NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 27th July 2022
9.45 am – 11.50 am
To be held in the Oak Room, Ladybridge Hall, Bolton

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2223/45	Staff Story	09:45	Information	Deputy, Chief Executive / Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2223/46	Apologies for Absence	10.00	Information	Chair
BOD/2223/47	Declarations of Interest	10.00	Decision	Chair
BOD/2223/48	Minutes of Previous Meeting held on 25th May 2022	10:00	Decision	Chair
BOD/2223/49	Board Action Log	10:05	Assurance	Chair
BOD/2223/50	Committee Attendance	10:10	Information	Chair
BOD/2223/51	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2223/52	Chairman & Non-Executive Directors Update	10:15	Information	Chair
BOD/2223/53	Chief Executive's Report	10:20	Assurance	Deputy Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2223/54	Board Assurance Framework and Corporate Risk Register Q1 2022/23	10.30	Decision	Director of Corporate Affairs
BOD/2223/55	Audit Committee Chairs Assurance Report – from the meeting held on 21st July 2022	10:40	Assurance	Mr D Rawsthorn, Non-Executive Director
QUALITY AND PERFORMANCE				
BOD/2223/56	Integrated Performance Report	10:50	Assurance	Director of Quality, Innovation, and Improvement
BOD/2223/57	IPC Board Assurance Framework	11:00	Assurance	Director of Quality, Innovation, and Improvement
BOD/2223/58	Learning from Deaths Q4 2021/22 Report	11:10	Assurance	Medical Director
BOD/2223/59	Quality and Performance Committee Chairs Assurance Report - from the meetings held on 23rd May 2022 and 27th June 2022	11:20	Assurance	Mrs A Chambers, Non-Executive Director
BOD/2223/60	Resources Committee Chairs Assurance Report - from the meeting held on 22nd July 2022	11:30	Assurance	Mr D Hanley, Non-Executive Director
COMMUNICATIONS AND ENGAGEMENT				
BOD/2223/61	Communications and Engagement Team Dashboard Report Q1 (April – June) 2022/23	11:40	Discussion	Deputy Chief Executive / Director of Strategy, Partnerships and Transformation

CLOSING				
BOD/2223/62	Any Other Business Notified Prior to the Meeting	11:50	Decision	Chair
BOD/2223/63	Items for Inclusion on the BAF	11.50	Decision	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 28th September 2022 in the Oak Room, Ladybridge Hall, Bolton				

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
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Minutes
Board of Directors

Details: Wednesday, 25th May 2022
Via Microsoft Teams

Mr P White	Chairman (Chair)
Mr G Blezard	Interim Deputy CEO/Director of Operations
Mrs C Butterworth	Non-Executive Director
Prof A Chambers	Non-Executive Director
Mr S Desai	Director of Strategy, Partnerships and Transformation
Prof A Esmail	Non-Executive Director
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director (Clinical)
Mr D Mochrie	Chief Executive Officer
Mr D Rawsthorn	Non-Executive Director
Mrs 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

Minute Ref:

BOD/2223/18 **Patient Story**

The Director of Strategy, Partnerships and Transformation introduced the Patient Story, which was presented in the form of a film.

The film was based on the service provided by NWAS for a 56-year-old lady, Bina Patel from Manchester, who was having breathing problems. The film featured her son, Akshay Patel, who detailed the calls made to the 999 service.

Mr Patel described the traumatic experience of repeat calls and requests for an ETA for an ambulance to attend for his mother, including the personal dilemma of whether to take his mother to A&E himself.

He stated that he would have liked to have been informed from his first 999 call exactly how long the ambulance would have taken and advised, if necessary, to make his own way to hospital to avoid the delays.

It was noted that when the initial call was received from Mr Patel at 02.31hrs it was triaged as a category 2 call and it was when Mr Patel called back for the fifth time, when his mother's condition had deteriorated, that it was re-categorised as category 1 and the ambulance arrived within 10 minutes of that call.

It was recognised that it was an exceptionally busy evening on the night of the incident and the trust was resourced at 108% in the sector where Mr Patel lived. Also, there were 17 incidents received into the sector between the hours of 01:31 and 03:27. Of these, 8 were received in the preceding hour of the incident.

Mr Patel described the upset caused when he made the repeat calls to the service, as his mother's condition deteriorated and sadly explained that when the ambulance arrived on scene, 45 minutes later, his mother was in cardiac arrest and resuscitation attempts were unsuccessful.

He questioned how resource was managed and encouraged the use of volunteers and more staff to avoid patient safety incidents and stressed the need to bring the waiting times down.

The Chairman acknowledged the extremely distressing situation for Mr Patel and his family and noted that sadly this was not an unfamiliar for the Trust during unprecedented times of high demand.

He stated it was important that the Trust Board heard from families and friends who's lives had been impacted by delayed responses and on the Board's behalf he sent his sincere condolences to Mr Patel and his family. He added that he recognised that NWAS had not delivered a service they would have liked to deliver.

Furthermore, he explained that his comments did not take away the grief experienced by the family and friends of Mrs Patel.

The Chairman encouraged an open discussion amongst Board members and stated it was unfortunate that Mr Patel couldn't be present to contribute to the discussion. As such, he encouraged the Board to discuss the story as if Mr Patel was in attendance.

The Director of Operations referred to resources and ways in which the Trust were seeking to improve operational resourcing, reducing hospital handover delays, and working with partners around alternative pathways of care which will free up ambulance capacity to response to Cat 1 and Cat 2 emergencies.

He explained that NWAS were working hard with commissioners at regional and national level to obtain further resource.

He understood patients' frustrations and the service were looking at more efficient ETAs and live estimated times of arrival, but ultimately it was

dependent on enough resources. He noted that although the Trust were making some inroads there was a lot more work to be done.

The Medical Director confirmed that himself and the Director of Strategy, Partnerships and Transformation had met with Mr Patel and highlighted an important lesson that despite challenges it was vitally important that the Trust make time to meet patients and their families to allow them to share their experiences. He added that it should not lose sight of individual patients.

Prof A Chambers queried the work being undertaken to review ETAs.

The Director of Operations explained that the Trust currently provided an NWAS response time but did not provide a region wide response and that NHS pathways would assist in attending to less patients and providing more resource for Category 2 calls.

The Chief Executive offered his sincere condolences and stated that this case could have quite easily been any one of the Board members relatives. He advised it was important to continue to receive stories at Board meetings and continued learning from patient stories.

Mrs C Butterworth confirmed that the review process following the incident involved looking at performance in other regions.

The Medical Director advised that considering region wide performance was part of the review process.

The Chairman thanked Mr Patel for talking to and engaging with the Trust and providing the opportunity to discuss and learn. He encouraged Board members to keep the story at the back of their minds as they progressed through the meeting and considered agenda items.

The Board:

- Welcomed and acknowledged the content of the Patient Story.

BOD/2223/19 Apologies for Absence

There were no apologies for absence.

BOD/2223/20 Declarations of Interest

There were no declarations of interest to note.

BOD/2223/21 Minutes of the Previous Meeting

It was noted that Prof A Esmail, Non-Executive Director was present at the meeting held on 30th March 2022.

The Board –

- Approved the Minutes of the meeting held on 30th March 2022 subject to the addition of attendance by Prof A Esmail.

BOD/2223/22 Board Action Log

The Board noted the updates to the Board action log.

BOD/2223/23 Committee Attendance

The Board noted the Board and Committee Attendance Record.

BOD/2223/24 Register of Interest

The Board noted the 2022/23 Register of Interest presented for information.

BOD/2223/25 Chairman & Non-Executives' Update

The Chairman advised of a visit to the Trust's SMART station at Kendal which had been extremely impressive.

He advised that Chair and Non-Executive appraisals had been conducted and meetings held with David Flory and Kevin Lavery, Chair and CEO Designates of the NHS Lancashire and South Cumbria Integrated Care Board. He advised that they had visited EOC and Broughton where they had observed live examples of demands on the service and witnessed the pressures, which linked to the Patient Story presented earlier.

He reported that he had attended a Wellbeing and Suicide Prevention Group and had spoken at a Governance Conference on Health Inequalities from an NHS perspective.

He commented that the Trust Board had recently held a Board Development Session and there was a committed focus on ensuring that the Trust covered the lost ground during the pandemic.

He added the need for a return to face to face meetings, with the option of a dial in facility for a hybrid approach and plans were in place to return to face to face Board meetings.

The Board:

- Noted the update from the Chairman.

BOD/2223/26 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.

He reported that PES, 111 and PTS performance had showed some more recent improvement, although the Trust still had challenges across PES and 111.

He stated it was pleasing to see that NHS Pathways has been rolled out in the first Emergency Operating Centre (EOC) with a plan in place to roll out to remaining the remaining EOCs over forthcoming months.

He acknowledged the fifth-year anniversary of the Manchester Arena attack on Sunday, 22nd May 2022 which was a terrible event which the service would never forget and acknowledged the families, friends, staff, and all those affected.

He reported that he had carried out local visits to see and talk to staff and to talk to patients and families to observe the care provided and thanked all staff involved. He noted that the Director of Corporate Affairs and himself had been proud to join the Armed Forces Network and thanked the team who ensured the successful launch of the Network.

He went on to note the Trust's recent CQC visit, the developments made in compiling the Trust's Strategy and the National Staff Survey including the Trust's benchmarked position, which was encouraging with further work to be completed.

The Chief Executive advised that a Freedom Speak Up Guardian would be appointed to compliment the Medical Director and the Medical Directorate.

He noted the additional bank holidays to mark the Platinum Jubilee and noted that many events would be taking place across the region. He reported that the Director of Operations and teams would be looking at additional resources required over the period.

In terms of ambulance waiting times, he commented that the Trust continued to work nationally in relation to hospital handover delays and he had met the Health Minister to discuss the pressures. He added that the Director of Quality, Innovation and Improvement and the Director of Operations continued to work locally and regionally to address the impact of ambulance waiting times; highlighted by the patient story.

He added that hospital handover delays were a significant health and wellbeing issue for staff and patients and NWAS would continue to strive to make improvements.

The Chairman reported that he had met with a senior member of the Trust's leadership group on Monday who had confirmed that everything that we hear about at Board level was real and it was important that board members heard

such feedback to understand the extent of the problem. He added that staff were tired, and it was the responsibility of the whole Trust Board to understand the pressures on the health and wellbeing of staff.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2223/27 **Trust Strategy 2022/25 *(extracted and added from Part 2 Agenda)***

The Chairman confirmed that the Trust Strategy had been tabled for Part 2 of the Board of Directors meeting, as an oversight.

He introduced the Director of Strategy, Partnerships and Transformation who presented the Trust Strategy 2022-25.

The Director of Strategy, Partnerships and Transformation provided an overview of the work completed and explained that the Equality Impact Assessment (EIA) had been included for consideration by the Board. He noted that the EIA had not been considered by the Resources Committee as work had been ongoing to ensure all aspects had been included.

He advised that staff and stakeholders had been involved early in the development process, which included an initial diagnosis of the current position, across a number of different areas; particularly considering the impact of Covid-19 and the restoration and recovery process. He noted that staff health and wellbeing had been a consideration over the past 2 years, outside the development of the ICS' and changes in NHS leadership.

He emphasised that there had been a robust process to ensure staff were engaged and consulted with, which had been supported by the Patient and Public Panel and the People Directorate, with consideration given by the Executive Leadership Committee and Resources Committee.

He acknowledged that the Trust had 6,000+ staff in 300 different roles which was a challenge but required a vision that had to cut across all service lines. He noted that the Trust's values had been refreshed with staff and provided very clear priorities in terms of how the Trust would progress.

He noted a commitment to equality, diversity, and inclusion, that would run across the whole organisation and set out clearly the work being undertaken, work to be completed and this was explicit in the document to support holistic engagement. He referred to page 22 of the Strategy which provided the aims to be achieved in Year 1.

Prof A Esmail stated he was pleased to see the involvement of staff and stakeholders at the beginning of the process and the Strategy was credit to the Director of Strategy, Partnerships and Transformation and his team. He was encouraged to see progress from an established baseline to enable monitoring of future progress.

Prof A Chambers welcomed the very clear process used to communicate the strategy and the clear direction of travel in terms of addressing health inequalities and thanked the team for engagement with Non-Executive Directors as part of the development process.

The Director of Quality, Innovation and Improvement noted that the IPR would include a blend of measures from the strategy and provided assurance that work was in hand to report from the baseline moving forwards.

The Chairman confirmed it would be very useful to have that line in the sand for future measure of progress against deliverables and thanked the Director of Strategy, Partnerships and Transformation and his team.

He also thanked the EDI and PPP networks for their engagement in the process, which had resulted in a holistic document.

In terms of the EIA, it was acknowledged that the aim had been to ensure a comprehensive assessment of the impacts and considered internal and external environments. It was noted that the document had undergone a Plain English Review, conducted by an external provider.

Prof A Esmail, referred to health inequalities and noted that the Quality and Performance Committee had discussed resource, data and future reporting.

The Director of Strategy, Partnerships and Transformation confirmed the need to revisit resource would be reported to the Resources Committee.

Dr D Hanley referred to the EIA and action planning. He queried if actions linked to issues identified in the EIA could be identified, to enable the Board to monitor progress.

The Director of Strategy, Partnerships and Transformation confirmed this could be completed and included.

The Chairman supported the ability to track progress against the actions identified, particularly in relation to the EIA.

The Board:

- Noted the assurance provided on the strategy development approach and how feedback has been considered to inform the final version.
- Approved the final draft of the Trust Strategy 2022-25.
- Endorsed the strategic planning approach and considered the role of the Board of Directors in developing and assuring strategic plans.
- Noted the timescales associated with annual plans.
- Approved the Equality Impact Assessment.

BOD/2223/28 **Annual Self-Certification: General Condition FT4 Corporate Governance Declaration**

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

She reported that a review had been carried out for the Corporate Governance Statement provided and based on the evidence, current arrangements confirmed that Board makes a positive declaration each clause and confirmed no material risks had been identified.

The Board:

- Approved the Confirmed declarations and confirmation that no material risks had been identified as described within the paper.

BOD/2223/29 **Annual Self Certification: General Condition 6 – Systems of Compliance with the Licence Conditions**

The Director of Corporate Affairs presented the Annual Self Certification: General Condition 6 – Systems for Compliance with Licence Conditions.

She reported that whilst Trusts were not issued with a provider licence, they were required to self-certify that they had complied with conditions equivalent to the licence that NHS improvement deemed appropriate.

She confirmed that a management review had been undertaken and confirmed compliance with General Condition 6 of the NHS Provider Licence, provided in appendix 1 for reference.

The Board:

- Approved the General Condition 6 self-certification as described within the paper.

BOD/2223/30 **Charitable Funds Chairs Assurance Report from the meeting held on 27th April 2022**

Mr D Rawsthorn presented the Charitable Funds Chairs Assurance Report from the meeting held on 27th April 2022.

The Board:

- Received assurance from the Charitable Funds Chairs Assurance Report from the meeting held on 27th April 2022.

BOD/2223/31 **Audit Committee Chairs Assurance Reports from the meeting held on 22nd April 2022 and 12th May 2022**

Mr D Rawsthorn presented the Audit Committee Chairs Assurance Report from the meeting held on 22nd April 2022.

The Chairman referred to the moderate assurance rating, related to MIAA High Risk follow up recommendations.

Mr D Rawsthorn explained that the outstanding action associated with Freedom to Speak Up had been impacted by Covid pandemic and confirmed that MIAA were happy with the narrative provided and the September date for completion.

The Director of People confirmed this related to the fundamental review of the Trust's Disciplinary Policy to ensure the organisation could fully embed the Just Culture approach and that had been interrupted by Covid, however she advised that the draft policy was currently in consultation through the staff side via the Policy Group. She added that this addressed the concerns raised by MIAA and the critical changes had been made.

Mr D Rawsthorn added that a further short Audit Committee meeting had been held on 12th May 2022 to consider the Trust's Draft Annual Accounts. He confirmed the accounts had shown a very good position and stated the Trust should be proud and confident of a positive Auditors Report.

The Board:

- Received assurance from the Audit Committee Chairs Assurance Reports from 22nd April 2022 and 12th May 2022.

BOD/2223/32 **Integrated Performance Report**

The Director of Quality, Innovation, and Improvement presented the Integrated Performance Report.

She confirmed the Trust's Quality and Performance Committee had fully discussed the performance and quality aspects of the report at their meeting on 23rd May 2022.

She reported an amendment to a heading in the finance section, month 11, which should read Month 1.

She highlighted that serious incident numbers were within normal limits.

The Director of Corporate Affairs confirmed complaints and incidents management had transferred to the Corporate Affairs Directorate on 1st April 2022 and the Trust had received 57 compliments in the period.

The Chairman referred to investigation of level 4 and 5 complaints and restrictions on operational teams.

The Director of Corporate Affairs confirmed that a complete root and branch review of the process, to identify efficiencies, was being undertaken. She added that the team were identifying learning from other organisations, not just health, to rebuild and realign resource; including the skill base required.

The Director of Strategy, Partnerships and Transformation provided an overview of the effectiveness of the service during the period and confirmed that narrative from patients had been provided in the report. He added this had proved helpful from a learning and improvement perspective.

Prof A Esmail welcomed the comments and narrative which supported the data and figures provided. The Chairman also noted EDI data and welcomed the work being completed.

The Medical Director highlighted two areas that were cross cutting in terms of operations, which were observations of acuity of Cat 1 and 2 patients' and resources deployed.

He reported that attempts to increase resources with voluntary colleagues had been conducted, however skill set couldn't always match those of substantive staff. He highlighted there was a risk that capacity could be get slightly misled by counting numbers, without looking at the skill set of staff. He added the importance of deploying appropriate staff to an incident to ensure that colleagues were not exposed to incidents not within their skill set.

He highlighted that call pick up work with CFRs was ongoing and there was a need to talk about totality and a system wide approach.

The Director of Operations confirmed that the Trust had a contract with the commercial arm of St John Ambulance.

At this point in the meeting, Mrs C Butterworth lost connection and left the meeting.

The Chairman recognised the importance of the data in relation to the Patient Story received at the start of the meeting. He stated it was good to see some improvement, although noted the lag in timeline of the data.

The Director of Operations reported on 999 and 111 performances and advised that the services had been challenged throughout April due to call volume and NHS pathway training, although there had been some improvements against ARP standards.

He advised that NHS Pathways had revealed benefits in reduction in C1 and C2 long waits but there was still a lot of work to be completed. He added that call taker staff had felt as though they were making a difference rather than delivering a scripted response and further roll out would deliver further improvements.

The hours lost due to hospital handover delays was discussed and confirmed that the Quality and Performance Committee had discussed the report at length at their meeting on Monday.

He reported that plans for the Jubilee bank holiday period had been submitted to NHSE for approval and resourcing work had been completed with the Director of Finance.

Dr D Hanley, referred to recruitment and the issue of recruiting at risk.

The Director of Finance provided an overview of the funding position which had been delivered in detail to the Trust's Resources Committee.

Prof A Chambers queried incentive initiatives related to the 111 service.
The Director of People confirmed that stabilising the rota, with a team focus, to create a sense of belonging had been effective and wellbeing initiatives to address underlying issues from exit questionnaires had been introduced.

The Chief Executive confirmed that some staff proposals were awaiting Trade Union feedback.

It was noted that PTS performance had been 56% under activity and had been severely impacted by Covid-19 restrictions. It was noted that recent changes to restrictions would impact positively on capacity.

At this point C Butterworth re-joined the meeting

The Finance Director provided an overview of the Trust's financial position and Dr D Hanley confirmed Resources Committee were sighted on the detail.

In terms of Workforce, the Director of People reported good recovery in relation to mandatory training and appraisal stretched targets. She advised that the vacancy position was strong and there had been improvements in case work timeliness. She noted that a deep dive had been presented to Resources Committee on sickness absence.

Dr D Hanley confirmed that the Committee had been assured with actions being taken and Mrs C Butterworth, Non-Executive Director had planned to work with Lisa on initiatives and a future report on the impact of work undertaken would be presented to the Committee in Q4.

The Chairman recognised the continued challenges and thanked the Executives and their teams for their ongoing hard work, he noted that the IPR report provided the scrutiny required at Board level.

The Board:

- Noted the content of the Integrated Performance Report.
- Noted some improvement in performance.
- Noted that SI's were within normal limits.
- Noted the ongoing work in terms of patient safety and compliance.

BOD/2223/33 Medicines Management Annual Report 2021/22 including Controlled Drugs Annual Report.

The Medical Director presented the Medicines Management Annual Report 2021/22 which included the Controlled Drugs Annual Report.

In terms of controlled drugs, he advised that the Trust's Chief Pharmacist had robust involvement across the sector and the issues that were pertinent to the ambulance sector. He added she had taken the lead to work with industry providers to ensure the Trust had safe systems of work in place.

He stated that the Trust's Controlled Drugs License provided resilience and assurance in terms of structure and processes and had led to a greater baseline and structure to allow effective working.

He went on to provide key achievements during 2021/22 and welcomed the Chief Pharmacist' robust approach and passed on his thanks to the whole Medicines management team.

The Chairman referred to the Electronic Patient Record (EPR) and its importance in relation to missing medicines. He acknowledged the significance of the EPR project and requested a future update to Board on the EPR project.

The Board:

- Noted the assurance and achievements provided in the report.
- Noted the forward plan for 22/23.
- Acknowledged future update to Board of Directors on the progress of the EPR project.

BOD/2223/34 Safeguarding Annual Report 2021/22

The Director of Quality, Innovation and Improvement presented the Safeguarding Annual Report 2021/22.

She advised that the report had been considered by the Quality and Performance Committee.

She highlighted the key points and the assurances gained from robust processes. She noted that the Trust submitted a return in relation to the safeguarding assurance framework to the commissioners and there had been two areas that NWAS had not been able to provide full compliance. However, she advised that action plans have been compiled and were in place and there had been no concerns from CQC related to safeguarding.

She noted that the Trust received regular MIAA external audits and substantial assurance had been provided.

The Director of Quality, Innovation and Improvement highlighted the need to ensure good systems for raising concerns were in place and conducted via telephone by Carlisle Contact Centre.

She reported a change in systems from ERIS to Cleric and that an implementation plan had been developed to ensure that risk was managed, and safeguarding concerns were not lost, as part of the transition process.

She stated that there had been mandatory training challenges during 2021/22 due to the pandemic, however these had been satisfied by the framework requirements. She added that in terms of assurance, the Board of Directors scrutinised safeguarding outcomes detailed in a Reportable Events Paper, presented to each Part 2 Board meeting for assurance.

Mrs C Butterworth noted the higher number of incidents in Greater Manchester and suggested that figures were presented were relative, to reflect the varying geographical populations across the Trust. The Director of Quality, Innovation and Improvement confirmed this would be possible in future reporting.

The Chairman confirmed the importance of the safeguarding function and reporting processes and thanked the team for their hard work during the year.

The Board:

- Noted the assurances within the Safeguarding Report 2021/22.

BOD/2223/35 Health, Safety and Security Annual Report 2021/22

The Director of Quality, Improvement and Innovation presented the Health, Safety and Security Annual Report 2021/22.

She confirmed that Covid had highlighted the importance of staff safety and the agenda had been driven by the Health, Safety and Security Sub Committee including staff side representation, during 2021/22.

She noted that the Violence and Aggression Group had been effective and strengthened during 2022/23 and work reported through the Quality and Performance Committee.

She highlighted that there had been significant activity and good assurance provided in year and staff injury rate for the Trust remained below industry standard and there was confidence that staff were reporting incidents.

She noted the key learning themes around equipment and violence and aggression and noted that there had been some staff shortages in the central team which had impacted on completion of the work programme but that a resolution had been managed.

Mrs C Butterworth queried the process for understanding the effectiveness of the subcommittee. The Director of Quality, Innovation and Improvement

confirmed that do an annual effectiveness review had been undertaken at the end of the year and staff side partners had been included in the process.

Prof A Esmail advised that the report had been received by the Quality and Performance Committee and the section on violence and prevention, in terms of threatening behaviour towards staff had been discussed. He welcomed further updates on the effectiveness of Body Worn Cameras.

The Director of Strategy, Partnerships and Transformation confirmed that a future report on Body Worn Cameras would be presented to the Resources Committee on the roll out of the project.

The Board:

- Noted the assurances provided in the Health, Safety and Security Annual Report 2021/22.
- Noted that a future report on Body Worn Cameras project would be presented to the Resources Committee.

BOD/2223/36 Senior Information Risk Owners (SIRO) Annual Report 2021/22

The Director of Quality, Innovation and Improvement presented the SIRO report 2021/22.

She reported that the Trust's Data Security and Protection Toolkit (DSPT) 2022 submission had given an overall score of 107 out of 110 and she added that two of the three assertions had now been met for the final submission to be made to NHSE.

She provided an overview of the areas included in the report for assurance which included increase in compliance in terms of data security awareness training and risk management.

Mr D Rawsthorn confirmed that he had attended the recent meeting of the Information Governance Sub Committee and had reviewed the final draft prior to Board. He advised that the submission provided assurance and in terms of governance, the subcommittee reported into the Trust's Audit Committee, who had received a full presentation on cyber security arrangements.

The Chairman thanked The Director of Quality, Innovation and Improvement and her colleagues for the report, and he felt assured by the content. He noted that the organisation had come an incredible distance.

The Board:

- Received assurance from the report.
- Noted that MIAA provided an assurance rating of Significant from the DSPT audit completed in 2021.

BOD/2223/37 Complaints Annual Report 2021/22

The Director of Quality, Innovation and Improvement presented the Complaints Annual Report 2021/22.

She reported that the report documented activity and included challenges during the year, which included maintaining activity and managing a backlog during the pandemic.

She highlighted that the extreme pressures had led to the associated right care strategy goals not being met.

She advised that the report detailed the actions taken to place additional staff into the complaints team to provide resilience, to look at systems and processes. She confirmed that the complaints' function had now transferred to the Corporate Affairs directorate, with the intention to allow a root and branch review of the system.

She added that Datix Cloud IQ would fundamentally change the way the team looked at data and extracted data to support learning; she added that the corporate affairs team and Patient Safety Specialist would have resource to provide resilience and reduce harm based on triangulated learning.

The Director of Corporate Affairs recognised that individuals had a significant role in investigations, including key stakeholders and the legal team and risk teams. She confirmed the new arrangements enabled the teams to come together and work holistically.

The Chairman welcomed the learning element of the new process and arrangements and would be interested in future discussions outside of the meeting to understand how these were being implemented.

The Board:

- Noted the assurances provided.
- Noted that extreme pressures during 2021/22 had led to the right care strategy goals not being met.
- Noted the ongoing work to reduce the backlog and the new arrangements in place for 2022/23.

BOD/2223/38 CQC Update

The Director of Quality, Innovation and Improvement provided a CQC update.

She reported that there had been two system inspections during 12th, 13th, 14th April 2022 as part of a wider UEC system inspection in North Mersey and South Cumbria and Lancashire.

She advised that following the inspection, the CQC had issued an interim letter outlining a number of issues and noted that the letter received and the NWAS response had been included in the report.

She noted that forty-six further data items had been requested and had been shared with the CQC. She added that the CQC inspection process included a discussion at Public Board, in response to their letter, and that a subsequent factual accuracy exercise had also been completed.

Mr D Rawsthorn queried the point regarding use of the Xray department as part of standard operating procedures.

The Director of Quality, Innovation and Improvement confirmed the Xray department had been used for overflow as a holding area for ambulance patients when the service experienced pressure points in the system., the area had been a radiology waiting room originally. She noted that the Standard Operating Procedure (SoP) had now been signed off.

The Chairman recognised the challenges at Blackpool and confirmed NWAS, as a leadership team, were working with partners. He added as ARP performance was constantly challenged it wasn't sustainable for ambulance crews to remain in the hospitals.

The Director of Quality, Innovation and Improvement confirmed NWAS were working with Blackpool to ensure handover of patients was safe and it was in response to a request from NHSE/I that space was provided and supported by a SoP which was still in negotiation at the point of the inspection. She added no patients were found to be at risk.

The Chairman requested NED session on future CQC inspection preparation.

The Board:

- Noted the assurance provided within the report.
- NED session to discuss future CQC inspection preparation.

BOD/2223/39 **Quality and Performance Committee Chairs Assurance Reports from the meetings held on 28th March 2022 and 25th April 2022**

Prof A Chambers presented the Quality and Performance Committee Chairs Assurance Reports from the meetings held on 28th March 2022 and 25th April 2022.

She provided a summary of the assurances received and scrutinised the Integrated Performance Reports and sought assurance in terms of mitigating actions to manage risk to patient safety.

The Board:

- Noted the assurance provided by the Quality and Performance Chairs Assurance Reports.

BOD/2223/40 **Resources Committee Chairs Assurance Report from the meeting held on 20th May 2022**

Dr D Hanley presented the Chairs Assurance Report from the Resources Committee meeting held on 20th May 2022.

He referred to the Trust Strategy which had been well received but noted that the Equality Impact Assessment had not been presented for consideration as work was ongoing. He advised that a deep dive on sickness absence had been presented with a further update requested at the January meeting. In terms of the digital update, he noted that further clarity on assurance reporting would be agreed with the Chair of the Audit Committee.

The Board:

- Noted the assurance provided by the Resources Committee Chairs Assurance Report.

BOD/2223/41 **EDI Annual Report 2021/22**

The Director of People presented the EDI Annual Report.

She advised that the report had been considered by ELC and the Trust's Resources Committee. She highlighted that the annual report included information on the EDI priorities which had been previously agreed by the Board.

She reported that there would be a focus on the EDI priority related to representation, which had been impacted by Covid, in terms of engagement with communities. She advised that the Trust had seen an increase in attraction rates particularly around entry grade roles.

She noted that the report outlined the positive work undertaken in relation to networks and the Patient and Public Panel and explained that future work would involve setting out priorities aligned to the Trust Strategy. In terms of the Trust's Diversity and Inclusion Sub Committee she reported that work would be triangulated with departments to deliver objectives.

Prof A Esmail praised the Director of People for a very good report which provided a good base for moving forward and bult upon the report from last year. He raised the point of aligning progress to the baseline figures and data to provide Board with clear sight of developments made.

The Director of People stated that the Trust were committed to ensure that measures reflected the Trust Strategy and recognised the challenges of monitoring successes. She noted that the NHSE had a Regional Director of Public Health which provided access to different sources of data rather than NWAS trying to obtain the data. She added the Trust would be working with partners to triangulate information based on the priorities of public health and other stakeholders.

The Director of Quality, Innovation and Improvement referred to the gender pay gap. She noted that although the Trust had a strong representation of women there was a deteriorating picture in terms of pay gap.

The Director of People confirmed that a Board Development Session would be dedicated to EDI during 2022/23 and highlighted key pieces of work that would contribute over the next 12 months.

The Chairman noted the explicit challenge and the important issue of gender pay gap. He requested a discussion with the CEO and relevant Executives in terms of the ambitious plans and progression.

The Board:

- Approved the EDI Annual Report.
- Noted a discussion led by Chairman and CEO regarding ambitious EDI plans, including gender pay gap, in terms of progression.

BOD/2223/42 **Communications and Engagement Team Dashboard Report Q4 January to March 2021/22.**

The Director of Strategy, Partnerships and Transformation presented the Communications and Engagement Team Dashboard Q4 report.

He provided an overview of work being undertaken across departments within the Trust and social media activity, including the Trust's intranet. He confirmed that Freedom of Information requests had been completed within the period, with 95% compliance.

The Chairman thanked the communications team for the report and the ongoing input of the Trust Networks and Patient and Public Panel.

The Board:

- Noted the content of the Communications and Engagement Team Dashboard Report

BOD/2223/43 **Any Other Business Notified prior to the meeting**

There was no other business notified prior to the meeting.

BOD/2223/44 **Items for inclusion on the BAF**

There were no items identified for inclusion in the BAF.

Date and time of the next meeting –
1.45pm 17th June 2022 (short meeting)
9.45am, 27th July 2022 Public Board meeting

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
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		Update 30.3.22: To be scheduled into a future Board Development Session. Date to be identified. **28.6.22 -** Included on Boad Development Schedule 2022/23	
64	30.03.22	152	Integrated Performance Report	Research undertaken by Public Health Team to be presented to the Quality and Performance Committee to provide the analysis to facilitate efficient distribution of defribillators.	CG	2022/23		Action to be scheduled into a future Quality and Performance Committee. **28.6.22 -** presented to Q&P Committee on 27.6.22	
65	25.05.22	33	Medicines Management Report	Progress update on EPR Project	CG	Sep-22			
66	25.05.22	35	Health, Safety and Security Annual Report	Report on Body Worn Cameras Project to be presented to the Resources Committee.	MP/GB	Jul-22		Body Worn Cameras project aligned to Quality and Performance Committee, report presented to the meeting held on 27.6.22	
67	25.05.22	38	QCQ Update	NEDs meeting to discuss future CQC preparation.	MP/NEDs	Jul-22		Meeting organised for 14.10.22	
68	25.05.22	40	EDI Annual Report	Meeting to discuss delivery of ambitious EDI plans, including gender equality progression.	Chair/CEO/MP LW	Jul-22		Meeting organised for 28.07.22.	

NWAS Board and Committee Attendance 2022/23

Board of Directors								
	27th April	25th May	17th June	27th July	28th September	30th November	25th January	29th March
Ged Blezard	✔	✔	x					
Prof Alison Chambers	✔	✔	✔					
Salman Desai	✔	✔	✔					
Prof Aneez Esmail	x	✔	✔					
Dr Chris Grant	✔	✔	✔					
Dr David Hanley	✔	✔	✔					
Daren Mochrie	✔	✔	✔					
Prof Maxine Power	✔	✔	✔					
David Rawsthorn	✔	✔	✔					
Catherine Butterworth	✔	✔	✔					
Lisa Ward	✔	✔	✔					
Angela Wetton	✔	✔	x					
Peter White (Chair)	✔	✔	x					
Carolyn Wood	✔	✔	✔					

Audit Committee						
	22nd April	12th May	17th June	21st July	21st October	20th January
Prof Alison Chambers	✔	✔	✔	✔		
Prof Aneez Esmail	✔	✔	✔	x		
David Rawsthorn (Chair)	✔	✔	✔	✔		
Catherine Butterworth	✔	x	✔	x		
Dr David Hanley				✔		

Resources Committee						
	20th May	22nd July	23rd September	25th November	20th January	24th March
Ged Blezard	✔	✔				
Salman Desai	✔	✔				
Catherine Butterworth	✔	x				
Dr David Hanley (Chair)	✔	✔				
Prof Maxine Power	x	✔				
David Rawsthorn	✔	✔				
Lisa Ward	✔	✔				
Carolyn Wood	✔	✔				

Quality and Performance Committee										
	25th April	23rd May	27th June	25th July	26th September	24th October	28th November	23rd January	27th February	27th March
Ged Blezard	✔	✔	✔							
Prof Alison Chambers	✔	✔	✔							
Prof Aneez Esmail (Chair)	x	✔	✔							
Dr Chris Grant	✔	✔	✔							
Dr David Hanley	✔	✔	✔							
Prof Maxine Power	✔	x	✔							
Angela Wetton	✔	✔	✔							

Charitable Funds Committee		
	27th April	26th October
Ged Blezard	✔	
Salman Desai	✔	
Catherine Butterworth	✔	
Dr David Hanley	✔	
David Rawsthorn (Chair)	✔	
Lisa Ward	✔	
Angela Wetton	✔	
Carolyn Wood	✔	

Nomination & Remuneration Committee						
	25th May	27th July	28th September	30th November	25th January	29th March
Catherine Butterworth	No meeting					
Prof Alison Chambers						
Prof Aneez Esmail						
Dr David Hanley						
David Rawsthorn						
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.
Catherine	Butterworth	Non-Executive Director	HR Consultant (no live commissions) for NLaG Acture Trust and Beacon GP Care Group				√	Position of Authority	Apr-22		Agreed with Chairman not to accept or start any NHS HR contracts without his prior approval and support.
			Non Executive Director - 3 x Adult Health and Social Care Companies owned by Oldham Countil				√	Position of Authority	Apr-22		Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating) - removed 25th May 2022				√	Position of Authority	Apr-22		4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	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
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	31-Mar-22	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	30-Apr-22	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, Partnerships and Transformation	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	
			Employed at the University of Manchester		√			Professor of General Practice	Apr-21	3rd Mar 22	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority	Apr-21	3rd Mar 22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
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

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	
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	31.3.22	N/A
			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
Lisa	Ward	Director of People	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.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 July 2022
SUBJECT:	Chief Executive's Report
PRESENTED BY:	Salman Desai, Deputy Chief Executive Officer

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☒	☒	☒	☒

SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒

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 25 May 2022.

The highlights from this report are as follows:

Paramedic Emergency Services

- A challenged call pick-up performance, due to staff abstractions for training, however the trust remains one of the better performing trusts on this measure
- ARP performance has increased across all standards
- Improvements in C1 and C2 achieved through improved resourcing

NHS 111

- NHS 111 continues to face recruitment, retention and sickness challenges and is working both locally and nationally with HR teams to address these
- A roster review has commenced although due to the complexities it is not anticipated to be completed until April 2023
- Final funding for 22/23 has been confirmed with all the SDF funding being passed across to NWAS NHS 111 from the commissioners

PTS

- PTS performance is reported one month in arrears. Year to date (July 2021 - May 2022) is performing at 22% below baseline

	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 recommended 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 25 May 2022

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

Throughout May and June we have continued to deliver training to the control staff in preparation for the NHS Pathways introduction late July and early August. This has impacted on call pick-up as we have abstracted staff to deliver the training courses. This has meant a challenged call pick-up performance, but we remain as one of the better performing trusts on this measure. NHS Pathways is on track to go live in Greater Manchester 26 July and Cheshire & Mersey 9 August. We continue to see the benefits in Cumbria & Lancashire of reduced C1 calls and increased Hear & Treat. It is anticipated we will see similar benefits as we roll it out further.

We have seen increased ARP performance across all standards. We are still only achieving the C1 90 metric but real improvements in C1 and C2 can be demonstrated. These improvements have been achieved through improved resourcing as Covid absence has reduced.

We celebrated the Platinum Jubilee in June and the 4-day bank holiday weekend was catered for with a dedicated operational plan for Service Delivery. The plan was very effective and NWAS was commented on nationally as being a robust performer over the challenging weekend.

2.2 NHS 111

The NHS 111 service continues to receive high call demand, however, June saw a slight improvement in performance of the calls answered in under 60 seconds KPI to 32.3%.

NHS 111 continues to face recruitment, retention and sickness challenges and is working both locally and nationally with HR teams to address these. The main cause of staff absence remains stress/anxiety/depression, and the 111 team have a number of projects in development and delivery phases to support staff to return/remain in work.

The 111 operational team await the ORH (Operational Research in Health Ltd) report, due for publishing in early to mid-August, which will identify the most efficient and effective delivery model for NWAS 111. The report will be shared with the regional NHS E/I team and commissioners and will inform future service provision.

Following Covid and the significant change in the demand profile in 111, a roster review has commenced. Due to the timeframe required to complete such a complex, collaborative project, it is not anticipated to be completed until April 2023. The NHS 111 team are working in collaboration with the 4 trade unions (Unison, GMB, Unite and RCN) and have agreed the core principles and have commenced diarising of the working parties.

Final funding for 22/23 has been confirmed with all the SDF funding being passed across to NWAS NHS 111 from the commissioners. This enables NHS 111 to continue to maintain the training and audit roles, on short term secondments, and maintains the ability to deliver the required recruitment and training levels for this year to optimise our staffing capacity.

The NWAS pilot project of SMS messaging for Self-Care went live in March 2022, with the support of colleagues in NHS Pathways. Following evaluation of the data there is a reduction of 20% of the average handling time (AHT) for the calls where self-care advice is delivered using the SMS method. As this is still a pilot, with oversight from NHS Pathways, the 111 team have taken the opportunity to investigate further opportunities to utilise SMS in the 111 space. A proposal is being prepared to share with NHS Pathways in early August.

At the end of June NHS E/I requested the development of an Improvement Plan for NHS 111. The team worked with commissioners to develop the plan which was presented at ODG on the 12th of July. The plan sets out improvement areas for NHS 111, alongside system improvements needed to support NHS 111 to prepare for winter and improve patient care.

2.3 **Patient Transport Services (PTS)**

PTS performance is reported one month in arrears. Year to date (July 2021 - May 2022) is performing at 22% below baseline

3. ISSUES TO NOTE

3.1 **Local Issues**

Visit from Greater Manchester Mayor

At the beginning of June, Parkway EOC welcomed the Mayor of Greater Manchester, Andy Burnham.

Chair, Peter White, Deputy CEO, Salman Desai, and I met Andy and we had a chat about various local GM matters including performance, hospital handovers and the Manchester Arena Inquiry.

The Mayor enjoyed talking to staff in the emergency operations centre, who gave him a great insight into the day-to-day job but also how we responded to the challenges of the pandemic. We were able to show him some digital innovations – thanks to Jonny Sammut, Head of Digital Intelligence, for talking through our work on smart stations, virtual reality and more; Andy was also very interested in hearing more about a local knife crime project that Advanced Paramedic, Kirsten McDermott, has been involved with.

We were able to give him a true insight into some of the challenges we face, but also demonstrate the brilliant work staff do and how we're always trying to innovate and make improvements for the future.

EOC live on air

The trust recently opened the doors of our Parkway EOC to BBC Radio Manchester to give listeners an insight into how we work.

In interviews broadcast throughout the day, a range of staff were interviewed, including emergency medical advisors, members of the dispatch team and the Clinical Hub, and Integrated Contact Centre Director, Dan Ainsworth.

The team did a fantastic job, showing a true picture of the challenges of dealing with the increased demand throughout the pandemic and since. They were also able to talk about the investments we've made in that time and what we're doing to help keep patients safe, including boosting the numbers of our Clinical Hub and call handling staff to deal with the increased call numbers.

3.2 **Regional Issues**

Super Star Awards

This year's staff awards celebration was bigger and better than ever before to make up for missed opportunities during the pandemic.

A record-breaking 400 nominations were submitted for colleagues across the 10 awards categories, which aim to recognise and celebrate their achievements whether for going the extra mile, showing courage, achieving something outstanding or being seen as an influencer and motivator.

Around 440 people attended the ceremony at Bolton Whites Hotel, including those who were shortlisted for an award; those who were allocated tickets in the staff open raffle and our 2020 Star Award winners who didn't have their official awards ceremony when Covid-19 hit. Comedians Dave Spikey and Steve Royle from Britain's Got Talent gave their time free-of-charge to host the awards ceremony, and the after party had entertainment from Squeeze Box, whose front man is Consultant Paramedic, Vinny Romano. The event brought together people from all parts of the organization, including a Community First Responder from Cheshire, the Support Centre team from Carlisle, and various frontline and corporate teams.

The Super Star Awards is funded entirely through charitable donations and sponsorship. A massive well done to all the Super Star Award Winners and shortlisted nominees and especially the Communications Team who spent months planning the evening to ensure it ran without a hitch

Out and About

I once again took the opportunity to visit sites around Merseyside.

I attended the Senior Paramedic Team Leaders training day in the Wirral before heading to Wallasey station where I met the staff and fleet maintenance team. Then I went onto Moreton and Heswall stations, and Arrowe Park emergency department before finishing up at Birkenhead joint fire and ambulance station. I then visited Fazakerley station and met a number of staff including the ICT and estates teams based there, before ending the day back in Liverpool City Centre.

I was also able to spend some time at the NHS Confed Expo, which was held in Liverpool this year. It was a good opportunity to catch up with ambulance service colleagues from across the country and have conversations with senior NHS leaders about what we're doing at NWAS and some of the opportunities and challenges we are facing at the moment. Hospital handovers was a hot topic and it was good that I was able to share some of the positive improvements we have made in the North West.

Another topic of conversation was the recent Messenger review, a report that looks at NHS Leadership. The report was well-balanced, while it highlighted some really good examples of leadership in the NHS, it also identified room for improvement, particularly around managing talent, increasing diversity and improving culture. Within the ambulance sector, and within the People Directorate at NWAS, there is so much positive work going on to support our leaders, so we're in a really good position to take on board some of the findings of the review and ensure we're addressing them.

CQC Findings

The CQC conducted an inspection of NWAS on 12-14 April 2022 as part of a wider UEC system inspection in North Mersey and South Cumbria & Lancashire. Draft reports were received by NWAS during May and a factual accuracy process was completed. The final inspection reports for Emergency and Urgent Care, the Emergency Operations Centre and 111; as well as system wide summaries were published on the CQC website on 22 July. The NWAS Rating has not been assessed and NWAS remains rated as "Good'. Selected examples of good practice identified within the reports at NWAS include: infection control; staff involvement and treating people with compassion, kindness, dignity and respect; innovation and improvement; and risk management systems. The CQC has issued no 'Must Do' findings, and only 3 'Should Do' findings for UEC and 3 'Should Do' findings for 111 (6 Should Do findings in total).

The 6 'Should do' relate to:

1. The trust should ensure it continues to take appropriate actions to improve ambulance response times in line with nationally agreed targets (EUC)
2. The trust should continue to influence and play a key role in the increasing demand on urgent and emergency care capacity, patient harm, and unmet patient needs throughout urgent and emergency care along with system partners and others. This should include a focus on improving the safety and effectiveness of services for patients and of its frontline and support staff (EUC)
3. The trust should develop clearer guidance for staff for the cleaning frequency of ambulance vehicles (EUC)
4. Continue to proactively monitor call demand to ensure staffing levels are appropriate (111)
5. Continue to review call audit data to meet the required national targets (111)
6. Continue with plan of safeguarding training for all clinicians (111)

An action plan has been shared in response to the CQC during the factual accuracy process; and learning from the inspection has been collated. The action plan and updates will be shared and reviewed via the Quality and Performance sub-committee and through to Board.

3.3 **National Issues**

Ambulance Leadership Forum

The annual Ambulance Leadership Forum (ALF) is being held on 6-7 September and the Association of Ambulance Chief Executives (AACE) is inviting abstract submissions to present at the event.

Those whose submissions are successful will be invited to do a 10-minute presentation at the event. The presentation should relate to service delivery and/or leadership within ambulance services and/or the paramedic profession. It should be evidence-based and drawn on staff's own work, for example, in research, service evaluation, quality improvement, audit or service improvement initiatives.

Successful applicants will also need to produce a poster about their work to be displayed at the event. This is a really good opportunity for staff to showcase a piece of their own work to the wider ambulance sector. It would be great to have lots of submissions to choose from and fantastic to hopefully see NWAS represented in one of the five papers that will be selected to be delivered to the conference.

Hospital handovers

A report by the Healthcare Safety Investigation Branch (HSIB) called on the Department of Health and Social Care to lead a national response to tackle hospital handovers, highlighting patient safety issues arising from flow into, through and out of hospitals. It reports the link between delays in being able to hand patients over and getting ambulances back on the road to respond to other incidents, contributing to people waiting longer than they should.

Hospital handovers continue to present challenges across the North West and it is absolutely right that it should get this level of national scrutiny and response. But whilst the headlines contain a lot of negativities some impressive work has been done in the region to drastically improve the handover situation. We are performing well in the North West when it comes to hospital handover times, compared with other parts of the country that are seeing waits in excess of 18 hours all too often.

There are still too many delayed handovers and we're still seeing safety concerns reported relating to hospital handovers, which is not acceptable. However, real progress has been made by working in partnership with our regions hospitals to help drive down these delays.

We acknowledge there is more to be done and local operational teams working alongside our quality improvement colleagues can continue to make a real difference in this area.

4. GENERAL

Deputy Chief Executive appointment

I am pleased to announce the appointment of Salman Desai as Deputy Chief Executive after a competitive interview process. Salman will take on the responsibilities in addition to his role as Director of Strategy, Partnerships and Transformation.

Salman's career in NWAS began on the frontline at Bury Ambulance Station and spans 25 years. During that time, he has worked as a paramedic and in roles across training, with the drug and alcohol action teams, service development, in a large teaching hospital as the transformation lead, strategy and planning and most recently as the director responsible for strategy, transformation, partnership and integration, programme management office, communications and engagement.

Platinum Jubilee coins for all staff

The eligibility criteria for receipt of the Jubilee Medals was set nationally by the Department of Health and Social Care and together with police and fire chiefs, we did write asking for other grades of staff to be included. Unfortunately, this was not approved.

The Trust Board and I are of the view that every member of staff across all service lines is deserving of recognition for their commitment, perseverance and hard work and, for this reason, I have worked with my AACE colleagues to commission the design of a unique minted Queen's Platinum Jubilee commemorative coin that has been distributed to all NWAS staff and volunteers.

The coin will be presented in a bespoke, printed velvet presentation box and features the Crown Badge emblem. It is the same for each ambulance trust and is intended to convey sincere appreciation and recognition of unwavering service as well as being reflective of our ambulance service values.

Celebrating the Platinum Jubilee

Jubilee party packs were distributed to all locations to help staff celebrate the historic occasion that was the Queen's Platinum Jubilee.

As the country celebrated with street parties and family gatherings, many staff were working hard across our services to ensure our communities continued to receive the best possible care and support.

A special thank you to everyone who worked over the Bank Holiday weekend, whether out on the road assisting patients, handling 111 or 999 calls, or working 'behind the scenes' in a support service. As with the Easter holiday, all NWAS services were well-prepared for an increase in activity, so while it was busy as predicted, we coped well.

I have heard and read the many stories of the various activities that took place across the trust to celebrate the Queen's Jubilee; from tea parties to more formal events, where I know a number of staff represented the trust. I was proud and humbled to represent not just NWAS but the ambulance sector at the National Service of Thanksgiving at St Paul's Cathedral followed by a formal lunchtime reception at the Guildhall in London with Her Majesty and other members of the Royal Family.

The Jubilee Bank Holiday, coupled with warmer weather and lots of local events, saw an increase in demand across NWAS and NHS 111 specifically experienced a huge increase in activity. For example, over the four-day weekend, our team experienced almost double the usual amount of calls for help with emergency medicine supplies / repeat prescriptions – many more than 111 services in other parts of the country. This is a wider system issue that has been raised with NHS England.

Team Talk Live

After every Board of Directors meeting, Chair, Peter White, and I hold a live MS Teams session for staff – Team Talk Live – to give everyone an insight into what we discussed, any decisions made, and give an overall organisational update.

Peter and I were joined by Salman Desai, Deputy CEO/Director of Strategy, Partnerships and Transformation, who gave us an update on the trust strategy refresh

As always, we were asked plenty of questions in our Q&A session, topics included electric vehicle charging points, the new national ambulance specification, long service awards, pay and contracts.

National Volunteers Week

Our amazing volunteers should be celebrated all year round, but 1-7 June was national 'Volunteers' Week' and the perfect opportunity to shine a spotlight on the incredible contribution that volunteers make to NWAS.

More than 1,000 people volunteer for NWAS, helping to make a positive difference to all staff and patients: from community first responders and BASICS doctors who work alongside the paramedic emergency service to save lives; to volunteer car drivers who provide a vital service for many people who need help getting to and from important medical appointments; to our Patient and Public Panel members who represent the patient voice and influence how our services are run and make improvements.

To help understand the scale of their contribution:

- Our team of 650 community first responders have given more than 110,000 hours (or 4,500 days!) of support in the last year
- 1 in 16 patient transport journeys is made by a volunteer car driver
- We have more than 200 patient and public panel members, of all ages and backgrounds, contributing to projects across the trust

Without each and every one of our volunteers, we couldn't continue to do what we do and deliver the best possible service to the people of the North West. This has been especially true during the last couple of years when our volunteers stepped up to help us respond to the pandemic.

Pride Month

Trust headquarters proudly flew the LGBT flag making Pride month when events across the world are held to recognise and celebrate members of the LGBTQ+ community and reflect on the struggle for equality. The work of the network was promoted throughout June.

