NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 25th January 2023
9.45 am – 1.00 pm

To be held in the Oak Room, Ladybridge Hall, Bolton

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2223/109	Patient Story	09:45	Information	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2223/110	Apologies for Absence	10.00	Information	Chair
BOD/2223/111	Declarations of Interest	10.00	Decision	Chair
BOD/2223/112	Minutes of Previous Meeting held on 30th November 2022	10:00	Decision	Chair
BOD/2223/113	Board Action Log	10:05	Assurance	Chair
BOD/2223/114	Committee Attendance	10:10	Information	Chair
BOD/2223/115	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2223/116	Chairman & Non-Executive Directors Update	10:15	Information	Chair
BOD/2223/117	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2223/118	Q3 Board Assurance Framework Review	10:30	Decision	Director of Corporate Affairs
BOD/2223/119	Trust Corporate Calendar 2023/24	10:40	Assurance	Director of Corporate Affairs
BOD/2223/120	Audit Committee Chairs Assurance Report, from the meeting held on 20th January 2022	10:50	Assurance	Mr D Rawsthorn Non-Executive Director
QUALITY AND PERFORMANCE				
BOD/2223/121	Integrated Performance Report	11:00	Assurance	Deputy Director of Quality, Innovation, and Improvement
BOD/2223/122	IPC Board Assurance Framework	11:30	Assurance	Deputy Director of Quality, Innovation, and Improvement
BOD/2223/123	Learning from Deaths Q2 Report	11:40	Assurance	Medical Director
BOD/2223/124	EPRR Assurance Report	11:50	Assurance	Director of Operations
BOD/2223/125	Manchester Arena Inquiry: Recommendations	12:00	Assurance	Director of Operations
BOD/2223/126	Quality and Performance Committee Chairs Assurance Report, from the meeting held on 28th November 2022	12:15	Assurance	Prof A Esmail Non-Executive Director
BOD/2223/127	Resources Committee Chairs Assurance Report, from the meeting held on 20th January 2022	12:25	Assurance	Mr D Hanley, Non-Executive Director

COMMUNICATIONS AND ENGAGEMENT				
BOD/2223/128	Communications and Engagement Q3 Report	12:35	Discussion	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation
BOD/2223/129	Partnerships and Integration Progress Update	12:45	Assurance	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation
CLOSING				
BOD/2223/130	Any Other Business Notified Prior to the Meeting	12:55	Assurance	Chair
BOD/2223/131	Items for Inclusion on the BAF	12:55	Assurance	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 29th March 2023 in the Oak Room, Ladybridge Hall, HQ, 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.				

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Minutes
Board of Directors

Details: 9.45am Wednesday, 30th November 2022
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mr G Blezard	Director of Operations
Mrs C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director
Mr S Desai	Deputy CEO / Director of Strategy, Partnerships and Transformation
Prof A Esmail	Non-Executive Director
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Mr D Rawsthorn	Non-Executive Director
Mrs L Ward	Director of People
Mrs A Wetton	Director of Corporate Affairs
Mrs C Wood	Director of Finance

In attendance:

Mrs P Harder	Head of Corporate Affairs (Minutes)

Minute Ref:

BOD/2223/84 **Staff Story**

The Director of Strategy, Partnerships and Transformation introduced the staff story in the form of a short film.

The film featured a newly qualified paramedic from Burnley and a senior paramedic from Rochdale who attended a complicated maternity incident in September 2022, which involved the delivery of twins.

The story highlighted that maternity incidents presented a challenge for frontline staff, who hadn't always received extensive training. It was acknowledged that in most instances, NWAS would convey pregnant patients to hospital prior to the birth, however in situations where this was not possible it presented complex situations for staff.

The film highlighted the daunting situation for the staff delivering twin babies, however, they explained they felt more confident following the incident, which was due in part to the Trust's midwifery led PROMPT training, which had been attended by the senior paramedic at the scene.

The Board recognised that the senior paramedic had attended the maternity training in her own time and queried the current arrangements for midwifery training for frontline staff across the Trust.

The Medical Director explained that the training was not part of core mandatory provision and the training qualified as CPD for advanced paramedics. He added the Trust had to consider proportion and competing priorities in terms of mandatory training.

The Board acknowledged that the Trust dealt with the same number of births as a small district hospital.

The Chair praised the staff for their excellent work and the time taken to provide the story, which had highlighted and supported the role of the Trust's Consultant Midwife. He added that he understood the balance required in relation to mandatory training, however welcomed maternity training to be considered as part of future planning and arrangements.

The Board:

- Welcomed and acknowledged the content of the Staff Story.

BOD/2223/85 Apologies for Absence

There were no apologies for absence.

BOD/2223/86 Declarations of Interest

There were no declarations of interest to note.

BOD/2223/87 Minutes of the Previous Meeting

The minutes of the previous meeting held on 28th September 2022 were agreed as true and accurate record.

BOD/2223/88 Board Action Log

The Board noted the updates to the Board action log.

BOD/2223/89 Committee Attendance

Prof A Esmail confirmed he had attended the Nominations and Remuneration Committee held on 28th September 2022.

The Board:

- Noted the amendment to the Committee Attendance Record.

BOD/2223/90 Register of Interests

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

BOD/2223/91 Chair & Non-Executives' Update

The Chair reported that he had attended various ICS meetings, where discussion had related to key performance issues, which had raised the challenges of hospital handover delays. He acknowledged the associated additional pressure on the hospital discharge system, and the work required to speed up the process to improve the flow of patients.

He emphasised the level of waits was unacceptable, and that recent data highlighted that NWAS crews were waiting more than 10 hours to hand over patients.

The Chair advised that he had attended a 2-day symposium on health and wellbeing in the emergency services, which was supported through various initiatives and would be shared across the organisation.

He recognised that staff were under significant pressure and stress, due to the inability to deliver the level of service they would like for patients.

He added that he had recently visited crews in the Lancashire and Cumbria and Cheshire and Mersey areas, who, despite the challenges, their mood and conversation had been positive. He acknowledged that the Trust were very fortunate to have such excellent people and he was extremely proud to be part of the organisation.

The Board:

- Noted the update from the Chairman.

BOD/2223/92 Chief Executive's Report

The Chief Executive presented a Chief Executive's report and provided an overview of activity since the last Trust Board meeting.

He reported that on 3rd November 2022 Sir John Saunders, Chair of the Manchester Arena Inquiry, published Volume 2 of his report which investigated the Emergency Response on the night of the terrorist attack.

The Chief Executive read out the statement which he had provided at the media launch.

He stated that the Trust had been issued with local and national recommendations which would be addressed, and the Chairman of the Inquiry

had requested each of the emergency services to report their progress in June 2023.

He advised that the Trust Board would discuss further local detail in their Part 2 meeting, to follow, however updates on progress would be presented to future Public Board meetings.

The Chair emphasised the need for the Trust to be as transparent as possible in reporting on progress made by NWAS, in response to the Inquiry recommendations. He added that the Trust's thoughts remained with the families of the victims of the attack and that the Trust were committed to addressing the recommendations and correcting the practice required.

In terms of performance, the Chief Executive confirmed the Trust were operating at REAP Level 4 and further detail would be discussed as part of the Integrated Performance Report agenda item.

The Chair referred to recent media reports regarding allegations of racism in other emergency services and emphasised that the Trust had made a commitment to anti-racism, within the organisation.

Mr David Rawsthorn referred to PTS activity reported as 16% below contract baseline and queried the operational and financial consequences.

The Chief Executive confirmed that the Patient Transport Service (PTS) was operated on a block contract basis and it was noted that the service was returning to a more normal use of contracted hours, in line with pre-covid levels of activity.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2223/93 Q2 Board Assurance Framework Review

The Director of Corporate Affairs presented the Q2 Board Assurance Framework Review.

She reported that the Trust's Executive Leadership Committee had recommended two changes, detailed in s4 of the report:

- To decrease in risk score of SR06 from 15 to 12
- To increase in risk score of SR09 from 15 to 20

Mr D Rawsthorn referred to SR01 and queried the likelihood scoring of the risk, which he felt could be higher due to the current pressures.

The Medical Director advised that in the context of the national position, the Trust's ARP performance was still amongst the highest in the UK, however he acknowledged the considerable challenges across the sector.

He reported that the Trust had implemented some significant mitigations during Q2, which included continued close monitoring of serious incident declarations, which was a marker to show how well the Trust were mitigating risk. He added NWAS had also input additional resources to Category 2 call groups, long waits and had invested in clinical oversight.

He acknowledged that it would be likely that the risk would increase during Q3, due to the increased challenges on call and demand activity.

The Chair referred to the recommendation to increase SR09 and the risks in relation to cyber security. He queried the impact of the risk increasing.

The Director of Quality, Innovation and Improvement reported that the Trust had recently seen significant cyber-attack activity and the Executive Leadership Committee had approved four new posts, with the aim of mitigating some of the risk. She anticipated an improved position by the end of the financial year.

The Board:

- Agreed the decrease in risk score of SR06 from 15 to 12.
- Agreed the increase in risk score of SR09 from 15 to 20.
- Agreed the Q2 position of the Board Assurance Framework.

BOD/2223/94 Use of Common Seal Biannual Report

The Director of Corporate Affairs presented the Use of Common Seal Biannual report.

She reported that use of the Common Seal was determined by section 8 of the Trust's Standing Orders which required a biannual report to be presented to the Board of Directors for assurance.

The Board:

- Noted the occasions of use of the Common Seal as detailed in s2 of the report.
- Noted compliance with s8 of the Standing Orders.

BOD/2223/95 Freedom to Speak Up Biannual Report

The Medical Director presented the Freedom to Speak Up (FTSU) biannual report.

He reported that there had been 47 concerns raised via the FTSU process during Q1 and Q2 2022/23, which had been a 28% reduction from the same period in 2021/22.

He highlighted that the reduction had been attributed to the turbulence caused during the pandemic and there had been a recent return to pre-covid activity rates.

He advised that a key theme within the concerns received had been inappropriate behaviour and attitudes. He reported that significant work had been undertaken across the Trust and the ambulance sector, which included benchmarking of staff survey results with other ambulance organisations.

The Medical Director noted that the Trust had newly appointed FTSU Guardians and a new Lead Guardian. He added that as the Executive Lead for the FTSU process he would work with the team to input data into future Integrated Performance Reports and particularly highlight signals within the data, to alert Board members to the trends and analysis of findings.

Mrs C Butterworth noted the 65% of concerns which related to the Trust's HR processes and queried whether the processes in place where fit for purpose to deal with the concerns raised.

The Director of People confirmed that the routes for FTSU concerns were dealt with in conjunction with HR processes.

Mrs C Butterworth added it would be useful to receive the number of concerns per service line based on headcount to understand the proportionality.

Dr D Hanley reported that as FTSU Non-Executive lead, he was pleased with the way in which the report was presented and felt confident that the working relationship between the Lead Guardian and the HR department was effective and positioned correctly.

The Chair recognised the importance of the Board's understanding of themes highlighted by FTSU data and welcomed future categorisation and analysis of the impact of patient safety and hospital handover delays; to focus the Board's attention.

Dr D Hanley confirmed that one of the objectives of the Guardian was to triangulate the FTSU activity into other performance reporting areas.

The Chief Executive added that this had been the first report provided by the Medical Director, as FTSU Executive Lead and welcomed requests from the Board of any further information required, which may be beneficial in future reports.

The Board:

- Noted the content of the report and the update in FTSU Guardian Structures.
- Noted the development of the new Freedom to Speak Up Policy.
- Welcomed categorisation and analysis of the impact of patient safety and hospital handover delays in future reports; to focus the Board's attention.

BOD/2223/96 Freedom to Speak Up Policy

The Medical Director presented the Freedom to Speak Up Policy.

He reported that the Executive Summary highlighted the work undertaken to interlink the FTSU process with HR Policies and Procedures and the focus on local resolution, which included greater clarification on how a complaint would be handled.

He added that the clarification of roles and responsibilities, including the Non-Executive Director lead, enabled direct oversight, with the activity clear and transparent. He noted that an Equality Impact Assessment was included in the Policy.

Prof A Esmail welcomed the revision which was clear and understandable.

Mrs C Butterworth queried the process in place for staff who weren't satisfied with the outcome of the FTSU process and if there was signposting to other relevant professional external agencies.

The Medical Director confirmed the guardians were aware of the process to be followed and this was shared with staff. He added there was networks and national guidance in terms of access to external professional bodies and that HR had clear links to these organisations.

The Board:

- Approved the Freedom to Speak Up Policy.

BOD/2223/97 Charitable Funds Annual Report and Accounts 2021/22

The Director of Finance presented the Charitable Funds Committee Annual Report and Accounts 2021/22.

She reported that the annual report and accounts were presented to the Board of Directors as the Corporate Trustee, for approval and adoption.

She confirmed that overall funds during 2021/22 had increased, with the largest element of expenditure attributed to the purchase of medical equipment, mainly defibrillators and staff welfare, which was all in line with donor's wishes.

The Board acknowledged the hard work of the finance team and the Head of Corporate Affairs.

The Board:

- Approved and adopted the Annual Accounts and Annual Report for 2021/22 and
- Approved the signing of the letter of representation and Statement of Trustees Responsibilities on behalf of the Corporate Trustee.

BOD/2223/98 Charitable Funds Committee Chairs Assurance Report

Mr D Rawsthorn presented the Charitable Funds Committee Chairs Assurance Report from the meeting held on 26th October 2022.

The Board:

- Noted the assurances within the Charitable Funds Chairs Assurance Report from the meeting held on 26th October 2022.

BOD/2223/99 Audit Committee Chairs Assurance Report from the meeting held on 21st October 2022

Mr D Rawsthorn presented the Audit Committee Chairs Assurance Report from the meeting held on 21st October 2022.

The Chair referred to the critical and high-risk recommendations.

Mr D Rawsthorn stated he was confident that the outstanding actions referred to, would be progressed by the next Board meeting in January 2023.

The Board:

- Noted the assurances within the Audit committee Chairs Assurance Report from the meeting held on 21st October 2022.

BOD/2223/100 Integrated Performance Report

The Director of Quality, Innovation, and Improvement introduced the Integrated Performance Report for the period October 2022.

The Director of Corporate Affairs reported the key points from the complaints data captured up to 30th September 2022.

The Chair recognised the challenges and referred to the two serious incidents reported in September and acknowledged the potential increase in serious incidents as the Trust progressed towards the winter period.

In terms of patient experience, the Deputy Chief Executive reported that the Patient Emergency Services (PES) and Patient Transport Services (PTS) had seen an increase in the number of responses received, with a decrease in satisfaction levels compared to the previous month by 4.2%.

The Director of Quality, Innovation and Improvement confirmed the intention for the IPR to include narrative both positive and negative, to be addressed by operations, in response to the issues raised through patient experience feedback.

The Chair recognised the importance of understanding patient experience and the role it played in triangulation of data. He acknowledged that the feedback

evidenced a healthcare system under pressure, and that national public satisfaction in the NHS had been impacted, following the pandemic.

The Medical Director summarised clinical outcomes and AQIs for key conditions. He acknowledged that the reporting period related to June and therefore data should be taken with a degree of caution.

Prof A Esmail advised that the Quality and Performance Committee had discussed the AQI performance at their meeting on 28th November 2022.

The Chief Executive noted that the Medical Director and himself would be seeking further discussions at national level in relation to the decline in performance of some AQIs, with a future update reported to Board, via the Trust's Quality and Performance Committee.

Data illustrated in s2.3 and s2.4 of the report highlighted the interconnection between the Trust and system level metrics and the Medical Director confirmed the team had completed a very good piece of work with the public health consultants to identify inequality protective characteristics, to provide the Trust with a focus. He added that as the fields within the electronic patient record became more embedded, the information extracted would become richer.

The Chair welcomed further insight into system wide and local data which would be monitored via the Quality and Performance Committee.

The Medical Director noted the time lag in reporting of care bundles and confirmed he was part of the national group revising the metrics, with changes were expected in the coming months.

In terms of Hear and Treat and See and Treat, good progress was noted, and the Medical Director advised that further focus was required to add value to the process.

The Chief Executive added that an increase in the on-scene time, highlighted that the service was making richer clinical decisions.

Prof A Esmail stated that the Quality and Performance Committee had discussed hear and treat figures and the variation across the areas in detail.

The Director of Operations reported that the emergency services had received 140,501 calls during October 2022 and had been operating at REAP Level 4 since mid-October, with call pick up considerably challenged.

He added that the Trust had not met the ARP standards and the average time for hospital handover had increased to 52mins and 23% with a turnaround time of over 1 hour. He added that category 1 and category 2 long waits had increased and were impacting on patient care.

He advised that the Trust had increased the number of Emergency Operating Centre (EOC) call takers in line with plans and a category 2 validation pilot, which sub categorises category 2 calls, had been implemented to manage risk.

It was noted that see and convey to emergency departments was below 50%, and NWAS were a more stable provider across the ambulance sector.

The Director of Operations reported that the Trust had taken additional calls from other ambulance services across the UK via an Intelligence Router Platform, which had been introduced on 1st November 2022, for long waiting calls. He confirmed NWAS had taken an additional 650 calls as part of the process.

Prof A Esmail, as Chair of the Quality and Performance Committee, confirmed he was confident that the Trust were doing as much as they could to meet the challenges which were system wide. He added the Committee remained concerned in respect of the current long waits and potential patient deaths, which were attributed to a lack of resource.

The Chief Executive advised that the Trust had paused recruitment over the summer to implement NHS Pathways into call centres, however NWAS were now recruiting a significant number of call handlers. He emphasised the need to focus on the reduction in staff absences in the contact centres, as long waits and calls increased.

Mrs C Butterworth congratulated the Trust on the work being undertaken to recruit call takers, however acknowledged the need for additional resource to support the increase in staff.

The Chair welcomed the comments from the Board and emphasised the core function of the ambulance service, which was to answer 999 calls effectively. He welcomed further details of the plans related to recruitment trajectory, for consideration by the Board Assurance Committees, and escalation to Board if required.

The Chair referred to the assurance reports from the Q&P Committee, related to handover, and sought further clarification on the work being undertaken.

The Director of Quality, Innovation and Improvement advised that the system wide improvement plan had an agreed portfolio of work to look at efficiency; minimise down time; work on job cycle time and to improve access to other pathways in the system, including digital referrals. She added that work had been undertaken to unpick national licenses to facilitate change and that the groundwork had progressed. She added that handover was key to improving efficiency and patient safety and the Trust were focused on partnerships within the health care system.

She noted that the Chief Executive had written to Integrated Care Board (ICB) Chairs to request that each nominate a senior lead, to lead on hospital handover in each of the areas. She confirmed that the leads were now established.

She advised that a North West Handover Improvement Board (NWHIB) had been established, with an agreed Terns of Reference and the Board were working through a series of plans to ensure handover was discussed at each ICB as a key objective. She added that the improvement collaborative would involve discussion between 50 leaders, to achieve the correct interactions across the system.

Mr D Rawsthorn welcomed the work undertaken to provide focus across the three areas and queried if there was a similar focus in North Cumbria.

The Director of Quality, Innovation and Improvement confirmed there was chief executive representation at meetings, and North Cumbria were an integral part of the conversations.

Prof A Esmail, referred to the additional financial resource for call handlers.

The Director of Finance confirmed the position of the additional national resource and use of agency and third-party providers. The Chair noted the wider issue of the financial position of the trust and confirmed there were similar deficits in the system and across the region.

The Chair noted the concern of Non-Executives, generally, across the health sector in relation to current performance and the challenges. He added that although he took assurance of the work being undertaken within the resource available, and that the Trust was not an outlier, he confirmed that long waits remained an area of major concern.

As such, he requested the Quality and Performance Committee obtained detail of the Trust's safety netting arrangements for patients, in terms of managing the risks associated with long waits, and to provide assurance to the Board in January 2023.

Furthermore, he stated that although he realised ICSs were in the early stages of implementation, he felt that the Trust Board should formally request that each of the ICBs, across NWAS, offered whatever support they could, to assist with hospital handover issues; he requested this should be done via a letter from the Chief Executive.

He emphasised that the current situation was having a major impact on the availability of resource to attend to patients in the community, and the greatest risk lay with those patients not yet seen.

In relation to 111, the Director of Operations outlined performance and noted the service had achieved 40% call pick up. He added the workforce position was behind trajectory and this had been scrutinised by the Resources Committee at their meeting on 25th November 2022, which had included a deep dive presented by the 111 service.

In terms of PTS activity, he reported full activity and noted communication with commissioners in terms of contracting arrangements. He advised that a

discharge bureau had been established on 1st November 2022 to enable the hospitals to book daily transport for discharging patients, which had gained positive feedback from the system and was improving the flow of patients from hospital.

The Director of Finance provided a financial update and noted the small year to date surplus and a forecast break-even position. She confirmed that the Resources Committee had been presented with further detail which included changes in NHS protocol for reporting a deficit position which could not be consumed by the system. She added that NWAS had adopted good financial governance, control, and financial improvement checklists. She added that the agency ceiling was below trajectory for the first time in 2022/23, however noted caution as the winter period approached.

The Chair recognised the Trust's forecasted break-even position, however stated it was imperative that the Trust did not undermine patient safety. He appreciated there was a need to be prudent, however the Board had a duty to sense check that the organisation was achieving the balance required.

The Chief Executive advised that he had recently attended check and challenge meetings with the ICB and thanked The Director and Deputy Director of Finance for their input and breadth of operational knowledge, which had enabled the Trust to convey the messages required.

The Director of People reported that the workforce indicators continued to be pressurised and the invested work of the attendance improvement teams was ongoing, which had included a qualitative audit of sickness management cases.

She advised on the trust's turnover and vacancy position and noted some narrowing of gaps in EOC and PES. She added that the Trust continued with initiatives to promote and attract candidates to the service and to reduce the number of new staff leaving the service. She noted a national piece of work to understand strategies for recruitment and retention.

She confirmed, that despite REAP Level 4, the service areas continued with appraisals and mandatory training.

The Board discussed and recognised the challenge of finding a balance on mandatory training and appraisals for staff, alongside the requirements of regulators.

The Board:

- Noted the Chair's request to the Quality and Performance Committee to obtain detail of the Trust's safety netting arrangements for patients, in terms of managing the risks associated with long waits, and to provide assurance to the Board in January 2023.
- Noted the Chief Executive would write to each of the ICBs on behalf of the Trust Board, to formally request that each ICB offered, whatever support they could, to assist with hospital handover issues.

- The Chief Executive and the Medical Director to hold further discussions at national level in relation to the decline in performance of some AQIs, with a future update reported to Board, via the Trust's Quality and Performance Committee.

BOD/2223/101 EPRR Annual Assurance 2022/23

The Director of Operations introduced the Trust's Emergency, Preparedness, Resilience and Response (EPRR) Annual Assurance report.

The Chair emphasised the importance of the report in relation to the publication of the findings from the Manchester Arena Inquiry (MAI) publication.

The Director of Operations confirmed the report had been approved by the Trust's Accountable Emergency Officer, Executive Leadership Committee (ELC) and submitted to the Lancashire and South Cumbria Integrated Care Board for their scrutiny and challenge, prior to submission to the regional assurance team.

He advised that the EPRR assurance rating of Substantially Compliant represented 89-99% compliance and Partially Compliant represented 77-88% compliance. He reported that out of 50 core applicable standards, NWAS had self-assessed full compliance with 45 of the standards and partial compliance with 5, with an overall rating of Substantially Compliant. He noted there were 12 brand new standards that the Trust was working towards and some of these related to interoperability.

The Chair referred to the areas of red assurance, which related to commander training.

The Director of Operations reported that following the Manchester Arena Terrorist Attack and during the legal process, the Trust had appointed a new Resilience Director and a Resilience Manager to work in the emergency operating centres. He added that the Trust's EPRR Sub Committee had the responsibility to ensure governance and that the Quality and Performance Committee and Board were clearly sighted on progress against action plans to deliver the work and improvement required.

He advised that the National Ambulance Resilience Unit (NARU) had conducted an assurance visit earlier in the year and found good assurance.

It was recognised that EPRR assurance reporting was scheduled in Q4 to the Quality and Performance Committee.

The Director of Operations confirmed that the Trust had appointed a temporary resilience manager to specifically focus on the MAI recommendations, to provide the focus required.

Mrs C Butterworth queried the role of ICBs in EPRR.

The Director of Operations advised that the EPRR report had been submitted to the Trust's lead ICB for review and challenge, as required.

The Chair stated that some elements of the report in relation to commander competencies required focus and it was important that the trust met the standards required, particularly in in the context of the arena inquiry findings. He advised that the Board would discuss timelines for completion of the actions in the Part 2 board meeting and an update reported to the next public board meeting.

The Director of Operations confirmed that the EPRR Sub Committee reported to the Quality and Performance Committee and onward to Board, however the Chair requested a specific progress report to the Board meeting in January and stated the Board of Directors had a duty to ensure the Trust delivered the improvement required.

The Board:

- Considered the content of the EPRR Annual Report and self-assessment statements.
- Requested a progress report for the next Board meeting on
- 25th January 2023.

BOD/2223/102 **The Kirkup Report into Maternity Services**

The Medical Director presented the Kirkup Report into Maternity Services.

He advised that the report had been prepared following the independent investigation which examined maternity and neonatal services across two hospitals in East Kent between 2009 and 2020, which had been released on 19th October 2022.

Prof A Esmail confirmed the report had been discussed at the Quality and Performance Committee and recognised that although the report focused on maternity, the report highlighted a wider cultural issue across the NHS.

The Director of Quality, Innovation and Improvement advised that the report had been discussed at the Trust's Patient Safety Sub Committee and Quality and Performance Committee and added NHS Trusts faced the challenge of managing resources. The report highlighted that significant change was required.

Dr D Hanley highlighted the need for a longer-term view on planning and learning lessons from previous years, to improve the use of resource in the future.

A Board Development Session in 2023/24 would be dedicated to reviewing a series of recent NHS investigation reports to consider how these impacted on the Trust.

The Chief Executive confirmed that the volume of births attended to by the service warranted focus by the Board acknowledgement within the system.

The Board:

- Acknowledged the Report and the recommendations.
- Noted that a Board Development Session would be dedicated to reviewing NHS investigation reports during 2023/24.

BOD/2223/103 **Quality and Performance Committee Chairs Assurance Reports from the meetings held on 26th September 2022 and 24th October 2022**

Prof A Esmail presented the Quality and Performance Chairs Assurance Reports form the meetings held on 26th September and 24th October 2022.

He outlined the areas of low and moderate assurance, attributed to the pressures on the service.

The Board:

- Noted the Chairs Assurance Reports from the Quality and Performance Committee meetings held on 26th September and 24th October 2022.

BOD/2223/104 **Resources Committee Chairs Assurance Report from the meeting held on 25th November 2022**

Dr D Hanley presented the Resources Committee Chairs Assurance Report from the meeting held on 25th November 2022.

The Board:

- Noted the Chairs Assurance Report from the Resources Committee meeting held on 25th November 2022.

BOD/2223/105 **Communications and Engagement Q2 Report**

The Deputy Chief Executive presented the Q2 Communications and Engagement Team Dashboard Report.

He provided an overview of activity since the last meeting and advised that youth representation was currently at 22% against a target of 25% for 2022/23. He noted that work continued with BAME communities to increase numbers. He added press and PR activity remained high and there had been a reduction in the use of social media due to the national mourning period, following the death of the Queen.

He advised that the Ambulance Academy launch had received significant hits and the Trust had interacted well with schools and colleges.

Mrs C Butterworth queried internal communication activity.

The Deputy Chief Executive confirmed that the Trust had an extensive internal communication plan, however details were not included in the report.

The Chief Executive thanked Mrs C Butterworth for the challenge and confirmed that consideration would be given to the format for a summary of the Trust's internal communication work.

The Board

- Noted the content of the report.
- Noted that a format for future summaries of internal communication activity would be considered.

BOD/2223/106 Any Other Business Notified prior to the meeting

There was no other business notified prior to the meeting.

BOD/2223/107 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

BOD/2223/108 Closing Remarks

The Chair thanked the team for the staff story and welcomed the significant discussion related to the Manchester Arena Inquiry. He confirmed that future reports on the progress made against the Manchester Arena Inquiry Volume 2 Recommendations would be included in public board meetings.

He noted the renewed FTSU report and welcomed inclusion of analysis of patient safety and hospital handover delays in future reports.

He welcomed the robust discussion in terms of the IPR, which had been reflective of the wider pressures, and recognised the need to improve 999 call handler performance.

He thanked the finance and HR teams for their hard work and focus on attendance levels and acknowledged a further EPPR report on progress would be presented to the Board in January. Finally, he thanked colleagues for a good discussion in relation to the Kirkup report which had highlighted wider thematic issues and for their continued scrutiny at the Trust's Board Assurance Committees.

Date and time of the next meeting –
9.45 am on Wednesday, 25th January 2023 in the Oak Room, Ladybridge Hall, Trust HQ.

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
69	30.11.22	96	Freedom to Speak Up Biannual Report	Welcomed categorisation and analysis of the impact of patient safety and hospital handover delays in future FTSU reports, to focus the Board's attention	C Grant	Apr-23			
70	30.11.22	100	Integrated Performance Report	Quality and Performance Committee to obtain detail of the Trust's safety netting arrangements for patients, in terms of managing the risks associated with long waits, and to provide assurance to the Board in January 2023.	Prof A Esmail / C Grant	25.1.23		January Q&P cancelled, included on meeting Action Tracker.	
71	30.11.22	100	Integrated Performance Report	Chief Executive to write to each of the ICBs on behalf of the Trust Board, to formally request that each ICB offered, whatever support they could, to assist with hospital handover issues.	D Mochrie	25.1.23		Chief Executive sent letters to CEOs of ICBs on 30/11/22.	
72	30.11.22	100	Integrated Performance Report	The Chief Executive and the Medical Director to hold further discussions at national level in relation to the decline in performance of some AQIs, with a future update to Board, via the Trust's Quality and Performance Committee.	D Mochrie / C Grant	25.1.23		January Q&P cancelled, included on Q&P Committee Action Tracker.	
73	30.11.22	101	EPRR Annual Assurance Report	Chair requested a EPRR Progress Report to be presented to the next Board meeting on 25th January 2023.	G Blezard	25.1.23			
74	30.11.22	102	Kirkup Report	A 2023/24 Board Development Session to be dedicated to review of NHS investigation reports.	A Wetton	25.1.23		Included on the BDS Plan for 23/24.	
75	30.11.22	105	Communications and Engagement Q2 Report	Noted that a format for future summaries on the Trust's internal communication acivity would be considered.	D Mochrie / S Desai	25.1.23		Email to Chair and Mrs C Butterworth, from S Desai.	

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	✔	✔	x	✔	✔		
Dr Chris Grant	✔	✔	✔	✔	✔	✔		
Dr David Hanley	✔	✔	✔	✔	✔	✔		
Daren Mochrie	✔	✔	✔	x	✔	✔		
Prof Maxine Power	✔	✔	✔	✔	✔	✔		
David Rawsthorn	✔	✔	✔	✔	✔	✔		
Catherine Butterworth	✔	✔	✔	✔	✔	✔		
Lisa Ward	✔	✔	✔	✔	✔	✔		
Angela Wetton	✔	✔	x	✔	✔	✔		
Peter White (Chair)	✔	✔	x	✔	✔	✔		
Carolyn Wood	✔	✔	✔	x	✔	✔		

Audit Committee						
	22nd April	12th May	17th June	21st July	21st October	20th January
Prof Alison Chambers	✔	✔	✔	✔	x	✔
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	✔	x	x	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	✔	✔	✔	✔	✔	x	✔			
Prof Alison Chambers	✔	✔	✔	✔	✔	x	✔			
Prof Aneez Esmail (Chair)	x	✔	✔	x	✔	✔	✔			
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	Cancelled		
Dr David Hanley	✔	✔	✔	✔	✔	✔	✔			
Prof Maxine Power	✔	x	✔	✔	✔	✔	✔			
Angela Wetton	✔	✔	✔	✔	✔	✔	✔			

Charitable Funds Committee			
	27th April	26th October	13th December
Ged Blezard	✔	x	Cancelled
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	✔	✔	Meeting not held		
Prof Alison Chambers		✔	✔			
Prof Aneez Esmail		x	✔			
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	Present	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	Present	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	Present	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	Self Employed, A&A Chambers Consulting Ltd	√				Self employment	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Trustee at Pendle Education Trust		√			Position of Authority	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Husband appointed as CEO at East Grinstead NHS Trust				√	Other Interest	Feb-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Husband works for Liverpool CCG (Cheshire and Mersey ICB)				√	Other Interest	Feb-22	31-Jan-23	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
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
			A member of Festival Medical Services, a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country. NWAS does not sub-contract events nor does FMS operate any significant activity in the North West.		√			Non Financial Professional Interest.	Jul-22	Present	If FMS run events in the North West, these would be undertaken via usual NWAS command functions and EPRR planning and I would remove myself from any interactions and engage with the NWAS Deputy Director should involvement be required from the Medical Directorate.
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.

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	Hanley	Non-Executive Director	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
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	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.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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
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

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2022					
SUBJECT:	Chief Executive's Report					
PRESENTED BY:	Daren Mochrie, Chief Executive					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☐	☐	☐	☐	☐	
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
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 30 November 2022. The highlights from this report are as follows: **Paramedic Emergency Services** • 22,866 hours of unproductive time in December due to handover delays directly impacting C1/C2 long waits • Two periods of industrial action (IA|) with further planned • Reduced call volume helped during the IA **NHS 111** • Increased call demand over Strep A • Health Adviser attrition increased • The 111 rota review has been delayed by four weeks **Patient Transport Services** • Year to date, July 2022 - November 2022 activity is at 14% 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					
RECOMMENDATIONS:	The Board is recommended to: • Receive and note the contents of the report					

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:				
	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 30 November 2022.

2. PERFORMANCE

2.1 Paramedic Emergency Service

None of the national ARP response standards were met within the reporting period. November and December have been challenging for several reasons. There was a marginal drop in hours lost due to extended handover times in November (16012), followed by a significant increase in lost hours during December. December saw the loss of 22866 hours of unproductive time which is the equivalent of 953 x 24-hour emergency vehicles or the entire fleet for central Manchester, Salford, Bolton and Wigan for a seven-day period. This loss of resource has a direct impact on C1 and C2 long waits, which increased over that period.

We continue to see improvements in hear & treat with no reduction in see & treat. The hear & treat for December was 17.7%, some of the improvements were as a result of escalation within the patient safety plan due to increased handover times and industrial action. Overall, the conveyance rate of patents to hospital reduced to 46.6%.

There were two periods of industrial action planned on December 21st and 28th. Action was taken on the 21st however the 28th was postponed. The action on 21st was taken by all three trade unions and impacted on normal resource availability. Derogations for staff to provide life and limb cover were agreed and in place, plus additional third-party provision. We also had the support of 87 military personnel who were utilised during the 24-hour period of action. We continue to monitor any impact of the action in terms of patient safety. Mitigations were put in place to provide the safest service possible. The Trust benefitted from a noteworthy response from the public and support of the trade unions with derogations. The call volume was reduced by 35-40% which aided the response to the calls we did receive.

The industrial action was quickly followed and preceded by the festive period. The usual annual winter and festive plans were put into place. The festive period, in particular New Year's Eve, were quieter than previous years.

Further action took place on 11 January with additional dates planned by all unions for January and February; planning and preparation is on-going. Currently, mid-January, the Trust is performing well in answering 999 calls within standard and seeing much less patients waiting on the stack for an ambulance.

2.2 NHS 111

Winter and the festive period brought NHS 111 more challenge with increased demand. The rise in calls was multifactorial with increased incidents of flu and Covid in our communities across the North West. The greatest surge in call demand however was due to the occurrence of the Strep A infection and, primarily due to the Government and NHS guidelines and perceived antibiotic shortages. This unplanned sudden surge in calls hit all NHS 111 providers across England, with call volumes on some days even higher than those seen during Covid.

The festive period this year presented the scenario of 4-day weekends with Primary Care shut on the bank holidays. Our busiest day was the 27th of December with 18,430 calls offered and our 111-team answering 8,298 calls.

Mid-January has seen a settling of the call demand back down to pre-Strep A volumes, which is resulting in better performance and reduction in abandoned calls. Throughout this period with the excessive call demand and staff sacrificing being with family and friends on the celebration days, the 111-leadership team have really focussed on the health and well-being of the staff. Provision of snacks and drinks utilising the charitable funding and the 111 Champions organising quizzes and dress down days has been positively received by the 111 teams.

The attrition rates for Health Advisors grew again in December; a review of the exit interviews is taking place to identify any themes. Considerations include the impact of the call demand through December, the end of the retention payments and season variation.

The 111-rota review continues, however due to the call demand and the Industrial Action in December the third working parties were cancelled. This means the project will now be delayed by 4 weeks.

Similar to PES, 111 services have been impacted by industrial action.

2.3 Patient Transport Service

PTS performance is reported one month in arrears. Activity in November was 9% Below contract baselines. Year to date July 2022 - November 2022) is performing at 14% below baseline.

Similar to PES, PTS services have been impacted by industrial action.

3. ISSUES TO NOTE

3.1 Local Issues

Learning from major incidents

The trust will soon be required to update the Manchester Arena Inquiry on progress against the recommendations.

In my Association of Ambulance Chief Executives' Chairman role, I recently spent some time at West Midlands Ambulance Service, meeting with the National Ambulance Resilience Unit to share thinking around major incident responses and influence nationally. This is going to be followed up with a workshop in February. I also spent some time with the Chief Constable of British Transport Police, discussing some of the same themes, but from a multi-agency perspective.

3.2 Regional Issues

Critical Incidents

On a few occasions at the beginning of December the trust reached critical level in terms of our ability to provide a safe service for our patients with over 600 patients

waiting in our communities for an ambulance. This was the same for other ambulance Trusts, who in some cases had more than this at any given time.

We issued appeals to the public asking them to think before dialling 999 and reminding them to consider alternative transport if they did need to go to hospital.

The number of incidents we dealt with each day remained consistently around 3,000, primarily due to improved Hear & Treat. These numbers represent typical numbers for the trust, but with handovers taking so long, the result for patients waiting in the community was longer than anyone would like.

Our NHS 111 teams have seen huge surges in calls by the thousands. Many of the additional calls are for people seeking prescriptions and trying to find antibiotics. Again, we reminded the public to use 111 online first and to get prescriptions through their usual GP.

Hospital Handover Collaboratives

Led by our Director of Quality, Improvement & Innovation, events took place in Cheshire & Merseyside as well as Greater Manchester, attended by NWAS and hospital representatives who discussed the importance of working together to reduce harm caused by long waits and various case studies were heard where there has been success.

Electric Vehicle Charging Points

The trust has introduced a pilot scheme of electric vehicle staff and visitor charging point at Ladybridge Hall, Estuary Point, Salford Station and Macclesfield station.

The charge points accommodate two vehicle bays, each accessed via contactless payment, charged below the commercial tariff rate. A minimum pre-authorised amount of £30 (including VAT) will be temporarily reserved against each transaction, however, only the actual cost of the charging session will be deducted.

Following a review of the initial trial, further installations will be rolled out across the NWAS footprint to grow the network, encourage the use of alternative fully electric/plug in models, reduce the carbon footprint, and greatly assist the trust to achieve its sustainability target zero by 2040.

3.3 **National Issues**

Industrial Action

RCN, GMB, Unison and Unite balloted their members for industrial action in relation to the national pay award and met the legal threshold to take action.

In order to manage industrial action, letters were issued to hospital trusts, primary care colleagues as well as care homes and assisted living facilities to update them on the potential disruption to our services due to the strike action and to assure them of the steps being taken to secure system support on those days and the anticipated significant operational challenges for the 48 hours beyond the days of industrial action.

Following the notification of strike action, the trade unions met with senior members of NWAS management team to negotiate derogations. Throughout the negotiations patient safety and staff welfare were priorities. These discussions aim to support colleagues' right to take action, whilst honouring a joint commitment to maintain

patient safety. The decision whether to strike or work remains a voluntary matter for the individual, but the derogations represent a joint agreement on the minimum level of cover needed to meet the legal obligation for strike action not to endanger life or cause serious harm. I would like to thank our trade union colleagues and staff for supporting us with those derogations.

On both days of strike action, staff volunteered and worked tirelessly to ensure our patients received the care they needed despite the reduced number of resources available, whether this was on the frontline responding to those in need, overseeing the situation in EOCs or volunteering to support us in different service lines.

Through our public messaging and the promotion of alternative healthcare provision via our NHS partners, thankfully, the demand level on both days was not at a critical level like it has been recently.

All ambulance service leaders have urged the government to continue to meet with unions and do everything in their power to resolve the issues raised. As Chair of AACE I have regular access to ministers and national union leads and I am doing all I can to make sure everyone is aware of the current challenges faced.

House of Lords Enquiry evidence

In November as the AACE Chairman, I was invited and gave oral evidence to the House of Lords Public Services committee, “Emergency Health Care a National Emergency”. I was able to share my 34 years’ experience in the NHS and nearly 32 years in the ambulance sector, the current position we find ourselves in and my ideas around solutions. This report has now been published and can be assessed using the following link:
https://publications.parliament.uk/pa/ld5803/ldselect/pubserv/130/130.pdf

Health Select Committee evidence

In December as the AACE Chairman, I was invited and gave oral evidence to the Health Select Committee in response to concerns around Urgent & Emergency Care and the forthcoming industrial action.

NHS Recovery Forum

I was invited to represent the ambulance sector at a meeting in Downing Street for the NHS Recovery Forum. Representatives from across the NHS were invited to discuss four key issues: social care and delayed discharge, urgent and emergency care, elective care and primary care. The aim of the event was to help share knowledge and practical solutions so that we can tackle the most crucial challenges being faced by the NHS such as delayed discharge and emergency care, ambulance response times and the pressure on our staff.

It was interesting to hear about correcting unwarranted variations in NHS performance between local areas so that, no matter where patients live, they have access to quality healthcare.

The NHS, local authority and voluntary sector partners have been working innovatively to try and manage demand and create extra capacity for years. Since Covid we have seen real challenges which are driven both by demand for services and by worsening hospital handover times, which are associated with an inability to discharge patients into social care.

I outlined what the sector is doing really well and the role we can play, but also stressed the importance of reducing handover delays to ensure patient safety in the community and the impact that this is having on staff. I also spoke about 'right sizing' the ambulance sector. This is about how we ensure ambulance services have the right number of resources to meet demand and the other things that matter to staff such as on-time finishes and protected development time. I have been asked to continue to lead on national work looking at what capital and revenue funding may be required to achieve this.

It's important that the unique position of ambulance services is represented nationally, and I am pleased to use my position to represent our sector with the hope of delivering benefits for all ambulance staff and I hope that the latest initiatives, and the recent pledge to publish a workforce strategy this year, are the first steps towards addressing the NHS' biggest challenge; looking after its staff.

4. GENERAL

New Year's Honours

Deputy Chief Executive and Director of Strategy, Partnerships & Transformation, Salman Desai, has been awarded the Kings Ambulance Medal in the New Year's Honours list.

Salman joined the service in 1997 as a paramedic before being appointed Head of Service Development and then joining the Board of Directors in 2016 as Director of Strategy & Planning and being appointed Deputy Chief Executive in 2021.

The Kings Ambulance Medal is awarded to ambulance staff who have shown distinguished service, exemplary dedication to their role and demonstrated outstanding ability, merit and conduct to their vocation

Salman has worked hard to redress the balance of representation from ethnic minority communities within our sector, acting as a trailblazer for equity, equality and a better understanding the personal challenges that can bring.

Ambulance staff crisis phoneline

Staff who work in the ambulance service are more likely to experience suicidal thoughts. AACE has commissioned the Ambulance Service Charity (TASC) to provide a new crisis phoneline to provide immediate and ongoing suicide and mental health care for all ambulance staff in the UK regardless of location, job role or length of service

The service includes 24-hour phoneline support staffed by qualified counsellors experienced in helping people in the blue light services, supported by clinicians and longer-term support once a person is safe and stable, specifically a five-session support programme tailored to people experiencing suicidal thoughts.

Research Forum 2023

NWAS has been selected as the host for the 999 EMS Research Forum Annual Conference 2023 which is a fantastic accolade for our Research and Development Team. The forum brings together academics and healthcare providers with a research interest in pre-hospital emergency care and takes place on 20th and 21st June in Manchester.

Abstracts are invited for oral, elevator, or poster presentations on any aspect of research or quality improvement in pre-hospital emergency care. I am delighted to be opening this really important event.

Armed Forces Covenant

Since 2014, our service has made a promise to those who serve, or who have served, in the armed forces, and their families, that they are treated fairly by signing the Armed Forces Covenant.

Our support to armed forces staff has been recognised in the form of a Gold Award by the Ministry of Defence's Employer Recognition Scheme. Our armed forces staff receive up to ten days paid leave for training and we have a strong and active staff network of our armed forces colleagues.

Wheelchair Rugby League World Cup

Congratulations to Adam Rigby, on a triumphant wheelchair rugby league world cup victory when England beat France. Adam works in the resilience team at Ashburton Point and plays wheelchair ruby for Wigan Warriors and England. In a recent media interview, I was really pleased to read that Adam has praised the mental health benefits of playing and how he's keen to increase participation in the sport.

Disability History Month – 16 November to 16 December

The year the trust campaigned to #StoptheStereotypes and shared stories from staff living with disabilities who talk about the stigma they have faced both in public and at work, to raise awareness of the prejudices people with disabilities face.

Responding to a mental health crisis

The Mental Health Education for Ambulance Services Conference took place at the end of November and the National Mental Health Workforce Development Project originated in response to the NHS Long Term Plan (2019) to improve mental health training in ambulance services. The HEE Mental Health Programme allocated £150,000 to a Workforce Transformation Fund specifically to support development of ‘mental health crisis response capability’ from the ambulance workforce.

From the project, a new training package has been created for all staff to help them feel prepared when attending mental health incidents. This module is a step forward in ensuring all staff entering the ambulance service have access to high quality mental health training at an induction level to help them feel equipped for their new roles.

Employers Network for Equality & Inclusion

The trust has achieved The Employers Network for Equality & Inclusion’s (ENEI) Gold Award for Talent, Inclusion and Diversity Evaluation (TIDE). This accolade comes after we previously achieved silver last year. Out of 155 global entries, and just 13 gold award winners, this is a great achievement for the trust.

TIDE (Talent, Inclusion and Diversity Evaluation) is a benchmarking tool that ENEI has developed to assess organisational performance and progress in relation to diversity and inclusion. TIDE measures organisations against eight different areas of diversity and inclusion practice and this award recognises the progress we have

made to improve the experience of staff from diverse groups and the commitment to keep this focus in place even at times of pressure.

Strep A spike for NHS 111

Our NHS 111 teams have seen huge increases in calls in general recently, as well as spikes in calls from worried parents about potential Strep A infections.

The UK Health Security Agency reported there were 851 cases reported in week 46, compared to an average of 186 for the preceding years. There is considerable variation across England with the highest rates seen in the North West.

In response to the demand at 111, our Communications Team has been working with NHS England to share key messages reminding people to use 111 online for the over 5s, for a timely and efficient response, and to promote good hand hygiene to prevent the spread of infection.

Ambulance Series

Filming of the next series of BBC's 'Ambulance' programme starts soon with crews from Lancashire and Cumbria being the first to take centre stage before the production team move into Greater Manchester in March.

Over the last few weeks, Dragonfly staff have been out and about meeting NWAS staff on stations and in EOCs, while behind the scenes there has been engagement with external stakeholders, completion of risk assessments and fit out of the ambulances to hold the cameras and sound equipment. This has been a whole team effort with staff from operations, HR, rostering, health and safety, infection control and communications, amongst others, to pull the project together.

As always, the issue of patient consent is being managed by Dragonfly, working closely with NWAS, and there are robust procedures to follow to obtain this from patients and/or their families.

In our Thoughts

It is with great sadness that I write to inform you of the death of our colleagues, Ben Lightburn and former colleague Linda Snape

Ben was a paramedic based in Cheshire & Merseyside and had worked for NWAS since 2014 when he joined as an emergency medical technician, later qualifying as a paramedic in 2021. Ben helped many communities in their time of need, showing immense care and compassion to all his patients and was a friend and mentor to many of his colleagues Tragically Ben was killed in a car crash on his way to work on New Year's Day.

Linda was a long serving member of staff who worked for the trust (and formerly Lancashire Ambulance Service) for over 19 years, working initially within emergency planning and then as a fire, safety and security practitioner. Sadly, Linda lost her fight to cancer after battling for three years

The trust sends sincere condolences to the family, colleagues and friends of Ben and Linda.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implications 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 this report

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 25 January 2023					
SUBJECT:	Q3 Board Assurance Framework Review 22/23					
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☒	☒	☒	☒	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☒	☐	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision					
EXECUTIVE SUMMARY:	The Corporate Risk Register detailing all risks scored ≥15 can be seen in Appendix 1 and the proposed Q3 position of the Board Assurance Framework (BAF) with the associated 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) recommend the following Q3 changes (s4): • Increase in risk score of SR01 from 15 to 25 • Decrease in risk score of SR02 from 16 to 12 • Increase in risk score of SR03 from 15 to 25 • Increase in risk score of SR04 from 12 to 16 • Increase in risk score of SR06 from 10 to 15 • Decrease in risk score of SR07 from 12 to 8 • Decrease in risk score of SR09 from 20 to 15					
RECOMMENDATIONS:	The Board of Directors are requested to agree the: • Increase in risk score of SR01 from 15 to 25 • Decrease in risk score of SR02 from 16 to 12 • Increase in risk score of SR03 from 15 to 25 • Increase in risk score of SR04 from 12 to 16 • Increase in risk score of SR06 from 10 to 15 • Decrease in risk score of SR07 from 12 to 8 • Decrease in risk score of SR09 from 20 to 15 • Q3 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 Q3		
	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 Q3 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 in Appendix 1.

4. REVIEW OF THE Q3 BAF POSITION

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**25** 5x5 CxL	C Grant

The risk has increased in risk score following review, with the following rationale provided by the Medical Director and Director of Quality, Innovation and Improvement:

1. Ongoing pressures within NHS111, PTS and 999 services and delivery of ARP standards and excessive waits for Category 2.
2. Escalation to REAP Level 4 and operating daily at Level 4 on Patient Safety Plan.
3. 111 telephony capacity reached on one day due to increased demand.
4. During December, there were an increased number of incidents scored at 4-5 as a result of resource availability and prolonged response times.
5. Industrial action resulted in additional significant organisational operational demands and clinical risk.

6. Pressures impacting on organisational change (SDMR) and delivery of core business activities.

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
20 4x5 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	C Wood

The risk has decreased in risk score following review, with the following rationale applied by the Director of Finance:

1. Identification of full and recurrent efficiency requirements.

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
20 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**25** 5x5 CxL	G Blezard

The risk has increased in risk score following review, with the following rationale applied by the Director of Operations:

1. Increase in pressure within the NHS and hospital handovers which resulted in the escalation to REAP Level 4 due to lost resource hours.
2. Industrial action and reduction in available resources.
3. Increased C1 and C2 long waits and potential patient harm.
4. Increase in call volume for NHS 111 due to prevalent illness and increase in flu and Covid-19.
5. Impact of industrial action has delayed completion of service delivery model review (SDMR).

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
12 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL	L Ward

The risk has increased in risk score following review, with the following rationale applied by the Director of People:

1. Industrial action has impacted on safe staffing levels resulting in a disparity between demand and available resources.

2. Challenging recruitment market has impacted on delivery of recruitment plans for contact centre and corporate roles.

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 4x3 CxL	**10** 5x2 CxL	**15** 5x3 CxL	M Power

The risk has increased in risk score following review, with the following rationale applied by the Director of Quality, Innovation and Improvement:

1. Risks remain associated with assurance reporting and checks compliance for clinical and non-clinical safe systems of work due to winter pressures, REAP Level 4 and capacity to complete assurance checks and rectify actions.
2. ARP performance deteriorated despite CQC 'should do' improvement following recent inspection.
3. Progress to redesign quality assurance visits (QAV) has paused due to development of reporting from safecheck and ensuring clinical audit risks can be mitigated through development of APEX.
4. Resource reallocated to support handover improvement in addition to national asks impacting on capacity to complete risk mitigation work.

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
12 4x3 CxL	**12** 4x3 CxL	**12** 4x2 CxL	**8** 4x2 CxL	S Desai

The risk has decreased in risk score following review, with the following rationale applied by the Director of Strategy, Partnerships and Integration:

1. ICS formalised within the Health and Care Act 2022 from July 2022.
2. External relationships across areas embedded.
3. Effective partnership working with ICB/ICPs.

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**15** 5x3 CxL	M Power

The risk has decreased in risk score following review, with the following rationale applied by the Deputy Director of Quality.

1. Key driver is the patching compliance which is at the highest level seen and well within tolerated limits.
2. There continues to be a high threat of cyber-attacks based on an increased attack surface through ongoing digital change and deployment.
3. Stable period and continued learning from events such as Silver Puncture which has aided the reduction of risk score.
4. Recent MIAA audit on mobile devices demonstrated significant assurance in terms of cyber security.

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 form 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 Q3 BAF Review process.

6. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

7. RECOMMENDATIONS

The Board of Directors are requested to agree the:

- Increase in risk score of SR01 from 15 to 25
- Decrease in risk score of SR02 from 16 to 12
- Increase in risk score of SR03 from 15 to 25
- Increase in risk score of SR04 from 12 to 16
- Increase in risk score of SR06 from 10 to 15
- Decrease in risk score of SR07 from 12 to 8
- Decrease in risk score of SR09 from 20 to 15
- Q3 position of the Board Assurance Framework

APPENDIX 1
Corporate Risk Register

Risk ID	Date Opened	Risk Description	Risk Status	Type	Subtype	Risk Register	Risk Owner	Initial Rating	Risk Treatment	Current Rating	Controls in Place Title	Gaps in Control Title	Assurance in Place	Gaps in Assurance	Last Risk Review	Date Next Review	Target Rating
246	17/11/2020	There is a risk that due to increasing numbers of 999 calls and patient acuity to EOCs, callers may experience call pick up delays resulting in increased emergency response times and negative impact on operational performance standards.	active	Operational	Operational Performance	Corporate Risk Register	Director of Operations	**20**	Treat - Implement controls and mitigating actions to reduce the risk	**15**	Agreed implementation of additional EMD Support Staff from April 2020 and additional staff from September 2021, Performance Management Framework, Call pick up performance data showing improvements as of w/c 17/01/22, Wallboards in EOCs to display call levels and EMD availability, NWAS Patient Safety Plan, EMD training and mentoring, Reduction in duplicate calls, Additional workforce resources for EOCs being managed via NHSE/I, HI reporting enables planning for Building Better Rota's, Ongoing recruitment into 2023., Call pick up action plan (see attached), Continual review of call escalation measures to improve call pick up., Integrated routing platform has gone live reducing the burden of buddy assistance.	NWAS' obligation to provide buddy support for other NHS Ambulance Services during periods of high demand, Unpredicted increased activity from members of the public due to follow-up calls, Increased pressures on the workforce, Increase in call demand/ follow-up calls, NHS pathways is unable to truncate call length., Difficulty in recruiting permanent staff.	National performance data, NWAS Integrated Performance Report, NWAS performance data to Commissioners, Performance Management Framework, Recruitment of 120 EMDs above base line by end of Q3 in 2021., A number of Agency EMDs have been offered fixed term NWAS contracts until end September 2021, Additional recruitment supported by NHSE/I, EMD training will release 40 staff over three sessions to assist with resourcing and mentoring, EOC Procedure for Subsequent Calls (EOC0015) - reviewed September 2021, NWAS Medical Director approved use of Emergency Disconnect via Clinical SMT, A further 140 Call handlers to be recruited by January 2022, BT introduce call scripts for screeening 999 calls for sub/duplicate calls from 28 October 2021 in an attempt to reduce call volume into EOC, Call pick up performance data showing improvements as of w/c 17/01/22, Improved call pick up time have been recorded late January - early February 2022, Call pick up has stablised up to w/c 01/03/2022.	Confirmation of attaining recruitment of 140 ECH's, Patient acuity increased w/c 17/01/22	20/12/2022	20/02/2023	**5**
259	04/07/2022	There is a risk that due to industrial action arising from the national pay dispute, we are unable to provide a safe or effective service leading to risk of serious patient harm.	active	Operational	People	Corporate Risk Register	Medical Director	**16**	Treat - Implement controls and mitigating actions to reduce the risk	**20**	Partnership Agreement, Regular structure of consultation and engagement, Legislation governing conduct of industrial action, National legal advice in place, Sector level NASPF for sector wide engagement, Input to pay review process, Ballot required prior to any action, Existing business continuity plans for disruption to services, Pay award announced, Governance structure, NWAS Governance Structure, National engagement, Derogations agreed, National escalation arrangements in place, Regular stakeholder engagement, Additional clinical oversight of call prioritisation on the day of action, National & local public messaging re use of service, Full command arrangements in place	No direct influence on outcome of pay discussions, Unofficial action or behaviours more difficult to address, Differing TU positions nationally, Impact of national issues on local discussions, Impact of industrial action in other Trusts on delivery of services, Ability of TU to persuade staff to deliver agreed derogations	Previous legal advice on record in respect of dispute management, Clear procedures for TU engagement, Minutes of AACE Steering Group meetings, Business Continuity Plans, Minutes of NASPF meetings, Minutes of NWAS IA meetings, Operation Constant Care Plan, Minutes of Executive Oversight IA meetings, Agreed derogations, Nationally agreed guidance and FAQs	Government position on pay, Current legal advice to address specific industrial relations plans/risk	13/01/2023	20/02/2023	**5**
304	15/09/2022	There is a risk that capacity constraints within the Digital team mean that new ACQI for 'Older people Falls not conveyed' is not included within phase 1 of APEX, and will lead to non-completion and non-submission of clinical audit information and participation within national quality frameworks meaning non-compliance with national clinical reporting standards.	active	Reputational	Clinical Effectiveness	Corporate Risk Register	Director of Quality Innovation & Improvement	**12**	Treat - Implement controls and mitigating actions to reduce the risk	**15**	APEX tool phase 1 is under development	Older persons falls not conveyed determined not in scope for phase 1 Apex, Apex phase 2 has not been commissioned as at 15/09/2022	Agreed at Quality SLT to progress with Falls ACQI, Next available sprint to be reallocated to Falls ACQI		28/10/2022	13/01/2023	**5**

Risk ID	Date Opened	Risk Description	Risk Status	Type	Subtype	Risk Register	Risk Owner	Initial Rating	Risk Treatment	Current Rating	Controls in Place Title	Gaps in Control Title	Assurance in Place	Gaps in Assurance	Last Risk Review	Date Next Review	Target Rating
318	13/07/2022	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	active	Operational	Patient Safety	Corporate Risk Register	Director of Operations	15	Treat - Implement controls and mitigating actions to reduce the risk	15	Trust SOP: Controlled Drugs Standard Operating Procedures 2021-2024 is currently in place., CDs stored on only 40 bases across the Trust footprint and some of these sites meet the required standard., Vehicles are stored with a locked compound where facilities permit, Audits are completed by the Medicines Management Team and the results fed back to the local management teams, Develop improvement plans where possible based upon audit results., Daily/weekly checks are in place for paramedics to complete, Task and finish group has undertaken an assessment of the security arrangements at those sites where CDs are stored, Task & Finish Group - Plan to assess the costs and other factors associated with installation of CCTV	Inability to store all vehicles containing controlled drugs in a locked compound., Inability to comply with the advice to install CCTV covering any room containing CDs or general medicines., Duty to operational pressures there is an inability to conduct the daily vehicle CD check in accordance with the SOPs, Proportionate level of security is unknown for all bases., SOP ; Controlled Drugs Standard Operating Procedures 2021-2024 requires auditing to show compliance levels., No formal risk-based approach agreed to determine proportionate provisions, No funding identified for any security upgrade work to take place, Some estates may not be suitable for storage of CDs	Raised at C & M Level 3 meeting, Escalation to the Medicines Management Team, Home Office conduct regular inspection on a limited number of bases.	Currently no escalation to SMT, ELC, Exact security provisions for each individual base are unknown, No plan to address any gaps	31/10/2022	28/03/2023	5
319	19/07/2022	There is a risk, due to the lack of a detailed emergency response specification for the use of private ambulance providers in the provision of PES, that variations in provision of drugs and associated training results in difficulties regarding assurance checks and could result in medicines not being administered in accordance with NWAS protocols leading to serious patient safety incidents	active	Operational	Patient Safety	Corporate Risk Register	Director of Operations	15	Treat - Implement controls and mitigating actions to reduce the risk	15	Third party framework is in place, Only approved providers vetted by NWAS operate on behalf of the Trust, A contract and specification outlining basic requirements is in place, All TPP are inspected on an annual basis, All TPP staff are issued with an NWAS PIN number upon receipt of DBS and qualification confirmation, Crew qualification linked to the individual's PIN number flags to the EOC dispatcher, TPP inspection process is in place, TPP report all incidents into NWAS, Cross match exercise to assess different external qualifications to NWAS skills has been undertaken	No specification within the current Contract to specify the requirements for PES Drugs., No standard specification for training for PES staff, Currently no audit to ensure than qualifications are kept up to date., No specification to assess new providers for Emergency response work, Limited number of PES vehicle checks undertaken	Working group established to look at the requirement., Reports on third party provider assurance submitted to the PTS Level 3 meeting and a chairs assurance report to the HSSSC, Annual report regarding third party provider assurance submitted to the Quality & Performance Committee, All providers are on a Framework which is vetted by NWAS before they operate on our behalf, Decision has been made that providers must work to NWAS' governance framework	Currently no independent oversight, Assessment processes against new requirements is required, Paper to ELC required to gain approval to implement proposed changes.	31/10/2022	31/01/2023	5
320	04/10/2022	There is a risk due to the current state of repair and lack of structural integrity at St Helen's Ambulance Station that may cause the structure to collapse leading to the potential for staff injury/death and disruption of services.	active	Operational	Estates and Facilities Management	Corporate Risk Register	Director of Operations	15	Treat - Implement controls and mitigating actions to reduce the risk	15	Structural survey undertaken on the 20/09/22 which stated no immediate risk but required urgent immediate work, Tell tales have been installed over the cracks, Remedial works are currently being costed., Email communication has been sent out to the staff to raise awareness.	Currently no timescales for remedial work, Station is still operational with alternative premises for relocation, No remedial action has been taken	Email sent to all staff members raising awareness of the issue, Structural survey received by the Estates Department	Currently no independent oversight	31/10/2022	31/01/2023	5
325	05/07/2022	There is a risk due to a significant vacancy gap and rise in turnover and healthy external job market the HR Hub are unable to recruit and retain resources resulting in unfulfillment of transactional recruitment activity.	active	Operational	People	Corporate Risk Register	Director of People	12	Treat - Implement controls and mitigating actions to reduce the risk	16	Close monitoring of HR Hub workforce, Review of workload distribution, Review budget with Finance to ensure all posts are filled and where possible to recruit permanently at risk	Buoyant labour market will impact on ability to attract and retain staff	Weekly meetings with HR Hub Team Managers, Review of adverts to ensure they are attractive, Linking in with agencies to support attracting applicants	Strategic Workforce Committee	31/10/2022	16/12/2022	4

Risk ID	Date Opened	Risk Description	Risk Status	Type	Subtype	Risk Register	Risk Owner	Initial Rating	Risk Treatment	Current Rating	Controls in Place Title	Gaps in Control Title	Assurance in Place	Gaps in Assurance	Last Risk Review	Date Next Review	Target Rating
327	17/11/2020	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.	active	Operational	Operational Performance	Corporate Sensitive Risk Register	Director of Operations	25	Treat - Implement controls and mitigating actions to reduce the risk	20	Shared learning via AACE and other NHS Ambulance Trusts, Preparatory workforce planning including overtime and recruitment opportunities, Senior operational representation at National level, NWAS representation on monthly conference calls, Implemented Pre-Determined Attendance (PDAs) part of ARP v2.3 and frequent reviews of PDAs, Implemented clinical leadership across all EOCs and Trauma cells, Auto-allocation to improve response times, Management of IFT/ HCP activity, DCA, RRV and ORH Modelling Review Building & Better Rota's Project, Fleet Replacement Programme, Operational Policies & Procedures and Operational Guidance, Operational, Tactical and Strategic Management, Performance Management Framework, Additional resources utilised to support performance, e.g. use of Third Party Providers with increased scope of practice, use of CFRs and PTS supporting PES work, NWAS Communications; use of social media, Clinical Leadership Model, NWAS Operational Performance Calls, ROCC Tactical Commanders & Strategic Commanders, Cancellation of mandatory training & appraisals, NWAS Winter Plan, Engagement with System Leaders & Acute Hospitals, Engagement with NHSE/I, Engagement with NWAS Lead Commissioner, Temporary suspension of Mandatory Training during winter 2021/22, Initiated actions for REAP 4 as agreed by ELC, Review of strategic intentions with increases in pressures., Additional 45 DCAs being utilised as part of Winter Plan, Additional 90 PTS staff being upskilled for PES up to 31 March 2022, Additional funding for 111 Service, Six Point Plan jointly devleoped with Commissioners to cover - Increase Resources, increase Hear and Treat, reduce loss of vehicle hours, Discussions with NHSE re `levelling up` investment, International recruitment is being Project led by NHSEE for NWAS, Australian Paramedics have commenced in post	Confirmation of the receipt of additional finances from Commissioner, Delivery of Urgent and Emergency Care Strategy, Workforce Planning, Awaiting outcome of ORH review, Monthly monitoring by Lead Commissioner to facilitate release of funding, International appointees will not be in post until circa Sept 2022, Current military resources are depleting in stages up to 31/03/2022 following which no further resources will be available., Due to external pressures, REAP level was escalated to REAP 4 24/03/0222	National Performance Data, National ARP Data, ORH Modelling Report, NWAS Integrated Performance Report, NWAS Performance Reports to Commissioners, NWAS Performance Reports to NHSE/I, NWAS Business Cases for Fleet Replacement, NWAS Workforce Indicators Report, National Hospital Handover Performance Data, NWAS Hospital Handover Performance Data to Commissioners, NWAS Hospital Handover Performance Data to NW NHSE/I, NWAS Integrated Performance Report, Hospital Handover Project partly implemented across NW Acutes, Every Minute Matters Project Documentation, £6.23 m investment to cover short-term increase in resources from September 2021 - 31 March 2022, Commissioners and NHSE are engaged in improving ED hospital delays, Buddy system from NHS Ambulance Trusts to alleviate pressures on EOC when required, Financial Investment and Monitoring Winter Plan presentation (30/11/21) provides projections of exenditure, MACCA application approved January 2022, 150 military assets deployed assisting NWAS between January 2022 - 31 March 2022	AACE to simplify the operating model., Continued hospital pressures, No confirmation for re-occurring funding levels for resources from 01 April 2022	31/10/2022	09/01/2023	5
328	17/11/2020	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.	active	Operational	Patient Safety	Corporate Risk Register	Director of Operations	20	Treat - Implement controls and mitigating actions to reduce the risk	25	Every Minute Matters` collaboration with Hospitals to improve handover times, Local management engagement with hospitals within their Sector, NWAS Executive Management engagement with hospitals, Implemented HALOs at hospital sites to improve delays, Hospital Handover Project to reduce delays at hospitals, Installed Hospital Arrival Screens for all hospitals across the NW, A&E Delivery Board with NWAS representation, Attendance at National calls regarding hospital handovers, QI Approach to hospital handover, The Hospital Handover Safety Checklist is supported by the Medical and Quality Directorate and can be used in all Emergency Departments, Attendance at NHSE/I North West Winter Planning Meeting, Attendance at NHSE/I Hospital Handover Delays Review Meetings, Identification of Hospitals to participate in `Every Minute Matters`, NWAS concerns raised with AACE for National level discussion, Strategic meeting chaired by Prof. A Marsh to review delays, NHSE/I and Commissioners taking the lead to reduce hosptial handover times, Escalations with Chief Executive Officers of appropriate Acute Trusts, Hospital outliers escalated to the Regional Director of NHSE, Targeted recovery plans for hospital handover improvements, Continued liaison between NWAS and Acute services (Gold Cell meetings in Cheshire and Mersey Region);, Monitoring is taking place between Acute and CQC 23 joint monitoring arrangements between lead Commissioners and NWAS, National Handover meeting with AACE, Operational Orders being reviewed., Hospital Handover Action Cards to assist with managing a deteriorating patient, Commissioners are leading on working with Acutes and monitoring bi-weekly with NHSE, Roll-out in Cheshire and Merseyside, National Pilot `Rapid Release` at Lancashire Teachng Hospitals (Royal Preston Hospital) as of 01/02/2022, Introduction of NHS Pathways during March 2022 - July 2022 in EOC aimed at reducing A & E journeys & redirect to alternative services, Regional Handover Board - chaired by Maxine Power, Launch of ICS Handover Collaboratives Dec 2022	Unpredictable increases in demand across the Service Directorate, Increased pressure within hospitals are increasing delays for the release of ambulances, DCA vehicle specification for 2023/24 does not include the provision of wheelchairs	.NWAS Hospital Handover Performance Data to Commissioners and NW NHSE/I, NWAS Hospital Handover Safety Checklist developed and being rolled out across the NW. Two sites fully implemented, NWAS Integrated Performance Report, Hospital Handover Project Documentation, ICS Collaborative Project Documentation, Right Care Closer to Home` allocated to SPTLs.	Continued hospital pressures affect NWAS' ability to handover patients in a timely manner, Continued abstraction rates of PES staff remains challenging to provide extra vehicles, National Performance Data, National Hospital Handover Performance Data, NWAS Hospital Handover Process redesign not fully implemented the NW, NWAS Hospital Handover Safety Checklist not fully implemented across the NW, NWAS Hospital Handover Fit2Sit ongoing with Tameside	30/11/2022	30/12/2022	5
329	03/02/2022	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	active	Operational	Patient Safety	Corporate Risk Register	Director of Quality Innovation & Improvement	20	Treat - Implement controls and mitigating actions to reduce the risk	16	Duty of Candour Procedure (Serious Incidents), Duty of Candour Training, Duty of Candour Enactment Documentation, Duty of Candour Documentation in DatixWeb System, Openness and Transparency Questions during Incident Reporting in DatixWeb System, Openness and Transparency Questions during Complaint Handling in DatixWeb System vv, Duty of Candour Questions Available during Incident Management in DatixWeb System, Duty of Candour Questions Available during Complaint Management in DatixWeb System	Inaccuracies within Duty of Candour Procedure, Organisational awareness of Duty of Candour, Enhanced Duty of Candour Training Package, Duty of Candour Repository, Duty of Candour Audits/ Compliance Reviews	Duty of Candour Training Compliance Data, Duty of Candour Compliance Reviews (Serious Incidents)	Duty of Candour Assurance Reporting to Patient Safety Sub Cttee, Duty of Candour procedure requires review	01/11/2022	17/02/2023	4

Risk ID	Date Opened	Risk Description	Risk Status	Type	Subtype	Risk Register	Risk Owner	Initial Rating	Risk Treatment	Current Rating	Controls in Place Title	Gaps in Control Title	Assurance in Place	Gaps in Assurance	Last Risk Review	Date Next Review	Target Rating
330	17/06/2021	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.	active	Operational	Digital and Innovation	Corporate Risk Register	Director of Quality Innovation & Improvement	15	Treat - Implement controls and mitigating actions to reduce the risk	20	Regular Audits undertaken by MIAA, Regular Pen Tests undertaken, Mandatory staff cyber training via ESR, External and internals scans and patching completed as released in hours, Cyber Incident Management Plan/Policy, IT health dashboard enabling real time monitoring of assets, visibility of security threats and vulnerabilities, and assurance around completion of mitigation (e.g. patching and CareCERTs), Cyber essentials Compliant assessment completed (2019 - 2020), Desktop central is utilised for maintaining software updates., Radically reduced the number of servers below 2012 - as of 17/06/2021 25 2008 servers are left, Patching effectiveness is very high. Regular security updates deployed for the latest security patches, New Cyber Security Manager recruited and in place (Oct 2020), New Firewalls were implemented at the end of 2020 offering better security and visibility, New Firewalls were implemented at the end of 2020 offering better security and visibility, Implementation of Mimecast email security service. Protecting NWAS from new and emerging threats through email, Microsoft ATP implemented on all servers. providing protection and visibility. This is monitored by the Trust and NHSD, Mobile Device Management in use to control services on some mobile devices, Anti-virus protection (including malware protection) on both physical and virtual clients/serverâ€™s, Device encryption on all laptops and some mobile devices mobile devices to protect data, Automated daily threat assessment in place for Windows 10, Business Continuity Plans	Admin Accounts have internet access, Out of support software, No SIEM, Lack of uptake in staff security awareness	Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021, Pen Test - External Vulnerability & DSPT Assessment (External) Feb 2021, Pen Test - External Vulnerability & DSPT Assessment (Safe check) Feb 2021, MIAA IT Continuity Audit Dec 2020, MIAA User Privilege Audit Dec 2020, New Cyber Security Manager recruited and in place (Oct 2020), ITHealth Dashboard - brithd01.northwestambulance.nhs.uk, Cyber Essential Certificate, Desktop Central - http://epdskc01.northwestambulance.nhs.uk:2581/homePage.do?actionToCall=homePageDetails, Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of unsupported Operating Systems, Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of patched/unpatched devices and servers, Firewall alerts and dashboard, Mimecast dashboard - https://login-uk.mimecast.com/u/login/?gta=apps&link=/home#/login, ATP Dashboard - https://security.microsoft.com/endpoints/dashboard	Lack of defined KPI's relating to Cyber Security & governance/assurance process, Actions from NHS Digital, Pen Tests & MIAA assessments to be addressed &b monitored, Lack of independent evaluation of security training re Social Engineering, Lack of multiple and immutable backups	01/11/2022	06/01/2023	5
331	17/06/2021	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.	active	Operational	Digital and Innovation	Corporate Risk Register	Director of Quality Innovation & Improvement	12	Treat - Implement controls and mitigating actions to reduce the risk	16	Digital Design Forum, Interoperability Forum, Change Advisory Board - monitoring and reporting, Control and managing product versions., Active fire wall restrictions and monitoring, Advanced threat protection linked to NHS Digital, DPIA Process for all systems, processes and applications, SLSP process for all systems, processes and applications, Logging and monitoring, Risk Management Process	Incomplete Information Asset Register, Not all systems have a completed SLSP or DPIA, Lack of penetration testing on new connections	Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021, Pen Test - External Vulnerability & DSPT Assessment (External) Feb 2021, Pen Test - External Vulnerability & DSPT Assessment (Safe check) Feb 2021, MIAA User Privilege Audit Dec 2020, New Cyber Security Manager recruited and in place (Oct 2020), Digital Design Forum, Firewalls in place, DPIA/SLSP process, Mandatory Training Data Protection Module over 80% compliance reported, Cyber Security Green Room Page, Bi-monthly Cyber Security Forum	Lack of a robust supplier assurance process, No all staff follow the correct route when developing digital solutions	01/11/2022	27/01/2023	4
332	04/05/2022	There is a risk that due to the number of HSS Practitioner vacancies and high level of abstractions within the HSS team, HSS statutory and operation activity will be compromised leading to a lack of assurance and increased staff and patient safety incidents.	active	Operational	Health, Safety and Security	Corporate Risk Register	Director of Quality Innovation & Improvement	12	Treat - Implement controls and mitigating actions to reduce the risk	16	HSS establishment consists of 5 substantive HSS Practitioners, 1 Administrator and 1 Team leader position, Head of Compliance incl HSS is a substantive position, Many staff in org hold NEBOSH/IOSH qualifications in HSS, beyond that of the HSS team	Vacancies are: 3 x HSS Practitioners, Head of Compliance incl HSS is also on long term sick	All vacant posts are substantive, HSSC committee has oversight of HSS team workplan, and associated risks, External reporting requirements such as RIDDOR to the HSE continue to be prioritised, MIAA review of RIDDOR scheduled in for 22/23, Agency support and temporary support arranged and in place, New team structure in place following process of organisational change, Mutual aid requested and given via TU colleagues to help support workplace inspections, Full review of internal process for security and safety audits in train and new standard work being tested, Weekly HSSE Moderation panel of audits across	Recruitment to be initiated for vacant positions	01/11/2022	13/01/2023	4
378	20/12/2022	There is a risk that due to significantly increased demand the Trust will run out of NHS 111 telephony line capacity again, leading to patients not being able to access the service.	active	Operational	Patient Safety	Corporate Risk Register	Director of Quality Innovation & Improvement	25	Treat - Implement controls and mitigating actions to reduce the risk	25	NHS 111 online providing alternative access point	Line capacity already reached at times of high demand, No ability to increase capacity as ISDN lines no longer supported, May impact on 999 call demand, National Contingency Mechanism not available during times of industrial action			20/12/2022	20/02/2023	5
379	20/12/2022	There is a risk that due to the new National Intelligent Routing Platform (IRP) NWAS Digital Team will not be able to fault find or make changes to the 999 telephony platform leading to slower response to telephony issues or outages.	active	Operational	Patient Safety	Corporate Risk Register	Director of Quality Innovation & Improvement	16	Treat - Implement controls and mitigating actions to reduce the risk	16	National IRP Programme Team - oversight with sign-off from AACE, In response to issue, Architecture Review with NWAS CTO and National Team on 19 December 2022 - Emergency Change Control implemented	National Change Control Process not well established., NWAS technical oversight of IRP limited	AACE Reporting and Governance Structures, Architecture Review Documentation	Fully established National Change Control Process with good attendance,	20/12/2022	20/02/2023	4

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2022/23

BOARD OF DIRECTORS – PART 1

25 JANUARY 2023

Q3 2022/23 Reporting Timescales:

Quality & Performance Cttee:	23/01/2023
Resources Cttee:	20/01/2023
Executive Leadership Cttee:	18/01/2023
Audit Cttee:	20/01/2023
Board of Directors:	25/01/2023

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	**25** 5x5 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	**12** 4x3 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	**25** 5x5 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	**16** 4x4 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	**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	**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	**12** 4x3 CxL	**8** 4x2 CxL		**8** 4x2 CxL	**4** 4x1 CxL
SR08: (**Sensitive Risk**)	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 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.	**Resources**	**DoQII**	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**15** 5x3 CxL		**10** 5x2 CxL	**5** 5x1 CxL
SR10: (**Sensitive Risk**)	**Resources**	**DoSPT**	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL		**15** 5x3 CxL	**10** 5x2 CxL
SR11: (**Commercially Sensitive Risk**)	**Resources**	**DoOps**		**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL		**4** 4x1 CxL	**4** 4x1 CxL
SR12: (**Commercially Sensitive Risk**)	**Resources**	**DoOps**			**15** 5x3 CxL	**15** 5x3 CxL		**10** 5x2 CxL	**4** 4x1 CxL

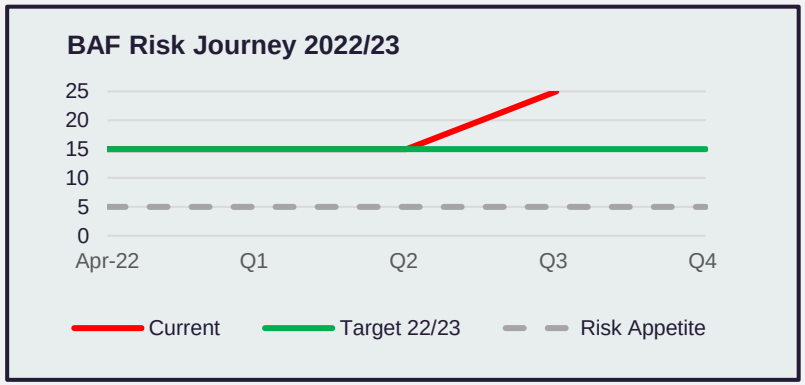
BOARD ASSURANCE FRAMEWORK 2022/23

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	25		15	5
	5x3	5x3	5x3	5x5		5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has increased to 25 due to ongoing pressures across NHS 111, PTS and 999 services that sees delivery against ARP standards an ongoing concern. The greatest clinical risks are deemed to reside in excessive waits in Category 2 incidents. The Trust has escalated to REAP Level 4 for a sustained period and predominantly operates daily at the highest Patient Safety Plan - Level 4. 111 telephony capacity reached a limit on one day due to increased demand. There were an increased number of incidents scored at 4-5 in December linked to lack of available resource and prolonged response times. In addition, national industrial action led to additional significant organisational operational demands and clinical risk. This has an ongoing impact on organisational change (Service Delivery Model Review) and is impacting on delivery of core business activities, including maintenance of good relationships with trade union partners. New risks have been identified linked to handover delays including staff working outside their scope of practice, sub-optimal care whilst waiting and vulnerable patients disproportionately impacted. These risks are being reviewed/processed and will flag against Q4. Resurgence of Covid-19 and emergence of seasonal influenza adds to staff sickness pressures and IPC concerns. In terms of improvement steps, considerable ongoing focus is required to address worsening hospital handover delays and the harm associated with system partnership collaborative sessions held in each ICB in December. Significant work has continued to increase access to falls services and ensure referral routes are available via the DOS. The pilot of the mental health joint response with mental health providers in the EOC has demonstrated a positive impact on increased hear and treat.

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/100) Reported to BoD (PBM/ 2223/65) Reported to Q&P Cttee (QPC/ 2223/148) Reported to Q&P Cttee (QPC/ 2223/122) Reported to Q&P Cttee (QPC/ 2223/149)
Clinical Audit	**Level 2:** 2022/23 Clinical Audit Plan	Reported to Q&P Cttee (QPC/ 2223/142)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework **Level 2:** IPC Sub Cttee Chairs Assurance Report **Level 2:** IPC Annual Report	Reported to Q&P Cttee (QPC/ 2223/53) Reported to Q&P Cttee (QPC/ 2223/123) Reported to Q&P Cttee (QPC/ 2223/97)
Digital Capture and Monitoring of Clinical Outcomes	**Level 2:** Clinical Effectiveness Sub Cttee Chairs Assurance Report	Reported to Q&P Cttee (QPC/2223/100)
Safety Culture	**Level 2:** Q&P Chairs Assurance Report	Reported to BoD (BoD/2223/59)
Single Primary Triage	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/2223/73)
Winter Plan	**Level 2:** NWAS Winter Plan	Reported to BoD (BoD/2223/76)
Constant Care Action Plan	**Level 2**: NWAS Operation Constant Care Plan 2022	Reported to ELC (ELC/2223/311)
Duty of Candour	**Level 2:** Duty of Candour Policy	Reported to ELC (ELC/2223/381)

Learning Disability and Austim Plan	**Level 2:** Learning Disability and Autism Assurance Report	Reported to Q&P Cttee (QPC/2223/145)			
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	2023/24	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
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	In Progress
Digital Capacity 111 Telephony Capacity	Implementation of SIP Telephony	Prof M Power	March 2024	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
259	Operational/ Patient Safety	There is a risk that due to industrial action arising from the national pay dispute, we are unable to provide a safe or effective service leading to risk of serious patient harm.	16 High	20 High	↑	5 low
319	Operational/ Patient Safety	There is a risk, due to the lack of a detailed emergency response specification for the use of private ambulance providers in the provision of PES, that variations in provision of drugs and associated training results in difficulties regarding assurance checks and could result in medicines not being administered in accordance with NWAS protocols leading to serious patient safety incidents	12 Moderate	15 High	⇔	5 Low
328	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	25 High	↑	5 Low
329	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
332	Operational/ Health, Safety & Safety	There is a risk that due to the number of HSS Practitioner vacancies and high level of abstractions within the HSS team, HSS statutory and operation activity will be compromised leading to a lack of assurance and increased staff and patient safety incidents.	12 Moderate	16 High	↑	4 Low
378	Operational/ Patient Safety	There is a risk that due to significantly increased demand the Trust will run out of NHS 111 telephony line capacity again, leading to patients not being able to access the service.	25 High	25 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	12		16	8
	4x5	4x4	4x4	4x3		4x4	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Within		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF has reduced to a score of 12. The revised and break-even plan was submitted and approved by Board in July with a high efficiency requirement of 4.18%. As at month 8, the latest reported position, financial performance is on plan with a small surplus to date. The full requirement of £15.5m has been identified with £9.4m achieved as at month 8. The recurrent efficiency target of £8.2m has been fully identified. There is also the continued risk in relation to the raising energy costs which is being closely monitored and the impact of the change in discount rate.

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)
Reviewed 2022/23 Financial Plans	**Level 2:** Update and approval of Financial Plans 2022/23	Reported to BoD and Resources Cttee (RC/2223/28 & PBM/2223/30)
Financial Performance	**Level 2:** M06 Financial Position **Level 2:** M07 Financial Position	Reported to ELC (ELC/ 2223/309) Reported to Resources Cttee (RC/2223/89)
2022/23 Planning Guidance from NHSEI	**Level 2:** Update and approval of Financial Plans 2022/23	Reported to BoD and Resources Cttee (RC/2223/28 & PBM/2223/30)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	February 2023	Resources Cttee	In Progress
Recurrent Funding	Recurrent funding requirement to PES and 111 to deliver safe & effective services	Ms C Wood	February 2023	Resources Cttee	In Progress
2023/24 Financial Planning	Receipt of 2023/24 Planning Guidance from NHSEI	Ms C Wood	January 2023	Resources Cttee	In Progress
	Draft 2023/24 Financial Plan (Revenue & Capital)	Ms C Wood	March 2023	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						
ERM 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 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	25		15	5
	5x4	5x3	5x3	5x5		5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of the BAF risk has increased to a score of 25 due to hospital handovers and the increasing pressure within the NHS. During Q3, the Trust escalated to REAP Level 4 as a result of increased lost resource hours due to handover delays. This has been compounded by industrial action. This has led to reduced availability of resources and increased C1 and C2 long waits (999) and potential patient harm. However there have been continued improvements in hear and treat which has improved up to 19%. For NHS 111 performance, there has been a significant increase in call volume (doubled) due to RSV, Strep A and as a result of prevalent illness and infection such as increases in flu and Covid 19. Contract discussions are ongoing with a view to having more financial resources available to the Trust. Due to ongoing industrial action during Q4, this will impact on the completion of the service delivery model review (SDMR).

CONTROLS	ASSURANCES	EVIDENCE
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/ 2223/31)
Single Primary Triage System	**Level 2:** Integrated Performance Report (IPR) **Level 2:** CEO Board of Directors Report	Reported to Q&P (Q&P/2223/95) Reported to BoD (BoD/2223/72)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	March 2023	ELC	In Progress
	Engagement with Commissioners surrounding NHS111 contracts	Mr G Blezard	March 2023	ELC	In Progress
	Engagement with Commissioners surrounding PTS 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	May 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						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
328	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	25 High		5 Low
327	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
379	Operational/ Patient Safety	There is a risk that due to the new National Intelligent Routing Platform (IRP) NWAS Digital Team will not be able to fault find or make changes to the 999 telephony platform leading to slower response to telephony issues or outages.	16 High	16 High	New Risk	4 Low

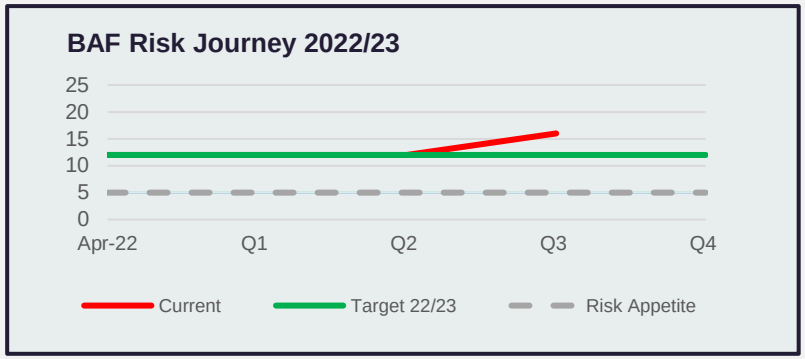
BOARD ASSURANCE FRAMEWORK 2022/23

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	16		12	4
	4x3	4x3	4x3	4x4		4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has increased to a score of 16. In the main as result of the impact of industrial action on safe staffing levels and the disparity between demand and available resources seen throughout the latter stages of Q3 and continuation into Q4. Robust workforce and recruitment/training plans in place but Q3 has started to see some impact on delivery of plans in light of the challenging recruitment market, this has particularly impacted on contact centre and corporate recruitment. Actions in place to maximise course fulfilment in place but plans not fully met in Q3. 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. PES vacancy position remains strong with substantive staffing, other vacancy positions are improving. AITs are in place to support improvement in attendance.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/ 2223/12, 2223/86)
Workforce Plan	**Level 2:** Operating Plan Submission	Reported to Resources Cttee (RC/ 2223/07)
Recruitment Delivery Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Strategic Workforce Assurance Report	Reported to Resources Cttee (RC/ 2223/85) Reported to Resources Cttee (RC/2223/41, 2223/70)
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report **Level 2**: Integrated Performance Report	Reported to Resources Cttee (RC/ 2223/13, 2223/39, 2223/67) Reported to BoD (BOD/2223/33, 2223/56, 2223/73)
Attendance	**Level 2:** Thematic Analysis: Attendance Management **Level 2:** Strategic Workforce Assurance Report	Reported to Resources Cttee (RC/ 2223/11) Reported to Resources Cttee (RC/2223/41, 2223/70)
Vaccination	**Level 2:** Vaccination Report 2022/23	Reported to BoD & Resources Cttee (RC/2223/68)
Retention	**Level 2:** Strategic Workforce Assurance Report **Level 2:** Deep Dive 111 Retention	Reported to Resources Cttee (RC/ 2223/84)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of Q3 Recruitment Plans	Ms L Ward	January 2023	Resources Cttee	In Progress
	Delivery of Q4 Recruitment Plans	Ms L Ward	March 2023	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	In Progress
Retention Plans	Delivery of Retention Plans	Ms L Ward	March 2023	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
332	Operational/ Health, Safety & Security	There is a risk that due to the number of HSS Practitioner vacancies and high level of abstractions within the HSS team, HSS statutory and operation activity will be compromised leading to a lack of assurance and increased staff and patient safety incidents.	12 Moderate	16 High	⇔	4 Low
325	Operational /People	There is a risk due to a significant vacancy gap and rise in turnover and healthy external job market the HR Hub are unable to recruit and retain resources resulting in unfulfillment of transactional recruitment activity.	12 Moderate	16 High	⇔	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	12		12	4
	4x3	4x3	4x3	4x3		4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has maintained at a score of 12. 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 for 2021 and NQPS have 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 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. However, the continuing high levels of demand combined with the additional operational pressures of industrial action are impacting on the roll out of initiatives and the experience of staff in work on a day to day basis, affecting impact.

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 **Level 2:** Wellbeing Annual Report **Level 2:** Health and Wellbeing Report	Reported to Resources Cttee (RC/ 2223/39, 2223/67, 2223/85) Reported to Resources Cttee (RC/ 2223/40) Reported to Resources Cttee (RC/2223/87)
CULTURE		
Equality & Diversity Priorities	**Level 2:** EDI Annual Report **Level 2:** D&I Chairs Assurance Report **Level 2:** EDI Assurance Report	Reported to BoD & Resources Cttee (RC/ 2223/14) Reported to Resources Cttee (RC/ 2223/88) Reported to BoD & Resources Cttee (RC/ 2223/69)
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/ 2223/88)
Just Culture & Treat Me Right	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2223/85)
Violence and Aggression	**Level 2:** Violence and Aggression Assurance Report	Reported to Q&P Cttee (QPC/ 2223/52)
Leadership	**Level 2:** Strategic Workforce Assurance Report	Reported to Resources Cttee (RC/2223/41, 2223/70)
Implementation of Phase 1 Management Restructure	**Level 2:** Strategic Updates and Proposals to ELC	Reported to ELC (ELC/2223/231)
EDI Priorities Review of Delivery Year 1 Action Plans (Workforce Elements)	**Level 2:** EDI Statutory and Regulatory Reporting	Reported to Resources Cttee (RC 2223/69)
Freedom to Speak Up (FTSU) Delivery of Agreed Actions	**Level 2:**Freedom to Speak Up Bi-Annual Report	Reported to BoD (BoD/ 2223/95)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	March 2023	ELC	In Progress
EDI Priorities	Review delivery of Year 2 Action Plans (Workforce Elements)	Ms L Ward	May 2023	Resources Cttee	In Progress

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	January 2023	Resources Cttee	In Progress
	Implementation of Disciplinary Procedure	Ms L Ward	April 2023	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	April 2023	ELC	In Progress
Evaluation of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	March 2023	Resources Cttee	In Progress
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 mental 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**
259	Operational/ Patient Safety	There is a risk that due to industrial action arising from the national pay dispute, we are unable to provide a safe or effective service leading to risk of serious patient harm.	16 High	20 High		5 low

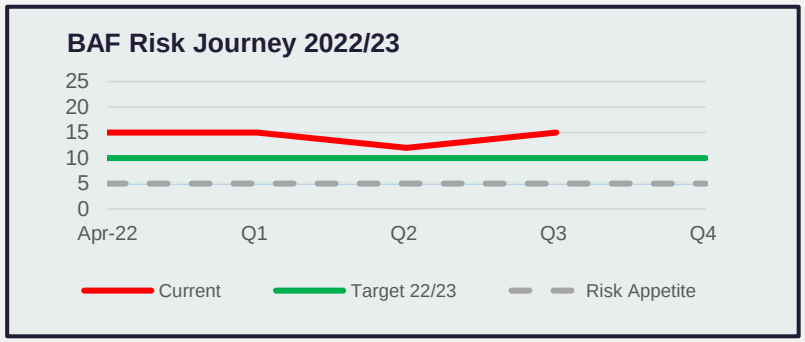
BOARD ASSURANCE FRAMEWORK 2022/23

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	15		10	5
	5x3	5x3	5x2	5x3		5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has returned to a 15 due to the increase in risks which remain associated with assurance reporting and checks compliance for both clinical and non-clinical safe systems of work which have been impacted by winter pressures, REAP Level 4 and available capacity to complete assurance tasks and rectification actions. Further ARP performance has deteriorated despite the CQC 'should do' for improvement in this area following the recent inspection. A revised Duty of Candour Policy is in train and the new medical devices oversight group has commenced following learning from the CQC inspection and new audit systems and SOPs are now in place for ambulance cleaning and work continues for embedding these areas including new processes for cleaning following exposure to dangerous substances such as asbestos. Progress to redesign our internal quality assurance visits (QAVs) programme in line with the new regulatory model has had to pause as has work to develop routine reporting from SafeCheck and ensure clinical audit risks can be mitigated through the development of the APEX tool following the EPR implementation whilst resource has been reallocated to support handover improvement and due to growth in short notice national asks impacting on capacity to complete the risk mitigation work.

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)
Complaints & Incidents	**Level 2:** Integrated Performance Report	Reported to Q&P Cttee (QPC/2223/95) Reported to Board (BOD/2223/73)
Medical Devices	**Level 2:** CESC Chairs Assurance Report	Reported to Q&P Cttee (QPC/2223/149)
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)
Mandatory and Statutory Training Compliance (75%)	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2223/39)
Quality and Safety Metrics (Complaints and Incidents)	**Level 2:** Complaints and Incidents Assurance Report	Reported to Q&P Cttee (QPC/2223/143)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					

Quality Assurance Processes	Redesign of Quality Assurance Visits	Prof M Power	September 2023	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Ms C Wood	September 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	Overdue
	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	June 2022	Q&P Cttee	Overdue
	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	September 2023	Q&P Cttee	In Progress
PEOPLE					
Appraisals Compliance	Achieve 80% compliance	Ms L Ward	March 2023	Resources Cttee	In Progress
Mandatory Training Compliance	Achieve 85% compliance	Ms L Ward	March 2023	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**
304	Reputational/ Clinical Effectiveness	There is a risk that capacity constraints within the Digital team mean that new ACQI for 'Older people Falls not conveyed' is not included within phase 1 of APEX, and will lead to non-completion and non-submission of clinical audit information and participation within national quality frameworks meaning non-compliance with national clinical reporting standards.	12 Moderate	15 High	↑	4 Low
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
320	Operational/Estates and Facilities Management	There is a risk due to the current state of repair and lack of structural integrity at St Helen's Ambulance Station that may cause the structure to collapse leading to the potential for staff injury/death and disruption of services.	15 High	15 High	⇔	5 Low
328	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	**25** High	↑	**5** Low
329	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
332	Operational/ Health, Safety & Security	There is a risk that due to the number of HSS Practitioner vacancies and high level of abstractions within the HSS team, HSS statutory and operation activity will be compromised leading to a lack of assurance and increased staff and patient safety incidents.	**12** Moderate	**16** High	⇔	**4** Low

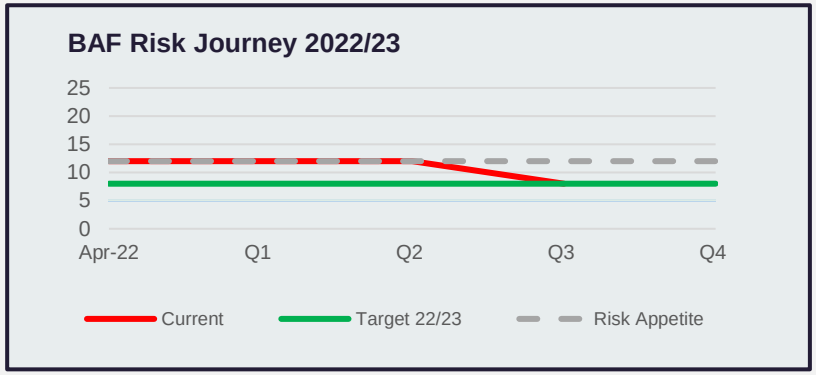
BOARD ASSURANCE FRAMEWORK 2022/23

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	12	8		8	4
	4x3	4x3	4x3	4x2		4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within	Within	Within		Within	Below

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has decreased to a score of 8 due to associated new structures and work programmes being proactively progressed by the Trust which will assist to ensure the 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
	Familiarisation sessions for managers across all three areas of the Trust	Mr S Desai	Q2	Resources Cttee	In Progress
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						

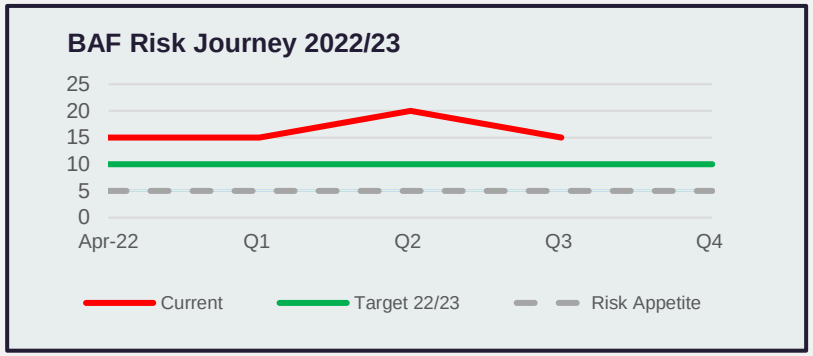
BOARD ASSURANCE FRAMEWORK 2022/23

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	20	15		10	5
	5x3	5x3	5x4	5x3		5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 position of this BAF risk has decreased to a score of 15. The key driver to this change is stemmed from our patching compliance, which is currently at the highest level seen and well within tolerated limits. There continues to be a high threat of a cyber-attacks, which is based on an increased attack surface through ongoing digital change and deployment. We have seen a stable period in the previous quarter and continue to receive and learn from events such as Silver Puncture, this has aided the reduction in likelihood score. The Trust continues to have a high standard of oversight and processes for cyber security. A desk top exercise has been undertaken with the resilience team and an options appraisal completed to increase resilience, follow up actions are in progress. The Trust continues to be responsive to nationally issued guidance and is progressing the cyber security work plan. Multifactorial authentication has concluded with deployment across the Trust and completion in Q2. A new backup solution has been implemented and our focus remains on closing unsupported servers (2008). A recent MIAA audit on mobile devices has demonstrated significant assurance in terms of our cyber security.

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)
Additional Back-ups	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (AC/2223/42)
Access Controls Multi factoral Authentication (email)	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (AC/2223/42)
Develop business case for 24/7 support	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/72)
Business Continuity Team to desktop worst case scenario	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/72)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Critical System Security	Implement recommendations from MIAA Internal Audit for Cleric	Prof M Power	March 2023	Audit Cttee	In Progress
Supported Systems	Decomission unsupported servers (2008) and (2008 R2)	Prof M Power	March 2023	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

	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
	Meet Multi-Factoral Authentication solution on remote access	Prof M Power	March 2024	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	Implement recommendations from desktop worst case scenario	Prof M Power	March 2023	Audit Cttee	In Progress

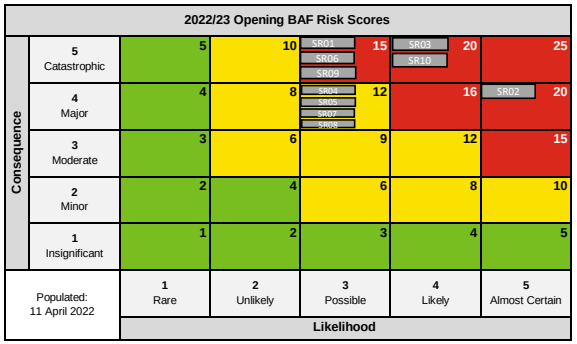
Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
330	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust 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	20 High	⇔	5 Low
331	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

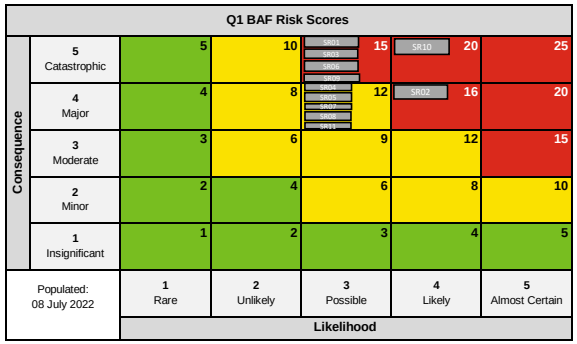
Appendix 2:

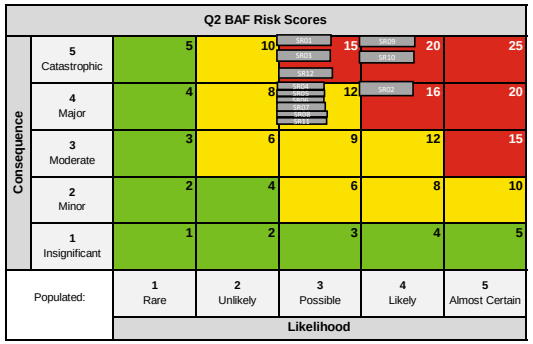
2022/23 Board Assurance Framework (BAF) Heat Maps

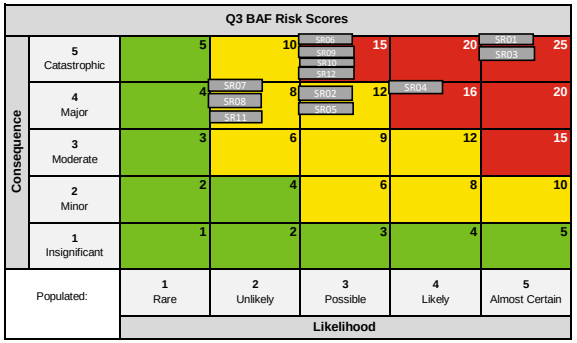
Q1 Position

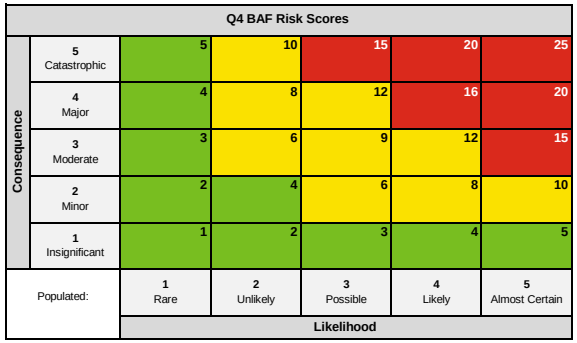
NHS North West Ambulance Service NHS Trust

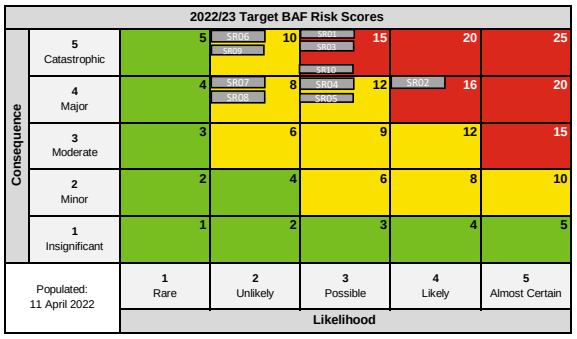


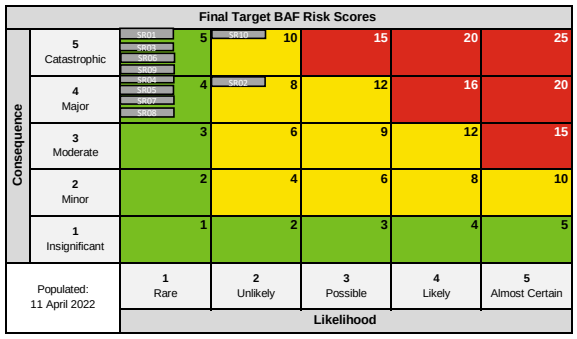












NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25th January 2023					
SUBJECT:	Board and Committee Calendar 2023/24					
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☒	☒	☒	☒	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☒	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision					
EXECUTIVE SUMMARY:	The proposed meetings dates for 2023/24 for the Board of Directors and its Committees can be seen in s3 of the report. These dates have been shared with Committee Chairs and Executive colleagues for agreement prior to presenting to Board.					
RECOMMENDATIONS:	The Board of Directors are requested to approve the Corporate Calendar 2023/24.					
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:				
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to present the proposed Board of Directors and Committee dates for 2023/24 for approval.

2. BACKGROUND

Following circulation of the draft dates in December 2022, the Corporate Calendar for 2023/24 has taken into consideration any feedback received from Board members.

3. CORPORATE CALENDAR 2023/24

Meeting	Dates
Board of Directors 9.45 am – 3.00 pm Bi-Monthly	26th April (short meeting) 31st May 21st June (Year End) 26th July 27th September 29th November 31st January 27th March
Board Development 9.30 am – 4.30 pm Bi-Monthly	26th April (timing tbc) 28th June 25th October 13th December 28th February
Charitable Funds Committee 10.00am – 11.30am Quarterly	19th April 19th July 18th October 17th January
Nominations and Remuneration Committee 9.00 am – 9.45 am Bi-Monthly when required	31st May 26th July 27th September 29th November 31st January 27th March
Audit Committee 10.00 am – 12.00 pm Quarterly	21st April 19th May 21st June (Year End) 21st July 20th October 19th January
Quality and Performance Committee 1.00 pm – 4.00 pm Monthly	24th April 22nd May 26th June 24th July 25th September 23rd October 27th November 29th January 26th February 25th March

Resources Committee 10.00 am – 1.00 pm Bi-Monthly	26th May 21st July (1.00pm – 4.00pm) 22nd September 24th November 26th January 22nd March

Membership of Committees will be reported to the Board of Directors in March 2023. Diary invites have been distributed to all Board Members for all meetings based on the current membership and will be updated accordingly in the event of any changes.

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

There are no specific legal implications, however there are governance and regulatory implications in terms of the establishment and membership of Board committees.

5. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the Corporate Calendar 2023/24.

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	20th January 2023	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Dr A Chambers, Non-Executive Director Ms C Butterworth, Non-Executive Director Prof A Esmail, Non-Executive Director	**Key Members Not Present:**	
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Chairs Assurance Report – Quality and Performance Committee	The Committee received the reports from the meetings held on 26th September 2022 and 24th October 2022.	Noted the assurance provided.	
Clinical Audit Progress Report Q2 2022/23	The Clinical Audit Progress Report for Q2 was presented to the Committee.	Noted the assurance provided.	
Audit Review Update – Team Rostering (Cheshire and Mersey)	The Area Director for Cheshire and Mersey attended to present a report providing an update against the nine agreed MIAA recommendations.	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

Critical and High Risk Recommendations	MIAA continue to follow up recommendations as follows: • The outstanding Freedom to Speak Up recommendation remains partially implemented with a revised due date of March 2023. • The Stock Management – Vehicle Workshops recommendation is partially implemented with a revised target date of April 2023. • In relation to Cleric 111 recommendation remains partially complete with a revised target date of January 2023. • Team Rostering (C&M) recommendation confirmed as partially complete with a revised target date of March 2023.	Noted the update provided.	
Internal Audit Progress Report Q3 2022/23	The Committee noted the assurance reviews completed within Q3: DBS Checks - Substantial Assurance IMT Mobile Devices – Substantial Assurance	Noted the assurance provided.	
Review of HFMA Improving NHS Financial Sustainability Checklist	The Committee received MIAA's assessment of the HFMA checklist Improving NHS Financial Sustainability; are you getting the basics right? MIAAs review provided an objective and unbiased assessment of the Trust's self-assessment against the checklist.	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

	The Committee noted MIAA were assured evidence was in place to support the self-assessment and where improvement actions were identified, actions plans with deadline dates were provided.		
Internal Audit Follow Up	The Committee noted the progress within the reporting period and that 8 recommendations were completed during the period. It was agreed the Committee would seek further assurance to the next meeting in relation to the partially complete recommendation relating to PTS Critical Apps, should no further progress be identified by MIAA.	Noted the assurance provided.	
Anti-Fraud Progress Report Q3 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 assurance provided.	
External Audit Progress Report and Technical Update	Progress report received detailing progress of the Trust's 2022/23 external audit.	Noted the assurance provided.	
Board Assurance Framework Q3 2022/23	The Committee received the updated BAF prior to submission to the Board of Directors for approval on 25th January 2023. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurance provided.	
Losses and Compensation Report Q3 2022/23	Losses and compensation for Q3 2022/23 totalled £870k.	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

Formal Assessment of External Auditors	The Committee received the outcome of the formal assessment of the effectiveness of the External Auditors.	Noted the assurance provided.	
Code of Governance for NHS Provider Trusts	The Committee received the outcome of mapping exercise undertaken to identify the additional or revised provisions of the updated code of governance where corporate governance processes will need to be strengthened in order to declare full compliance at the end of 2023/24.	Noted the assurance provided.	
Waiver of Standing Orders Q3 2022/23	A total of six waivers were approved during Q3 2022/23. The Committee noted all waivers requested had been approved in line with the Scheme of Delegation.	Noted the assurance provided.	
MIAA 2022/23 Checklist Series – Fit and Proper Persons	The Committee received the Trust's response to MIAAs checklist for Fit and Proper Persons to support NHS organisations ensure sufficient, effective processes together with governance arrangements are in place.	Noted the assurance provided.	
Chairs Assurance Report – Resources Committee	The Committee received the report from the meeting held on 25th November 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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25th January 2023.					
SUBJECT:	Integrated Performance Report					
PRESENTED BY:	Deputy Director of Quality, Innovation and Improvement					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☒	☐	☐	☐
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	The Integrated Performance Report for January 2023 shows performance on Quality, Effectiveness, Operational Performance, Finance and Organisational Health during **December 2022** unless otherwise stated. **Quality** • 158 complaints were received, against a 12-month average of 162 per month. • 83% of complaints risk scored 1-3 were closed within the agreed time frame with the data signalling improvement • The accumulation of complaints has significantly improved and has been below 40 since the middle of August. • During December 2022 there were 8 serious incidents reported on the StEIS database. • In December 2022, 1,030 internal and external incidents were opened with no incidents still to be risk scored. • There were 82 incidents risk scored 4-5 which represents a significant increase and signals a likely higher number of SIs will be reported once reviewed • A review of incidents risk scored 4-5 for the last two weeks of December has been undertaken **Effectiveness** • **Patient experience:** Satisfaction has grown from the last reporting period for PES (now at 88.9%). For PTS we have seen a small drop in satisfaction levels (now at 91.3%). • The NHS 111 service has seen a substantial drop in the number of responses (69.46% compared to the last reporting period) combined with a small drop in satisfaction levels (1.10%). This large drop in returns is attributed to delivery and collection issues associated with the postal strikes.						

- For NHS 111 First the current cumulative experience rating of patients who described their experience as 'very good/good' is 85.02% (April 2022 to December 2022). At the end of the last financial year, March 2022, the cumulative rating was that 92.68% of patients felt their need for calling the service was met. This currently stands at 90.63%.
- **Ambulance Clinical Quality Indicators (ACQI's):** There is no significant change in the ACQI indicators apart from the stroke care bundle which is on the lower limit.
- The STEMI care bundles were not reported for this month.
- **H&T, S&T, S&C:** For December we achieved 17.7% Hear & Treat, 29% See & Treat and an aggregate non-conveyance of 46.7%. Hear & Treat along with See & Convey AE and Non AE show special cause in December. This signals a significant increase in Hear & Treat and reduction in See & Treat, See & Convey AE and Non AE.

Patient Emergency Service (PES)

- **Activity:** In December 2022, the Trust received 156,347 calls of which 92,997 became incidents.
- **Call Pick Up** has been adversely affected by staff abstractions increased sickness and increased demand. Performance was 55.3% (target 95%) and has deteriorated from the November 2022 position. The mean pick up time for December was 82 seconds (1 minute 22 seconds) and the 95th percentile, 285 seconds (4 minutes 45 seconds). Both call pick up and pick up in 5 show special cause in December.
- **Ambulance Response (ARP) Performance**

	Standard	Actual
C1 (Mean)	7:00	9:58
C1 (90th)	15:00	16:56
C2 (Mean)	18:00	1:12:11
C2 (90th)	40:00	2:45:19
C3 (Mean)	1:00:00	5:16:07
C3 (90th)	2:00:00	12:52:41
C4 (90th)	3:00:00	15:52:25

- **Handover**: Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 58:51. 11,717 attendances (26.8%) had a turnaround time of over 1 hour, with 2,116 of those taking more than 3 hours. There were 1,775 delayed admissions in December, with total accumulated hours of 4,659.
- A system wide improvement plan to look at handover performance continues to progress and collaborative sessions took place in December.
- **C1 & C2 Long Waits:** The number of C1 and C2 long waits have increased in December compared to the previous the previous months.

NHS 111

	Standard	Actual
Calls Within 60s	95%	23.77%
Average Time to answer		28m 31s
Abandoned Calls	<5%	42.8%
Call back Within 10 min	75%	5.24%
Call back Within 20 min	90%	7.33%
Average Call Back		2 hours
Warm Transfer to Nurse	75%	8.42%

- Safety measures are in place. Demand increased, primarily due to the Government and NHS guidelines on Strep A care, winter pressures, Industrial action and a rise in 'in-hour' requirement.
- Average call to answer time, calls abandoned and call back in 20 show special cause in December.

PTS

- PTS performance is reported one month in arrears. Activity in November was 9% below contract baselines. Year to date July 2022 - November 2022) is performing at 14% below baseline.

Finance

- The year to date expenditure on agency is £3.56m which is £0.009m below the year to date ceiling of £3.56m.
- As at month 9 (December) the trust is recording a surplus position for the year to date of £0.751m.
- As at month 9 (December) the trust has delivered the planned level of efficiency of £10.5m.

Organisational Health

- **Sickness**: The overall sickness absence rate for the latest reporting month (November 2022) was 8.64%.
- **Turnover** has increased to 12.28%. All service lines have seen a slight increase in turnover. PES turnover is showing an upward trend but remains low in comparison with other service lines.
- **Appraisal:** The overall appraisal completion increased to 81.9%.
- **Mandatory Training:** Overall compliance is slightly behind trajectory but not a cause for concern.

RECOMMENDATIONS:

The Board of Directors are asked to:

- Note the content of the report
- Note the improvements seen in complaints handling times
- Note pressures on performance with handover times increased
- Note that SI's are within normal limits however there has been a significant increase in incidents risk scored 4-5
- Note that a learning review has been undertaken of these incidents
- Note that long waits for C1 & C2 have increased in December
- Note the improvements in Hear & Treat and reduction in See and Convey AE and Non AE.

	• 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:				
	Date:			
	Outcome:			

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1 PURPOSE

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

- 158 complaints were received, against a 12-month average of 162 per month.
- 83% of complaints risk scored 1-3 were closed within agreed timeframes. The data is signalling a more consistent and improved complaint handling position. The continued use of the rapid closure process is leading to an improvement in those complaints closed within SLA (Figure Q1.5) which is showing a new phase.
- The accumulation of complaints continues to reduce which releases capacity within the team to provide greater focus on responding to complaints and begin to improve the quality of the written responses.
- Trajectories have been agreed to maintain open complaints below 180 with an allowance of less than 50% within the accumulation. The accumulation has been less than 50 since July and less than 40 since the middle of August with there being 32 in the final week of December.
- 50% of level 4-5 complaints were closed within the agreed time frames.
- 65 Compliments were received in December. This number is lower than the previous two months (October, 127, November 89). The number reported for December is likely to increase as compliments continue to be processed.
- During December 2022 there were 8 serious incidents reported on the StEIS database, this continues to be significantly lower than the 20 serious incidents reported in January and the second consecutive month of improvement and remains within normal control limits.
- In December 2022, 1,030 internal and external incidents were opened against a 12-month average of 1,116.
- There were 82 incidents risk scored 4-5 which represents a significant increase and signals a likely higher number of SIs will be reported once reviewed.
- Incidents opened with a risk score 1-3 are signalling a change with a new phase being created. Incidents opened with a risk score 4-5 are signalling a change with a new phase being created. Following the launch of DCIQ, the Incident Management Team have been undertaking an initial triage of the incident reported, risk scoring before allocating to service lines for review and, if necessary, investigation.

- Incidents risk scored 1-3 completed within SLA is showing special cause signalling improvement for the last six months. Since July 2022, the appointment of a new Incidents Coordinator has continued to collaboratively work with services lines on lower risk scored incidents leading to an improved position
- The 8 most common themes for incidents reported since the introduction of Datix IQ in October, were delays (475), call handling (335), care and treatment (257), accidents and injuries (214), violence and aggression (205), communication (191), road traffic collisions with vehicle (115) and medicines: general (88).

