Conflict Resolution Training. • Recommended approval to the Board of Directors.
BAF RISK SR02: Contract to appoint supplier to provide the End Point Assessments for apprenticeships		• Received the outcome of the procurement exercise undertaken to appoint a preferred supplier to provide End Point Assessments for Apprenticeships.	• Approved the contract award for supplier of End Point Assessments for Apprenticeships. • Recommended approval by the Board of Directors.
BAF RISK SR05: Estates, Fleet and Facilities Management Assurance Report		• Presented with the estates, fleet and facilities management assurance for period October 2020 to January 2021, against key work areas identified in the estates and fleet strategies and progress towards attaining the desired outcomes. • The Committee noted the progress to address the estates maintenance backlog.	• Noted and received assurance from the report.
BAF RISK SR05: Green Plan Review		• Following approval of the Trusts Green Plan by the Trust Board on the 2nd of March 2020, a revision of the plan had been undertaken following NHS acceleration of the de-carbonisation programme to improve on the current statutory target of net zero by 2050 down to 2040 and a new publication *Delivering a 'Net Zero' National Health Service*.	• Recommended the revised Green Plan for approval by the Board of Directors.

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		• The revised plan had been refreshed and included inclusion of NHS Building to Net Zero and updated SDAT score and SDG's. • The Trust's approved Sustainable Development Assessment Tool (SDAT) % scores and its contribution towards the United Nations Sustainable Development Goals (SDG's) had also been updated. • The refreshed SDAT submission resulted in an improved score of 69%, a positive increase from the last submission of 60%. This score ranked NWAS as the highest scoring ambulance service in the UK that currently use the model.	
BAF RISK SR05: Sustainability Update		• The re-written Sustainable Development Management Plan (SDMP), approved by the Trust Board in September 2019 had been re-named the Green Plan in line with NHSE and NHSI requirements. • Noted that included in the Green Plan was a target objective for the formation of a Sustainability Steering Group which is essential to the ongoing development and the delivery of the Trust's Plan. • The Sustainability Steering Group had now been established and the inaugural meeting held 6th December 2019 with further group meetings taking place and sustainability actions being identified. • Within the report some key current projects have been identified and progressed to enhance the Trust's sustainability commitment including renewable energy, carbon literacy, electric vehicles, LED lighting and Hydrogen fuel cells.	• Noted and received assurance from the report.
BAF RISK SR04:		The Workforce indicators report included –	• Noted and received assurance from the report.

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Key Workforce Indicators Assurance Report		i. Staff appraisals – as a result of Covid-19 appraisals had been paused in line with national guidance and as a result completion rates are currently 61% overall, a reduction from previous 2 months. PES rates are at 60% and PTS at 69% with 111 having the most challenged rates at 40%. A revised target as part of recovery planning has been agreed by ELC of 75% for September 2021, 85% for March 2022 and 95% by March 2023. Corporate Departments and Managers in Band 8A posts target remains at 85%. Work ongoing to develop a more sustainable, digitally supported model of delivery. ii. Mandatory training for frontline staff had been disrupted with significant pauses in delivery. PTS met their target for classroom completions of 95% by December. PES overall classroom attendance compliance at 51% to be recovered during 2021/22 programmes. iii. The overall Trust mandatory training compliance position at the end of February 2021 was 75%. This is on track with revised targets. iv. Sickness - increased in January 2021 (February dashboard) to 10.41% which included Covid-19 related sickness of 4.27%. The Covid-19 related sickness had significantly increased since the last report to Committee from below 1% to now over 4%. v. Highlighted that non-Covid-19 sickness absence levels across all service lines are lower than last year but attention to be paid particularly to call centre underlying sickness levels which remain high. Noted that the formal management of	

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		sickness absence had been paused and recovery now in progress. vi. Vacancy position - overall positive with all planned growth now included in establishments giving a true vacancy position against budgeted resources. An over-establishment at the end of February 2021 in EOC of 6.96% to support Single Primary Triage roll out. In relation to 111, recruitment was progressing with current vacancy against establishment at 8.37%. vii. Staff Turnover – remains low at 7.41%. viii. HR Case Management – following pause in progressing Employee Relations casework, noted that this was now progressing with a plan to agree a position to manage the backlog of cases. ix. NWAS Covid-19 Vaccination Programme – uptake rate currently approx. 79% 111 service uptake rate of 66% with an ongoing communications strategy to support an increase in uptake amongst staff. Work being undertaken to address vaccine hesitancy especially amongst ethnic minority staff.	
BAF RISK SR04: Staff Survey 2020 Review and Findings		• A paper summarised the 2020 staff survey report published by the National NHS Staff Survey Co-ordination Centre on 11th March. It was noted that the survey had been completed during a period when the trust were experiencing the pressures of the second wave of Covid-19 and also immediately followed the Culture and Wellbeing audit. • Overall the report illustrated a picture of stability with little significant decrease/increase in most areas with scores being around the average for the sector.	• Noted and received assurance from the report.

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		• The Committee noted the staff engagement and team working reduction in score and a positive increase in our Health and Wellbeing score. • Noted the results depicted an extremely challenging and difficult year with managers under extreme pressures. • Similar themes acknowledged in the Culture and Wellbeing Audit and the Trust's Executive Leadership Committee approved development of local wellbeing plans to address the criticality of local management and the impact on staff experience. • Themes will be used to inform a review of the Workforce Strategy and planned work to include the launch of the Treat me Right campaign and launch of the new organisational values and behaviours framework.	
BAF RISK SR04: Agency Exit Strategy Q4 progress		• Reported that the year to date expenditure on agency was £5.319m, £2.469m above the year to date ceiling of £2.850m. 111 and PES (including EOC and the Clinical Hub) above the year to date ceiling. • Highlighted that the Trust was currently operating under an emergency budget due to Covid-19 so financial risk rating unaffected by current spend. Any changes to agency ceiling arrangements and/or ceiling value are expected to be confirmed for Q2 of 21/22 onwards. • Noted that an appropriate exit strategy had been prepared. This included a managed transition to pre-COVID levels of spend in 111 and Clinical Hub during Q1. • In EOC, based on ELC approval of the next SPT gateway, it was planned to transition agency staff onto	• Noted the exit strategies in place to reduce current levels of agency staff.

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		fixed term contracts at the end of their 12 week introductory period, to complete by the end of Q1 2021.	
BAF RISK SR04: Clinical Education Assurance Report		• Received a report highlighting the actions taken by NWAS to implement and develop national key requirements in relation to the paramedic profession; in line with NHSE and NHSI Joint Ambulance Improvement Programme. • Developments included degree entry for paramedic registration, introduction of a national 2 year Newly Qualified Paramedic (NQP) consolidation of learning programme implemented through joint working arrangements. • Noted that an MIAA audit of the NQP programme provided moderate assurance with recommendations identified and completed for presentation to Audit Committee in April 2021. • Recognised that CPD funding for upskilling of existing non-degree level paramedics and development of a paramedic apprenticeship programme as a route for in-service staff to become a paramedic.	• Noted and received assurance from the report.
BAF RISK SR04: Occupational Health Assurance report		• Occupational Health activity reported from April 2020 – Jan 2021 78.6% of the standard contracted activity had taken place resulting in a current underspend of just under £83k, with the value of additional activity at £62.5k and resulting in a current overall underspend of £20.5k. • In terms of Standard Activity, underactivity in physiotherapy services resulted in 48% of the contracted activity being utilised resulting in a saving of approx. £49k. • An overspend of £18.9k for pre-employment checks with activity at 133% and an overspend for counselling services of £8.4k with 110% activity.	• Noted and received assurance from the report.

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		• Noted that the overspend for counselling activity attributed to death in service and Arena enquiry support. • Reduced activity reported for additional activity in relation to the Covid-19 pandemic in first half of the year, with an increase more recently of £19.7k due to the demand for therapeutic support services and Covid-19 assessments.	
BAF RISK SR04: NHS People Plan – Progress Report		• A status report presented the progress in relation to actions detailed in the NHS plan. • The Committee noted the moderate (amber) assurances provided in the update position relating to untaken annual leave; appointment of a well-being guardian; work required on the impact and implementation of flexible working arrangements for front line and clinical roles and to include flexible working in the NWAS staff induction process. • In addition, the Trust are required to publish progress against the model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce and multifunctional review of disciplinary processes to eliminate any ethnicity gap. It was noted that actions were included in the recovery plan for 2021/22.	• Noted and received assurance from the report.
BAF RISK SR08: Integrated Business Plan (IBP) Refresh		• Performance against the Strategic Objectives was presented and progress noted. • Due to the current uncertainty created by the delay in the publication of the national planning guidance, it is anticipated there will need to be a further refresh in the near future with future objectives and milestones to be updated; once for the recovery and restoration plans have been completed.	• Noted and received assurance from the report.

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BAF RISK SR07: Digital Strategy Update		• Noted update on the delivery of the Digital Strategy and associated risks including progress with the EPR. • EPR evaluation and learning from the pilot had enabled good progress of the roll out of the programme. • Options for future developments to be presented to Executive Leadership Committee and Resources Committee in May. • Following external funding for Body Worn Cameras, the team would be considering implementation including consideration of national guidance during April 2021.	• Noted and received assurance from the report.
BAF RISK SR07: Digital Strategy Refresh		• Received an update on the refresh of the Trust's Digital Strategy with an Annual Report to be presented to Board of Directors in May. • The Refresh had been approved the Executive Leadership Committee for approval by Resources Committee and the Board of Directors.	• Noted and received assurance from the report. • Recommended approval by the Board of Directors.
BAF RISK SR07: Chairs Assurance Report – Information Management Group		• Noted the assurance provided with moderate assurance in the areas of subject access requests, Draft Records Management Policy and Patching. • Assurance ratings related to resource and timeframes for patching completion rates. • Acknowledged the good progress and governance reporting in all areas of the Information Management Group meeting.	• Noted and received assurance from the report.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	31 March 2021			
Subject:	Green Plan Review			
Presented by:	Director of Finance			
Purpose of Paper:	For Decision			
Executive Summary:	The Trusts Green Plan was approved by the Board of Directors on the 2 March 2020. The NHS has recently decided to accelerate its decarbonisation programme to improve on the current statutory target of net zero by 2050 down to 2040 and has published a new document *Delivering a 'Net Zero' National Health Service*. A review and revision of the Green Plan has been undertaken to update the document to reflect the recent NHS changes and ambitions. Opportunity has also been taken at this time to update the Trust's Sustainable Development Assessment Tool % scores and its contribution work towards the United Nations Sustainable Development Goals.			
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Approve the changes made within the revised Green Plan			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	No
Previously Submitted to:	Executive Leadership Committee / Resources Committee
Date:	9 December 2020 / 26 March 2021
Outcome:	Supported / Supported

1. PURPOSE

The purpose of this report is to seek approval from the Board of Directors for the revised Green Plan. The plan has previously been presented to the Executive Leadership Committee and the Resources Committee on the 9 December 2020 and 26 March 2021 respectively.

