NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 29th March 2023
9.45 am – 12.35pm

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

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2223/133	Staff Story	09:45	Information	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2223/134	Apologies for Absence	10.00	Information	Chair
BOD/2223/135	Declarations of Interest	10.00	Decision	Chair
BOD/2223/136	Minutes of Previous Meeting held on 25th January 2023	10:00	Decision	Chair
BOD/2223/137	Board Action Log	10:05	Assurance	Chair
BOD/2223/138	Committee Attendance	10:10	Information	Chair
BOD/2223/139	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2223/140	Chairman & Non-Executive Directors Update	10:15	Information	Chair
BOD/2223/141	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2223/142	Board Assurance Framework Strategic Risks 2023/24	10:30	Decision	Director of Corporate Affairs
BOD/2223/143	Trust Risk Appetite Statement 2023/24	10:40	Decision	Director of Corporate Affairs
BOD/2223/144	Modern Slavery Act 2015	10:50	Decision	Director of Finance
BOD/2223/145	Chairman's Annual Fit and Proper Persons' Declaration	11:00	Assurance	Director of People
BOD/2223/146	Charitable Funds Committee Chairs Assurance Report, from the meeting held on 9th February 2023	11:10	Assurance	Mr D Rawsthorn Non-Executive Director
QUALITY AND PERFORMANCE				
BOD/2223/147	Integrated Performance Report	11:15	Assurance	Director of Quality, Innovation, and Improvement
BOD/2223/148	Learning from Deaths Q3 Report	11:45	Assurance	Medical Director
BOD/2223/149	Ockenden Review of Maternity Services - Update Report	11:55	Assurance	Medical Director
BOD/2223/150	Quality and Performance Committee Chairs Assurance Report, from the meeting held on 27th February 2023	12:05	Assurance	Prof A Esmail Non-Executive Director
BOD/2223/151	Resources Committee Chairs Assurance Report, from the meeting held on 24th March 2023	12:10	Assurance	Mr D Hanley, Non-Executive Director

WORKFORCE				
BOD/2223/152	Trust Disciplinary Policy Review	12:15	Decision	Director of People
BOD/2223/153	Annual Staff Survey Results and Speaking Up Review of Ambulance services	12:25	Information	Director of People / Medical Director
CLOSING				
BOD/2223/154	Any Other Business Notified Prior to the Meeting	12:35	Assurance	Chair
BOD/2223/155	Items for Inclusion on the BAF	12:35	Assurance	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 31st May 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, 25th January 2023
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:

Ms A Harrison	Deputy Director of Quality, Innovation, and Improvement
Ms E Orton	Assistant Director of Nursing & DIPC (Agenda item 122 only)
Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2223/109 Patient Story

The Director of Strategy, Partnerships and Transformation introduced the patient story, which featured a 68 year old lady who sought help from the Trust's 111 and Patient Emergency Service.

The film captured the lady's concerns in relation to long waits and signposting advice given by call takers in contact centres.

The Board recognised the need to ensure that information given to patients was effective and patients expectations were managed effectively.

The Chair stated the story was an all too familiar experience for patients during the challenging times faced by the Trust and the wider health care system, and in particular the impact of long waits at acute trust emergency departments and the deployment of ambulance resources back into the community.

He stated that some patients accessing the system during these times were experiencing difficulties, however noted that these were not experiences the Trust would wish for patients.

He emphasised the importance of effective signposting, which was a significant part of the triage process, however noted this was currently influenced by the long waits at acute trusts. He added that the more information patients could be given, to make their own decisions in terms of appropriate urgent and emergency care, the better.

He referred to his New Year message to staff across the organisation and explained the difficulty in remaining positive, considering the extent of the pressure, the pending industrial action, and feelings towards the NHS nationally.

He acknowledged the exceedingly difficult times for staff and senior leaders of the organisation who were all feeling the pressures.

The Chair thanked all involved with the story and stressed the importance of patient stories as part of public board meetings.

The Board:

- Welcomed and acknowledged the content of the patient story.

BOD/2223/110 Apologies for Absence

Apologies for absence were received from Dr M Power, Director of Quality, Innovation, and Improvement.

BOD/2223/111 Declarations of Interest

There were no declarations of interest to note.

BOD/2223/112 Minutes of the Previous Meeting

The minutes of the previous meeting held on 30th November 2022 were agreed as true and accurate record subject to the following amendment:

Dr M Power, Director of Quality, Improvement, and Innovation to be added to the attendance list.

The Board:

- Agreed the Minutes of the Meeting held on 30th November 2022 were a true and accurate record, subject to the amendment recorded.

BOD/2223/113 Board Action Log

The Board noted the updates to the Board action log.

The Chair noted that the Quality and Performance Committee had not on Monday, 23rd January 2023 due to industrial action and requested a discussion, during the meeting, to address action ref 70. related to patient safety netting.

BOD/2223/114 Committee Attendance

The Board:

- Noted the Committee Attendance Record.

BOD/2223/115 Register of Interests

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

BOD/2223/116 Chair & Non-Executives' Update

The Chair reported that recently meetings had been less frequent due to the impact of industrial action, however noted that inter system working with Integrated Care Boards (ICBs) and provider collaboratives continued.

He reported that Integrated Care System (ICS) meetings had started to feel established and recognised the financial challenges and the issue of elective community care.

He referred to the Trust's performance and the position nationally and noted that NWAS were one of the better performers in terms of hospital handover. He confirmed that in terms of hospital handover, the risk was positioned in the community, with the patient and the Trust must continue to be clear in relation to the management of risk.

He reported that the Trust had recently held interviews for an Associate Non-Executive Director.

Mrs C Butterworth referred to hospital handover times at acute trusts and the impact this had on the Trust's own performance.

The Deputy Chief Executive clarified the collaborative work being undertaken with acute trusts and acknowledged the need to further understand some of the variables in performance data. The Chief Executive added that the work the Trust had contributed to nationally in relation to hospital handover was recognised and some recent improvements had made a difference across the wider system.

Dr D Hanley referred to data averages and the need to recognise that part of the solution must be escalation during times of significant pressure.

The Deputy Director of Quality, Innovation and Improvement agreed and referred to work undertaken by the Trust to establish shared risk between the ICBs and the Trust.

The Board:

- Noted the update from the Chair.

BOD/2223/117 Chief Executive's Report

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

He recognised the local and national pressures in relation to the demand on the service and the impact of industrial action.

He reported that 111 had felt pressures in relation to flu, Covid and Strep A at the beginning of December and work had been undertaken to manage the pressure. He added there had been some recent improvement in performance measures in terms of call pick up and the Trust had been closer to achieving ARP standards. He acknowledged the need to sustain improvements moving forward into Easter.

He stated that work continued in relation to the Trust's Emergency, Preparedness, Resilience and Response (EPRR) and meeting the recommendations of the Manchester Arena Inquiry. He noted his work as Chair of AACE and his attendance, with the Trust's Director of Operations, at a national workshop. He added further meetings had been held with emergency service leaders in relation to Joint Emergency Service Interoperability Programme (JESIP) and mental ill health.

The Chief Executive stated that the Trust continued to monitor quality and safety and was keen to ensure that processes were in place to support immediate learning. He added the need to quickly learn and respond to incidents and to ensure the wider health system understood the impact of incidents on the Trust, particularly those associated with long response times, including hospital handover delays. He emphasised the importance of sharing incidents of learning with wider system colleagues, which had been well received by ICBs.

In relation to industrial action, he reported that the Trust continued to plan as effectively as possible. He added that in his AACE role he had attended regular meetings with the Secretary of State for Health and provided oral evidence at the House of Lords and Health Select Committee. He noted he had also met with the Prime Minister, senior officials, and health leaders to discuss the issues related to NHS recovery.

He welcomed national engagement with the ambulance sector, which had been front and centre of the conversations and added that in his AACE role he would work with the newly appointed National Director for Urgent and Emergency Care.

The Chief Executive congratulated the Deputy Chief Executive on his Kings Ambulance Medal, awarded in the New Year's Honours List. He also congratulated a member of staff, Adam Rigby, who played Rugby for England in the Wheelchair Rugby World Cup, when England beat France.

He referred to a new 24/7 crisis line, commissioned by AACE, 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.

He reported that the Trust had received the Gold Award for Talent, Inclusion and Diversity Evaluation (TIDE). He noted this was a great achievement for the Trust and added that TIDE measured organisations against eight different areas of diversity and inclusion practice. He recognised the progress and improvement the Trust had made.

He advised that filming for a new series of the BBC Ambulance programme had been scheduled with Dragonfly, who had been out and about meeting NWAS staff at stations.

Finally, and with great sadness the Chief Executive reported the death of Ben Lightburn, paramedic, and a former colleague Linda Snape. He offered his sincere condolences on behalf of the Board and added that the families and friends were in his thoughts.

Prof A Esmail referred to the impact on the 111 service, in response to the Strep A public media campaign.

The Chief Executive reported that the public media campaign caused a significant surge in activity, which in reality resulted in very few cases. The Medical Director confirmed the impact of the public media message on the service had been fed back via regional group channels.

Dr A Chambers congratulated the teams on providing and continuing to prioritise the mental health support and networks for staff, particularly during times of considerable pressure.

Mrs C Butterworth, as the Trust's Health and Wellbeing Guardian, referred to the prevalence of mental health and supported the 24/7 crisis helpline.

The Chair recognised the hard work undertaken since the last report and recognised the award achievements. He congratulated the Deputy Chief Executive on the Kings Award.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2223/118 Q3 Board Assurance Framework Review

The Director of Corporate Affairs presented the Q3 Board Assurance Framework Review.

She reported that the paper outlined the Q3 changes to the Board Assurance Framework, recommended by the Trust's Executive Leadership Committee as follows:

- 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

Mr D Rawsthorn welcomed forward looking narrative in the 2023/24 reporting process and recognised the reduction in SR09. He advised that the hard work of the team, reported to the Trust's Audit and Resources Committee meetings, had resulted in a reduction of the risk.

The Chair recognised the cases where there had been an increase in risk score and acknowledged that assurance was provided by the Board Assurance Committees. However, he requested a discussion as part of the Integrated Performance Report (IPR) agenda item, in relation to patient safety netting and communication with leaders of the ICBs.

The Board:

Agreed 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

BOD/2223/119 Trust Corporate Calendar 2023/24

The Director of Corporate Affairs presented the Trust's Corporate Calendar 2023/24. She advised that preparation of the Corporate Calendar had incorporated Board member's feedback.

The Board:

- Approved the Corporate Calendar 2023/24.

BOD/2223/120 Audit Committee Chairs Assurance Report from the meeting held on 20th January 2023

Mr D Rawsthorn presented the Chairs Assurance Report from the Audit Committee meeting held on 20th January 2023.

He referred to the amber rated assurances and recognised the overall position in relation to external audit was positive. He added that MIAA's assessment of the HFMA checklist - Improving NHS Financial Sustainability: are you getting the basics, right? had received a good audit outcome, in terms of management of the Trust's finance.

The Board:

- Noted the assurances provided in the Audit Committee Chairs Assurance Report from the meeting held on 20th January 2023.

BOD/2223/121 Integrated Performance Report

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

The Director of Corporate Affairs reported that 158 complaints had been received, against a 12-month average of 162 per month, with 83% of complaints risk scored 1-3 closed within the agreed time frame, and data highlighting further improvements.

She added that the closure of more complex complaints had improved from the November position, however noted there was still work to do. She recognised the importance of keeping in touch with family and patients throughout the duration of the investigation process.

She reported that outcomes of triaging had been scored by the incident management team and passed onto operational teams for review and 82 incidents had been referred to ROSE during the reporting period.

She advised that a co-ordinator had been appointed to support the improvement of lower risk scored incidents.

Dr D Hanley queried when it would be possible to quantify the improvements and learning from incidents.

The Director of Corporate Affairs advised that learning had been identified from the serious incidents received during the two-week spike in December and more information would be shared in Part 2 of the Board meeting.

The Deputy Director of Quality, Innovation and Improvement added that learning had been shared with ICBs and the Trust's Medical Director and Director of Quality, Improvement and Innovation had also undertaken interim actions with Regional Directors.

The Chair requested an opportunity for the Board to see the outcomes from the investigations. The Director of Corporate Affairs advised that the presentation slides would be shared with the Board.

The Chief Executive acknowledged that meetings had been held with ICB leaders across the region, who had welcomed the information and the transparency.

The Deputy Director of Quality, Innovation and Improvement confirmed that the Trust's Patient Safety Specialist and the Corporate Serious Incidents team had been involved in the early stages of the process as well as clinical teams in EOC.

The Chair referred to the timing of learning in the review process.

The Medical Director advised that clinical oversight had been conducted as part of the review process and added that as part of the learning process system SIs were being considered to ensure primacy in terms of learning and achieving balance and a positive response had been received from partners.

The Deputy Chief Executive suggested a briefing for the non-executive board members detailing the outcomes of the SIs received during the 2-week period.

The Deputy Chief Executive referred to the level of patient satisfaction feedback, received during the period and the Chair expressed his thanks to the teams in the call centres who continued to advise and speak to people in a professional manner.

The Medical Director referred to the AQI performance level and noted that overall performance was good.

The Chair referred to the meeting action tracker and action ref 72 which referred to further discussions related to AQIs. The Medical Adviser confirmed that a meeting had taken place and the Trust's frequency of reporting was within the national remit.

The Director of Operations reported an extremely pressurised call pick up period, due to extended response times, and no ARP standards had been met. He advised that the Trust had experienced a significant loss in ambulance hours.

He advised that industrial action and seasonal festive planning had been undertaken with call pick up mitigations in place. He noted that the Trust had observed a change in patient and public behaviour due to the industrial action.

The Chair referred to long waits and acknowledged the public's response to the industrial action raised some future questions for the Trust.

In terms of long waits, the Medical Director explained that the triage system was designed to determine who waited to enable the service to respond to Cat

1 calls. He added that answering calls quickly and reducing call handling waits was key and the ETA script was an important measure to help the public to make an informed choice.

He advised that changes to scripts had been made in response to public feedback, such as eating and drinking instructions, and the introduction of clinicalised rotational specialist paramedics had improved decision making.
He also reported there had also been a focus on despatch and a new system had been introduced to allocate resource based on wait, with technology introduced in the despatch suite so that everyone could see who's waiting.

He referred to the importance of clinical oversight, to improve the management of categories of calls in the call stack. He noted the process for referrals to mental health practitioners had been summarised and made available during the day.

From an organisational point of view, he advised that the Trust's overarching Patient Safety Plan would be revised to include the use of data, as a method for identifying problem areas, which would be presented in the future to the Trust's Quality and Performance Committee.

Prof A Esmail referred to the focus required at the front end of the service, in relation to primary care and emphasised the need to create new processes and improve systems.

The Chair recognised the role of the ICSs in relation to primary care networks and confirmed the route for the Trust was through the ICS structures.

The Deputy Chief Executive noted that the system wide improvement plan included a whole section on improvement in primary care, including 111, however acknowledged that the primary care improvement plans had not progressed as quickly as the hospital handover improvement work.

The Chair acknowledged that a Board Development Session in February would provide Non-Executive Directors with an overall view of the plans in place.

Dr A Chambers noted the Trust's non-conveyance rate of 47% which was important to acknowledge and a testament to the system.

In terms of 111 performance, the Director of Operations reported that during December, call pick up performance against standard had reduced and call volume doubled. He added that inconsistent national messaging related to 111 online had contributed to an increase in demand on 111 call centres.

Dr D Hanley queried communication with primary care, in terms of the level of direct calls to 111 and the Director of Operations confirmed that the impact of GP practices reducing their protected learning time had slightly improved the position.

He acknowledged that the Patient Transport Service continued to deliver an effective service.

The Director of Finance reported the Trust's financial position for Month 9 2022/23 which had been discussed in detail at the Trust's Resources Committee held on Friday, 20th January 2023. She advised that 2023/24 planning discussions were ongoing with the ICSs.

The Director of People provided an overview of performance in relation to the workforce indicators and key risk areas had been a focus for the Trust's Resources Committee, particularly in relation to sickness absence and turnover.

She advised that sickness levels remained above pre pandemic levels, and two deep dives had been presented to the Resources Committee in November and January, which included the work of the Trust's Attendance Improvement Teams (AITs). She added that covid related long term sickness had reduced significantly since July 2022 due to a change in guidance.

She reported that turnover had stabilised, albeit at a higher level, with a balance between pressures and opportunities. She added that there had been significant investment in 999 call centres and PES to address the vacancy gap.

The Director of People advised that with support, staff had been able to maintain levels of appraisal and mandatory training compliance and shifted focus to wellbeing and development. She added that there had been some progress in case management and a deduction in the number of outstanding cases.

Mrs C Butterworth recognised the enormous amount of work being undertaken and encouraged a continuation of the work of the AITs. She also encouraged recuperative duties to maximise return to work opportunities.

The Chair recognised the immense pressures on the Director of People and the People Directorate and praised the work of the Director and her teams.

In relation to mandatory training, the Chief Executive added that the Trust had been operating at REAP Level 4 for a considerable time and from 1st April 2023 onwards would review the mandatory training target of 85%.

In summary, the Chair thanked the Medical Director for his update in terms of patient safety netting in the absence of a Q&P Committee meeting in January. He also acknowledged the assurance he received that Executive Directors were aware of the demands and the initiatives to be implemented, and he thanked the Executive team for their ongoing efforts.

The Board:

- Noted the content and recommendations made in the Integrated Performance Report.
- Noted the SI presentation slides would be shared with the Board.

- Welcomed a briefing for the non-executive board members detailing the outcomes of the SIs received during the 2-week period.

BOD/2223/122 IPC Board Assurance Framework

The Assistant Director of Nursing and Director of Infection, Prevention and Control presented the Infection Prevention and Control (IPC) Board Assurance Framework.

She reported that the paper had been circulated for comment to members of the Trust's ICP Sub Committee, however had not been considered by the Quality & Performance Committee due to cancellation of the January meeting.

She highlighted the risk related to FIT testing and advised that although some actions remained outstanding, overall, the Trust's position had improved; with a reduction in risk score to 8 from 15. She added that a paper on future long term funding for the FIT testing programme would be presented to the Trusts Executive Leadership Committee in April 2023.

The Chief Executive confirmed that the Trust had the hoods available for first stage protection, prior to FIT testing, and recognised the challenges of future resource for the programme.

The Board:

- Noted the content and recommendations within the report.

BOD/2223/123 Learning from Deaths Q2 Report

The Medical Director presented the Learning from Deaths Q2 Report.

He advised that the report had not been considered by the Quality and Performance Committee due to cancellation of the January meeting.

He highlighted the predominant themes and areas identified for improvement which included delays in responding to patients with chest pain and falls. He confirmed the learning from deaths and serious incident processes.

The Medical Director advised that a key area of improvement related to incomplete patient records and poor record keeping, which had been actioned via a work programme to encourage accuracy and completion.

The Board acknowledged that 76.2% of patients had received appropriate care and queried the nature the 24% patients, who received inappropriate care.

It was agreed that further assurance on the detail of what was classed as inappropriate care should be sought be the Trust's Quality and Performance Committee and a future report added to the Committee work plan.

The Chair referred to the areas for improvement identified in s3.7 of the report and queried how the learning was disseminated across the organisation and for assurance that the learning reached the relevant staff.

The Medical Director advised that learning themes were identified and shared at SPTL away days and significant themes dedicated to mandatory learning, with an ongoing work programme to address points raised via the learning from deaths process.

The Director of People added that learning themes formed part of discussions in planning the Trust's mandatory training programmes in addition to the standard offer and that a cycle to inform the content of mandatory training was in place.

The Chair thanked the Medical Director for a comprehensive report, which was a key document and provided an understanding of the action taken by the Trust, from the learning from deaths of patients.

The Board:

- Supported the content of the report and the recommendations made.
- Noted the key areas for improvement identified and the areas of good practice.
- Requested further assurance on the detail of the 24% of cases that were classed as inappropriate care, via a report to the Quality and Performance Committee.

BOD/2223/124 EPRR Assurance Report

The Director of Operations presented the Emergency Preparedness, Resilience and Response (EPRR) assurance report.

He advised that the report detailed progress made following the Trust's self-assessment against the EPRR core standards, in October 2022.

He reported the Trust's EPRR Statement of Compliance for 2022/23 as -

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

The Chair referred to standard C7, which related to the recruitment and selection criteria for command roles.

The Director of Operations confirmed that this was planned to be resolved by the end of the month.

In terms of standard C26, regarding the on-call rota, he advised that work had progressed, and the Trust had appointed an Assistant Director of Resilience to provide further focus.

Mrs C Butterworth queried how the Trust faired in comparison with other ambulance trusts, in terms of compliance.

The Director of Operations reported that NWAS had previously been one of the top-rated services based on the self-assessment which was then validated by NHS England.

Mr D Rawsthorn queried whether the report had been submitted to the Trust's Executive Leadership Committee.

The Director of Operations advised that the report had been discussed by the Trust's EPRR Sub Committee and would be presented to the Quality and Performance Committee for further scrutiny in February, due to cancellation of the January meeting.

The Chair emphasised the importance of the EPRR compliance for the Trust and acknowledged the progress made.

The Board:

- Received assurances within the paper.
- Acknowledged that the EPRR report would be presented to the next Quality and Performance Committee meeting.

BOD/2223/125 Manchester Arena Inquiry Recommendations

The Director of Operations presented a report on the Manchester Arena Inquiry (MAI) recommendations.

He reported that the MAI Inquiry Volume 2 report had been published on 3rd November 2022 and included 149 recommendations with 14 defined as monitored recommendations for NWAS. He advised that in July 2023 all evidence on progress made against the recommendations would be presented in front of the Inquiry.

The Director of Operations provided an overview of the current position in terms of actions that were completed, in-progress and incomplete. He confirmed that the Trust's Incident Response Plan would be presented to ELC in February 2023.

He reported the challenges related to Recommendation 20 which required training and exercising in a multi-agency setting for all front-line A&E staff, which was approximately 4,000 NWAS staff in total.

He confirmed he was working with the Trust's legal team as part of the ongoing work and updates were presented to the Trust's Executive Leadership Committee, EPRR Sub Committee and Quality and Performance Committee.

He advised that an internal working group had been established, led by the Assistant Director (AD) of Resilience and the AD regularly updated the Director of Operations, who was the Accountable Emergency Officer on progress. He added that the composition of the working group consisted of the Head of Contingency Planning, Head of Special Operations and another senior EPRR leader had also been appointed.

Dr D Hanley recognised the challenges related to recommendation 20 and training in a multiagency setting for all A&E frontline staff.

The Director of Operations stated that an innovative approach would be required.

The Chair and Chief Executive confirmed the Trust would be monitoring closely the progress made against the recommendations.

