North West Ambulance Service NHS Trust

Board of Directors Meeting
Wednesday, 30th March 2022

9.45am – 12.30pm

To be held
in the
Nat Lofthouse Suite, Lancashire FA, County Ground Thurston Road, Leyland PR25 2LF

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2122/137	Patient Story	09:45	Information	Director of Strategy, Partnerships and Transformation	
INTRODUCTION					
BOD/2122/138	Apologies for Absence	10:00	Information	Chairman	
BOD/2122/139	Declarations of Interest	10:00	Decision	Chairman	
BOD/2122/140	Minutes of Previous Meeting held on 26th January 2022	10:00	Decision	Chairman	
BOD/2122/141	Board Action Log	10:05	Assurance	Chairman	
BOD/2122/142	Committee Attendance	10:10	Information	Chairman	
BOD/2122/143	Register of Interest	10:10	Assurance	Chairman	
STRATEGY					
BOD/2122/144	Chairman & Non-Executive Directors Update	10:15	Information	Chairman	
BOD/2122/145	Chief Executive's Report	10:20	Assurance	Chief Executive Officer	
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/146	Board Assurance Framework (BAF) Risks 2022/23	10:30	Decision	Director of Corporate Affairs	
BOD/2122/147	Trust Risk Appetite Statement 2022/23	10:40	Decision	Director of Corporate Affairs	
BOD/2122/148	Risk Management Policy Review	10:50	Decision	Director of Corporate Affairs	
BOD/2122/149	Modern Slavery Act 2015	11:00	Decision	Director of Finance	
BOD/2122/150	Non-Executive Terms of Office; Committee Membership 22/23 and Non-Executive Champion Roles	11:10	Assurance	Director of Corporate Affairs	
BOD/2122/151	Chairman's Annual Fit and Proper Persons' Declaration	11:20	Assurance	Director of People	
QUALITY AND PERFORMANCE					
BOD/2122/152	Integrated Performance Report	11:30	Assurance	Director of Quality, Innovation and Improvement	
BOD/2122/153	Learning From Deaths Q3 Report	11:40	Assurance	Medical Director	

BOD/2122/154	Ockenden Review of Maternity Services Update	11:50	Assurance	Medical Director	
BOD/2122/155	Quality and Performance Committee Chairs Assurance Report - from the meetings held on 24th January 2022 and 28th February 2022	12:00	Assurance	Prof A Chambers, Non-Executive Director	
BOD/2122/156	Resources Committee Chairs Assurance Report from the meeting held on 25th March 2022	12:10	Assurance	Mr R Groome, Non-Executive Director	
WORKFORCE					
BOD/2122/157	Annual Staff Survey Results - To follow	12:20	Assurance	Director of People	
CLOSING					
BOD/2122/158	Any Other Business Notified Prior to the Meeting	12:30	Decision	Chairman	
BOD/2122/159	Items for Inclusion on the BAF	12:30	Decision	Chairman	

Date and Time of Next Meeting 1.00pm, Wednesday, 27th April 2022 via Microsoft Teams

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

NHS
North West
Ambulance Service
NHS Trust

Minutes
Board of Directors

Details: Wednesday, 26th January 2022
Via Microsoft Teams

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

In attendance:

Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2122/115 Staff Story

The Director of Strategy, Partnerships and Transformation introduced the staff story.

The story was presented via a film and related to the work of NWAS colleagues who had been involved in a Stepwise 8-10 week programme for 17-18 year olds in the Greater Manchester community, funded by the proceeds of crime related activity in the region.

It was noted that this had been the first year NWAS had been involved in the programme and the Trust's contribution had increased awareness of the paramedic role, alongside promoting the ambulance service.

The film highlighted the programme had made a difference and inspired young adults, who had attended from Oldham College, youth clubs and sixth form colleges.

The programme included first aid teaching in response to the prevalence of street violence and knife crime in the area. The students were taught lifesaving

skills and the acronyms used to call an ambulance; as well as breaking down concerns related to the confidentiality of calls.

It was noted that on completion of the course, the students received a First Aid in Work qualification and learning resulted in them feeling inspired, in conjunction with keeping them safe.

The Chairman welcomed the community work conducted by NWAS and the positive impact on the young people. He queried how NWAS would continue to input into community programmes in the future.

The Director of Strategy, Partnerships and Transformation advised that the Trust would assess future involvement as part of the Trust's Public Health and strategic priorities.

Prof R Thomson noted the challenge for NWAS in terms of resources and the importance of the Trust's long term engagement and commitment. He queried the need for future discussions with GM Police Commissioners in the long term.

The Director of Strategy, Partnerships and Transformation confirmed that similar work had been conducted in other areas across the Region and the Trust had worked closely with the Police and Crime Commission in the past. However, he noted that Covid-19 had impacted on recent work, but future consideration would be given as part of the recovery agenda.

The Chief Executive praised NWAS colleagues and their involvement in the programme, he added that national work was being undertaken with future resourcing required, to ensure a more structured format.

The Director of People added the work was a foothold to promote the role of the paramedic as a career and noted the importance of the Trust's social responsibility.

Prof A Chambers suggested the opportunity of utilising student paramedics to promote the role within colleges and the community.

The Chairman welcomed the suggestion and praised the work undertaken by Trust colleagues on the Stepwise Programme. He praised their efforts to promote NWAS within the community and amongst vulnerable young people in the region.

The Board:

- Welcome and acknowledged the content of the Staff Story.

BOD/2122/116 Apologies for Absence

Apologies for absence were received from Prof A Esmail, Non-Executive Director.

BOD/2122/117 Declarations of Interest

There were no declarations of interest to note.

BOD/2122/118 Minutes of the Previous Meeting

Mr D Rawsthorn referred to agenda item BOD/2122/99 Q2 Board Assurance Framework Review and reference SR01, which should have read Mr D Rawsthorn.

The minutes of the previous meeting held on 24th November 2021 were agreed as a true and accurate record subject to the above amendment.

The Board:

- Approved the Minutes of the previous meeting held on 24th November 2021 subject to the above amendment.

BOD/2122/119 Board Action Log

The Board noted the updates to the Board action log.

BOD/2122/120 Committee Attendance

The Board noted the Board and Committee Attendance Record.

BOD/2122/121 Register of Interest

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

BOD/2122/122 Chairman & Non Executives' Update

The Chairman reported that in response to Reducing the Burden, the Trust had considered governance meetings and cancelled the Resources Committee meeting, scheduled for 21st January 2022. He confirmed that decision papers had been scheduled for Part 2 of the Board meeting.

In terms of the Trust's position in relation to the Covid-19 vaccination for staff, he acknowledged this was a key risk to all NHS organisations and stated that NWAS had evaluated the risk and would plan accordingly. He reiterated the Trust's position to encourage the Covid-19 vaccination to staff, in the interest of patient safety.

The Board:

- Noted the update from the Chairman.

BOD/2122/123 Chief Executive's Report

The Chief Executive presented a report to the Board of Directors, which provided information on a number of areas since his last report to Board on 24th November 2021.

He reported that the Trust had submitted closing statements to the Manchester Arena Inquiry and awaited volume 2 of the Chair's report which was expected to be published in Spring 2022.

In terms of regional issues, he stated that work to address hospital handover delays continued to be a priority for the Trust and was embedded in the Trust's 6 point plan, however noted the ongoing challenging position and the impact on patients and staff.

He added that work involved new initiatives to end handover delays and improve the patient flow at emergency departments, to help reduce unnecessary harm to patients and reduce the impact this had on ambulance staff and colleagues in the acute hospital sector.

In relation to Covid-19, he reported that work continued with staff side representatives on the issues and risks associated with the vaccination programme in advance of the law being introduced from 1st April 2022.

The Chief Executive stated the Trust had made arrangements for a partnership with the Military of Defence to provide 150 military personnel working alongside NWAS frontline staff to assist the Trust and maximise the number of resources available. He added that the wider system had experienced a high number of staff absences due to Covid-19 sickness and isolation. He expressed his thanks to all staff across the organisation for their continued hard work, including the staff behind the scenes, who had continued to roll out strategy work across the Trust.

He referred to the Disability Network Launch and advised that following the virtual launch on 14th December 2021, Adam Rigby and the team worked to provide a forum for staff to work together, in a safe and confidential environment; to highlight the issues affecting staff with disabilities and long term health conditions in order to improve them.

In relation to Freedom to Speak Up (FTSU), he reported that interim arrangements were in place following the departure of the Guardian, with future plans to transfer the FTSU function to the clinical directorate.

The Chief Executive reported that the National staff survey had closed in November with 36% of staff taking the time to complete the survey, which was just over a third of the total workforce which was positive. Despite this, the Trust had the lowest ambulance trust response rate in the country and added that findings from the survey were expected in February to March 2022.

He welcomed Mr Mike Crawford who had been appointed as the Trust's Estates Manager (Capital), to support the Trust's plans to address the maintenance backlog and progress the hub and spoke model.

The Chief Executive acknowledged the sad death of former colleague Clive Heather who passed away on 12th December 2021 and had served for over 47 years in the ambulance service. He conveyed his condolences to the family and Clive's daughter Lisa, who was an employee of the Trust in the GM area. He went on to recognise the death of a young paramedic Alice Clark, aged 21, who had served in South East Coast Ambulance service and had sadly died following a RTA whilst on duty. He added he had spoken with a number of colleagues, to offer his condolences and support.

Mr D Rawsthorn referred to the PTS service model review highlighted in the paper. The Chief Executive stated that the PTS Contract was due to expire and NWAS, with commissioners, would be involved in considerations for the future model and specification of the contract.

Prof A Chambers noted that the Q&P Committee had received a deep dive into the Trust's Mental Health provision for patients and staff, which had highlighted the significant work undertaken across NWAS.

The Chief Executive added that a high volume of work had been conducted with patients and the NHSE/I to bring together Mental Health colleagues across the region, to maximise utilisation and reduce calls into the emergency service.

Mr R Groome referred to the funding for military personnel and queried how this was being resourced. The Chief Executive confirmed that the Government would provide funding.

The Chairman thanked the Chief Executive for the update and referred to the Manchester Arena Inquiry and the awaited publication. He confirmed that the findings and recommendations would be addressed and monitored through the Trust's governance processes.

He referred to the Staff Survey results and the response rate.

The Director of People advised that low response rates had been common across the NHS and that the 36% for the Trust equated to approximately 2000 staff, which would provide sufficient data to identify trends. She added that the results would be shared in full with the Resources Committee and Board of Directors.

The Chairman welcomed the arrival of an Estates Manager which would support the work to improve the Trust's Estates provision.

The Board:

- Noted the Chief Executive's Report

BOD/2122/124 Q3 Board Assurance Framework Review

The Director of Corporate Affairs presented the Q3 Board Assurance Framework Review. She advised that the report presented the Board Assurance Framework (BAF) position at 31st December 2021 with associated Corporate Risk Register and Heat Maps for reference.

She reported that the Executive Leadership Committee (ELC) had reviewed the BAF strategic risks and proposed the following Q3 changes for consideration –

- Increase in risk score of SR01 from 15 to 20
- Increase in risk score of SR04 from 12 to 16
- Decrease in risk score of SR06 from 20 to 15

She went on to advise that the ELC had also considered the current operating environment and the achievement of target risk scores which had resulted in a proposal to increase target risk scores –

- SR01 from a target risk score from 10 to 20
- SR03 from a target risk score from 15 to 20
- SR04 from a target risk score from 8 to 12
- SR06 from a target risk score from 10 to 15

She stated that the proposed target risk scores were deemed to be achievable and realistic given the current operational and systematic pressures placed on the organisation at present.

Mr D Rawsthorn acknowledged that the Audit Committee had been pleased to recognise how much the BAF had developed and that future work by the Head of Risk and Assurance had been agreed, to look at strategic risk and target risk scores at a future development session.

He queried SR02 and the Integrated Performance Report, which stated that the Trust was expected to break even at the end of the year, however the strategic risk had a year-end target risk score of 15.

The Director of Finance advised that at the time of reporting the BAF Q3 position the Trust had not been aware of the 2022/23 funding position and once 2022/23 planning started to become clearer, the risk score would be reviewed.

Dr D Hanley welcomed the review of risk scores and the recommended proposals in the paper.

The Director of Corporate Affairs welcomed the comments from the Board and the support for the recommended changes. She added that the BAF Strategic Risks for 2022 and 2023 were now being considered, with forthcoming meetings scheduled with Board members.

The Chairman recognised the complexities of the BAF for observers, however highlighted the importance of the Framework, particularly during times of service pressures.

The Board:

- Agreed the proposed changes to target risk scores for 2021/22.
- Agreed the Q3 position of the Board Assurance Framework.

BOD/2122/125 Trust Corporate Calendar 2022/23

The Chairman presented the Trust Corporate Calendar for 2022/23 which had been previously circulated to Board members.

The Board:

- Approved the Trust Corporate Calendar for 2022/23.

BOD/2122/126 Health, Safety and Security Policy Revision

The Director of Quality, Innovation and Improvement presented the Health, Safety and Security Policy Revision. She reported that the Policy had been reviewed and updated to reflect the trust's current organisational structure and had been strengthened as a result of key stakeholder feedback.

She advised that the report included a summary of the significant and minor changes and provided details of the implementation process for the revised Policy.

Mr D Rawsthorn welcomed the revision and the summary which had been helpful in referring to the changes made.

He recognised that the Policy did not refer to the Violence and Aggression Policy. The Director of Quality, Innovation and Improvement advised that she would ensure that reference was made via the minor amendments process.

The Chairman noted that the Non-Executive Director responsible for Health and Safety would need to be updated and he reminded Non-Executive Directors of the importance of PPE requirements when visiting Trust sites.

The Board:

- Noted the review process undertaken.
- Noted the summary of changes and their impact.
- Supported the proposed implementation process.
- Accepted the revised health, safety and security policy subject to the minor amendments agreed.

BOD/2122/127 Policy on Prevention and Reduction of Violence

The Director of Quality, Innovation and Improvement presented the Policy on Prevention and Reduction of Violence. She reported that the Policy had been developed in line with the national violence prevention and reduction standard 2020, which was part of requirements for NHS providers.

She advised that the purpose of the policy was to clearly define the expectations of the Trust and provide policy guidance which the organisation could use to set standards and behaviours as well as the rationale, monitoring arrangements and mechanisms for Trust staff to participate in the prevention and reduction of violence and aggression.

The Director of Quality, Innovation and Improvement highlighted that the Policy had been considered by the Trust's Health, Safety and Security Sub Committee and the Quality and Performance Committee. She added there had been robust conversation regarding the Equality Impact Assessments and a number of initiatives had been addressed; related to the exposure of the 929 Trust staff who had reported either physical assault, threatening behaviour or verbal abuse.

Mr D Rawsthorn referred to s4.9 and the bullet point that stated staff would be responsible for using any equipment provided to ensure their safety. He queried if the Body Worn Cameras would be included within the requirement.

The Director of Quality, Innovation and Improvement confirmed that the cameras were included in this section of the Policy.

Prof R Thomson endorsed the Policy and queried if the Trust would be incorporating the content of the Policy into staff's education and related de-escalation techniques. He added the importance of partnership work to ensure collaborative learning continued.

The Director of Quality, Innovation and Improvement confirmed that a full implementation plan would be presented to the Health, Safety and Security Sub Committee and the comments from Board would be directed and addressed by the members of the team and Sub Committee.

The Director of People confirmed that de-escalation techniques was an element of the Trust's mandatory training and classroom training and was reviewed to reflect best practice.

Prof A Chambers advised that the Quality and Performance Committee had discussed at the meeting held on 24th January 2022.

The Chairman welcomed the Policy for staff safety and recognised the levels of violence and aggression towards staff were unacceptable. He supported collaborative work, which was key to the prevention of incidents and the use of body worn cameras.

The Board:

- Noted the development process undertaken.
- Noted the policy attached at appendix 1.
- Supported the proposed implementation process.
- Accepted the Violence Prevention and Reduction policy.

BOD/2122/128 Learning from Deaths Policy

The Medical Director presented the Learning from Deaths Policy Review. He reported that a scheduled review had been undertaken by the Trust's Consultant Paramedic for the Medical Directorate with minor amendments and updates identified which related to changes to the Corporate Governance structure and processes.

Dr D Hanley referred to the Policy and the section related to liaising with families. He advised that he would welcome feedback on the outcomes to a future Quality and Performance Committee to understand the learning from the process.

The Board:

- Noted the minor updates to the Trust's Policy on Learning from Deaths.
- Approved the updated Trust Learning from Deaths Policy.
- Noted that learning from the liaising with families' process would be reported to a future Quality and Performance Committee.

BOD/2122/129 Audit Committee Chairs Assurance Report from the meeting held on 21st January 2022

Mr D Rawsthorn, Non-Executive Director presented the Audit Committee Chairs Assurance Report from the meeting held on 21st January 2022.

He reported that the members received the Board Assurance Framework and a Data Quality Update report which had been a very good paper and highlighted the steps taken by the Trust to improve data quality; with consideration as to how this would be reported to the Board Assurance Committees in the future.

The Audit Committee had welcomed the progress made, which had resulted from an internal audit report in 2021.

The Board:

- Noted the content and assurances provided in the report.

BOD/2122/130 Integrated Performance Report

The Director of Quality, Innovation and Improvement introduced the Integrated Performance Report for the December period. In terms of the 999 service, she reported that the Trust had seen an increase in calls compared to December 19th 2021 by 7% and a decrease in incidents, which was associated with regard to how Ambulance Quality Indicators were measured.

She advised that there had been significantly higher hear and treat rates which hadn't impacted on see and treat, with a collective non-conveyance of 48%.

The Director of Quality, Innovation and Improvement noted that the Trust had not met response time standards due to abstraction rates which had peaked due to increased Covid-19 Omicron rates. She also noted the Trust had seen a high number of long waits, particularly Category 2 calls.

She reported that there had been a spike in serious incidents associated with long waits and the Trust were working with commissioners to ensure that a detailed review of incidents, themes and learning were shared.

She added that the Integrated Performance Report had undergone robust review by the Quality and Performance Committee.

The Chairman referred to the 6 point plan in the paper regarding recovery and performance. He queried the current position and if a review of the plan was scheduled to highlight lessons learnt. The Director of Operations advised that feedback on the military aid deployed across the region was working well. However, he noted the short term nature of the resource, which was in place up to the end of March 2022. He confirmed the Trust continued with the 6 point plan, monitored by the NHSE and although the impact of the increased resources had dipped over the festive period, this was now returning back to the forecasted trajectories.

He added the significant improvements in Hear and Treat and See and Treat had resulted in a 20% reduction in the number of lost production hours.

He advised that work with Commissioners had been undertaken to address access to the Directory of Services and a focus continued on hospital turnaround times, with an escalation process implemented by NWAS. He added that work with NHSE/I on a rapid release trial at Preston was also improving mental health access.

He reported that there was concern of the number of hours lost per month due to ambulances sat outside A&E departments and ambulances not being productive. He noted that the increase in vehicles, from additional investment, had progressed but there were some delays. He added that a full contracting round had commenced and internal monitoring was ongoing with a review of the modelling outcomes from 2019.

Dr D Hanley observed the figures of increased acuity and demand and questioned how this was linked to the ICS and future configuration of the service, which he felt should be a strategic priority for the Board.

The Director of Quality, Innovation and Improvement agreed that there was a need to understand the position and this was a National picture especially in Trusts using the Medical Priority Dispatch System (MPDS). She added that the rise had resulted in a disproportionate impact on other patients waiting longer.

The Chairman recognised the impact of the significant volume on the service and highlighted his concern at the 20,000 people waiting longer than an hour for a Category 2 response.

The Medical Director advised that the Category 2 calls was a concern during periods of significant activity and the Trust had a model in place where the system would flag the long waits for clinician input, to identify and prioritise calls. He highlighted that there had been a number of serious incidents, however the number of SIs and harm occurred was far less with the system in place than previous years. He confirmed the challenge was sufficient resource.

The Chairman stated the number of 18 serious incidents, out of the 20,000 people waiting longer than an hour highlighted that the process for safety netting patients was effective.

The Director of Operations advised that the Trust were almost delivering the standards, however the Category 2 call stack was significant and the key was sufficient and sustained resources to meet demand across the North West.

The Chief Executive referred to the ongoing triage and continued investment required locally and nationally into 2022/23. He added the key factor was releasing vehicles at hospitals to allow resources back into the community. He advised of the need to do more as a wider system to manage the C2 calls.

The Chairman confirmed that discussions had been held previously on resource and demand and advised that the Part 2 Board agenda included discussion on the progress of the Trust's Service Delivery Model Review. He recognised the need to influence the wider system to ensure engagement with key stakeholders.

The Director of Operations reported that 111 performance had stabilised with consistency in activity. He advised that initiatives were ongoing to the end of March 2022 with focused work on CAT 3 and 4 calls and mental health pathways. He added that ETA scripts had been developed in line with PES to provide an estimated time for call back and SMS messaging had been put in place to promote self-care and assist call taking time.

He advised that 111 had transitioned from an Out of Hours service to an In Hour service and an increase in staffing levels had been recognised in order to meet demand levels.

The Director of People updated the position in relation to staff abstractions and sickness levels. She advised that long term sickness had been impacted by delays in elective surgery and there had been a rise in short term sickness.

She reported that the key focus was on the capacity of managers to provide oversight and management of short term sickness. She added that Covid-19 pay arrangements would cease at the end of March 2022. She highlighted that further work was required to link in with wellbeing initiatives and preventative work in order to support and train managers to promote a preventative focus.

The Director of People reported that work was ongoing in respect of the wellbeing agenda in EOC and 111 to recognise and respond to the issues related to attendance management and the risk to capacity related to the mandating of the Covid-19 vaccination. She advised that pressures were being seen across the NHS and NWAS would need to consider how capacity could be sustained in a productive manner.

Mr D Rawsthorn referred to recent feedback from ambulance station visits and comments from staff that a mobile occupational health service such as physiotherapy support would be beneficial. The Director of People acknowledged the feedback and advised that the Trust had a good network with access to physiotherapy which could be obtained within 24-48 hours.

In terms of mandatory training, she advised that PTS, 111 and Corporate Teams were on track to achieve targets, however EOC and PES were under pressure due to mandatory training being paused during January to train Military personnel.

As such, she confirmed February and March would be a challenge to retrieve compliance and there would be a focused push from 1st February to ensure that compliance continued to reach 85%. She added that a radical assessment would be undertaken of the mandatory training modules to ensure that regulated and statutory training modules were the priority with other modules revisited, to allow staff to complete the core competencies.

The Director of Quality, Innovation and Improvement referred to the sickness absence reporting and the IPC activity which highlighted the successful outcomes of action taken by the IPC Sub Committee and IPC team to ensure clusters and outbreaks were closed in a timely manner. She added that learning from previous Covid-19 outbreaks had been applied and the reduction in outbreaks had been a credit to the work undertaken by the IPC team.

The Chairman highlighted the significant pressures on the organisation and across the health care system, he recognised the work being undertaken to mitigate risk and welcomed the robust discussion generated by the Integrated Performance Report.

The Board:

- Noted the content and recommendations of the Integrated Performance Report.

BOD/2122/131 Learning from Deaths Q2 Report

The Medical Director presented the Learning from Deaths Q2 report. He highlighted that Learning from Deaths Process, despite the loss of life provided a positive learning opportunity for the Trust.

He reported s3.3 highlighted the cases identified and reviewed which included lower category patients that contacted the service. He added that the Safer Care Closer to Home Audit assured the public that seeing patients and not transporting them to hospital was safe and effective.

Prof A Chambers confirmed that the report had been discussed in detail at the Quality and Performance Committee meeting held on 24th January 2022 and that triage reviews were being undertaken and actions to mitigate risk were in place.

The Medical Director confirmed that there had been a risk highlighted that was associated to the absence of a senior clinical resource, however the outcome of the Trust's Service Delivery Model Review in Q1 of 2022/23 would mitigate the risk. He confirmed the risk was sighted and reported to the Quality and Performance Committee.

The Chairman referred to the 42 patients and 28 deaths that occurred where patients were not initially conveyed.

The Medical Director explained that the process mandated certain cohorts of patients being in scope for investigations, hence non-conveyed patients featured in a disproportionate manner. He advised that out of the 42 patient deaths 28 patients were identified for review. Out of the 28 reviewed, it was found that 7 patient deaths had occurred where the incident was coded Cat 3 or 4 and 7 initially coded as Cat 1 or 2.

The Chairman queried the process for dissemination of learning within the Trust. The Medical Director advised that the role of consultant paramedics was to identify the system level improvements that were made and how these would be implemented and learning disseminated. He added that learning was not only an individual learning process but system level improvements were also required to support the process.

Prof A Chambers added that the Quality and Performance Committee had received and triangulated the IPR, Learning from Deaths and Legal Services reports to seek assurance that learning and systems and processes were being enhanced.

The Chairman stated he was pleased to hear that focus had been given to learning processes.

The Board:

- Noted the content of the Learning from Deaths Q2 report.

BOD/2122/132 Quality and Performance Committee Assurance Report – from the meeting held on 22nd November 2021

Prof A Chambers presented the Chairs Assurance Report from the Quality and Performance Committee meeting held on 22nd November 2021.

She reported that the amber and red assurance ratings related to the significant pressures at that time and assurance continued to be sought through the Committee deep dives and work plan.

The Board:

- Noted the content of the Quality and Performance Committee Chairs Assurance Report form the meeting held on 22nd November 2021.

BOD/2122/133 Communications and Engagement Team Dashboard

The Director of Strategy, Partnerships and Transformation presented the Q3 Communications and Engagement Team Dashboard. He reported the level of return of patient surveys had been lower than the previous quarter however SMS text messaging had improved response rates and would be considered for future surveys.

In relation to the Patient and Public Panel he advised that the team continued to make progress against challenging targets and a good number of expressions of interest had been obtained. He added there were currently 198 members on the Panel with 20% made up of young people and work ongoing within diverse communities.

The Director of Strategy, Partnerships and Transformation reported that Press and publications had experienced a busy period and social media activity had benefited from quality over quantity methodology; which had provided a higher engagement rate and had made a significant difference.

He confirmed that the Trust had received 78 Freedom of Information requests and a consistent number of films and stakeholder communications had continued throughout the quarter. He added that the winter campaign had included communication on what to expect when the public called 999.

Mr D Rawsthorn thanked the communication team for the regular communication bulletins, which he felt were good in content and well-pitched.

Prof R Thomson welcomed the quality over quantity methodology and the Trust's approach to social media activity.

The Chairman acknowledged the work completed by the communications team and recognised the challenges of social media. He asked for his thanks to be passed to the team.

The Board:

- Noted the content of the Q3 Communication

BOD/2122/134 ICS and Stakeholder Engagement Update

The Director of Strategy, Partnerships and Transformation presented an ICS and Stakeholder Engagement Update. He reported that guidance continued in the North West related to the three substantive ICS', North Cumbria and Glossop

He advised that the CEOs and Chairs for the ICS' had been recruited, with Cheshire and Mersey Chair appointed on an interim basis and a substantive appointment due in the future. He noted the delayed implementation date from May 2022 to July 2022 to allow for the timing of the parliamentary process.

He commented that the delay allowed NWAS to continue to build relationships and strategy and strengthen partnership work.

He explained that the Trust were interacting with the shadow structures and had requested feedback from key stakeholders to gain an understanding of the quality of external communication and engagement.

In terms of the ICS profiles, he noted that these had been included in the report to provide system information and provide an overview for members. He added the profiles were also available on the Trust's intranet to be updated as changes occurred.

The Chairman recognised the delay in implementation of the ICS' and the importance of the ICS profiles. He welcomed the Trust wide knowledge vault which would support the Trust's requirement to be prepared for the future key decisions to be made.

He emphasised the benefits to understanding the ICS profiles and the need for ongoing support amongst Board Executive and Non-Executive members.

The Board:

- Noted the content of the ICS and Stakeholder Engagement Update.

BOD/2122/135 Any Other Business Notified prior to the meeting

There was no other business notified prior to the meeting.

BOD/2122/136 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

Date and time of the next meeting – 9.45am on 30th March 2022 via Microsoft Teams.

Signed: _____Date:_____

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

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
61	24.11.22	101	Freedom to Speak Up Bi Annual Report	A follow up on the five FTSU anonymous referrals to identify if any action required by the Board.	AW	26.1.22		LW. 26.1.22 - nothing profiled yet but it is one of the subjects that will be included in Board development next year.	
62	24.11.22	111	Health and Wellbeing Update	Further detail of the Wellbeing Framework diagnostic tool to be shared at future Board Development Session.	LW/AW	2022/23			
63	26.01.22	128	Learning from Deaths Policy	The learning from the Liaising with Families process to be presented to future Quality and Performance Committee.	CG	2022/23		Included on Q&P Committee action tracker	

NWAS Board and Committee Attendance 2021/22

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

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

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

Quality and Performance Committee										
	26th April	24th May	28th June	26th July	27th September	25th October	22nd November	24th January	28th February	28th March
Ged Blezard	✔	✔	Cancelled	✔	✔	x	✔	✔	x	
Prof Alison Chambers (Chair)	✔	✔		✔	✔	✔	✔	✔	✔	
Prof Aneez Esmail	✔	✔		✔	✔	✔	✔	✔	✔	
Dr Chris Grant	✔	✔		✔	✔	✔	✔	✔	✔	
Dr David Hanley	✔	✔		✔	✔	✔	x	x	✔	
Prof Maxine Power	✔	✔		✔	✔	✔	✔	✔	✔	
Prof Rod Thomson	✔	✔		✔	✔	✔	✔	✔	✔	
Angela Wetton	x	x		✔	x	✔	✔	✔	✔	

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

Nomination & Remuneration Committee							
	30th June	28th July	29th September	24th November	15th December	26th January	30th March
Prof Alison Chambers	x	Meeting not held	x	Meeting not held	✔	Meeting not held	Meeting not held
Prof Aneez Esmail	✔		✔		✔		
Richard Groome	✔		x		✔		
Dr David Hanley	✔		✔		✔		
David Rawsthorn	✔		x		✔		
Gillian Singh	✔						
Prof Rod Thomson	✔		✔		x		
Peter White (Chair)	✔		✔		✔		

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	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
			Husband works for Liverpool CCG (Cheshire and Mersey ICB)				√	Other Interest	Feb-22	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	Other Interest	Aug-19	Feb-22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Salman	Desai	Director of Strategy and Planning	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Employed at the University of Manchester		√			Professor of General Practice		Present	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority		Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director of Avantage (Cheshire) Ltd	√				Position of Authority	Dec-20	Present	Withdrawal from any Cheshire Care Home related discussions.
			Chair, Fix360 (part of Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Deputy Chair , Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Chair of Association of Ambulance Chief Executives (AACE) Advisory role to the NHS Leadership Review Team		√				Jan-22	Present	No conflict.
			Member of the JESIP Ministerial Board, HM Government		√			Position of Authority	Jan-22	Present	No conflict.
			Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Member of NHSE/I Ambulance Review Implementation Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Rod	Thomson	Non-Executive Director	Visiting Professor at the Universities of Chester, Staffordshire and Liverpool John Moores University		√			Position of Authority	Sep-19	Present	No conflict
			Trustee of the mental health charity "listening ear". The charity is based in Merseyside and provides services in the NW region,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Volunteer at Severn Hospice, Shewsbury and do so as part of CPD requirements for NMC registration.		√			Volunteer	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governing Body Member, Royal College of Nursing		√			Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Locum Consultant in Public Health, Cheshire East Council	√				Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Fellow of the Royal College of Nursing and the Faculty of Public Health,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Lisa	Ward	Interim Director of Organisational Development	Member of the Labour Party	N/A	N/A	√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – The Riverside Group	√				Position of Authority	Apr-19	Jan-22	-
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
Gillian	Singh (Resigned August 2021)	Associate Non Executive Director	Non Executive Director - The Riverside Group	√				Position of Authority	Jan-20		N/A

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30 March 2022				
SUBJECT:	Chief Executive's Report				
PRESENTED BY:	Daren Mochrie, Chief Executive				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☒	☒	☒	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board on 26 January 2022. The highlights from this report are as follows: **Paramedic Emergency Services** • Improvements noted in all reporting standards with 999 call pick up remaining strong • Military deployment has reduced and will cease by the end of March • Improvements in all areas of the NHSE Commissioner six-point plan **NHS 111** • Call demand still outstrips staffing capacity • Retention premium payment approved for 12 months • SMS messaging pilot introduced which will deliver a reduction in call handling time **PTS** • Activity in January for the Trust was 28% below contract baselines • IPC measures still reducing capacity. The paper also provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as				

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

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 26 January 2022

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

January and February continued to be challenging in terms of activity and performance, with only the C1 90th standard being achieved. That said improvements have been seen across all ARP standards within the reporting period. When compared to the other English ambulance trusts NWAS are mid pack on all ARP standards, ranging from 4th to 7th out of the 11 trusts. Call pick up (CPU) has been strong throughout the months and has achieved both the mean and 90th centile standards. NWAS is consistently in the upper quartile of English Ambulance trusts for 999 CPU. The Trust de-escalated to REAP Level 3 on 2 February. This was based upon reduction in staff absence due to Covid-19 and the introduction of the military support from early January which has led to increased resources being available to respond. The military support has been gradually reduced over March as the military personnel have been re deployed. We have re-introduced mandatory training to meet our obligations to meet the revised mandated targets.

Hospital handovers have remained as a pressure with marginal improvement throughout the winter period. This is despite a reduction in patients being conveyed to hospital. Hear & Treat and See & Treat rates have remained good with an average of 40% not conveyed.

Progress against the 6-point plan agreed with NHSE and commissioners has been monitored and improvements in all 6 areas have been evident.

Reductions in C1 and C2 long waits have been significant in January and February which is an indication of improved patient safety.

2.2 NHS 111

Delivery of the service against the KPIs continues to be challenging due to call demand out-stripping the staffing capacity. Recruitment to fully resource the service within the current contract value continues, with ongoing work to improve staff retention showing early signs that the rate of leavers is decreasing slightly. The two main factors identified by staff via exit interviews are booking of annual leave and access to Team Managers due to differing rotas. The Trust have agreed to support the 111 Service by approving a Retention Premium for a period of 12 months, it is anticipated this will ease attrition during the coming months whilst the Team implement changes to processes to book annual leave and conduct a further rota review (post ORH) that focusses on team-based scheduling.

Calls answered in 60s performance remains below the standard but stable; the 111 team are currently working with ORH to demonstrate increase and moving of the demand over the last 12 months alongside the increase in AHT (average handling time), to inform contract discussions.

The 111 Service has grown over the past two years on non-recurrent funding, which has created a risk to service delivery in 22/23 as a number of advisor roles, as well as a small number of managerial and support roles that audit and training, are not permanent.

The SMS pilot project to deliver self-care digitally is now live, and it is anticipated this will deliver a reduction in AHT. Monitoring of the impact on AHT and the clinical safety of the use of SMS for self-care advice is now being monitored and will report in 3 and 6 months to NHS Pathways.

The national Covid Response Service (CRS) went live in early January 2022 but is currently only taking Pharmacy calls via Pathways Light modules. The element of the service for Covid related calls was stood down on 27 January due to low volumes. Alongside the CRS the national Covid Clinical Assessment Service (CCAS) is also still live supporting clinical queues. Both of these services are expected to end on 31 March 2022.

The National busy message was removed temporarily during February 2022, however monitoring of activity found an increase in 10% of calls to the 111 service during that time. Due to the risk of further rising demand into 111 services, NHS England 111 leads have reinstated the message until further notice.

2.3 Patient Transport Services (PTS)

Due to reporting timing issues PTS performance is reported one month in arrears.

Activity in January for the Trust was 28% below contract baselines with Lancashire and 38% below baselines for Merseyside, whilst the year-to-date position (July 2021 – January 2022) is performing at 23% below baseline.

IPC measures are still affecting capacity and this is being reviewed nationally.

3. ISSUES TO NOTE

3.1 Local Issues

High School Major Incident

On 16 February, the service was called to an incident involving a release of gas at a High School in Wythenshawe, Manchester, which we declared as a major incident due to the number of potential casualties and the resources needed at the scene.

Twenty-one resources were sent, including emergency ambulances, our Hazardous Area Response Team (HART), advanced paramedics, MERIT doctors and volunteer services, who between them assessed more than 100 people. Of those, two were taken to Wythenshawe Hospital with breathing difficulties – thankfully, none of the conditions were life-threatening.

3.2 Regional Issues

NHS Pathways

The project to implement NHS Pathways in our emergency operations centres has been slightly delayed due to a technical issue which is awaiting a fix from the provider. A phased go-live will commence at Broughton EOC, with the other EOCs shortly after. Pathways will replace MPDS as the triage tool we use for 999 calls and

is already used in 111. The NHS Pathways system is a clinical tool used to assess, triage and direct patients and the public to urgent and emergency care services.

Having a single primary triage system for 999 and 111 calls will bring significant benefits to those staff working on the frontline and our patients, including consistent outcomes for patients regardless of which number they use to call us.

One of the greatest benefits is the ability to refer to alternative care at the point of call. Other ambulance services report fewer incidents prioritised as C1 and C2 with Pathways compared to MPDS.

CQC Inspection

The Care Quality Commission (CQC) has recommenced its inspections of health and care organisations following a pause during the COVID-19 pandemic. The trust is aware that an ambulance service inspection is likely so it's something we should all be expecting and be prepared for.

The CQC is adopting a new 'place-based' approach to inspections and we have been notified that Lancashire and South Cumbria will be the first area to receive a visit.

The new place-based approach means inspectors will focus on one integrated care system (ICS) area which is a partnership between the health and care services within an area, who work together to plan and deliver care to improve the health of the population. An ICS-level inspection might mean that inspectors visit an ambulance station, emergency operations centre (EOC), 111 contact centre or other NWAS site, as well as other healthcare services and settings in that area. For example, they may be inspecting a hospital site and ask to look at one of our vehicles or have a chat with a crew on a PES or PTS ambulance.

Whilst Lancashire and South Cumbria is the first ICS area in our region to be inspected we expect the others will follow.

The role of the CQC is to monitor and regulate our services to ensure they are safe for patients and much of what they are interested in are the things we do on a daily basis. The last two years have been very challenging and there are things within the service at the moment that are not perfect, but we should use the opportunity to demonstrate to inspectors that we are addressing any issues and showcase the outstanding work done every day to provide safe and effective care for patients.

Media Coverage

There has been a lot of coverage in the news recently about an incident in Manchester where we were unable to reach a patient quickly and who sadly died.

The trust has dealt with in excess of 4.5 million calls between 999, 111 and PTS this financial year so far and predict over 5.3 million by the end of the financial year. This is during the most challenging time in our history and behind every one of those is a person and their worried family. It is easy, when we are busy, to look at the statistics and the numbers of positive outcomes, but we must also reflect on, and learn from, those occasional times when our patients do not receive the response they deserve from us, even when the situation is beyond our control.

When a loved one is seriously ill and someone calls for help – how busy we are is not on their mind, all they are thinking about is wanting us to come quickly. We work to manage expectations but when people are scared and worried, no matter how serious the condition is, they just want the reassurance that help or advice is on its

way. When that help doesn't come for whatever reason, they feel angry, sad, frustrated and disappointed – these emotions are not reflected in our data but they are real and staff also experience those feelings when they come across a family who believes they have been let down.

I am immensely proud of the work that we do as an organisation, and the care and compassion shown when responding to our patients. Negative media coverage is by no means a true reflection of all the amazing work that we do, but these stories impact us all because we care and because we know that on that occasion, we weren't able to be there for someone in need. The headlines might fade away but for that family, the grief will remain, and the best way we can help them is to do all we can as an organisation to minimise the chances of these types of incidents ever happening again.

I have recently met with senior leaders locally and nationally as well as minsters and local political leaders to discuss the current pressures on the ambulance sector not just within NWAS but across the whole of the UK.

National Issues

Our thoughts are with the people of Ukraine

Our thoughts are with everyone in Ukraine and all those affected, which may include some of our colleagues and patients: those who are from Ukraine or have relatives or friends in the country and surrounding areas; those with links to Russia who are equally upset by and against the violence; and those who have served in conflict and find the news coming out of Ukraine particularly distressing.

A national effort is underway to provide support to Ukraine and to ensure the NHS stands ready to provide further support as needed. Through its coordinated work with the Department of Health and Social Care (DHSC), the UK has already provided over 650,000 medicines and medical items such as wound packs and intensive care equipment, deployed a humanitarian team to the region, and is exploring further options to support Ukraine.

The Charity Commission and Fundraising Regulator have urged the public to 'give safely' to registered charities as people make generous donations to causes helping to support and protect people affected by the invasion of Ukraine. The Disasters Emergency Committee, a coalition of 15 leading UK charities, has launched its collective appeal to provide emergency aid and rapid relief to civilians suffering during the conflict.

Ukrainian Children to receive Cancer care in the UK

The trust also supported a national effort to help bring 21 Ukrainian children with cancer to the UK to receive care through the NHS. The children were brought over from Poland to a triage centre in the West Midlands where they were assessed before being transferred to be cared for at appropriate hospitals across the country.

A team of 13 of our patient transport service staff, five paramedic emergency service staff and two operational commanders took the 180-mile round trip to bring some of the patients and their families to our region to continue their care.

The extremely fast-moving operation was made possible by the quick and efficient planning and co-ordination of our Resilience Team and ROCC. It was an honour for us to be able to support in this humanitarian effort and do what we do best, which is provide care to those who need us the most.

Cyber Security

Cyber security is currently a key topic of discussion generated by the situation in Ukraine and the National Cyber Security Centre has called on UK organisations to take steps to ensure they are protecting themselves from the heightened risk of cyber-attacks.

It is increasingly important that we remain vigilant and understand how to identify potential threats and what we need to do to remain secure. Emails are our biggest vulnerability and account for around 80% of cyber-attacks globally.

Mandatory covid vaccines

On 31 January 2022, the government announced its intention to revoke the regulations making coronavirus (COVID-19) vaccination a condition of deployment in health and social care, subject to consultation and parliamentary process.

As part of the announcement, the government set out the changes in clinical evidence which made it right to revisit the balance of risks and benefits that had guided the government's original decisions to introduce COVID-19 vaccination as a condition of deployment in health and social care. With a population that had immune systems that had limited exposure to COVID-19, and with vaccine effectiveness against infection after 2 doses estimated at 65% to 80%, the clinical evidence weighed heavily in favour of introducing the requirement in order to protect patients and the people who receive care and support.

The Government subsequently held a consultation between 9 and 16 February 2022 to seek views on the government's intention to revoke the vaccination as a condition of deployment in health and social care.

In light of scientific evidence and having considered the views received as part of the consultation, as well as an analysis of equalities impacts, the government will now revoke the legislation of vaccination as a condition of deployment.

LAMP testing

The LAMP saliva testing programme that is currently offered to NWAS staff is coming to an end after 31 March. Regular asymptomatic staff testing remains as important as ever for patient and staff safety, and staff should continue to do lateral flow tests on a weekly basis, even if fully vaccinated.

Integrated Care Systems

Integrated care systems bring together providers and commissioners of NHS services across a geographical area, along with local authorities and other local partners to plan health and care services for their population.

ICSs are part of a fundamental shift in the health and care system, designed to break down barriers between services. Following years of emphasis on autonomy and competition for organisations and the separation of commissioners and providers, ICSs depend on partnership working.

Through the ICSs, there is a real opportunity to provide genuine patient-centred care where people have choice and control over the way their care is planned and delivered, regardless of which service or budget the care comes from.

Parliament has approved these reforms and, as of July 2022, we will be duty-bound to collaborate with partner organisations. As part of each ICS in our region, we will have a shared duty to provide better health and better care at lower cost.

While the functions and duties of our service will remain unchanged, we will be expected to collaborate at ICS 'system' level and at more locally at 'place' level too.

Over recent years we have increasingly been expected to look beyond our organisational priorities to focus on system-wide objectives to improve patient outcomes. This is a fundamental part of our Urgent and Emergency Care Strategy and the NHS Long Term Plan. Exploring opportunities for additional funding will be a key priority for the area directors, as funding will flow through ICSs and any locality 'provider collaborative' structures.

As part of the NWAS senior leadership review in the operations and medical directorates, we are introducing new areas directors who will head up each of our geographical areas and will work with the integrated care systems. The addition of our area directors and the restructuring of area-based teams is the next step to ensure that NWAS is an active and influential participant at each of the ICSs in our region. ICSs have been appointing locality director roles and our new area directors will work closely with them as well as each of the ICS executive leadership teams.

The area teams' portfolios will span the service lines and the trust will see a more integrated service with a greater mix of opportunities for staff both inside and outside of this organisation and better outcomes for patients; fundamental to all of our roles in the NHS.

4. GENERAL

Team Talk Live

Once again, following the last Board meeting, I, together with our Chairman, shared some highlights from what was discussed in the meeting. I explained how we heard from a couple of our colleagues, Kirsten McDermott and Scott McAughtrie, who have done a fantastic job working with young people in the Greater Manchester community looking at what we can do to support them to make the right choices.

I also spoke about the update I gave to the Board which covered how we've been doing in terms of performance since the previous Board meeting in November. Further updates included the Manchester Arena Inquiry, COVID-19 – including military support and how we're working with our acute partners to improve hospital handover delays.

I covered some of the work we've been doing around mental health support for emergency services staff. The Association of Ambulance Chief Executives (AACE) recently co-hosted with the National Police and Fire Chiefs Councils and the Duke of Cambridge's mental health and wellbeing seminar in London which was attended by over 300 senior leaders from across the UK.

LGBT+ History Month

February was LGBT+ History Month, an opportunity to celebrate achievements and support our LGBTQ+ colleagues. The campaign is celebrated across the NHS to increase the visibility of the community and raise awareness of moments in history and staff experiences that have got us to where we are today.

The theme of LGBT+ History Month 2022 was The Arc is Long, inspired by the Martin Luther King quote: 'The arc of the moral universe is long, but it bends towards justice'. This quote is thought to mean that no matter how long it takes, we are moving towards social fairness and will achieve equality.

Creating an organisational culture where everyone feels that they belong is a priority for NWAS and the wider NHS.

The Health and Care LGBTQ+ Leaders Network has produced a comprehensive set of resources to improve the experiences of LGBTQ+ staff. The Royal College of Nursing's PROUD network has developed an online exhibition called Hidden in plain sight, that explores diversity in nursing including how the LGBTQ+ community have helped shape the nursing profession throughout history.

Within our service, the NWAS LGBT network, championed by Director of People, Lisa Ward, is open to all staff and aims to improve staff and patient experience and provide an influential voice on behalf of all LGBT+ staff.

In recent years, the network has made fantastic progress. Some of the network's achievements include the co-production and updating of the procedure for supporting trans staff in the workplace, hosting the National Ambulance LGBT conference in Manchester in 2018, becoming a more visible presence within the service and actively participating in the development of a CPD resource regarding the experiences of HIV positive patients. Well-done to all involved in this important work.

International Women's Day

Tuesday 8 March marked International Women's Day 2022 and this year's theme was '#BreakTheBias'. It encourages us to commit to calling out bias, smash stereotypes, break inequality and reject discrimination. 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.