2. BACKGROUND

The Trust's Green Plan was approved by the Board of Directors on the 2 March 2020.

The NHS recently decided to accelerate its decarbonisation programme to improve on the current statutory target of net zero by 2050 down to 2040 and published a new document *Delivering a 'Net Zero' National Health Service*, in October 2020. A review and revision of the Green Plan has been undertaken to update the document to reflect the recent NHS changes and ambitions.

The Trust completes the NHS approved Sustainable Development Assessment Tool (SDAT) every 6 months to assess its progress towards embedding sustainability within the Trust.

The SDAT measures progress within 10 core modules and has helped inform the development of the Green Plan by highlighting the areas within each module that needs to improve.

Opportunity has also been taken at the time of this review to update the Trust's Sustainable Development Assessment Tool % scores and its contribution work towards the United Nations Sustainable Development Goals (SDG's) which confirms progress and improvements.

All changes are noted in red in the attached revised Green Plan for ease of review

3. LEGAL and/or GOVERNANCE IMPLICATIONS

The Climate Change Act sets out the mandatory target for achieving net zero carbon by 2050.

4. RECOMMENDATIONS

The Board of Directors is asked to approve the revised Green Plan.

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North West Ambulance Service NHS Trust

Green Plan

2019 - 2025

Green Plan 2019 - 2025		Page:	Page 1 of 35
Author:	Environmental Sustainability Officer	Version:	1.2
Date of Approval:	02/03/20	Status:	Issued
Date of Issue:	02/03/20	Date of Review	Oct 2022

Recommended by	Estates Manager Environmental
Approved by	Trust Board of Directors
Approval date	02/03/20
Version number	1.0
Review date	October 2022
Responsible Director	Director of Finance
Responsible Manager (Sponsor)	Assistant Director of Estates, Fleet & FM
For use by	All staff

This policy is available in alternative formats on request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	15.05.2019		Environmental Sustainability Officer	Content structure development, sections 1.1, 2 and 3
0.2	30.07.2019		Environmental Sustainability Officer	Addition to Section 4 and Climate Change Risk Assessment.
0.3	16.08.2019		Environmental Sustainability Officer	Addition to Section 4
0.4	19.08.2019		Environmental Sustainability Officer	Addition to section 4, amendment to section 3, amendment to section 1
0.5	28.08.2019		Environmental Sustainability Officer	Addition to section 4, 5 and 6
0.6	29.08.2019		Environmental Sustainability Officer	Sections 7-11
0.7	05.09.2019		AD and Estates Manager Environmental	Document Review
1.0	26.09.2019	26.09.2019	Assistant Director E&F	Board approved 25/9/19 and issued version
1.0	14.02.2020	02.03.2020	Estates Manager Environmental	NHS requirement for re-naming of document from SDMP to Green Plan including all references.
1.1	23.11.2020		Estates Manager Environmental	Inclusion of NHS Building to Net Zero
1.2	25.11.2020		Environmental Sustainability Officer	Update of SDAT score, SDGs, formatting and page numbers

Green Plan

Contents

1. Introduction

1.1 Organisation

In the provision of emergency healthcare and patient transport services, The North West Ambulance Service NHS Trust:

- Employs over 6,000 staff;
- Operates in 130 buildings, including ambulance stations, patient transport bases, corporate offices, emergency operations centres, a 111 call centre and vehicle maintenance workshops;
- Operates across Cumbria, Lancashire, Cheshire, Merseyside and Greater Manchester, an area of 5,400 square miles with a population of 7.5 million people; and
- Currently has over 1,000 emergency and non-emergency vehicles in operation.

This Green Plan has been created with this in mind to ensure that, as one of the larger ambulance services in the UK, we act as an anchor institution and reaffirm our commitments to the delivery of a sustainable health and care system.

A sustainable health and care system reduces inequalities, environmental impacts and preventable diseases whilst enabling environmental improvements, independence and wellbeing and the creation of strong social assets.

1.2 Current Progress

The NHS Long Term Plan released in January 2019 included several environmental targets. This Green Plan in conjunction with other Trust documents aims to work towards achieving all of these. The Trust has taken an ambitious approach by aligning its targets with the targets in the NHS Long Term Plan and the updated 2050 target in the Climate Change Act, these five targets are listed below.

- 51% reduction in carbon by 2025 (1990 baseline).
- Net Zero Carbon by 2040.
- Cut business mileages and fleet air pollutant emissions by 20% by 2023/24.
- Ensuring that at least 90% of the NHS fleet uses low-emissions engines (including 25% ultra-low emission) by 2028.
- Phasing out primary heating from coal and oil fuel in NHS sites.

In 2020 the NHS launched its latest initiative “Delivering a ‘Net Zero’ National Health Service”. Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

• For the emissions the NHS control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
• For the emissions the NHS can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

An overview of the interventions required by the NHS to meet these targets is provided below, accompanied by analysis of the expected carbon reductions and any risks, and opportunities for an accelerated timeline.

A number of early steps will be taken to decarbonise:

1. Our care: By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.
2. Our medicines and supply chain: By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.
3. Our transport and travel: By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4. Our innovation: By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service, and implementing a net zero horizon scanning function to identify future pipeline innovations.
5. Our hospitals: By supporting the construction of 40 new 'net zero hospitals' as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6. Our heating and lighting: By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7. Our adaptation efforts: By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.
8. Our values and our governance: By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme For a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff. Meeting this commitment will only be achievable if every part of the NHS – more than 1.3 million of us – are working together. Whether it is a physiotherapist keeping their patients active with sustainable mobility aids, a mental health nurse providing high quality care via telemedicine or a hospital chef sourcing their ingredients from the local community, we all have a role in delivering a net zero NHS, providing health and high quality care for all, now and for future generations.

2. Drivers for change

Drivers provide legal and policy context for improving sustainability and can be categorised into four key groups, as outlined below. These drivers are correct at the time of publication but are subject to regular review and updates across the lifetime of this plan.

1. Legislative

- Civil Contingencies Act
- Climate Change Act
- Environmental Protection Act
- The Waste Regulations
- European Emissions Trading Scheme
- Public Sector (Social Value) Act

3. International and European Guidance

- European Union Waste Directive
- United Nations Sustainable Development Goals
- World Health Organisation: Environmentally Sustainable Health Systems in Europe
- The Global Climate and Health Alliance
- Intergovernmental Panel on Climate Change

Global Warming 1.5°C

- Mitigation and Co-Benefits of Climate Change
- World Health Organisation: European Policy for Health and Wellbeing

2. Healthcare specific guidance, strategies and policy

- Sustainable Development Strategy for the Health and Social Care System
- HM Treasury Sustainability Reporting Framework
- NHS Long Term Plan
- The Carter Review
- The Naylor Review
- Adaptation Report for the Healthcare System
- Public Health Outcome Framework
- Fair Society, Healthy Lives (The Marmot Review)
- NHS Standard Contract 2019/20
- Health Technical Memoranda and Building Notes
- NICE – Physical Activity, Walking and Cycling
- Sustainable Transformation and Partnership Plans
- NHS Delivering a 'Net Zero' National Health Service.

4. UK Strategy and Guidance

- The Stern Review 2006: The Economics of Climate Change
- National Policy and Planning Framework 2012
- DEFRA: The Economics of Climate Change
- National Adaptation Program
- HPA Health Effects of Climate Change
- Making the Country Resilient To The Changing Climate
- DEFRA 25 year Environment Plan
- UK Air Quality Strategy
- BEIS Industrial Strategy: Building a Britain Fit For The Future
- DEFRA Waste and Resources Strategy
- Building Regulations
- Government Buying Standards
- GM Carbon Neutrality / 5 year plan

3. The NWAS Vision

NWAS Mission Statement: To be the best Ambulance Service in the UK.

NWAS Sustainability Mission Statement: To be a leader in sustainable development and healthcare.

Strategy for Delivery:

- By operating responsibly we aim to enhance social value, protect our environment and reduce our environmental impact.
- We will collaborate with key stakeholders to develop a sustainable health and care system that improves community health and quality of life.

- We will integrate sustainability practices and principals across the Trust and within our supply chain.
- We will empower our staff to drive sustainability forwards.

4. Areas of Focus

The Trust completes the NHS approved Sustainable Development Assessment Tool (SDAT) every 6 months to assess its progress towards embedding sustainability within the Trust.

The SDAT measures progress within 10 core modules and has helped inform the development of this Green Plan by highlighting the areas within each module that needs to improve.

Currently in only 1 out of 10 of the modules, the Trust has a poor or satisfactory performance, with the remaining 9 modules showing a satisfactory, good or excellent performance. Overall the trust has scored 69% in the most recent assessment which reflects a satisfactory performance overall. This is an increase from the last score of 60%.

Module	Score
Corporate Approach	75.64%
Asset Management & Utilities	71.67%
Travel and Logistics	55.21%
Adaptation	100%
Capital Projects	74.60%
Green Space & Biodiversity	21.05%
Sustainable Care Models	56.41%
Our People	84.95%
Sustainable use of Resources	55.56%
Carbon / GHGs	72.97%

Overall SDAT Score

69%

	Poor Performance or Insufficient Information
	Satisfactory Performance
	Good Performance
	Excellent Performance

The SDAT also highlights the Trust's contribution to the United Nations Sustainable Development Goals (SDGs). The 2030 Agenda for Sustainable Development, adopted by all United Nations Member States in 2015, including the UK. This provide a shared blueprint for achieving peace and prosperity for people and the planet both for now and into the future.

At its heart are the 17 Sustainable Development Goals (SDGs), an urgent call for action by all countries in a global partnership. They recognise that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth – all the while tackling climate change and working to preserve our oceans and forests.