2.2 Effectiveness

Patient experience

- The 280 PES responses are 13.58% lower in number compared to the last reporting period (324). Supporting comments have also decreased by 15.35% (241 to 204). The overall experience score for December of 88.9% is 2.81% higher (previously 86.4%).
- For PTS the 1,165 responses are 5.75% lower in number compared to the last reporting period (1165). Supporting comments have also decreased by 12.07% (944 to 830). The overall experience score for December of 91.3% is 1.20% lower (previously 92.4%).
- The NHS 111 service has seen a substantial drop in the number of responses (69.46% compared to the last reporting period) combined with a small drop in satisfaction levels (1.10%). This large drop in returns is attributed to delivery and collection issues associated with the postal strikes. NHS 111 patient experience surveys are still processed via post whereas our other service lines have all moved to digital surveys. The NHS 111 survey is nationally mandated, but we understand is currently under review.
- For NHS 111 First the current cumulative experience rating of patients who described their experience as 'very good/good' is 85.02% (April 2022 to December 2022). At the end of March 2022, the cumulative rating was that 92.68% of patients felt their need for calling the service was met. This currently stands at 90.63%.

Ambulance Clinical Quality Indicators (ACQI's)

August 2022's data see us within normal limits and close to the mean across all indicators apart from the Stroke and which is on the lower limit. The STEMI care bundle was not reported for this month (latest is July). 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 42.4% (national mean 48%). For the overall group the rate was 17.8% (national mean 25.6%).
- Survival to Discharge rates in August 2022 were at 5.6% (national mean 8.0%).
- In June 15.2% of patients in the Utstein group survived to hospital discharge. The national mean at 25.1%.
- Mean call to PPCI time in August for patients suffering a myocardial infarction was above the national mean of 2h 42mins; 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 41mins. The trusts performance was 1h 32mins.

- The Stroke Care Bundle performance for August was 96.3%. The national mean at 95.9%
- The Stemi Care Bundle performance was not reported for August in line with the NHSE schedule.

Hear & Treat, See & Treat, See & Convey

- For December we achieved 17% Hear & Treat and ranked 2nd nationally.
- See & Treat we achieved 29% and we are ranked 11th nationally.
- In total there was an aggregate non-conveyance of 46.7%.

Hear & Treat data points are showing an upward trend and moved into a new phase at the beginning of December. Weekly hear & treat figures in December are over 16%, with 1 week at 18.8% in special cause over the new phased upper control limit.

Hear & Treat continues to improve as demonstrated by the number of data points signalling positive special cause variation. The improvement is being generated through internal NWAS CHUB and EMA efficiencies which is increasing the volume of secondary triage and conversion to Hear and Treat. EMA Hear and Treat continues to run at around 5% of calls triaged with the CHUB providing the significant majority of remaining Hear & Treat . CAS capacity for 999 referrals has decreased. This is due to the increase of 111 online and locality referrals into the local CAS.

As respond standards deteriorate the opportunity for Hear & Treat increases as the time to triage extends in line with response. This can be clearly seen within the Cheshire and Mersey footprint. As the area with most challenged operational resources and response standards, the opportunity and number of Hear & Treat generated has increased.

Work continues through the CP cohort to improve See & Treat. It should be recognised that some of the mitigation actions put in place at times of high demand reduce the opportunity for See & Treat. Through Industrial Action and times of high demand where a critical incident is declared, enhanced signposting is implemented. The utilisation of sign positing (which involves no send to some C3s) reduces some of the See & Treat opportunities. CPs are focusing on locality variation and reducing unwarranted aspects of the variation. See & Convey to AE and Non-AE also moved into special cause within December.

2.3 Operational Performance - Patient Emergency Service (PES)

Activity: In December 2022, the Trust received 156,347 calls of which 92,997 became incidents. Compared with December 2021, we have seen an 9% increase in calls and an 1% decrease in incidents. The increase in call volume can be attributed to general winter pressures, likely enhanced by prevailing flu, COVID alongside increases in duplicate calls due to extended waits for response. It should be noted that often increases in call volume do not translate into increases in incident volume. This is due to the increase in 'no outcome' calls. No outcomes include signposted calls (no sends), ETA scripts that enable the caller to make a decision on their care when an estimated ambulatory response is provided. For December duplicate calls stood at 1,473 per day and no outcomes at 970 per day. When appraising the overall NWAS demand, all indicators should be considered as opposed to incident count in isolation.

- **Call volume:** call volume is 9% above the equivalent month for 2021.
- **Call Pick Up** has seen a deterioration in December and performance worsened from 68.7% in November to 55.3% in December (target 95%). The data points within call pick up showed special cause throughout December and Pick up in 5 the first weeks

of December. The mean pick up time for December was 82 seconds (1 minute 22 seconds) and the 95th percentile, 285 seconds (4 minutes 45 seconds).

Call pick up has deteriorated within the month of December vs November. This is primarily due to the increase in call volume received into the EOCs. A1 calls answered have increased by around 450 call per day. As a result, the mean and centile CPU measures have deteriorated. This is despite increases in front line call handling through recruitment, training, and deployment of new EMAs. The EOC has continued to experience high levels of abstraction with sickness continuing to be high. This has mitigated some of the benefits of increase in overall call handling staff.

NWAS continues to perform above the national average for CPU although this reflects the pressures on 999 nationally as opposed to stepped improvements from NWAS. IRP data for December reflects this position. For December, nationally 29,255 calls were routed via IRP. NWAS passed out 1,210 and answered 2,907, therefore net imported 1,697 additional calls.

Projecting forward it is anticipated that CPU will improve. The EOCs recruitment and training plans continue to deliver increases in call handling staff through to the end of Q4. This increases the numbers of call handlers and should improve CPU.

Ambulance Response (ARP) Performance

Category	Standard	December 2022 Actual
C1 (Mean)	7:00	9:58
C1 (90th)	15:00	16:56
C2 (Mean)	18:00	1:12:11
C2 (90th)	40:00	2:45:19
C3 (Mean)	1:00:00	5:16:07
C3 (90th)	2:00:00	12:52:41
C4 (90th)	3:00:00	15:52:25

For December response time targets were not met for any ARP measures. All the ARP standards have seen an upward trajectory in December signalling deteriorating response times. C1 and C2, mean and 90th have exceeded normal control limits in December. All data points are positioned outside the upper control limit apart for C1 90th, week commencing 26th December. C3 saw 3 out of the 4 December data points above the upper control limit, only falling below week commencing 19th December,

The primary drivers.

C1 and C2 incident proportions remain high. The percentage of C1 has marginally decreased vs November but C2 has risen. This is due to acuity of patients, extended response standards leading to upgrades and utilisation of sign positing which reduced the number of C3 and 4 incidents.

- Handover has increased by around 10 minutes per attendance which increases job cycle and reduces operational capacity.

- Variation in operational resources by sector. Movement of resources into these areas reduce capacity in other sectors and can increase response times by virtue of distance.
- Call pick up is also having a negative impact on C1 response standards. As the mean and centile CPU increases, the frequency of clock start prior to triage increases. This results in extended allocation and response times.
- There has also been a reduction in C3/4 incident count, especially on days of high activity and Industrial Action. Signposting closes a proportion of C3 and C4 cases as no outcome. This results in a smaller data set and more variable response standards as a result.

Overall NWAS continue to perform better than the sector in respect to C1 and C2. In addition, the Clinical Coordination Desk (CCD) continues to provide senior clinical oversight to waiting patients. It is undesirable patients wait but the CCD ensures the patients who do wait are the most clinically appropriate to do so.

Handover is the primary barrier to improved performance and the trend of extended handover is a concern. It is difficult to foresee stepped improvements in response if handover does not improve.

In response to this challenge the EOC/CHUB team are working closely with operations to increase secondary triage capacity and reduce the number of patients a resource is dispatched to and ultimately the number of patients we take the front door of hospital. This will be achieved through highbred working and focusing on the lower acuity / less complex C2 patients.

Handover

- Average turnaround time has increased and continues to be above the national standard of 30:00 with a turnaround time of 58:51. This is the highest turnaround time this calendar year.
- Within December, 3 out of the 4 weekly data points are showing special cause moving outside the upper control limit.
- 11,717 attendances (26.8%) had a turnaround time of over 1 hour, with 2,116 of those taking more than 3 hours. There were 1,775 delayed admissions in December, with total accumulated hours of 4,659.
- The Trust is increasing the use of cohorting patients to mitigate decreasing performance.
- A system handover improvement board has been established with ICB Chief Executive leads nominated. Handover collaborative session are being hosted in each ICB. The first meetings took place in December with more planned in February and April 2023. A move towards a more system-based approach will see the spread of responsibility for handover performance.

C1 & C2 Long Waits

Long waits for C1 saw an increase to 959 in September and to 1,619 for December. This is the highest level of long waits since October 21. The number of C2 long waits increased from 12,153 in November to 21,089 in December. This is highest number of long waits overall since October 21. Turnaround, poor call pick up and abstractions are the primary drivers.

The risk in the waiting stack continues to be mitigated by the clinical co-ordination desk (CCD). The CCD utilises Advance Practitioners to review the waiting stack and identify high risk patients.

2.4 Operational Performance - NHS 111

Measure	Standard	December 2022 Actual
Calls Within 60s	95%	23.77%
Average Time to answer		28m 31s
Abandoned Calls	<5%	42.8%
Call back Within 10 min	75%	5.24%
Call back Within 20 min	90%	7.33%
Average Call Back		2 hours
Warm Transfer to Nurse	75%	8.42%

Call demand for 111 throughout December remains very high. The service saw 334,479 calls offered compared with 236,233 December 2021. 156,023 of those calls were answered, 116,662 abandoned and the additional calls redirected via IVR signposting.

Demand increase was primarily caused due to the Government and NHS guidelines on Strep A care, winter pressures and Industrial action. Within December, 111 saw a 25% increase on under 15 triages from the previous month. Additionally, 'in-hour' call demand increased within November and December, work is ongoing with Primary care networks to look at variability of usage of 111 between practices.

Increased demand has directly affected overall performance throughout December. Answered in 60 fell to 23.7% and abandoned is now showing special cause at 42.8%. Average time to answer saw an increased to 28 minutes 31 seconds, pushing the metric into special cause. The resource gap between capacity and demand has also a causal factor in the decline of performance. Variation at interval level along with staff sickness, attrition and industrial action have been a significant challenge. Focus on strategies to improve this position are well underway and monitored within the 111 people plan.

The team are continuing to work with ORH to demonstrate the change in profile and increase in demand over the last 12 months, 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. Warm Transfer to nurse and time taken for a call back continues to be well below the target. Warm transfer for December is 8.42%, call back in 10 minutes 5.24% , just above the lower control limit. Call back in 20 minutes for December is now in special cause, below the lower control limit at 7.33%. Measures continue to be in place to ensure patient safety.

2.5 PTS

- Due to reporting timing issues PTS performance is reported one month in arrears.
- Activity in November for the Trust was 9% below contract baselines with Lancashire and Cumbria 22% and 23% below baselines respectively. Year to date July 2022 - November 2022) is performing at 14% below baseline.

2.6 Finance

- The year to date expenditure on agency is £3.56m which is £0.009m under the year to date ceiling of £3.56m.
- As at month 9 (December) the trust is recording a surplus position for the year to date of £0.751m.
- As at month 9 (December) the trust has delivered the planned level of efficiency of £10.5m.

2.7 Organisational Health

Sickness

The overall sickness rate for November 2022 decreased to 8.64% (OH1.1) with COVID sickness at 0.94%. COVID sickness is at its lowest rate for 8 months. Non COVID sickness remains stable but with a slight increase at 7.7% in November which is in line with seasonal trends. However, over the last six months non-COVID sickness has been tracking on average 1% below the same period last year which indicates some impact of the measures being taken to improve attendance. This has resulted in 3 months being at or below the lower control limit. Contact Centres remain above average for sickness but both EOC and 111 have shown some improvements in management of underlying non – COVID absence.

- Data analysis continues to show the top 5 reasons for absence are Mental Health, Covid, Injury, MSK and Back problems.
- Following the withdrawal of COVID terms and conditions arrangements, staff absent long term with COVID have now fully transitioned onto occupational sick pay. Cases are being managed through a robust Occupational Health process in line with a nationally agreed framework with the aim of where possible returning staff to work. The extended periods of long term sickness associated with COVID reflect in higher than normal long term sickness levels but overall long term sickness has been on a downward trend since April
- 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.
- Discussions and developments are taking place regarding embedding attendance management accountability within the overall performance oversight framework.

Turnover

Staff turnover for December 22 is 12.28% showing a very small increase within the context of a broadly stable position over the last six months. This is calculated on a rolling year average. Overall staff turnover has shown a steady increase in the last 12 months. The Green Star indicates a potential new phase with PTS exceeding the upper control limit, however robust plans are in place to deliver additional staffing in this area.

- EOC turnover is at 14.57% in December. This has shown a small increase over the last 2 months after a previous downward trend. This may reflect the extreme operational pressures combined with high vacancy gap seen in Q3.
- 111 turnover continues to stabilise with a very slight increase to 36% from 35.56% in September 22 however, the data is showing improvements in recent months.

- PES is being closely monitored with the turnover reflecting increases in retirement and opportunities within primary care. It remains lower in comparison with other services lines. Recruitment plans are also in place.
- 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. These payments completed in December and the impact of this will be monitored.

Temporary Staffing

As a result of COVID-19, restrictions in relation to agency usage were paused but these have been reinstated under the 22/23 financial regime. The position for December shows continuing agency usage at a stable position. The agency ceiling, which is the maximum spend allowable, has now been confirmed as the level set out within our operational plan. Further reductions in agency usage will be required.

- Agency staff have continued to support the Contact Centre environments. However, those staff in EOC who have wanted to transfer to Trust contracts have now done so (OH 4.3).
- 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 until further recruitment in 111 is delivered.

Vacancy

- Chart OH5.1 shows the vacancy gap at –4.88% in December 2022. This is an improvement on the previous month however signals a significant change from five months ago as a result of the increases to PES & EOC establishment arising from additional investment. The slight worsening position in December represents a normal seasonal impact of reduced new starts during the Christmas period.
- Recruitment plans for 111 remain a risk. The current vacancy position is -14.90% (OH5.5) with vacancies being focused in the Health Advisor and Clinical Advisor roles. This is mitigated to –12.2% by agency staff waiting for transfer onto permanent contracts but is a variation on plan. Whilst turnover is improving, the recruitment market is proving challenging for call handler positions. Work is ongoing locally and nationally to review processes and improve attraction. Agency recruitment on an introductory fee basis is being used to help fill any gaps in courses.
- The PTS vacancy position (OH5.2) has remained stable. Robust plans are in place to reduce the gap over the coming months, but PTS also have robust bank arrangements in place to help bridge the vacancy position.
- PES position (OH5.3) shows -2.83% under-established due to increased establishment but robust recruitment plans are in place for the remainder of the year. This gap is primarily the Paramedic workforce.
- The substantive EOC position shows an improved position at –3.66%, this improvement results from the transfer of agency staff to permanent contracts and an intensive period of recruitment in Q3.

Appraisal

- Appraisal completion rates are at 82% for December 22 (OH6.1) which exceeds target.
- PES, PTS and 111 remain at or ahead of target (OH6.3, OH6.2, OH6.5). 111 have shown consistent improvement despite vacancy challenges as this forms part of retention plans. EOC have dropped behind target to 68% as a result of the Pathways roll out and recovery plans are in place

- ELC have recently approved a revised target of 80% compliance for service lines and 90% for corporate teams and Band 8 and above management positions by March 2023. This aims to consolidate and equalise current performance. In addition, the transition back to a fuller appraisal has been approved following engagement with service line teams.

Mandatory Training

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

PES classroom attendance is in line with trajectory with PTS exceeding the target.

Overall compliance is slightly behind target 78% but not a cause for concern. EOC are slightly behind trajectory at 77% with recovery plans in place.

There has been some impact on mandatory training resumption in Q4 as a result of military training to support industrial action but this is being closely monitored to ensure overall compliance remains on track.

Case Management

- Overall case levels have reduced since the last report to Board supported by more cases being closed than opened in the last six months
- Average case times are reducing
- The number of suspensions has increased to 10, which is an increase in four since the last report. Several cases have exceeded 10 weeks due in the main to complexity and the involvement of third parties

COVID 19

- 368 staff have tested positive for Covid-19 in December 2022. At the end of this reporting period, there was 5 open outbreaks 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

A review of data against protected characteristics to understand and improve patient experience is being undertaken by the Diversity and Inclusion sub committee. Patient experience data has previously been broken down however data quality and gaps in reporting of ethnicity challenge our ability to analyse performance data. A plan to improve this is in place and reports to the Diversity and Inclusion sub committee.

A move to increase Hear & Treat and see and treat supports our sustainability goals.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the content of the report
- Note the improvements seen in complaints handling times
- Note pressures on performance with handover times increased
- Note that SI's are within normal limits however there has been a significant increase in incidents risk scored 4-5
- Note that a learning review has been undertaken of these incidents
- Note that long waits for C1 & C2 have increased in December
- Note the improvements in Hear & Treat and reduction in See and Convey
- Note the ongoing work to maintain patient safety and regulatory compliance.
- Clarify any items for further scrutiny

North West Ambulance Service NHS Trust

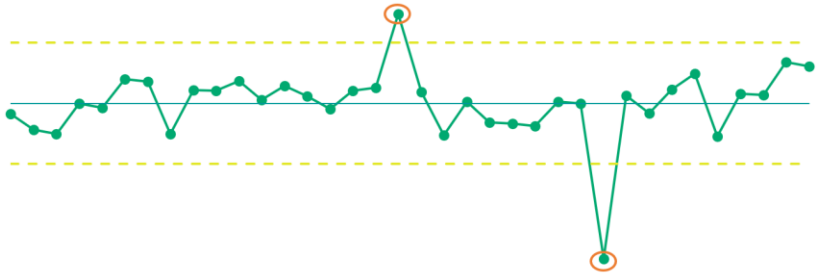
Integrated Performance Report

Board - January 2023

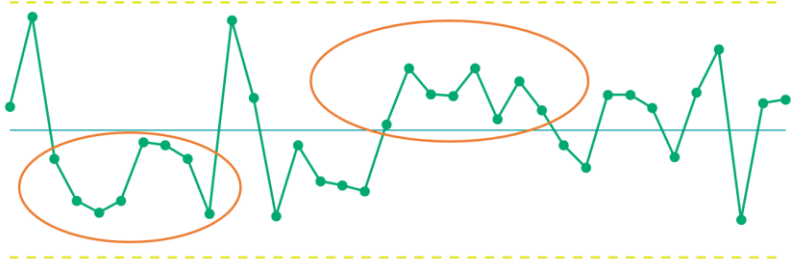
Rules for interpreting SPC Charts

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

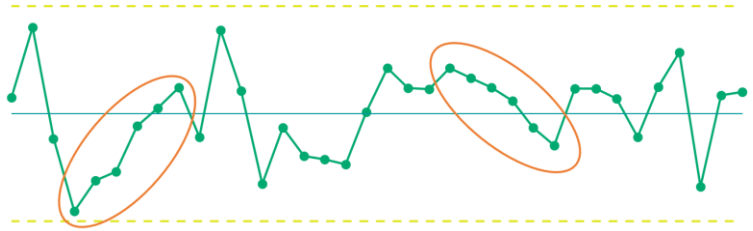
Rule 1: Single data point outside the control limits



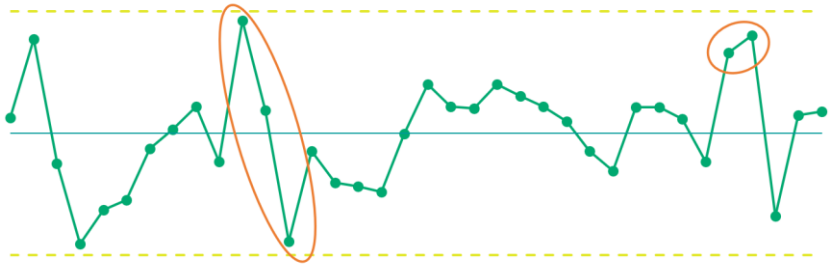
Rule 2: 8 or more consecutive data points above or below the centre line



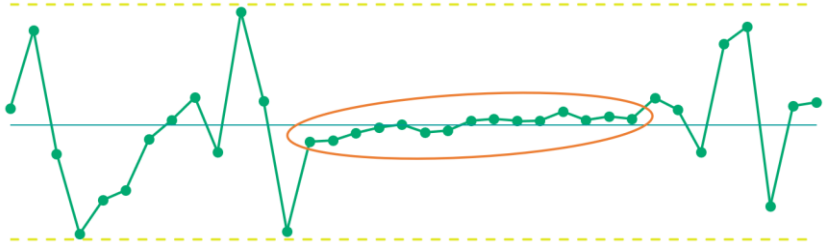
Rule 3: A trend of at least six consecutive points (up or down)



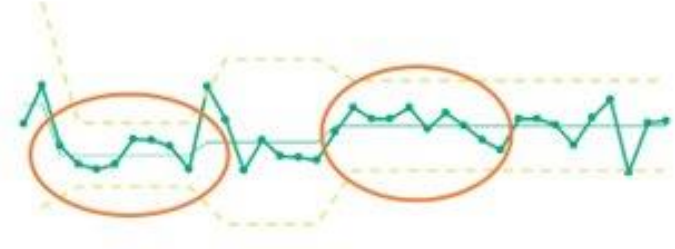
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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

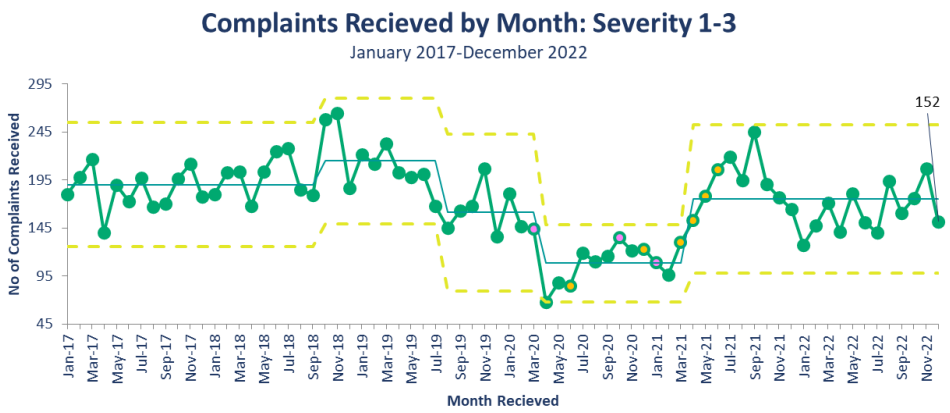


Figure Q1.2

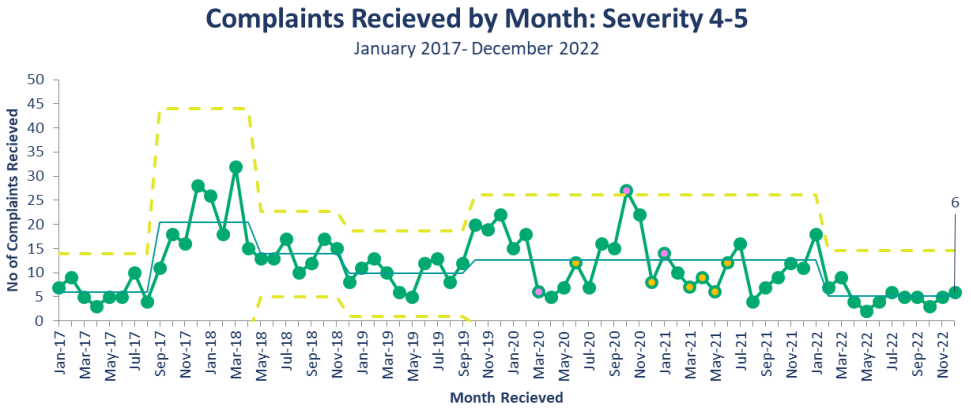


Figure Q1.3

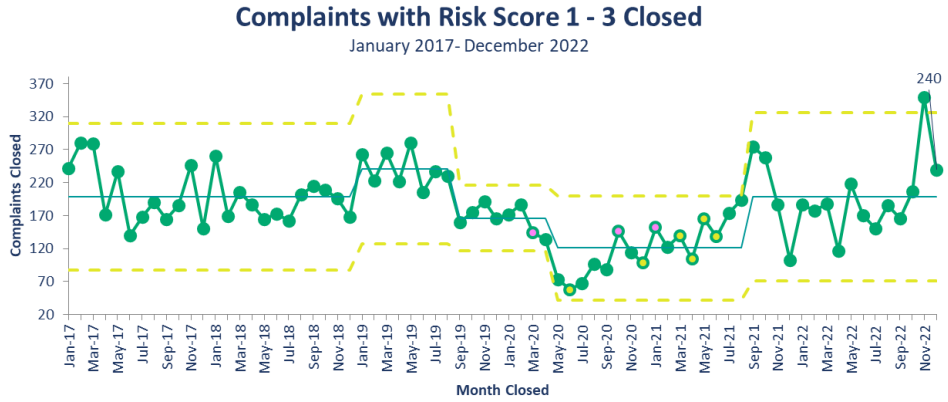


Figure Q1.4

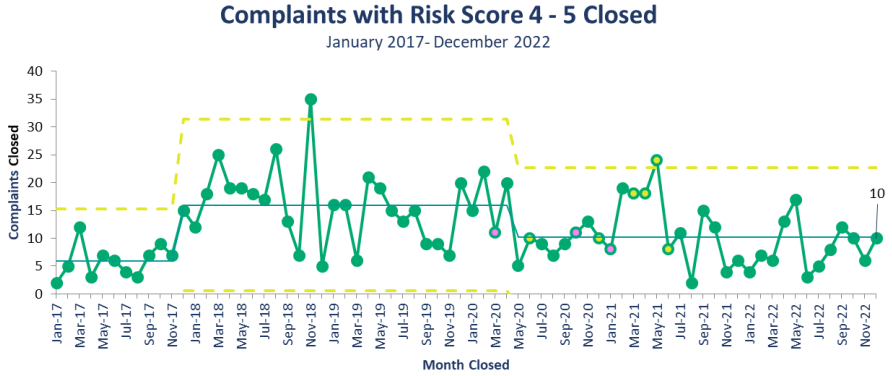


Figure Q1.5

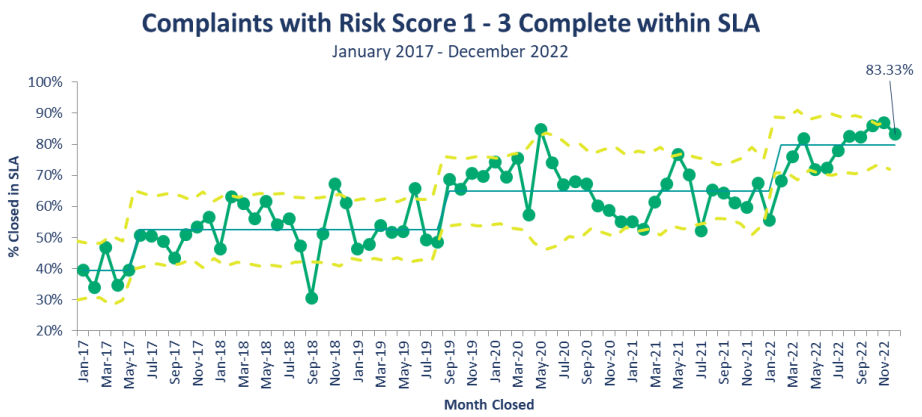


Figure Q1.6

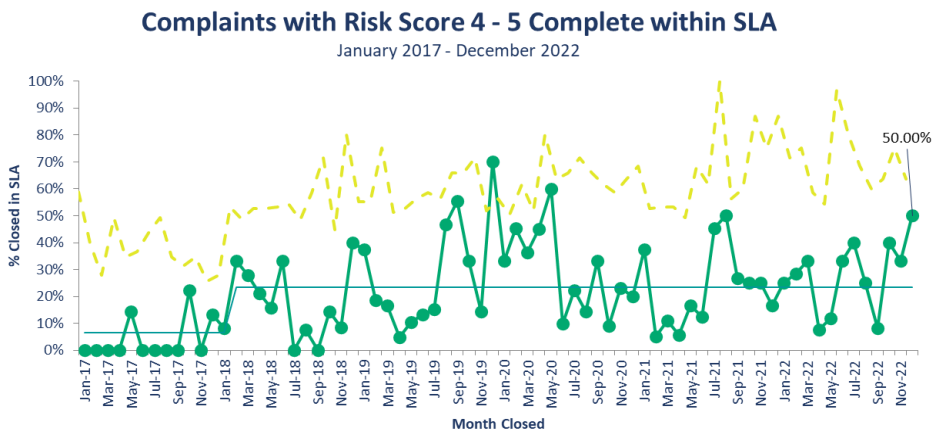
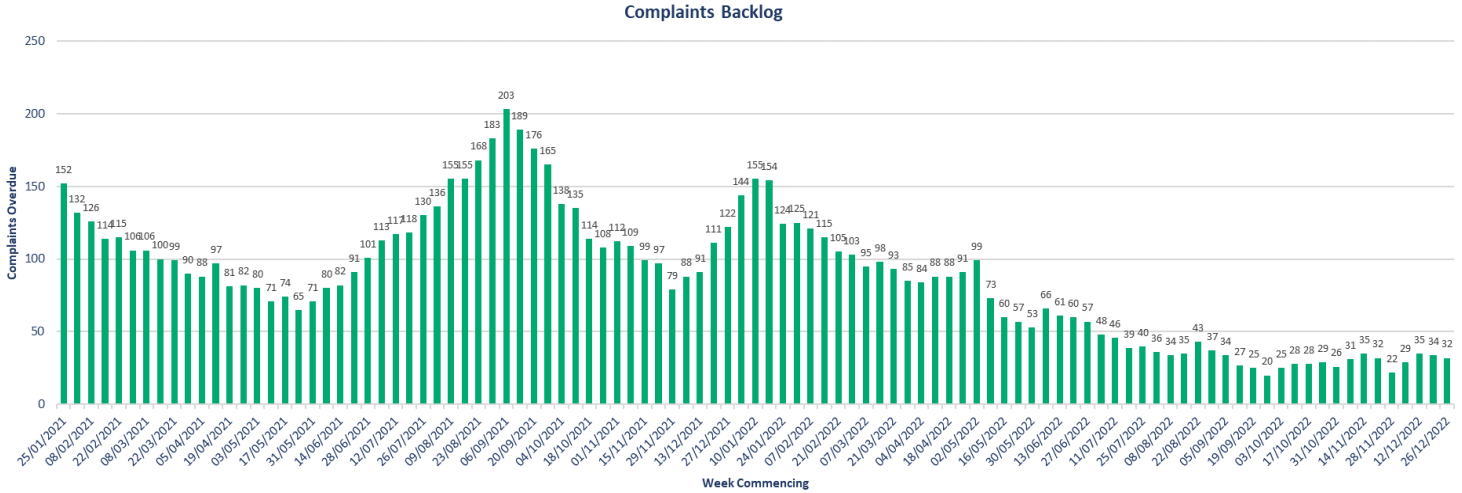


Figure Q1.7



Q2 Incidents

Figure Q2.1

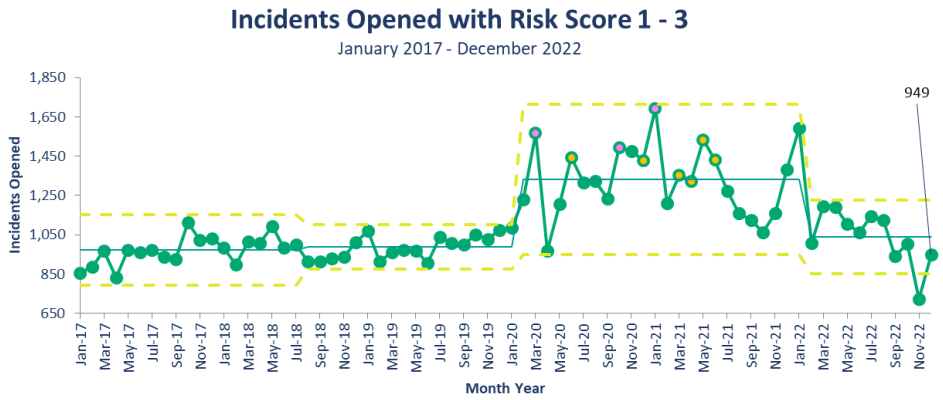


Figure Q2.2

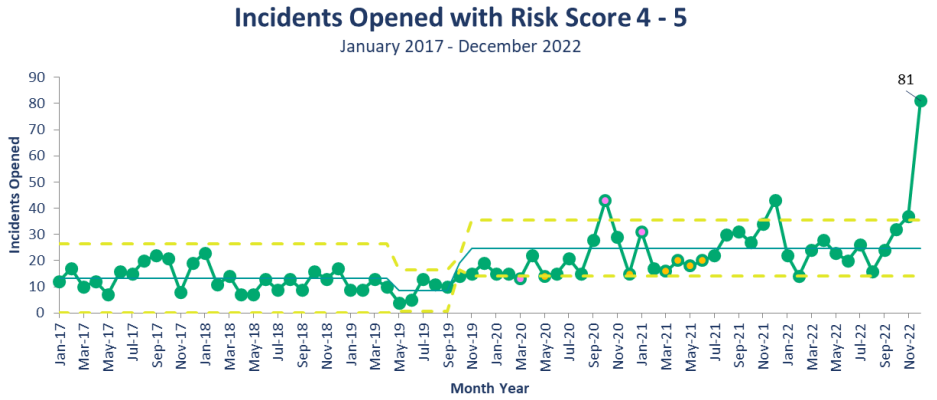


Figure Q2.3

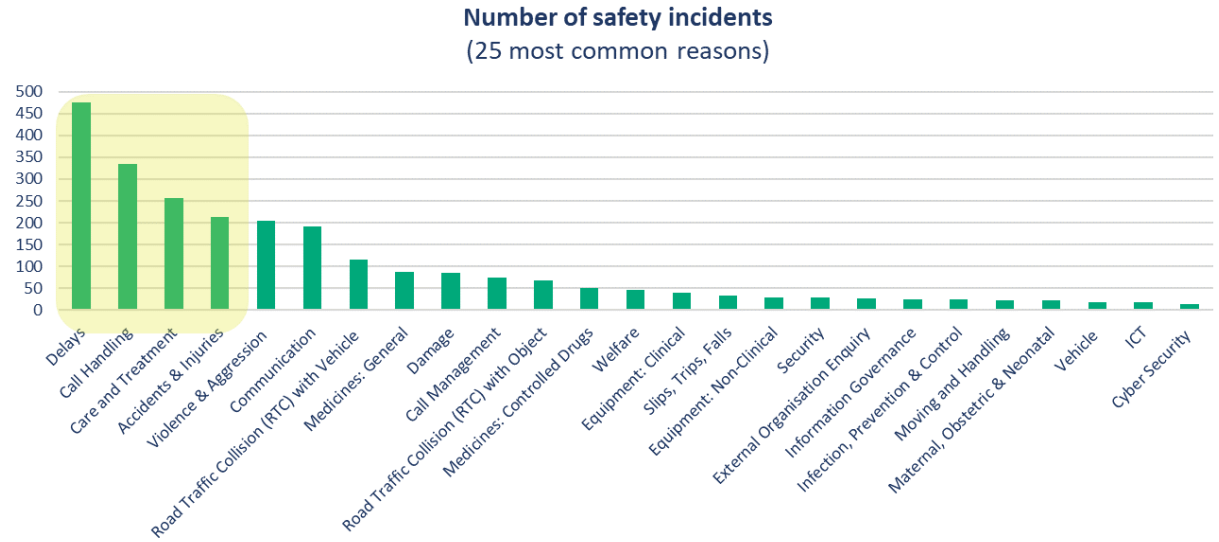


Figure Q2.4

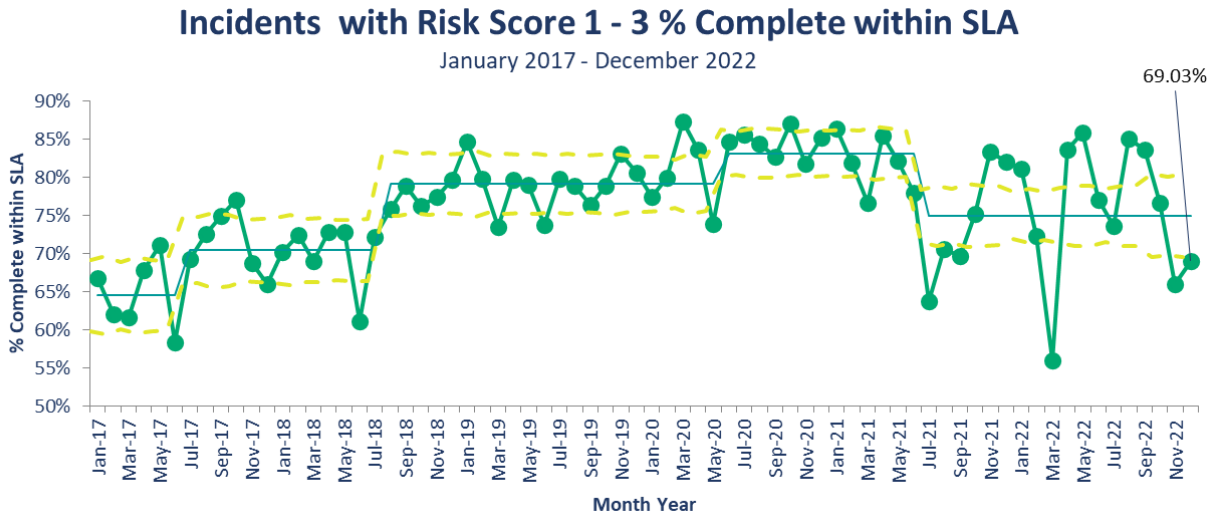
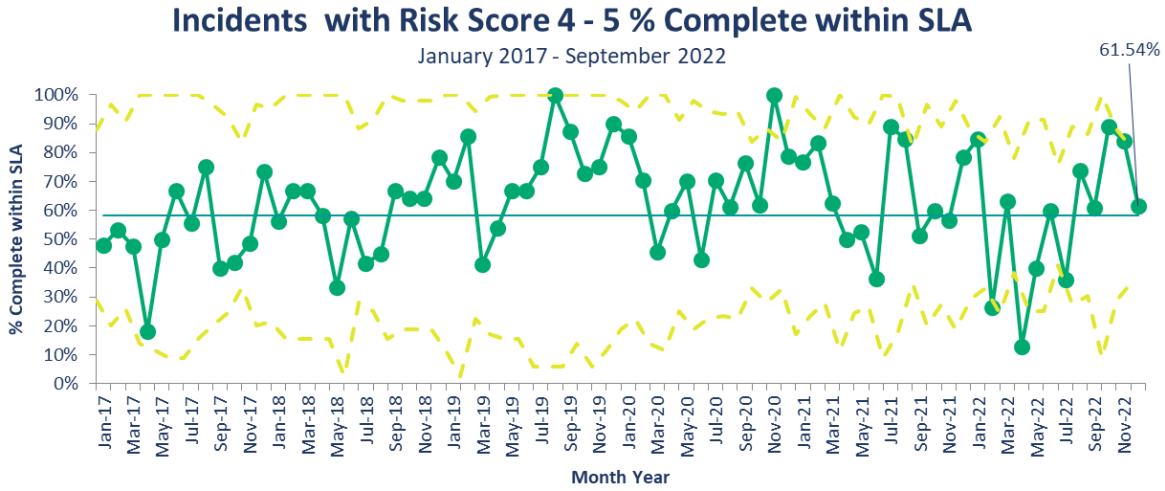


Figure Q2.5



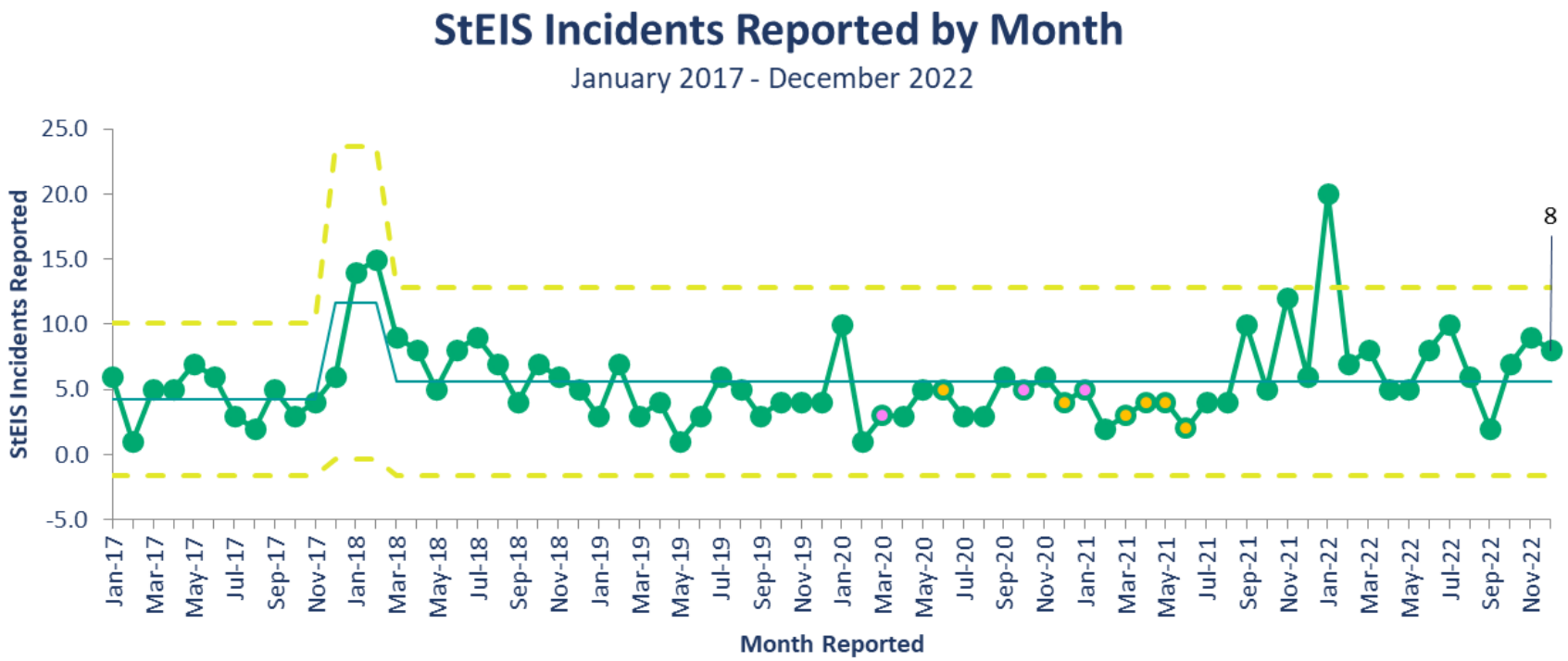
SLAs are calculated using the following measures/targets.

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 (Jan 22 – Dec 22)	Number of Alerts Applicable (Jan 22 – Dec 22)	Number of Open Alerts	Notes
CAS/ NHS Improvement	1	0	0	

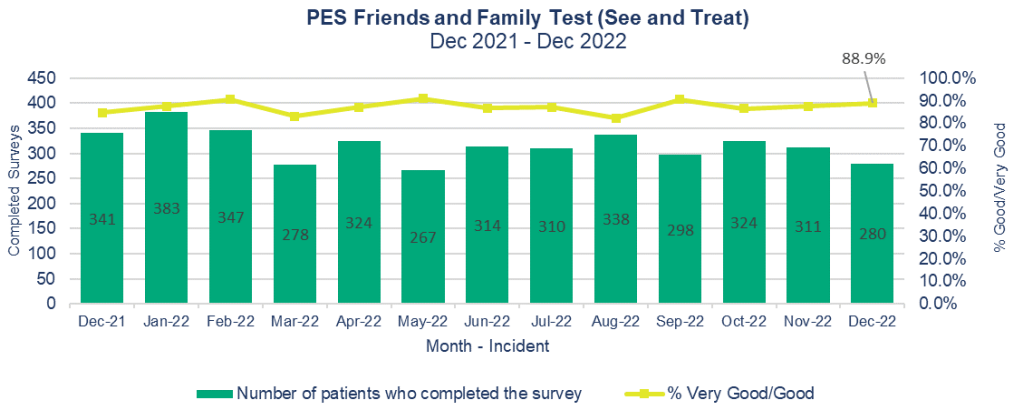
Safety Alerts	Number of Alerts Received (Jan 22 – Dec 22)	Number of Alerts Applicable (Jan 22 – Dec 22)	Number of Open Alerts	Notes
MHRA – Medical Equipment	5	0	0	

Safety Alerts	Number of Alerts Received (Jan 22 – Dec 22)	Number of Alerts Applicable (Jan 22 – Dec 22)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	58	2	0	Class 2 recall of Amiodarone Injections. All stocks were checked and then re checked, no recalled batch codes were found.

Safety Alerts	Number of Alerts Received (Jan 22 – Dec 22)	Number of Alerts Applicable (Jan 22 – Dec 22)	Number of Open Alerts	Notes
IPC	0	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1



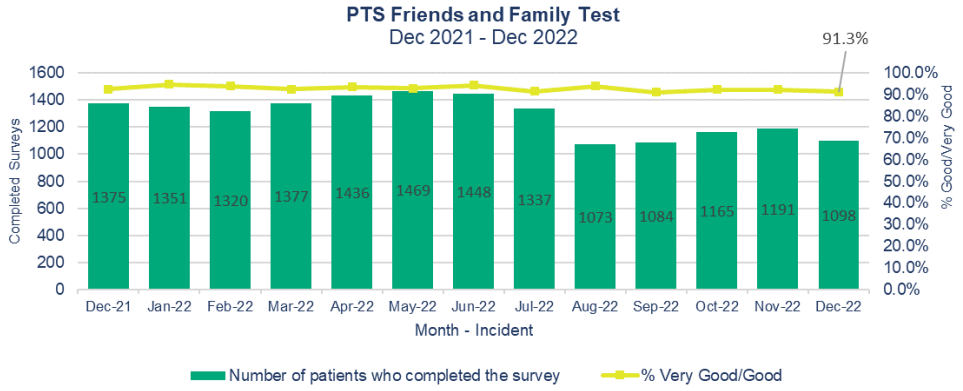
Positive

- *"The paramedics were so thorough, compassionate, and took the time to explain everything not only to the patient but also his parents. They went way beyond their call of duty and are a credit to the NHS."*
- *"My father's case was upgraded by a paramedic who phoned us whilst waiting for ambulance that was going to take several hours, and they came soon after. The paramedics were so kind and reassuring to my elderly father."*

Negative

- *"Unprofessional paramedics who were more interested in their mobiles and looking who was near their house on their ring doorbell. They were patronising and made me feel I was wasting their time. They made me walk down the street to the ambulance rather than coming to my house, I felt like I had been picked up off the street. Very upsetting experience by paramedics who didn't seem to care!"*
- *"Was not listening when I said I'm not going to hospital and became rude."*

Figure E1.2



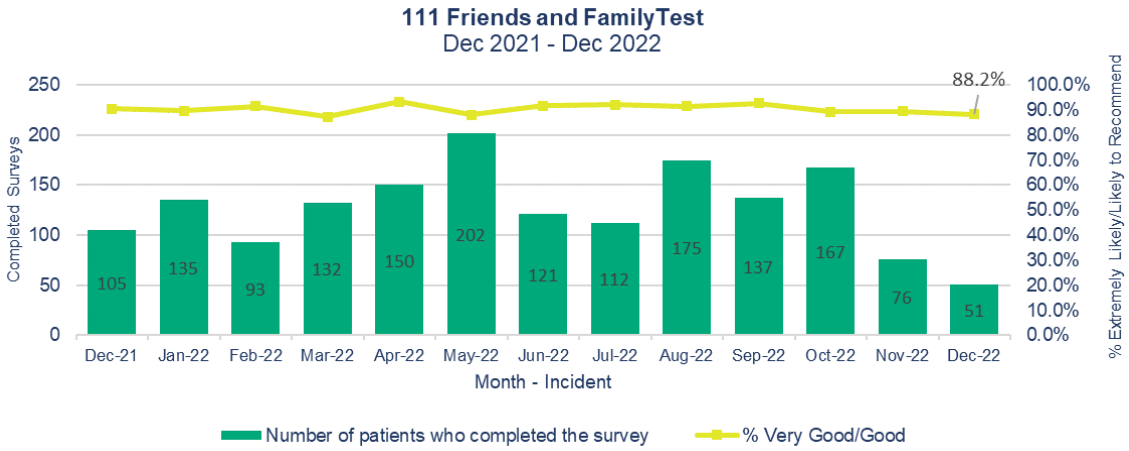
Positive

- *"The ambulance staff were fantastic, they were friendly, helpful and went above and beyond to make my mother's experience as easy as possible."*
- *"Service on time, been friendly and professional. It took so much stress from me having this service as my husband is terminally sick and would usually take me and. I have cancer too. So, this service is so valuable at moment. Thankyou."*

Negative

- *"They failed to read the notes about our Dad having hemiparesis and needing stretchering out. By the time they had sent 2 crews out he had missed his surgery so had to just come home. They turned up with a wheelchair and no stretcher so it was distressing for Dad having to sit there for hours and then to be sent back because he was over 2 hours late."*
- *"No communication during the strikes and was left stranded."*

Figure E1.3



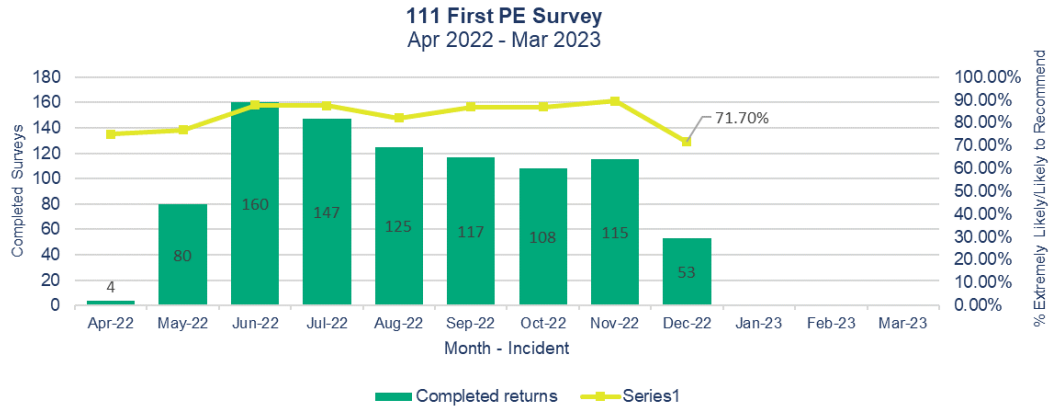
Positive

- *"Quick service. My little girl needed antibiotics and she was seen to within 2 hours of the phone call. Lovely female doctor."*
- *"Very prompt to arrange call back from doctor, and also fast (within 1 hour) to arrange walk in appointment."*

Negative

- *"First of all, the phone call lasted 45 mins with a translator. The adviser told us to go to Accrington Hospital. They sent us back to our Burnley Hospital because they only check injured patients not with infections."*
- *"I was dissatisfied with how long it took to get through. The time someone did call me back was too late for me to take my daughter to an out of hours appointment which is the reason for my call in the first place. Ended up at my own GP the following day. My daughter had an ear infection."*

Figure E1.4



Positive

- "Got good advice. My injury turned out more serious than I thought so grateful 111 sent me to A and E."
- "Given the correct advice from someone with knowledge, told what to do and arranged a telephone call."
- "It was quick and directly addressed the issue when we missed the first call back. They tried again."
- "Kind, caring staff who acted quickly. Chased up the GP for me.

Negative

- "Misleading. Why give an appointment time for A and E? I discharged myself after 1 and a half hours, not having been triaged."
- "Took 3 hours to receive the call back by a clinician."
- "Was not told where to go when got to hospital. No one could help when I got there."