We have a brilliant LGBT network which is open to all staff and focuses on improving the staff and patient experience for the LGBTQ+ community.

Corporate Teams

The Finance Team is just one of the many corporate teams working hard behind the scenes to keep the organisation running smoothly.

The end and start of each financial year is a particularly busy time for the team, which has recently received some well-deserved praise for its work.

External audit is an essential part of the process of accountability for public money, providing an independent review of NWAS' accounts and financial statements. The external auditors have to be satisfied that proper arrangements are in place for securing economy, efficiency and effectiveness in our use of resources. The external auditor reports back to the audit committee on any significant findings from the audit that need to be addressed.

For our 2021/22 accounts (year-ending 31 March 2022) the Finance Team had a very challenging deadline to prepare and complete the draft unaudited accounts. The External Audit Completion Report and final audited accounts have now been received and signed off by the Audit Committee and Board of Directors, and have provided the trust with a significant level of assurance. A key element is also the value for money (VFM) conclusion and, like last year, the auditor has no recommendations to make. This reflects very well on the organisation overall

Recognising our Armed Forces colleagues

During June there was a series of celebrations to mark the contribution of our colleagues who work in the armed forces.

Flags were raised across our sites to honour Reserves Day and Armed Forces Day and there were events at several locations to shine a light on the work of some of the many armed forces personnel we have in NWAS.

A small group of representatives travelled to Oxfordshire to visit the Royal Logistics Corp barracks in Bicester, which is the base of the military personnel who supported us earlier this year.

A coin parade and formal presentation ceremony was held to recognise the achievements of the 150 personnel and 30 command support colleagues who came to work in the North West for up to 10 weeks at the start of the year.

During that time, they partnered with our paramedics, emergency medical technicians and urgent care assistants to respond to more than 12,000 incidents. Whilst the vast majority of these would have been lower acuity incidents, I'm sure the kind and caring approach from our military colleagues would have made a difference to patients and their loved ones. By attending those 12,000 incidents with us, they allowed other paramedic crew resources to be prioritised for life-threatening emergencies, significantly helping us to manage the increased demand we were facing.

Dave Kitchin, Area Head of Service, passed on my sincere gratitude to everyone in attendance. I know many staff who worked with our military colleagues really did value their assistance and enjoyed getting to know them, and we were sure to relay these warm sentiments.

My thanks go to Jan Barnes-Orme and Caroline Hastings who were instrumental in arranging the visit to Bicester, ensuring that each person received a framed certificate of appreciation and Covid-19 pin badge to mark their time with us. Two of the personnel were also presented with Chief Executive Special Commendations after they were nominated for going above and beyond in their duties while working with us.

Cyber security

The NHS has been alerted to the heightened risk of Russian cyber attacks and it is under instruction from NHS Digital that we have introduced an extra layer of cyber security into the trust – multi-factor authentication (MFA) and although this did lead to challenges accessing trust systems, emails etc on devices including mobile phones and iPads, the ICT department has done a lot of work to make our systems and devices safe from a heightened risk of cyber-attacks. This is absolutely vital in order to protect our services and data from being compromised by cyber criminals.

Celebrating International Paramedics Day 2022

Since the news at the start of this year that International Paramedics Day was being launched by the College of Paramedics, there has been a real buzz among ambulance trusts as to the celebrations taking place to mark it – it is the first time we have had a day dedicated to the paramedic profession.

We launched our week of celebrations on Friday 1 July starting with a message from Chief Consultant Paramedic, Mike Jackson, who has been a paramedic for over 36 years. Mike talked about loving every minute of providing care for patients in those years. It is this passion for patient care that I see every day from our teams, whatever their role, and it makes me proud to lead a service which means so much to the public.

I joined the NHS at 16 and the ambulance service at 19, and for over 26 years I've been proud to be a paramedic.

I remember as if it were yesterday, how proud I was to become a paramedic and I can still remember many of the jobs I attended back in the early 1990's, where they were, who attended, what happened, the outcome and some with joy and others with real sadness. I also remember how proud I was in 2001 when I became one of the first paramedics to pass the Diploma in Immediate Medical Care from the Royal College of Surgeons Edinburgh. This was even more special as my Dad who had terminal cancer was able to join me in Surgeons Hall and watch me graduate before sadly passing away shortly afterwards.

I am still a registered paramedic and really enjoy, albeit not as much as I would like, going out on shift and doing the job, seeing first hand how our staff all work together to be at their best, making a difference daily to the lives of so many people. Our staff are here because they care and because they are excellent at what they do, and it shows as we receive hundreds of thank you messages from patients and their friends and families.

Being part of an ambulance crew isn't an easy job – we are facing real pressures within the system, and I appreciate just how hard our staff have worked over the last two years and beyond. The personal achievements many have made in this time, on top of the pressures faced, have been phenomenal.

It is humbling for me to see the impact our staff have and makes me proud to be part of this profession, proud to be a paramedic, and proud of every person, in every role, who makes up Team NWAS.

Integrated Care Systems from 1 July

On Friday 1 July, we saw a big change to the way the NHS system is structured. Integrated care systems (ICSs) legally became responsible for the planning and funding of health and care services.

ICSs have been operating in 'shadow form' as partnerships of health and care providers for some months now, but the legal changes that came into force mean clinical commissioning groups (CCGs), which were previously responsible for funding of NHS services, have now been dissolved and their function has been taken over by the ICSs.

Each ICS has:

- An integrated care partnership, which is a committee made up of health and care partners in that area, responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area
- An Integrated Care Board, which is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

There are also place-based partnerships, provider collaboratives and involvement from local authorities in ICSs. This means that we are in a unique position as we deliver services across several ICSs:

- Lancashire and South Cumbria ICS
- Cheshire and Merseyside ICS
- Greater Manchester ICS
- North East and North Cumbria ICS
- Derbyshire ICS (Glossop area)

While the functions and duties of our service will remain unchanged, as part of each ICS in our region, we are duty-bound to collaborate with partner organisations at ICS 'system' level and more locally at 'place' level.

As many of our managers will know, over recent years we have increasingly been expected to look beyond our organisational priorities to focus on system-wide objectives to improve patient outcomes. In fact, this is a fundamental part of our Urgent and Emergency Care Strategy, the NHS Long Term Plan and our soon-to-be-launched new trust strategy for 2022-2025.

Alongside the work of existing senior managers in our service, our Partnerships and Integration Team has strengthened our position as a collaborative organisation. The team is building effective stakeholder relationships and produces a regular briefing for managers who meet and engage with external partners called NWAS Link.

The ongoing recruitment of Area Directors at NWAS is the next step to ensure that NWAS is an active and influential participant at each of the ICSs in our region.

The Area Directors' portfolios will span service lines, so what we can expect to see in the future is a more integrated service with a greater mix of opportunities for staff both inside and outside of this organisation and, of course, better outcomes for patients; fundamental to all our roles in the NHS.

Death of former staff member Kath Adams

It is with great sadness that I write to inform you of the death of our former colleague, Kath Adams

Kath passed away on 8 July after a 5-year battle with cancer. Kath worked for NWAS (formerly Lancashire Ambulance) for over 25 years as a secretary within PES. She was known for her love of all animals and was a kind-hearted person who would help any of her friends and colleagues. She will be fondly remembered for her dry sense of humour and delightful quirkiness

The trust sends sincere condolences to her family, colleagues and friends.

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 recommended to:

- Receive and note the contents of the report.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27 July 2022
SUBJECT:	Q1 Board Assurance Framework Review
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs
LINK TO BOARD ASSURANCE FRAMEWORK:	

SR01	SR02	SR03	SR04	SR05
☒	☒	☒	☒	☒

SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The Corporate Risk Register can be seen in Appendix 1 and the proposed Q1 (as of 30 June 2022) of the Board Assurance Framework (BAF) with the associated Corporate Risk Register (CRR) risks scored ≥15 can be viewed in Appendix 2. The BAF Heat Maps for 2022/23 year to date can be viewed in Appendix 3. The Executive Leadership Committee (ELC) recommends the following Q1 changes (s4): • Decrease in risk score of SR02 from 20 to 16 • Decrease in risk score of SR03 from 20 to 15 • Decrease in 2022/23 target risk score of SR09 from 15 to 10 • Decrease in the final target risk score of SR09 from 10 to 5
RECOMMENDATIONS:	The Board of Directors are requested to: • Agree the decrease in risk score of SR02 from 20 to 16 • Agree the decrease in risk score of SR03 from 20 to 15 • Agree the decrease in 2022/23 target risk score of SR09 from 15 to 10 • Agree the decrease in the final target risk score of SR09 from 10 to 5 • Agree the Q1 position of the Board Assurance Framework.
CONSIDERATION OF THE TRUST'S 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

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Assurance Committees, ELC and Audit Committee			
	Date:	Throughout Q1		
	Outcome:	For Assurance		

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1. PURPOSE

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

This paper provides an opportunity for the Board of Directors to review the 2022/23 Q1 position of the Board Assurance Framework (BAF) along with the Corporate Risk Register (CRR) risks scored 15 and above that are aligned to each BAF risk.

2. ASSURANCE PROCESS

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

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

3. REVIEW OF THE CORPORATE RISK REGISTER

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

4. REVIEW OF THE Q1 BAF POSITION

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

SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services

- Decrease in current risk score for Q1 from 20 to 16

Opening Score 01.04.2022	Q1 Risk Score	Exec Lead
20 4x5 CxL	**16** 4x4 CxL	Ms C Wood

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

1. The Trust has an approved financial plan, although in a deficit position, the Trust has received confirmation for additional recurrent funding for the ambulance sector which will result in a recovery of the deficit position

2. The additional recurrent funding will de-risk some of the assumptions made in the approved opening plan
3. Based on the recurrent funding, the financial plans will be reviewed and reported to the Resources Committee and Board of Directors in July 2022
4. The efficiency requirement whilst remaining high at 5%, this has reduced slightly in the draft plans to 4.18%; 2.18% recurrent and 2% non-recurrent
5. Further capacity modelling will be undertaking during H1 to inform the recurrent funding required to deliver safe and effective services.

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

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

Opening Score 01.04.2022	Q1 Risk Score	Exec Lead
20 5x4 CxL	**15** 5x3 CxL	Mr G Blezard

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

1. NWAS is in the top three on the balanced scorecard for ambulance trusts across the country
2. Improvements seen in all ARP standards for May and June 2022
3. Decrease in Category 2 long waits
4. Expected for performance deterioration in Q2 due to high abstractions, performance demands and COVID-19
5. Additional funding envelope has been agreed to increase NWAS internal resources
6. NHS Pathways is live in Cumbria and Lancashire, with Cheshire and Merseyside and Greater Manchester on plan for implementation in August 2022
7. PTS has resumed to pre-COVID for loading configurations
8. A Workstream and Action Plan by NWAS and Commissioners has been jointly agreed.

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

- Decrease in 2022/23 target risk score from 15 to 10
- Decrease in final target risk score from 10 to 5

Opening Score 01.04.2022	Q1 Risk Score	2022/23 Target	Final Target	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL	Prof M Power

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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

The Board Assurance Framework contains the application of the Trust's Risk Appetite Statement and has been reviewed as part of the Q1 BAF Review process.

6. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

7. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the decrease in risk score of SR02 from 20 to 16
- Agree the decrease in risk score of SR03 from 20 to 15
- Agree the decrease in 2022/23 target risk score of SR09 from 15 to 10
- Agree the decrease in the final target risk score of SR09 from 10 to 5
- Agree the Q1 position of the Board Assurance Framework.

Appendix 1:
Corporate and Commercially Sensitive Risk Register (15+ risks) at 29 June 2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3255	24/04/2020	There is a risk of continued sub-optimal functionality, effective and efficient use of Datix Web because of data inaccuracies, current system functionality and limited use across the organisation which may impact negatively on compliance with regulatory requirements.	Approved Risks	Project	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Angela Wetton	12	Treat - Implement controls and mitigating actions to reduce the risk.	5	3	15	1. DCIQ Contract 2. DCIQ Service Level Agreement 3. Datix Web Server move to RLDatix Cloud 4. DCIQ Business Case 5. DCIQ Project Initiation Document 6. DCIQ Project Controls 7. DCIQ Project Plan 8. DWeb BAU Governance and Processes 9. DCIQ Health Check - PMO Assurance 10. NWAS Controlled Release Customer	1. DCIQ Launch 2. DCIQ Reporting Requirements (YellowFin) 3. DCIQ Reporting Requirements (NWAS) 4. DCIQ Data Dashboards (NWAS) 5. Controlled Launch of DCIQ 6. NHSEI Patient Safety Strategy Delivery 7. LFPSE Functionality 8. DWeb Change Requests 9. DCIQ Education & Learning 10. DCIQ Communications 11. DCQ Project Resource 12. N3/ Gateway Connection	1. Project initiation document (PID) 2. DCIQ Project Plan 3. DCIQ Health Check Assurance Reports 4. DCIQ Project Exemption Reports 5. DCIQ Project Progress Reports 6. DCIQ Project Board Agenda & Minutes 7. DCIQ Project Controls Documentation: Issues Log 8. DCIQ Project Controls Documentation: Lessons Learnt Log 8. DCIQ Project Controls Documentation: Risk Register 9. Presentations/ Assurance to CPB 10. DCIQ Project Resource Extension Report (ELC) 11. DCIQ Roadmap	1. Final DCIQ Project Plan 2. DCIQ Project Delivery (Launch Date) 3. DCIQ Education and Training Packages 4. DCIQ Data Quality/ Assurance 5. DCIQ Data Triangulation 6. DCIQ Data Interoperability with NWAS Data Warehouse 7. N3/ Gateway Connection Completion 8. RLDatix DCIQ Roadmap Delivery	3	13/06/2022	13/07/2022
3210	26/02/2020	There is a risk that due to strategic interdependencies not being aligned to the Estates Strategy, timescales will be delayed resulting in the non-delivery of the Estates Strategy.	Approved Risks	Financial	Estates and Facilities Management	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	20	Treat - Implement controls and mitigating actions to reduce the risk.	3	5	15	Estates Contact Centre Programme Group Trust IBP has links with all key Trust strategies Corporate Programme Board has oversight of Estates Strategy progress Oversight Forum established August 20 UEC Report approved by the Corporate Programme Board highlighting preferred option and spec. EOF to provide oversight HART Project Group established to proceed OBC	Functional strategies from all key areas including estates elements Outcome of options from Estates Contact Centre Programme Group Workforce Analysis - action for LM Business Case may require submission to NHSI for approval	Strategic Implementation Plan Through quarterly meeting reports to Resources Committee PMO High Level Plan completed, updates regularly presented at EOF Meeting held with property management (Orbit) to gain their understanding and support EOF established Aug 20 Training highlevel oversight PMO/CPB highl level plan Task and Finish Group established in May 21 Strategic Delivery Board established Nov-21 of which the AD estates, fleet & FM is a member	Limited necessary resources available resulting in not able to complete working group tasks to schedule Trust decision on strategic direction of EOC. HART option 8, Ops changing data/scope from original ELC paper putting it in jeopardy, local resistance to proposal high though no viable alternative proposed. Awaiting decision by ELC re HART report May 22 and further CCR report to be submitted 01-Jun-22	5	23/06/2022	29/07/2022
3643	13/05/2022	There is a risk that 2022-23 statutory financial duties will not be achieved due to a forecast £6.7m deficit which includes a challenging CIP; increased estimated 2022-23 inflation rates; continuation of Covid 19 and associated additional expenditure, resulting in a failure to achieve statutory breakeven duty.	Approved Risks	Financial	Value for Money/ Efficiency	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	15	Treat - Implement controls and mitigating actions to reduce the risk.	3	5	15	Financial Plans have been submitted to the ICS with a planned deficit of £6.7m and approved by the Board in May 2022, which is driven by £3.6m for Covid-19 quarter one costs associated with third party support to PTS which is still being incurred whilst revised national IPC guidance is reviewed and implemented, and £3.2m anticipated excess non pay inflation above national funded rates. As Covid 19 expenditure is forecast to reduce nationally with the de-escalation of the pandemic, the national planning guidance indicated a 57% reduction to systems allocations. NWAS's share of system funding has now been confirmed at £40.5m for Covid-19, top up and growth, with NWAS's Covid -19 specific allocation at £7.0m NHS block contract income equalling £373m for PES, PTS and 111 contracts have been agreed with all North-West CCGs which includes a net uplift of 1.7% in line with national planning guidance. Therefore 84% of NWAS total planned income (£446m) is covered by agreed NHS contracts. Further additional growth has been agreed by North-West inter ICS's to fund 3.4% forecast growth in PES activity, equating to an additional £7.5m income. Efficiencies have been included in plan based on 3% recurrent efficiency target (£11m), plus an additional 2% non-recurrent efficiency target (£7.3m). The Trust has identified £7.8m efficiencies schemes leaving an unidentified gap of £10.4m. The Efficiency and Productivity Oversight group will be responsible for the delivery of efficiency plans within the financial year and identify schemes to achieve the remaining balance to ensure the CIP programme is fully identified and achieved. Additional £9.4m national ambulance Call Handling/Winter allocation is anticipated to fund additional PES call handlers as per national planning guidance FAQs Monthly Finance Reporting to ELC and Resources Committee detailing financial performance to date compared to plan, commentary on significant variances and risks, indicting if/when remedial actional to be taken. Cashflow will continue to be closely monitored to ensure there is no negative impact on the Trust to meet payment obligations.	Efficiency and Productivity Oversight group are yet to meet formally. Whilst financial agreement has been obtained with all North-West CCGs, formal NHS contracts are yet to be completed and physically signed, therefore implied contracts are currently in operation, reducing the effectiveness of this control. Process to receive additional 999 call handling funding from NHSE/I is still unknown.	M1 financial position is a deficit of £1.413m , which is £0.047m better than the year to date planned deficit £1.460m. Whilst NHS 111 SDF allocations have not been formally confirmed, lead commissioners have paid the full assumed monthly allocation for month 1.	Nationally the financial plans have yet to be formally approved, requiring resubmission in June 22 due to a national deficit position. NHS 111 SDF and continuation of winter allocations are yet to be confirmed	10	23/06/2022	29/07/2022
3630	22/04/2022	There is a risk that due to the lack of assurance regarding medical devices that the organisation may not be sighted on safety critical risks which may lead to device failure, patient safety incidents or staff safety incidents and potential regulatory enforcement.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Chris Grant	20	Treat - Implement controls and mitigating actions to reduce the risk.	4	5	20	Medical Devices Alert action log implemented from 1.5.22 Review medical devices policy to incorporate assurance framework	Assurance to be sought via clinical effectiveness sub committee	Senior Clinical Quality Manager reviews alerts and distributes to appropriate person	No action log to monitor compliance with the healthcare or medical device alerts	5	23/06/2022	29/07/2022

North West Ambulance Service NHS Trust

APPENDIX 2

BOARD ASSURANCE FRAMEWORK 2022/23

BOARD OF DIRECTORS

WEDNESDAY 27 JULY 2022

nwas.nhs.uk

Q1 2022/23 Reporting Timescales:

Quality & Performance Cttee:	25/07/2022
Resources Cttee:	22/07/2022
Executive Leadership Cttee:	20/07/2022
Audit Cttee:	21/07/2022
Board of Directors:	27/07/2022

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

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

Board Assurance Framework Legend

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

OUR STRATEGY AT A GLANCE

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

Values:

WORKING TOGETHER.

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

BEING AT OUR BEST.

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

MAKING A DIFFERENCE.

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

Priorities:

Urgent and Emergency Care

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

Quality

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

Digital

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

Business and Commercial Development

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

Workforce

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

Stakeholder relationships

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

Infrastructure

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

Environment

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

Supporting strategies:

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

BOARD ASSURANCE FRAMEWORK DASHBOARD 2022/23

BAF Risk	Committee	Exec Lead	01.04.22	Q1	Q2	Q3	Q4	2022/23 Target	Final Target
SR01: There is a risk that the Trust may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL				**15** 5x3 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services	**Resources**	**DoF**	**20** 4x5 CxL	**16** 4x4 CxL				**16** 4x4 CxL	**8** 4x2 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**15** 5x3 CxL				**15** 5x3 CxL	**5** 5x1 CxL
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	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**4** 4x1 CxL
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	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**5** 5x1 CxL
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	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL				**8** 4x2 CxL	**4** 4x1 CxL
SR08: (**Commercially Sensitive Risk**)	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL				**8** 4x2 CxL	**4** 4x1 CxL
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.	**Quality & Performance**	**DoQII**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**5** 5x1 CxL
SR10: (**Commercially Sensitive Risk**)	**Resources**	**DoSPT**	**20** 5x4 CxL	**20** 5x4 CxL				**15** 5x3 CxL	**10** 5x2 CxL
SR11: (**Commercially Sensitive Risk**)	**Resources**	**DoOps**		**12** 4x3 CxL				**4** 4x1 CxL	**4** 4x1 CxL

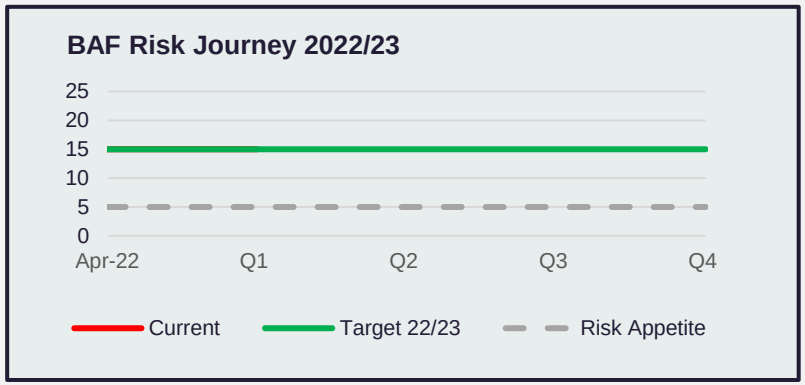
BOARD ASSURANCE FRAMEWORK 2022/23

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

Strategic Priority: Quality & Digital

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	15	15				15	5
	5x3	5x3				5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has maintained at a score of 15 due to ongoing pressures across NHS 111, PTS and 999 services that sees delivery against ARP standards on going concerns. The greatest clinical risks are deemed to reside in excessive waits in Category 2. This has been significantly mitigated with several clinical initiatives and improved and now stabilised in the previous quarter. In terms of improvement steps, considerable ongoing focus is required to address hospital handover delays and the harm associated. In addition, the workstreams for maternity and MH throughout 22/23 address the high-risk patient groups across all service lines. With reference to digital, the delivery of single primary triage system and Phase 2 of EPR are critical steps to provide both operational resilience and patient centred care across the North West footprint.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD (PBM/ 2223/24)
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report **Level 2:** HS&S Sub Cttee Chairs Assurance Report **Level 2:** Patient Safety Sub Cttee Chairs Assurance Report **Level 2:** Clinical Effectiveness Sub Cttee Chairs Assurance Report	Reported to BoD (BoD/ 2223/31) Reported to BoD (PBM/ 2223/12) Reported to Q&P Cttee (QPC/ 2223/35) Reported to Q&P Cttee (QPC/ 2223/34) Reported to Q&P Cttee (QPC/ 2223/33)
Clinical Audit	**Level 2:** 2022/23 Clinical Audit Plan	Reported to Q&P Cttee (QPC/ 2223/31)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework **Level 2:** IPC Sub Cttee Chairs Assurance Report	Reported to Q&P Cttee (QPC/ 2223/53) Reported to Q&P Cttee (QPC/ 2223/55)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Duty of Candour	Implementation of Duty of Candour review recommendations	Prof M Power	March 2023	Q&P Cttee	In Progress
Midwifery Strategic Plan	Deliver the NWAS Midwifery Strategic Plan	Dr C Grant	March 2023	Q&P Cttee	In Progress
Mental Health, Dementia, LD & Autism Strategic Plan	Develop an integrated MH joint review & response model	Prof M Power	March 2023	Q&P Cttee	In Progress
Hospital Handover	System working to agree plans to address handover to reduce harm	Prof M Power	March 2023	Q&P Cttee	In Progress
Digital Capture and Monitoring of Clinical Outcomes	Deliver Phase 2 EPR roll out and systems for automating clinical audit	Dr C Grant	March 2023	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Prof M Power Dr C Grant	March 2023	Q&P Cttee	In Progress
NHS Patient Safety Strategy	Implementation of the Patient Safety Incident Response Framework	Prof M Power Ms A Wetton	2023/24	Q&P Cttee	In Progress

DIGITAL					
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Prof M Power	March 2023	Audit Cttee	In Progress
Single Primary Triage System	Delivery of Phase 2: Migration to Single Primary Triage System	Prof M Power	March 2023	Audit Cttee	In Progress
Quality & Safety Business Intelligence	Triangulation of data with performance activity to predict key risks	Prof M Power	March 2023	Q&P Cttee	Not Commenced
Digital Interoperability	Joint working with ICSs to enable data sharing solutions and referrals	Prof M Power	March 2023	Q&P Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	**20** High	**20** High	⇔	**5** Low
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	**20** High	**16** High	⇔	**4** Low
3630	Operational/ Patient Safety	There is a risk that due to the lack of assurance regarding medical devices that the organisation may not be sighted on safety critical risks which may lead to device failure, patient safety incidents or staff safety incidents and potential regulatory enforcement.	**20** High	**20** High	New Risk	**5** Low

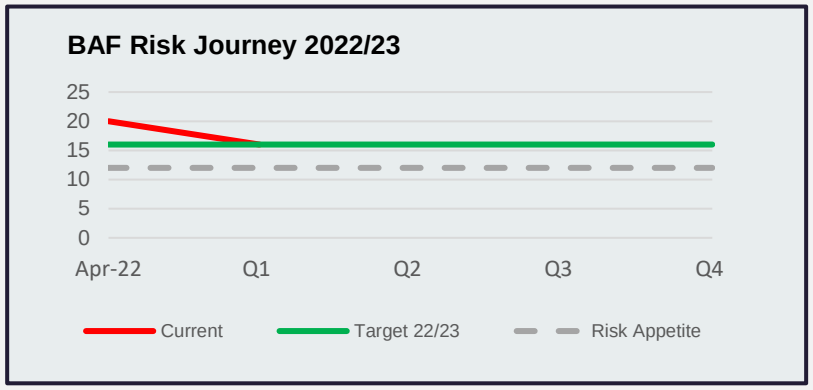
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR02:
There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	20	16				16	8
	4x5	4x4				4x4	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has decreased in risk score to a score of 16. Although the approved plan is a deficit position, the Trust has received confirmation of additional recurrent funding for the ambulance sector which will result in a recovery of the deficit position and de-risk some of the assumptions made in the approved opening plan. Based on the recurrent funding, the financial plans will be reviewed and presented to the Resources Cttee and Board of Directors in July 2022. The efficiency requirement whilst remaining high, has reduced slightly from 5% in the opening plans to 4.18%. Further capacity modelling will be undertaken during the first six months of the year to inform the recurrent funding required to deliver safe and effective services.

CONTROLS	ASSURANCES	EVIDENCE
Financial Controls	**Level 3:** MIAA Internal Audit: Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Annual Accounts/ VfM Statement	**Level 3:** Audit Completion Report (ISA 260) **Level 3:** Independent Auditors Report **Level 3:** Audited Annual Accounts 2021/22	Reported to Audit Cttee (AC/ 2223/48 & AC/ 2223/49) Reported to BoD (PBM/ 2223/20 & PBM/ 2223/21)
2022/23 Opening Financial Plans (Revenue and Capital)	**Level 2:** 2022/23 Opening Financial Plans & M01 Financial Position	Reported to Resources Cttee (RC/ 2223/07)
Financial Performance	**Level 2:** M02 Financial Position	Reported to ELC (ELC/ 2223/125)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2022/23 Planning Guidance	Receipt of 2022/23 Planning Guidance from NHSEI	Ms C Wood	2022/23	Resources Cttee	Completed
2022/23 Financial Plan Revenue	Approval of 2022/23 Financial Plan (Revenue)	Ms C Wood	2022/23	Resources Cttee	Completed
2022/23 Financial Plan Capital	Approval of 2022/23 Financial Plan (Capital)	Ms C Wood	2022/23	Resources Cttee	Completed
Reviewed 2022/23 Financial Plans	Review & Approval of 2022/23 Financial Plans	Ms C Wood	July 2022	Resources Cttee/ BoD	In Progress
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	September 2022	Resources Cttee	In Progress
Allocation Funding	Recurrent funding allocation to PES and 111 to deliver safe & effective services	Ms C Wood	November 2022	Resources Cttee	In Progress
2023/24 Financial Planning	Receipt of 2023/24 Planning Guidance from NHSEI	Ms C Wood	October 2022	Resources Cttee	Not Commenced
	Draft 2023/24 Financial Plan (Revenue & Capital)	Ms C Wood	December 2022	Resources Cttee / BoD	Not Commenced
	Approval of 2023/24 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2023	Resources Cttee / BoD	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3210	Operational/ Estates & Facilities Management	There is a risk that due to strategic interdependencies not being aligned to the Estates Strategy, timescales will be delayed resulting in the non-delivery of the Estates Strategy.	**20** High	**15** High		**5** Low
3643	Finance/ Value for Money/ Efficiency	There is a risk that 2022/23 statutory financial duties will not be achieved due to a forecast £6.7m deficit which includes a challenging CIP; increased estimated 2022-23 inflation rates; continuation of Covid 19 and associated additional expenditure, resulting in a failure to achieve statutory breakeven duty.	**15** High	**15** High	New Risk	1**0** Moderate

BOARD ASSURANCE FRAMEWORK 2022/23

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

Strategic Priority: Urgent & Emergency Care

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	20	15				15	5
	5x4	5x3				5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has reduced to a score of 15 due NWAS being in the top 3 balanced scorecard for ambulance trusts across the country. Improvements in all PES ARP performance standards for May and June 2022, although expected for performance deterioration in Q2 due to high abstractions and performance demands. There has been a decrease in Category 2 long waits. Risk mitigation plans are in place. Additional funding envelope has been agreed to increase NWAS internal resources. NHS Pathways is live in Cumbria and Lancashire, with Cheshire and Merseyside and Greater Manchester on plan for implementation in August 2022. An additional £2m above planned investment with an agreed recovery plan with Commissioners and NHSEI, acknowledging the funding gap of actual to required levels. PTS has resumed to pre-COVID for loading configurations. The Trust has been at REAP Level 3 since April 2022. A Workstream and Action Plan by NWAS and Commissioners has been jointly agreed.

CONTROLS	ASSURANCES	EVIDENCE
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/ 2223/31)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Singlel Primary Triage System	Phase 2 migration to Single Primary Triage System	Mr G Blezard	September 2022	Q&P Cttee	In Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	March 2023	ELC	In Progress
Recurrent Financial Gap	Engagement with Commissioners surrouding PTS & NHS111 contracts	Mr G Blezard	March 2023	ELC	In Progress
Alternative Care Pathways	Improve availability of alternative care pathways	Dr C Grant	March 2023	Q&P Cttee	In Progress
	Optimise the use of Hear and Treat and See and Treat pathways	Dr C Grant	March 2023	Q&P Cttee	In Progress
Hospital Handover	Embedding the Hospital Handover Escalation process into BAU	Mr G Blezard	March 2023	Q&P Cttee	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve working practices	Mr G Blezard	March 2023	Q&P Cttee	In Progress
	Maximise use of existing resources	Mr G Blezard	2023/24	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, there maybe increased numbers of patients being held on the back of ambulances and the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 High	20 High	⇔	5 Low
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 High	20 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK 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

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12	12				12	4
	4x3	4x3				4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has maintained at a score of 12 due to robust workforce plans have been prepared, triangulated with Finance, and approved. There is continual support with recruitment and training plans including the additional training capacity to support with local recruitment plans. PES and EOC are over-established with substantive staffing, other vacancy positions are improving. AITs are in place to support improvement in attendance. NHS111 recruitment and retention remains a risk with plans being implemented which are showing early signs of improvement and continue to remain a key area of focus.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/ 2223/12)
Workforce Plan	**Level 2:** Operating Plan Submission	Reported to Resources Cttee (RC/ 2223/07)
Recruitment Delivery Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/13)
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/13)
Attendance	**Level 2:** Thematic Analysis: Attendance Management	Reported to Resources Cttee (RC/ 2223/11)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of Q1 Recruitment Plans	Ms L Ward	June 2022	Resources Cttee	Complete
	Delivery of Q2 Recruitment Plans	Ms L Ward	October 2022	Resources Cttee	In Progress
	Implementation of additional training capacity to support plans	Ms L Ward	March 2023	Resources Cttee	In Progress
Attendance	Delivery of actions to improve attedance including AIT	Ms L Ward	March 2023	Resources Cttee	In Progress
Vaccination	Delivery of 2022/23 Flu Campaign	Ms L Ward	March 2023	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3632	Operational/ Health, Safety & Security	There is a risk the statutory HSS activity will be compromised due to the number of HSS Practitioner vacancies carried within the HSS team which may lead to risk of reduced assurance all matters HSS meet minimum operating requirements including training.	**12** Moderate	**16** High	New Risk	**4** Low

BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK 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

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12	12				12	4
	4x3	4x3				4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has maintained at a score of 12 due to the Trust continuing facing challenges in a climate where pressure on staff and managers demand, activity and recovery from COVID-19 continues to be significant. There continues to a good health and wellbeing offer that remains in place and has been further strengthened through additional NHSEI funding. The staff survey results shown an improvement in comparison with sector scores and provides a foundation for the Trust to build upon in 2022/23. There is a clear plan for developing work to improve culture and staff experience is being implemented and has been reported to Resources Cttee. Key elements of the work have commenced including leadership development roll out, appointment of a Consultant Psychologist, and progress with the review of disciplinary procedure.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
People Plan	**Level 2:** People Plan 2022/23 Objectives	Reported to Resources Cttee (RC/ 2223/07)
Appraisals & Wellbeing	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/13)
CULTURE		
Equality & Diversity Priorities	**Level 2:** EDI Annual Report **Level 2:** D&I Chairs Assurance Report	Reported to BoD & Resources Cttee (RC/ 2223/14) Reported to Resources Cttee (RC/ 2223/15)
Staff Networks	**Level 2:** EDI Annual Report **Level 2:** D&I Chairs Assurance Report	Reported to BoD & Resources Cttee (RC/ 2223/14) Reported to Resources Cttee (RC/ 2223/15)
Just Culture & Treat Me Right	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/13)
Violence and Aggression	**Level 2:** Violence and Aggression Assurance Report	Reported to Q&P Cttee (QPC/ 2223/52)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Phase 1 Senior Management Restructure	Mr G Blezard Ms L Ward	May 2022	ELC	Completed
	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	March 2023	ELC	In Progress
EDI Priorities	Review delivery of Year 1 Action Plans (Workforce Elements)	Ms L Ward	May 2022	Resources Cttee	Completed
	Review delivery of Year 2 Action Plans (Workforce Elements)	Ms L Ward	May 2023	Resources Cttee	In Progress
FTSU Action Plan	Delivery of agreed actions	Ms L Ward	May 2022	Resources Cttee	Completed
Fully embedding Just Culture Principles	Improved investigation training compliance	Ms L Ward	March 2023	Resources Cttee	In Progress

	Review of Disciplinary Procedure	Ms L Ward	November 2022	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	April 2023	ELC	Not Commenced
Evaluation of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	March 2023	Resources Cttee	Not Commenced
Trailblazer for National Health and Wellbeing Framework	Review and report outcomes from dianostics	Ms L Ward	March 2023	Resources Cttee	In Progress
Wellbeing	Implementation of menta health pledge and AACE commitment	Ms L Ward	2023/24	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2024	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

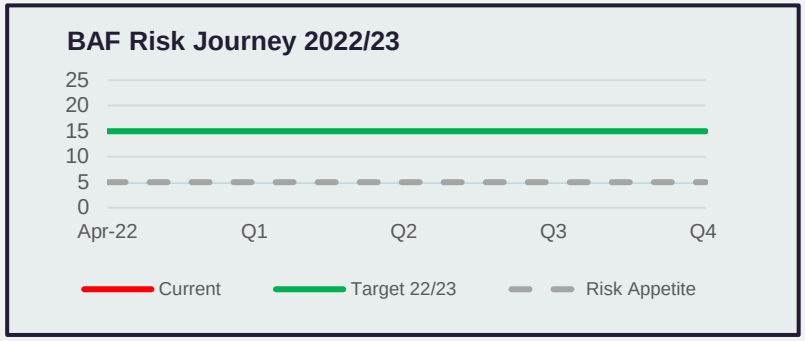
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR06:
There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has maintained at a score of 15 due to some risks which remain including that associate with health and safety and continued system pressures which may impact on patient safety. A recent CQC Urgent and Emergency Care System Inspection was well managed. The final report has not been published but we expect a concentrated number of 'should do' recommendations and a recommendation for the system to focus on handover pressures. The Trust is committed to working with system partners to minimise the risks to patient safety. In addition, the Trust is redesigning our internal quality assurance visits (QAVs) programme and is commencing work to redevelop our quality management platform – SafeCheck.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY & SAFETY		
CQC Overall Rating of 'Good'	**Level 3:** CQC Inspection Report	Reported to BoD (2020)
CQC UEC System Inspection	**Level 2:** CQC Assurance Report	Reported to BoD (BoD/ 2223/37)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (QPC/ 2223/53)
PEOPLE		
People Plan	**Level 2:** People Plan 2022/23 Objectives	Reported to Resources Cttee (RC/ 2223/07)
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/13)
Mandatory Commander Competencies	**Level 2:** Mandatory Commander Training Assurance Report	Reported to Q&P Cttee (QPC/ 2223/26)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Medical Devices	Improve assurance arrangements with servicing and checks	Dr C Grant	October 2022	Q&P Cttee	In Progress
Quality and Safety Metrics (Complaints & Incidents)	Devise improvement action plan to address the backlog	Ms A Wetton	November 2022	Q&P Cttee	In Progress
Quality Assurance Processes	Redesign of Quality Assurance Visits	Prof M Power	March 2023	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Ms C Wood	March 2023	Q&P Cttee	In Progress
Learning from IPC and RPE Audits	Improve compliance with IPC practices, including ambulance cleaning and RPE across the Trust	Prof M Power	March 2023	Q&P Cttee	In Progress

	Improve processes for FFP3 Face Fit Testing	Prof M Power	October 2022	Q&P Cttee	In Progress
	Embed learning from all IPC Audit findings	Prof M Power	March 2023	Q&P Cttee	In Progress
Clinical Audit Submissions	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant	September 2022	Q&P Cttee	In Progress
	Undertake a review of all clinical audits including AGP	Prof M Power	March 2023	Q&P Cttee	In Progress
Electronic Quality Measurement Auditing/ Reporting Systems	Develop automated systems for non-clinical audits	Prof M Power	March 2023	Q&P Cttee	In Progress
PEOPLE					
Mandatory & Statutory Training Compliance	Achieve 85% compliance	Ms L Ward	March 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, there maybe increased numbers of patients being held on the back of ambulances and the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	**20** High	**20** High	⇔	**5** Low
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	**20** High	**16** High	⇔	**4** Low
3255	Project/Digital & Innovation	There is a risk of continued sub-optimal functionality, effective and efficient use of Datix Web because of data inaccuracies, current system functionality and limited use across the organisation which may impact negatively on compliance with regulatory requirements.	**12** Moderate	**15** High	⇔	**3** Low
3630	Operational/ Patient Safety	There is a risk that due to the lack of assurance regarding medical devices that the organisation may not be sighted on safety critical risks which may lead to device failure, patient safety incidents or staff safety incidents and potential regulatory enforcement.	**20** High	**20** High	New Risk	**5** Low
3632	Operational/ Health, Safety & Security	There is a risk the statutory HSS activity will be compromised due to the number of HSS Practitioner vacancies carried within the HSS team which may lead to risk of reduced assurance all matters HSS meet minimum operating requirements including training.	**12** Moderate	**16** High	New Risk	**4** Low

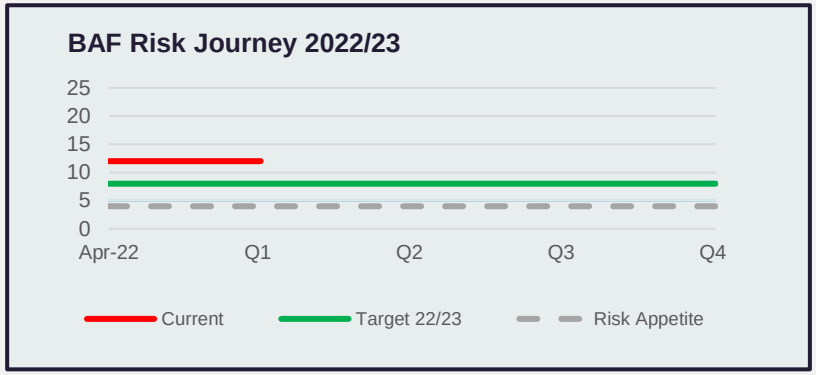
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK 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

Strategic Priority: Stakeholder Relationships

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12	12				8	4
	4x3	4x3				4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within				Within	Below

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk is at a score of 12 due to associated new structures and work programmes being proactively progressed by the Trust which will assist to ensure the proposed Parliamentary changes for the ICS to be placed on a statutory footing are mitigated. Ongoing issues remain surrounding the clarity on how the Ambulance Service will work and function with the various ICSs. The Trust will be utilising the extra time to embed processes and systems in place for effective engagement and influencing across the various ICSs and ICPs across the NWAS catchment area.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		
CEO via AACE Role Engagement with NHSE/I	**Level 2:** CEO Report	Reported to BoD (BoD/2122/97) & (BoD/2122/98)
Designated Executive Director Lead for each ICS	**Level 2:** Executive Portfolios	Reported to BoD (BOD/2122/87)
Partnership & Integration Team	**Level 2:** Established in September 2021	Reported to BoD (BOD/2122/87)
NWAS Manager Representation at Key Meetings	**Level 2:** Assessment to ensure the right expertise is in attendance	Reported to Board (BOD/2122/87)
ICS		
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Utilisation and monitoring by Senior Managers within the Trust	Mr S Desai	Q2	Resources Cttee	In Progress
	Familirisation sessios for managers across all three areas of the Trust	Mr S Desai	Q2	Resources Cttee	Completed
Stakeholder Mapping	Refresh stakeholder mapping across the Trust for external meetings	Mr S Desai	Q2	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

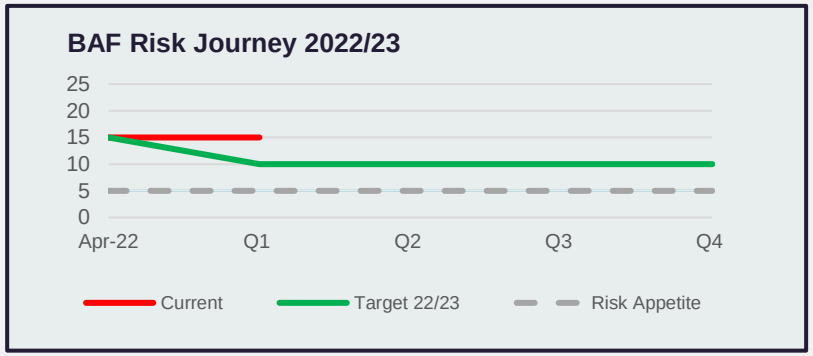
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK 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

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	15	15				10	5
	5x3	5x3				5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of this BAF risk has maintained at a score of 15 due to the continuing high threat level of a cyber-attack. The Trust continues to have a high standard of oversight and processes for cyber security. During Q1, there continues to be significant volumes of attempted cyber breaches, locally, nationally, and globally. The Trust is responsive to nationally issued guidance and progressing the cyber security work plan. Multifactorial authentication has commenced deployment across the Trust with expected completion by the end of Q2 and a new backup solution is mid implementation. Our focus remains on closing unsupported servers (2008) and ensuring all systems are supported and patched as required.

CONTROLS	ASSURANCES	EVIDENCE
Data Security Protection Toolkit	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
CareCert Compliance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Patching	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Penetration Testing	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Monitoring and Surveillance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Additional Back-ups	Implement additional back-ups as required	Prof M Power	August 2022	Audit Cttee	In Progress
Critical System Security	Implement recommendations from MIAA Internal Audit for Cleric	Prof M Power	September 2022	Audit Cttee	In Progress
Supported Systems	Decomission unsupported servers (2008) and (2008 R2)	Prof M Power	September 2022	Audit Cttee	In Progress
	Upgrade windows operating systems to within a supported 12 month version	Prof M Power	March 2023	Audit Cttee	In Progress
	Replacement of all system using SQL 2008 and 2008 R2	Prof M Power	March 2023	Audit Cttee	In Progress
Access Controls	Implement Multi-Factoral Authentication	Prof M Power	August 2022	Audit Cttee	In Progress
	Strengthen Password Policy in line wth best practice & national recommendations	Prof M Power	March 2023	Audit Cttee	In Progress
	Implement express route in Azure to block public route	Prof M Power	March 2023	Audit Cttee	In Progress
Cyber Security Plan	Implement the Cyber Security plan	Prof M Power	March 2023	Audit Cttee	In Progress

	Implementation of BeyondTrust	Prof M Power	March 2023	Audit Cttee	In Progress
Patching (999 and NHS 111)	Enable monthly failover & patching opportunities	Prof M Power	March 2023	Audit Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Prof M Power	March 2023	Audit Cttee	In Progress
	Implement findings from DSPT Audit findings	Prof M Power	March 2023	Audit Cttee	In Progress
Out of Hours Resilience	Develop business case for 24/7 support	Prof M Power	March 2023	Audit Cttee	In Progress
	Work with Business Continuity Team to desktop worst case scenario	Prof M Power	March 2023	Audit Cttee	In Progress
	Implement recommendations from desktop worst case scenario	Prof M Power	March 2023	Audit Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3537	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 High	15 High	⇔	5 Low
3540	Operational/ Digital and Innovation	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	12 Moderate	16 High	⇔	4 Low

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	21st July 2022	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Chambers, Non-Executive Director Dr D Hanley, Non-Executive Director	**Key Members Not Present:**	Prof A Esmail, Non-Executive Director Ms C Butterworth, Non-Executive Director
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Chairs Assurance Report – Quality and Performance Committee	The Committee received the reports from the meetings held on 28th March 2022 and 25th April 2022.	Noted the assurances provided.	
Clinical Audit Q4 Update 2021/22 and Clinical Audit Plan 2022/23	The Clinical Audit Q4 and Clinical Audit Plan 2022/23 update was presented to the Committee.	Noted the assurances provided.	
Chair's Assurance Report – Information Governance Sub Committee	The Committee received the report from the meeting held on 17th May 2022.	Noted the assurance provided.	

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

SIRO Annual Report	The Committee received the SIRO Annual Report for information following presentation to the Board of Directors in May 2022.	Noted the assurance provided.	
Limited Assurance Report	A limited assurance opinion report was reported relating to the Cleric 111 Clinical Hub Application. A management representative attended the Committee to provide a verbal update around the progress of the identified recommendations. All the recommendations in the report had deadlines of 30 June. Whilst some had been implemented by this date not all had. Progress of recommendations are to be reported to the Committee via the Internal Audit Follow Up report.	Noted the update provided.	
Critical and High Risk Recommendations	MIAA continue to follow up recommendations. It was noted 1 high risk recommendation remains outstanding relating with Freedom to Speak Up which is due for completion in September 2022.	Noted the update provided.	
Internal Audit Progress Report Q1 2022/23	The Committee noted the assurance reviews completed within Q1: Conflicts of Interest – Substantial Assurance Stock Management Vehicle Workshops – Moderate Assurance Cleric 111 Clinical Hub (21/22 review) – Limited Assurance Data Security & Protection Toolkit – Substantial Assurance The Committee approved a revision to the audit plan as a result of NHSE requesting that all trusts	Noted the assurances provided.	

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

	commission a financial sustainability audit. This audit will replace the scheduled Key Financial Controls Audit scheduled for Q3.		
Internal Audit Follow Up	The Committee noted the progress within the reporting period and that 9 recommendations were completed during the period.	Noted the assurance provided.	
Anti-Fraud Progress Report Q1 2022/23	The Committee received the Anti-Fraud Progress Report outlining the wide range of activities undertaken in relation to Strategic Governance; Inform and Involve; Prevent and Deter and Hold to Account since the last meeting.	Noted the assurances provided.	
Auditor's Annual Report	The Auditor's Annual Report confirmed the outcome of the audit of the financial statements and included commentary on the Trust's value for money arrangements. This is a public facing document and will be published on the Trust's website.	Noted the assurance provided.	
Board Assurance Framework Q1 2022/23	The Committee received the updated BAF prior to submission to the Board of Directors for approval on 27th July 2022. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurances provided.	
Board Assurance Framework Opening Position 2022/23	The Committee received the 2022/23 Opening Position of the BAF prior to submission to the Board of Directors on 27th April 2022.	Noted the assurances provided.	
2021/22 Risk Management Assurance Report	The Committee received assurance on the adequacy and effectiveness of risk management arrangements in place throughout the year.	Noted the assurances provided.	

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

Losses and Compensation Report Q1 2022/23	Losses and compensation for Q1 2022/23 totalled £258k.	Noted the assurance provided.	
Waiver of Standing Orders Q1 2022/23	A total of five waivers were approved during Q1 2021/22. The Committee noted all waivers requested had been approved in line with the Scheme of Delegation.	Noted the assurances provided.	
Committee Self-Assessment	MIAA completed the first of two checklists required for the Committee and reported positive outcomes, with all actions from the previous year addressed. One item for action by the Committee is to formally evidence the performance of external audit, though it was noted that performance has been informally assessed. The work plan has been updated to include this piece of work during the financial year.	Noted the assurance provided.	
Chairs Assurance Report – Resources Committee	The Committee received the report from the meeting held on 20th May 2022.	Noted the assurances provided.	

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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th July 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	SR10	SR11
☐	☐	☐	☐	☐	☐

PURPOSE OF PAPER: For Assurance

EXECUTIVE SUMMARY:

The Integrated Performance Report for July 2022 shows performance on Quality, Effectiveness, Operational Performance, Finance and Organisational Health during **June 2022** unless otherwise stated.

The format of this report has been revised to ensure that there is greater clarity on the key measures. Data are presented over time using statistical process control charts. Statistical rules are applied to determine whether something significant has happened which needs to be flagged to committee.

Quality

- 156 complaints were received, against a 12-month average of 185 per month.
- 72% of complaints risk scored 1-3 were closed within the agreed time frame with data signalling a significant improvement.
- The backlog of complaints has significantly improved and is at its lowest level of 57.
- During June 2022 there were 8 serious safety incidents reported on the StEIS database.
- Incidents risk scored 1-3 completed within SLA have significantly improved for April, May and June.
- In June 2022, 1,077 internal and external safety incidents were opened with an additional 43 still to be scored.

Effectiveness

- **Patient experience:** PTS and 111 have all seen an increase in satisfaction levels compared to last month (PTS 1.4% and 111 3.2%) while satisfaction levels for PES have fallen by 4.4%.

- **111 First** experience rating of 'very good/good' has increased by 10%.
- **Ambulance Clinical Quality Indicators (ACQI's):** There is no significant change in the ACQI indicators apart from the stroke and STEMI care bundles which have reduced.
- **H&T, S&T, S&C:** For June we achieved 11.1% Hear and Treat, 30.2% See and Treat and an aggregate non-conveyance of 41.3%.