The Trust is clearly contributing to or starting to contribute to the following goals:

Clearly contributing to…		Starting to contribute to…	
5 GENDER EQUALITY	Goal 5: Gender Equality	1 NO POVERTY	Goal 1: No Poverty
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE	Goal 9: Industry, Innovation and Infrastructure	2 ZERO HUNGER	Goal 2: Zero Hunger
		3 GOOD HEALTH AND WELL-BEING	Goal 3: Good Health and Wellbeing
		4 QUALITY EDUCATION	Goal 4: Quality Education
		6 CLEAN WATER AND SANITATION	Goal 6: Clean Water and Sanitation
		7 AFFORDABLE AND CLEAN ENERGY	Goal 7: Affordable and Clean Energy
		8 DECENT WORK AND ECONOMIC GROWTH	Goal 8: Decent Work and Economic Growth
		10 REDUCED INEQUALITIES	Goal 10: Reduced Inequalities

			Goal 11: Sustainable Cities and Communities
			Goal 12: Reponsible Consumption and Production
			Goal 13: Climate Action
			Goal 16 Peace, Justice and Strong Insitutions
			Goal 17: Partnersip for the Goals

Using this as a foundation and taking into account the overall SDAT score indicating an overall satisfactory performance, the areas of focus for this Green Plan will align with the core modules of the SDAT and aim to ensure that the Trust starts actively contributing to SDG's.

This approach will improve the Trusts SDAT performance and ensure that the performance makes the intended contribution to the SDG's.

4.1 Corporate Approach

Corporate Approach Score

75.64%

In order to successfully deliver a sustainable healthcare system, NWAS will ensure that the principals of sustainability are embedded throughout all its organisational activity. This will require essential engagement and accountability for senior staff and stakeholders.

Aim:

- To take a holistic approach to delivering sustainable healthcare driven from the top down.

Delivery:

- To support the Board Sustainability Lead (Director of Finance) with training, access to CPD events and local and national forums for knowledge sharing and innovation.
- Include a sustainability and social value assessment on all business cases.
- Create a cross departmental sustainability steering group to ensure the delivery of this Green Plan and the creation of future Green Plans.

Measurement:

- Assess SDAT score and monitor improvements.
- Sustainability Steering Group to report 6 monthly to the Resource Committee
- Include a comprehensive sustainability section in the Annual Report.

4.2 Asset Management and Utilities

Asset Management and Utilities Score
71.67%

The Trust operate 24 hours a day, 7 days a week, 365 days a year and places a constant demand on its utilities which means a continuing impact on the environment.

Aim:

- To continue implementing innovative and new technologies/systems in estates and facilities management where practical.

Delivery:

- To approve and implement a waste and resources strategy.
- To explore the financial feasibility of switching all electricity supplies to green tariffs.
- To bid for appropriate funding to enable the implementation of energy saving technology where applicable.

Measurement:

- Assess savings via annual reporting.

4.3 Travel and Logistics

Travel and Logistics Score
55.21%

Service delivery, staff travel and transportation of goods all have a significant impact on local air quality, road congestion and the health of the communities we serve.

Aim:

- Deliver ambitious Fleet Strategy, Lease Car and Pool Vehicle Policies and supporting staff and visitors to make more sustainable choices when travelling to or between trust sites.
- To encourage sustainable and active methods of travel for staff and reduce the environmental impacts of operational and business miles.

Delivery:

- Engage with sustainable travel groups across the North West to improve access to discounted sustainable travel options.
- Ensure that all new trust vehicles under 3.5t are zero, ultra-low or low emission where practical to do so.
- Continue to review and assess emerging technologies for alternative fuels and engage with vehicle manufactures to ensure suitability for operational vehicles.

Measurement:

- Health Outcomes of Travel Tool (HOTT)
- Increase in travel discounts available to staff
- Proportion of trust vehicles which are EV and associated charging infrastructure.

- Assess carbon reduction via the annual report

4.4 Adaptation

Adaptation Score

100%

Climate change presents a significant threat to human health and the environment; it presents one of the biggest challenges public health today.

The extreme weather impacts of climate change, such as flooding and heatwaves create new challenges for our operation and place increasing demands on health services and therefore we must adapt to ensure we are able to continue operating under new pressures whilst working to mitigate the acceleration of climate change and its associated risks.

Appendix B is the Trust's current Climate Change Adaptation Plan.

The Trust will work to raise awareness of the links between climate and increased risks to health and our operation.

Aim:

- To ensure senior level staff have sufficient awareness of climate change to be able to deal with the operational impacts of extreme weather events caused by climate change and continue to invest in mitigation measures.

Delivery:

- To regularly review the climate change risk assessment contained within this Green Plan.
- To include the risks in the climate change risk assessment on the Trust risk register.
- To deliver Carbon Literacy Training to all very senior and senior management and work towards making appropriate sustainability training available to all staff.

Measurement:

- Approved Green Plan
- Approved and implemented Carbon Literacy program
- Ongoing review of the Trust's Climate Change Adaptation Plan

4.5 Capital Projects

Capital Projects Score

74.60%

There is a significant opportunity to embed sustainability during refurbishment and development of the Trust's estate portfolio, by implementing new technologies as standard into improvements and by designing new-build projects to achieve net zero standards.

Aim:

- To reduce the environmental impacts of our building works during construction, refurbishment, operation and decommissioning.

Delivery:

- Integrating sustainability into trust building standards for capital projects.
- Explore the implementation of lifecycle analysis into all capital projects to understand the whole life cost and to drive resource efficiency.
- Ensure that waste disposal costs are captured in all capital business cases.

Measurement

- Reduction in energy use via annual reporting

4.6 Green Space and Biodiversity

Green Space and Biodiversity Score
21.05%

Improving and maintaining green space has positive benefits on mental health and wellbeing whilst supporting cleaner air, noise reduction and supporting biodiversity.

Will we pursue a staff led approach to our green spaces and biodiversity to support staff wellbeing, an improved environment to support good mental health which will provide a safe space for our local wildlife and pollinators.

Aim:

- To empower staff to take pride in and improve their green spaces.

Delivery:

- Create 'no mow' zones at our large corporate sites to encourage growth of wildflowers for pollinators.
- Create a sustainability steering group and use the group to design a biodiversity toolkit to empower staff to look after their on-site green spaces.

Measurement:

- Sustainability Steering Group approved and embedded.
- Toolkit approved.
- Increase biodiversity / green space across the Trust.

4.7 Sustainable Care Models

Sustainable Models of Care Score
56.41%

There is a need for better understanding of how to deliver a low carbon and integrated healthcare service to ensure operational efficiency and environmental impact reduction.

To deliver the right care, at the right time, in the right place, every time and within the environmental, social and economic resources available is an ever growing challenge. As we expect to see the impacts of climate change increase in severity, ensuring we have an ambulance service that is fit for the future is vital to delivering a high quality of care.

Aim:

- To deliver low carbon, high quality healthcare.
- Include a sustainability and social value assessment on all business cases.

Delivery:

- Create a cross departmental sustainability steering group to ensure the delivery of this Green Plan and the creation of future Green Plans.
- Delivery overall of the Green Plan.

Measurement:

- Sustainability Steering Group approved and embedded.

4.8 Our People

Our People Score
84.95%

Engaging staff in sustainability is essential to the delivery of a sustainable healthcare system. All staff have a role to play in ensuring the success of this strategy and should be adequately supported.

Aim:

- To empower staff by providing them with the support, knowledge and tools to develop more sustainable habits.

Delivery:

- Deliver programs to raise awareness of sustainability and the links between our environment and health and wellbeing.
- Incorporate sustainability into all job descriptions.
- Develop a sustainability team to provide adequate resource to support staff engagement and education.
- Develop a mandatory training module to be completed by all staff.

Measurement

- Increase in staff participation of sustainability programs.
- All job descriptions refer to personal responsibility within all roles towards sustainability.
- Creation of a mandatory training module on sustainability.

4.9 Sustainable Use of Resources

Sustainable use of Resources Score
55.56%

The Trust produces a significant volume of waste across the organisation and the management of this waste currently meets minimum compliance standards once an item becomes waste.

Better implementation of the waste hierarchy through an approved Waste and Resources Strategy will ensure that the Trust is able to move towards a circular economy.

Aim:

- To focus on waste prevention and reuse to begin eliminating waste by ensuring resources are put back into the system for recycling.

Delivery:

- Maintain the current diversion of domestic waste streams from Landfill to Energy Recovery.
- Implement a Board approved Waste and Resources Strategy

Measurement

- Year on year reduction in waste produced via annual reporting
- Year on year increase in recycling rate via annual reporting
- Improvement in SDAT Score

4.10 Carbon / Greenhouse Gases

Carbon / GHG Score
72.97%

As a large organisation we are required to measure and report on our carbon footprint. This incorporates the emissions from every aspect of our operation.

Aim:

- To engage all stakeholders in carbon reduction and identify opportunities to implement new technologies/innovative ways of working which will result in the reduction of emissions.

Delivery:

- Design, implementation and roll out of a staff training program
- Engage our supply chain in carbon reduction
- Improve data collection on supply chain emissions
- Explore and implement new technologies / innovative

Measurement

- Year on year reduction in total CO_2e via annual reporting
- Active staff training program

5. Tracking Progress

We will track the progress of this Green Plan using both qualitative and quantitative methods of data collection. The main form of measurement the Trust will be via the NHS Sustainable Development Unit's Sustainable Development Assessment Tool (SDAT).

However, we will also continue to measure:

- Health Outcomes of Travel Tool will measure progress towards reducing our impact on air quality.
- Waste Assurance Report for the Safety Management Group uses internal data to measure progress relating to waste reduction and recycling.
- Sustainability Report for the Resources Committee will include updates on our progress towards all targets outlined within this Green Plan and other specific areas of achievement.
- Internal data collation for waste and utilities on a monthly basis.

6. Governance

Senior leadership is vital in order to successfully deliver this strategy, this is due to the behaviour change element required across all departments and the work streams which fall outside the control of the Estates team.

The Governance Structure is outlined below.

The Board – The Director of Finance is the Trust sustainability lead.
The Board offers senior level leadership, supports implementation and ensures alignment with the organisation's value, culture, strategy and operations.

Sustainability Steering Group – The Sustainability Steering Group will be chaired by the Board Sustainability Lead. The Sustainability Steering Group minutes will be available to the Resources Committee and updates will be communicated in the form of a written bi-annual Sustainability Report to the Resources Committee.