The Board:

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

BOD/2223/126 **Quality and Performance Committee Chairs Assurance Report from the meeting held on 28th November 2022**

Prof A Esmail presented the Chairs Assurance Report from the Quality and Performance Committee meeting held on 28th November 2022.

He provided an overview on the red rated assurance items which included the IPR in relation to call pick up and AQI performance against standards.

The Chair referred to the escalation of the hospital handover pressures, which had been discussed at length at the last Board meeting.

In terms of hospital handover pressures, the Chief Executive advised that letters had been sent to the ICB Chief Executives and each of the integrated care systems now had a lead, nominated by the Chief Executive, to work with NWAS on the hospital handover position.

He added that Lancashire and South Cumbria ICB had invited him to attend a Development Session and for him to contribute as a participant at future ICB meetings.

In terms of the mental health update, the Deputy Director of Quality, Innovation, Improvement confirmed 18 months funding for the Mental Health Team resource had been approved by the Trust's Executive Leadership Committee.

The Board:

- Noted the assurances provided.
- Acknowledged that letters had been sent to the ICB Chief Executives regarding hospital handover.

BOD/2223/127 **Resources Committee Chairs Assurance Report from the meeting held on 20th January 2023**

Dr D Hanley presented the Chairs Assurance Report from the Resources Committee meeting, held on 20th January 2023.

He acknowledged the deep dive into sickness absence, presented by the Director of People, which had been gratefully received.

He advised that the Committee had acknowledged that the Trust had a considerable number of ambitious programmes to achieve, against a challenging resource position. He added that there had been limited assurance due to the overall pressure.

The Deputy Chief Executive stated that he had presented a plan to the Resources Committee which detailed those programmes which were progressing and those which were delayed and would not be met within the timescales.

The Chair thanked Dr D Hanley for the report and welcomed continued monitoring of resource and planning. He acknowledged the pressure on the teams.

The Board:

- Noted the Chairs Assurance Report from the Resources Committee meeting held on 20th January 2023.

BOD/2223/128 **Communications and Engagement Q3 Report**

The Deputy Chief Executive presented the Q3 Communications and Engagement Team Dashboard Report.

He reported that the number of letters during the period had increased, and internal communications were summarised in the report provided. In terms of industrial action, he confirmed that communications had been issued to the public and NHSE had commended the efforts of the ambulance sector in communicating messages to patients and the community during the times of strike action.

The Chair referred to the tremendous amount of work carried out by the communications team, both internally and externally, and in particular the bulletins regarding the Manchester Arena Inquiry and industrial action.

The Board

- Noted the content of the report.

BOD/2223/129 **Partnerships and Integration Progress Update**

The Deputy Chief Executive presented a Partnership and Integration Progress Update.

He reported that the paper detailed work completed and further implementation and development work in relation to the ICS and overarching priorities. He referred to earlier discussion in the meeting and advised that the trust would consider the ICS 5–10 year plans and consideration given as to how these aligned with NWAS plans and an understanding of the mutual gains and benefits.

He advised that the summary provided on ICS objectives evidenced a heavy focus on health inequalities.

He added that the knowledge vault continued to look at guidance documents that were published.

The Chair commented that the Knowledge Vault was very helpful and a good reference tool.

The Chair referred to the new statutes of ICBs and the need for NWAS to support the wider objectives of the system. He added there was also a need for board members to be clear on how the trust's objectives impacted on those of the regional ICSs.

Mr D Rawsthorn referred to the high-level objectives and progress in relation to the ICSs and stated he found the NHS briefing documents very helpful.

Prof A Esmail queried the term PIMs and where they fit in the overall structure.

The Deputy Chief Executive confirmed PIMs stood for Partnership and Integration Managers, who were allocated within each of the regions, with some additional support for Lancashire and South Cumbria. He added their role was to work with a range of individuals, executives, internal and external partners.

The Deputy Chief Executive confirmed that the mapping of ICS plans to NWAS plans had been undertaken, with lots of discussion as to how NWAS would be involved in working within the ICS. He added there had been some encouraging initial signs that the Trust was influencing the system.

The Chief Executive confirmed that as Chair of AACE he was involved at a senior and national level, and it was important this involvement was rolled out locally within the ICS.

The Board:

- Noted the Partnerships and Integration Update.

BOD/2223/130 Any Other Business Notified prior to the meeting

There was no other business notified prior to the meeting.

BOD/2223/131 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

BOD/2223/132 Closing Remarks

The Chair thanked board members for their input during the meeting. He referred to the pertinent patient story and the level of system working which continued. He summarised other highlights of the meeting and emphasised the need for the Trust to ensure that it continued to focus on the recommendations of the Manchester Arena Inquiry to make the improvements necessary for the public and staff.

Date and time of the next meeting –

9.45 am on Wednesday, 29th March 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			
106	25.01.22	121	Integrated Performnce Report	Noted the SI presentation slides would be shared with the Board and welcomed a briefing for the non-executive board members on the outcomes of the SIs received during the 2-week period.	A Wetton / S Desai	29.3.23			
107	25.01.22	123	Learning from Deaths Q2 report	Requested further assurance on the detail of the 24% of cases that were classed as inappropriate care, via a report to the Quality and Performance Committee.	C Grant				

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	✔	✔	✔	✔	✔	✔	x	
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	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	✔	✔	✔	✔	✔		x	
Angela Wetton	✔	✔	✔	✔	✔	✔	✔		✔	

Charitable Funds Committee				
	27th April	26th October	13th December	22nd February
Ged Blezard	✔	x	Cancelled	✔
Salman Desai	✔	✔		✔
Catherine Butterworth	✔	✔		x
Dr David Hanley	✔	✔		x
David Rawsthorn (Chair)	✔	✔		✔
Lisa Ward	✔	✔		✔
Angela Wetton	✔	✔		✔
Carolyn Wood	✔	✔		✔

Nomination & Remuneration Committee							
	25th May	27th July	28th September	30th November	25th January	22nd February	29th March
Catherine Butterworth	No meeting	✔	✔	Meeting not held	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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th March 2023					
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 Board of Directors on 25th January 2023.

The highlights from this report are as follows:

Industrial Action

- Following intensive negotiations between the trade unions and Government, a pay offer has now been received and is being consulted upon.

PES

- The combination of planning and the changes in public behaviour meant the Trust was able to provide a safe service during the period of industrial action.
- Call answering standards achieved.
- Significant improvement in hospital handover during the months.

111

- Recent developments include the roll out of Visual IVR to reduce average handling time.
- Recruitment remains a challenge, new ways of recruiting are being explored.
- Growth of 9% to be used for forecasting for 23/24.

PTS

- Activity in January was 21% below contract baselines
- YTD July 22 to Jan 23 performance is 17% below baseline

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 Board of Directors on 25th January 2023.

2. PERFORMANCE

2.1 Paramedic Emergency Service

During January and February there were several industrial action dates for the various trade unions. The action varied in dates, time and types of action, from action short of strike to strike action. The Trust put in place plans to minimise the impact of the dispute which included the deployment of up to 100 military personnel supporting frontline operations and a small number from the civil service supported call taking within the control centres. The combination of joint working with our trade union leads, planning and the changes in public behaviour meant the Trust was able to provide a safe service.

From early January and into February NWAS experienced a change in activity, notable from week commencing 6th January. Overall, we have seen a 5-6% reduction which, combined with stable staffing levels, meant that our call answering standards have been met for the past two months. During the same period, we experienced a significant improvement in hospital handover times, this freed up ambulance resources and enabled us to respond more effectively with a reduction in C1 and C2 long waits. Whilst only the C1 90th standard was met the Trust was much closer to the targets. This level of performance is favourable when compared to other ambulance trusts.

2.2 NHS 111

Pressure within the 111 service continues. Extensive analysis conducted by NHSE now suggests a growth of around 9% should be assumed for forecasting into 2023/24. The service continues to adapt and react to any surge in demand due to public messaging, throughout February relating to Industrial action.

Considering the continued gap with capacity and demand the Development & Systems Team within 111 strive to make the service as efficient as it can be during this time. Some of the recent developments due to be rolled out imminently include 'Visual IVR', this presents an option for patients to part complete their demographic record pre the call being answered should they be waiting to be answered for longer than 3 minutes, it is anticipated that this will reduce average handling time (AHT) and consequently release capacity for more calls to be answered by the service. During February, the team were also invited to present to the national provider forum to showcase another development around SMS for interim care advice to patients, again this is an innovative way to save valuable AHT.

The Rota review is now in its final stages, staff have been formally invited for a consultation should they have any concerns about their new rotas following the voting period, feedback overall is positive, and managers are supporting staff that are still experiencing challenges with their new rota. Anticipated go live date is May 2023.

Recruitment remains a challenge within 111, and to varying degrees across the contact centre, new ways of doing this are being explored currently with a view to

recruiting to an 'NWAS call handler' rather than call handlers to each service line within contact centres. It is anticipated this will prevent disproportionate interest in areas that are deemed 'more exciting' and provide a wider opportunity for new staff to experience a wider range of call types within the Trust.

In October 2021, the IUC Commissioning Framework set out a case for 111 call handling at scale, and a requirement to adopt a regional footprint. Technical enablers were required to progress this work which has been funded by NHSE. The national vision is to have a Single Virtual Contact Centre (SVCC), partitioned into regions, this will allow calls to be distributed across providers within a region, with the intention of enabling calls to be answered faster, dependant on available resource within the region.

This requirement has no immediate impact on NWAS as we already operate as a region, however there is a requirement to work with NHSE to move to the national cloud-based platform. It is expected that no change will take place to how calls within the North West are answered but it will give NWAS the ability to utilise additional nationally provided resource should this be required, this will only happen if agreed by NWAS and appropriate business rules applied to the platform.

2.3 **Patient Transport Service**

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

Activity in January for the Trust was 21% below contract baselines with Lancashire and Cumbria 33% and 34% below baselines respectively. Year to date July 2022 - January 2023) is performing at 17% below baseline.

3. ISSUES TO NOTE

3.1 **Local Issues**

Blackpool Hub

Staff and volunteers from the Fylde sector were welcomed to the brand-new Blackpool Hub. The open day was organised for all those staff who are due to migrate over, to bring their families to view the ready-to-go-live hub and spoke model station. Retired members were also welcomed in to see the amazing transformation of the old Waterloo Road site.

The station has been designed to maximise operational effectiveness and efficiency, moving from a traditional service delivery model to the preferred model of Hub and Spoke which supports the 'make ready' service. It will improve staff morale and welfare, improve the opportunities for visible line management, training and audit and will result in increased efficiency in stores and logistics.

The Blackpool Hub is the first full construction of a hub site, so it has been a huge project to manage and I would like to thank all those involved for delivering such an impressive building.

Later in the month, the chair and I were honoured to welcome The Rt Hon The Lord Shuttleworth, Lord Lieutenant of Lancashire, to officially open the new Blackpool Hub site. Guests and staff gathered to mark the occasion and take tours of the new site. It was also an opportunity for us to thank Lord Shuttleworth for his commitment and services to Lancashire on behalf of the late Her Majesty the Queen, and King Charles, by presenting him with an NWAS shield. Lord Shuttleworth is due to retire

this summer and has attended many Long Service Awards to present Queen's medals to staff, for which we have been extremely grateful.

Manchester City Council praise staff

Area Director, Ian Moses, and Head of Operations, Dan Smith, joined representatives from all parts of the NHS and Social Care to attend an extraordinary meeting of the Manchester City Council Health and Social Care Scrutiny Committee.

The committee had been convened specially to examine the access to healthcare for patients in Manchester, following the extreme pressures we've been experiencing through the last year, and especially in winter.

The committee received a combined report which examined the challenges and performances of NWAS, primary care and acute trusts. Each organisation was then questioned separately by the panel of councillors. The questions were centred on ambulance handover delays, their impact on patients waiting in the community, along with interest in the welfare of our staff.

At the end of the session, the committee was eager to pass on their respect, sincere admiration and thanks to all our staff for their hard work and resilience delivering excellent patient care in some of the most challenging times ever experienced.

3.2 **Regional Issues**

Industrial Action

Following a number of days of strike action through December to March, industrial action by all three ambulance trade unions (Unite, GMB and Unison) was suspended between 18-23 March following ongoing talks with trade unions. All arrangements to mitigate the impact of the strike were subsequently stood down.

REAP

During the days of industrial action, the trust moved from REAP Level 2 (moderate pressure) to Level 4 (extreme pressure) in order to maximise all available resources with clinical trained staff responding in front line roles and working closely with our private transport providers. Our escalation plans were implemented proactively, and we worked closely with other healthcare organisations to safely signpost patients to other services where appropriate whilst continuing to deliver statutory/mandatory training.

NHS Pay

After intensive talks, the government made a pay offer to unions representing staff on the Agenda for Change contract including Unison, GMB and Unite. As employers we have been keen to see the government enter discussions to listen to the concerns of staff, so we welcomed the talks taking place and I am really pleased they have resulted in an offer to resolve the current dispute which has been recommended by most of the trade unions involved.

Whilst the negotiations were between the government and the health service trade unions, there were employer representatives from the NHS Staff Council involved in support. Our very own Director of People, Lisa Ward, was one of those involved as a representative of the ambulance sector with years of experience about the issues that matter most to our staff.

Following the talks, I received a letter from Steven Barclay, Secretary of State for Health and Social Care, which confirmed the offer as a non-consolidated 2% payment for 2022-23, along with a backlog bonus to recognise the extraordinary efforts of NHS staff, which is a tiered cash payment variable by band. For 2023/24 the offer includes a 5% increase in pay for 2023-24 in addition to further enhancements for the lowest paid staff.

The letter stated that on top of the pay elements of the package, the offer includes other measures including the development of a national, evidence-based policy framework which will build on existing safe staffing arrangements and amendments to terms and conditions to support existing NHS staff develop their careers through apprenticeships. The offer also includes a commitment to improving support for newly qualified healthcare registrants and to tackle violence and aggression.

There will now be a period of consultation undertaken by individual trade unions with their members to allow them the opportunity to consider and respond to the offer. The period of consultation is expected to take 3-4 weeks with a position from all the trade unions expected on the offer by mid to late April.

During this period of consultation, and pending any final decisions from their members, the AfC trade unions have agreed to continue with the pausing of all planned industrial action. The period of industrial action to date has been challenging for everyone but we have been able to work well in partnership with our trade union partners and staff to try to keep an appropriate balance between enabling staff to exercise their right to take industrial action and minimising the impact to those patients who have needed us most.

Focusing on the Year Ahead

During February I hosted a session with the executive team on priorities for the year ahead, including strategy development, diversity and inclusion, finances and staff opinion via NHS Staff Survey results. It was a positive session with a focus on the incoming financial year. Corporate teams in particular should soon start to see how the trust's latest strategy which launched in 2022, will influence departmental plans.

Commander training

The executive team and I were recently joined by our strategic commanders for a development day with the National Ambulance Resilience Unit (NARU). The informative session covered duty of care for emergency service commanders, media handling and reputation, legal accountability, learning from past incidents and much more.

It's important for all ambulance staff and leaders to learn and exercise frequently as part of our continued professional development to ensure we are prepared for whatever the future brings.

NARU was established in 2011 as a central support unit for all UK ambulance services, to ensure the ambulance service as a whole can respond to a variety of hazardous and challenging incidents in the safest and most effective way possible.

Congratulations paramedic apprentices

Our first cohort of EMT1 staff studying on the paramedic apprenticeship have successfully completed the programme. Congratulations to all 46 successful students.

We are now on cohort seven of the paramedic apprenticeship, with three new groups starting every year. The June group has already been selected and soon we will be recruiting to the October cohort.

First women's HART taster day

At the end of February, HART welcomed 19 paramedics from across the whole trust to Ashburton Point for the very first women's HART taster day. The day opened with each attendee introducing themselves to their colleagues explaining why they had chosen to attend the session. After a short presentation and safety brief the day got underway. Split into five smaller teams they quickly got to grips with the various disciplines the team had arranged for them.

Each discipline was overseen by an experienced female HART member of staff and included a safe working at height exercise, climbing the tower and abseiling down whilst having their confidence tested with a dexterity exercise whilst suspended several meters in the air. They undertook a confined space exercise in the station rig as well as a breathing apparatus and communication exercise in a pitch black room.

Unfortunately they were unable to experience a live water exercise because of restrictions at Salford Quays due to a bird flu outbreak but they did get the chance to don the PPE and try out some bank side rescue techniques. They even got to trial the new Virtual Reality MTA triage equipment developed by one of our very own at NWAS HART.

Manchester Arena Inquiry Volume Three

At the beginning of March, Volume Three of the Manchester Arena Inquiry was released. The report, titled 'Radicalisation and Preventability', examined the evidence heard by the Chairman on the radicalisation of Salman Abedi, the planning and preparation of the attack and whether the attack could have been prevented.

Although the third and final report focuses on MI5 and the Security Services, it serves as an important reminder of the key findings and recommendations given to emergency services in Volume Two of the report late last year.

We continue to improve, train and learn from such a devastating event while keeping the loved ones of those who lost their lives that day at the forefront of our minds. Following the publication of Volume Two in November, we are currently working on a paper to inform the Chairman of the changes we have made based on his recommendations.

Isle of Man Health Service

Together with Ged Blezard, Director of Operations and Steve Hynes, Assistant Director of Resilience, we recently met with the CEO of Manx Care for a discussion regarding a strategic partnership between NWAS and the provider of health and social care on the Isle of Man (IOM), and in particular the Isle of Man Ambulance Service. The IOM already has similar arrangements in place with Merseyside NHS trusts and other emergency services.

During our meeting, we talked about how we can work together in the event of a major incident. We looked at data and spoke about how we could support them with modelling based on the increase in demand they have experienced. Opportunities for joint commander training, clinical training and education and 'critical friend' support for both services were also key topics of conversation.

Upcoming community conversations

Following the success of community engagement events in Greater Manchester and Lancashire, our Patient Engagement Team is planning three additional events in our communities to listen to the views and experiences of the public and professionals who interact with our services.

The events are for those interested in the ambulance service or the NHS; those who have used any of NWAS' services (999, 111, PTS); those who champion health and care in their community; those who interact with our services as part of their job or voluntary role and anyone willing to share their views and listen to other people.

3.3 **National Issues**

Recovery plan and the year ahead

The Urgent & Emergency Care Recovery Plan for the NHS was launched at the end of January and whilst I was previously working as part of a national team on a plan for the long-term future of urgent and emergency care, with recent changes in government the focus has shifted to this being a recovery plan.

I welcome the additional ambulance sector investment that will come with the plan, and in my AACE Chair role I said that AACE welcomes the focus being given to recovery across urgent and emergency care, and the opportunity the ambulance sector has had to inform its content.

This is at a time where all trusts, ICSs and NHSE are setting plans for the new financial year. What we know is that one of the core objectives for ambulance services in 2023/24 will be to reduce Category 2 response times to 30 minutes by increasing ambulance capacity and reducing handover delays. There will be a requirement to increase referrals to community providers and improve access to mental health services, as well as general work on reducing inequalities and improving public health. There will also be a continued focus on improving staff experience and retention.

Speak Up review of ambulance trusts published

At the end of February, the National Guardian's Office (NGO) published a report called 'Listening to Workers', following its Speak Up review of NHS ambulance trusts in England. Unfortunately, the review found that the culture in ambulance trusts did not support workers to speak up and that this was impacting staff wellbeing and ultimately, patient safety.

The report found ambulance workers' experiences of a culture of bullying, harassment and discrimination contributed to not feeling able to speak up for fear of retaliation. The fear of the consequences was one of the main barriers to people speaking up about anything getting in the way of delivering great patient care. Those who did speak up, often faced intimidation or inaction as a result.

Although our service was not part of this review, it is still important to shine a light on these findings and their recommendations for improvement. Together with our Medical Directorate and Freedom to Speak Up (FTSU) Guardian, Graham Pacey, we will examine this report and pull out any key recommendations we could adopt to further encourage an open and honest speaking up environment.

The NGO included a number of recommendations for ambulance trusts to adopt, including a review of broader cultural matters, making speaking up business as usual and effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts.

4. GENERAL

2022 NHS Staff Survey

The results from the 2022 National Staff Survey have now been released by the National Coordination Centre.

The survey results present a mixed picture showing some good progress in a number of key areas which we can be proud of. At the same time however, the results highlight areas in which we need to improve further.

The results show some clear areas where we are making good progress as an organisation. These include fewer staff reporting negative experiences such as bullying, harassment or abuse from patients, colleagues, and managers. This shows that things like the 'Treat Me Right' campaign, body worn cameras and training programmes such as 'Beyond Bias', and 'Civility Saves Lives', are making a positive difference. There is still more we need to do to improve on negative experiences, especially for disabled colleagues or those with long-term conditions and to increase reporting, but it is refreshing to see a positive trend.

For the second year in a row, relationships with immediate line managers, were improving and responses from our staff have shown a more positive employee experience compared to the ambulance sector average.

Over 80% of those who completed the survey said that work is emotionally exhausting, for PES colleagues over 90% of those who completed the survey said they feel this way. It's clear from the results, and across the NHS, that many staff are feeling the emotional and physical effects of burnout. We know this isn't surprising given the continued high demand for our services and the incredible commitment shown on a day-to-day basis. We continue to work hard to address some of those underlying issues, such as hospital handovers.

In addition, we have continued to focus on wellbeing initiatives such as the rollout of the proactive wellbeing phone calls from 'Just B'. The calls are an opportunity to discuss any health and wellbeing challenges or concerns and get information about the range of services available. Clinical Psychologist, Dr. Rosey Tattersall has been sharing the findings of her review into the health and wellbeing experiences of staff throughout NWAS, and we are looking at recommendations to provide additional support to help with burnout, and health and wellbeing in general. The full report is available on the Green Room

LGBT History Month

As part of LGBT History Month in February, colleagues are sharing their stories and experiences of working in the service. Resilience Manager, Nick Bell, shared a fascinating insight explaining how he's had to 'come out' again and again in the workplace. I am glad Nick has found NWAS to be a safe and inclusive place to work, and I echo his comments that there is more we can do to improve. With the support of our LGBT staff network, I am sure we will continue to make strides in the right direction.

Our LGBT+ Network is open to all staff. It focuses on improving staff and patient experience for the LGBT+ community and aims to provide an influential voice on behalf of all LGBT+ staff throughout NWAS.

This coming summer, we will host the national ambulance LGBT+ conference in Manchester again. All ambulance services will come together to share best practices and ultimately help make improvements.

Meetings with the Network Chairs

Over the last two months I have undertaken the bi-annual review meetings with the trust Networks' Chairs and Executive Leads to understand the progress made in identifying where NWAS can enhance its approach to support and improve our network communities.

Royal Garden Party

I recently met with the chair of the staff Race Equality Network, Paramedic Wes Proverbs. The network is making great strides in the service and is open to all staff (ethnically diverse people and allies).