The day gave us another opportunity to reflect on this, consider what further action we can take, and say thank you to the women of Team NWAS for everything they do. The whole week was marked in a number of ways, but one focus was to share stories and experiences from NWAS women.

AACE also hosted a webinar covering a range of topics relating to women in leadership. Our Director of Quality, Innovation and Improvement, Maxine Power, was one of the speakers and discussed how ambulance services can improve and what needs to happen for us to eradicate sexism within the service. Maxine is a real champion for women in leadership.

Mental Health Continuum

On 10 March AACE, in partnership with the College of Paramedics**,** hosted a mental health continuum CPD session. I was delighted to be asked to open the session and it was great to see Craig Haden our Advanced Practitioner and Suicide Prevention Lead, speak at the event too. Raising the awareness of mental health, reducing the stigma about speaking up and developing ways to support each other such as the continuum tool kit is a key priority for me, both in my NWAS CEO role and AACE Chairs role.

Work Without Fear

With input from ambulance services across the country and support from NHS England, the Association of Ambulance Chief Executives launched the national #WorkWithoutFear campaign to highlight the impact of abuse on staff.

The campaign, which features real-life case studies from people who have faced abuse such as kicking, slapping, head-butting and verbal abuse, aims to encourage the minority of people who might commit these offences to have respect for those who are trying to help them, their friends and families, when they need it most.

Many of our staff start their shift facing the possibility of violence, assault or aggression, and abuse of this, or any kind, is totally unacceptable. The campaign raises awareness of the impact this behaviour has on our staff and demonstrates that it will not be tolerated, and ensures staff are treated with the respect they deserve when they turn up to work to help people.

The Health and Social Care Secretary, Sajid Javid, and NHS Chief Executive Amanda Pritchard are backing the campaign.

It has been really eye-opening to see the case studies that have been shared so far that really shine a light on the impact of abuse on ambulance staff. It can't be easy to relive those experiences to share them with us, but these stories are very powerful and they help to demonstrate that our staff are all caring individuals who come to work to help people and never deserve to be subjected to abuse.

National Apprenticeship Week

National Apprenticeship Week took place at the beginning of February and is an annual week-long celebration of apprenticeships that takes place across England.

It was an opportunity to highlight the positive impact our apprentices make to Team NWAS and our communities.

The role of apprenticeships within the ambulance service has grown significantly over the recent years, opening opportunities for new learning programmes and allowing us to continue to develop a workforce that delivers the best patient care, with both clinical and non-clinical roles.

Between March 2020 and January 2022, we recruited 182 new EMT1 apprentices, including 78 from our Patient Transport Service (PTS) who had undertaken the Paramedic Emergency Service (PES) upskill programme. During the same period, 178 EMT1 apprentices completed their apprenticeship, with an impressive 74 achieving a distinction, 78 achieving merit and 26 achieving a pass grade. We even started some new apprenticeships during the pandemic, with the first of our paramedic apprentices beginning in early 2021 and due to complete in 2023.

The trust knows how important it is to invest in and provide opportunities, to not only attract new talent but to develop the expertise and experience we already have within the service.

On a similar topic, I was pleased to be able to join some of our practice education facilitators on a visit to Bolton University last Tuesday. We had a look around the facilities there and met some of the paramedic students, which was a real pleasure. It was great to be able to welcome them to the course and have a chat with a group of people who could become our colleagues in the not-too-distant future.

Super Star Awards

After receiving a record number of nominations for this year's Super Star Awards ceremony, our judging panel has now made the difficult decision of deciding the finalists for each category.

The nominations were initially whittled down by our Patient and Public Panel (PPP) members. They had the challenging task of picking through 400 nominations across our ten categories before a final decision on the finalists and overall winners was selected by the Chairman and myself, and facilitated by the Director of Strategy and Planning, Salman Desai.

Huge congratulations to all our shortlisted nominees and we look forward to announcing the winners on the evening of 9 June at the Bolton Whites Hotel.

Developing the Trust Strategy

The trust is undertaking a review and refresh of the strategy in recognition of just how much has changed over the last two years. COVID-19 impacted everything we do and gave us plenty to learn from. At the same time, the structure of the health and care systems in which we operate has been changing with the further development of integrated care systems.

Staff provided feedback as it was important that staff views were reflected in the strategy and, importantly, when describing our purpose and vision. There was also focused work undertaken with the Patient and Public Panel so we could be confident patient views were captured and considered also.

The feedback helped the Board to consider some changes to how we describe our trust purpose and outline our vision. There was some rich and detailed feedback about our current strategy, and many people across the service did feel that our existing 'right care, right time, right place' focus resonated with them. Unsurprisingly, there was consensus from across the whole trust that patients should be our focus and our main role is to help people at their time of need.

There is more work to be done but the aim is to launch the refreshed strategy in the new financial year.

Going Greener

As part of our commitment to reducing our carbon emissions, three brand new zero-emission vehicles are set to join our fleet from next month.

Funding has been secured under an initiative with Greener NHS to test and evaluate two new models of electric vehicles. This includes two Kia EV6 response vehicles as well as a Mercedes E-Vito van which will be a dedicated mental health unit. The response vehicles will have improved technology and additional range capacity compared to the BMW i3 electric models that we currently use, which will be approaching a range of 300 miles.

To pilot these in both rural and urban settings they will be based at Central station in Greater Manchester and Distington station in Cumbria. The mental health unit will be based in Merseyside.

Outrun an Ambulance – supporting the challenge

Whilst in London recently, I was invited to take part in the Outrun an Ambulance charity fundraiser. Two London-based paramedics were embarking on a 31-mile run to support the fundraiser, so their Chief Executive and I put on our running shoes and joined them for the first two miles!

The Outrun an Ambulance challenge is a shared initiative with other NHS ambulance charities, including our own North West Ambulance Service Charity. Participants can sign up to walk, run, cycle, or swim the distance an ambulance completes on an average shift. The challenge says you can spread the distance over a period of time but the London paramedics decided to run it in one go which is an impressive achievement!

The Queen's Platinum Jubilee

The UK government's department for Digital, Culture, Media and Sport (DCMS) has confirmed that there will be an additional public holiday on Friday 3 June 2022 to honour the Queen's special anniversary. The May bank holiday weekend will be moved to Thursday 2 June and an additional bank holiday on Friday 3 June will create a four-day weekend.

The Queen's Platinum Jubilee will be a historic moment, the first time any reigning British monarch has reached 70 years on the throne. Reflecting on the Queen's reign, and her impact on the UK and the world since 1952, the government is planning to mark the Platinum Jubilee with a one-off additional Bank holiday in June 2022. The four-day Jubilee weekend will bring the entire nation and the Commonwealth together in a fitting tribute to the Queen's reign.

Whilst the additional day of leave has been announced nationally, the arrangements for payment of the day have been left to local determination. As a Trust, along with our ambulance service colleagues, we recognise the extraordinary sacrifices that our staff have made during the pandemic and that many will be unable to participate in this special holiday because they will again be working to continue to deliver care and support to our patients across the North West. As a result, we believe it is appropriate to ensure that staff working are afforded the full bank holiday terms and conditions for the day.

Also to mark The Queen's Platinum Jubilee, a special commemorative medal will be awarded to eligible emergency services personnel as a token of the nation's thanks and to celebrate Her Majesty The Queen's 70 year reign. The eligibility criteria is set nationally by the Department of Health and Social Care (DHSC) which we have shared this with staff and broadly includes: emergency services staff who have been in paid service, retained or in a voluntary capacity, who have to publicly face the prospect of dealing with emergencies as part of their conditions of service, and have completed five full calendar years of service on 6 February 2022 will receive a medal.

Death of former staff members

It is with great sadness that I write to inform you of the death of our former colleagues, Sandra Parker and Amanda Stelfox.

Sandra, aged 58, passed away in February after a short illness. Sandra worked in GM, commencing her career in 1986 on patient transport at Rochdale station, she moved to Oldham for a period, but returned to Rochdale where she remained until her retirement in 2018.

Amanda, aged just 48, passed away on Wednesday 16 March after a short illness. Amanda also worked in GM, predominantly from Sale Station. She joined NWAS in 2014, transferring to us from London Ambulance Service, where she had worked since 2006.

Both staff members were highly respected, not just for the excellent clinical care they provided to their patients, but also their exceptional professionalism.

The trust sends sincere condolences to the families, colleagues and friends of Sandra and Amanda.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implication contained within this report

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

7. RECOMMENDATIONS

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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 30 March 2022				
SUBJECT:	Board Assurance Framework (BAF) Risks 2022/23				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☒	☒	☒	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The Board of Directors has overall responsibility for ensuring that systems and controls are in place are adequate to mitigate any significant risks which may threaten the achievement of strategic objectives. The proposed BAF Risks for 2022/23 can be viewed in **Appendix 1**.				
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the proposed 2022/23 BAF risks.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee				
	Date:	23 March 2022			
	Outcome:	Supported Onward Reporting to 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 (BAF) Risk for 2022/23.

2. BACKGROUND

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

Following focused discussion sessions with both Executive and Non-Executive Directors surrounding the BAF risks for 2022/23, the proposed BAF Risks for 2022/23 can be viewed in **Appendix 1**.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the proposed 2022/23 BAF risks.

Appendix 1: 2022/23 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 achieve financial sustainability impacting on its ability to deliver safe and effective services	Director of Finance
SR03	There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	Director of Operations
SR04	There is a risk that the Trust will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to maintain safe staffing levels	Director of People
SR05	There is a risk that sufficient progress is not made in developing a compassionate, inclusive and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity	Director of People
SR06	There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	Director of Quality, Innovation and Improvement
SR07	There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	Director of Strategy, Partnerships & Transformation
SR08	**(Commercially Sensitive)**	Director of Strategy, Partnership & Transformation
SR09	There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm	Director of Quality, Innovation & Improvement
SR10	**(Commercially Sensitive)**	Director of Strategy, Partnerships & Transformation

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 30 March 2022				
SUBJECT:	Risk Appetite Statement 2022/23				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☒	☒	☒	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors during the Board Development Session held in Q4 2021/22. The proposed 2022/23 Risk Appetite Statement has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.				
RECOMMENDATIONS:	The Board of Directors are requested to approve the Risk Appetite Statement for 2022/23.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee				
	Date:	23 March 2022			
	Outcome:	Supported Onward Reporting to Board of Directors			

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1. PURPOSE

This report provides the Board of Directors with an opportunity to consider the Risk Appetite Statement for 2022/23.

2. BACKGROUND

The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors in Q4 2021/22 during a developmental session with the Board.

The proposed Risk Appetite Statement for 2022/23 has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the Risk Appetite Statement for 2022/23.

NHS
North West
Ambulance Service
NHS Trust

RISK APPETITE STATEMENT (RAS) 2022/23

North West Ambulance Service (NWAS) NHS Trust recognises as a healthcare provider that risks will inevitably occur while providing care and treatment to patients, employing staff, owning, leasing and maintaining 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 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 and volunteers.

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 may impact on finance/ value for money. However, budgetary constraints will be exceeded when required to mitigate risks to patient, staff or volunteer 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 has a high appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities.

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**
Compliance/ Regulatory	Low	1-5	We have a **LOW** appetite, and we will not take any risks which will impact on out ability to meet our legislatory requirements.
Quality Outcomes: ▪ Safety ▪ Effectiveness ▪ Experience	Low	1-5	We have a **LOW** appetite for taking in relation to quality outcomes. We will take measured and considered risks to improve and delivery of 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, volunteers, or patients in our care.
Financial/ Value for Money (VfM)	Moderate	6-12	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 financial risks which will have a negative impact on the overall sustainability of the Trust.
Reputation	Moderate	6-12	We have a **MODERATE** appetite for risk taking that will enhance to be an 'outstanding' organisation. We will not take any risks that will have a negative impact on the reputation of the Trust.
Innovation	High	15-25	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 ensure value for money.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 30 March 2022
SUBJECT:	Risk Management Policy Review
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☒	☒	☒

SR05	SR06	SR07	SR08	SR09
☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The Risk Management Policy has been through an annual review and refresh. The current version of the Risk Management Policy was approved by the Board of Directors on 27 January 2021, following the approval of the Risk Management Strategy in November 2020. Risk management is a statutory requirement and an indispensable element of good management. The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation. The changes made to the Policy can be viewed in s4 of the repot. The Risk Management Policy can be viewed in **Appendix 1**.
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the Risk Management Policy for the Trust.
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation

	☒ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee			
	Date:	Wednesday 23 March 2022		
	Outcome:	Supported Onward Reporting to the Board of Directors		

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1. PURPOSE

The purpose of the report is to provide the Board of Directors with the revised and refreshed Risk Management Policy.

2. BACKGROUND

The Risk Management Strategy was approved by the Board of Director in November 2020 and subsequently, the Risk Management Policy has been revised to define the approach taken by the organisation in applying risk management consistently across the Trust.

Risk management is a statutory requirement and an indispensable element of good management. It is a fundamental part of the approach to quality, corporate and clinical governance. Good risk management is integral to the effectiveness of all the Trust's activities and as such must be integrated into all functions day-to-day practice and embedded within the culture of the organisation so that appropriate risk-based decisions are regularly made by managers and staff at all levels.

An effective policy enables the Board of Directors to determine the extent of risk exposure it currently faces with regard to the achievement of its objectives. As a key component of the internal control framework, regular review and routine monitoring of the Risk Management Policy will also inform the Trust's Annual Governance Statement

3. PURPOSE OF THE RISK MANAGEMENT POLICY

The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The Risk Management Policy applies to all areas of the Trust and at all levels. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making.

It is expected that all risk management activities in the Trust will follow the process described within the Risk Management Policy, to ensure a common and robust approach is adopted to risk management.

The full refreshed Policy can be viewed in **Appendix 1**.

4. SUMMARY OF POLICY CHANGES

As part of the annual review of the Risk Management Policy, the below key points of change are to note:

- The policy is presented on the new policy template and complies with Trust branding
- Amendments to the 5x5 risk matrix, following the Board Development Session with Non-Executive and Executive Directors
- Changes to risk review frequency
- Amendments to the naming of the Corporate Risk and Assurance Team
- Amendments to the naming of the Corporate and Commercially Sensitive Risk Register
- Articulates the role of the Executive Leadership Committee (ELC) for the approval of risks for inclusion on the Corporate and Commercially Sensitive Risk Register
- Risk reporting cycles to various meeting throughout the Trust to reflect the Terms of Reference
- Amendments to reflect Sub Committees as opposed to Management Groups
- Risk reporting diagram has been refreshed to integrate Directorate governance arrangements with the Integrated Governance Structure
- Amendments to the Risk Awareness and Management training via MyESR
- Amendments to the Consequence Scoring Matrix
- Review of both the references and Equality Impact Assessment (EIA)
- Review of the monitoring of compliance.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

7. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the Risk Management Policy for the Trust.

North West Ambulance Service NHS Trust

Policy on Risk Management

Recommended by	Audit Committee
Approved by	Board of Directors
Approval date	
Version number	0.3
Review date	April 2023
Responsible Director	Director of Corporate Affairs
Responsible Manager (Sponsor)	Head of Risk and Assurance
For use by	All staff and volunteers

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	December 2020	-	J Taylor	New Policy
0.2	January 2021	January 2021	J Taylor	Amendments from Audit Committee
0.3	April 2022	April 2022	J Taylor	Annual Review

Policy on Risk Management

Contents	

1. Introduction

Risk management is both a statutory requirement and a key element of good management and risk management is everyone's responsibility, with the principles of effective risk management forming an integral component of decision making at all levels.

The activities associated with caring for patients, employing staff, providing facilities and services and managing finances are all, by their nature, activities that involve risk. These risks are present on a day-to-day basis throughout the organisation and whilst it may not always be possible to eliminate these risks, they can be managed to an acceptable level by ensuring that risk management is embedded into day-to-day practice and the culture of the organisation so that appropriate risk-based decisions are regularly made by managers and staff at all levels.

Effective risk management enables the Board of Directors to determine the extent of risk exposure it currently faces with regard to the achievement of its objectives. As a key component of the internal control framework, regular review and routine monitoring of this policy will also inform the Trust's Annual Governance Statement.

2. Purpose

The purpose of this Risk Management Policy is to define the approach taken by North West Ambulance Service NHS Trust (the Trust) in applying risk management to its decision making at all levels and the main objective is to establish the foundations for a culture of effective risk management throughout the organisation.

This policy sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The principles and techniques of risk management as defined in this policy should be fully integrated within the formal governance arrangements and decision making processes of the organisation.

All Trust staff are responsible for making sure that they are aware of the organisation's objectives and are empowered to make decisions to manage risks as long as those decisions are within the scope of their role and level of authority.

Where a risk is identified but cannot be managed without some significant change to the way the organisation operates, it must be escalated through the relevant line management structure.

The Risk Management Policy applies to all areas and levels of the Trust. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making.

All risk management activities in the Trust will follow the process described within this document to ensure a common and robust approach is adopted to risk management.

3. Roles & Responsibilities

This section details those groups and individuals within the Trust that have specific responsibilities with regard to the Risk Management Policy.

The **Board of Directors** is responsible for providing strategic leadership to risk management throughout the organisation, which includes:

- Maintaining oversight of strategic risks through the Board Assurance Framework (BAF)
- Leading by example in creating a culture of risk awareness

The **Audit Committee** is responsible for reviewing the established and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisations' activities. The Committee will provide assurance to the Board of Directors that there are effective systems operating across the Trust.

The **Chief Executive** as the ***Accountable Officer*** is responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's strategic objectives. This includes:

- The establishment and maintenance of effective corporate governance arrangements
- Ensuring that this Risk Management Policy is applied consistently and effectively throughout the Trust
- Ensuring that the Trust is open and communicates effectively about its risks, both internally and externally
- Retaining sufficient professional risk management expertise to support the effective implementation of this Policy

The **Director of Corporate Affairs** is accountable to the Board of Directors and Chief Executive for the Trust's Governance and Risk Management activities. With Executive responsibility for governance and risk management the Director of Corporate Affairs (with support from the Head of Risk and Assurance) provides a clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements on behalf of the Board of Directors.

Members of the **Executive** and **Directorate Senior Management Teams** are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Maintaining an awareness of the overall level of risk within the organisation
- The management of specific risks that have been assigned to them, in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties

Heads of Service (all departments) are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Making active use of the Trust risk register and the processes described in this Policy to support the management of their service
- The management of specific risks that have been assigned to them in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties
- Ensuring that as far as possible risk assessments carried out within their service are based on reliable evidence

Every member of staff is responsible for identifying and managing risks within their day-to-day work, which includes:

- Maintaining an awareness of the primary risks within their service

- The identification and as far as possible the management of risks that they identify in the course of their duties
- Bringing to the attention of their line manager any risks that are beyond their ability or authority to manage

4. Risk Management Approach

The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels.

This requires not only the active engagement of all staff with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation.

This will ensure that major strategic, policy and investment decisions are made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

5. Risk Management Process

The risk management process, which can be seen in Figure 1 below, involves the identification, analysis, evaluation and treatment of risks. More importantly, the process provides iterative steps, which when taken in a coordinated manner can support recognition of uncertain events which could lead to a negative outcome and therefore allows actions to be put in place to minimise the likelihood (how often) and consequence (how bad) of these risks occurring.

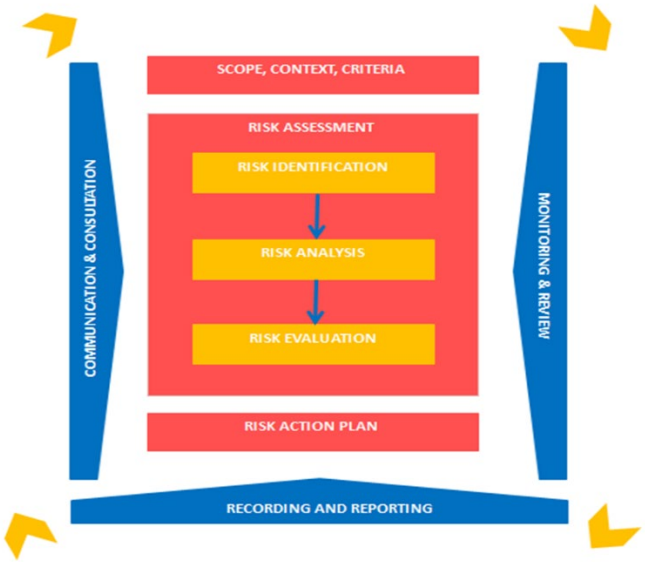

Figure 1: *ISO 3100:2018 Risk Management Process*

5.1. Scope, Context and Criteria

The Trust Strategy sets out how the organisation will become the best ambulance service in the UK, which is broken down into 8 Strategic Priorities. These are:

- Quality
- Urgent and Emergency Care

- Workforce
- Infrastructure
- Environment
- Stakeholder Relationships
- Digital
- Business and Commercial Development

Risks are linked to the strategic priorities because failing to control risks may lead to non-achievement of our strategic goals and priorities.

5.2. Risk Assessment

Risk assessment is an objective process and where possible, staff should draw upon evidence or qualitative data to aid assessment of risk. Where evidence or data is not available, assessors will be required to make subjective judgement.

Risk vs Issue

It is important to understand the difference between a risk and an issue/ incident.

The fundamental difference between a risk and an issue/incident is that an issue/incident has **already happened**, there is no uncertainty, and it is a matter of fact.

A risk is an uncertain event that has **not yet happened**, but if it did, it could affect the achievement of an objective.

Risk	Issue/ Incident
An uncertain even that **HAS NOT** happened	An unplanned event that **HAS** happened

Risk Articulation

In order to assist the risk management process, it is essential that risks are described in a way that allows them to be understood by all who read them. Articulating a risk in this way will enable effective controls, assurances and action plans to be put in place to mitigate the risk.

There should be three components to the description of a risk:

Cause (Source of Risk)	Risk (Uncertain Event)	Consequence (Impact)
What has caused the risk? Where has the risk originated from?	The uncertain event (risk) that may happen if we do nothing	What would be the impact if the risk materialised?
Risk descriptions must tell a convincing story		
There is a risk 'as a result of/ due to/ because of'… *existing condition* **Present Condition**	*An uncertain event…* may occur **Uncertain Future**	Which would lead to… *effect on objectives* **Conditional Future**

Risk Identification

New risks and factors which increase a known risk may be identified at any time and by anyone within the organisation and can take many different forms.

All staff play a vital role in the identification of risk. All new risks should be reported and discussed with your line manager in the first instance, who will consider the best approach to manage the risk; this could be actions to immediately eliminate the risk, signposting of the risk to the appropriate person to manage the risk or inclusion on a risk register with an action plan in place.

Some risks can be managed effectively by the person identifying them taking appropriate action themselves or within their immediate team. This is particularly true with types of safety risk, where identification and removal of the hazard will often be sufficient to manage the risk.

Staff should initially consider what their main areas of work are and how these relate to their local objectives, and the objectives of the Trust. Every work activity that has a significant hazard should be assessed for risk. Identification using a systematic approach is critical because a potential risk not identified at this stage will be excluded from further analysis.

All risks, whether under the control of the Trust or not, should be included at this stage. The aim is to generate an informed list of events that might occur. Key sources that will inform this exercise include (but are not limited to):

- Compliance requirements with regulators and stakeholders such as the CQC, HSE, NHSE/I etc
- Recommendations from recent internal / external audit reports
- Thematic and trend analysis of incidents, inquiries, complaints, claims and inquests
- Performance data
- Quality Assurance Audits
- Quality Impact Assessments
- Safety Alerts
- Trend and forecasting analysis
- Risks associated with the achievement of corporate objectives
- Other methods of horizon scanning.

Business Continuity Exercises
Recommendations from business continuity exercises are captured within the risk management process to ensure the delivery of actions to reduce risk of failure in the event of an actual incident.

5.3. Risk Analysis

The purpose of analysing and scoring a risk is to estimate the level of exposure which will then help inform how the risk should be managed.

When analysing a risk, you will need to:

- Identify who is affected and what is the potential consequence/ impact should the risk occur
- Estimate the likelihood (how often) the risk may possibly occur
- Assess and score the level of exposure to that risk using the risk scoring process below.

Risk Analysis Process
Risks are analysed using the Trust Risk Matrix. The Trust has adopted a 5x5 matrix with the risk scores taking account of the consequence and likelihood of a risk occurring.

The scoring of a risk is a 3-step process:

Step 1: Evaluate the consequence of a risk occurring. The consequence score has five descriptors:

Score	Consequence Descriptor	Consequence Description
1	Insignificant	Please see **Appendix 2** for Consequence Descriptions
2	Minor	
3	Moderate	
4	Major	
5	Catastrophic	

Step 2: Analysing the likelihood (how often) a risk may occur. The table below gives the descriptions of the likelihood of a risk occurring:

Score	Likelihood Descriptor	Likelihood Frequency	Likelihood Probability
1	Rare	Not expected to occur in years	May only occur in exceptional circumstances
2	Unlikely	Expected to occur at least annually	Unlikely to occur
3	Possible	Expected to occur at least monthly	Reasonable chance of occurring
4	Likely	Expected to occur at least weekly	Likely to occur
5	Almost Certain	Expected to occur at least daily	More likely to occur

Step 3: To calculate the risk score, multiply the consequence score with the likelihood score:

CONSEQUENCE score x **LIKELIHOOD** score = **RISK** score

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

5.4. Risk Evaluation

Once the risk analysis process has been completed, the risk score should now be compared with the level of risk criteria below which enables the Trust to measure the potential level of risk exposure and proceed to identify appropriate actions and management plans.

Level of Risk
1 - 5 (Low)
6 - 12 (Moderate)
15 - 25 (High)

Each risk will be assigned 3 risk scores: initial, current and target. The risk scoring process above will be carried out three times for each score using the guidance below.

1. **Initial Risk Score**
   The initial risk score is when the risk is first identified, the risk analysis process for initial risk scores should be a measure of the consequence and likelihood before any controls/ mitigating actions are proposed. The initial risk score will not change for the lifetime of the risk.

2. **Current Risk Score**
   The current risk score, the risk analysis process for current risks should be a measure of the consequence and likelihood once controls and mitigating actions are in place, taking into account the effectiveness of the controls added.

3. **Target Risk Score**
   The target risk score, the risk analysis process for the target risk should be a realistic measure of the consequence and likelihood once improved mitigating actions have been achieved and improved controls added.

5.5. Risk Management

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified, analysed and that appropriate controls and responses are in place.

Risk Treatment
Risk treatment a process to modify risk and the selection and implementation of measures to treat the risk. This includes as its major element, risk control/ mitigation, but extends further to the appropriate selection of a risk treatment option, these are outlined in the table below.

Tolerate (Accept)	**Can we accept the risk as it is i.e., without further controls? Would the cost of controlling the risk outweigh the benefits to be gained?** Where the ability to do anything about certain risks may be limited or the cost of taking any further action may be disproportionate to the potential benefit gained. In these cases, the response is to manage the risk to as low as reasonably practicable (ALARP) then tolerate the risk. This option can also be supplemented by contingency planning for handling the consequences that may arise if the risk is realised. Where the status of the risk is to tolerate, the risk must be monitored and reviewed by the risk owner at least annually. All risks tolerated, will be subject

	to review by the Corporate Risk and Assurance Team and a decision made by the Executive Leadership Committee if the risk should be tolerated or not.
Treat (Reduce or Remove)	**Can we put controls in place to reduce the likelihood of the risk occurring or its impact?** Treat is the most widely used approach and will be the course of action to take for the majority of risks within the Trust before any other course of action is considered.
Terminate (Suspend the risk situation/ activity)	**Can we avoid or withdraw from the activity causing risk? Can we do things differently?** A decision will be made by the Executive Leadership Committee if the risk should be terminated or not.
Transfer (Responsibility)	**Can we transfer or share, either totally or in part, by way of partnership, insurance or contract?** This course of action should only be taken following consideration and decision by the Executive Leadership Committee.

Identifying Controls and Gaps
Controls are arrangements that are already in place to mitigate or manage the risk and these can include policies and procedures, monitoring and audit.

Every control should be relevant to the risk that has been described, it should be clear that the control directly impacts on managing the risk and the strength of the control should be considered when deciding the influence this will have on the risk score.

Despite having identified controls, where the service has established a risk exists, it is the uncontrolled issues that are articulated as gaps. Gaps are issues which are not controlled and directly affect our mitigation of the risk. Gaps require clear and proportionate actions to address them.

Risk Mitigating Action Plans
The purpose of risk action plans is to document how the chosen treatment options will be implemented.

Information should include:

- A description of what the planned action is
- Expected benefit(s) gained
- Responsibilities (risk owners and action owners)
- Reporting and monitoring requirements
- Resourcing requirements
- Timing and scheduling

Differentiating between Controls, Gaps and Actions
To summarise:

- Controls are things that are already in place to manage or monitor the risk

- Gaps are the issues that we need to address to control the risk fully
- Actions describe how you will address the gaps to reduce the risk identified.

Contributory Factors

Contributory factors are the influencing and casual factors that contribute to the identified risk. These factors affect the chain of events and can be positive as well as negative, and they may have mitigated or minimised the outcome of the risk materialising. More than one contributory factor can be selected.

Risk Monitoring and Review

The monitoring process should provide assurance that there are appropriate controls in place. The frequency of ongoing monitoring and review depends upon the seriousness of the risk. As a **minimum**, this must be:

Current Risk Score	Review Timescales
1 - 5 (Low)	Bi-Annually
6 - 12 (Moderate)	Quarterly
15 - 25 (High)	Monthly

6. Risk Registers

The Datix Cloud IQ (DCIQ) system is used by the Trust to record, manage and monitor risks throughout the organisation. Where risks cannot be immediately resolved, these risks should be recorded onto the Departmental/ Team Risk Register.

The purpose of the risk register is to:

- Provide a summary and overview of potential risks to each Directorate
- Evaluate the level of existing internal control in place to manage the risk
- Be an active live system to record and report risks using the risk management process.

Risk registers must:

- Be fully complete
- Be updated and reviewed regularly
- Have measurable controls added for all live risks
- Have action plans must be in place
- Be discussed and reported to Directorate SMT Meetings at least quarterly.

7. Risk Escalation

The Trust aims to support staff throughout the organisation to manage risk at the most appropriate level in the organisation whilst ensuring that there is a clear process for risk to be escalated when necessary to ensure discussion, action, advice, and support can be provided.

All staff can escalate a risk for discussion, action, advice, and support. The table below shows the floor to Board escalation route.

Escalation From	Escalation To

Team/ Department	Directorate Senior Management Team
Directorate Senior Management Team	Executive Leadership Committee
Executive Leadership Committee	Board of Directors

The diagram below defines the 'Assurance and Escalation Pyramid' and demonstrates the route of assurance and escalation takes.

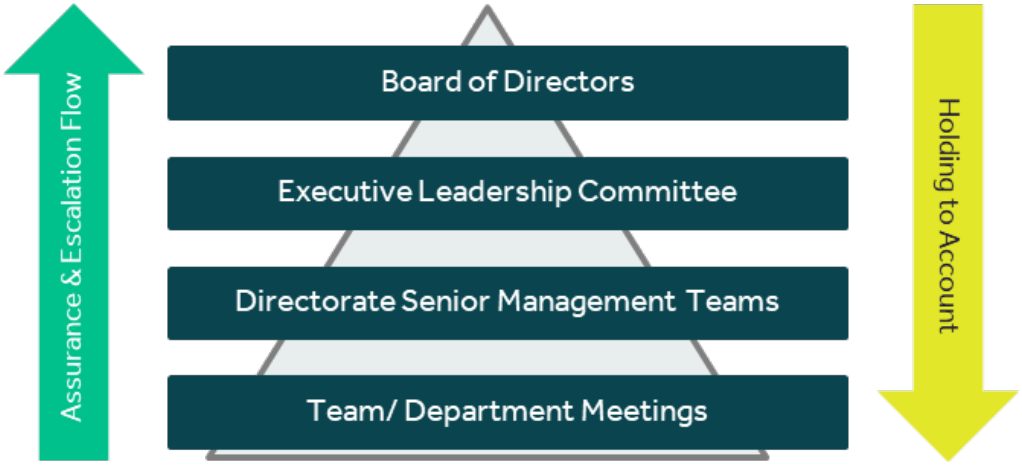

Figure 2: *NWAS Assurance and Escalation Pyramid*

8. Executive Oversight

All risks held on the DCIQ system scored 15 and above are automatically reviewed by the Corporate Risk and Assurance Team and the below steps are followed to ensure the Executive Leadership Committee have oversight of all risks which are deemed as significant to the organisation.

- All risks scored 15 and above are reviewed and analysed by the Corporate Risk and Assurance Team weekly
- Risks are discussed with Risk Owners and Executive Lead to explore the risk in further detail and ensure risk scoring is accurate
- Corporate & Commercially Sensitive Risk Register is submitted to Executive Leadership Committee monthly for review, discussion and approval of risks for inclusion onto the Corporate & Commercially Sensitive Risk Register.

9. Risk Management Governance Structure

Risks are overseen at various levels throughout the Trust as per the table below:

Meeting	Type of Risk	Report Type	Risk Cycle
Board of Directors	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework Corporate &Commercially Sensitive Risk Register	As per Terms of Reference
Board Committees	Risks identified against delivery of strategic objectives relevant to their area of focus	Committee Board Assurance Framework Report	As per Terms of Reference
Audit Committee	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework	As per Terms of Reference
Executive Leadership Committee	New risk(s) scored 15 and above which indicate a significant/ increased risk or where support is requested by the Directorates in the management of risk Trust-wide profile of risk Enterprise Risk Management Report	Quarterly Board Assurance Framework Corporate & Commercially Sensitive Risk Register Trust-wide Risk Management Report Enterprise Risk Management Lessons Learnt Report	As per Terms of Reference Monthly Quarterly Bi-annual
Sub Committees	Visibility of risks scored 15 and above relating to the management groups area of focus	Sub Committee Board Assurance Framework Report	As per Terms of Reference
Directorate Senior Management Team Meetings	Risks identified on the Directorate Risk Register	Directorate Risk Management Report	At least quarterly

10. Risk Reporting and Assurance Diagram

The risk reporting and assurance diagram highlights how the Trust aims to assure, scrutinise, escalate, and inform on risk management from front line to Board:

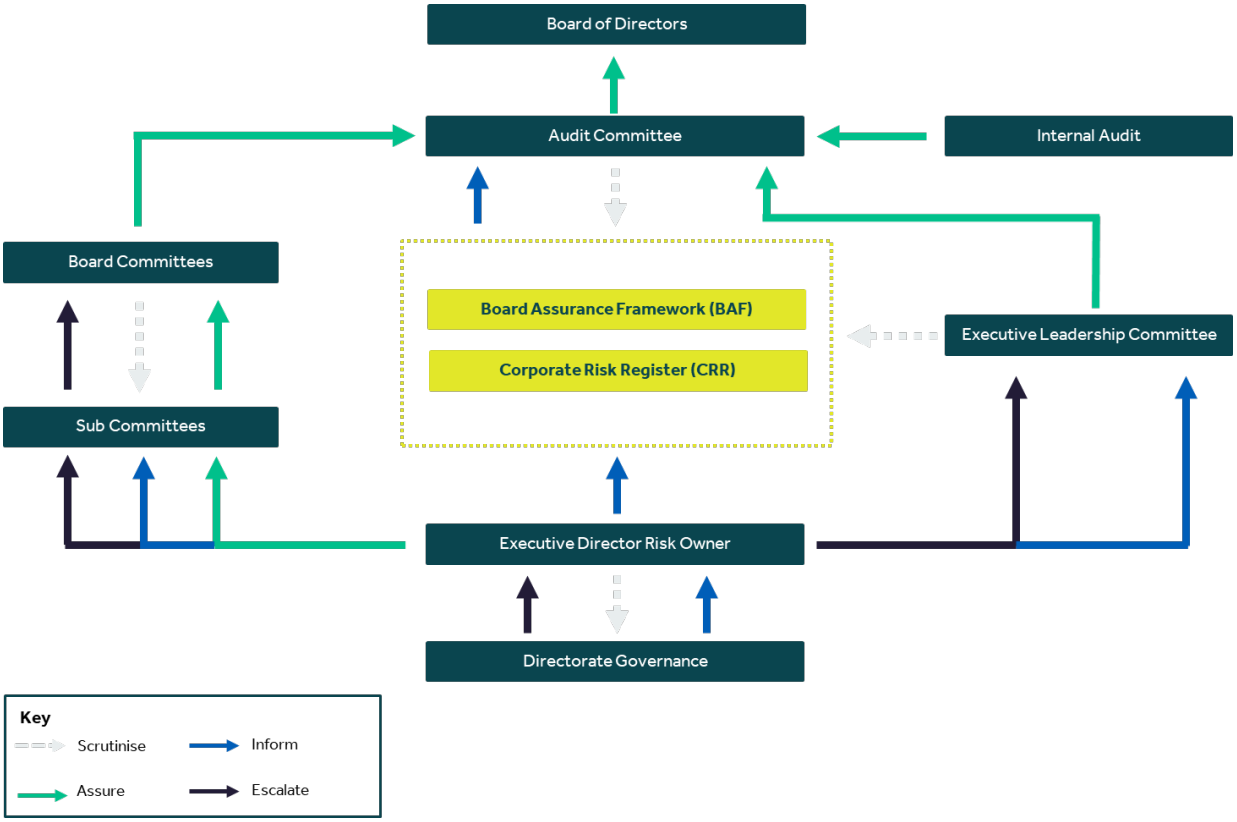

Figure 3: *North West Ambulance Service NHS Trust; Risk Reporting and Assurance Diagram*

11. Assurance

A key element of the Trust's risk management system is providing assurance. Assurance provides evidence that risks are effectively managed by ensuring the effectiveness of controls and actions being put in place are making a positive impact and mitigating risks appropriately.

12. Risk Registers

A risk register is a centralised repository of identified risks that may threaten the delivery of services. A risk register should be live, dynamic, and populated through the risk assessment and evaluation process. Risks are recorded using the Datix Cloud IQ system, Enterprise Risk Manager module.

13. Corporate and Commercially Sensitive Risk Register

The Corporate Risk Register allows the Executive Leadership Committee to have oversight of particular risks where:

- Risk owners have communicated the need for additional support;
- The risk has a current risk score of 15 and above; and/or;
- The risk indicates a significant/ increased risk;
- The risk has the potential to significantly impact a strategic objective

Risks held on the Corporate and Commercially Sensitive Risk Register continue to be managed at their current level, with input and support from the Executive Leadership Committee where appropriate.

14. The Board Assurance Framework (BAF)

The Board Assurance Framework is a key document used to record and report the Trust's key strategic objectives, risks, controls, and assurances to the Board of Directors. The Board Assurance Framework takes in account the recommendations from Audit, Executive Leads and Committees of the Board as to what should be included, amended, or removed. The Board Assurance Framework is updated and approved by the Board of Directors four times per year.

14.1. Audit Committee

As outlined in the HFMA Audit Committee Handbook, the Audit Committee's primary role in relation to the BAF is to provide assurance that the BAF itself is valid. The role of the Audit Committee is not to manage the processes of populating the BAF but to satisfy itself that the systems and processes surrounding the BAF are working as they should. This includes whether:

- The format of the BAF is appropriate and fit for purpose
- The way in which the BAF is developed is robust
- The objectives in the BAF reflects the Boards' priorities
- Key risks are identified
- Adequate controls are in place and assurance are reliable
- Actions are in place to address gaps in controls and assurances.

14.2. Board Assurance Committees

Board Assurance Committees have the following responsibilities pertaining to the BAF risks pertaining to their areas of focus:

- Review of the BAF to ensure the Board of Directors receive assurance that effective controls are in place to manage strategic risk;
- Report to the Audit Committee/ Board of Directors on any significant risk management and assurance issues.

14.3. Sub Committees

Sub-Committees/ Management Groups have the following roles regarding the BAF risks pertaining to their areas of focus:

- Review of the BAF to ensure their parent Board Assurance Committee receives assurances that effective controls are in place to manage strategic risks;
- Review the management of the operational risks pertaining to the Sub-Committee/ Management Groups areas of focus;
- Report to their parent Board Assurance Committee of any significant risk management and assurance issues.

15. Annual Governance Statement (AGS)

The Chief Executive is responsible for 'signing off' the Annual Governance Statement, which forms part of the statutory Annual Report and Accounts.

The organisation's Board Assurance Framework gathers all the evidence required to support the Annual Governance Statement requirements alongside the Head of Internal Audit's annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

16. Clinical Risk Management

Clinical risk management can be defined as:
"The continuous improvement of the quality and safety of healthcare services by identifying the factors that put patients at risk of harm and then acting to control/ prevent those risks."

Clinical risk is identified through the analysis of patient safety incidents, clinical negligence claims, and complaints, identified areas of sub-optimal care, clinical audit and non-compliance with clinical policies, guidance, and training.

17. Risk Governance and Internal Audit

The Executive Leadership Committee and the Audit Committee continually review and monitor all aspects of the Trust's risk management system and play a key role in the standardisation and moderation of risks that are added to the Trust-wide risk register.

The Head of Internal Audit (HoIA) provides an annual opinion, based upon, and limited to the work carried out to assess the overall adequacy and effectiveness of the organisations' risk management, control, and governance processes.

18. Risk Awareness & Management Training and Support

Risk management guidance and advice are provided through the Corporate Risk and Assurance Team.

Risk management training is made available for staff, via MyESR as per the below table.

Staff/ Group	Type of Training	Type of Delivery	Frequency of Training
All staff	Level 1 Risk Awareness Training	E-Learning	3 Yearly
All staff who require access DCIQ Enterprise Risk Manager Module	DCIQ ERM Module Training	Virtually	Once
First line, Middle & Senior Managers	Level 2 Risk Management Training	E-Learning	3 Yearly
Board of Directors	Level 3 - Risk Management and Assurance Training	E-Learning	Annually

19. Implementation

Taking into consideration the implications associated with this policy, it is considered that a target date of *01 April 2022* is achievable for communications about changes in this Policy, with any specific training being implemented on an ongoing basis. This will be monitored by the Executive Leadership Committee and the Audit Committee through the review process. If at any stage there is an indication that the target date cannot be met, then the Policy author will implement an action plan.

20. Equality, Diversity, and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The Equality Impact Assessment can be viewed in **Appendix 3**.

21. Monitoring Compliance

Monitoring of compliance with this policy will be undertaken on a day-to-day basis by the Corporate Risk and Assurance Team, discussing any issues with the relevant team/ department/ Directorate and, if necessary, reporting to the Director of Corporate Affairs and relevant Executive Director Leads. The monitoring matrix can be viewed in **Appendix 4** for further information.

22. Consultation and Review

This is an existing policy which has had moderate changes that relate to operational and/ or clinical practice therefore requires a consultation process. The Head of Risk and Assurance has consulted with the Director of Corporate Affairs, Internal Audit and Local Counter Fraud to invite any comments or suggestions with regard to this policy.

The policy will be presented to the Executive Leadership Committee and the Board of Directors for approval.