Patient Emergency Service (PES)

- **Activity:** In June 2022, the Trust received 131,065 calls of which 90,923 became incidents.
- **Call Pick Up** has been adversely affected by staff abstractions due to Pathways training and increased sickness. Performance was 71.5% (target 95%). and has deteriorated from the May 2022 position.
- **Ambulance Response (ARP) Performance**

	Standard	Actual
C1 (Mean)	7:00	8:12
C1 (90th)	15:00	13:59
C2 (Mean)	18:00	39:46
C2 (90th)	40:00	1:27:30
C3 (Mean)	1:00:00	2:59:47
C3 (90th)	2:00:00	7:20:40
C4 (90th)	3:00:00	12:38:49

- For June, response time targets were not met for any ARP category apart from C1 90th.
- The trust has taken a number of measures to improve performance and maintain patient safety including an agreed 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 aim of this plan is to optimise existing operational resource.
- **Handover**: Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 39:45. 5,589 attendances (12%) had a turnaround time of over 1 hour, with 521 of those taking more than 3 hours. 1,831 hours were lost to delayed admissions in June.
- **C1 & C2 Long Waits:** The number of C1 and C2 long waits has reduced in May and June compared to the previous two months.

NHS 111

	Standard	Actual
Calls Within 60s	95%	32.3%
Average Time to answer		9m 06s
Abandoned Calls	<5%	20.82%
Call back Within 10 min	75%	7.72%
Average Call Back		1hour 36min
Warm Transfer to Nurse	75%	14.6%

- Call volume remains high. The gap between activity and resource continues to be as high as 50% at various points of the day. Time taken for a call back continues to be well above the target.
- Safety measures are in place. Increased demand during out of hours (OOH) operation are leading to increased call volume and conversations between CCGs and OOH provides are taking place. Early indications are that self-care advice via SMS has been a significant factor in the reduction of triage length by 20% in the trialled calls.

PTS

- PTS performance is reported one month in arrears. Activity in March was 13% below contract baselines. Year to date July 2021 - May 2022) is performing at 22% below baseline.

Finance

- The year to date expenditure on agency is £1.932m which is £1.154m above the year to date ceiling of £0.777m.
- As at month 3 (June) the trust is recording a surplus position for the year to date of £0.184m.

Organisational Health

- The overall sickness absence rate for the latest reporting month (May 2022) was 9.35%.
- The vacancy gap has significantly reduced as a result of increasing the establishment for PES and EOC.
- Turnover has decreased to 12.19%. PES turnover is showing an upward trend but remains low in comparison with other service lines.
- The overall appraisal completion rate improved to 79.38%.
- We are currently on track at 75% for mandatory training against the agreed target of 85% overall by March 2023.

RECOMMENDATIONS:	The Board of Directors are asked to: • Note the content of the report • Note the improvements seen in complaints and incidents handling times. • Note pressures on performance with handover times increasing. • Note that SIs are within normal limits. • Note that long waits for C1 and C2 have reduced in May and June . • Note the ongoing work to maintain patient safety and regulatory compliance. • Clarify any items for further scrutiny.
CONSIDERATION OF THE TRUST'S 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

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	25/7/22		
	Outcome:	Not known at time of submission		

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1 PURPOSE

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

The format of this report has been revised to ensure that there is greater clarity on the key measures. Data are presented over time using statistical process control charts. Statistical rules are applied to determine whether something significant has happened which needs to be flagged to committee.

2 SUMMARY

2.1. Quality

- 156 complaints were received, against a 12-month average of 185 per month.
- 72% of complaints risk scored 1-3 were closed within agreed timeframes. The data show special cause variation signalling a significant improvement.
- 14% of level 4-5 complaints were closed within the agreed time frames.
- Trajectories have been agreed to maintain open complaints at under 180 with an allowance of under 50% within the backlog. The backlog has been under 75 each of the last 8 weeks and is at its lowest ever level of 57.
- 48 Compliments were received in June, this is lower than the 69 and 100 received in April and May of 2022.
- During June 2022 there were 8 serious safety incidents reported on the StEIS database, this continues to be significantly lower than the 20 incidents reported in January and is similar the last 5 months and remains within normal control limits.
- In June 2022, 1,077 internal and external safety incidents were opened against a 12-month average of 1,218, with an additional 43 still to be scored.
- Incidents risk scored 1-3 completed within SLA is showing special cause signalling improvement for April, May and June.
- The 6 most common reasons for safety incidents were Infection control (120), Information (100), 111 assessment/Advice (96), 111 issue with other service (56), Communication (53) and Verbal abuse (47) and between them cover 50% of those reported. The top 25 cover over 86%.

2.2 Effectiveness

<u>Patient experience</u>

- PES saw an increase in returns by 17.6%, while PTS and 111 both saw a decrease of 1.4% and 79.5% respectively. The reason for the large fall in 111 returns is due to a backlog of returns being processed at the time of this report. So, this number will change. PTS and 111 have all seen an increase in satisfaction levels compared to last month (PTS 1.4% and 111 3.2%) while satisfaction levels for PES have fallen by 4.4%.

- For 111 First, the level of returns has started to increase during May and June following an extensive review of the survey questions in April. Cumulatively to date, i.e., April 2022 to June 2022, 82.00% of patients describe their experience as 'very good/good'. At the end of April 2022 this was 90.12%. Additionally, 90.29% of patients felt their need for calling the service was met as opposed to 93.83% at the end of April 2022.
- Experience data broken down by protected characteristics will be socialised with senior leaders to understand what we might learn from it. For example, in PTS we can see that there is a high proportion of patients with more than one disability signalling the complexity of care required.

Ambulance Clinical Quality Indicators (ACQI's)

February 2022's data see us within normal limits and close to the mean across all indicators apart from the Stroke and STEMI care bundles. The apparent reduction may be due to implementation of the new EPR and Apex audit tool which has impacted on records access (dual running of paper and electronic) and consequently on the denominator alongside the challenges with C2 long waits in February 2022. This is being closely monitored by the audit team and plans are in place to address these issues. 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.

- Return of spontaneous circulation (ROSC) achieved for the Utstein group was 45.6% (national mean 47.2%). For the overall group the rate was 31.6% (national mean 28.0%).
- Survival to Discharge rates in February 2022 were at 7.8% (national mean 9.9%).
- In February 17.9% of patients in the Utstein group survived to hospital discharge. The national mean at 23.8%.
- Mean call to PPCI time in February for patients suffering a myocardial infarction was above the national mean of 2h 29mins; the Trust's performance was 2h 32mins.
- Mean call to hospital time in August for patients suffering a hyper acute stroke was below the national mean of 1h 44mins. The trusts performance was 1h 27mins.
- The Stroke Care Bundle performance for February was 92.8%. The national mean at 95.8%
- The STEMI Care Bundle performance was not reported for December in line with the NHSE schedule.

H&T, S&T, S&C

- For June we achieved 11% Hear and Treat and ranked 7th nationally.
- See & Treat we achieved 30.2% and we are ranked 8th nationally.
- In total there was an aggregate non-conveyance of 41.3%.

2.3 Operational Performance - Patient Emergency Service (PES)

- **Activity:** In June 2022, the Trust received 131,065 calls of which 90,923 became incidents. Compared with June 2021, we have seen an 8% decrease in both calls and incidents. This is due to the increase in signposting and duplicate calls.
- **Call volume:** call volume is 8% below the equivalent month for 2021.
- **Call Pick Up** has seen a deterioration in June and performance worsened from 82% in May to 71.5% in June (target 95%).

- Call pick up has deteriorated due to an increase in abstractions and increase in call volume. The increase in abstractions is due to an increase in sickness and covid but primarily due to NHS Pathways training. The Trust will soon see a stepped increase in deployable staff and reduction in abstraction levels. We are assured looking at the modelling that call pick up will improve from the start of August and return to normal levels of performance by the end of august at the latest.
- The Trust is a net recipient of calls from other trusts rather than being in a net gain in support from other trusts.

Ambulance Response (ARP) Performance

Category	Standard	June 2022 Actual
C1 (Mean)	7:00	8:12
C1 (90th)	15:00	13:59
C2 (Mean)	18:00	39:46
C2 (90th)	40:00	1:27:30
C3 (Mean)	1:00:00	2:59:47
C3 (90th)	2:00:00	7:20:40
C4 (90th)	3:00:00	11:13:16

For June response time targets were not met for any ARP measures apart from C1 90th. This continued the position this financial year. All the ARP standards are within normal limits. As previously reported response times were starting to signal improvement with data points close to the lower control limit however since mid-June this improvement trajectory has ceased.

The primary drivers for us not meeting performance standards are: 1. A high acuity (although this is showing signs of reducing due to pathways implementation) 2. Abstractions (due to covid) and 3. Job cycle time including handover delays and time on scene.

- Acuity remains high. This means that nearly 67.37% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat.
- Abstractions have started to rise due to Covid, both within the Trust and across the system.
- Turnaround continues to be above the National standard of 30:00 with a turnaround time of 39:45.The trust has taken several measures to improve performance and maintain patient safety including an agreed 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 areas we are continuing to focus on in terms of improvement are:

- Our response strategy for C1, including area reviews, meaning each area now has a comprehensive C1 improvement plan.
- A significant drive to enhance NHS Service Finder and DOS (Directory of Service) utilisation. This will aim to increase alternative pathways, both via Hear & Treat via task and finish groups working with 999 and 111 system improvements to increase alternative referrals.
- Focus of management of 'unfunded unavailability', this is led through operational heads of service with enhanced reporting monitoring and actions taken to increase availability to increase availability of operational crews.

Handover

- Average turnaround time has increased and continues to be above the national standard of 30:00 with a turnaround time of 39:45. This is down from highs in March and April 2022 of 42:06 and 42:27 respectively.
- The data are signalling continued variation with 2 of the last 6 data points below the lower control limit and another 2 near the upper limit. We are starting to see the effect of warmer weather and the increase in both Covid admissions in acute trusts and staff abstractions due to covid in acute trusts and the Trust.
- 5,689 attendances (12%) had a turnaround time of over 1 hour, with 521 of those taking more than 3 hours. 926 cases of delayed admissions were reported – down from 1,057 in April 2022 but up from the 891 reported in May 2022.
- 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.

C1 & C2 Long Waits

Long waits for C1 have stayed at the same number as in May 2022(2) this is significantly lower than the high of 18 in March 2022. The number of long waits for C2 has increased slightly from May (from 7,564 to 10,374 respectively) however this is significantly lower than the high of 20,038 recorded in December 2021 and the previous two months March and April 22. The highest category continues to be delays '60-75 minutes'. We have seen the number of serious incidents associated with delays 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.

2.4 Operational Performance - NHS 111

Measure	Standard	June 2022 Actual
Calls Within 60s	95%	32.3%
Average Time to answer		9m 06s
Abandoned Calls	<5%	20.8%
Call back Within 10 min	75%	7.72%
Average Call Back		1hour 36min
Warm Transfer to Nurse	75%	14.60%

- Call volume continues to be high Calls answered in 60s performance remains below the standard but stable with Call to Answer time also stable within control limits.
- The team are still 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 within control limits. Safety measures are in place.

2.5 PTS

- Due to reporting timing issues PTS performance is reported one month in arrears.
- Activity in March for the Trust was 13% below contract baselines with Lancashire and Cumbria 24% and 23% below baselines respectively. Year to date July 2021 - May 2022) is performing at 22% below baseline.

2.6 Finance

- The year to date expenditure on agency is £1.932m which is £1.154m above the year to date ceiling of £0.777m.
- As at month 3 (June) the trust is recording a surplus position for the year to date of £0.184m.
- 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.

2.7 Organisational Health

Sickness

The overall sickness rate for May 2022 was 9.15% (OH1.1). Sickness has increased steadily over the last 12 months, peaking in January 22 but a reduction in non-COVID sickness has been seen since December. Contact Centre rates remain higher than other service lines.

- The impact of COVID related sickness has decreased to just 2% of overall sickness however, it is expected that a further rise will occur in June and July 2022 given the increased community transmission.
- Data analysis shows the top 5 reasons for absence are 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 which has resulted in extended sickness for COVID related absence. However, NHS Employers have now withdrawn the COVID T&C. Staff will transition back to normal contractual occupational sick pay arrangements and a joint set of principles for managing these cases has been agreed within the sector.
- A dedicated Attendance Improvement Team is continuing to focus on supporting operational teams to improve attendance management and wellbeing. In the main the work focuses on ensuring organisational grip; data quality and thorough case review; coaching and developing managers to both manage and work to prevent ongoing absence. They are also currently supporting the withdrawal of the COVID T&Cs and supporting the administration required to transition staff back over through information and 1:1 meetings.

Turnover

Staff turnover for June 22 is 12.19%. This is calculated on a rolling year average. Staff turnover has shown a steady increase in the last 12 months but is just within the upper

control limit. Most service lines are at or exceeding the upper control limit. This position is replicated across the sector.

- 111 turnover is showing a slightly improved position to 43.9% in June 2022 which is within the upper control limit (OH2.5). Average monthly turnover for call handlers since the introduction of the short-term retention payments in February has been 4.25% compared with average monthly turnover in the 10 months prior of 5.3%.
- EOC turnover has also shown an upward trend, primarily driven by turnover amongst call handlers. June 22 turnover at 15.92% (OH2.4). However, the EOC staffing position is stable moving into the roll out of Single Primary Triage.
- The Trust is working across the Ambulance Sector and with NHSEI on specific targeted interventions to support contact centre retention including the retention payments that NWAS have applied. PES turnover is showing an upward trend but remains low in comparison with other service lines. Average monthly turnover for call handlers since the introduction of the short-term retention payments in February has been 4.25% compared with average monthly turnover in the 10 months prior of 5.3%. NHS turnover is typically between 10% & 12% according to NHS SBS. (Shared Business Services).

Agency

As a result of COVID-19, restrictions in relation to agency usage were paused but these are being reinstated under the 22/23 financial regime. The position for June shows continuing agency usage although it has slightly reduced. The agency ceiling, which is the maximum spend allowable, may be at risk of being breached, but confirmation of the ceiling is still awaited.

- Agency staff have continued to support the Contact Centre environments. The majority of Agency staff remains in EOC and a process is in place to transfer remaining 128 Agency staff onto Trust contracts. There has been a slight delay in this work being completed but plans are in place to prioritise this work.
- Further EOC recruitment is planned during 2022/23 but this will be through normal recruitment process rather than Agency. A small number of Agency staff are continuing to be used in 111 and CHUB, in Clinical roles and reflect pre pandemic usage.
- Current agency usage is therefore anticipated to continue across Q2 but should reduce following this.

Vacancy

- Chart OH5.1 shows the vacancy gap at –5.95% in June 2022. The significant change from last month is as a result of the increases to PES & EOC establishment arising from additional investment.
- Recruitment plans for 111 are on track with the vacancy position gap of –9.86% (OH5.5). This is an improved position as a result of positive recruitment and some reduction in monthly turnover.
- The PTS vacancy position (OH5.2) shows a slight widening of the vacancy gap which reflects the timing of planned PTS courses. Robust plans are in place to reduce the gap over the coming months, but PTS also have robust bank arrangements in place to bridge the vacancy position.
- PES position (OH5.3) shows the positive impact of plans to maximise recruitment into PES during 2022/23 and are 0.31% over-established. This is primarily the Paramedic workforce.
- The substantive EOC position shows at –25.45% due to the baseline establishment. Increases. Work is progressing to move 128 Agency staff working in EOC on to Trust contracts which will stabilize this position.

Appraisal

- Appraisal completion rates are at 79% for June 22 (OH6.1) which is a stable position. This exceeds the recovery target of 75% set by ELC. And is above the upper control limit.
- Recommendations will be made to ELC in July / August 2022 with regards to a revised target for 2022/23. Trajectories will then be developed to map expected progress by Service Lines during 2022/23.
- PES and PTS remain ahead of target (OH6.3, OH6.2) and corporate teams have all reached the 75% target. 111 ahead of target at 78% (OH6.5) and EOC at 73%. Which demonstrates significant progress given how low rates had fallen by August 2021.

Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and was extended through to the end May 2022 with a recovery plan in place and target to achieve 75% compliance. Corporate Services remain at 95% compliance. Overall competency compliance for the Trust in the June 2022 reports is 75%.

- 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.
- Overall competency compliance for the Trust achieved 75% at the end of May, with PTS, 111 and EOC meeting / exceeding the 75% target at the end of April. 2022. Corporate is slightly behind trajectory at 91% compliance.
- PTS classroom attendance was 91% and the final PES classroom position was 80% at the end of May 2022. PES overall competency compliance remains a risk with on-line mandatory training compliance not being maintained.

ELC have approved the 22/23 mandatory training programme which has a primary focus on ensuring a strong foundation of statutory compliance given the disruption of the last 2 years. It remains limited to a one-day programme for 2022/23 in recognition of operational pressures. This programme has started at the end of June with target compliance of 85% by end of March 2023.

COVID 19

- 441 staff have tested positive for Covid-19 in June 2022. At the end of this reporting period, there was 1 open outbreak on Trust sites.

3 LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

.

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

4 EQUALITY OR SUSTAINABILITY IMPACTS

.

The data in this report are presented at an aggregate level for the trust. An EDI view is now applied to the patient experience data which breaks data down by protected characteristics were available. 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

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The Board of Directors is recommended to:

- Note the content of the report
- Note the improvements seen in complaints and incidents handling times
- Note pressures on performance with handover times increased
- Note that SIs are within normal limits
- Note that long waits for C1 Have reduced in May and June
- Note the ongoing work to maintain patient safety and regulatory compliance.
- Clarify any items for further scrutiny

North West Ambulance Service NHS Trust

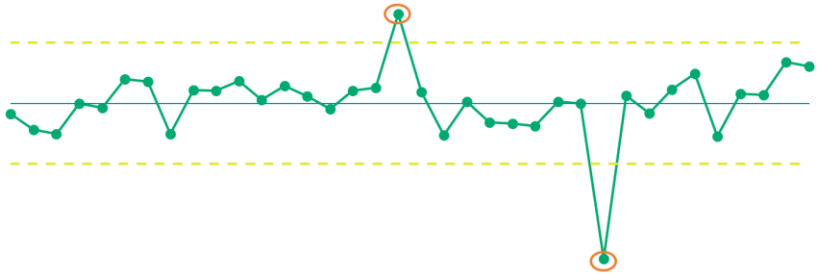
Integrated Performance Report

Board - July 2022

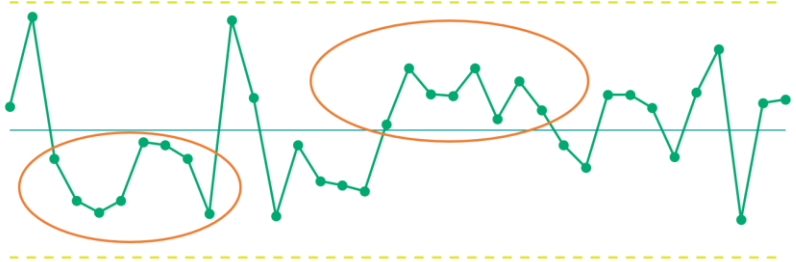
Rules for interpreting SPC Charts

Most charts contained in the report are SPC (Statistical Process Control). SPC charts follow the rules shown below to determine when something statistically significant has happened. Once these rules are triggered the control limits - dotted lines above and below the mean (centre line) are adjusted around the new data – this is known as resetting the limits

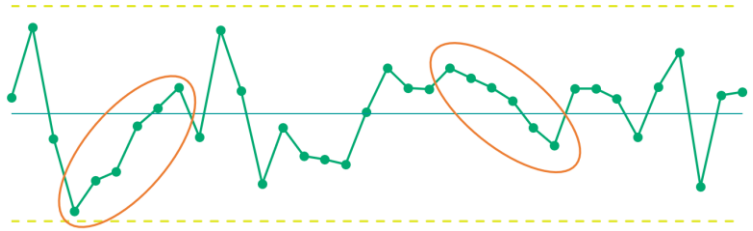
Rule 1: Single data point outside the control limits



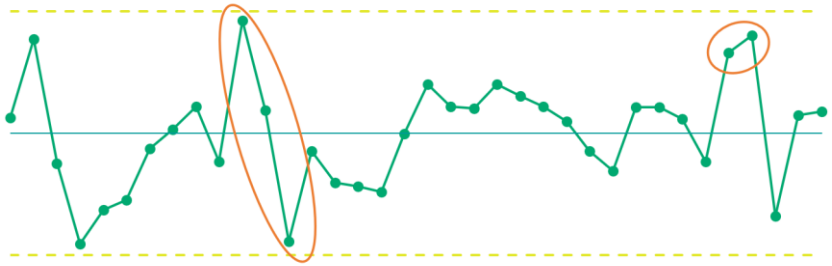
Rule 2: 8 or more consecutive data points above or below the centre line



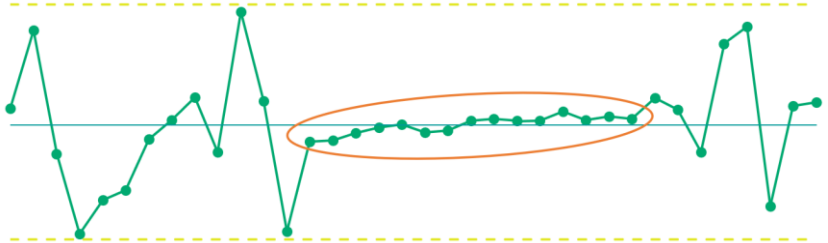
Rule 3: A trend of at least six consecutive points (up or down)



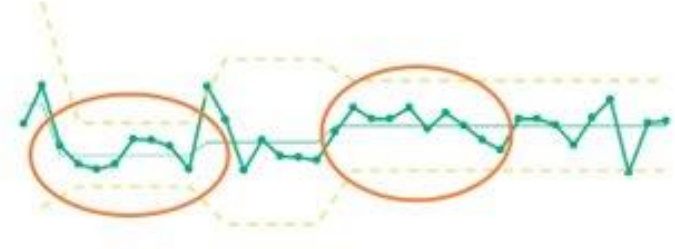
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



Rule 5: At least 15 consecutive data points "hugging" the centre line



Example of Limits reset following special cause



Quality & Effectiveness

Q1 COMPLAINTS

Figure Q1.1

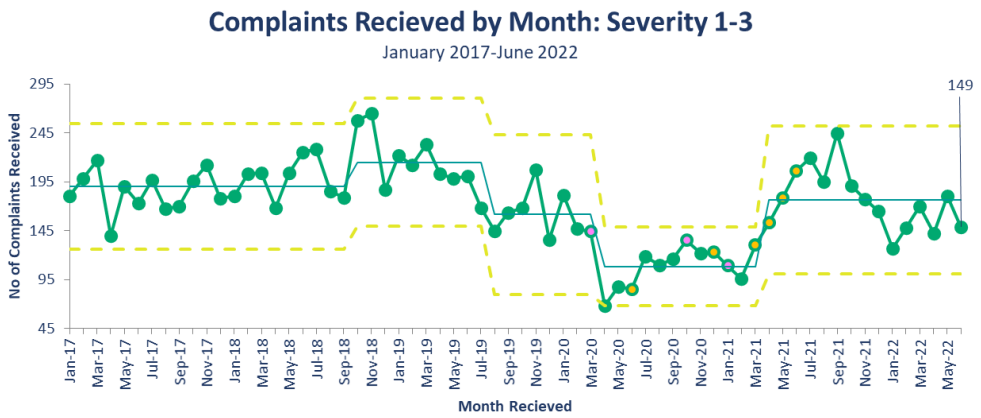


Figure Q1.2

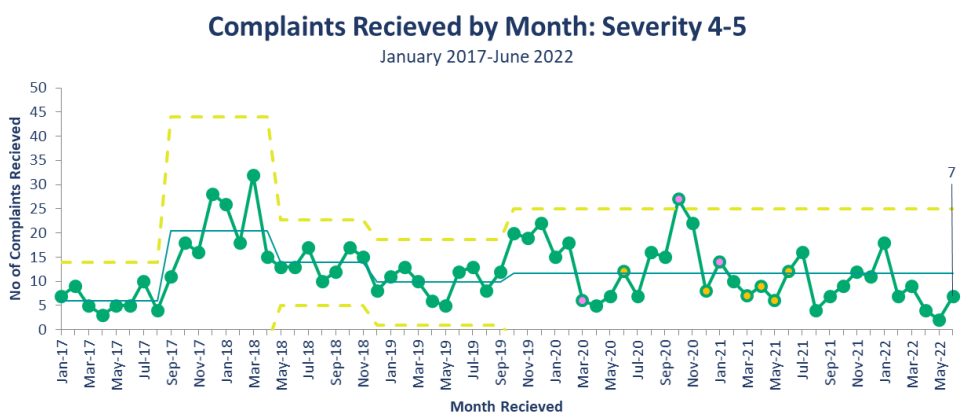


Figure Q1.3

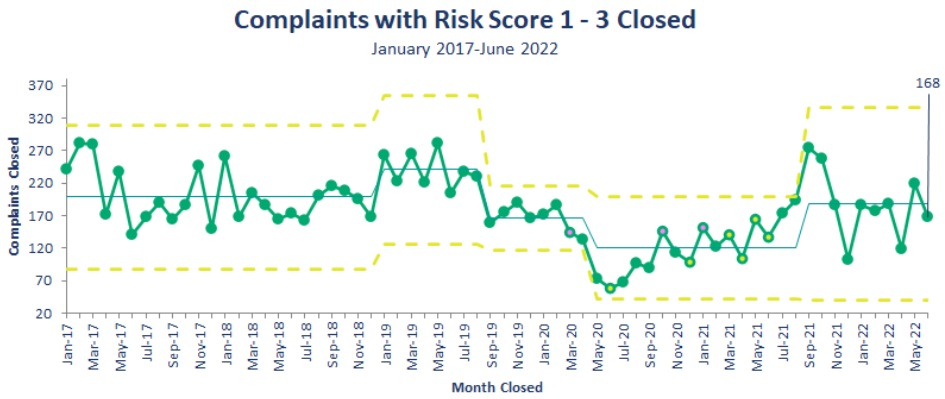


Figure Q1.4

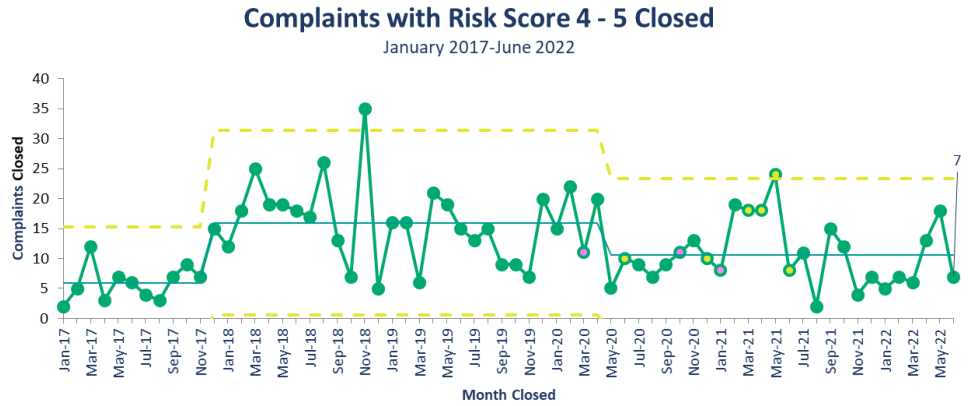


Figure Q1.5

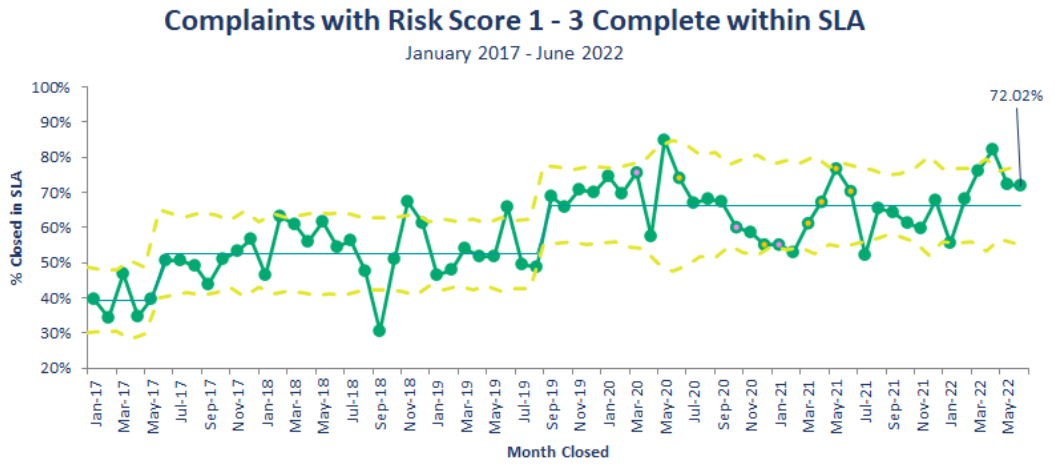


Figure Q1.6

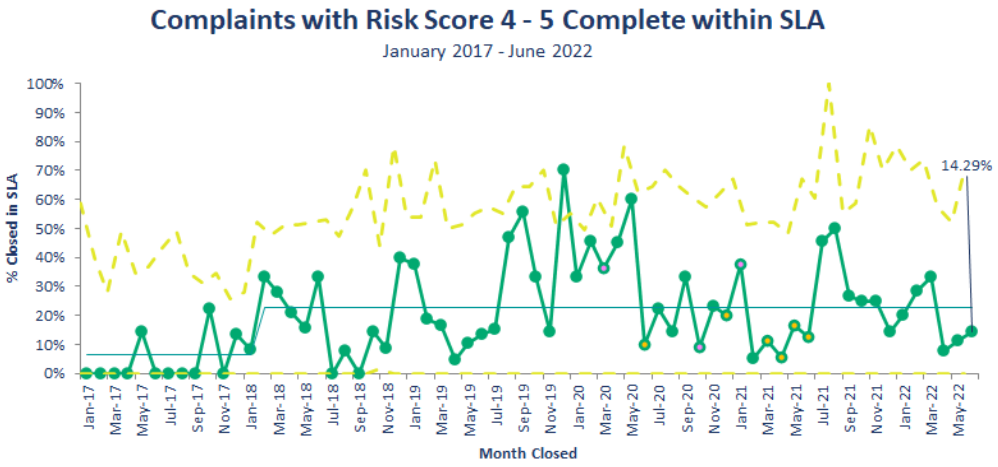
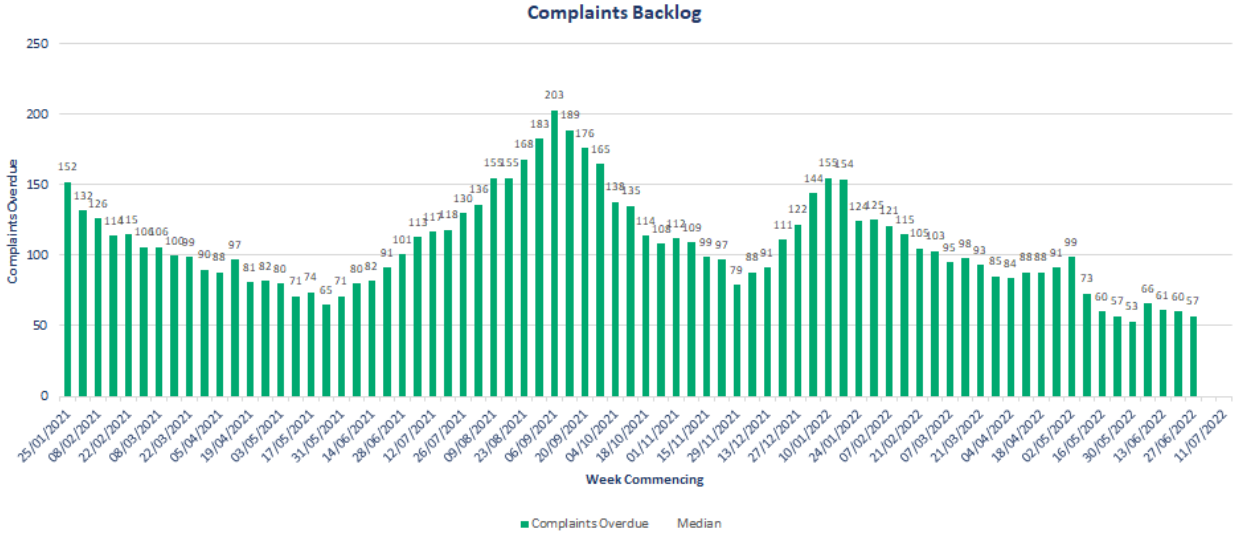


Figure Q1.7



Q2 Incidents

Figure Q2.1

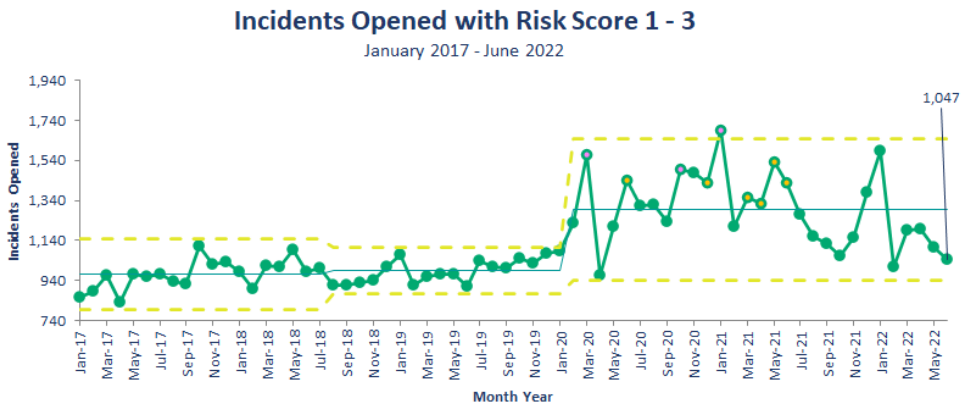


Figure Q2.2

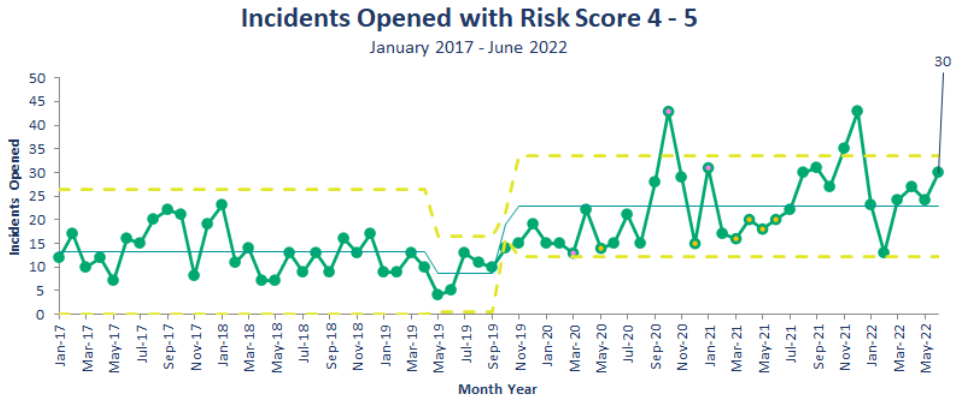


Figure Q2.3

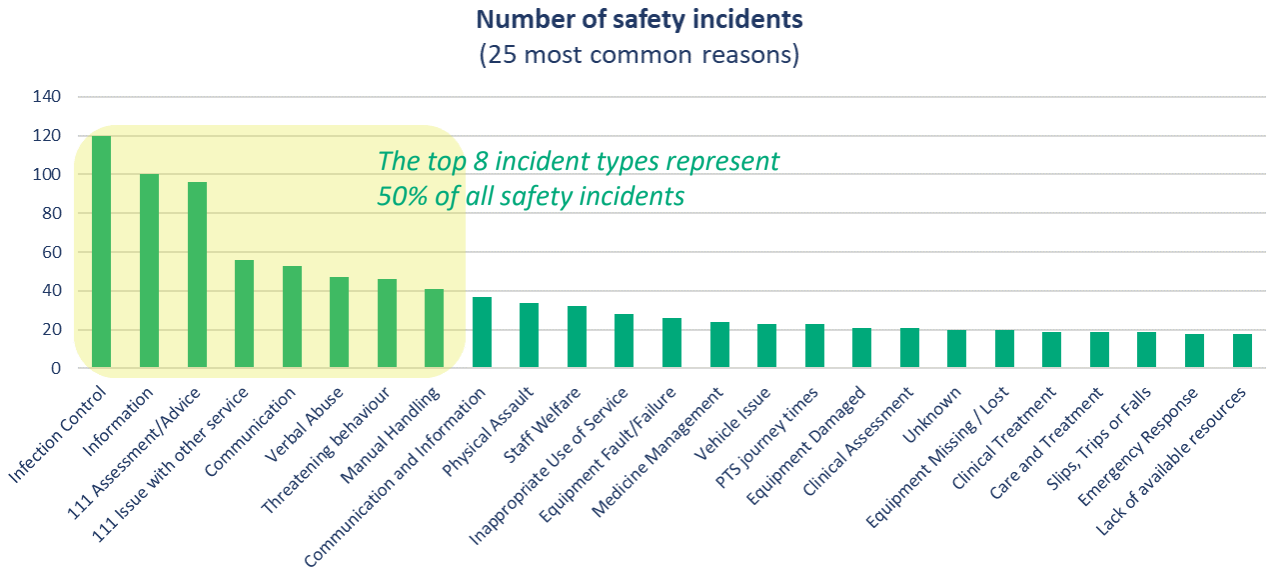


Figure Q2.4

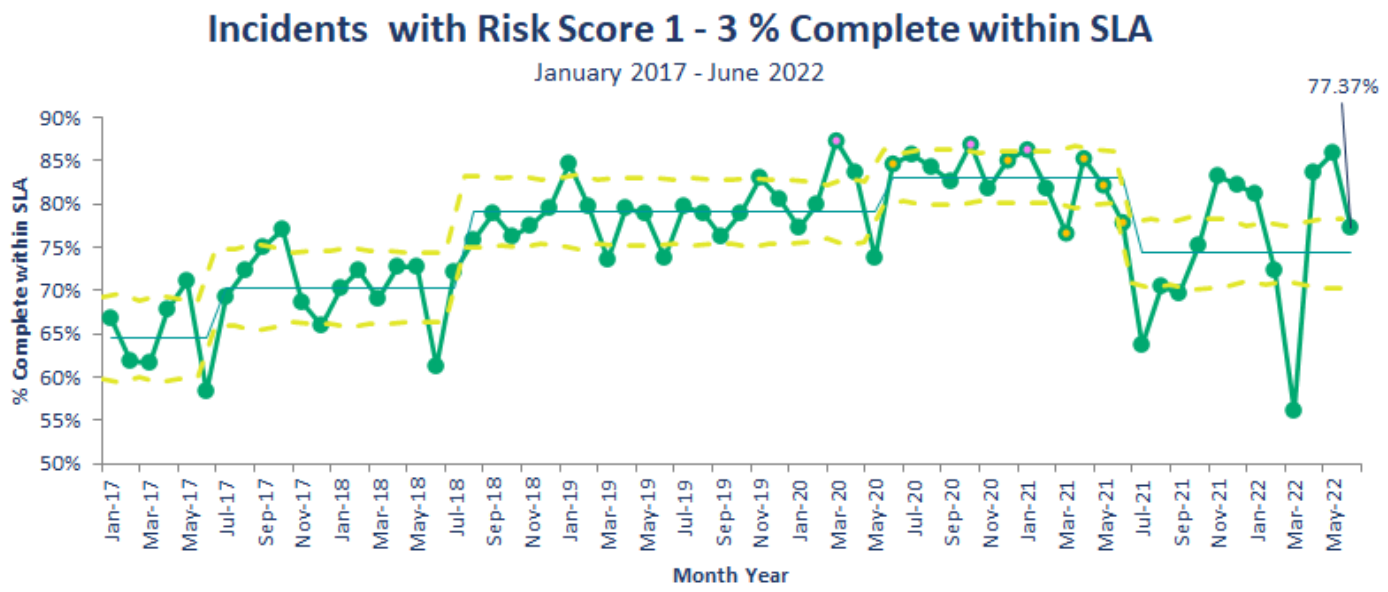


Figure Q2.5

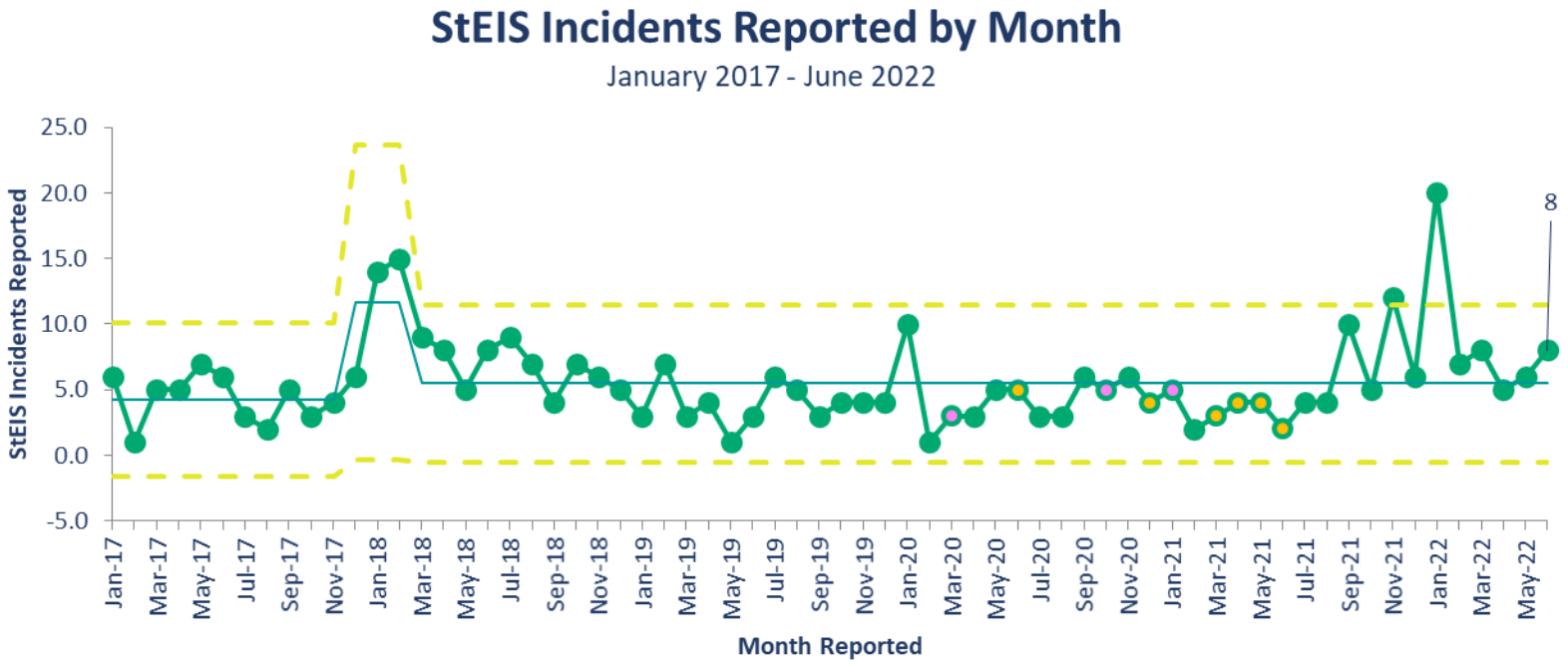
SLAs are calculated using the following measures/targets.

No exceptions are taken into account:

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

Q3 SERIOUS INCIDENTS

Figure Q3.1



Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Number of Alerts Received (June 21 – July 22)	Number of Alerts Applicable (June 21 – July 22)	Number of Open Alerts	Notes
CAS/ NHS Improvement	4	1	0	

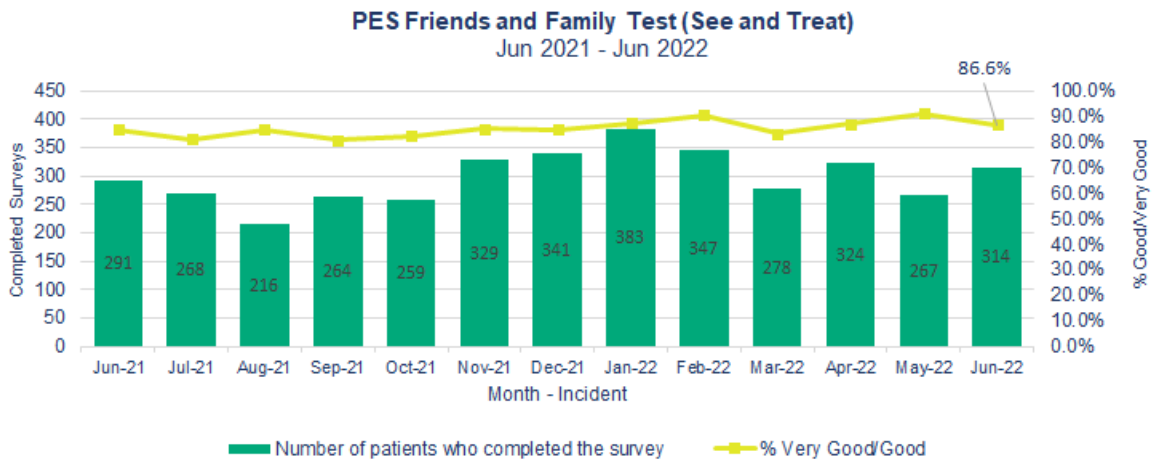
Safety Alerts	Number of Alerts Received (June 21 – July 22)	Number of Alerts Applicable (June 21 – July 22)	Number of Open Alerts	Notes
MHRA – Medical Equipment	26	0	0	

Safety Alerts	Number of Alerts Received (June 21 – July 22)	Number of Alerts Applicable (June 21 – July 22)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	65	1	0	

Safety Alerts	Number of Alerts Received (June 21 – July 22)	Number of Alerts Applicable (June 21– July 22)	Number of Open Alerts	Notes
IPC	0	0	1	Continue to follow national guidance. The Omicron variant is the prominent variant of Coronavirus (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).

E1 PATIENT EXPERIENCE

Figure E1.1



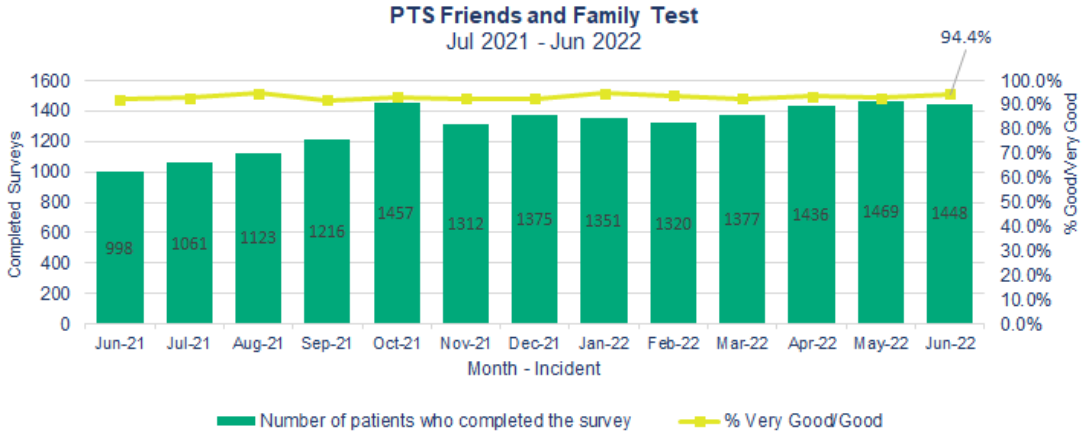
Positive

"The response from control room was fast, reassuring and professional, I was informed that help was in its way. Paramedics arrived in approximately 20 minutes and dealt with the situation kindly, sensitively and thoroughly, asking relevant questions and recording responses, reassuring the patient (my niece) who was in a distressed state. Overall excellent service."

Negative

"I rang at 12pm as my brother was having a mental health crisis and suicidal. I rang three times to chase up the arrival. I got a call at 9.30 the following morning asking if we had been attended to yet from triage and at that time still nobody had been."

Figure E1.2



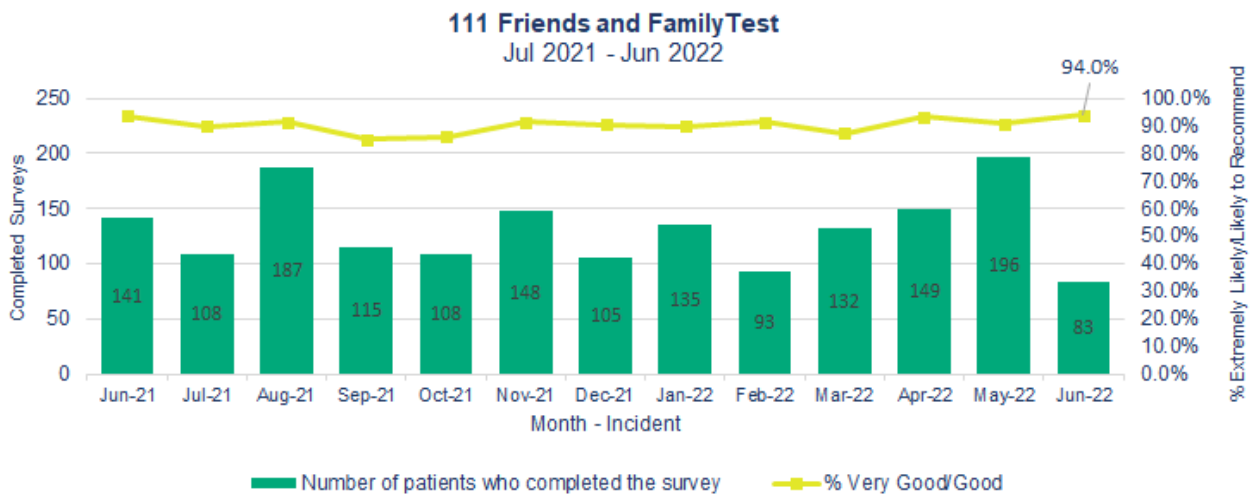
Positive

"It's the first time I've used this wonderful service. The crews were so thoughtful, caring and thoroughly lovely in demeanor it made the journeys a pleasure. The first crew in particular, were really amazing. They made sure I had everything I needed to bring before I left the house. The driver was incredibly sensitive to subtle cues of sensory discomfort, which he remedied immediately without comment or judgement. They both just made me feel completely at ease. And they clearly had a good relationship and just made you feel completely safe in every sense. I felt in incredibly good hands."*

Negative

"I was waiting over 3 hours for transport. You used normal taxi. It made me very ill."

Figure E1.3



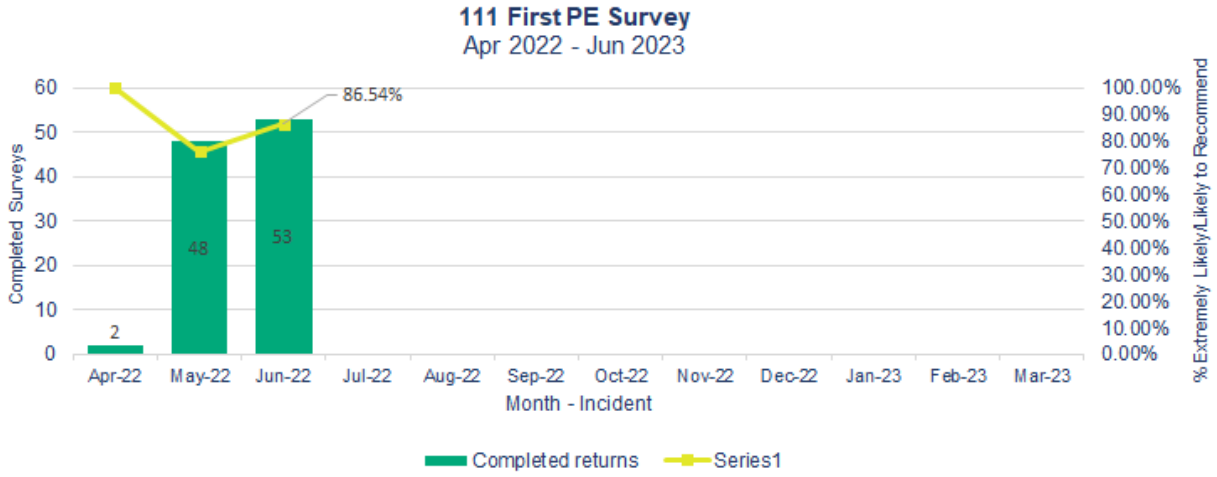
Positive

"The speed in which I was treated was exceptional - 2 hours from initial call to seeing doctor in urgent care department."