I was delighted to ask Wes to represent NWAS at a Royal Garden Party. This year's garden parties will be the first to be held by The King and will take place at Buckingham Palace close to the Coronation weekend.

High Sheriff visit

At Parkway, Deputy CEO Salman Desai met with the High Sheriff of Greater Manchester, Lorraine Worsley-Carter.

High Sheriffs represent the Sovereign in their counties in upholding all matters relating to the Judiciary and maintaining law and order. Lorraine was pleased to see the emergency operations centre and meet staff.

BBC Ambulance

Dragonfly has completed its first block of filming in the Lancashire and Cumbria area and I wanted to pass on my thanks to the management team for their work in organising this. I would also like to thank those who agreed to work with a member of the film production team both on the road and behind the scenes in EOC. It can't be easy having your entire working shift recorded on film but it is a great way to show the public the challenges faced on a daily basis, as well as the care and compassion towards our patients and their families. Filming then moved to Greater Manchester until the end of April.

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:	29 March 2023					
SUBJECT:	Board Assurance Framework (BAF) Risks 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 Board of Directors has overall responsibility for ensuring that systems and controls are in place are adequate to mitigate any significant risks which may threaten the achievement of strategic objectives. The proposed BAF Risks for 2023/24 can be viewed in **Appendix 1**.					
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the proposed 2023/24 BAF risks.					
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:	Executive Leadership Committee			
	Date:	22nd March 2023		
	Outcome:	Supported onward reporting to Board of Directors		

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1. PURPOSE

This report provides the Board of Directors with an opportunity to agree the proposed Board Assurance Framework (BAF) Risk for 2023/24.

2. BACKGROUND

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

Following focused discussion sessions with both Executive and Non-Executive Directors surrounding the BAF risks for 2023/24, the proposed BAF Risks for 2023/24 can be viewed in **Appendix 1**.

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

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the proposed 2023/24 BAF risks.

Appendix 1

NHS North West Ambulance Service NHS Trust

PROPOSED 2023/24 BOARD ASSURANCE FRAMEWORK (BAF) RISKS

SR	Risk Description	Exec Director Lead
SR01	There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	Medical Director
SR02	There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services	Director of Finance
SR03	There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	Director of Operations
SR04	There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes	Director of People
SR05	There is a risk that the Trust does not deliver its People Strategy to improve its culture and staff engagement and this impacts on NWAS being a brilliant place to work.	Director of People
SR06	There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	Director of Quality, Improvement and Innovation
SR07	There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment	Director of Strategy, Partnerships and Transformation/ Deputy CEO
SR08	There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm	Director of Quality, Improvement and Innovation
SR09	There is a risk that the Trust continues to attract negative media attention arising from long delays and harm leading to significant loss of public confidence	Director of Strategy, Partnerships and Transformation/ Deputy CEO
SR10	There is a risk that the that level of uncertainty and unpredictability both nationally and regionally impacts on, or results in, delayed achievement of our strategic priorities and objectives	Director of Strategy, Partnerships and Transformation/ Deputy CEO

NHS
North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 29 March 2023					
SUBJECT:	Risk Appetite Statement 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 Trust's Risk Appetite Statement underwent a full revision by the Board of Directors during the Board Development Session held in Q4 2022/23. The proposed 2023/24 Risk Appetite Statement has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.					
RECOMMENDATIONS:	The Board of Directors are requested to approve the Risk Appetite Statement for 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:	Executive Leadership Committee			
	Date:	22 March 2023		
	Outcome:	Supported Onward Reporting to Board of Directors		

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1. PURPOSE

This report provides the Board of Directors with an opportunity to consider the Risk Appetite Statement for 2023/24.

2. BACKGROUND

The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors in Q4 2022/23 during a developmental session with the Board.

The proposed Risk Appetite Statement for 2023/24 has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.

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

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the Risk Appetite Statement for 2023/24.

RISK APPETITE STATEMENT (RAS) 2023/24

North West Ambulance Service (NWAS) NHS Trust recognises as a healthcare provider that risks will inevitably occur while providing high quality and inclusive care and treatment to patients, recruiting our people, owning, leasing, and maintaining premises and equipment, and managing finances.

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

The Board of Directors is committed to ensuring an effective risk management system is in place to manage risks from operational to Board level and where is identified, robust mitigating action plans are put in place. NWAS recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, our people, including volunteers, members of the public and strategic partners.

As such:

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

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

- NWAS has a moderate appetite for taking risks that may adversely impacts our people.
- NWAS has a moderate appetite to accept risks that may impact on finance/ value for money. However, budgetary constraints will be exceeded when required to mitigate risks to patient, our people's safety, or quality of care
- NWAS has a moderate appetite regarding pursuit of commercial development, collaboration, and partnerships. Although, the preference is for safe delivery options that have a low degree of inherent risk and may only have limited potential reward
- NWAS has a high appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities.

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

PETER WHITE
Chairman

DAREN MOCHRIE
Chief Executive

North West Ambulance Service NHS Trust Risk Appetite			
Key Risk Category	**Risk Appetite Level**	**Risk Tolerance Score**	**Risk Appetite Statement**
Compliance/ Regulatory	Low	1-5	We have a **LOW** appetite, and we will not take any risks which will impact on out ability to meet our legislatory requirements.
Quality Outcomes: ▪ Safety ▪ Effectiveness ▪ Experience	Low	1-5	We have a **LOW** appetite for taking in relation to quality outcomes. We will take measured and considered risks to improve and delivery of quality outcomes where there is potential for long term benefit, however, we will not compromise the quality of care we provide or the safety of our staff, volunteers, or patients in our care.
People	Moderate	6-12	We have a **MODERATE** appetite for risk taking that may adversely impacts on our people. We will take measured and considered risk that does not compromise the safety and to liberate the potential of our people, engaging with, supporting, and enabling our people to shape the culture of the organisation to enhance inclusion, staff safety and create a healthy workplace.
Financial/ Value for Money (VfM)	Moderate	6-12	We have a **MODERATE** appetite for measured risk taking to support growth whilst making best use of resources, delivering value for money whilst minimising the possibility of financial loss allowing the Trust to develop and provide highest standards of healthcare. We will not take any financial risks which will have a negative impact on the overall sustainability of the Trust.
Reputation	Moderate	6-12	We have a **MODERATE** appetite for risk taking that will enhance to be an 'outstanding' organisation. We will not take any risks that will have a negative impact on the reputation of the Trust.
Innovation	High	15-25	We have a **HIGH** appetite for innovation and will take measured risks to maximise technological innovation and commercial opportunities to improve patient outcomes, transform services and ensure value for money.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 March 2023					
SUBJECT:	Modern Slavery Act 2015					
PRESENTED BY:	Executive Director of Finance					
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 Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2022/23. Although there was a public consultation between July and September 2019 the recommended legislative changes have not currently passed the House of Lords. Procurement will continue to monitor progress and will ensure that future Modern Slavery statements reflect any legislative outcome. This statement meets the current requirements.					
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the content of the report; and • Approve the recommendation of the drafted statutory statement for the year ending March 2023.					
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 5 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

1. PURPOSE

1.1 The Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2022/23.

2. BACKGROUND

2.1 The Modern Slavery Act 2015 is an Act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

2.2 A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude; or
- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

2.3 The Act establishes a duty for commercial organisations, with an annual turnover in excess of £36m, to prepare an annual slavery and human trafficking statement. Income earned by NHS bodies from government sources, including CCGs, ICBs and local authorities, is considered to be publicly funded and is therefore outside the scope of these reporting standards.

2.4 The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). It includes a provision for large businesses to publicly state each year the actions they are taking to ensure their supply chains are slavery free.

2.5 The 'slavery and human trafficking statement' must include either an account of:

- The steps being taken by the organisation during the financial year to ensure that slavery and human trafficking is not taking place in any part of its business or its supply chains, including:
    - Information about the organisation's structure, business and its supply chains.
    - Its policies in relation to slavery and human trafficking.
    - Its due diligence processes in relation to slavery and human trafficking in its business and supply chains.
    - The parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk.
    - Its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate.
    - The training about slavery and human trafficking available to its staff.

OR

- That the organisation is not taking any such steps (although this is permitted under the Act, it is likely to have public relations repercussions).

2.6 The Trust has previously produced a Modern Slavery statutory statement for each financial year since the year ending March 2017.

3. CURRENT POSITION

3.1 The statement must be formally approved by the Board of Directors and must be published on its website. Failure to do so may lead to enforcement proceedings being taken by the Secretary of State by way of civil proceedings in the High Court. The Act is clear that the link must be in a prominent place on the homepage itself. A prominent place may mean a modern slavery link that is directly visible on the home page or part of an obvious drop-down menu on that page. The link should be clearly marked so that the contents are apparent.

3.2 The Trust is required to produce a Statutory Statement that includes both the supply chain & the wider organisation.

3.3 An exercise has been undertaken to prepare a Statutory Statement that demonstrates compliance with the Act – attached at Appendix 1.

3.4 A Supplier Code of Conduct has been published on the Trust website.

3.5 Organisations, who are affected by the Modern Slavery Act 2015, must publish a formally approved annual statement of compliance with the Act as soon as reasonably practical after the end of the financial year. The statement should include:

- Information about the organisation and its business
- Its policies in relation to slavery and human trafficking
- Its due diligence processes in its business and its supply chain
- The parts of the supply chain where there is a risk of modern slavery and trafficking, including the steps taken to manage this risk.
- Its effectiveness in ensuring that modern slavery and human trafficking are not present with the organisations supply chain.
- Staff training about modern slavery and human trafficking.

3.6 All staff at North West Ambulance Service NHS Trust, in clinical and non-clinical roles, have a responsibility to consider issues relating to modern slavery in their day to day practice. Frontline NHS staff are well placed to identify and report any concerns they may have about individual patients and modern slavery is part of the safeguarding agenda for children and adults in which all our staff are trained. All frontline staff have a duty to report a notification of a concern raised regarding modern slavery through the safeguarding notification process.

3.7 The Trust is fully aware of the responsibilities toward patients, employees and the local community and we have a strict set of values that we use as guidance with regard to our

commercial activities. We therefore expect that all of the Trust's suppliers and sub-contractors adhere to the same ethical principles.

3.8 In compliance with the obligations the following supply chain actions have been embedded within procurement processes:

- The Trust has developed a Modern Slavery Statement and a Supplier Code of Conduct.
- NHS Procurement Template Documents – ensure that Modern Slavery is considered in procurement exercises.
- NHS Terms and Conditions – requires suppliers to comply with all relevant Law and Guidance and to use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains.
- All current Trust suppliers have been contacted to provide evidence of compliance with the Act and have been issued with the "Supplier Code of Conduct". In addition, suppliers have been made aware of how to inform the Trust if they become aware of any breaches to the act within their own supply chain. The same process has been adopted for new suppliers.
- When we write to new Suppliers for information to enable them to be set up on our systems, we ask them for certain information, and this has been expanded to cover a Modern Slavery Declaration.
- We have a Modern Slavery section in our "Procurement Manual" which is an internal guidance document that should raise awareness for all staff.
- The Senior Procurement Team has completed the "Ethical Procurement and Supply Certificate" that is a recognised qualification of the Chartered Institute of Procurement & Supply.

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

4.1 The obligations of the act apply to all commercial organisations:

- Operating wholly or partially in the United Kingdom; and
- Companies with an annual turnover over £36m.

Legislation Changes

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

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

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to:

- Note the content of the report; and
- Approve the recommendation of the drafted statutory statement for the year ending March 2023.

Appendix 1

NWAS MODERN SLAVERY ACT 2015
Statutory Statement for the Year Ending March 2023

Background

The Modern Slavery Bill was introduced into Parliament on 10 June 2014 and passed into UK law on 26 March 2015. The Modern Slavery Act is an Act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude; or
- The person requires another person to perform forced or compulsory labour and the circumstance are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Larger organisations must publicly report steps they have taken to ensure their operations and supply chains are trafficking and slavery free.

This disclosure duty, contained in the Modern Slavery Act 2015, applies to companies and partnerships supplying goods or services (wherever incorporated or formed) with global turnovers of £36 million and above, providing they carry on business in the UK.

The Trust has previously produced a Modern Slavery statutory statement for each financial year since the year ending March 2017.

Organisational Structure

North West Ambulance Service NHS Trust serves an approximate population of 7 million covering an area of 5,500 square miles and employs over 6,300 staff. The Trust receives 1.3 million emergency calls per year, which is 16% of the national (999) activity. To meet this demand the Trust has 3 emergency control centres and approximately 700 emergency vehicles.

The Trust also provides urgent care and patient transport services across the region and manages the NHS non-emergency helpline, 111, regionally.

The Trust has an overall annual budget of around £450 million.

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

The Trust has a non-pay budget of £135m per annum which is spent on goods and services. Over 80% of the £135m is spent with the Trusts top 100 suppliers.

Our Supply Chain

It is important to ensure that suppliers to the Trust have in place robust systems to ensure that their own staff, and organisations within their own supply chain are fully compliant with the requirements of the Modern Slavery Act 2015.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Trust continues to monitor its supply chains with a view to confirming that such behaviour is not taking place.

The following actions in terms of Modern Slavery and Code of Conduct have been embedded within procurement processes:

- The Trust has developed a Modern Slavery Statement and a Supplier Code of Conduct.
- NHS Procurement Template Documents – ensure that Modern Slavery is considered in procurement exercises.
- NHS Terms and Conditions – requires suppliers to comply with all relevant Law and Guidance and to use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains.
- All current Trust suppliers have been contacted to provide evidence of compliance with the Act and have been issued with the "Supplier Code of Conduct". In addition, suppliers have been made aware of how to inform the Trust if they become aware of any breaches to the act within their own supply chain. The same process has been adopted for new suppliers.
- When we write to new Suppliers for information to enable them to be set up on our systems, we ask them for certain information, and this has been expanded to cover a Modern Slavery Declaration.
- We have a Modern Slavery section in our "Procurement Manual" which is an internal guidance document that should raise awareness for all staff.
- The Senior Procurement Team has completed the "Ethical Procurement and Supply Certificate" that is a recognised qualification of the Chartered Institute of Procurement & Supply.

Safeguarding

- The Safeguarding Vulnerable Persons Policy was reviewed in July 2021 and makes reference to modern slavery.
- The Safeguarding Team have added Modern Day Slavery to the level 3 training and the induction training for the Trust.
- The safeguarding crib sheets has a modern day slavery tick box option for staff who are raising concerns if they feel that the patient is a victim of modern day slavery.
- It has been made very clear to staff during training that modern day slavery is a crime and so if a patient is at risk of MDS or is believed to be a victim then the Police should be contacted.

Recruitment

The Trust has a robust recruitment policy and follows all the NHS Employment checks standards including right to work and identity checks. The checks standards are rigorously applied to all prospective employees and bank workers, whether in paid or unpaid employment. Agency staff are sourced through Agencies listed on the approved Procurement Framework (s).

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2023.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 March 2023					
SUBJECT:	Chairman's Annual Fit and Proper Persons' Declaration					
PRESENTED BY:	Lisa Ward, Director of People					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☐	☐	☐	☒	☐	☐
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5). The report sets out the Chair's annual declaration of compliance and has been informed by compliance with the agreed Board procedure; assurances from NHSE regarding non-executive directors; individual declarations of interest and an annual individual declaration of compliance with the regulations.					
RECOMMENDATIONS:	The Board of Directors is recommended to: • Note the assurance given by the Chairman that he is confident the Trust is compliant with regulations and that the Board meets the Fit & Proper Persons criteria.					
CONSIDERATION 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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FIT AND PROPER PERSONS REQUIREMENTS: DIRECTORS AND NON-EXECUTIVE DIRECTORS

CHAIRMAN'S ANNUAL DECLARATION

In line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust is required to ensure that all individuals appointed to or holding the role of Executive Director (or equivalent) or Non-Executive Director meet the requirements of the Fit and Proper Persons Test (Regulation 5).

The Fit and Proper Persons Test will apply to Directors (both executive and non-executive, whether existing, interim or permanent and whether voting or non-voting) and individuals *"performing the functions of, or functions equivalent or similar to the functions of a director".*

Regulation 5 states that a provider must not appoint or have in place an individual as a director who:

- is not of good character;
- does not have the necessary qualifications, competence, skills and experience;
- is not physically and mentally fit (after adjustments) to perform their duties.

Regulation 5 also decrees that directors cannot have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity.

These requirements play a major part in ensuring the accountability of Directors of NHS bodies and outline the requirements for robust recruitment and employment processes for Board level appointments. [In exceptional circumstances, Trusts may allow an individual to continue as Director without having met the requirements following approval of the Chairman and following an assessment of all elements of risk.

As Chairman of North West Ambulance Service NHS Trust, I confirm that all existing Executive and Non-Executive Directors (both permanent and interim) meet the requirements of the Fit & Proper Persons Test.

My declaration has been informed by:

The application of the Board approved Procedure on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:
    - Proof of identity
    - Disclosure and Barring Service check undertaken at a level relevant for the post
    - Occupational Health clearance
    - Evidence of the right to work in the UK
    - Proof of qualifications, where appropriate
    - Checks with relevant regulators, where appropriate
    - Appropriate references, covering at least the last three years of employment, including details of gaps in service.

- Additional checks for all Directors on the following appropriate registers:
    - Disqualified directors
    - Bankruptcy and insolvency

- Confirmation from the Chair of appointment panels of compliance with the checks process

- All new appointments for Non-Executive Director positions are undertaken in conjunction with NHSE. The pre-employment checks undertaken by NHSE checks are shared with the Trust so there is a retained record in the Trust of the individual's fitness to undertake their role as Non-Executive Director.
- A review of checks by NHSE in circumstances of the reappointment of Non-Executive Directors to ensure that they remain 'fit and proper'.
- Assessment of the Ongoing Independence of Non-Executive Directors carried out by the Director of Corporate Affairs.
- Annual and on-going Declarations of Interest for all Board members.
- Annual Fit & Proper Persons Test self-declarations completed by all Executive and Non-Executive Directors.
- Annual audit of the personal files has been undertaken to ensure that the files remain up to date and in line with the regulations.
- The Trust completed the MIAA Fit and Proper Persons considerations checklist in January 2023 to provide an additional layer of assurance of our processes. The checklist measures against a best practice approach and no areas of risk were identified. This was reported to Audit Committee.
- If there have been any individual concerns raised regarding Directors during the previous year, the outcome of any investigations is reviewed to provide continuing assurance that Directors remain 'Fit and Proper'.
- The retention of checks data on personal files.

PETER WHITE
CHAIR
March 2023

Relationships or circumstances which may be relevant to the Board's determination of the independence of Non-Executive Directors (The NHS FT Code of Governance, Monitor, July 14)						
	PW	**CB**	**AE**	**DH**	**DR**	**AC**
Has been an employee of the NHS Trust within the last five years	No	No	No	No	No	No
Has, or has had within the last three years, a material business relationship with the NHS Trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS Trust	No	No	No	No	No	No
Has received or receives additional remuneration from the NHS Trust apart from a director's fee, participates in the NHS Trust's performance-related pay scheme, or is a member of the NHS Trust's pension scheme	No	No	No	No	No	No
Has close family ties with any of the NHS Trust's advisers, directors or senior employees	No	No	No	No	No	No
Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies (Cross-directorships are where: an executive director of organisation A serves as a NED in organisation B and, at the same time, an executive director of organisation B serves as a NED at organisation A.)	No	No	No	No	No	No
Has served on the board for more than six years from the date of their first appointment	9 years	1 year	2 years	4 years	4 years	4 years
Is an appointed representative of the NHS Trust's university medical or dental school.	No	No	No	No	No	No

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Charitable Funds Committee			
Date of Meeting:	9th February 2023	**Chair:**	David Rawsthorn
Quorate:	No Due to the unplanned absence of Dr D Hanley, it was agreed to continue with the meeting and make decisions, subject Dr D Hanley's consideration/approval via email.	**Executive Leads:**	Carolyn Wood, Director of Finance Angela Wetton, Director of Corporate Affairs
Members Present:	Mr S Desai, Director of Strategy, Partnerships & Integration Mr G Blezard, Director of Operations Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs C Wood, Director of Finance	**Key Members Not Present:**	Dr D Hanley, Non-Executive Director Mrs C Butterworth, Non-Executive Director

Link to Board Assurance Framework (Strategic Risks): N/A

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Hardship Fund Update	An update was provided in relation to the Hardship Fund and it was noted that 150 staff had applied for the scheme as at the end of December 2022.	Noted the assurances provided.	

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

	Although it was accepted 20 of these had not been processed for viable reasons. The Committee noted a total spend of £32,750 to date and that the allocated funds would be exhausted by mid-March. Within the report, there was a proposal to approve a further £25,000 to be allocated from general funds to continue with the scheme until June 2023.	The Committee considered the proposal and decided that the additional funding should be sufficient to cover up to the end of August, rather than June. Subject to the agreement of Dr D Hanley, the Committee agreed a further £50,000 would be allocated from general funds to continue with the scheme until August 2023. Future updates to be received in relation to spend against budget at future meetings.	
Restricted Funds Update	An update report was provided to the Committee in relation to the status of a number of restricted funds and the progress to date in reducing these funds. The Committee noted the work undertaken to apply the legal test in reviewing available records and the exercise on station specific funds to ensure the charity only retained funds allocated to a particular location. In addition, the Committee noted the progress of the work being undertaken by the Head of Charity in engaging with local teams to use the funds within their restrictions for impactful grant making.	Subject to the agreement of Dr D Hanley, agreed that the Head of Charity should continue working with local teams to expend the funds. Future updates to be provided to the Committee.	

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

Aims and Objectives	The Committee were presented with the proposed new Purpose, Aims and Objectives for the NWAS Charity for approval. Committee members provided feedback and agreed further work was required to provide clarity.	Subject to the agreement of Dr D Hanley, agreed the revised purpose, aims and objectives in principle however noted the further work required.	

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:	29th March 2023					
SUBJECT:	Integrated Performance Report					
PRESENTED BY:	Director of Quality, Innovation, and Improvement					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☒	☐	☐	☐
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					

EXECUTIVE SUMMARY:

The Integrated Performance Report for March 2023 shows performance on Quality, Effectiveness, Operational Performance, Finance and Organisational Health during **February 2022** unless otherwise stated.