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

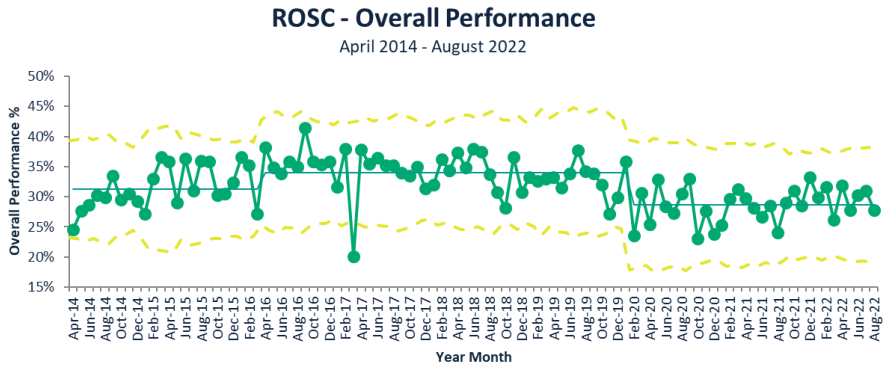


Figure E2.2

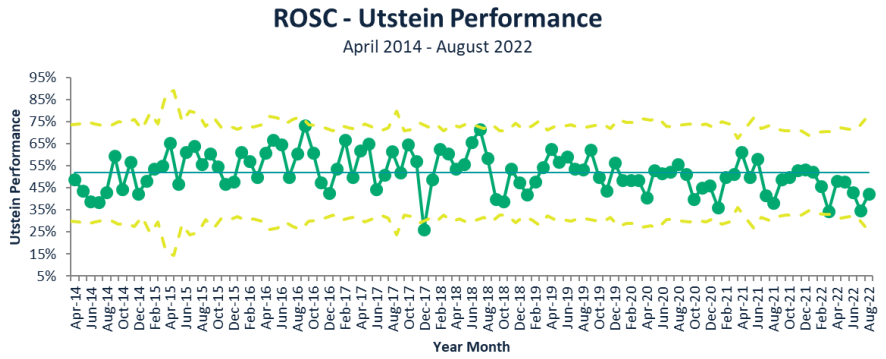


Figure E2.3

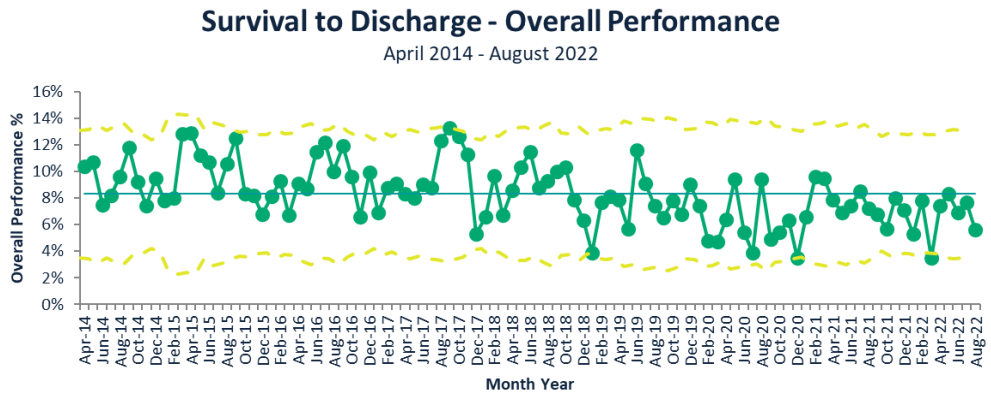


Figure E2.4

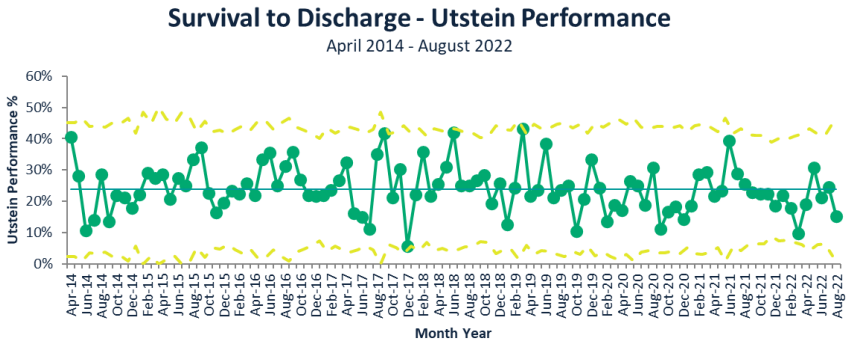


Figure E2.5

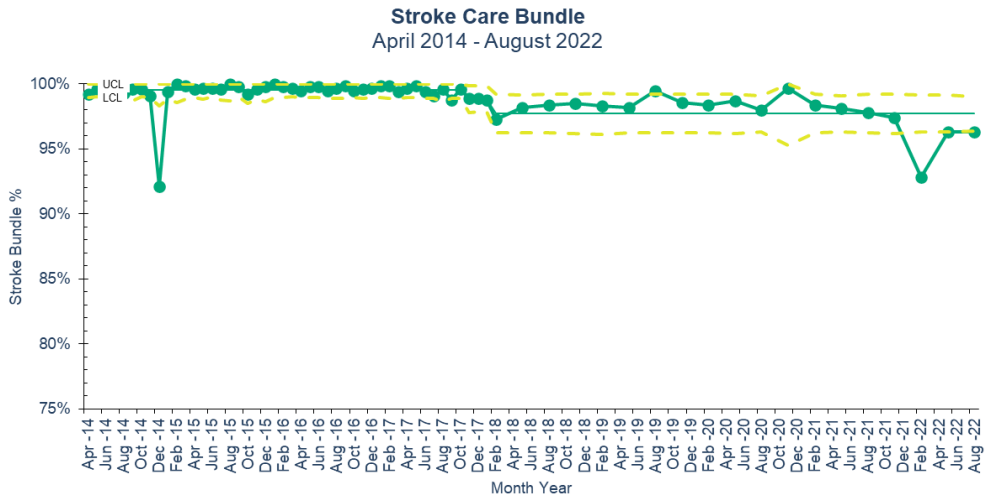
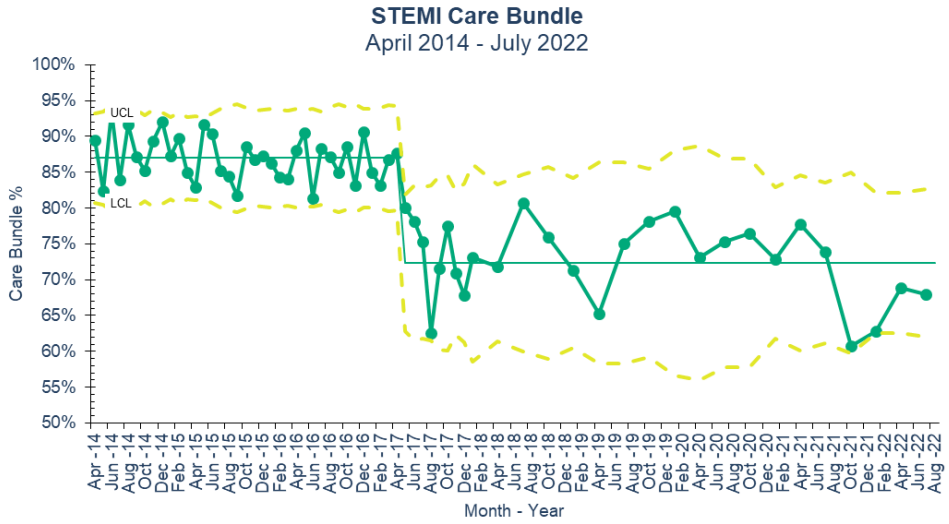


Figure E2.6



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

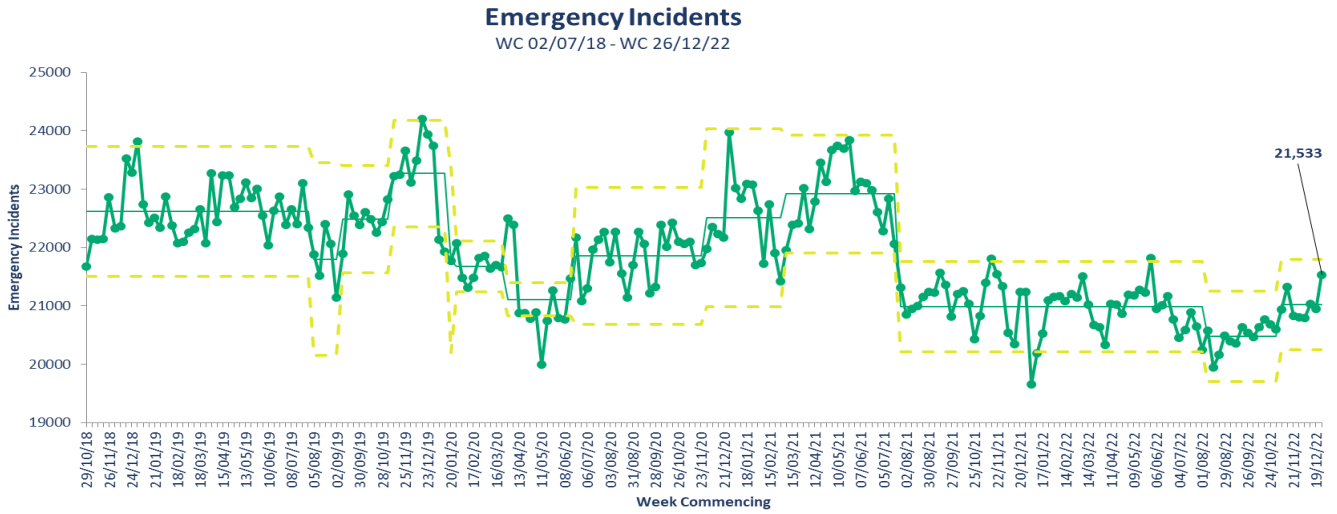


Figure E3.2

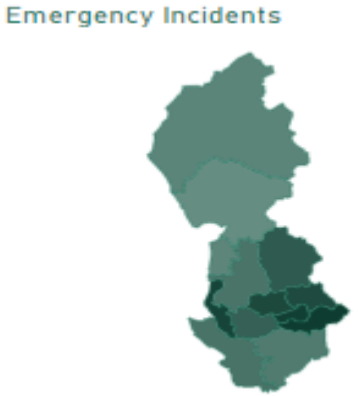


Figure E3.3

Sector	No. of Emergency Incidents
G South	9,816
G Central	9,597
M North	9,273
G West	8,939
G East	8,822
CL East Lancashire	7,731
M East	7,312
M West	6,055
CL South Lancashire	5,942
M South	5,479
CL North Cumbria	4,808
CL Fylde	4,800
CL Morecambe Bay	4,251

Figure E3.4

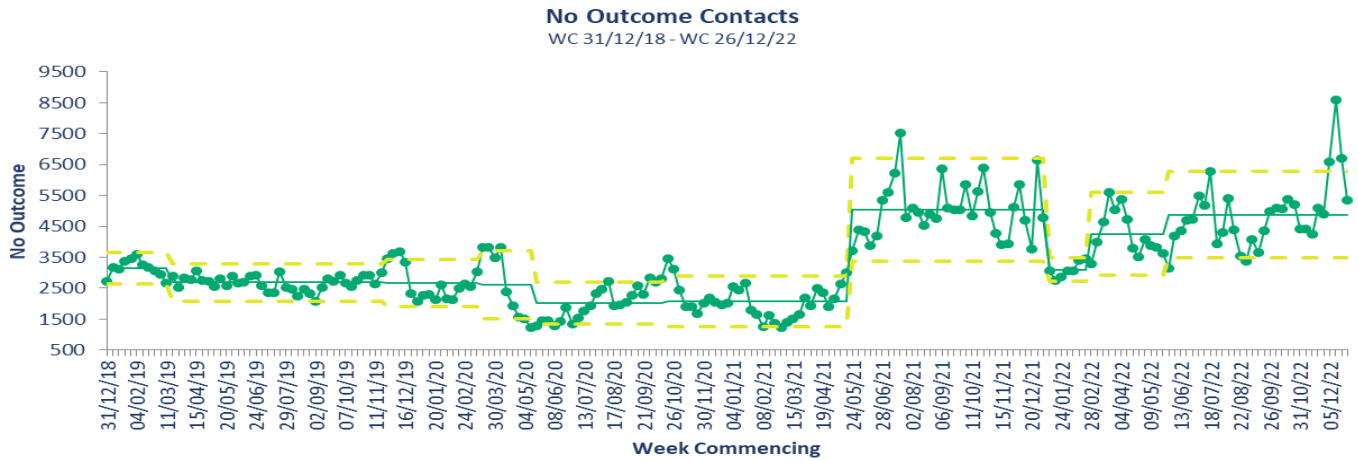


Figure E3.5

Dec	Calls	% Change from previous year	Incidents	% Change from previous year
2019	134,607		104,810	
2020	109,842	-18%	99,062	-5%
2021	143,568	31%	92,294	-7%
2022	156,347	9%	92,997	1%

Figure E3.6

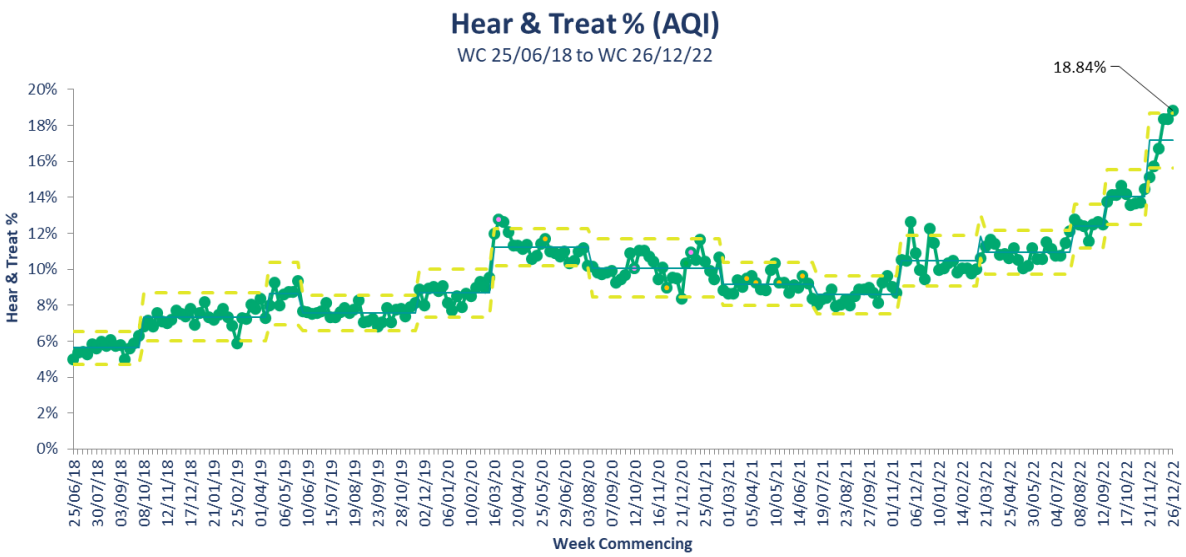


Figure E3.7

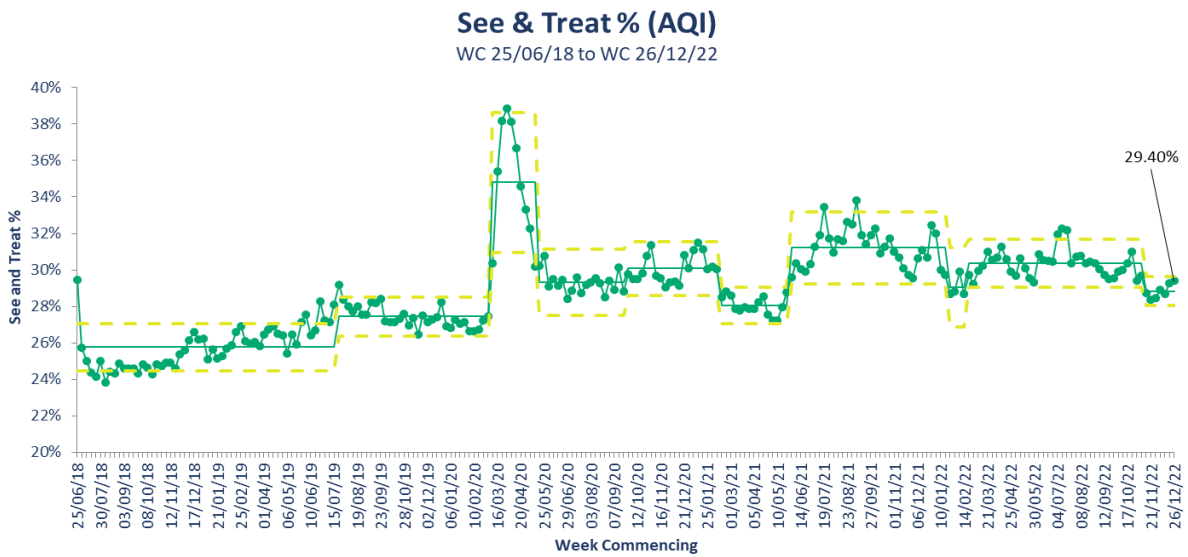


Figure E3.8

Sector	Hear & Treat	%
M East		20.93%
M North		20.29%
G Central		20.11%
M West		19.23%
CL Fylde		19.02%
G West		17.90%
G East		17.62%
M South		17.10%
CL East Lancashire		16.02%
CL South Lancashire		15.88%
G South		14.94%
CL North Cumbria		14.08%
CL Morecambe Bay		12.49%

Figure E3.9

Sector	See & Treat	%
CL South Lancashire		32.27%
CL Morecambe Bay		32.20%
CL North Cumbria		31.91%
G Central		30.18%
CL Fylde		29.79%
G East		29.79%
G West		29.48%
G South		28.79%
M West		28.61%
CL East Lancashire		28.21%
M South		27.86%
M North		26.86%
M East		24.57%

Figure E3.10

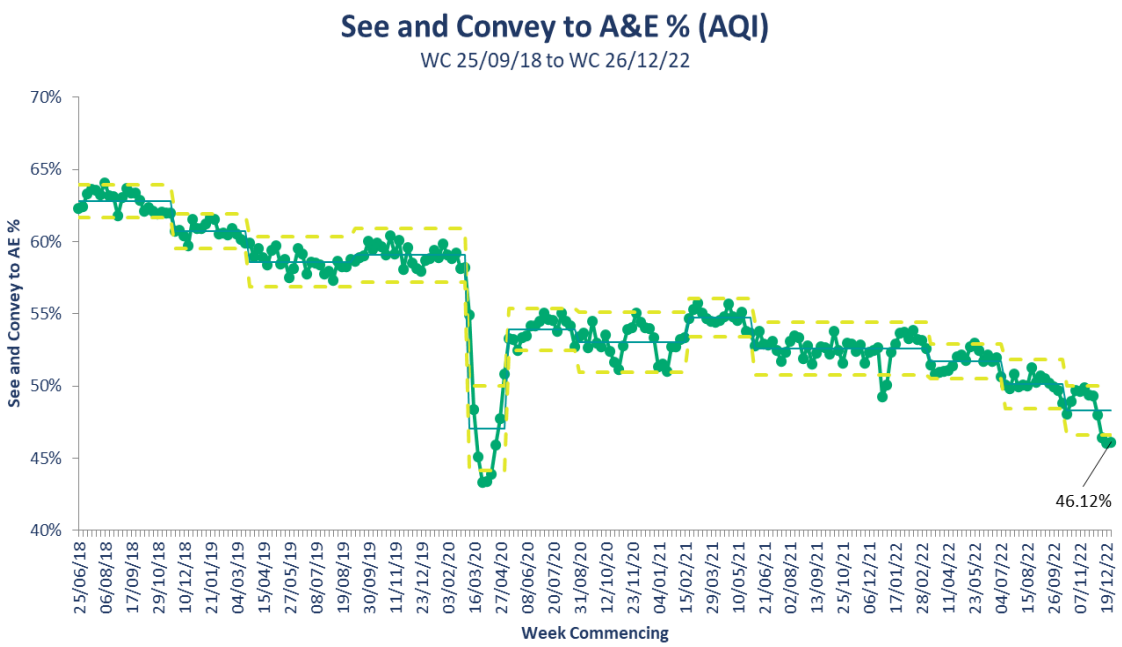


Figure E3.11

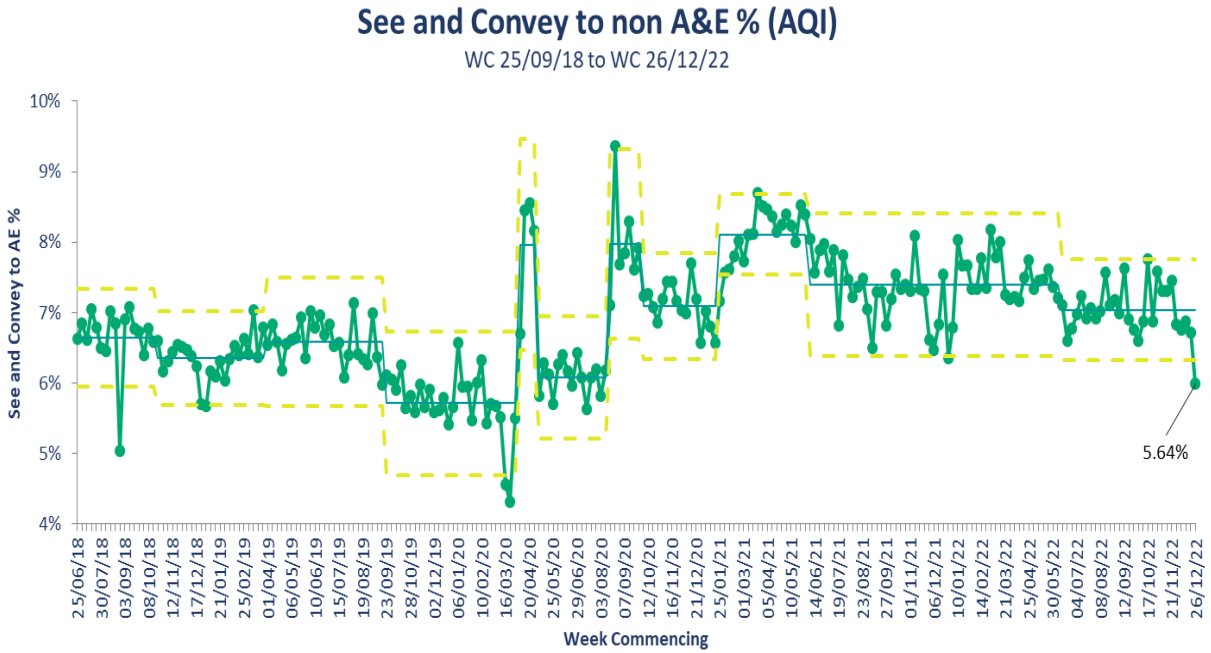


Figure E3.12

Sector	See & Convey	%
G South		56.28%
CL East Lancashire		55.77%
CL Morecambe Bay		55.30%
M South		55.04%
M East		54.50%
CL North Cumbria		54.01%
M North		52.84%
G West		52.62%
G East		52.59%
M West		52.16%
CL South Lancashire		51.85%
CL Fylde		51.19%
G Central		49.71%

Figure E3.13

Sector	See & Convey to AE	%
CL Morecambe Bay		51.68%
M South		50.63%
G South		50.48%
CL North Cumbria		49.23%
M East		48.12%
M North		47.58%
G East		46.40%
G West		46.33%
CL East Lancashire		45.98%
CL Fylde		45.23%
M West		44.38%
G Central		43.90%
CL South Lancashire		43.39%

Figure E3.14

Sector	See & Convey to Non AE	%
CL East Lancashire		9.79%
CL South Lancashire		8.46%
M West		7.78%
M East		6.38%
G West		6.28%
G East		6.20%
CL Fylde		5.96%
G Central		5.81%
G South		5.79%
M North		5.27%
CL North Cumbria		4.78%
M South		4.42%
CL Morecambe Bay		3.62%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	East Midlands		19.7%
2	North West		17.7%
3	London		16.7%
4	West Midlands		16.7%
5	South Western		16.5%
6	South Central		14.2%
7	North East		12.5%
8	Isle of Wight		11.6%
9	South East Coast		9.5%
10	East of England		8.5%
11	Yorkshire		7.9%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		39.1%
2	South Central		35.9%
3	East of England		34.9%
4	South East Coast		33.8%
5	Isle of Wight		32.8%
6	East Midlands		32.2%
7	West Midlands		31.4%
8	London		31.3%
9	Yorkshire		29.4%
10	North East		29.1%
11	North West		29.0%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		44.4%
2	East Midlands		48.0%
3	South Central		49.9%
4	London		52.0%
5	West Midlands		52.0%
6	North West		53.3%
7	Isle of Wight		55.5%
8	East of England		56.6%
9	South East Coast		56.7%
10	North East		58.4%
11	Yorkshire		62.7%

Operational

O1 CALL PICK UP

Figure O1.1

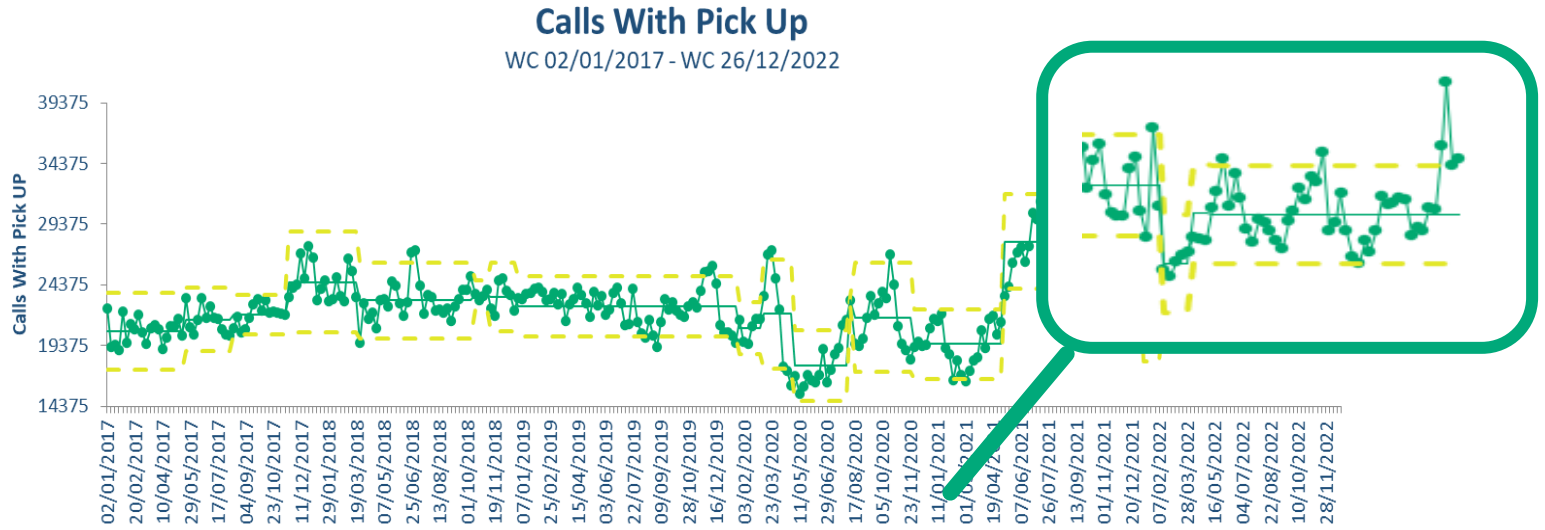
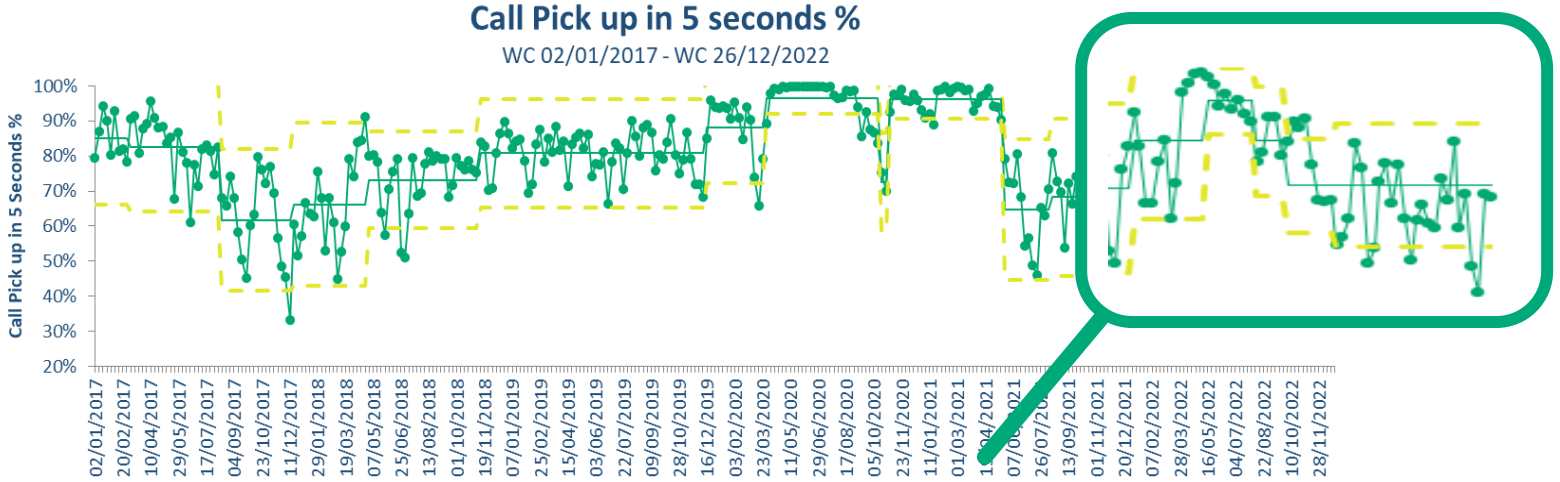


Figure O1.2



02 A&E TURNAROUND

Figure O2.1

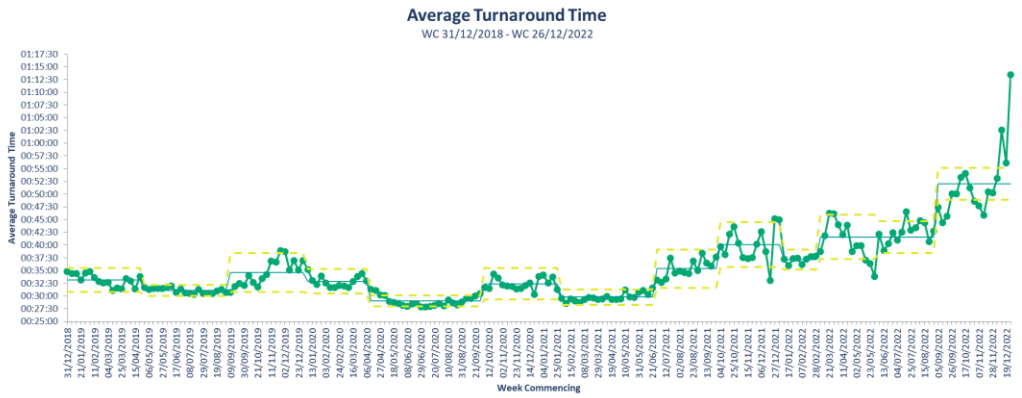


Figure Q1.2

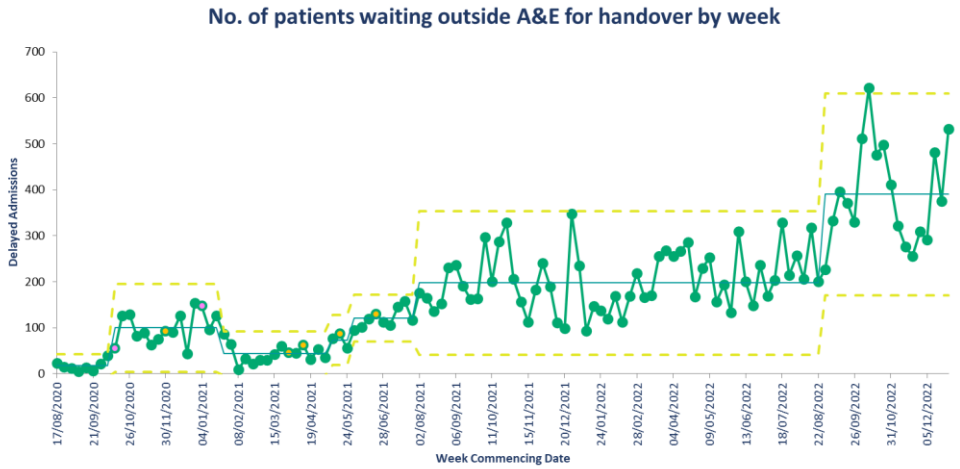


Table Q1.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
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
May-22	49,135	0:37:56	0:26:22	11:34
Jun-22	47,276	0:39:45	0:27:56	11:40
Jul-22	46,006	0:42:52	0:31:39	11:14
Aug-22	45,186	0:43:33	0:31:50	11:22
Sep-22	44,198	0:46:00	0:34:15	11:32
Oct-22	44,715	0:52:16	0:40:13	11:25
Nov-22	44,310	0:48:32	0:37:10	11:57
Dec-22	43,703	0:58:51	0:48:18	11:40

Table Q1.2

Top 5 Trusts with most hours lost due to delayed	
Trust	**Hours lost to delayed admissions**
Blackpool Victoria Hospital	656.2
Royal Oldham Hospital	582.7
Whiston Hospital	554.7
Royal Lancaster Hospital	408.9
Royal Bolton Hospital	394.1

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
Jul-22	975
Aug-22	1099
Sep-22	1490
Oct-22	2319
Nov-22	1283
Dec-22	1775

O3 ARP RESPONSE TIMES

December 2022

Figure O3.1

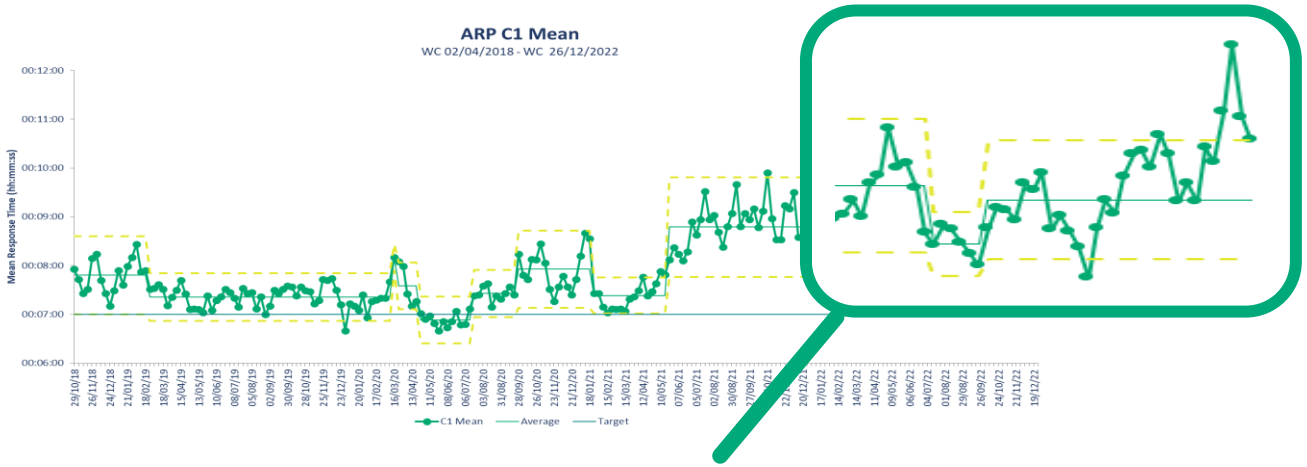


Figure O3.2

Figure O3.3

Sector	C1 Mean	Time
G Central		00:08:29
G South		00:08:33
G East		00:08:51
G West		00:09:26
M North		00:09:54
CL Fylde		00:10:14
CL East Lancashire		00:10:25
M East		00:10:28
CL Morecambe Bay		00:10:40
CL South Lancashire		00:11:07
CL North Cumbria		00:11:20
M South		00:11:35
M West		00:11:45

Figure O3.4

C1 Mean	
Target	7:00
Dec 2022	9:58
YTD	8:40

Figure O3.5

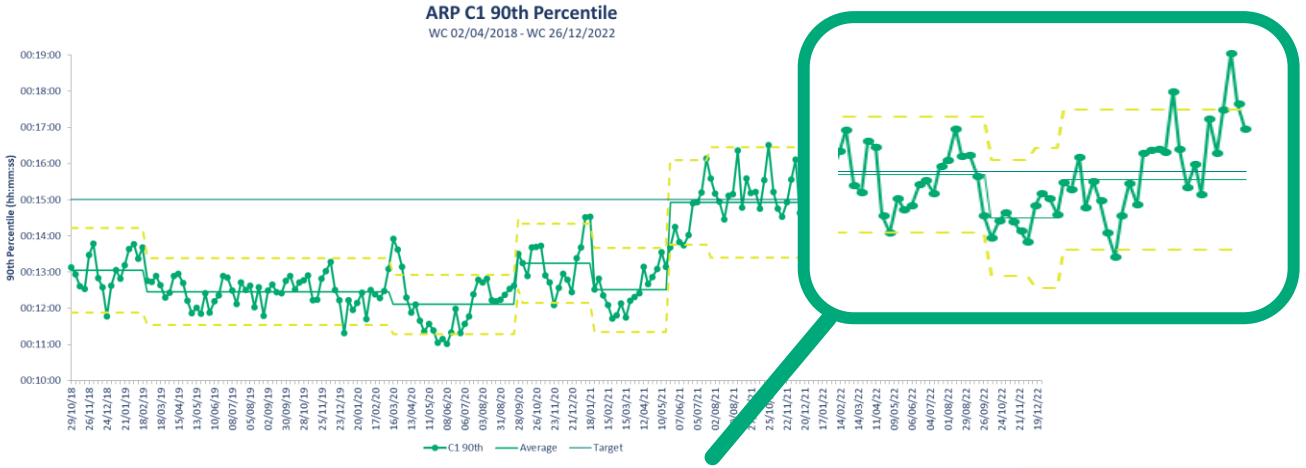


Figure O3.6

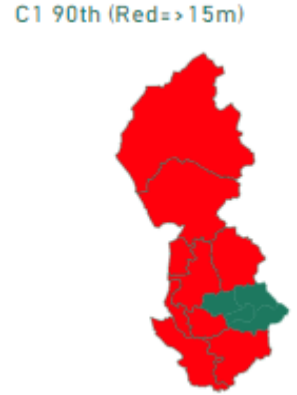


Figure O3.7

Sector	C1 90th	Time
G Central		00:13:46
G East		00:13:55
G South		00:14:05
G West		00:14:55
M North		00:16:45
M East		00:17:25
CL Fylde		00:17:53
CL East Lancashire		00:18:03
CL Morecambe Bay		00:19:01
CL South Lancashire		00:19:08
M South		00:19:56
CL North Cumbria		00:20:13
M West		00:21:16

Figure O3.8

C1 90th	
Target	15:00
Dec 2022	16:56
YTD	14:47

December 2022

Figure O3.9

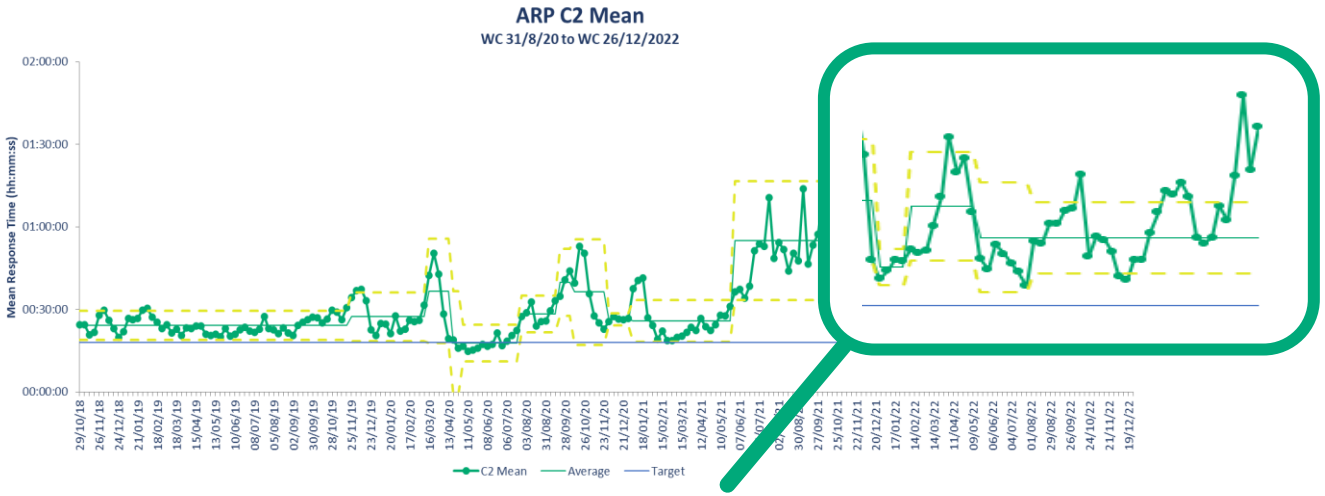


Figure O3.10

Figure O3.11

Sector	C2 Mean	Time
CL North Cumbria		00:32:03
CL Morecambe Bay		00:43:52
CL East Lancashire		00:47:52
G South		00:50:21
G East		00:52:11
G Central		00:54:34
CL South Lancashire		01:05:36
M South		01:09:17
G West		01:13:07
CL Fylde		01:13:59
M West		01:57:03
M East		02:06:33
M North		02:07:45

Figure O3.12

C2 Mean	
Target	18:00
Dec 2022	01:12:11
YTD	46:49

Figure O3.13

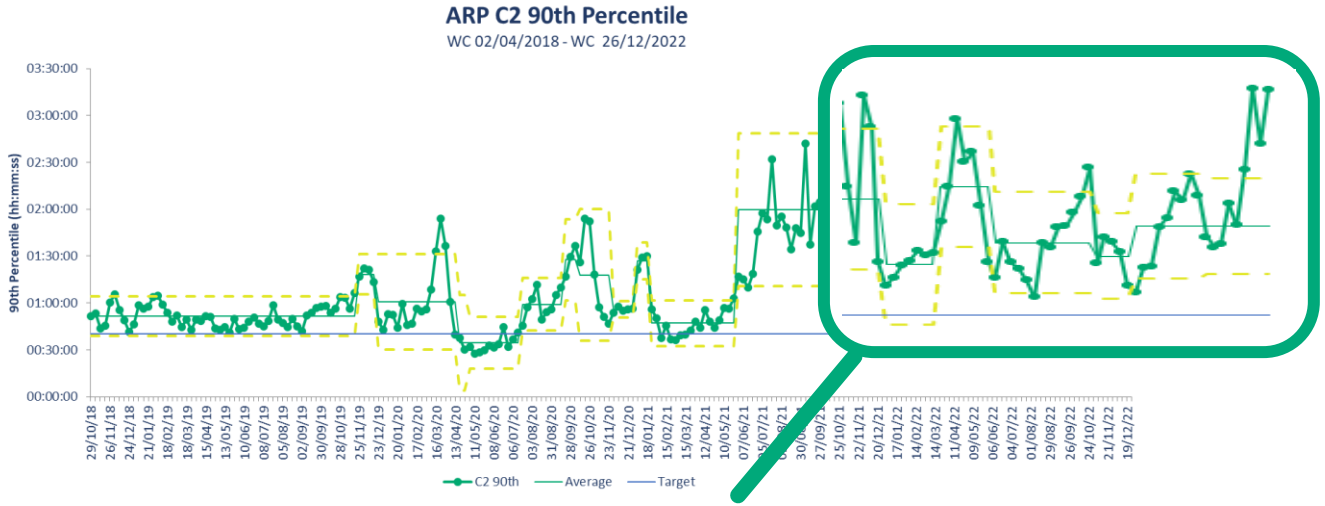


Figure O3.14

Figure O3.15

Sector	C2 90th	Time
CL North Cumbria		01:10:53
CL Morecambe Bay		01:40:00
CL East Lancashire		01:46:52
G South		01:52:07
G East		01:55:41
G Central		02:01:31
M South		02:26:53
CL South Lancashire		02:26:54
G West		02:31:39
CL Fylde		03:00:49
M East		04:12:12
M West		04:13:01
M North		04:23:42

Figure O3.16

C2 90th	
Target	0:40:00
Dec 2022	2:45:19
YTD	1:43:52

December 2022

Figure O3.17

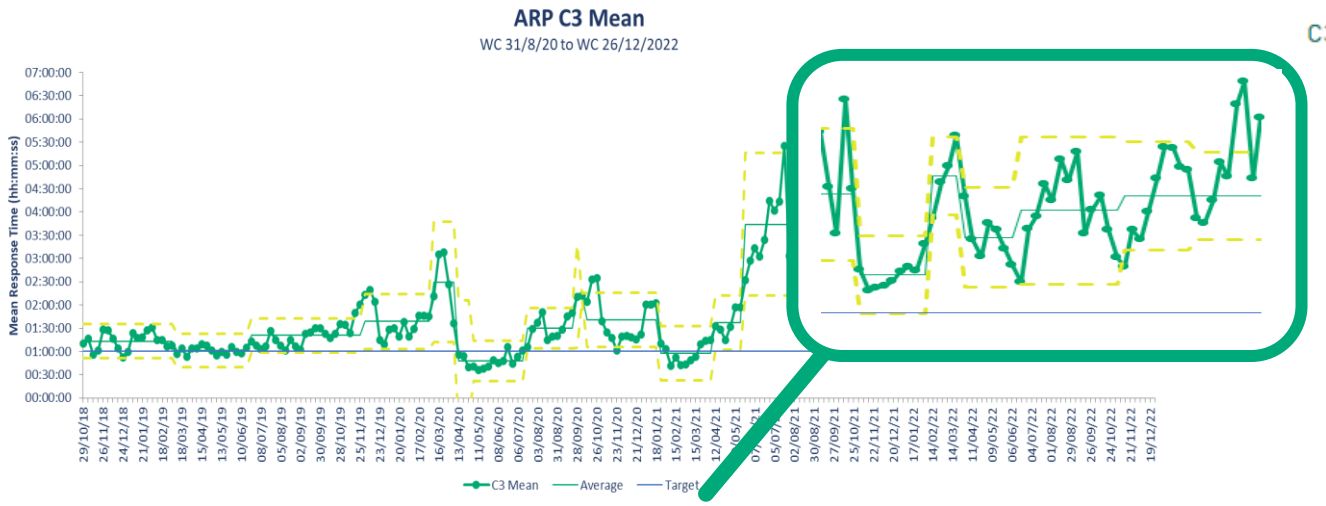


Figure O3.18

C3 Mean (Red=>60m)

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:51:32
CL Morecambe Bay		02:43:36
CL Fylde		03:24:00
CL East Lancashire		03:25:30
CL South Lancashire		04:03:48
G South		05:09:54
G East		05:48:01
G Central		05:48:15
G West		06:07:44
M West		06:10:28
M South		06:16:24
M North		07:07:55
M East		08:23:41

Figure O3.20

C3 Mean	
Target	1:00:00
Dec 2022	5:16:07
YTD	3:30:27

Figure O3.21

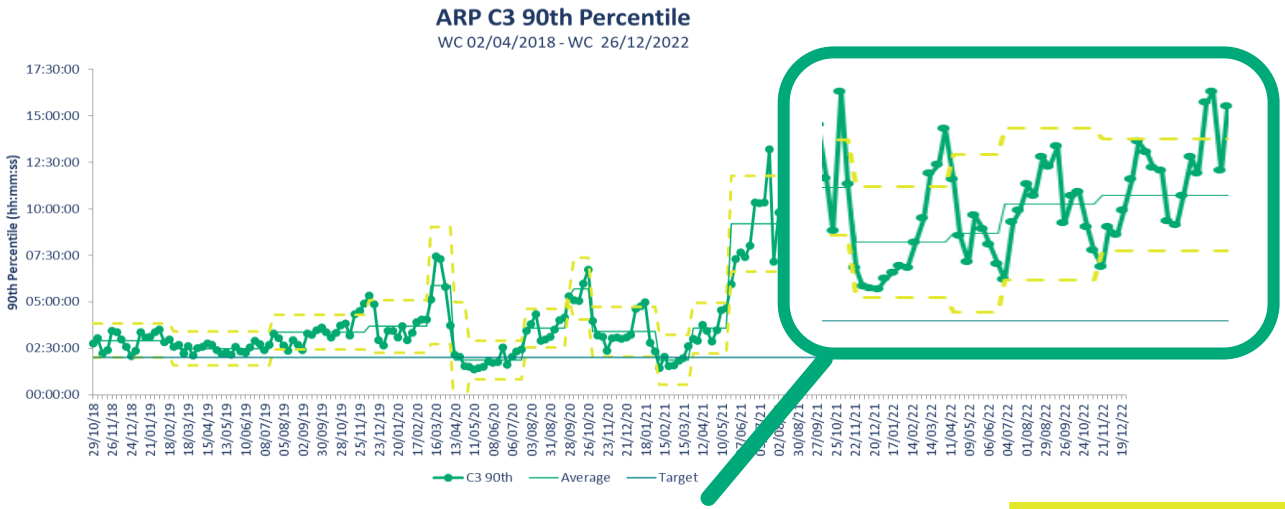


Figure O3.22

C3 90th (Red=>2h)

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		04:35:34
CL Morecambe Bay		06:21:34
CL Fylde		07:48:54
CL East Lancashire		08:43:53
CL South Lancashire		09:55:42
G South		11:46:05
G East		12:41:33
G Central		12:59:55
G West		13:45:16
M South		14:05:24
M West		14:34:46
M North		15:58:30
M East		18:04:14

Figure O3.24

C3 90th	
Target	2:00:00
Dec 2022	12:52:41
YTD	8:29:23

December 2022

Figure O3.25

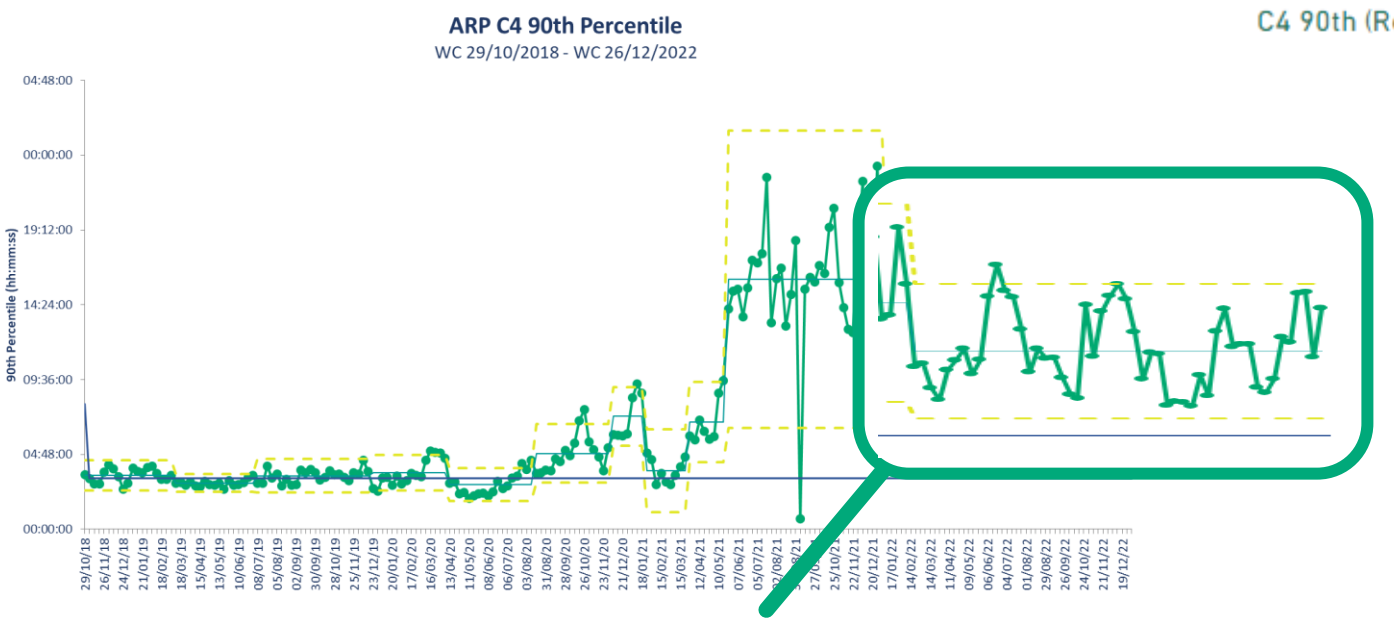


Figure O3.26

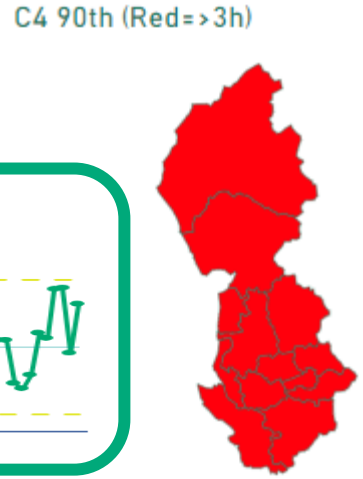


Figure O3.27

Sector	C4 90th	Time
CL North Cumbria		04:01:14
CL Morecambe Bay		09:02:49
CL Fylde		09:55:54
CL East Lancashire		10:29:55
G Central		12:59:14
CL South Lancashire		13:36:56
G West		14:53:03
G East		14:57:02
G South		16:41:11
M North		19:57:38
M South		20:19:32
M West		22:11:59
M East		24:18:10

Figure O3.28

C4 90th	
Target	3:00:00
Dec 2022	15:52:25
YTD	10:51:10

O3 ARP Provider Comparison

Figure O3.25

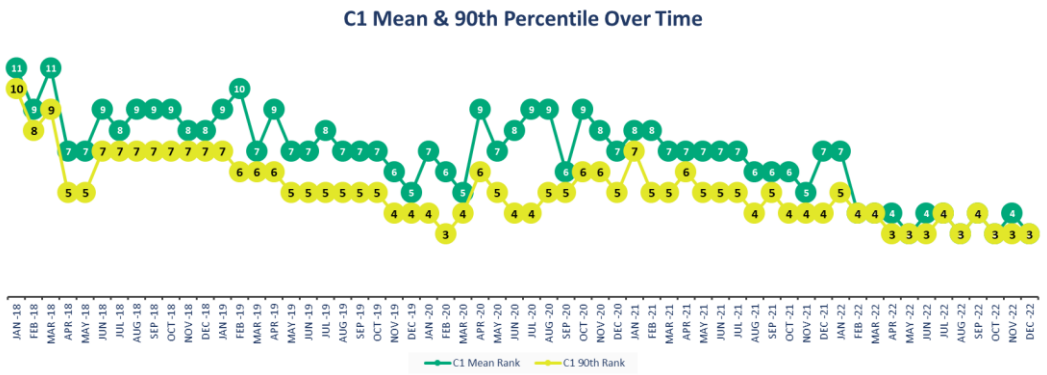


Figure O3.26

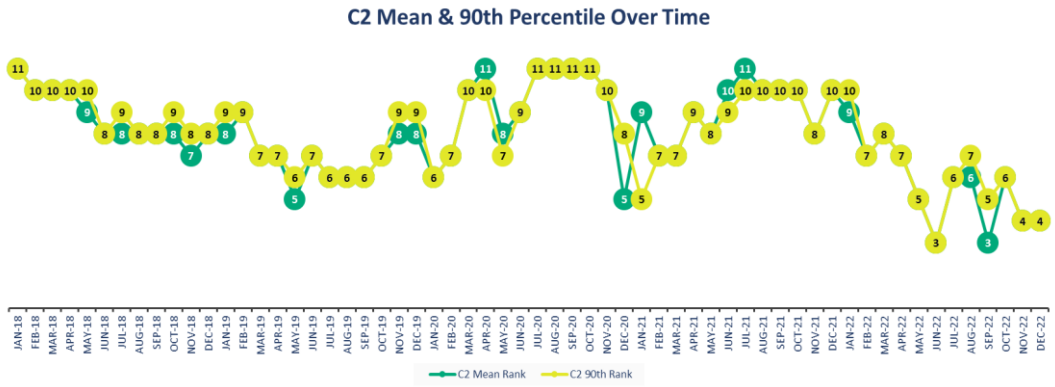


Figure O3.27

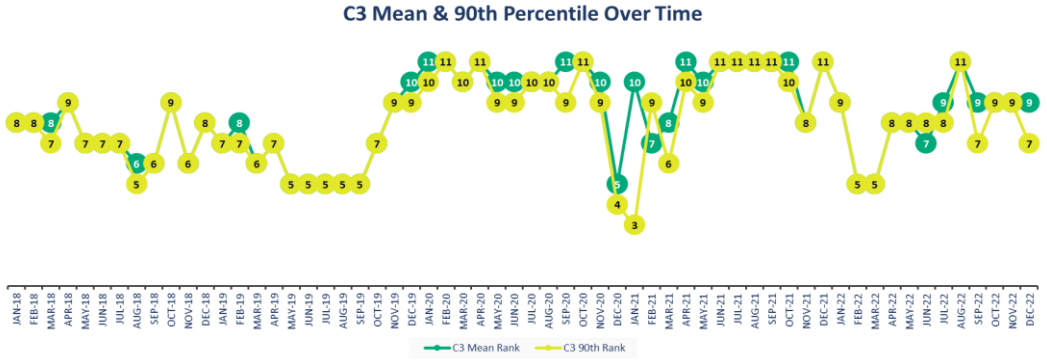
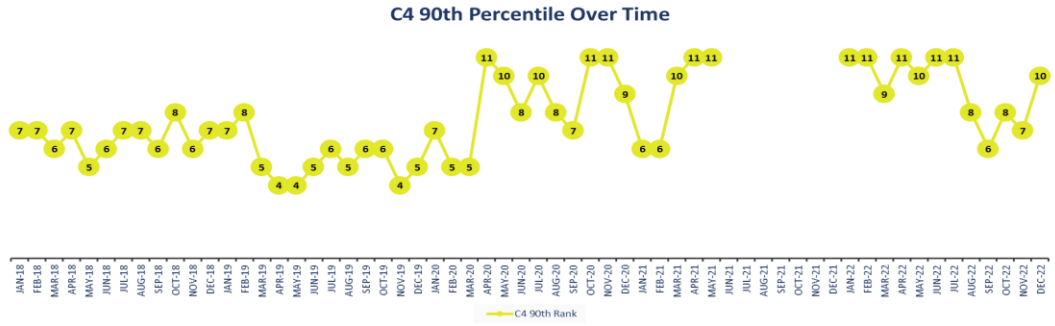


Figure O3.28



Rank	Trust	C1 Mean Time
1	North East	08:51
2	West Midlands	09:14
3	North West	09:58
4	London	10:34
5	East Midlands	10:54
6	Isle of Wight	10:55
7	South Central	10:55
8	South East Coast	11:02
9	Yorkshire	11:19
10	East of England	11:54
11	South Western	13:11

Rank	Trust	C1 90th Time
1	North East	15:27
2	West Midlands	16:09
3	North West	16:56
4	London	18:12
5	Isle of Wight	19:24
6	South East Coast	19:28
7	Yorkshire	19:34
8	South Central	19:37
9	East Midlands	19:59
10	East of England	22:16
11	South Western	23:39

Rank	Trust	C2 Mean Time
1	Isle of Wight	0:39:45
2	South East Coast	0:46:14
3	South Central	0:54:02
4	North West	1:12:11
5	Yorkshire	1:18:01
6	London	1:23:33
7	West Midlands	1:31:10
8	North East	1:36:23
9	East of England	2:06:00
10	East Midlands	2:16:05
11	South Western	2:39:12

Rank	Trust	C2 90th Time
1	Isle of Wight	1:30:17
2	South East Coast	1:36:50
3	South Central	1:53:24
4	South East Coast	2:45:19
5	South Central	3:02:20
6	North East	3:13:21
7	North East	3:39:26
8	West Midlands	3:56:50
9	East of England	5:16:40
10	East Midlands	5:23:16
11	South Western	6:39:34

Rank	Trust	C3 Mean Time
1	Isle of Wight	01:43:15
2	London	02:24:21
3	Yorkshire	03:32:43
4	South East Coast	03:52:13
5	South Central	03:58:24
6	North East	04:11:02
7	West Midlands	04:48:31
8	East of England	05:10:51
9	North West	05:16:07
10	East Midlands	05:24:09
11	South Western	05:45:06

Rank	Trust	C3 90th Time
1	Isle of Wight	04:36:58
2	London	06:11:51
3	Yorkshire	08:36:54
4	South Central	09:52:24
5	South East Coast	09:55:36
6	North East	10:41:57
7	North West	12:52:41
8	East Midlands	13:13:44
9	South Western	13:19:48
10	East of England	13:29:50
11	South Western	15:34:41

Rank	Trust	C4 90th Time
1	Isle of Wight	04:30:53
2	North East	05:21:42
3	Yorkshire	08:31:26
4	London	08:57:44
5	West Midlands	12:00:13
6	South Central	12:10:42
7	South East Coast	12:38:11
8	East Midlands	13:59:50
9	South Western	14:35:37
10	North West	15:52:25
11	East of England	18:32:35

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
Jul-22	1,207
Aug-22	653
Sep-22	804
Oct-22	1,186
Nov-22	959
Dec-22	1,619

Figure O3.29

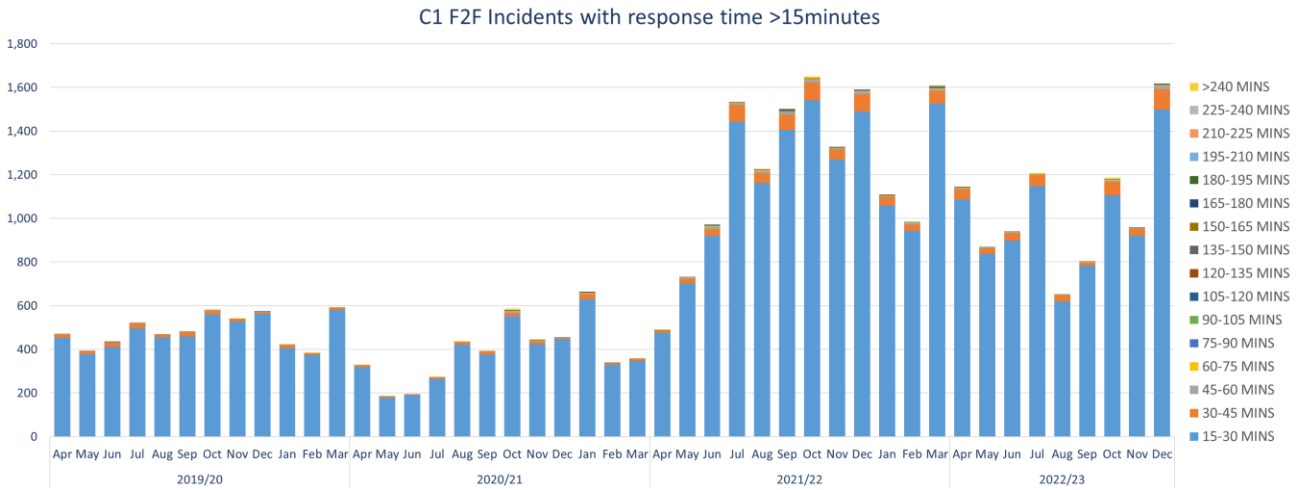


Figure O3.30

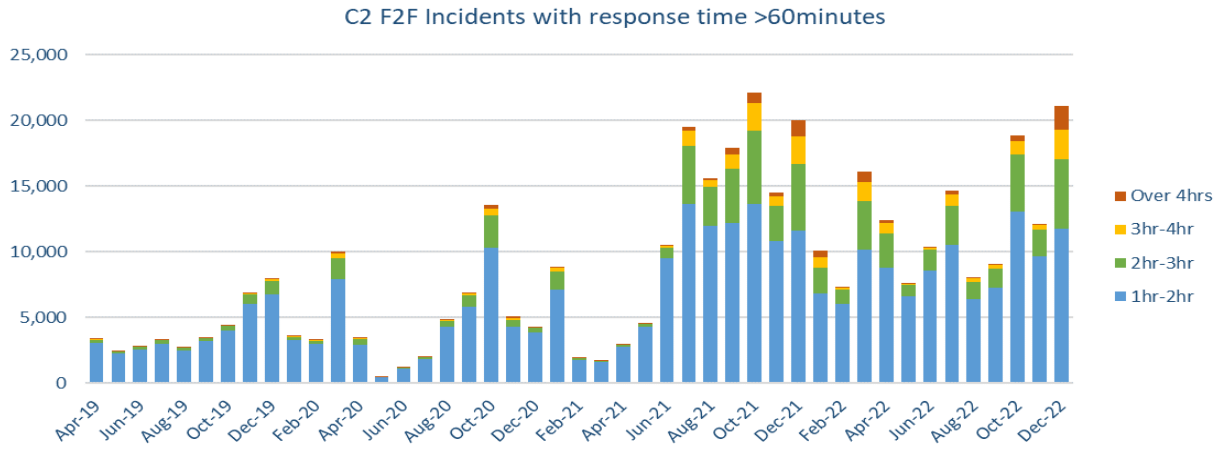
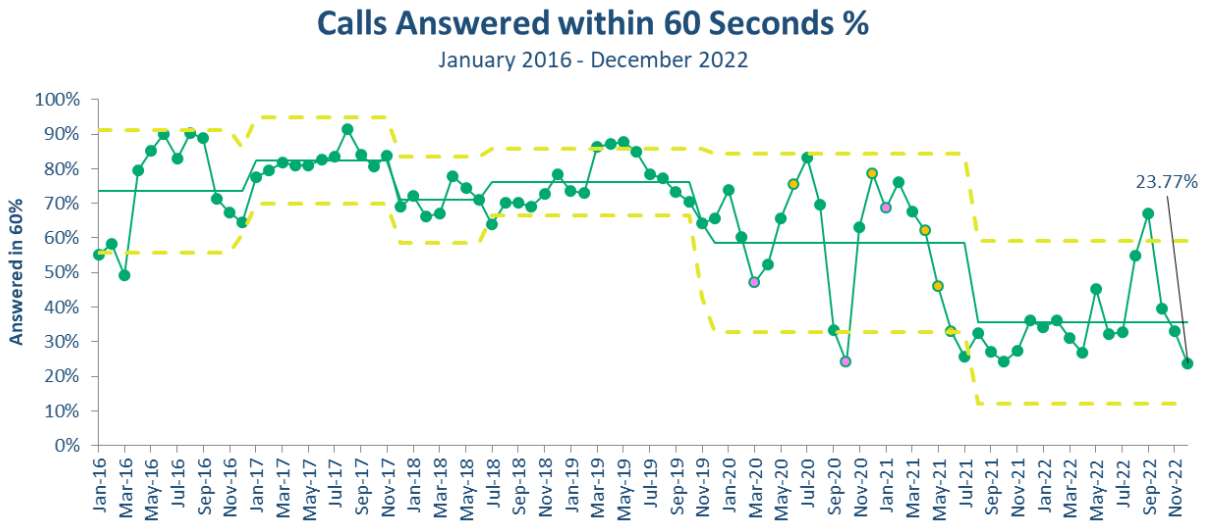