Negative

"I was dissatisfied because they were asking too many questions and I was really feeling unwell. It was about half an hour asking me a lot of questions, in the end I gave up!! Fortunately, I was okay in the next 12 hours."

Figure E1.4



Positive

"I have never used NHS 111 service before, I received an excellent service, given a time slot at A and E had a phone call in afternoon to make sure I had been for my appointment."

Negative

"What is the point?! Give slots at A and E to be told not valid. Wasn't the point to stop sending everyone to A and E? Where the walk ins gone? "

.

Figure E1.5

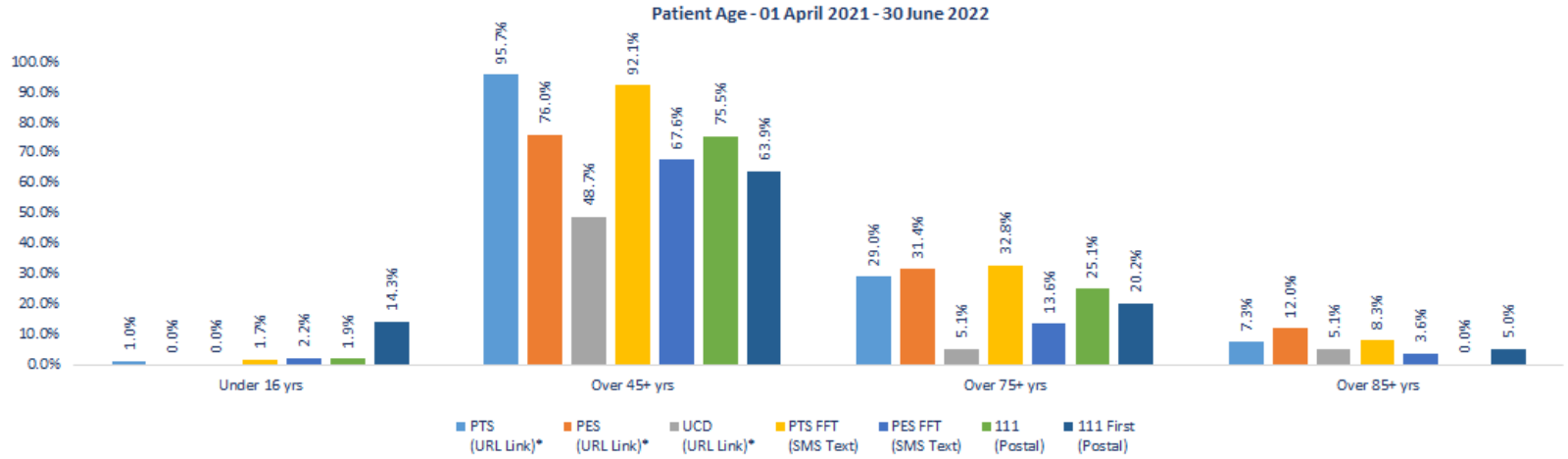


Figure E1.6

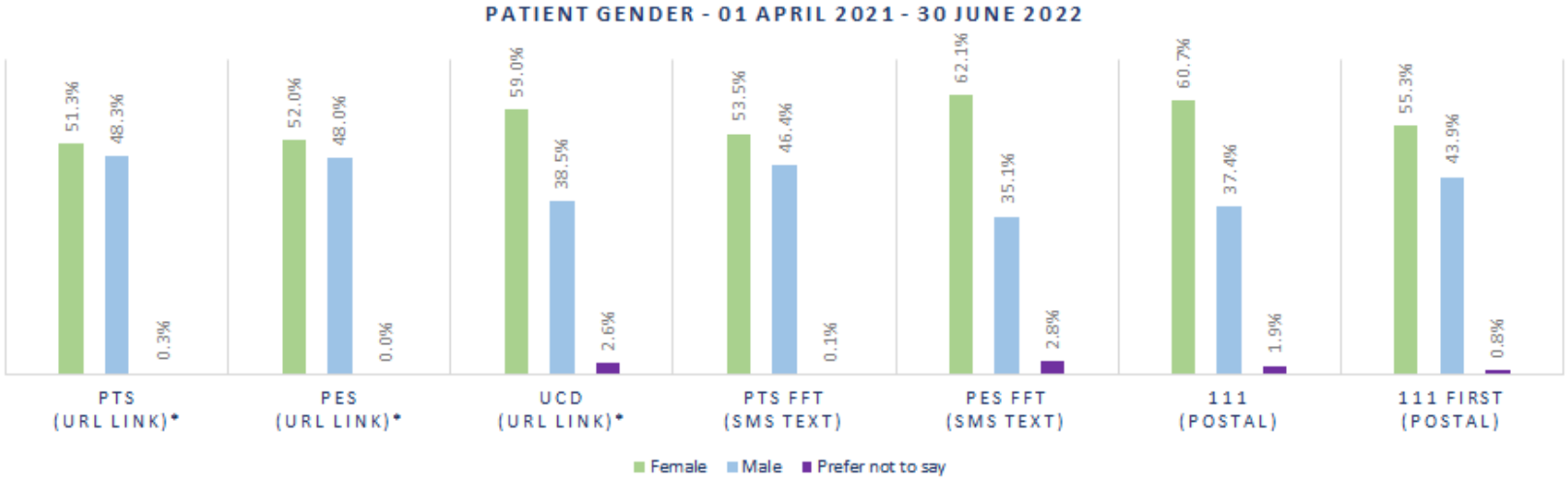


Figure E1.7

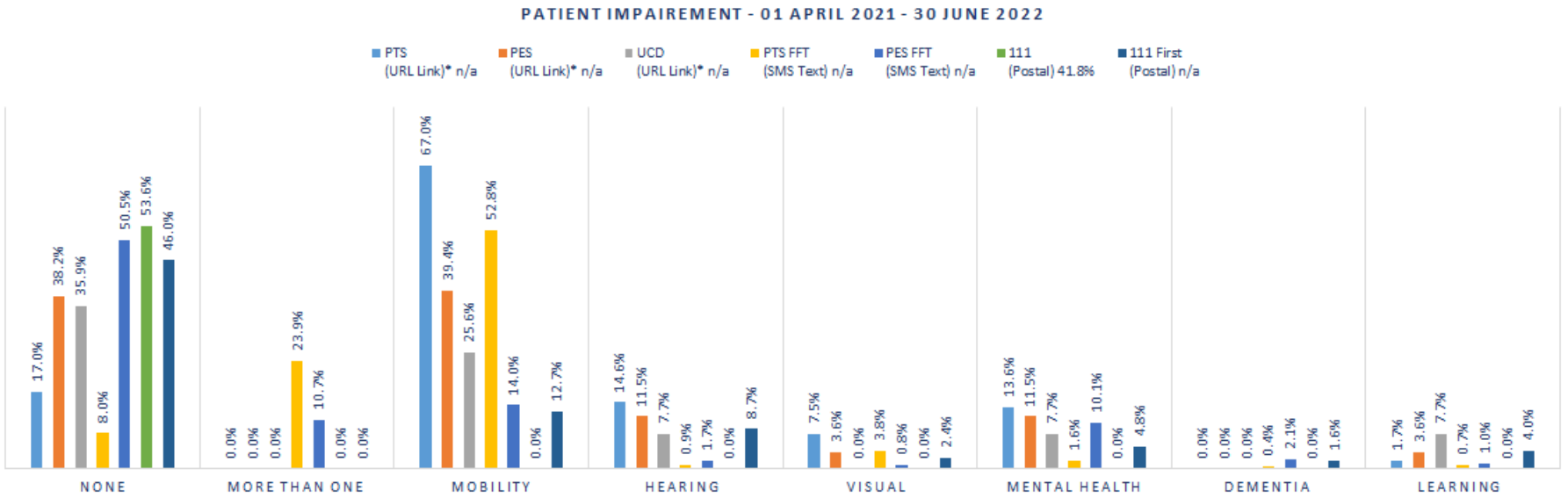
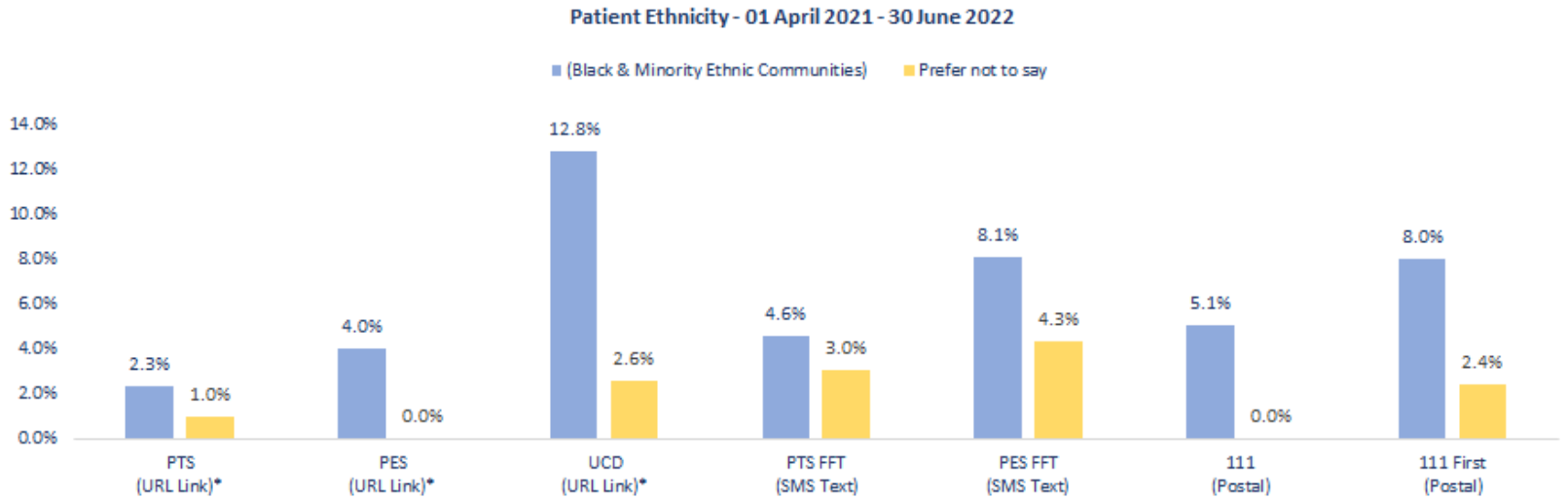


Figure E1.8



E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

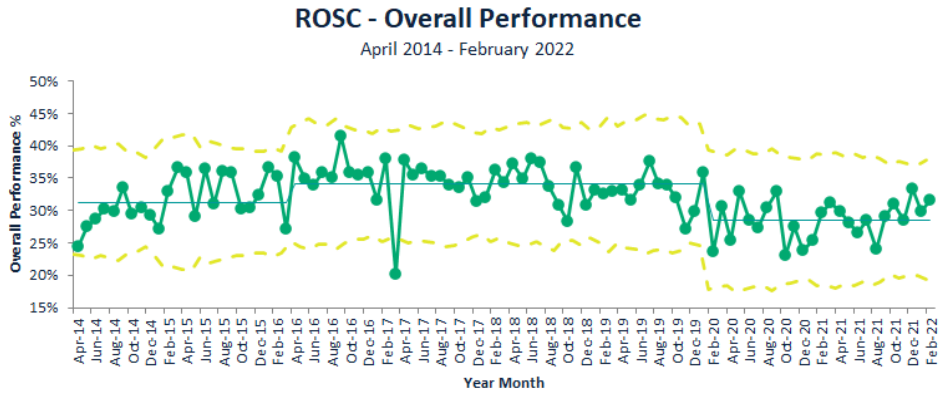


Figure E2.2

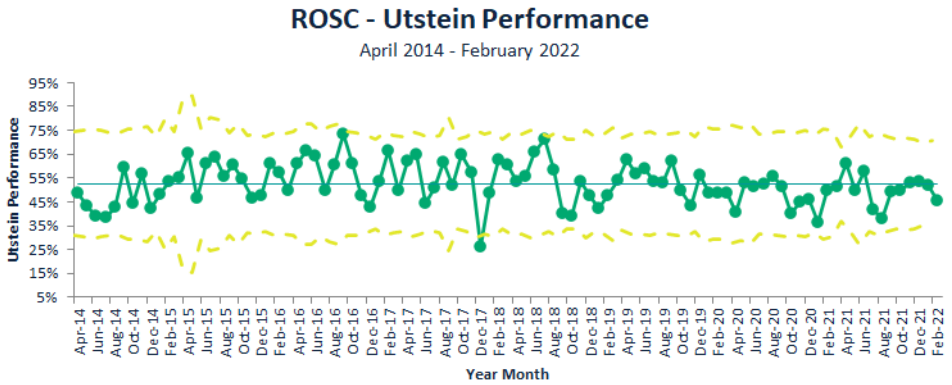


Figure E2.3

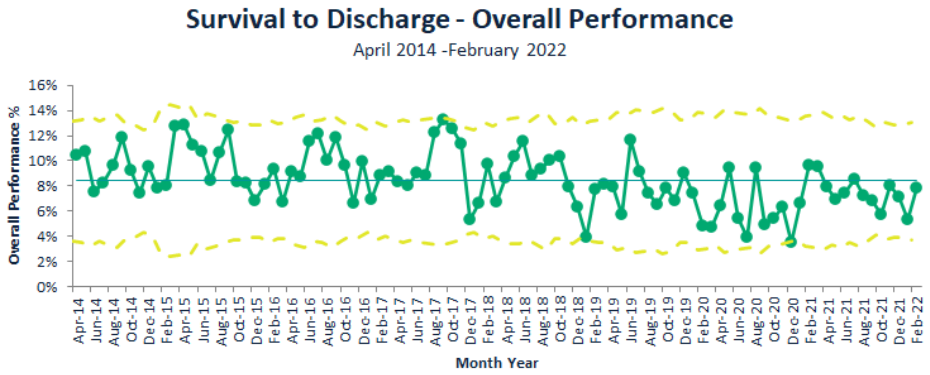


Figure E2.4

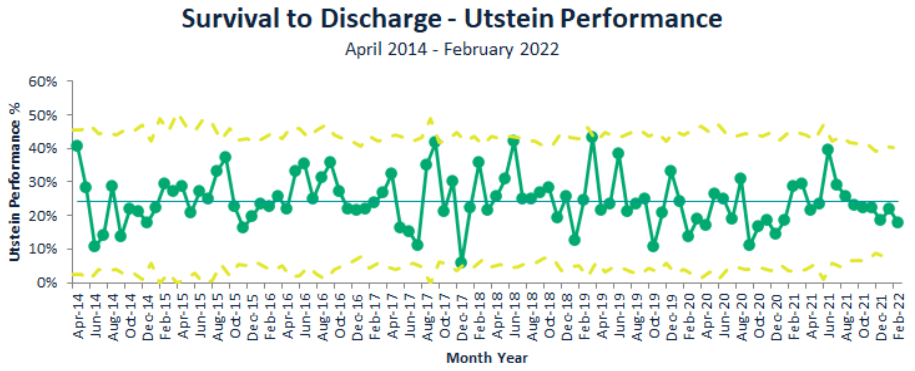


Figure E2.5

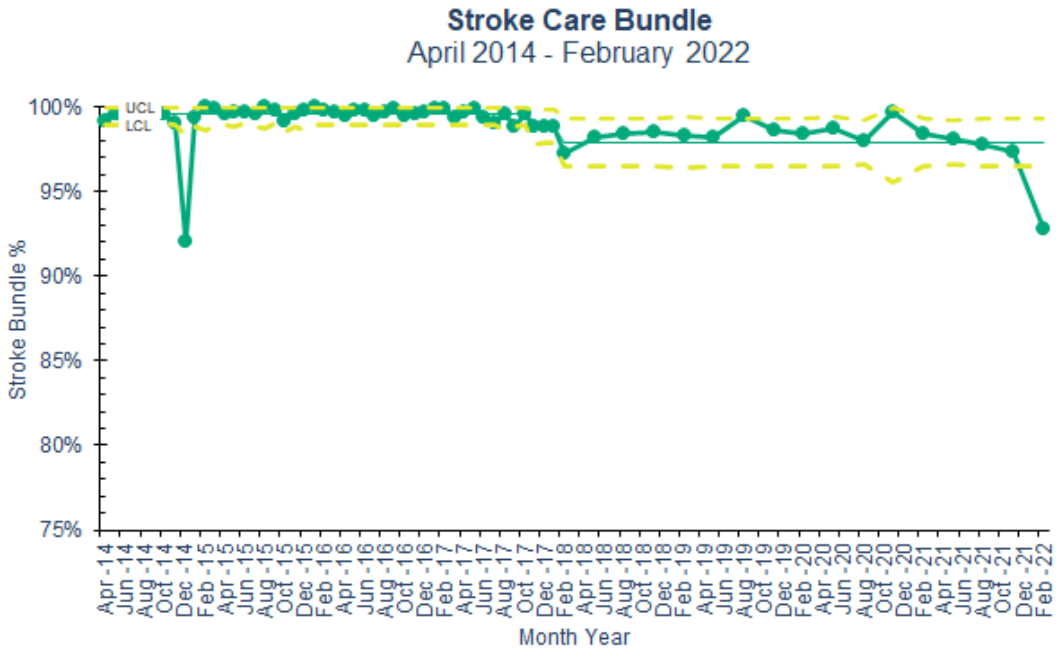
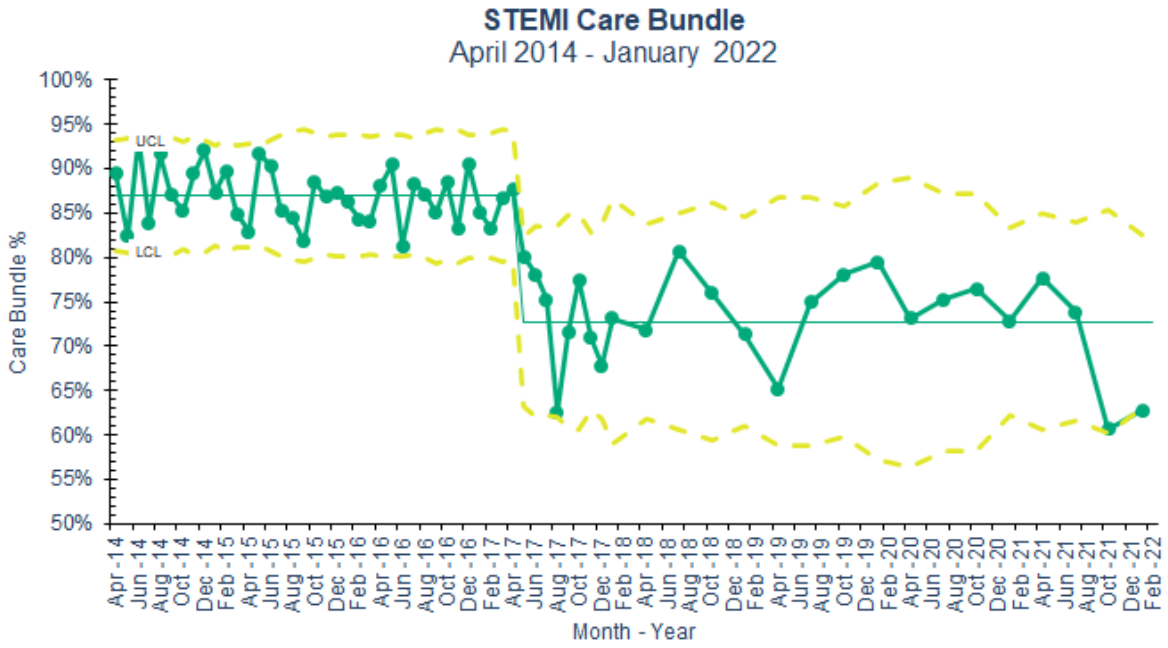


Figure E2.6



The axis for the Stroke Care Bundle starts at 75%, the axis for STEMI Care Bundle starts at 50%.

E3 ACTIVITY & OUTCOMES

Figure E3.1

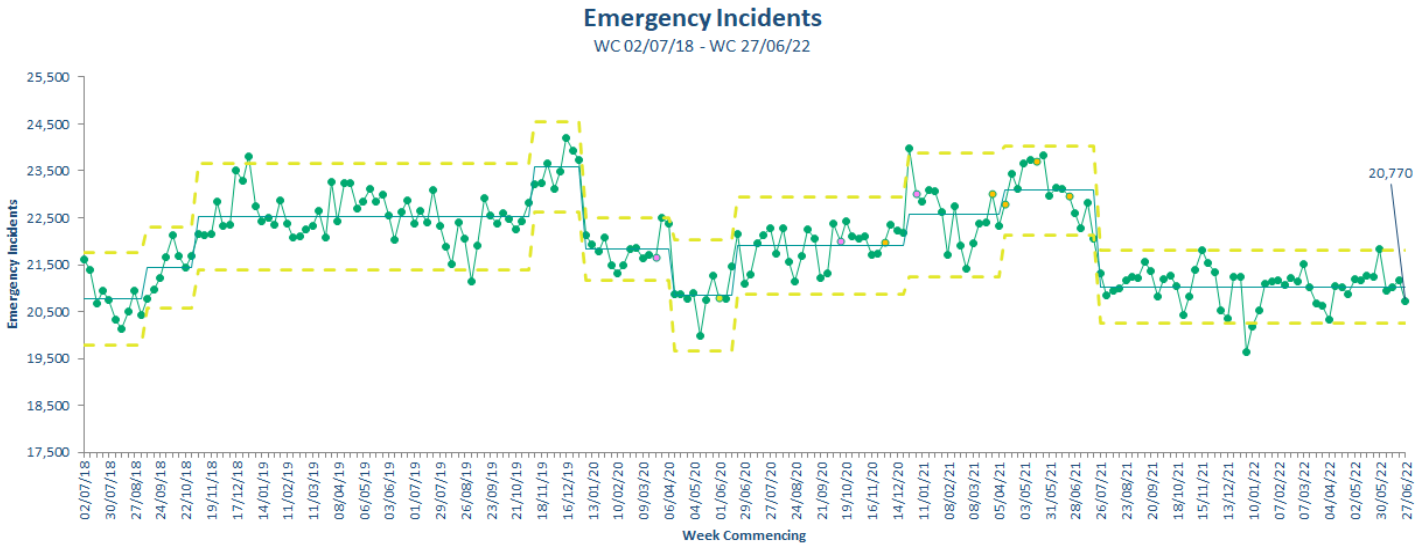


Figure E3.2

Sector	No. of Emergency Incidents
G South	9,740
G Central	9,335
M North	9,127
G West	8,881
G East	8,387
M East	7,415
CL East Lancashire	7,289
M West	5,864
CL South Lancashire	5,794
M South	5,205
CL Fylde	5,089
CL North Cumbria	4,564
CL Morecambe Bay	4,173

Figure E3.3

Figure E3.4

Jun	Calls	% Change from previous year	Incidents	% Change from previous year
2019	115,795		96,953	
2020	95,331	-18%	91,239	-6%
2021	143,031	50%	98,510	8%
2022	131,065	-8%	90,923	-8%

Figure E3.5

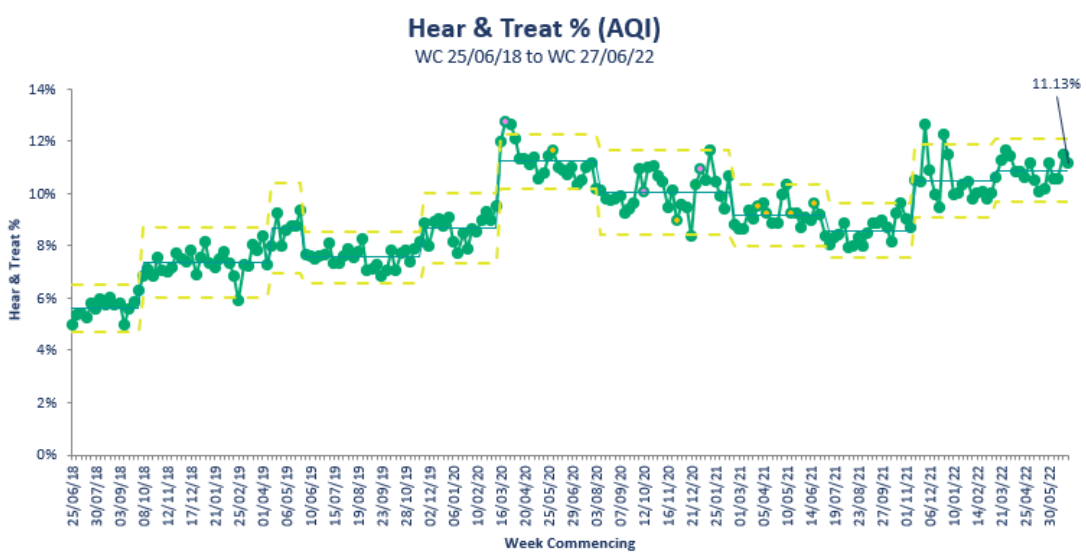


Figure E3.6

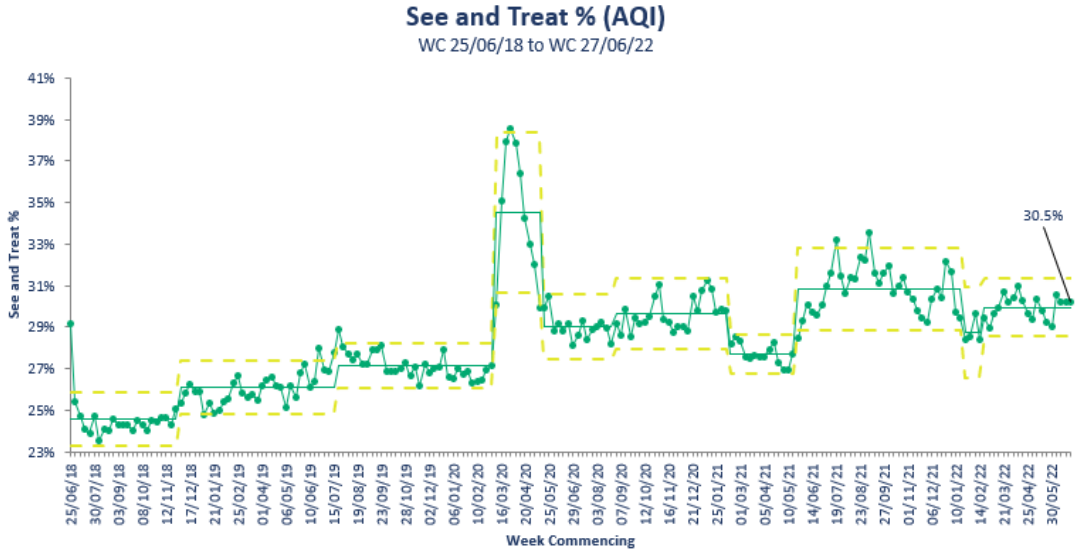


Figure E3.7

Sector	Hear & Treat	%
CL Fylde		16.29%
CL South Lancashire		13.43%
CL East Lancashire		13.06%
G Central		12.97%
G West		11.17%
G East		10.62%
CL North Cumbria		10.56%
CL Morecambe Bay		10.33%
G South		9.53%
M North		9.37%
M East		9.27%
M West		9.12%
M South		9.11%

Figure E3.8

Sector	See & Treat	%
G Central		31.55%
M South		31.39%
CL North Cumbria		31.31%
CL Morecambe Bay		31.27%
G East		31.19%
M West		30.80%
CL Fylde		30.62%
M North		30.32%
G South		30.10%
G West		29.88%
CL South Lancashire		28.74%
M East		28.40%
CL East Lancashire		28.34%

Figure E3.9

Sector	See & Convey	%
CL Fylde		53.09%
G Central		55.48%
CL South Lancashire		57.84%
CL North Cumbria		58.13%
G East		58.19%
CL Morecambe Bay		58.40%
CL East Lancashire		58.60%
G West		58.95%
M South		59.50%
M West		60.08%
M North		60.32%
G South		60.37%
M East		62.33%

Figure E3.10

Sector	See & Convey to AE	%
G Central		48.76%
CL Fylde		49.40%
CL East Lancashire		49.84%
CL South Lancashire		50.57%
G East		51.04%
M West		51.33%
G West		51.47%
CL North Cumbria		52.34%
G South		53.57%
CL Morecambe Bay		54.30%
M South		54.49%
M North		54.57%
M East		55.44%

Figure E3.11

Sector	See & Convey to Non AE	%
CL Fylde		3.69%
CL Morecambe Bay		4.10%
M South		5.01%
M North		5.74%
CL North Cumbria		5.78%
G Central		6.72%
G South		6.80%
M East		6.89%
G East		7.14%
CL South Lancashire		7.27%
G West		7.48%
M West		8.75%
CL East Lancashire		8.75%

Figure E3.12

Rank	Trust	Hear & Treat	%
1	West Midlands		16.3%
2	London		15.7%
3	South Western		13.8%
4	East Midlands		13.7%
5	Yorkshire		13.5%
6	South Central		12.2%
7	North West		11.1%
8	South East Coast		10.6%
9	North East		9.8%
10	East of England		8.6%
11	Isle of Wight		8.3%

Figure E3.13

Rank	Trust	See & Treat	%
1	South Western		38.4%
2	South Central		34.6%
3	Isle of Wight		33.1%
4	East of England		33.1%
5	East Midlands		32.5%
6	London		32.2%
7	South East Coast		31.4%
8	North West		30.2%
9	West Midlands		30.2%
10	North East		28.0%
11	Yorkshire		26.5%

Figure E3.14

Rank	Trust	See & Convey	%
1	South Western		47.8%
2	London		52.1%
3	South Central		53.2%
4	West Midlands		53.5%
5	East Midlands		53.7%
6	South East Coast		58.0%
7	East of England		58.3%
8	Isle of Wight		58.6%
9	North West		58.7%
10	Yorkshire		60.0%
11	North East		62.1%

Operational

O1 CALL PICK UP

Figure O1.1

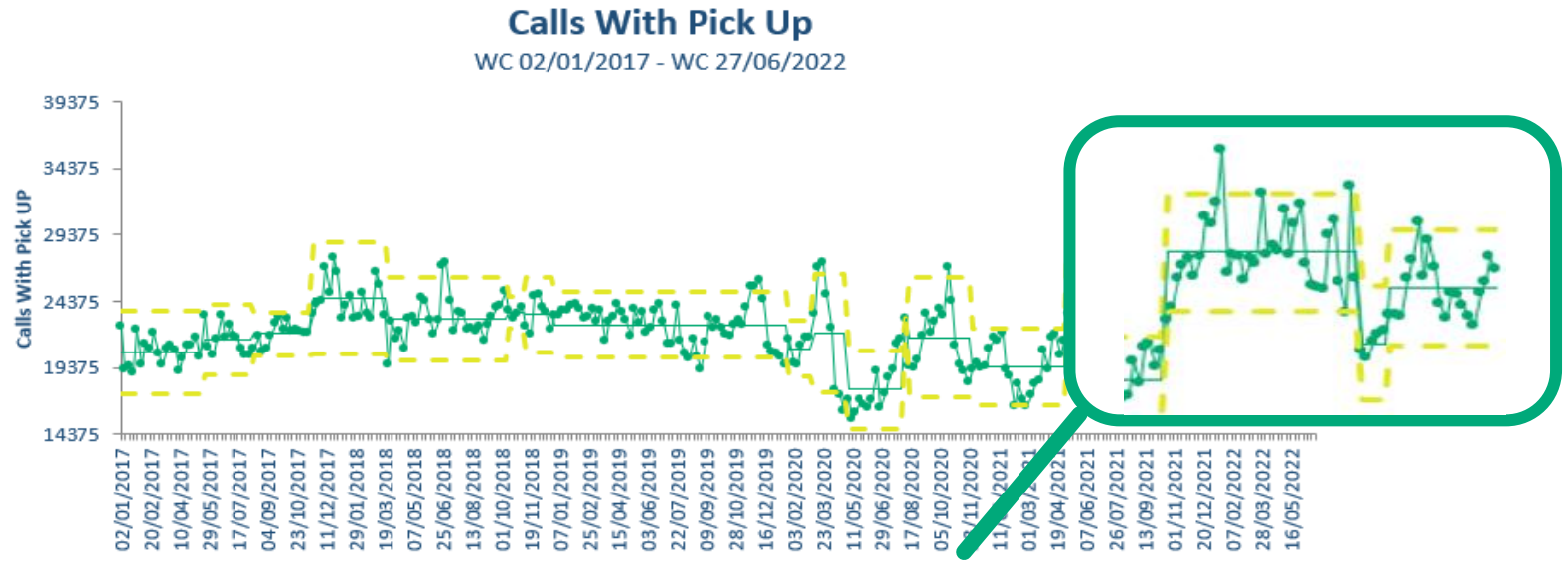
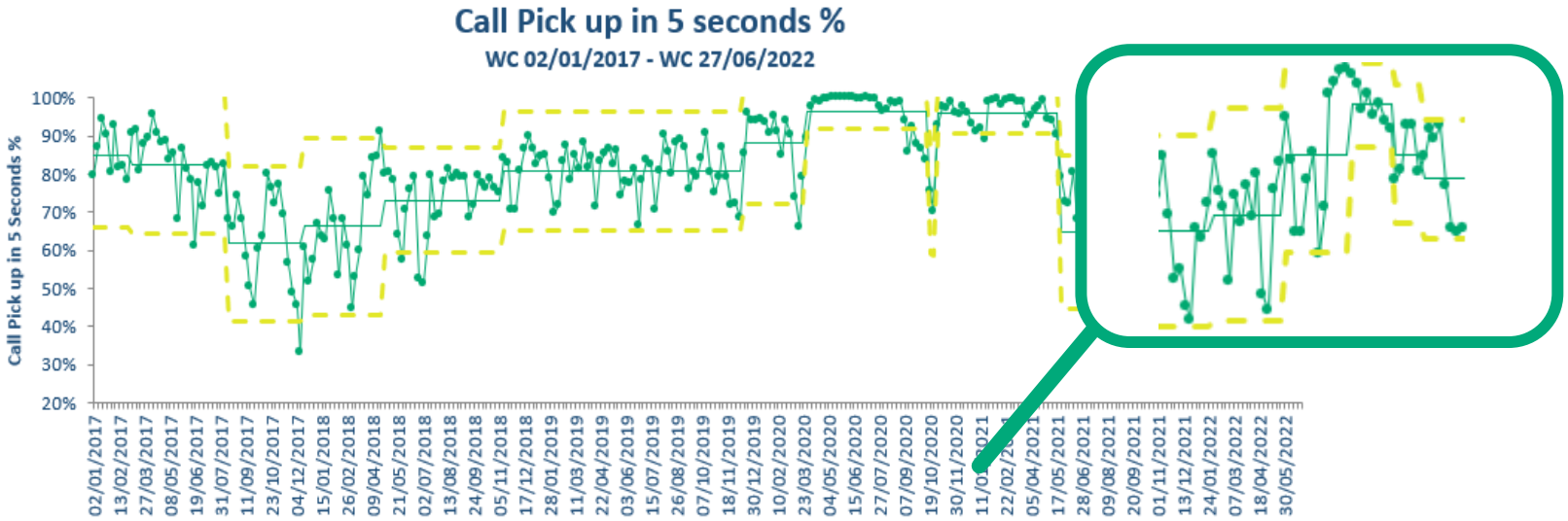


Figure O1.2



02 A&E TURNAROUND

Figure O2.1

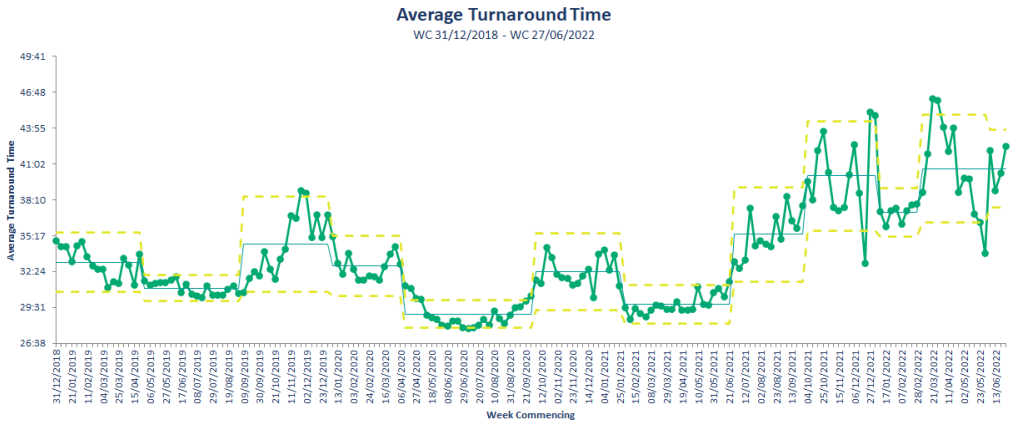


Figure Q1.2

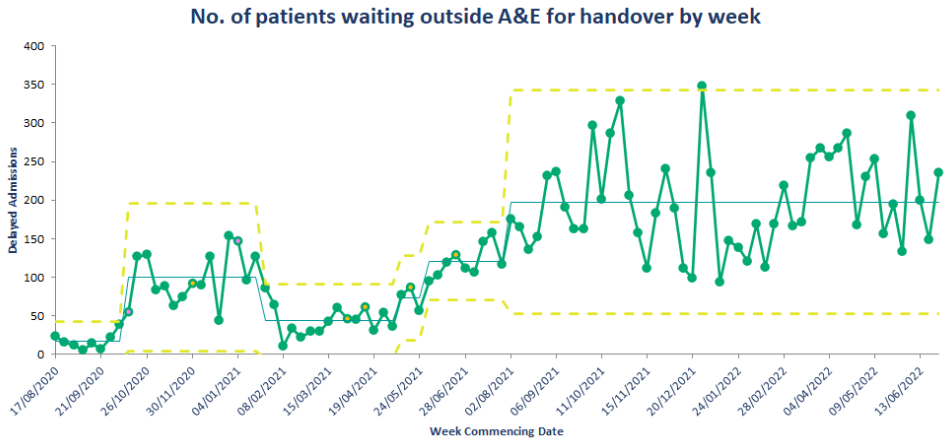


Table Q1.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
May-21	57,212	29:56:00	18:46	11:17
Jun-21	52,324	31:20:00	20:11	11:24
Jul-21	51,396	34:16:00	23:12	11:20
Aug-21	49,377	35:06:00	23:45	11:32
Sep-21	47,467	36:49:00	25:26:00	11:41
Oct-21	38,181	39:27:00	27:56:00	11:25
Nov-21	48,412	0:38:29	0:27:28	11:34
Dec-21	47,723	0:39:22	0:27:58	11:18
Jan-22	47,332	0:39:09	0:27:47	11:31
Feb-22	45,232	0:37:13	0:25:56	11:15
Mar-22	47,939	0:42:06	0:30:57	11:48
Apr-22	45,768	0:42:27	0:30:52	11:22

Table Q1.2

Top 5 Trusts with most hours lost due to delayed	
Trust	**Hours lost to delayed admissions**
Fairfield General Hospital	335.6
Royal Preston Hospital	328.1
Royal Lancaster Hospital	310.5
Royal Oldham Hospital	284.4
Blackpool Victoria Hospital	127.8

Table Q1.3

Month	No. of patients waiting outside A&E for handover
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
Mar-22	936
Apr-22	1057
May-22	891
Jun-22	926

O3 ARP RESPONSE TIMES

June 2022

Figure O3.1

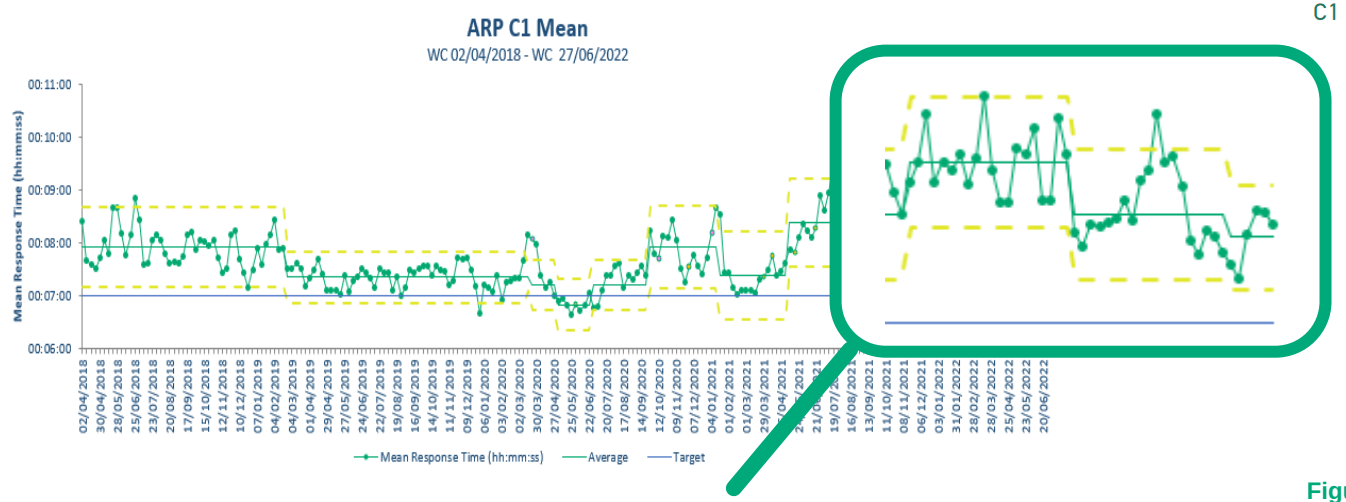


Figure O3.2

C1 Mean (Red=>7m)

Figure O3.3

Sector	C1 Mean	Time
G Central		00:06:49
CL Fylde		00:07:16
G South		00:07:29
G East		00:07:39
G West		00:07:50
M North		00:07:51
CL Morecambe Bay		00:08:25
CL East Lancashire		00:08:31
CL South Lancashire		00:08:57
M East		00:09:02
CL North Cumbria		00:09:05
M West		00:09:23
M South		00:10:45

Figure O3.4

C1 Mean	
Target	7:00
June 2022	8:12
YTD	8:15

Figure O3.5

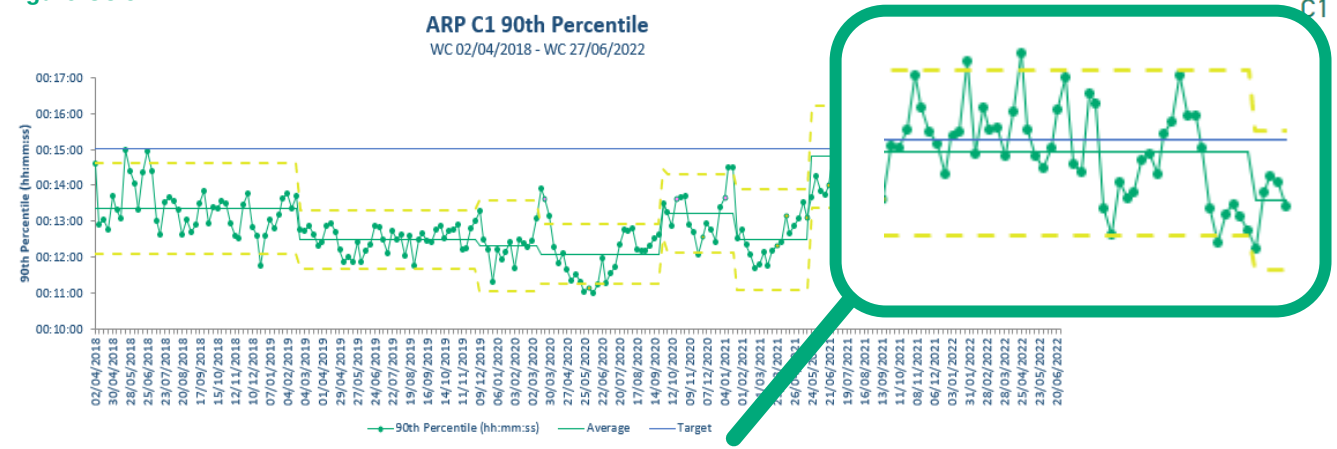


Figure O3.6

C1 90th (Red=>15m)

Figure O3.7

Sector	C1 90th	Time
G Central		00:11:04
G South		00:12:09
G East		00:12:27
CL Fylde		00:12:51
G West		00:12:54
M North		00:13:25
CL East Lancashire		00:14:57
M East		00:15:11
CL South Lancashire		00:15:23
M West		00:15:36
CL Morecambe Bay		00:16:24
CL North Cumbria		00:17:20
M South		00:18:23

Figure O3.8

C1 90th	
Target	15:00
June 2022	13:59
YTD	14:02

June 2022

Figure O3.9

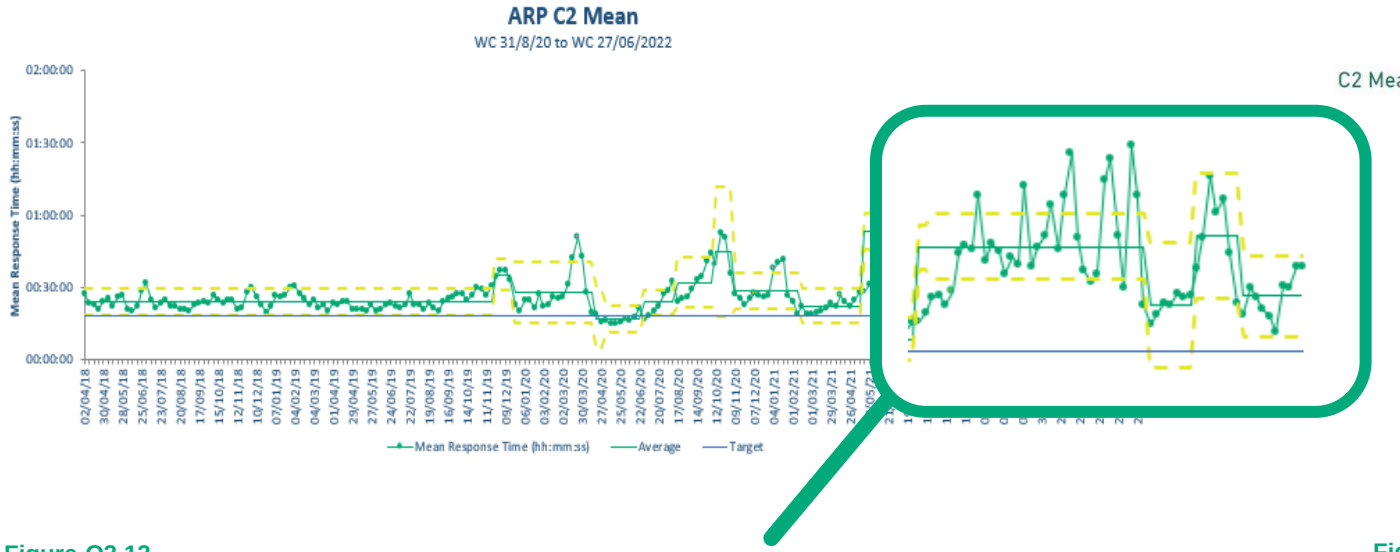


Figure O3.10

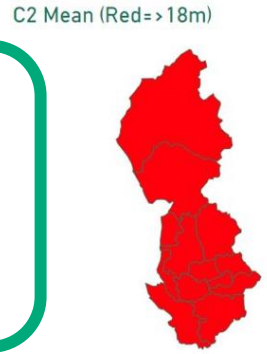


Figure O3.11

Sector	C2 Mean	Time
CL North Cumbria		00:19:44
CL Morecambe Bay		00:26:39
G South		00:33:35
G East		00:35:04
G Central		00:36:45
CL East Lancashire		00:37:57
M South		00:38:31
CL Fylde		00:40:04
CL South Lancashire		00:42:14
G West		00:42:28
M West		00:47:00
M North		00:51:36
M East		00:54:22

Figure O3.12

C2 Mean	
Target	18:00
June 2022	39:46
YTD	40:09

Figure O3.13

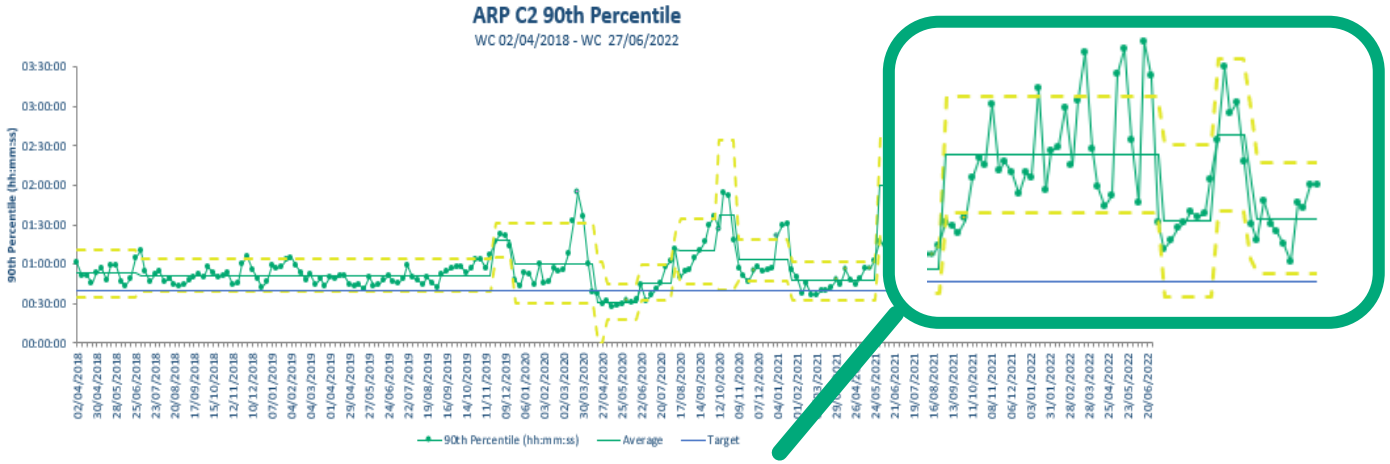


Figure O3.14

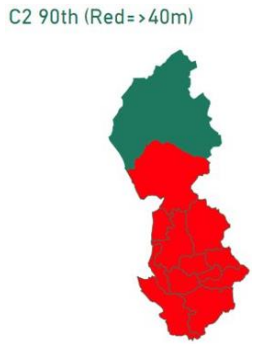


Figure O3.15

Sector	C2 90th	Time
CL North Cumbria		00:37:47
CL Morecambe Bay		00:58:08
G South		01:13:27
G East		01:18:09
CL East Lancashire		01:19:43
M South		01:21:31
G Central		01:22:21
G West		01:29:09
CL South Lancashire		01:29:24
CL Fylde		01:29:57
M West		01:41:29
M North		01:52:32
M East		01:53:42