Safety Management Group – The Safety Management Group meets on a quarterly basis to discuss all matters relating to Health and Safety within the Trust; the Safety Management Group reports into the Quality & Performance Committee. Progress on waste reduction and recycling is communicated every 6 months to the group via a Waste Assurance Report.

Sustainability Team – At the time of writing this document there is one full time role, of Environmental Sustainability Officer, which is solely dedicated to Sustainability. This role reports to the Estates Manager (Environmental) who has overarching responsibility for Sustainability alongside an Estates Manager responsibilities. These two roles sit within the Estates team and retain ownership of the delivery of this plan, in addition to compliance, project delivery, education and engagement of staff. Progress is reported via the Waste Assurance Report to the Safety Management Group and the Sustainability Report to the Resources Committee.

7. External Reporting

There are currently a number of mandatory and voluntary reporting streams which Trusts are required to undertake:

Completion of SDAT

This will measure the Trusts qualitative progress on sustainability for the previous year, inform plans for the coming year, and will eventually enable comparative performance against similar Trusts Nationally. The results of the SDAT are reported to the Resources Committee.

Completion SDU Sustainability Reporting Portal

This requires Trusts to input their annual data collection which then calculates the carbon emissions the various areas of organisational activity e.g. energy, estates, travel and procurement etc. which then informs and helps populate the mandatory sustainability section within the Trust's Annual Report. The portal calculates all of the Trust's carbon emissions inclusive of Scope 1, 2 and 3 emissions. These are:

Scope 1

- Fuel combustion
- Company vehicles and
- Fugitive emissions

Scope 2

- Electricity
- Heat and steam

Scope 3

- Purchased goods and services

- Business travel
- Employee commuting
- Waste disposal
- Use of sold products
- Transportation and distribution (up and downstream)
- Investments, leased assets and franchises

ERIC (Estates Return Information Collection)
A mandatory data collection for all NHS Trusts required by the Department of Health and Social Care.

8. Communications

Good communication is essential to the successful delivery of this Green Plan; the communication plan highlights all the forms of communication to be used to raise awareness, engage and educate various levels of staff across the Trust.

Audience	Objective	Message	Channel	Frequency
Board and EMT	Support the Board in developing a better understanding of Sustainable Healthcare to ensure future decisions are environmentally, socially and financially sustainable, in addition to the Sustainable Development Goals.	Highlight good practice, progress and areas requiring improvement.	Via the Sustainability Report to the Resources Committee.	6 monthly
		What sustainable healthcare is and why it is important to NWAS.	Board engagement session.	Annually
Sustainability Champions	Empower Champions to drive local behavioural change.	Updates on sustainability at NWAS and upcoming events and campaigns which they can support locally.	Email	Relaunch the Sustainability Champions Network and provide a quarterly email to align with upcoming campaigns.
All Staff	Develop staff knowledge on environmental issues, sustainable healthcare and Sustainable Development Goals.	Various	Twitter	The Environmental Sustainability Officer will continue to manage the official NWAS twitter account.
			Bulletin	Provide a regular bulletin piece on sustainability at NWAS.
			Events / campaigns	Support 4 x campaigns each year and reinstate an annual Seminar.
			Seminar	
			Posters / noticeboards	Educational materials will be reviewed annually by the Sustainability Steering
			Mandatory / voluntary training	

9. Risk

The UK Climate Change Risk Assessment 2017 Evidence Report identified 6 priority risks from climate change within the United Kingdom:-

- Flooding and Coastal change risks to communities, business and infrastructure
- Risk to health, well-being and productivity from high temperatures
- Risks of shortages of public water supply
- Risks to natural capita (ecosystems, soil and biodiversity)
- Risks to domestic and international food production
- New and emerging pests and diseases (public and animal health threats)

Climate change is bringing more frequent and severe weather events, as well as more gradual change to the UK. In the North West these risks include hotter, drier summers, warmer, wetter winters, and more extreme weather events, such as downpours, heatwaves and intense periods of snowfall and ice. These events would impact across many sectors and affect the quality of life and health and wellbeing of the communities we serve.

Solutions to such challenges (such as Green Infrastructure) offer a significant opportunity to increase climate resilience, whilst potentially also improving health outcomes, economic performance and overall quality of life.

See Appendix A for the current risk assessment of the likely impact of threats and hazards of climate change to the Trust.

10. Finance

10.1 Known costs

The Carbon Literacy Training program has received funding from the Department for Business, Energy and Industrial Strategy for the development of a bespoke Carbon Literacy Training program, accreditation and 'Train the Trainer', training. However, a cost of £10 per person who undertakes the training will be required to obtain the 'Carbon Literate Citizen' certification.

10.2 Unknown Costs

Currently there is no dedicated budget towards sustainability projects; a business case for each project has been written in the past, funding options or existing budgets have also been used to be able to deliver some projects.

In order to successfully deliver the communications plan and projects required to meet the targets outlined in this plan whilst still maintaining compliance, additional resources maybe needed to support the small environmental team which will need to be explored further.

Revenue funding will be required to deliver an annual engagement program, including the sustainability seminar; this will allow the sustainability team to make small purchases to assist with the behaviour changes required to create a sustainable NWAS.

10.3 Sources of Funding

There are various external sources of funding available to NWAS, in addition to Trust capital funding, for the delivery of sustainability projects and initiatives. The following funding streams are available:

- **Carbon and Energy Fund** – Launched by Greg Barker MP at IHEEM in 2011, the Carbon and Energy Fund (CEF) has been specifically created to fund, facilitate and project manage complex energy infrastructure upgrades for the NHS and wider Public Sector.

- **Salix** – Salix funding can be used in conjunction with a variety of procurement frameworks and covers over 100 energy efficient technologies including boilers, combined heat and power, LED and lighting upgrades, and heat recovery. Funding for Salix's NHS programme must be repaid within 5 years and cost less than £172 to save one tonne of carbon over the lifetime of the technology being installed.

- **Sponsorship** – Sponsorship from large environmental organisations can be sought to support staff engagement and smaller projects.

- **Charitable Funds** – Some funding is available from charities for environmental improvement projects, historically NWAS have not been eligible for these as our buildings and grounds are not open public access.

- **Government, Local Authority & NHSI / Department of Health and Social Care Funding** – Each year NHSI request funding for sustainability projects, this could include energy efficiency schemes, electric vehicle charging or new and emerging technologies such as hydrogen fuel cell. Local Authorities also have access to funding pots to install electric vehicle charge points in public spaces and solar installations, some Local Authorities are willing to share these funding pots with NHS Trusts. In addition to this there is also funding from central government schemes which can be accessed but it tends to be reserved for specific technologies.

11. What can you do?

Bring your habits to work!
The simple and automatic actions like turning off lights and screens and recycling whilst you're at home can be applied in the workplace too!

Take a moment to consider the bigger picture!
Review the actions within this Green Plan and think about how you can contribute within your own role, is there something you could improve?

Be part of the conversation!
Talk to your colleagues, line manager and embed sustainability practices within your area of work. Whether it's a small or large project, it all adds up to make a difference. Share it on Twitter or in the Staff bulletin.

APPENDIX A – Climate Change Risk Assessment

1948	20/05/2016	Corporate/Directorate Risk	Service/Business Interruption Resilience	There is a risk of core business interruption through infrastructure challenges, staff absence, loss of estates or increases in activity caused by the direct or indirect impacts of Climate Change.	Winchester, Mr David	12	NWAS Climate Change Adaptation Plan. Business Continuity Management Plans. Specific NWAS Resilience Plans including Heatwave Plan. National Contingency Plans. Local Resilience Forum and other agency contingency plans. Information and intelligence from key agencies to provide early warning of sudden events. Government Emergency Powers under Part 2 of the Civil Contingencies Act (2004)	2	4	8	4	Treat - Implement controls and mitigating actions to reduce the risk.	Currency of some departmental Business Continuity Plans Lack of cross departmental Climate Change plans and mitigation measures.	NWAS Climate Change Adaptation Plan. Internal Contingency Plans External Contingency Plans. NWAS Business Continuity Plans	Widespread nature of Climate Change effects difficult to mitigate against \some impacts of Climate Change likely to be slow and impercetable Health Impacts of Climate Change may be difficult to attribute to a single causative factor.		4	4	20/12/2024	12/08/2019	20/12/2024

APPENDIX B

CLIMATE CHANGE ADAPTATION PLAN

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Recommended by	Estates Manager Environmental
Approved by	
Approval date	
Version number	2.0
Review date	October 2020
Responsible Director	Director of Finance
Responsible Manager (Sponsor)	Assistant Director Estates and Fleet Estates Manager Environmental
For use by	All Trust employees

Contents

1. Introduction

Climate change is associated with substantial risks for both society and nature. The two fundamental response options for reducing the risks posed by climate change are the mitigation of climate change and adaptation to the climate change.

Mitigation means limiting global climate change by reducing the emissions of greenhouse gases and Adaptation means planning and taking action targeted at reducing the effects that climate change has on our environment at a local level. Instigating coping mechanisms will help to overcome or at least manage better the effects on society caused by climate change.

Adaptation Plans are developed in consideration of what actions are required for reducing the risks posed by severe weather conditions caused by climate change.

2. Aims and Objectives

This document follows the principals of the Climate Change Adaptation Report which has been reviewed nationally and approved by the Association of Ambulance Chief Executives (AACE) and adopted as a central ambulance service document. The document was also reviewed by the Green Environmental Ambulance Network (GrEAN). Prior to adoption, access to the document was given nationally, for comment/input to Ambulance Trust resilience managers, estates managers, fleet managers, operational managers and directors of finance.

NWAS has followed the guidance of this and other appropriate documentation then modified it to meet North West's local and regional level context.

3. Stakeholders

Some examples of the stakeholders are considered to be:

- Patients
- Staff
- National Health Service (NHS)
- Local Resilience Forums (LRF) including members from the Police, Fire, Local Authorities
- General public of Great Britain

4. Purpose of the Adaptation Plan

The purpose of this Adaptation Plan is to provide all stakeholders with some background information as to what North West Ambulance Service (NWAS) is doing to reduce and mitigate issues related to climate change as well as their responses to risks in the future.

It is essential that organisations responsible for vital services and infrastructure make the necessary plans to prepare for the risks from a changing climate.

The Climate Change Act 2008 introduced a new power for the Secretary of State to direct "reporting authorities" (companies with functions of a public nature such as water and energy utilities) to prepare reports on how they are assessing and acting on the risks and opportunities from a changing climate.