Table O3.30

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
Jul-22	14,649
Aug-22	8,051
Sep-22	9,057
Oct-22	18,870
Nov-22	12,153
Dec-22	21,089

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
Dec 2022	23.77%
YTD	39.52%
National	45%

Figure O4.2

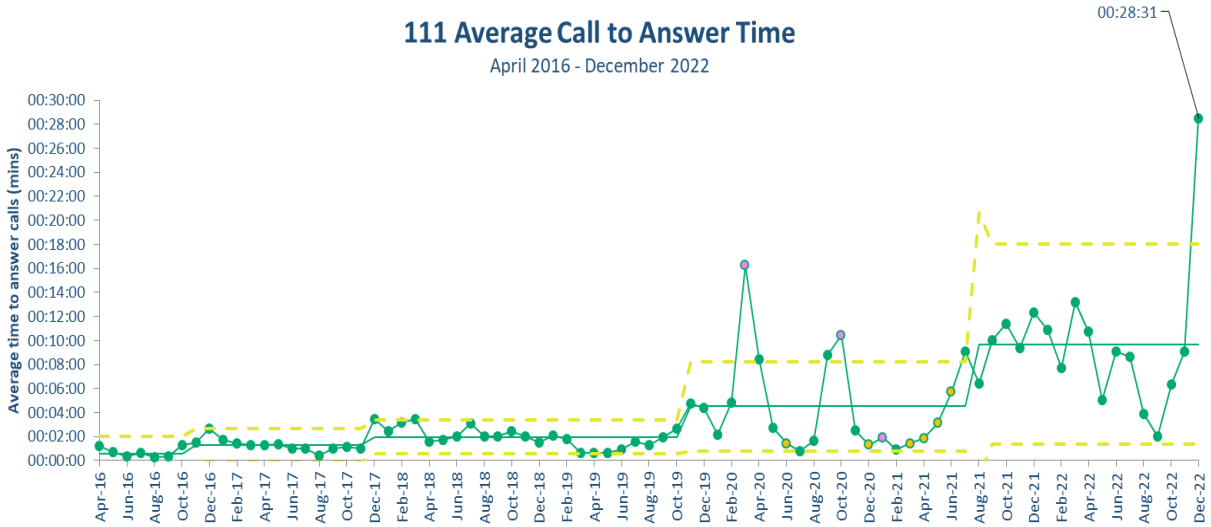
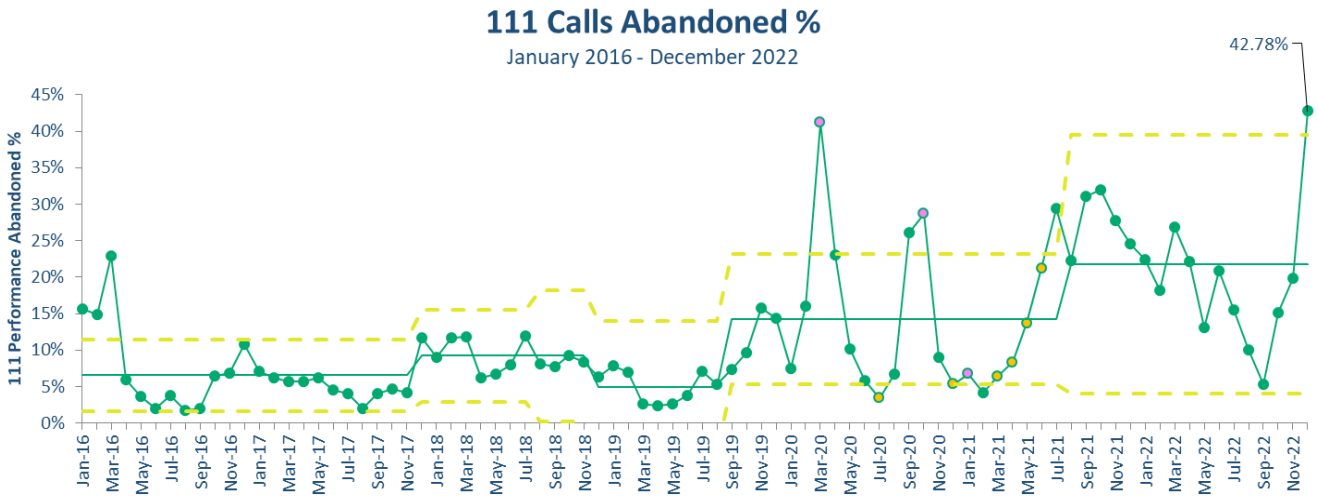


Figure O4.3



Calls Abandoned %	
Target	<5%
Dec 2022	42.78%
YTD	18.30%
National	14.5%

Figure O4.4a

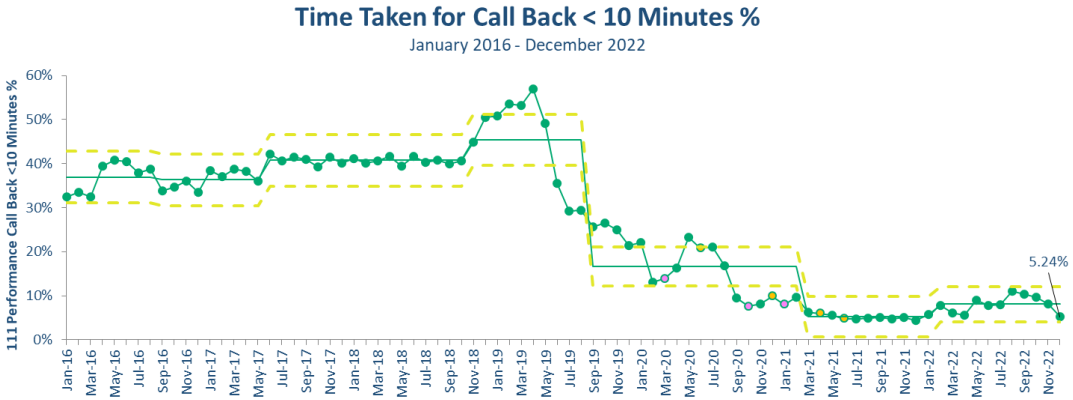
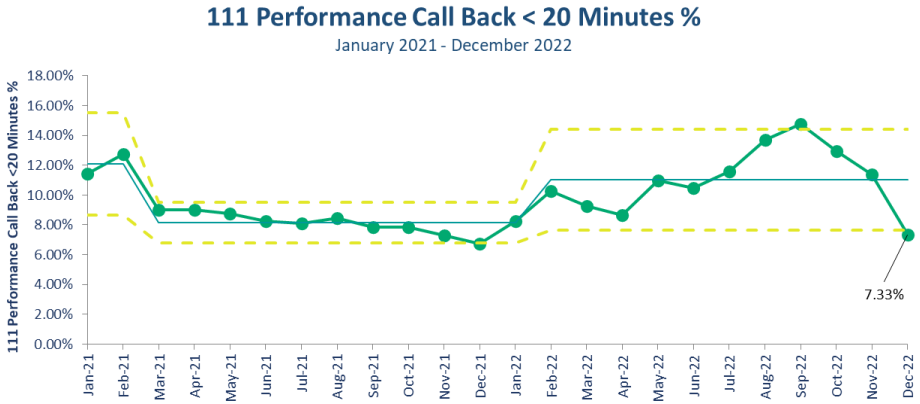


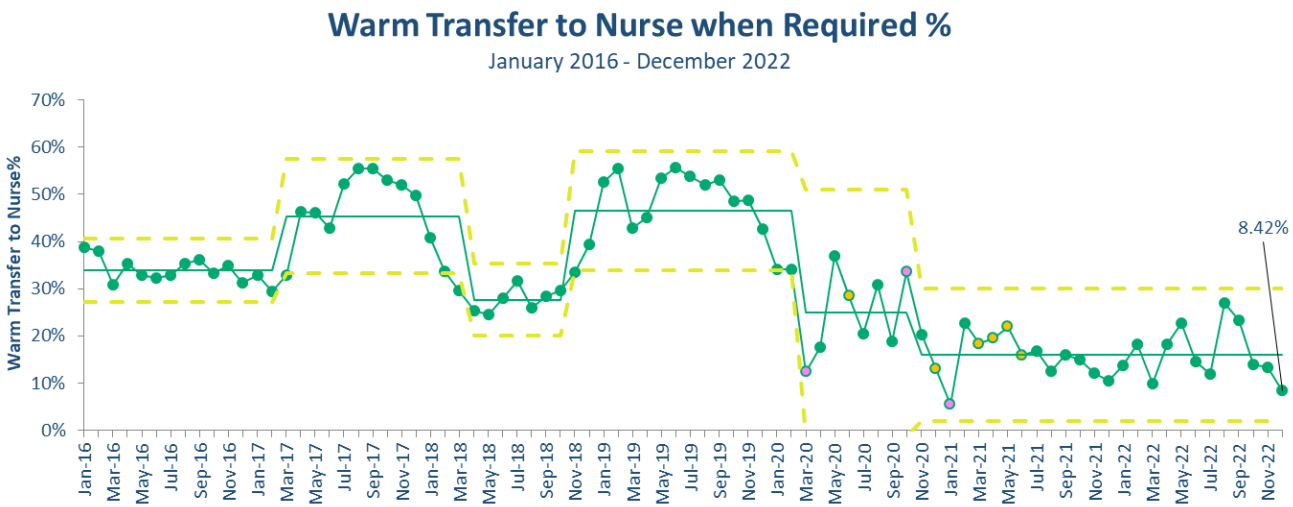
Figure O4.4b



Calls Back <10 Mins	
Target	75%
Dec 2022	5.24%
YTD	8.31%

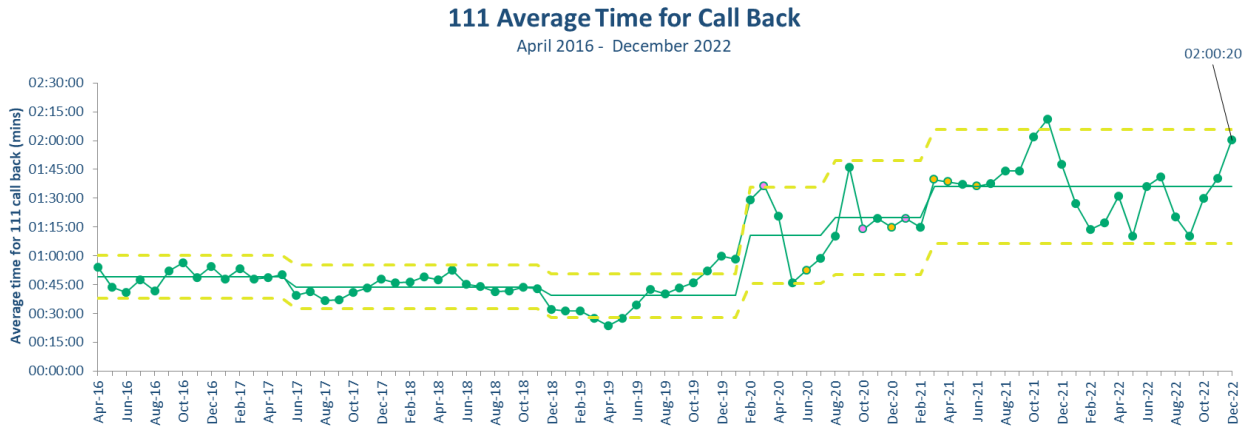
Calls Back <20 Mins	
Target	90%
Oct 2022	7.33%
YTD	9.35%

Figure O4.5



Warm Transfer %	
Target	75%
Dec 2022	8.42%
YTD	17.08%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY

TOTAL ACTIVITY

	Current Month: November 2022					Year to Date: July 2022 - November 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	10,940	(3,084)	(22%)	70,121	50,592	(19,529)	(28%)
Greater Manchester	526,588	43,882	45,362	1,480	3%	219,412	214,653	(4,759)	(2%)
Lancashire	589,181	49,098	38,014	(11,084)	(23%)	245,492	179,475	(66,017)	(27%)
Merseyside	300,123	25,010	25,897	887	4%	125,051	119,805	(5,246)	(4%)
NWAS	1,584,182	132,015	120,213	(11,802)	(9%)	660,076	564,525	(95,551)	(14%)

UNPLANNED ACTIVITY

	Current Month: November 2022					Year to Date: July 2022 - November 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	505	(742)	(60%)	6,237	2,273	(3,964)	(64%)
Greater Manchester	49,133	4,094	4,189	95	2%	20,472	20,921	449	2%
Lancashire	58,829	4,902	3,149	(1,753)	(36%)	24,512	15,553	(8,959)	(37%)
Merseyside	22,351	1,863	2,085	222	12%	9,313	8,142	(1,171)	(13%)
NWAS	145,282	12,107	9,928	(2,179)	(18%)	60,534	46,889	(13,645)	(23%)

ABORTED ACTIVITY

	November 2022								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	282	6,362	4%	44	423	10%	54	3,439	2%
Greater Manchester	1,905	19,015	10%	1,163	4,206	28%	1,102	18,642	6%
Lancashire	1,221	19,708	6%	633	3,233	20%	564	12,889	4%
Merseyside	754	10,858	7%	328	1,431	23%	884	11,504	8%
NWAS	4,162	55,943	7%	2,168	9,293	23%	2,604	46,474	6%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

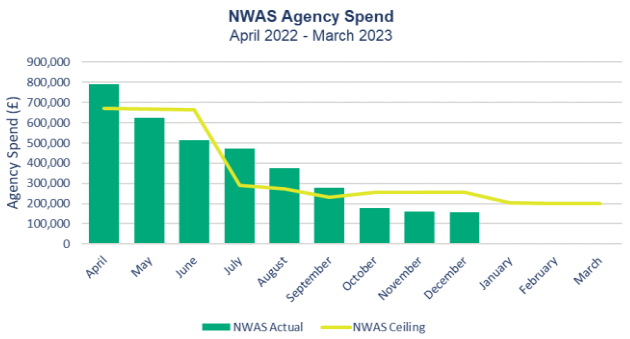


Figure F1.2

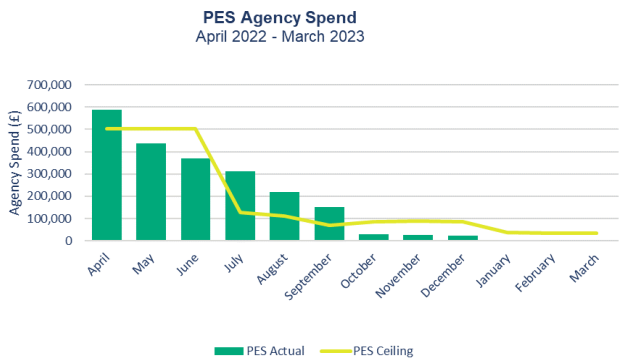


Figure F1.3

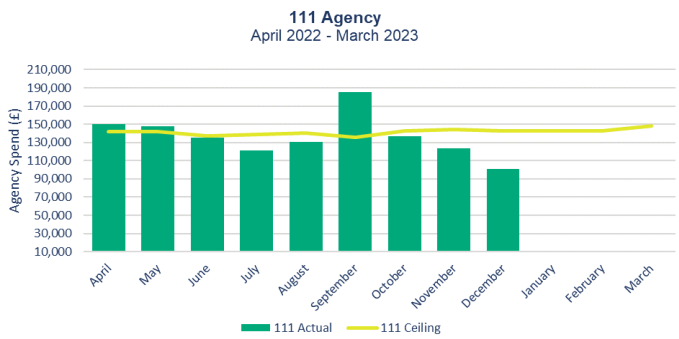


Figure F1.4

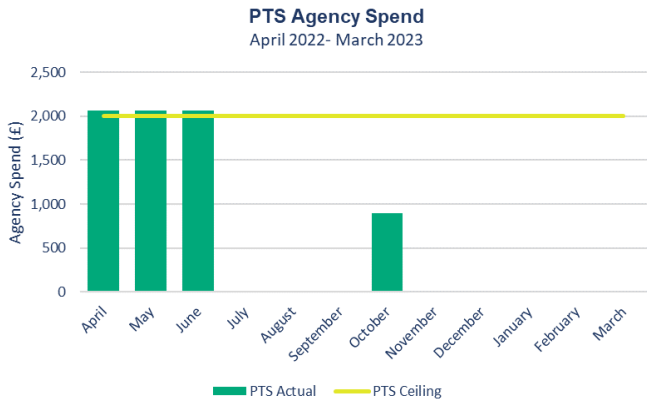


Figure F1.5

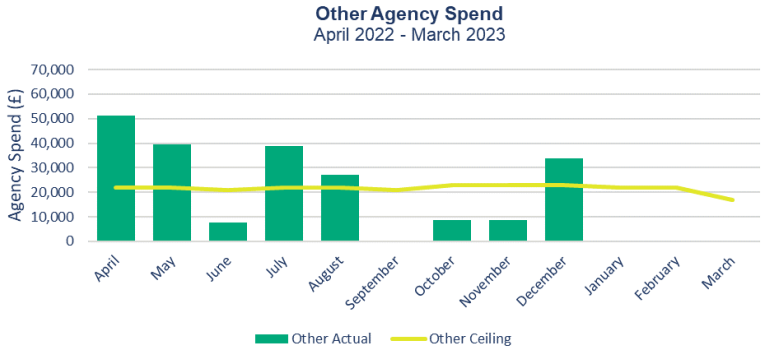
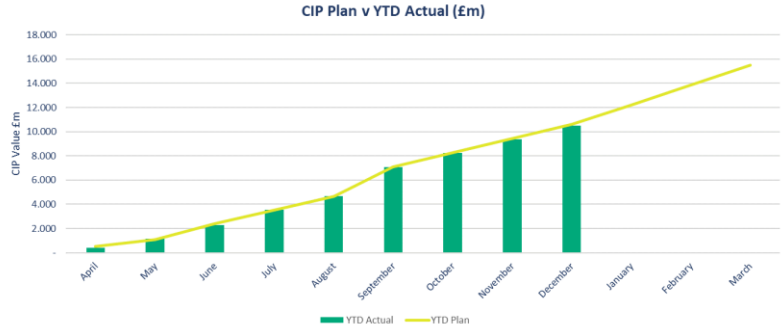


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

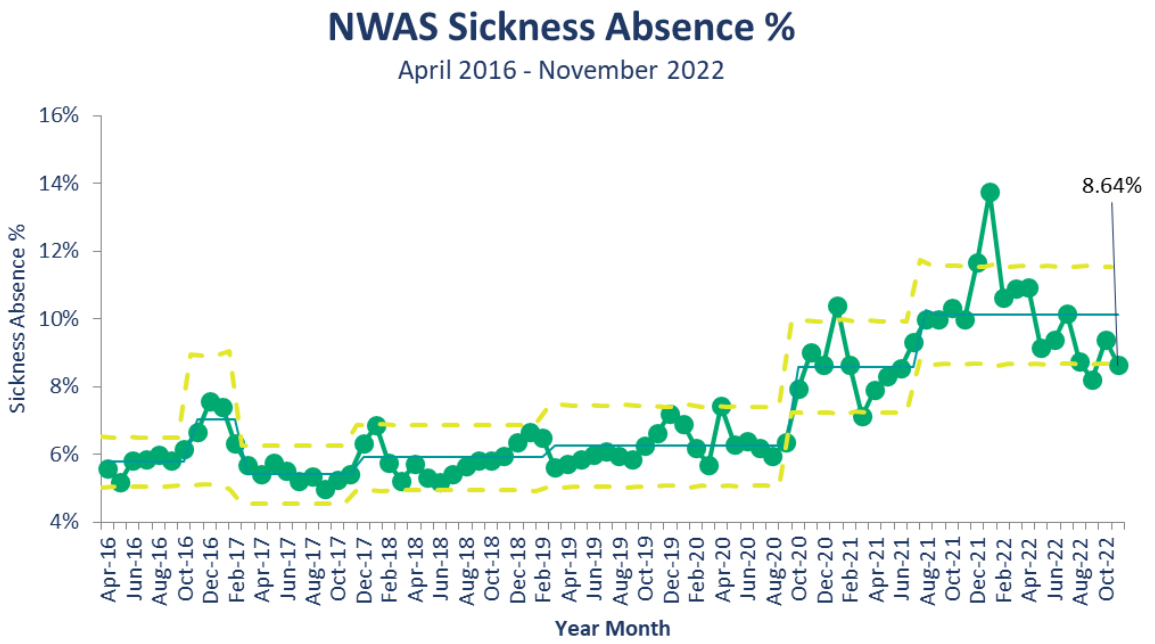


Table OH1.1

Sickness Absence	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul–22	Aug-22	Sep-22	Oct-22	Nov-22
NWAS	11.66%	13.74%	10.56%	10.91%	10.92%	9.15%	9.40%	10.16%	8.73%	8.21%	9.38%	8.64%
Amb. National Average	9.41%	9.91%	8.56%	9.10%	9.18%	7.64%	7.90%	8.73%	7.45%			

Figure OH1.2

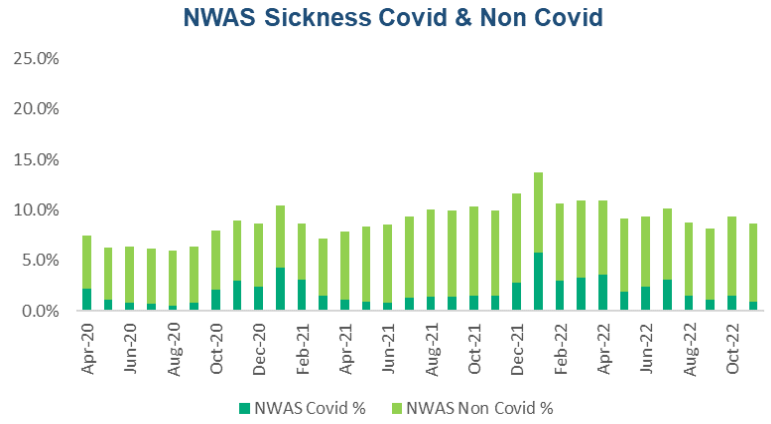


Table OH1.2

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%
Jun-22	2.4%	7.0%	9.4%
Jul-22	3.1%	7.1%	10.2%
Aug-22	1.5%	7.2%	8.7%
Sep-22	1.1%	7.1%	8.2%
Oct-22	1.5%	7.9%	9.4%
Nov-22	0.9%	7.7%	8.6%

Figure OH1.3

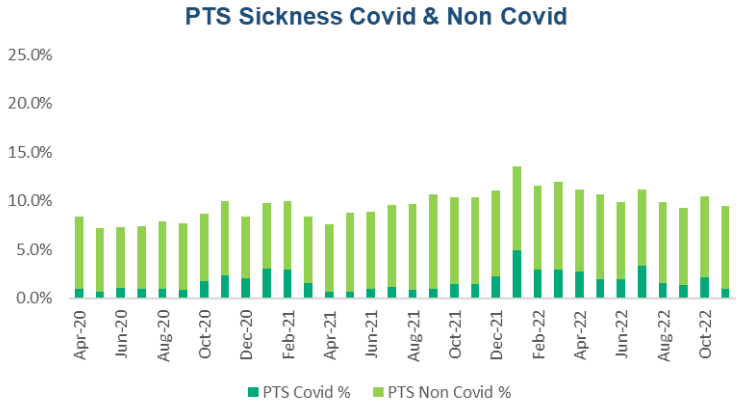


Table OH1.3

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%
Jun-22	2.0%	7.9%	9.9%
Jul-22	3.3%	7.8%	11.1%
Aug-22	1.5%	8.3%	9.9%
Sep-22	1.4%	7.9%	9.3%
Oct-22	2.1%	8.3%	10.4%
Nov-22	1.0%	8.5%	9.5%

Figure OH1.4

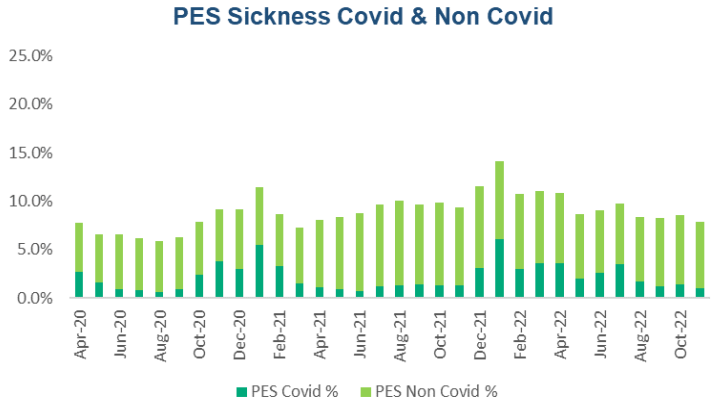


Table OH1.4

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%
Jun-22	2.6%	6.4%	9.0%
Jul-22	3.5%	6.3%	9.8%
Aug-22	1.7%	6.6%	8.3%
Sep-22	1.2%	7.0%	8.3%
Oct-22	1.4%	7.1%	8.5%
Nov-22	1.0%	6.9%	7.9%

Figure OH1.5

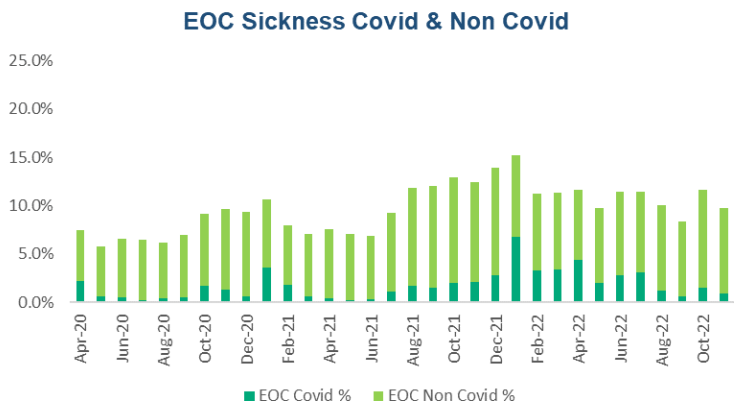


Figure OH1.6

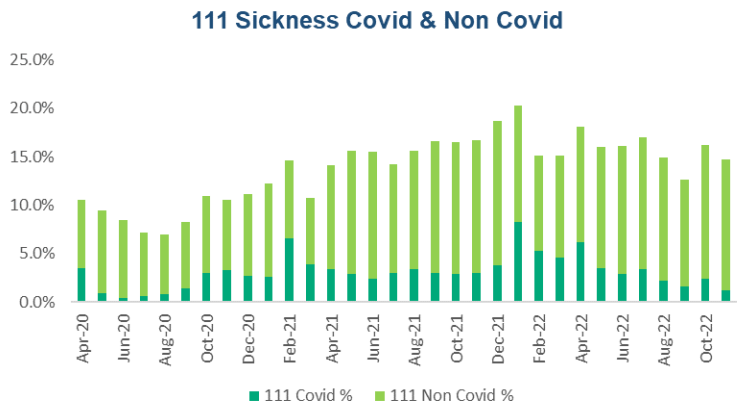


Figure OH1.7

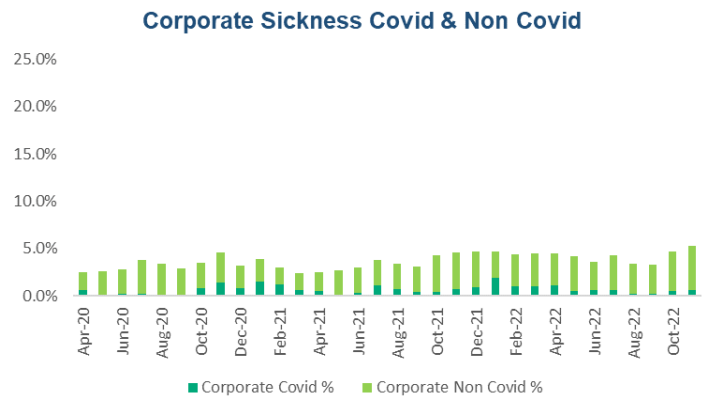


Table OH1.5

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%
Jun-22	2.8%	8.7%	11.5%
Jul-22	3.1%	8.3%	11.4%
Aug-22	1.2%	8.9%	10.1%
Sep-22	0.7%	7.6%	8.3%
Oct-22	1.6%	10.1%	11.6%
Nov-22	0.9%	8.9%	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%
Jun-22	2.9%	13.2%	16.1%
Jul-22	3.5%	13.6%	17.0%
Aug-22	2.2%	12.6%	14.9%
Sep-22	1.7%	11.0%	12.7%
Oct-22	2.4%	13.8%	16.2%
Nov-22	1.2%	13.5%	14.7%

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%
Jun-22	0.6%	3.0%	3.6%
Jul-22	0.7%	3.7%	4.3%
Aug-22	0.3%	3.1%	3.4%
Sep-22	0.3%	3.1%	3.4%
Oct-22	0.5%	4.2%	4.7%
Nov-22	0.6%	4.7%	5.3%

OH2 STAFF TURNOVER

Figure OH2.1

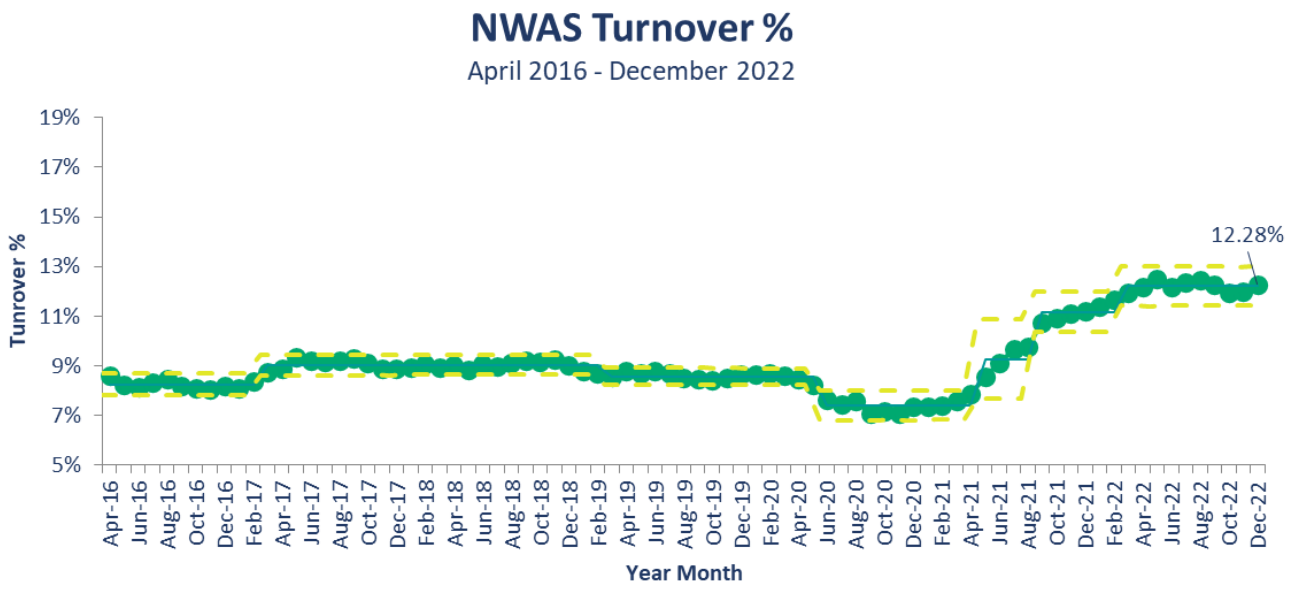


Table OH2.1

Turnover	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
NWAS	11.37%	11.68%	11.94%	12.17%	12.49%	12.19%	12.35%	12.45%	12.28%	11.94%	12.01%	12.28%
Amb. National Average	10.80%	11.09%	11.43%	12.09%	12.10%	12.27%	12.27%	12.27%	12.23%			

Figure OH2.2

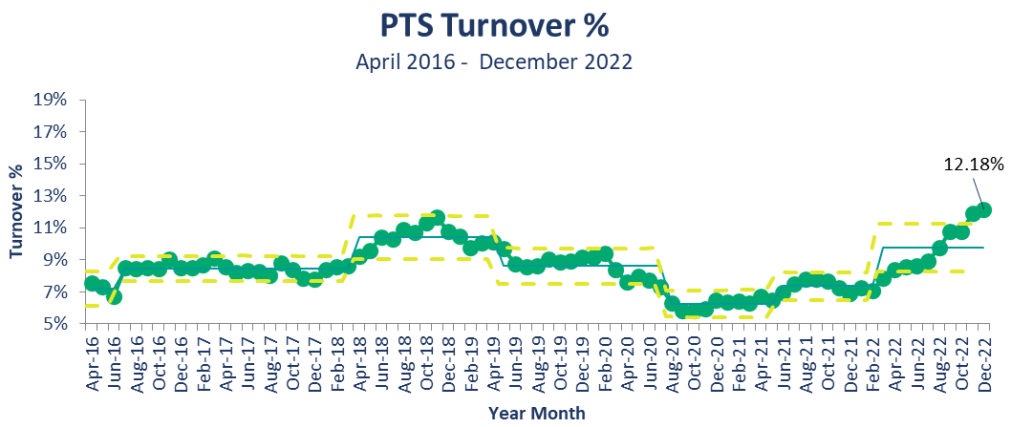


Figure OH2.3

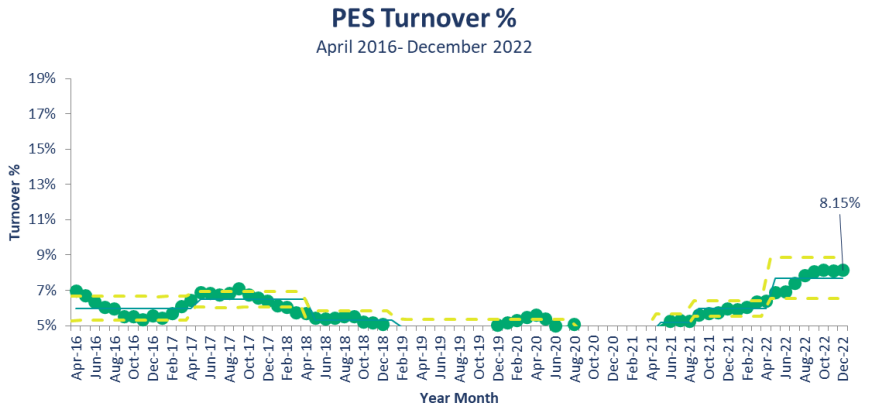


Figure OH2.4

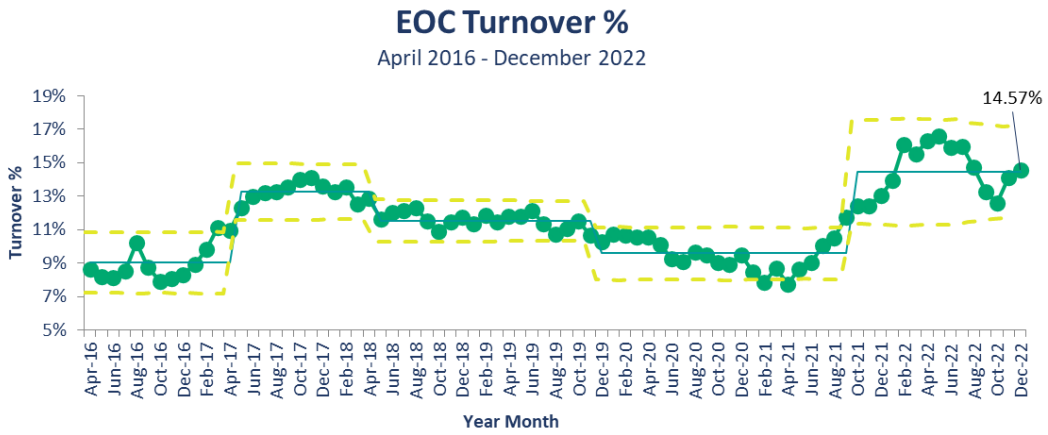
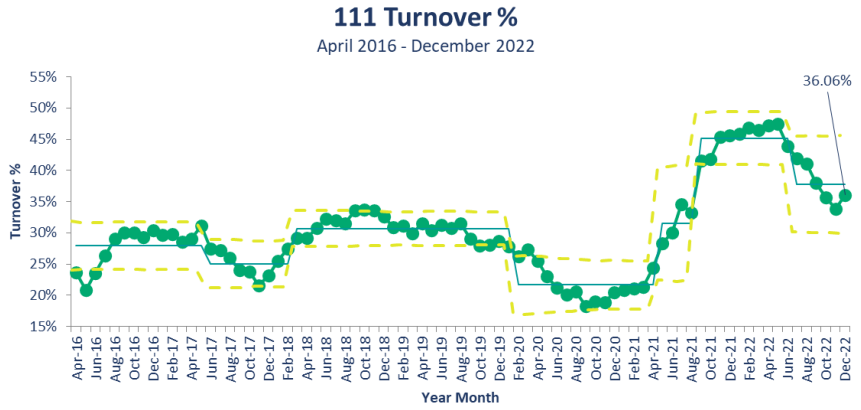


Figure OH2.5



The scale on the 111 Turnover % is different to the others. 15%-55% for 111 and 5% to 19% for the others.

OH4 TEMPORARY STAFFING

Figure OH4.1

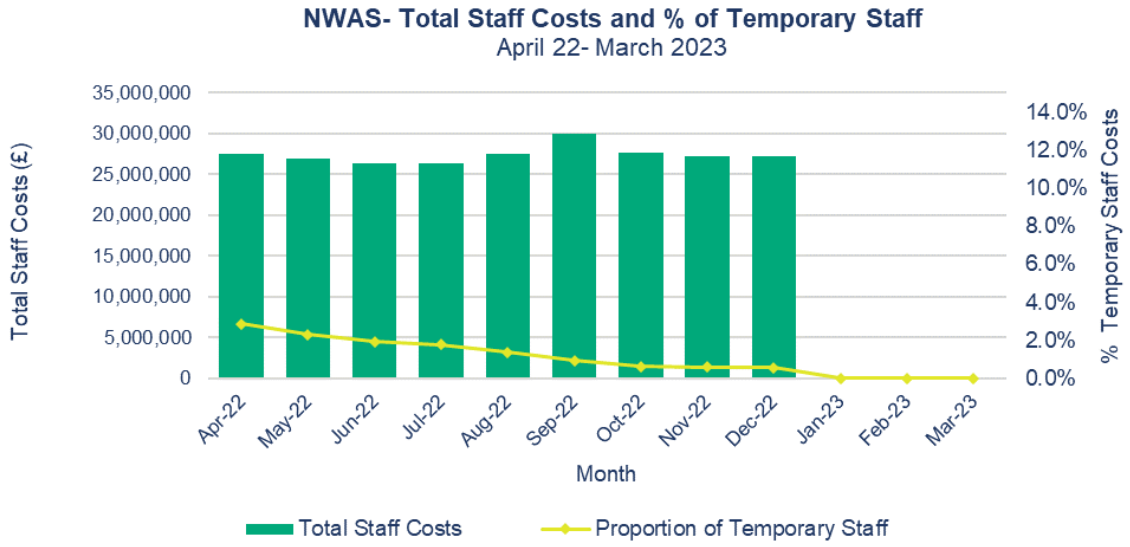


Table OH4.1

NWAS	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July -22	Aug-22	Sep-22	Oct-22	Nov- 22	Dec-22
Agency Staff Costs (£)	783,115	864,691	1,072,794	792,309	624,873	514,594	472,303	376,736	279,546	176,850	159,947	157,417
Total Staff Costs (£)	27,466,754	26,722,244	42,104,411	27,581,772	26,920,461	26,399,198	26,352,765	27,478,110	29,946,339	27,740,005	27,494,954	27,204,469
Proportion of Temporary Staff %	2.9%	3.2%	2.5%	2.9%	2.3%	1.9%	1.8%	1.4%	0.9%	0.6%	0.6%	0.6%

Figure OH4.3

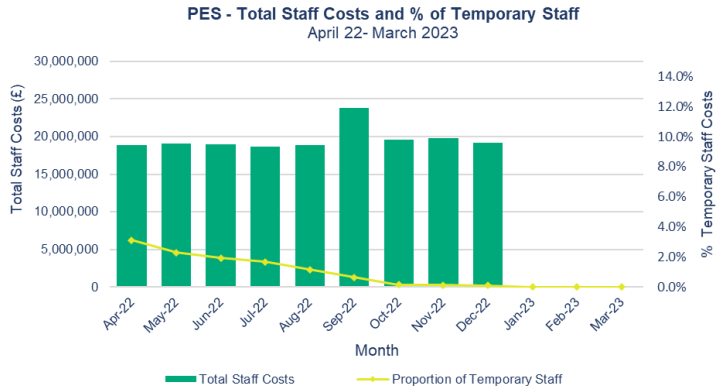


Figure OH4.4

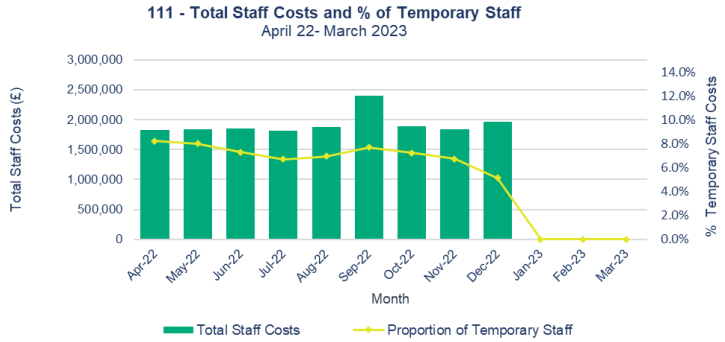


Figure OH4.5

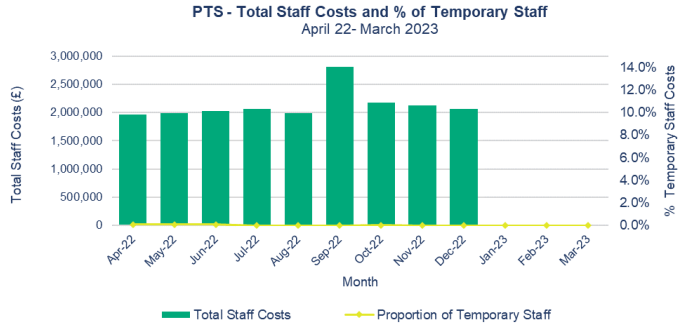
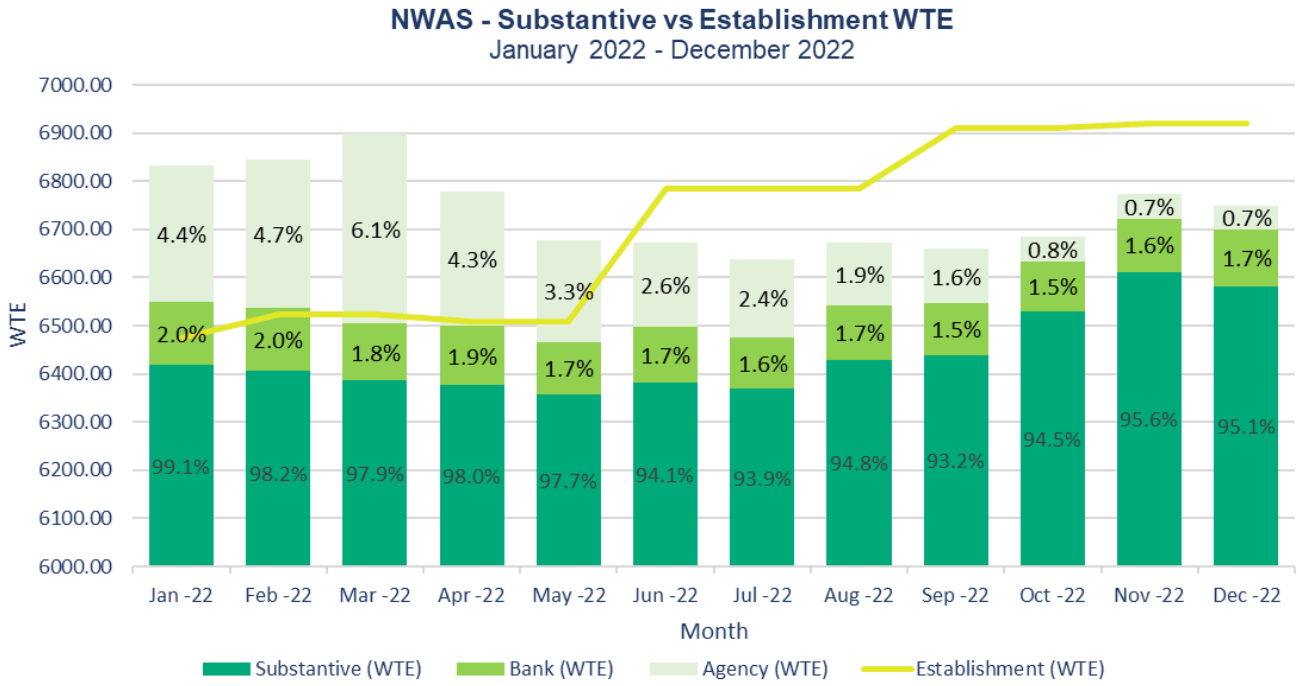


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

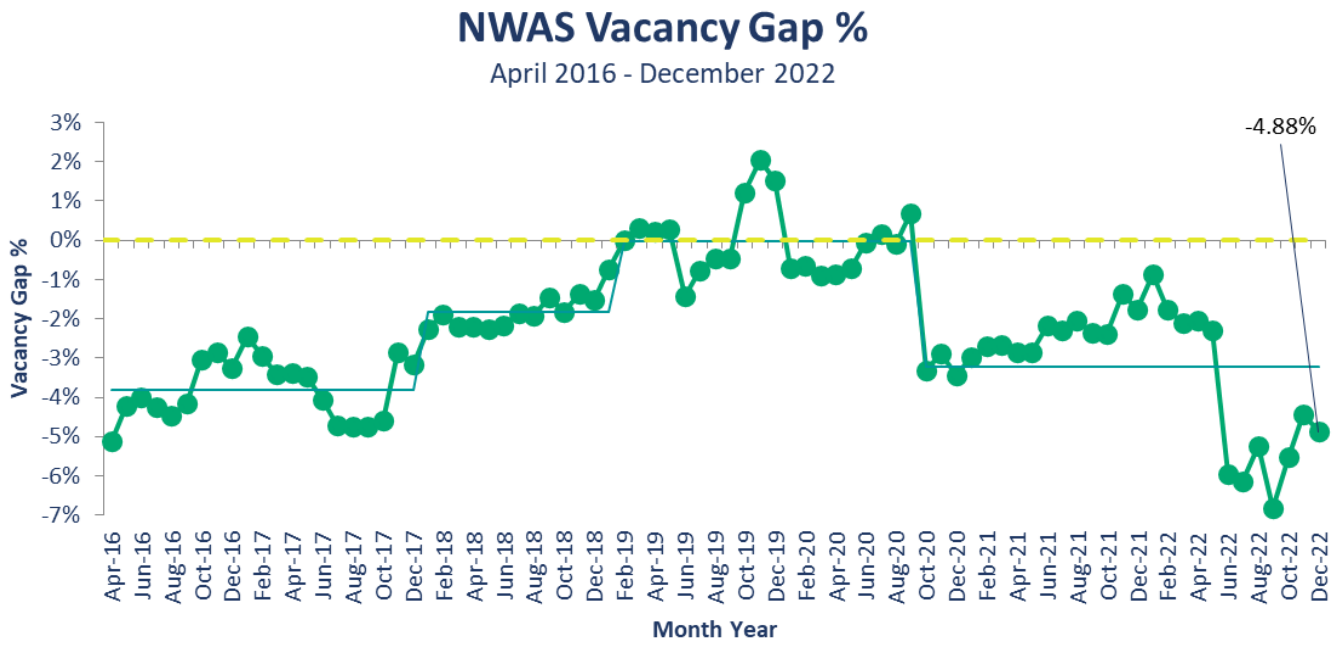


Table OH5.1

Vacancy Gap	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22	Sep-22	Oct-22	N0v-22	Dec-22
NWAS	-0.87%	-1.77%	-2.10%	-2.03%	-2.30%	-5.95%	-6.13%	-5.24%	-6.81%	-5.51%	-4.44%	-4.88%

Figure OH5.2

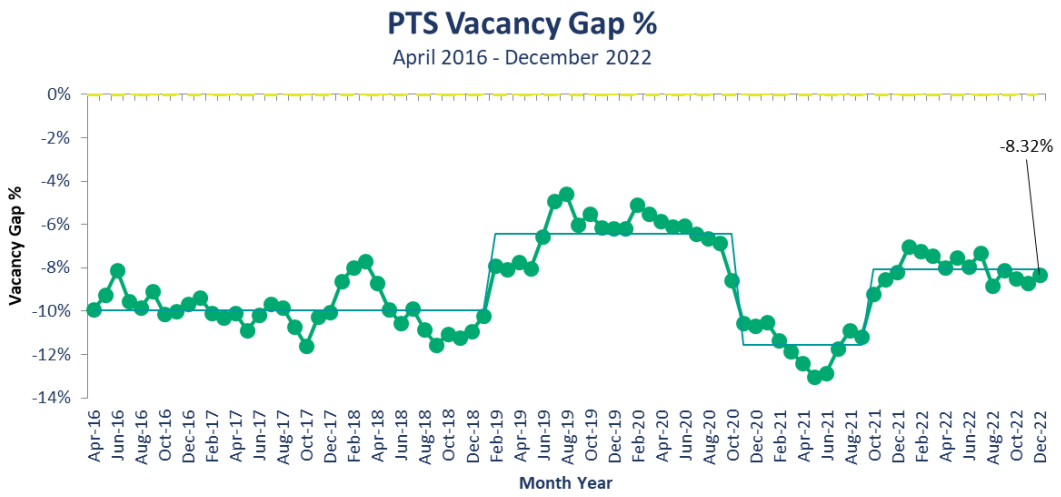


Figure OH5.3

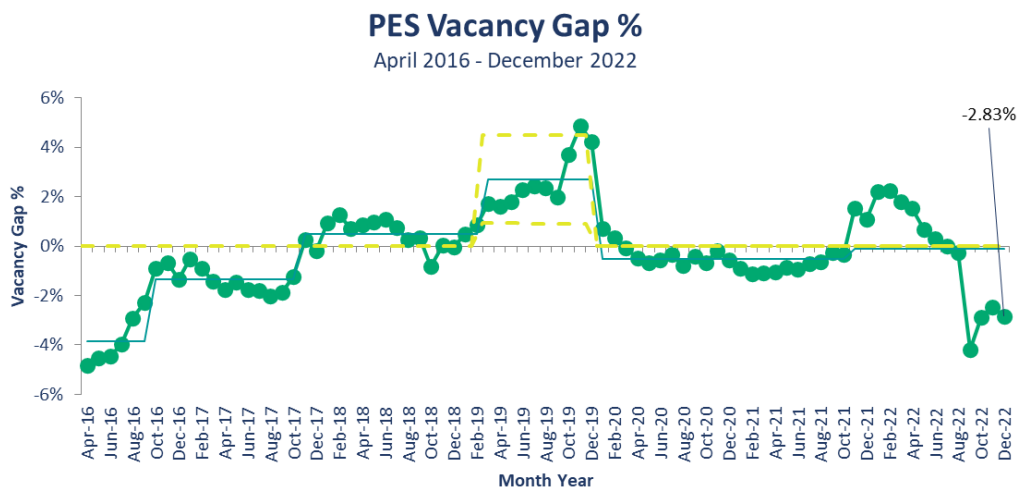


Figure OH5.4

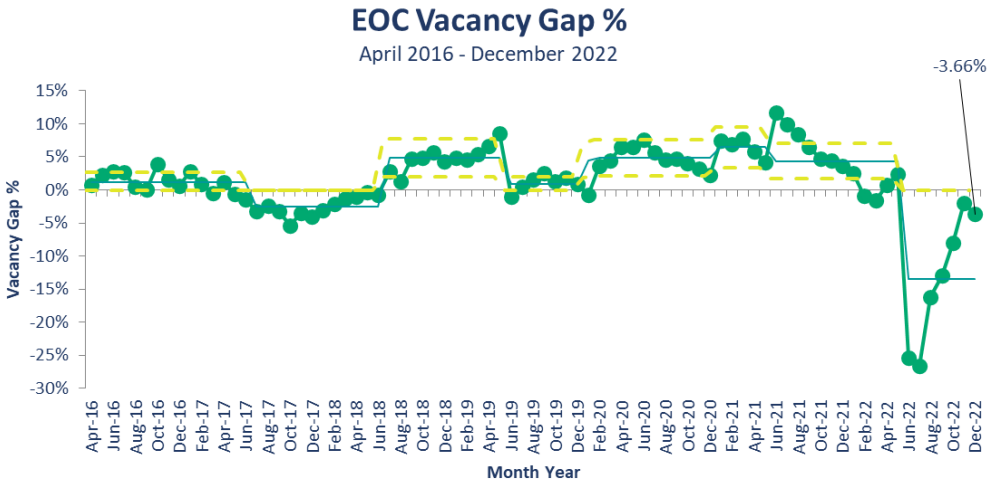
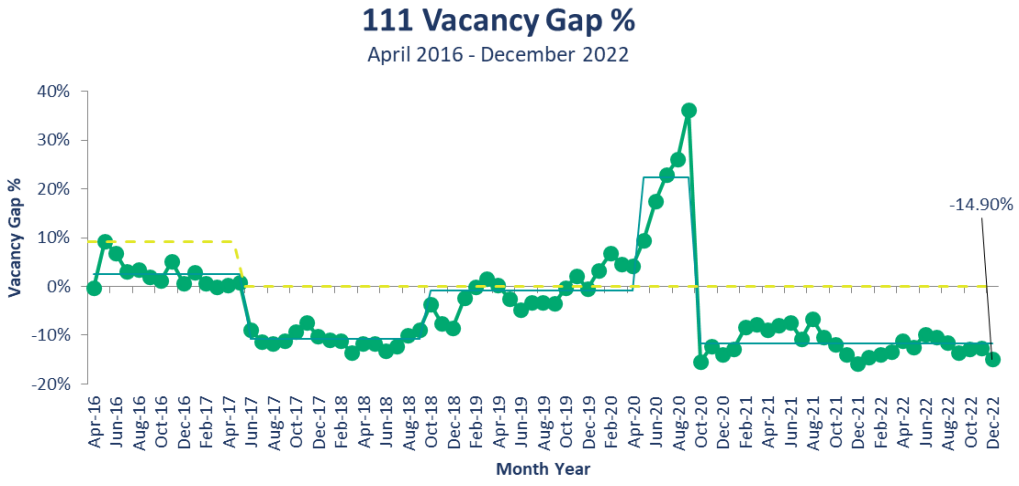


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

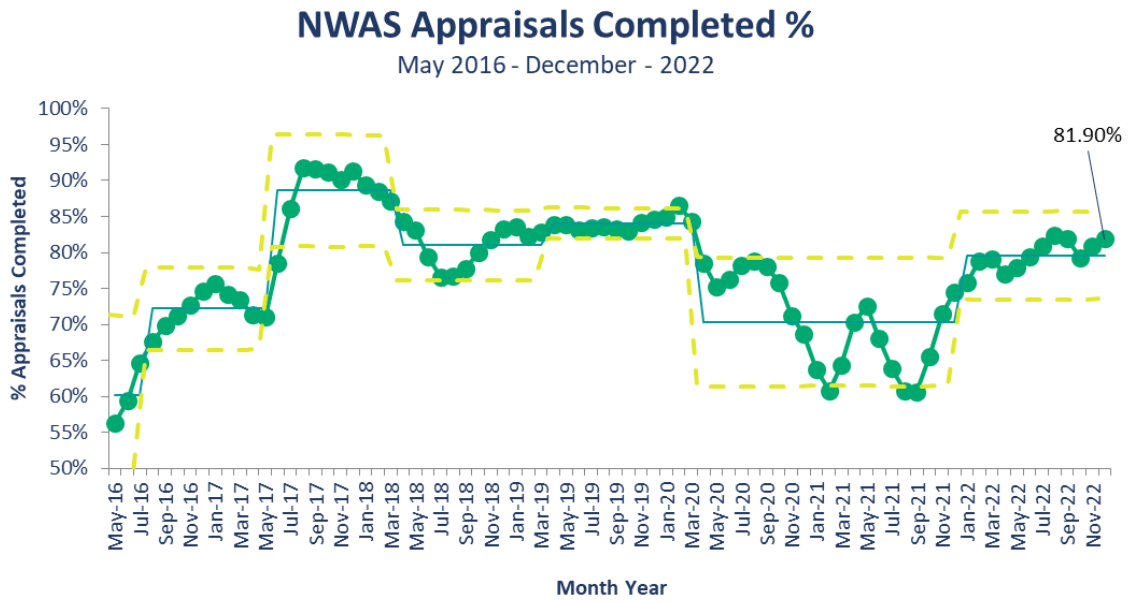


Table OH6.1

Appraisals	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
NWAS	76%	79%	79&	77%	78%	79%	81%	82%	82%	79%	81%	82%