Quality:

- **Complaints and Incidents:** whilst overall numbers of complaints and incidents remain stable the number of serious complaints (scoring 4-5 on risk assessment) and incidents has increased. In both cases the data are showing increases on the SPC charts (special cause variation), however, the closure rate for complaints continues to improve and the backlog of outstanding complaints is being managed.
  The most common reasons for incidents being reported include: care and treatment issues; call handling; violence and aggression and delays. For the second consecutive month we have reported high numbers of serious incidents (n=12) compared with our average (n=5).
- Incidents risk scored 1-3 completed within SLA (Service Level Agreement) has deteriorated over the few months, with February seeing our lowest performance in 5 years The 8 most common themes for incidents reported since the introduction of Datix Cloud IQ in February, were:
  - care and treatment (97),
  - call handling (78),
  - violence and aggression (67),
  - delays (51),
  - accidents and injuries (38),
  - communication (36),
  - road traffic collisions with vehicle (24) and
  - medicines: general (20)

Effectiveness:

- **Patient Experience:** We continue to take seriously all feedback received by patients via the friends and family test. This month, of

concern were issues raised related to pick up times and the responsiveness of our PTS control. Both issues are being managed by PTS operations.

- **Patient Experience:** across all areas we saw increases in returns in February 2023, in particular the 111 survey. This large increase in return is attributed to delivery and collection issues associated with the postal strikes being remedied.
- **Ambulance clinical quality indicators:** Outcomes for cardiac arrest remain stable, however, STEMI care bundle is impacted and has been at 70% since April 2022
- **Survival to Discharge – Utstein Performance:** Whilst this has remained in control limits, we have now seen 3 consecutive months where this is below the mean, with the previous 2 months decreasing consecutively to circa 20%

Operational Performance:

- **Activity and Outcomes:** incident volume has decreased and the number of contacts with 'no outcome' has also dropped. Both H&T and S&T have stabilized at 15% and 27% respectively resulting in a total non conveyance of 42%.
- **National Positioning:** NWAS remain 2nd in terms of Hear & Treat performance (14.8%), middle of the pack in 6th re See & Convey (57.8%) and 11th in terms of See & Treat (27.4%).
- **999 ambulance response times:** in control, 97% of calls were picked up within 5 seconds. Response times have improved across all category of calls with performance much closer to national standards,
- **ARP Standards:** The standards were met for one ARP standard C1 90th. Long waits for C1 and C2 incidents also reduced to **n=543** and **n=2,048** respectively.
- compared to December at n=45,664
- **Call Pick Up:** this has seen a significant improvement in February 2023, with the overall mean answer being 2 seconds (compared to 82 seconds in December)
- **Average Turnaround Time:** Average turnaround time has decreased but continues to be above the national standard of 30:00 with a turnaround time of 38:35. This is the lowest turnaround time since May 2022 and the third lowest since January 2022.
- **111:** the data show an improved position for access to a clinician and warm transfer to a clinician. The calls answered within 60s and call back rates continue to be a focus for improvement.

Finance

- The year to date expenditure on agency is £3.8m which is £0.167m under the year to date ceiling of £3.97m.
- As at month 11 (February) the trust is recording a surplus position for the year to date of £4.073m. As at month 11 (February) the trust has delivered the planned level of efficiency of £13.673m

Organisational Health

- **Sickness**: **Sickness**: The overall sickness absence rate for the latest reporting month (January 2022) was 9.11%.
- **Turnover** . has increased to 12.08%. All service lines have seen a slight increase in turnover. PTS is signifying special cause with both January and February above the upper limit. Robust plans are in place to deliver additional staffing in this area.
- **Appraisal:** . The overall appraisal completion increased to 83%.

	• **Mandatory Training:** Overall compliance is slightly behind trajectory at 82% There is a concerted focus on classroom and online compliance to deliver improvement in March.
RECOMMENDATIONS:	The Board of Directors are asked to: • Note the content of the report • Note the number of incidents risk scored 4-5 remains above normal limits. • Note the decrease in handover times and improvement in ARP performance although still above targets. • Note that long waits for C1 & C2 have decreased in January/February. • Clarify any items for further scrutiny
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	27th March 2023		
	Outcome:	Not known at time of submission		

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1 PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **February 2023**. 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

- Overall numbers of complaints and incidents remain stable (n=193) the number of serious complaints (scoring 4-5 on risk assessment) and incidents has increased. In both cases the data are showing increases on the SPC charts (special cause variation), however, the closure rate for complaints continues to improve (Figure Q1.5) and the backlog of outstanding complaints is being managed.
- The most common reasons for incidents being reported include: care and treatment issues; call handling; violence and aggression and delays. For the second consecutive month we have reported high numbers of serious incidents (**n=12**) compared with our average (**n=5**)
- An agreed target of open complaints has been set to **n=180**. Overdue complaints have stood at fewer than **n=55** since July 2022.
- 75% of level 4-5 complaints were closed within the agreed time frames, the highest performance we have seen over the last 5 years.
- **n=105** Compliments were received in February. The number reported for February is likely to increase as compliments continue to be processed throughout March.
- During February 2023 there were **n=12** serious incidents reported on the StEIS database, whilst this is lower than the peak seen in January 2022 (**n=20**), we remain at the upper control limit in terms of overall performance.
- In February 2023, **n=678** internal and external incidents were opened against a 12-month average of **n=1,012**.
- There were **n=48** incidents risk scored 4-5 which represents a significant increase and signals a potential impact to the number of SIs that will be reported once reviewed.
- Incidents risk scored 1-3 completed within SLA (Service Level Agreement) has deteriorated over the few months, with February seeing our lowest performance in 5 years. The reasons (being multi-factorial) include: the significant increased number of SIs and operational pressures (including industrial action) which has negatively impacted on the closure of low scoring incidents. Supportive measures

are in place to increase compliance, including supportive collaborative work with service lines.

- The 8 most common themes for incidents reported since the introduction of Datix Cloud IQ in February, were:
    - care and treatment (**n=97**),
    - call handling (**n=78**),
    - violence and aggression (**n=67**),
    - delays (**n=51**),
    - accidents and injuries (**n=38**),
    - communication (**n=36**),
    - road traffic collisions with vehicle (**n=24**) and
    - medicines: general (**n=20**).

2.2 Effectiveness

Patient experience

- February 2023 saw **n=337** PES responses, the third highest we have seen in the last 12 months with 90.8% identifying "Very good/good" as the outcome.
- For PTS we saw **n=1204** responses in February 2023, this was 9.8% higher compared to December (**n=1,098**). The overall experience score for February was 91.4% is slightly higher than the 91.3% reported in December, by 0.1%.
- The NHS 111 service returns from February of **n=114** are 29.5% higher in comparison to December's return of **n=88**. The large increase in return is attributed to delivery and collection issues associated with the postal strikes being remedied.
- For NHS 111 First the returns for February of **n=104** are 8.3% higher compared to December's return of **n=96**. In February, 97.4% respondents described their overall experience as 'very good/good', an uplift of 21.3% when compared to the month of December at 76.1%.
- NHS 111, In addition to the above point, 93.3% of respondents 'felt their need for calling NHS 111 was met', an increase of 4.8% against the month of December at 88.5%.

Ambulance Clinical Quality Indicators (ACQI's)

October 2022's data see us within normal limits and close to the mean across all indicators apart from the Stroke care bundle, which was on the lower limit when last reported (August). 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 49.2% (national mean 46.8%). For the overall group the rate was 31.7% (national mean 25.5%).
- Survival to Discharge rates in October 2022 were at 7.8% (national mean 7.7%).
- In October 18.6% of patients in the Utstein group survived to hospital discharge. The national mean at 22.6%.
- Mean call to PPCI time in October for patients suffering a myocardial infarction was below the national mean of 2h 48mins; the Trust's performance was 2h 38mins.
- Mean call to hospital time in August for patients suffering a hyper acute stroke was below the national mean of 1h 59mins. The trusts performance was 1h 52mins.

- The Stroke Care Bundle performance was not reported for October in line with the NHSE schedule.
- The Stemi Care Bundle performance for October was 68.5%. The national mean at 72.2%

The SEPSIS ACQI Bundle has been stood down following national agreement in May 2022. The has been archived and will no longer be reported in the IPR

A new Falls ACQI Bundle has been stood up following national agreement in May 2022. The first return for this national audit was due in December 2022 and this was not submitted. The second return was due in March 2023 and this has not been submitted. Work is ongoing to renew processes using APEX to mitigate the risk of non submission of the audit data and to ensure submission of the next return due in June 2023 for the Falls ACQI Bundle.

Hear & Treat, See & Treat, See & Convey

- For February we achieved 14.8% Hear & Treat and ranked 2nd nationally.
- See & Treat we achieved 27.4% and we are ranked 11th nationally.
- In total there was an aggregate non-conveyance of 42.2%.

Hear & Treat data points appear to have remained static over the February period. Weekly hear & treat figures in February are over 14% and have not fluctuated to the degree seen throughout December. The level of H&T in February is higher than any levels seen during 2022.

Previously, the improved picture was managed through EMA (Emergency Medical Advisor). Performance has seemingly worsened for the last few weeks and special cause variation has moved performance from the upper control limit, to the bottom control limit. Given the reduction in overall demand, coupled with increased availability of resource also reduces the conversation rates to hear and treat, more work is required to understand this drop in hear & treat percentage.

See and treat results have moved to the upper control limit in the last few weeks of February 2022, this appears to correlate with the reduction in hear and treat performance for the same period.

2.3 Operational Performance - Patient Emergency Service (PES)

Activity: In February 2023, the Trust received **n=97,181** calls of which **n=79,935** (82%) became incidents. Compared with January 2022, we have seen an 12% decrease in calls and a 6% decrease in incidents.

There is no overt reason for the step-change in call-volume, however it has been noted to be a national trend. There has been a notable reduction in calls attributed to flue like or COVID symptoms, which may suggest the Strep A, COVID and seasonal flu increases are ending.

For February duplicate calls stood at **n=17,053**, compared to December at **n=45,664**. No outcome incidents (which includes those cancelled or close through sign-posting) sat at 12,245 versus Decembers 30,178. When appraising the overall NWAS demand, all indicators suggest a significant decrease in demand on the service.

- **Call volume:** call volume is -14% above the equivalent month for 2022.
- **Call Pick Up** has seen a significant improvement in February 2023, with the overall mean answer being 2 seconds (compared to 82 seconds in December) and 95% sitting at 1 second (compared to 285 seconds for December).

Call pick up has improved significantly in February, this is due to a decrease in demand, coupled with an increase in available EMAs. Due to ongoing recruitment, established EMAs increased to **n=405** (from **n=360** throughout December). Abstractions have also reduced for the call-handling service line, increasing the number of call-takers available on any given day.

Despite the national reduction in demand, NWAS continues to perform above the national average, ranked 1st for the month of February. Given current recruitment trajectories it is anticipated that CPU will be maintained.

Ambulance Response (ARP) Performance

Category	Standard	February 2023 Actual
C1 (Mean)	7:00	8:10
C1 (90th)	15:00	13:46
C2 (Mean)	18:00	22:36
C2 (90th)	40:00	44:20
C3 (Mean)	1:00:00	1:36:27
C3 (90th)	2:00:00	3:38:37
C4 (90th)	3:00:00	5:50:39

For February response time targets were only met for C1 90th. All the ARP standards have seen an significant downward trajectory in January with a smaller upward trajectory in February. This signalled significantly improved response times across the board with a far less significant increase in February. The data are signalling an improvement with a new phase from wc 9th January across all ARP measures. The primary drivers are:

1. Handover times have decreased significantly, having a subsequent effect of reducing overall job cycle time.
2. Significant decrease in overall activity, coupled with improvements within call pick-up and maintenance of hear & treat levels has provided an opportunity for improved operational performance.
3. Industrial action dates throughout January and February have provided significant challenge to operational responses and increased the overall response times reported for these months.

Overall NWAS continue to perform better than the sector in respect to C1 and C2, ranking 3rd and 1st respectively. This is reflective of the specific effort taken by service delivery teams to maintain and improve response times to the most unwell patients who contact the service.

Handover has significantly improved for the month of January and February, which has offered an opportunity for improved response times for the patients of the Northwest.

Despite a reduction in activity, the utilisation of Category 3 and 4 validation, coupled with the use of the NHS Pathways triage system has resulted in the trust maintaining high levels of Hear & Treat, ensuring that operational resources are targeted towards the sickest patient groups. During periods of surge, or significant challenge (e.g. Industrial Action), the trust has successfully shifted its clinical workforce to focus further on secondary triage, undertaking proportionate changes to its response model to keep patients safe.

Handover

- Average turnaround time has decreased but continues to be above the national standard of 30:00 with a turnaround time of 38:35. This is the lowest turnaround time since May 2022 and the third lowest since January 2022.
- From early January the data has signalled an improvement with a new phase in both Average turnaround time and the number of patients waiting outside A&E. This correlates with improvements in ARP performance at the same time.
- It should be noted that during February both average turnaround time and the number of patients waiting outside A&E have increased but are within normal limits.
- **n=4,547** attendances (11.2%) had a turnaround time of over 1 hour, with **n=366** of those taking more than 3 hours. There were **n=514** delayed admissions in February, with total accumulated hours of **n=905**.
- 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 and February/ March with more planned during April 2023. A move towards a more system-based approach has seen the spread of responsibility for handover performance.

C1 & C2 Long Waits

Long waits for C1 saw a decrease to **n=694** in January and to **n=543** for February. This is the lowest level of long waits since April 2022.

The number of C2 long waits decreased from **n=4,631** in January 2023 to **n=2,048** in February. This is lowest number of long waits overall since March 2022.

Reduction in overall demand and activity, coupled with improved handover times and maintained levels of hear and treat have driven these positive improvements. The risk in the waiting stack continues to be mitigated by the clinical co-ordination desk (CCD). The CCD utilises Advanced Practitioners to review the waiting stack and identify high risk patients and take appropriate action, this may include expediting care through an upgrade, facilitating telephone triage or dispatching a specialist resource.

2.4 Operational Performance - NHS 111

Measure	Standard	February 2023
Calls Within 60s	95%	37.9%
Average Time to answer		4m 56s
Abandoned Calls	<5%	16.9%
Call back Within 10 min	75%	12.5%
Call back Within 20 min	90%	17.2%
Average Call Back		49m 49s
Warm Transfer to Nurse	75%	28.5%

February has seen a decrease in the call demand for 111, compared to the previous two months. The service saw **n=191,554** calls offered compared with **n=207,331** in January. **n=122,927** of those calls were answered, **n=25,009** abandoned and the additional calls redirected via IVR signposting.

Demand drivers within February were primarily due to the Government and NHS guidelines on strep A, winter pressures and Industrial action. 'In-hour' call demand continues to drive demand and ongoing efforts are being made in collaboration with Primary Care Networks to investigate the variability of 111 usage between different practices.

Answered in 60 decreased from 41% in January to 38% in February with call abandoned increasing to 17% in February from 15%. Average time to answer saw a decrease to 4 minutes 56 seconds, pushing the metric into special cause just below the lower control limit. The decline in performance was partly attributed to the resource gap between the available capacity and the overall demand for services. Several factors such as variation at the interval level, staff sickness, attrition, and industrial action also played a significant role.

Efforts to improve this situation are underway and closely monitored within the framework of the 111 people plan. Strategies to mitigate the resource gap and address the underlying challenges are being prioritized to improve the overall performance of the service.

The demand pressures on the 111 service continue to directly impact the clinical queue, with all clinical performance metrics below target. Nevertheless, February has seen marginal increases in all clinical performance metrics. Warm transfer is showing special cause, improving from 26% in January to 28% and Average time for call back in February was at 47 minutes and 49 seconds from 1 hour 6 minutes in January. Average time for call back is now below the lower control limit. Call back in 10 and 20 have also seen improvements, call back in 10 has risen to 12% reaching the upper control limit and call back in 20 to 17%, showing special cause above the upper control limit. 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 January for the Trust was 21% below contract baselines with Lancashire and Cumbria 33% and 34% below baselines respectively. Year to date July 2022 - January 2023) is performing at 17% below baseline.

2.7 Organisational Health

<u>Sickness</u>

The overall sickness rate for January 2023 was 9.11% which includes COVID-19 related sickness of 0.80%. Covid sickness at this point is at its lowest rate for the last two years. This reduction continues to be facilitated through phased return to works and adjusted duties for some Long Covid sufferers to ease back towards their substantive roles and hours however clearly some people continue to remain unwell with longer term effects or new short term following infection or re-infection. Symptoms of those re-infected do appear to be much less severe than previous Covid strains.

In the 6 months since the transition back from temporary Covid Terms and Conditions onto normal sick pay arrangements, we have seen the majority of our covid related long term cases return to work.

Underlying non-COVID sickness is starting a downturn towards pre seasonal levels with January's non-Covid sickness rate back at 8.31% following December's peak. Data analysis continues to show the top 5 reasons for absence being Mental Health, Covid, Injury, MSK and Back problems.

The Trust Attendance Improvement Team continues to support management of attendance and delivery of a workplan informed by regional and national best practice with a 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 February 23 is 12.09% showing a very small decrease 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 remained steady in the last 12 months and has been tracking below national average since October.

- PTS turnover is of concern at 12.93% exceeding the upper control limit, however robust plans are in place to deliver additional staffing in this area.
- EOC turnover is at 14.27% in February. This has shown a small decrease since the last report.
- 111 turnover continues to stabilise with a slight decrease to 34.94% from 36% in December 22.
- 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 and has been stable for 6 months. 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, although no adverse impact is currently being seen.

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 February shows continuing agency usage however that position has reduced by 10 WTE. 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 –3.61% in February 2023. This is a slight widening from 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.
- Recruitment plans for 111 remain a risk. The current vacancy position is -14.73% (OH5.5) with vacancies being focused in the Health Advisor and Clinical Advisor roles. 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 at -8.8% (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.
- The vacancy position for PES (OH5.3) and EOC (OH5.4) are both within -1.5% of establishment which is an improved position in line with the delivery of intensive recruitment plans.

Appraisal

- Appraisal completion rates are at 83% for February 23 (OH6.1) which exceeds target.
- All service lines are 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 made strong improvements since last report and are now ahead of target.
- 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 behind target at 71% which is mainly a result of the impact of MACA training and industrial action. PTS classroom attendance is ahead of trajectory at 81%. There is a risk that due to industrial action, PES may not achieve the 85% target by end March 23. Additional course places have been profiled for March in order to provide capacity to recover to the 85% target.

Overall compliance is slightly behind target 82%. This is partly influenced by the position in relation to classroom training with the main driver being PES compliance levels. There is a concerted focus on classroom and online compliance to deliver improvement in March. EOC, 111 and Corporate are slightly exceeding the target.

Case Management

- Overall case levels have increased since the last report to Board with +9 disciplinary cases and + 11 grievance cases. Whilst fluctuations are expected, there are no underlying themes in relation to the increase in numbers or any identified hotspots for the increases.
- Average case times are continuing to reduce.
- The number of suspensions has decreased from 10 to 7. Several cases have exceeded 10 weeks due in the main to complexity and the involvement of third parties
- The disciplinary policy is being presented to Board for approval and it is anticipated that the roll out of this revised policy will bring further improvements and help to resolve some of the inconsistencies in case length and prevalence.

COVID 19

- 193 staff have tested positive for Covid-19 in February 2023. At the end of this reporting period, there was 1 open outbreak on Trust sites.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

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 number of incidents risk scored 4-5 remains above normal limits.
- Note the decrease in handover times and improvement in ARP performance although still above targets.
- Note that long waits for C1 & C2 have decreased in January/February.
- Clarify any items for further scrutiny

North West Ambulance Service NHS Trust

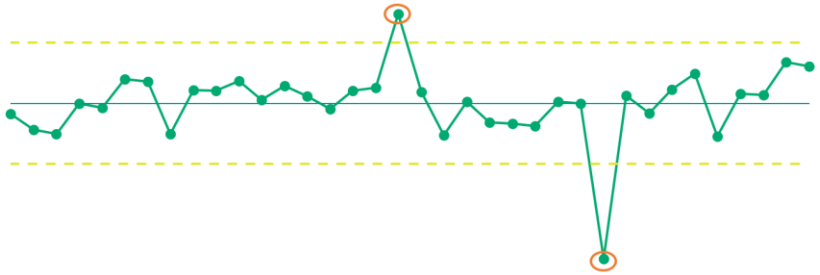
Integrated Performance Report

Board - March 2023

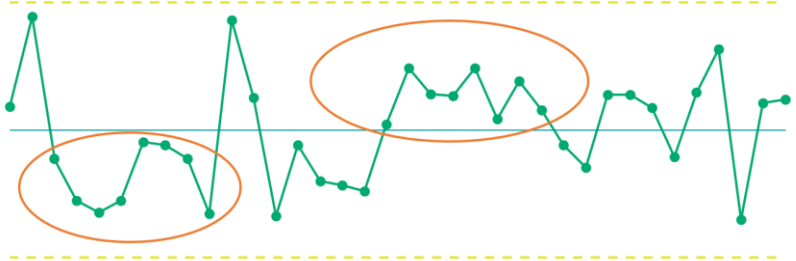
Rules for interpreting SPC Charts

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

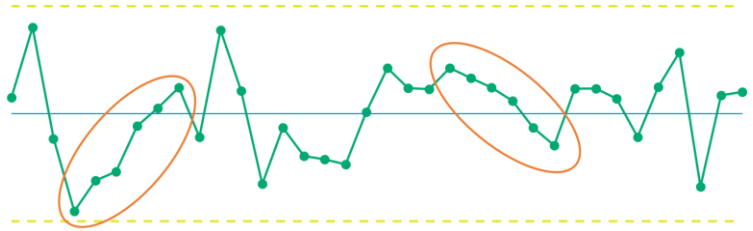
Rule 1: Single data point outside the control limits



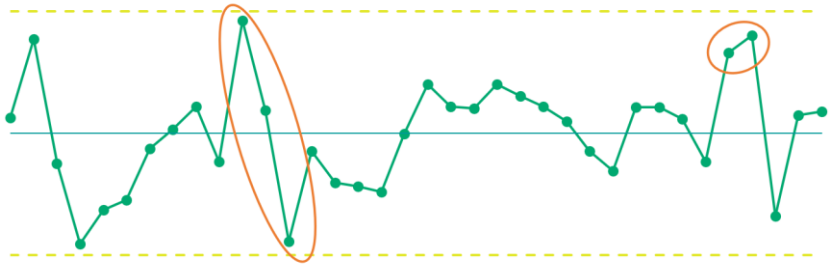
Rule 2: 8 or more consecutive data points above or below the centre line



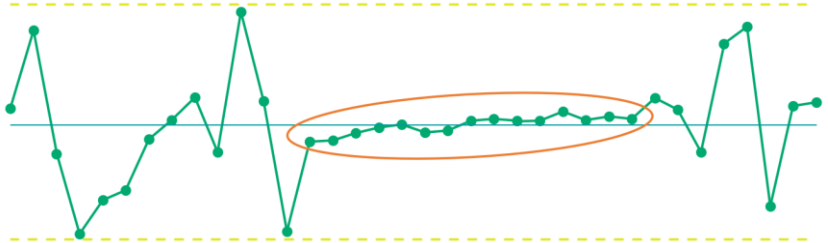
Rule 3: A trend of at least six consecutive points (up or down)