5. Background information

In the first round of Climate Adaptation reporting, over 100 organisations, primarily from the energy, transport and water sectors provided reports under the Adaptation Reporting Power to the Department for Environment, food and Rural Affairs (DEFRA).

The National Climate Change Adaptation Report described in section 2 of this plan and on which this plan is based, was carried out in conjunction with DEFRA, Department of Health (DoH) and Climate Ready, as well as the Ambulance Environmental, Business Continuity and Resilience teams across the UK in response to the National Adaptation Programme (NAP).

In order to adapt to climate change and the impact that it could have on the British Ambulance Services, the national climate change adaptation plan guidance document was put together to assess the impacts.

DEFRA have published 'The Climate Change Risk Assessment' document that identifies over 700 different climate risks associated with increases in flooding and heatwaves. This report is in response to the impact and effects that climate change is already having:

Climate Ready working on behalf of DEFRA and the DoH are looking to get together a climate adaptation plan that covers all sectors and ensures that there is resilience to a wide range of issues.

DEFRA are trying to identify where there is potential for adaptation plans to be incorporated into future planning.

DEFRA are looking to see what has already been carried out to date – flood risk assessment, planning for the future, business continuity, heatwave plans and what part of this covers adaptation.

Ambulance Services signed up to the Sustainable Development assessment Tool for measuring organisational progress on sustainability are recommended to, and should be working towards having a Climate Change Adaptation Plan in place as part of their Carbon Management Plans/Green Plan.

6. Climate Risks

The following sections identify the risks that the current and predicted impacts of climate change have on the community which the Ambulance Service serves. North West Ambulance Service (NWAS) responses to the issues that have been identified are also detailed.

7. Potential Impacts of Climate Change

The impacts from Climate Change might include increases in flooding, temperature, drought and extreme weather events. These could create risks and opportunities such as: impacts to transport infrastructure from melting roads or buckling rails, increases in tourism, increased damage to buildings from storms, impacts on local ecosystems and biodiversity, scope to grow new crops, changing patterns of disease, impacts on planning and the local economy and public health. All of these elements will have an impact on the way in which the Ambulance Service responds as well as the potential drain on resources.

8. Flooding

It is estimated that over 5 million people in England and Wales live and work in properties that are at risk of flooding from rivers or the sea. Identification aids in the form of Flood Mapping and Flood warning direct are both available via the Governments Web site (www.gov.uk) and are available to assist in the identification of areas that are at risk from

flooding. The Ambulance Service has to respond to all areas of the country so flooding can detrimentally affect services and response times.

9. Pluvial Flooding

Pluvial flooding occurs when an extremely heavy downpour of rain saturates the urban drainage system and the excess water cannot be absorbed into the system causing flooding. These unpredictable events occur without warning and in the worst cases can cause huge destruction and devastate large areas.

According to the research carried out by the Joseph Rowntree Foundation, around 2 million people are at risk from pluvial flooding, which represents around a third of all flood risk in the UK. This figure could increase by 1.2 million by 2050 due to a combination of climate change and population change. Population change has the potential to put three times more people at risk than climate change.

Existing flood risk assessments are based on the number of properties at risk as opposed to the number of people. This approach downplays the impact on people, and in particular potentially vulnerable groups such as the elderly. Lower income groups and renters are slightly more exposed to pluvial flood risk because of the number that live in low lying areas around town centres dominated by higher density terraced housing and flats.

NWAS Response

Mapping systems have been developed by local councils to identify localised flooding issue into and are available via the central governments web site www.gov.uk which the Business Resilience and Continuity Resilience Teams can tap into.

Staff should undertake dynamic operational risk assessment when driving in flood waters and comply with the guidance issued by the Trust on the matter.

Historical flooding areas will be taken into consideration by the Estates Team when planning for ambulance station and office locations.

The Government has updated their web portal to cover flooding from surface water situations and these are set to be incorporated into flood warnings in the future.

It is Ambulance Service policy that at a major incident involving flooding, all patients and staff are disinfected prior to entering an ambulance to minimise and eliminate contamination of ambulances with sewage and other pathogens if they have been in contact with flood waters.

10. Fluvial Flooding

Fluvial flooding occurs when rivers overflow and burst their banks. This is due to high or intense rainfall which flows into the rivers. It can cause localised flooding and accentuate pluvial flooding.

NWAS Response

The Government has a mapping system that Ambulance Services across the country have access to in order to gain up to date information on the flood risk associated with ambulance stations, driving routes and communities that may be affected by flooding.

Staff should undertake dynamic operational risk assessment when driving in flood waters and comply with the guidance issued by the Trust on the matter.

NWAS work with other emergency services, local coastal communities and local resilience forums to ensure that the impact can be assessed and management of evacuation programmes can be implemented if required.

At a major incident involving flooding, all patients and staff are disinfected prior to entering an ambulance to minimise and eliminate contamination of ambulances with sewage and other pathogens if they have been in contact with flood waters.

11. Sea Flooding

Through Met Office assessments, coastal Ambulance Services and those further inland will be aware of high sea level issues that may create flooding further inland as well as localised flooding to sea areas as well as erosion. Storm surges can be assessed and at risk areas are identified. All Operations, Business Continuity/Resilience, Estates and Fleet departments should factor in potential sea level rises over the next few decades when identifying where new ambulance stations, fleet workshops, offices and standby locations should be located.

NWAS Response

NWAS actively monitor roads and network infrastructure to aid easy transition throughout the region.

Staff should undertake dynamic operational risk assessment when driving in flood waters and comply with the guidance issued by the Trust on the matter.

Work with Local Resilience Forums (LRFs) to identify areas that could be at risk and implement a strategy to support patients and members of the public at risk.

At a major incident involving flooding, all patients and staff are disinfected prior to entering an ambulance to minimise and eliminate contamination of ambulances with sewage and other pathogens if they have been in contact with flood waters.

12. Storms and Tornados

The impact of storms and tornados can be localised and unpredictable. The most extreme storms can cause widespread structural damage, e.g. roofs blown off, mobile homes overturned, loss of power if the power lines are brought down, risk to personal safety from flying debris and trees, potentially widespread and/or prolonged interruptions to power and widespread transport disruption could be caused due to fallen trees and debris.

NWAS Response:

NWAS work with local resilience forums and other emergency services to identify areas that have could be affected by storms.

Work with multi agency media teams to recommend that general public stay inside and minimise personal injury by staying out of storm weather and recommend not driving unless your journey is essential and avoiding exposed routes.

13. Temperature

Assessments of who is 'vulnerable' to climate change are highly complex. Vulnerability is generally understood as a combination of someone’s exposure and sensitivity to climate hazards (e.g. heatwaves, cold) as well as their ability to adapt.

14. Heat

A heat wave is classified as '….four main levels (Levels 1-4)…. Levels 1-3 are based on threshold day and night-time temperatures as defined by the Met Office. These vary from region to region, but the average threshold temperature is 30ºC during the day and 15ºC overnight.' (Department of Health's Heatwave Plan).

NWAS Response

The Department of Health's Heatwave Plan details how the health and care sectors should respond to heatwaves. Water is supplied to all staff during hot weather.

Ambulance Services will work with media teams to raise awareness of what the Heatwave Plan entails as well as educate the public as to how to minimise the impact to themselves and their family.

By working with local fuel poverty charities, Ambulance Services can ensure that those most vulnerable will be able to obtain help to insulate their homes to reduce the internal temperature, for heat as well as for cold.

Drugs stored in vehicles will need to be kept in cool environments according to the temperatures specified by the drug manufacturers. The Ambulance Association of Chief Executives have a best practice document for the storage of medicines and explains the effects of temperature on ambulance medicines.

15. Drought

A drought is a period of water shortage for people, the environment, agriculture or industry. A drought can be created from a hot, dry summer or a dry winter both having a large impact on water resources. It is extremely unlikely that public health in the UK will be detrimentally and directly affected by drought. However, drought can lead to situations where health can be put at risk. Several factors play a part in contributing to a drought, including:

- lack of rainfall
- an environment/soil which is poor at retaining water
- hot weather which increases evaporation of water

Modern forecasting systems can predict how severe a drought will be and which areas will be affected, but it is difficult to predict a drought more than a month in advance for most locations.

Several health impacts can be associated with drought, although developed health and sanitation systems reduce the potential for drought-related health effects. Health impacts that may be relevant and could have an impact on the number of calls to the Ambulance Service include:

- Injury due to risk of swimming in rivers, reservoirs and other natural bodies of water. Diving into shallow water can cause injury, including serious spinal injury leading to lifelong paralysis.
- Public water supplies - In the UK, public drinking water supplies are tightly regulated to ensure they are safe. The Drinking Water Inspectorate (DWI) provides an independent reassurance that public water supplies in England and Wales are safe and drinking water quality is acceptable to consumers. Warnings are issued in case of any problems.
- Private water supplies - Private water supplies serve 1% of the population in England and Wales. During a drought, continued vigilance is needed to ensure water remains of adequate quality and quantity.
- Hand washing - Whilst it is important to minimise water wastage during a drought, hand washing should still continue as normal as this is one of the most effective ways to prevent transmission of infectious diseases.

- Algal blooms - Some algal blooms and their surface scums, which grow on open waters and are often blown onto shorelines, can release toxins which adversely affect human and animal health. Symptoms following ingestion of contaminated water during recreational activities include gastro intestinal effects (e.g. abdominal pain, nausea, vomiting and diarrhoea) and respiratory features (e.g. sore throat and cough). Symptoms following recreational exposure include skin and eye irritation, respiratory features, and hay fever/asthma-like symptoms. Water treatment removes algal bloom contamination from drinking water.
- Dust-related problems - Parched soils can increase the amount of dust in the environment as can dust from wildfires/fires which commonly occur during drought. This may have consequences for those with pre-existing respiratory or cardiovascular disease.
- Mental health and wellbeing - Drought can be difficult for those whose livelihood or lifestyle depends on water. If drought conditions continue and worsen then, for example, farmers and rural populations may experience stress related to financial worries and employment uncertainty. (Source: HPA)

Drought is associated with several other natural hazards already detailed including:

- Heat waves - These have well-documented health effects.
- Wildfires - Drought, coupled with extreme heat and low humidity, can increase the risk of wildfire and may lead to air pollution concerns.
- Flood - The risk of flooding may increase following a drought because of extremely dry soil conditions.

NWAS Response

NWAS will work closely with the other emergency services, Environment Agency, local authorities and Water Authorities to identify areas that could be subject to issues associated with drought.