Figure OH6.2

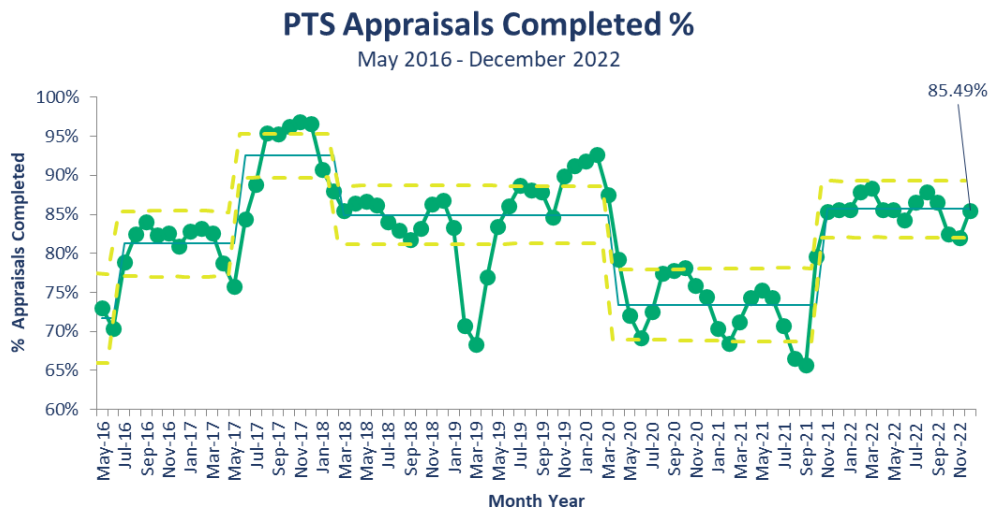


Figure OH6.3

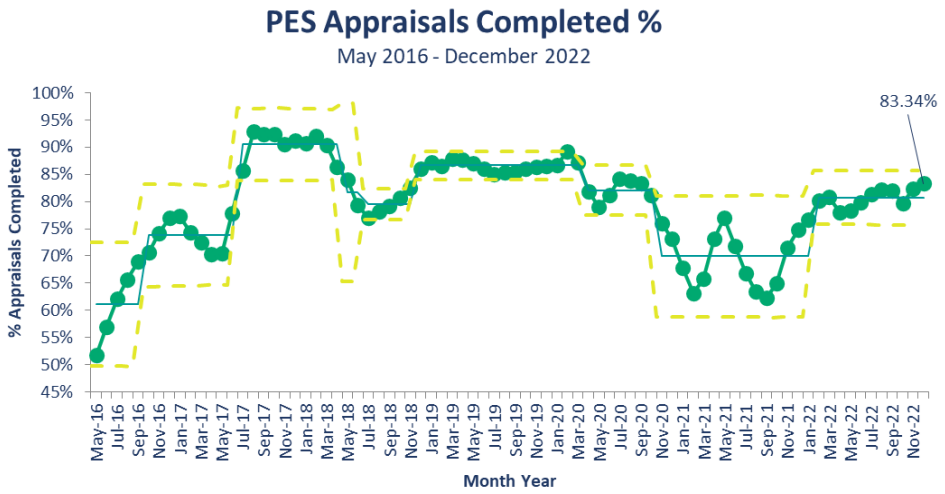


Figure OH6.4

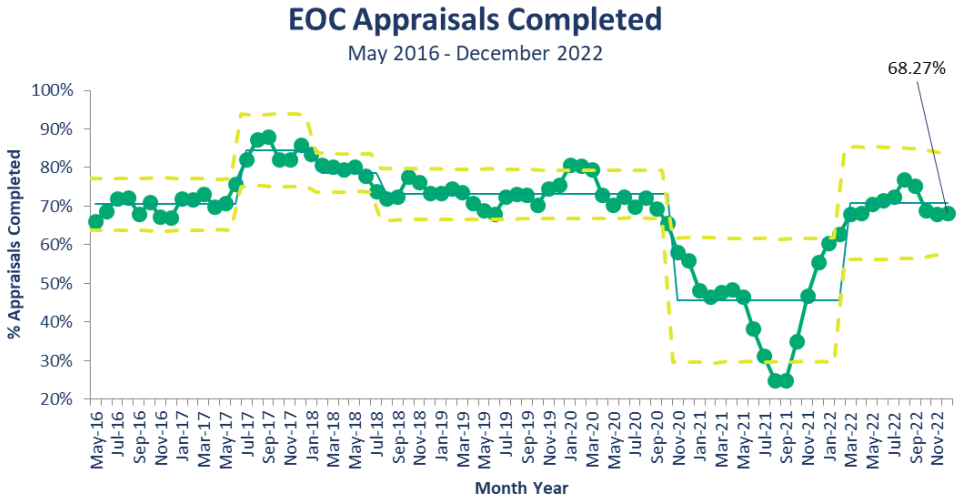
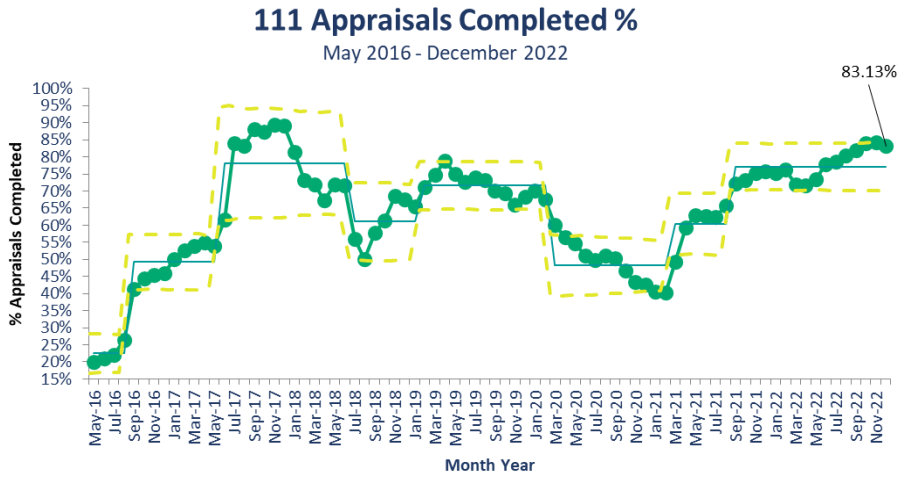


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

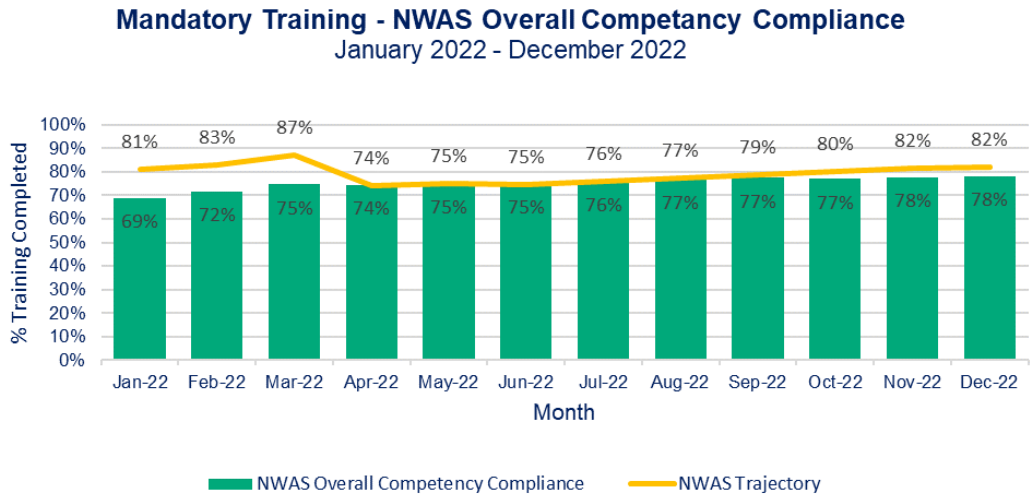


Figure OH7.2

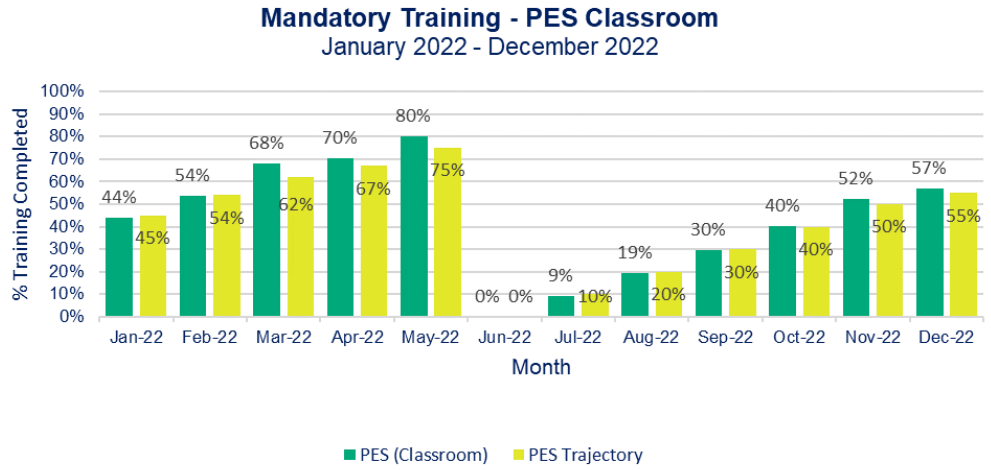


Figure OH7.3

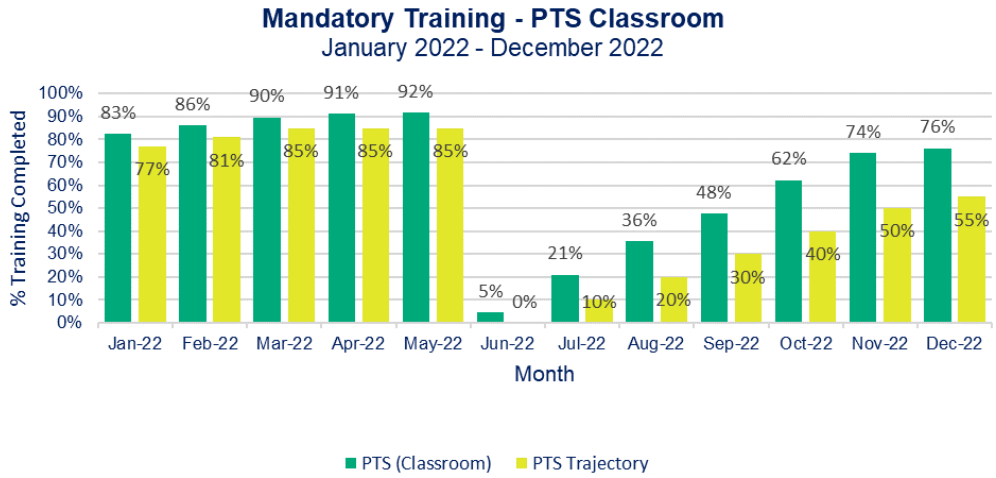


Figure OH7.4

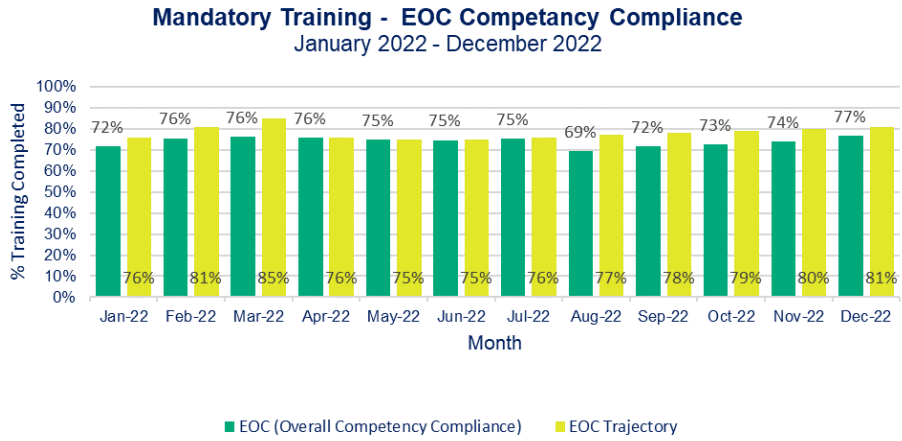


Figure OH7.5

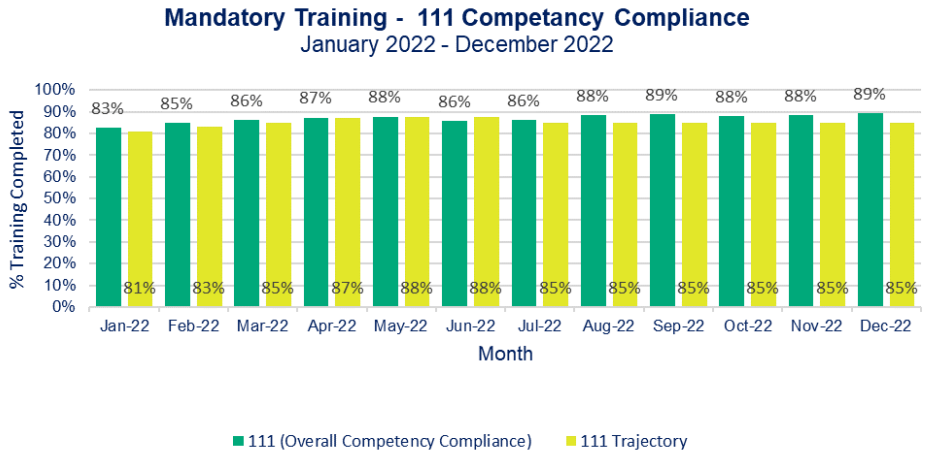
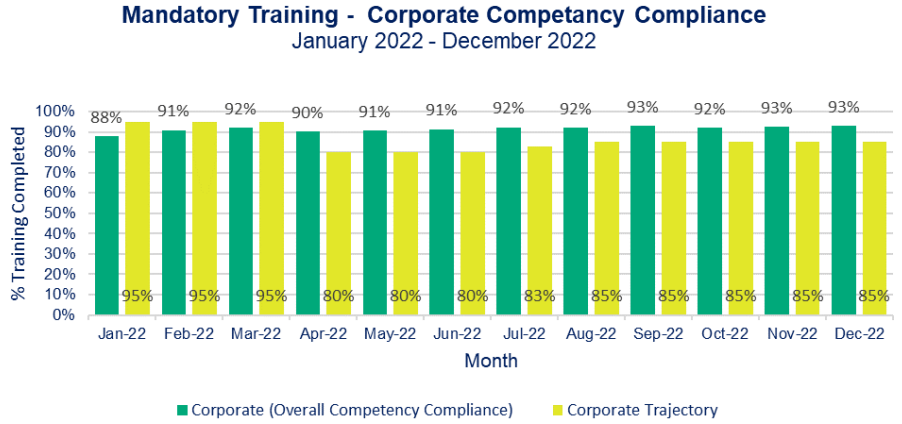


Figure OH7.6



OH8 CASE MANAGEMENT

Figure OH8.1

Employee Relation Dashboard @ 5th December 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	40	202	13.05
Operations ~ EOC	8	37	8.04
Operations ~ 111	5	52	5.81
Operations ~ PTS	6	46	9.76
Operations ~ Resilience	0	1	12.86
Corporate	2	16	14.74
Other*	5	42	11.82
NWAS Summary	**66**	**396**	**11.36**

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	7
Assault/threatening behaviour	3
Breach of H&S	1
Breach of social media policy	5
Carelessness in the use of equipment or resources	2
Conviction of a Criminal Offence	1
Discriminatory Behaviour	1
Failure to follow reasonable management instructions/procedures	9
Fraud	13
Inappropriate / Unprofessional Behaviour	20
Incapacity through alcohol/substance misuse	5
Misrepresentation/Deception	1
Negligent Behaviour	3
On-Going Lateness	2
Police Investigation	2
Poor patient care	2
Theft	2
Unauthorised absence	8
Victimisation/Bullying and Harassment	2
DIS - Appeal received ref: Final Written Warning	1
Sexual misconduct	3
SOSR	3
DIS - Appeal received ref: Dismissal	3
DIS - Appeal received ref: First Written Warning	1
NWAS Summary	**100**

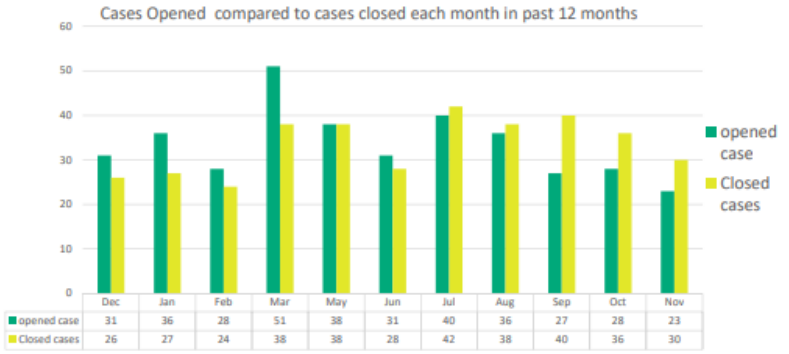
*table shows a rolling 12 months so can go down as well as up

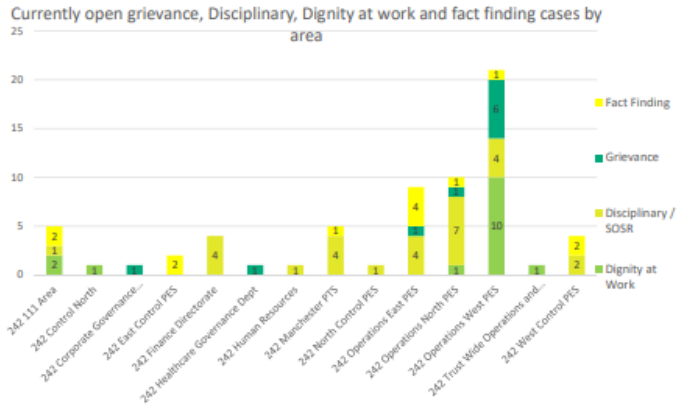
Length of current live cases

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	6	5	2	2
Grievance	6	1	3	0
Fact Finding	12	1	0	0
Disciplinary / SOSR	14	9	5	0
Case Total	**38**	**16**	**10**	**2**

Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	15	51	14.47
Disciplinary	28	89	19.87
Fact Finding	13	169	6.81
Grievance	10	87	9.65
Case Summary	**66**	**396**	**11.36**





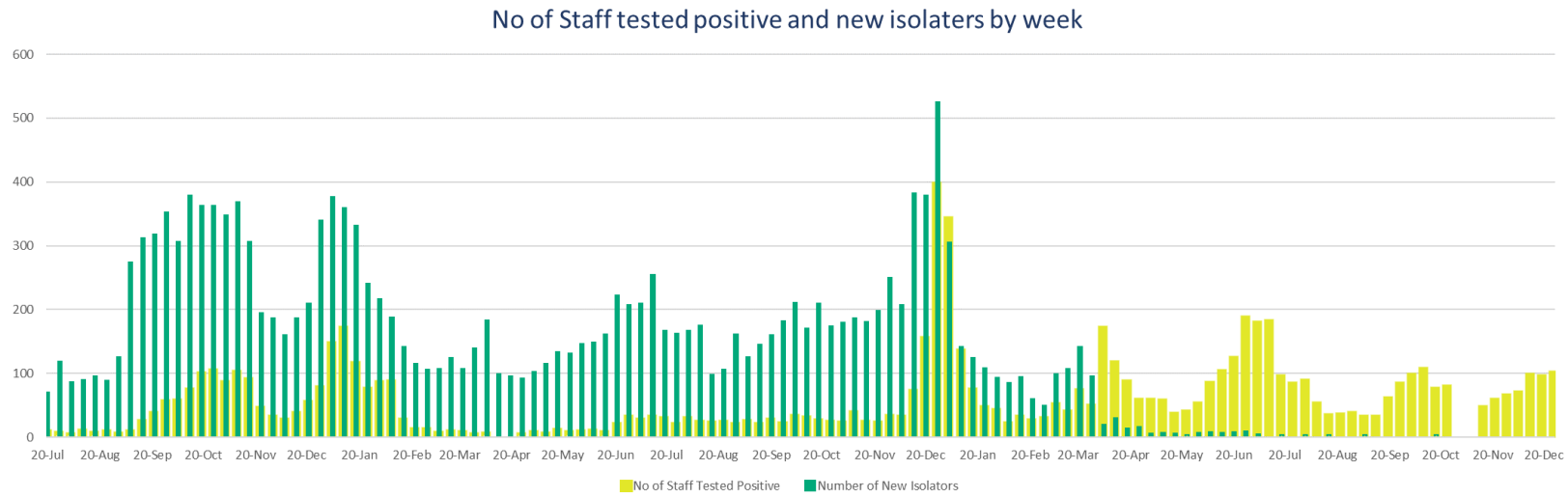
Covid

COVID 19

Figure CV1.0

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	11-Oct	27
27-Jul	3	18-Oct	23
03-Aug	1	25-Oct	21
10-Aug	7	01-Nov	19
17-Aug	3	08-Nov	35
24-Aug	5	15-Nov	20
31-Aug	2	22-Nov	19
07-Sep	6	29-Nov	30
14-Sep	22	06-Dec	28
21-Sep	34	13-Dec	69
28-Sep	53	20-Dec	152
05-Oct	54	27-Dec	393
12-Oct	71	03-Jan	339
19-Oct	96	10-Jan	132
26-Oct	101	17-Jan	71
02-Nov	83	24-Jan	43
09-Nov	99	31-Jan	39
16-Nov	87	07-Feb	18
23-Nov	42	14-Feb	28
30-Nov	28	21-Feb	23
07-Dec	24	28-Feb	26
14-Dec	34	07-Mar	48
21-Dec	52	14-Mar	37
28-Dec	75	21-Mar	70
04-Jan	144	28-Mar	46
11-Jan	168	04-Apr	168
18-Jan	113	11-Apr	114
25-Jan	72	18-Apr	84
01-Feb	83	25-Apr	55
08-Feb	84	02-May	55
15-Feb	24	09-May	54
22-Feb	9	16-May	33
01-Mar	9	23-May	36
08-Mar	3	30-May	49
15-Mar	6	06-Jun	82
22-Mar	4	13-Jun	100
29-Mar	1	20-Jun	121
05-Apr	2	27-Jun	184
12-Apr	0	04-Jul	176
19-Apr	0	11-Jul	178
26-Apr	1	18-Jul	92
03-May	4	25-Jul	80
10-May	2	01-Aug	85
17-May	8	08-Aug	49
24-May	4	15-Aug	31
31-May	5	22-Aug	32
07-Jun	7	29-Aug	34
14-Jun	4	05-Sep	29
21-Jun	17	12-Sep	28
28-Jun	28	19-Sep	57
05-Jul	24	26-Sep	80
12-Jul	29	03-Oct	94
19-Jul	26	10-Oct	103
26-Jul	17	17-Oct	72
02-Aug	26	24-Oct	76
09-Aug	21	30-Aug	0
16-Aug	19	06-Sep	0
23-Aug	20	13-Sep	43
30-Aug	17	20-Sep	55
06-Sep	22	27-Sep	62
13-Sep	17	04-Oct	67
20-Sep	24	11-Oct	94
27-Sep	18	18-Oct	92
04-Oct	30	25-Oct	97

Figure CV1.1



North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Infection Prevention and Control Bi-Annual IPC BAF					
PRESENTED BY:	Director of Quality, Improvement and Innovation					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☐	☐	☐	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	This paper provides the Board of Directors with a the NWAS response against the revised 10 Key Lines of Enquiry (KLOEs) for the updated Infection Prevention and Control Board Assurance Framework (IPC BAF) (v1.11). The IPC BAF provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of transmission of respiratory infection 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 October 2022 NHS England and Improvement provided an updated IPC BAF (V1.11) in which the Trust has now developed in line with the overarching Trust BAF. The new format is included in the appendix of this report. It is to be noted by Board that there have been significant steps in improving IPC within the Trust and that at present we have no red rag rated areas and 13 amber rated areas. Gaps in Control are clearly articulated and a timeline to improve declared throughout the BAF. The key risk to note is related to fit testing where some actions remain outstanding although our position has improved. In this reporting period the associated corporate risk has been reduced from 15 to 8. The updated IPC BAF will be monitored by the IPC Sub Committee.						
RECOMMENDATIONS:	The Board is asked to:						

	1) Note and acknowledge the significant steps of improvement in relation to IPC within the Trust 2) Note the gaps in control and the measures being taken to improve performance and provide further assurance
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:	Under normal circumstances the BAF would have been reviewed at IPC sub committee and Quality and Performance Committee prior to Board. It has been circulated to IPC sub committee members.			
	Date:			
	Outcome:			

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1. PURPOSE

1.1 The purpose of this paper is to introduce the Infection Prevention and Control Board Assurance Framework (IPC BAF). The IPC BAF provides the Board of Directors with the NWAS response against the revised 10 KLOEs. This report summarises the assurance given and any outstanding risks with associated mitigations.

2. BACKGROUND

2.1 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 transmission of respiratory infection to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. It also demonstrates the significant progress and achievements that have been made in delivering effective staff and patient safety.

2.2 In normal times the BAF is presented bi-annually to IPC Sub Committee, Quality and Performance Committee prior to the Board of Directors. Due to the demands of on-going Industrial action within the organisation, a decision was made to stand these committees down. However, the BAF has been circulated to all IPC Sub Committee members.

2.3 The IPC team await the publication of a revised BAF, which is due to be circulated for use in April 2023. This revised version, will lend itself more closely to the ambulance service. At present there are a number of indicators that are not relevant to the ambulance service as these are focused on acute care in hospitals.

2.4 It is of note that there have been significant improvements in the compliance with fit testing over the last 4 months – since September over 4000 face fit tests have been carried out across the organisation. The process for recording individual staff members fit test has been centralised & is now recorded on ESR so that sector managers can have an oversight on compliance. All staff who fail the fit test are advised that they must wear a sundstrum hood as level 3 protection.

2.5 The IPC team have been extremely responsive in communicating information out to staff in response to revised national guidance on emerging diseases – including Covid and Monkeypox – they have been a specialist resource and have improved visibility to ensure that staff are supported in the workplace. The IPC team have also spent a significant amount of time revising and streamlining policies and procedures and producing action cards to provide a quick reference for staff. QR codes have been produced for all documents to enable staff to access the necessary information in a timely manner and from any location.

2.6 In the last 6 months all IPC audits have been revised and inputted via safecheck – this is a far more efficient system and provides the necessary information for a dashboard which is presented at the IPC Sub Committee for assurance and can identify any key themes where the IPC workplan need to target.

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

3.1 This report and the associated work plan has been assessed against the trusts risk appetite statement. Two areas are of particular relevance:

- Regulatory Compliance for which we have a low-risk appetite to accept any risk that could result in staff being non-compliant with legislation or any frameworks provided by professional bodies. This BAF and the associated work plan ensure we meet our regulatory compliance requirements
- Safety for which we have a low appetite to accept risks that could materially provide a negative impact on quality. This report and the associated work plan ensures we are providing a safe environment for staff and patients

3.2 It is to be noted by Board that there have been significant steps in improving IPC within the Trust and that at present we have no red rag rated areas and 13 amber rated areas. Gaps in Control are clearly articulated and a timeline to improve declared throughout the BAF.

3.3 The key risk to note is related to fit testing where some actions remain outstanding although our position has improved. In this reporting period the associated corporate risk has been reduced from 15 to 8. The current solution for fit testing is externally sourced and a paper will go to ELC with an options appraisal of the long term solution in February.

4. EQUALITY OR SUSTAINABILITY IMPACTS

4.1 There are no equality or sustainability impacts.

5. RECOMMENDATIONS

5.1 The Board is asked to:

- Note and acknowledge the significant steps of improvement in relation to IPC within the Trust
- Note the gaps in control and the measures being taken to improve performance and provide further assurance

North West Ambulance Service NHS Trust

APPENDIX 1

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

BOARD OF DIRECTORS

25 JANUARY 2023

H2 2022/23 Reporting Timescales:

IPC Sub-Cttee	16/01/2023
Quality & Performance Cttee:	TBC
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 IDENTIFIED ON THE RISK REGISTER

Operational IPC Risks					
Datix ID	**Directorate**	**Service Line/ Area**	**Risk Description**	**Current Risk Score**	**Risk Owner**
236	Quality, Innovation, and Improvement	Clinical Safety	There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff	8 **Moderate**	E. Orton

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 plan incorporating respiratory seasonal viruses that includes: ○ point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g clinically immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections. ○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	• NWAS Operational Winter Plan • Local Resilience Forums (LRFs) • A&E Delivery Boards • NHSEI Regional Calls • National RSV Plan • Post Patient Ambulance Cleaning guidance updated May 22 • Outbreak procedure • NASIPCG weekly calls	
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 • Further reassessed where there is a change or new risk identified e.g., Changes to local prevalence	• 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 • IPC Cell minutes (monthly) • Outbreak procedure	
The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• IPC Sub-Committee (bi monthly) • Health, Safety and Security Sub-Committee (bi-monthly) • NWAS IPC BAF: Reported Bi-Annually to the Board of Directors • IPC Bi-Annual/ Annual Assurance Report • Reporting to UKHSA • Reporting to NHSEI North West • Quality and Safety Group Meeting with Lead Commissioner	

	• 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	
Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	**This KLOE is not directly applicable for an ambulance service**	
Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, 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 the NIPCM is monitored e.g., 10 elements of SICPs	• 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 (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	• 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 associated 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 (fit testing staff against 5 masks – no issue with supply) • In line with National Resilience Document (NHSE) • FFP Training Programme • Training Compliance Records • Availability of Hoods	

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 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.	• Awaiting publication – expected in next few months • Standards currently meet national IPC standards • Monitoring via IPC Sub Committee	In progress
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 Action plans (6 monthly completed by IPC practitioners) • Operational IPC Audits completed monthly • Working with compliance to add actions onto Trust integrated action tracker • IPC walk rounds • IPC Assurance to IPC Sub-Committee	
Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	• IPC Policy & Procedures • JPR Deep cleans & contract to complete deep cleans as requested • Deep clean audits completed by IPC Practitioners & reported into contract manager • IPC Audits • IPC Assurance to IPC Sub-Committee	
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 • IPC policy	
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	
The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	• Awaiting cleaning standards for ambulance service • Assurance reports for IPCSC (bi-monthly) • Cleaning and Decontamination Process: Premises • Cleaning and Decontamination Process: Vehicles • Cleaning Products Utilised by NWAS	

For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ patient isolation rooms ○ cohort areas ○ donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting.	**This KLOE is not applicable for an ambulance service**	
A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). • following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	**This KLOE is not applicable for an ambulance service** • 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 • before inspection, servicing, or repair equipment.	• Single use items used where possible • IPC Policy and Procedures maintained • IPC Audits completed • Decontamination Documentation for Reusable Equipment • Post patient transportation, ambulances & equipment are cleaned • Ambulance Deep Cleaning Programme contract in place	in progress
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	• IPC Policy and Procedures maintained • IPC Audits completed • Decontamination Documentation for Reusable Equipment • Post patient transportation, ambulances & equipment are cleaned • Ambulance Deep Cleaning Programme contract in place	In progress
Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	• Ventilation Assurance Report: NWAS Premises • Ventilation Assurance Report: NWAS Fleet	
Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.	• Risk Assessments completed by Subject Matter Experts • Risk Assessments/ Assurance presented to Sub-Committees	

Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• IPC Guidance disseminated • IPC Communications and Bulletins to staff • Agile Working	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLEANLINESS					
National Standards for Healthcare Settings	Review & assess relevance to Ambulance Service/await ambulance specific guidance Ensure IPC audits updated in line with ambulance specific guidance when published Cleanliness standards as part of IPC audits reported to IPCSC via area assurance reports IPCT complete post deep clean audits in conjunction with the private provider	IPC Specialist	April 2023	IPC Sub-Cttee	In progress
Use of Decontamination documentation	Ensure vehicles are cleaned prior to servicing/maintenance & that correct documentation utilised IPCT to monitor incident reporting on decontamination certification IPCT to attend area QBGs to promote use of policy/completion of certification	IPC Specialist	April 2023	IPC Sub-Cttee	In progress
IPC Policy Compliance	Local clinical & operational leadership teams to improve compliance – outstanding actions to be incorporated into Trust Intergrated Action Tracker (IAT) which is monitored at IPC Sub-Committee IPC incidents to be discussed at area learning forums Area reports and Power BI dashboard presented by area representatives at IPCSC IPCT join the QA Visits IPC Dashboard monitoring	HoS/ Sector Managers	March 2023	IPC Sub-Cttee	In Progress

INFECTION, PREVENTION & CONTROL (IPC) BOARD ASSURANCE FRAMEWORK

Section 3: sent to RF 9.1.23

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
Systems and processes are in place to ensure that: Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	• Antimicrobial stewardship for NWAS • Paramedic Drug Formulary: Antibiotics • AMS led identified as Chief Pharmacist	
NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	**This KLOE is not applicable for an ambulance service**	
The use of antimicrobials is managed and monitored: ○ to optimise patient outcomes ○ to minimise inappropriate prescribing ○ to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed	**This KLOE is not applicable for an ambulance service**	
Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ○ total antimicrobial prescribing. ○ broad-spectrum prescribing. ○ intravenous route prescribing. adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	• Assurance Via Clinical Effectiveness Sub-Committee	
Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	• JRCALC Guidance for Benzylpenicillin	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
ANTIMICROBIAL STEWARDSHIP					
Antimicrobial Stewardship Reporting	Adherance to reporting requirements and ensuring Board have full oversight	R Fallon	April 2024	IPC Sub-Cttee	In 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
IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	• IPC Information/ Infographics & Posters in Ambulances	In progress
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 principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented.	**This KLOE is not applicable for an ambulance service**	
Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.	**This KLOE is not applicable for an ambulance service**	
Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	**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, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Green Room resources	
If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	**This KLOE is not applicable for an ambulance service**	
Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	**This KLOE is not applicable for an ambulance service**	

Visitors, carers, escorts should not be 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 adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises Communications bulletins • IPC Resources on Green Room • IPC Annual Workplan (to implement IPC Guardians within NWAS April 2023)	In progress

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
RESOURCES					
Providing information to support visitors, carers and escorts	Ensure information available on all vehicles External website to contain relevant IPC information for visitors in relation to IPC measures Staff to support visitors/escorts and provide information to minimise the risk of transmission of infection	IPC Specialist	June 2023	IPC Sub-Cttee	In progress
GUIDANCE					
Supporting Excellence in IPC Behaviours Implementation Toolkit	To fully Implement the Supporting Excellence in IPC Behaviours Toolkit To recruit IPC guardians across NWAS to support the cascade of IPC information To ensure up to date resources are available to all NWAS staff in an easy to understand format IPC resources /action cards to be added to Green Room Ensure ready supply of PPE available to all staff Incorporate new national guidance into IPC teaching sessions Appropriate signage is installed and replaced as required	IPC Specialist	June 2023	IPC Sub-Cttee	In progress

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
All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	• Information from call handler/MDT • Individual patient risk assessment • IPC policies & procedures	
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 (see NIPCM).	• 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, ensuring correct management/placement.	• Telephony Screening & Triaging Scripts • Ambulance Crew Handover • ePRF • PTS Screening/Risk assessment	
Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	**This KLOE is not applicable for an ambulance service**	
Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	**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 test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	**This KLOE is not applicable for an ambulance service**	
Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	**This KLOE is not applicable for an ambulance service**	
If a patient presents with signs of infection 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	
The use of face masks/coverings should be determined following a local risk assessment.	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Availability of Masks in all Ambulances & NWAS Premises • IPC Guidance • IPC Communications and Bulletins • NIPCM • Risk Assessment • Outbreak procedure • National AACE position statements	
Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy	• PTS Risk assessment/booking process	
Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	• NWAS flu vaccination Campaign • Flu Leads Meeting Minutes/Action tracker • Communication Bulletins • Flumis/NIVs • Signposting to Covid clinics	

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
IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	• IPC Policy and Procedure • IPCSC Assurance reports bi-monthly • Core skills for health • IPC Training Packages • IPC Training at Operational Induction • IPC Audits • IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • NHSE IPC education packages - joint working with education team to ensure content is relevant and appropriate	
Training in IPC measures is provided to all staff, including: the correct use of PPE	• IPC Policy and Procedure • Training Needs Analysis – PES/PTS/EOC/Private providers/volunteers • IPC Training Packages Inc. FFP3 • IPC Training Compliance Monitoring • FFP3 Training/ Fit Testing Compliance • IPC Audits	
All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);	• IPC Policy and Procedure • IPC Training Packages Inc. FFP3 • IPC Training Compliance Monitoring • FFP3 Training/ Fit Testing Compliance • IPC Audits	
Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	• IPC Audits • Clinical contact shifts • Assurance Reporting to IPC Sub-Committee • Local Action Plans to Mitigate Identified Risks /Integrated action tracker • National and Regional attendance at IPC meetings as required	
Gloves and aprons 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	
Hand hygiene is performed:	• IPC Policy and Procedure • IPC Training Packages	

○ before touching a patient. ○ before clean or aseptic procedures. ○ after body fluid exposure risk. ○ after touching a patient; and ○ after touching a patient's immediate surroundings.	• IPC Audits • Assurance Reporting to IPC Sub-Committee	
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 (NIPCM)	• IPC Information/ Infographics & Posters in Ambulances • IPC Information/ Infographics & Posters in NWAS Premises • Absence of Hand Air Dryers in all clinical Areas • Paper Towel Dispensers Situated Next to Handwashing Sinks • IPC Audits • Quality Assurance Visits (QAVs)	
Staff understand the requirements for uniform laundering where this is not provided for onsite	• IPC Policy and Procedure • Linen policy • Uniform Policy	

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 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**	
Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, their care is provided following the NIPCM.	**This KLOE is not applicable for an ambulance service**	
patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	**This KLOE is not applicable for an ambulance service**	
Standard infection control precautions (SIPC's) are applied for all patients, at all times in all care settings	**This KLOE is not applicable for an ambulance service**	
Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	• IPC Policy and Procedure • Cleaning procedure • Ambulance deep cleaning process in place with private provider if and when required	

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
Laboratory Testing for infectious illnesses is undertaken by competent and trained individuals	**This KLOE is not applicable for an ambulance service**	
Patient testing for infectious agents is undertaken promptly and in line with national guidance	**This KLOE is not applicable for an ambulance service**	
Staff Testing protocols are in place for the required health checks, immunisations and clearance	• IPC Policy and Procedure • Occupational Health pre-employment checks • Availability of LFD's	
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**	
Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	**This KLOE is not applicable for an ambulance service**	
COVID-19 Specific	**This KLOE is not applicable for an ambulance service**	
Patients being discharged to a care home are tested for SARS – CoV-2 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 Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	**This KLOE is not applicable for an ambulance service**	
For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.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
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
Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	• IPC Information/ Infographics & Posters in Ambulances – available to all PTS/PES/Volunteers/Private providers • IPC Information/ Infographics & Posters in NWAS Premises - – available to all PTS/PES/volunteers/private providers • 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 and AMS policies	• IPC Policy and Procedure • IPC Training Packages • IPC Audits • IPC Communication and Bulletins • National UKHSA Guidance	
Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	• Daily TTT reports from business intelligence • IPC Policy and Procedure • IPC Guidance • Outbreak Management procedure • IIMARCH by ePortal • Assurance Reporting to IPC Sub-Committee	
All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	• IPC Policy and Procedure • IPC Guidance • Risk Assessments • Clinical waste storage (private providers)	In progress
PPE stock is appropriately stored and accessible to staff when required as per NIPCM	• 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
Clinical Waste					
Clinical Waste not stored as per national guidance	IPC to monitor repirted incidents in relation to clinical waste. This will be monitored through IPC Sub-Committee IPC audits to identify/provide assurance that waste is disposed of correctly in appropriate streams	Estates and Facilities	March 2023	IPC Sub-Cttee	In progress

	To ensure all clinical waste stored in locked bins/compound as per national guidance IPCT to work with Estates+Facilities to ensure that Clinical waste is collected on a regular basis Appropriate collections are readily available for all categories of waste and staff are aware how to access these services				

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 • Green Room information – easily accessible for staff	
Bank, flexible, 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 understand and are adequately trained in safe systems of work commensurate with their duties	• Induction and mandatory training • 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 • CPD training packages	
A fit testing programme is in place for those who may need to wear respiratory protection.	• Continual Face Fit Testing Programme • ESR records	in progress
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 • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	• Action cards and flowcharts been developed for staff • Policies and Procedures • Employee Self-Referral to Occupational Health • Absence Reporting • Incident Reporting • Risk Assessments • 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 NIPCM	• IPC Policy & Procedures • IPC Guidance • IPC Communications and Bulletins • Accessibility to PPE • Area assurance reports presented at IPCSC	
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 • Information on Green room & from HR • Individual 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	
Testing policies are in place as advised by occupational health/public health.	• • Outbreak management lead by UKHSA • IPC Policies and Procedures • Guidance • Communications and Bulletins • HR Recruitment Processes • Occupational Health Provider	
NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• Policies and Procedures • Guidance • Communications and Bulletins	
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	in progress
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	In progress

	• Assurance via IPC Sub-Committee	
Fit testing is repeated each time a different FFP3 model is used.	• 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	in progress
All staff required to wear an FFP3 respirator should be fit tested to use at least 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	
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 • Central ESR records • 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	In progress
staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	• Occupational Health Referral • Policies and Procedures • Guidance for Managers • Local Line Management • Accessibility of HR Support • Health and Wellbeing Mechanisms • Return to Work Process	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Fit Testing					
Robust process for the testing and recording of Fit Tests within the Trust	SOP developed for the testing & recording of fit testing IPCT work with Education department to ensure fit testing of all new starters/students completed and documented on EPR New record developed on Teams to ensure correct recording of individual fit test Satff who fail fit test recorded on ESR and are advised on PPE to wear Centralisied recording of fit tests on ESR now taking place, this needs to be maintained and updated regularly Reporting of fit testing compliance through the RPE group	IPC Specialist	March 2023	IPC Sub-Cttee	In progress
Compliance rates for staff fit testing	Regualr monitoring of compliance rates in sector to ensure all staff have had facial fit test/readily available fit testing Reports presented at RPE group	Sector Managers	Ongoing	IPC Sub-Cttee	In progress

	Sector managers advised of low uptake areas and to target fit testing in these areas. This is communicated by the IPC team so plans can be put in place to develop further fit testing opporunties for the area				
Ongoing fit testing within Trust after 31.3.23 once DoH support no longer available	Scoping exercise to ascertain requirements of NWAS for fit testing Liaise with current providers to identify ongoing costs should DoH support be withdrawn Paper with options appraisal to be developed and presented at ELC by DIPC/Infection control specalist, outlining both external and internal options to manage this going forward	IPC Specialist	April 2023	IPC Sub-Cttee	In progress

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Learning from Deaths. Summary Report and Dashboard Q2 2022/23					
PRESENTED BY:	Dr Chris Grant – Executive Medical Director					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☐	☐	☐	
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
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 From Deaths. The Q2 dashboard (Appendix A) describes the opportunities to learn. The main contributory factor to patient deaths, identified in Datix, were attributed to delays in the emergency response. The peer review process identified that 76.2% of patients received appropriate care. The key areas for improvement identified were: • using a medical model when documenting a patient's assessment • correct use of Manchester Triage System • completing capacity to consent fully • detailing specific worsening advice • sub-optimal quality of patient records documentation The peer review also identified areas of good practice. This included: • holistic decision not to resuscitate • safety net and hand over to OOH GP • organising care for end of life. The panel continues to welcome observers to help raise awareness of the process and embed learning from the peer reviews. The DCIQ Mortality Module has undergone refinements and work is still ongoing. DCIQ listing reports have been created to allow the team to report on concerns logged in DCIQ for Q3.						

RECOMMENDATIONS:	The Board is recommended to: • Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account • Acknowledge the impact of the Structured Judgment Reviews in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust. • Note key areas for improvement identified • Note areas of good practice.
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			
	Date:	17 January 2023		
	Outcome:	Approved		

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q2 2022/23 Learning from Deaths Review. It is proposed this document is published on the Trust's public accounts by 31st January 2023 in accordance with the national framework and trust policy. The Q2 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q2. Learning from the panels is discussed later in this paper.

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

2. BACKGROUND

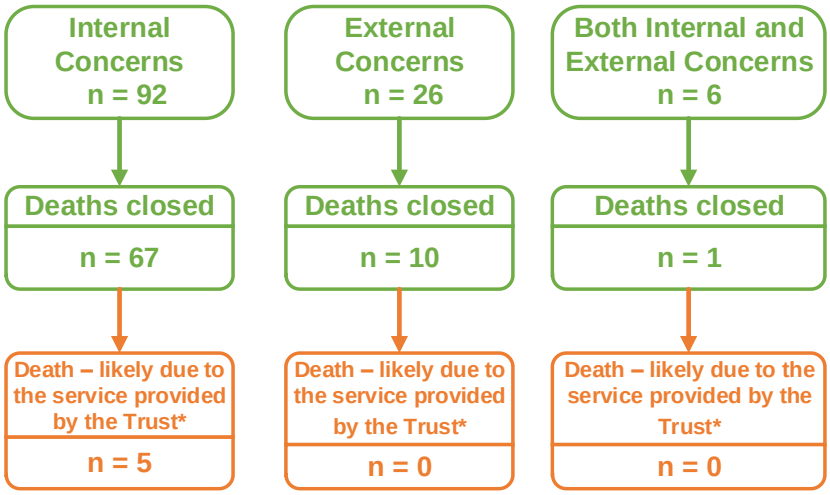
Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at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

3.0 LEARNING FROM DEATHS DASHBOARD Q2 2022/23: APPENDIX A

3.1 Of the 124 patient deaths:

- 92 internal concerns were raised through the Incidents module
- 26 external concerns were raised through the Patient Experience module
- And a further 6 concerns were raised both internally and externally.

The flow chart below provides a summary:



Flow chart to describe the Datix deaths Q2 2022/23

3.2 **Internal Concerns: Tables 2 and 3, Figures 2 and 3**

Of the 92 patients, 67 were reviewed and closed. In five cases the investigation concluded the Trust had contributed in some way to that patient death. A lack of available resources was cited as the main contributing factor to the deaths.

3.3 **External Concerns: Tables 4 and 5 and Figure 4**

Of the 26 external concerns that have been reported, 16 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. Ten concerns have been closed and no causal factors were identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- Significant delay in responding to a chest pain patient
- Significant delay in responding to patients with Difficulty In Breathing , Falls, End Of Life Care and Inter Facility Transfers.
- Problems related to treatment and management planning
- Problems with capacity to consent recording

3.4 **Concerns raised internally and externally: Tables 6 and 7 and Figure 5.**

Six patient deaths were raised internally and externally – note these are different concerns from those referenced above. One investigation has been closed and no causal factors were identified. The remaining five investigations are all still open and the learning themes are:

- Significant delay in responding to a patient (Chest Pain, Falls)
- Problem with communication of handover

3.5 Structured Judgement Review (SJR): Cohort Discussion: Tables 8, 9 and Figure 6.

The process requires frontline staff to review and make explicit statements on 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.

21 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined. 16 patients (76.2%) received adequate care.

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'.

The Patient and Public Panel (PPP) representatives continue to support the panels and their contribution, and perspectives are greatly appreciated by the panel members.

3.6 Quality of Patient Records

The quality of patient records improved slightly from 67.0% to 71.4% during this quarter. Whilst the EPR is undergoing development from a hardware and software perspective, general feedback and support should be offered to improve the quality.

3.7 Structured Judgment Review - Learning Outcomes: Tables 11 -12

The key areas for improvement identified were:

- using a medical model when documenting a patient's assessment,
- incorrect use of Manchester Triage System
- completing capacity to consent fully
- detailing specific worsening advice
- sub-optimal quality of patient record documentation

The peer review also identified areas of good practice. This included:

- holistic decision not to resuscitate
- safety net and hand over to OOH GP
- organising care for end of life.

3.8 Learning Dissemination

Lessons identified will be shared through the area learning forums (ALFs) and with individual frontline staff. The Q2 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership teams. This is a new development aimed at embedding improvement identified in this paper.

The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs by the Consultant Paramedic, Medical on a bi-annual basis.

Good practice letters have been circulated to commend 10 clinicians, who through their care and professionalism, have supported families and patients to experience a good death during Q2.

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

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

5. RECOMMENDATIONS

The Board is recommended to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account
- Acknowledge the impact of the Structured Judgment Reviews in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust.
- Note key areas for improvement identified
- Note areas of good practice.

NWAS Learning From Deaths Dashboard Quarter 2 2022-2023 (July - September)

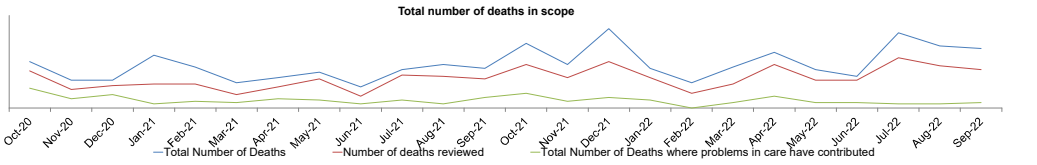
Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

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
Jul-22	57	38	66.7%	3
Aug-22	47	32	68.1%	3
Sep-22	45	29	64.4%	4
This Quarter	**149**	**99**	**66.4%**	**10**
This Financial Year	244	174	71.3%	27

** 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*

Table 1

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below.



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.

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occurred; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death- Caused by the incident'. Patient Experience module data, is included in the cohort where the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death'.NB This is the month the incident occurred, not when the notification of raised concern for care was received.

Internal Concerns - Incidents (including SIs)

Total Datix Death Incidents in Scope		Risk grading		
		1 or 2	3	4 or 5
July	31	5	13	13
August	34	10	13	11
September	27	6	12	9
Total	**92**	**21**	**38**	**33**

Table 2

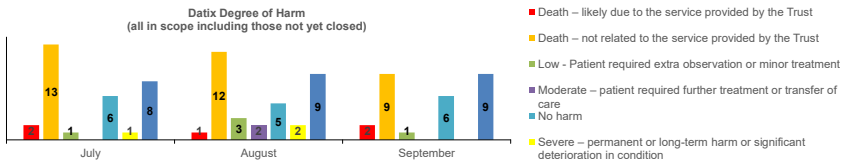


Figure 2

Number of Deaths Closed on Datix		Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
July	24	2	2
August	25	1	1
September	18	2	2
Total	**67**	**5**	**5**

Table 3

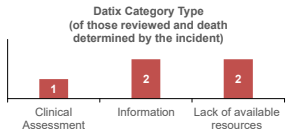


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service
July	13	6	0
August	8	3	0
September	5	1	0
Total	**26**	**10**	**0**

Table 4

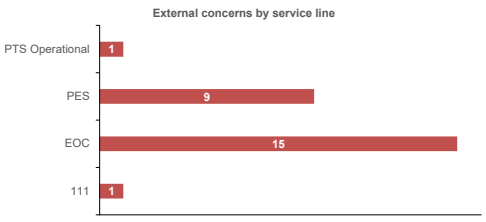


Figure 4

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation	Demand outstripped resources; No actions	1
		No causal factors; No actions	1
		Still under review	1
	Problem with call taking and response allocation (DIB)	Demand outstripped resources; Incorrect coding of call; No actions	1
		No causal factors; No actions	1
		Still under review	2
	Problem with call taking and response allocation (chest pain)	Still under review	2
	Problem with call taking and response allocation (fall)	Demand outstripped resources; Hospital handover delays; No actions	1
	Problem with transporting EOLC patient back home	Still under review	3
	Problem with call taking and response allocation (baby with DIB)	Demand outstripped resources; Hospital handover delays; No actions	1
	Problem with call taking and response allocation (IFT)	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
PES	Problem related to treatment and management plan	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Staff feedback and/or reflection	1
		Still under review	1
	Problem with capacity to consent	Still under review	1
	Problem with patient disposition	No causal factors; No actions	2
		Still under review	4
PTS Operational	Problem with mobilisation	Still under review	1
111	Problem with management of call	Incorrect reason of call logged in system; Staff feedback and/or reflection	1

Table 5

Internal and External Concerns - Incidents and Complaints

Number of concerns that have been raised internally and externally		Incidents Closed on both modules	Number closed and Deaths likely due to the service
July	4	1	0
August	1	0	0
September	1	0	0
Total	**6**	**1**	**0**

Table 6

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation	Demand outstripped resources; Staff feedback and/or reflection	1
	Problem with call taking and response allocation (chest pain)	Still under review	2
	Problem with call taking and response allocation (fall)	Still under review	2
	Problem with communication of handover	Insufficient information conveyed to ED; System/procedure review/update requested	1

Table 7

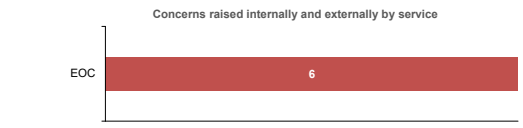


Figure 5

Data last exported 27/10/2022 and last updated 21/11/2022

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

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.

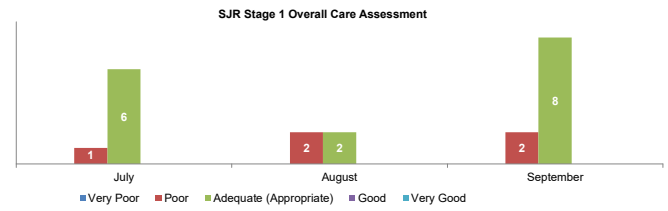
Structured Judgement Review

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have
July	9	7	1
August	4	4	2
September	12	10	2
Total	**25**	**21**	**5**

Table 8

SJR Category Type			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
July	2	2	5
August	0	0	4
September	3	2	7
Total	**5**	**4**	**16**

Table 9



	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	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	4	17	0	**17/21 patients**	**81%**
	Management Plan/Procedure Rating	2	18	1	**19/21 patients**	**90%**
Right Place	Patient Disposition Rating	2	18	1	**19/21 patients**	**90%**

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 21 patients)

Evidence of Poor/Very Poor Practice

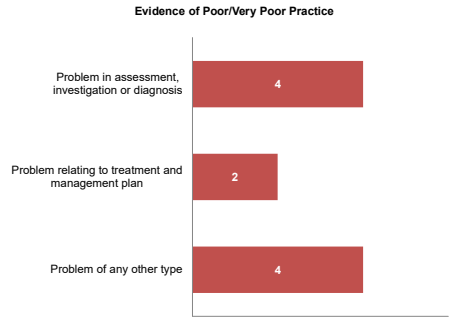


Figure 7

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Capacity to consent not assessed correctly	2
		Limited information recorded regarding clinical assessment, examination and outcome	1
		No indication of the status of the disease or the prognosis, no indication of current treatments, or plan	2
		No physical examination documented	2
		No systematic examination of respiratory, abdominal, urinary or MSK	2
		Normal oxygen saturations not recorded	1
	Problem related to treatment and management plan	Crew documented patient refusal but don't stay why - always good to document the wishes or reasons of the patient as gives / builds a picture as to why	1
		Details of the GP discussions not recorded	1
		Differential diagnosis and border line infection not considered	1
		MTS/Pathfinder not applied correctly	2
		No documented attempt to contact the GP to discuss the patient or the presence of a statement of intent given the nature of the history.	2
		No referral to AVS/GP/alternative providers when appropriate to do so	1
		No senior clinical advice sought	1
	Problem of any other type	No documentation of plan, worsening advice or SOS advice	1
		Possible Sepsis Red Flag missed	2
		Quality of EPR	4

Table 11

Evidence of Good/Very Good Practice

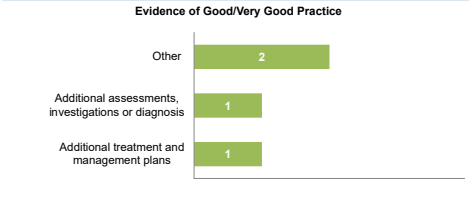


Figure 8

Data last accessed 01/12/2022

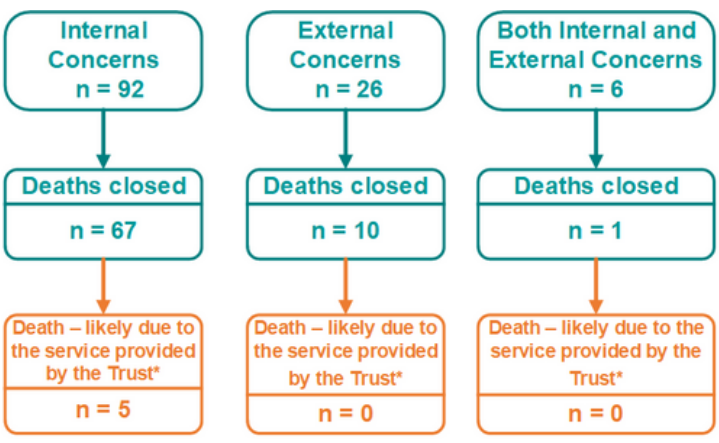
Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Holistic decision not to resuscitate.	1
	Additional treatment and management plans	Handover to OOHGP noted with reference to organising package of care for end of life	1
	Other	Documentation states involvement of those important to the patient, with holistic conversation noted	1
		Quality of EPR	2

Table 12

NWAS LEARNING FROM DEATHS (LFD)

Q2 2022/23 Report

DEATHS WITH CONCERNS RAISED IN DATIX



*as classified by the Datix investigator

94%

had no causal factors identified

KEY LEARNING THEMES FROM CONCERNS

Emergency Operations Centre (EOC)

- Significant delay responding to a patient with difficulty in breathing (x2)
- Significant delay in responding to a chest pain patient (x2)
- Significant delay in responding to a patient (x8)

Paramedic Emergency Service (PES)

- Problem related to treatment and management plan (x2)
- Problem with capacity to consent
- Problem with patient disposition (x6)

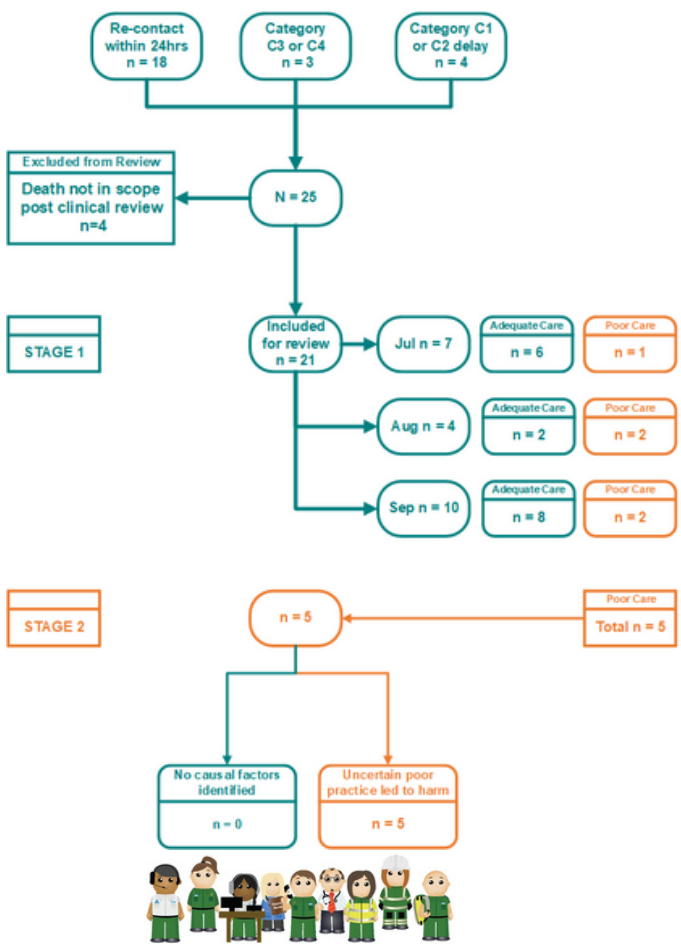
for more information on themes, full dashboard available on request

STRUCTURED JUDGEMENT REVIEW PHASES & OUTCOMES

- Call Handling/ Categorisation/ Resource Allocation **(not live)**
- Patient Assessment
- Management Plan/Procedure
- Patient Disposition

If any phase has a poor or very poor outcome, stage 2 is triggered to assess if it led to any harm in terms of assessment, medication, management plan, monitoring or resuscitation.