Figure O3.16

C2 90th	
Target	0:40:00
June 2022	1:27:30
YTD	1:29:17

June 2022

Figure O3.17

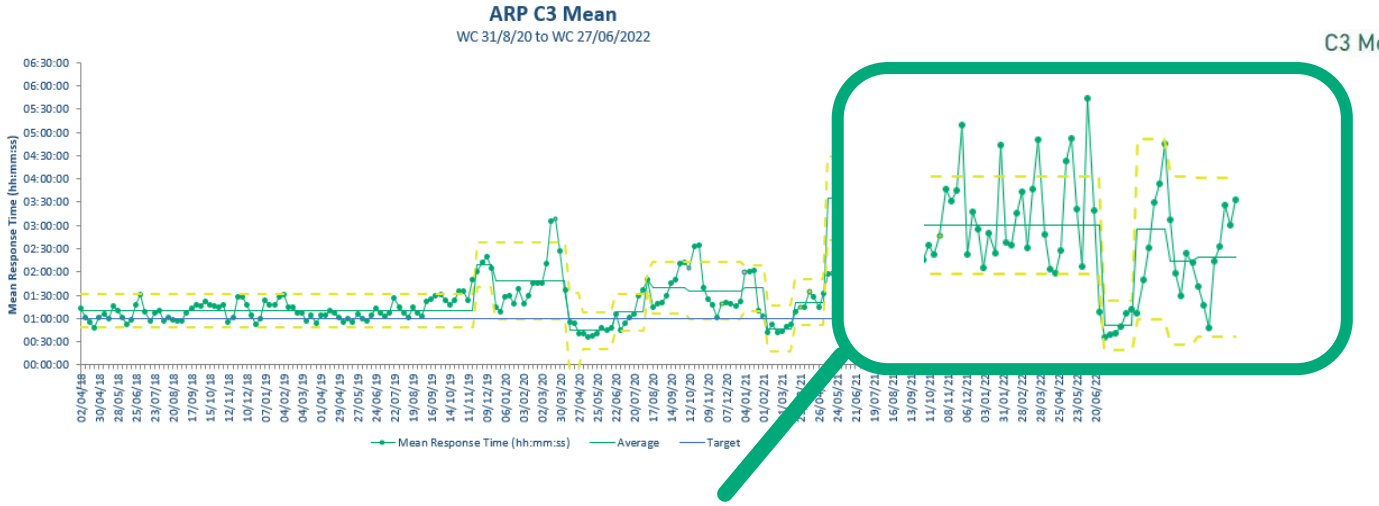


Figure O3.18

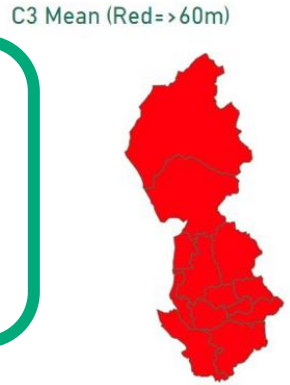


Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:00:22
CL Morecambe Bay		01:26:15
M West		02:39:13
CL Fylde		02:40:09
M South		02:42:08
CL South Lancashire		03:02:37
G South		03:05:13
M North		03:07:17
CL East Lancashire		03:09:52
G East		03:11:47
G Central		03:44:54
G West		03:48:48
M East		03:51:36

Figure O3.20

C3 Mean	
Target	1:00:00
June 2022	2:59:47
YTD	2:57:44

Figure O3.21

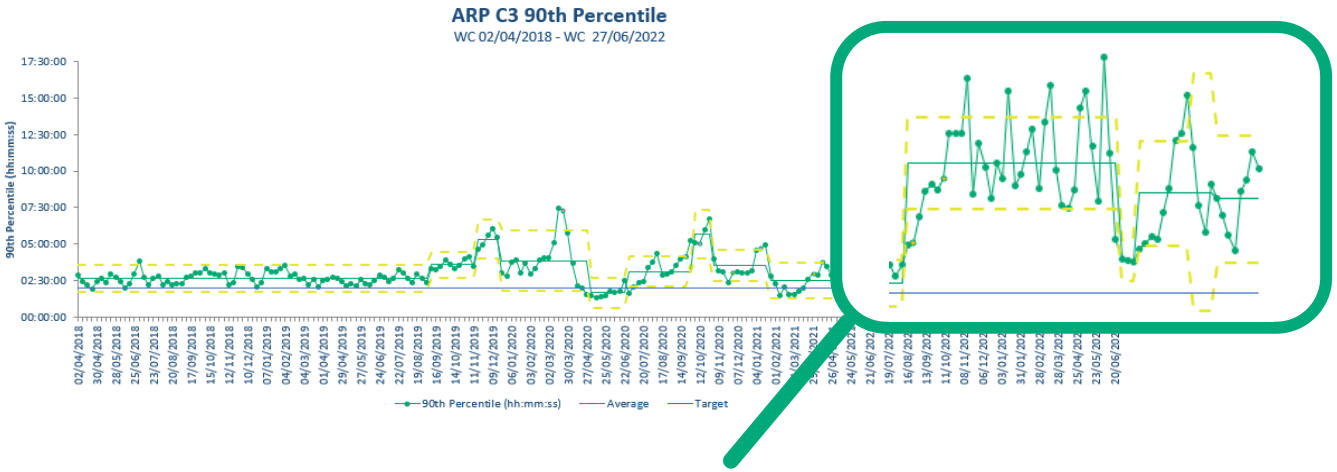


Figure O3.22

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:11:30
CL Morecambe Bay		03:27:14
CL Fylde		06:13:41
M South		06:44:33
M West		06:48:49
CL South Lancashire		06:56:53
G South		07:17:12
CL East Lancashire		07:28:47
G East		07:34:31
M North		08:12:51
G West		09:23:50
G Central		10:01:21
M East		10:15:13

Figure O3.24

C3 90th	
Target	2:00:00
June 2022	7:20:40
YTD	7:16:21

O3 ARP Provider Comparison

Figure O3.25

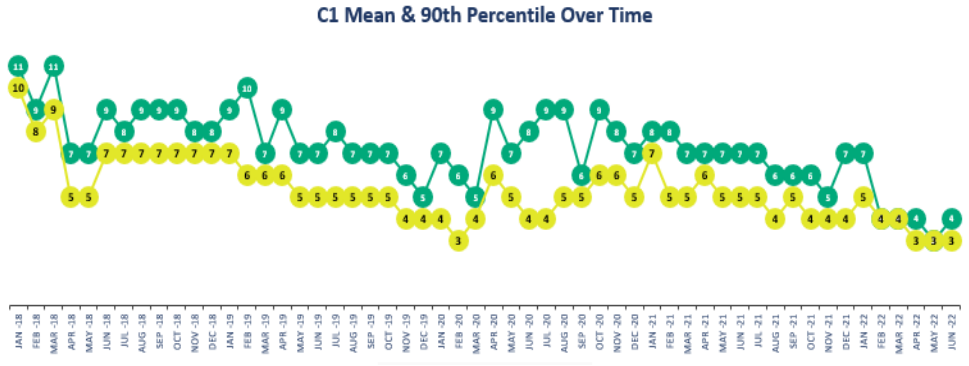


Figure O3.26

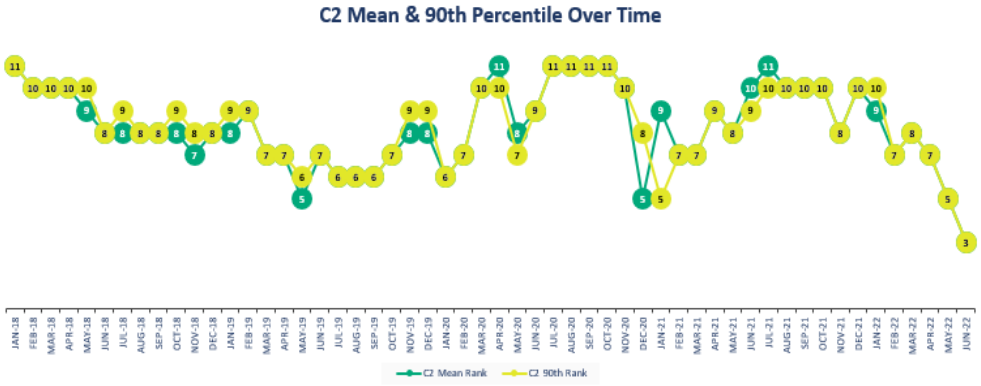


Figure O3.27

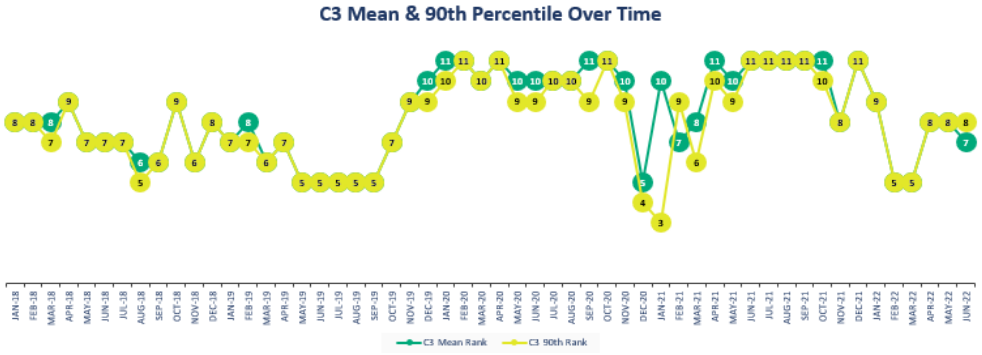
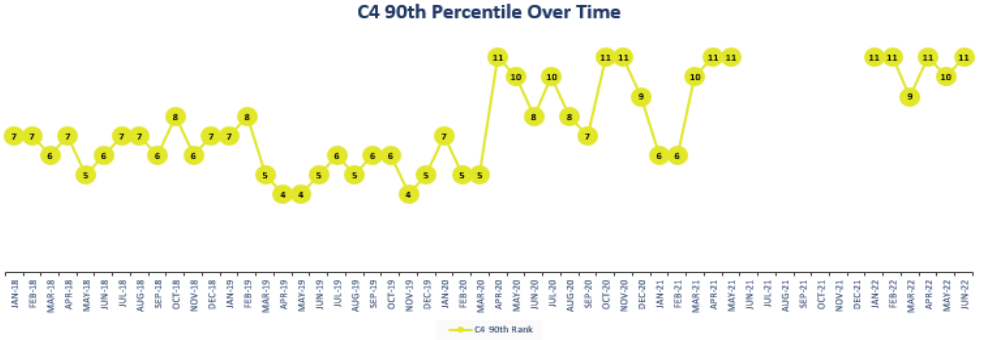


Figure O3.28



Rank	Trust	C1 Mean	Time
1	London		07:33
2	North East		07:33
3	West Midlands		08:09
4	North West		08:12
5	South East Coast		09:04
6	Yorkshire		09:30
7	East Midlands		09:46
8	South Central		09:48
9	East of England		10:15
10	Isle of Wight		10:46
11	South Western		11:28

Rank	Trust	C1 90th	Time
1	London		12:41
2	North East		12:55
3	North West		13:59
4	West Midlands		14:13
5	South East Coast		16:28
6	Yorkshire		16:28
7	South Central		17:27
8	East Midlands		17:42
9	Isle of Wight		17:52
10	East of England		18:47
11	South Western		21:01

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:27:53
2	South East Coast		0:35:31
3	North West		0:39:46
4	Yorkshire		0:43:18
5	South Central		0:43:28
6	North East		0:44:00
7	West Midlands		0:52:11
8	London		0:55:44
9	East of England		0:56:48
10	South Western		1:09:50
11	East Midlands		1:11:51

Rank	Trust	C2 90th	Time
1	Isle of Wight		0:55:24
2	South East Coast		1:14:10
3	North West		1:27:30
4	South Central		1:29:16
5	North East		1:32:45
6	Yorkshire		1:35:57
7	East of England		2:02:30
8	London		2:03:29
9	West Midlands		2:05:50
10	South Western		2:36:56
11	East Midlands		2:38:30

Rank	Trust	C3 Mean	Time
1	Isle of Wight		01:14:45
2	London		02:08:52
3	North East		02:16:42
4	Yorkshire		02:17:01
5	South East Coast		02:46:35
6	East of England		02:50:52
7	North West		02:59:47
8	South Western		03:03:41
9	South Central		03:04:24
10	East Midlands		03:35:14
11	West Midlands		03:55:47

Rank	Trust	C3 90th	Time
1	Isle of Wight		02:50:11
2	London		05:21:10
3	Yorkshire		05:24:57
4	North East		05:51:57
5	South East Coast		06:33:14
6	East of England		06:57:53
7	South Central		07:03:14
8	North West		07:20:40
9	South Western		08:36:08
10	East Midlands		09:17:38
11	West Midlands		11:04:30

O3 LONG WAITS

Table O3.29

Year Month	Total No. of long waits
Apr-19	471
May-19	393
Jun-19	436
Jul-19	523
Aug-19	471
Sep-19	482
Oct-19	582
Nov-19	542
Dec-19	575
Jan-20	425
Feb-20	385
Mar-20	594
Apr-20	329
May-20	186
Jun-20	196
Jul-20	274
Aug-20	437
Sep-20	394
Oct-20	586
Nov-20	447
Dec-20	455
Jan-21	663
Feb-21	340
Mar-21	358
Apr-21	489
May-21	734
Jun-21	971
Jul-21	1,534
Aug-21	1,226
Sep-21	1,501
Oct-21	1,650
Nov-21	1,329
Dec-21	1,590
Jan-22	1,109
Feb-22	985
Mar-22	1,609
Apr-22	1,145
May-22	869
Jun-22	940

Figure O3.29

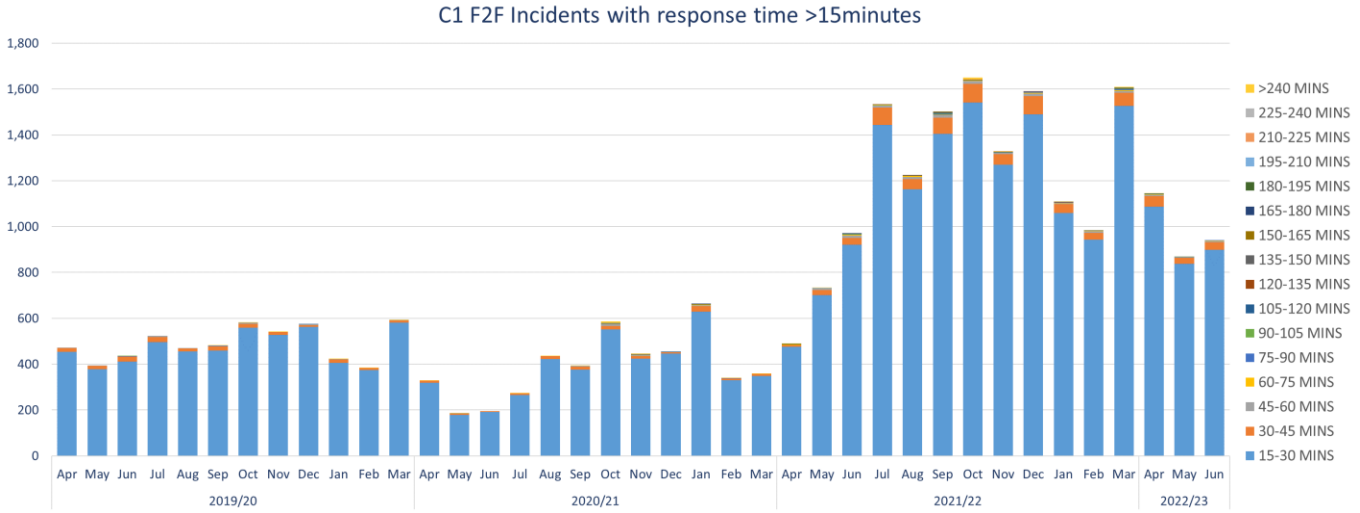


Figure O3.30

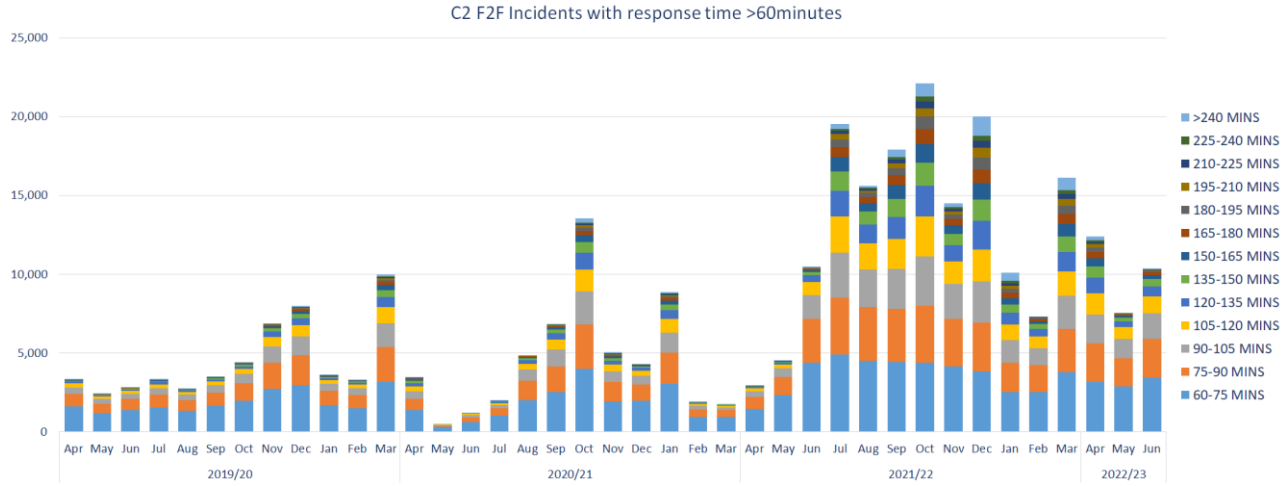
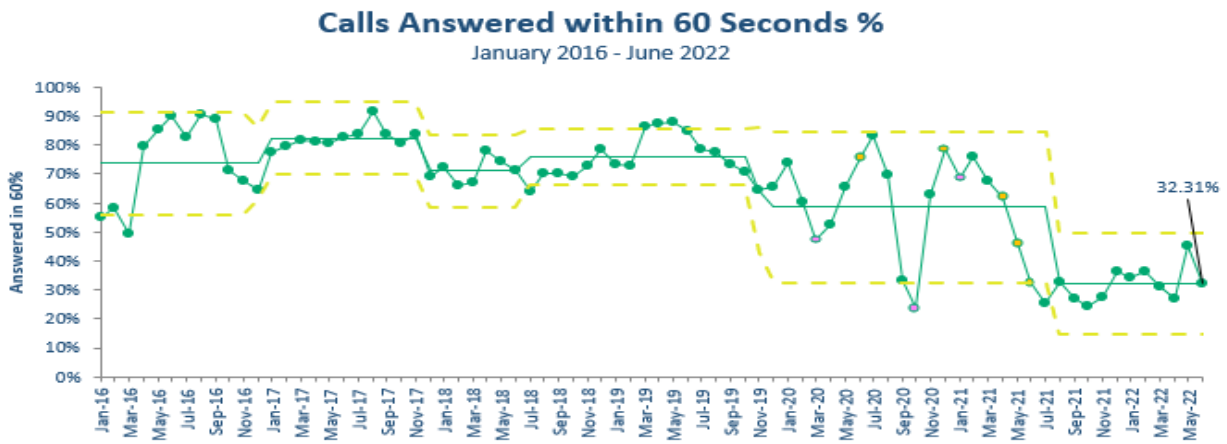


Table O3.30

Year Month	Total No. of long waits
Apr-19	3,344
May-19	2,412
Jun-19	2,817
Jul-19	3,332
Aug-19	2,765
Sep-19	3,479
Oct-19	4,412
Nov-19	6,888
Dec-19	7,998
Jan-20	3,604
Feb-20	3,303
Mar-20	10,001
Apr-20	3,458
May-20	483
Jun-20	1,193
Jul-20	2,003
Aug-20	4,860
Sep-20	6,874
Oct-20	13,563
Nov-20	5,090
Dec-20	4,290
Jan-21	8,889
Feb-21	1,908
Mar-21	1,739
Apr-21	2,918
May-21	4,523
Jun-21	10,503
Jul-21	19,540
Aug-21	15,612
Sep-21	17,922
Oct-21	22,113
Nov-21	14,518
Dec-21	20,038
Jan-22	10,127
Feb-22	7,349
Mar-22	16,135
Apr-22	12,400
May-22	7,564
Jun-22	10,374

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
June 2022	32.3%
YTD	34.8%
National	47%

Figure O4.2

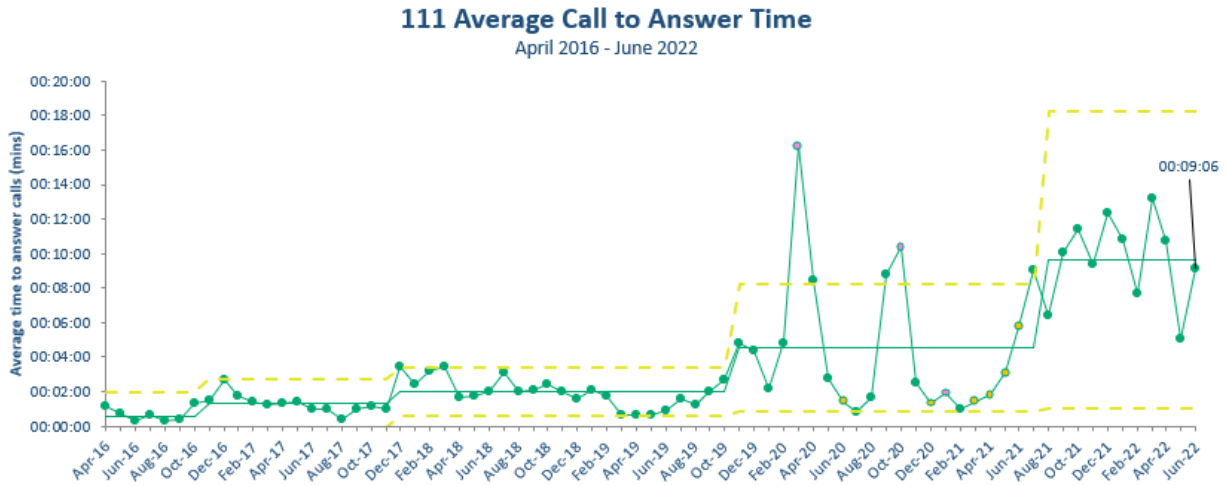
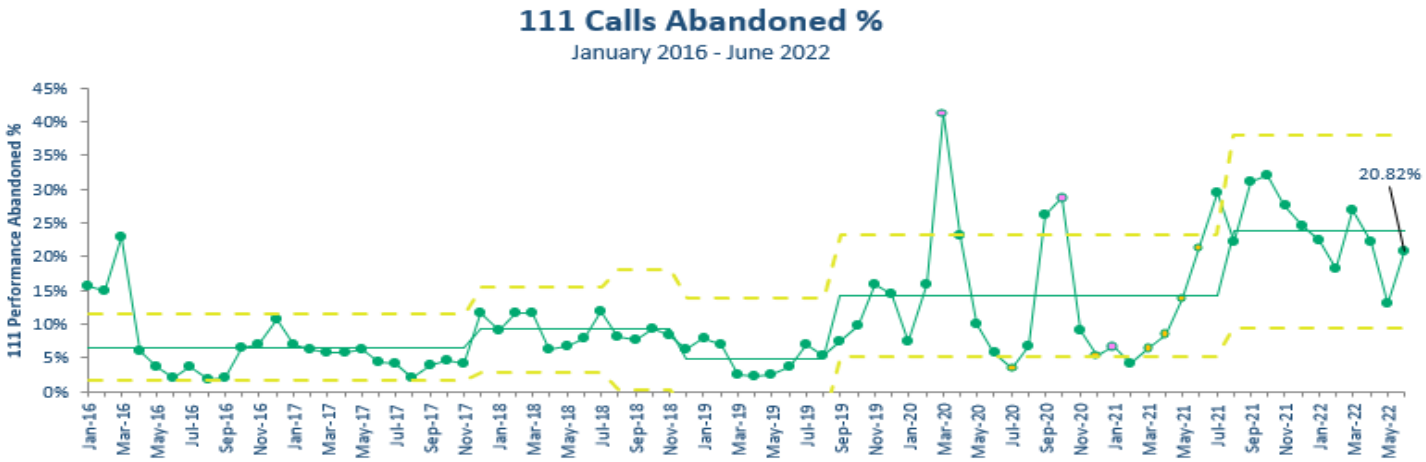
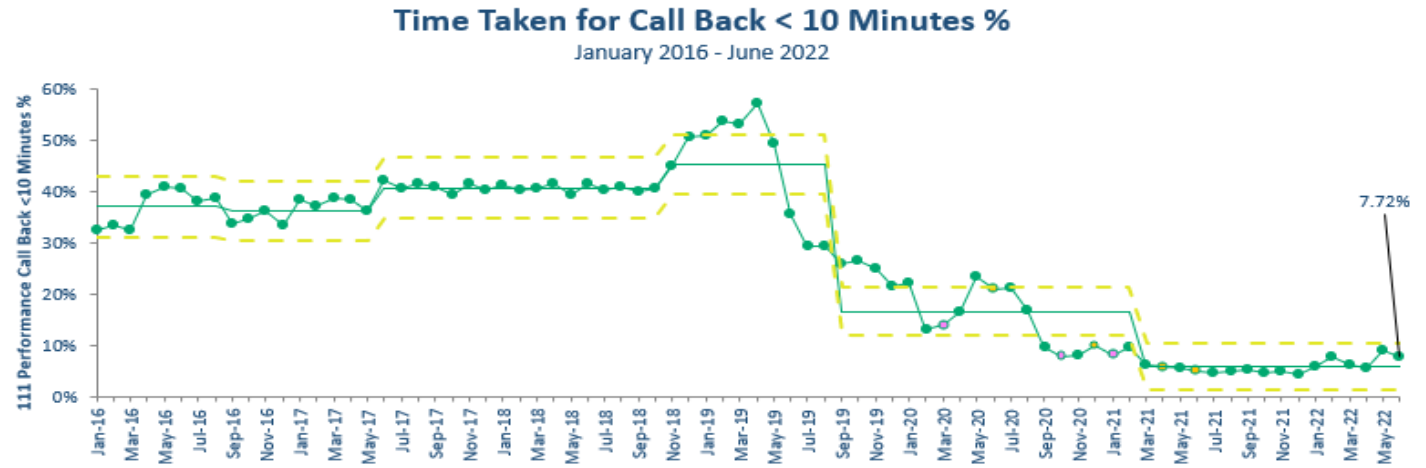


Figure O4.3



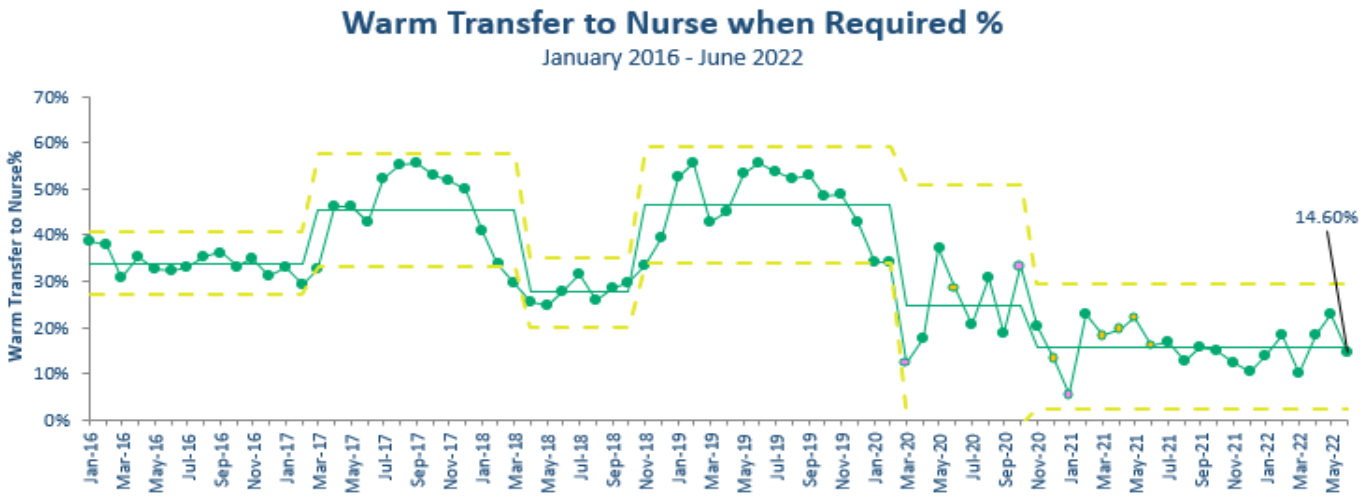
Calls Abandoned %	
Target	<5%
June 2022	20.82%
YTD	18.84%
National	15.9%

Figure O4.4



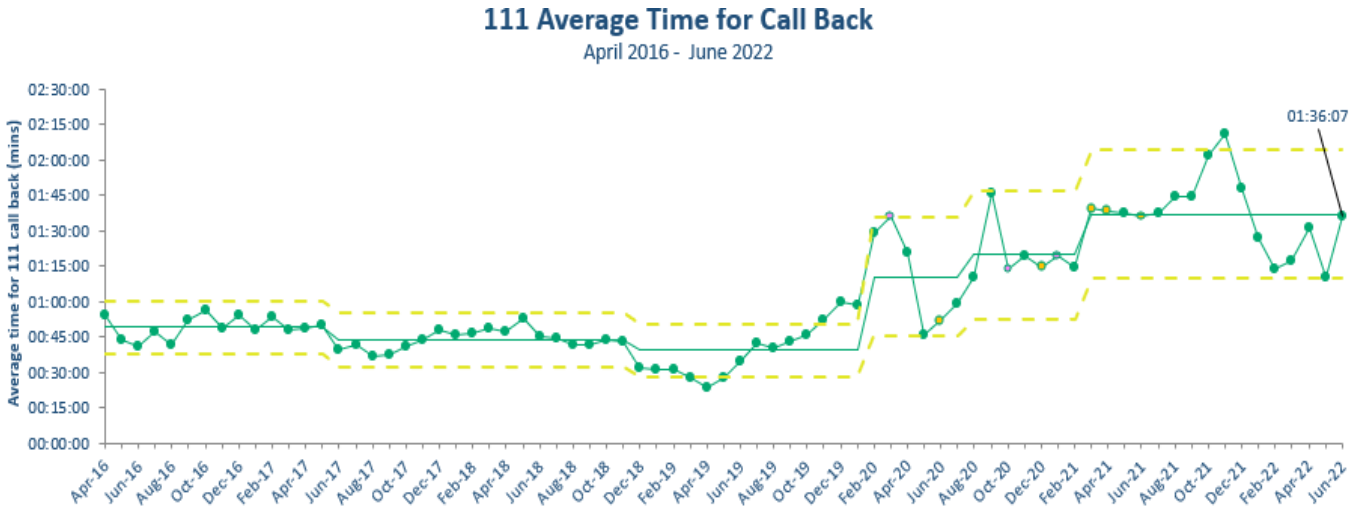
Calls Back <10 Mins	
Target	75%
June 2022	7.72%
YTD	7.42%

Figure O4.5



Warm Transfer %	
Target	75%
June 2022	14.6%
YTD	18.6%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: May 2022					Year to Date: July 2021 - May 2022			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	10,738	(3,286)	(23%)	154,266	104,249	(50,017)	(32%)
Greater Manchester	526,588	43,882	42,788	(1,094)	(2%)	482,706	418,359	(64,347)	(13%)
Lancashire	589,181	49,098	37,354	(11,744)	(24%)	540,083	371,428	(168,655)	(31%)
Merseyside	300,123	25,010	23,995	(1,015)	(4%)	275,113	243,127	(31,986)	(12%)
NWAS	1,584,182	132,015	114,875	(17,140)	(13%)	1,452,167	1,137,163	(315,004)	(22%)

UNPLANNED ACTIVITY									
	Current Month: May 2022					Year to Date: July 2021 - May 2022			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	519	(728)	(58%)	13,722	5,689	(8,033)	(59%)
Greater Manchester	49,133	4,094	4,394	300	7%	45,039	49,304	4,265	9%
Lancashire	58,829	4,902	3,301	(1,601)	(33%)	53,927	37,477	(16,450)	(31%)
Merseyside	22,351	1,863	1,637	(226)	(12%)	20,488	18,234	(2,254)	(11%)
NWAS	145,282	12,107	9,851	(2,256)	(19%)	133,175	110,704	(22,471)	(17%)

ABORTED ACTIVITY									
	May 2022								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	246	6,551	4%	45	510	9%	90	3,612	2%
Greater Manchester	1,951	20,343	10%	994	4,252	23%	1,247	17,667	7%
Lancashire	1,175	20,399	6%	574	3,224	18%	453	13,402	3%
Merseyside	693	10,961	6%	283	1,588	18%	747	11,193	7%
NWAS	4,065	58,254	7%	1,896	9,574	20%	2,537	45,874	6%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

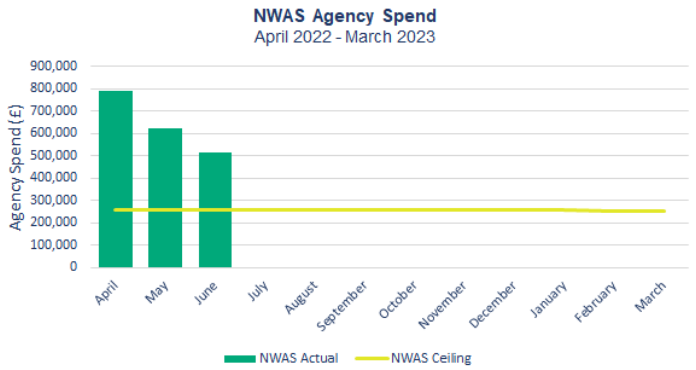


Figure F1.2

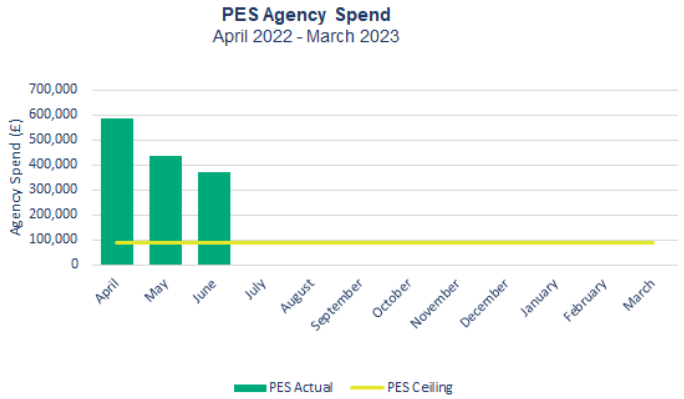


Figure F1.3

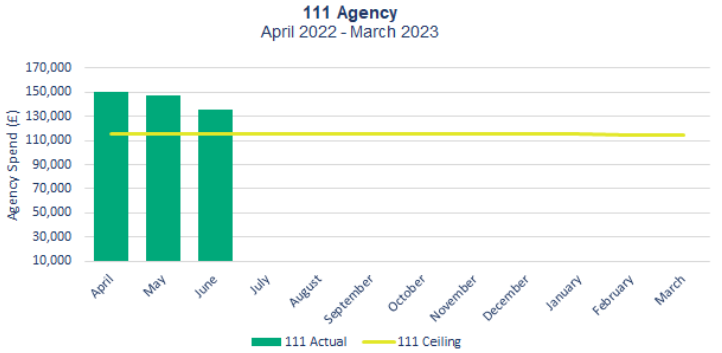


Figure F1.4

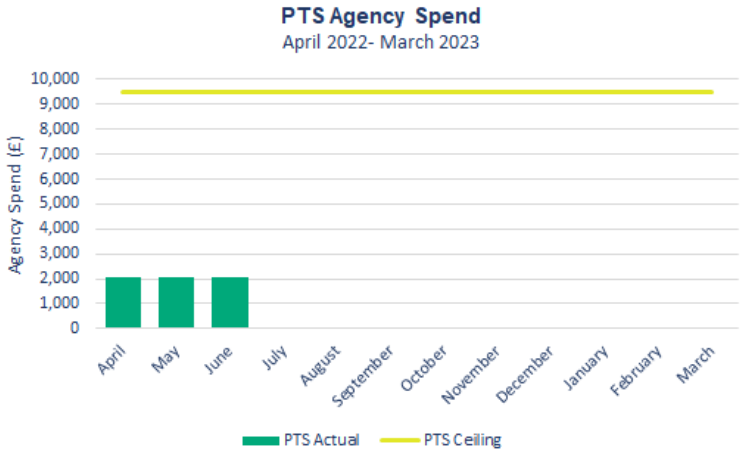


Figure F1.5

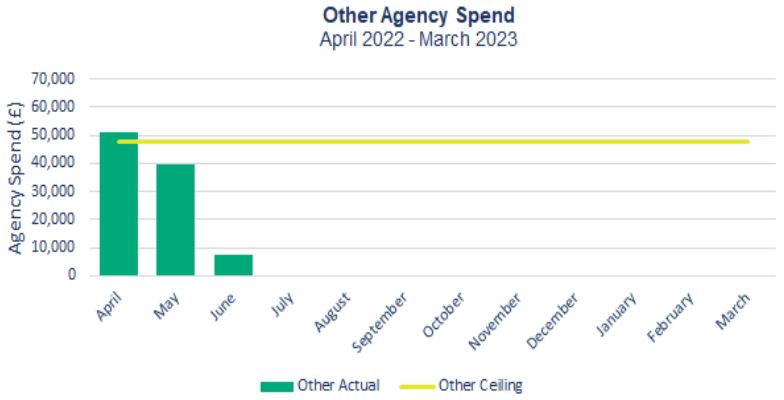
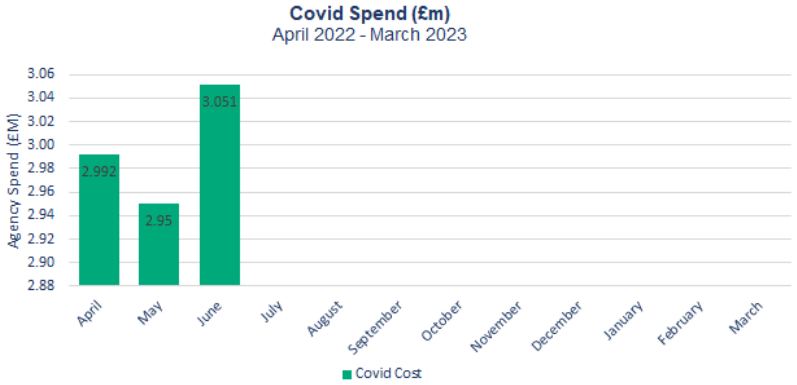


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

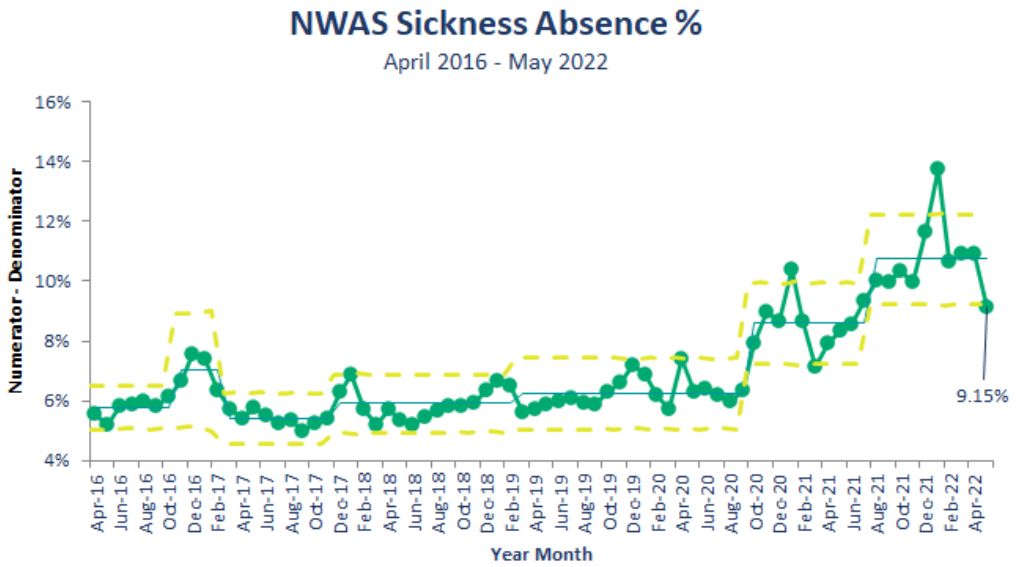


Table OH1.1

Sickness Absence	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec -21	Jan-22	Feb-22	Mar-22	Apr -22	May -22
NWAS	8.55%	9.33%	10.00%	9.97%	10.32%	9.97%	11.66%	13.74%	10.56%	10.91%	10.92%	9.15%
Amb. National Average	6.98%	7.73%	8.17%	8.22%	8.32%	8.23%	9.41%	9.91%	8.56%			

Figure OH1.2

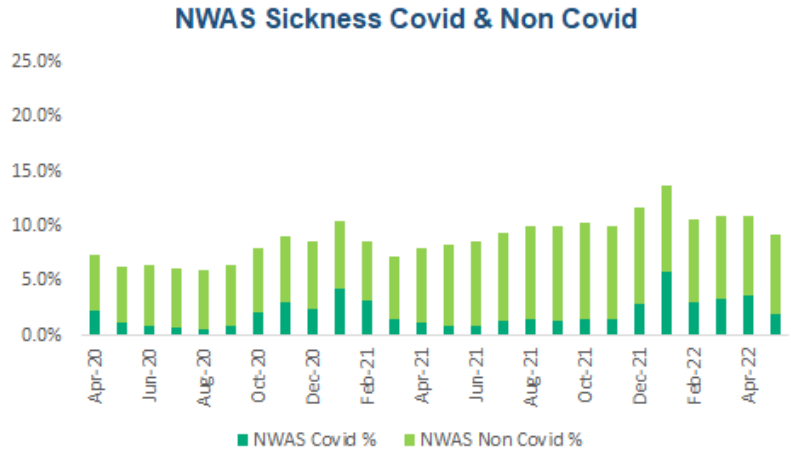


Figure OH1.3

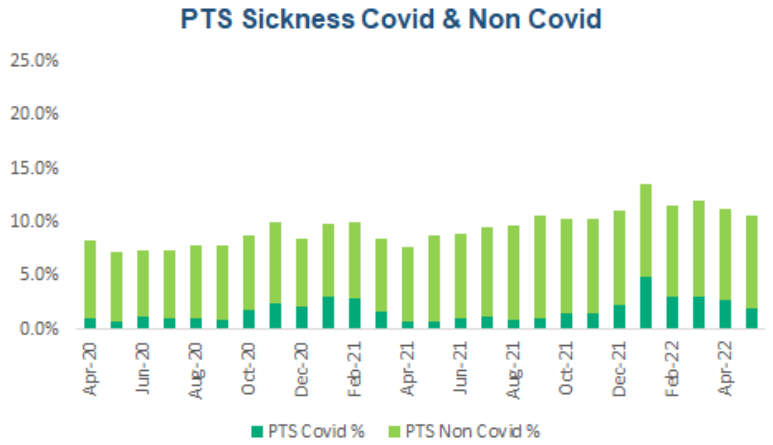


Figure OH1.4

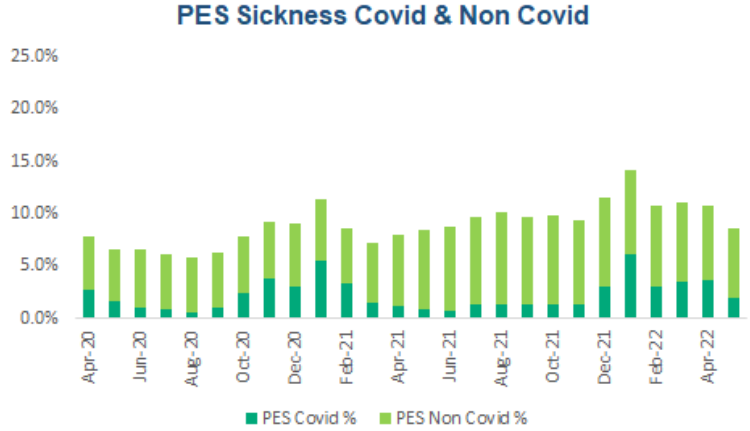


Table OH1.2

NWAS			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.2%	5.2%	7.4%
May-20	1.1%	5.2%	6.3%
Jun-20	0.8%	5.6%	6.4%
Jul-20	0.7%	5.5%	6.2%
Aug-20	0.6%	5.4%	6.0%
Sep-20	0.8%	5.5%	6.4%
Oct-20	2.1%	5.8%	7.9%
Nov-20	3.0%	6.0%	9.0%
Dec-20	2.4%	6.3%	8.7%
Jan-21	4.3%	6.1%	10.4%
Feb-21	3.1%	5.5%	8.6%
Mar-21	1.5%	5.6%	7.1%
Apr-21	1.1%	6.8%	7.9%
May-21	0.9%	7.4%	8.3%
Jun-21	0.8%	7.7%	8.6%
Jul-21	1.3%	8.0%	9.3%
Aug-21	1.4%	8.6%	10.0%
Sep-21	1.4%	8.6%	10.0%
Oct-21	1.5%	8.8%	10.3%
Nov-21	1.5%	8.4%	10.0%
Dec-21	2.8%	8.9%	11.7%
Jan-22	5.8%	8.0%	13.7%
Feb-22	3.0%	7.6%	10.7%
Mar-22	3.3%	7.6%	10.9%
Apr-22	3.6%	7.3%	10.9%
May-22	2.0%	7.2%	9.1%

Table OH1.3

PTS			
Month Year	Covid %	Non Covic	Total %
Apr-20	1.0%	7.4%	8.4%
May-20	0.7%	6.5%	7.2%
Jun-20	1.1%	6.2%	7.3%
Jul-20	0.9%	6.4%	7.4%
Aug-20	0.9%	6.9%	7.9%
Sep-20	0.9%	6.9%	7.7%
Oct-20	1.7%	7.0%	8.7%
Nov-20	2.4%	7.6%	10.0%
Dec-20	2.1%	6.3%	8.4%
Jan-21	3.0%	6.7%	9.8%
Feb-21	2.9%	7.0%	10.0%
Mar-21	1.6%	6.8%	8.4%
Apr-21	0.7%	6.9%	7.6%
May-21	0.7%	8.1%	8.8%
Jun-21	1.0%	7.9%	8.8%
Jul-21	1.2%	8.4%	9.6%
Aug-21	0.9%	8.8%	9.7%
Sep-21	0.9%	9.7%	10.7%
Oct-21	1.5%	8.9%	10.4%
Nov-21	1.5%	8.9%	10.4%
Dec-21	2.2%	8.9%	11.1%
Jan-22	4.9%	8.6%	13.6%
Feb-22	3.0%	8.6%	11.6%
Mar-22	2.9%	9.0%	11.9%
Apr-22	2.7%	8.4%	11.2%
May-22	1.9%	8.7%	10.7%

Table OH1.4

PES			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.7%	5.1%	7.7%
May-20	1.6%	5.0%	6.6%
Jun-20	1.0%	5.6%	6.6%
Jul-20	0.8%	5.4%	6.2%
Aug-20	0.6%	5.3%	5.8%
Sep-20	1.0%	5.3%	6.3%
Oct-20	2.4%	5.5%	7.9%
Nov-20	3.8%	5.4%	9.1%
Dec-20	3.1%	6.1%	9.1%
Jan-21	5.5%	5.9%	11.4%
Feb-21	3.3%	5.3%	8.6%
Mar-21	1.5%	5.7%	7.2%
Apr-21	1.1%	6.9%	8.0%
May-21	0.9%	7.5%	8.4%
Jun-21	0.7%	8.0%	8.8%
Jul-21	1.3%	8.4%	9.6%
Aug-21	1.3%	8.8%	10.1%
Sep-21	1.4%	8.2%	9.6%
Oct-21	1.4%	8.5%	9.9%
Nov-21	1.3%	8.0%	9.4%
Dec-21	3.1%	8.4%	11.5%
Jan-22	6.1%	8.0%	14.1%
Feb-22	3.0%	7.8%	10.8%
Mar-22	3.6%	7.5%	11.1%
Apr-22	3.6%	7.2%	10.8%
May-22	2.0%	6.7%	8.7%

Figure OH1.5

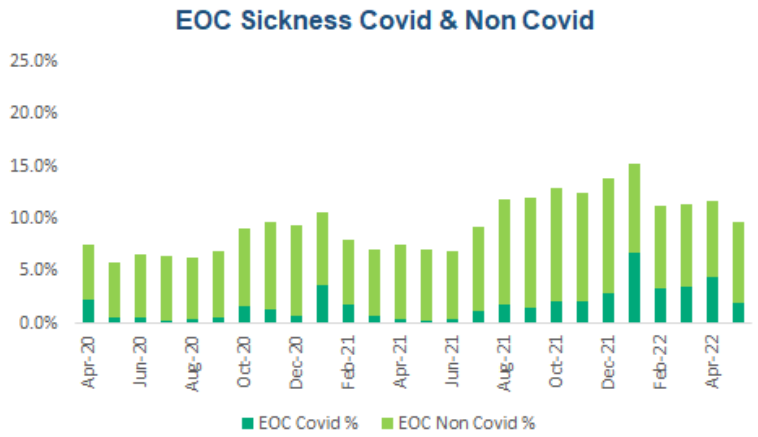


Figure OH1.6

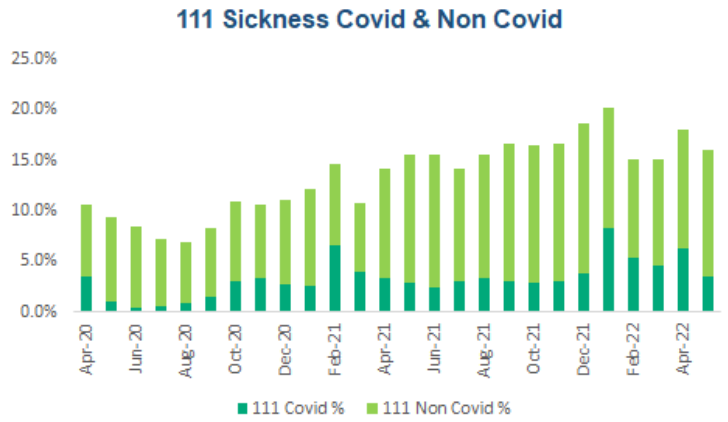


Figure OH1.7

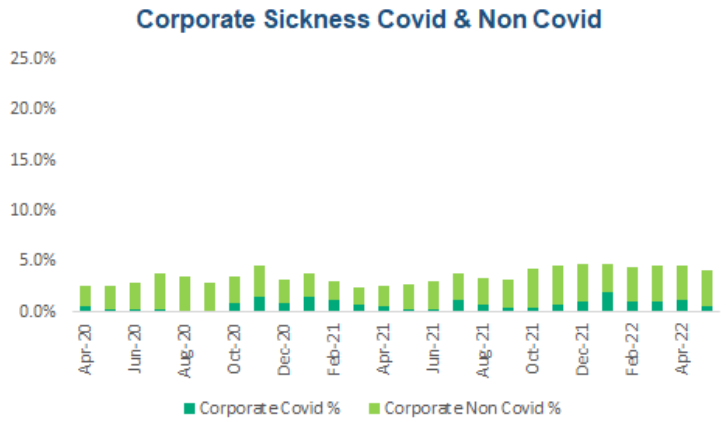


Table OH1.5

EOC			
Month Year	Covid %	Non Covic	Total %
Apr-20	2.2%	5.3%	7.5%
May-20	0.6%	5.2%	5.8%
Jun-20	0.5%	6.1%	6.6%
Jul-20	0.3%	6.2%	6.5%
Aug-20	0.4%	5.8%	6.2%
Sep-20	0.5%	6.5%	7.0%
Oct-20	1.7%	7.4%	9.1%
Nov-20	1.4%	8.2%	9.6%
Dec-20	0.7%	8.7%	9.4%
Jan-21	3.6%	7.1%	10.7%
Feb-21	1.8%	6.2%	8.0%
Mar-21	0.6%	6.4%	7.1%
Apr-21	0.4%	7.1%	7.5%
May-21	0.3%	6.8%	7.0%
Jun-21	0.3%	6.6%	6.9%
Jul-21	1.1%	8.2%	9.3%
Aug-21	1.7%	10.0%	11.8%
Sep-21	1.5%	10.5%	12.0%
Oct-21	2.0%	10.9%	12.9%
Nov-21	2.1%	10.3%	12.4%
Dec-21	2.8%	11.1%	13.9%
Jan-22	6.7%	8.5%	15.2%
Feb-22	3.3%	7.9%	11.2%
Mar-22	3.4%	7.9%	11.3%
Apr-22	4.4%	7.3%	11.6%
May-22	2.0%	7.7%	9.7%