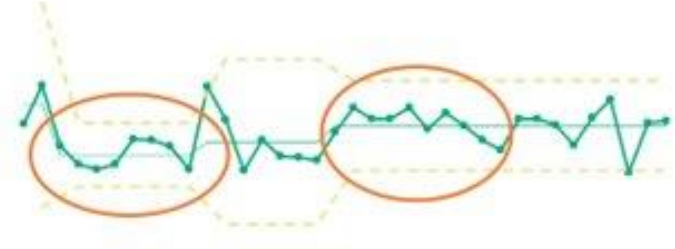
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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

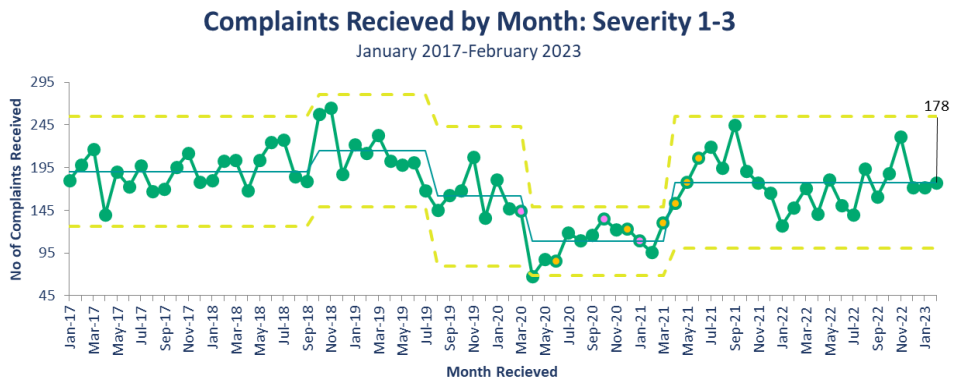


Figure Q1.2

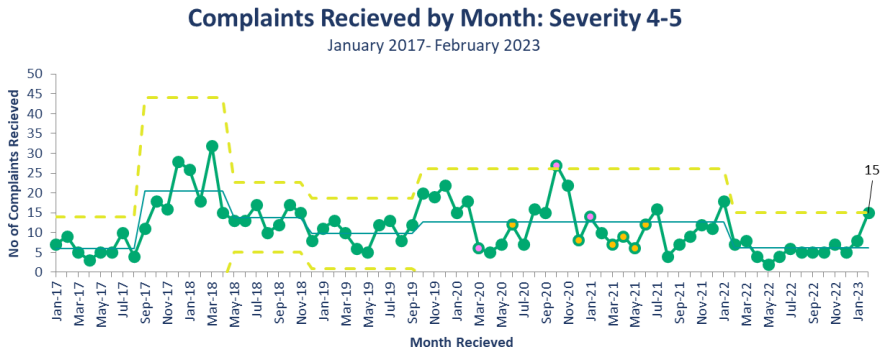


Figure Q1.3

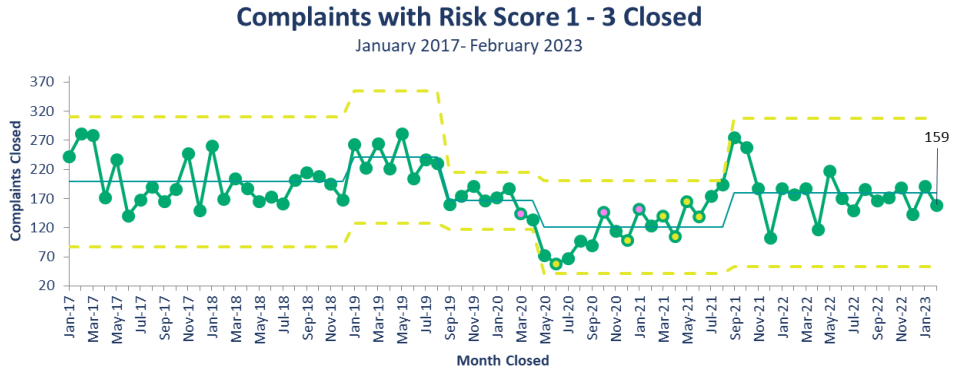


Figure Q1.4

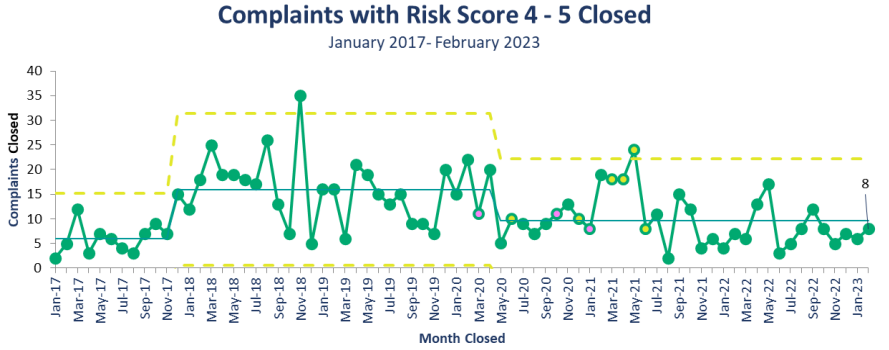


Figure Q1.5

Figure Q1.6

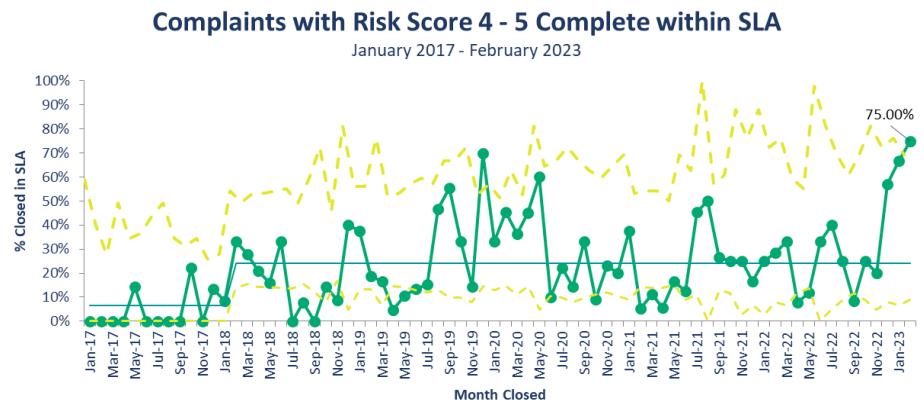
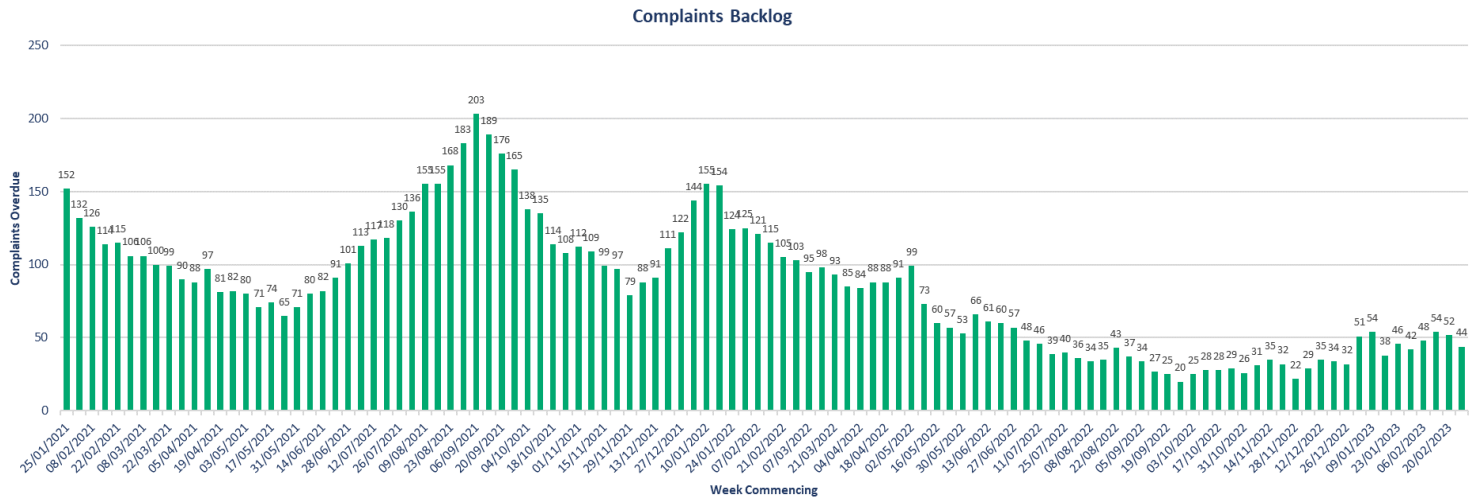


Figure Q1.7



Q2 Incidents

Figure Q2.1

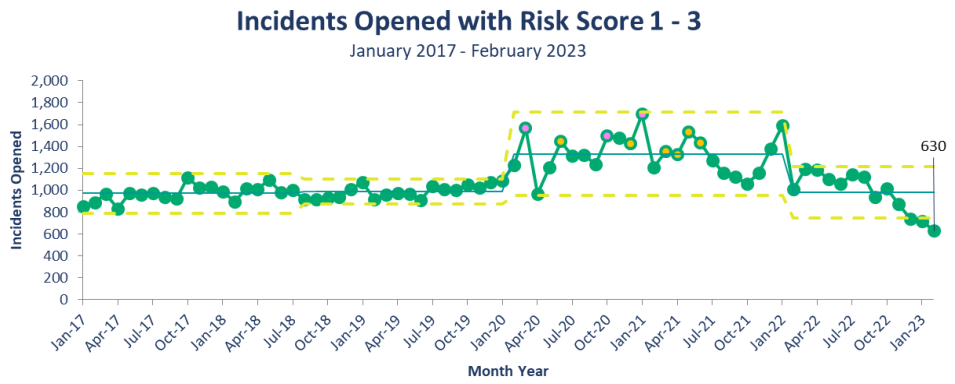


Figure Q2.2

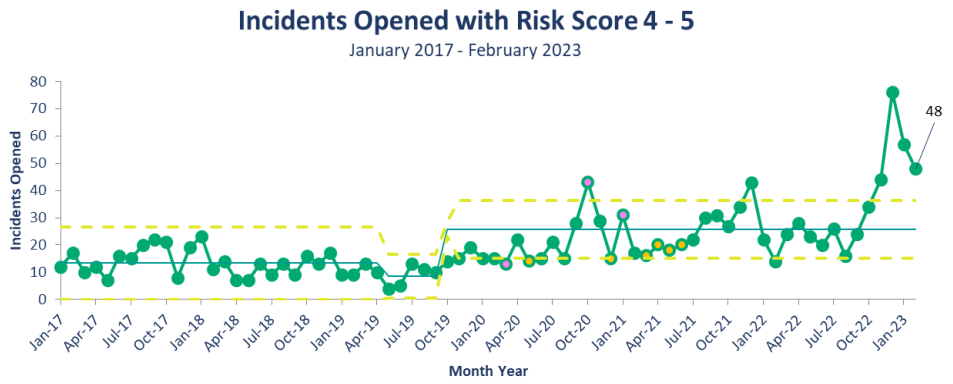


Figure Q2.3

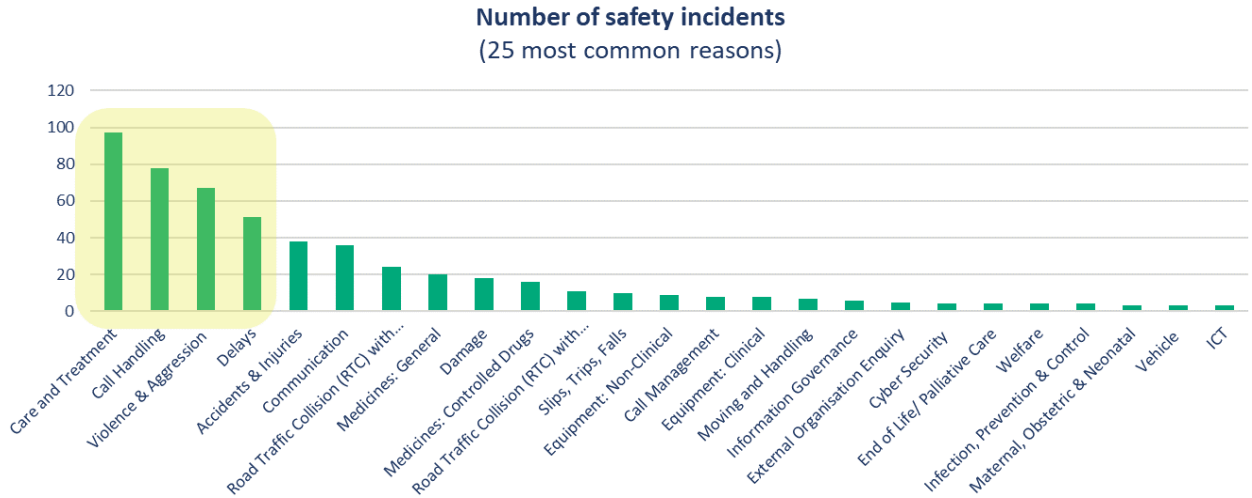


Figure Q2.4

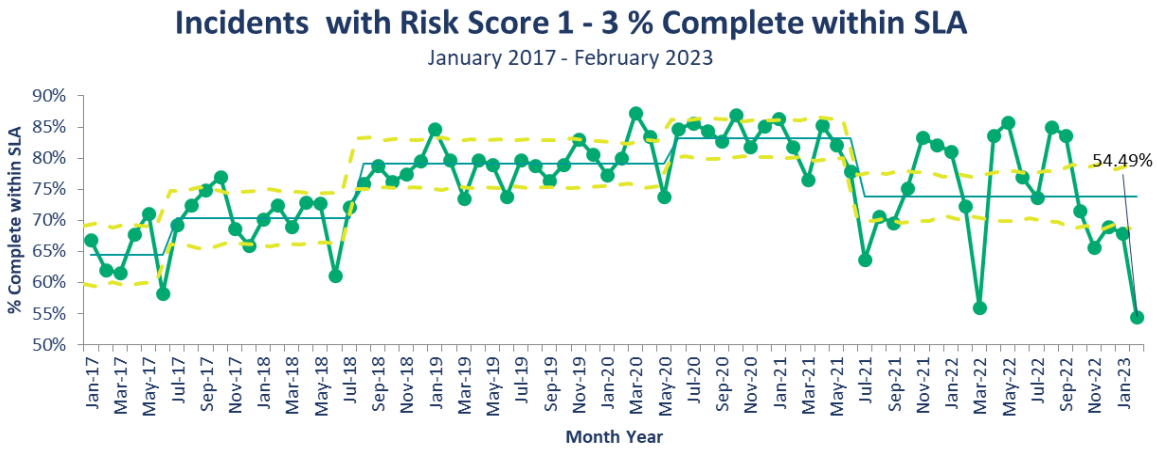
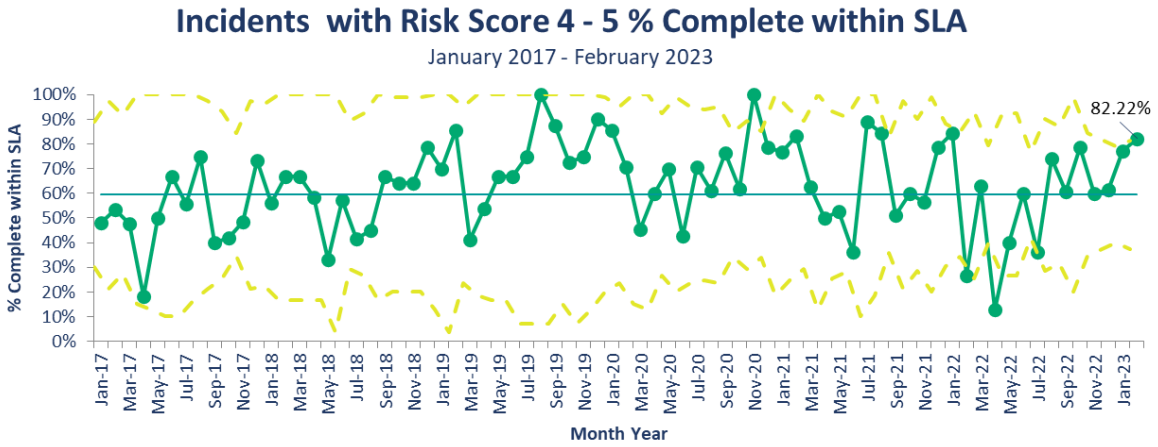


Figure Q2.5



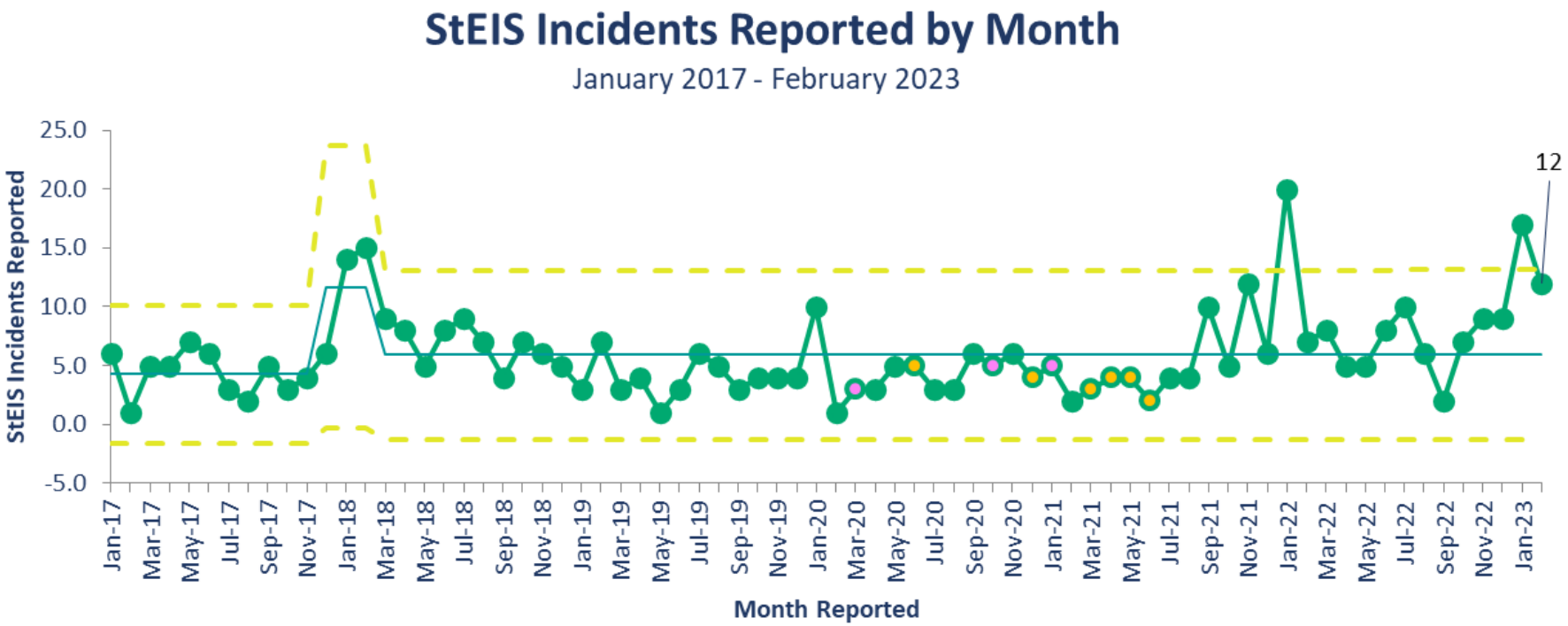
SLAs are calculated using the following measures/targets.

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 (Mar 22 – Feb 23)	Number of Alerts Applicable (Mar 22 – Feb 23)	Number of Open Alerts	Notes
National Patient Safety Alert – NHS England	0	2	0	Use of Oxygen Cylinders where patients do not have access to medical gas pipeline systems. Supplier confirmed no issues, NWAS contacted each accute for confirmation and taken to Medicines optimisation group
National Patient Safety Alert - DHSC	0	2	0	
National Patient Safety Alert - UKHSA	0	2	0	
CMO Messaging	0	6	0	
MHRA – Medical Equipment	1	6	0	
MHRA - Medicine Alerts	56	2	0	Class 2 recall of Amiodarone Injections. All stocks were checked and then re checked, no recalled batch codes were found.
IPC	0	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1

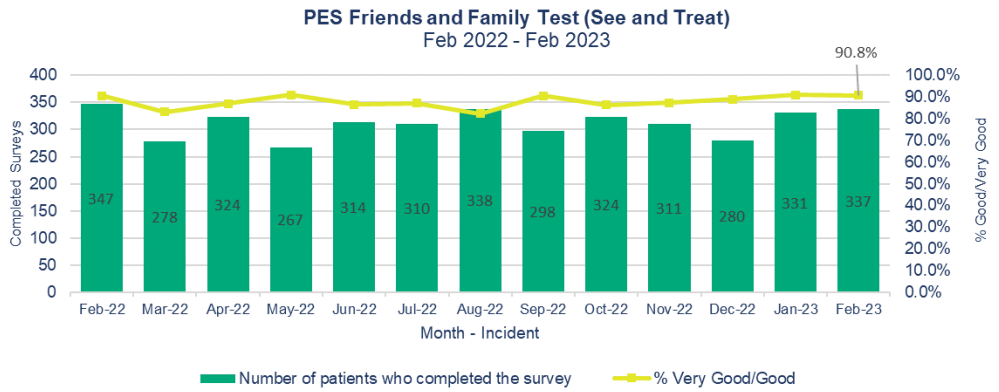
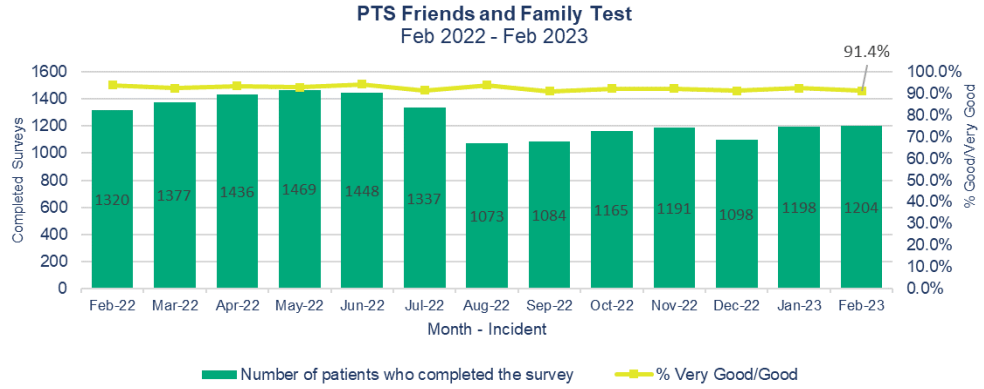


Figure E1.2



Positive

- "Clear communication from responders over the phone, very friendly and capable paramedics who treated my 93-year-old mum with respect and kindness."
- "Excellent communication from the ambulance team who had attended my elderly aunt. They telephoned throughout their visit informing me at all stages what was happening as I don't live with her. They assessed her very quickly and made sure she was safe and well enough to remain at her home."