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APPENDIX 1: Risk Management Definitions

APPENDIX 2: Consequence Scoring Matrix

APPENDIX 3: Equality Impact Assessment

APPENDIX 4: Monitoring Compliance

Appendix 1: Risk Management Definitions

Term	Definition
Action	A response to control or mitigate risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted
Assessment	Means by which risks are evaluated and prioritised by undertaking the 4 stage risk assessment processes
Assurance	Confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are achieved
Board Assurance Framework	A document setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
Consequence (Impact)	The effect on the Trust if a risk materialises
Control	Action taken to reduce the likelihood and or consequence of a risk
Gaps in Control	Action to be put in place to manage risk and achieve objectives
Frequency	A measure of rate of occurrence of an event
Internal Audit	An independent, objective assurance and consulting activity designed to add value and improve organisations' operations
Initial Risk	The score on identification before any controls are added
Likelihood	Evaluation of judgement regarding the changes of a risk materialising, established as probability or frequency
Mitigation	Actions taken to reduce the risk or the negative impact of the risk
Current Risk Score	The score with controls/ actions in place
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives
Risk Matrix	A grid that cross references consequence against likelihood to assist in assessing risk
Risk Owner	The person responsible for the management and control of all aspects of individual risks
Risk Rating	The total risk score worked out by multiplying the consequence and likelihood scores on the risk matrix
Risk Register	The tool for recording identified risks and monitoring action plans against them
Risk Tolerance	The degree of variance from the Risk Appetite that the Trust is willing to tolerate
Strategic Risk	Risks that represent a threat to achieving the Trusts' Strategic Objectives
Operational Risk	Risks which are a by-product of the day to day running of the Trust

Appendix 2: Consequence Scoring Matrix

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Adverse Publicity/ Reputation/ Public Confidence	Rumours No public/ political concern	Local media area interest – short-term reduction in public confidence Local public/ political concern Elements of public expectation not being met	Local media interest – reduction in public confidence Damage to reputation Extended local/ regional media interest Regional public/ political concern	Regional/ national media interest with less than 1 day service well below reasonable public expectation Loss of credibility and confidence in organisation Independent external enquiry Significant public/ political concern Significant damage to reputation	National media interest with more than 1 day service well below reasonable public expectation MP concerned (questions in Parliament) Full public enquiry Total loss of public confidence in organisation Major damage to reputation
Business Programmes/ Projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance (Performance may be related to time, cost & quality – either singularly or in combination of)	Poor project performance shortfall in area(s) of secondary importance (Performance may be related to time, cost & quality – either singularly or in combination of)	Poor performance in area(s) of critical or primary purpose (Performance may be related to time, cost & quality – either singularly or in combination of)	Significant failure of the project to meet its critical or primary purpose
Clinical Audit **(Provision of Clinical Information)**	No or limited/ single disruption to the provision of timely and accurate clinical information across NWAS Meets local clinical audit standards	Minor disruption to the provision of timely and accurate clinical information on an individual CBU/ business area Minor discrepancy with local clinical audit standards	Reduction in the provision of timely and accurate clinical information in CBU's/ business areas Moderate discrepancy with meeting local clinical audit standards	Inconsistent production of timely and accurate clinical information across all CBU's/ business areas Non-compliance with local clinical audit standards agreed by NWAS Delay in participation with national and local quality frameworks	Failure to produce clinical information or participate within any local or national quality frameworks Non-compliance with national clinical and standards
Clinical: Medication Error	Incorrect medication dispensed but not taken	Wring drug or dosage administered, with no adverse effects	Wrong drug or dosage administered with potential adverse effects	Wrong drug or dosage administered with adverse effects	Unexpected death or permanent incapacity Incident leading to ling-term health problems

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Cyber Security	The threat is expected to have negligible adverse effect on Trust operations, assets, individuals, or other organisations	The threat is expected to have limited adverse effect on Trust operations, assets, individuals, or other organisations. A limited adverse effect means that the threat might: Cause a degradation in capability to an extent and duration that the Trust is able to perform its primary functions, but the effectiveness of the functions is notably reduced Results in minor damage to Trust assets Minor financial loss Minor harm to individuals	The threat could be expected to have a serious adverse effect on Trust operations, assets, individuals, or other organisations. A serous adverse effect means that the threat might: Cause significant degradation in capability to an extent and duration that the Trust is able to perform its primary functions, but the effectiveness of the functions is significantly reduced Results in significant damage to Trust assets Significant financial loss Significant harm to individuals that does not result in loss of life or serious lie threatening injuries	The threat could be expected to be a severe or catastrophic adverse effect on Trust operations, assets, individuals, or other organisations. A severe or catastrophic adverse effect means that the threat might: Cause severe degradation in capability to an extended and duration that the Trust is not able to perform one or more of it primary functions Results in major damage to Trust assets Major financial loss Severe or catastrophic harm to individual that results in loss of life or serious life threatening injuries	The threat could be expected to have a multiple severe or catastrophic adverse effect on Trust operations, assets, individuals or other organisations
Data Security & Protection	No adverse effect that can arise from the breach	Minor adverse effect or any incident involving vulnerable people even if no adverse effect occurred	Potential for some adverse effect	Potential pain and suffering/ financial loss	Death/ Catastrophic event
Environmental Impact	Minimal or no impact on the environment (Small spillage or escape of non-clinical or non-harmful material on Trust premises)	Minor impact on environment (Spillage or escape of clinical or toxic waste with effects contained within unit or department)	Moderate impact on environment (Spillage or escape of clinical or toxic waste affecting an entire building)	Major impact on environment (Significant spillage or escape of clinical or toxic waste with effects contained to Trust property)	Catastrophic impact on environment (Significant discharge or escape of clinical or toxic waste with widespread effects beyond Trust property
Financial Inc. Claims	Small loss Risk of claim remote (£0-£5,000)	Loss of 0.1-0.25% of budget Claim less than (£5,000-£10,000)	Loss of 0.25-0.5% of budget Claim(s) between (£10,000-£100,000)	Loss of 0.5-1.0% of budget Claim(s) between (£100,000-£1 million) Uncertain delivery of key objective Purchase failing to pay on time	Loss of >1% of budget Claim(s) (>£1 million) Loss of significant contract/ income Non-delivery/ failure to meet key objective/ specification

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Infection Prevention & Control and/ or Ill Health	Exposure to blood/ body fluids/ other sources of infection with no risk	Exposure to blood/ body fluids/ other sources of infection with minimal risk/ no sickness Outbreak involving 3 or more people Physically unwell – GP treatment or treated by staff	Exposure to blood/ body fluids/ other sources of infection resulting in short term sickness (minimum 3 days) Outbreak causing disruption to service or short-term closure (days/ weeks) Physically unwell – planned admission/ attendance at A&E (not blue light) or transfer to general medical ward Inoculation contamination with no infection	Exposure to blood/ body fluid/ other sources of infection resulting in very serious infection, long term sick leave Outbreak causing medium term closure (weeks/ months) Physically unwell – emergency admission to general hospital Inoculation contamination from infected person	Sudden or unexpected death (including where evidence may be related to exposure to infection) Outbreak causing long term closure or termination of service Inoculation contamination causing life threatening disease or death
Moving/ Manual Handling Inc. Slips, Trips & Falls	Malfunction/ fault with equipment Slipping, falling with no injuries	Minor injury as a result of moving or handling Short term staff sickness/ absence (less than 3 days off work) Slipping, falling with minor injuries requiring first aid only Short term staff sickness/ absence (less than 3 days off work)	Moderate injury to staff as a result of moving or handling Staff sickness – more than 7 days off work (RIDDOR reportable) Slip/ trip/ fall resulting in injury such as a sprain, requiring medical attention Staff sickness – more than 7 days off work (RIDDOR reportable)	Serious injury to staff resulting in long term damage Long term staff sickness (RIDDOR reportable) Slip/ trip/ fall resulting in injury such as dislocation/ fracture/ head injury, requiring medical attention and hospitalisation Long term staff sickness (RIDDOR reportable)	Unexpected death or permanent incapacity Incident leading to long-term health problem Unexpected death or permanent incapacity Incident leading to long-term health problem
Patient Safety (Harm to patients and/ or public, including physical and/or psychological harm)	A patient safety incident that results in no/ minimal intervention or treatment	A patient safety incident that results in minor injury or illness, requiring extra observation or minor treatment	A patient safety incident that requires a moderate increase in treatment/ transfer of care and significant, but not permanent harm Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days Causes ongoing pain to a service user for a continuous period of at least 28 days	A patient safety incident that has resulted in unexpected or avoidable injury to one or more people that has resulted in serious harm Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm Actual or alleged abuse not prevented by staff or occurring in our care (for example, sexual abuse, physical or psychological ill treatment, or acts of omission which constitute neglect)	A patient safety incident that has resulted in the unexpected or avoidable death of one or more service users (likely due to service provided by the Trust) A significant patient safety event which impacts on a large number of patients – more than 50 people affected or impacts on the Trust's ability to continue to deliver our services

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Physical Violence/ Aggression Inc. Hostage Situation	Minimal or no impact	Physical attack/ assault such as pushing, shoving, pinching, slapping, hair pulling etc. Causing minor injury (not requiring immediate medical assessment or treatment) Threats to prevent staff member leaving property but is persuaded and allows exit	Assault on patients, public or staff which may have physical health/ psychological implication on the victim Injury may require A&E or GP assessment but no further treatment Deliberate delay in the departure of staff using minor threats or physical obstruction	Serious assault resulting in physical injuries that require hospital treatment Deliberate delay in the departure of staff using significant threats or physical obstruction	Homicide or attempted homicide resulting in death or serious prolonged injury or disability Staff member held hostage using physical force
Service/ Business Interruption	Loss of ability to provide services (Interruption of >1 hour)	Loss of ability to provide services (Interruption of >8 hours)	Loss of ability to provide services (Interruption of >1 day)	Loss of ability to provide services (Interruption of >1 week)	Permanent loss of service or facility
Staff Competence	Staff are adequately equipped with the appropriate skills, knowledge, and competence to undertake their duties Staff attendance at mandatory/ key training Insignificant effect on delivery of service objectives due to failure to maintain professional registration (less than 10 staff)	Minor error due to a lack of appropriate skills, knowledge, and competence to undertake duties Insignificant staff attendance at mandatory/ key training (Within 5%) Minor effect on delivery of service objectives due to failure to maintain professional development or status (between 11-50 staff)	Moderate error due to limited skills, knowledge & competence to undertake duties Poor staff attendance for mandatory/ key training (6 – 10%) Moderate effect on delivery of service objectives due to failure to maintain professional developments or status (between 51-100 staff)	Serious error or due to limited skills, knowledge & competence to undertake duties Regular poor/ low attendance at mandatory/ key training (11 – 20%) Major effect on delivery of service objectives due to failure to maintain professional development or status (between 101-250 staff)	Critical error due to limited skills, knowledge & competence to undertake duties Significant/ inconsistent low uptake of attendance at mandatory/ key training (>21 or 2 months+) Significant effect on delivery of service objectives due to failure to maintain professional development or status (more than 250 staff)
Staff Safety (Harm to staff and/or contractors, including physical and/or psychological harm)	No time off work Minor injury not requiring first aid or no apparent injury	Minor injury, illness, Mental Health issue or first aid treatment needed Requiring intervention Short term staff sickness/ absence (less than 3 days off work)	Moderate injury, illness, Mental Health issue requiring hospital treatment/ outpatient appointments/ assessment of social care needs Staff sickness – more than 7 days off work Possible RIDDOR/ MHRA/ StEIS reportable incident	Major injury, illness, Mental Health issue requiring long term treatment or community care intervention Long term staff sickness More than 15 staff affected Post-traumatic stress disorder	Death Life threatening injury or illness or harm Permanent injury/ damage/ loss of limb/ long term incapacity or disability StEIS
Staffing Levels	Short-term low staffing levels that temporarily reduces service quality (less than 1 day)	Low staffing levels that reduces the service quality (1-5 days)	Late delivery of key objective/ service due to lack of staff/ capacity Unsafe staffing level (1-2 weeks) Staff Turnover	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level (more than a month) Loss of key staff Staff Turnover	Non-delivery of key objective/ service due to lack of staff Constant ongoing unsafe staffing levels or competence Loss of several key staff

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Statutory Duty/ Inspection	No breach/ minimal impact of guidance/ statutory duty	Single breach identified which if repeated would result in significant infringement of any person's rights or welfare (of less than one week duration), minor reduction in quality of life, minor reversible health condition	Single breach, if repeated, would result in a risk of harm including temporary disability (of more than one week's but less than one month's duration), reversible adverse health condition, significant infringement of any person's rights or welfare (of more than one week but less than one month duration) and /or moderate reduction in quality of life	More than one breach of a regulation or relevant requirements at the same location (sector, Directorate) or across the whole or part of the service, which may indicate that the current conduct is part of a pattern Failure to make improvements since previously identified breach or enforcement action Known failure to assess or act on a breach Breaches that may result in civil enforcement action, low performance rating or improvement notices	Breaches that result in criminal enforcement action or removal of registration for example: A breach/ multiple breaches that has resulted in death of one or more patient

NHS
North West
Ambulance Service
NHS Trust

North West Ambulance NHS Trust
Equality Impact Assessment Form (EIA) - Policies & Procedures

Name of policy or procedure being reviewed: **Risk Management**

Equality Impact Assessment completed by: **Head of Risk and Assurance**

Initial date of completion: **24 December 2020**

It is anticipated that this EIA will be reviewed throughout the lifecycle of the policy or guidance. Relevant documentation should be maintained relating to the review. Please also record any stakeholders who input into this now or in the future. There is a longer version of this form for assessing the impact of strategy and major plans.

Section 1 – Overview

What kind of policy/procedure is this – eg clinical, workforce?

This 'Corporate' policy is to ensure a structured and systematic approach to risk management is implemented throughout the Trust.

Who does it affect? (Staff, patients or both)?

This policy is intended to cover ALL employees of the Trust, bank staff, and agency staff, all self-employed NHS Professionals, trainees, student placements working for NWAS (herein known as NWAS staff). In addition, all volunteers are expected to adhere to this policy.

How do you intend to implement it? (Trust wide communications plan or training for all staff)?

The policy will be placed on the Green Room for all staff to access.

Section 2 – Data and consultation

In order to complete the EIA it may be useful to consider the following:-

- What data have you gathered about the impact of policy or guidance on different groups?
- What does it show?
- Would it be helpful to have feedback from different staff or patient groups about it?

Please document activity below:

Equality Group	Evidence of Impact
Age	The policy includes litigation risks; this will incorporate any risks in relation to Equality legislation and other standards relating to the needs of people with protected characteristics. The Trust has staff and systems in place to identify equality related risks.
Disability – considering visible and invisible disabilities	

Gender	
Marital Status	
Pregnancy or maternity	
Race including ethnicity and nationality	
Religion or belief	
Sexual Orientation	
Trans	
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	

Section 3: Impact Grid

Having considered the data and feedback through consultation, please detail below the impact on different groups (Age, Disability – considering visible and invisible disabilities, Gender, Marital Status, Pregnancy or maternity, Race including ethnicity and nationality, Religion or belief, Sexual Orientation, Trans, Any other characteristics for patient or staff e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee):

Equality Group	**Evidence of Impact**	**Is the impact positive or negative?**
All groups	This is a corporate policy relating to the application of Risk Management across the Trust for all staff equally.	Neither

Section 4 – Action plan

At this point, you should prepare an action plan which details the group affected, what the required action is with timescales, and expected progress. You may still be seeking further information as part of your plan. You can use the table 3 above to detail any further action.

Section 5 – Monitoring and Review

You should document any review which takes place to monitor progress on the action plan or add any information through further data gathering or consultation about the project. It is sensible for the review of this to be built into any plans. More information about resources can be found on the greenroom.

Further information about groups this policy may affect can be found here pages 10-11.
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Appendix 4: Monitoring Compliance

Monitoring	Monitoring Lead	Reported to Person/ Group	Monitoring Process	Monitoring Frequency
Identifying Risk *Effective use of DCIQ ERM form*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Assessing Risk *All new risks will be reviewed for completeness and quality of information against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Weekly review of risks on DCIQ ERM Module	Monthly
Assessing Risk *All risks will be scored and graded according to consequence and likelihood using the Trust Risk Matrix*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Managing Risk *New risks with a current risk score of 15 and above will be discussed, managed and presented to Executive Leadership Committee on a monthly basis*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Weekly review of risks on DCIQ ERM Module	Monthly
Reviewing Risk *Risks will be reviewed by Directors consistently against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Reviewing Risk *All tolerated/ transferred/ accepted risks will be reviewed annually*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Reviewing Risk *Strategic risks will be reviewed each quarter with the appropriate Executive Director and recorded on the BAF*	Head of Risk and Assurance	Director of Corporate Affairs/ Board of Directors	Board Assurance Framework	Quarterly

Risk Management Process *Annual review of the Trust risk management process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually
Risk Management Process *Annual review of the BAF process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30 March 2022
SUBJECT:	Modern Slavery Act 2015
PRESENTED BY:	Carolyn Wood, Director of Finance

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☐	☒	☐	☐

SR05	SR06	SR07	SR08	SR09
☐	☐	☐	☐	☐

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 2021/22. Although there was a public consultation between July and September 2019 the recommended legislative changes have not currently passed the House of Lords. Procurement will monitor progress and will ensure that future Modern Slavery statements reflect any legislative outcome. This statement meets the current requirements.
RECOMMENDATIONS:	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 2022. • Note the potential changes to legislation.
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☒ Reputation

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

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 2021/22.

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;
- Year ending March 2020; and
- Year ending March 2021.

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; and
- 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, GOVERNANCE AND/OR RISK 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.

Legislation Changes

The Government published a consultation paper "*Transparency in supply chain*" on the 9 July 2019 which closed on the 17 September 2019. The consultation sort views on proposed changes including:

- The areas the statements must cover
- Potential features for the new Government –run reporting service for modern slavery statements
- A single reporting deadline
- Civil penalties
- The extension of reporting to the public sector.

A response was published on the 22 September 2020 which set out how the government would introduce changes as per the consultation recommendations. However, legislation is required to change the act, which is currently still with the House of Lords. The expectation is that new guidance will be published once the changes become law. NWAS will continue to monitor the progress and will implement all appropriate changes once published.

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no direct equality or sustainability implications associated with this report.

6. 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 2022
- Note the potential changes to legislation.

Appendix 1

NWAS MODERN SLAVERY ACT 2015
Statutory Statement for the Year Ending March 2022

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;
- Year ending March 2020; and
- Year ending March 2021

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 5,900 staff. The Trust receives 1.1 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 £450 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 £135m per annum which is spent on goods and services. Over 80% of the £135m is spent with the Trusts top 100 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 September 2021 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 approved Procurement Framework (s).

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 2022.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30th March 2022
SUBJECT:	Non-Executive Terms of Office; Committee Membership 22/23 and Non-Executive Champion Roles
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☒	☒	☒

SR05	SR06	SR07	SR08	SR09
☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Assurance
EXECUTIVE SUMMARY:	This report confirms Non-Executive Directors Terms of Office (s2) and provides assurance to the Board of Directors that: 1. 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. 2. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) The Non-Executive Director Committee membership for 2022/23 can be seen in s3. The new approach to non-executive director champion roles can be seen in s4.
RECOMMENDATIONS:	The Board of Directors is asked to note: • The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended); and • 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 Non-Executive Directors Committee membership for 2022/23. • The Non-Executive Director Champion Roles
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

	☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to raise Board awareness of Non-Executive Directors Terms of Office and to provide assurance to the Board of Directors that:

3. 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.
4. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)

This paper also confirms the Non-Executive Director Committee membership for 2022/23.

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 2022 are shown below:

Non-Executive Directors	
Name	**Term of Office**
Peter White (Chairman) Non-Executive Director Terms of Office	01/02/19 – 31/01/23 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	Renewed 01/08/21 – 31/07/23 01/08/19 – 31/07/21
Prof Aneez Esmail	01/04/21 – 31/03/23
Catherine Butterworth	01/04/22 – 31/03/24

3. COMMITTEE MEMBERSHIP

As a result of the Chairman's annual review of Committee membership, the Non-Executive Director membership for 2022/23 is as follows:

Committee	Membership
Audit Committee	David Rawsthorn (Chair) Prof Alison Chambers Prof Aneez Esmail Catherine Butterworth
Nominations & Remuneration Committee	Chair and all Non-Executive Directors
Quality and Performance Committee	Prof Aneez Esmail (Chair) Prof Alison Chambers Dr David Hanley
Resources Committee	Dr David Hanley (Chair) David Rawsthorn Catherine Butterworth
Charitable Funds Committee	David Rawsthorn (Chair) Dr David Hanley Catherine Butterworth

The Terms of Reference for each of these Committees will be updated to reflect the revised membership and presented to the Board of Directors in April 2022 for approval.

4. ENHANCING BOARD OVERSIGHT: A NEW APPROACH TO NON-EXECUTIVE DIRECTOR CHAMPION ROLES

Guidance was issued in December 2021 (see appendix 1) which described a move away from several champion roles, transitioning oversight into the Board Assurance Committees – all the subjects covered (where relevant to an Ambulance Trust) are already reported through our Board Assurance Committees. The guidance also contains links to role descriptors.

The roles to be retained can be seen below along with the named Non-Executive:

Role	Type of Role	Legal Basis	Named Non-Executive
Maternity board safety champion	Assurance	Recommended	Aneez Esmail
Wellbeing guardian	Assurance	Recommended	Catherine Butterworth
FTSU NED Champion	Functional	Recommended	David Hanley
Security management NED champion	Assurance	Statutory	David Rawsthorn

5. LEGAL, GOVERNANCE AND/OR RISK 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.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

7. RECOMMENDATIONS

The Board of Directors is asked to note:

- The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended); and
- 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 Non-Executive Directors Committee membership for 2022/23.
- The Non-Executive Director Champion Roles

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30 March 2022				
SUBJECT:	**Chairman's Annual Fit and Proper Persons' Declaration**				
PRESENTED BY:	Lisa Ward, Director of People				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☐	☐	☐	☐	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☐	☒	☐	☐	☐
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:	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.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☒ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	

PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

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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 2022

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)								
							Associate Non-Executive Directors	
	PW	RG	AE	DH	DR	AC	GS Ended 10.8.21	RT
Has been an employee of the NHS Trust within the last five years	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
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
Has close family ties with any of the NHS Trust's advisers, directors or senior employees	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
Has served on the board for more than six years from the date of their first appointment	8 years	7 years	1 year	3 years	3 years	3 years	<1 year	3 years
Is an appointed representative of the NHS Trust's university medical or dental school.	No	No	No	No	No	No	No	No

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30/03/2022				
SUBJECT:	Integrated Performance Report				
PRESENTED BY:	Director of Quality, Innovation and Improvement				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☐	☒	☐	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Integrated Performance Report for March 2022 shows performance on Quality, Effectiveness and Operational Performance during **February 2022** unless otherwise stated. **PES (Patient Emergency Services)** • The Trust received 110,735 calls of which 84,645 became incidents. Compared with February 2020, we have seen a 2% increase in calls and an 5% decrease in incidents. The decrease in incidents is due to the use of signposting to self-transport or other services. • Call pick up has significantly improved at 95.4% • Overall, we achieved 10.1% Hear and Treat, 29.3% See and Treat. • The number of C2 long waits have fallen by 27% with 7,349 patients waiting more than 60 minutes. • Response time targets were not met for any ARP measures apart from C1 90th. • The 3 primary drivers for us not meeting performance standards are: 1. A rise in acuity (and fleet profile against this) 2. Abstractions and 3. Job cycle time including handover delays. • Turnaround continues to be above the National standard of 30:00 with a turnaround time of 37:13. • The trust has taken a number of measures to improve performance and maintain patient safety including an agreed 6 point plan (jointly with commissioners and the 4 ICS footprints). • The MACA arrangements continue and will be phased out by the end of March 22.				

	• 7 serious incidents were reported in February which is a significant reduction from the previous month. • ACQI measures continue to show no change with the exception of the STEMI care bundle where performance for October 2021 was 60.7% (national mean 74.2%), ranking tenth nationally. **NHS 111** • Call demand in February 2022 has continued to be stable. 111 are currently working with ORH again to demonstrate the change in profile and increase in demand. • Time taken for a call back has improved significantly over the last three months but continues to be well above the target. Safety measures are in place. • The 111 service are making progress to implement self-care advice via SMS to enables a reduction in call times. **PTS** • PTS performance is reported one month in arrears. Activity in January for the Trust was 28% below contract baselines. **Finance** • The year to date expenditure on agency is £5.750m which is £2.900m above the year to date ceiling of £2.2850m. • As at month 11 (February) the trust is recording a surplus position for the year to date of £0.271m. **Organisational Health** • The overall sickness absence rate for the latest reporting month (January 2022) was 13.74% • Turnover has increased at 11.68% • The overall appraisal completion rate was improved at 78.75% • We are currently off track at 72% for mandatory training against the agreed target of 87% overall by March 2022. **COVID 19** • 107 staff have tested positive for Covid-19 in February 2022 . At the end of this reporting period, there were 6 open outbreaks on Trust sites.
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the content of the report • Note the improved call pick up performance in 999 • Note the decrease in demand with data starting to signal some improvement in performance • Note the move back within normal limits for SIs • Note the ongoing work to maintain patient safety and regulatory compliance.

<table>
<tr><td></td><td colspan="4">Note the partnership delivery of a whole system 6-point improvement plan to optimise performance.
Clarify any items for further scrutiny</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust’s Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☒</td><td>Sustainability</td><td>☒</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">28/03/2021</td></tr>
<tr><td>Outcome:</td><td colspan="3">Not known at time of submission</td></tr>
</table>

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1. PURPOSE

1.1 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 2022**. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

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

2. SUMMARY

2.1 Quality

- 151 complaints were received, against a 12 month average of 188 per month.
- 70% of complaints risk scored 1-2, 54% of level 3 and 29% of level 4-5 complaints were closed within the agreed time frames.
- A revised plan is being followed to address the complaints backlog which fell to 79 at the end of November and rose to 125 at the end of January but has fallen to 103 at the end of February
- During February 2022 there were 7 serious safety incidents reported on the StEIS database, this is significantly lower than the 20 incidents reported in January and is back within normal control limits.
- In February 2022, 981 internal and external safety incidents were opened against a 12-month average of 1,302, with an additional 80 still to be scored.
- Content analysis of safety incidents by type shows that the top two reasons (by volume) are incidents associated with 111 services or staff welfare.

2.2

Effectiveness

- . **Patient experience:** All service lines have seen a decrease in returns (PES 9.4%, PTS 2.3%, 111 37.7%) 111 and PES have seen an increase in satisfaction levels compared to last month (PES 3%, 111 0.3%) while PTS has seen a margin fall of 0.8%.
- This report contains a high-level summary of the experience of patients using NHS 111 First, which shows a decrease in responses (171 to 118) and a decrease in satisfaction in February compared to January (91.4% to 86.4%).

2.3 **Ambulance Clinical Quality Indicators (ACQI's) – October 2021: :** October 2021's data see us within normal limits and close to the mean across all indicators. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

Cardiac Outcomes

- **Return of spontaneous circulation (ROSC)** achieved for the Utstein group was 50% (national mean 45.3%). For the overall group the rate was 31% (national mean 24.8%).
- **Survival to Discharge** rates in October 2021 were at 5.7%.
- In October 22.4% of patients in the Utstein group survived to hospital discharge. The national mean at 22.9%.
- Mean call to PPCI time in October for patients suffering a myocardial infarction was slightly outside of the national mean of 2h 42mins; the Trust's performance was 2h 57mins.
- Mean call to hospital time in August for patients suffering a hyper acute stroke was below the national mean of 1h 58mins. The trusts performance was 1h 56mins.
- The stroke care bundle performance was not reported for October in line with the NHSE schedule.
- The Stemi Care Bundle performance for October was 60.7%. The national mean at 74.2%. The change is due to a drop in performance in 3 of the 4 elements that make up a bundle (aspirin administration, two pain scores and analgesia). This has resulted in a large combined drop in performance. Some of this may be driven by gaps in completion in the new EPR which is a key focus of our data quality and audits team

2.4 **H&T, S&T, S&C**

- For February we achieved 10.1% Hear and Treat and ranked 7th nationally.
- See & Treat is at 29.72% with the first and third weeks of February signalling special cause with performance for both at 28.6% and we are ranked 9th nationally.

In total there was an aggregate non-conveyance of 39.4%.

2.5 **Patient Emergency Service (PES)**

- **Activity:** In February 2022, the Trust received 110,736 calls of which 84,645 became incidents. Compared with February 2020, we have seen a 2% increase in calls and a 5% decrease in incidents. The decrease in incidents is due to the increased use of signposting to self-transport or other services.
- **Call volume:** call volume is 2% and 22% above the equivalent month for 2020 and 2021 respectively.
- **Duplicate calls** fell to 25,168 (22.7%) during February but these can still add complexity and reduce CPU performance.
- **Call Pick Up** has seen improvement in February and performance improved from 85.7% in January to 95.4% in February (target 95%).

2.6 **Ambulance Response (ARP) Performance**

Category	Standard	February 2022 Actual
C1 (Mean)	7:00	8:23
C1 (90th)	15:00	14:29

C2 (Mean)	18:00	35:34
C2 (90th)	40:00	1:18:50
C3 (Mean)	1:00:00	1:50:16
C3 (90th)	2:00:00	4:26:48
C4 (90th)	3:00:00	9:45:19

- For February response time targets were not met for any ARP measures apart from C1 90th. Several measures are close to signalling improvement with multiple data points below the mean.

The 3 primary drivers for us not meeting performance standards are: 1. A rise in acuity (and fleet profile against this) 2. Abstractions and 3. Job cycle time including handover delays.

- We have seen an increase in acuity. This means that nearly 70% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat.
- Because fleet includes voluntary ambulance services who cannot respond to a category 1 and 2 incidents this rise in acuity puts increased pressure on substantive NWAS fleet and prolongs response times.
- Although abstractions remain high we have seen improved rates of abstraction, specifically associated with COVID and sickness. The improvements are increasing operational resources. This is mirrored within the EOC environment.
- Turnaround continues to be above the National standard of 30:00 with a turnaround time of 37:13. 4,655 attendances (10.3%) had a turnaround time of over 1 hour. 895 hours were lost to delayed admissions.

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

The £6.2M for increase for winter is being used for:

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

In addition to the implementation of the Trusts 6 point plan NWAS has now enacted MACA. MACA Has seen 150 army personnel deployed to increase operational resource. This will increase DCA production and improve response times to lower acuity patients (C3&C4). The employment commenced from 17th January 2022 and as a result, C3 response times significantly improved the last two weeks of January and February 22. The MACA arrangements continue and will be phased out by the end of March 22

C3/4 validation continues to reduce the number of low acuity incidents that require an ambulatory response. ETA scripts remain in place and provide patients with an estimated time for response. Some patients as result will take the decision to self

convey or contact an alternative service. This approach provides patients with a choice and on average reduces the number of incidents by around 10% to 15%.

2.7 **Handover**

Average turnaround time has decreased but continues to be above the national standard of 30:00 with a turnaround time of 37:13. 4,655 attendances (10.3%) had a turnaround time of over 1 hour, with 303 of those taking more than 3 hours. 590 cases of delayed admissions were reported – down from 824 and 708 reported in December 2021 and January 2022 respectively.

The trust continues to work with those most challenged trusts and focus on trust engagement and continues to implement the delayed handover crew and managers escalation action card across the North West.

2.8 **C1 & C2 Long Waits**

In February we had 5 patients in the C1 category who waited longer than 60 mins and 7,349 patients in the C2 patients who waited longer than 60 mins. We have seen a month on month reduction in long waits since December. We have invested in clinical staff in the control room environment to ensure that patients are monitored whilst they are waiting and those who require their response to be expedited (on clinical need) are upgraded quickly. We have seen the number of serious incidents reduce with the improving position on C1 and C2 long waits.

The ambulance service across the NHS have had challenges with long waits and the national ambulance coordination centre have produced comparator metrics for ambulance trusts. Whilst our ambition is to eliminate long waits the current 'league table' signals NWAS is 4/11 compared with other trusts.

2.9 **NHS 111**

Measure	Standard	Feb 2022 Actual
Calls Within 60s	95%	36.3%
Average Time to answer		7m 41s
Abandoned Calls	<5%	18.25%
Call back Within 10 min	75%	7.82%
Average Call Back		1 hour 13min
Warm Transfer to Nurse	75%	12.15%

- Call demand in January has stabilised. Calls answered in 60s performance remains below the standard but stable, however Call to Answer time has continued to increase towards the upper control limit, this is partly due to the continuing significant gap between capacity and demand.

- The team are currently working with ORH again to demonstrate the change in profile and increase in demand over the last 12 months, it is anticipated this will be used during future conversations with commissioners.
- The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target but has significantly improved over the last three months. Safety measures are in place.

  The 111 service is now progressing to implement self-care advice via SMS, this will enable the call handle to reduce call time by sending a message rather than reading out lengthy scripts, this went live on the 1st March

2.10 **PTS**

- Due to reporting timing issues PTS performance is reported one month in arrears.
- Activity in January for the Trust was 28% below contract baselines with Lancashire and 38% below baselines for Merseyside, whilst the year-to-date position (July 2021 – January 2022) is performing at 23% below baseline.

2.11 **Finance**

- The year to date expenditure on agency is £5.750m which is £2.900m above the year to date ceiling of £2.2850m.
- As at month 11 (February) the trust is recording a surplus position for the year to date of £0.271m. H2 (October to March) income has been agreed along with additional top up elements for Covid & winter pressures, spend related to these top ups is monitored and we are bringing in additional staff as appropriate to help operational performance. It is expected that the trust will finish the year in a break even position.
- 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.

2.12 **Organisational Health**

- **Sickness:** The overall sickness absence rate for the latest reporting month (January 2022) was 13.74% including COVID related sickness of 5.8%. Additional resource has been identified to provide additional focus on managing attendance and wellbeing.
- The top 5 reasons for absence are Mental health, Covid, Injury and MSK and back problems.
- **Turnover** was 11.68% with the main increases arising in call centres which mirrors national trends. This is showing special cause variation for EOC, 111 and PES with all being above the upper control limit.
- **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 3.2% in February.
- **Vacancy**: Positions across the trust are under establishment by 1.77%. This is mainly as a result of establishment changes and turnover in 111 and vacancies in PTS following the use of PTS staff on PES. EOC are under-established by 0.92% and PES are fully staffed.

- **Appraisal**: The overall appraisal completion rate was improved at 78.75% against a revised trust target of 75% by March 2022 for the service lines and to 85% by March 2022 for Corporate and band 8a and above.
- **Mandatory Training:** A new cycle of mandatory training started in April with additional online topics included and a new classroom cycle. The starting Trust compliance position was 60% in April 21 as a result new topics being added. This rate will build during the year but has been impacted by pauses in mandatory training at Reap 4. We are currently off track at 72% against the agreed ELC target of 87% overall by March 2022. This target is made up of 85% for service lines and 95% Corporate services by March 2022. A recovery plan for classroom training has been implemented and this will run in parallel with a focus on recovery of online completion.

2.13 **COVID 19**

- 107 staff have tested positive for Covid-19 in February 2022. At the end of this reporting period, there were 6 open outbreaks on Trust sites.
- The outbreaks are contained and linked to community prevalence and individual lack of compliance with PPE. The controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively with outbreaks limited to very small numbers of individuals at each site.

3. LEGAL, GOVERNANCE AND/OR RISK 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. EQUALITY OR SUSTAINABILITY IMPLICATIONS

4.1 The data in this report are presented at an aggregate level for the trust and so any issues related to equality and diversity are not highlighted. An initial review of the potential to understand EDI measures against the friends and family test has demonstrated that although data are available, it is complex and requires further work to define correctly, in order to drive meaningful information. We are also looking to add EDI measures into the complaints process. This work has been delayed but is now progressing. A digital sprint has begun to improve our data sharing across NWAS services / systems of patient ethnicity. This will enable us to view our ACQIs by ethnicity and understand if quality of outcomes is different for different groups.
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The effectiveness measures related to ‘hear and treat’ and ‘see and treat’ have the potential to impact on our carbon emissions however this is not explored in the report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Note the content of the report
- Note the improved call pick up performance in 999
- Note the decrease in demand with data starting to signal some improvement in performance
- Note the move back within normal limits for SIs
- Note the ongoing work to maintain patient safety and regulatory compliance.
- Note the partnership delivery of a whole system 6-point improvement plan to optimise performance.
- Clarify any items for further scrutiny

Q1 COMPLAINTS

Figure Q1.1

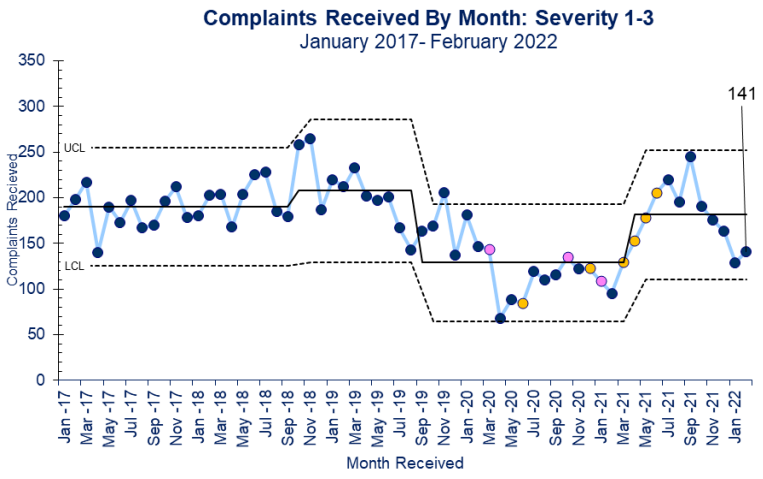
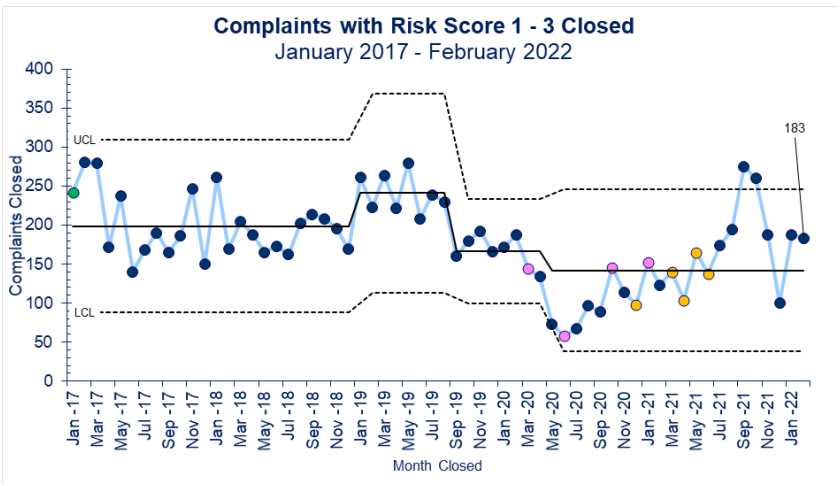


Figure Q1.2



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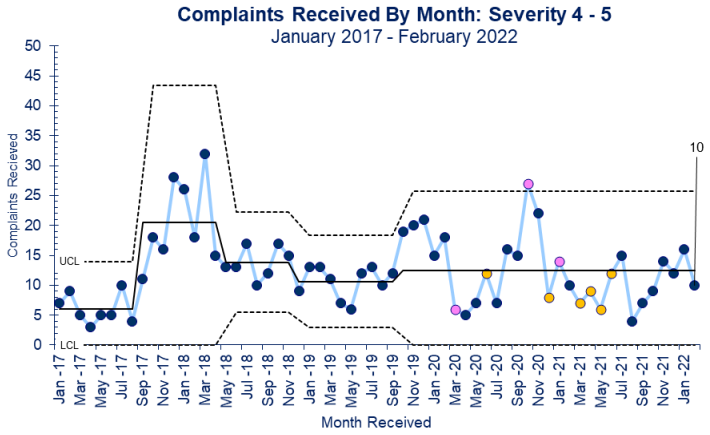

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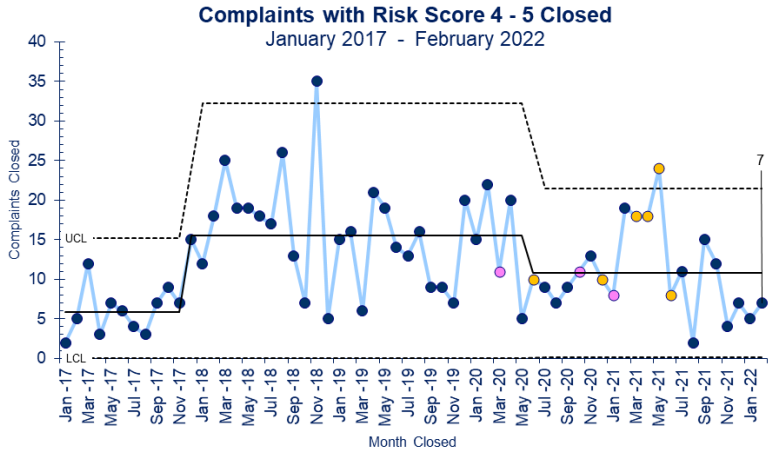


* *Lockdown* *Easing of Restrictions*

Complaints & Compliments

In February, **151 complaints** were received (figures Q1.1 & Q1.3), against a 12-month average of **188** per month.

95 compliments were received this month which was similar to December and January (**73** and **90** respectively), but significantly lower than October and November (**153** and **128** respectively)

The rate of complaints in February 2022 was **24 per 1000 WTE**. The average for the fiscal year (1 April 2021 – 30 April 2022) is **30** per 1000 WTE. The year to date rate is above the strategy goal for 2021/22 of **27** with the Month of January being below.

A total of **190** complaints were closed in January 2022 (**183** were risk scored 1-3 Q1.2 and **7** were risk scored 4-5 Q1.4).

The rapid closure process continues to be a success with rotation of focus for this across the peer group who manage low risk complaints.

Access to platforms and tools has also enabled a more efficient investigation process enabling the team to respond in line with targeted timeframes.

Figure Q1.5

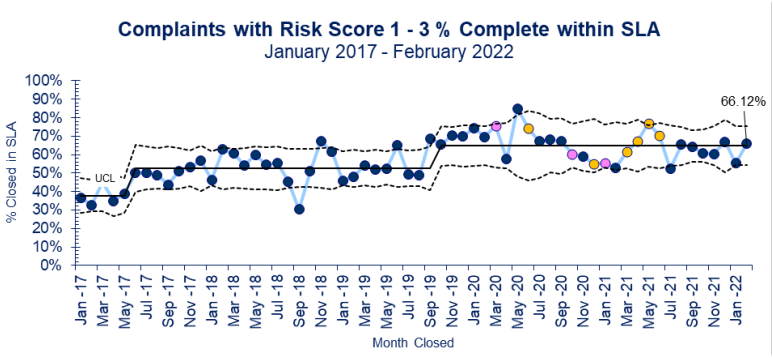


Figure Q1.6

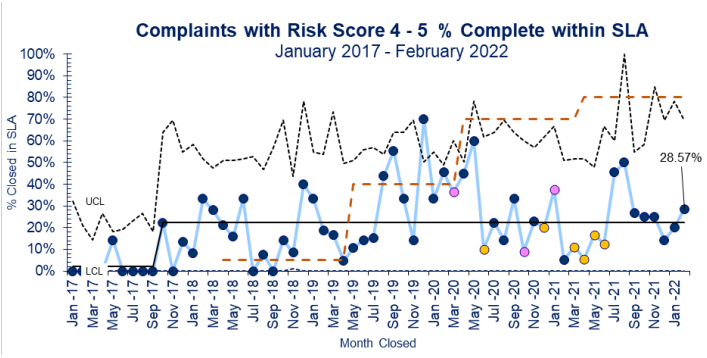
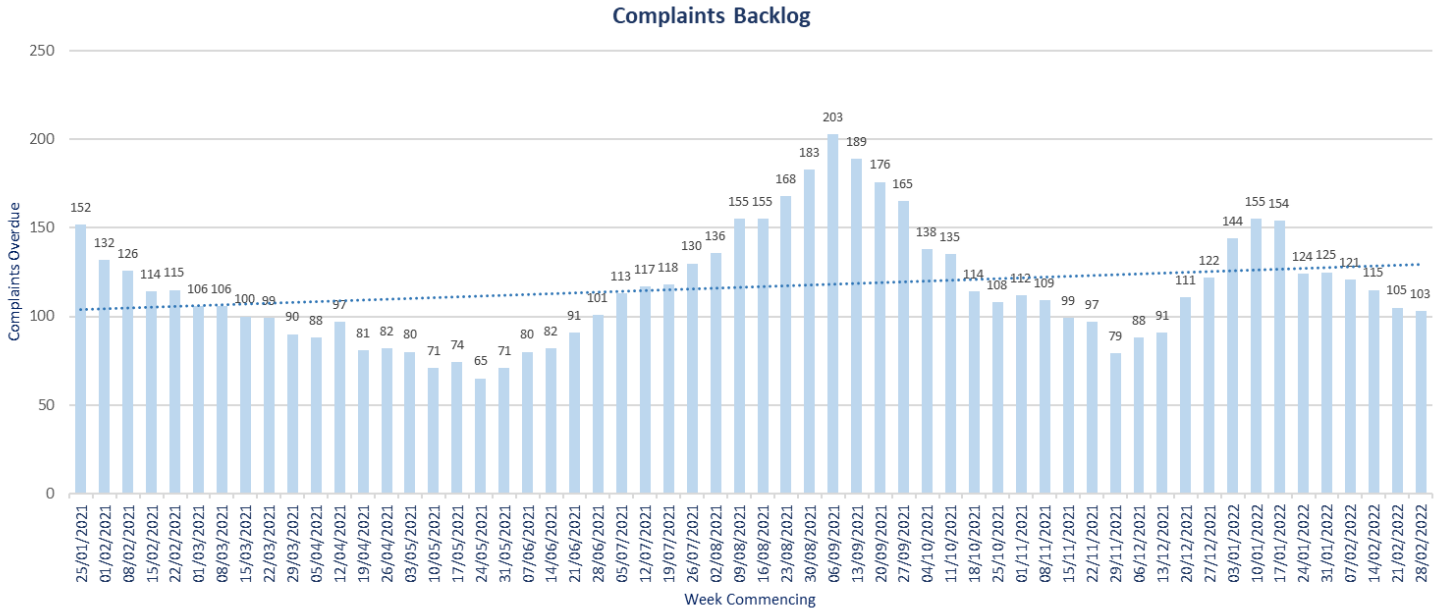


Figure Q1.7



* Lockdown Easing of Restrictions Right care strategy goal

Complaints Closure

Overall, **66%** of cases risk scored 1-3 were closed within the agreed timescales (Q1.5).

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

- **70%** of level 1-2 complaints were closed within agreed timescales against a right care strategy goal of **75%** by the end of 21/22.
- **54%** of level 3 complaints were closed within agreed timescales against a right care strategy goal of **70%** by the end of 21/22.
- **29%** of level 4-5 complaints were closed within agreed timescales (Q1.6) against a right care strategy goal of **80%** by the end of 21/22.

The closed complaints scored 1-3 within SLA has improved in the month. This is due to smarter and efficient process being implemented in previous months and the evening out of workload. We have focused new processes on new cases being received in January and February, but continue to work on closure of backlog cases where newer processes were not applied.

There continues to be on-going discussions on how to progress risk 4-5 complaints in an efficient and smarter way but this has significantly impacted on the closure rates of risk 4-5 complaints.

The backlog has started to decrease again from **125** (WC 31st January) to **103** (WC 28th February). A trajectory and improvement plan had been agreed with the Executive Leadership Team, where assurance was provided that the backlog was to be back to low levels **c30%** by mid-November.

New trajectories have been agreed to maintain open complaints at under **180** with an allowance of under **c50%** within the backlog.

Q2 INCIDENTS

Figure Q2.1

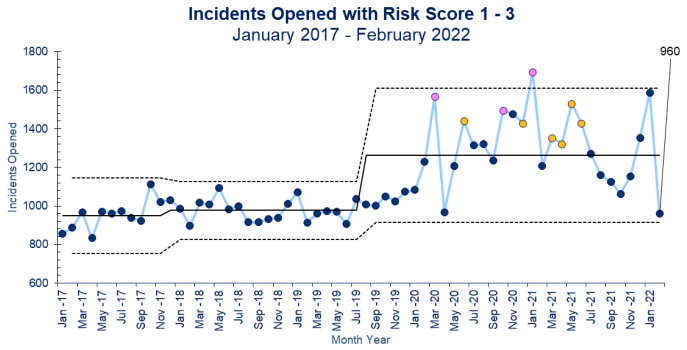


Figure Q2.3 - Highest number of safety incidents October 2021 by subcategory are from 111

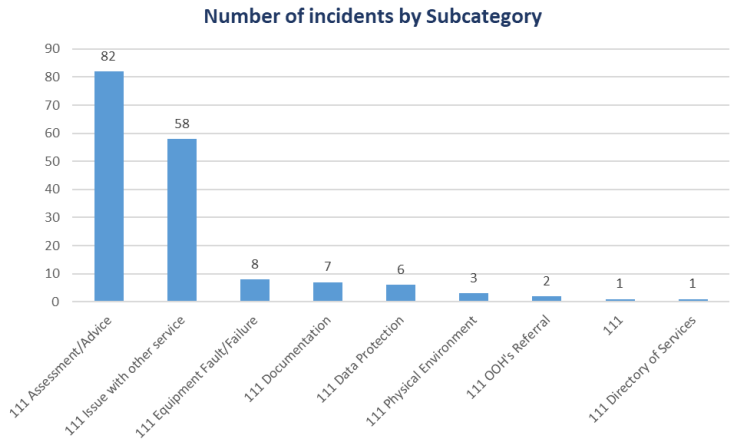


Figure Q2.2

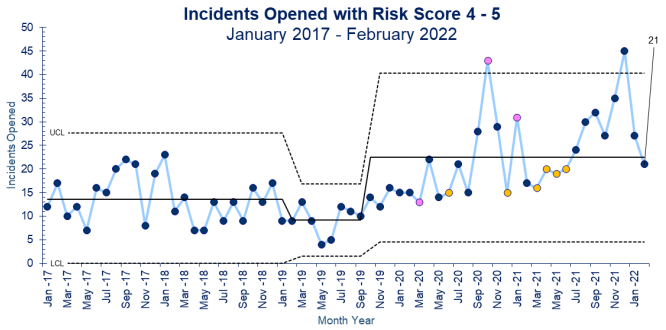
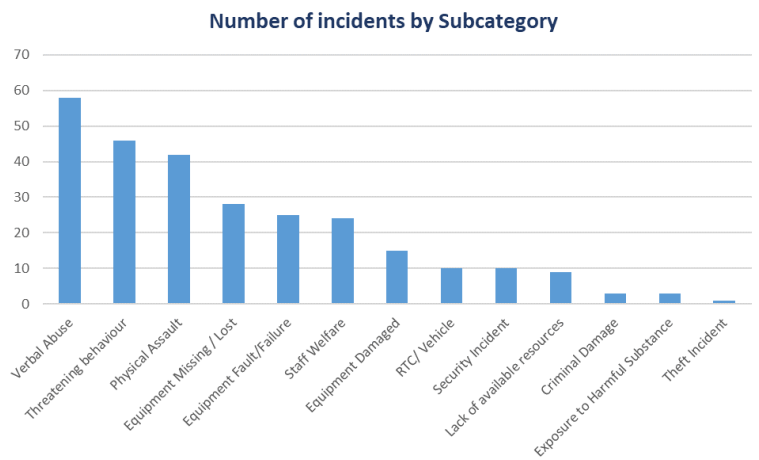


Figure Q2.4 - Second highest number of safety incidents October 2021 by subcategory are staff welfare



* Lockdown Easing of Restrictions

Reporting: In February 2022, **981** internal and external safety incidents were opened (Q2.1 and Q2.2) against a 12-month average of **1,302**, with an additional **80** still to be scored. High levels of reporting are important and considered a marker of a positive culture where staff feel able to speak up.