Table OH1.6

111			
Month Year	Covid %	Non Covic	Total %
Apr-20	3.5%	7.1%	10.6%
May-20	1.0%	8.5%	9.4%
Jun-20	0.4%	8.0%	8.4%
Jul-20	0.6%	6.6%	7.2%
Aug-20	0.8%	6.1%	7.0%
Sep-20	1.4%	6.8%	8.3%
Oct-20	3.0%	8.0%	11.0%
Nov-20	3.3%	7.3%	10.6%
Dec-20	2.7%	8.4%	11.1%
Jan-21	2.6%	9.7%	12.2%
Feb-21	6.5%	8.0%	14.6%
Mar-21	3.9%	6.8%	10.7%
Apr-21	3.4%	10.7%	14.1%
May-21	2.9%	12.7%	15.6%
Jun-21	2.5%	13.1%	15.5%
Jul-21	3.0%	11.2%	14.2%
Aug-21	3.4%	12.2%	15.6%
Sep-21	3.0%	13.6%	16.6%
Oct-21	2.9%	13.6%	16.5%
Nov-21	3.0%	13.7%	16.7%
Dec-21	3.8%	14.9%	18.7%
Jan-22	8.3%	12.0%	20.3%
Feb-22	5.3%	9.8%	15.1%
Mar-22	4.6%	10.5%	15.1%
Apr-22	6.2%	11.9%	18.0%
May-22	3.5%	12.5%	16.0%

Table OH1.7

Corporate			
Month Year	Covid %	Non Covic	Total %
Apr-20	0.6%	1.9%	2.5%
May-20	0.2%	2.4%	2.6%
Jun-20	0.3%	2.6%	2.8%
Jul-20	0.2%	3.5%	3.8%
Aug-20	0.1%	3.4%	3.4%
Sep-20	0.1%	2.8%	2.9%
Oct-20	0.8%	2.6%	3.5%
Nov-20	1.4%	3.2%	4.6%
Dec-20	0.9%	2.4%	3.2%
Jan-21	1.5%	2.3%	3.9%
Feb-21	1.2%	1.8%	3.0%
Mar-21	0.7%	1.8%	2.5%
Apr-21	0.5%	2.0%	2.6%
May-21	0.2%	2.6%	2.7%
Jun-21	0.3%	2.7%	3.0%
Jul-21	1.1%	2.7%	3.8%
Aug-21	0.7%	2.7%	3.4%
Sep-21	0.4%	2.8%	3.1%
Oct-21	0.4%	3.9%	4.3%
Nov-21	0.7%	3.9%	4.6%
Dec-21	0.9%	3.8%	4.7%
Jan-22	1.9%	2.8%	4.7%
Feb-22	1.1%	3.3%	4.4%
Mar-22	1.0%	3.5%	4.5%
Apr-22	1.1%	3.4%	4.5%
May-22	0.6%	3.6%	4.2%

OH2 STAFF TURNOVER

Figure OH2.1

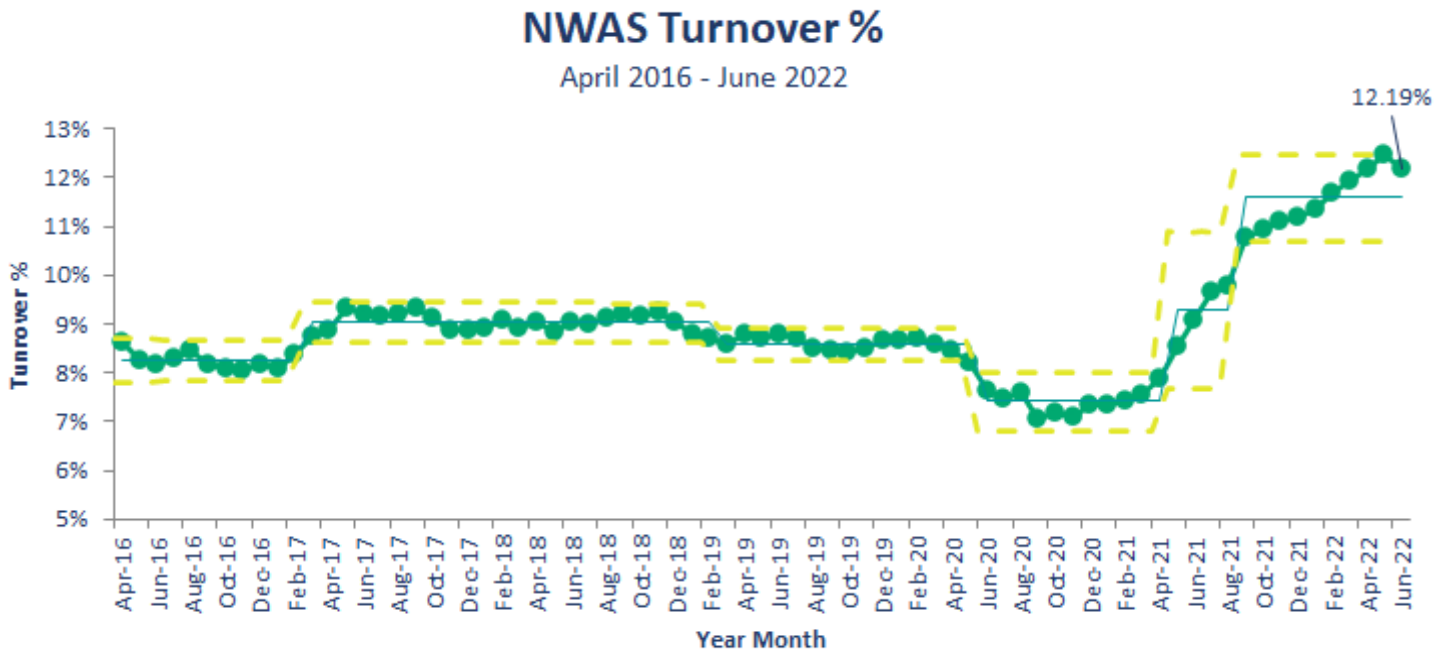


Table OH2.1

Turnover	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NWAS	9.67%	9.77%	10.76%	10.93%	11.11%	11.21%	11.37%	11.68%	11.94%	12.17%	12.49%	12.19%
Amb. National Average	8.44%	8.85%	9.25%	9.69%	10.09%	10.36%	10.80%	11.09%	11.43%			

Figure OH2.2

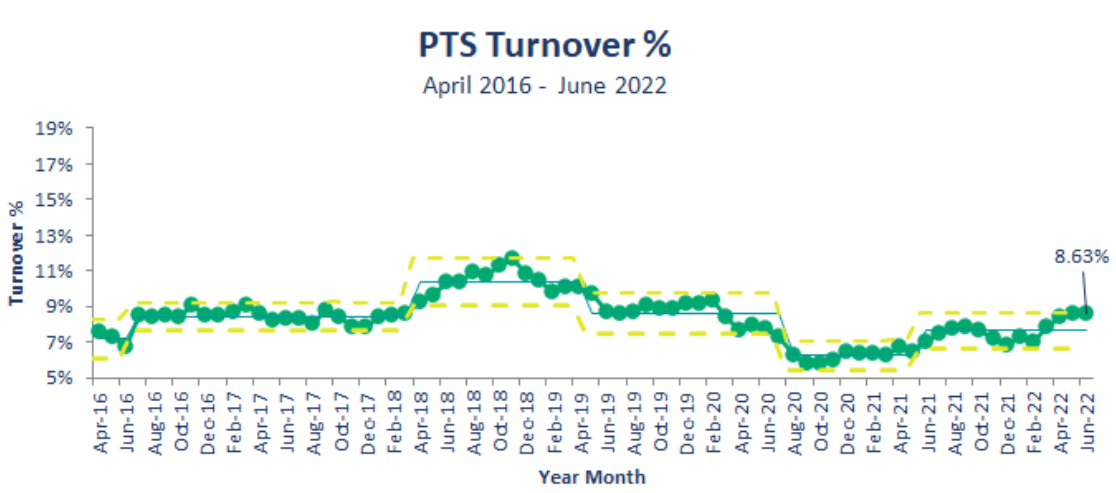


Figure OH2.3

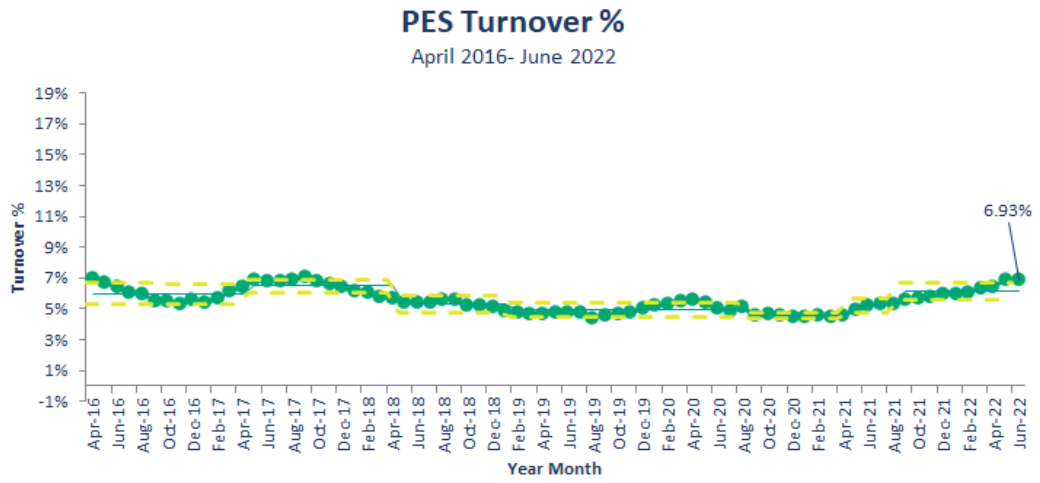


Figure OH3.4

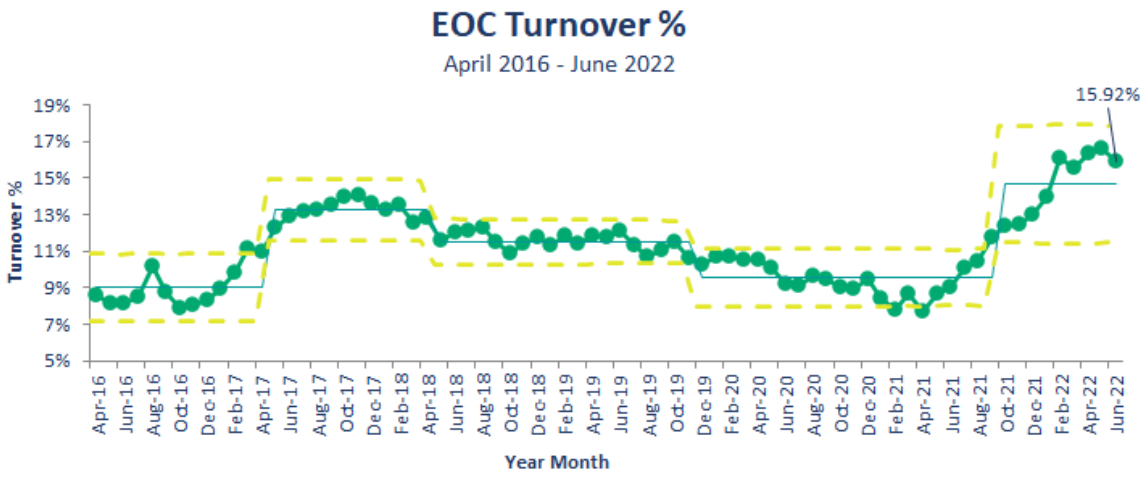
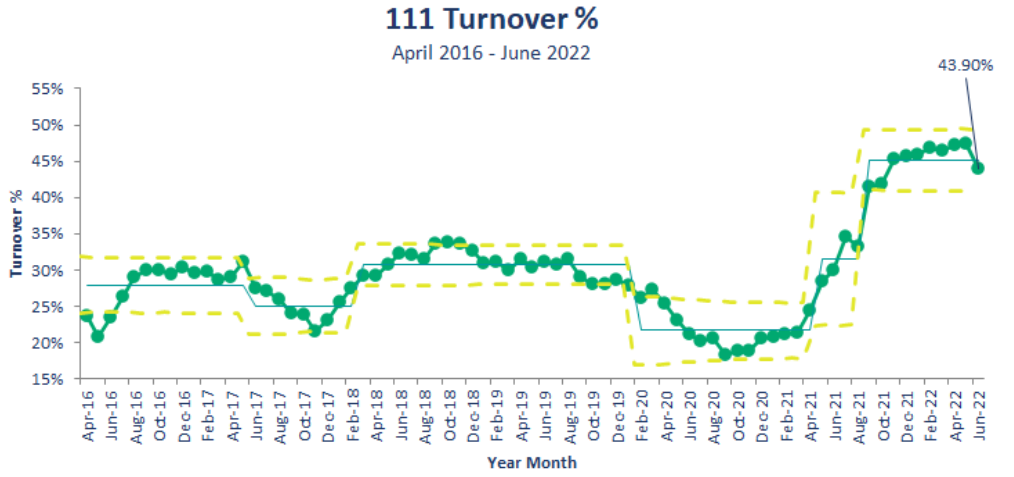


Figure OH3.5



The scale on the 111 Turnover % is different to the others. 15%-55% for 111 and 0% to 19% for the others.

OH4 TEMPORARY STAFFING

Figure OH4.1

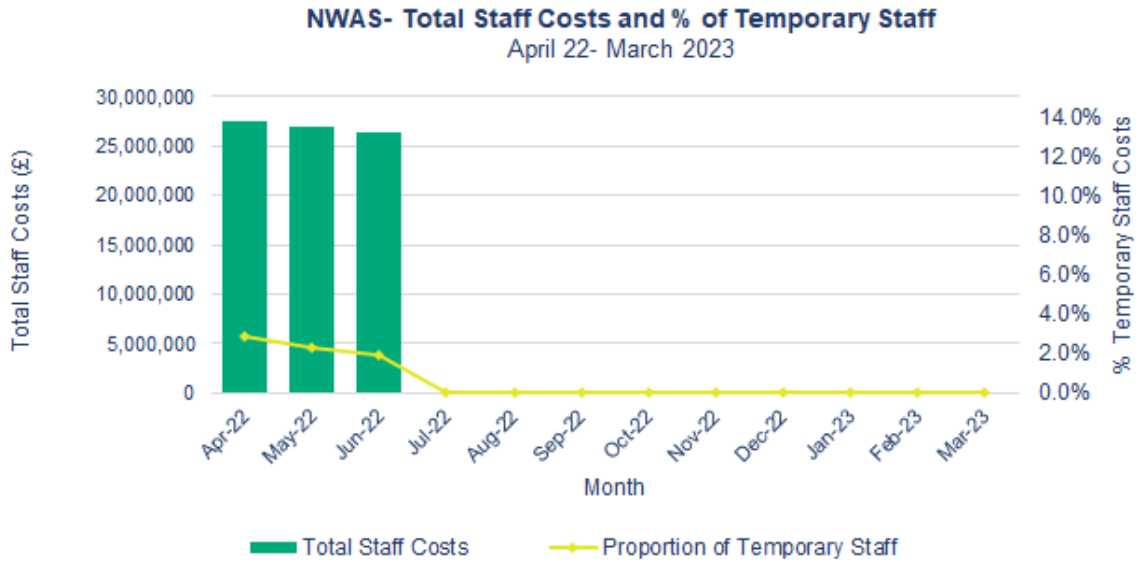


Table OH4.1

NWAS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Agency Staff Costs (£)	241,475	356,466	518,275	444,941	553,502	796,039	783,115	864,691	1,072,794	792,309	624,873	514,594
Total Staff Costs (£)	24,909,469	25,379,411	29,910,317	26,091,860	26,356,720	26,930,619	27,466,754	26,722,244	42,104,411	27,581,772	26,920,461	26,399,198
Proportion of Temporary Staff %	1.0%	1.4%	1.7%	1.7%	2.1%	3.0%	2.9%	3.2%	2.5%	2.9%	2.3%	1.9%

Figure OH4.3

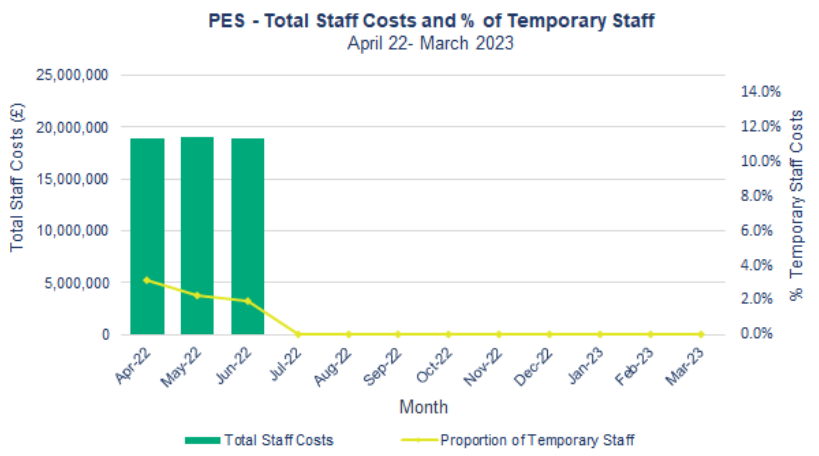


Figure OH4.4

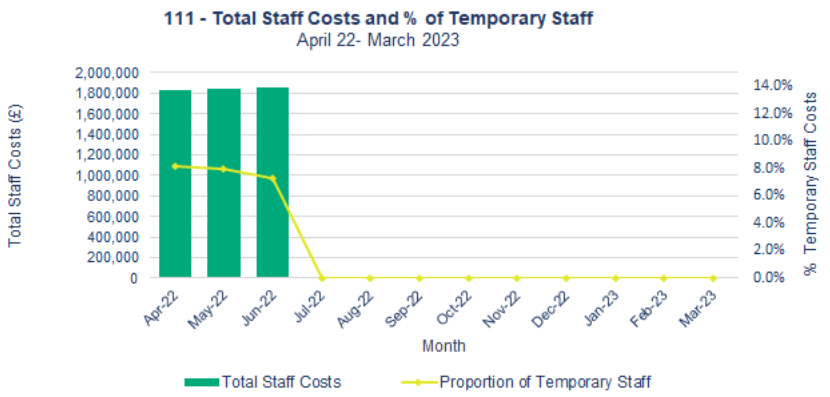


Figure OH4.5

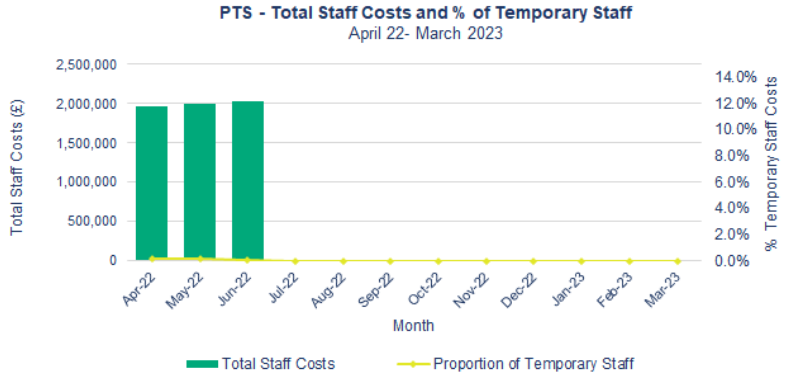
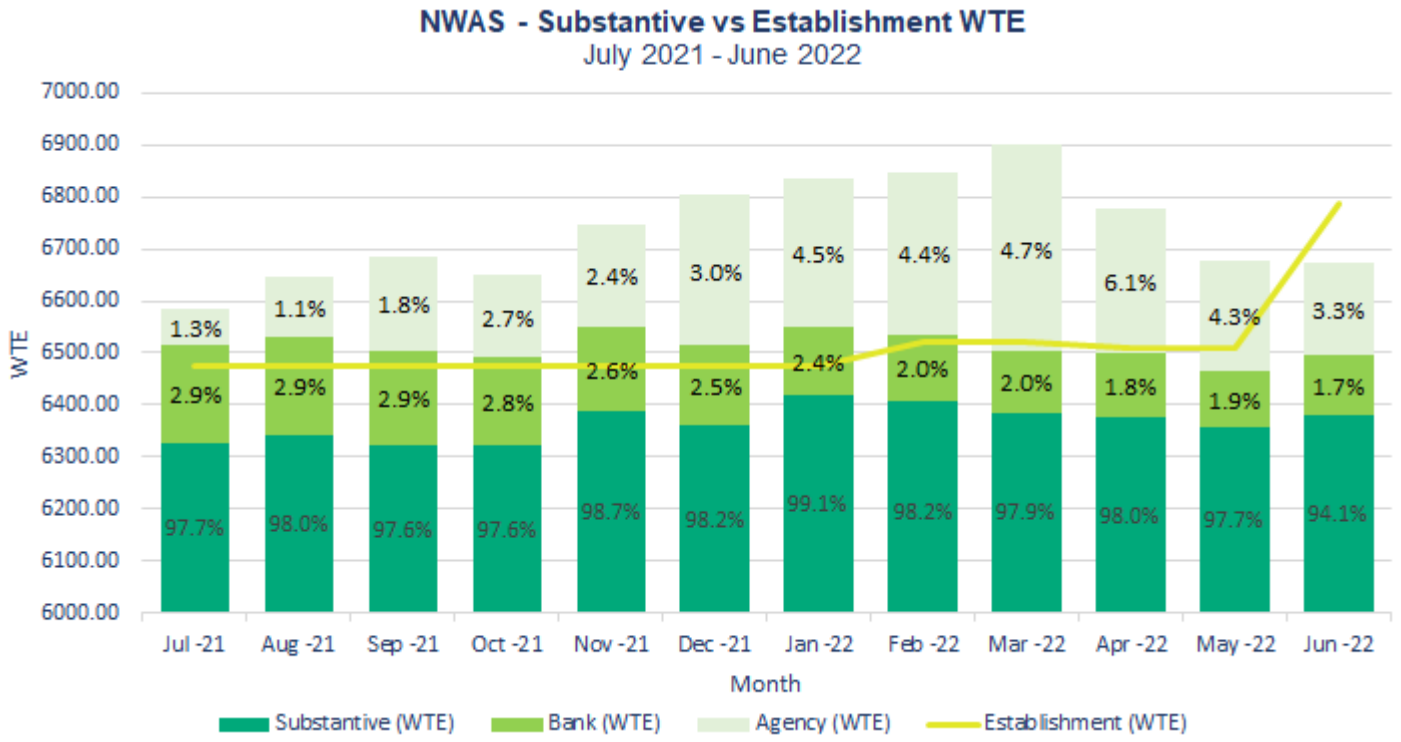


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

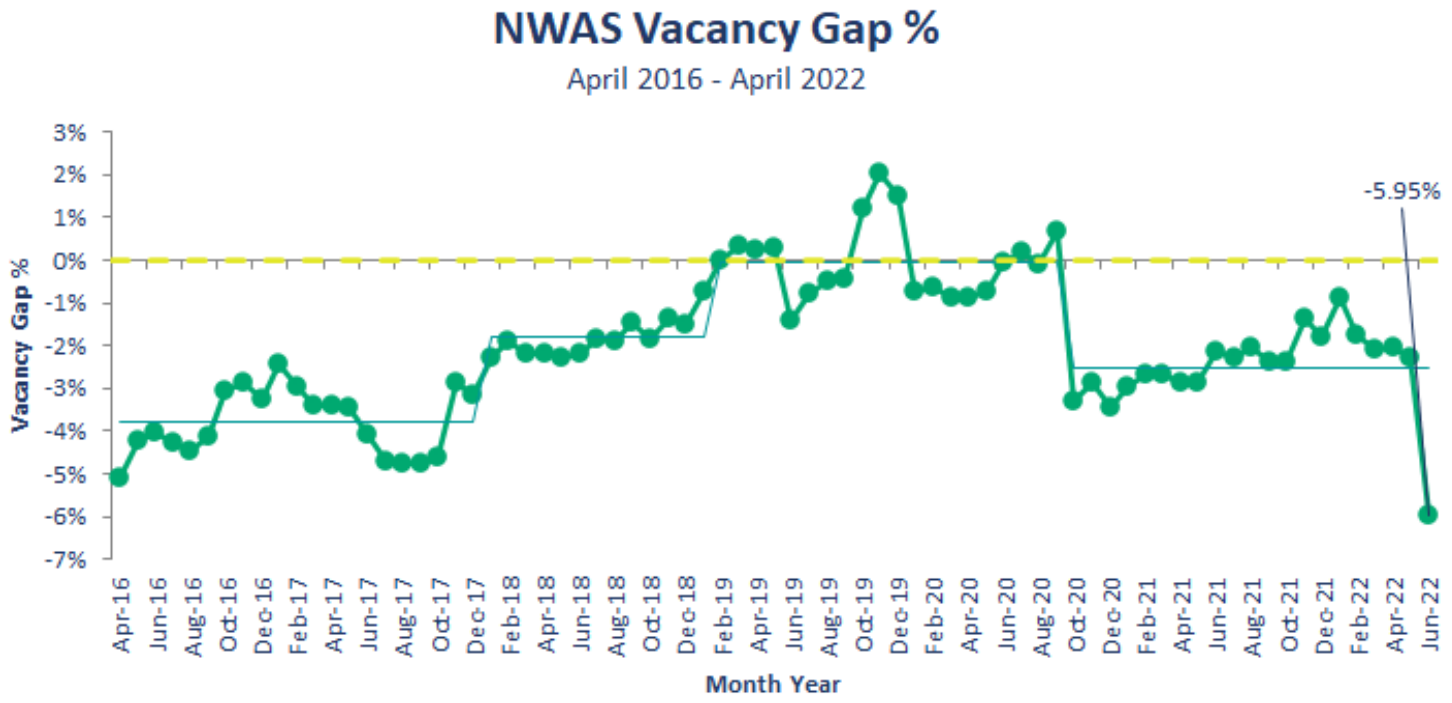
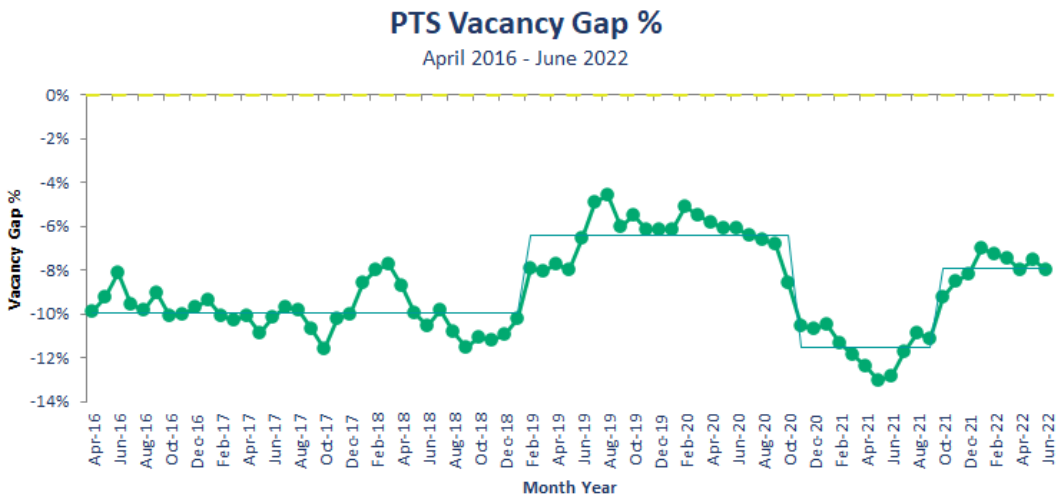


Table OH5.1

Vacancy Gap	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NWAS	-2.30%	-2.03%	-2.36%	-2.37%	-1.35%	-1.78%	-0.87%	-1.77%	-2.10%	-2.03%	-2.30%	-5.95%

Figure OH5.2



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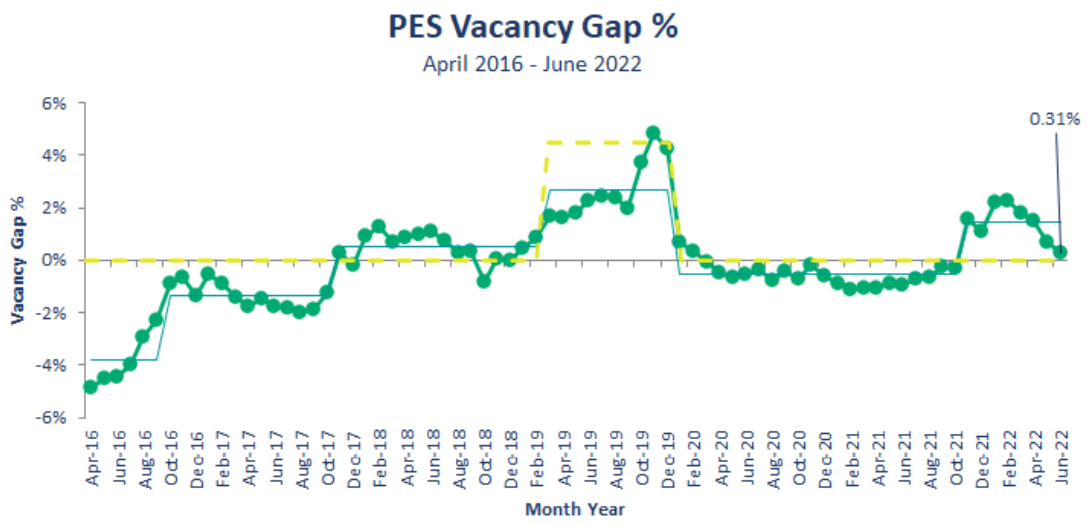

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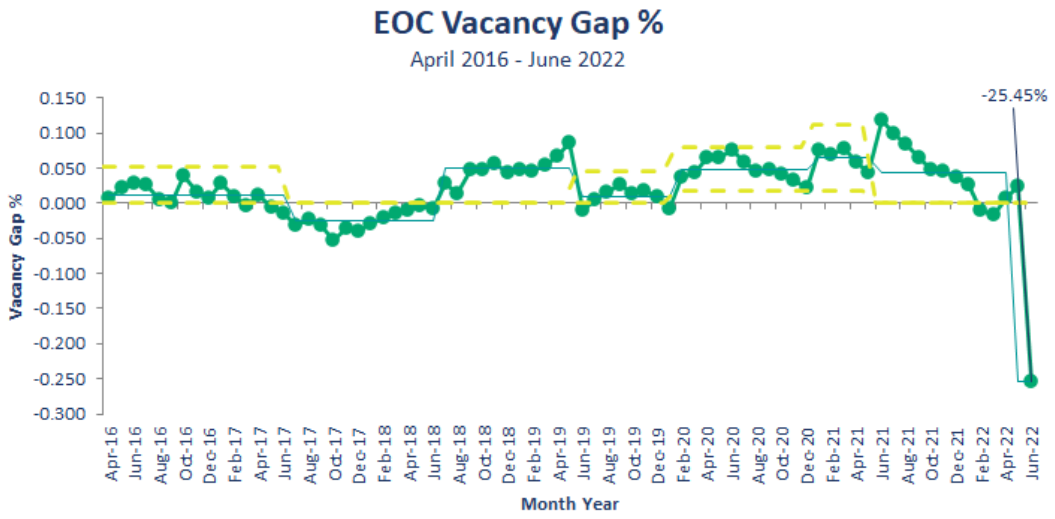
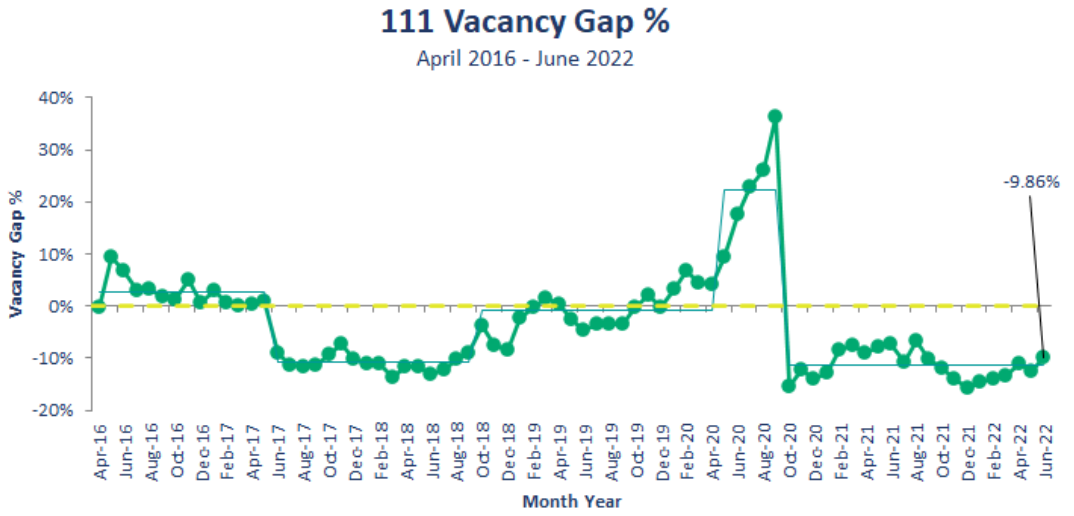


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

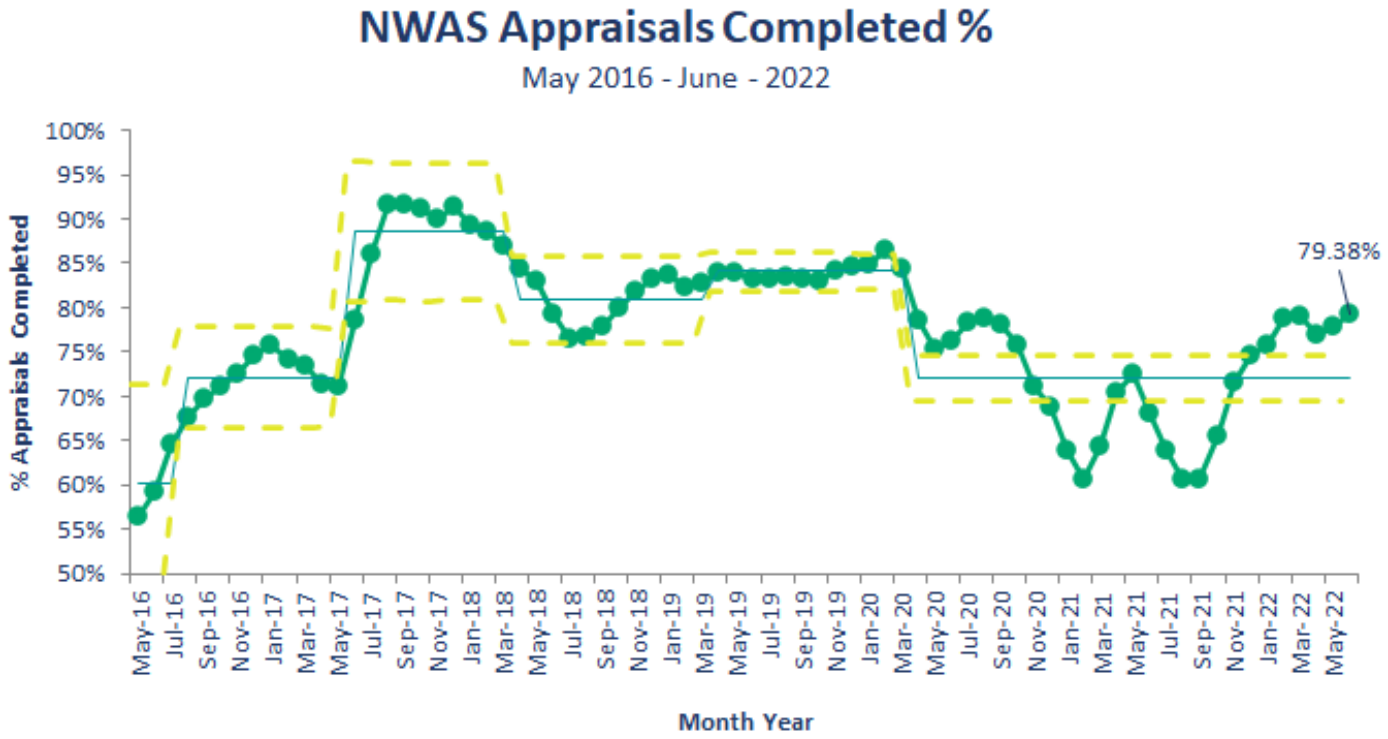


Table OH6.1

Appraisals	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NWAS	64%	61%	59%	65%	72%	75%	76%	79%	79&	77%	78%	79%

Figure OH6.2

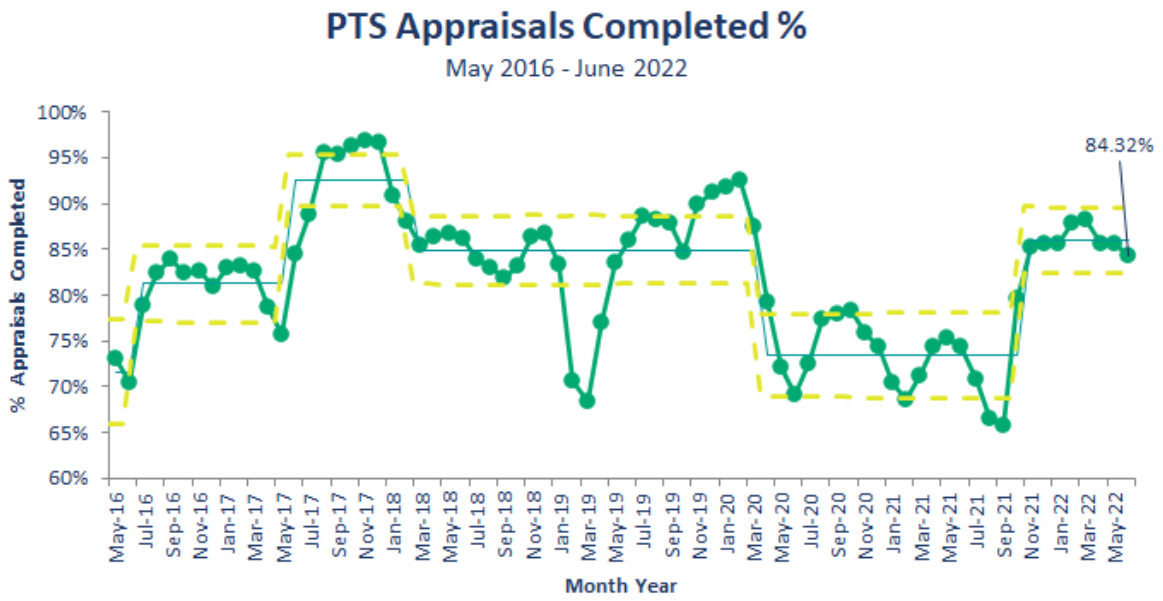


Figure OH6.3

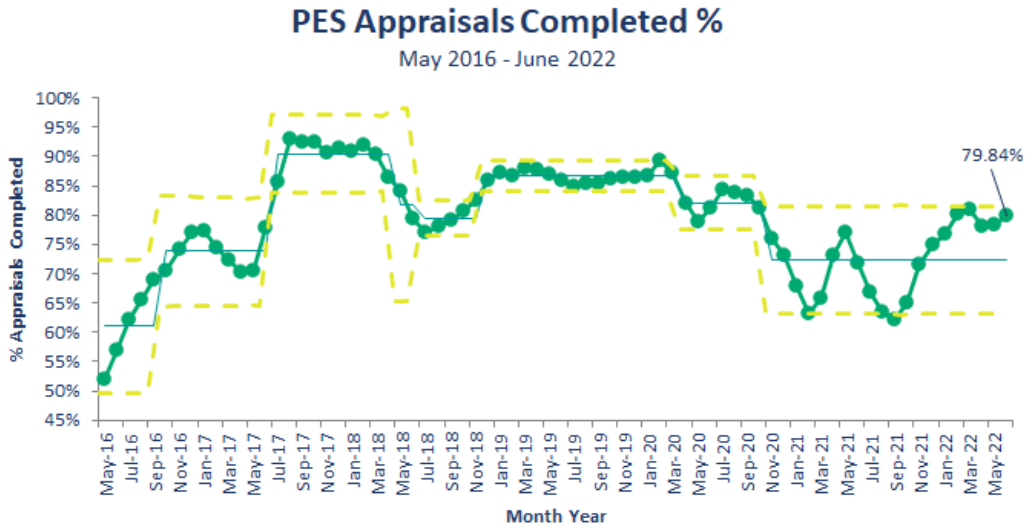


Figure OH6.4

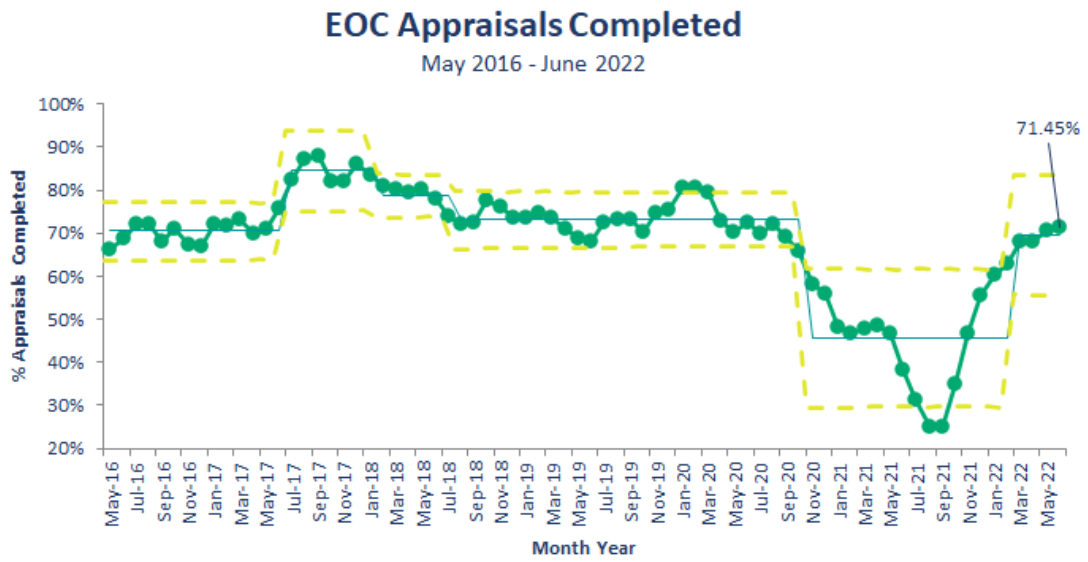
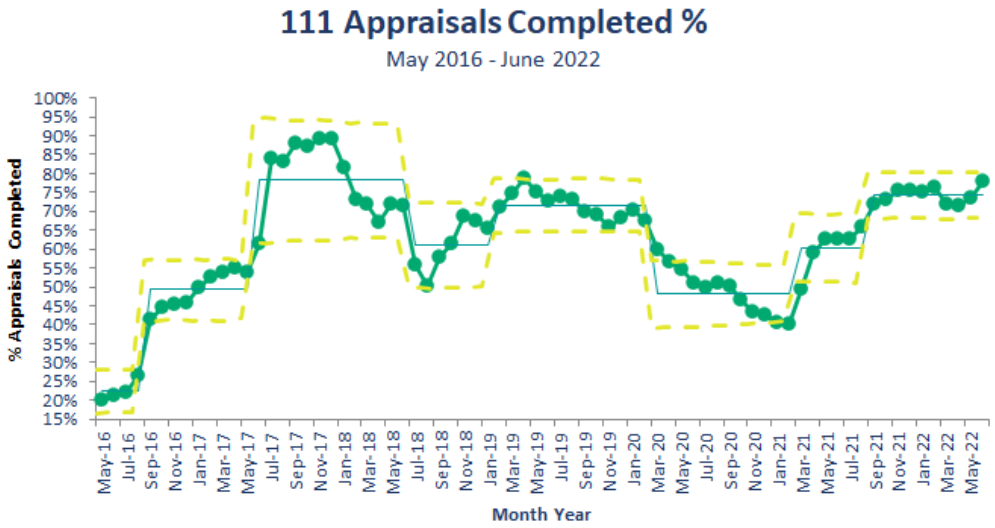


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

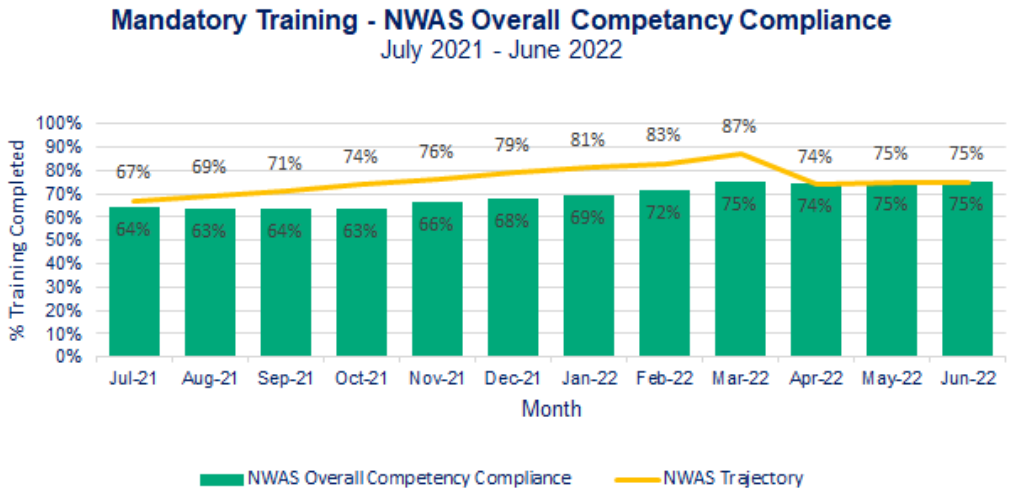


Figure OH7.2

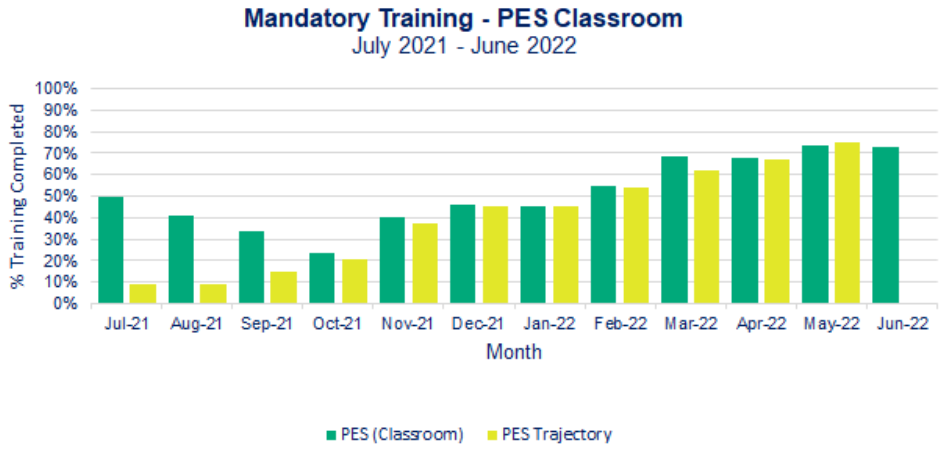


Figure OH7.3

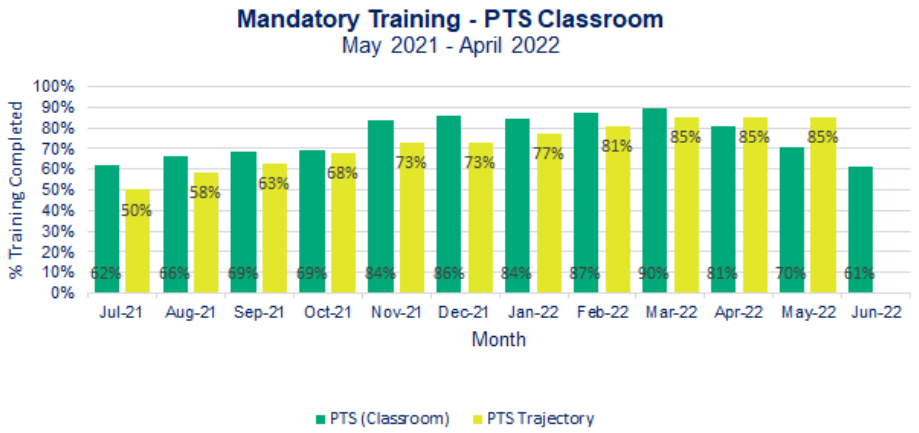


Figure OH7.4

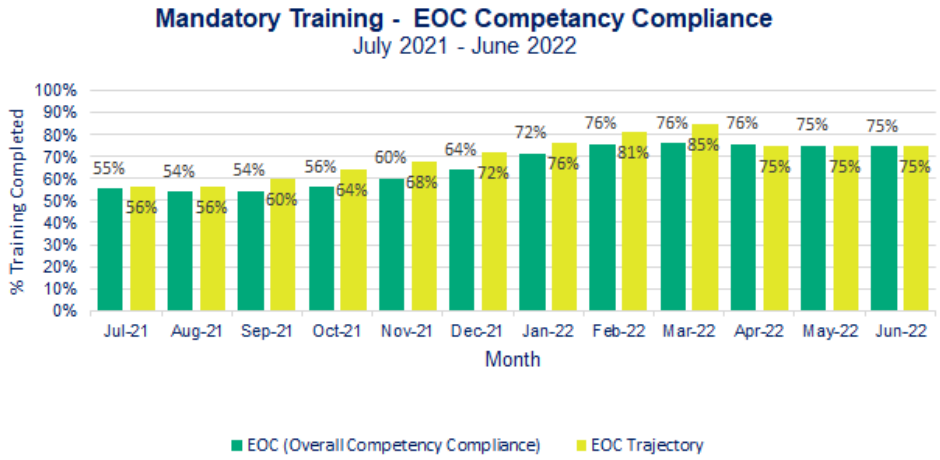


Figure OH7.5

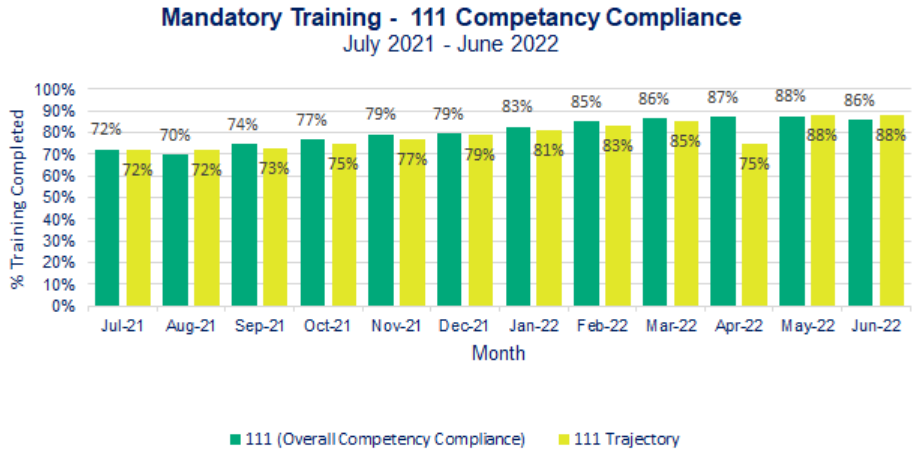
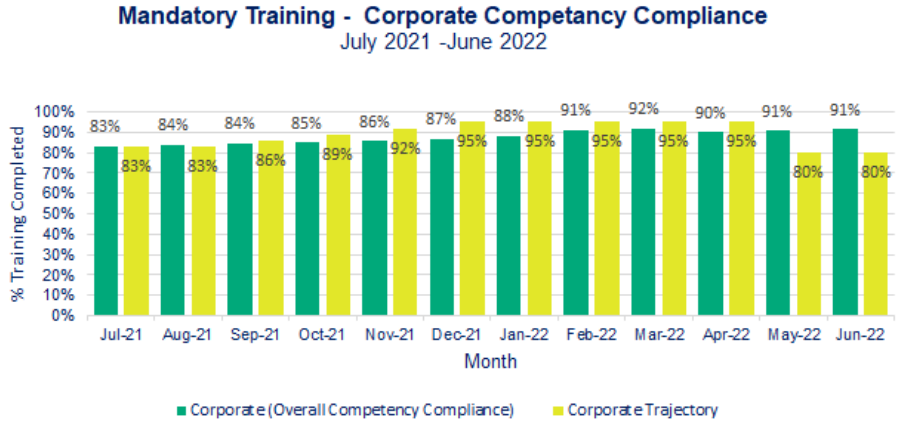