Ambulance Service communication teams to work closely with media teams to raise awareness of droughts and the effects and indirect effects associated with them.

Vehicle washing and cleaning should ideally be minimised or external garages should be used that recycle water.

Hand washing and disinfection will continue in line with infection prevention control policies.

16. Cold, ice and snow

The impact of cold weather on health is predictable and mostly preventable.

The direct effects of winter weather include an increase in incidence of:

- heart attack
- stroke
- respiratory disease
- flu
- falls and injuries
- hypothermia

Indirect effects of cold include mental health illnesses such as depression, stress as well as carbon monoxide poisoning from poorly maintained or poorly ventilated boilers, cooking and heating appliances and heating systems.

After a mild cold spell the Ambulance Service has identified a rise in health issues:

- After 2 days – rise in heart attacks
- After 5 days – rise in strokes
- After 12 days – rise in respiratory illness

All of these will have an effect on the Ambulance Service and the number of emergency calls that they will receive after cold spells.

NWAS Response:

NWAS will work closely with the other emergency services, Environment Agency and local authorities to identify areas that could be subject to issues associated with cold.

The Ambulance Service should also work with the local authorities to identify routes that should be gritted in the event of ice and snow.

Business Continuity plans are in place across the Trust for each department to ensure continuation of business during this type of disruption.

All Ambulance Services assess will their tyres and tyre supplies prior to the winter season. All NWAS emergency vehicles are fitted with cold weather tyres.

The Ambulance Service offers staff the opportunity to have flu jabs.

Drugs stored in vehicles will need to be kept in warm environments according to the temperatures specified by the drug manufacturers to prevent freezing and cracking of the drug bottles. The Ambulance Association of Chief Executives has a best practice document for the storage of medicines and explains the effects of temperature on ambulance medicines.

The Ambulance Service complies with the Cold weather plan as detailed by Public Health England and the Department of Health. The Cold Weather Plan is underpinned by the Cold Weather Alert system which has been updated and now comprises five main levels. Level 0 - long term winter planning for between 1st November – 31st March, Levels 1 to 4, comprising winter and cold weather preparedness to a major national emergency. Each alert level should trigger a series of indicative actions.

The Met Office issues cold weather alerts which are used to alleviate pressure on the Ambulance Services across the country. These are integrated into planning and business continuity as well as resilience.

Cold weather alerts are issued by the Met Office on the basis of either two measures: low temperatures or widespread ice/heavy snow. Often low temperature criteria are met at the same time as the ice and snow. However, sometimes one may occur without the other. The thresholds for what constitutes severe winter weather have been developed in consultation between the Met Office, Department of Health, Cabinet Office and other experts.

Cold Weather Plan levels		
Level 0	**Long-term planning** All Year	
Level 1	**Winter preparedness programme** 1 November – 31 March	
Level 2	**Severe winter weather is forecast - Alert and readiness** Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence	
Level 3	**Response to severe winter weather - Severe weather action** Severe winter weather is now occurring: mean temperature 2°C or less and/or widespread ice and heavy snow	
Level 4	**Major Incident - Emergency response** Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health	

17. Fuel Poverty

Fuel poverty has several measurable effects of cold housing on adult's physical health, well-being and self-assessed general health, in particular for vulnerable adults and those with existing health conditions. Effects of cold housing are evident in terms of higher mortality risk, physical health and mental health.

The Department of Health in 2009 estimated that for every cold-related death there are eight non-fatal hospital admissions. In the coldest months of the year, NHS expenditure was reported as rising by 2% in 1998 and it is estimated that the annual cost to the NHS of cold-related ill-health is in excess of £1 billion.

NWAS Response

NWAS works with multiple agencies to help and assist in identifying vulnerable people.

18. Wildfires

Drought, coupled with extreme heat and low humidity, can increase the risk of wildfire and may lead to air pollution concerns. There were over 15,000 wildfires in the UK in 2012. There can also be an increase in the potential health risks associated with wildfires.

- Those with heart or lung disease, such as congestive heart failure, angina, COPD, emphysema, or asthma, are at higher risk of having health problems than healthy people.
- Older adults are more likely to be affected by smoke, possibly because they are more likely to have heart or lung diseases than younger people.
- Children are more likely to be affected by health threats from smoke because their airways are still developing and because they breathe more air per pound of body weight than adults. Children also are more likely to be active outdoors.

NWAS Response

NWAS will work closely with the other emergency services, Environment Agency and local authorities to identify areas that could be subject to issues associated with wildfires and look at affected individuals.

19. Business Continuity and Resilience

Business Continuity and Resilience Business Continuity Management is a management led process which identifies and mitigates the risks and disruptions that could affect the performance of any of the Ambulance Services. The objective of the Business Continuity Management plan is to ensure that during an emergency or disruption, it has identified and prioritised those activities at risk of the organisation that are in need of protection planning so that the business can continue to operate effectively with minimal disruption.

NWAS Response

NWAS is committed to having in place, a Business Continuity Management (BCM) programme as required under the Civil Contingencies Act 2004. The NWAS BCM programme provides the framework within which the Trust can comply with the business continuity requirements of our customers by aligning the BCM with ISO 22301:2012. BCM has been established to ensure the Trust can continue to deliver a minimum level of service to our stakeholders in the event of any disruption. The Trust is also committed to meeting legal and regulatory requirements of the BCM and continual improvements of BCM systems.

20. Health Impacts

A changing climate is expected to have significant impacts on human health and wellbeing. The heatwave in 2003 resulted in excess of 35,000 deaths across Europe and at least 2,000 premature deaths in the UK alone. Climate change can also have indirect effects on the population:

- flooding can seriously undermine the mental health of communities that are impacted or those that fear they may be in the future
- the quality and quantity of the food supply chain can be impacted
- high temperatures increase ozone and other pollutants in the air, aggravating cardiac and respiratory problems
- pollen levels are frequently high during a heatwave aggravating allergy sufferers symptoms
- stress and depression can result from climate change effects

- The vulnerable groups in our society such as the elderly, young or chronically ill are likely to be worst affected by the impacts – caring for these groups must be factored into planning to meet future demand for health services.

21. Engagement

To Risk Assess the potential impact and opportunities for business, the Ambulance Service Trusts will engage with many other stakeholders, authorities and trusts:

- **Key Stakeholders**
  - Patient representative groups
  - Trust and Foundation Trust members
  - Staff
  - NHS England
  - Public Health England
  - CCGs
- **Local authorities**
  - Become members of Local Strategic Partnerships to enable interaction and information exchange
  - Potential impact and actions in respect of sea level changes
- **Health Trusts**
  - Liaison with local Acute Trusts will enable planning for the transport of patients between centres
    - access to regional Trauma Centres
    - Planning for changes in the local health communities resulting from climatic changes
- **Adjacent Ambulance Trusts**
  - Liaison with other Ambulance Trusts will enable planning for cross border support where environmental factors are identified as potentially joint issues.

22. Guidance Documents

There are several guidance documents that are available to Ambulance Services across the country to aid business resilience and continuity.

- Each Ambulance Service should have in place:
- A Winter Weather plan
- Heatwave Plan in line with the Department of Health's Heatwave Plan 2012
- Business resilience and continuity plans

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	31 March 2021			
Subject:	Modern Slavery Act 2015			
Presented by:	Carolyn Wood, Director of Finance			
Purpose of Paper:	For Decision			
Executive Summary:	The Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2020/21.			
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the content of the report; and • Approve the recommendation of the drafted statutory statement for the year ending March 2021.			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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1. PURPOSE

The Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2020/21.

2. BACKGROUND

The Modern Slavery Act 2015 is an Act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if:

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

The Act establishes a duty for commercial organisations, with an annual turnover in excess of £36m, to prepare an annual slavery and human trafficking statement. Income earned by NHS bodies from government sources, including CCGs and local authorities, is considered to be publically funded and is therefore outside the scope of these reporting standards.

The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). It includes a provision for large businesses to publicly state each year the actions they are taking to ensure their supply chains are slavery free.

The 'slavery and human trafficking statement' must include either an account of:

- The steps being taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any part of its business or its supply chains, including:
    - Information about the organisation's structure, business and its supply chains.
    - Its policies in relation to slavery and human trafficking.
    - Its due diligence processes in relation to slavery and human trafficking in its business and supply chains.
    - The parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk.
    - Its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate.
    - The training about slavery and human trafficking available to its staff.

OR

- That the organisation is not taking any such steps (although this is permitted under the Act, it is likely to have public relations repercussions).

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

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

3. CURRENT POSITION

The statement must be formally approved by the Board, and must be published on its website. Failure to do so may lead to enforcement proceedings being taken by the Secretary of State by way of civil proceedings in the High Court. The Act is clear that the link must be in a prominent place on the homepage itself. A prominent place may mean a modern slavery link that is directly visible on the home page or part of an obvious drop-down menu on that page. The link should be clearly marked so that the contents are apparent.

The Trust is required to produce a Statutory Statement that includes both the supply chain & the wider organisation.

An exercise has been undertaken to prepare a Statutory Statement that demonstrates compliance with the Act – attached at Appendix 1.

A Supplier Code of Conduct has been published on the Trust website.

Organisations, who are affected by the Modern Slavery Act 2015, must publish a formally approved annual statement of compliance with the Act as soon as reasonably practical after the end of the financial year. The statement should include:

- Information about the organisation and its business
- Its policies in relation to slavery and human trafficking
- Its due diligence processes in its business and its supply chain
- The parts of the supply chain where there is a risk of modern slavery and trafficking, including the steps taken to manage this risk.
- Its effectiveness in ensuring that modern slavery and human trafficking are not present with the organisations supply chain.
- Staff training about modern slavery and human trafficking.

All staff at North West Ambulance Service NHS Trust, in clinical and non-clinical roles, have a responsibility to consider issues relating to modern slavery in their day to day practice. Frontline NHS staff are well placed to identify and report any concerns they may have about individual patients and modern slavery is part of the safeguarding agenda for children and adults in which all our staff are trained. All frontline staff have a duty to report a notification of a concern raised regarding modern slavery through the safeguarding notification process.

The Trust is fully aware of the responsibilities toward patients, employees and the local community and we have a strict set of values that we use as guidance with regard to our commercial activities. We therefore expect that all of the Trust's suppliers and sub-contractors adhere to the same ethical principles.