Unscored Safety Incidents (RCS): 23 safety incidents raised in January were still unscored in February, which is below the end of year Right Care Strategy goal of **25** unscored safety incidents in the previous month reported. The scoring and management of safety incidents in a timely way is monitored via the clinical effectiveness meeting and plans are in place to ensure the end of year target is achieved.

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

111: It is important to frame the total number of safety incidents in 111 against the total number of calls received (**168** safety incidents from **171,017** calls). Many of these safety incidents are raised by healthcare professionals who want clarity on outcome decisions. All calls are audited and action taken where concerns are upheld. The majority of 111 safety incidents have been raised because of concerns about the assessment or advice given (n=**82**), because we have had issues with another NHS service (n=**58**), for documentation or data protection issues (n=**7+6**) , equipment failure (n=**8**) or for out of hours referrals (n=**2**). Around **15% -20%** of safety incidents raised within 111 can be resolved locally

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

Figure Q2.5

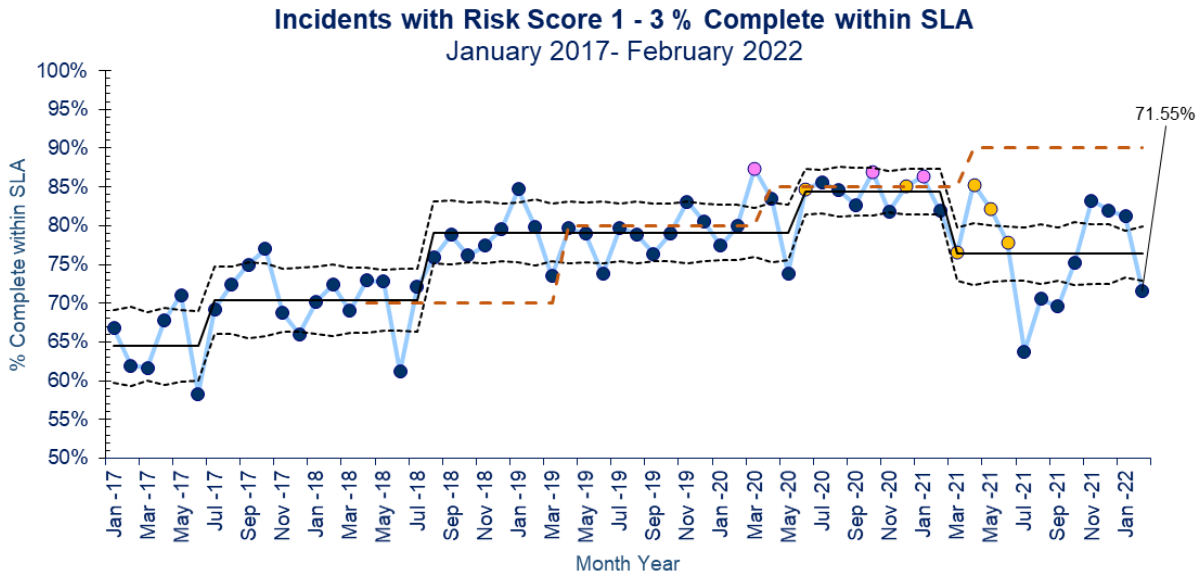
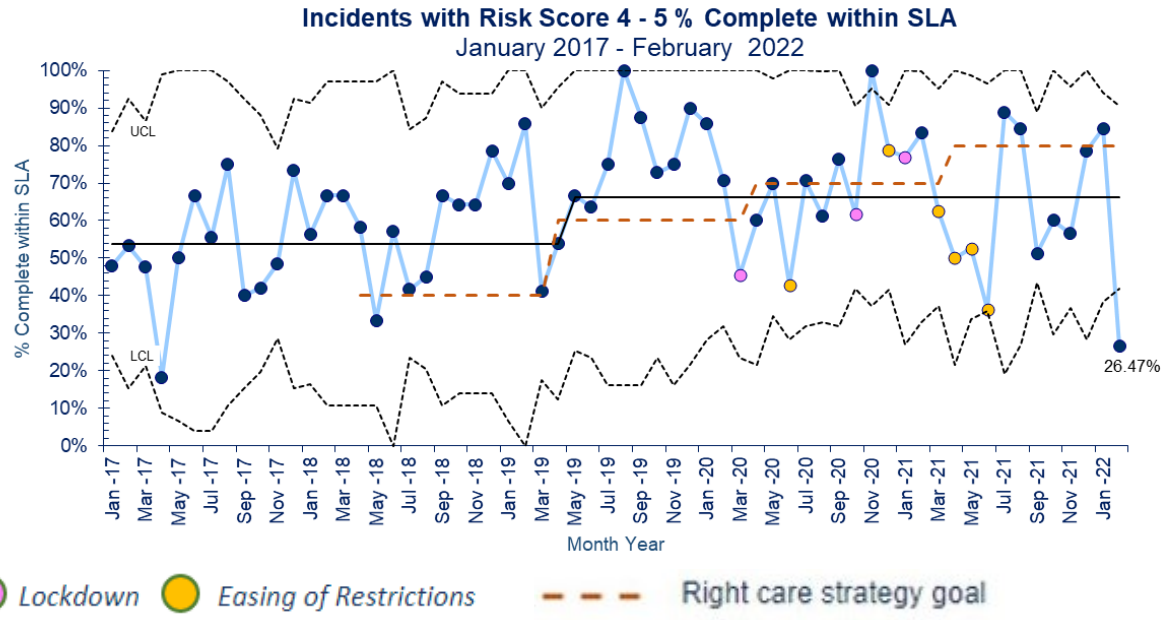


Figure Q2.6



Incidents Closure

In total, **1,356** safety incidents (level 1-5) were closed during February 2022.

72% level 1-3 were closed within agreed standard (Q2.5) which is currently showing as special cause variation to the bad being below the lower control limit and is also below the right care strategy goal of **90%**.

26% of level 4-5 safety incidents were closed within the agreed standard (Q2.6) against a right care strategy goal of **80%** for the end of 2021/22.

Incidents closure rates have been affected by the scoring of historic unscored incidents. The trust was still impacted by the ability of front-line staff to produce the required statements and investigation reports to close off safety incidents. As well as the availability of senior management teams for approval of investigations. The Patient Safety team have implemented new processes to support this.

The risk scoring, management and learning from safety incidents remains a priority. The patient safety management team meet with each area and head of service on a regular basis to discuss a plan for recovery of their back log and a goal to get safety incidents scored and closed in a timely manner. Establishing a collaborative approach to investigations and complaint closures has been key moving through December and continues in to 2022.

The closure of incidents in a timely manner continues to be a goal moving in to 2022 and will be reported via Quarterly right care strategy updates to the Quality and Performance Committee.

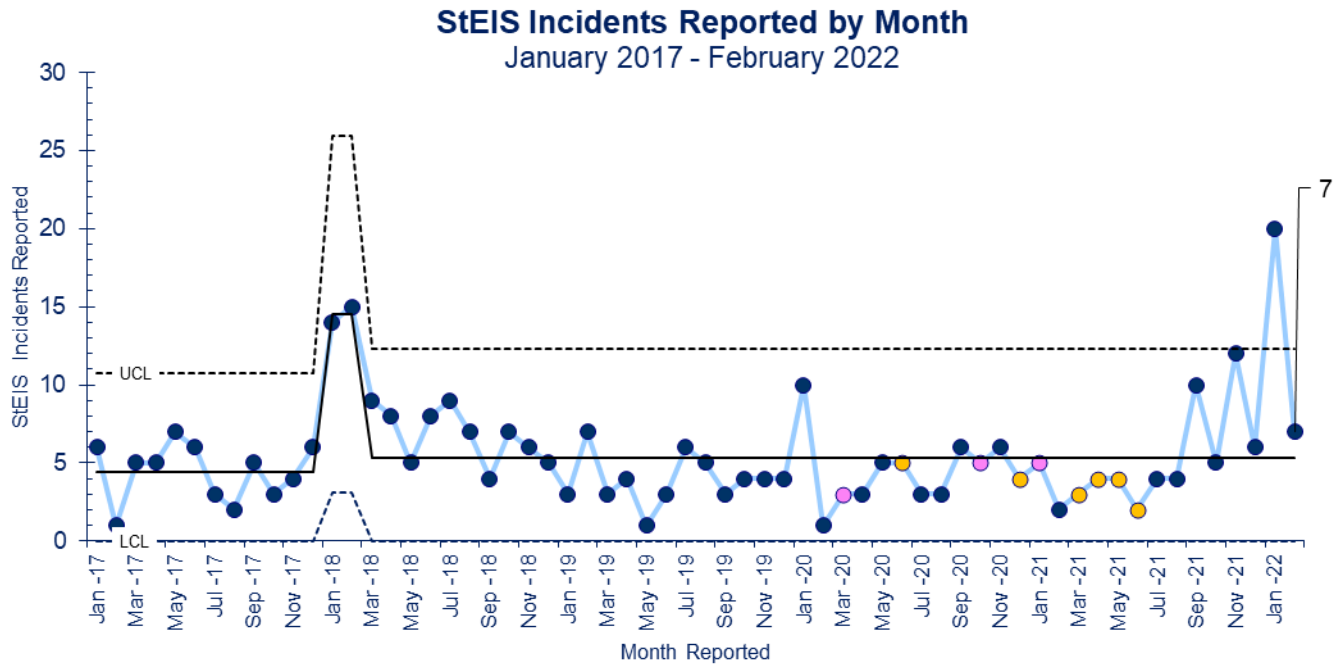
SLAs are calculated using the following measures/ targets.

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

Q3 SERIOUS INCIDENTS

Figure Q3.1



* Lockdown Easing of Restrictions

Serious Safety Incidents

7 Serious safety Incidents (SIs) were reported in February 2022. The data is back within normal control limits.

The **7** SIs can be broken down by the following themes:

- **5** related to treatment delays
- **2** relating to sub optimal care

12 SI reports were due with the commissioners in February 2022. **5** were submitted within the 60-day timescale. **6** were submitted after their due date. **1** is still awaiting submission.

Significant work has been undertaken, and this remains ongoing to ensure that incident reporting is encouraged, and we proactively seek out harm, therefore it is expected that we may see a steady increase in incidents / serious incidents reported. This will be monitored to ensure we highlight any new areas of risk.

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

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Mar 21 – Feb 22)	Number of Alerts Applicable (Mar 21 – Feb 22)	Number of Open Alerts	Notes
CAS/ NHS Improvement	14	0	0	

Safety Alerts	Number of Alerts Received (Mar 21 – Feb 22)	Number of Alerts Applicable (Mar 21 – Feb 22)	Number of Open Alerts	Notes
MHRA – Medical Equipment	13	0	0	

Safety Alerts	Number of Alerts Received (Mar 21 – Feb 22)	Number of Alerts Applicable (Mar 21 – Feb 22)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	52	0	0	

Safety Alerts	Number of Alerts Received (Mar 21 – Feb 22)	Number of Alerts Applicable (Mar 21– Feb 22)	Number of Open Alerts	Notes
IPC	1	1	0	Coronavirus is a viral disease (COVID-19). There is a multi-faceted action plan that operates across the Trust, this includes HR, Procurement, Communications, Operations and the Quality teams. This is being discharged by L Yeomans (Lead and DIPC) and the Executive Leadership Committee (ELC).

NWAS Response

There has been **8** new safety alerts in February 2022.

The total number of CAS/NHS Improvement alerts received between February 2021 and January 2022 is **14**, with no alerts applicable.

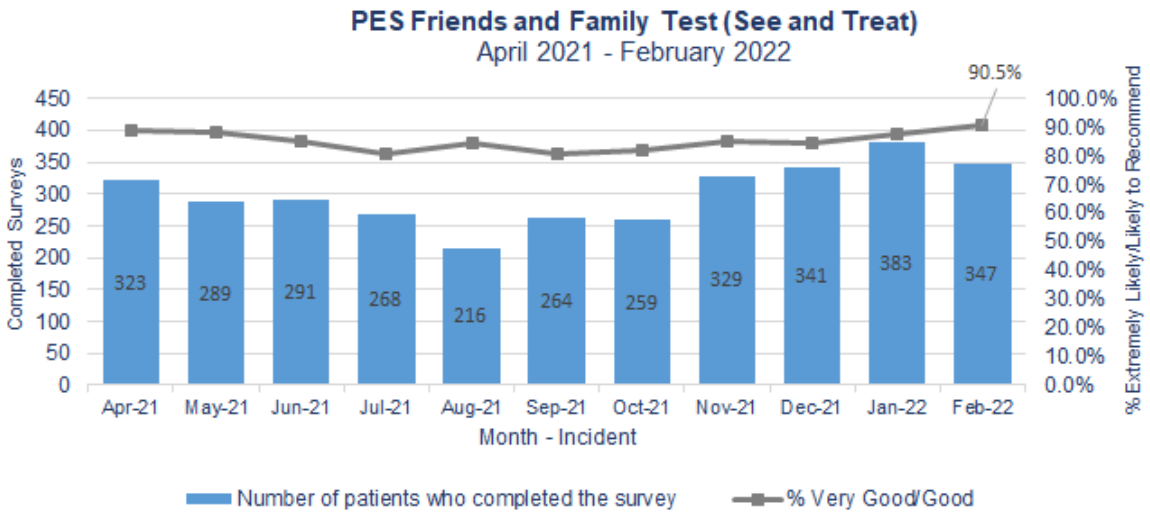
13 MHRA Medical Equipment Alerts have been received with no alerts applicable.

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

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

E1 PATIENT EXPERIENCE

Figure E1.1



Patient Experience

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

Patient Experience (PES)

The **347** responses for February are **9.4%** less than for January, of **383**, with comments lower by **7.6%** (**257** for February compared to **278** from January). This may be attributable to February having less days.

The overall experience score for February of **90.5%** January's is **3.0%** higher than the **87.5%** reported in January.

For respondents who indicated a **'very good/good'** experience of using the service, the corresponding themes continue to be around; speed of response, reassurance provided both on the phone and by the paramedics, being treated with kindness and respect shown, with empathy, the professionalism and teamwork of the paramedics to meet the needs of the patient, along with clarity of what was being done and why.

Comments included:

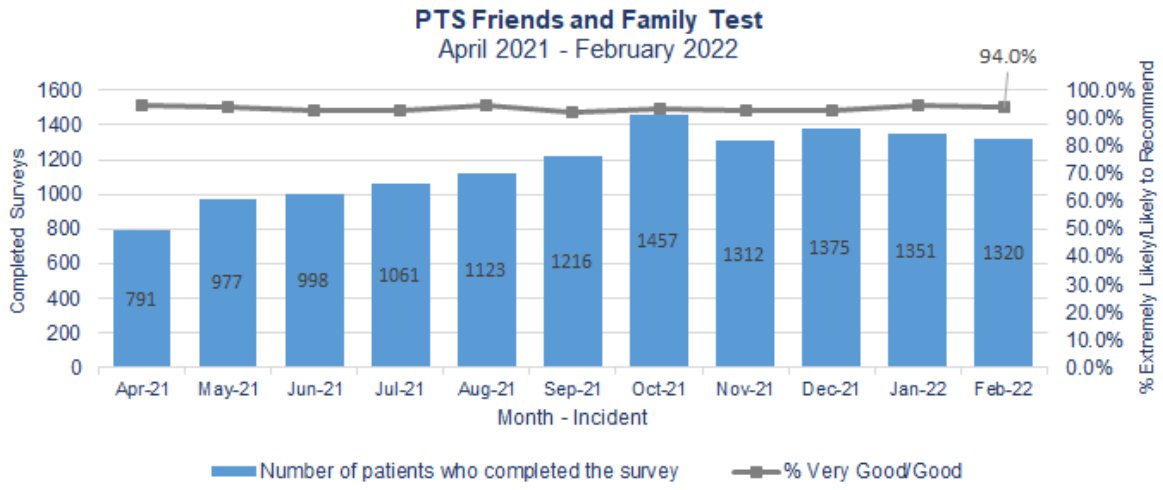
- *"I cannot praise these angels high enough. They are professional, caring, clever, genuine, lovely, patient thorough, determined. They showed compassion and empathy and fully understood the upsetting and difficult situation. They went well above and beyond their call of duty and did not rush the situation and made extensive notes. I really appreciated their assistance. The person in question is now in hospital getting the help they desperately need. Please tell them a big thank you from me."*
- *"The crew were so caring and professional in the way they dealt with my mum. Her needs were always put first and at all times they made her feel safe. Their manner was first class."*
- *"Reasonably quick response, great communication from call answering and paramedics were caring professional and reassuring for my 88 year old Dad."*

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

Comments included:

- *"Ambulance took over 5 hours to arrive."*
- *"Took their time coming out. Come when I rang them not 7 hours later when I was in bed a sleep."*
- *"Waited over 6 hours - poor communication. Paramedics no interest on arrival. Better communication - rang 111 for advice. Advices I needed paramedics. Paramedics did not want to attend. Need better communication between services."*
- *"The patient was panicked and anxious struggling to breathe. There was not a shred of compassion to be found.*
- *They said take some paracetamol and good luck as a quick summary. Pathetic."*

Figure E1.2



Patient Experience (PTS)

In February, there were **1,320** returns, **2.29%** less than that of **1,351** in January. There was also a **4.42%** drop in comments, (**1,060** in February and **1,109** in January). Again this may be attributable to less days in the month of February.

When compared to the previous month, the **94.0%** overall experience score for February sees a drop of **0.8%** on January at **94.8%**.

Where respondents in January indicated **'very good/good'**, the corresponding themes continue to be around; efficient and excellent service, patient comfort and safety, timely pick up, friendly polite and helpful staff, professionalism, being treated with dignity and respect.

Comments included:

- *It was nothing short of FIRST CLASS my wife is bed bound so it was a difficult move for the two ambulance guys Steve and Paul (ex-fire fighters) they were excellent couldn't speak highly enough. My wife's appointments was for 10:30am. The guy's came early and we were back home at 10:30 brilliant. Thanks to all."*
- *"Staff communicated within a professional but friendly manner at a level off my understanding and listened to me with patience, ensuring I was safe such as I use oxygen. Linked me up to appropriate oxygen during travel to and from my hospital appointment and also checking I was warm enough. Kept their face masks on and sanitising hands. I felt comfortable and they was approachable if I needed any other assistance. Also took me into the building of my appointment and hooked me up on my oxygen. Very pleasant journey from both ambulance transport crew. Thank you, very much appreciated."*
- *"Elaine and Dave made Ian so at ease and carried out transfer from bed to trolley with care and efficiency. Ride to hospital was comfortable and return journey and back into bed was done in an equally calm and friendly manner. The procedure at hospital is definitely not to look forward to but if everything is calm before we get there it helps!! Thankyou again for your much appreciated support."*

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

Comments included:

- *"The journey to the hospital was good. My mum is in a wheelchair & the driver strapped her in safely. The journey back to the nursing home was awful. The driver just put her brakes on. He didn't strap her in & asked me to hold onto the wheelchair especially when we went round the roundabout!!!! When we drove up the drive way to the home there was a pothole & as we hit it the wheelchair tipped up & I had to grab it. Health & safety was non-existent on the return journey. If taxi drivers have no straps they shouldn't be responsible for transporting patients.*
- *"The car arrived on time, BUT it was over 10 years old.it was not very clean and there was no help when dropped off at Preston 1hr later. At 3.30pm the return transport was arrange and it took nearly 2 hrs to arrive. It was the same car and it came from Barrow approximately 2hrs away. The car had no lights at all and the driver had to stop at Burton services.to buy bulbs but he could not fix. Eventually he got me home after 7 pm in the dark traveling with no lights on. What an experience I would not like me or anyone else to undertake. The car was not fit for purpose*
- *"My last two appointments I was late for as the ambulance didn't pick me up until just before my appointment time & then well after my appointment time."*
- *On the way there the taxi driver was saying that he's running late, he has to pick someone up at 8.20 and do the school runs. He pushed me to the lift on ground floor. I had to get out of wheelchair and push my wheelchair to the other side of building to get to physio. I was informed by physio that it was wrong to push my wheel chair. I explained they were annoyed. Tried ringing transport but they were busy. I finally got InTouch and was given the email address and the phone number.*

Figure E1.3

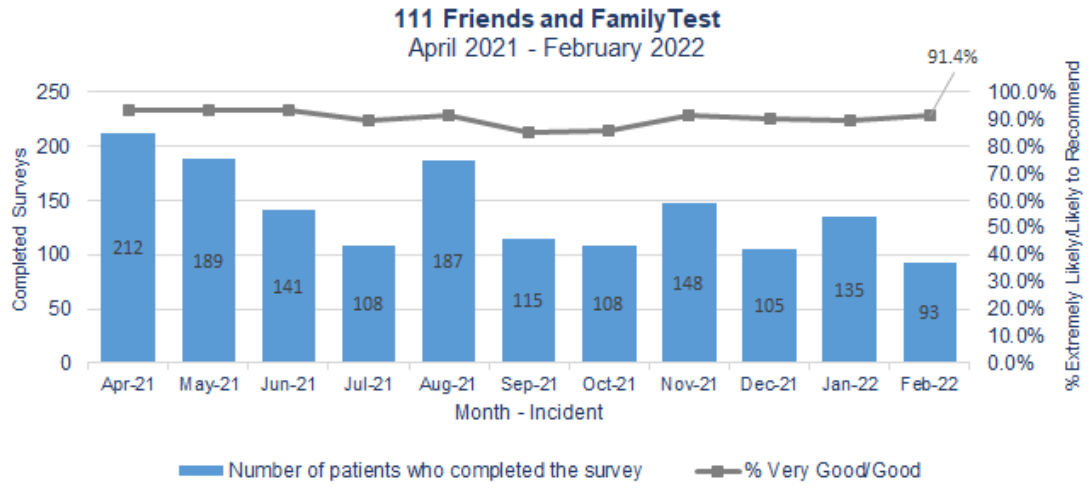
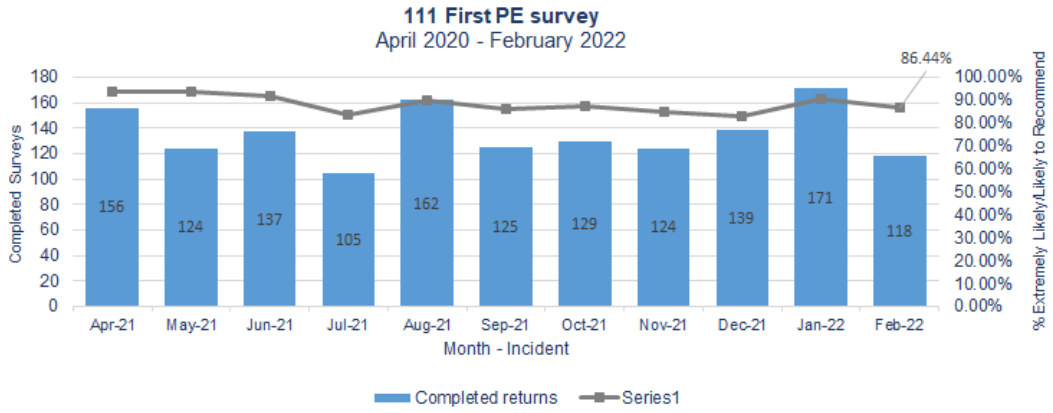


Figure E1.4



Patient Experience (NHS 111)

The February return figure of **93** was **37.7%** less compared to the previous figure of **135** returns for January.

At this touch point, we see a **91.4%** likelihood of recommending the service, a marginal increase of **0.3%** compared to the previous month of January at **91.19%**.

NHS 111 First

The above high level summary table shows the number of returns, reasons for using the service, outcome and the levels of overall patient satisfaction.
Cumulatively to date, since the service commenced last August, **90.84%** (previously **91.18%**) of patients describe their experience as 'very good/good' and **94.08%** (previously **94.31%**) of patients felt their need for calling the service was met.

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

- *"On the whole I was quite satisfied. The only issue is that I had to explain who I was and give my details to the first call handler and then was transferred to a clinician who had no idea who I was and why I had called so had to go over it all again."*
- *"Very professional calm and very helpful. Also the lady I spoke to was caring and understanding."*
- *"Speed of response. Setting expectations."*
- *"Call back from clinician was prompt and quick. In depth discussion with doctor by telephone contact as advised by clinician. Doctor call out and discussion with this soctor. Timescales and wait time for phone call from doctor and doctor coming on home visit."*
- *"Call back from clinician was prompt and quick. In depth discussion with doctor by telephone contact as advised by clinician. Doctor call out and discussion with this soctor. Timescales and wait time for phone call from doctor and doctor coming on home visit."*
-
-

Where respondents indicated they were '**extremely unlikely/unlikely**' to recommend the service, the following three comments were provided:

- *"Firstly nearly 45 mins wait time to get through. Secondly having to wait 24 hours for a GP to phone back is unacceptable."*
- *"Phone 111 at 1750 approx received calls back from 111 at 0305am and 0430am two days later!!! And did not leave message."*
- *"I have used 111 as my GP surgery will not see anybody with even a slight temperature. They just tell you to go to A and E. 111 also now does the same. Go to A and E."*

Table E1.1

2021 - 2022 Patient Engagement Surveys Summary of Key Demographic Data *(01 April 2021 - 28 February 2022)*		PTS *(URL Link)**	PES *(URL Link)**	UCD *(URL Link)**	PTS FFT *(SMS Text)*	PES FFT *(SMS Text)*	111 *(Postal)*	111 First *(Postal)*
Patient Age	**Under 16 yrs**	**1.9%**	**0.3%**	**2.7%**	**1.3%**	**0.9%**	**3.7%**	**8.1%**
	Over 45+ yrs	**91.1%**	**77.2%**	**72.0%**	**91.9%**	**65.2%**	**70.8%**	**66.0%**
	Over 75+ yrs	**20.3%**	**31.3%**	**29.3%**	**29.8%**	**11.2%**	**21.1%**	**17.6%**
	Over 85+ yrs	**5.3%**	**11.5%**	**16.0%**	**8.0%**	**3.9%**	**No data**	**4.7%**
Patient Gender	Female	53.9%	55.5%	66.7%	53.3%	62.2%	60.7%	61.3%
	Male	15.2%	44.5%	32.0%	46.6%	33.9%	37.8%	37.8%
	Prefer not to say	1.2%	0.0%	1.3%	0.1%	3.9%	1.5%	0.9%
Patient Impairment	**Limiting illness**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**38.6%**	**n/a**
	None	**17.0%**	**41.4%**	**45.2%**	**9.1%**	**51.2%**	**57.1%**	**46.3%**
	More than one	**n/a**	**n/a**	**n/a**	**23.0%**	**9.9%**	**n/a**	**n/a**
	Mobility	**61.2%**	**32.0%**	**28.8%**	**51.2%**	**14.1%**	**n/a**	**11.3%**
	Hearing	**14.2%**	**13.5%**	**12.3%**	**1.0%**	**1.8%**	**n/a**	**8.7%**
	Visual	**8.4%**	**6.1%**	**4.1%**	**3.9%**	**0.7%**	**n/a**	**1.9%**
	Mental Health	**9.4%**	**17.1%**	**16.4%**	**2.0%**	**9.7%**	**n/a**	**5.9%**
	Dementia	**n/a**	**n/a**	**n/a**	**0.7%**	**2.1%**	**n/a**	**1.6%**
	Learning	**3.4%**	**2.8%**	**2.7%**	**0.9%**	**1.2%**	**n/a**	**2.2%**
Patient Ethnicity	(Black & Minority Ethnic Communities)	2.9%	3.0%	9.3%	5.3%	8.4%	6.7%	4.1%
	Prefer not to say	2.6%	1.1%	5.3%	2.1%	3.3%	0.0%	1.5%
Demographic Data Request	**None respondent**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.4%**	**0.0%**

EDI

Table E1.1 shows percentage breakdown of respondents by demographics for our PES, PTS, NHS 111 and NHS 111 First surveys as well as where we have received FFT feedback via SMS on our PES and PTS service lines. Some key headlines show

- Over **90%** of PTS respondents are over 45 years of age.
- Over **60%** of NHS 111 respondents are female.
- Over **90%** of PTS respondents declared their disability.
- An average **5%** of all respondents were from ethnic minority communities.
- Just **2.5%** of all respondents preferred not to declare their ethnicity.

The next step is to understand if our response rates represent the communities proportionally and to understand if there is a difference in patient experience for different groups.

We are working to improve our capturing of ethnicity data and have begun a digital sprint to enable the sharing of ethnicity data cross our systems – for example pulling it from Cleric in to our EPR as we are much more likely to have the information captured in 111.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

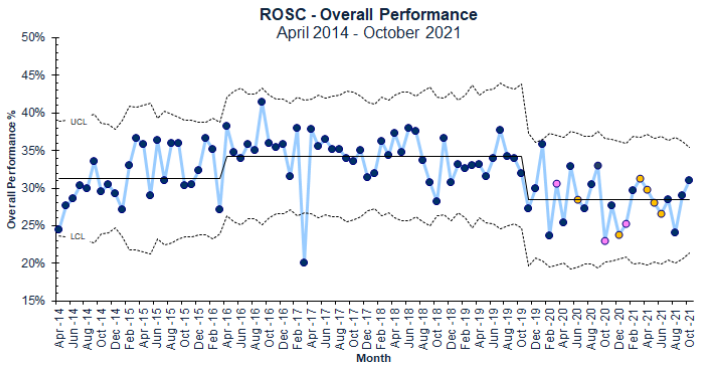
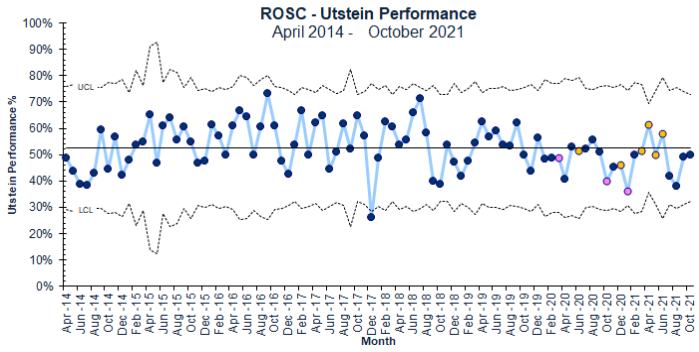


Figure E2.2



* Lockdown Easing of Restrictions

Figure E2.3

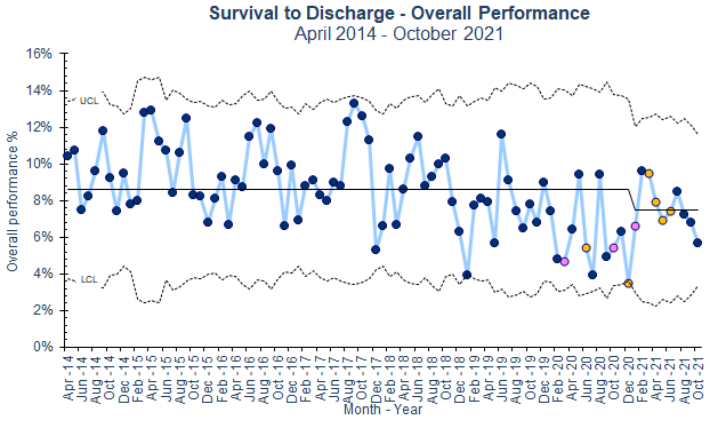
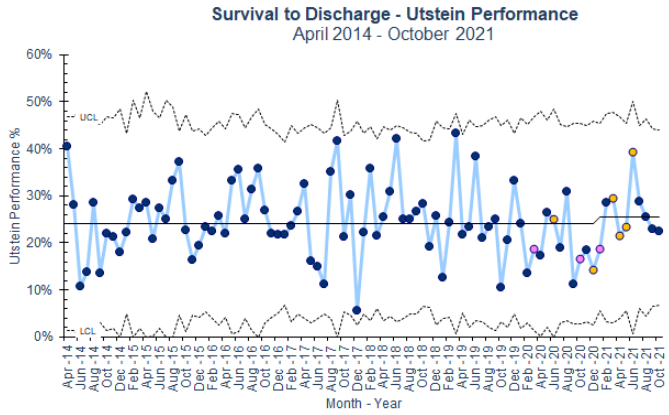


Figure E2.4



ACQIs (Last data point: September 2021)

October 2021's data see us within normal limits and close to the mean across all indicators signalling no significant overall change apart from the Stemi care bundle where we see a significant reduction. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

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

The ROSC achieved for the Utstein group was **50%** (national mean **45.3%**), ranking second nationally. For the overall group the rate was **31%** (national mean **24.8%**) ranking second nationally. This indicator is predominantly influenced by pre-hospital factors.

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

Survival to Discharge rates overall in October 2021 were at **5.7%** (national mean **7.3%**). representing no significant change and ranking eleventh nationally.

In October **22.4%** of patients in the Utstein group survived to hospital discharge; the national mean was **22.9%.** This remains within the control limits and ranked the Trust 6th nationally.

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

Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

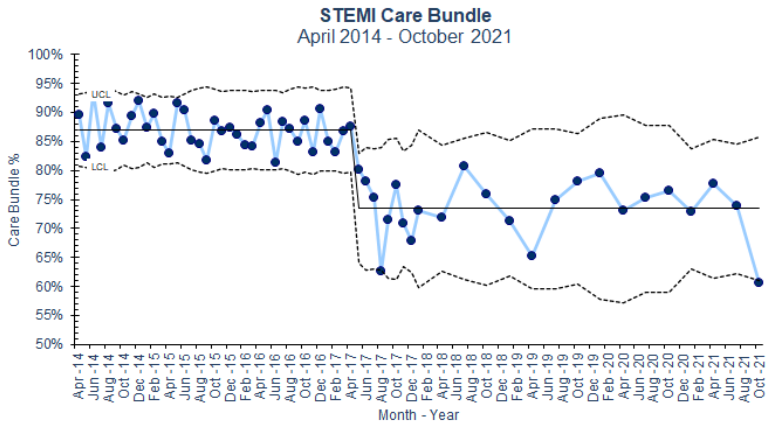
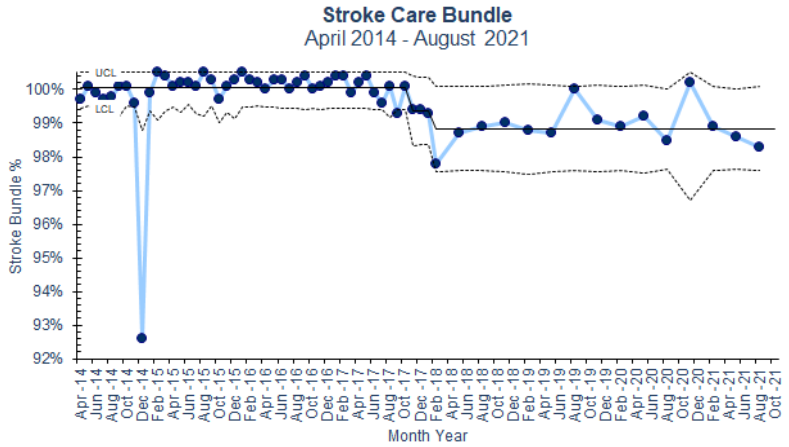


Figure E2.6



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

Care Bundles

STEMI (2.5): STEMI care bundle performance for October 2021 was **60.7%** (national mean **74.2%**), ranking tenth nationally. This performance hit the lower control limit representing the most significant change since summer 2019. The change is due to a drop in performance in 3 of the 4 elements that make up a bundle (aspirin administration, two pain scores and analgesia). This has resulted in a large combined drop in performance. Some of this may be driven by gaps in completion in the new EPR which is a key focus of our data quality and audits teams.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of **2h 42mins**; the Trust's performance was **2h 57mins.**

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

STROKE (2.6): Stoke care bundle performance was not reported for October 2021 as is consistent with the NHSE schedule.

Mean call to hospital arrival for stroke was **1h:56min** in October 2021, was below the national mean time (**1h 58min)**.

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

The audit process will be undergoing a transition with the implementation of the EPR. NHS E/I have been informed of any associated potential disruption to the returns

F1 FINANCIAL SCORE

Figure F1.1

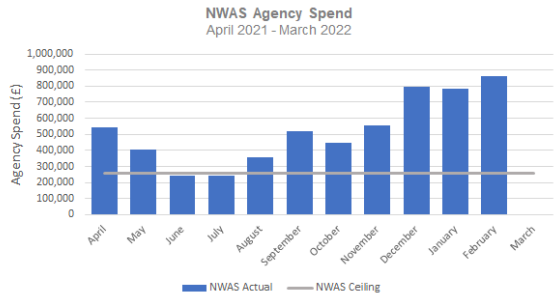


Figure F1.2

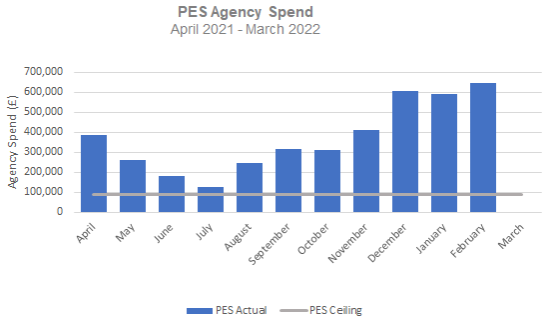


Figure F1.3

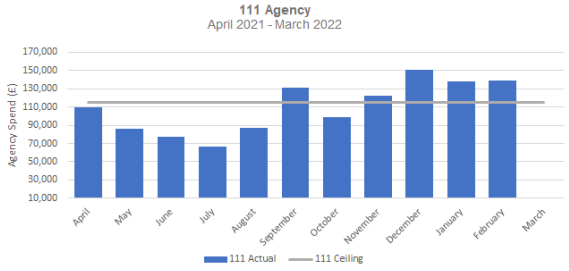


Figure F1.4

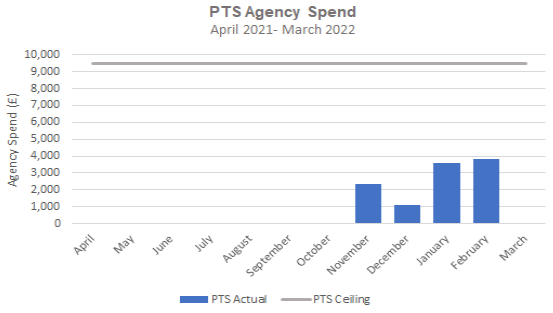


Figure F1.5

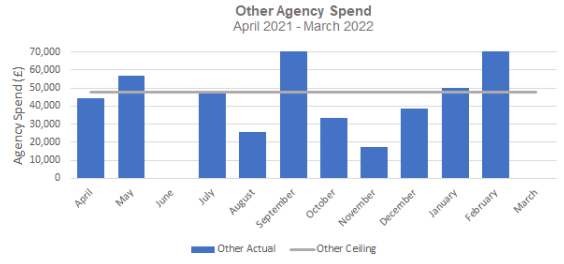
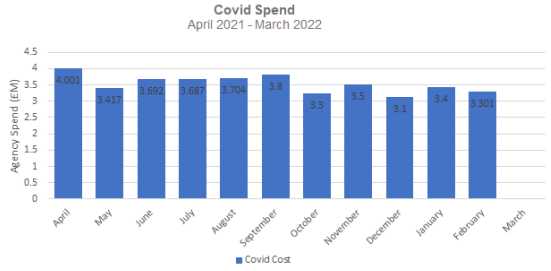


Figure F1.6



Finance Position

Month 11 Finance Position

As at month 11 (February) the trust is recording a surplus position for the year to date of **£0.271m**, this surplus is reducing each month. H2 (October to March) income has been agreed along with additional top up elements for covid & winter pressures, spend related to these top ups is monitored and we are bringing in additional staff as appropriate to help operational performance. It is expected that the trust will finish the year in a break even position.

Agency Expenditure

The year-to-date expenditure on agency is **£5.750m** which is **£2.900m** above the year-to-date ceiling of **£2.2850m**.

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

Risk Rating

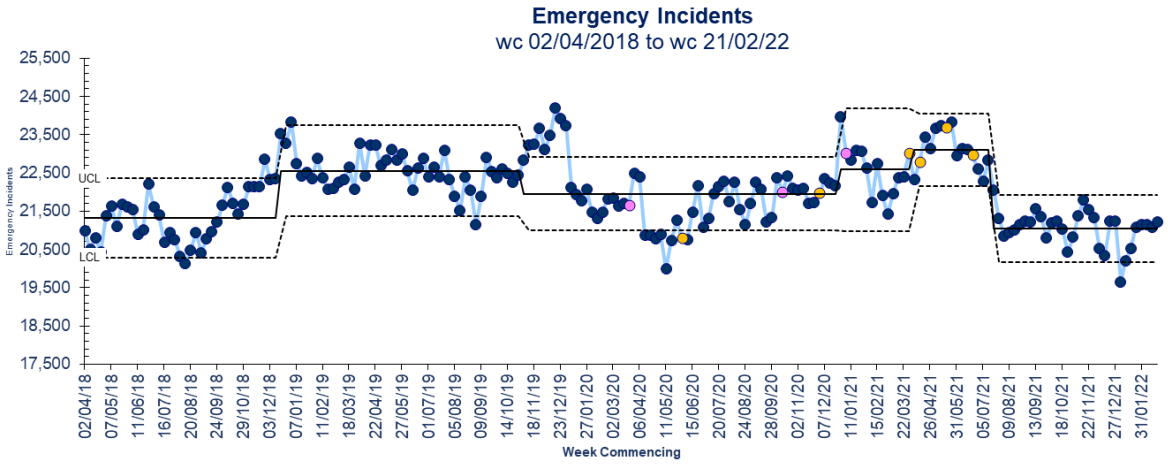
The COVID-19 financial framework in place for H1 (1 April 2021-30 September 2021) and the redesigned monthly financial returns collect a minimum dataset to reduce the burden on organisations wherever possible, has remained in place for H2 (1 October 2021 - 31 March 2022).

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

E3 ACTIVITY & OUTCOMES

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

Figure E3.2



* Lockdown Easing of Restrictions

Activity:

In February 2022 the Trust received **110,736** calls of which **84,654** became incidents. Compared with February 2020, we have seen a **2%** increase in calls and a **5%** decrease in incidents. This is due to the increase in signposting. The number of emergency incidents are within normal control limits and have been on or around the mean during February

Feb	Calls	% Change from 2020	Incidents	% Change from 2020
2020	108,982		89,281	
2021	90,436	-17%	88,997	0%
2022	110,736	2%	84,645	-5%

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

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

For February we achieved **10.1%** Hear and Treat and ranked **7th** nationally. See & Treat marginally decreased to **29.3%** but is within normal limits and we are ranked **9th** nationally. In total there was an aggregate non-conveyance of **39.3%**.

Figure E3.4

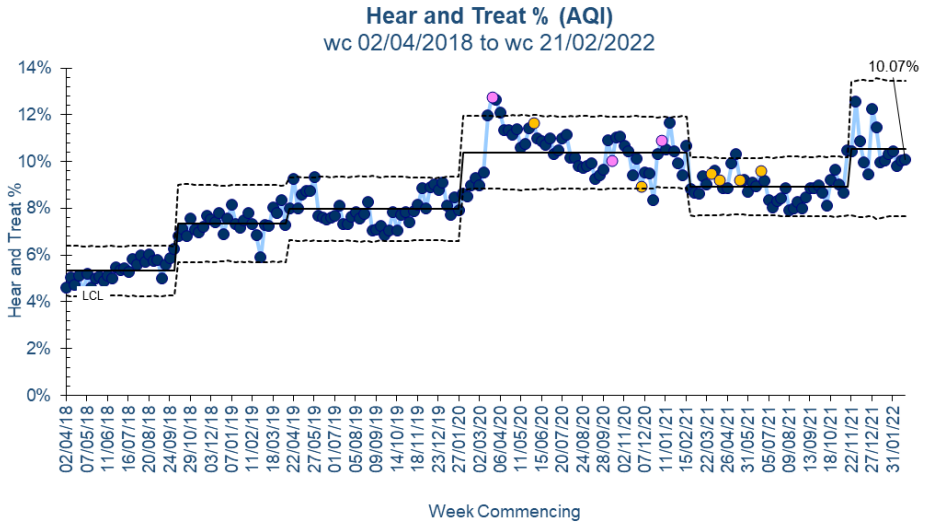


Figure E3.5

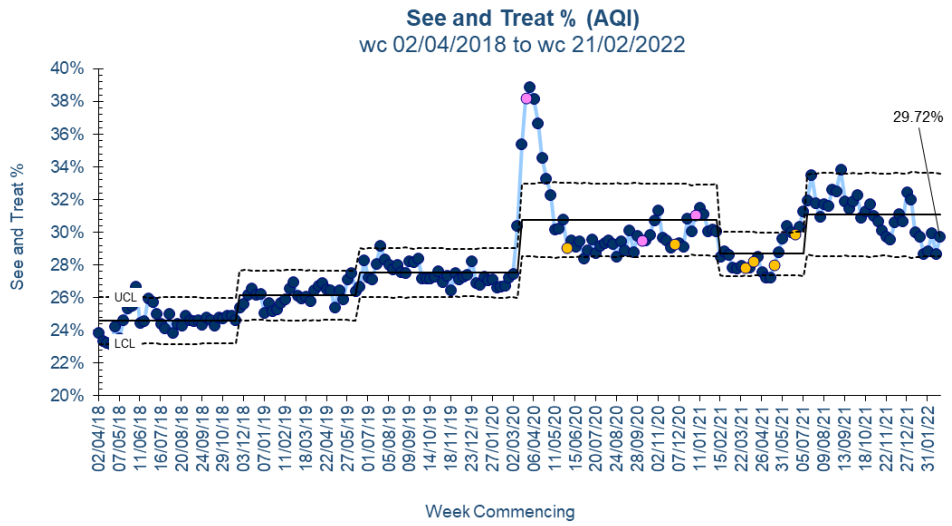
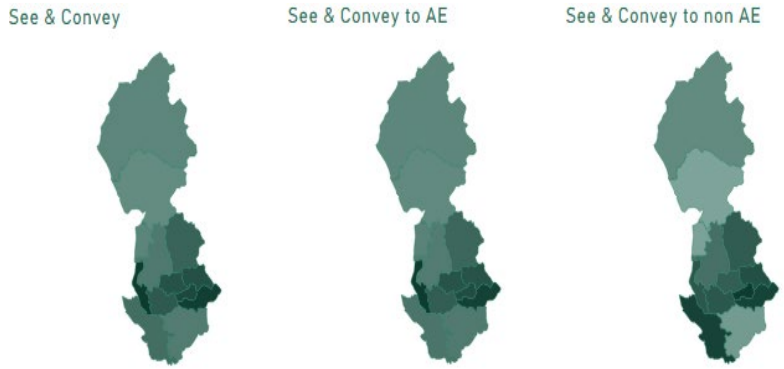


Figure E3.6



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

* Lockdown Easing of Restrictions

- **Hear and Treat**. The introduction of the category 3 and 4 validation process in November 2021, Hear and Treat increased to c**12%** during a number of weeks. In February we have seen the continuation of the reduction in call volumes and an increase of resources available for dispatch, mainly due to the assistance of army personnel. This generally leads to significant reduction in Heat and Treat rates, however the Category 3 and 4 validation process prevented this from happening by hiding the incident from dispatch. This allows for a smarter way of working, enabling a Senior Clinician time to review the incidents, prior to dispatch of a resource. This has resulted in Hear and Treat rates maintaining at **10%.** Clinical Hub continues to split its focus on patient safety, Crew advice and Hear and Treat.