Negative

- "Asked for an ambulance and was told chronic blood loss isn't an emergency and had to get the patient to hospital myself."
- "I was told to take a 91-year-old man to A&E who needed an X-ray on his hip. Sat there all day with him and a gentleman from the same village came in late in the day and was seen well before my dad."

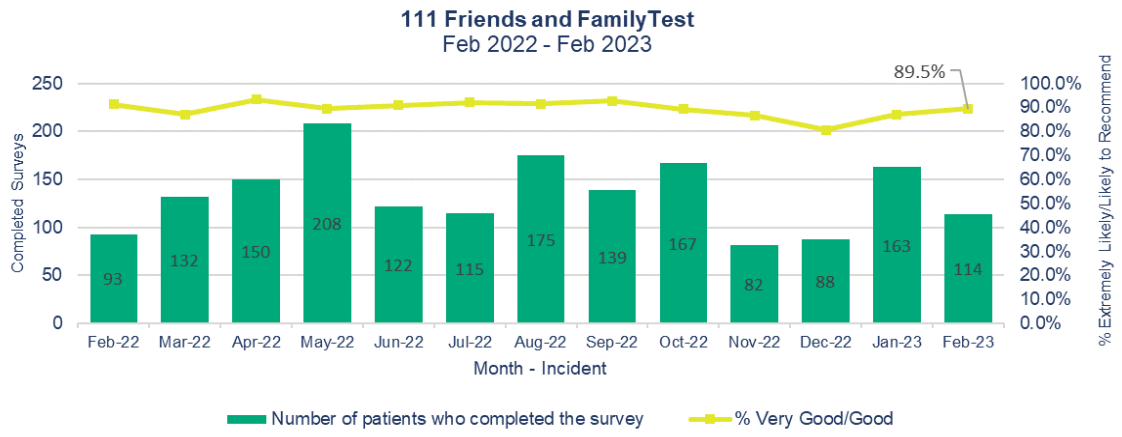
Positive

- "Staff introduced themselves & communicated within a professional but friendly manner and listened to me, reassured me while getting my coat and things (oxygen) that they can help. To take my time and locked my door for me, assisted me safely on to transport ambulance. Thank you."
- "Driver on time, got wheelchair and took us up to the dept. Waited 2 hrs to bring us back. Excellent driver. Good conversation. Asset to PTS. Very comfortable car."

Negative

- "Your service getting me to Chorley Hospital was excellent, but you left me stranded there after my general anesthetic. Nurses on the ward were very frustrated in trying to communicate with you. Eventually contact promised transport at 18:00, nothing arrived by 20:00. No communication to say what was happening, attempts to phone you not answered. Dependent person at home requiring care distraught, forced me to use private taxi costing £52 arriving home 21:00 hrs. Finding a very distraught person to calm and reassure. Not the service promised when the booking was made."

Figure E1.3



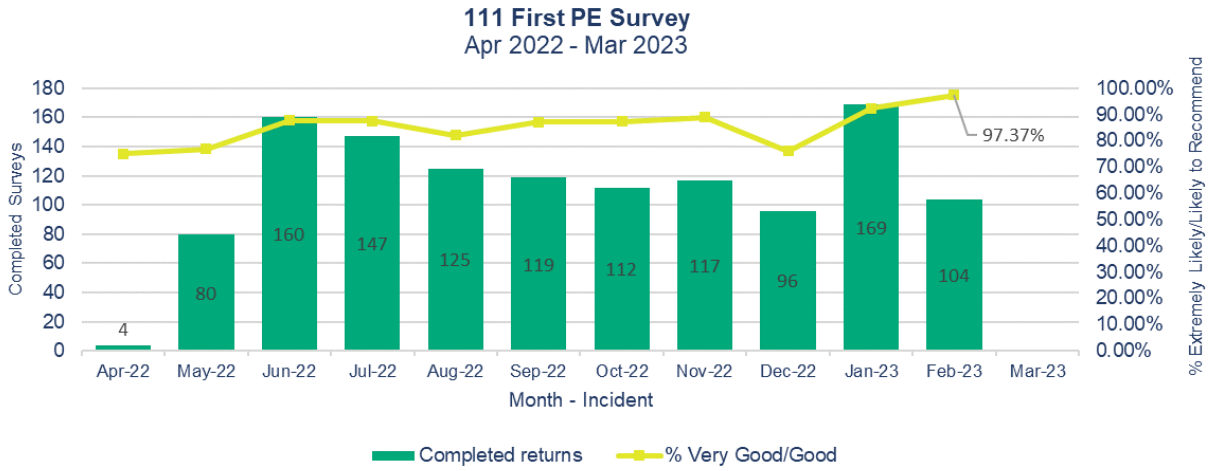
Positive

- "Extremely helpful, arranged for a doctor to visit me at home, good examination, informative, able to ask questions. Overall, a great service."
- "I'm very satisfied with this service because it helped me a lot.... even though my English is not good, they still found me a translator, for which I am extremely grateful."
- "Very quick response. Dealt without judgement and mind put at ease."

Negative

- "It took over 90 minutes for someone to answer the call! There was not a suitable option for treatment or to see a medical professional. No option to see someone in the next few hours or to even offer a medical opinion."
- "Takes far too long to get through call back 18 hours."
- "Was told out of hours doctors call back could be up to 12 hours. after 12 hours an information sheet from NHS website."

Figure E1.4



Positive

- "Call was quickly answered, the person I spoke to was both competent & reassuring and had a good outcome (an ED slot& clear advice to attend)."
- "Always unable to get GP appointment but without exception every time it has been necessary to call 111, their service has been 100% & I have received emergency treatment I needed."

Negative

- "Didn't receive a text, wasted my time as told to go to A&E for 9am. When arrive A&E said makes no difference to us if you rang 111, get in the queue."
- "I didn't need to go to hospital, but the questions asked always seem to point you in that direction and you start believing you actually do."

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

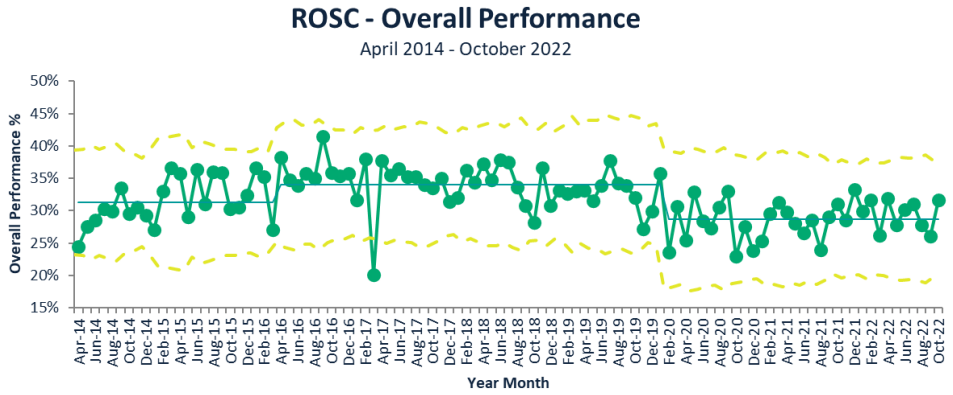


Figure E2.2

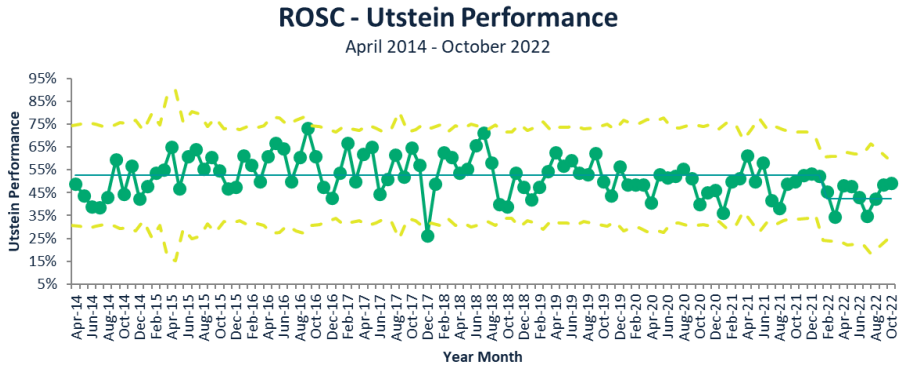


Figure E2.3

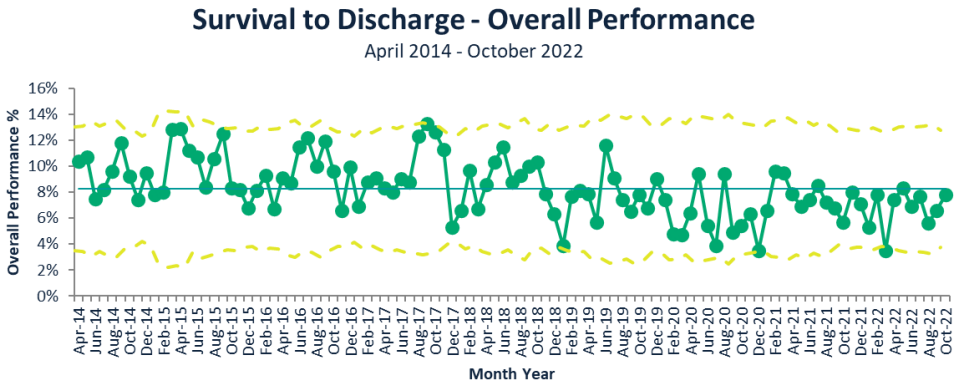


Figure E2.4

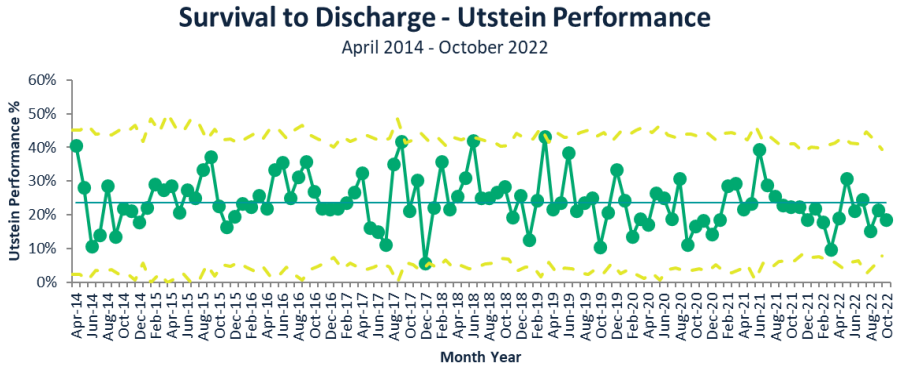


Figure E2.5

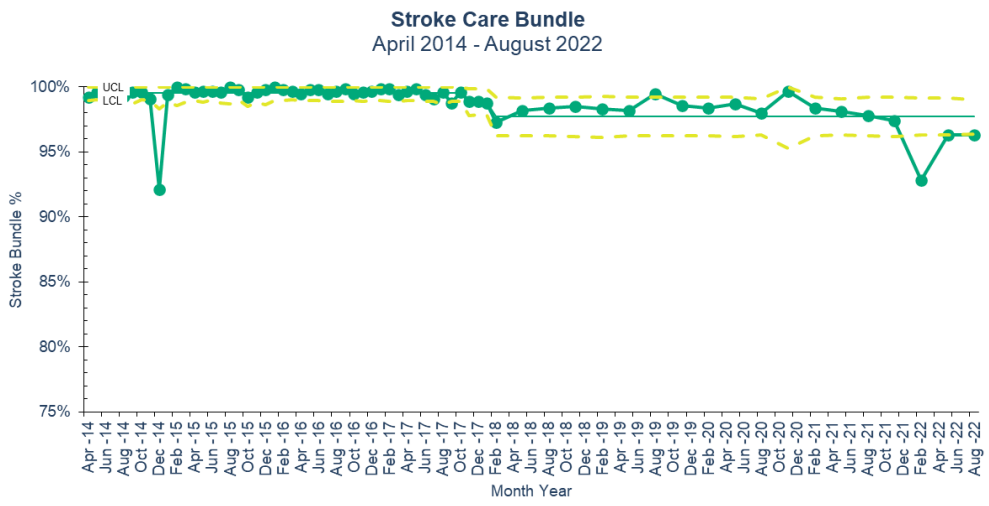
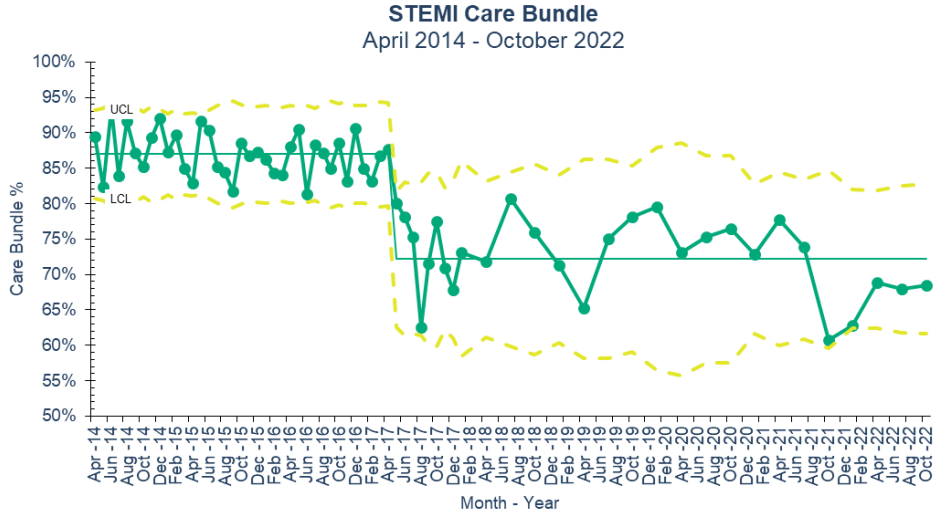


Figure E2.6



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

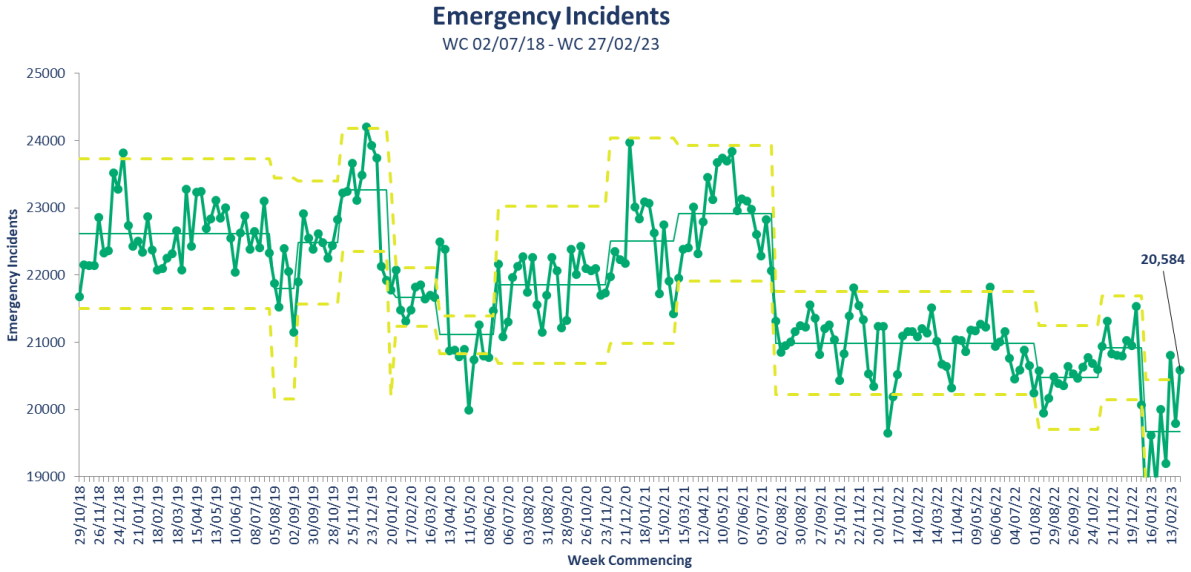


Figure E3.2

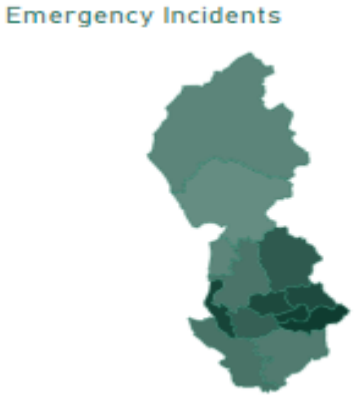


Figure E3.3

Sector	No. of Emergency Incidents
M North	8,487
G South	8,450
G Central	8,430
G East	7,549
G West	7,541
M East	6,406
CL East Lancashire	6,405
M West	5,291
CL South Lancashire	5,144
M South	4,586
CL Fylde	4,327
CL North Cumbria	3,851
CL Morecambe Bay	3,383

Figure E3.4

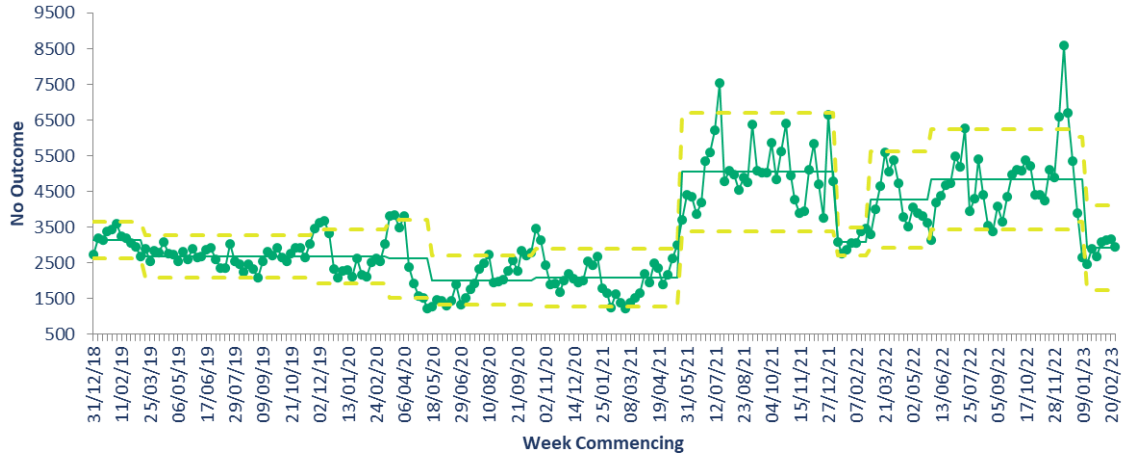


Figure E3.5

Feb	Calls	% Change from previous year	Incidents	% Change from previous year
2020	108,982		89,281	
2021	90,436	-17%	88,997	0%
2022	110,736	22%	84,651	-5%
2023	97,181	-12%	79,935	-6%

Figure E3.6

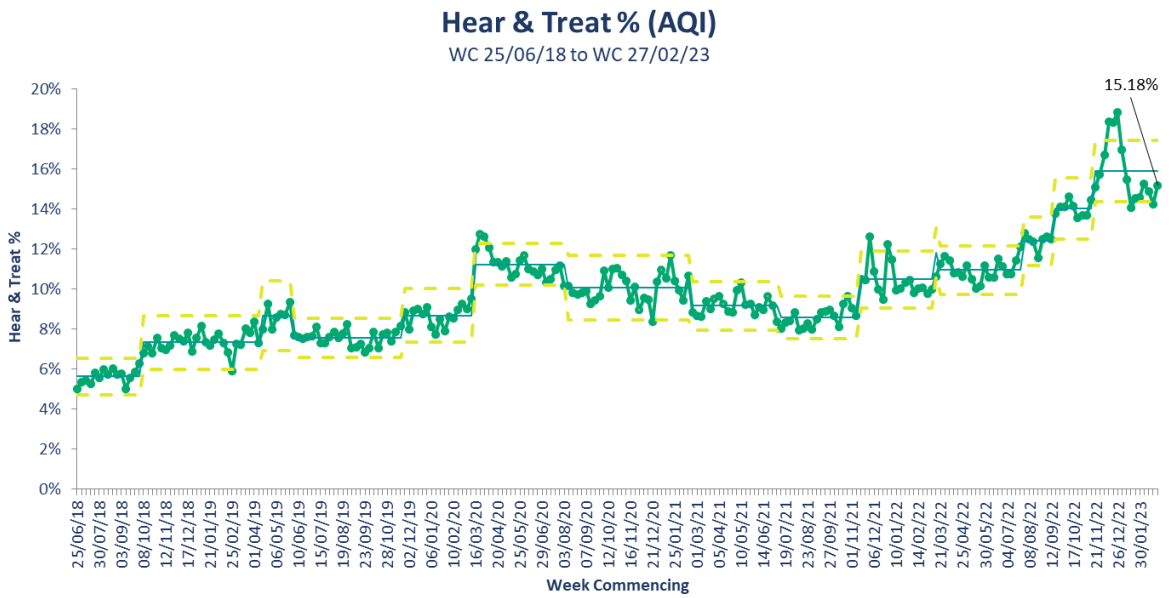


Figure E3.7

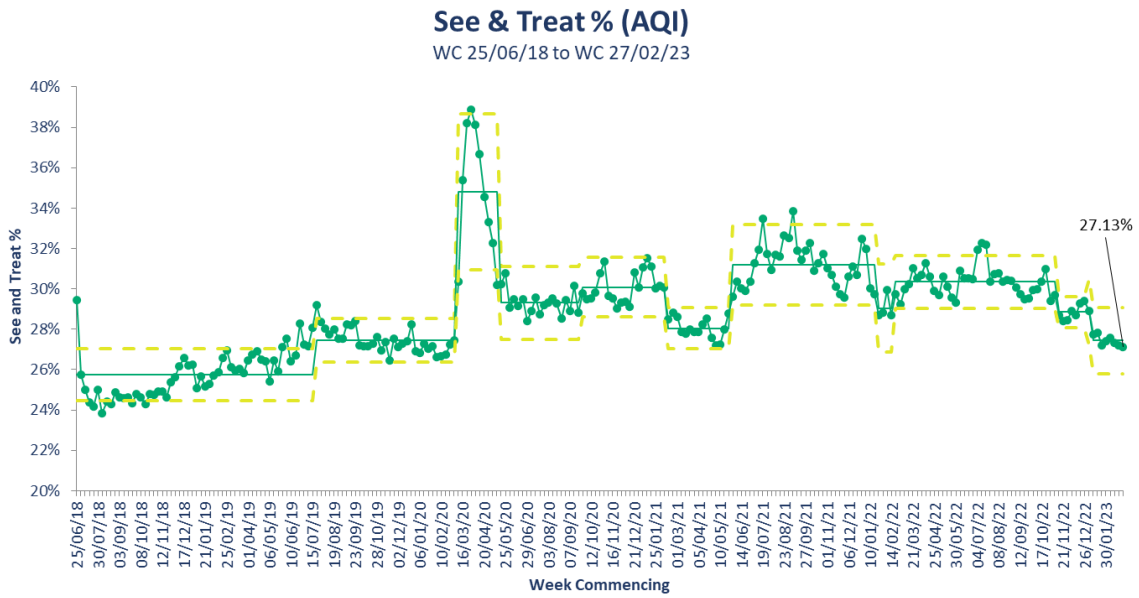


Figure E3.8

Sector	Hear & Treat %
CL Fylde	17.81%
G Central	17.66%
CL East Lancashire	15.33%
M East	15.14%
M North	14.83%
G West	14.82%
M West	14.80%
G East	14.69%
CL South Lancashire	14.42%
M South	13.67%
CL North Cumbria	13.11%
G South	13.09%
CL Morecambe Bay	11.11%