Figure OH7.6



OH8 CASE MANAGEMENT

Figure OH8.1

Employee Relation Dashboard @ 05 June 2022 All information related to Dignity at work, Disciplinary, Fact Finding 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	51	179	13.44
Operations ~ EOC	8	28	9.65
Operations ~ Resilience	0	0	8.67
Operations ~ 111	6	47	10.36
Operations ~ PTS	6	24	22.14
Corporate	0	17	11.64
Other*	11	46	12.80
NWAS Summary	82	341	12.36

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

Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	13	50	13.67
Disciplinary	42	55	24.88
Fact Finding	12	149	7.27
Grievance	15	87	12.41
Case Summary	82	341	12.36

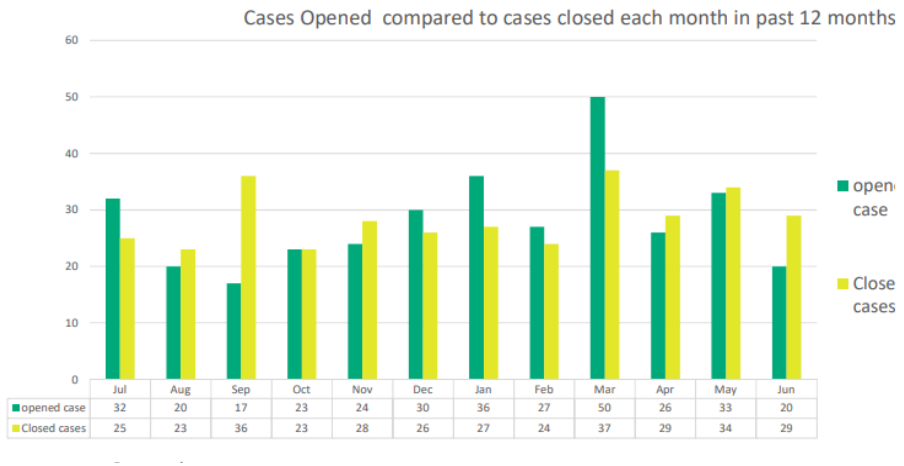
Reason for opening Disciplinary cases in the past 12 months

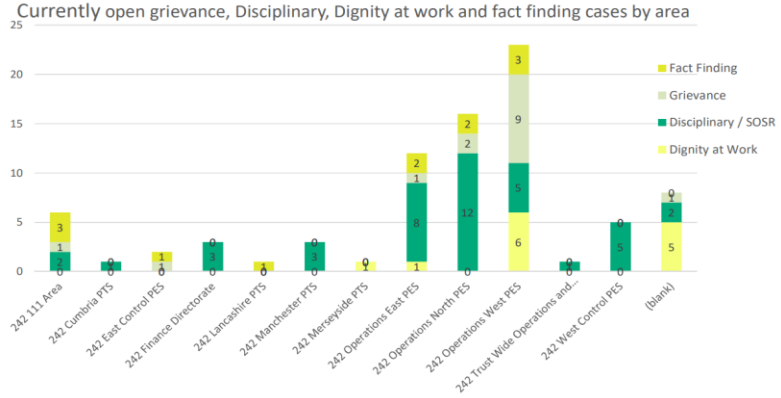
Opening reason	Number of cases in 12 months
Any actions that bring the Trusts reputation into disrepute	6
Assault/threatening behaviour	3
Breach of social media policy	1
Carelessness in the use of equipment or resources	2
Discriminatory behaviour	2
Failure to follow reasonable management instructions/procedures	5
Fraud	6
Incapacity through alcohol/substance misuse	1
Inappropriate / Unprofessional Behaviour	22
Misrepresentation/Deception	1
Negligent Behaviour	3
On-Going Lateness	1
Police Investigation	1
Poor patient care	2
Theft	1
Unauthorised Absence	6
DIS - appeal received ref: Final Written Warning	1
Victimisation/Bullying and Harassment	3
SOSR	1
Sexual misconduct	3
NWAS Summary	71

*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	6	3	3	1
Grievance	13	1	0	1
Fact Finding	10	1	1	0
Disciplinary / SOSR	17	23	1	1
Case Total	46	28	5	3





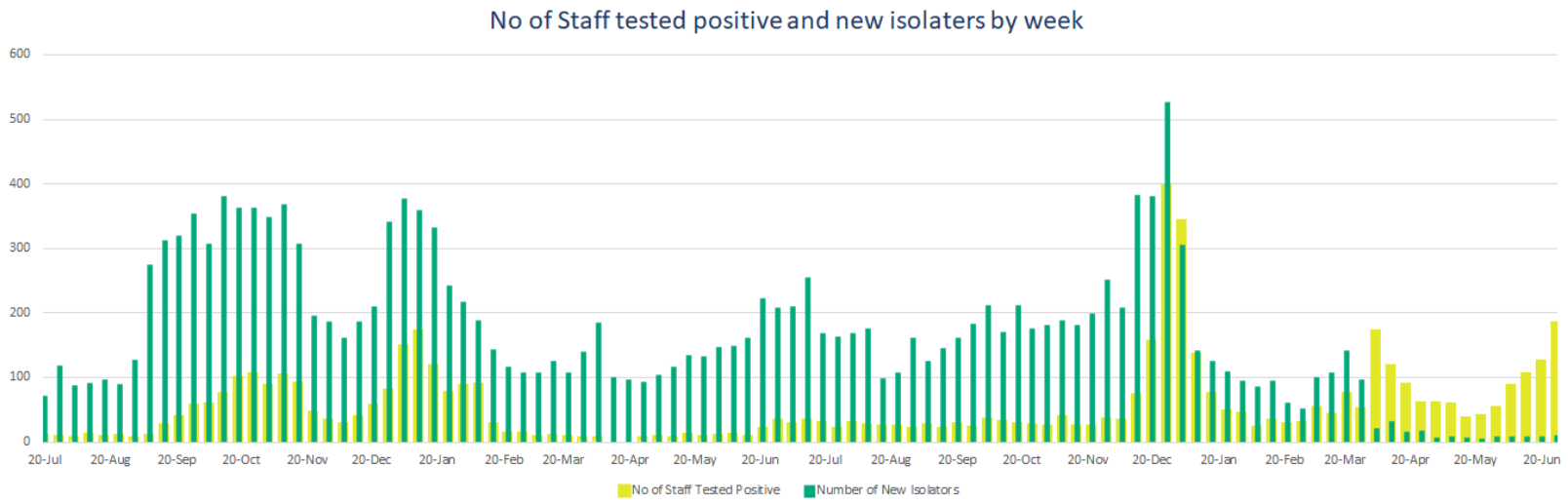
Covid

COVID 19

Figure CV1.0

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	12-Jul	29
27-Jul	3	19-Jul	26
03-Aug	1	26-Jul	17
10-Aug	7	02-Aug	26
17-Aug	3	09-Aug	21
24-Aug	5	16-Aug	19
31-Aug	2	23-Aug	20
07-Sep	6	30-Aug	17
14-Sep	22	06-Sep	22
21-Sep	34	13-Sep	17
28-Sep	53	20-Sep	24
05-Oct	54	27-Sep	18
12-Oct	71	04-Oct	30
19-Oct	96	11-Oct	27
26-Oct	101	18-Oct	23
02-Nov	83	25-Oct	21
09-Nov	99	01-Nov	19
16-Nov	87	08-Nov	35
23-Nov	42	15-Nov	20
30-Nov	28	22-Nov	19
07-Dec	24	29-Nov	30
14-Dec	34	06-Dec	28
21-Dec	52	13-Dec	69
28-Dec	75	20-Dec	152
04-Jan	144	27-Dec	393
11-Jan	168	03-Jan	339
18-Jan	113	10-Jan	132
25-Jan	72	17-Jan	71
01-Feb	83	24-Jan	43
08-Feb	84	31-Jan	39
15-Feb	24	07-Feb	18
22-Feb	9	14-Feb	28
01-Mar	9	21-Feb	23
08-Mar	3	28-Feb	26
15-Mar	6	07-Mar	48
22-Mar	4	14-Mar	37
29-Mar	1	21-Mar	70
05-Apr	2	28-Mar	46
12-Apr	0	04-Apr	168
19-Apr	0	11-Apr	114
26-Apr	1	18-Apr	84
03-May	4	25-Apr	55
10-May	2	02-May	55
17-May	8	09-May	54
24-May	4	16-May	33
31-May	5	23-May	36
07-Jun	7	30-May	49
14-Jun	4	06-Jun	82
21-Jun	17	13-Jun	100
28-Jun	28	20-Jun	121
05-Jul	24	27-Jun	180

Figure CV1.1



North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th July 2022
SUBJECT:	Infection Prevention and Control, Board Assurance Framework (IPC BAF)
PRESENTED BY:	Maxine Power – Executive Director of Quality, Innovation, and Improvement

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☐	☐	☐	☐

SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Assurance
EXECUTIVE SUMMARY:	NWAS Infection Prevention and Control (IPC) Board Assurance Framework (BAF) provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of COVID – 19 transmissions to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry, each with a series of questions which need to be addressed. In December 2021 NHS England and Improvement provided an updated IPC BAF which the Trust has developed aligned with the NWAS BAF. The new format is included in the appendix of this report. It is to be noted by the Trust Board that there have been significant steps in improving IPC within the Trust and that at present we have no red rag rated areas. Gaps in control are clearly articulated and a timeline to improve is included. The IPC BAF and accompanying action plan were last presented at Q&P Committee in June 2022. The action plan includes cross cutting actions for the whole trust and is monitored by the IPC Sub Committee. This report provides the Board with a brief update on achievements and risks against the 10 KLOEs for the FY 2021-22 (1st September 2021 – 31st March 2022).
RECOMMENDATIONS:	The Board of Directors receive assurance that:

	1. IPC risks are being effectively identified against key lines of enquiry. 2. IPC risks have been reviewed. 3. IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance. The Board of Directors are asked to acknowledge that IPC improvements are still ongoing and observe improvement in all areas of the 10 KLOEs.
CONSIDERATION OF THE TRUST'S 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

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality: Equality: Equality Impact assessments have been completed for relevant issues including a review of the EQI for FFP3 face fit testing.	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality & Performance Committee			
	Date:	27th June 2022		
	Outcome:	The Quality & Performance Committee were happy for onward submission to July's Board of Directors Meeting		

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1. PURPOSE

1.1 The purpose of this report is to update the Board of Directors with the position for Q3 and Q4 of FY 2021-22 (1st September 2021 to 31st March 2022) as measured against the Infection Prevention and Control Board Assurance Framework (BAF) and to evidence the key controls which are in place to satisfy the 10 key lines of enquiry (KLOEs).

2. BACKGROUND

2.1 The IPC Covid-19 BAF was developed by NHSE/I to support provider organisations to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance. The framework is used to identify gaps in assurance risks and evidence the corrective actions applied.

2.2 During 2021 and early 2022, the trust continued to enhance and establish new processes and systems for IPC these were based on the development of the IPC board assurance framework focussing attention of the following 10 key lines of enquiry;

IPC BAF KLOEs	
1.	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7.	Provide or secure adequate isolation facilities
8.	Secure adequate access to laboratory support as appropriate
9.	Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections
10.	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.3 For each KLOE there is a requirement to provide evidence, identify any gaps in assurance and provide a high-level overview of mitigating actions. This report provides an update against the achievements made and risk status against the initial 10 KLOEs.

2.4 The framework was initially presented and approved by the Trust Board on the 30 September 2020 with a bi-annual update agreed to be presented to Quality and Performance. The BAF was updated in December 2021 and appendix 1 presents the evidence and assurance gaps for the updated version (version 1.8). It is to be noted that the new version of the BAF once again identifies multiple areas for assurance that are not applicable to an ambulance service. As a Trust we have where possible reported levels of assurance on areas which would be seen as additional to the requirements for an ambulance service. We have identified some gaps in control, which we have RAG rated Red. Notably, there has been some significant improvements and there are now far less gaps than when previously presented at this committee. This paper is to provide assurance that these areas are reviewed as part of an IPC Team workplan and a

2.5 trajectory for improvement is reviewed as part of IPC Team meetings and IPC Sub- Committee. The appointment of our IPC Specialist Nurse (Band 8b), starting 1 December 2021 had provided the Trust with a specialist resource to prioritise areas in which we require to improve.

The IPC BAF has been reviewed, evidenced and updated bi-monthly at the IPC Sub Committee and evidenced to Quality and Performance Committee via the Chairs assurance report. The documents used to monitor and document progress against the BAF include the Risk Register and the IPC Sub-Committee Action Log. These documents are appended, and a summary of the key issues is provided in No. 3 Assurance.

3. ASSURANCE

3.1 Risk Register

There are currently 4 active risks that fall within the IPC remit. Please see Appendix 1 Infection Prevention Control Board Assurance Framework Template where risks and mitigating actions are detailed. The risks are evidenced in the IPC BAF which is an appendix.

3.2 IPC Sub-Committee Action Tracker

The IPC sub-committee continues to meet bimonthly and has delivered the expected work plan. The DIPC has chaired the group and provided chairs assurance reports to the Quality and Safety Committee. These reports identify emerging risks. Overdue risks are flagged by the corporate governance team who attend each meeting.

The IPC Sub-Committee action tracker is reviewed at each meeting and assurances are provided by committee members who own the risks. Open actions are continuously being reviewed to ensure RAG ratings and due dates are updated and met. These actions include key priorities such as strengthening the service line assurance reports to the IPC Sub- Committee. The introduction of service line assurance reports has improved the Trust wide ownership of IPC and provides more robust assurance.

This BAF also includes provides information on fit testing, risks associated with respiratory protective equipment and actions taken to mitigate risks.

3.3 Context

The Covid pandemic situation nationally and regionally, has continued to remain a concern. Public Health England/NHS England/Improvement and Department of Health continue to update and produce national guidance that is reviewed within the Trust via the IPC team on a regular basis. Where necessary this is incorporated into local procedures/guidance and cascaded out to staff through several communication streams.

A new Variant of Concern (VOC) - Omicron was identified and found to be much more transmissible than previous variants, this led to increased pressure on the NHS due to both the impact on increased admissions but also with staff sickness as the prevalence in the community was so high. The Trust saw a large increase in staff testing positive in the festive period and early January and also a number of outbreaks.

This significant increase in cases had an impact on the NWAS Test, Track and Trace service who were not always able to contact all reported positive cases in a timely manner – support was enlisted from other Trust staff to help with the increased workload.

National guidance on testing, mask wearing, and isolation has changed during the reporting period for the public, however, guidance for health care worker has remained the same. The only variation has been that staff do not have to attend for a confirmatory PCR test once they have tested positive on a lateral flow.

The number of bulletins has decreased over the reporting period as guidance, in the main, has remained static for health care workers. It should be noted though that staff are reminded that new guidance for the public does not necessarily apply to the NHS, to avoid any confusion. Other sources of cascading such messages includes the use of the Trusts social media sites and the messaging devices in the Trusts vehicles.

IPC Audit and Assurance

3.4

We have developed a new methodology for collecting IPC audit data using the NWAS Safecheck system and a prototype IPC dashboard using Microsoft power BI which analyses this data by area, service line, sector and station. The information is currently being piloted with operational management teams. Once it has been checked and piloted it will be used in the IPC subcommittee as part of the assurance process and will be included in IPC reporting to committees. Our expectation is that the information will identify gaps and will be used to identify areas for improvement and further monitoring.

There have been some significant changes in the IPC BAF when it was reissued in December 2021 and a large proportion of the KLOE's are different, however, there have been noteworthy improvements in a number of the KLOE's which have remained the same. This includes the implementation of Covid Risk assessments, assurance how national guidance is cascaded through the organisation, implementation of staff testing processes and the inclusion of Covid guidance into all training programmes

It was identified at IPC Sub Committee that we required a robust reporting process to obtain assurance from all Service Lines in the Trust in relation to IPC. The reports were designed to complement the IPC BAF and provide assurance from PES, 111 and PTS.

Areas where we previously reporting in the IPC BAF version 1.7 that were a RAG rating of amber, include key themes around risk assessments of the environment, PPE adherence, Staff testing for COVID 19, IPC Training and cleaning and decontamination. The implementation of Service line reports has allowed us to start to focus on improving these areas and has helped IPC Sub Committee provide a better level of assurance in these areas in version 1.9 of the IPC BAF (there was no IPC BAF version 1.8 issued).

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

4.1 The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The framework has been structured around the existing 10 criteria set out in Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

4.2

The Health and Safety at Work Act 1974 places wide-ranging duties on NWAS, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

4.3

The management of the IPC Board Assurance Framework and action plan is the responsibility of the Director of Infection Prevention and Control (DIPC) and monitored through the following groups and committees:

- Infection Prevention and Control Sub Committee (Bi-Monthly)

- Quality and Performance Committee Bi- annually

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

5.1 Equality Impact assessments have been completed for relevant issues including a review of the EQI for FFP3 face fit testing.

6. RECOMMENDATIONS

6.1 The Board of Directors receive assurance that:

- IPC risks are being adequately identified against key lines of enquiry.
- IPC risks have been reviewed in line with the updated IPC BAF
- IPC improvements have been achieved which are aligned with IPC risks and actions from the original IPC BAF and the revised board guidance.

North West Ambulance Service NHS Trust

APPENDIX 1

Infection, Prevention & Control (IPC) Board Assurance Framework (BAF)

MEETING NAME,

DATE

H2 2021/22 Reporting Timescales:

IPC Sub-Cttee	08/03/2022
Quality & Performance Cttee:	28/03/2022
Executive Leadership Cttee:	TBC
Board of Directors:	TBC

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

IPC Responsibilities:	
DoQII	Director of Quality, Innovation & Improvement
DIPC	Director of Infection, Prevention & Control
IPCS	Infection, Prevention, and Control Specialist
IPCP	Infection, Prevention, and Control Practitioner
HoS	Head of Service
CP	Consultant Paramedic
HoFM	Head of Facilities Management
HoC	Head of Communications
SEM	Senior Education Manager

Board Assurance Framework Legend

Key Line of Enquiry	This is a question that will help to establish whether NWAS is safe, caring, effective, responsive, and well-led				
Evidence	This is the platform that reports the assurance				
RAG Status	A RAG rated assessment of the level of assurance	Not Assured/ Limited Assurance	Moderate Assurance	Assured	
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the IPC BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the IPC BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Action Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
Monitoring	The forum that will monitor completion of the required action				
Progress	A RAG rated assessment of how much progress has been made on the completion of the required action	Incomplete/ Overdue	In Progress	Completed	Not Commenced

Operational IPC Risks

OPERATIONAL IPC RISKS IDENTIFIED ON THE RISK REGISTER

Datix ID	Directorate	Service Line/ Area	Risk Description	Current Risk Score	Risk Owner
3598	Quality, Innovation, and Improvement	Clinical Safety	There is a risk that due to not all staff being FFP3 fit tested, staff are unable to respond to Aerosol Generating Procedures (AGPs) leading to risk to staff personal safety. Options to mitigate this risk are being explored with external providers, and a proposal outlined in a paper will be a request to fund a specific in-house Fit testing team.	12 High	L. Yeomans
3474	Service Delivery	Directorate	There is a risk that the AGP audit 24hr later voice to voice live ring back between operations and identified crews will fail due to a suitable robust resource not being identified which would lead to NWAS not being able to assure the HSE that clinical staff are adequately protected when attending an AGP incident	9 High	S. Hynes
3496	Service Delivery	PTS	There is a risk of non-compliance with the COVID requirements because of insufficient space to accommodate the number of staff on the Oldham site which would lead to staff having to undertake inappropriate practice	6 Moderate	C. Marshall
3481	Service Delivery	PTS	There is a risk to staff safety due to inappropriate allocation to a journey requiring Level 3 PPE which would lead to potential exposure to Covid-19	6 Moderate	C. Marshall

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Systems and processes are in place to ensure that: • a respiratory/ winter plan is in place • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. • plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	• NWAS Operational Winter Plan • Local Resilience Forums (LRFs) • A&E Delivery Boards • NHSEI Regional Calls • National RSV Plan • Deep Cleaning and Terminal Cleaning Regimes/Schedules/SOPS	
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	• IPC Hand Hygiene Audits • IPC FRSM Audits • IPC PPE Audits • IPC Policy and Procedures • IPC Assurance Reporting to IPC Sub-Committee • IPC Communications and Bulletins • Local Operational & Clinical Leadership Compliance Reviews • IPC Practitioner Compliance Reviews • COVID-19 Secure Workplace Risk Assessments • Incident Reporting & RIDDORs • Quality Assurance Visits (QAVs) • Agile Working • Local IPC Risks (Local Risk Registers)	
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. • applied in order and include elimination; substitution, engineering, administration and PPE/RPE. • communicated to staff.	• COVID-19 Secure Workplace Risk Assessments • Premises Ventilation Risk Assessment • Vehicle Ventilation Risk Assessment • IPC Communications and Bulletins • IPC Assurance Reporting to IPC Sub-Committee • IPC Policy and Procedures	
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• IPC Sub-Committee • Health, Safety and Security Sub-Committee • NWAS IPC BAF: Reported Bi-Annually to the Board of Directors • IPC Bi-Annual/ Annual Assurance Report	

	• Reporting to Public Health England • Reporting to NHSEI North West • Quality and Safety Group Meeting with Lead Commissioner	
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	• NWAS has not differed from recommendations stated in national guidance	
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	• Risk Assessments Completed by Health, Safety & Security Practitioners (Subject Matter Experts) • Risk Assessments Completed by Estates & Facilities Management Teams (Subject Matter Experts) • Risk Assessments Completed by Consultant Paramedics for AGPs (Subject Matter Experts) • Dynamic Operational Risk Assessments Completed by Operational Staff	
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	• IPC Audits • AGP Audits • IPC National Guidance • IPC Communications and Bulletins	
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	**This KLOE is not directly applicable for an ambulance service**	
The Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	• All staff cases are reviewed by the Director of Infection, Prevention and Control (DIPC) or the Medical Director ahead of submission to NHSEI • Staff Data Submissions to NHSEI via ePortal	
There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• IPC Practitioners 'Check and Challenge' • Local Clinical and Operational leadership 'Check and Challenge' • DIPC 'Check and Challenge' • 10 Point Plan	
Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	• IPC Hand Hygiene Audits • IPC FRSM Audits • IPC PPE Audits • IPC Policy and Procedures • IPC Assurance Reporting to IPC Sub-Committee • IPC Communications and Bulletins • Local Operational & Clinical Leadership Compliance Reviews • IPC Practitioner Compliance Reviews • COVID-19 Secure Workplace Risk Assessments • Incident Reporting & RIDDORs • Quality Assurance Visits (QAVs) • Agile Working • Third Party Provider Audits/ Inspections • Local IPC Risks (Local Risk Registers)	

The application of IPC practices within this guidance is monitored, e.g.: • hand hygiene • PPE donning and doffing training • cleaning and decontamination.	• IPC Hand Hygiene Audits • IPC FRSM Audits • IPC PPE Audits • IPC Policy and Procedures • IPC Assurance Reporting to IPC Sub-Committee • IPC Communications and Bulletins • Local Operational & Clinical Leadership Compliance Reviews • IPC Practitioner Compliance Reviews • Incident Reporting & RIDDORs • Quality Assurance Visits (QAVs) • Agile Working • Third Party Provider Audits/ Inspections • Local IPC Risks (Local Risk Registers) • Learning Forums				
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• Presented to IPC Sub-Committee (Bi-monthly), Quality & Performance Committee and at the Board of Directors (Bi-annually)				
The Trust Board has oversight of ongoing outbreaks and action plans	• Reported weekly to Executive Leadership Committee (ELC • Reported to IPC Sub-Committee • Reported to Quality & Performance Committee • Reported to Board of Directors via IPC BAF				
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	• Procurement Stock Levels • FFP Training Programme • Training Compliance Records • Availability of Hoods				
OPERATIONAL AND CORPORATE TEAMS					
IPC Mandatory Training	Improve IPC mandatory training compliance inline with Trust trajectory	HoS/ CPs	September 2022	IPC Sub-Cttee	In Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	• Monitoring via IPC Sub Committee	
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	**This KLOE is not applicable for an ambulance service**	
Cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	• IPC Policy & Procedures • IPC Audits • IPC Assurance to IPC Sub-Committee	
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	**This KLOE is not applicable for an ambulance service**	
Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses	• Cleaning and Decontamination Process: Premises • Cleaning and Decontamination Process: Vehicles • Cleaning Products Utilised by NWAS	
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance	• Cleaning products used in accordance with manufacturers guidance	
A minimum of twice daily cleaning of: • patient isolation rooms. • cohort areas. • Donning & doffing areas • 'Frequently touched' surfaces e.g., door/toilet handles, patient call bells, over bed tables and bed rails. • where there may be higher environmental contamination rates, including: • toilets/commodes particularly if patients have diarrhoea.	**This KLOE is not applicable for an ambulance service**	
A terminal/deep clean of inpatient rooms is carried out: • following resolutions of symptoms and removal of precautions. • when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). • following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	• Post AGP Procedures, ambulances returned to station for cleaning • Post patient transportation, ambulances are cleaned • Ambulance Deep Cleaning Programme	
Reusable non-invasive care equipment is decontaminated: • between each use • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol	• IPC Policy and Procedures • IPC Audits • Decontamination Documentation for Reusable Equipment • Post patient transportation, ambulances & equipment are cleaned	

• before inspection, servicing, or repair equipment.	• Ambulance Deep Cleaning Programme	
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• IPC Policy and Procedures • IPC Audits • Decontamination Documentation for Reusable Equipment • Post patient transportation, ambulances & equipment are cleaned • Ambulance Deep Cleaning Programme	
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	• Ventilation Assurance Report: NWAS Premises • Ventilation Assurance Report: NWAS Fleet	
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	• Risk Assessments completed by Subject Matter Experts • Risk Assessments/ Assurance presented to Sub-Committees	
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**This KLOE is not applicable for an ambulance service**	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• IPC Guidance • IPC Communications and Bulletins • Agile Working	
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	• Ventilation Assurance Report: NWAS Premises • Ventilation Assurance Report: NWAS Fleet	
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	**This KLOE is not applicable for an ambulance service**	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLEANLINESS					
National Standards for Healthcare Settings	Review & assess relevance to Ambulance Service	IPC Specialist	June 2022	IPC Sub-Cttee	Not Commenced

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Arrangements for antimicrobial stewardship are maintained	• Antimicrobial stewardship for NWAS • Paramedic Drug Formulary: Antibiotics	
Previous antimicrobial history is considered	**This KLOE is not applicable for an ambulance service**	
The use of antimicrobials is managed and monitored: • to reduce inappropriate prescribing. • to ensure patients with infections are treated promptly with correct antibiotic.	**This KLOE is not applicable for an ambulance service**	
Mandatory reporting requirements is adhered to, and boards continue to maintain oversight	• Assurance Via Clinical Effectiveness Sub-Committee	
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	• JRCALC Guidance for Benzylpenicillin	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	**This KLOE is not applicable for an ambulance service**	
National guidance on visiting patients in a care setting is implemented	**This KLOE is not applicable for an ambulance service**	
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	**This KLOE is not applicable for an ambulance service**	
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises	
If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	**This KLOE is not applicable for an ambulance service**	
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	**This KLOE is not applicable for an ambulance service**	
Visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	**This KLOE is not applicable for an ambulance service**	
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	**This KLOE is not applicable for an ambulance service**	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
GUIDANCE					
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Telephony Screening & Triaging Scripts	
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	• Telephony Screening & Triaging Scripts • Ambulance Crew Handover • ePRF	
Staff are aware of agreed template for triage questions to ask	• Telephony Screening & Triaging Scripts	
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	**This KLOE is not applicable for an ambulance service**	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	**This KLOE is not applicable for an ambulance service**	
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Telephony Screening & Triaging Scripts • Resource Allocation: Competent & Trained Professional (PES/ PTS) • Clinical Pathways: Hear & Treat, See & Treat, See & Convey • Self-Care, Primary Care, Out of Hours Providers, Community Care	
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	**This KLOE is not applicable for an ambulance service**	
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	• IPC Information/ Infographics & Posters in Ambulances • Availability of Masks in all Ambulances	
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	**This KLOE is not applicable for an ambulance service**	
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing	**This KLOE is not applicable for an ambulance service**	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	**This KLOE is not applicable for an ambulance service**	
Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	• Telephony Screening & Triaging Scripts • Resource Allocation: Competent & Trained Professional (PES/ PTS) • Clinical Pathways: Hear & Treat, See & Treat, See & Convey • Self-Care, Primary Care, Out of Hours Providers, Community Care	

Face masks/coverings are worn by staff and patients in all health and care facilities.	• IPC Information/ Infographics & Posters in Ambulances and all NWAS Premises • Availability of Masks in all Ambulances & NWAS Premises • Increased visibility from IPC practitioners at all NWAS premises to support staff adhering with IPC policy • IPC Guidance on handwashing and the use of hand gel. • IPC Communications and Bulletins providing regular updates	
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	**This KLOE is not applicable for an ambulance service**	
Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	• IPC Guidance for Staff • IPC Communications and Bulletins for Staff • COVID-19 Secure Risk Assessments • Agile Working • Availability of Masks in all Ambulances & NWAS Premises • Use of Perspex Screens in Contact Centres/ Reception Areas A	
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	**This KLOE is not applicable for an ambulance service**	
Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	**This KLOE is not applicable for an ambulance service**	
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• COVID-19 Management/ Transportation: PTS Patients	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Appropriate infection prevention education is provided for staff, patients, and visitors.	• IPC Policy and Procedure • IPC Training Packages • IPC Training at Operational Induction • IPC Training Compliance Monitoring • IPC Audits • IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises	
Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. IPC Practitioners supporting teams in PES/111 and in Stations with IPC measures.	• IPC Policy and Procedure • IPC Training Packages available on the Green Room – both PowerPoint and videos guiding staff on how to correctly don & doff PPE, correct handwashing technique and the correct use of the sundstrum hood • IPC Training Compliance Monitoring - figures presented at IPCSC as part of area assurance report • FFP3 Training/ Fit Testing Compliance – compliance figures from areas presented at IPCSC – some disparity between those and figures on ESR. Data cleansing currently occurring to ensure have correct centrally recorded compliance figures • IPC Audits completed and presented at IPCSC in form of power BI dashboard	
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	• IPC Policy and Procedure • IPC Training Packages Inc. FFP3 • IPC Training Compliance Monitoring • FFP3 Training/ Fit Testing Compliance • IPC Audits	
Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• IPC Audits • AGP Audits • Assurance Reporting to IPC Sub-Committee • Local Action Plans to Mitigate Identified Risks	
Gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	• IPC Policy and Procedure • IPC Training Packages • IPC Training at Operational Induction • IPC Training Compliance Monitoring	

The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Absence of Hand Air Dryers Clinical Areas • Paper Towel Dispensers Situated Next to Handwashing Sinks • IPC Audits • Quality Assurance Visits (QAVs)	
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • COVID-19 Secure Risk Assessments • Availability of PPE: Premises and Vehicles	
Staff understand the requirements for uniform laundering where this is not provided for onsite	• IPC Policy and Procedure • Uniform Policy	
All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Communications and Bulletins	
A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	• Surveillance data of infection rates across the Northwest • Surveillance data of infection rates within NWAS • Assurance Reported to IPC Sub-Committee	
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	**This KLOE is not applicable for an ambulance service**	
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	• Outbreak Policy and Procedure • Outbreak Management: IPC Cell • Outbreak management assurance report IPC Sub Cttee	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Add Header					
Uniform Laundry	Production of staff laundry policy or procedure	IPC Specialist	September 2022	IPC Sub-Cttee	Not Commenced
A consitent approach to fit testing across the Trust	Improved Fit Testing Processes and identify funding	IPC Specialist	September 2022	IPC Sub-Cttee	Not Commenced

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 7: Provide or secure adequate isolation facilities.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	**This KLOE is not applicable for an ambulance service**	
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	• Guidance was implemented in PTS • PPE Policy and Social Distancing Policy	
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	**This KLOE is not applicable for an ambulance service**	
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	**This KLOE is not applicable for an ambulance service**	
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	**This KLOE is not applicable for an ambulance service**	
Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	**This KLOE is not applicable for an ambulance service**	
The principles of SICPs and TBPs continued to be applied when caring for the deceased	• IPC Policy and Procedure	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 8: Secure adequate access to laboratory support as appropriate.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Testing is undertaken by competent and trained individuals	**This KLOE is not applicable for an ambulance service**	
Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Staff Asymptomatic Testing Undertaken as Per National Guidance	
Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	**This KLOE is not applicable for an ambulance service**	
Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	**This KLOE is not applicable for an ambulance service**	
Screening for other potential infections takes place	**This KLOE is not applicable for an ambulance service**	
That all emergency patients are tested for COVID-19 on admission	**This KLOE is not applicable for an ambulance service**	
That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	**This KLOE is not applicable for an ambulance service**	
That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	**This KLOE is not applicable for an ambulance service**	
That sites with high nosocomial rates should consider testing COVID negative patients daily	**This KLOE is not applicable for an ambulance service**	
That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	**This KLOE is not applicable for an ambulance service**	
That patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation	**This KLOE is not applicable for an ambulance service**	
There is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	**This KLOE is not applicable for an ambulance service**	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • IPC Training Packages • IPC Training at Operational Induction • Premises Cleaning • Ambulance Cleaning • Ambulance Deep Cleaning Programme • IPC Audits • Communications and Bulletins • IPC Assurance Reporting to IPC Sub-Committee	
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IPC Policy and Procedure • IPC Training Packages • IPC Audits • IPC Communication and Bulletins • National PHE Guidance	
Safe spaces for staff break areas/changing facilities are provided.	• IPC Policy and Procedure • IPC Guidance • COVID-19 Secure Workplace Risk Assessments • IPC Audits • Quality Assurance Visits (QAVs)	
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• IPC Policy and Procedure • IPC Guidance • Outbreak Management • IIMARCH by ePortal • Assurance Reporting to IPC Sub-Committee	
All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• IPC Policy and Procedure • IPC Guidance • Risk Assessments –	
PPE stock is appropriately stored and accessible to staff who require it	• Procurement of PPE • PPE Stock Levels • Accessibility to PPE on all NWAS Premises • Accessibility to PPE on all NWAS Vehicles • Local Monitoring of PPE Stock Levels	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
There are no identified Gaps in Controls/ Assurances					

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK		
Section 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.		
KEY LINE OF ENQUIRY	**EVIDENCE**	**RAG**
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	• Policies and Procedures • Guidance • Communications and Bulletins • HR Risk Assessments • Operational and Clinical Leadership Models in situ • H&WB Support Mechanisms • Occupational Health Self-Referral	
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	• Policies and Procedures • Guidance • Communications and Bulletins • HR Risk Assessments • Operational and Clinical Leadership Models in situ • H&WB Support Mechanisms • Occupational Health Self-Referral	
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self- isolate (see Staff isolation: approach following updated government guidance)	• Policies and Procedures • Guidance • Communications and Bulletins • HR Risk Assessments • Operational and Clinical Leadership Models in situ • H&WB Support Mechanisms • Occupational Health Self-Referral	
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	• IPC Policy & Procedures • IPC Training Packages • IPC Training Package Inc FFP3 • IPC Guidance • IPC Audit • IPC Communications & Bulletins	
A fit testing programme is in place for those who may need to wear respiratory protection.	• Continual Face Fit Testing Programme - paper in progress and to be presented at ELC to secure funding/process to ensure effective fit testing programme is in place	
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce	• Policies and Procedures • Employee Self-Referral to Occupational Health • Absence Reporting • Incident Reporting • Risk Assessments	

• lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	• Vaccination Uptake Campaigns • Vaccination Clinics Trust-wide	
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	• IPC Policy & Procedures • IPC Guidance • IPC Communications and Bulletins • Accessibility to PPE	
A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. • That advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	• Policies and Procedures • Risk Assessments • Occupational Health Referral • Operational and Clinical Leadership Model in situ • Accessibility to PPE • FFP3 Face Fit Testing • Protective Hoods in situ • Alternative Duties/ Redeployment Processes	
Vaccination and testing policies are in place as advised by occupational health/public health.	• Policies and Procedures • Guidance • Communications and Bulletins • HR Recruitment Processes • Occupational Health Provider	
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained andheld centrally/ESR records.	• Policies and Procedures • Guidance • Communications and Bulletins • IPC Training Packages • FFP3 Face Fit Testing Programme • Protective Hoods in situ • Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions • MyESR Compliance Data	
Staff who carry out fit test training are trained and competent to do so.	• Policies and Procedures • Training Certification • Training Competences • Training Revalidation Competences • Face Fit Testing Resources • Assurance via IPC Sub-Committee	
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model isused.	• Policies and Procedures • Guidance • Communications and Bulletins	

	• IPC Training Packages • FFP3 Face Fit Testing Programme • Protective Hoods in situ • Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions • MyESR Compliance Data	
All staff required to wear an FFP3 respirator should be fit tested to use atleast two different masks	• Policies and Procedures • Guidance • Communications and Bulletins • IPC Training Packages • FFP3 Face Fit Testing Programme • Protective Hoods in situ • Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions • MyESR Compliance Data	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• IPC Training Package • FFP3 Training Package • MyESR Compliance Data • HR Records: Local Management Discussions	
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• IPC Training Package • FFP3 Training Package • MyESR Compliance Data • HR Records: Local Management Discussions • Protective Hoods in situ	
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	• Policies and Procedures • Guidance • Communications and Bulletins • IPC Training Packages • FFP3 Face Fit Testing Programme • Protective Hoods in situ • Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions • MyESR Compliance Data	
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	• Policies and Procedures • Guidance • Communications and Bulletins • IPC Training Packages • FFP3 Face Fit Testing Programme • Protective Hoods in situ	

	• Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions • MyESR Compliance Data	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	• Policies and Procedures • Guidance • Communications and Bulletins • Alternative Duties/ Redeployment Processes • Occupational Health Records • HR Records: Local Management Discussions	
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Assurance via IPC Sub-Committee • Assurance from IPC Sub-Committee to Q&P Committee • Assurance from Q&P Committee to Board of Directors • Bi-annual Assurance on IPC to Committee & Board of Directors • IPC BAF • MyESR Data	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	**This KLOE is not applicable for an ambulance service**	
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• COVID-19 Secure Workplace Risk Assessments	
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Policies and Procedures • NWAS Test, Track and Trace • Local Line Management • Absence Reporting • Health and Wellbeing Support Mechanisms • Occupational Health Referral • Accessibility to Staff COVID-19 Testing • Guidance • Communications and Bulletins	
Staff who test positive have adequate information and support to aid their recovery and return to work	• Policies and Procedures • Guidance for Managers • Local Line Management • Accessibility of HR Support • Health and Wellbeing Mechanisms • Occupational Health Referral • Return to Work Process	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
A consitent approach to fit testing across the Trust	Improved Fit Testing Processes and identify funding	IPC Specialist	September 2022	IPC Sub-Cttee	Not Commenced

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th July 2022
SUBJECT:	Learning from Deaths summary report and dashboard Q4 2021/22
PRESENTED BY:	Dr Chris Grant, Medical Director

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☐	☐	☐	☐

SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Assurance
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q4 dashboard (Appendix A) describes the opportunities to learn from deaths. In summary the two main contributory factors to patient death were attributed to Emergency Operations Centre (EOC) procedures (specifically calls being incorrectly categorised) and lack of available resources against demand. The peer review process identified most patients received appropriate care. However, where failings occurred these included suboptimal recording of observations/assessment/investigations, MTS being applied incorrectly, absence of ECGs attached to clinical records, lack of escalation for decision making, failure to record GP discussions, and suboptimal clinical management. The peer review identified areas of good practice such as discussions around best interests and their wishes documented; patient and family centric bereavement care and family support leading to delivery of incontinence sheets and body wipes. A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums and individual frontline staff. The form design within the DCIQ Mortality Module has been modified and work is ongoing to improve the reporting outputs.

RECOMMENDATIONS:	The Trust Board is asked to:
	• Approve the quarterly dashboard (Appendix A) as the report to be published on the Trust public account.
	• Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
	• Acknowledge the impact of the Structured Judgment Review process in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust.
	• Acknowledge the good practice identified including:
	  ○ Crew recognised end of life and specialist pathway used
	  ○ Discussion around best interests and their wishes documented
	  ○ Crew supportive to family, condolences offered and signposted to bereavement care, and extended family members contacted for emotional support
	  ○ Family provided with personal hygiene assistance
	• Support the dissemination process as described in 3.4

CONSIDERATION OF THE TRUST'S 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

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub-Committee Quality and Performance Committee			
	Date:	05/07/2022 and 25/07/2022		
	Outcome:	CESC: Recommendations approved Q&PC: Unknown at time of writing		

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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 Learning from Deaths Policy.

Appendix A is a summary dashboard of the Q4 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st July 2022 in accordance with the national framework and trust policy. The Q4 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q4. The learning from the panels is discussed later in this paper.

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

It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2022/23 progresses.

2. BACKGROUND

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

LEARNING FROM DEATHS DASHBOARD Q4 2021/22: APPENDIX A

2.1 The number of patients whose deaths were identified as in scope for review was 76 (45 Datix incidents and 31 sampled - *table 1, Fig.1*).

2.2 ***Datix Cohort Discussion***

Of the 45 patient deaths.

- 29 patients were identified through the Incidents module
- 14 patients were identified through the Patient Experience module
- And a further two (2) patient was identified as having records on both the Incidents and the Patient Experience module.

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

Of the 29 patients, 12 were reviewed and closed. In six (6) cases the investigation concluded the Trust had contributed in some way to that patient death.

- Clinical treatment was cited as the main contributing factor to the patient's death

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

14 patients 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. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures

    - Call incorrectly categorised with a missed opportunity to manually upgrade the call
    - Significant delay in responding to a difficulty in breathing patient, with a subsequent cardiac arrest
    - Significant delay in responding to a patient who had collapsed, with a subsequent cardiac arrest
    - Significant delay in responding to a stroke
- PES/Operations
    - Lack of safety-netting, incorrect MTS application in a chest pain patient
- Communication
    - Concern raised about the use of terminology for a trauma incident
- Relative/external health professional concern raised
    - Delay in emergency transfer of patient with confirmed ruptured abdominal aortic aneurysm.
    - Family raised a concern around the mobilisation of a bariatric patient from upstairs to ambulance.
    - Social worker raised a concern about the management of the 111 call.
    - Concern raised around the mobilisation of a baby in cardiac arrest
    - Significant delay in responding to a sepsis patient
    - Delay in emergency transfer of patient with cardiac symptoms

2.2.3. ***Investigation and Patient Experience Modules: Tables 6 and 7 and figure 5.***
Two (2) patient deaths were recorded on both modules – note this is a different incident from those referenced separately in the incident and patient experience modules. Both of these investigations have been closed and concluded:

- EOC and EMD procedures:
    - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
    - Significant delay responding to a patient with breathing difficulties
- PES/Operations:
    - Concern raised around the management of a patient with abdominal pain

2.3 ***Structured Judgement Review (SJR): Cohort Discussion: tables 8, 9 and fig 6.***
Of the 60 patient deaths:

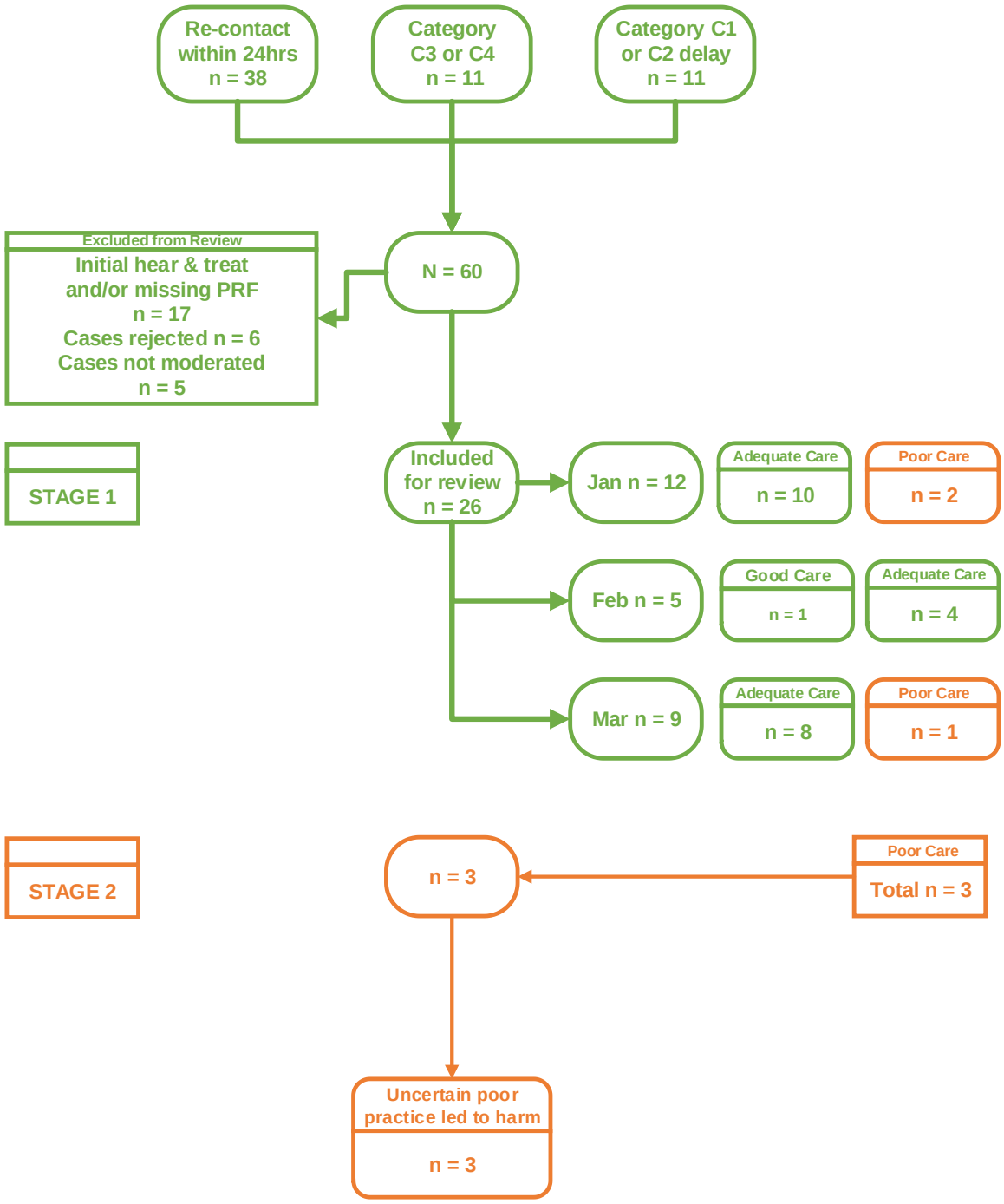
- 38 patient deaths occurred where patients were not initially conveyed, and the service was re-contacted within 24 hours*
- 11 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- 11 deaths occurred where they were initially coded as Cat 1 or Cat 2 and were subjected to a long wait.

**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 several reasons why the whole cohort identified are not reviewed:

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

3. Death not in scope post clinical review
4. SJR not moderated



Flow chart to describe sample cohort attrition and treatment Q4 2021/22

2.3.1 ***Structured judgement review methodology***

The process requires the reviewing frontline staff to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' (PRF 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 statement's 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.

2.3.2 ***SJR Stage 1 Outcomes:***
26 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below.

Month	Very Poor	Poor	Adequate	Good	Very Good
Jan 22		2	10		
Feb 22		0	4	1	
Mar 22		1	8		

Moderation Panels held on 15/03/2022, 12/04/2022, & 17/05/2022

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'*.

2.3.3 ***SJR Stage 2 Outcomes:***
Three (3) cases were identified as needing second stage review following Stage 1. It was identified that it was uncertain whether poor practice had led to harm for all 3 cases in terms of assessment, management plan and disposition.

2.3.4 ***SJR Learning Outcomes: Tables 11 -12***
Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Assess and document capacity to consent appropriately
- Escalate complex cases
- Recognise differential symptoms and red flags
- Provide detailed observation history to AVS providers
- Attach/transmit ECGs to the electronic patient record (EPR)
- Perform 12-lead ECGs for patients presenting following a transient loss of consciousness (TLOC)
- Provide a comprehensive clinical narrative within the EPR, especially details involving GP discussions and worsening advice

Good Practice: Table 12 fig 8.

The panel review identified numerous positive examples of practice over and above expected practice. This included

- Performing additional investigations and assessments beyond expected practice
- End of life recognised and specialist pathway used
- Discussion around best interests and their wishes documented

- Supportive to family, condolences offered and signposted to bereavement care, and extended family contacted for emotional support.

Family provided with incontinence sheets and body wipes.

2.4 ***Dissemination Process***
A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the area learning forums (ALFs) and 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, on a bi-annual basis.

Good practice letters have been circulated to commend 13 clinicians who, through their care and professionalism, have supported families and patients to experience a good death during Q4.

2.5 ***Report Development***
DCIQ: Mortality Module

The Clinical Audit Team has been working with the DCIQ team to improve the mortality module. Improvements have been made to the forms to improve data capture and reporting. Work is still ongoing to develop the dashboards.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

DX3408: *(risk score 6)* There is a risk that the lack of resource will mean the competing priorities to perform additional high risk defined audits (such as the Learning from Deaths audit) will not be undertaken in their entirety and this will have a negative impact upon the annual clinical audit plan resulting in a failure to provide assurance to the trust and regulatory bodies.