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

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

Outcome Provider Comparison Figures January 2022

Figure E3.7

Provider	Hear & Treat
	15.4%
	12.3%
	11.4%
	11.1%
	11.0%
	11.0%
North West	10.1%
	9.6%
	9.5%
	9.0%
	8.6%

7/11

FigureE3.8

Provider	See & Treat
	38.4%
	33.7%
	32.2%
	32.1%
	31.6%
	31.2%
	31.2%
	29.9%
North West	29.3%
	27.1%
	26.8%

9/11

Figure E3.9

Provider	See & Convey
	50.5%
	54.7%
	54.9%
	56.5%
	57.4%
	58.8%
	59.3%
	59.3%
North West	60.7%
	61.9%
	63.6%

9/11

- **HEAR & TREAT**: The Trust moved from **5th** in January to **7th** in February. The trust is working closely with clinical assessment service providers to increase the number of calls closed through the clinical assessment service and this is likely to improve H&T throughout Q4.

- **SEE & TREAT: The Trust is preforming 9th in the national rankings.** In August 2020 we moved to **9th** and remained in that position, then moving to **5th** in October and November before moving to **7th** in November and **9th** since December 2021. The RIGHT care at Home Improvement Programme has been paused as the improvement team focus is on hospital handover pressures.

- **SEE & CONVEY:** See and Convey rankings were steadily improving between Jan 2018 and September 2019 but since October 2019 we have been ranked **9th** out of 11 ambulance services apart from September and December 2021 and January 2022 when the trust was ranked **8th**.

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

O1 CALL PICK UP

Figure O1.1

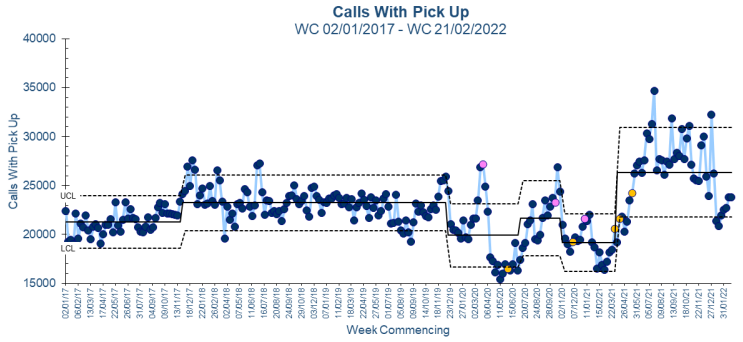


Figure O1.2

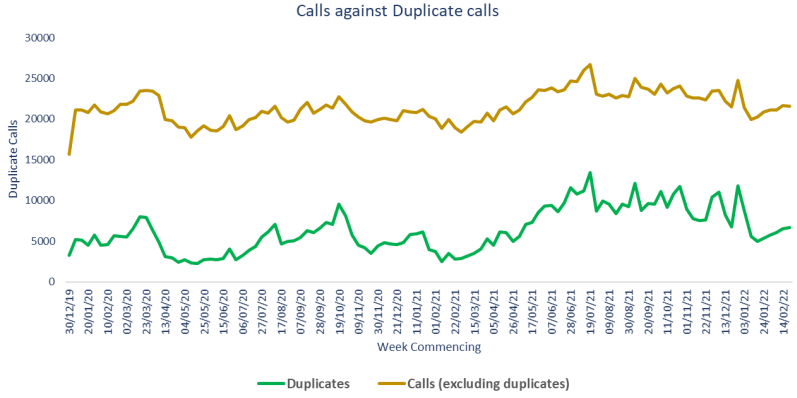
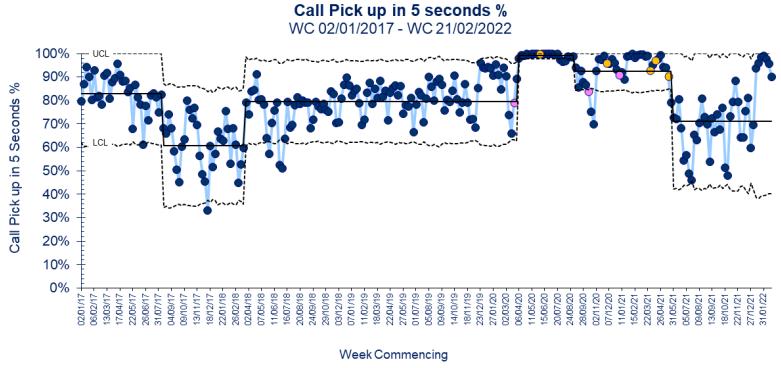


Figure O1.3



* *Lockdown* *Easing of Restrictions*

Call Pick Up

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

Performance: Call pick up performance for February is the significantly improved when compared to January 2022 and vs previous months.

- **Mean call answer 3 seconds (10 second improvement vs Jan 22)**
- **90th centile call answer 0 seconds (33 second improvement vs Jan 22).**
- **95th centile call answer 3 seconds (82 second improvement vs Jan 22).**
- **Percentage of calls answered within 5 seconds 95.37% (9.71% improvement vs Jan 22).**

National Context: Nationally we are observing significant variation in call pick up performance. NWAS and a number of other Trusts are delivering excellent call pick up. There are number of Trusts where call pick up performance is well below the standards required. NWAS continue to rank 1st or 2nd in weekly CPU indicators.

Figure O1.1 This chart shows the variability of inbound call volume. This is influenced by a number of factors including response times, which influence duplicate calls, patient behaviour, access into other parts of the NHS and over the past two years lockdowns have influenced demand. The variability of demand increases the complexity of forecasting and planning.

Figure O1.3 The chart reflects the stepped improvement in CPU for February. NWAS has not delivered CPU of this level since the early stages of COVID lockdowns. What should be noted and provide assurance is the performance delivered in Feb 22 is against higher levels of inbound call demand. This demonstrates the increased call handling capacity NWAS now has. It should be noted that this increased capacity over time has potential to improve further as throughout Jan and Feb high levels of call handling staff have been abstracted to be trained in NHS Pathways in readiness for Cumbria and Lancashire go live.

O2 A&E TURNAROUND

Figure O2.1

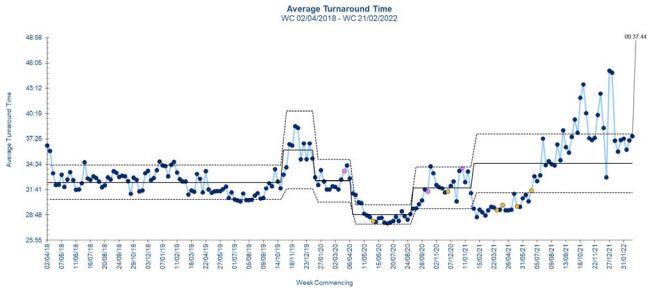
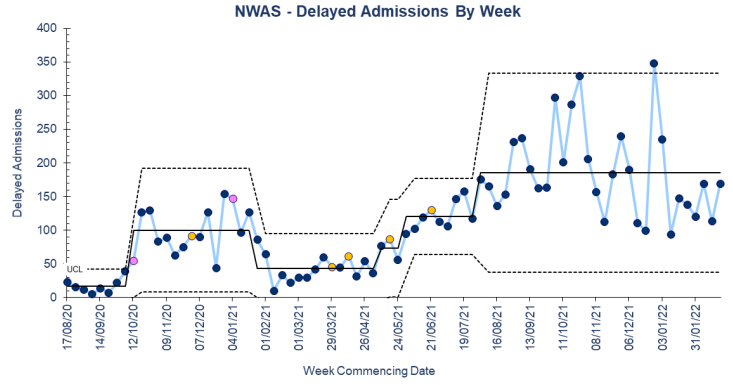


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Mar-21	54,174	29:25	17:57	11:42
Apr-21	53,552	29:26	18:14	11:18
May-21	57,212	29:56	18:46	11:17
Jun-21	52,324	31:20	20:11	11:24
Jul-21	51,396	34:16	23:12	11:20
Aug-21	49,377	35:06	23:45	11:32
Sep-21	47,467	36:49	25:26	11:41
Oct-21**	38,181	39:27	27:56	11:25
Nov-21	48,412	38:29	27:28	11:34
Dec-21	47,723	39:22	27:58	11:18
Jan-22	47,380	39:08	27:24	11:31
Feb-22	45,278	37:13	25:56	11:15

Figure O2.2



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

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

Table O2.2

Month	No. of Delayed Admissions
Aug-20*	38
Sep-20	46
Oct-20	355
Nov-20	347
Dec-20	406
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct-21	1156
Nov-21	739
Dec-21	824
Jan-22	708
Feb-22	590

A&E Turnaround Times

Average turnaround time was **37:13** (Table O2.1). Whilst this is the ninth consecutive month that the trust has not met the standard of 30 minutes, it is the second consecutive month that there has been improvement (from **39:22** in December 2021 to **37:13** in February 2022 (Table O2.1). The trend in the weekly view (Chart O2.1) identifies a move to more controlled distribution (within control limits) within the data, signalling a likely future improvement based on this trajectory.

Data are demonstrating we are becoming more consistent within a tight distribution with a number of trusts who have high turnaround times. The trust continues to work with those most challenged trusts and is also ensuring a focus on patient safety while the system is challenged.

4,655 attendances (**10.3%**) had a turnaround time of over 1 hour, with **303** of those taking more than 3 hours. The number of delayed admissions has been deteriorating month by month, peaking at **1,156** in October. Since December we have seen the number reduce from **824** in December with **708** and **590** delayed admissions in January and February respectively (Table O2.2). Despite the peak being during October there was a general upward trend over time and the highest weekly number of delayed admissions occurred in WC 27/12/2021 (Figure 02.2). However, this has started to stabilise over the last 7 weeks with further improvement expected as a result of the ongoing engagement with the acute trusts.
A total of **895.4** hours lost. Below are tables showing both the 5 trusts with the highest mean arrival to handover time and the most hours lost due to delayed admissions.

Top 5 Trusts with the highest Arrival to Handover time	
Trust	Mean Arrival to Handover time
Whiston	00:45:10
Southport District General	00:35:03
Royal Oldham	00:34:48
Royal Preston	00:32:30
Macclesfield General	00:32:27

Top 5 Trusts with most hours lost due to delayed	
Trust	Hours lost to delayed admissions
Royal Oldham Hospital	217.8
Royal Preston Hospital	140.5
Fairfield General Hospital	105.6
North Manchester General Hospital	103.7
Cumberland Infirmary	74.1

Whilst performance for turnaround is outside the standard we are seeing similar performance around the country for other ambulance trusts. The increase is of high priority as seen by the head of NHS England & Improvement writing to acute trust to ask for improvement in this area. During December 2021 the trust started to test and implement the delayed handover crew and managers escalation action card throughout Greater Manchester. During January and February 2022 saw all areas within the North-West have started to implement the initiative.

O3 ARP RESPONSE TIMES

January 2022

C1 Mean (Red=>7m)

C1 90th (Red=>15m)

C2 Mean (Red=>18m)

C2 90th (Red=>40m)

C3 Mean (Red=>60m)

C3 90th (Red=>2h)

C4 90th (Red=>3h)

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

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

measures are meeting standard

measures are below standard

Activity: ARP Response Times

For February response time targets were not met for any ARP measures apart from C1 90th. Several measures are close to signalling improvement with multiple data points below the mean.

The 3 primary drivers for us not meeting performance standards are: 1. A rise in acuity (and fleet profile against this) 2. Abstractions and 3. Job cycle time including handover delays.

- We have seen an increase in acuity. This means that nearly **70%** of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat .
- Because fleet includes voluntary ambulance services who cannot respond to a category 1 and 2 incidents this rise in acuity puts increased pressure on substantive NWAS fleet and prolongs response times.
- Although abstractions remain high we have seen improved rates of abstraction, specifically associated with COVID and sickness. The improvements are increasing operational resources. This is mirrored within the EOC environment.
- Turnaround continues to be above the National standard of **30:00** with a turnaround time of **37:13**. **4,655** attendances (**10.3%**) had a turnaround time of over 1 hour. **895 hours** were lost to delayed admissions.

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

The £6.2M for increase for winter is being used for:

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

In addition to the implementation of the Trusts 6 point plan NWAS has now enacted MACA. MACA Has seen **150** army personnel deployed to increase operational resource. This will increase DCA production and improve response times to lower acuity patients (C3&C4). The employment commenced from 17th January 2022 and as a result, C3 response times significantly improved the last two weeks of January and February 22. The MACA arrangements continue and will be phased out by the end of March 22.

C3/4 validation continues to reduce the number of low acuity incidents that require an ambulatory response. ETA scripts remain in place and provide patients with an estimated time for response. Some patients as result will take the decision to self convey or contact an alternative service. This approach provides patients with a choice and on average reduces the number of incidents by around **10%** to **15%**.

C1 Performance

C1 Mean

Target: **7 minutes**

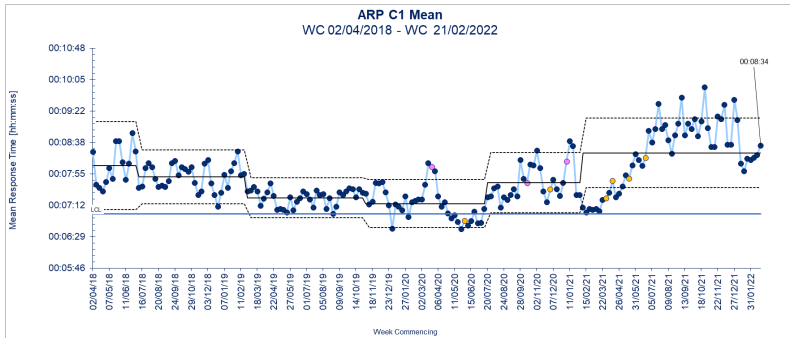
NWAS

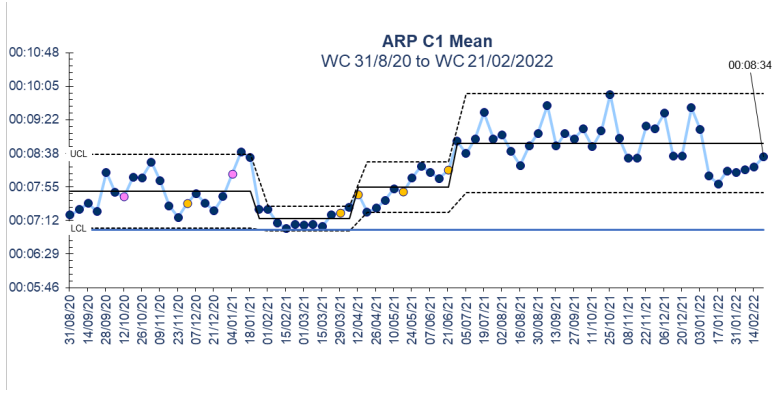
February 2022: **8:23**

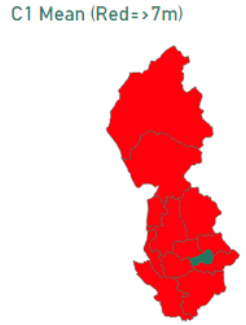
YTD: **8:40**

For February C1 mean has stabilised. Whilst performance for C1 mean is not meeting the target response the target for C1 90th is being met. NWAS do compare positively vs the other ambulance providers. The trust rank 4/11 for both C1 mean and 90th percentile.

Figure O3.1







Green sectors

G Central

C1 90th Percentile

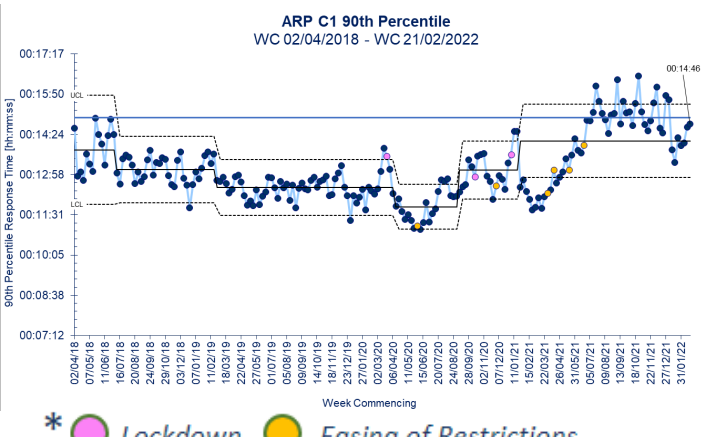
Target: **15 Minutes**

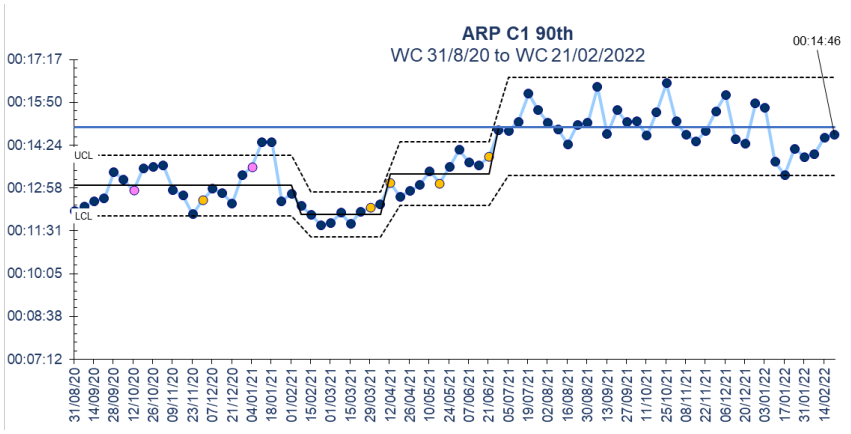
NWAS

February 2022: **14:29**

YTD: **14:42**

Figure O3.2

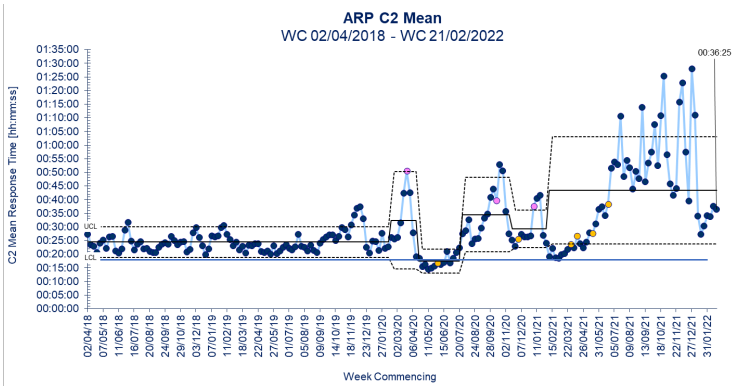


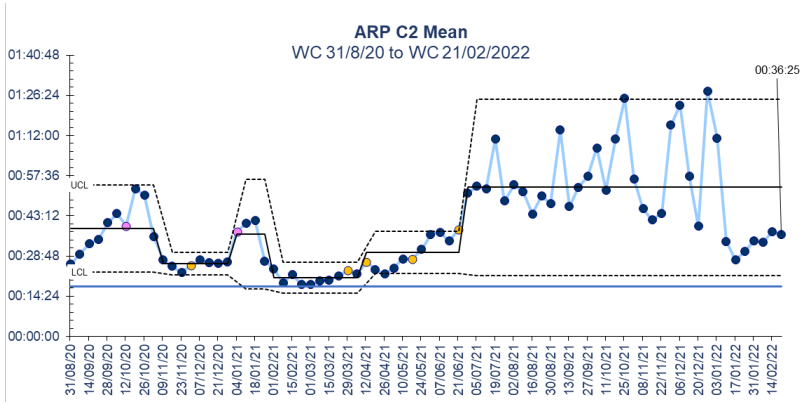


Green sectors

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

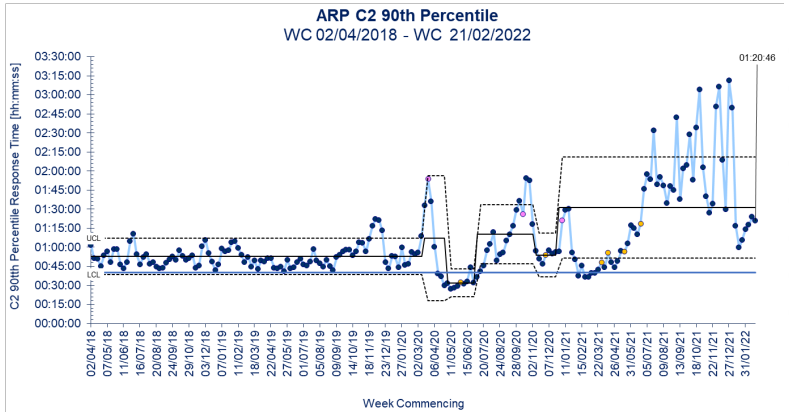
Figure O3.3

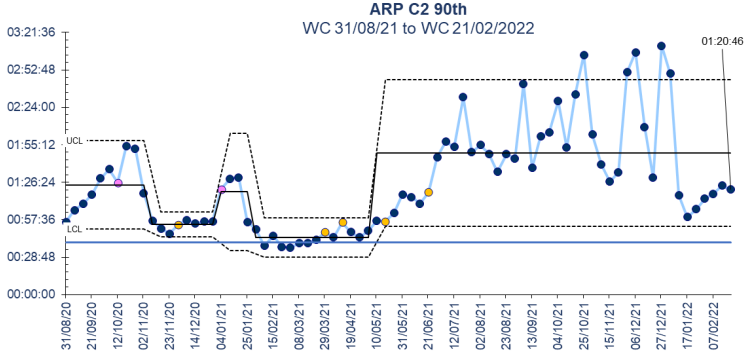


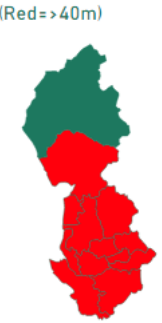


Green sectors

Figure O3.4







Green sectors
CL North Cumbria

C2 Performance

C2 Mean

Target: **18 minutes**

NWAS:

February 2022: **35:34**

YTD: **46:47**

C2 response times over the latter part of January and February have improved and stabilised. NWAS are not achieving response targets and rank 7/11 for C2 response standards.

It should be noted that the longer waiting C2 patients are effectively safeguarded via the CCD. The CCD provides oversight and interventions for long wait C2 patients, which reduces risk and patient harm.

C2 90th Percentile

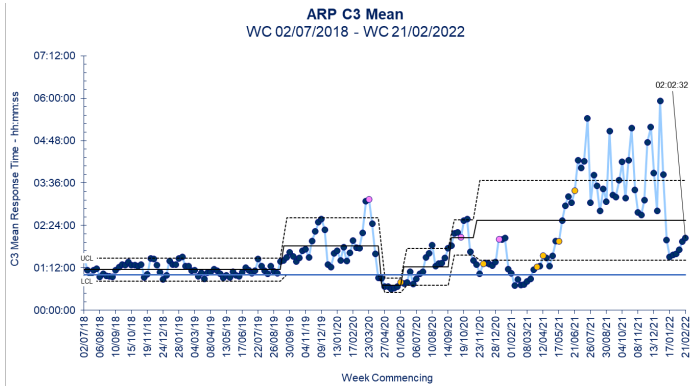
Target: **40 Minutes**

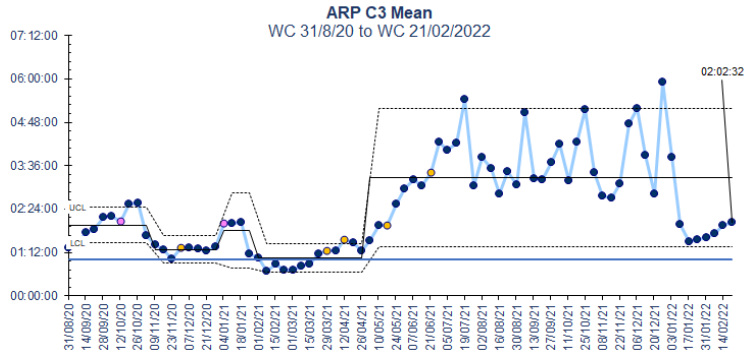
NWAS

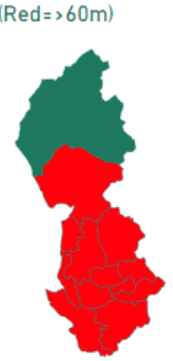
February 2022: **1:18:50**

YTD: **1:42:14**

Figure O3.5



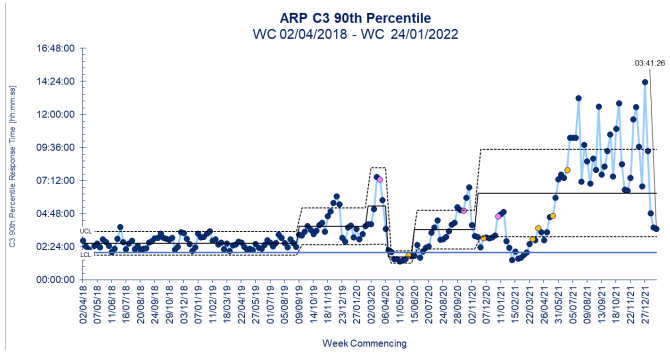


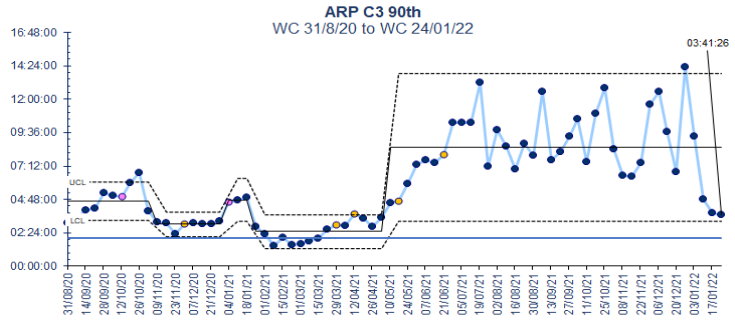


Green sectors

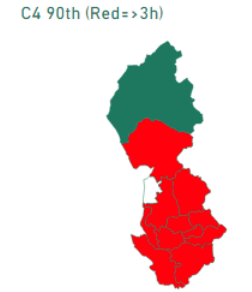
CL Cumbria North

Figure O3.6





Green sectors



Green sectors

CL Cumbria North

C3 Performance

C3 Mean
Target: **1 Hour**

NWAS:
February 2022 **1:50:16**
YTD: **2:52:17**

C3 response has stabilised through January and February. The improved performance can be attributed to several factors. The primary enablers are the introduction of C3/4 validation, military support via MACCA arrangements and improvements in abstractions rates within operations. It should be noted that the MACCA arrangements will cease at the end of March and the funding to support C3/4 validation ceases at the end of March.

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

NWAS
February 2022: **4:26:48**
YTD: **7:05:09**

C4 90th Percentile

Target: **3 Hours**

NWAS:
January 2022: **9:45:19**

Figure O3.8

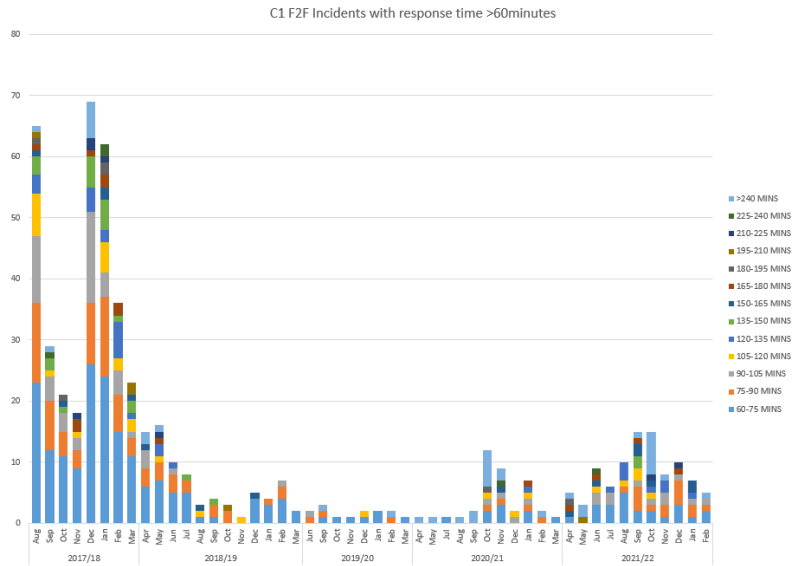


Figure O3.9

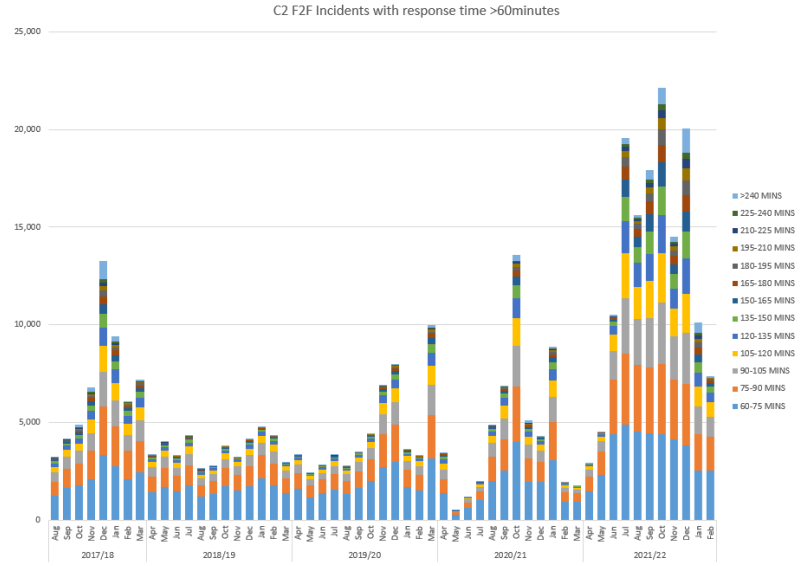


Figure O3.10

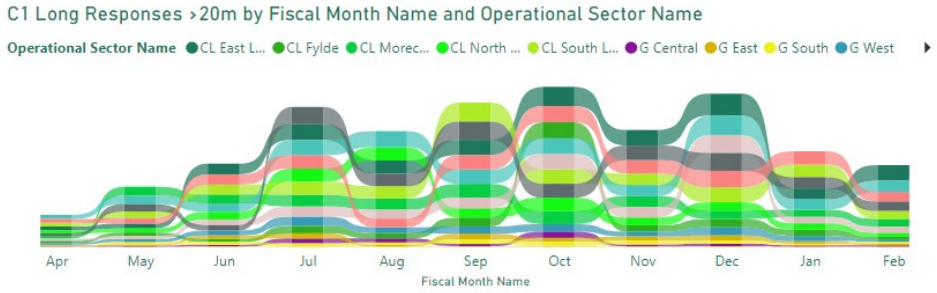
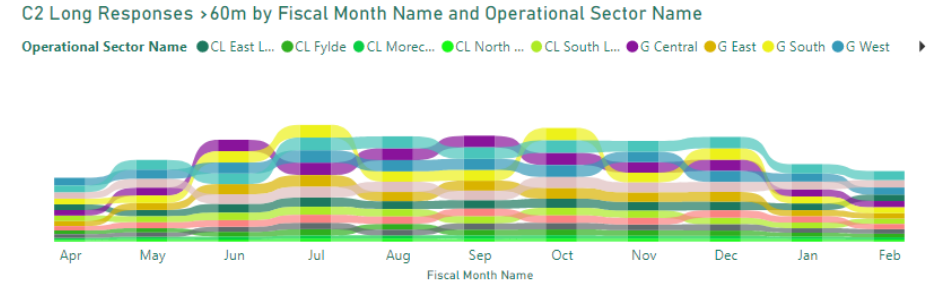


Figure O3.11



C1 & C2 Long Waits

In February we had 5 patients in the C1 category who waited longer than 60 mins and 7,349 patients in the C2 patients who waited longer than 60 mins. We have seen a month on month reduction in long waits since December. We have invested in clinical staff in the control room environment to ensure that patients are monitored whilst they are waiting and those who require their response to be expedited (on clinical need) are upgraded quickly. We have seen the number of serious incidents reduce with the improving position on C1 and C2 long waits.

The ambulance service across the NHS have had challenges with long waits and the national ambulance coordination centre have produced comparator metrics for ambulance trusts. Whilst our ambition is to eliminate long waits the current 'league table' signals NWAS is 4/11 compared with other trusts.

ARP Provider Comparison Figures January 2022

Figure O3.8

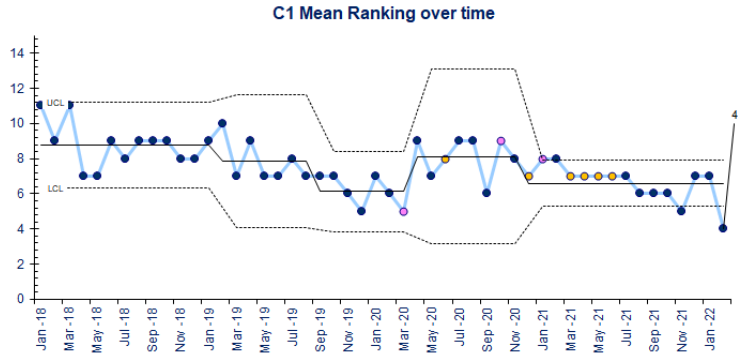


Figure O3.9

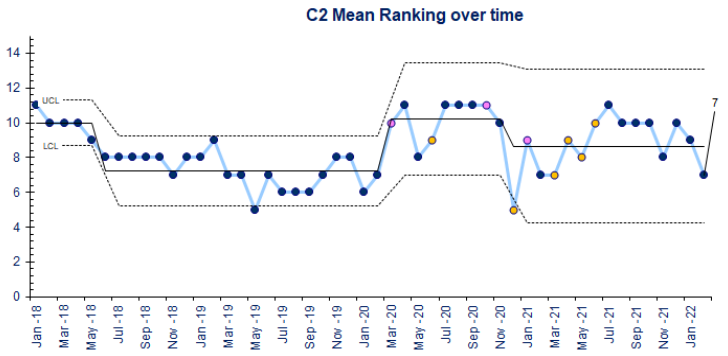


Figure O3.10

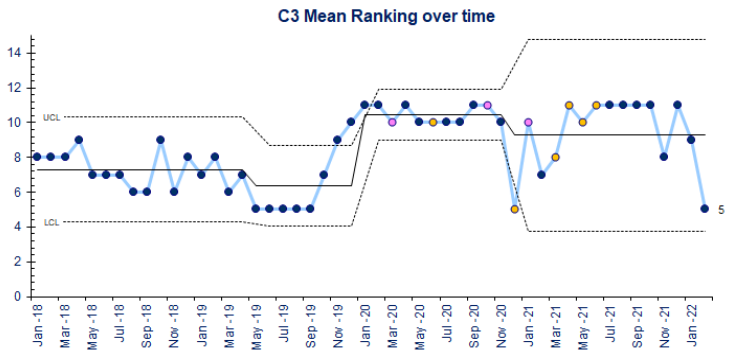


Figure O3.11

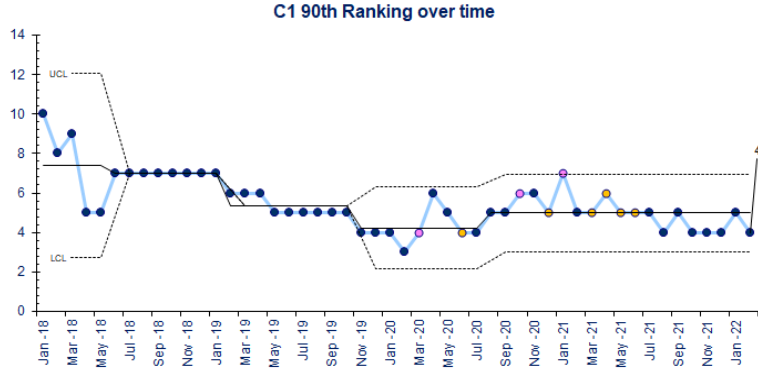


Figure O3.12

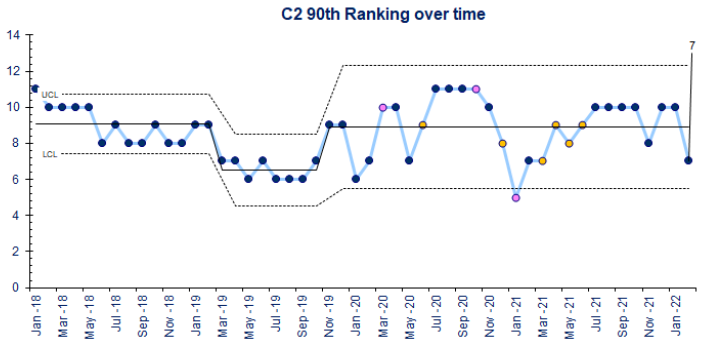
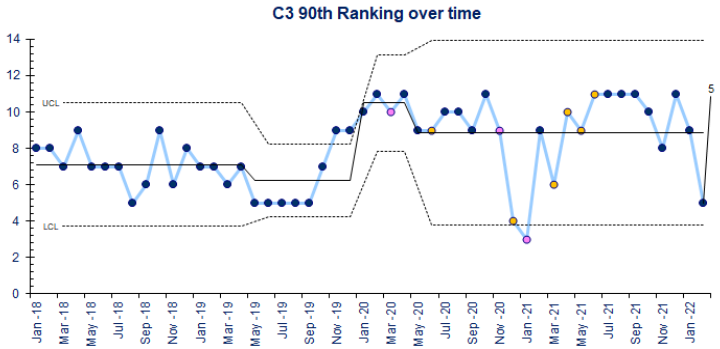


Figure O3.13



Provider	C1 Mean
	06:37
	06:47
	08:11
North West	08:23
	08:32
	08:43
	08:45
	08:51
	08:56
	10:43
	11:39

Provider	C1 90th
	11:28
	11:54
	14:17
North West	14:29
	15:13
	15:47
	16:03
	16:18
	16:31
	19:42
	21:04

Provider	C2 Mean
	0:25:45
	0:27:20
	0:29:45
	0:30:42
	0:32:16
	0:33:36
North West	0:35:34
	0:37:31
	0:48:19
	0:53:44
	1:25:25

Provider	C2 90th
	0:51:03
	0:55:19
	1:02:49
	1:03:41
	1:06:24
	1:11:51
North West	1:18:50
	1:22:05
	1:41:47
	1:57:05
	3:20:06

Provider	C3 Mean
	01:12:21
	01:17:58
	01:21:33
	01:48:23
North West	01:50:16
	02:13:52
	02:26:14
	02:28:05
	02:41:09
	03:03:05
	03:51:49

Provider	C3 90th
	02:54:12
	02:58:23
	03:15:59
	04:23:58
North West	04:26:48
	04:50:46
	05:34:59
	05:55:34
	06:26:43
	07:29:54
	10:32:57

O4 111 PERFORMANCE

Figure O4.1

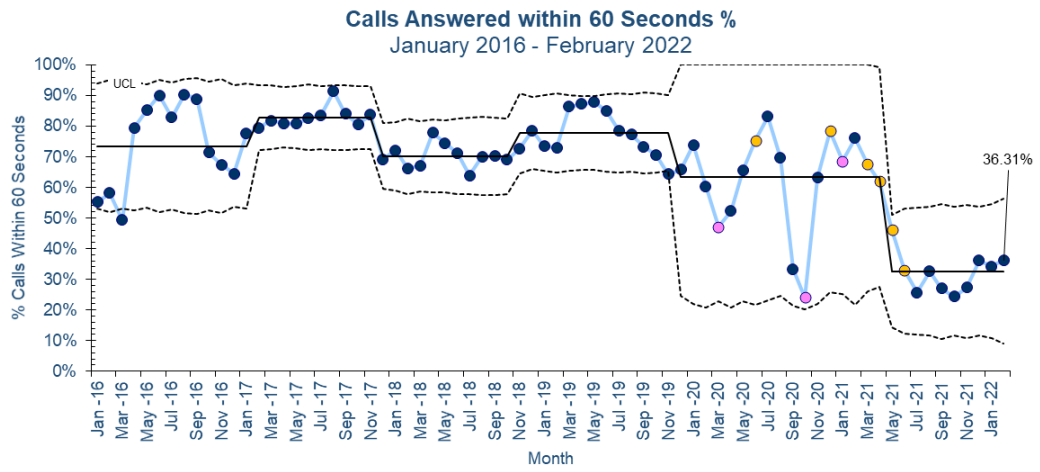
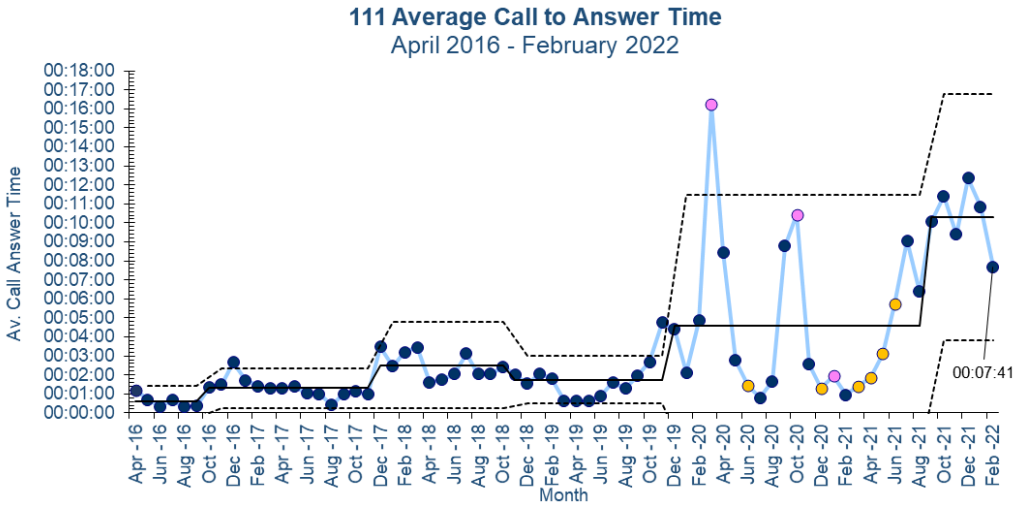


Figure O4.2



* Lockdown Easing of Restrictions

111 Performance

Calls Answered within 60 seconds %

Target: **95%**

NWAS
February 2022: **36.31%**
YTD: **35.81%**

National **54.3%**

Performance for the headline KPI continues to challenge the service. Calls Answered within 60s, Average Call To Answer Time and Calls Abandoned directly relates to available resource (Q4.1).

Calls answered in 60s performance remains below the standard but stable, this is partly due to the significant gap between capacity and demand. The team are currently working with ORH again to demonstrate the change in profile and increase in demand over the last 12 months, it is anticipated this will be used during conversations with commissioners.

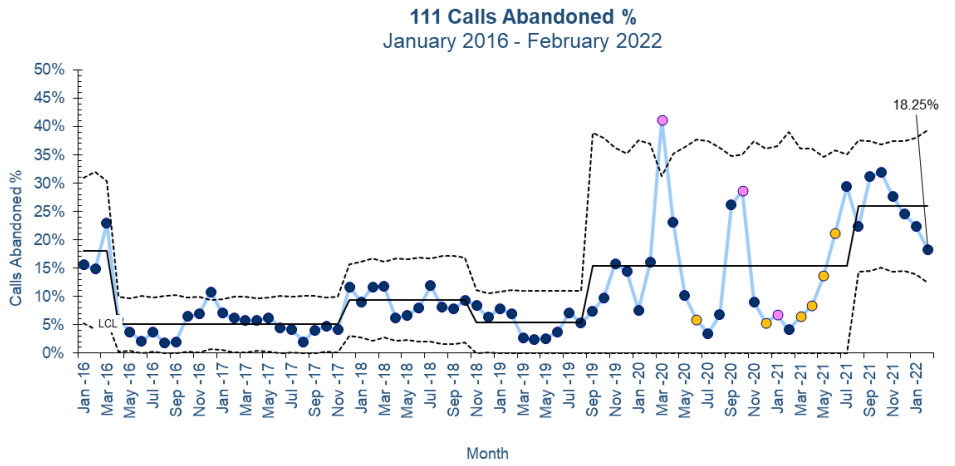
In addition to overall capacity gaps, attrition remains a challenge for the service. Two main factors identified by staff via exit interviews and general feedback are booking of annual leave and access to Team managers due to differing rotas.

A Retention Premium has been introduced for a period of 12 months, It is too early to comment but it is anticipated this will ease attrition during the coming months whilst the Team implement changes to processes to book annual leave and conduct a further rota review (post ORH) that focusses on team-based scheduling.

Call demand in January appears to have stabilised though fell in February which has fewer days, which has helped the workforce planning team in developing the 22/23 capacity plan. Confirmation of future funding remains a risk to the service as many of the support roles that deliver Audit and training capacity are on seconded bases which ends March 2022 extended by 3 months, conversations with finance are scheduled in the coming weeks to review this position.