In compliance with the obligations the following supply chain actions have been embedded within procurement processes:-

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

4. LEGAL and/or GOVERNANCE IMPLICATIONS

The obligations of the act apply to all commercial organisations:

- Operating wholly or partially in the United Kingdom; and
- Companies with an annual turnover over £36m.

5. RECOMMENDATIONS

The Board of Directors are asked to:

- Note the content of the report; and

- Approve the recommendation of the drafted statutory statement for the year ending March 2021

Appendix 1

NWAS MODERN SLAVERY ACT 2015
Statutory Statement for the Year Ending March 2021

Background

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

A person commits an offence if:

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

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

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

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

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

Organisational Structure

North West Ambulance Service NHS Trust serves an approximate population of 7 million covering an area of 5,500 square miles and employs over 6,000 staff. The Trust receives 1.3 million emergency calls per year, which is 16% of the national (999) activity. To meet this demand the Trust has 3 emergency control centres and approximately 700 emergency vehicles.

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

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

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

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

Our Supply Chain

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

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

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

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

Safeguarding

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

Recruitment

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

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

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	31 March 2021
Subject:	Communications and Engagement Dashboard Report – Q3 2020-21
Presented by:	Salman Desai, Director of Strategy and Planning
Purpose of Paper:	For Discussion
Executive Summary:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. For quarter 3 (Q3 – October - December 2020), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q3, including updates on how patient and public engagement activity has adapted during the COVID-19 pandemic. It includes the number of virtual engagement opportunities attended, action we have taken from the feedback, and information about our patient surveys. For example, this quarter: • 27 virtual community engagement opportunities were attended or facilitated, 14 of which included the chance to gather feedback on our COVID-19 response. • Based on feedback we influenced the regional NHS 111 First campaign and adapted our own 'Can we see your number?' campaign. • Online patient surveys responses were down slightly this quarter but overall feedback was positive. • 92% were likely to recommend the service to friends and family. • 86% agreed they were treated with dignity, respect, kindness and compassion. **Patient and public panel (PPP)** A summary of the Q3 activity for the PPP, including up-to-date figures for panel recruitment and information about events the PPP has been involved in over the last few months. For example, this quarter: • 24 new panel members confirmed and inducted to the trust • 130 panel members in total, a 21% increase from Q2 • 25 new expressions of interest in Q3 • 208 panel 'voices' to call on for a piece of work • 34 requests for panel involvement by end of Q3

Press and public (patient) relations
A summary of our media relations activity for Q3. This includes the number of incident check calls and some highlights of the positive, pro-active media relations work that has been undertaken this quarter. There are still fewer incident checks than we usually receive due to a shift in press interest in COVID-19, and proactive interviews continued to be limited in line with NHS England guidance. In Q3:

- 61 incident check calls
- 25 proactive media stories/interviews, a decrease from last quarter
- 28 statements prepared in response to press enquiries, a sharp increase from Q2. This is because of media enquiries relating to the major incident declaration, along with press interest in high demand
- 184 pieces of media coverage
- Highlights included our campaign to encourage people to make their house numbers more visible when the clocks went back, plus industry award news

FOI performance
An update on the FOI performance against the national target of 90% completion within 20 days, plus mention of any FOIs requested by the media. In Q3, we received an increase in FOIs for the second consecutive quarter, but still managed to improve our performance against the 20 working day response target, increasing by 4% to hit 100% compliance with the target.

Stakeholder communications
A summary of stakeholder activity for Q3, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 3 stakeholder bulletins
- 3 stakeholder letters
- 10 MP letters

Publications and events
This quarter our Your Call publication attracted almost 6,000 readers, up from just 900 for the last edition.

Social media: Facebook, Twitter and Instagram
A summary of our social media statistics for this quarter. Reach and engagement figures were up across all channels – this is due, in part, to the attention caused by the major incident declaration. Instagram following continues to grow thanks to effort from the team to increase engagement on this platform.

Website
A summary of statistics for the website, including page views and visitor numbers. Despite a busy Q1 and Q2, web figures have remained steady for Q3. Views on the careers page dropped slightly after a busy Q2, but news views increased with a story about a firework attack on ambulance staff.

External (public/patient facing) campaigns
Brief information about key campaigns that ran in Q3, including:

- NHS 111 First
- COVID-19
- Halloween and Bonfire Night
- Drugs and alcohol awareness

	• Self-care week • Festive messaging **Internal projects and campaigns** Highlights and figures about the main internal communication projects and campaigns from Q3, including EPR, flu vaccination, lateral flow testing, rota review, staff survey, IPC campaign, staff Facebook group, Black History Month and Freedom to Speak Up. **Internal bulletins and the Staff App** Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q3: • 23 COVID-19 bulletins • 22 Clinical bulletins • 14 CEO bulletins • 966 more staff app downloads **Films produced in-house** A summary of in-house videography activity. 18 films were completed this quarter. This is slightly more than Q2 and included a Freedom to Speak Up film, 1st anniversary message for the Patient and Public Panel, a men's health awareness film, IPC message from Maxine Power, EPR film, Christmas messages for social media and two Facebook live sessions. **Focus on…** **Winter plan** - An overview of how the Communications and Engagement Team has supported winter planning by delivering a winter communications plan to make people aware of the actions they can take to help us help them, including how to stay well, alternatives to 999, 111 First and the steps we are taking to reduce seasonal demand. **Film -** An update on how the Communications and Engagement Team has increased its use of film over the last 12 months to improve both internal and external communication.
Recommendations, decisions or actions sought:	The Board of Directors are requested to – • Discuss and note the provision of any comments.

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

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

To provide the Board of Directors with a summary of key outputs and associated highlights on the work of the combined Communications and Engagement Team for Q3 (October - December 2020).

2. BACKGROUND

The Communications and Engagement Team has created a dashboard providing high level statistical content and themes from Q3 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- Publications and events
- Stakeholder communications
- External (public/patient facing) campaigns
- Social media: Facebook, Twitter and Instagram
- Website
- Internal projects and campaigns
- Internal communications including the Staff App
- Films produced in-house

Each report also goes into more detail on some priority pieces of work. This quarter's dashboard provides a 'focus on' the winter communications plan, plus a look at how the team has made use of video over the last year.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.
- NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

Communications and engagement dashboard

Q3 2020/21: October - December

NHS North West Ambulance Service NHS Trust

CORONAVIRUS (COVID-19)

COVID-19 has continued to be a part of the work of the Communications and Engagement Team and in Q3, much of the work has become 'business as usual'. You will see this referenced thoughout the report.

PATIENT AND PUBLIC ENGAGEMENT

27 virtual community engagement opportunities facilitated or attended.

14 of which included the chance to gather feedback on NWAS' COVID-19 response.

Some groups we attended were:

- Preston Health Mela
- Sefton Older Persons Forum
- Healthwatch Cumbria and Lancashire 'What Matters to You'
- Sandbach Dementia Café

We hosted a workshop as part of Halton and Warrington CCG's winter digital conference, which focused on the implementation of NHS 111 First. It highlighted how people may be confused about whether NHS 111 and NHS 111 First are the same service and the need to tailor messages to different audiences.

Based on feedback from our public engagement we have:

- Informed national communications on NHS 111 first
- Undertaken some partnership work with Healthwatch Wirral on locating addresses during the winter promoting #whatthreewords app and 'Can we see your number?'

Q3 saw postal 111 First surveys alongside the posted national NHS 111 survey. There was a slight drop in responses for the quarter. Figures increased again at the start of Q4 and this will be reported in the next dashboard.

There was a drop of 10% in those that agreed they were treated with dignity, respect, kindness and compassion but overall results were still largely positive.

The combined results of these surveys are as follows:

- **92%** were likely to recommend the service to friends and family
- **86%** agreed they were treated with dignity, respect, kindness and compassion
- **93%** of respondents were very or fairly satisfied with the overall service they recevied

PATIENT AND PUBLIC PANEL (PPP)

24 new panel members confirmed in Q3

130 panel members now in total ▲ 21%

25 new expressions of interest in Q3

34 requests for panel involvement by the end of Q3 ▲ 26%

84 of the panel members are involved in two levels of participation meaning we have...

208 panel voices to call on for a piece of work

- 124 Consult
- 56 Co-produce
- 28 Influence

13 structured and/or task orientated involvement opportunities delivered

4 ad hoc opportunities (virtual only) offered for panel members in Q3

3 virtual events - one taster evening and two induction events

PRESS AND PUBLIC (PATIENT) RELATIONS

Handled **61** 'incident checks' through email

25 proactive media stories / interviews ▼ 28%

Prepared **28** statements in response to press enquiries ▲ 154%

184 pieces of media coverage ▲ 17%

- 51% incidents
- 30% positive
- 5% neutral
- 14% negative

Including:

- A campaign to make sure house numbers were visible as the days got shorter and the clocks went back.
- A story about one of our SPTLs who represented all ambulance trusts around the country at the Remembrance Sunday service at the Cenotaph.
- Blackpool Tower lit in green in honour of NWAS at Christmas.
- We also issued a number of releases to highlight success in industry awards, including winning Ambulance Trust of the Year at the Health Business Awards.

In addition, we had attention from the Manchester Evening News following the major incident declaration in November, which required responses to issues including high demand and our response, hospital handovers, and ARP targets - this led to an increase in statements this quarter. Requests from national TV news to film with us were turned down due to IPC restrictions.

NOTES

Major Incident coverage - We received widespread media coverage locally, regionally and nationally following the major incident in November. Although the coverage did support our messaging and encouraged a significant drop in calls, it could be seen negatively from a reputational perspective. We are working to educate and inform the public about the work we are doing to manage additional demand during the pandemic.

FREEDOM OF INFORMATION (FOI)

NOTES

FOIs: *We have a statutory duty to reply to FOIs within 20 working days. The national target is 90% for this and we set an internal stretch target of 95%.*

FOI performance has increased over the financial year and all FOIs for Q3 went out on time. The percentage for the year to date is 97%.

Stakeholders: *this group is external audiences such as MPs, commissioners, patient groups and other healthcare professionals / partner organisations.*

100 FOIs completed ▲25%

100% within 20 working day target ▲4%

97% year to date on 20 working day target

Topics included:

- Suicide calls,
- COVID-19 calls and deaths
- Call outs
- Response times
- Fleet lists and costs

PUBLICATIONS AND EVENTS

Your Call

Autumn edition of Your Call: issued end of October.