SJR DEATHS



STAGE 1 - SJR OUTCOMES

76.2% of patients received appropriate care

SJR STAGE 2 THEMES

Problem in assessment, investigation or diagnosis

- Lack of comprehensive documentation of the patient assessment
- No indication of the status of the disease or the prognosis, no indication of current treatments or plan
- Normal O2 saturation level not recorded
- Capacity to consent not assessed correctly

Problem relating to treatment and management plan

- Incorrect application of MTS/Pathfinder
- Lack of escalation for decision making
- No narrative regarding GP discussion
- No specific worsening advice
- No patient referral when appropriate to do so
- No documented attempt to contact the GP to discuss the patient or the presence of a statement of intent given the nature of the history
- No evidence of sepsis being considered

Problem of any other type

- Poor clinical documentation (x4)

EVIDENCE OF GOOD PRACTICE

Additional assessments, investigations or diagnosis

- Holistic decision not to resuscitate

Additional treatment and management plans

- Handover to OOHGP noted with reference to organising package of care for end of life

Other

- Documentation states involvement of those important to the patient, with holistic conversation noted
- Quality of EPR (x4)

Acknowledging good care and practice - **10 letters sent out**

well done!

SJR ACTIONS/ IMPROVEMENTS

- Case escalated for a local clinical review
- EOC specialists invited to November's panel (17/01/23)
- Regular observers in attendance

More information contact:
Learning.FromDeaths@nwas.nhs.uk

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2022/2023					
PRESENTED BY:	Ged Blezard – Director of Operations & Accountable Emergency Officer					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☐	☐	☐	☐	☐	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☒	☐	☐
PURPOSE OF PAPER:	For Assurance					

EXECUTIVE SUMMARY:

This report describes NHS England 2022/23 Emergency Preparedness, Resilience and Response (EPRR) Assurance process and presents the updated NWAS Statements of Compliance.

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

The report provides assurance on the progress made against the action plans put in place following on from the trusts annual self-assessment in October 2022 against the EPRR Core Standards.

The EPRR Statement of Compliance for 2022-2023 is as follows:

- EPRR Core Standards: Substantially Compliant
- Interoperability Capabilities: Substantially Compliant
- NHS 111 EPRR Core Standards: Substantially Compliant
- PTS EPRR Core Standards: Substantially Compliant

Since the submission of the self-assessment of the EPRR Annual Assurance report to the ELC (19/10/2022) and then to the Lancashire and South Cumbria Integrated Care Board (24/10/22), Interoperability Capabilities, NHS 111 and PTS have moved from partial compliant to substantially compliant.

	Substantially Compliant states the organisation is 89-99% compliant. A breakdown of each core standard is covered in the body of the report.
RECOMMENDATIONS:	The Board of Directors is recommended to: • Receive assurance on the actions already taken following the EPRR Annual Assurance Audit in October 2022. • Receive assurance on the improvement made across all core standards. • Receive assurance on the improvement made against Interoperability Capabilities, NHS 111 and PTS from partial compliance to substantially compliant. • Receive assurance on the action plans in place to move all core standards from substantially compliant to fully compliant.
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:				
	Date:			
	Outcome:			

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1. PURPOSE

This report and describes NHS England 2022/23 Emergency Preparedness, Resilience and Response (EPRR) Assurance process and presents the updated NWAS Statements of Compliance.

2. BACKGROUND

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

The NHS England Board has a statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. This is provided through the EPRR annual assurance process and assurance report. This report is submitted to the Department of Health and Social Care and the Secretary of State for Health and Social Care.

As the NHS core standards for EPRR provide a common reference point for all organisations, they are the basis of the EPRR annual assurance process. Providers and commissioners of NHS-funded services complete an assurance self-assessment based on these core standards. This assurance process is led nationally and regionally by NHS England and locally by integrated care boards.

The purpose of the NHS core standards for EPRR is to:

- enable health agencies across the country to share a common approach to EPRR
- allow co-ordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

There are 10 domains that cover the NHS core standards for EPRR, with an 11th domain applicable only to the NHS ambulance trusts which covers interoperable capabilities they must have in place. A full review of the core standards is conducted every three years, which was last conducted in 2022. This has seen an increase in the number of core standards that need to be assessed within the domains, as well as requiring Patient Transport Service (PTS) to be assessed for the first time as well as NHS111 and the wider Trust.

NHS England requires that this assurance exercise identifies any areas of limited or non-compliance (as well as highlighting areas of complete compliance) of resilience

arrangements against the EPRR core standards and that any deficiencies in particular areas inform an individual Action Plan. This plan will demonstrate the intention of each Trust to address any outstanding issues and give an indication of priority and timescale for resolution.

NHS England also require a formal statement of compliance from each Trust based on the findings from the self-assessment process and taking into account those core standards which necessitate additional attention through the Action Plan. For 2022/23, the process requires four separate Statements of Compliance to be made, to indicate performance across EPRR Core Standards (NWAS), EPRR Core Standards (NW111), EPRR Core Standards (PTS) and Interoperable Standards (NWAS response). These statements are required to be signed by the AEO as being a satisfactory assessment of NWAS' preparedness and that these statements are presented to the ELC for assurance, followed by the Public Board.

The completed Statements of Compliance, and self-assessments were submitted to the South Cumbria and Lancashire Integrated Care Board on the 24th October 2022.

3. NWAS EPRR Annual Assessment 2022/2023 Update

Since the EPRR Annual Assessment and submission to South Cumbria and Lancashire Interrelated Care Board in October 2022 the senior team in Resilience, including Special Operations have been leading an action plan to improve all elements of the assessment.

Detailed action plans were developed for each standard with clear owners documented, dates to be completed by and a RAG rating. Regular updates take place direct to the Director of Operations. **Appendix 1** provides a copy of the current action plans in place.

Since the submission of the self-assessment of the EPRR Annual Assurance report to the ELC (19/10/2022) and then to the Lancashire and South Cumbria Integrated Care Board (24/10/22), Interoperability Capabilities, NHS 111 and PTS have moved from partial compliant to substantially compliant.

The EPRR Statement of Compliance as from January 2023 is as follows:

- EPRR Core Standards: Substantially Compliant
- Interoperability Capabilities: Substantially Compliant
- NHS 111 EPRR Core Standards: Substantially Compliant
- PTS EPRR Core Standards: Substantially Compliant

Table 1 below provides a breakdown of each core standard and the areas of change:

Table 1: EPRR Annual Assurance Compliance Summary

Core Standard	Non-Compliant		Partially Compliant		Fully Compliant		Overall Compliance	
	Oct 2022	**Jan 2023**	Oct 2022	**Jan 2023**	Oct 2022	**Jan 2023**	Oct 2022	**Jan 2023**
EPRR Core Standard	0	0	6	4	1	3	Substantial	Substantial
Interoperability Capabilities	2	2	18	14	6	10	Partial	Substantial
NHS 111 Core Standards	0	0	6	4	1	3	Partial	Substantial
PTS Core Standards	0	0	6	4	1	3	Partial	Substantial

Out of the 163 applicable standards included in the EPRR Annual Assessment, NWAS have reviewed its self-assessment in January 2023 and can now report full compliance against 147 elements, and partial compliance against 14 and non-compliant against 2 elements.

The two non-compliant elements are within Interoperability's Capabilities, C7 and C26.

- C7: NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards.

- C26: Any Strategic, Tactical and Operational Commander that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required levels of competence and CPD evidence.

The senior team within Resilience are engaged with partners across Digital and the People Directorate to address these non-compliant elements to fully compliant with target dates for C7 as January 2023 and C26 April 2023.

Appendix 1 provides more detailed information across all elements across each of the core standards.

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

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the Civil Contingencies Act (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Health and Care Act 2022 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022, together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

The Trust also has to meet the obligations outlined in the Ambulance Standard Contract, all CQC Domains and the key requirements of the NHS England EPRR Framework.

5. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

6. RECOMMENDATIONS

The Board of Directors is recommended to:

- Receive assurance on the actions already taken following the EPRR Annual Assurance Audit in October 2022.
- Receive assurance on the improvement made across all core standards.
- Receive assurance on the improvement made against Interoperability Capabilities, NHS 111 and PTS from partial compliance to substantially compliant.
- Receive assurance on the action plans in place to move all core standards from substantially compliant to fully compliant.

APPENDIX 1

EPRR Core Standards 2022/2023

Action Plan

Key	
	Non-Compliant
	Partial Compliance
	Fully Compliant

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Progress	Owner	Target Completion Date	Current RAG Status
2		**The organisation has an overarching EPRR policy or statement of intent.**	The Trust has an EPRR subgroup that is chaired by the AEO that meets every quarter and has a work programme in place which looks to provide assurance across a number of business lines which includes training and exercising, and the embedding of lessons identified from Debriefs. This is forwarded to the Quality & Performance Committee and Board of Directors to ensure the Trust is meeting the required standards laid out nationally.	NWAS to produce a clear EPRR policy statement of intent.	05 Jan 2023, draft EPRR policy statement produced by Head of Contingency to be discussed with Director of Resilience in Jan and presented to EPRR Sub-committee for sign off.	Head of Contingency Planning	January 2023	
4		**The organisation has an annual EPRR work programme.**	The Trust does have a EPRR work programme that has been in place since May 2021. The plan specifies exactly what has to be produced in the quarterly report, some areas are reported on in each quarter including the review of debriefs and the learning and action that has taken place. 111 and PTS provide a quality assurance update at each quarter including that all processes are up to date and have been tested and associated learning identified.	EPRR work programme reviewed through the EPRR Sub-committee.	05 Jan update – Completed and reviewed annually by the EPRR Sub-committee	Head of Contingency Planning	December 2022	

12		**The organisation has arrangements in place to respond to an infectious disease outbreak.**	The Trust holds a plan Communicable Diseases policy version 5 which details the actions to be considered by Trust staff, including Action Cards, overdue review, but does include HCID and detailed appendix of infections. Overdue review currently May 2022, this document was used in line with National direction with the Monkeypox outbreak.	Requires review of policy document.	E-mail from J Dziobon 13/12/22. The communicable disease policy has been approved at the IPC Sub-committee and has now gone to M Power for final sign off.	IPC/Head of Contingency Planning	December 2022	
13		**The organisation has arrangements in place to respond to a new and emerging pandemic.**	The Communicable Diseases Policy holds the detail on how the Trust will respond to a new or emerging pandemic under chapter 5.	Currently there is no specific national document for emerging pandemics, but the Trust does have a draft document moving to approval.	05 Jan 2023 – update. An updated draft document is to be produced between Resilience and IPC and presented in draft to the EPRR Sub-committee in April 2023.	IPC/Head of Contingency Planning	April 2023	
16		**The organisation has arrangements in place to evacuate and shelter patients, staff and visitors.**	Business Continuity (BC) plans are in place in particular for the Contact Centre sites Emergency Operations Centre (EOC) EOC BC 02 refers, being reviewed against the NHS E guidance for evacuation. Action Cards in place for Evacuation and the control of that.	Plans being reviewed against NHSE guidance.	16 Dec 22-Contact Centres, PTS & 111 have reviewed their arrangements including confirmation of PEEPS for individuals. Rules regarding evacuation for Fire are also in place.	Head of Contingency Planning/ Business leads with BC Resilience Manager	December 2022	
22		**The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.**	Each Commander has their own personal CPD that can be accessed by the Head of Spec Ops in order for them to assess the quality of reflections and when individuals last attended training or exercises at their level. Command Training is conducted annually over 2 days, one day at a time. Specific themes will be included based on Debriefs and lessons learned as well as subjects including CBRNE, JESIP, logging, Critical thinking. Separate training events for NILOs based on the National guidelines. The TNA is based more on the evidence of the lessons learnt.	Ongoing consultation regarding the development of a Command & Resilience Education Facilitation team, that will conduct training based on need rather than based on mandated requirements.	05 Jan 2023 – update. The Trust does not have a centralised matrix that captures all of the mandatory requirements for each level of command. This is under review and will form part of the requirement under the Command & Resilience Education team that is being presented to the ELC in January 2023.	Head of Contingency Planning/ Assistant Director of Workforce Development	April 2023	

44		**The organisation has in place a policy which includes a statement of intent to undertake business continuity.**	Business Continuity 2 is ISO 22301 compliant and is a host for all departmental BC plans. These Plans form the Trusts approach to BC. Strategic plans include how BC is to be conducted e.g., Constant Care Plan. The Trust is currently considering the requirement for an overarching BC plan.	Develop a statement of intent for Business Continuity.	05 Jan 2023 – update. This will be drafted following the recent exercises on cyber-attacks and power outage which reinforced the requirement for this to be completed. This will be drafted and presented to the EPRR Sub-committee in April 2023.	Head of Contingency Planning	April 2023	

EPRR Interoperable Capabilities 2022/2023

Action Plan

Key	
	Non-Compliant
	Partial Compliance
	Fully Compliant

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Progress	Owner	Target Completion Date	Current RAG Status
H8		**Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.**	HART funded to deliver six HART operatives per team. However, short-term abstractions, recertifications and increased level of training impact on compliance. Hence national review of HART funding. To mitigate any noncompliance actions are taken by Head of Special Operations. YTD 90% compliance.	Head of Special Operations to confirm target date for increase in funding.	05/01/2023 – Discussions ongoing nationally led by NARU regarding additional investment to increase staffing levels.	Head of Special Operations	April 2024	
H13		**Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.**	Emergency Operations Centre (EOC) Procedures are in place and well embedded within the organisation: EOC0014 – Deployment of HART Team EOC EOC0029 – Marauding Attack and Major Incidents EOC0035 – NWAS Attendance at Chemical & Nuclear Sites EOC0057 – HART RRV Cat 1 Diverts.	Ongoing audit on application of procedures post Trust moving to NHS Pathways.	05/01/2023 – NWAS HART PDAs in place since 2017/18. Migration of PDAs from AMPDS to NHSP Sept 2022.	Head of Special Operations	Ongoing	

H14		**Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.**	A Number of EOC Procedures are in place and well embedded within the organisation: EOC0014 – Deployment of HART Team EOC EOC0029 – Marauding Attack and Major Incidents EOC0035 – NWAS Attendance at Chemical & Nuclear Sites EOC0057 - HART RRV Cat 1 Diverts	Ongoing audit on application of procedures post Trust moving to NHS Pathways.	05/01/2023 – Audit reports to be provided by Strategic Head of EOC to Head of Special Operations.	Strategic Head of EOC /Head of Special Operations	December 2022	
H15		**In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.**	There have been no occasions in the last 12 months whereby HART capabilities have been reconfigured. Procedures in place should HART capabilities be compromised.	No action required.	05/01/2023 – No change to current position.	Head of Special Operations	Ongoing	
H16		**Organisations must record HART resource levels and deployments on the nationally specified system.**	HART resource levels and deployments are recorded via PROCLUS.	No action required	05/01/2023 – Reported through PROCLUS twice daily.	Head of Special Operations	May 2022	

H17		**Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.**	HART response time standards will be captured in the SOE / CAD. HART deployments are internally captured and manually inputted into PROCLUS and a deployment spreadsheet documenting time of allocation and number of staff deployed.	This is only done manually currently however work ongoing with the Trusts informatics team to scope mechanisms to move away from manual input.	05/01/2023 – HART latest meeting with informatics took place on 6 October 2022 to discuss reporting requirements in line with H17. Informatics advised (11/10/22) they were unable to provide timescales due to other trust priorities.	Chief of Digital & Innovation /Head of Special Operations	April 2023	
H33		**Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.**	Ashburton Point partially compliant as it only has 3 showers instead of the 4 outlined in the service specification. Croxteth however is non-compliant although we have a derogation in place supplied by NARU until a new HART site is established at Liverpool.	Pending new build and opportunity to increase ablutions with option to increase training facilities within Ashburton.	05/01/2023 – Ashburton; Head of Special Operations and Head of Estates met to review options. Croxteth; ELC decision approved (21 September 2022) to scope a HART site at Elm House. A pre planning application has been submitted to Liverpool City Council for review and a decision is expected end of January 2023.	Assistant Director of Estates and Fleet/Head of Special Operations	September 2023 (TBC by Estates) December 2024	
M11		**Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing:** **• 100% Strategic Commanders** **• 100% designated MTFA Commanders** **• 80% all operational frontline staff**	100% of the NWAS command structure - Strategic/Tactical and Operational commanders have received MTA training including designated MTA commanders (January/February 2021). All operational frontline staff have access to MTA familiarisation through ESR and current compliance as of January 2023 is TBC	Area Heads of Operations to develop improvement plan to deliver on minimum 80% compliance.	05/01/2023 – Review of JOPs 2 led by JESIP with workshops planned February 2023. NWAS scheduled to attend.	Head of Special Operations with Area Heads of Operations	April 2023	

M15		**Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).**	There have been no live deployments of the full MTA capability.	Until deployment takes place we cannot be shown as fully compliant.	05/01/2023 – No live deployments to date.	Head of Special Operations	Ongoing	
B24		**Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.**	NWAS EOC Procedure 0028 (not tested live yet).	Plans to undertake a live test.	05/01/2023 – Notional live test completed on 6 December 2022.	Head of Special Operations	April 2023	
C7		**NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards.**	Currently the selection is focussed on managerial role and Be Think Do rather than the ability to Command.	Requires further work in the recruitment process and can be included as part of the CARE study on command training.	05/01/2023 – Discussion with Assistant Director of Workforce Development around incorporating a set of selection criteria to sit alongside the Be Think Do competencies, to ensure those in a command or command support roles are assessed during the recruitment phase against management and command. These criteria are to be confirmed and drafted.	Assistant Director of Workforce Development /Head of Special Operations	January 2023	

C16		**C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.**	Loggist rota in place with one currently available on call 24/7/365. Sufficient additional loggists can be called via Cascade system and those on duty in EOCs can step up to role as can admin and clerical staff across most functions in Trust.	To enhance the compliance of C16 SORT staff currently being trained to support Operational Commanders for the loggist role. Training will be completed by April 2023.	05/01/2023 – Compliant.	Head of Special Operations/ Head of Contingency Planning	December 2022	
C18		**Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in Schedule 2 of the Standards for NHS Ambulance Service Command and Control.**	Commanders will have previously demonstrated competence but not all will have attended or been assessed at an exercise in last 12 months. NWAS is aligned with Schedule 2.	Review attendance on Exercises.	05/01/2023 – EPRR session including NOS delivered at OPG Dec. Further work ongoing to digitalise NOS. Rollout planned through February and March 2023. Digital enhancement expected to be complete in Q1 2023/24.	Chief of Digital and Innovation/ Head of Special Operations/ Head of Contingency Planning	30 June 2023	

C20		**Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in Schedule 2 of the Standards for NHS Ambulance Service Command and Control.**	Not all Commanders will have attended and been assessed at an exercise.	Review attendance on Exercises.	05/01/2023 – As above	Head of Special Operations/ Head of Contingency Planning	Jan 2023	
C22		**Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in Schedule 2 of the Standards for NHS Ambulance Service Command and Control.**	Not all Commanders will have attended and been assessed at an exercise.	Review attendance on Exercises.	05/01/2023 – As above	Head of Special Operations/ Head of Contingency Planning	Jan 2023	
C24		**All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.**	Not all Commanders have a comprehensive record of their NOS CPD.	Ongoing review with Line Managers.	05/01/2023 – As above Accountability for NOS compliance aligned to Area Directors for all strategic, tactical and operational commanders.	Area Directors	30 June 2023	

C25		**All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.**	Not all Commanders have attended and been assessed at an exercise in the last 18 months partially due to the reduction in numbers of exercised held during the pandemic.	Review attendance of Commanders and prioritise.	05/01/2023 - Accountability for NOS compliance aligned to Area Directors for all strategic, tactical and operational commanders.	Area Directors	30 June 2023	
C26		**Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.**	Commanders identified as not having a comprehensive NOS have not been removed from the on call rota. Currently this is not a policy that is being enforced, but needs to be considered if we are to become compliant.	Review current On Call structure aligned to Commanders maintaining NOS and actions to be taken when Commanders are non-compliant with NOS and / or training mandated.	05/01/2023 – EPRR session including NOS delivered at OPG Dec Further work ongoing to digitalise NOS. Rollout planned through February and March 2023. Digital enhancement expected to be complete in Q1 2023/24. For non-compliance for any commander, it will be aligned to the Performance Management Accountability Framework.	Assistant Director of Resilience/ Chief of Digital and Innovation/ Area Directors	June 2023	
C27		**Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.**	A deep dive was undertaken by NARU during the annual IC review in 2022. Staff reviewed were found to be compliant. A review of all command CPD was undertaken and action discussed with Heads of Service.	Head of Area Operations are to ensure compliance of all commanders.	05/01/2023 – Head of Special Operations undertakes annual audits against all strategic, tactical, operational, NILOs and loggists NOS. This is reported through the workplan to EPRR Sub-Committee.	Head of Special Operations/ Head of Contingency Planning/ Assistant Director of Workforce Development.	Compliant	

C36		**Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the online major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.**	Action cards are held on all operational front-line vehicles. Also available on the Battle box and Green Room. Major Incident DVD was shown on the annual mandatory training sessions. Functional roles are covered in the mandatory training, but this does currently not provide enough time to exercise and ensure what has been covered is understood. Request submitted for increase in mandatory training for first line responders in functional roles.	Continue discussions with Assistant Director of Workforce Development and make recommendations to Service Delivery Senior Management Team.	05/01/2023 – Further work required with Assistant Director of Workforce Development in how the level of understanding of functional roles can be enhanced for those front line crews and incorporated into training opportunities.	Head of Special Operations/ Head of Contingency Planning/ Assistant Director of Workforce Development	April 2023	
J12		**All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.**	JESIP approved interoperability command courses profiled across the region (except Cumbria) for all staff required to perform a command role.	All commanders have attended or profiled to attend JESIP interoperability command course 2022/2023.	05/01/2023 – Head of Contingency Planning (interim) provides an assurance report to the EPRR sub-committee twice yearly (April & October), showing attendance records and the courses conducted by NWAS Resilience Managers and Multi Agency facilitators	Head of Contingency Planning	April 2023	
J14		**Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.**	See J12 EPRR committee provided with update in quarterly reports, currently there remains a number of commanders who are still pending attendance.	All commanders have attended or profiled to attend JESIP interoperability command course 2022/2023.	05/01/2023 – Head of Contingency Planning (interim)) provides an assurance report to the EPRR Sub-committee twice yearly (April & October), showing attendance records and the courses conducted by NWAS Resilience Managers and Multi Agency facilitators	Head of Contingency Planning	April 2023	

J15		**Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.**	Exercise log held by Head of Contingency Planning. Area Directors accountable for compliance of their area commanders.	Audit and report to April 2023 EPRR Sub Committee.	05/01/2023 – Compliance report to be submitted to EPRR Sub-Committee April 2023.	Area Directors/ Head of Contingency Planning	April 2023	
J20		**All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.**	This would require a run off of data from the ESR JESIP training course, which can be linked to the self-assessment courses, this was conducted as part of the Feb 22 self-assessment.	Devise process to provide a run off as part of the JESIP update provided to the EPRR sub-committee reports.	05/01/2023 – Confirm with the Assistant Director of Workforce Development if there is a report that can be run to identify all of those front line and EOC personnel that fit the criteria for this recommendation.	Head of Contingency Planning	Jan 2023	
J22		**All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.**	JESIP is covered as an objective on Exercises and on annual command training, however currently there is not the structure to review each following an exercise or incident. To be considered as part of the requirements within the proposed EPRR training framework.	Confirm that the Trust Learning Themes around CSCATT cover this requirement	05/01/2023 – The JESIP Learning outcomes are captured in the objectives set for Exercises and included in command training. The Trust uses CSCATTT to cover the themes that have been identified through Trust learning and debriefs. The online JESIP awareness course is also available as a handrail for all staff on ESR.	Head of Contingency Planning/ Assistant Director of Workforce Development	December 2022	

J23		**All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.**	These are referenced but do not provide enough detail or clarity for objectives that have to be set to capture all elements of training for NWAS.	Review JESIP templates against the facilitator's briefs, look to include the JESIP objectives into those identified from the Trusts internal learning under CSATTT.	05/01/2023 – The Exercise objectives provided on the JESIP Template are included within the Exercise objectives set by the Trust and within the template utilised around CSCATTT, most recent included Ex GOSHAWK and Ex CLAYTON	Head of Contingency Planning	December 2022	

EPRR Core Standards – NHS 111 2022/2023

Action Plan

Key	
	Non-Compliant
	Partial Compliance
	Fully Compliant

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Progress	Owner	Target Completion Date	Current RAG Status
2		**The organisation has an overarching EPRR policy or statement of intent.**	The Trust has an EPRR sub-group that is chaired by the AEO that meets every quarter and has a work programme in place which looks to provide assurance across a number of business lines which includes training and exercising, and the embedding of lessons identified from Debriefs. This is forwarded to the Quality & Performance Committee and Board of Directors to ensure the Trust is meeting the required standards laid out nationally.	NWAS to produce a clear EPRR policy statement of intent.	05 Jan 2023, draft EPRR policy statement produced by Head of Contingency to be discussed with Director of Resilience in Jan and presented to EPRR Sub-committee for sign off.	Head of Contingency Planning	January 2023	
4		**The organisation has an annual EPRR work programme.**	The Trust does have a EPRR work programme that has been in place since May 2021. The plan specifies exactly what has to be produced in the quarterly report, some areas are reported on in each quarter including the review of debriefs and the learning and action that has taken place. 111 and PTS provide a quality assurance update at each quarter including that all processes are up to date and have been tested and associated learning identified.	EPRR work programme reviewed through the EPRR Sub-committee.	05 Jan update – Completed and reviewed annually by the EPRR Sub-committee.	Head of Contingency Planning	December 2022	

12		**The organisation has arrangements in place to respond to an infectious disease outbreak.**	The Trust holds a plan Communicable Diseases policy version 5 which details the actions to be considered by Trust staff, including Action Cards, overdue review, but does include HCID and detailed appendix of infections. Overdue review currently May 2022, this document was used in line with National direction with the Monkeypox outbreak.	Requires review of policy document.	E-mail from J Dziobon 13/12/22. The communicable disease policy has been approved at the IPC sub-committee and has now gone to M Power for final sign off.	IPC/Head of Contingency Planning	December 2022	
13		**The organisation has arrangements in place to respond to a new and emerging pandemic.**	The Communicable Diseases Policy holds the detail on how the Trust will respond to a new or emerging pandemic under chapter 5.	Currently there is no specific national document for emerging pandemics, but the Trust does have a draft document moving to approval.	05 Jan 2023 – update. An updated draft document is to be produced between Resilience and IPC and presented in draft to the EPRR Sub-committee in April 2023.	IPC/Head of Contingency Planning	January 2023	
16		**The organisation has arrangements in place to evacuate and shelter patients, staff and visitors.**	Business Continuity (BC) plans are in place in particular for the Contact Centre sites Emergency Operations Centre (EOC) EOC BC 02 refers, being reviewed against the NHS E guidance for evacuation. Action Cards in place for Evacuation and the control of that.	Plans being reviewed against NHSE guidance.	16 Dec 22-Contact Centres, PTS & 111 have reviewed their arrangements including confirmation of PEEPS for individuals. Rules regarding evacuation for Fire are also in place.	Head of Contingency Planning/ Business leads/BC Resilience Manager	January 2023	
22		**The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.**	Each Commander has their own personal CPD that can be accessed by the Head of Spec Ops in order for them to assess the quality of reflections and when individuals last attended training or exercises at their level. Command Training is conducted annually over 2 days, one day at a time. Specific themes will be included based on Debriefs and lessons learned as well as subjects including CBRNE, JESIP, logging, Critical thinking. Separate training events for NILOs based on the National guidelines. The TNA is based more on the evidence of the lessons learnt.	Ongoing consultation regarding the development of a Command & Resilience Education Facilitation team, that will conduct training based on need rather than based on mandated requirements.	05 Jan 2023 – update. The Trust does not have a centralised matrix that captures all of the mandatory requirements for each level of command. This is under review and will form part of the requirement under the Command & Resilience Education team that is being presented to the ELC in January 2023.	Head of Contingency Planning/ Assistant Director of Workforce Development	April 2023	

44		**The organisation has in place a policy which includes a statement of intent to undertake business continuity.**	Business Continuity 2 is ISO 22301 compliant and is a host for all departmental BC plans. These Plans form the Trusts approach to BC. Strategic plans include how BC is to be conducted e.g., Constant Care Plan. The Trust is currently considering the requirement for an overarching BC plan.	Develop a statement of intent for Business Continuity.	05 Jan 2023 – update. This will be drafted following the recent exercises on cyber-attacks and power outage which reinforced the requirement for this to be completed. This will be drafted and presented to the EPRR Sub-committee in April 2023.	Head of Contingency Planning	April 2023	

EPRR Core Standards – Patient Transport Service (PTS) 2022/2023

Action Plan

Key	
	Non-Compliant
	Partial Compliance
	Fully Compliant

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Progress	Owner	Target Completion Date	Current RAG Status
2		**The organisation has an overarching EPRR policy or statement of intent.**	The Trust has an EPRR sub-group that is chaired by the AEO that meets every quarter and has a work programme in place which looks to provide assurance across a number of business lines which includes training and exercising, and the embedding of lessons identified from Debriefs. This is forwarded to the Quality & Performance Committee and Board of Directors to ensure the Trust is meeting the required standards laid out nationally.	NWAS to produce a clear EPRR policy statement of intent.	05 January 2023 – Draft EPRR policy statement produced by Head of Contingency Planning to be discussed with Director of Resilience in January and presented to EPRR Sub-committee for sign off.	Head of Contingency Planning	January 2023	
4		**The organisation has an annual EPRR work programme.**	The Trust does have an EPRR work programme that has been in place since May 2021. The plan specifies exactly what has to be produced in the quarterly report, some areas are reported on in each quarter including the review of debriefs and the learning and action that has taken place. 111 and PTS provide a quality assurance update at each quarter including that all processes are up to date and have been tested and associated learning identified.	EPRR work programme reviewed through the EPRR Sub-committee.	05 January 2023 – Completed and reviewed annually by the EPRR Sub-committee.	Head of Contingency Planning	Quarterly	
12		**The organisation has arrangements in place to respond to an infectious disease outbreak.**	The Trust holds a plan Communicable Diseases policy version 5 which details the actions to be considered by Trust staff, including Action Cards, overdue review, but does include HCID and detailed appendix of infections. Overdue review currently May 2022, this document was used in line with National direction with the Monkeypox outbreak.	Requires review of policy document.	E-mail from J Dziobon 13/12/22. The communicable disease policy has been approved at the IPC sub-committee and has now gone to M Power for final sign off.	IPC/Head of Contingency Planning	December 2022	

13		**The organisation has arrangements in place to respond to a new and emerging pandemic.**	The Communicable Diseases Policy holds the detail on how the Trust will respond to a new or emerging pandemic under chapter 5.	Currently there is no specific national document for emerging pandemics, but the Trust does have a draft document moving to approval.	05 January 2023 – An updated draft document is to be produced between Resilience and IPC and presented in draft to the EPRR Sub-committee in April 2023.	IPC/Head of Contingency Planning	January 2023	
16		**The organisation has arrangements in place to evacuate and shelter patients, staff and visitors.**	Business Continuity (BC) plans are in place in particular for the Contact Centre sites Emergency Operations Centre (EOC) EOC BC 02 refers, being reviewed against the NHS E guidance for evacuation. Action Cards in place for Evacuation and the control of that.	Plans being reviewed against NHSE guidance.	14/11/22 C Marshall. Confirm that BC is in place in each location relating to site evacuation. Identified lack of PEEPS. Each of the mgrs. Have been asked to review and update. 16 Dec 22-Contact Centres, PTS & 111 have reviewed their arrangements including confirmation of PEEPS for individuals. Rules regarding evacuation for Fire are also in place.	Head of Contingency Planning/ Business leads/BC Resilience Manager	January 2023	
22		**The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.**	Each Commander has their own personal CPD that can be accessed by the Head of Spec Ops in order for them to assess the quality of reflections and when individuals last attended training or exercises at their level. Command Training is conducted annually over 2 days, one day at a time. Specific themes will be included based on Debriefs and lessons learned as well as subjects including CBRNE, JESIP, logging, Critical thinking. Separate training events for NILOs based on the National guidelines. The TNA is based more on the evidence of the lessons learnt.	Ongoing consultation regarding the development of a Command & Resilience Education Facilitation team, that will conduct training based on need rather than based on mandated requirements. Further discussions taking place to develop a Command & Resilience Education Facilitation team in partnership with the training and education service line.	05 Jan 2023 – The Trust does not have a centralised matrix that captures all of the mandatory requirements for each level of command. This is under review and will form part of the requirement under the Command & Resilience Education team that is being presented to the ELC in January 2023.	Head of Contingency Planning/ Assistant Director of Workforce Development	April 2023	

44		**The organisation has in place a policy which includes a statement of intent to undertake business continuity.**	Business Continuity 2 is ISO 22301 compliant and is a host for all departmental BC plans. These Plans form the Trusts approach to BC. Strategic plans include how BC is to be conducted e.g., Constant Care Plan. The Trust is currently considering the requirement for an overarching BC plan.	Develop a statement of intent for Business Continuity.	05 Jan 2023 – update. This will be drafted following the recent exercises on cyber-attacks and power outage which reinforced the requirement for this to be completed. This will be drafted and presented to the EPRR Sub-committee in April 2023.	Head of Contingency Planning	April 2023	

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Manchester Arena Inquiry – Recommendations					
PRESENTED BY:	Ged Blezard, Director of Operations					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☐	☐	☐	☐	☐	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☒	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	The purpose of this paper is to provide assurance in regard to the governance and progress relating to the recommendations highlighted from the Manchester Arena Inquiry (MAI) volumes currently published. To date two volumes have been published with a number of recommendations: • Volume 1, 'Security for the Arena' published June 2021. • Volume 2, 'Emergency Response' published November 2022. A further report Volume 3 'Security Services/Prevention is yet to be published. The Trust has reviewed volumes 1 and 2, however the main area of focus has been from volume 2. The chair of the inquiry has indicated a total of 149 recommendations in volume 2 with 14 of the recommendations defined as monitored recommendation for NWAS. An internal working group has been established, led by the Assistant Director of Resilience. The AD of Resilience regularly updates the Director of Operations (Accountable Emergency Officer). The composition of the working group consists of the Head of Contingency Planning, Head of Special Operations and another senior EPRR leader appointed through a cost pressure on a 10 month fixed term. Further work is being scoped to identify what additional resource is required to ensure NWAS deliver on not just the 14 monitored recommendations but also the work required as a stakeholder in the other 135 recommendations. The working group works closely with the Head of Legal Services.					

	Internal and external groups have been established to ensure there is a clear and consistent approach against the 149 recommendations. Of the 14 Monitored Recommendations NWAS has made progress and on production of this report can provide assurance against 2 of the 14 monitored recommendations as complete. The remaining 12 are currently RAG rated as Amber, and have clear timescales defined. A review of the timescales aligned to each recommendation will now take place following receipt of the correspondence from the Inquiry Legal Team (ILT). Appendix 1: sets out the 14 monitored recommendations for NWAS with a RAG rating on the progress status and action timelines for each one.
RECOMMENDATIONS:	The Board of Directors is recommended to: • Receive assurance on the actions taken to establish a dedicated resource to lead on the Manchester Arena Inquiry recommendations. • Receive assurance that the 14 monitored recommendations from the MAI are being reviewed, actioned. • Receive assurance NWAS are engaged with relevant stakeholders to review and action all recommendations.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk the trust's 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:				
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to provide an update to the Board of Directors on the actions taken since the Manchester Arena Inquiry published volume 2, Emergency Response, including the progress made against the 14 monitored recommendations.

2. BACKGROUND

The Manchester Arena Inquiry has to date published two reports with a further one to be released:

- Volume 1: *Security for the Arena* (17 June 2021)
- Volume 2: *Emergency Response* 2-I (a/b) / 2-II (3 November 2022).

Volume 3, *Security Services / Prevention* has yet not been published.

The Trust has reviewed volumes 1 and 2, and a detailed action plan has been developed. The initial review of volume 1 has not identified any specific recommendations for NWAS. The chair of the inquiry has made a total of 149 recommendations in volume 2, designed to ensure that these alternatives are considered, and that everything than can be done to fill the care gap is done. The 149 recommendations are aligned to specific agencies/stakeholders, with 14 of the 149 recommendations defined as monitored recommendations for NWAS.

Focus will be on all recommendations working with the required agencies/stakeholders, however due to the timescales given by the chair of the inquiry to report back on the monitored recommendations, the primary focus and actions taken have been aligned to the 14 monitored recommendations. This report will provide assurance on the actions taken to date against the 14 monitored recommendations.

The Trust has been advised by the Inquiry Legal Team (ILT) that the first update is required to be presented by 1000hrs on the 3rd February 2023. The update will be published on the inquiry website.

The ILT has set a broad timetable for subsequent updates/submissions as follows:

- **Deadline 2: By the beginning of May 2023 (or possibly earlier):**

  The service of a witness statement, with a detailed update on progress of the recommendations, including service of supporting exhibits and materials.

  The witness statement and exhibits will be published online.

- **Stage 3: Hearings**

  Oral hearings will take place after May 2023. It is predicted by the Director of Corporate Affairs this may take palce in July 2023. It is almost certain that

NWAS will be invited to give oral evidence during the recommendations hearings.

The process of providing updates on the 14 monitored recommendations will involve further, and intense scrutiny of the Trust, particularly with the service of the witness evidence and the subsequent hearing.

Previous works from the NWAS internal debrief after the arena has enabled the Trust to identify areas of learning, this had led to some of the 14 monitored recommendations having partial or some works completed. This will become apparent when reading Appendix 1.

An action plan has been developed for all 14 of the monitored, and discussions are taking place to ensure we work with all relevant stakeholders locally, regionally, and nationally to ensure we take a co-ordinated and consistent approach.

3. MONITORED RECOMMENDATIONS UPDATE

An internal working group has been established, led by the Assistant Director of Resilience. The AD of Resilience regularly updates the Director of Operations (Accountable Emergency Officer). The composition of the working group consists of the Head of Contingency Planning, Head of Special Operations and another senior EPRR leader appointed through a cost pressure on a 10 month fixed term. Further work is being scoped to identify what additional resource is required to ensure NWAS deliver on not just the 14 monitored recommendations but also the work required as a stakeholder in the other 135 recommendations. The working group works closely with the Head of Legal Services. The working group will need the support of all directorates to address the recommendations, for example digital development, and training.

The working group will report to the Emergency Preparedness Resilience and Response (EPRR) subcommittee and through the trusts governance structure through to Board.

An action plan has been developed for all 14 of the monitored, and discussions are taking place to establish the required structures to work with all relevant stakeholders locally, regionally, and nationally and to ensure we take a co-ordinated and consistent approach. Stephen Groves, Director of EPRR (National) for NHS England will be the national lead for the NHS in terms of the recommendations. In relation to blue light agencies (national) aligned to the Manchester Arena Inquiry a meeting is scheduled 23/01/2023, including the National Ambulance Resilience Unit (NARU).

The Association of Ambulance Chief Executives (AACE) is leading a workshop planned for the 7th February 2023 on the Manchester Arena Inquiry recommendations.

Previous works from the NWAS internal debrief after the arena has enabled the Trust to identify areas of learning, this had led to some of the 14 monitored recommendations having partial or some works completed. This will become

apparent in the Manchester Arena Inquiry Monitored Recommendations action plan in Appendix 1.

An action plan has been developed for all 14 of the monitored recommendations, and discussions are taking place to ensure we work with all relevant stakeholders locally, regionally, and nationally to ensure we take a co-ordinated and consistent approach.

In terms of an update specific to the 14 Monitored Recommendations NWAS has made some progress and on production of this report can provide assurance against 2 of the 14 monitored recommendations as complete. The remaining 12 are currently RAG rated as Amber, and have clear timescales defined. A review of the timescales will now take place following receipt of the correspondence from the ILT. The senior team engaged directly in the Manchester Arena Inquiry recommendations are confident the 14 monitored recommendations will be delivered in a timely manner aligned to the updates required to the chair of the inquiry, and with the support of all ELC members.

Appendix 1 provides detailed information relating to each of the 14 monitored recommendations and provides assurance on actions taken, evidence available and each one RAG rated leading to all 14 being reported as complete within defined timescales.

4.

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

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the CCA (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards which are revised annually.

NWAS has a legal duty to respond within defined timescales set by the Chair of the Inquiry against 14 *Monitored* recommendations.

5. **EQUALITY OR SUSTAINABILITY IMPACTS**

N/A

6. RECOMMENDATIONS

The Board of Directors is recommended to:

- Receive assurance on the actions taken to establish a dedicated resource to lead on the Manchester Arena Inquiry recommendations.
- Receive assurance that the 14 monitored recommendations from the MAI are being reviewed, actioned.
- Receive assurance NWAS are engaged with relevant stakeholders to review and action all recommendations.

Manchester Arena Inquiry - Monitored Recommendations (NWAS)

Serial	Recommendation	Evidence	Owner	Deadline	RAG	Emergency Response - Volume 2 reference number and page	Update
R14	North West Ambulance Service should review its Major Incident Response Plan to consider whether it should be updated to include a pre-determined attendance for Major Incidents.	•Report to ELC – the development of a PDA •Abstract from ELC approval •Command training – what is a PDA •PDA Tutor notes •EOC bulletin •Operational bulletin •Command and Management Deployment guidance v6.1 •IRP v8.4 page 58 7.3 •PDA tested Exercise Clayton March 2022	HOC Planning HO Special Operations	21/01/2023		12.448 (pg. 206)There was no specific pre-determined attendance for a Major Incident, such as the Attack, suggested in the Major Incident Response Plan. This would have been helpful and should be a consideration for future planning.	
R15	North West Ambulance Service should review its Major Incident Response Plan to consider whether, in order to speed up mobilisation, it should provide pre-determined attendances for the Hazardous Area Response Team, Ambulance Intervention Team and Special Operations Response Team crews for Major Incidents.	• IRP 8.4 page 58 7.3 identifies HART and other specialist response • SORT Core Standards 2022 • Exercise completed 6 December 2022	HOC Planning HO Special Operations AD Resilience	21/01/2023		12.449 (pg. 206) It is not clear to me whether a pre-determined attendance would have assisted in relation to non-specialist paramedics on the night of the Attack. But a pre determined attendance on 22nd May 2017 for the specialist crews may have accelerated the mobilisation process of these assets, which are of critical importance in a Major Incident.582	•Ambulance Intervention Teams name no longer exist as a new national standard is to uplift the specialist resource number within the Special Operational Response Teams (SORT) as set out in the SORT core standards 2022 - Due to the uplift there are now 265 staff trained across the Trust. NWAS reports three times a day to the national ambulance coordination centre on the Trust compliance •NWAS to review the command-and-control structure for specialist assets; any updates will be included in the April, May and June 2023 Annual Commander Training programme •Updates for IRP v9 and action cards 31 June 2023
R16	North West Ambulance Service should ensure that it has up-to-date site-specific plans for all large, complex or high-risk locations within its area.	•GM Multi-agency TOR blue lights •NWAS Guidance of Management for complex sites •MTA JOPS •SSQRS – developed after 2017	HOC Planning	21/01/2023		12.455 (pg. 207) There was no site-specific plan for the Victoria Exchange Complex or the Arena.591 There was only a "site information sheet" dated October 2011 for the Arena.592 Site-specific plans can provide detailed information, including maps and building plans, which would have assisted command and control planning for establishing an FCP, locating exits, and considering appropriate locations for a Casualty Collection Point and a Casualty Clearing Station.593 12.456 (pg. 207) Although not required by NHS England, site-specific plans were not uncommon and NWAS itself had some. NWAS had not chosen to produce or share with another responder agency a plan for the Victoria Exchange Complex. It should have done. The Ambulance Service Experts informed me that site-specific plans for high-risk locations were "commonplace" in 2017. They considered that NWAS should have had such a plan for the Arena.594 12.457 (pg. 207) A particular advantage for NWAS of a site-specific plan would have been dialogue between NWAS and Emergency Training UK (ETUK) and discussion of how they would interact if there were an emergency at the Arena. The lack of interaction between NWAS and ETUK, particularly at command level, was a significant failure on the night of the Attack. I will consider the relationship between ETUK and NWAS further in paragraphs 12.502 to 12.505, and in Part 16. 12.458 (pg. 207) NWAS should ensure there is an up-to-date site-specific plan for all large, complex or high-risk locations within its area. These plans should include a floorplan layout so that entrances and exits are marked. It should include relevant contact details for those in charge of the location.595 12.459 (pg. 208) While it is open to any single agency to produce its own site-specific plan, good practice would have been to ensure that there was a single multi-agency plan specific to the Victoria Exchange Complex. Fault for the failure to produce or share in such a plan for the Arena does not lie exclusively with NWAS. This was a failure of all of the Category 1 responders in the Greater Manchester area. There was a failure to collaborate through GMRF. All site-specific plans should be multi-agency with contributions from all categories of responders.	•NWAS has developed a Guidance document for the management of complex sites; this is in light of helping create site specific plans for internal use. These plans are reviewed annual or in some cases every three year (COMAH) in line with legislation. •NWAS currently uploads all SSQRS sheets to RD for internal use however the GM area have developed an blue light working group to develop multi agency plans •Action on recommendation 17 – Assistant Director of Resilience will be writing to all LRF chairs for this multi-agency sharing of plans to be put on the agenda as a standing item (31/01/2022)

R17	North West Ambulance Service should ensure that all its site-specific plans are multi-agency and that all Category 1 responders operating in the areas it serves have contributed to them.	•GM Multi-agency TOR blue light	HOC Planning HO Special Operations AD Resilience	31/01/2023		As above	•Assistant Director of Resilience to write to the chairs of the five Local Resilience Forums (LRF)to request a standing agenda item: *Review of site-specific plans for all Category 1 responders* This will allow for any of the responder agency to be aware of changes or impacts on each other responsibilities •GM Area blue light group for sharing of plans chaired by NWAS RM
R18	North West Ambulance Service should ensure that it has a policy that sets out the circumstances in which an Operational Commander may be relieved and how that should occur and be communicated to the outgoing Operational Commander and beyond.		HOC Planning Head of Special Operations AD Resilience	31/03/2023		12.480 (pg. 211)There will be circumstances in which it is appropriate for the Operational Commander to remain in place throughout an incident. There will also be circumstances in which it will be appropriate for an Operational Commander to be relieved. This needs to be set out in a policy. If it is not, then a policy should be drawn up. All commanders should be clear on when and how this will occur according to the policy. The handover should follow an established procedure. Training of commanders should include practising handing over and taking over command.	•Review of the Incident Response Plan (IRP) v8.4 and action cards v8.0 to be updated including policy for the release of Operational Commander showing new versions (v9) for each – IRP and Action card - both document will be distributed electronically •Introduction to the handover policy will be part of the Annual Commander Training April/May and June 2023 •NWAS will review all levels of command structures Operational/Tactical and Strategic in relation to being relieved by another commander •Current National Ambulance Resilience Unit (NARU) v3.1 pg. 42 (A) describes information about status but this is for Tactical Commander and not the Operational Commander
R19	North West Ambulance Service should train its Operational Commanders on the appropriate practice for relieving another of command and being relieved of command.		HOC Planning Head of Special Operations AD Resilience	30/06/2023		As above	•Introduction to the handover policy will be part of the annual commander training April/May and June 2023
R20	North West Ambulance Service should ensure that non specialist ambulance personnel are involved in multi agency exercising.		AEO AD Resilience	30/06/2023		12.500 (pg. 214) One further issue that emerged from the evidence was the limited extent to which non-specialists were involved in multi-agency exercises. This is something which I am told NWAS is considering how to improve.646 I encourage NWAS to address this area for improvement as soon as possible. It is essential that the way specialist and non-specialist ambulance personnel work together and with the other agencies in a Major Incident is tested in multi-agency exercises	•Review of full training for non-specialist ambulance personnel to take place
R21	North West Ambulance Service should review its Major Incident Response Plan to make clear that the first resource on scene should assume the role of Operational Commander only once they have achieved situational awareness.	•MIRP story line from V3 to V8.4 (4.6.1) page 34	HOC Planning	31/03/2023		14.121 (pg. 450) The Major Incident Response Plan should make clear that the attendant from the 'First Resource on Scene' should assume the role of Operational Commander only once they have achieved situational awareness. Situational awareness must be the priority because, until that person has such knowledge, he or she will not be able to discharge his or her other responsibilities properly	•Review of current IRP v8.4 and action cards v8.0 1-3 to include 'first resource on scene' •Changes to IRP and action cards to be introduced in annual commander training April/may and June 2023

R22	North West Ambulance Service should ensure that its commanders are adequately trained in the use of operational discretion.		HOC Planning HO Special Operations AD Resilience	30/06/2023		14.214 (pg. 468) As I set out in Part 12, NWAS Operational Commanders had a discretion, following a robust risk assessment, to send non-specialist paramedics into the inner cordon. It is important that commanders should understand that exercising such a discretion may save lives and that they should feel supported if they choose to do so. NWAS should review its training to ensure that commanders are not left with a false impression.	•Development of training programme 2 February 2023 •Deliver of training on the new Annual Commander training profiled April/May and June 2023 •The development of the training programme will be for all levels of commanders
R23	North West Ambulance Service should review its policies for mobilising the Hazardous Area Response Team resource, to ensure that this team is available as soon as possible for an emergency where its specialist skills are required.	•EOC0014 Procedure October 2021 •IRP HART response v8.4 3.10.1	HOC Planning HO Special Operations J Kelly Regional Manager EOC	31/01/2023		14.25 (pg. 432) while xxxxx was correct to identify that HART was required, in light of the clear report at 22:32 that 'a bomb' had detonated, it would have been better if the need for HART had been identified before 22:39 by NWAS. One of the issues with HART is the limited number of teams covering a large area. For this reason, it is essential that contact is made with the nearest HART crew as early as possible. it should be possible for the control room to do this as part of a standard response. NWAS should review it policies for mobilising the HART resource, to seek to ensure that it is available as soon as possible for any emergency where its specialist skills are required. This important issue is examined in further details in Part 20 in Volume 2-11.	Awaiting assurance that the codes for HART have been changes in the new pathway system
R24	North West Ambulance Service should review how it rosters Tactical Advisors and National Interagency Liaison Officers so as to ensure that there is adequate geographical coverage enabling those on duty to arrive promptly at the scene of any Major Incident.		HO Special Operations HOC Planning	30/06/2022		14.542 (pg. 526) However, journey time for on-call staff is capable of building in substantial delay. I recommend that NWAS review its approach to Tactical Advisors/NILOs in light of this issue. NWAS should consider whether it is possible and practical to identify in advance of any shift which of its on-call NILOs is best placed to travel to a Major Incident should it occur and which of them should operate from home to provide cover for particular areas.	•Review of current NILO/Tactical Advisors taken place. Since 2017, 3 trained NILO left. The rota currently has 12 with a further 2 members of staff profiled on national course and another 5 waiting for national courses •Head of Special Operational to seek further places should they become available •Head of Contingency Planning to work with NWAS training school re blue light training for all NILO staff
R25	North West Ambulance Service should review the number of Tactical Advisors and National Interagency Liaison Officers it has, and whether the number of such specialists, both generally and on call, should be increased.		AD Resilience Director of Operations HOC Planning	30/06/2023		14.574 (pg. 532) xxxxxxxx suggested that increasing the Tactical Advisors/NILOs within NWAS may lead to overall improvement.761 xxxxxx said that a third Tactical Advisor/NILO on call “would have been ideal”.762 I recommend that NWAS review the number of Tactical Advisors/NILOs it has and whether the number of such specialists, both generally and on call, should be increased.	•To be raised at national meeting 6 February 2023 •Assistant Director of Resilience to write a paper to explain the rationale that all NWAS Tactical Advisor will be trained at the national recognised standard for NILO
R26	North West Ambulance Service should review its procedures with local NHS trusts to ensure that it has effective policies in place for quickly dispatching patients injured in a Major Incident to an appropriate hospital.		AD Resilience Medical Director HOC Planning	31/03/2023		12.370 (pg. 190) In the response to a Major Incident, NWAS has responsibility for all NHS responders, the command and control of all health assets, and the pre-hospital management of casualties including treatment, triage and distribution to an appropriate hospital 12.371 (pg. 190) NHS ambulance services in the UK are required to comply with a comprehensive range of standards and national policies in respect of emergency preparedness. 12.372 (pg. 191) Having considered the wide range of emergency plans and procedures that NWAS had in place, the Ambulance Service Experts considered that NWAS was compliant with the national standards for emergency preparedness at the time of the Attack.507 Support for this view is found in the conclusion of the Emergency Preparedness, Response and Resilience annual assurance process and verified through an NHS England sponsored audit.508 12.373 (pg. 191) While I accept that NWAS met those national standards, I have concluded that there were areas where NWAS's planning for an emergency could and should have been improved 14.503 (pg. 519) In my view, first accessing the draft GM Patient Dispersal Plan 68 minutes after the explosion was later than should be expected. xxxxxxx should have had this essential information more readily to hand. Although the plan was in draft, xxxxxx was sent a copy and instructed to use it in a mass casualty situation. The need for it should have been among her first thoughts when realising the scale of the incident	•Meeting arranged with Assistant Director of Resilience, Medical Director, and Head of Contingency Planning •A review in IRP v8.4 seen changes to several of functional roles including Primary Triage Officer, Casualty Clearing Officer and Medical Emergency Response Team enhancing the policies around clinical care at scene •Review for IRP v9 to have effective systems in place for dispatching of injured patients in a major incident •Review of action card v8.0 should any changes in the above IRP v8.4 to v9.0 take place

R27	North West Ambulance Service should reflect on its approach to record-making during and immediately following a Major Incident, with a view to improving the current practice	•Command training July 2017 and May 2021 featured best practice logging •NWAS invested in a new position a Resilience Manager with the responsibility for Quality and Improvement around any type of incident •New NWAS debrief policy released May 2021 with clear lines of debrief and allocations of lessons identified (review date 2022)	HOC Planning	31/03/2023		Record of events Written notes (pg. 74 through to 79) 19.13 There was a requirement imposed by some organisations for written notes or decision logs to be kept relating to the response to the Attack. For example, firearms commanders were expected to keep a record of their decisions.7 Under the third edition of the Joint Operating Principles (JOPs 3), “decision makers” were required to “record the rationale and information sources for their tactical decisions”. 8 Police officers operated under a general expectation to keep notes in their pocket notebooks. North West Ambulance Service (NWAS) expected its commanders to keep a decision log. Greater Manchester Fire and Rescue Service (GMFRS) expected its officers to record decisions in a log or, where this was not possible, to record notes later and within 24 hours of an incident.9 Debriefs 19.33 A number of debriefs took place following the Attack. Some were termed “hot debriefs”.20 These were proximate to events and were intended to capture raw impressions of what had occurred. There were also more formal debrief processes where individuals completed questionnaires and attended debrief meetings. 19.34 The debrief process provides an invaluable opportunity for organisations to understand what may have gone wrong and how improvements in their practices can be made. They must be conducted constructively and candidly. Given the importance of joint working, the debrief process of Major Incidents involving more than one emergency service should be overseen by the local resilience forum Continued to 19.42 I recommend that each emergency service involved in the response to the Attack seek to understand why the issues considered in Volume 2 of my Report were not identified sooner. This is intended to be a constructive exercise aimed at improving the current system. I recognise that the answer to some may simply be attributable to the highly detailed and forensic process that the Inquiry has been able to undertake, but not all.	•Changes from IRP v8.4 to v9.0 will show the changes for commanders to record their notes no later than 24hr after an incident and submitted within 72hrs •Changes to action cards v8.4 to v9.0 to show the changes in regard to recording and submitting logs •Introduction to the new changes to be included in the annual commander training April/May and June 2023 •NWAS debrief policy to be updated

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	28th November 2022	**Chair:**	Prof A Esmail, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Dr 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 A Chambers Dr D Hanley Mrs A Wetton Mr G Blezard Dr M Power Dr C Grant	**Key Members Not Present:**	-

Link to Board Assurance Framework (Strategic Risks):

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

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 outstanding BAF actions for completion during Q4 2022/23. • Highlighted the challenges in relation to balancing operational challenges and achieving transformational organisational changes. • Noted the early work of the Handover Improvement Board (HIB), which included establishment of Terms of Reference, overarching principles and focus for improvements with each ICB. • Meetings scheduled in early December with frontline teams, led by the HIB to discuss risks. • Discussed actions to mitigate risks related to long waits and acknowledged the challenges remained. • Introduced sub-categorisation of C2 waits to provide more focus. • Noted work undertaken within the Health, Safety and Security Team to reconfigure the structure and recruit new members of staff. • Acknowledged that the digital risk and additional resource had been scrutinised by the Resources	• Gained assurance that BAF risks were being managed effectively.	

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	Committee at their meeting held on 25th November 2022.		
Patient Safety Incident Response Framework	• Received a presentation on the Patient Safety Incident Framework (PSIRF). • Discussed the Trust's approach to the Framework, as a contractual requirement from NHSE. • Acknowledged progress made by NWAS and the need for future Board consideration of patient safety priorities and the safety culture across the organisation.	• Received and noted the update on the Patient Safety Incident Response Framework	
Integrated Performance Report	• **Complaints –** noted a reduction in the rate of closure of Level 4-5 complaints since the last meeting. • Recognised the delays caused by obtaining input from more than one service line. • Complaints team working with operational colleagues to improve compliance. • **Call Pick Up** – 999 call pick up significantly challenged due to staff abstractions and follow up training for NHS Pathways. • No ARP standards met. • **Average hospital handover times** - had increased and were above the national standard, with average time of	• Noted reduction in Level 4-5complaints closed within the required timeframe. • Noted work being undertaken to address risk in C2 long waits. • Recognised the Trust's current performance in relation to call pick up, no ARP standards met during October 2022. Although NWAS were rated one of the better performing Trust's in terms of C1 and C2 calls, across the ambulance sector. • Worse hospital handover times and increased risks associated to patient safety.	

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	52 mins 16, with 23% of handovers taking over an hour and over 1,000 attendances over 3 hours. • 5236 hours lost due to delayed admissions during October and position showed no signs of improvement. • Queried the steps being taken to manage risks associated to C2 long waits. • Director of Operations noted that NWAS were well placed in terms of C1 and C2 performance across the sector, although Trust hadn't met ARP standards. • Reported the Trust had lower performance for C3 and C4 calls due to prioritisation of C1 and C2 waits. • C2 validation recruitment and crew reconfiguration had been undertaken. • Director of Quality, Innovation and Improvement reported worsening position of hospital handover delays, since the last meeting. • Recommended input at Board level to influence the system and provide a collective approach to the risks which were expected to increase over the coming months.	• Number of resource hours lost due to hospital handover delays. • **Action:** escalate the increased risk to patient safety associated with worsening hospital handover delays to the Board of Directors.	

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	• 111 call pick up performance deteriorated to 40%, during October. • Service experienced high attrition rates. • Noted Resources Committee had received deep dive into 111 recruitment and retention, challenges, and risks.		
CFR Assurance Report	• Received detail of the current number of CFRs within the service, and volunteer time in total hours. • Queried the process for returning NWAS uniform and kit for inactive CFRs. • Noted that an internal audit had been conducted and some kit retrieved, however further assurance would be provided in the next report to the committee. • Discussed the deployment of CFRs and pilots being undertaken across the region including deployment of Emergency CFRs to fall incidents.	• Noted the assurances provided.	
Third Party Assurance Reports	• Third party assurances for PES and 111 services reported. • Recognised contract review and governance process in place to monitor quality of current providers.	• Noted the third-party assurance provided.	