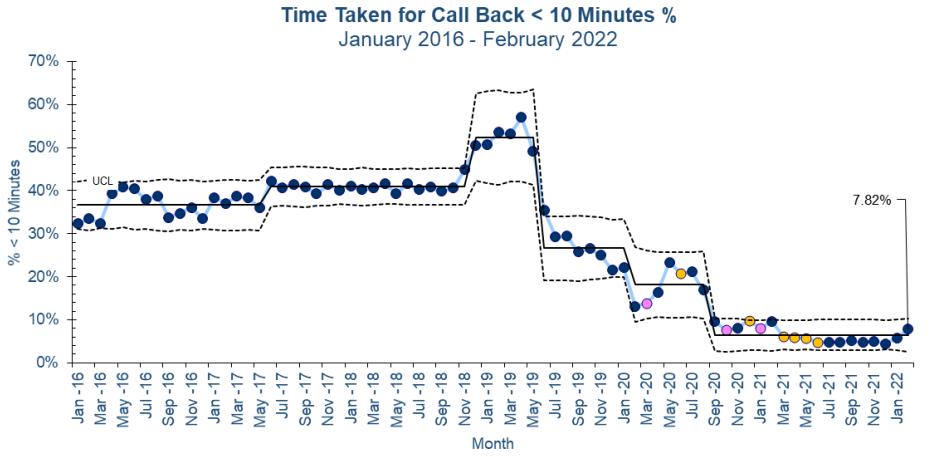
Alongside the 6-point plan that is currently being delivered, a further project to deliver SMS for Self-Care is now in progress with the support of colleagues in NHSD. It is anticipated that this project will deliver a reduction in AHT as self-care advice will no longer be required if the patient is happy to receive an SMS message.

Figure O4.3:



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

Figure O4.4



* Lockdown Easing of Restrictions

Calls Abandoned %
Target: **<5%**

NWAS
February 22: **18.25%**
YTD: **22.97%**

National **12.3%**

Call Back < 10 Minutes %

Target: **75%**

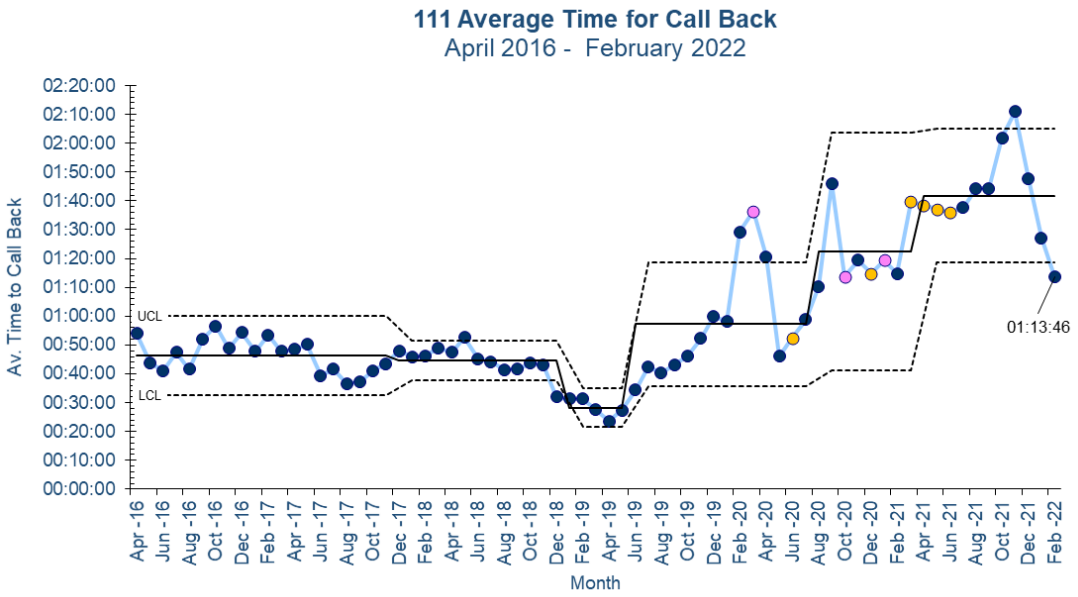
NWAS
February 22: **7.82%**
YTD: **5.03%**

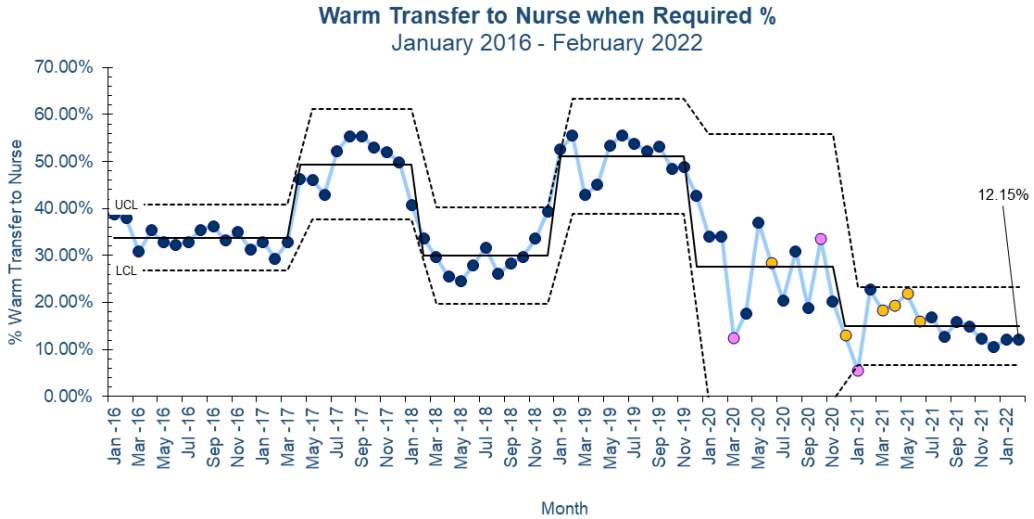
As with previous comments call abandoned directly correlates with the answered in 60 KPI.

Time taken for a call back (10 mins). After stabilising over a number of months has started to gradually improve over the last two months.

The CAQ is managed 24/7 by the Clinical Duty Manager (CDM) and any calls of concerns are flagged for Clinicians to pick up as a priority. February was the fourth month that percentage of calls abandoned fell.

Figure O4.5





* Lockdown Easing of Restrictions

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

NWAS
February 22: **12.15%**

As per previous commentary due to the increase in demand warm transfer to Clinicians has been affected. This has resulted in a 'bottle neck' with health advisors being on hold for prolonged periods of time waiting to get through to the next available clinician. Many of these calls are now checked with the Clinical Duty Manager and were appropriate are then placed on the Clinical advice queue to be called back. This then releases the HA to take another incoming call. The CDM will monitor the CAQ and assign any calls of concern to a clinician to pick up as their next call.

Average call back time has fallen for the last three months and is now below the lower control limit. In November 2021 the average call back was at **2** hours **11** minutes, in February 2022 it is now at **1** hour **13** minutes, seeing nearly **1** hour reduction in average call back wait.

Warm transfer has gradually decreased since May 2021 with and started to stabilise over the last two months.

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY

TOTAL ACTIVITY

	Current Month: January 2022					Year to Date: July 2020 - January 2022			
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	168,290	14,024	8,593	(5,431)	(39%)	140,242	64,968	(75,274)	(54%)
Greater Manchester	526,588	43,882	34,945	(8,937)	(20%)	438,823	258,023	(180,800)	(41%)
Lancashire	589,181	49,098	30,588	(18,510)	(38%)	490,984	231,353	(259,631)	(53%)
Merseyside	300,123	25,010	20,389	(4,621)	(18%)	250,103	151,035	(99,068)	(40%)
NWAS	1,584,182	132,015	94,515	(37,500)	(28%)	1,320,152	705,379	(614,773)	(47%)

UNPLANNED ACTIVITY

	Current Month: January 2022					Year to Date: July 2020 - January 2022			
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	442	(805)	(65%)	12,474	3,806	(8,668)	(69%)
Greater Manchester	49,133	4,094	4,237	143	3%	40,944	31,380	(9,564)	(23%)
Lancashire	58,829	4,902	3,210	(1,692)	(35%)	49,024	24,199	(24,825)	(51%)
Merseyside	22,351	1,863	1,474	(389)	(21%)	18,626	11,792	(6,834)	(37%)
NWAS	145,282	12,107	9,363	(2,744)	(23%)	121,068	71,177	(49,891)	(41%)

ABORTED ACTIVITY

	January 2022								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	155	4,893	3%	38	527	7%	46	3,406	1%
Greater Manchester	1,529	15,588	10%	964	4,483	22%	1,274	16,613	8%
Lancashire	803	15,378	5%	530	3,300	16%	499	13,067	4%
Merseyside	489	7,727	6%	212	1,642	13%	643	11,608	6%
NWAS	2,976	43,586	7%	1,744	9,952	18%	2,462	44,694	6%

PTS Performance

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

Activity during January 2022 was **28%** below contract baselines with Lancashire 38% below contract baselines whilst Merseyside is operating at **-18%** (**-4621**) Journeys below baseline. For the year to date position (July 2020 - January 2022) PTS is performing at **-47%** (**-614773** journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at **54%** and **53%** below baseline whilst Greater Manchester and Merseyside are operating at **41%** and **40%** below baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are **-23%** (**-9564** journeys) and **-37%** (**-6834** journeys) against baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges achieving contract KPI performance. Cumbria and Lancashire are **-69%** (**-8668** journeys) and **-51%** (**-24825** journeys) below baseline.

In terms of overall trend analysis, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas.

Aborted activity for planned patients averaged **7%** during January 2022 however Cumbria experiences **3%**, Greater Manchester operates with **10%** whilst Lancashire and Merseyside both experience **5% & 6%** aborts respectively. There is a similar trend within EPS (renal and oncology) patients with an Trust average of **6%** aborts whereas Cumbria has **1%** and Greater Manchester **8%** Lancashire and Merseyside operate with **4%** and **6%** respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average **18%** (1 in 6 patients) with variances of **7%** in Cumbria, **22%** in Greater Manchester, **16%** in Lancashire and **13%** Merseyside.

The impact of the temporary transfer of workforce is being managed via retention of additional levels of third-party support i.e., double staffed ambulance resources to help manage capacity challenges associated with social distancing measures which continue to impact utilisation of resource.

Discussions continue with commissioners and colleagues internally with respect to a new service model(s) for PTS with a view to the procurement of a new service due to commence in April 2023 and as reported previously outputs from these discussions are reported at the UEC Oversight Forum.

Planned digital work will enable future reporting of PTS performance over time.

OH1 STAFF SICKNESS

Figure OH1.1

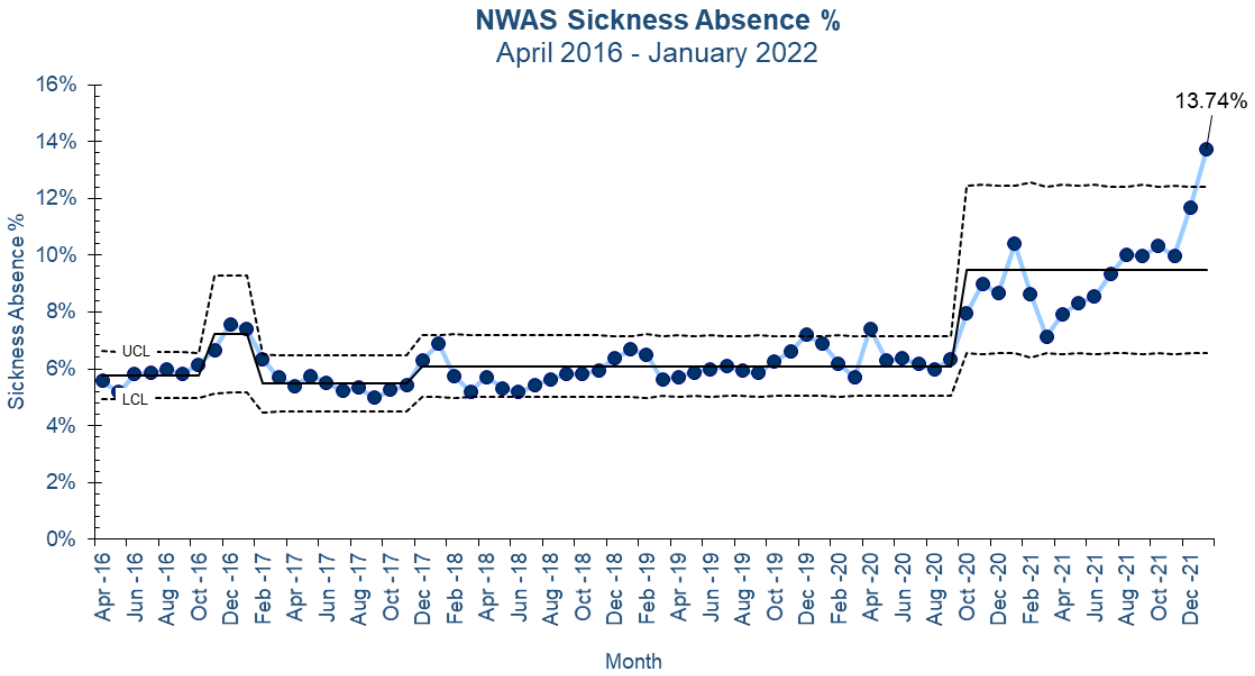


Table OH1.1

Sickness Absence	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec -21	Jan-22
NWAS	8.65%	7.15%	7.90%	8.32%	8.55%	9.33%	10.00%	9.97%	10.32%	9.97%	11.66%	13.74%
Amb. National Average	7.03%	6.06%	6.36%	6.59%	6.98%	7.73%	8.17%	8.22%	8.32%			

Staff Sickness

The overall sickness rate for January 2022 was **13.74%** (OH1.1). Sickness has increased steadily over 11 months since February 21, where the result now sits above the upper control limit as special cause variation.

The impact of COVID related sickness has increased significantly to from 2.2% in December to 5.8% in January 22 (OH1.2). The underlying non-COVID position has decreased from **9.4%** to **8.%** which is higher than the same period last year of **6.1%.**

Data analysis shows the top 5 reasons for absence being Mental Health, Covid, Injury, MSK and Back problems.

The percentage of long term sickness (LTS) absence shows a material increase on previous years. This reflects the impact of the pandemic on underlying wellbeing, delayed elective surgery and COVID changes to national terms and conditions. Short-term sickness in 111 and EOC is high which is likely to be as a result of sustained demand on the service combined with a higher prevalence of short term COVID absence. The full impact of the Omicron variant creating additional sickness and isolation is now clearly showing in the data sets.

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

A dedicated Attendance Improvement Team has been established to focus on supporting operational teams to improve attendance management and wellbeing. A detailed Action Plan has been developed alongside working with NHSEI and the Ambulance Sector on specific areas of best practice. A deep dive will be presented to Resources Committee at a future meeting.

Figure OH1.2:

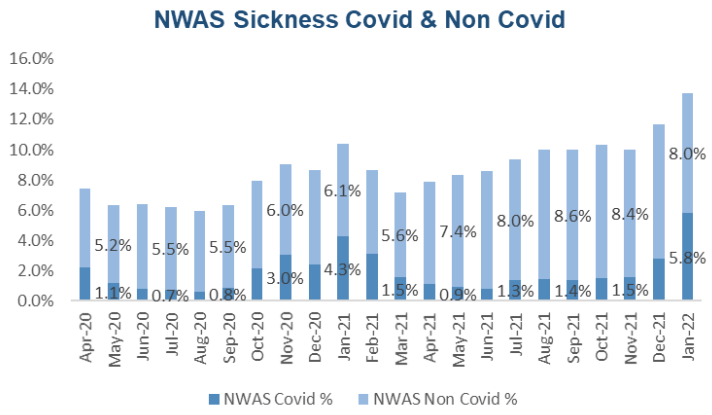


Figure OH1.3:

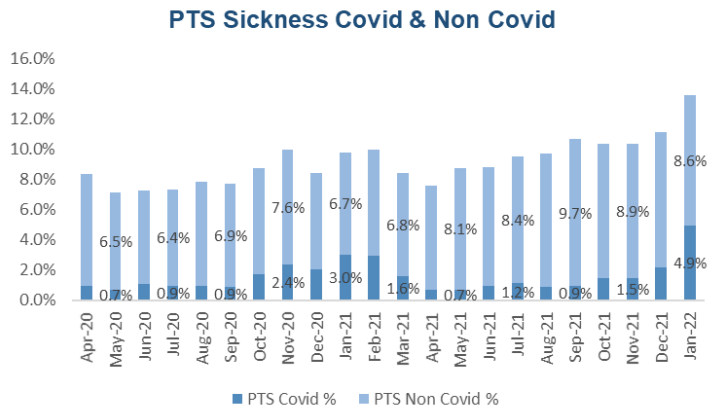


Figure OH1.4:

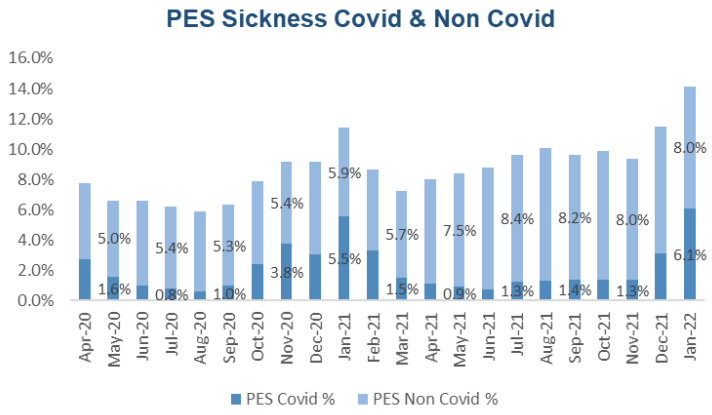
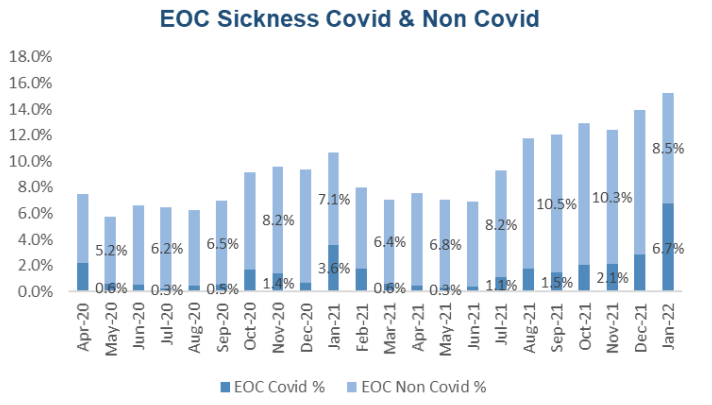


Figure OH1.5:



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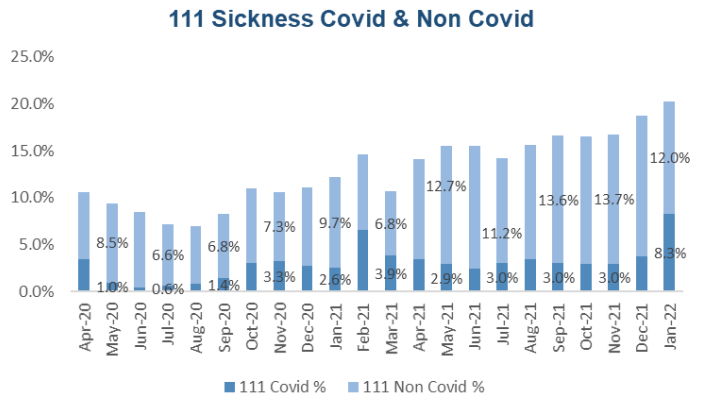

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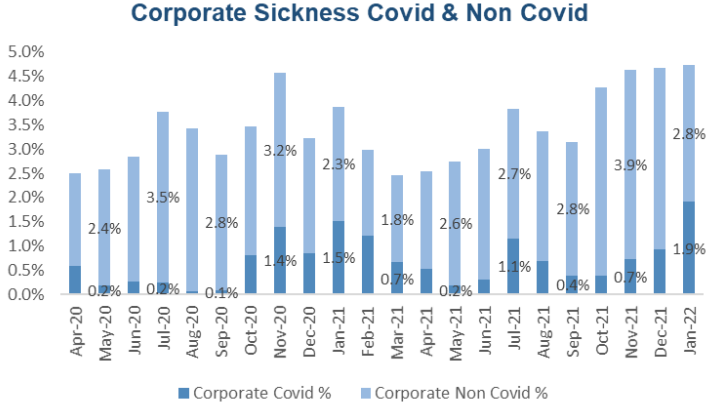


OH2 STAFF TURNOVER

Figure OH2.1

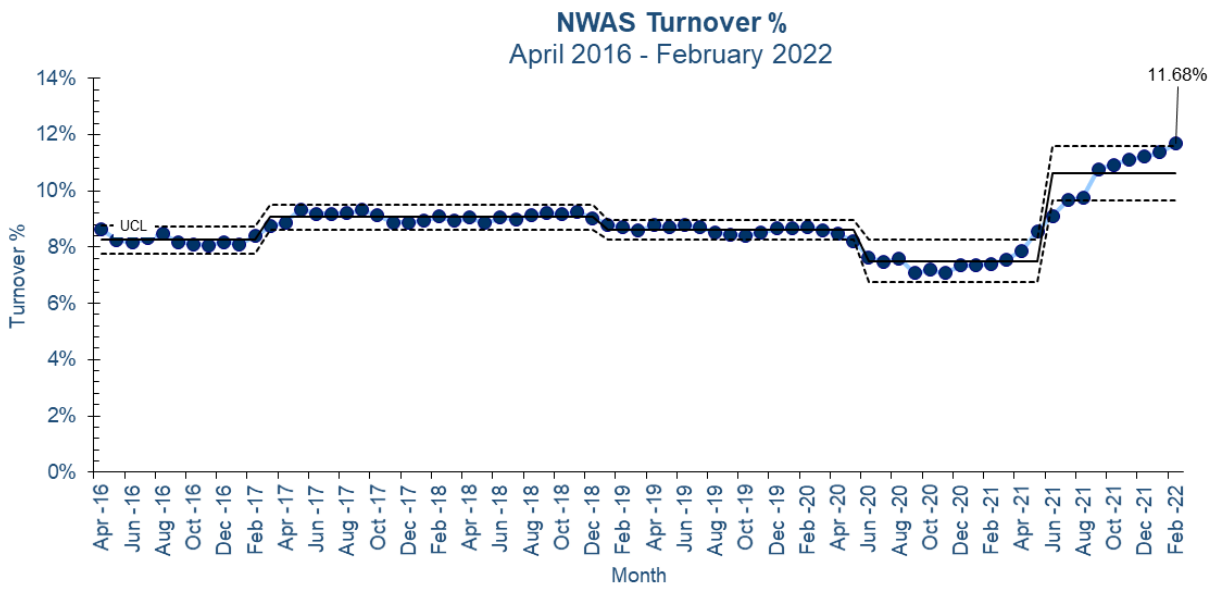


Table OH2.1

Turnover	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
NWAS	7.57%	7.87%	8.56%	9.10%	9.67%	9.77%	10.76%	10.93%	11.11%	11.21%	11.37%	11.68%
Amb. National Average	7.35%	7.57%	7.52%	8.07%	8.44%	8.85%	9.25%	9.69%	10.09%			

Staff Turnover

Staff turnover for February 22 is **11.68%**. This is calculated on a rolling year average.

Staff turnover has shown a steady increase in the last 11 months and is at the upper control limit. This position is replicated across the sector. 111 turnover is showing a significant upward trend to **46.82%** in February 2022 which is outside of the upper control limit (OH2.5). EOC turnover is also outside the upper control limit.

The Trust is working across the Ambulance Sector and with NHSEI on specific targeted interventions to support 111 retention including the retention payments that NWAS have applied. It is too early to assess the impact of these payments. Further national work around EOC retention is also ongoing.

EOC has also seen an increase with February 22 turnover at **16.06%** (OH2.4), it is up on previous months. Some of this reflects the loss of fixed term staff seeking permanent positions elsewhere. However, the EOC staffing position is stable moving into the roll out of Single Primary Triage given the levels of over-recruitment which have taken place.

PES turnover is showing an upward trend, however this is broadly in line with pre-COVID levels. Turnover amongst Paramedics to primary care has not materialised to any extent in 2021/22 but further analysis on emerging turnover trends is being undertaken

NHS turnover is typically between **10%** & **12%** according to NHS SBS. (Shared Business Services)

Figure OH2.2

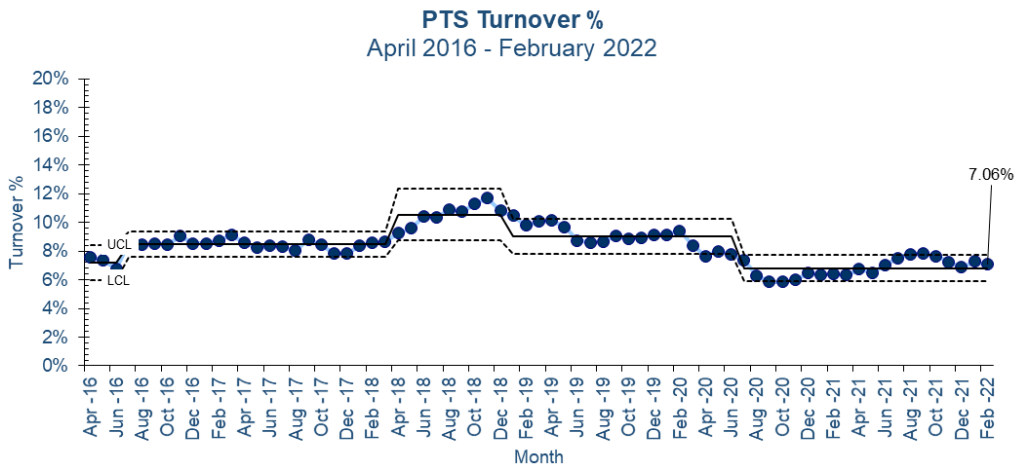


Figure OH2.3

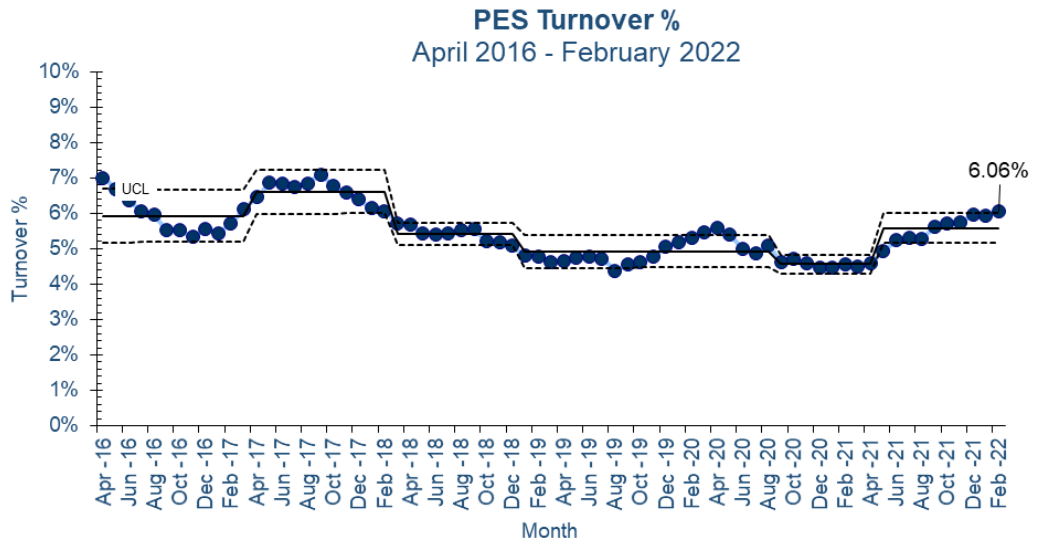


Figure OH2.4

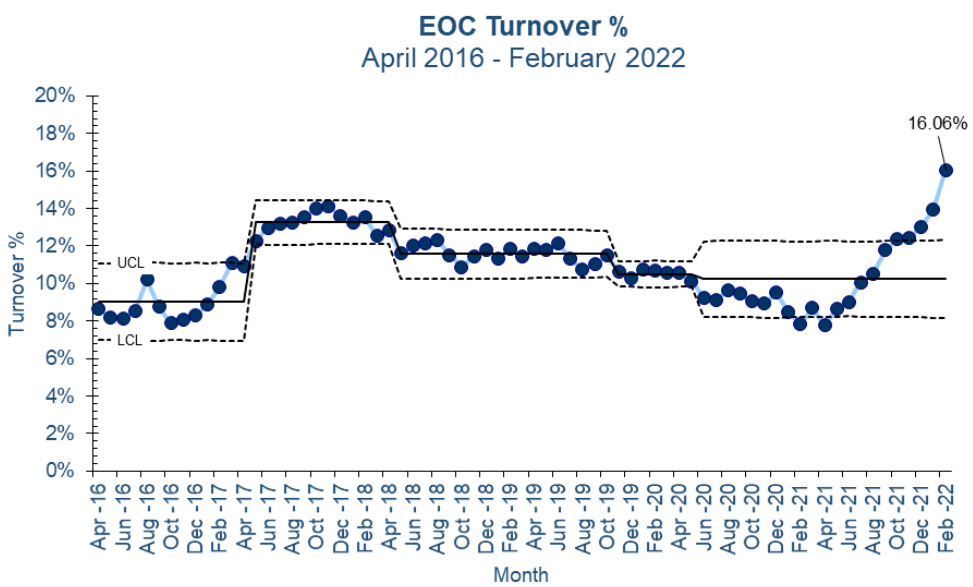
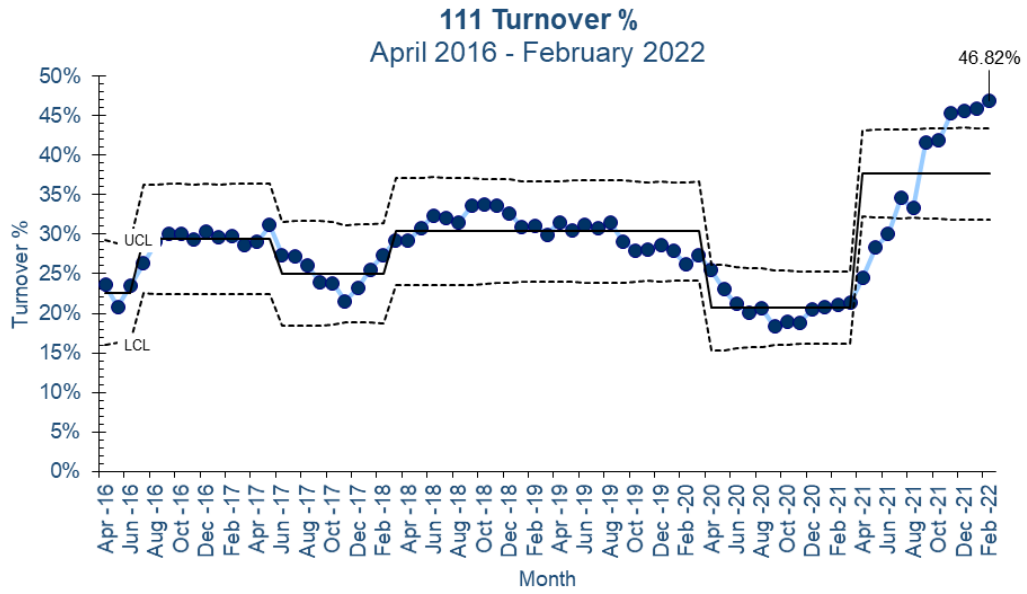
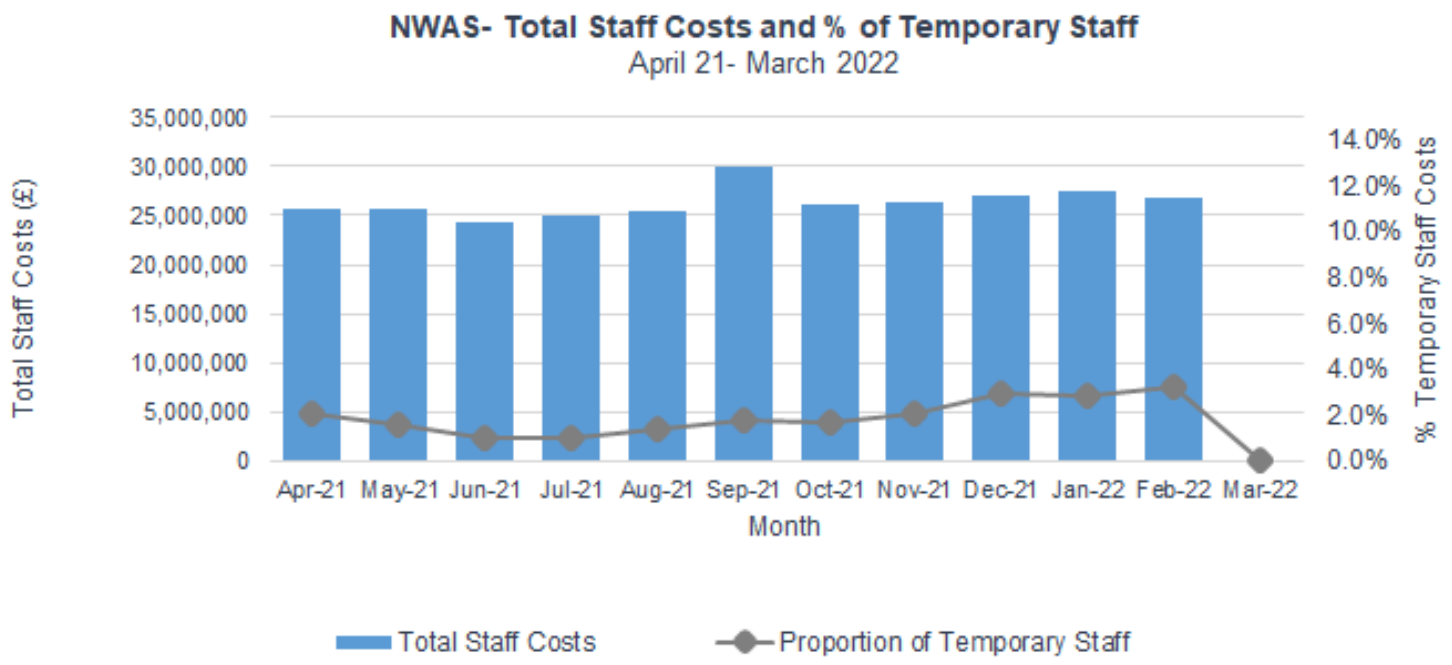


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

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

Agency staff have continued to support the Contact Centre environment.

111 had temporary funding to recruit into Service Advisor posts for a 3 month period. To support ongoing recruitment, these Agency staff are being considered at the end of the 12 week period to transfer on to a Trust contract to support vacancy gaps overall. Therefore, these staff should be moving to a Trust contract by the end of the financial year.

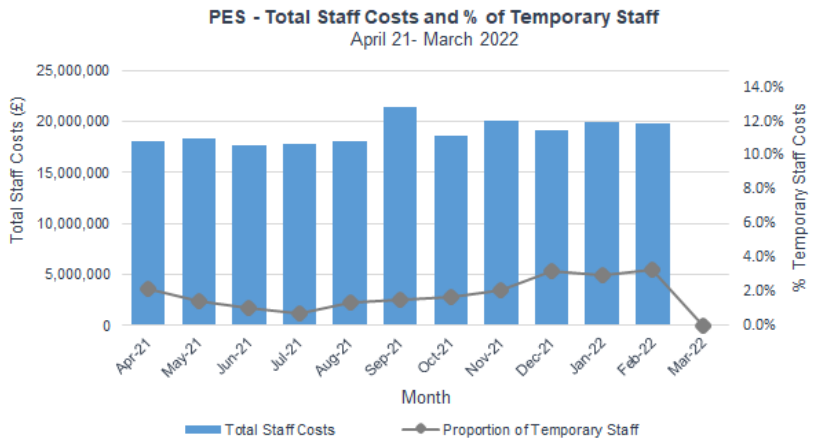
Overall there are **199** agency staff supporting EOC call taking. **75** are due to transfer to Trust contracts by the end of March 22 with the remainder by the end of Q1.

Current agency usage is therefore anticipated to continue across Q4 but reduce into Q1.

Table OH4.1

NWAS	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Agency Staff Costs (£)	647,483	541,873	404,321	245,748	241,475	356,466	518,275	444,941	553,502	796,039	783,115	864,691
Total Staff Costs (£)	48,192,045	25,673,168	25,780,966	24,317,963	24,909,469	25,379,411	29,910,317	26,091,860	26,356,720	26,930,619	27,466,754	26,722,244
Proportion of Temporary Staff %	1.3%	2.1%	1.6%	1.0%	1.0%	1.4%	1.7%	1.7%	2.1%	3.0%	2.9%	3.2%

Figure OH4.2:



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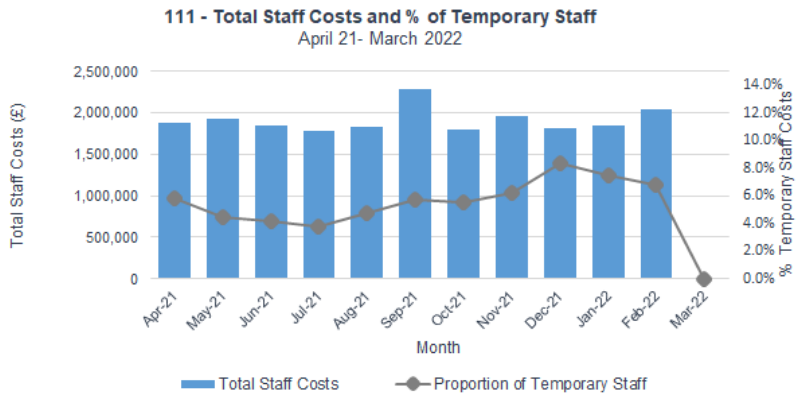

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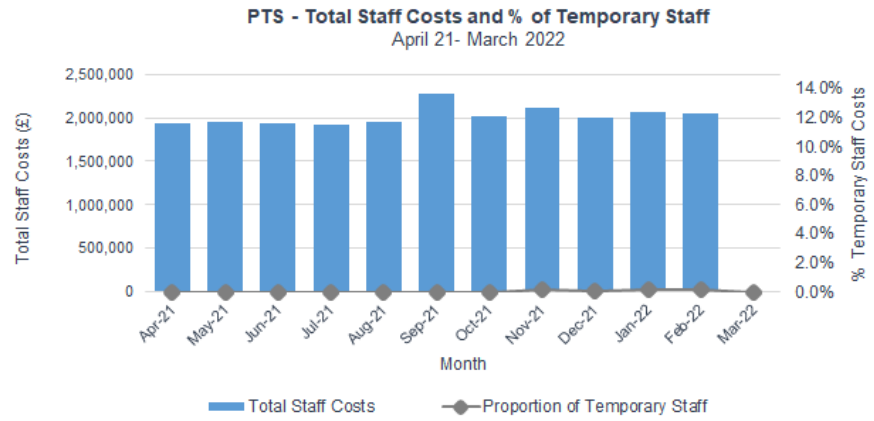
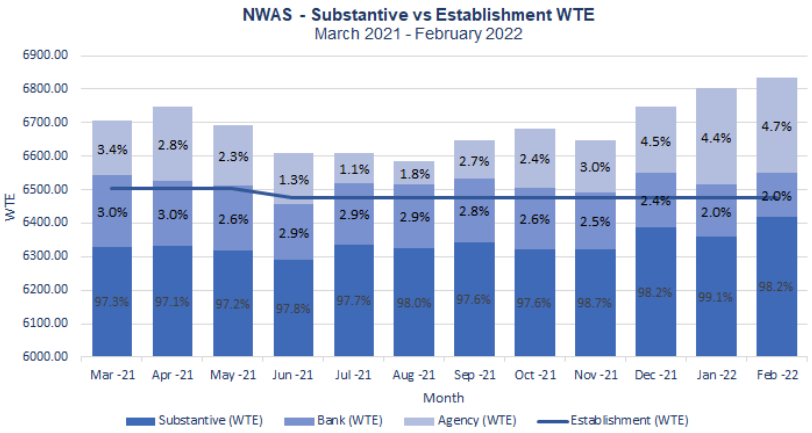


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

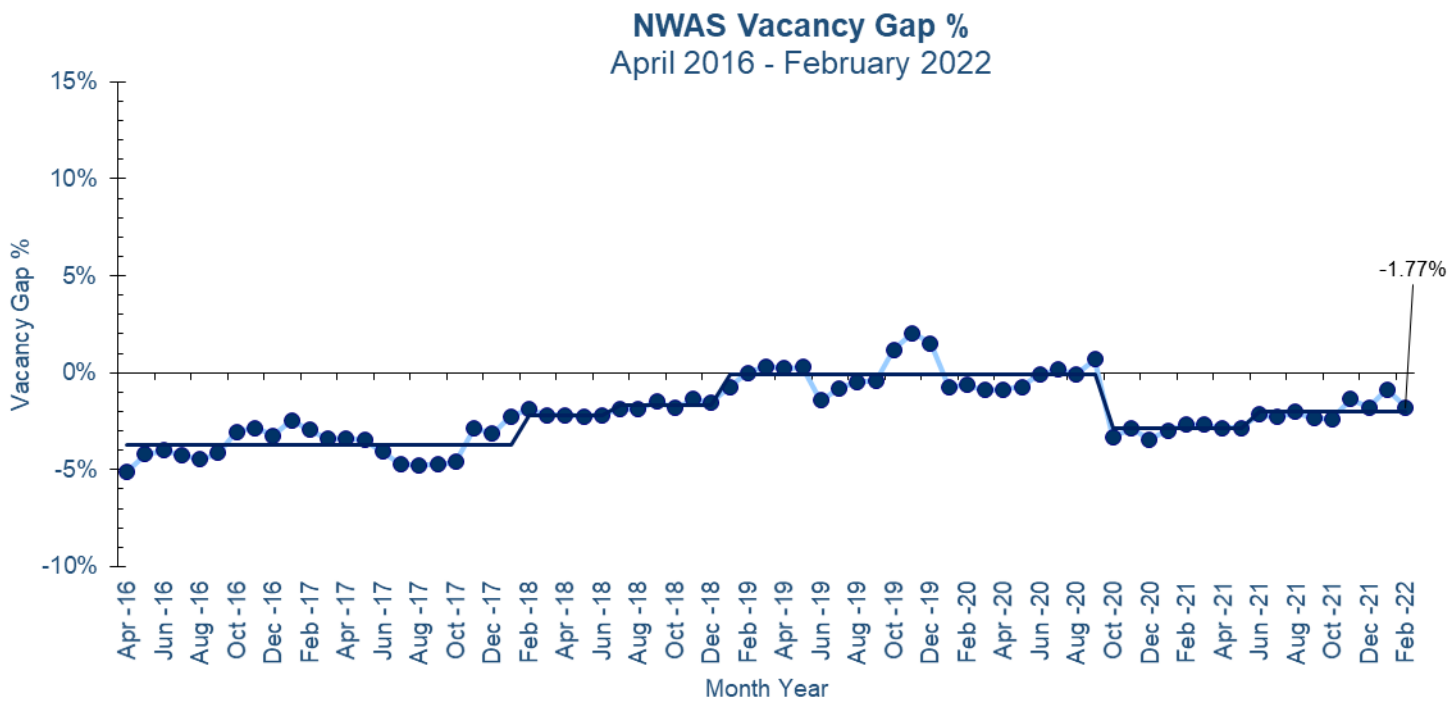


Table OH5.1

Vacancy Gap	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
NWAS	-2.97%	-2.68%	-2.67%	-2.86%	-2.85%	-2.16%	-2.30%	-2.03%	-2.36%	-2.37%	-1.35%	-1.78%	-0.87%	-1.77%

Vacancy Gap

Chart OH5.1 shows the vacancy gap at **–1.78%** reflecting overall a positive position.

Although recruitment plans for 111 are on track the vacancy position is a gap of -**13.95%** (OH5.5). This is a slightly improved position. This is mainly a combination of vacancies and high turnover which has moved the service into a deficit position. The recruitment plan focuses on maximising Health Advisor and Clinical Advisor recruitment. Additional Agency staff recruited for an initial 12 week period will be moving to Trust contracts by the end of the Financial Year impacting positively on the gap.

The PTS vacancy position (OH5.2) shows a reducing gap resulting from robust recruitment plans to replace PES upskill staff taking up apprentice EMT1 positions. The temporary workforce agreement that was in place because of Covid ends on 31st March with some staff anticipated to return to PTS which should ease the vacancy position.

PES position (OH5.3) shows the positive impact of plans to maximise recruitment into PES during Q4 and are **2.25%** over-established. This is primarily the Paramedic workforce.

The substantive EOC position shows at **–0.9% below** establishment and has shown a decreasing trend. This does not reflect the recruitment via agency which has been the route of all winter recruitment. The combined position is that EOC is currently **+194** over-established which equates to 35%.