Figure E3.9

Sector	See & Treat %
G East	28.84%
M South	28.71%
CL South Lancashire	28.64%
CL Morecambe Bay	28.55%
CL East Lancashire	28.45%
CL Fylde	28.12%
G West	27.98%
CL North Cumbria	27.47%
G Central	27.31%
M West	27.04%
M North	26.96%
G South	25.60%
M East	24.13%

Figure E3.10

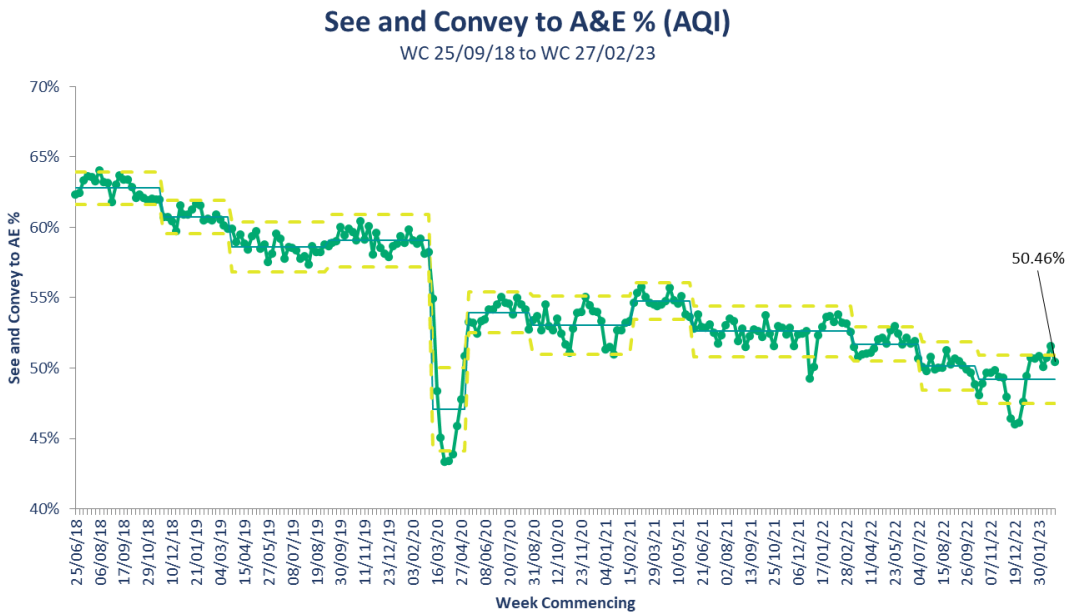


Figure E3.11

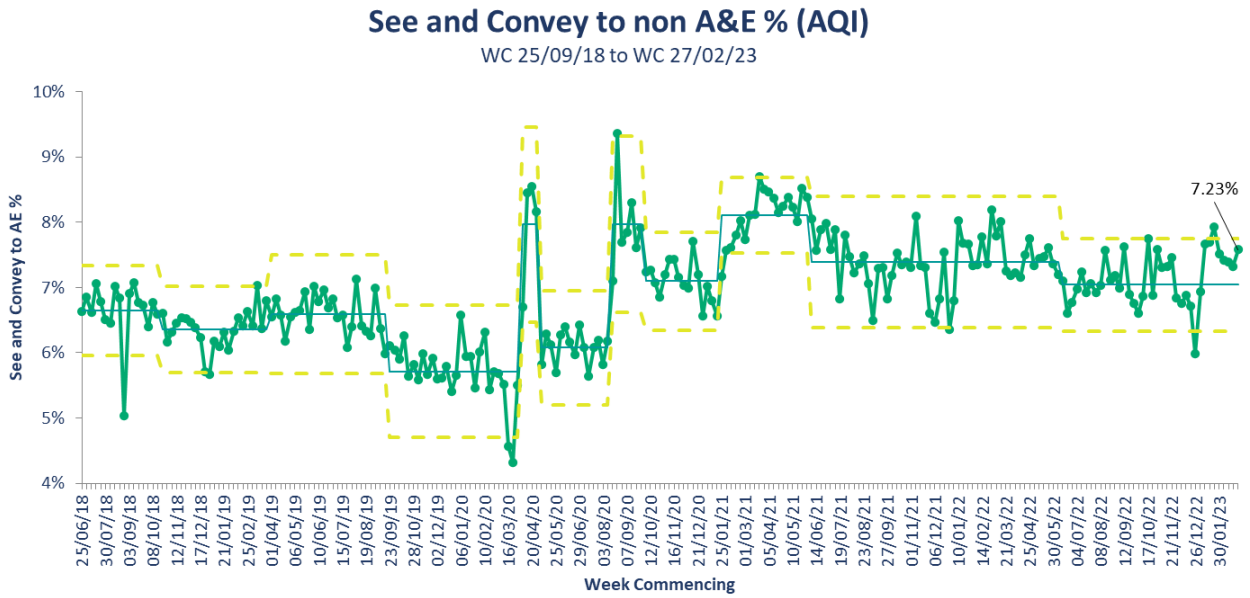


Figure E3.12

Sector	See & Convey	%
G South		61.31%
M East		60.73%
CL Morecambe Bay		60.33%
CL North Cumbria		59.41%
M North		58.21%
M West		58.16%
M South		57.62%
G West		57.20%
CL South Lancashire		56.94%
G East		56.47%
CL East Lancashire		56.22%
G Central		55.03%
CL Fylde		54.07%

Figure E3.13

Sector	See & Convey to AE	%
G South		55.57%
CL Morecambe Bay		55.22%
M East		52.91%
CL North Cumbria		52.69%
M South		51.89%
G West		51.56%
G East		51.04%
M North		50.47%
G Central		49.31%
CL Fylde		48.51%
M West		48.21%
CL South Lancashire		46.99%
CL East Lancashire		45.96%

Figure E3.14

Sector	See & Convey to Non AE	%
CL East Lancashire		10.26%
CL South Lancashire		9.95%
M West		9.95%
M East		7.83%
M North		7.74%
CL North Cumbria		6.73%
G South		5.74%
M South		5.73%
G Central		5.73%
G West		5.64%
CL Fylde		5.56%
G East		5.43%
CL Morecambe Bay		5.11%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	London		15.8%
2	North West		14.8%
3	East Midlands		13.4%
4	West Midlands		12.7%
5	South Western		10.7%
6	South Central		10.0%
7	South East Coast		9.8%
8	East of England		7.3%
9	North East		7.2%
10	Yorkshire		6.9%
11	Isle of Wight		6.6%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		38.7%
2	South Central		35.3%
3	East of England		33.5%
4	Isle of Wight		33.4%
5	East Midlands		32.3%
6	South East Coast		31.5%
7	West Midlands		30.8%
8	North East		29.2%
9	London		29.1%
10	Yorkshire		28.3%
11	North West		27.4%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		50.6%
2	East Midlands		54.3%
3	South Central		54.7%
4	London		55.1%
5	West Midlands		56.5%
6	North West		57.8%
7	South East Coast		58.7%
8	East of England		59.2%
9	Isle of Wight		60.1%
10	North East		63.6%
11	Yorkshire		64.8%

Operational

O1 CALL PICK UP

Figure O1.1

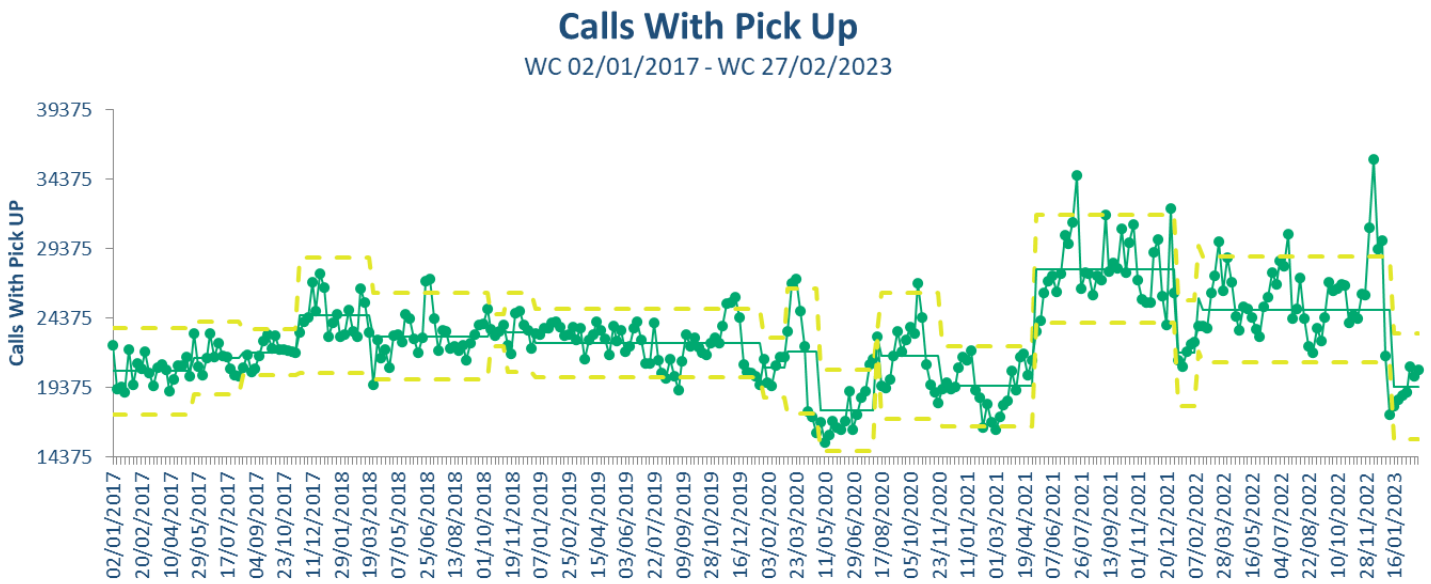
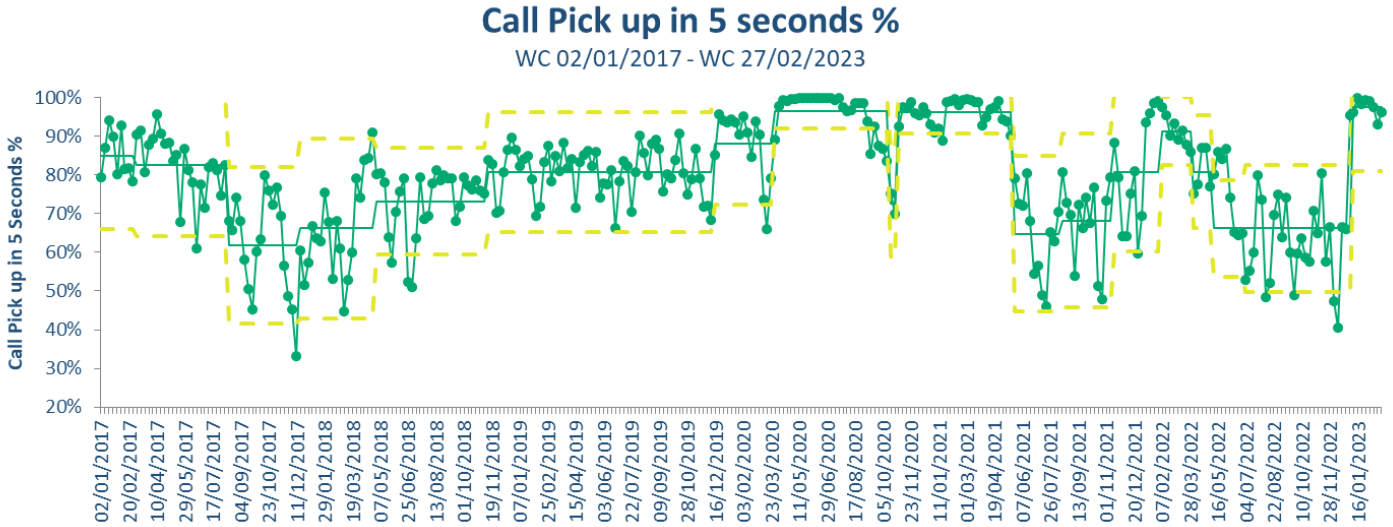


Figure O1.2



02 A&E TURNAROUND

Figure O2.1

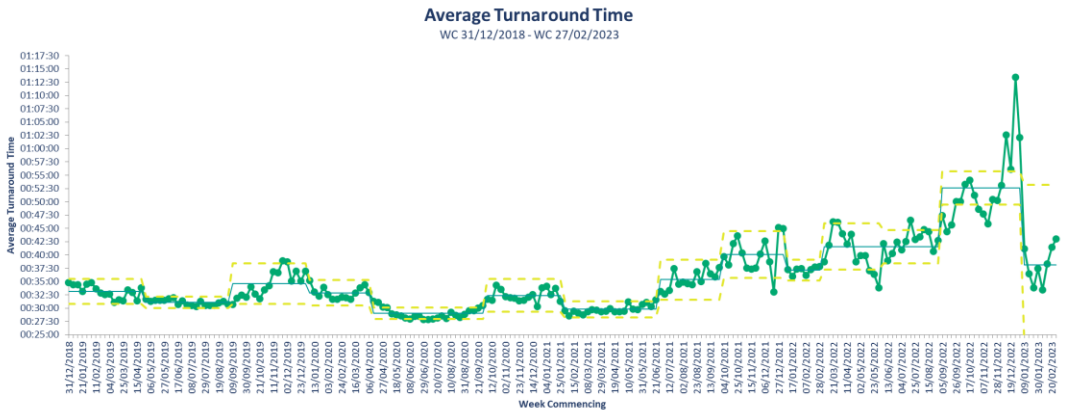


Figure Q1.2

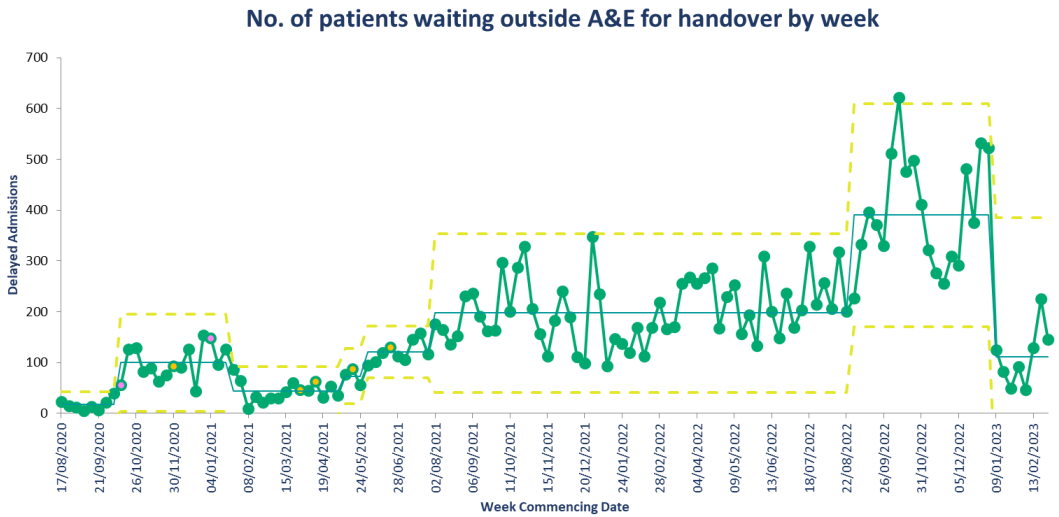


Table Q1.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
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
Jan-23	42,663	0:44:05	0:32:25	12:03
Feb-23	40,467	0:38:35	0:25:35	11:37

Table Q1.2

Top 5 Trusts with most hours lost due to delayed	
Trust	Hours lost to delayed admissions
Blackpool Victoria Hospital	284.8
Royal Oldham Hospital	132.3
Royal Lancaster Hospital	116.6
Cumberland Infirmary	76.0
Royal Preston Hospital	62.0

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
Jan-23	862
Feb-23	514

O3 ARP RESPONSE TIMES

December 2022

Figure O3.1

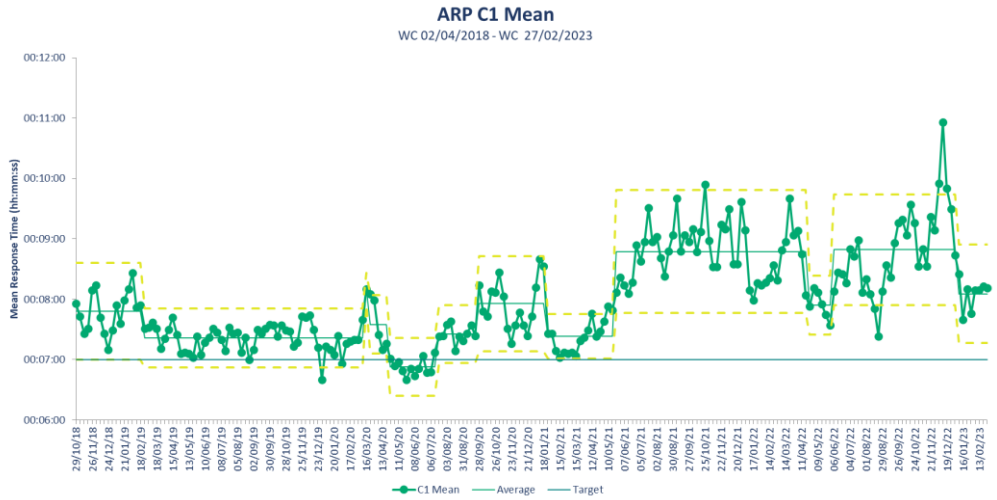


Figure O3.2

Figure O3.3

Sector	C1 Mean	Time
G South		00:07:06
G Central		00:07:17
CL Fylde		00:07:34
G East		00:07:37
G West		00:07:49
M North		00:07:50
CL East Lancashire		00:08:14
CL Morecambe Bay		00:08:23
CL South Lancashire		00:08:41
M East		00:08:44
M West		00:09:19
CL North Cumbria		00:09:30
M South		00:10:16

Figure O3.4

C1 Mean	
Target	7:00
Feb 2022	8:10
YTD	8:36

Figure O3.5

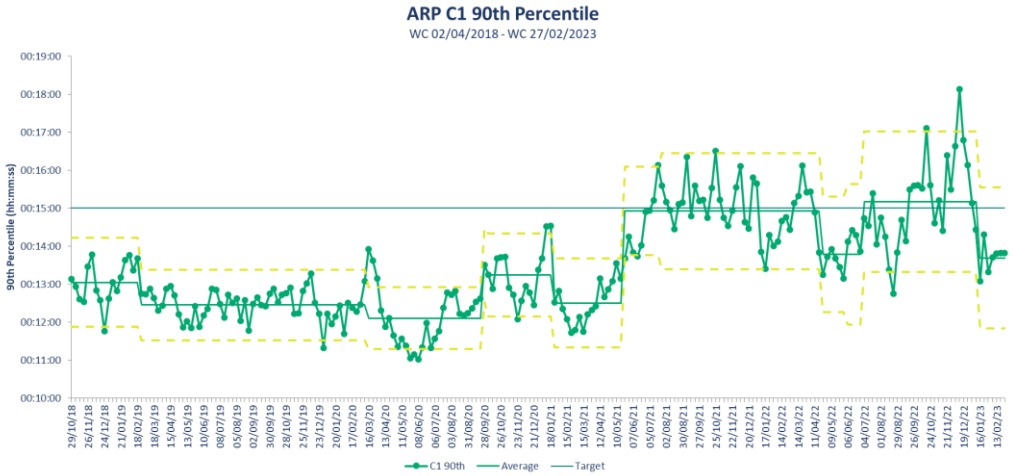


Figure O3.6

Figure O3.7

Sector	C1 90th	Time
G South		00:11:30
G Central		00:11:33
G East		00:12:19
M North		00:12:28
CL Fylde		00:12:51
G West		00:13:00
CL East Lancashire		00:14:05
CL South Lancashire		00:14:31
M East		00:14:58
M West		00:15:38
CL Morecambe Bay		00:16:12
CL North Cumbria		00:17:09
M South		00:18:05