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

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. EQUALITY OR SUSTAINABILITY IMPACTS

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

5. RECOMMENDATIONS

The Trust Board is recommended to:

- Agree the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
- 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:
    - Crew recognised end of life and specialist pathway used
    - Discussion around best interests and their wishes documented
    - Crew supportive to family, condolences offered and signposted to bereavement care, and extended family members contacted for emotional support
    - Family provided with incontinence sheets and body wipes
- Acknowledge the dissemination process as described in 2.4.

NWAS Learning From Deaths Dashboard Quarter 4 2021-2022 (January - March)

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

Total Number of Deaths in scope (sample cohort and Datix incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
January	32	23	71.9%	8
February	17	6	35.3%	0
March	27	11	40.7%	3
This Quarter	**76**	**40**	**52.6%**	**11**
This Financial Year	412	347	84.2%	90

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

Table 1.

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 07/06/2022.

Learning from Deaths: Data over time

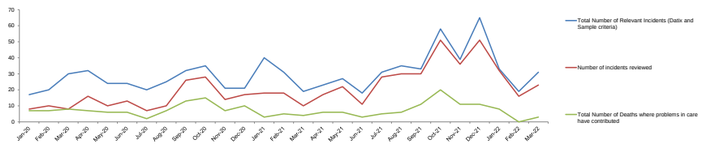


Figure 1.

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 St Unexpected /Potentially avoidable death'.

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
January	13	2	5	5
February	6	0	1	4
March	10	0	2	6
Total	**29**	**2**	**8**	**15**

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
January	9	4	1
February	1	0	0
March	2	2	1
Total	**12**	**6**	**2**

Table 3.

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

Figure 2.

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

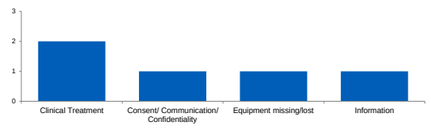


Figure 3.

Data source: Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter. Last extracted 04/04/2022. Last accessed 07/06/2022

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
January	5	0	0
February	5	0	0
March	4	0	0
Total	**14**	**0**	**0**

Table 4.

Learning theme

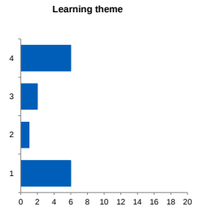


Figure 4

(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 04/04/2022. Last accessed 07/06/2022.

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
January	2	2	2
February	0	0	0
March	0	0	0
Total	**2**	**2**	**2**

Table 6.

Learning theme

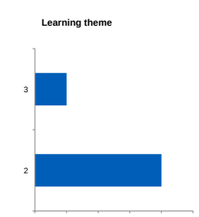


Figure 5

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

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	1	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a patient who had collapsed leading to a cardiac arrest	1	Demand outstripped resources; reflection and/or feedback; still under review
	Significant delay in responding to a patient with stroke symptoms	2	Reflection and/or feedback; refresher training to be undertaken; still under review
	Significant delay in responding to a patient with DIB	2	Demand outstripped resources; reflection and/or feedback; still under review
PES/Operations	Lack of safety-netting, MTS not used, 2nd set of observations is best practice and GP referral should have been considered	1	Reflection and/or feedback; refresher training to be undertaken
	Management of a deteriorating patient from ambulance to hospital, patient went into cardiac arrest during handover	1	Still under review
Communication	Concern raised about the use of terminology for a trauma incident	1	Good communication during handover although some confusion around silver trauma and frail injured patient pathway (FrIP)
Relative/external health professional concern raised	Delay in emergency transfer of patient with confirmed ruptured AAA	1	Demand outstripped resources;
	Family raised a concern around the mobilisation of a bariatric patient from upstairs to ambulance, patient went into cardiac arrest on stretcher	1	Feedback and recirculated bulletins around mobilisation of bariatric patients
	Social worker raised a concern about the management of the 111 call. Inappropriate outcome - too low	1	Feedback and support regarding probing and the use of warm and hot transfer to SA and HA. Additional training around warm and hot transfers for
	Concern raised around the mobilisation of a baby in cardiac arrest	1	Still under review
	Significant delay in responding to a sepsis patient	1	Still under review
	Delay in emergency transfer of patient with ST Elevation	1	Still under review

Table 5

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	2	Reflection and/or feedback; refresher training to be undertaken; discussed at the EOC learning forum to review whether training is sufficient/robust enough; review any staff on PDP and appropriate risk assessment in place to practice call handling; failed audits or poor performance have full and thorough reviews to ensure they are safe enough to take calls; still under review
	Significant delay responding to a patient with DIB	2	Demand outstripped resources; Reflection and/or feedback; training guidance given to call handling staff re: ineffective breathing; still under review
PES/Operations	Concern raised around the management of a patient with abdominal pain	1	Individual learning around JRCALC abdominal pain assessment and management. Considering further medical referral or ED attendance. A disparity of management between JRCALC abdominal pain and MTS Abdominal pain. This is to be discussed at the Area Learning Forum for further discussion.

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 04/04/2022. Information recorded on these incidents: last accessed 07/06/2022. Datix Incidents query 'Inc.: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report': last extracted on 04/04/2022. Last accessed 30/05/2022

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
January	12	12	2
February	6	5	0
March	13	9	1
Total	**31**	**26**	**3**

Table 8.

Quarter 4 2021-2022 Sample Data Breakdown			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
January	3	2	7
February	3	1	2
March	1	5	7
Total	7	8	16

Table 9.

SJR Stage 1 Overall Care Assessment

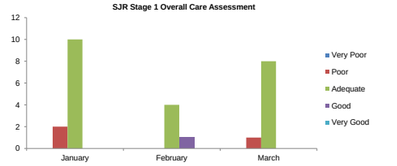


Figure 6.

	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	2	23	1	**24/26 patients**	**92%**
	Management Plan/Procedure Rating	3	20	3	**23/26 patients**	**88%**
Right Place	Patient Disposition Rating	3	22	1	**23/26 patients**	**88%**

Table 10

† SJR Scoring Key:

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

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

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

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 26 patients)

Evidence of Poor/Very Poor Practice

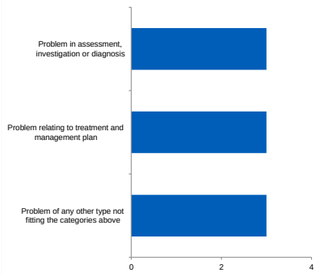


Figure 7.

Learning Theme	Learning Detail	Frequency (n=26 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	2
	Poor assessment/ investigations	2
Problem relating to treatment and management plan	Capacity to consent not assessed appropriately	1
	MTS/Pathfinder applied incorrectly/not used	2
	Lack of escalation for decision making	1
	No narrative regarding GP discussion	1
	No worsening advice	1
	Poor handover to AVS regarding sepsis markers	1
	Failure to recognise differential symptoms and red flags	1
Problem of any other type	Poor clinical documentation	2
	Indication for a 12-lead ECG missed	1

Table 11.

Evidence of Good/Very Good Practice

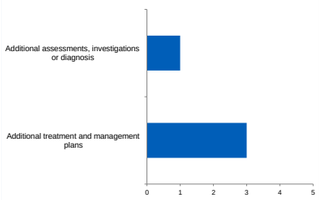


Figure 8.

Learning Theme	Learning Detail	Frequency (n=26 patients)
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice.	1
Additional treatment and management plans	End of life recognised and specialist pathway used	2
	Discussion around best interests and their wishes documented	2
	Supportive to family, condolences offered and signposted to bereavement care, extended family members contacted for emotional support.	1
	Family provided with incontinence sheets and body wipes	1

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. Due to PRFs being unavailable and a lack of EOC subject experts for the SJR process, 26 reviews took place, 14 less than the minimum random sample size of 40 required. There were 11 SJRs rejected from Q4 for being out of scope/ not being moderated at a panel.

Data source: Informatics Learning from Deaths SSRS Feed last run on 07/04/2022, SJR data source: Learning from Deaths SJR Database, last accessed on 31/05/2022.

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	23rd May 2022	**Chair:**	Prof A Esmail
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation, and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Esmail Dr D Hanley Mrs A Chambers Mrs A Wetton Mr G Blezard Dr C Grant Ms A Harrison (Deputy Director of Quality, Innovation and Improvement)	**Key Members Not Present:**	Prof M Power

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	• Discussed the opening score and target closing score of SR01 which was forecast to remain the same at 15. • Agreed that as long waits and patient safety continued to be significant pressures, the BAF score would be reviewed in year. • Acknowledged the long-standing risk associated with Meal Break Policy. • Reported that work in relation to this continued to raise challenges and that planned re-negotiations with trade unions had been scheduled for June 2022. • Agreed that a timeline for the work planned would be presented to future meeting. • Agreed the need to re-articulate the meal break policy risk, to reflect the current position. • Recognised the need to ensure Patient Safety Culture was reported via the Sub Committee in terms of progress and timelines to obtain assurance in relation to the BAF. • Noted that progress was linked to the Freedom to Speak Up Index and specific objectives of the Patient Safety	• Received assurance that BAF risks were being managed effectively. • Meal Break Policy risk to be rearticulated and a timeline of the actions to be presented to future meeting.	

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	Specialist role which would be in place by end of March 2023.		
Integrated Performance Report	**Patient Safety –** • Reported that hospital handover times had been extremely challenging during April. • Queried the impact of the action taken by the trust but noted difficult to ascertain due to the current pressure within the service. • Noted the need to look at how resources were utilised across the whole system and not just standalone for NWAS. • Recognised the factors associated with elective surgery backlog and the work underway to evaluate non-productivity to minimise the impact of lost vehicle hours.	• Noted significant risk in relation to hospital handover delays.	
	Complaints, Clinical and Quality – • Received complaints activity. • 145 complaints and 57 compliments had been received during the month. • Closure of complaints had improved and was being managed using a risk-based system with good progress made regarding Level 4-5 complaints. • Welcomed the reconfiguration of organisational structure to deal with	• Noted progress made in relation to closing of complaints within the required timeframe.	

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	complaints and the realignment of teams to fit the Patient Safety Incident Framework from 1st April 2023. • Noted the AQI performance and areas for improvement in relation to STEMI care bundles, which had been included in the Trust's Clinical audit plan for 2022/23.		
	Performance – • 999 – call pick up during April had been challenging due to implementation of NHS Pathways and staff training. • Noted some improvement in ARP standards and signs that C1 and C2 long waits had decreased in April 2022. • Roll out of NHS Pathways continued. • Noted hear and treat and see and treat trends and discussed levelling up of performance across the region. • Highlighted that in areas using NHS Pathways the performance had improved. • 111 – noted high call demand with some slight improvement in performance against standards. • Advised of work with NHSE and national pieces of work to share calls	• Moderate assurance due to some improvement in ARP standards performance across 999 and 111 during April 2022. • Implementation of NHS Pathways in some areas showing early signs of reduced C1 and C2 long waits.	

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	and evenly distribute, during times of high demand were ongoing. • PTS performance reported for March 2022, reported 1 month in arrears.		
Mandatory Commander Training Assurance Report	• Received an update on the training undertaken by HART team against national deliverables. • 93% compliance rate with improvement required in EOC. • Advised that a Resilience Manager for the Control Rooms had been appointed with a view to achieve 100% compliance in EOC early 2022/23. • NARU Interoperability Audit revealed some areas for improvement using RAG rating system. • Reported that amber and red rated actions had been rectified since the report had been published and that the Trust's HART operatives were constantly monitored on competencies and stages of qualifications. • Recognised that the EPRR Sub Committee were sighted on the actions and had discussed Trust wide learning to ensure key training was delivered to the relevant people. • Reported that funding would be associated to the pending	• Received assurance from the Mandatory Commander Training Assurance Report.	

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	recommendations from the Manchester Arena Inquiry.		
Complaints Annual Report 2021/22	• Noted the annual report which detailed improved processes, investment made and plans to transition the team from the Quality to the Corporate Affairs Directorate. • Discussed the section on learning and thematic review and progress made in relation to EDI data. • Recognised the backlog pressures during 2021 / 22 and that regular updates to Executive Leadership Committee had been provided for oversight. • Discussed future development of EDI data and assurance reporting.	• Received assurance from the Complaints Annual Report. • Recommended for onward reporting to the Board of Directors.	
Health and Safety Annual Report 2021/22	• Chief of Regulatory Compliance provided an overview of H&S activity aligned to the Regulatory requirements. • Highlighted those checks put on hold during the pandemic had now been recovered. • Noted the work planned to recover a backlog in relation to markers which was now in a controlled position.	• Received assurance from the Health and Safety Annual Report. • Recommended for onward reporting to the Board of Directors.	

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	• Reported that Violence and Aggression Group had assisted in the development of the Policy during the year and work overseen by the H&S and Security Sub Committee. • Discussed the work with police forces to address the risks faced by crews. • Noted that an update on the work of the Violence and Aggression Group and body worn cameras to be presented to the next meeting.		
Safeguarding Annual Report 2021/22	• Received summary of safeguarding activity during the year. • Highlighted that all safeguarding concerns received by the Trust had been shared with the relevant Social Services Department. • Noted the training position and the challenges faced during the pandemic which had been identified as a risk. However, noted level 2 and 3 packages of training had been released and compliance rates were increasing. • Discussed types of referrals and noted that a further breakdown of safeguarding activity would be provided in future reports once Cleric system had been implemented.	• Received assurance from the Safeguarding Annual Report • Recommended for onward reporting to the Board of Directors.	

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	• Recognised the work of the team during 2021/22.		
Draft Quality Account 2021/22	• Noted the Draft Quality Account for 2021/22. • Approved the report for onward approval by the Board of Directors on 17th June 2022.	• Approved the Draft Quality Account 2021/22 for onward approval by the Board of Directors.	
Clinical Audit Q4 report and Clinical Audit Plan 22/23	• Highlighted key areas including stretched targets to address care bundles. • Discussed the challenges of managing audit resource. • Agreed Clinical Audit Plan for 22/23 was a good balance and would be monitored and refined throughout the year. • Noted the importance of the pan wide learning across the Trust and triangulation of learning outcomes.	• Received assurance from the Clinical Audit Q4 report and Clinical Audit Plan 22/23.	
Medicines Management Q4 and Annual Report 21/22 (including Controlled Drugs Annual Report)	• Recognised the significant achievements made by the Medicines Management Team during 2021/22. • Controlled Drugs Audits had been undertaken and new process of eLearning introduced for PGDs. • Medicines Optimisation Goals – work continued with digitalisation agenda and SafeCheck, with increase in	• Received assurance from the Medicines Management Q4 and Annual Report.	

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	compliance of MMQI audits on vehicles. • Trust meeting regulatory requirements in terms of CDs and team had clear visibility through processes to safeguard staff and patients, plus monitoring of wastage and value for money.		
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Received assurances from the meeting held on 3rd May 2022.	• Noted the assurances provided by the Clinical Effectiveness Sub Committee.	
Patient Safety Sub Committee Chairs Assurance Report	• Received assurances from the meeting held on 3rd May 2022.	• Noted the assurances provided by the Patient Safety Sub Committee.	
Health, Safety and Security Sub Committee Chairs Assurance Report	• Received assurances from the meeting held on 3rd May 2022.	• Noted the assurances provided by the Health, Safety and Security Sub Committee.	
Diversity and Inclusion Sub Committee Chairs Assurance Report	• Recognised the work being undertaken to review the Sub Committee Terms of Reference. • Agreed reporting on Health Inequalities would be received by the Committee.	• Noted that further work required to review Terms of Reference for the Sub Committee. • Agreed future reporting on Health Inequalities to the Quality and Performance Committee.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	27th June 2022	**Chair:**	Prof A Esmail
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation, and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Esmail Dr D Hanley Mrs A Chambers Mrs A Wetton Mr G Blezard Dr C Grant Prof M Power	**Key Members Not Present:**	None

Link to Board Assurance Framework (Strategic Risks):

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

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North West Ambulance Service NHS Trust

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Discussed the risks associated with SR03 and organisational changes, potential challenges, and resources. • Noted update on Service Delivery Model Review (SDMR) and the future investment for resources required from commissioners. • The Trust's Project Management team and Medical Director continued to deliver the changes required. • Requested an update on the position related to upskilling of staff from PTS to PES. • Noted update associated to APEX tool and welcomed progress made in relation to Freedom to Speak Up arrangements and appointment of FTSU Guardian. • Welcomed recruitment of staff into permanent positions to conduct stack management in the critical incident hub. • Noted some improvements in terms of risk and received assurance that actions were being progressed.	• Received assurance that BAF risks were being managed effectively.	

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Deep Dive: Maternity Incidents	• Received a comprehensive overview of work undertaken by the Trust's Consultant Midwife and the team to date. • Initial survey undertaken to understand the baseline position across the Trust with key findings to be published in the British Paramedic Journal. • Recognised the extent of the initiatives introduced in relation to maternity incidents and Datix recording to gain an improved understanding of prevalence. • Noted significant funding received for training and resources including multi-disciplinary prehospital training. • Red standby phone introduced and included in each maternity unit, which underpinned work and developments of maternity pathways. • Reported that future work on Datix and coding required to address and extract more detailed learning. • Number of births cared for by NWAS had increased. Discussed the role of call takers and crews. • Noted that Healthcare Safety Investigations Branch would soon be known as the Special Health Authority, with responsibility to oversee case	• Noted the assurances provided. • Acknowledged the work undertaken and progress made by the Consultant Midwife and the NWAS team.	

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	reviews of maternity incidents and a requirement to conduct rapid case reviews within 72 hours. • NWAS involved in partnering work to proactively prepare and address requirements. • Recognised the variance in risk levels across the region's maternity units and services and all pressurised in terms of staffing; focus to ensure NWAS were updated on working arrangements across the areas. • Ockenden Review had impacted upon working arrangements with partners and recognised a need for system partners to understand the remit and limits of the ambulance service. • Noted the role of the EPR in terms of collating data and recording activity to provide data intelligence and support maternity projects. • First draft of the Trust's Maternity Education and Training Strategy completed, and training packages evaluated to ensure being delivered effectively. • Discussed the figures associated with incidents and number of babies born before crews arrived, recognised that most cases were dealt with by NWAS		

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	call takers which highlighted the significance of effective training and support for the staff. • Noted that maternity diverts were being reviewed in the ROCC and ELC sighted in terms of NWAS position in relation to transference of risk. • Reported that the Patient Safety Incident Response Framework would facilitate future investigations and the Trust's new Datix system would enhance and provide true risk profile. • Acknowledged the excellent work undertaken, actions undertaken and understanding of the risks.		
Q&P Dashboard	• Received dashboard and BI screenshots, with a draft template for future bimonthly reports to be presented alternately with the IPR. • Draft report discussed and agreed a separate meeting to finalise the format for future meetings. • In terms of 999 performance, noted slight reduction in call volume during May. • C1 90th achieved, NWAS seen as one of the better performing Trusts across the country. • Recognised that training for NHS Pathways had presented challenges	• Welcomed draft report for future alternate bimonthly reporting of quality and performance. • Noted some improvement in performance during May. • Continued challenges associated with roll out of NHS pathways and lost hours caused by hospital handovers.	

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	and lost hours due to hospital handovers continued. • Overview of 111 and PTS presented and welcomed future reporting using the dashboard and bimonthly report. • New six-point plan signed with commissioners which included hospital handovers, mental health, clinical pathway development, resources to reduce downtime, digital interoperability, and the PTS service.		
EPRR Sub Committee Chairs Assurance Report from the meeting held on 17th May 2022	• Noted assurances provided. • Recognised that not all service lines had been represented at the meeting. • Terms of Reference specifically membership and quoracy to be revisited along with the work plan.	• Noted work to be undertaken to review the terms of reference, membership, quoracy and work plan to improve attendance levels across all service lines.	
Defibrillator Assurance Report	• Received assurance on the NWAS position in terms of The Circuit, National Defibrillator Network. • Noted current position in relation to management and deployment of community defibrillators. • Acknowledged the roles of call handlers and crews in the use of equipment at scene.	• Noted the assurances provided.	

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Violence and Aggression Report	• Welcomed an update on the Trust's position as of 31st March 2021/22. • Noted the number of incidents reported during 2021/22 and the method for scoring incidents using the NWAS risk assessment framework. • Acknowledged work ongoing to encourage completion of data fields to ensure that detail can be collated in terms of identifying trends and themes from incidents. • Noted the progress made to reduce the backlog of markers and received assurance that the backlog was being actively managed. • Body worn camera group working with the national team to implement Violence and Aggression Standard and noted Trust's recently approved Policy provided a foundation to deliver the full scope of the standard. • Paper provided examples of support to staff and collaboration work with local communities and youth teams. • Work to strengthen reporting continued. • Recognised the comprehensive update.	• Noted the assurances provided.	

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IPC Board Assurance Framework	• Received the IPC Board Assurance Framework and discussed moderate and red rated assurances. • Recommended a review of risks associated with compliance of new mask fit testing. • Head of Risk Assurance and IPC specialist to update risks. • IPC Area Practitioners in place to prioritise staff training and work undertaken with universities to promote face fit testing of students prior to joining the Trust. • Recognised the progress made by the DIPC and the IPC team and the much-improved position of the BAF.	• Noted assurances provide in the IPC BAF.	
Final Quality Account	• Received the final Quality Account 2021/22 presented to the Board of Directors on 17th June 2022. • Approved the final version for publication by 30th June 2022.	• Discussed and approved the Quality Account 2021/22.	
IPC Sub Committee Chairs Assurance Report from the meeting held on 17th May 2022	• Received assurances from the meeting held on 17th May 2022.	• Noted the assurances provided by the IPC Sub Committee.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	22nd July 2022	**Chair:**	Dr D Hanley, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Dr D Hanley Mr D Rawsthorn Ms C Wood Ms L Ward Mr S Desai Mr G Blezard Prof M Power	**Key Members Not Present:**	Mrs C Butterworth, Non-Executive Director

Link to Board Assurance Framework (Strategic Risks):

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

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Received the proposed Q1 position prior to presentation to the Board of Directors.	• Received assurance that the BAF risks were being managed effectively.	

Key		
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	• Noted the current and potential challenges of the risks aligned to the Committee. • Reported reduction in SR02 risk score and amendments to SR09 in year and target risk score. • Proposal for realignment of SR09 to alternative Board Assurance Committee to be discussed with Chair and Director of Quality, Innovation and Improvement, following recent discussion at Executive Leadership Committee. • Discussed SR08 and acknowledged the monthly briefing to Non-Executive Directors as a good method of reporting on progress. • Referenced SR09 and actions contained within the external auditor's report which were being monitored by the Trust's Audit Committee.		
Update on financial plans – approval of final 22/23 plan	• Received the final financial plan for 2022/23 which delivered a breakeven position for the Trust. • Work required since the May financial planning paper, including confirmation of the national additional funding has been completed. • The Trust's financial plans had been produced by following NHS operational	• Noted the contents of the report. • Endorsed the Trust's Final Financial Plan 2022/23 and recommended approval by the Board of Directors.	

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	Assured	No or minor impact on quality, operational, workforce or financial performance

	guidance for 2022/23 and the system-based approach to funding and planning. • The financial plan has been developed within the Lancashire and South Cumbria (L&SC) ICS plans and the final provider and system breakeven plans were submitted to the NHSE/I on 20th June 2022. • Acknowledged that the deficit position reported to the Board of Directors in May had now been reviewed following the national announcement and additional funding and the Trust's Financial Opening Position reviewed; to finalise a breakeven plan for 22/23. • Income assumptions included in the opening plans now confirmed and noted a reduced recurrent productivity and efficiency target. • Discussed the challenges associated with the recurrent efficiencies. • Acknowledged the work being currently undertaken to work through national allocation and income assumptions.		
Finance Report to 30 June 2022 – Month 3 2022/23	• Received the financial position for the Trust for Month 3 up to 30 June 2022. • Noted an underspend of £0.184m against a planned break-even position.		

Key		
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	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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	• Factors included additional funding confirmed nationally in May 2022 which had been updated in the final financial plan. • Following the review of the financial plans, acknowledged that the annual efficiency and productivity target for 2022/23 had reduced. • Forecasted annual savings noted. • Opening Capital Programme for 2022/23 received and noted system funding slippage from 2021/22. • Acknowledged the YTD gross capital expenditure and net capital expenditure position. • Noted the cash and equivalents balance that the Trust had achieved the Better Payment Practice Code Targets in 2022/23.	• Noted the 2022/23 financial performance.	
Agency Performance Report Q1 2022/23 (30th June 2022)	• Updated on the level of agency expenditure across the Trust. • Received assurance that agency staff had been procured at or below the price caps and via the approved framework agreements. • Presented with an overview of spending position since last report in September 2021.	• Noted the assurances provided.	

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	• NHSE monitoring of agency spending to recommence and providers expected to abide by previously set usage and rate limits. • Noted that the Trust had not received notification of any change to the ceiling and as such the report assumed the historical agency ceiling. • Agency spending reported above the year-to-date ceiling. Usage attributed to significant increase in EOC staffing to support winter pressures; attributed to the timing of funding confirmation and recruitment timescales. • Agency staff also supported introduction of NHS Pathways. • Noted timelines and initiatives to improve the position including improvement in recruitment and retention and transference of agency staff onto NWAS contracts. • No breaches reported during 2021/22 or 2022/23 monitoring returns submitted to NHSE/I on a monthly basis.		
PES Private Ambulance Expenditure Report	• In response to Lord Carter's Review of operational productivity and performance, received an update on the annual expenditure on private ambulances in the PES directorate.	• Noted the assurances provided.	

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	• An increase on previous year reported and largely due to utilising private providers during the Covid-19 pandemic and increasing demand during winter 2021/22. • Reported that Senior Management Team were reviewing the projected level of staffing resource available throughout 2022/23 including use of private ambulance providers. • Recognised the significant factors to consider alongside utilisation of private providers such as high demand and pressures caused by the pandemic. • Obtained operational perspective and noted action being undertaken to reduce spend and the reliance on private providers. • Acknowledged the correlation between sickness absence and impact on utilisation activity and spend.		
Patient Level Information and Costing Systems (PLICS) 2021/22	• Received update on PLICS process including data collection and cost validation requirements. • Current requirements being finalised by the financial planning team and due for submission on 8th August 2022. • Summary of NWAS draft unit costs for 2021/22 provided and compared with previous year.	• Received assurance from the report.	

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	• Noted comparisons with other ambulance trusts. • Noted that AQI activity definitions applied to 2021/22 PLICS calculations and contributed to increase in unit cost and decrease in activity for hear and treat activity. • Welcomed the benchmarking information available on the NHS Ambulance Portal and the planned development of Power BI dashboard to utilise the PLICS information to support NWAS operational and business decision making. • Discussed future use of data and how this would be used for decision making. • Executive Leadership Committee to receive future proposal for linking PLICS and the digital team agenda; future update to be presented to the Committee.		
Supply of Water and Waste Water Services Contract Award (TR/NWAS/04/22)	• Endorsed a Contract Award for Water and Waste Water Services. • Recommended approval by the Board of Directors on 27th July 2022.	• Recommended approval of the Contract Award by the Board of Directors.	
Procurement Update	• Noted progress made within the Trust's procurement function.	• Received assurance from the update.	

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	• Received an update on the status of the 63 projects aligned to the procurement team. • Noted the work plan and key achievements to date. • Acknowledged the waivers and tenders which expired before 31st March 2023. • Savings position and sufficient resources to deliver the savings during 22/23 discussed.		
Estates and Fleet Assurance Report	• Received an update on the progress made against the work areas identified in estates and fleet strategies. • In terms of fleet, noted that the Lancashire workshops merger had completed and recognised the risk associated with the age profile of the PES RRV vehicles. • Discussed the risk associated to the vehicle profile and sought additional information related to the risk. Noted the plans, which were being accelerated to replace RRVs. • Acknowledged update in terms of Estates activity and referred to the variance in quality of estates across the Trust.	• Received assurance from the report.	

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	• Noted the importance of reporting on any progress made to improve some of the priority sites. • Noted updates in terms of Estates which included an energy deep dive to be conducted at the 10 most intensive NWAS locations, to allow the Trust to apply for Public Sector Decarbonisation Scheme Grants. • Further roll out of EV chargers at NWAS sites, subject to outcome of 6-month pilot at a selection of Trust sites. • Queried the HART business case and contingency plans should delays arise. • ELC to discuss proposals in August and future update to be presented to the Committee.		
Payroll Contract Extension	• Received a proposal to extend the current payroll contract. • Recommended approval by the Board of Directors on 27th July 2022.	• Recommended approval of the extension of the Contract Award by the Board of Directors.	
Annual Plan 2022/23 Strategic Planning Review Q1 Progress	• Received the Trust's Annual Plan 22/23. • Recognised the phased approach to planning and the challenges. • Noted that 3-year road map had been impacted by other significant developments being undertaken within	• Approved the 2022/23 Annual Plan and noted the priorities for Q1-Q2.	

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	the organisation and timelines adjusted accordingly. • Received detail of the proposed activities which would commence as phase 2 of the strategic planning review. • Measures and metrics to be in place by end of financial year 22/23. • Board development day in February 2022/23 to review resourcing and current position.		
PTS Contract Re-tender	• Received a verbal update on the current position. • Recognised the ongoing work with ICS partners.	• Noted the verbal update and the ongoing work to be undertaken in collaboration with the ICS.	
Workforce Indicators Report	• Note that sickness absence had decreased in May 2022 to 9.15% and included Covid-19 related sickness. • Reduction in Non-Covid sickness. • Covid sick pay arrangements withdrawn nationally and liaising with Trade union partners across the sector. • Mandatory training achieved overall compliance of 75% in line with target. • Compliance rates for appraisals 79% overall. Target exceeded. • Staff turnover small decrease and trends typical of the sector.	• Noted the improvements made. • Recognised the challenges associated the recruitment, retention and vacancy gaps.	

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	• 111 turnover slightly reduced with some stabilisation. • Short term retention payments had an impact with slight reduction in average monthly turnover rate. • EOC turnover showing upward trend primarily driven by turnover amongst call handlers. • Work to commence in EOC to reflect best practice utilised in 111. • Work continued with the national team around call handler retention. • Overall vacancy position stable, slight under establishment overall. Growth in EOC and PES establishment and contributing the vacancy position. • Recruitment plans in place to recruit to new establishment. • Challenges in PTS and 111 in terms of vacancy gaps. • HR Case management remains stable. • Discussed retention plans and challenges and evaluation of improvement methods being implemented. • Noted the risks which were sighted on the Trust's risk register.		
Health and Wellbeing Annual Report	• Welcomed the Annual Wellbeing Report 2021/22.		

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	• Provided progress update and achievements to date which included Trust's burn out programme for staff, proactive wellbeing calls, associated toolkits, and Treat Me Right Campaign. • Noted that report provided support for the role of the Trust's Health and Wellbeing Guardian and provided a platform for future developments. • Approved the publication of the report.	• Approved publication of the Trust's Annual Wellbeing Report 2021/22.	
Strategic Workforce Sub Committee Chairs Assurance Report	• Received the assurances obtained via the Sub Committee. • Noted the lack of attendance by some operational service lines. • Reported that discussions were underway with operational leads to ensure representation at future meetings. • Recognised the need to ensure attendance improved to allow local plans to be actioned/implemented across all service lines.	• Received moderate assurance from the report. • Noted lack of representation by some key members of the sub committee.	
Digital Strategy Update	• Received comprehensive Digital Update. • Key areas highlighted which included highlights in the areas of digital pioneers, Solving Everyday problems, Our Digital Journey, Secure and	• Received assurance from the report.	

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	Joined up Systems, Smarter Decisions, and risk changes. • Welcomed the report and noted the assurances provided.		

Key		
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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 July 2022
SUBJECT:	Communications and Engagement Team Dashboard Report – Q1 (April-June) 2022/23
PRESENTED BY:	Salman Desai, Director of Strategy, Partnerships and Transformation

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☐	☐	☐	☐

SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Discussion
EXECUTIVE SUMMARY:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. For Q1 (April-June 2022), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q4. It includes the number of virtual engagement opportunities attended and feedback gathered, and information about our patient surveys. For example, this quarter: • 27 virtual community engagement opportunities were attended or facilitated. • In Q1 we reverted back from the previously piloted 2% survey of patients to our commissioned 1% survey of patients. An overall drop of 1% in return rates confirmed that the reversion did not significantly impact the overall return rate. • Satisfaction with services again increased in Q1 after previously declining for three quarters in a row. Based on survey responses: - 91% were likely to recommend the service to friends and family, up 1% from Q4. - 89% were very or fairly satisfied with the overall service they received, up 3% from Q4. - 94% agreed they were cared for with dignity, compassion and respect, up 1% from Q4. **Patient and public panel (PPP)** A summary of the Q1 activity for the PPP, including up-to-date figures for panel recruitment and performance against objectives for the year. For example, this quarter: • 19 new expressions of interest in Q1

- 7 new panel members were confirmed and inducted to the trust
- 221 panel members in total
- 13 involvement opportunities delivered in Q1
- Our youth representation is at 22% against a target for 22/23 of 25%

- Our diversity representation is at 11% against a target for 22/23 of 30%. We have created an action plan to help us improve this position for the year ahead.

Press and public (patient) relations
A summary of our media relations activity for Q1. This includes the number of incident check calls and some highlights of the media relations work that has been undertaken this quarter. In Q1:

- 291 incident check calls
- 45 proactive web or media stories, a 21% increase from last quarter
- 24 statements prepared in response to press enquiries, a 100% increase from Q4
- 6 broadcast media interviews arranged with NWAS spokespeople
- This quarter has seen us give opportunities for radio and TV to see behind the scenes for the first time in 2 years which received significant coverage by BBC Radio Manchester and ITV Tonight.
- 317 pieces of general media coverage – The majority of these were incident checks and a very small percentage were considered negative coverage. Negative coverage related to long wait times for individual patients.

Social media: Facebook, Twitter and Instagram
A summary of our social media statistics for this quarter.

The report highlights our:

- **Audience** – which has grown by 1% across our channels in Q1, with a combined following of more than 152,000 people.
- **Engagement** – which shows our 654 social media posts potentially reached more than 5 million people in Q1 and achieved an engagement rate of 4.5% (very high compared to an industry standard of 2.5%).
- **Content** – our quality over quantity approach to posting means posts achieved more than 13,000 engagements for Q1, compared to an average for other ambulance trusts of around 8,500. Posts with the most engagement included a public message about keeping roads clear for ambulance access during Jubilee street parties and the negative reaction received by a crew when they had to block a driveway to attend an emergency.

Green Room
A summary of statistics for the Green Room – our staff intranet - including page views and visitor numbers. In Q1, staff accessed the Green Room more than 373,000 times and looked at an average of three pages per visit.

Our new staff recognition page to allow colleagues to send a personalised thank you message to each other continues to do well with a further 66 thank you e-cards sent in this quarter. Paper copies will be making their way to contact centres very soon. so far and we are now working on an offline version for contact centres.

We have also launched our Buy, Sell, Swap page that is currently being piloted by NHS 111, following which it will be rolled out to the entire trust.

Website
A summary of statistics for our website, accessed by members of the public and partner organisations. In Q1, the website was visited over 182,717 times.

The most popular pages were the patient transport service (PTS), vacancies and apprenticeships. Most people found our website by searching on Google or clicking through from social media.

Visitors to the vacancies section of the website peaked at the end of May/beginning of June which coincided with the EMT adverts that went out on the radio and social media. It was the sixth most viewed page with 13,193 views.

A huge spike (199%) increase was logged for views to the PTS page with no obvious cause for this.

FOI performance
An update on the FOI performance against the national target of 90% completion within 20 days. 64 FOIs were completed in Q1 with performance falling just short of the target by 1% (89%). A plan is in place to improve performance.

Stakeholder communications
A summary of stakeholder activity for Q1, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 12 MP letters, an increase of 200%. Queries related to resources, performance, PTS delays and Preston Station.
- Other stakeholder work included Andy Burnham's visit to Parkway, a response to Commissioners regarding an enquiry on private providers by Sara Britcliffe MP and a major incident communications handling presentation to NWAA comms team.

Internal projects and campaigns
Highlights and figures about the main internal communication projects and campaigns from Q1, including:

- Armed Forces Week
- CQC Inspection
- Trust Network Brand Identity Toolkit
- Blackpool Ambulance Hub

	- 111 Communications And many more. **Internal bulletins and the Staff App** Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q1: • 14 CEO bulletins • 19 Clinical bulletins • 16 Operational bulletins • 25 other bulletins including covid-19, digital, EOC, PTS and Communications bulletins together with the Weekly Bulletin • 335 staff app downloads, most used to access rostering and ESR. **Films produced in-house** A summary of in-house videography activity. 19 films were completed this quarter, 46% more than Q1 with a further 5 underway. For this year's Super Star Awards we introduced films for each of the categories to focus on nominees and the reasons for nomination. **Spotlight on…Super Star Awards** The Communications Team hosted a super-sized star awards event for staff in June. A total of 400 nominations were received for the 10 award categories, an increase of 74% on the previous event and the highest number of nominations ever achieved. 440 staff attended the event which was fully funded by sponsorship secured by the team. **Improved interpretation services** The Patient Engagement Team supported the trust's roll out of the British Sign Language emergency video relay service. This new services improves access to 999 for deaf patients. The team liaised with the service's providers to give the opportunity for interpreters to observe live 999 call handling in our emergency operations centres before the scheme went live in June. Working with Language Line Solutions, the team has helped to simplify access to interpreters for staff by reducing the number of access codes for the audio language interpretation service available by phone. A pilot of the new insight app which provides both audio and sign language interpreting is also in place via trust iPads.
RECOMMENDATIONS:	For discussion, noting and the provision of any comments.

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

To provide the Board of Directors with a summary of key outputs and associated highlights on the work of the combined Communications and Engagement Team for Q1 (April-June 2022).

2. BACKGROUND

The Communications and Engagement Team has created a dashboard providing high level statistical content and themes from Q1 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- Stakeholder communications
- Social media: Facebook, Twitter and Instagram
- Website and Green Room
- Internal projects and campaigns
- Internal communications including the staff app
- Films produced in-house

Each report also goes into more detail on some priority pieces of work. On the last page, this quarter's dashboard highlights the recent Super Star Awards and work undertaken by the Patient Engagement Team to support the trust's roll out of the British Sign Language emergency video relay service.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.

NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. EQUALITY OR SUSTAINABILITY IMPACTS

All of the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all.

5. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

Communications and engagement dashboard

Q1 2022/23: April - June

North West Ambulance Service
NHS Trust

PATIENT AND PUBLIC ENGAGEMENT

27 events/engagement opportunities with groups including:

Central Lancashire Partnerships Patient, Public and Carers Forum meeting, Patient Involvement Group Leads and a regular meeting with other ambulance services on engagement. ▲ 59%

- Feedback from groups within engagement meetings have primarily been around the ambulance changes within other trusts (smaller cabs, wheelchairs on board) and if we are also doing the same.
- This month we successfully implemented the national BSL 999 emergency video relay service – see end section for details. We also attended a BLS video relay launch event in Cheshire with the Deafness Support Network, police and fire colleagues.
- Going forwards, we will be looking at introducing dashboards for PES and NHS 111. The proposed dashboards are like the one developed for PTS which is shared at PTS Level 2 meeting on a bi-monthly basis. The aim is to share FFT response scores, samples of free text supporting commentaries and thematic analysis, backed up with feedback comments.

16,149 surveys sent ▼ 39%

1,159 surveys returned ▼ 43%

In Q1 we see just a **1%** drop in overall return rate when compared to Q4. This overall drop of 1% in return rates confirmed that the reversion from the '2% pilot send' to '1% send' did not drastically impact the overall return rates.

91% were likely to recommend the service to friends and family ▲ 1%

89% were very or fairly satisfied with the overall service they received ▲ 3%

94% agreed they were cared for with dignity, compassion and respect ▲ 1%

Q1 sees a continued increase across all three key response measures when compared to Q4.

PATIENT AND PUBLIC PANEL (PPP)

19 new expressions of interest in Q1

7 new panel members in Q1

221 total panel members ▲ 4%

13 structured and/or task orientated involvement opportunities delivered ▲ 8%

PERFORMANCE AGAINST OBJECTIVES:

- Increasing youth representation – target is to have **25%** of the PPP made up of young people (16-24 years old) by the end of the year. The youth element of the PPP (16-24) is our highest category at **22%**.
- Ensuring we represent our diverse communities – target is to have **30%** of members from ethnic minority communities. We were at **11%** in Q1. Our recruitment plan for 22/23 will focus on improving this figure. We have produced an action plan to help improve diversity with the PPP for the year ahead.
- The panel became finalists at North West Coast Research and Innovation Awards 2022 in Outstanding Contribution to Patient and Public Involvement (PPI) category.

PRESS AND PUBLIC (PATIENT) RELATIONS

291 'incident checks' handled ▼ 14%

45 proactive website and media articles ▲ 21%

24 statements in response to press enquiries ▲ 100%

6 broadcast media interviews arranged ▼ 16%

The media continues to be interested in our response times and current pressures. A large proportion of our reactive statements remain in relation to long wait times for individual patients.

This quarter has seen us give opportunities for radio and TV to see behind the scenes for the first time in two years.

Recently we:

- Opened the doors of EOC at Parkway to BBC Radio Manchester for the day,
- Let a film crew, filming a programme for ITV Tonight observe an ambulance crew's shift, as they looked to understand the pressure currently facing the service.

317 pieces of media coverage ▼ 3%

262 were reports of incidents including a mention/contribution of NWAS with details provided by our press office about what resources were there, number of patients and nature of injuries. This is considered 'neutral' coverage as the story itself about an incident may be considered positive or negative, but the information about NWAS is factual and neutral in tone. ▼ 5%

14 pieces were considered negative. These are stories that overall, reflect negatively on NWAS, but include a statement from us in response to a situation. Most pieces were in relation to ambulance waiting times.

NOTES: This is coverage available online and may not include all mentions of NWAS in local publications or on broadcast media outlets, although most broadcast outlets also publish online stories which will be captured.

SOCIAL MEDIA - FACEBOOK, TWITTER AND INSTAGRAM

AUDIENCE

73,082 Facebook page likes

63,417 Twitter followers

15,848 Instagram followers

1% Overall audience growth in Q1

ENGAGEMENT

654 Posts published across all channels

5,232,575 Impressions

236,487 Engagements (comments, likes, retweets, shares etc)

4.5% Overall engagement rate

CONTENT

Our quality over quantity approach:
We are leading the way with engagement compared with competitors (other ambulance trusts). Our overall public engagement average across all three channels is 13,219 with the competitor average at 8,500. Our engagement per post average across all channels is 62.8 with competitor average at 44.64.

NOTES:

'Impressions' means a post has appeared on someone's social media feed. It is the number of times our content may have been seen by a member of the public.

'Engagements' is when someone engages with our content e.g. clicks a link, reacts to it by clicking 'like', or shares or retweets it.

'Engagement rate' shows us how many people engage, for example for every 1,000 people who see our post, 54 engage.

According to social media industry experts, the average engagement rate is less than 0.5% for Facebook, 2.5% for Twitter and 1.5% for Instagram, making our engagement very high.

Posts with the most engagement included a public message about keeping roads clear for ambulance access during Jubilee street parties and the negative reaction received by a crew when they had to block a driveway to attend an emergency.

Have you and your neighbours planned a street party for the #JubileeWeekend? Don't forget that a medical emergency can happen to anyone at any time – we ho...

Total Engagements 22,959

Our ambulance crews will always park as considerately as possible; however, we are here for life threatening emergencies which means we need to get to our...

Total Engagements 13,138

EXTERNAL HIGHLIGHTS

AMBULANCE ACADEMY

We have teased that it will be launching in September by contacting schools across the North West and we have over 20 schools interested in the resource.

EOC RECRUITMENT

We launched across social media, press and radio advertising to recruit to over 150 EMA roles across our GM, Liverpool and Lancashire sites. The response and engagement to the campaign has been really positive so far with almost half of the available roles appointed.

PTS VOLUNTEER DRIVER CAMPAIGN

Working with PTS, we are in the design phase of launching the new Star in a Car campaign to recruit volunteers to the service from all over the North West.

PRESS

We have seen a flurry of positive coverage in the last couple of months including our work on improving maternity care, day in the life of an emergency call handler and urging the public to utilise 111 over busy bank holiday weekends.

DEMAND MESSAGING

We have covered two 4 day bank holiday weekends with increased demand messaging across our channels to help raise awareness to the benefits of using 111 over 999 for urgent medical care.

YOUR CALL

We carried on releasing stories from the January edition on social media through to May.

13,086 reads

23,997 impressions

FILMS

19 completed ▲**46%**

5 underway ▲ **25%**

- Clinical Research film
- Becoming a CFR
- Becoming a SPTL
- Becoming a EMT1
- Bina's Story – a patient story
- Team Talk Live: May
- Super Star Awards ceremony film looking back
- X10 Super Star Awards nominee films
- Setting up Multi Factor Authentication
- Para Pass – What is it?

NOTES:

Videos are filmed and/or edited in-house using team skills and equipment.

For the Star Awards ceremony this year we introduced films for each of the categories to focus on each of the nominees and why their nominator put them forward for an award.

NWAS WEBSITE (EXTERNAL)

182,717 visits in Q1- the number of times people have visited our website

403,953 page views - meaning every time someone visits, they view approx 2 pages

MOST VIEWED:

- Vacancies – 176,624 views ▲ **73%**
- Apprenticeships - 22,942 views ▼ **2%**
- Patient Transport Service – 69,404 views ▲ **199%**

ROUTE IN:

- Search (Google etc) – 86,747 visits (66%)
- Social – 14,969 visits (11%)
- Direct (typing in URL) – 23,077 visits (17%)
- Referral from other site – 5,165 visits (4%)
- Email – 41 visits (<1%)

HIGHLIGHTS:

- PTS page views have jumped from 23k to 69k with no obvious cause for this.
- Visits on the site peaked to our vacancies section at the end of May/beginning of June, this coincides with the EMT adverts that went out on the radio and social media. It was the sixth most viewed page with 13,193 views.

STAKEHOLDER COMMUNICATIONS

12 MP letters ▲ **200%**

In response to queries regarding various resources, regular performance statistics, PTS delays and Preston Station.

Other:

- Andy Burnham visit to Parkway.
- Response for Commissioners to Sara Britcliffe MP enquiry – use of private providers.
- Major incident communications handling presentation to NWAA.

THE GREEN ROOM (INTERNAL)

373,236 visits in Q1 - the number of times staff members have used it

1,111,775 page views - meaning every time a person visits, they view approx 3 pages

HIGHLIGHTS:

66 A further 66 thank you cards were sent through the Green Room to colleagues across the trust.

Paper copies will be making their way to contact centres very soon.

NEW

We have launched our Buy, Sell, Swap page that is currently being piloted by NHS 111, this will be piloted for 2-4 weeks, following which it will be rolled out to the entire trust.

COMING SOON: We are exploring options for single sign on so that staff using iPads on the frontline have an improved user experience. Currently users are required to enter log in details every time they want to access the Green Room.
In Q2 we will be looking at how the publication scheme and core publications will be displayed/viewed on the external NWAS website

FREEDOM OF INFORMATION (FOI)

64 FOIs completed

89% within 20 working day target

89% year to date on 20 working day target

Topics included:

- Call outs to specific locations
- IT systems and contracts
- Response times
- Fleet lists

NOTES:

FOIs: We have a statutory duty to reply to FOIs within 20 working days. The national target is 90% for this and we set an internal stretch target of 95%.

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

14 CEO bulletins **19** Clinical bulletins **16** Operational bulletins

Plus 25 others, including weekly bulletins, coronavirus, digital, communications EOC and PTS.

Topics included:

- Long service awards
- iPads
- Mask guidance

335 staff app downloads in Q1, most used to access rostering and ESR.

INTERNAL (STAFF) ACTIVITY

ICT Changes

Office 365 online replaced installed versions of Word, Excel and PowerPoint on shared machines. We supported the change with a branded 'how to' guide. To boost cyber security and add an extra layer of protection to NWAS accounts, ICT enabled Multi-Factor Authentication. We supported the roll-out of this change, advising staff on how to enable the software, via our comms channels. Once the software went live, we continued to support staff with any issues they were experiencing

Network Toolkit

We worked with our design agency and four staff networks to design brand new identities. The toolkit includes individual icons, characters, documentation and merchandise. This is to ensure the networks now fit with our NWAS brand but also have their own identity so staff and the public know they are a network and which service they are part of.

Armed Forces Week

Members of our Armed Forces Network got involved in the awareness month by sharing stories and photos of life as a reservist. We held a flag raising ceremony at HQ, followed by a special visit from the British Army Recruitment Team who told staff what it's really like to be part of the armed forces. We also shared photos from events staff attended outside of work to mark the Falklands Anniversary and Armed Forces Day.

Invest in Yourself

We relaunched our health and wellbeing site, Invest In Yourself. We supported HR with the roll-out by arranging the design and printing of the Invest In Yourself keyrings and air fresheners, letters to all staff, and communications.

CQC Inspection

Prior to the CQC inspection, to ensure staff were prepared, we created a CQC toolkit. This was hosted on the Green Room and included a staff handbook, trust facts and figures, need-to-know information and some handy 5 minute briefings on key topics.

Blackpool Ambulance Hub

We invited children from two local primary schools put their own stamp on our newest state of the art community ambulance hub as part of the redevelopment of Blackpool's Ambulance Station. As part of the build, the children were invited to the site to put their mark on a steel frame by drawing, writing messages or simply adding their name, so that in years to come they can say they're personally linked to the site.

LGBT History Month

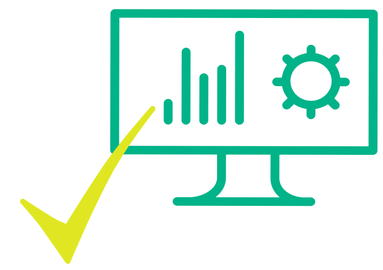
Members of our LGBT Network got involved in the awareness month by telling us what current struggles or prejudices they still face to this day and their opinions on historic events. Topics included the history or pride, the NHS rainbow badge and donating blood.

111 Communications

We are supporting the 111 Rota Review, a 10-month project that will re-evaluate the 111 rota system and make changes to benefit staff and the service we provide. We are in the early stages of the project, agreeing the core principals and informing staff that this is coming and what we need from them. We have recorded a video message from Sally Rose, 111 Senior Service Delivery Manager, which tells staff in two minutes what the project is, why we are doing it and how they can get involved.

We also continued to support other priority work, including:

- Long service awards
- Jubilee coins
- Strategy refresh
- International Nurses Day
- iPad rollout
- Pride Month



SPOTLIGHT ON...

IMPROVED INTERPRETATION SERVICES

The Patient Engagement Team is supporting frontline care with improved interpretation services.

To improve access to 999 for deaf patients, a new national British Sign Language emergency video relay service became available in June 2022.

Our team liaised with the service's providers to provide the opportunity for interpreters to observe live 999 call handing in our emergency operations centres before the scheme went nationwide.

Working with Language Line Solutions, the team has simplified access to interpreters for staff by reducing the number of access codes for the audio language interpretation service available by phone.

The team has also organised a pilot of Language Line's new Insight app via trust iPads which provides both audio and sign language interpreting.

SUPER STAR AWARDS

The Communications Team hosted a supersized star awards event for staff in June.

A TOTAL OF

400 nominations were received for the **10** award categories, an increase of 74% on the previous event and the highest number of nominations ever achieved.

74%

Representatives from the trust's patient and public panel were invited to shortlist the award entries before the chair and chief executive picked the winners.

On the night, all guests received chocolate favours, welcome drinks, canapés, a three course meal and tea and coffee.

440 staff attended which was completely free to them and fully funded by sponsorship secured by the team.