Figure OH5.2

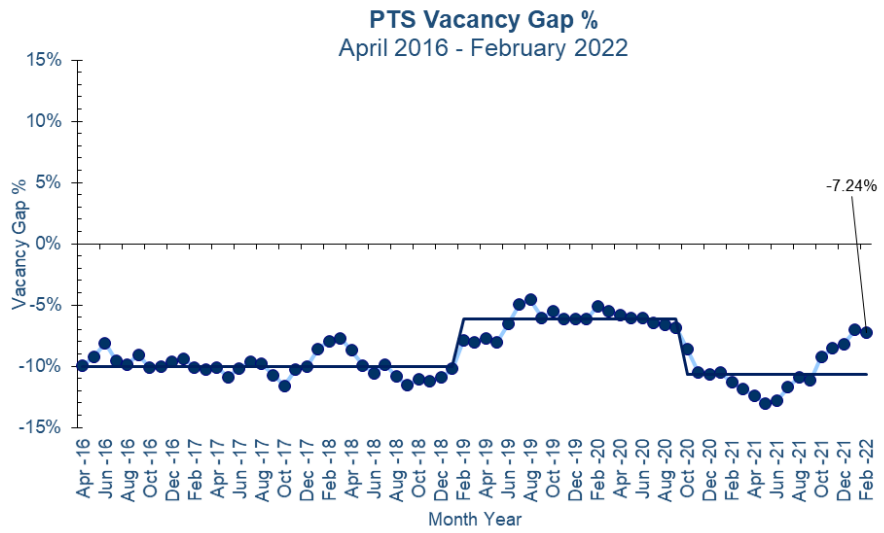


Figure OH5.3

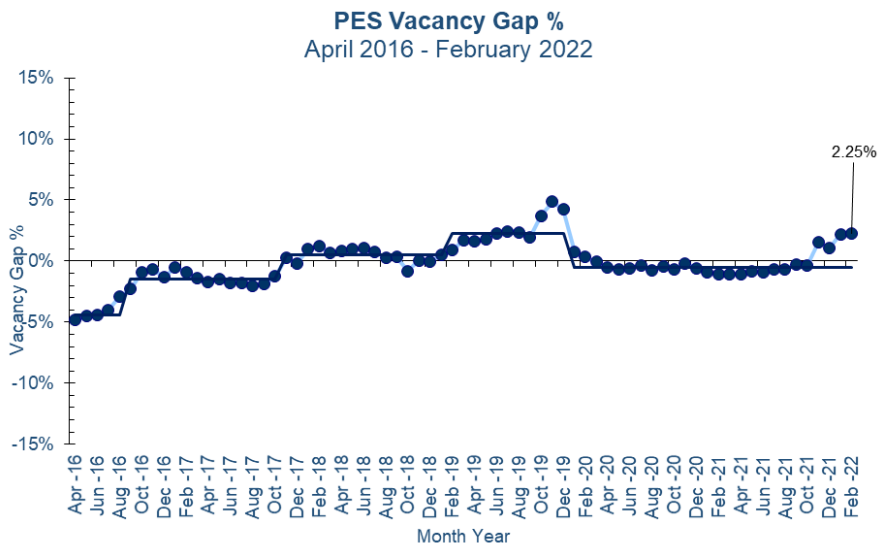


Figure OH5.4

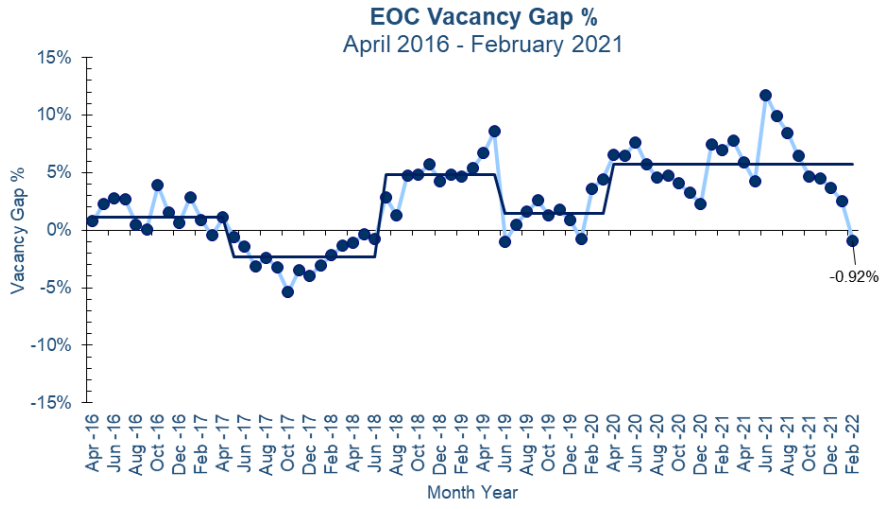
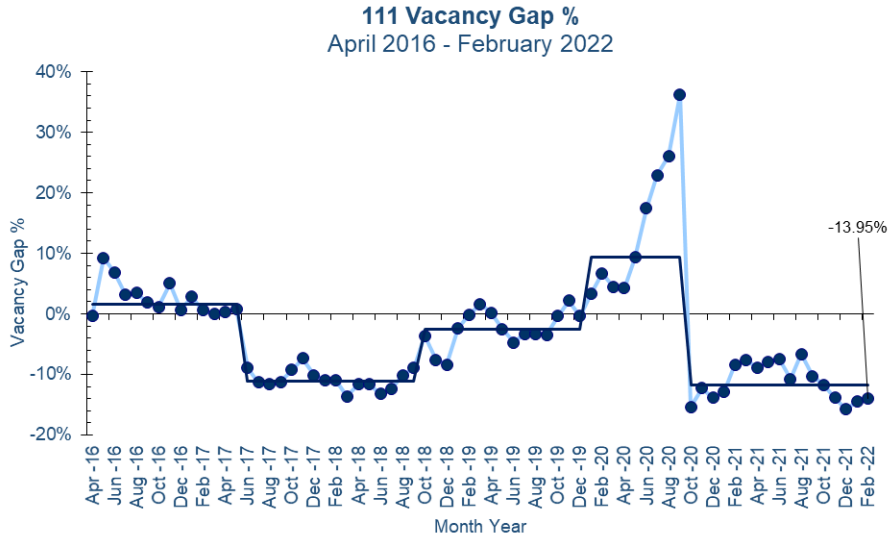


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

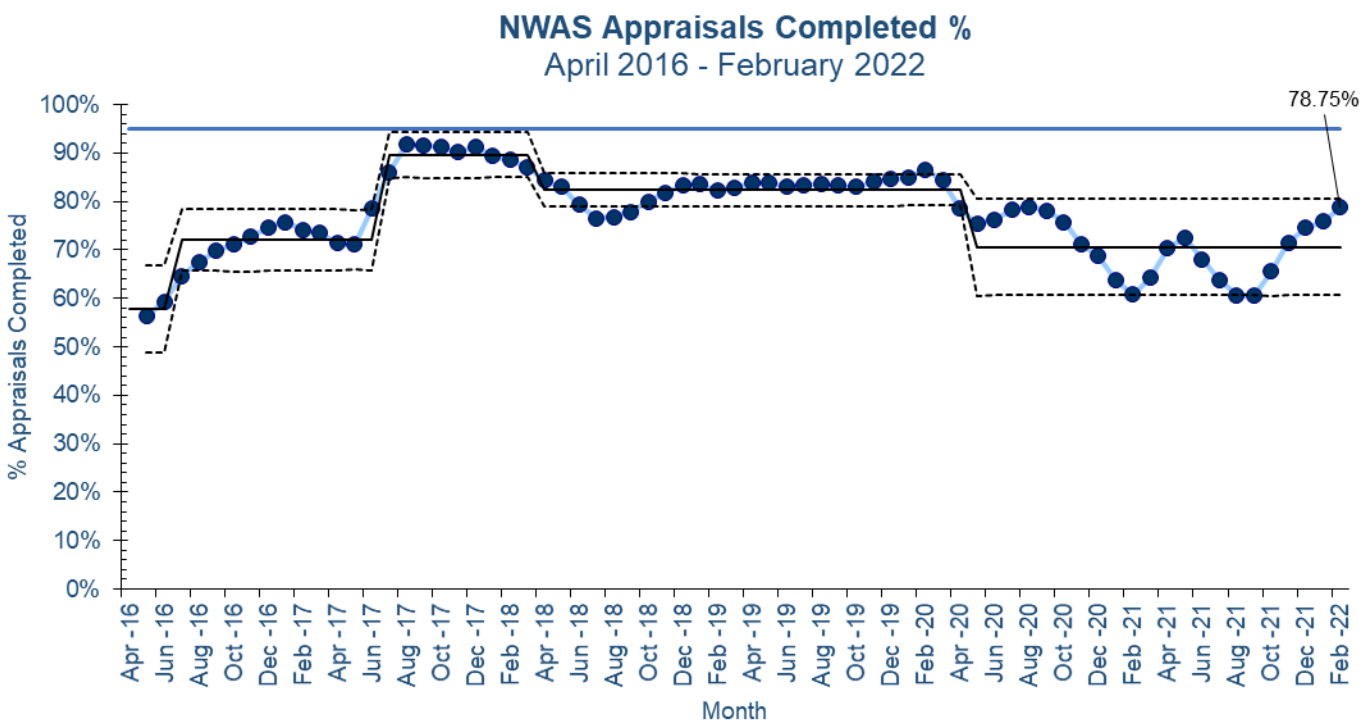


Table OH6.1

Appraisals	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
NWAS	64%	70%	73%	68%	64%	61%	59%	65%	72%	75%	76%	79%

Appraisals

Appraisal completion rates are at **79%** for February 22 (OH6.1) which is an improved position. This exceeds the recovery targets set by ELC are:

75% of Appraisals by March 22 – Service Lines
85% of Appraisals by March 22 – Corporate and Band 8a and above.

The previous dip in the summer was caused by operational pressures and the move to Reap 4 which has impacted on compliance, but good progress has been seen and maintained through the winter period.

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

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

PES rates are at 80% which is significant progress and EOC have also made good progress at 63%. PTS are at 87.9% with 111 at 76.2%.

Figure OH6.2

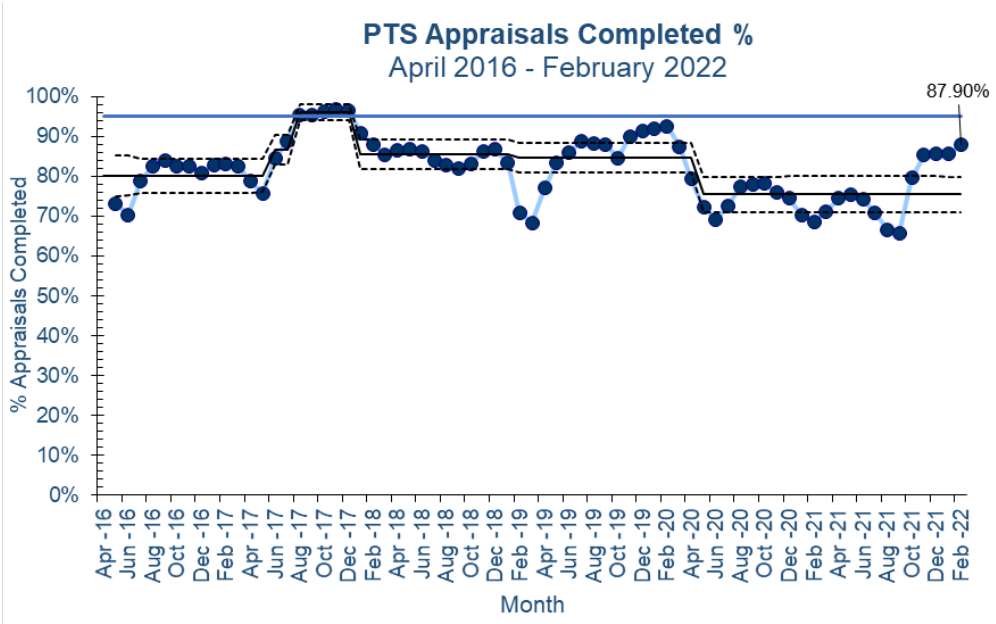


Figure OH6.3

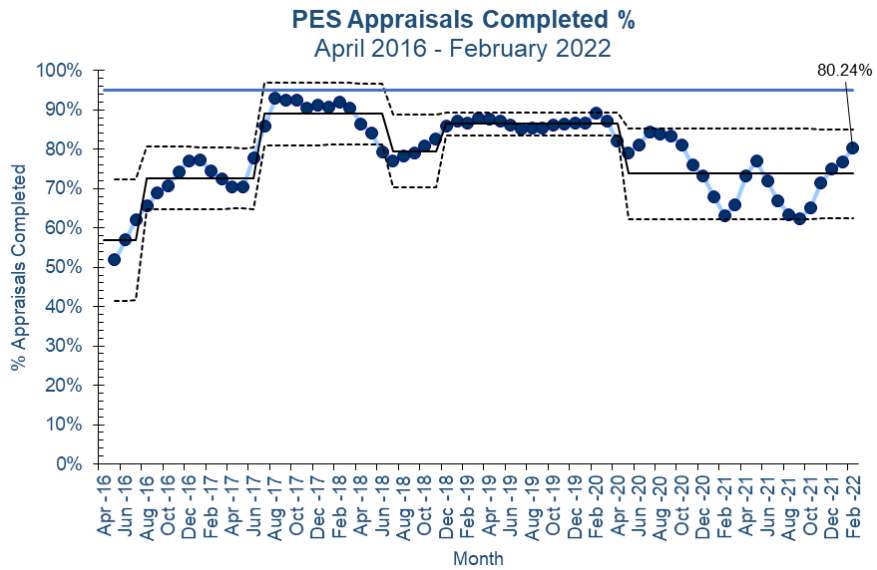


Figure OH6.4

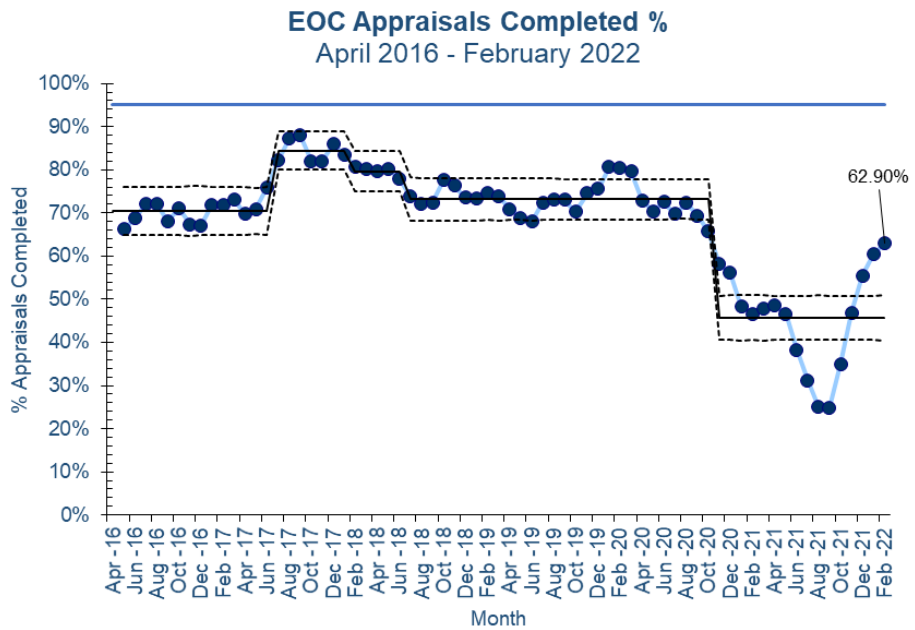
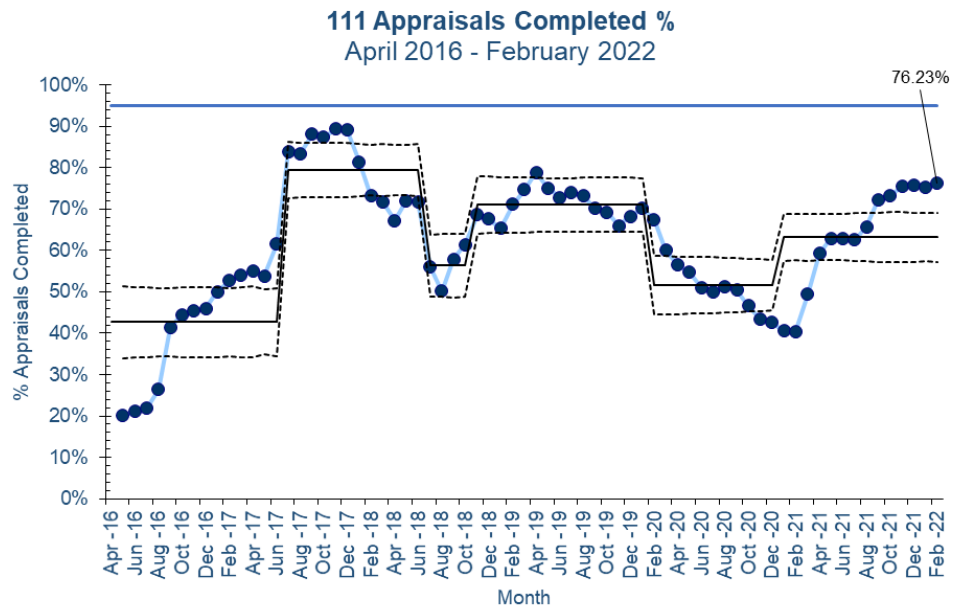


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

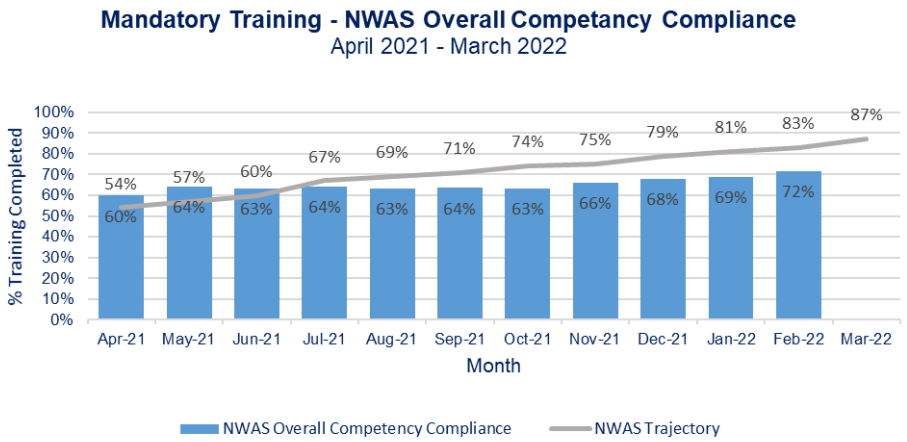
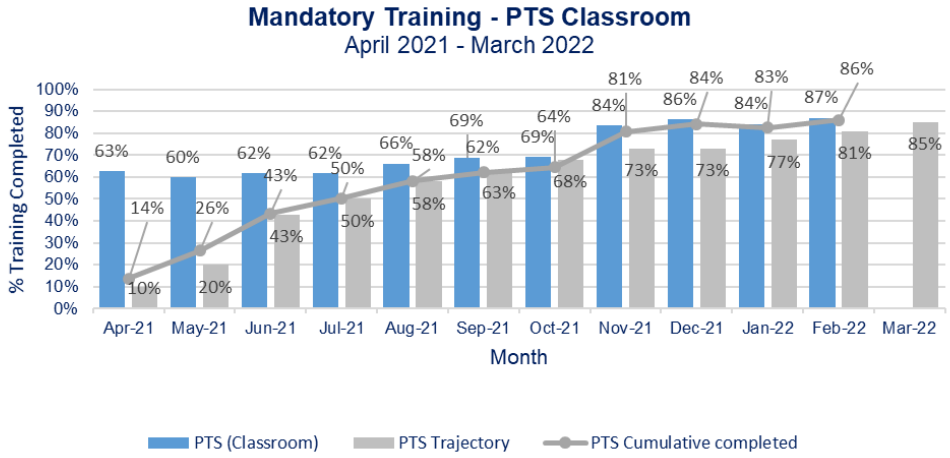


Figure OH7.2



Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and runs across the financial year. Mandatory training has been impacted by operational pressures and Reap escalation leading to a period in excess of 3 months where training has been paused.

Recovery plans have been reviewed and the programme is being extended through until the end of May 2022 with a target to achieve **75%** compliance. Corporate Services targets remain at **95%** compliance.

Please note that the graphs still reflect the targets and trajectories prior to the recent ELC decision. These are being worked through and will be revised for the next IPR.

PTS (OH7.2 **86%**) and 11 1 (OH7.5 **85%**) have already exceeded target and continue to improve.

Corporate teams (OH7.6) are at **91%** compliance which should enable the target to be met by March.

The EOC recovery plan has delivered improved compliance since September which now meets the **75%** target.

The key risk areas is PES . Classroom mandatory training has been paused in January for PES and PTS in order to facilitate training for the army deployment. PES classroom attendance was at trajectory at pause but online completions are also behind plan leaving overall compliance for PES at **64%** with classroom compliance at **54%**. There are capacity and operational capacity issues impacting on classroom attendance but the agreed extension should facilitate delivery of the target.

Figure OH7.3

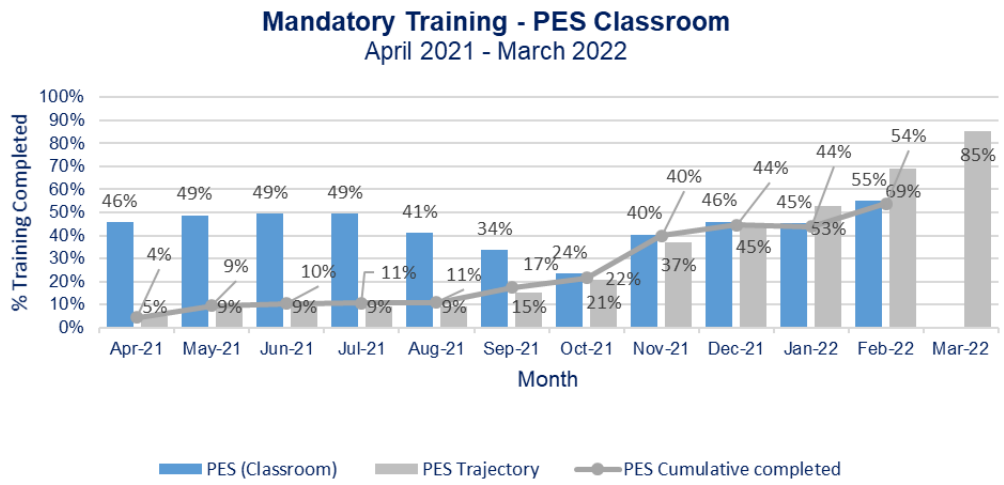


Figure OH7.4

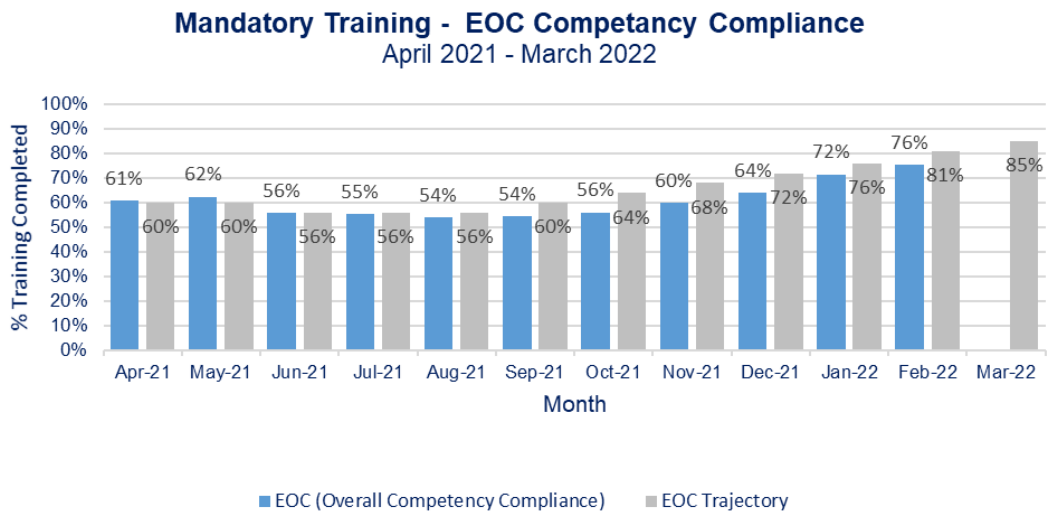


Figure OH7.5

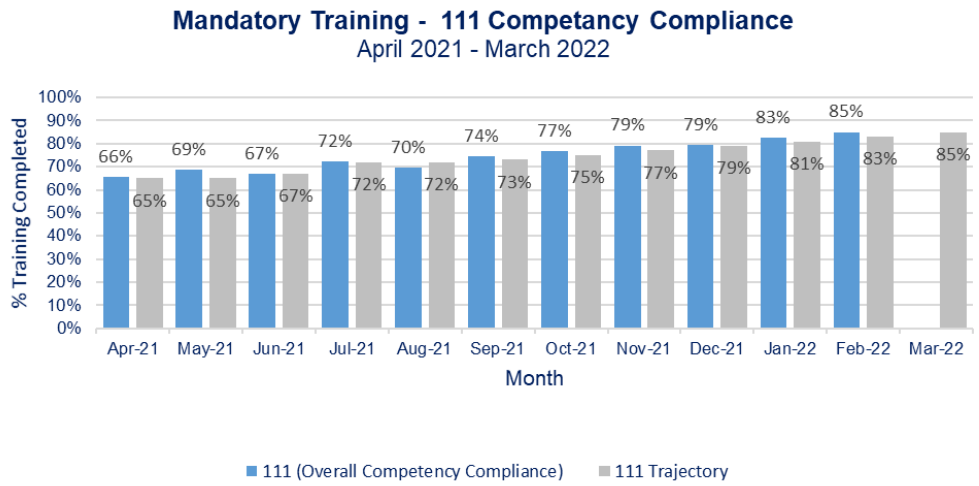
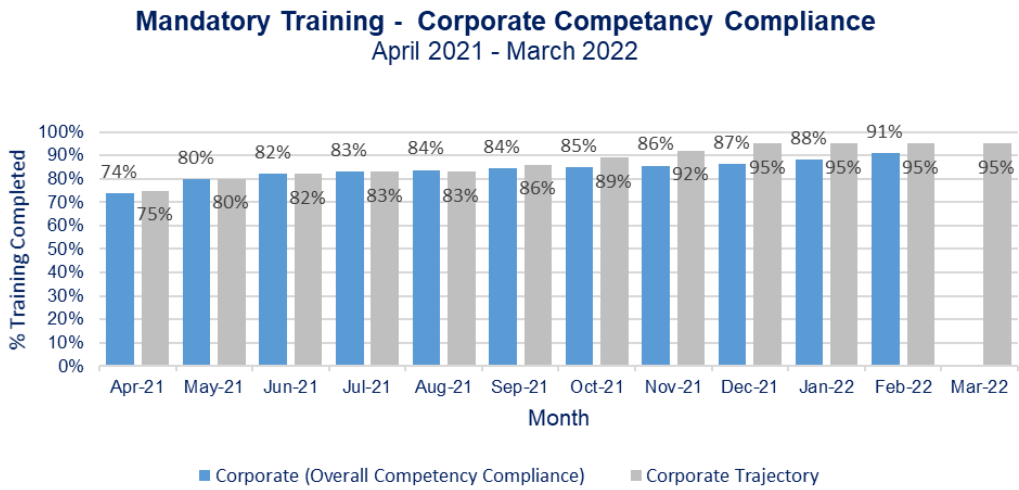


Figure OH7.6



OH8 CASE MANAGEMENT

Employee Relation Dashboard @ 08 February 2022 All information related to Dignity at work, Disciplinary, Fact Finding/Investigation and Grievance cases only

NWAS Summary

Service Line	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	39	140	12.79
Operations ~ EOC	8	23	12.02
Operations ~ Resilience	0	0	14.59
Operations ~ 111	7	34	6.97
Operations ~ PTS	3	27	12.09
Corporate	5	9	14.35
Other*	16	31	15.29
NWAS Summary	78	264	11.01

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

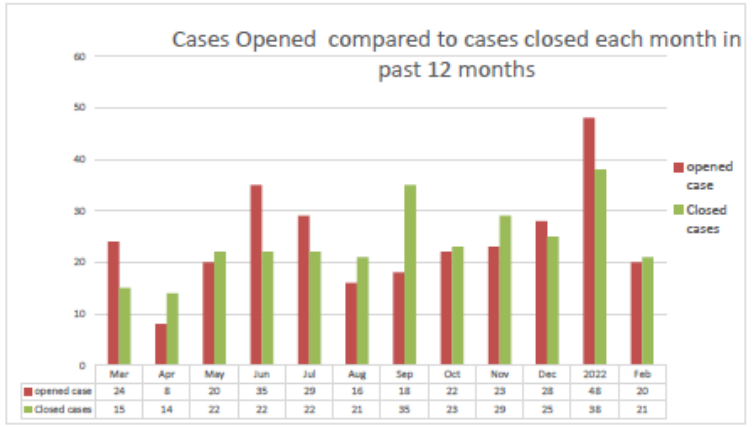
Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	15	41	14.34
Disciplinary	8	59	26.50
Fact Finding/Investigation	41	73	10.43
Grievance	14	91	16.49
Case Summary	78	264	10.98

Reason for opening Disciplinary cases in the past 12 months

Opening reason	Number of cases in 12 months
Any action that brings the trust in disrepute	2
Assault/Threatening behaviour	1
Breach of Health and Safety	1
Clinical Error	4
Conviction of a Criminal Offense	1
Fraud	3
Inappropriate/Unprofessional Behaviour	13
Negligent Behaviour	1
On-Going lateness	1
Poor Patient Care	2
Failure to follow reasonable Management instructions/procedures	1
Victimisation/Bullying and Harrassment	2
NWAS Summary	32

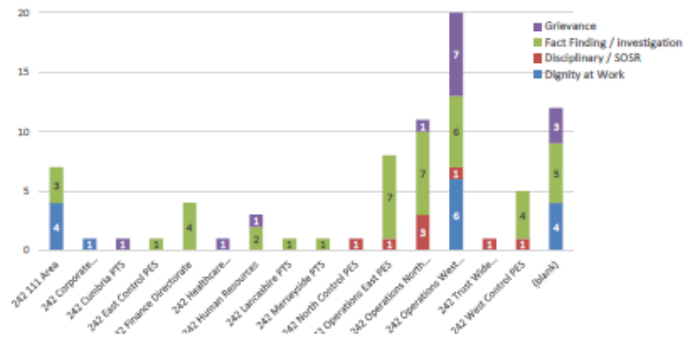
*table shows a rolling 12 months so can go down as well as up



Length of current live cases

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	10	2	1	2
Grievance	8	4	2	0
Fact Finding/Investigation	25	8	7	1
Disciplinary / SOSR	7	0	1	0
Case Total	50	14	11	3

Currently open grievance, Disciplinary and Dignity at work and Fact Finding cases by area



Human Resources Case Management

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

The HR case management position continues to show high numbers as a result of the pause in progressing ER casework due to COVID-19.

February sees a return to a positive position of more cases being closed than opened in month, following pressures in December and January, where closure had been impacetd by winter pressures and VCOD.

The length of current live cases also shows a reduction in cases between 3-6 months and those more than 6 months which is indicative of earlier closure of new cases. There remains some challenges in closure of some longstanding cases often linked with long term sickness absence, level of complexity or involvement of external parties such as police.

There has been **20** pre-investigation review panels considering over **113** cases ensuring appropriateness of entry into formal process, welfare support and resources required for investigation. This is reducing the number of cases entering formal processes with **40%** of cases have been deflected to informal conclusion, learning or no further action.

Progress in improving timeliness is also impacting positively on FTSU cases.

COVID 19

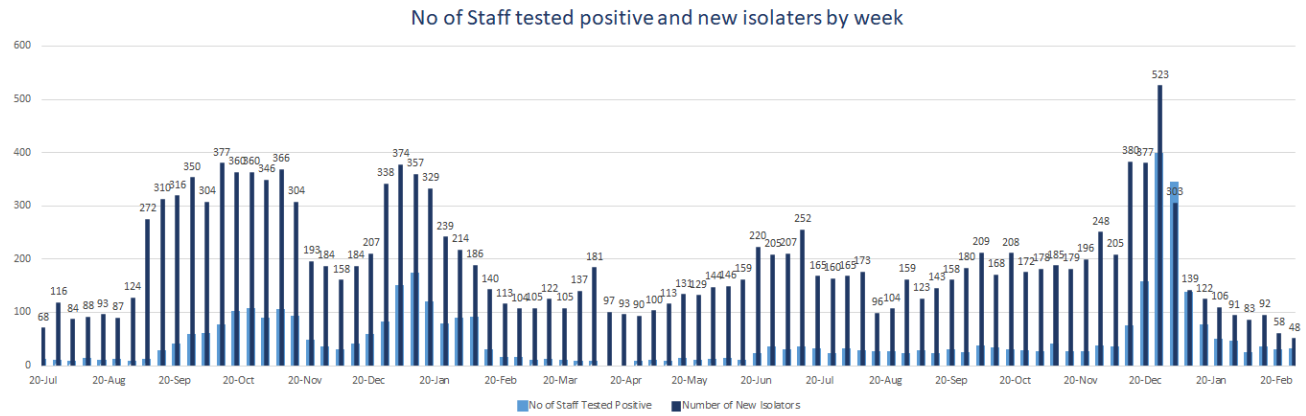
Table CV19.1 – Number of staff tested positive by week

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	17-May	8
27-Jul	3	24-May	4
03-Aug	1	31-May	5
10-Aug	7	07-Jun	7
17-Aug	3	14-Jun	4
24-Aug	5	21-Jun	17
31-Aug	2	28-Jun	28
07-Sep	6	05-Jul	24
14-Sep	22	12-Jul	29
21-Sep	34	19-Jul	26
28-Sep	53	26-Jul	17
05-Oct	54	02-Aug	26
12-Oct	71	09-Aug	21
19-Oct	96	16-Aug	19
26-Oct	101	23-Aug	20
02-Nov	83	30-Aug	17
09-Nov	99	06-Sep	22
16-Nov	87	13-Sep	17
23-Nov	42	20-Sep	24
30-Nov	28	27-Sep	18
07-Dec	24	04-Oct	30
14-Dec	34	11-Oct	27
21-Dec	52	18-Oct	23
28-Dec	75	25-Oct	21
04-Jan	144	01-Nov	19
11-Jan	168	08-Nov	35
18-Jan	113	15-Nov	20
25-Jan	72	22-Nov	19
01-Feb	83	29-Nov	30
08-Feb	84	06-Dec	28
15-Feb	24	13-Dec	69
22-Feb	9	20-Dec	152
01-Mar	9	27-Dec	393
08-Mar	3	03-Jan	339
15-Mar	6	10-Jan	132
22-Mar	4	17-Jan	71
29-Mar	1	24-Jan	43
05-Apr	2	31-Jan	39
12-Apr	0	07-Feb	18
19-Apr	0	14-Feb	28
26-Apr	1	21-Feb	23
03-May	4	28-Feb	26
10-May	2		

Table CV19.1 – Number of staff tested positive and Isolating by Month

Month	No of Staff Tested Positive	Number of New Isolators
July 2020	8	166
August 2020	17	408
September 2020	86	1151
October 2020	346	1555
November 2020	326	1280
December 2020	166	894
January 2021	536	1448
February 2021	200	653
March 2021	22	481
April 2021	4	530
May 2021	18	524
June 2021	48	735
July 2021	107	871
August 2021	97	611
September 2021	82	648
October 2021	108	823
November 2021	101	808
December 2021	565	1523
January 2022	689	822
February 2022	107	327

Figure CV19.1 – Number of staff tested positive and isolating by week



Covid-19

Trust Position

In the Trust there have been **107** instances of staff that have tested positive for Covid-19 in February 2021 with **23,633** instances since July 2020 (Table CV19.1). This has fallen significantly in February from 689 cases in January to 107 in February.

Weekly breakdowns are shown in both Table CV19.1 and Figure CV19.1.

Outbreaks

As at the end of February 2021 there were **6** outbreaks on trust sites.

There have been **133** outbreaks since reporting began with **127** outbreaks closed.

The outbreaks are contained and linked to community prevalence and individual lack of compliance with PPE. The controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively with outbreaks limited to very small numbers of individuals at each site.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	30th March 2022
SUBJECT:	Learning from Deaths - Summary Report and Dashboard Q3 2021/22
PRESENTED BY:	Dr Chris Grant, Executive Medical Director

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☐	☐

SR05	SR06	SR07	SR08	SR09
☐	☒	☐	☐	☐

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 its Learning from Deaths. This is the fourth quarterly report. 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 the correct call categorisation and demand exceeding available resources. The peer review process identified most patients received appropriate care, but where sub optimal care occurred, these included the recording of observations/assessment/investigations, utilisation of Manchester Triage Systems (MTS), ECGs not being attached to EPRs and communication of DNACPR/futile arrest. The peer review identified areas of good practice such as shared decision making and safety netting between NWAS and GP whilst respecting the patient's wishes to remain at home (re-contact death), crews showing care and compassion by facilitating a natural death and supporting the family/caregivers in the process; and providing a detailed management plan to a patient within the community who is at risk of dying and refusing conveyance (re-contact death). A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through Area Learning Forums and individual frontline staff. The DCIQ Mortality Module is now business as usual and four Structured Judgment Review (SJR) panels have been

<table>
<tr><td></td><td colspan="4">completed meaning the Q3 data was pulled using the DCIQ Mortality Dashboard.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board Of Directors are recommended to:

• Support the Quarterly Dashboard (Appendix A) as the report to be published on the public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths.
• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust.
• Acknowledge the good practice identified including:
  ○ Collective decision making and safety netting between NWAS and GP whilst respecting the patient's wishes to remain at home
  ○ Crew demonstrated care and compassion by facilitating a natural death and supporting the family/caregivers in the process
  ○ Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance
• Support the dissemination process as described in 3.4
• Note the DCIQ Mortality module is now business as usual.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☐ Compliance/ Regulatory
☐ Quality Outcomes
☐ Innovation
☐ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee
Clinical Effectiveness Sub Committee</td></tr>
<tr><td>Date:</td><td colspan="3">28th March 2022
1st March 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Assurance received</td></tr>
</table>

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q3 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st March 2022 in accordance with the national framework and trust policy. The 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 experts to undertake the dispatch and triage review.

It is acknowledged this must remain an iterative reporting process and this will continue to become more sophisticated and informative throughout 2022/23.

2. BACKGROUND

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

3. LEARNING FROM DEATHS DASHBOARD Q2 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 162 (101 Datix incidents and 61 sampled - *Table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 101 patient deaths;

- 67 patients were identified through the Incidents module
- 27 patients were identified through the Patient Experience module
- A further 7 patients were identified as having records on both the Incidents and the Patient Experience modules.

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

Of the 67 patients, 33 were reviewed and closed. In 19 cases the investigation concluded the Trust had potentially contributed in some way to that patient death. No available clinical resource was cited as the main contributing factor to those deaths.

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

Of the 27 patients reported, 26 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. For one case that has been closed, death was not considered to have been caused by the incident. The

content of the reviews so far suggest the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures
  - Call incorrectly categorised with a missed opportunity to manually upgrade.
  - Delay in responding to a difficulty in breathing patient.
  - Delay in responding to a chest pain patient.
- PES/Operations
  - Lack of safety-netting, incorrect MTS application in a chest pain patient
  - Lack of safety-netting, incorrect MTS application in an anticoagulant patient with a haemorrhage
- Communication
  - 111 did not convey sufficient information to EOC/EMD
- Relative/external health professional concern raised
  - Relative concerned that patient was not prioritised by call handler

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

Seven patient deaths were recorded on both modules. None of the incident investigations have been fully closed though themes emerging from the investigations include:

- EOC and EMD procedures:
  - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
  - Significant delay responding to a patient with breathing difficulties
- Relative/external health professional concern raised:
  - Relative concerned patient was not prioritised by call handlers

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

Of the 61 patient deaths:

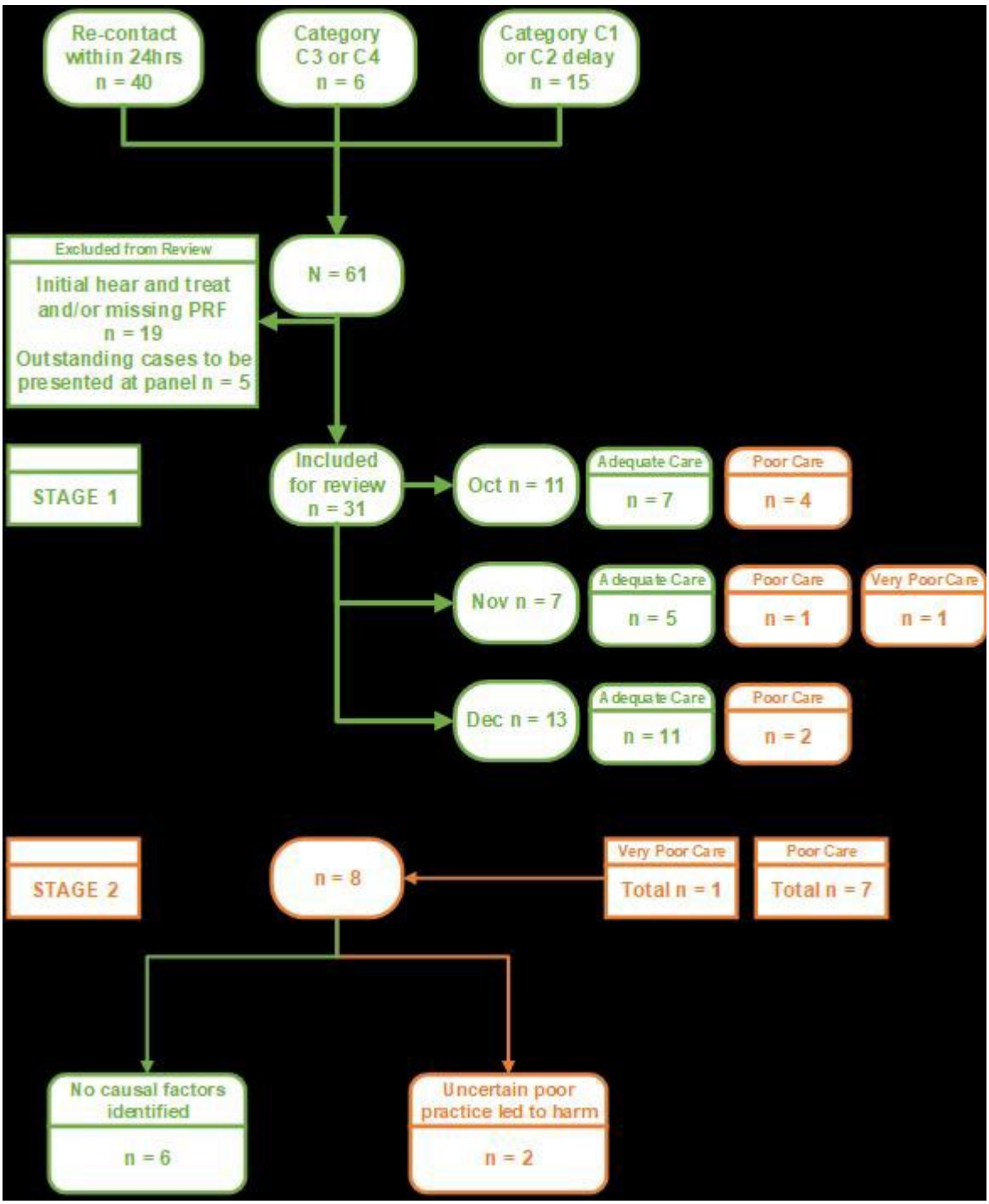
- 40 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- 6 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- 15 deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait.

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

The flow chart below provides a summary of which of the cases identified were reviewed and how the numbers referred to in Tables 8 and 9 and Fig 6 of the Q4 dashboard change.

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

1. Without a patient report form, the review cannot be undertaken
2. Where a 24hr re-contact incident is initiated as a “hear and treat” and subsequently completed as a “see and treat”; the ‘hear and treat’ element review cannot be undertaken without an EOC Clinical Hub Specialist.



3.3.1 ***Structured judgement review methodology***

The process requires the reviewing frontline staff to make explicit statements upon the clinical practice using the 'Sequence of Events' (SoE) and 'Patient Report Form' (PRF or Electronic Patient Record) 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 to use each of the statements multiple times in a single review.

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

3.3.2 ***Outcome: Q2 Review: Stage 1.***

31 patient deaths were reviewed and following the moderation panels, the outcomes of the reviews were determined as described below:

Month	Very Poor	Poor	Adequate	Good	Very Good
Oct 21		4	7		
Nov 21	1	1	5		
Dec 21		2	11		

Moderation Panels held on 14/12/2021, 11/01/2022, & 15/02/2022

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

3.3.3 ***Q2 Review: Stage 2.***

Eight cases were identified as needing second stage review following Stage 1. It was identified that in six cases, no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect. The second stage review for the two remaining patients remained as uncertain whether poor practice had led to harm.

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

Poor Practice: Table 11 Fig 7.

The panel identified areas for improvement including:

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Ensure SOS/red flag/worsening advice is given and recorded
- Ensure bias does not impact clinical assessment and investigations
- Ensure ECGs are attached to the electronic patient record (EPR)
- Follow NWAS/JRCALC guidance on COVID 19 when appropriate to do so
- Ensure termination of resuscitation protocols are followed
- Ensure patients with breathing difficulties have 12-lead ECGs
- Encourage crews to escalate complex cases
- Improve clinical narrative within the EPR

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

Escalation and Learning

Nine cases have been escalated for a further review but unfortunately due to the current REAP demands on EOC and local operational teams, these are delayed.

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

- Clinicians performing additional investigations and assessments beyond expected practice.
- Shared decision making for complex cases to ensure the patient is safety netted whilst respecting their wishes to remain at home.
- Care and compassion by facilitating a natural death and supporting family and caregivers in the process.
- Detailed management plan to support the patient in the community and involved the patient in the decision making so that they could make a fully informed decision regarding their care and risks of dying.

3.4 ***Dissemination Process***

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the Area Learning Forums and individual frontline staff. The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs by the Consultant Paramedic, (Medical) on a bi-annual basis.

Good practice letters have been circulated to commend 28 clinicians who through their care and professionalism have supported families and patients to experience a good death during September 2020 to September 2021.

3.5 ***Report Development***

DCIQ: Mortality Module

The project team for DCIQ has worked with the Clinical Audit Team and Consultant Paramedic (Medical) to develop the structured judgement review process in Datix. The DCIQ Mortality Module is now business as usual and four SJR panels have been completed at the time of writing. This now means all of the Q3 data and findings are now hosted on one secure platform allowing for a more efficient process of review and reporting. The DCIQ Mortality Dashboard designed by project team helped compile the dashboard for this report. Minor improvements are needed to ensure data capture and analysis is more robust. The Clinical Audit Team will outline those development requests to the DCIQ team.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4.2 Risks associated with Learning from Deaths process are scored 12 or less and are manged by relevant teams.

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

6. RECOMMENDATIONS

The Board Of Directors are recommended to:

- Support the Quarterly Dashboard (Appendix A) as the report to be published on the public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust.
- Acknowledge the good practice identified including:
    - Collective decision making and safety netting between NWAS and GP whilst respecting the patient's wishes to remain at home
    - Crew demonstrated care and compassion by facilitating a natural death and supporting the family/caregivers in the process
    - Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance
- Support the dissemination process as described in 3.4
- Note the DCIQ Mortality module is now business as usual.

NWAS Learning From Deaths Dashboard Quarter 3 2021-2022 (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	58	26	44.8%	12
November	39	18	46.2%	8
December	65	27	41.5%	7
This Quarter	162	71	43.8%	27
This Financial Year	331	170	51.4%	67

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2018) - Where concern raised on quality of care provided where the patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of initial contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.*

Table 1.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 24/02/2022.

Learning from Deaths: Data over time

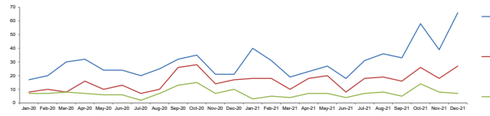


Figure 1.

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 occurred 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 occurred; 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	26	0	7	18
November	18	2	1	15
December	23	4	5	12
Total	**67**	**6**	**13**	**45**

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	13	9	0
November	9	5	0
December	11	5	0
Total	**33**	**19**	**0**

Table 3.

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

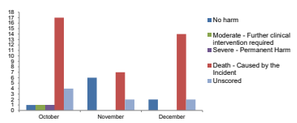


Figure 2.

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

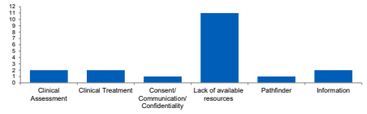


Figure 3.

Data source: Datix Incidents query 'Inc.: LID (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 09/02/2022. Last accessed 09/02/2022

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	9	0	0
November	8	1	0
December	10	0	0
Total	**27**	**1**	**0**

Table 4.