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	• 90.5% of audits completed and 81.9% compliant. • Noted the processes for addressing non-compliance. • Themes and trends arising from reviews of service quality and noted no high-level patient safety incidents had been reported during the calendar year 2022. • Noted the thorough work undertaken by the Trust to ensure private providers were fit for purpose.		
Service Delivery Oversight Forum Q2 Report	• Received detail of the service delivery model programme and completed programme objectives, with outcomes achieved. • Noted amber assurance related to the NAD CAD programme, which had been delayed due to delays in the integration strategy. • Progress reported to the Trust's Corporate Programme Board which escalated concerns to the Trust's Executive Leadership Committee. • Consideration of productivity and efficiencies and formalisation of reporting to be included in the 2023/24 Forum work plan.	• Noted Q2 progress detailed in the Q2 report.	

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Diversity and Inclusion Sub Committee Chairs Assurance Report	• Noted the assurances provided by the Diversity and Inclusion Sub Committee from the meeting held on 11th November 2022.	• Noted the assurances provided.	
The Kirkup Report into Maternity Services	• Received comprehensive overview of the independent investigation into maternity and neonatal services across East Kent Hospitals between 2009 and 2020. • Acknowledged the significance of the report and the role of the Trust's Consultant Midwife. • Recognised the need to consider alternative ways of delivering training to ensure staff developed the skills necessary to care compassionately for mothers and babies.	• Noted the content of the report.	
Clinical Audit Q2 Report	• Received an overview of the assurances received by the Clinical Effectiveness Sub Committee. • Noted the status and impact of the APEX tool. • Acknowledged NHSE would discontinue collection of data for the sepsis bundle and supported Trust's collation of data at local level.	• Noted content of the Q2 Clinical Audit Report.	
Complaints Q2 Report	• Noted delays in closing level 4-5 complaints.		

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	• Noted as the most complex cases and took longer to conclude due to service the line input required. • Noted the work being undertaken to address the backlog by the head of legal services, included weekly monitoring and team meetings to prioritise workloads. • Director of Corporate Affairs sighted on the position and work continued by the complaints team, to support operational teams • Key theme from complaints received, related to delayed emergency response. • Noted further work on learning from key themes would be progressed during Q4. • Discussed correlation of learning themes with future PSIRF arrangements.	• Noted the work undertaken by the complaints team and assurances provided. • Noted the challenges associated with closure of level 4-5 complaints within the required timeframe.	
Legal Services Q2 Report	• Received an update on legal services activity including the level of inquests and claims received during Q2. • Noted 62% of inquests attributed to non-conveyance and see and treat assessment. • Agreed further assurance required.	• Received assurance that processes were in place for managing the Trust's claims and inquests. • **Action:** Requested assurance related to the 62% of inquests attributed to non-conveyance and see and treat assessment.	

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Learning Disability and Autism (LD&A) Report	• Mental Health Service Lead and Clinical Transformation Manager presented an overview of the Trust's approach and work undertaken in respect of LD&A. • Noted the Trust's LD&A Plan which included collaborative approach to delivery of the plan and extensive engagement with LD&A specialists. • Datix used to collate information and influence areas of focus. • Acknowledged the wider collaboration with NWAS patient and public panel and NHS regional steering groups. • Six main themes identified to influence the Plan over the next 3 years. • Plan awaited final approval by the Trust's Executive Leadership Committee. • Queried and noted the challenges associated to the process for identifying service users with a learning disability or autism. • Noted the LD&A improvement standards published in 2018, part of the NHS Long Term Plan and advised that these would be included in the Trust's Quality Account 2022/23.	• Received assurance from the Learning Disability and Autism (LD&A) Report. • Noted the funding and resource required to deliver the 3-year LD&A plan and the further discussion and consideration required.	

Key		
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	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	• Work ongoing to adapt the improvement standards to the ambulance sector. • Discussed the resource requirements required for future consideration by the Executive team and the Board. • Welcomed and acknowledged comprehensive report and noted resources required to deliver the 3-year plan.		
Safeguarding Biannual Report	• Noted the Trust had been involved in 115 system safeguarding reviews - 63 adult and 38 child reviews, since the beginning of the financial year. • Acknowledged that LADO arrangements were working effectively. • Recognised the risk related to delivery of Level 3 safeguarding training due to impact of the pandemic. • Members queried how the risk related to training impacted on current safeguarding activity, in practice. • Acknowledged Assistant Director of Nursing represented the team on the Trust's Mandatory Training Oversight Committee and a review of current practice was being undertaken. • Key objective of the Mandatory Training Oversight Forum is to provide	• Noted safeguarding activity. • **Action:** requested future report on the findings and outcomes of the review being undertaken of safeguarding practice and the quality of training.	

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	focus and prioritise statutory and mandatory training. • Requested future report on the findings and outcomes of the review of safeguarding practice including the quality of training.		
Health, Safety and Security Biannual Report	• Received key highlights of activity during the previous 6 months. • Review of team structure undertaken, and new posts established to provide the required skills, knowledge, and expertise. New posts would also support moderation of practice and centralised monitoring processes. • Noted significant work undertaken to manage and review violence and aggression markers. • Collaborative working with estates department, activity included fleet risk assessments and outcomes. • Acknowledged quality of the report and the hard work undertaken by the team.	• Received assurance from the Health and Safety Biannual Report.	
Health, Safety and Security Chairs Assurance Report	• Assurances reported from the Health, Safety and Security Sub Committee on 1st November 2022.	• Noted the assurances provided.	
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Assurances reported from the Clinical Effectiveness Sub Committee on 1st November 2022.	• Noted the assurances provided.	

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	20th January 2023	**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 Butterworth Ms C Wood Ms L Ward Mr S Desai Mr G Blezard	**Key Members Not Present:**	Dr M Power, Director of Quality, Innovation, and Improvement

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11	SR12
☐	☒	☒	☒	☒	☐	☒	☒	☒	☒	☒	☐

Key		
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Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Board Assurance Framework	• Received the proposed Q3 position of the BAF. • Noted decrease in risk score of SR02, SR07, SR08, SR09, SR10, SR11. • Discussed the increase in risk score of SR04 from 12 to 16 and the basis of rationale for increase in SR04. • Discussed the score and rationale of SR05.	• Received assurance that the BAF risks were being managed effectively.	
Deep Dive – Sickness Absence	• Presented comprehensive report which reflected on data and analysis to support an improved understanding of root causes and indicators in relation to staff absence. • Acknowledged the consideration and work and interventions being undertaken to mitigate risks and examples provided. • Noted the key areas of work of the Trusts Attendance Improvement Teams (AITs) and savings that had been achieved. • Discussed the assurances received, however acknowledged the need to maintain oversight of the longer-term position.	• Received assurance on the work being undertaken. • Recognised the ongoing challenge for the Trust and continuation of the work required to manage sickness levels. • Recognised future resource for funding Attendance Improvement Teams would be discussed and considered by Executive Directors.	

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	• Noted that ELC would be required to consider future investment of AITs. • Assured that work being undertaken, however noted Committee would maintain a longer-term view.		
Workforce Indicators Report	• Reported that sickness absence had decreased in November 22 to 8.64% with COVID-19 sickness at 0.94%. Lowest rate of COVID absence in the last 8 months. • Mandatory Training overall compliance on track at 78%. • Appraisal compliance rates currently 82% overall. Revised targets approved by ELC in November. • Staff turnover 12.28% and broadly stable position over the last six months. • Key areas of challenge noted in terms of vacancy gaps. • Noted the risk mitigated by bank usage, in the short term. • Also noted the risk associated to a variation in the recruitment plan, due to recruitment challenges for 111. • Discussed the need to escalate the staffing risk to Board and support a separate risk	• Recognised the good progress in relation to appraisal and mandatory training compliance. • Noted the risk associated to recruitment challenges in 111 service and the variations to plan. • Noted the external factors, outside of the Trust's capacity to control, such as recruitment marketplace and 23/24 funding and resourcing allocations.	

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	• HR Case Management position reported, and case type activity noted. • Noted the position in terms of the Trust's Flu vaccination campaign.		
Diversity and Inclusion Sub Committee Chairs Assurance Report	• Discussed the assurances provided within the Chairs Assurance Report, from the meeting held on 9th December 2022.	• Received assurance from the Diversity and Inclusion Sub Committee Chairs Assurance Report.	
Finance Report Month 9 22/23	• Received details of the Trust's financial position up to 31 December 2022. • Noted the Trust's position in terms of the efficiency and productivity target, on track for 2022/23. • Discussed the latest capital programme for 2022/23 and the spend during Q4. • Acknowledged that the Trust had achieved the Better Payment Practice Code targets in 2022/23.	• Received assurance from the report.	
Update on 2023/24 Financial Plans	• Received an update on the latest situation with NHS England (NHSE) in terms of operational planning guidance and provided with an update in relation to the 2023/24 draft revenue and capital financial plans. • Acknowledged that the NHSE had issued a series of operational planning guidance documents on	• Received assurance from the report.	

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	23rd December 2022. • Recognised that Integrated Care Systems (ICSs) would continue to be the key unit for financial planning purposes, as set out in the NHS finance business rules. • Noted that ICBs and their partner trusts were collectively tasked with delivering a breakeven financial position across their system. • NWAS required to submit an organisational plan, in line with the system planning submission. • Noted that the Board of Directors would discuss the draft and final plan in February and March 2023 to meet the system deadlines. • Also noted the position in relation to the Trust and the ICS in terms of Capital Departmental Expenditure Limit (CDEL).		
HART Liverpool Relocation Update	• Received an update on progress of the project to relocate the Liverpool HART facility and contingency plans. • Noted the contingency options in the event of timescale slippage. • Noted the mid stage position and costs.	• Received assurance that contingency plans with viable options were in place.	

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	• Briefed on the most recent position and discussed contingency plans in place. • Assistant Director of Estates, Fleet and Facilities Management and Director of Operations confirmed the viability of the contingency options.		
Strategic Planning Update	• Received a strategic planning update from the Deputy CEO/Director of Strategy, Partnerships and Transformation. • Noted the progress made within the strategic planning review during Q2-Q3. • Acknowledged the summary of the objectives identified within 2022/23. • Received an overview of the original workplan timescales agreed by Resources Committee in July 2022. • Discussed the areas of risk which had been reviewed and included on the Trust's Risk Register. • Agreed that continued operational pressures were expected and the challenge of delivering against planning objectives. • Noted the risk to the organisation and that the Board of Directors would discuss future planning at the next	• Received and noted the Q2-Q3 planning update. • Acknowledged the ongoing challenges and the implications on objectives and associated risks. • Noted the significant risk associated to challenges and ongoing difficulties. • Noted further discussion scheduled at Board Development Session, scheduled for February 2023.	

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	Board Development Session to be held in February. • Agreed to escalate the challenge and risk to the Board, in relation to the Strategy.		
Digital Update	• Received progress in relation to delivery of the digital strategy and the mitigation of associated risks for October – December 22. • Report included a view of new 'target adherence over time' which outlined the overall percentage of measures on target across each of the digital pillars outlined in the Digital Strategy. • Noted that the last quarter saw the highest mean and an increase up to 57%, a significant increase. • Recognised the improvements made against the five digital pillars. • Noted two new risks created since the last meeting and considered by the Trust's Executive Leadership Committee. • Discussed the risks, included on the Board Assurance Framework. • Further assurance to be presented to the Resources Committee at the next meeting in relation to overall digital strategy, risk, and resource savings.	• Received assurance from the digital update however recognised the extensive work programme and risks. • Further assurance to be presented to the Resources Committee at the next meeting.	

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 January 2023					
SUBJECT:	Communications and Engagement Team Dashboard Report – Q3 (October – December) 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**	**SR12**
	☐	☐	☐	☒	☐	☐
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, impact and associated highlights. Statistical content and themes are provided on: • Patient and Public Engagement – an area of note this time is the significant increase in engagement events as well as the first in a series of NWAS-hosted back to basics events in each of our counties. Satisfactions rates in our services have deteriorated for the second quarter consecutively, as found by patient surveys. • Patient and Public Panel – targeted work has increased ethnic minority and youth membership by 2% each. • Press and Public Relations – a significant increase in negative coverage has resulted from the arena inquiry and pressures facing the entire NHS. • Social Media – engagement rate has increased by 39% and remains well above the industry average thanks to a range of dynamic content. • FOI – slightly fewer responses were received and processed by the team this quarter. • Stakeholder Engagement – six questions have been answered in relation to discussions in parliament. • Films – another 16 films have been produced supporting internal work such as F2SU and external work such as winter messages. • Internal Communications – the team supported the launch of the women's network along with a number of corporate projects, and flu and staff survey messages.					

	• Website and Green Room – Use of tables to access the green room has increased again, this time by 30%, suggesting trust-issue iPads are changing the way users access our content. There is also an in depth look at the team's role in Industrial Action, winter demand management and the publication of the Manchester Arena Inquiry report.
RECOMMENDATIONS:	The Board of Directors is asked to note the contents of this report and discuss the impact of its content.
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:				
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined Communications and Engagement Team for quarter three (October to December 2022).

2. BACKGROUND

2.1 Patient and Public Engagement

A summary of our patient and public engagement activity for Q2. It includes feedback from 46 engagement opportunities attended and information about our patient surveys.

Based on survey responses:

- 89% were likely to recommend the service to friends and family, down 2% from Q2.
- 85% were very or fairly satisfied with the overall service they received, down 2% from Q2.
- 93% agreed they were cared for with dignity, compassion and respect, up very slightly by 0.2% from Q2.

Satisfaction with services dropped again as it did last quarter.

Patient and Public Panel

A summary of the Q3 activity for the PPP, including up-to-date figures for panel recruitment and performance against objectives for the year. For example, this quarter:

- 36 new expressions of interest
- 18 new panel members were confirmed and inducted to the trust
- 251 panel members in total
- Our youth representation is at 24% against a target for 22/23 of 25%
- Our diversity representation is at 15% against a target for 22/23 of 30%.

To assist with achieving the diversity target, we have produced new promotional materials suitable to be placed in mosques and various flyers containing quotes from diverse members as to why they joined the PPP.

Press and Public Relations

A summary of our media relations activity for Q3. This includes the number of incident check calls and some highlights of the media relations work that has been undertaken this quarter.

In Q3:

- 294 incident check calls were answered.
- 47 proactive web or media stories against our target of 16.

- 24 statements prepared in response to press enquiries - a 17% decrease from Q2.

Most media coverage pieces in this quarter were in relation to the Manchester Arena Inquiry, industrial action, ambulance waiting times and hospital handover times. There was less in the way of general incident coverage and a new focus on service demand/pressures in the lead-up to the industrial action.

Social Media

An overview of social media engagement and growth in Q3. Including:

- Audience growth across all channels grew by 2%.
- 551 posts publishes across all channels
- 417,357 engagements – interactions with our content.
- Our engagement rate improved by 39%. 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 current engagement rate of 4.8% very high.

FOI

An update on the FOI performance against the national target of 90% completion within 20 days. 92 FOIs were completed in Q3, an decrease in responses of 10% on the previous quarter, with performance exceeding target at 97%.

Stakeholder Engagement

A summary of stakeholder activity for Q2, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 10 MP letter responses
- 6 Parliamentary Questions responded to – Cumbria response times, GM resources, Grange station, CFR defibs, Aintree handovers & forced entry policy
- Facilitated x2 meetings with Tim Farron MP re. Grange station and 2x OSC meetings – GM Combined and Cheshire West & Chester.
- Facilitated visit to EP for Raj Jain Cheshire & Mersey ICB.
- Mental health practitioner info for Amanda Pritchard.
- Specialist Stakeholder bulletins issued re. Arena inquiry, industrial action and December Winter Watch.

Films

A summary of in-house videography activity. 16 films were completed this quarter, the same as Q2 with a further 6 underway, including a number of first aid videos.

Internal Communications

Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q3:

- 7 CEO bulletins
- 14 Clinical bulletins

- 32 Operational bulletins

48 other bulletins including EOC, PTS and Communications bulletins together with the Weekly Bulletin.

The staff app was downloaded 421 times.

Website and Green Room
A summary of statistics for our website, accessed by members of the public and partner organisations. In Q3, the website was visited 220,262 times. Consistently the most popular pages are the patient transport service (PTS), vacancies and apprenticeships. Most people (89,820) found our website by searching on Google.

Visitors to the vacancies section of the website are up by 10% on Q2.

Focus on winter

Our winter communications plan launched during Q3. The main Every Second Counts campaign has seen nearly 28,000 engagements (likes, comments, shares) to date across social media with the Instagram video reel being the highest performing reel to date at 69.7k plays.

Overall feedback from staff is that they feel their experience at work has been heard and support the message to keep reminding the public that 999 is for life-threatening calls only. Similarly, 111 staff have spoken out on the support shown towards guiding the public to 111 online first instead of increasing demand to the 111 phone line. Public feedback is 95% in support of the message, showing a move towards the behaviour change we are looking to achieve.

Focus on Manchester Arena Inquiry

At the beginning of November, Sir John Saunders published volume two of his report in the Manchester Arena Inquiry, which looked at the response of the emergency services response on the night of the terrorist bombing at the Arena on 22 May 2017. This had a large amount of national and regional interest for the press and the public, and presented a significant reputational risk to the trust.

Detailed feedback was obtained from other blue light partners who had experienced other large-scale public crises and this was used to develop bespoke communication plans to support all aspects of our communications approach.

Working closely with the legal team, the comms team put plans into place well before the publication date to ensure relevant people were informed of key information, particularly our staff and those who were called as witnesses to give evidence. As well as updates on progress, we provided practical guidance on where to get mental health/wellbeing support, handling 'door stepping' reporters, how to avoid upsetting stories by changing social media settings and more.

In relation to publication day, our communications actions ensured the trust board, staff and stakeholders were kept up to date with the progress of the inquiry; staff

members and key witnesses affected by the incident were supported and kept informed; the media, public, as well as the victims and their families, were provided with a response to the findings, which showed contrition but also provided reassurance that changes and improvements had already been put in place.

It was agreed to hold a joint blue light press conference on the day of publication fronted by the NWAS Chief Executive Daren Mochrie, Greater Manchester Police Chief Constable Stephen Watson, British Transport Police Chief Constable Lucy D'Orsi and Greater Manchester Chief Fire Officer Dave Russel. Each person delivered an opening statement and then took questions from the press. We also agreed not to provide any other media opportunities in advance or immediately post-publication.

Whilst we had information from our legal team and witness hearings on the likely areas of criticism, we were not given access in advance of the publication date and could only see the final report at the same as all other core participants, and this happened just a few before it was released to the general public. All communications, including the opening statement, were written in advance but refined in the hours before publication by senior comms leads.

The comms team were assigned a range of actions on the day to deal with media handling and monitoring. The team found 60 core pieces of negative media coverage on the publication date, and reviewed social media commentary which ranged in tone from negative to supportive.

The team will be prepared to support progress updates to the inquiry and for additional media interest around anniversary dates in the future. In Q4 we will undertake specialist training in rebuilding reputation after a crisis.

Focus on Industrial Action

A comprehensive set of media handling plans are being delivered in response to industrial action as a result of NHS trade unions being in dispute with the government over pay and conditions. The first of the plans was fully developed and initiated within two weeks after we were notified of the first strike in December.

Our plans ensure we deliver our public warning and informing responsibilities under the Civil Contingencies Act, maintain public trust and provide reassurance, and that all stakeholders are fully briefed on our service provision throughout the period of industrial action.

Specifically, concerning the first strike date on 21 December 2022, the communications team:

- Developed three letters to NHS and domiciliary partners explaining how our services would be affected to aid their planning.
- Prepared correspondence asking our blue light partners for potential mutual aid.
- Issued two stakeholder briefings, both pre and post-strike day.
- Prepared nine internal bulletins to ensure staff we kept as informed as possible about how industrial action would affect them whether they were taking strike action or not.

- Distributed briefs through our PPP and local Healthwatch organisations.
- Published a dedicated page on our external website containing up-to-date strike information and frequently asked questions.
- Issued a media release to the press containing our key public messages.
- Offered seven proactive regional broadcast opportunities with our area directors and executive medical director, who were all supplied with complete interview briefs.

We continue to work closely with NHSE and ICB comms partners to ensure a coordinated approach that also ties in with Royal College of Nursing strikes taking place at other NHS trusts in the north west.

This work continues into the new year and Q4 as the industrial dispute continues.

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

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

Q3 2022/23 (October, November and December)

NHS North West Ambulance Service NHS Trust

PATIENT AND PUBLIC ENGAGEMENT

46 events/engagement opportunities with groups including: ▲ 25%

The events/engagement opportunities included: Lancashire Carers Forum, Gujrat Health Forum, Healthwatch Wirral, Healthwatch Sefton and Furness Carers. Total events for the year to date = 85.

Feedback themes: sympathetic support and high regard for ambulance services. Ability to run ambulances during the 'fuel crisis', opportunities to access BSL interpreters when contacting 999, use/cost of third parties and pressure ulcers training for staff queried.

The team hosted two Back to Basics community events in Trafford, Greater Manchester and Blackburn, Lancashire. Over 110 individual community member interactions found lack of awareness of 111 online, PTS and language support for ethnic minority communities.
The team's PTS dashboards were presented at bimonthly Level 2 meetings in relation to experience survey data and PTS-specific feedback from events/engagement.

19,334 surveys sent ▼ 26%

1,596 surveys returned ▼ 28%

In Q3 we saw a slight fall in overall return rate (0.19%) compared to Q2, due to a reduction in surveys sent and the impact of postal strikes.

89% were likely to recommend the service to friends and family ▼ 2%

85% were very or fairly satisfied with the overall service they received ▼ 2%

93% agreed they were cared for with dignity, compassion and respect ▲ 0.2%

We see a continued drop in satisfaction across one key measure: overall service received.

PATIENT AND PUBLIC PANEL (PPP)

36 new expressions of interest

18 new panel members

251 total panel members ▲ 9%

6 new requests for panel involvement

24 structured and/or task orientated involvement opportunities delivered ▶ 0%

NOTES
Panel members receive a weekly roundup newsletter showing how their involvement has supported key projects. Colleagues are reminded monthly of the benefits of panel involvement in new initiatives in The Bulletin.

PERFORMANCE AGAINST OBJECTIVES

- Increasing youth representation – target is to have **25%** of the PPP made up of young people (16-24 years old) by year end. The youth element of the PPP (16-24) is currently 24%. We have been attending various college and university fairs to promote the panel which has been working well and seen a good increase in interest from young people.
- Ensuring we represent our diverse communities – target is to have **30%** of members from ethnic minority communities. Currently, diverse members account for **15%**. We have produced new promotional materials suitable to be placed in mosques and various flyers containing quotes from diverse members as to why they joined the PPP.
- Areas of involvement include attendance at various learning forums, hospital handover improvement events, EDS2 grading event and feedback on PTS web pages.
- We have told members how their feedback has supported the delivery of our 'back to basics' events and shared information about the use of gender and non-gender-specific pronouns.

PRESS AND PATIENT/PUBLIC RELATIONS

294 incident checks handled ▼ 12%

24 statements in response to media enquiries ▼ 17%

47 proactive stories, against our internal target of 16 (includes 33 web stories, 11 press releases and 3 contributions to other organisations' releases).

Topics include:
- Award wins for communications and charity teams
- Response to Manchester Arena Inquiry report
- Appeal to public about pressures on 999/111
- King's Ambulance Medal for Salman Desai

Most media coverage pieces in this quarter were in relation to the Manchester Arena Inquiry, industrial action, ambulance waiting times and hospital handover times. There was less in the way of general incident coverage and a new focus on service demand/pressures in the lead-up to the industrial action.

279 pieces of media coverage. ▼ 27%

101 were reports of incidents, including a mention of NWAS with details provided by our press office about resources sent, 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. ▼ 68%

67 pieces were considered negative. These are stories which overall, reflect negatively on NWAS, but include a statement from us in response to a situation. Most pieces in this quarter were in relation to the Manchester Arena Inquiry report. ▲ 139%

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.

EXTERNAL HIGHLIGHTS

Campaigns

- We launched our Every Second Counts campaign in early December as the main public-facing campaign supporting the wider winter plan.
- The video reached 136,500 and had engagements of 19.5k on Facebook for the launch post.
- The Instagram video real has seen 69.7K plays reaching 61,677 accounts reached to date.
- Across all platforms, the campaign video and supporting image assets have seen 27,867 engagements in total and a reach of 212,698.

Festive film

- With both staff morale in mind and to reassure our public over the festive period, we produced a Christmas video that saw staff from all core services and facilities/estates join in to sing, dance and wish our communities a Merry Christmas.
- The lyrics were changed to reflect high demand and to reiterate what our PES, PTS and 111 services are for and appropriate use of them.
- The video saw the highest engagement of any festive video we've done in recent years – with 18k views on the first Facebook post alone and 5,969 engagements

See the 'focus on' section for details of Manchester Arena Inquiry and industrial action communications plans.

NHS 111 demand

We continued to support increasing 111 demand by working closely with service leads and NHSE to share specific messaging with the public. This included re-directing callers to online, GP or pharmacy when we saw a surge in requests for antibiotics due to Strep A worries and the ongoing issue of calls for repeat prescriptions.

Your Call – summer edition

11 article stories released on social media
Finishing on 12,020 reads.

Top stories:

- Paramedic Paul's cycling accident
- EMD staff member poem to colleagues
- Abuse you can't ignore - Paramedic Tammy's story
- Dying matters - Michelle's story

Wellbeing podcast – Turn off the Blues

Two further podcasts have been recorded to support staff wellbeing. They were on the topics of:

- bowel cancer
- menopause

Total of 648 listens.

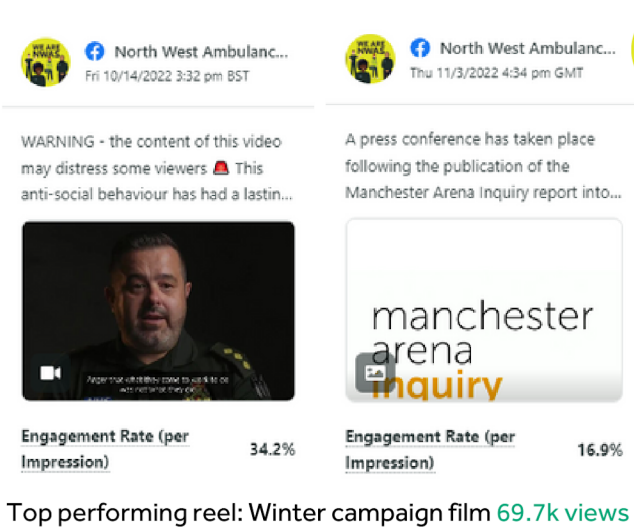
SOCIAL MEDIA - FACEBOOK, TWITTER AND INSTAGRAM

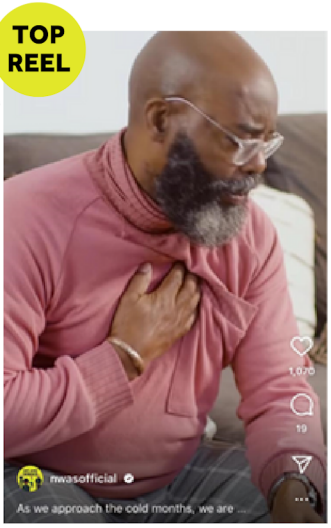
AUDIENCE

74,805 Facebook likes
65,336 Twitter followers
16,682 Instagram followers
Audience growth ▲ 2%

ENGAGEMENT

551 posts published on all channels
6,190,713 impressions
417,357 engagements (comments, likes, retweets, shares etc)
6.7% engagement rate ▲ 39%





Top performing reel: Winter campaign film 69.7k views

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 eg clicks a link, reacts to it by clicking 'like', or shares or retweets it.

'Engagement rate' shows us the number of interactions our content receives per follower.

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 extremely high.

'Reels' are short-form vertical videos with editing tools and audio tracks, they are 'entertaining and immersive'.

CONTENT

Whilst our published posts have been down in Q3 by 12% due to the blackout periods during the MAI and industrial strike action, our engagements are strong increasing by 97.4%. Equally, our engagement rates have increased in Q3 to 6.7%, compared to 4.8% in Q2. This is due to savvy pre-planning posts/content around such events, using only strong, quality content in advance and tailoring key winter and non-winter-related messages to suit our audiences' needs.

Engagement highlights have been warning and informing public notices about people posing as staff to ask for money, a shout-out to staff working the extra hour (paired with great photography), our Christmas card singing video, dementia-friendly ambulance story, EMA job alert, EMT job alert live chat, demand posts - all achieving over 5,000 engagements on a post which is considered high performing.

FREEDOM OF INFORMATION (FOI)

92 responded to ▼ **10%**

97% within 20 working days

95% YTD 20 working days

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%.

Topics included:

- Long covid staff absence
- Serious incidents
- Deaths whilst waiting for an ambulance
- Cat 1 response times
- Overseas recruitment
- Fleet profile
- Bullying and harassment complaints
- Sexual misconduct reports
- Staff suicides and mental health absences

STAKEHOLDER COMMUNICATIONS

10 MP letters ▼ **16%**

Subjects include: PTS, NHS pressures, property access, school emergencies, recruitment.

Other stakeholder work includes:

- 6 Parliamentary Questions responded to – Cumbria response times, GM resources, Grange station, CFR defibs, Aintree handovers & forced entry policy
- Facilitated x2 meetings with Tim Farron MP re. Grange station and 2x OSC meetings – GM Combined and Cheshire West & Chester.
- Facilitated visit to EP for Raj Jain Cheshire & Mersey ICB.
- Mental health practitioner info for Amanda Pritchard.
- Specialist Stakeholder bulletins issued re. Arena inquiry, industrial action and December Winter Watch.

FILMS

16 completed

6 underway

(16 in the previous quarter)

- Freedom to Speak Up
- Learn how to Restart a heart (children and infants)
- First Aid: How to deal with burns and scalds
- Top tips on having a safe Halloween
- Reasons why we're getting our flu jab this winter
- PROMPT maternity training – a staff story
- Team Talk Live: November
- Every Second Counts
- What is social prescribing
- Christmas time is here
- Christmas messages from the CEO and Chair
- First Aid: How to puts someone in the recovery position
- First Aid: How to help someone having a seizure
- Alcohol and drug awareness
- Helping you when you need us the most

INTERNAL BULLETINS

During this quarter, we shared:

7 CEO bulletins

14 Clinical bulletins

32 Operational bulletins

Plus 48 others including weekly bulletins, HR, communications, EOC and 111.

Topics included:

- Manchester Arena Inquiry
- Industrial Action
- NHS staff survey
- Flu and COVID-19 vaccines

421 staff app downloads.
The increase in staff app downloads was a result of a bulletin article on 22 November that advertised an app competition to win tickets to see Peter Kay. The rostering and ESR tiles were the most viewed.

INTERNAL (STAFF) ACTIVITIES

Flu campaign

- Launched an eight-week campaign working with an external design company to produce posters and stickers.
- Shared key messages and stats about the vaccine and produced a short film of staff getting the flu vaccine, telling us the reasons why they were getting boosted.
- Achieved our target of offering 100% of staff a flu vaccine.

NHS staff survey

- Worked with HR to encourage staff to complete the NHS staff survey using a two-night getaway incentive.
- Shared key messages and evidence of how previous survey results helped make improvements for staff.
- Featured winners of the incentives and asked them to share their reasons for doing the survey.

Project support – New EPR

- Worked with the project team to support receiving locations with communication and updated website information for healthcare professionals.
- Ensured key updates, developments and delays were communicated to staff via weekly regional bulletin and Green Room information page.

Project support – iPads

- A series of communications have been issued to staff and managers to ensure iPads are set up and ready for the launch of the new EPR.
- Green Room page with FAQs updated.

Health and wellbeing

- Shared podcast episodes via our new health and wellbeing newsletter and other digital platforms.

Star Awards

- Entered the CIPR Pride awards for last year's Super Star Awards and won silver for the 'best event'.
- Enhanced the sponsorship ahead of next event.
- Nominations opened for Star Awards 2023 with new and improved categories.

Staff networks

- Supported the Race Equality Network's Black History Month roadshow and shared key messages.
- Marked Remembrance Day by supporting the official wreath laying at HQ and sharing photos.
- Worked closely with the Disability Network to share staff stories focusing on their experiences and the stereotypes/stigmas they have faced for Disability History Month.
- Supported the launch of the Women's Network and created a year-long plan for awareness days/events.
- Supported the LGBT Network with their external work for World AIDS Day.

Community calendar

- Produced the 2023 calendar that includes various religious celebrations and special inclusion dates.,
- A digital copy is available online and printed copies were sent to all trust sites. Additional copies have been offered to our community contacts and stakeholders.

111

- Issued winter edition of the 111 newsletter which included positive staff news, working improvements and celebrations for key events.
- Continued support with the rota review.

WEBSITE AND GREEN ROOM

220,262 visits in Q2- the number of times people have visited our website ▲ 18%

434,539 page views - meaning for every visit, approx. 2 pages are viewed

MOST VIEWED

Vacancies – 100,851 views ▲ 10%
Patient Transport Service – 58,232 views ▼ 9%
Apprenticeships - 18,998 views ▼ 9%

Insight: Popular pages remain the same. Overall views of the website increased due to the sharing of industrial action related information.

ROUTE IN

Search (Google etc) – 89,820 visits
Social – 33,674 visits
Direct (typing in URL) –31,104 visits
Referral from another site – 4,975 visits
Email – 5 visits

425,432 visits in Q2- the number of times people have visited the Green Room

1,237,088 page views - meaning every time someone visits, they view approx 3 pages

DEVICE

64,604 Desktop

6,082 Mobile

1,877 Tablet

Insight: Tablet use has increased again, by 29% on the previous quarter, indicating that trust-issue iPads are changing the way users access the Green Room.

Top pages: managers on duty, current vacancies, bulletins, HR Portal, library.

HIGHLIGHTS

Changes have been made to the managers' sign-on section, to allow a quicker and easier way to sign on.

FOCUS ON...

Manchester Arena Inquiry

At the beginning of November, Sir John Saunders published volume two of his report in the Manchester Arena Inquiry, which looked at the response of the emergency services response on the night of the terrorist bombing at the Arena on 22 May 2017. This had a large amount of national and regional interest for the press and the public, and presented a significant reputational risk to the trust.

Detailed feedback was obtained from other blue light partners who had experienced other large-scale public crises and this was used to develop bespoke communication plans to support all aspects of our communications approach.

Working closely with the legal team, the comms team put plans into place well before the publication date to ensure relevant people were informed of key information, particularly our staff and those who were called as witnesses to give evidence. As well as updates on progress, we provided practical guidance on where to get mental health/wellbeing support, handling 'door stepping' reporters, how to avoid upsetting stories by changing social media settings and more.

In relation to publication day, our communications actions ensured the trust board, staff and stakeholders were kept up to date with the progress of the inquiry; staff members and key witnesses affected by the incident were supported and kept informed; the media, public, as well as the victims and their families, were provided with a response to the findings, which showed contrition but also provided reassurance that changes and improvements had already been put in place.

It was agreed to hold a joint blue light press conference on the day of publication fronted by the NWAS Chief Executive Daren Mochrie, Greater Manchester Police Chief Constable Stephen Watson, British Transport Police Chief Constable Lucy D'Orsi and Greater Manchester Chief Fire Officer Dave Russel. Each person delivered an opening statement and then took questions from the press. We also agreed not to provide any other media opportunities in advance or immediately post-publication.

Whilst we had information from our legal team and witness hearings on the likely areas of criticism, we were not given access in advance of the publication date and could only see the final report at the same as all other core participants, and this happened just a few before it was released to the general public. All communications, including the opening statement, were written in advance but refined in the hours before publication by senior comms leads.

The comms team were assigned a range of actions on the day to deal with media handling and monitoring. The team found 60 core pieces of negative media coverage on the publication date, and reviewed social media commentary which ranged in tone from negative to supportive.

The team will be prepared to support progress updates to the inquiry and for additional media interest around anniversary dates in the future. In Q4 we will undertake specialist training in rebuilding reputation after a crisis.

Winter comms plan

November saw the launch of our winter plan, including the launch of our Every Second Counts campaign which helped educate the public on when to call 999. We did this by showing how the rising number of non-urgent calls can block the line for emergency calls.

The campaign was launched on social media, radio, the website, and through stakeholder briefings. We worked closely with NHSE, ICBs, and NWAS service leads and staff to ensure the tone and message were just right.

To ensure a consistent stream of messaging, we released two radio adverts that echoed the key messages in Every Second Counts to run across four major radio stations in the north west between November and Christmas.

Considering not all our communities will be digital focussed we created and helped develop two winter guidance leaflets. These were Winter Wise, a guide to self-care at home, wellness and primary care services. Also 'We are here for you this winter' an NWAS service guide and appropriate use of service for 999, 111 and PTS. These were shared via PTS stations to go direct to patients and public, via health watches, community groups and the Patient and Public Panel.

We also re-launched our Winter Watch monthly newsletter which looks at previous month statistics for PES, 111 and PTS to show performance and pressures to our stakeholders. These statistics also support our day-to-day comms when we need to highlight demand data and reasons across our social media.

The main Every Second Counts campaign has seen nearly 28,000 engagements (likes, comments, shares) to date across social media with the Instagram video reel being the highest performing reel to date at 69.7k plays.

Overall feedback from staff is that they feel their experience at work has been heard and support the message to keep reminding the public that 999 is for life-threatening calls only. Similarly, 111 staff have spoken out on the support shown towards guiding the public to 111 online first instead of increasing demand to the 111 phone line. Public feedback is 95% in support of the message, showing a move towards the behaviour change we are looking to achieve.

Industrial action

A comprehensive set of media handling plans are being delivered in response to industrial action as a result of NHS trade unions being in dispute with the government over pay and conditions. The first of the plans was fully developed and initiated within two weeks after we were notified of the first strike in December.

Our plans ensure we deliver our public warning and informing responsibilities under the Civil Contingencies Act, maintain public trust and provide reassurance, and that all stakeholders are fully briefed on our service provision throughout the period of industrial action.

Specifically, concerning the first strike date on 21 December 2022, the communications team:

- Developed three letters to NHS and domiciliary partners explaining how our services would be affected to aid their planning.
- Prepared correspondence asking our blue light partners for potential mutual aid.
- Issued two stakeholder briefings, both pre and post-strike day.
- Prepared nine internal bulletins to ensure staff we kept as informed as possible about how industrial action would affect them whether they were taking strike action or not.
- Distributed briefs through our PPP and local Healthwatch organisations.
- Published a dedicated page on our external website containing up-to-date strike information and frequently asked questions.
- Issued a media release to the press containing our key public messages.
- Offered seven proactive regional broadcast opportunities with our area directors and executive medical director, who were all supplied with complete interview briefs.

We continue to work closely with NHSE and ICB comms partners to ensure a coordinated approach that also ties in with Royal College of Nursing strikes taking place at other NHS trusts in the north west.

This work continues into the new year and Q4 as the industrial dispute continues.

COMING SOON

In our next report, we'll share updates on:

- New series of Ambulance: filming to start in Lancashire in January 2023 and Greater Manchester in March 2023.
- Accessibility improvements, including easy-read document creation and ensuring compliance on our digital channels.
- Focus on reputation building with team development opportunities and a focus on community engagement with further 'back to basics' events to be delivered.
- Supporting staff networks with LGBT history month celebrations.
- International paramedic recruitment.
- NHS 75th anniversary celebrations.

communications@nwas.nhs.uk

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	25 January 2023					
SUBJECT:	Partnerships & Integration Progress Update					
PRESENTED BY:	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☐	☐	☐	☐	☐	
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☒	☒	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	The purpose of this report is to inform the Board of Directors of the progress being made in relation to stakeholder engagement across the trust areas. • The ICB priorities/ objectives • Managing external stakeholder relationships since the start of the ICBs in July 2022, and the priorities of the ICBs • Internal work with directorates in all areas, in particular Service Delivery to build the capability, capacity and competence of managers in work with partners • Relationship maturity exercise conducted externally as well as meeting mapping exercise internally. • The work around service developments and the design, development and implementation of the Knowledge Vault across the trust • Building on the momentum into 2023/24					
RECOMMENDATIONS:	The Board of Directors are recommended to: • Note the contents of this report					
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:		
	Date:	
	Outcome:	

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1. PURPOSE

The purpose of this report is to inform the Board of Directors of the progress being made in relation to stakeholder engagement across the trust areas.

2. BACKGROUND

Our stakeholders and healthcare partners previously expressed a view that our external engagement and relationships could be better, that we needed to be more engaged and have the right representation at external meetings to support joint working.

The implementation of the new Health & Social Care Act provided the opportunity to reset and re-establish engagement and collaboration across the system with partners and stakeholders.

As part of this new way of working, an emphasis was placed on how we improve:

- Our relationships with partners and stakeholders
- The capacity, capability and competence around our external engagement, by ensuring the right person, giving the right message, at the right meeting
- Our management of information and intelligence.
- Our internal communications with managers around key topics and service lines

The partnership and integration structure was fully in place by September 2021, and the team of partnerships and integration managers (PIMs) set up to meet the new challenging external environment.

The team works to the partnership principles as set out below:

- **Direction –** we will collaboratively agree priorities for partnership working based on shared challenges and opportunities, and clearly articulate our 'offer' to the system.

- **Intelligence –** we will utilise our data and insight to identify inequalities, influence improvements and measure success.

- **Accountability –** we will ensure our leaders are equipped with the skills and knowledge to confidently engage and collaborate with our partners and follow through on commitments.

- **Consistency –** we will provide consistent communication and representation to ensure our leaders are engaged at the right levels.

The key objective for the team is to ensure that the trust is connected to external partners that allows honest, open dialogue and debate and a working together approach to help deliver services in a better joined up way.

The intention in this report is to give an overview of the progress of the team and how they continue to make a difference to the way the trust works.

3. THE ICBs

The new NHS structures have meant the Integrated Care Systems (ICS) have replaced the previous Clinical Commissioning Groups from July 2022. There are three main ICS areas in the North West as well as an additional two which cover the North Cumbria and Glossop areas, namely North East & North Cumbria and Derbyshire ICSs.

Work has been ongoing across all Integrated Care Boards (ICBs) prior to July 2022. All ICB areas have now recruited fully to their executive board and all committees established.

The ICBs overarching priorities have been set and these are:

- improving outcomes in population health and health care.
- tackling inequalities in outcomes, experience and access.
- enhancing productivity and value for money.
- helping the NHS to support broader social and economic development.

Each ICB has prepared a full or interim strategy on how it intends to operate and work in each of their systems.

The ICB objectives based on the interim or full strategies are as follows:

ICB Area	Objectives
Lancashire & South Cumbria	**Starting well** • Supporting children and their families in the first 1000 days of a child's life **Living well** • Supporting people into employment and staying in work • Large scale organisations' role in social and economic development • Preventing ill health and tackling health inequalities **Ageing well** • High quality care that supports people to stay well in their own home **Dying well:** • Supporting people to choose their preferred place of death and that they and their families receive holistic support
Greater Manchester	• Opportunity to live a good life • Experience high quality care and support where and when they need it • Improved health and wellbeing • Making a difference now and for the future by working together

Cheshire & Merseyside	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Create fair employment and good work for all • Ensure a healthy standard of living for all • Create and develop healthy and sustainable places and communities • Strengthen the role and impact of ill health prevention • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.
North East & North Cumbria	• Longer, healthier lives • Fairer Outcomes • Best start in life • Improving health & care services
Derbyshire	• Prevent physical and mental ill health and help people to make better lifestyle choices • Ensure services are tailored and targeted to people and their communities • Make it easy for people to get the right care, when they need it, in the right place for them • Health and social care need to work seamlessly • Make organisations as efficient as possible

The trust is working proactively across each ICB area to ensure engagement is taking place.

4. EXTERNAL ENGAGEMENT

It has taken time to put processes and systems in place to ensure that external engagement with stakeholders is managed effectively and consistently across the areas. Previous arrangements were unstructured and ad-hoc.

It has been important to put in place a system of engagement to ensure that the external representation is both appropriate and adds value to the way the trust works.

A number of important things needed to be put in place for the trust to move forward into the new NHS structures externally.

A relationship maturity assessment was completed in the early 2022/23 with external stakeholders to gain a view of how our external engagement was perceived and how we could potentially put improvements in place.

The expectation is that this will be repeated with partners in mid to late 2023 to gain a view on how things have progressed.

An **external engagement mapping** exercise was conducted across all directorates to map our external meetings in terms of when, how often, and who was representing the trust.

This has now been completed and a review of all external meetings has taken place with Area Directors (AD) and Heads of Service (HoS) to identify which meetings the trust needs attendance at, at an appropriate seniority level, to ensure that we get value from attending meetings.

Key meetings across the ICBs have been identified, and there is appropriate executive / senior attendance at these meetings. Below is a sample of the meetings across the areas where the trust are either invited or members.

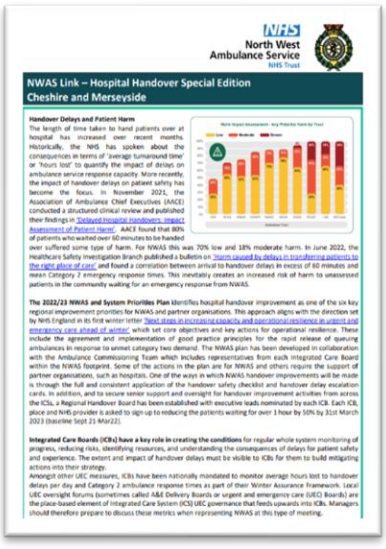
- Chairs meeting
- ICB Boards – (observing only)
- System Finance Group
- Monthly Financial Review
- People Board
- System Executive
- Joint Provider Collaboratives
- Leadership Board
- Strategic Advisory Group
- UEC Board
- Provider Federation Board

A further set of meetings have been identified with Area Directors, which will be attended by senior managers in their respective areas. There have also been a number of new things introduced which will ensure that the support for managers is available to build on their capability, capacity and competence for consistent external engagement.

In order to support this external engagement, **NWAS Link** provides narrative around the ask / offer; the latest intelligence and data available to/from ICBs, and helps with consistency of message across the areas. The PIMs are working closely with Service Delivery to ensure that managers received as much timely and appropriate information as is possible.

Feedback received from managers shows the NWAS Link is an effective means of keeping managers updated on the key areas of our work, and it ensures that they all have the same message, at the same time.

NWAS Link topics have included Hospital Handover, digital improvements, system control centres and 111, NWAS Link shown below:


NHS
North West
Ambulance Service
NHS Trust

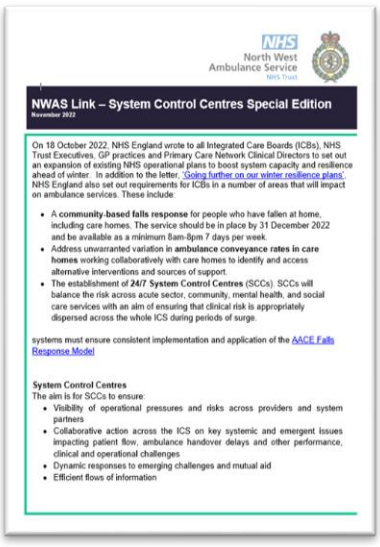
NWAS Link – Hospital Handover Special Edition
Cheshire and Merseyside

Handover Delays and Patient Harm

The length of time taken to hand patients over at hospital has increased over recent months. Historically, the NHS has spoken about the consequences in terms of 'average turnaround time' or 'hours lost' to quantify the impact of delays on ambulance service response capacity. More recently, the impact of handover delays on patient safety has become the focus. In November 2021, the Association of Ambulance Chief Executives (AACE) conducted a structured clinical review and published their findings in 'Delayed Hospital Handovers: Impact Assessment of Patient Harm'. AACE found that 80% of patients who waited over 60 minutes to be handed over suffered some type of harm. For NWAS this was 70% low and 18% moderate harm. In June 2022, the Healthcare Safety Investigation Branch published a bulletin on 'Harm caused by delays in transferring patients to the right place of care' and found a correlation between arrival to handover delays in excess of 60 minutes and mean Category 2 emergency response times. This inevitably creates an increased risk of harm to unassessed patients in the community waiting for an emergency response from NWAS.

The 2022/23 NWAS and System Priorities Plan identifies hospital handover improvement as one of the six key regional improvement priorities for NWAS and partner organisations. This approach aligns with the direction set by NHS England in its first winter letter 'Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' which set core objectives and key actions for operational resilience. These include the agreement and implementation of good practice principles for the rapid release of queuing ambulances in response to unmet category two demand. The NWAS plan has been developed in collaboration with the Ambulance Commissioning Team which includes representatives from each Integrated Care Board within the NWAS footprint. Some of the actions in the plan are for NWAS and others require the support of partner organisations, such as hospitals. One of the ways in which NWAS handover improvements will be made is through the full and consistent application of the handover safety checklist and handover delay escalation risks. In addition, and to secure senior support and oversight for handover improvement activities from across the ICSs, a Regional Handover Board has been established with executive leads nominated by each ICB. Each ICB, place and NHS provider is asked to sign up to reducing the patients waiting for over 1 hour by 50% by 31st March 2023 (baseline Sept 21-Mar22).

Integrated Care Boards (ICBs) have a key role in creating the conditions for regular whole system monitoring of progress, reducing risks, identifying resources, and understanding the consequences of delays for patient safety and experience. The extent and impact of handover delays must be visible to ICBs for them to build mitigating actions into their strategy.
Amongst other UEC measures, ICBs have been nationally mandated to monitor average hours lost to handover delays per day and Category 2 ambulance response times as part of their Winter Assurance framework. Local UEC oversight forums (sometimes called A&E Delivery Boards or urgent and emergency care (UEC) Boards) are the place-based element of Integrated Care System (ICS) UEC governance that feeds upwards into ICBs. Managers should therefore prepare to discuss these metrics when representing NWAS at this type of meeting.


NHS
North West
Ambulance Service
NHS Trust

NWAS Link – System Control Centres Special Edition
November 2022

On 18 October 2022, NHS England wrote to all Integrated Care Boards (ICBs), NHS Trust Executives, GP practices and Primary Care Network Clinical Directors to set out an expansion of existing NHS operational plans to boost system capacity and resilience ahead of winter. In addition to the letter, 'Going further on our winter resilience plans', NHS England also set out requirements for ICBs in a number of areas that will impact on ambulance services. These include:

- A **community-based falls response** for people who have fallen at home, including care homes. The service should be in place by 31 December 2022 and be available as a minimum 8am-8pm 7 days per week.
- Address unwarranted variation in **ambulance conveyance rates in care homes** working collaboratively with care homes to identify and access alternative interventions and sources of support.
- The **establishment of 24/7 System Control Centres** (SCCs). SCCs will balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge.

systems must ensure consistent implementation and application of the AACE Falls Response Model

System Control Centres
The aim is for SCCs to ensure:

- Visibility of operational pressures and risks across providers and system partners
- Collaborative action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges
- Dynamic responses to emerging challenges and mutual aid
- Efficient flows of information

The PIMs are providing a single point of contact in their areas for external partners to engage. A key role for them is ensuring they:

Observe - Find out what's going on externally and how it affects the trust
Connect - Connect the right people externally to the teams / managers internally
Monitor - initially monitor and be part of the discussions and dialogue between partners and the trust
Withdraw - once the relationships are established and work priorities/ joint working agreed, then after a period of time, but still having an awareness and understanding of what is going on**.** Some examples are shown below:

Liverpool University Hospital Foundation Trust	service delivery changes where intensive work has taken place to model the changes, discuss the outputs and put in place an agreement on a way forward with Service Delivery.
NHS Pathways roll out	supported the successful roll out across the trust, including detailed engagement at an ICS level, as well as providing lessons learned document to Contact Centres following the implementation
North Mersey	Coordinated trust involvement both internally and externally. Participated in a lessons learned session with the ICB and ensured that the trust were sufficiently represented by the required directorates
Lancashire & South Cumbria Stroke reconfiguration	helped an initial case for change which secured funding to support NWAS resource requirements
Community Diagnostic centres	Coordinated with PTS and Finance to submit impact and financial assessment over three years

In resetting how external engagement should work, it is important to recognise a process is in place for horizon scanning and quickly translating and disseminating regional and national documents into an easily readable format with the potential implications for the trust, previously having provided consultation feedback regarding:

- North East and North Cumbria ICB Engagement and Involvement Strategy
- Cumbria Fire & Rescue Service Governance Proposal
- Lancashire & South Cumbria Health Infrastructure
- Strategy GM ICS Strategy Development: Our vision, Shared Outcomes and Commitments
- Cheshire & Mersey Prevention Pledge

and more recently for example the Operational Planning Guidance; Joint Forward Plan; and CQUIN 2023/24 documents that came through on 23 December and were summarised and disseminated quickly in early January 2023

Currently the interim strategy for ICPs is becoming available and it's important that we look at what this means for each area of the trust. To see where the linkages are and where joint work can take place, and where it impacts on our internal strategies going forward. This will be picked up by the team this month.

The improvement in relationships has primarily take place due to the PIMs being exposed to the wider health partners, by being the face of the trust in most external forums, and connecting with the senior team in their respective ICBs, and by being trusted by external partners.

It has been important for them to make the connections early before the formal structures were in place and to feed this back internally to the senior teams in the areas. This is something that will continue as ICBs and ICPs look to embed further and make a positive progress and change with the priorities, workstreams and plans they have.

One of the key strengths of the new team has been the relative consistency across the areas in external engagement, the team have sought to expose themselves to areas not normally associated with an Ambulance Service, in terms of giving views on ICB plans, priorities and workstreams, as well as working with consultation responses to NHSE and AACE, in a partnership way that promotes working together and a collaborative approach.

External engagement will continue with partners as systems are further embedded and priorities are worked on.

In Cheshire and Merseyside area, the PIM has worked closely with external partners and ICS colleagues and submitted a successful application for the trust to be awarded the Social Value Award. The Social Value Awards highlight the positive impact public sector organisations have in the areas and communities in which they work. Achievement of the award cements our efforts to collaborate and work in partnership with complementary organisations to deliver enhanced services for our patients.

5. INTERNAL ENGAGEMENT & PROCESSES

As well as impacting external engagement it has been important to ensure that the internal engagement is on a similar footing.

The introduction of the **executive led information sharing meetings** in each area, by the ICS lead execs, along with AD, HoS, Consultant Paramedic and the PIMs has ensured that early intelligence, information and data is shared across the key people in each area.

Early information has enabled positions to be thought through and plans to be put in place for things coming to the trust. This is working well in each area at the moment, but as time progresses will need refining to ensure that we continue to make progress on things.

A critical component of external engagement has to be the recording of discussions, information and actions at external meetings. Therefore, a significant part of our improvements in external engagement has been the introduction of a **Knowledge Vault** across the trust to ensure discussions, dialogue and decision are noted and progressed.

It has taken a significant amount of time and resource investment to build the KV into something that allows us to manage, monitor and progress external actions as well as allowing users the facility to quickly be briefed on the background to developments and meetings.

The KV allows managers to access the latest intelligence, information and data. As well as actions for meetings, allowing them to be better prepared.

Prior to the KV, external meeting notes were generally not recorded or available in a quick or effective manner, resulting in managers being ill-prepared for meetings or able to report progress. The KV allows the trust to be proactive in engagement.

The team have put in place a comprehensive familiarisation, awareness and support package. The PIMs and Area Directors are taking steps to ensure take up and usage continues to increase in all the areas.

The recruitment of a KV administrator has allowed for improvements, both from user feedback and technical changes to be put in place quickly and efficiently, as well as providing management information and progress chasing of actions across the trust. This has enabled the trust to gain momentum in its external relationships.

In terms of take up and usage of the KV since its start in April 2022, we currently have:

Narrative	Number
Number of accounts requested by managers	154
Number of documents uploaded	282
Number of meeting notes uploaded	137
CAM Accounts	24
GM Accounts	35
CAL accounts	34

This is a good starting point for the KV in terms of access as well as uploads of documents and meeting notes, work ongoing in the areas will help build on this, work will continue through the team and areas to ensure this improvement continues through the remainder of 2022/23 and into the next year.

6. CAPACITY, CAPABILITY AND COMPETENCE

One of the key objectives has been to build the capacity, capability and competence of the trust in external engagement, to ensure anyone engaged in discussions or decision making externally has the capability and competence to speak about the services, the ask, and the offer of the trust.

The team have also been actively involved in:

Hewitt Call for Evidence	The call for evidence by the Rt Hon Patricia Hewitt, in order to enable ICSs to succeed – The team coordinated responses from the trust and responded via AACE to the DHSC.
Responses to consultations	from ICBs, AACE and the regional NHSE team
NHSE Stocktake Interviews	to feedback views on how ICS development has taken place as well as how relationships should work going forward.
ICS Roadshows	Roadshows in the North West with Policy Projects to provide insight into how the developments are working for the trust and how things could be improved.

The team also have input to **Level 3 meetings** with senior managers allowing a consistent singular message across the areas, as well as allowing the flexibility to share information with Sector Managers on developments across the region.

The team have been proactive in meetings with Service Delivery to share external information and intelligence to ensure managers are fully aware of the priorities and workstreams that ICB partners are working towards.

All the PIMs are actively engaged at the system development meetings with the senior management team in each area (Area Director; Head of Service; and Consultant Paramedic) to ensure that all key meetings within the area are covered at the appropriate seniority level as well as sharing information, intelligence, data and the latest horizon scanning to ensure a singular voice and consistency of narrative and understanding.

The team has also supported the development of the trusts “System Leadership” module as well as input to the CMI Level 5 managerial development programme around managing stakeholder relationships effectively.

As previously stated, NWAS Link provides key information for managers on the work the trust is involved in across local and regional and initiatives. This allows for a singular message to be conveyed regardless of area differences.

It was important that as ICBs took shape that we put together System Profiles for each of the systems to show what the main challenges were in each area, including the priorities and key personnel. This has helped managers know the their areas in detail and what the priorities and challenges are.

Work around ensuring external engagement competence will continue throughout the areas into 2023/24.

7. LOOKING FORWARD

As the external partners, both locally and regionally become aware of the work being done, the trust continues to receive more invites to system led initiatives across the areas, as well as ICB workstreams and priorities.

Feedback from partners has shown that the trust is on a much better footing in its relationship management with partners, with many stating the good work being done by the PIMs as well as managers within the trust.

Going forward it will be important to ensure that we select the areas that will give us a return on the time investment and which align to our strategy and forward plan on delivery of services.

A number of Ambulance Services have also expressed interest in the KV as a means of capturing stakeholder discussions and actions. At this moment this has not been progressed further, due to the development work needed to improve the KV and to ensure usage across all areas.

It will continue to be important to build on the momentum that has been achieved so far both internally, and externally with partner organisations and to continue building on the relationships with key personnel in each ICB area.

It is also essential that the trust supports the external facing work as the right course to deliver partnership arrangements and working together with stakeholders in delivering as we go into 2023/24.

The team will continue to work with directorates to ensure managers in all areas are at the same level in terms of confidence, competence, and capability to manage external relationships and deliver on the priorities of the trust and its partners.

The team are becoming increasingly effective and maturing into the new structures both internally and externally, and more involved the workstreams and priorities of the ICBs.

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

There are no legal or governance implications.

In terms of risk implications, as highlighted on the cover sheet, stakeholder engagement features on Business Assurance Framework Strategic Risk, numbers 07 and 08. Mitigations are in place to minimise the risk, with systems and processes in place throughout 2022/23 enabling the risk score to be reduced.

9. EQUALITY OR SUSTAINABILITY IMPACTS

There are no equality or sustainability impacts

10. RECOMMENDATIONS

The Board of Directors are recommended to:

- Note the contents of this report