- Read **5, 800** times
- **9,735** impressions (number of times the page was displayed)
- **8** article stories for social media which drive up readership
- **Growth in readership** from an audience of **900** to almost **6,000** readers in the latest edition. Tactics for this have been to ensure all key stakeholders including the PPP and community groups have the magazine.

STAKEHOLDER COMMUNICATIONS

3 stakeholder bulletins **3** stakeholder letters **10** MP letters

- October/ December Stakeholder News and winter watch (PES and 111 stats) issued for November and December. Letters included briefs on MPDS, 999 demand management and Protocol 36 escalation (COVID MPDS code)
- MP letters re: use of CFRs in the pandemic, November major incident and winter preparations, PPE, removal of RRV at Buckley Hill as well as a number of proactive engagement with MPs, Healthwatch and Overview Scrutiny Committees around the Blackpool Hub and Spoke proposal. In addition we assisted with selecting MPs to invite to meet with Chief & Chair, and provided briefs for Andrew Stephenson MP, Rosie Cooper MP and Liverpool Metro Mayor meetings.

FACEBOOK

64,776 total followers

11,990 this quarter

427% rate of growth in new followers

5,844,781 reach ▲98%

805,057 engagements ▲200%

Top post:
NWAS has declared a major incident (2 Nov)

13,228 shares

13,106 reactions

1,436,367 reach

TWITTER

55,214 total followers

4,147 this quarter

170% rate of growth in new followers

3,639,575 reach ▲7%

334,861 engagements ▲95%

Top post:
We've declared a major incident

2,657 retweets

1,917 likes

828,925 reach

INSTAGRAM

11,763 total followers

2,563 this quarter

114% rate of growth in new followers

56,899 engagements ▲164%

1,403,936 reach ▲154%

Top post:
PTS care assistant Kieran looking after patient's dog

1,287 likes

33,890 reach

NOTES

"Reach" *is the number of people who may have seen our content.*

"Engagements" *is when someone engages with our content e.g. clicks on a link, reacts to it by clicking 'like', shares or retweets it.*

FACEBOOK: *Facebook figures increased significantly this quarter - this spike can be attributed to the attention attracted by the major incident declaration in November. The top post reach for Q3 was up 295% whilst shares were up considerably at 491% from last quarter's top post. To further back this up we can see from insights that the number of organic followers increased around the time of the major incidents, just shy of 8k.*

TWITTER: *As is expected the same trends can be seen on Twitter, with figures increasing significantly. In comparison to Q2 top post, we saw a 283% increase in likes, a 467% increase in reach and a staggering 16,506% increase in retweets in Q3 top post – again about the major incident declaration.*

INSTAGRAM: *Interestingly, whilst the major incident drove engagement up on all channels, it didn't impact Instagram engagement in the same way. For example, around the time of the major incident we saw significant increases in Facebook reach but then decreases down to usual level, however on Instagram we saw consistent levels of reach month to month. This is a reflection of the consistent focus on improving our Instagram content.*

WEBSITE: *Traffic to the website in Q3 saw a slight decrease but remains fairly steady. Our top page remains the vacancies page however this saw a slight decrease in views. This is to be expected as it follows high figures in Q2 which had been boosted by an EMT job advert.*

WEBSITE

391,030 page views ▼6%

123,030 total visitors ▲1%

Most visited page:
1 Careers/vacancies
100,493 views ▼15%

38,138 'news' views ▲6%

Top news story:
Firework attack on ambulance staff

EXTERNAL (PUBLIC/PATIENT) CAMPAIGNS

- **NHS 111 First -** Activity around North West go live with internal and external updates, filming of 111 videos including other language versions, engagement sessions and media training for 111 senior managers.
- **Refresh of demand messages** or social media to align with Patient Safety Plan and support high levels of demand.
- **COVID-19 messaging** – supporting national guidance through lockdowns, tiers and advice on keeping safe. Creating NWAS specific content with key messages relating to 'hands, face, space' messaging and 'stay home, protect NHS, save lives'.
- **Can we see your house number?** – shared videos and created images on social media to time with the dark nights arriving giving advice to the public to ensure their house name or number is visible for ambulance crews.
- **Halloween messaging** – Created a video on Instagram asking people to stay safe which had 10.6k views. Shared video and messaging on social platforms asking people to stay home, stay safe in line with tier restrictions and keeping ambulances free for emergencies.
- **Bonfire night messaging** – shared a number of posts, resources, information and video on social media about keeping safe and staying inside this year as well as advice on what to do in case of a burn injury and using our services wisely.
- **Drugs and alcohol messaging** – Shared video of staff member recalling teen who had taken drugs for the first time as well as statistics on drug-taking and advice for people in the lead up to Christmas celebrations.
- **Self-care week** – shared self-care tips in videos and images from 111 staff across social platforms.
- **Christmas messaging** – Shared a number of video profiles with staff giving helpful Christmas tips about when to call 999/keeping safe. Shared the NWAS Christmas card which featured staff from across all services saying thank you to those who have supported through the pandemic.

INTERNAL (STAFF) PROJECTS / CAMPAIGNS

EPR
Launched pilot with video and news stories on internal platforms, personalised letter of thanks from Chris Grant to Fylde staff and social media activity. Pilot successful, roll out planned for Spring.

Flu vaccination
Used traditional internal platforms to run hard-hitting stats on flu, as well as case studies on social channels. New outlets explored including wallboards, safecheck home screens, and the staff app. This was NWAS' most successful campaign ever.

Lateral flow tests
Supported the roll out lateral flow tests across the trust at speed. 3,000 kits successfully distributed within just 2 weeks of launch.

Rota Review
Q3 saw the first instalment of EOC rotas being discussed and voting go live. Surveys were built and data collated.

Staff Survey
Worked with HR to incentivise staff to fill in the survey by offering gift vouchers - 41% of staff completed the survey.

IPC campaign
Supported the 'Stop COVID spreading at work' campaign through personal case studies in newsletters and on social media platforms; organised facebook live with Maxine Power and Chris Grant and produced IPC-focused Clear Vision magazine.

Staff Facebook group
Focus on growing membership of the page which now has over 2000 members. Tactics are to encourage senior colleagues to respond to questions ideally personally, and to get more staff to post content themselves.

NHS 111
- 7 bulletins on topics including infection asymptomatic COVID-19 testing, lateral flow testing introduction, 111 First go live, UCP prep, DoS, and new issued SOP
- 16 posters or wallboard graphics and 1 newsletter

Black History Month
Colleagues talking about their experiences and thoughts on BHM. Sustained month long interest through a carefully planned social media campaign across all platforms.

Freedom to Speak Up
To highlight FTSU month arranged for FTSU champion Rachael to interview Daren Mochrie. A new icon was added to the staff app, and new posters and case studies were shared internally.

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

14 CEO weekly bulletins
22 Clinical bulletins
12 Weekly Regional Bulletins
23 COVID-19 bulletins
9 Wellbeing Wednesday bulletins
4 Feel Good Friday bulletins

plus **56** others, including operational, HR, health and safety, Rota Review, 111, PTS, Digital, ICT, lessons learnt and Staff bulletins.

Topics included:
- COVID-19 vaccination updates,
- NHS111 First go live sites with full roll out,
- New patient safety plan,
- Pathways
- Lateral flow testing

FILMS

18 completed **5** underway
▲2 (12.5%)

- Freedom to Speak Up month film
- 1st anniversay message to our PPP
- Mens Health Awareness film
- IPC campaign from Maxine Power.
- EPR film
- x2 Facebook Live recordings
- Christmas films
- x4 short festive self care social media messages

Videos are filmed in-house using team skills and equipment. Activty was upped again from Q2 including all the festive related films and key IPC messages. find out more in the focus on section

STAFF APP

7,401 total downloads
+966 this quarter
Most popular pages: GRS and ESR

FOCUS ON... the winter plan

As a team we delivered a plan to support service delivery in providing the right care during the winter period 2020/21, by making people aware of the actions they can take to help us help them; including how they can stay well, promoting alternatives to 999 and NHS 111 first, and raising awareness of the steps we are taking to reduce seasonal demand.

We did this through a number of overarching themes which included:

- Informing the public about how to make the right health care choices
- Promote dedicated awareness day; including alcohol, drugs, mental health, loneliness and other important winter-related advice.
- Raising awareness of the ambulance services role in tackling winter pressures amongst NHS organisations and key stakeholders through the publication of four (minimum) briefing documents
- Providing our staff, our volunteers and the public with health and wellbeing advice including why they should have the flu jab (there is a separate communications plan for flu for staff)
- Encouraging the public to help us help them by treating ambulance staff well and not abusing them.

Some of the actions included in the plan were:

- Promotion of the national NHS winter campaign through our own channels
- Infographics on winter watch tips on staying well
- Internal campaign for flu jab
- Support of NHS 111 First
- Mental health support
- Alcohol and Self-care awareness weeks
- Can we see your house number - Campaign to promote ways people can help us to find them in an emergency
- Impact and risks of drug use during party season
- How NWAS is preparing for Christmas/New Year
- Showcase voluntary sector especially CFRS who live in the community and can help share our messages especially with the more vulnerable and elderly
- Stop Abuse feature
- Loneliness and mental health at Christmas
- Cold/wintry weather
- Winter illnesses

Evaluation against winter plan activity to be completed in Q4.

FOCUS ON... Films

55 films completed this year so far (Q1-Q3)

7 per month, on average

Films are a vital part of our external but especially our internal communications, and as we have increased our capability within the team to provide high-quality films,we have seen the demand for them increase.

Film is an effective way to communicate messages in seconds. Those watching often react more positively as it feels more personal than emails and documents and film also gives us the chance to create emotive content which helps to further increase engagement.

The regular short films that feature the CEO and Executive Leadership Committee in which they provide organisational updates, developments and congratulate staff on their great work, help to create feelings of openness, transparency and increase in morale amongst staff.

The pandemic has created a further demand for film as all aspects of our lives have become more virtual and there has been richness in content showcasing COVID-19 updates and how we work as an organisation.

The pandemic has also created challenges as lockdown restrictions have stopped us getting out and about to get the footage we would usually have liked to have captured. However, we have been extremely grateful that staff and the public have supported us by sending us their own footage which we have then been able to use to incorporate to support our messages and campaigns.

The time taken to make films also varies, simple messages to camera such as the CEO messages of 2 minutes can be put together with subtitles in two hours. However, films that have lots of different shots, captions, subtitles and interviews like the EPR film can take over a week to put together and then additional days with re-editing various drafts depending on feedback and getting approval.