Learning theme

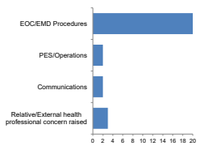


Figure 4

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	4	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a patient with chest pain	7	Demand outstripped resources; reflection and/or feedback; EMD guidance re: EOC0001 & EOC0015 to be circulated; still under review
	Significant delay in responding to a patient with DIB	9	Demand outstripped resources; reflection and/or feedback; measures put in place for all EMDs to see which incidents have waited the longest.
PES/Operations	Lack of safety-netting, incorrect MTS application in a chest pain patient	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Lack of safety-netting, incorrect MTS application in an anticoagulant patient with a haemorrhage	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Communication	111 did not convey sufficient information to EOC/EMD	2	Reflection and/or feedback; refresher training to be undertaken; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	3	Demand outstripped resources; still under review

Table 5

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

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 09/02/2022. Last accessed 09/02/2022.

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	3	0	0
November	2	0	0
December	2	0	0
Total	**7**	**0**	**0**

Table 6.

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

Learning theme

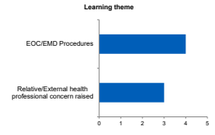


Figure 5

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	3	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay responding to a patient with DIB	1	Reflection and/or feedback; training guidance given to call handling staff re: ineffective breathing; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	3	Demand outstripped resources; 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 04/01/2022. Information recorded on these incidents: last accessed 09/02/2022. Datix Incidents query 'Inc.: LID (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 09/02/2022. Last accessed 09/02/2022

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 initially 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	20	13	3
November	11	8	3
December	30	16	2
Total	**61**	**36**	**8**

Table 8.

Quarter 3 2021-2022 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
October	5	3	13
November	2	1	8
December	8	3	19
Total	15	6	40

Table 9.

SJR Stage 1 Overall Care Assessment

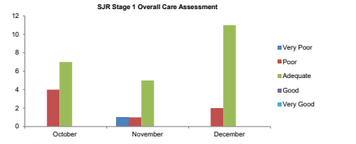


Figure 6.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	**N/A**	
Right Care	Patient Assessment Rating	5	24	2	**26/31 patients**	**84%**
	Management Plan/Procedure Rating	4	23	4	**27/31 patients**	**87%**
Right Place	Patient Disposition Rating	3	28		**28/31 patients**	**90%**

Table 10

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

† 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

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 31 patients)

Evidence of Poor/Very Poor Practice

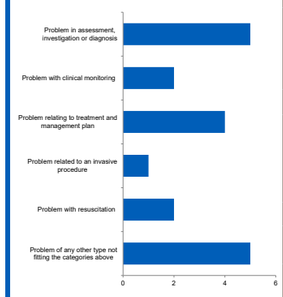


Figure 7.

Learning Theme	Learning Detail	Frequency (n=31 patients)
Problem in assessment, investigation or diagnosis	Family informed crew there was a DNACPR in place and crew commenced resuscitation and ALS	1
	Lack of observations or investigations performed	3
	Poor assessment/ investigations anchoring bias	1
Problem with clinical monitoring	No ECG attached, digital blocker with GETAC	2
Problem relating to treatment and management plan	Poor experience for family	2
	MTS/Pathfinder incorrectly/not used	2
	No worsening advice documented	1
	NWAS COVID-19 guidance not followed	1
Problem related to an invasive procedure	Intraosseous inserted whilst waiting for DNACPR documents	1
Problem with resuscitation	Intraosseous inserted whilst waiting for DNACPR documents	1
	TOR protocol not followed	1
Problem of any other type	Poor clinical documentation	1
	Missed understanding of DNACPR/Futile arrest	2
	Indication for a 12-lead ECG missed	1
	Lack of escalation for decision making	1
	EOC to check if clinical support is needed for prolonged on scene time to support decision making.	1

Table 11.

Evidence of Good/Very Good Practice

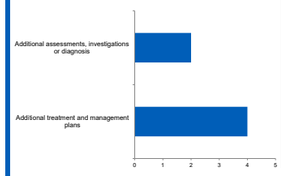


Figure 8.

Learning Theme	Learning Detail	Frequency (n=31 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice.	2
Additional treatment and management plans	Collective decision making and safety netting between crew, SPTL, AP and GP whilst respecting the patient's wishes to remain at home.	1
	Crew demonstrated care and compassion by allowing a natural death and supporting the family/caregivers in the process.	2
	Detailed management plan to support the patient in the community who is at risk of dying and refusing conveyance.	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 PRF's being unavailable and a lack of EOC subject experts for the SJR process, 36 reviews took place, 4 less than the minimum random sample size of 40 required. There are 5 reviews that need to go through panel moderation for Q3.

Data source: Informatics Learning from Deaths SSRS Feed last run on 04/01/2022, SJR data source: Learning from Deaths SJR Database, last accessed on 24/02/2022.

REPORT TO BOARD OF DIRECTORS

DATE:	30th March 2022				
SUBJECT:	Ockenden Report – Update.				
PRESENTED BY:	Dr Chris Grant – Executive Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**		**SR04**
	☒	☐	☐		☐
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☐	☒	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	Donna Ockenden released the report **"Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury & Telford Hospital NHS Trust"** in December 2020 (Ockenden 2020). The report provided Local Actions for Learning and Immediate and Essential Actions (IEAs) to improve safety across all maternity services in England. On the 25th January 2022, NHS England published an "Ockenden - One Year On" letter asking all Trusts to provide updated Board assurances against the IEAs. NWAS has taken a proactive approach to reviewing the report and addressing IEAs in the context of prehospital maternity care. This report provides assurance that IEAs are being addressed to enhance patient safety.				
RECOMMENDATION:	The Board of Directors be: • Assured that the Trust is fully responsive to Ockenden IEAs and continues its focus on reviewing pre-hospital maternity provision. • Assured that this report details the initiatives in place to support delivery of safe, effective and patient centred maternity care.				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee				
	Date:	28th March 2022			
	Outcome:	Assurance Provided			

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1. PURPOSE

To provide assurance that the Northwest Ambulance Service NHS Trust (NWAS) is responding and addressing immediate and essential actions detailed in the interim Ockenden review. This was released in December 2020 (Ockenden 2020) and then re-referenced in the "One Year On" letter to all NHS maternity trusts in January 2022. The full Ockenden review will be released later this year (2022) which will detail 1,862 maternity cases. Within the interim report, it was identified that increased authority and accountability must be given to Local Maternity Systems (LMS) to further ensure safety and quality in the maternity services they represent. Moving towards system level assurances and reporting across the North West, NWAS will provide the regional maternity teams with a bi-annual Ockenden Report to evidence dedication to safety, quality, and collaboration with key partners.

2. BACKGROUND

The serious complications and tragic deaths resulting from substandard maternity care at Shrewsbury and Telford Hospitals NHS Trust between 2000-2019 has had an everlasting impact on families and their loved ones. NWAS welcomes Donna Ockenden's review and is committed to the prevention of substandard care and practices. NWAS does not offer a commissioned maternity service. In cases where pregnancy, labour or birth has deviated from the normal, women and birthing people choose to seek medical attention and guidance from ambulance services for themselves or their new-born baby, via 111 or 999. Although the Ockenden report is aimed at maternity providers, as an emergency ambulance service responsible for pre-hospital maternity care, NWAS must be an active participant. Self-assessment is required against immediate and essential action's (IEA) highlighted within the report. Five of the seven IEAs are applicable to the prehospital environment. The report sets out (in the required tabular format) the responses:

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
The role of the NWAS Consultant Midwife is recognised in the North West Single Perinatal Plan. The role is a member of the Perinatal Board. This ensures prehospital maternity/neonatal care is fully represented and as such, plays a key role	NWAS is one of only three ambulance trusts to have a substantive Consultant Midwife. This key role provides assurance that national drivers in maternity and reports (such as Ockenden) are fully reviewed and actioned.	As this process is new to NWAS, assurances / feedback is being sought via the NW maternity systems to the usefulness of reporting via the Perinatal Board. In addition, specific focus on ensuring a clear	No further actions needed at this stage. The NW Perinatal Board is a key meeting of all maternity leads across the system, supporting clear governance procedures and risk assurance	NWAS Consultant Midwife now attends the quarterly meeting. Regular meetings occur with regional HSIB team to ensure robust process	The role of the Consultant Midwife was substantiated in early 2022. This has a regional profile. Considerations for additional maternity support forms part of SDMR considerations.	To mitigate the risk, key responsibilities have been allocated to the Consultant Midwife. In addition, the current SDMR will look to ensure subject matter specialists are identified and aligned to key work streams. In the interim, the Advanced Paramedic cohort will continue to

in the integration of care provided across the North West. New potential SI incidents are presented and reviewed weekly at our Review of Serious Events (ROSE). These reviews provide assurance that risk scoring is appropriate, and that investigations, recommendations and actions take place in a timely manner and by the appropriate level of manager or advanced clinician. Completed reports (after commissioner review) are forwarded to the appropriate organisations involved, providing opportunities for shared learning. NWAS new Datix-IQ platform has a dedicated maternity module to host all investigations and incidents. Key relationships have been built with the regional Healthcare Safety Investigation Branch (HSIB) team to support collaborative and timely approaches to supporting their investigation process. A revised internal protocol has been developed to ensure Executive oversight of all final HSIB reports, with a new internal review	Since the first NWAS Ockenden Board Report, a maternity dashboard has been developed and a reporting platform within Datix allows identification of themes / areas for focus. Now the Consultant Midwife is in post, key assurance reporting will be determined to embed maternity assurance in the formal governance processes.	reporting system via the regional midwifery team is under review The new SOP for dealing with HSIB now includes a clear mapping of all key safety recommendations for the trust. These will be presented at Clinical SMT for action.	across the NW maternity systems. This meeting provides NWAS with a dedicated agenda item to provide updates and raise safety concerns.	continue to support investigations in a timely manner and support staff included in such processes. All national HSIB reports are addressed internally, ensuring any actions or safety concerns raised and addressed.		provide expertise to mitigate risk.

mechanism in place to ensure all safety recommendations are charted and addressed.						

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
NWAS has a process to gather service user feedback via the patient experience team. The Trust website also includes clear information informing patients how they can complain, compliment, or	As part of NWAS Annual Report, feedback, compliments and compliments are published. The Consultant Midwife will work to identify how MVPs may	Feedback via official methods (patient experience team) are useful in identifying key points for consideration from those who	A coordinated response to addressing maternity related complaints and feedback ensure subject matter experts within the organisation are	The patient experience team and newly appointed Consultant Midwife will review current processes. A	Key links with NW MVP networks and to ensure the NW systems include NWAS in case reviews, patient stories and investigations reviews to ensure learning is triangulated.	Key relationship will be built with NW MVP network and relevant LMS Boards.

tell us how we did as a service. As NWAS are not a commissioned maternity provider, we do not have an Executive Director for Maternity Services. However, the recently appointed substantive Consultant Midwife, (sitting within the Medical Directorate) ensures the Executive Medical Director acts as the responsible Executive for maternity provision. Advanced Paramedics with a speciality interest in maternity care also link in with LMS and maternity steering groups. These maternity leads are encouraged to work collaboratively with their corresponding LMS's and regional maternity units. Oversight is provided by the Consultant Midwife with any regional / local issues raised via the LMS and regional maternity teams. In addition, there is a maternity leads ambulance group that meets quarterly. An NWAS AP currently Chairs the group.	assist with NWAS specific feedback.	access the service. Action plans will be developed to show learning has occurred and been embedded.	included and able to support process.	maternity specific work plan and associated governance will be developed and presented to Clinical SMT by end of Q3 22/23 .	In addition, working closely with NWAS Patient Public Panel will be required to ensure patient voices are heard, their input collated in any key recommendations and/or policy changes that affect maternity care.	

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
NWAS is not commissioned directly for specific maternity staff training. However, as part of the wider MDT, prehospital clinicians will need to be considered in training provision currently delivered by maternity training units. This recommendation aligns with national reports that highlight the importance of interprofessional training	A bi monthly meeting is held with the Consultant Paramedic – Education, to support governance and oversight of any new teaching materials. NWAS developed resources are being reviewed by AACE as these may form basis for national scaling via E-Lfh	This training offer currently sits outside of mandatory training. As part of the initial evaluation, staff will be encouraged to engage as part of CPD. It is anticipated that Advanced Paramedics will receive this	Scaling up MDT training within NWAS requires support for training faculty. In collaboration with the NW regional maternity team, next steps include a MDT approach to existing training days.	Following evaluation of the Pre hospital PROMPT, Clinical SMT will consider the potential for scale up of the package in collaboration with the education team.	A training faculty to deliver the training over the course of the year in their subsequent areas. Purchase of the PROMPT train the trainer course will quality assure those who deliver the course. Further conversations required with Heads of Service and operational	Initial training is to be targeted at Advanced Paramedic cohort, as these clinicians are the most likely to be called/assist at complex and high risk maternity incidents.

in obstetric and neonatal emergencies. NWAS funding was secured via external bid in January 2022 to support the development of training resources for staff and to scale up MDT obstetric emergency training. HEE awarded NWAS £145,000 to support the purchase of training equipment. NWAS purchased Pre-Hospital PROMPT training package, enabling us to deliver face to face simulated obstetric emergency training. A formal service evaluation has been undertaken to identify what aspects of training would support staff and what are their preferred methods of engagement. This service development report has been accepted for publication in the British Paramedic Journal.	(the online national NHS e-learning education platform). JRCALC have also requested that the material developed (interactive videos) be used on their national platform. The e learning developed will be launched April 22, with analytic mechanisms allowing NWAS the ability to map engagement and evidence learning via a knowledge check. This will support staff in refreshing skill training.	training as part of their required yearly CPD. Once initial phase evaluated, discussion will proceed with mandatory training group to determine next steps.	Agreements with HoMs will be sought via the NW Perinatal Board.	Plans for trust wide delivery commence Sept 2022.	managers to mitigate impact upon service delivery.	
Immediate and essential action 4: Managing Complex Pregnancy						

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
N/A to NWAS	N/A	N/A	N/A	N/A	N/A	N/A

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet	**What are our monitoring mechanisms and**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

all requirements of IEA 5?	**where are they reported?**					
NWAS has engaged with HoM to ensure emergency risks are discussed with women who are considering home birth. Fully informed consent must include information relating to emergency transport, should this be required. To support this process, NWAS Consultant Midwife has assisted the NW Chief Midwife to produce an information and communication document. These detail information relating to the ambulance service including REAP levels, national ARP times and the categorisation of ambulances responses and IFTs. Additionally, a patient communication was produced to support midwives in providing balanced information to women and birthing people in the antenatal period. The joint publications were shared via the NW networks to support HoM and their clinical teams.	Consultant Midwife attends the NW Maternity Safety Surveillance and Concerns Meeting, to raise any key safety risks across the system. Reporting occurs via: 1) Regional NW maternity team 2) Individual direct contact with HoMs 3) NWAS Partnership & Integration Managers.	All updates and concerns form part of NW regional maternity logs and actions. Clinical Effectiveness Sub Committee will receive maternity assurance reports in 22/23. Internally, any safety concerns flagged via the Datix system are monitored and managed via usual process with oversight from the patient safety team.	To ensure a clear process is agreed with CESC for reporting maternity care following agreed NWAS assurance framework.	To be agreed and actioned by Consultant Midwife and Medical Director. Official substantive midwife role begins in May.	The Consultant Midwife will need assistance in collating, reporting and presenting data for assurance. This would include key relationships with the Business Intelligence team and Informatics within the trust.	Current processes in place supports the identification of clinical risk (via Datix / patient experience) and DATIX IQ will allow for maternity specific incidents to be identified. Substantive Consultant Midwife now in post to provide speciality input.
Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.						

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
N/A to NWAS	N/A	N/A	N/A	N/A	N/A	N/A

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions: Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?						
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.						
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
At present NWAS does not provide information on the public website detailing what routine practice and procedures maternity patients are expected to receive if an ambulance is called to a maternity related incident. NWAS is now in receipt of the joint communication written and cascaded across the NW networks (in response to IEA 5) which now supports our ability to further communicate this standardised information. Working with the communications team, the actions set out on the 30/08/2021 report are in progress with a dedicated Green Room space for staff focused on maternity workstream and ongoing work to support general information available to	No formal reporting system for this IEA within NWAS as we have no MVP. EPR will capture the clinical care records ensuring that informed consent is gained in line with all clinical procedures / care provider interactions.	An audit of EPR data would allow us to gather a high level overview of informed consent compliance and the level to which staff document this. The use of interpreter services for non-English-speaking women would also be a measure of compliance with informed consent procedures.	Public information included on NWAS website will be actioned by the 31st March.	This will be undertaken by the Consultant Midwife by 31st March 2022	Communication team support to ensure the information is correctly uploaded and accessible. The information will be agreed by Clinical SMT prior to publication ensuring it aligns to NWAS policy and clinical service delivery.	NWAS will continue to support the wider maternity systems in understanding the operational aspects of the service, to best support informed conversations with women regarding the potential need to access the ambulance service during pregnancy or following birth. Internally, work is underway via the development of resources to support staff in understanding and upholding informed consent and recognising potential challenges. These principles are embedded within the E-learning resources that have been developed. Funds via the maternity network are supporting a training session delivered by Birthrights UK who focus on providing NHS

women and families who access NWAS service on the trust website.						organisations with training related to the legal and ethical frameworks and policies that underpin maternity care. This will be offered to all senior leads within the organisation to support the cascaded of learning within and amongst teams.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Ockenden report encourages all services that provide maternity care to acknowledge areas for improvement and action. Despite no mandated requirements for ambulance trusts to respond directly, reviewing services against this report provides internal assurances and a proactive approach to mitigating risks and adverse outcomes.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

The forthcoming maternity plan (as part of refreshed Quality Strategy) will focus on addressing inequalities in maternity care and responding to the full Ockenden report upon release. The Consultant Midwife will work closely with the Executive Medical Director and Public Health team to identify opportunities to support national equity and equality agendas.

5. RECOMMENDATIONS

The Board be:

- Assured that the Trust is fully responsive to Ockenden IEAs and continues its focus on reviewing pre-hospital maternity provision.
- Assured that this report details the initiatives in place to support the delivery of safe, effective and patient centred maternity care.

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	24th January 2022	**Chair:**	Prof A Chambers
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director
Members Present:	Prof A Chambers Prof A Esmail Dr D Hanley Prof R Thomson Mr G Blezard Prof M Power Dr C Grant Ms A Wetton	**Key Members Not Present:**	Mr N Barnes, Deputy Director of Quality, Innovation and Improvement

Link to Board Assurance Framework (Strategic Risks):

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

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Reported that ELC had reviewed the risks and target risk scores which had been reflected in the Q3 position of the BAF. • Noted SR01 target risk score of 20, SR03 target risk score of 15 and SR06 target risk score of 15. • Discussed the risk associated to the mandated Covid-19 vaccination and operational performance in relation to hospital handover delays. • Advised a number of regional meetings had been held to highlight the impact on the service from primary care. • Noted that the Trust were included on a National Improvement Team which involved hospital handovers being addressed in parallel with primary care. • Acknowledged the delay in developments of the APEX audit tool to Q4 due to technical challenges. • Discussed reduction in risk score of SR06 from 20 to 15 in light of outstanding operational risks. Confirmed that there had been	• Received assurance that BAF risks were being managed effectively.	

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	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	strategic mitigation taken which had provided an improved position. • Noted that a caveat had been included in the rationale of SR06 to allow for an increase of the risk score if required.		
Deep Dive – Mental Health Provision	• Received a presentation from the Trust's Mental Health and Dementia Lead with an update on the Mental Health and Dementia Strategic Plan launched in October 2019. • Recognised the number of Mental Health 999 calls had increased year on year from 2019 to 135,116 in 2021. • Acknowledged the development of pathways to reduce long waits, included daily huddles with key members from the Trust, Police and acute services. • Noted the pending implementation by Lancashire Police of the Right Care Right Person Strategy which would refer welfare calls into the ambulance service from February 2022; noted meetings were ongoing with the police. • In terms of suicide prevention it was noted that the Trust were working with ICS' and public health leads across the region with work ongoing with the Zero Suicide Alliance and Mersey Care Trust to lead on a national piece of	• Received moderate assurance from the Deep Dive into Mental Health Provision. • Recognised the temporary nature of the funding for mental health resource in EOC and 111.	

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	work on a shared resource for use in a pre-hospital environment. • A Just B Pilot had been launched in EOC to support frontline staff with mental health guidance and signposting advice, with further developments which included a mental health toolkit and postvention advice. • If data proved EOC Pilot had been successful, further roll out into 111 planned. • Noted funding for a Clinical Psychologist 12 month post, to scope provision available and assess staff experience; with a Higher Educational Transformation Post funding by the Trust to work across the UK and develop an induction package for frontline staff. • Agreed temporary funding for mental health post caused some concern regarding future resource. • Discussed the Trust's mental health cars provision and highlighted that the service model, which included mental health cars, was tailored to the needs of the areas in the region; which varied. • Recognised that 15% of calls into NWAS were mental health patients		

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	with the greatest demand being the need for a mental health assessment. • Discussed future re-profiling of the workforce to meet patient needs and recognised the challenges. • Sought a future update to the Committee on the effectiveness of the interventions discussed.		
Integrated Performance Report	• Received a report on December 2021 quality and performance activity. • Acknowledged that staffing across the service lines continued to be a challenge due to Covid-19 and long term sickness related staff abstractions. • Actions to address staffing included in the Trust's 6 point Improvement Plan and Trust's Winter Plan 21/22. • Noted that military support had been deployed until March 2022. • Advised that significant work had been undertaken to address see and treat and hear and treat rates, which had resulted in improvement. • Work of Advanced Paramedics to manage the C2 call stack and extreme waits had been initiated and improvements were expected in January data.	• Noted the ongoing staffing and resource challenges on the Trust. • Requested further update on Hospital Handover Delays to monitor the impact on patient harm. • Recognised that the overall BAF score for SR01 had been increased to 25 and the Trust's risk profile reflected the current risk.	

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	• Highlighted that the Trust were bidding for additional resource and the work completed by ORH in 2019 being further developed by OPTIMA to reflect changes to the organisation. • Suggested that ICS' were made aware of progress made against the 6 point improvement plan. • Acknowledged that 3 out of the 6 points were on target and noted that improvement in the processes to manage hospital handover delays had been implemented. • Noted the significant work undertaken by NWAS and the team to improve hospital handover delays. • Requested a further update on the hospital handover position to monitor the impact on patient safety. • Discussed areas for escalation to the Board of Directors and recognised that the overall BAF score for SR01 had been increased to 25 to reflect the challenges and risk. • Noted that the BAF would be presented to the Board of Directors and the Trust's risk profile had been reviewed to reflect the current position. • Highlighted that serious incidents were associated to long waits, however		

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	despite the Trust's performance there had been some good patient feedback using the EDI metrics. • Acknowledged the benefits for Committee to understand the year end data in relation to patient deaths and those associated to a lack of resource; to identify the numbers and trends to provide learning. • Noted that evaluation work was currently being undertaken by the Trust's Patient Safety Specialist. • In relation to 111, noted a 36% improvement rate in December with less extreme days. • Significant pieces of work had been undertaken to realign staff rotas and re-profile working patterns to improve staff retention rates. • PTS continued to support PES and provide a good service to patients. • Acknowledged that further discussion on the Service Delivery Review Model would be held in Part 2 of the Board of Directors meeting, which would support future initiatives to improve service delivery and performance. • Highlighted that despite the challenges ROSE meetings had continued and		

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	processes were in place to manage the associated risks.		
Progress Against the Trust's Winter Plan 21/22	• Received a progress update on the Trust's Winter Plan which had been reviewed on a monthly basis since November 2021. • Reviews consisted of representatives from departments across the Trust to provide comprehensive input and assessment of the effectiveness of the plan through the winter. • Omicron pressures and staffing were key factors of reviews. • Noted the Plan had facilitated measures taken to manage resources over the winter and festive period.	• Received assurance from the report.	
Medicines Management Q3 Update	• The Chief Pharmacist provided key highlights of Q3 which included an update on New Patient Group Directions, a Home Office Inspection for Controlled Drugs and introduction of audit to reflect PGDs was on target for 1st April 2022. • Received an update on the Trust's performance against the Medicines Management Quality Indicators. NWAS achieved 100% in 5 out of 10 and 2 had received 90%. • Confirmed that work had progressed to achieve compliance across all MMQIs	• Received assurance from the report.	

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	but had been impacted by REAP level 4 pressures. • Acknowledged that the team had sight of the challenges and the work required in order to effectively report on progress and governance arrangements to regulators. • Recognised the significant amount of work undertaken by the Chief Pharmacist and the team and welcomed the comprehensive report.		
Learning from Deaths Summary Report and Dashboard Q2 2021/22	• Noted the contributory factors from learning from deaths activity during Q2 which were associated with EOC procedures, specifically incorrectly categorised calls and a lack of available resources. • Peer review process identified that most patients received appropriate care, and where failings occurred included a failure to record observations; incorrect use of triage system and absence of safety netting or a comprehensive Patient Report Form. • It was recognised that future monitoring via the DCIQ module would provide enhanced triangulation of activity.	• Received moderate assurance from the report. • Noted the actions being taken to mitigate the risk associated to audit resource in EOC.	

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	• Noted that limited audit capacity in EOC due to the extreme volume of activity. • Queried if the Trust were missing key information due to the lack of resource, which would result in future patient harm. The Medical Director advised that the team continued to request audit reviews of cased that identified concern, however the end to end audit review was not being undertaken due to the lack of expert audit resource in EOC. Noted the subject related expert was rare and required a specific knowledge to audit the outcomes. • Recognised the team were working with Patient Safety Specialist to identify pathways and a new triage system expected to provide a more robust model and provide future audit capacity. • Confirmed that the audit resource would be resolved by the Trust's Service Delivery Model Review which was expected to be effective by end of Q1 22/23. • Agreed that the Committee would review the position of audit resource during Q1 with escalation to Board if required.		

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	• Noted that the Learning from Deaths Annual Report would include overall themes of learning to include evidence of the outcomes from audit work throughout the year. • Acknowledged that themes would be triangulated through ROSE and the SI team and complaints in Datix system would support identification of any consistent areas of concern. • Discussed shared learning with stakeholders and noted that learning was shared via national forums. • Noted the link between the SI data in the IPR and the Legal Services Quarterly report provided triangulation on learning from deaths.		
Legal Services Assurance Report Q3 2021/22	• Received the key headlines in relation to HM Coroner's inquests. There had been no findings of neglect with no Regulation 28 cases identified. • Noted there had been 17 new claims and 66 Legal Subject Access Requests had been processed. • Acknowledged the upward trend of incidents and a significant increase in high scoring requests where the Trust had been designated as an interested party, associated to long waits and delayed attendances.	• Received assurance from the report.	

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	• Noted the triangulation with SI's and complaints and incidents. • Highlighted that 10 cases had been identified by legal services which highlighted gaps for improvement in internal processes. Gaps attributed to the high level of activity during Q3. • Suggested a future Board Development Session to understand the processes involved, to promote understanding and recognise learning opportunities.		
Health, Safety and Security Policy Revision	• Received a revision of the Trust's Health and Safety Policy. • The changes highlighted and summarised as significant where appropriate. • Discussed the arrangements for Fire Safety provision across the Trust and noted that Health, Safety and Security Practitioners had fire expertise within their core competencies. • Acknowledged the skill set of the team provided the Trust with resilience. • Reported that fire assessment compliance was 89%. • Suggested that fire provision arrangements were included in the Health, Safety and Security Policy for transparency.	• Recommended approval of the Health, Safety and Security Policy to the Board of Directors.	

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Policy on Prevention and Reduction of Violence	• Received a new Trust Policy on the Prevention and Reduction of Violence, produced in line with the National Violence Prevention and Reduction Standard 2020. • Noted the Policy had undergone an extensive consultation process which included Trust staff networks and considered equality and diversity. • Recognised that Body Worn Cameras was a separate Trust procedure which linked to the overall Strategy and part of the Trust's Violence and Aggression Group. • The Violence Reduction Prevention Plan also included a suite of initiatives to support the Policy statement and work would be undertaken at sub-committee level. • Welcomed the Policy and requested future update on the development of reporting mechanisms to link characteristics with incidents, to provide an understanding of the prevalence and numbers within the Trust.	• Recommended approval of the Policy on Prevention and Reduction of Violence to the Board of Directors.	
Clinical Effectiveness Sub Committee Chairs Assurance Report, from	• Received an update on the key assurances provided. • Discussed the decision to remove Memorandum of Understanding		

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the meeting held on18th January 2022	(MOUs) which had been supported by the Trust's Legal department. • Quality of services and the principles to be maintained via the use of the Electronic Patient Record and the Directory of Service. • Noted that service would be required to meet the required Kite mark standard and would improve quality of services. • Noted amendments to the report included EOC had provided a verbal update due to pressures on resource and that the Deputy Director of Operations had been present at the meeting.	• Received assurance from the report.	
Patient Safety Sub Committee Chairs Assurance Report, from the meeting held on 18th January 2022	• Received updates which included a new national training programme for patient safety training. • Highlighted the benefits of Committee members undertaking Level 1 training for awareness. • Discussed the work streams of the subcommittee and assurance provided.	• Received assurance from the report.	
Health, Safety and Security Sub Committee Chairs Assurance Report	• Noted the assurances provided and that attendance levels had been maintained throughout the pressure on operational staff.	• Received assurance from the report.	

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from the meeting held on 18th January 2022	• Recognised the work being undertaken by the team in relation non clinical incidents. • Acknowledged the impact of operational challenges on written reports from some service lines.		
IPC Chairs Assurance Report from the meeting held on 11th January 2022	• Noted that assurances had been sought in relation to the IPC Board Assurance Framework (BAF). • Quarterly outbreak report discussed and positive impact on clusters due to IPC measures being implemented. • Recognised the actions being undertaken to mitigate risk and the ongoing work required in relation to IPC BAF risks	• Received assurance from the report.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	28th February 2022	**Chair:**	Prof A Chambers
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director
Members Present:	Prof A Chambers Prof A Esmail Dr D Hanley Prof R Thomson Prof M Power Dr C Grant Ms A Wetton	**Key Members Not Present:**	Mr G Blezard, Director of Operations Mr J Taylor, Head of Risk and Assurance

Link to Board Assurance Framework (Strategic Risks):

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

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Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Patient Story	• Received a presentation by Community Specialist Paramedic related to a category 2 call for a 90 year old male. • Highlighted the action taken following telephone assessment and the risks associated to the admission of the patient to hospital. • Referral made to Urgency Care Response Team at Wirral who provided medical and social care intervention. • Recognised the positive impacts of the referral and the outcome for the patient which included specialist knowledge of delirium and frailty. • Highlighted the benefits associated to UCR referrals and noted the Trust had made low number of referrals to the service. • Discussed actions to promote an understanding of the UCR service amongst crews including the positive outcomes. • Agreed the need for a 24 hour UCR team referral service and to promote accessibility via revised processes for non-ED referrals.	• Welcomed the learning from the Patient Story.	

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	• Welcomed the patient story and the positive outcome for the elderly patient and learning achieved.		
Board Assurance Framework	• Received the Q3 BAF position approved by the Board of Directors. • Noted the actions outstanding for completion by the end of Q4. • Discussed SR03 and resources and requested a review of the narrative in the BAF to reflect the pressures and the action taken to mitigate some of the risk. • Reported that the Trust's 6 point improvement plan would address some of the challenges, however narrative would be helpful to understand short term actions achieved and implemented. • Reported that actions to address hospital handover delays would continue into 22/23 and the need for unilateral actions across the health care system were required. • Overall assurance that actions were being taken but target risk scores would not be met. • Requested that narrative was more robust in terms of performance to ensure the BAF represented the	• Received assurance that BAF risks were being managed effectively. • Requested a review of SR03 narrative in the BAF to include more robust detail of the work and initiatives being undertaken across the Trust.	

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	initiatives being undertaken within the Trust. • Confirmed that the Trust's risk appetite for SR01 and SR03 was low and the risk status was high, which was at conflict with the Trust's risk appetite.		
Q&P Dashboard (IPR)	• Received the IPR for January 22. • Data reported increased activity and reported a 4% increase in calls. • She noted that call pick up had significantly improved from 68.6% in December to 85.7% against a target of 93%. • Improvement attributed to the work in EOCs through clinical triage and significant increase in hear and treat. • Noted an improvement in ARP performance in terms of turnaround times however extreme long waits were reported and being managed and monitored. • Noted a 50% reduction in waits over an hour, although still remained high some assurance that C2 waits over an hour were reviewed by EOC in real time and retrospectively as part of patient safety work. • Safety culture had improved with increased governance ongoing throughout the pandemic.	• Received moderate assurance due to some improvement in call pick up times and performance standards. • Noted the continued pressure on demand and the long waits.	

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	• Increased level of serious incidents reported during January 2022 which included incidents pre January. • Discussed variation in ARP run charts associated with the impacts caused by varied levels in workforce and adverse weather conditions. • 111 received high level of calls and delivery against performance standards challenged. • Continued investment and improved audit standards reported and praise given to 111 staff for their hard work during very difficult time. • A specific improvement and recovery plan had been developed for 111 to provide focus. • PTS continued to support PES. Activity level below contract baseline and increase of elective activity to be monitored. • Future reporting and deep dive into PTS during 22/23 requested.		
Serious Incidents Update	• Received an update on the number of serious incidents received in January and the learning identified from a review of a high profile complaint, featured recently in the media. • Received a copy of the briefing from NWAS to CEO of the NHS.	• Received an overview of the serious incidents reported during January 2022. • Noted a further report on learning themes to be presented to the Committee in April 2022.	

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	• Acknowledged that investigations of serious incidents received in January were ongoing. • Noted that SI processes, including ROSE panels had been effective and met and reported against required timescales, with a duty of candour lead identified for each case. • Trends and learning from the outcomes of the investigations to be discussed further in April 22. • Patient Safety Specialist confirmed the outcome of reviews would identify areas for priority and support proactive processes for learning across the Trust. • Thematic learning from serious incidents during 2021/22 would be shared with commissioners and presented to Committee in March 22.		
EPRR Chairs Assurance Report from the meeting held on 7th February 2022	• Noted assurances from the EPRR Sub Committee. • Noted the duration of the meeting was not quorate with some outstanding assurances to be reported at the next subcommittee meeting.	• Received moderate assurance from the report.	

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Progress against Right Care Strategy Q3 2021/22	• Noted progress made against Right Care Strategy key deliverables. • Received assurance that RAG ratings reflected progress made against action required. • Highlighted the progress made in EOC and proactive raising of incidents. • Noted an updated mental health dashboard to include mental health long waits. • Acknowledged that serious incident targets were met during Q3. • 77% of trust premises had a current 2021/22 H&S site review in place, ahead of the 75% target by Q3. • Noted deep dive into safeguarding specifically domestic abuse scheduled for Q4. • 99% of Quality Assurance Visits had been completed by December 2021.	• Received assurance from the Q3 progress report.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	25th March 2022	**Chair:**	Mr R Groome, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Mr R Groome Mr D Rawsthorn Mr D Hanley Ms C Wood Ms L Ward Mr S Desai Ms A Wetton Mr G Blezard Dr C Grant (agenda item 114 only)	**Key Members Not Present:**	Prof M Power, Director of Quality, Innovation and Improvement

Link to Board Assurance Framework (Strategic Risks):

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

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Draft Annual Report and Terms of Reference Review	• Discussed the outcome of the Committee annual effectiveness review.		

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	• Highlighted overall positive feedback on the effectiveness of the meetings during 2021/22. • Noted areas for focus during 2022/23 which included, further maturity of work related to the BAF and continue to assess the meeting effectiveness at the end of each meeting. • Revised Terms of Reference included updated membership, strategies aligned to the Committee and additional reporting items in relation to Strategy, Partnerships and Transformation.	• Approved the Annual Report and Terms of Reference for onward reporting to the Board of Directors.	
Board Assurance Framework	• Received Q3 position, approved by the Board of Directors. • Discussed SR04 and the challenges for the Trust in relation to staff morale and fatigue and actions that would roll into 2022/23. • Noted high level staff survey results supported BAF position. • Discussed SR09 in relation to cyber security and the commentary on progress made. • Noted the next BAF report would be presented in Q1 2022/23 and include the updated Q4 Executive Director narrative.	• Received assurance from the BAF report.	

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Operational Planning Submission 2022/23	• Reported that NWAS had submitted the first draft of the submission templates to the ICS team and uploaded by the ICS to the regional team on 17th March. • Noted the approach taken to 2022/23 operational planning and the content of the narrative provided. • Recognised that the submission considered the planning guidance issued by NHSE in December 2021 which included several priorities which required system focus. • Noted the process for submitting the Trust's planning templates which involved the ICS' reconciling assumptions, actions and risks of each plan, on behalf of the ICS footprint. • Acknowledged the four planning templates – workforce planning, activity planning and financial planning and the assumptions made by the Trust against each of the four areas.	• Received assurance from the report.	
Benefits Management Framework	• Details of the Trust's Benefit Management Framework presented. • Noted the Framework had been developed following recommendation by Trust's Corporate Programme Board. • Included the approach to be adopted to consider programmes of work to	• Received assurance from the report.	

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	support the strategic direction of the Trust. • The Framework to be part of the Trust's PMO Project Management Toolkit and soft launch planned, prior to full implementation, initial reporting expected from Q1 2022/23. • Process highlighted new governance structures to support the Trust's three year strategy an annual planning process.		
Workforce Indicators Assurance Report	• Reported compliance rates for appraisals currently 79% overall, an improved position and exceeds 75% target and reflected focus by frontline teams. • Noted PES (80%), PTS (88%) and 111 (76%) ahead of target. • Highlighted that EOC had made significant improvement - 63% but remained behind target. • Corporate teams ahead / on track to reach 85% target by end of March. • 85% target set for managers at band 8a and above – currently behind target at 76%. • Noted focus on recovery continued where targets not currently being met. • In terms of mandatory training, noted new cycle runs across the financial	• Received moderate assurance from the report. • Noted some improvement in compliance, however recognised the ongoing challenges associated with mandatory training targets. • Noted level of sickness absence which reflected current pressures.	

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	year and Trust initially reinstated the target of 95% compliance by March 2022. • Noted the impact of operational pressures on mandatory training and recovery plans included extended date to deliver a minimum compliance of 75% by the end of May. • Overall compliance currently stands at 72% • Noted PTS (86%), 111 and corporate compliance either ahead or on track with target. EOC recovery plan had resulted in improved compliance. • Main risk PES compliance given previous pauses in training for 3 months but decision to extend delivery period expected to mitigate. Acknowledged a focus on staff who have not attended for 2 years and also ensuring staff, who have received release for classroom training, also complete online modules. • Confident that compliance will return to standard moving into 22/23. • Recovery of Level 3 safeguarding training to move online, with a phased release and compliance increased. • Noted that sickness absence levels had increased in January 2022 (13.7%),		

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	• Non-Covid sickness higher than in previous years across all frontline services, most pronounced in call centres – although decrease on previous month. COVID sickness 5.8% in January. • Vacancy position positive, planned growth now included in establishments. • Slight under establishment at the end of February 2022 overall but PES over-established by 2.2% • Substantive EOC staffing showed vacancy gap, however recognised recruitment through winter via agency to support call handling which means staffing equates to 135%. • Under establishment in 111 and retention plan presented to Board in January progressing. • PTS vacancy position improving. • Noted 111 and PTS supported by bank and agency working. • Staff turnover affected by Covid-19 overall, monthly turnover in 111 stabilised. • Trust working across the ambulance sector with NHSE/I to target specific interventions to support 111 service. • Deep dive analysis of turnover currently being undertaken.		

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	• HR case management position impacted by the pause in progressing ER workload due to Covid-19. However, more cases were closed in February 22 than were opened. • Dramatic reduction in 3-6 month cases and will have an overall impact on timeliness. • Trust Covid-19 vaccination rates reported as 87% fully vaccinated, 66% fully vaccinated and had the booster, 2.6% partially vaccinated and 0.5% had an unknown vaccination status. • Flu campaign closed with final vaccination position 57%		
Staff Survey – Initial Results	• Received a high level summary of the National Staff Survey Results for 2021, from data collected in October 2021. • Noted a review of the questions had been undertaken for the 2021 survey and questions now aligned to People Promise themes alongside staff engagement and morale. • Overarching themes from the key data provided. • Data evidenced most declined scores related to staffing levels and impact of Covid-19 on staff. • Presented the national trends compared against NWAS results.	• Received moderate assurance due to the lack of time to discuss the outcomes in full. • Further reporting to be received during 2022/23 workforce reporting to the Committee.	

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	• Overall improvement with highest score related to being a compassionate and inclusive organisation. • Quarterly Pulse Survey outcomes reported and noted NWAS best scores in four areas across the ambulance sector in Q4. • Retention and progression and flexible working scores require focus but bullying and harassment outcomes improved overall. • Continued focus required on disability and BAME staff experience which showed some worsening of scores. • Next steps involved embedding the outcome from staff survey into the Trust's People Plan and local plans. • Reported the Trust had secured funding for a 12 month Consultant Psychologist post to carry out a deeper review of the underpinning factors associated with staff wellbeing and mental health. • Local plans to include a focus on leadership and management, burn out and progression. • Communications Plan to share the survey findings with staff and implementation of local plans, to facilitate improvement.		

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Strategic Workforce Sub Committee Chairs Assurance Report from the meetings held on 14th December 2021 and 24th February 2022	• Noted content of the assurance reports. • Acknowledged updates from service lines on service line workforce plans and NWAS People Plan. • Assurance reports received from the Trust's CFR and VCS service. • Assurance reports received on key workforce contracts of Payroll and Occupational Health • Recognised the ongoing work to implement the Health and Wellbeing Framework and diagnostic tool to be applied across service lines. • Overall scrutiny of operational assurance reporting, including risk, provided by the Sub Committee.	• Received assurance from the report.	
Strategic Workforce Sub Committee Annual Report and Terms of Reference	• Received the outcome of the Sub Committee Annual Effectiveness and Terms of Reference Review. • Positive feedback with areas of improvement - to improve consistency of operational reports and attendance levels by some service lines. • Highlighted he good work of the Sub Committee during 2021/22. • Approved the revised terms of reference for 22/23, acknowledged membership would be reviewed	• Noted the content of the Annual Report. • Approved the Strategic Workforce Sub Committee Terms of Reference for 2022/23.	

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	following outcome of the Trust's Service Delivery Model Review.		
Finance Report to 28th February 22 – Month 11 2021/22	• Received financial performance report, including update on headline financial activity since last report in November 2021. • Noted a financial position of surplus £0.271m, against a planned surplus of £0.051m. • H2 financial plans include additional income of £23.532m above baseline, agreed as part of L&SC ICS Covid-19 allocation. • Plans include SDF income and expenditure for 999 winter pressures of £6.230m, plus £6.762m for 111 services. • Noted that during H2 period additional non recurrent revenue funding received from NHSE/I for UEC, Mental Health infrastructure, call handling and a share of winter funding, withheld nationally. Majority of funding to be spent by end of March 22. • Reported that H2 plans included efficiency and productivity target and residual target identified for H2. • Acknowledged majority of savings identified during 21/22 had been non recurrent.	• Received assurance from the report.	

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	• Latest capital forecast reported and confirmed the Trust had achieved Better Payment Practice Code Targets.		
Update on 2022/23 Financial Plans	• Received an update on the Trust's position in relation to 22/23 draft revenue financial plans and draft opening of the capital programme. • Noted the draft NHS operational planning guidance for 22/23 had been issued. • Reported key change that current emergency financial regime, put in place as a response to the pandemic would cease at the end of March 2021/22, with a return to signed contracts with local ownership for setting payment values. • NHSE/I continue with system based approach to funding and revenue allocations based on current system funding envelopes. • Draft individual provider plans submitted in March and final system plans due 28th April 22. • Noted that the Trust's plans were in line with the system guidance and consistent with other providers in the North West. • Acknowledged that the Trust had submitted a 3 year capital plan to the	• Received assurance from the report.	

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	ICS and noted forecast for capital programme for 22/23.		
Defibrillator Full Business Case	• Received a Defibrillator Project full business case to procure and deploy new defibrillator devices across the Trust. • Noted the level of Defibrillators due to be replaced and the opportunity to evaluate the market to assess best device available to suit the Trusts requirements. • Discussed and approved the full business case for onward approval by the Board of Directors.	• Approved the Defibrillator Full Business Case. • Recommended approval by the Board of Directors.	
PES VRP 22/23 Increased Costs	• Following presentation and approval of the PES business case in September 2021, reported that changes had been made in relation to an updated national specification which had impacted on cost. • Received details of the impact on the original business case. • Discussed the changes and the impact on the original business case. • Recommended approval of the changes to the Board of Directors.	• Recommended approval to the Board of Directors.	
	• Noted key activities of the Trust's procurement function, against the 21/22 procurement work plan.	• Received assurance from the report.	

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Procurement Strategy Update	• Received assurance on the tender and waiver process and audit actions. • Acknowledged updates on the 26 projects approved by the Trust's sub £500k activity process, including procurement of PES vehicles in line with business case. • Highlighted a pilot of EV chargers on four Trust sites and the related processes completed. • Acknowledged efficiencies made and the factors associated to the fuel efficiency project.		
Estates, Fleet and Facilities Management Assurance Report	• Update on Vehicle replacement programme provided, delay due to availability of parts and supply chain, however deliver in progress and all vehicles expected to be delivered by end of March. • Age profile of the fleet reported and plans for replacement of vehicles continues. • In terms of Estates, in the process of planning relocating PES from Preston fire station to new site by the end of the year. • Blackpool decant site working well and building works on existing site progressing and on track.	• Received assurance from the report.	

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	• HART hub and spoke solution discussed by ELC earlier in the year and scoping work ongoing. • Corporate Programme Board Health report provided and included work progressing in 2021/22 and 2022/23. • Backlog of Repairs programme discussed and timeframes.		
Green Plan Update	• Sustainability Steering Group overseeing key developments. • Blackpool Hub being built with Net Zero approach including intelligent building management systems. • Blackpool development will provide lessons learnt for next build project. • In terms of carbon literacy, Trust received Bronze accreditation. • Trust had been named 2021 Climate Champion receiving four awards from Healthcare without Harm. Also achieved Gold in climate leadership, Silver in Renewable Energy and Silver in climate resilience – most awards given to any one Trust within Europe. • Electric vehicles update provided which will run into 2022/23 with future updates including charging pilot.	• Received assurance from the report. • Recognised Awards achieved by the Trust.	

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	• 24 sites identified for tree planting in line with Queens Green Canopy and Platinum Jubilee Project. • Energy Apprenticeship sponsored by NHSE/I to develop data skills into estates and energy initiatives. • Future objectives and areas of focus outlined for the next 12 months.		
Digital Update	• Reported updates in relation to digital measures, customer feedback scores and infrastructure upgrades which had significantly progressed. • Noted that the Trust had rolled out 2500 IPad devices to staff. • Digitising of workforce projects commenced and trialling immersive training methods in HART and Parkway. • Interoperability progress made in terms of patient records and revisiting measure in relation to asset owners'. • New measure in relation to Corporate Programme Board projects. • Developments on cloud network to accommodate server usage and support cost efficiencies. • Good progress on station level projects including patient markers in 999 and 111.	• Received assurance from the report.	

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	• Members pleased to see developments in relation to hybrid meeting facilities and pilot to be hosted from NWAS HQ.		

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