Figure O3.8

C1 90th	
Target	15:00
Feb 2022	13:46
YTD	14:10

December 2022

Figure O3.9

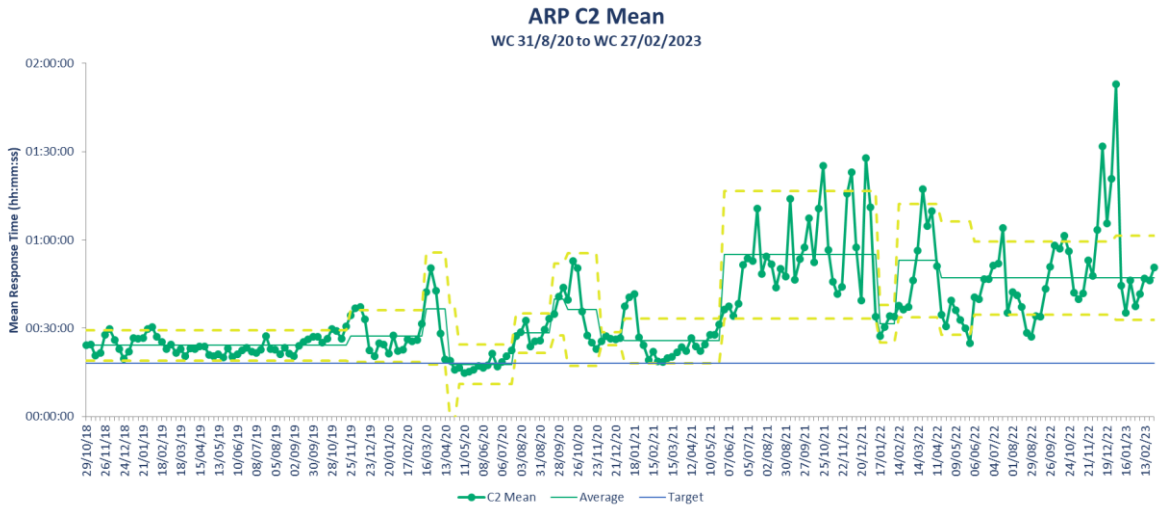


Figure O3.10

C2 Mean (Red=>18m)

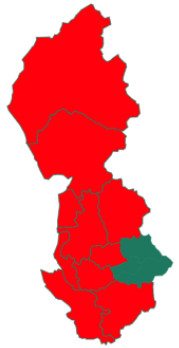


Figure O3.11

Sector	C2 Mean	Time
G South		00:17:00
G East		00:17:35
G Central		00:17:56
CL East Lancashire		00:19:28
CL North Cumbria		00:20:40
CL Morecambe Bay		00:21:08
CL South Lancashire		00:22:57
G West		00:23:55
M South		00:24:50
CL Fylde		00:26:15
M West		00:27:33
M East		00:28:47
M North		00:29:23

Figure O3.12

C2 Mean	
Target	18:00
Feb 2023	22:36
YTD	43:23

Figure O3.13

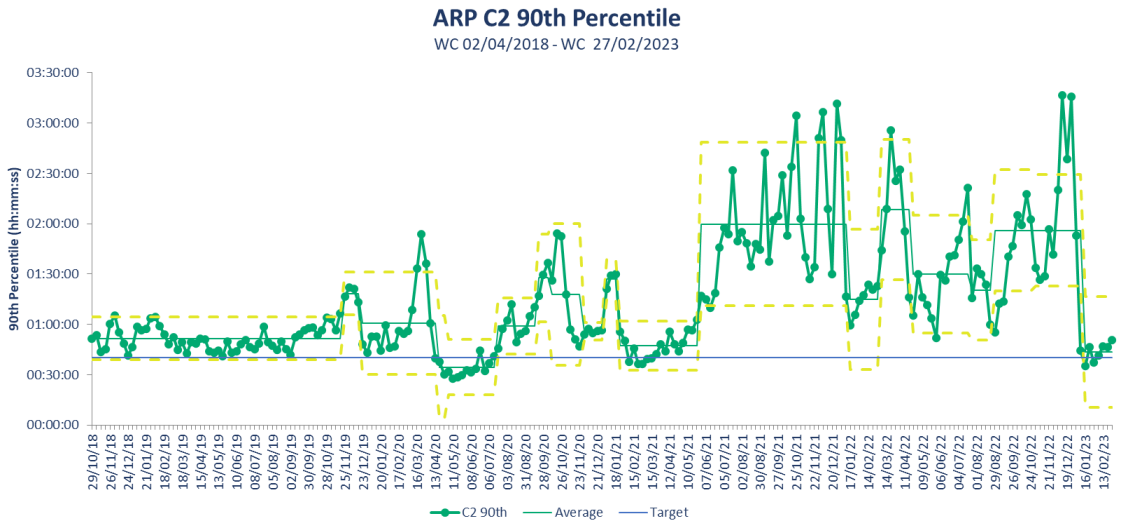


Figure O3.14

C2 90th (Red=>40m)

Figure O3.15

Sector	C2 90th	Time
G South		00:30:44
G East		00:31:15
G Central		00:33:08
CL East Lancashire		00:35:05
CL North Cumbria		00:40:10
CL South Lancashire		00:43:44
CL Morecambe Bay		00:43:54
G West		00:46:56
M South		00:47:16
M West		00:56:33
CL Fylde		00:57:21
M East		00:57:58
M North		01:01:22

Figure O3.16

C2 90th	
Target	0:40:00
Feb 2023	44:20
YTD	1:35:27

December 2022

Figure O3.17

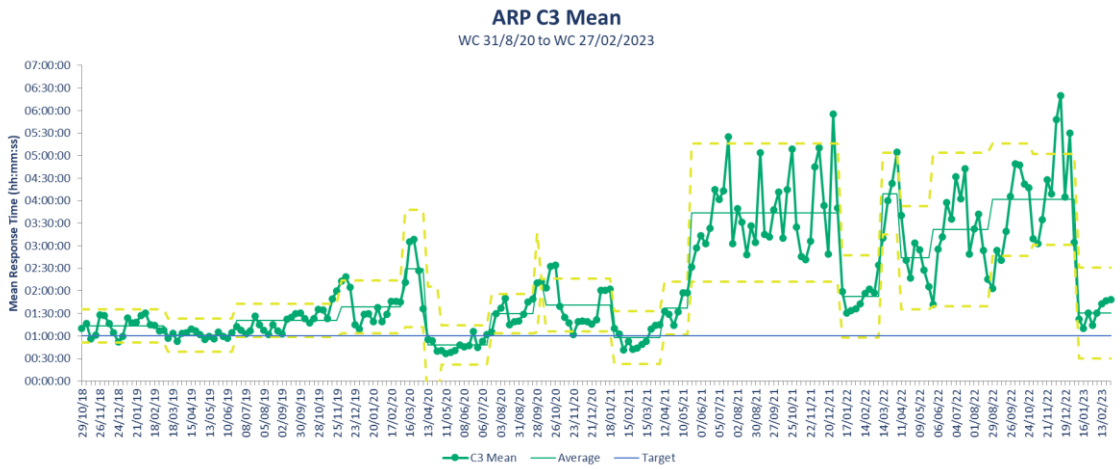


Figure O3.18

C3 Mean (Red=>60m)

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:03:45
CL Morecambe Bay		01:05:39
CL East Lancashire		01:09:06
CL South Lancashire		01:17:24
M South		01:24:38
G South		01:25:51
CL Fylde		01:30:31
M West		01:33:05
G East		01:40:17
M North		01:48:57
M East		01:58:02
G Central		02:01:16
G West		02:07:58

Figure O3.20

C3 Mean	
Target	1:00:00
Feb 2023	1:36:27
YTD	3:10:39

Figure O3.21

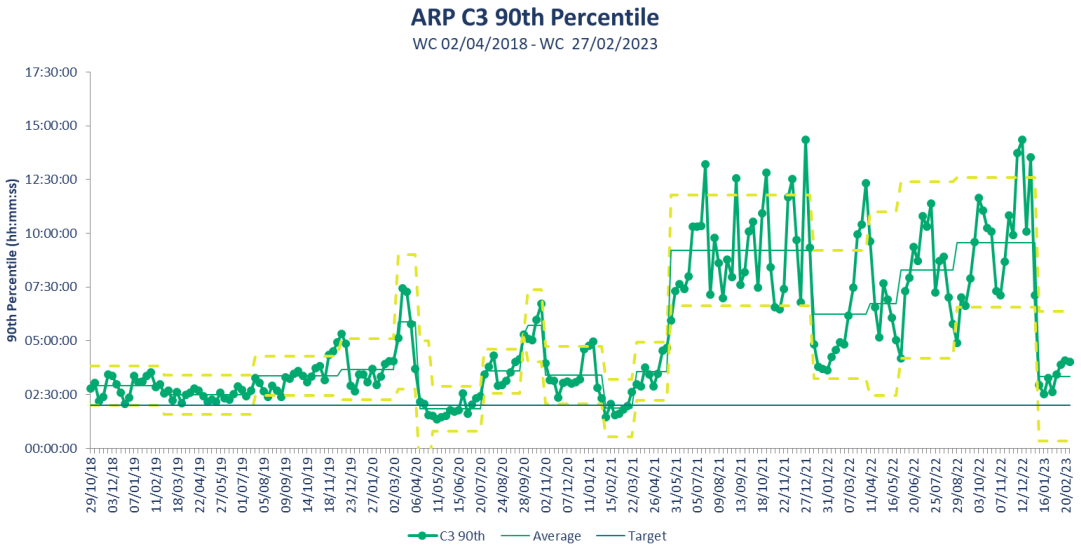


Figure O3.22

C3 90th (Red=>2h)

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:25:34
CL Morecambe Bay		02:34:10
CL East Lancashire		02:38:17
CL South Lancashire		02:49:03
G South		02:59:16
M South		03:20:10
G East		03:35:15
CL Fylde		03:35:35
M West		03:50:56
M North		04:21:43
G Central		04:31:52
G West		04:36:34
M East		04:37:51

Figure O3.24

C3 90th	
Target	2:00:00
Dec 2022	3:38:37
YTD	7:37:29

February 2023

Figure O3.25

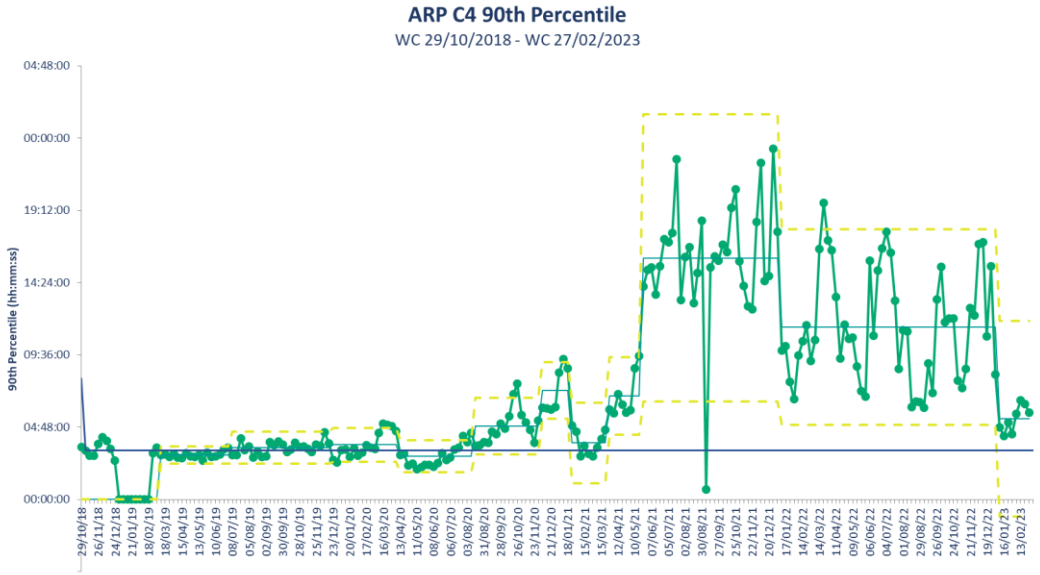


Figure O3.26

C4 90th (Red=>3h)

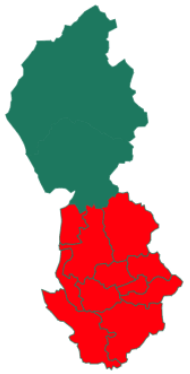


Figure O3.27

Sector	C4 90th	Time
CL Morecambe Bay		02:26:13
CL North Cumbria		02:45:34
CL East Lancashire		03:29:46
CL South Lancashire		03:45:27
M South		05:29:17
G South		05:46:24
M West		06:10:29
G West		06:11:20
CL Fylde		06:24:22
G Central		07:48:09
M East		08:57:46
G East		09:40:50
M North		10:28:05

Figure O3.28

C4 90th	
Target	3:00:00
Feb 2023	5:50:39
YTD	9:40:53

O3 ARP Provider Comparison

Figure O3.25

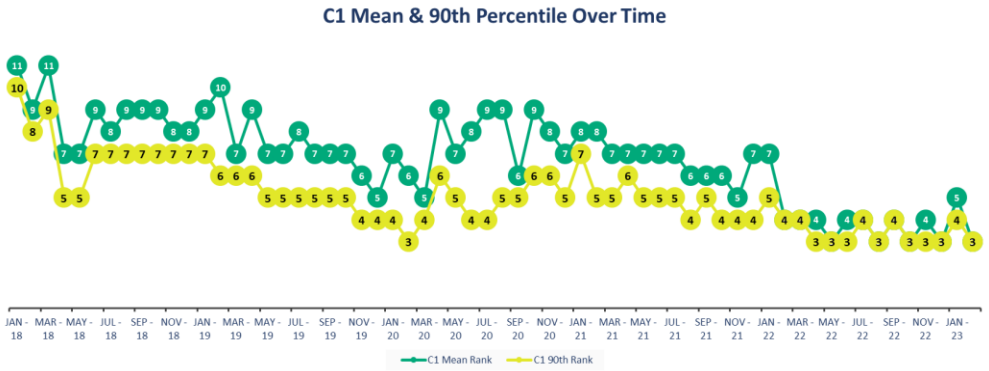


Figure O3.26

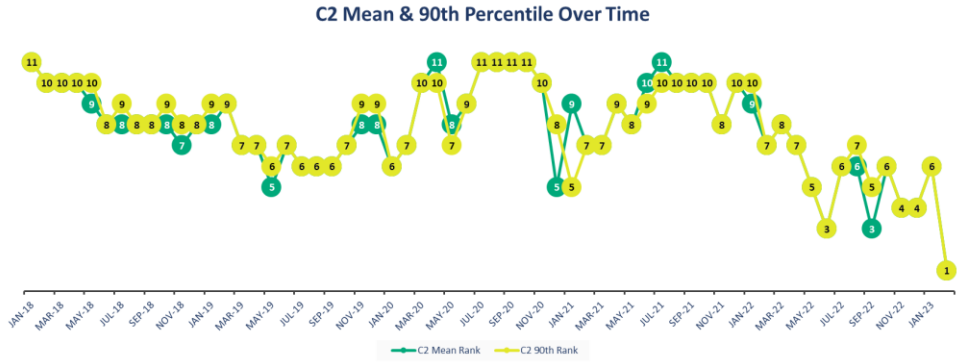


Figure O3.27

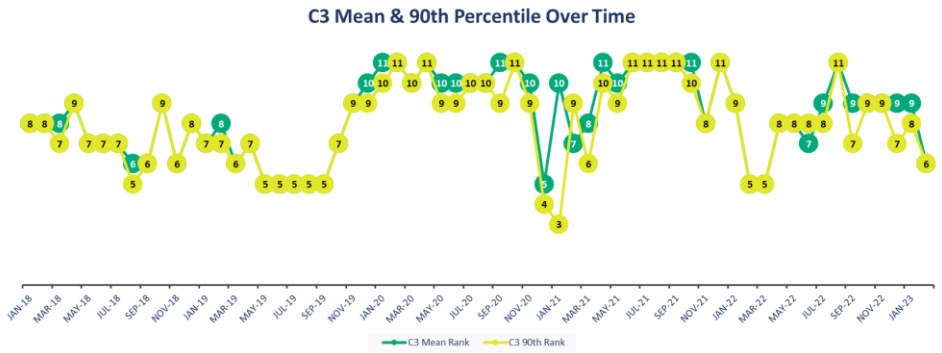
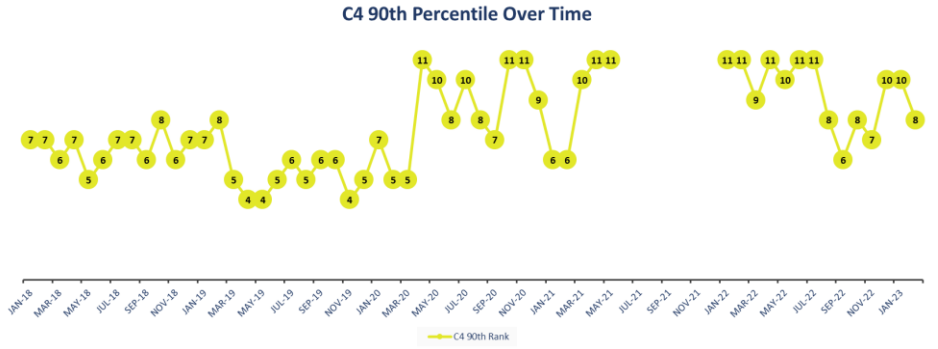


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		06:51
2	London		07:50
3	North West		08:10
4	West Midlands		08:18
5	Yorkshire		08:25
6	South Central		08:32
7	East Midlands		08:45
8	South East Coast		08:48
9	East of England		09:11
10	South Western		09:25
11	Isle of Wight		10:25

Rank	Trust	C1 90th	Time
1	North East		11:43
2	London		12:57
3	North West		13:46
4	West Midlands		14:25
5	Yorkshire		14:44
6	South Central		15:25
7	South East Coast		15:54
8	East Midlands		15:56
9	South Western		17:34
10	East of England		17:35
11	Isle of Wight		18:51

Rank	Trust	C2 Mean	Time
1	North West		0:22:36
2	Isle of Wight		0:24:02
3	South Central		0:25:48
4	West Midlands		0:25:48
5	Yorkshire		0:27:35
6	South East Coast		0:28:18
7	North East		0:29:22
8	London		0:33:40
9	South Western		0:39:59
10	East Midlands		0:44:52
11	East of England		0:45:06

Rank	Trust	C2 90th	Time
1	North West		0:44:20
2	Isle of Wight		0:48:55
3	South Central		0:51:10
4	West Midlands		0:54:25
5	Yorkshire		0:59:04
6	North East		0:59:09
7	Yorkshire		1:02:15
8	London		1:14:46
9	South Western		1:25:18
10	East Midlands		1:36:48
11	East of England		1:36:55

Rank	Trust	C3 Mean	Time
1	Isle of Wight		00:47:50
2	North East		01:07:13
3	London		01:07:52
4	Yorkshire		01:23:04
5	South Central		01:28:45
6	North West		01:36:27
7	South Western		01:37:43
8	West Midlands		01:54:43
9	East of England		02:06:15
10	South East Coast		02:11:09
11	East Midlands		02:32:20

Rank	Trust	C3 90th	Time
1	Isle of Wight		01:44:57
2	North East		02:35:05
3	London		02:42:21
4	Yorkshire		03:08:19
5	South Central		03:16:12
6	North West		03:38:37
7	South Western		04:13:03
8	South East Coast		04:53:11
9	West Midlands		04:59:46
10	East of England		05:13:24
11	East Midlands		06:13:41

Rank	Trust	C4 90th	Time
1	Isle of Wight		02:14:55
2	North East		02:30:30
3	Yorkshire		03:34:22
4	South Central		04:26:50
5	London		05:08:14
6	South Western		05:41:19
7	North West		05:50:39
8	East Midlands		05:50:45
9	South East Coast		06:02:25
10	West Midlands		06:46:43
11	East of England		08:28:42

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
Jan-23	694
Feb-23	543

Figure O3.29

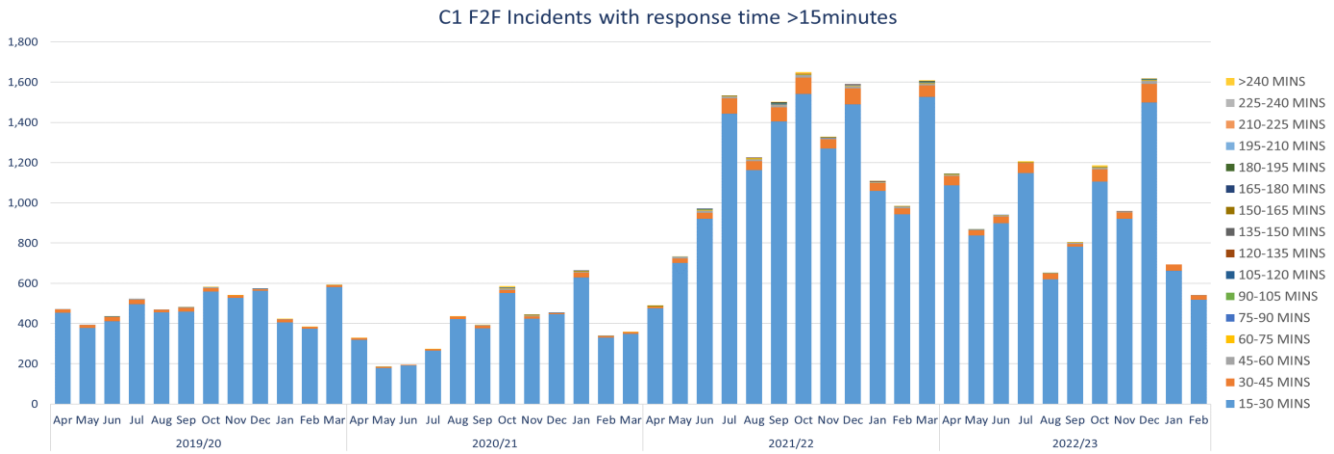


Figure O3.30

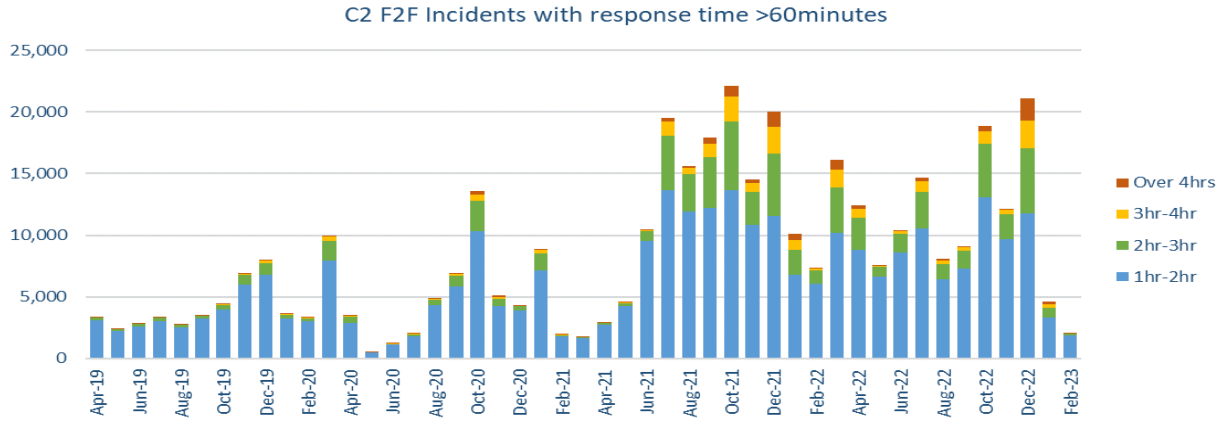
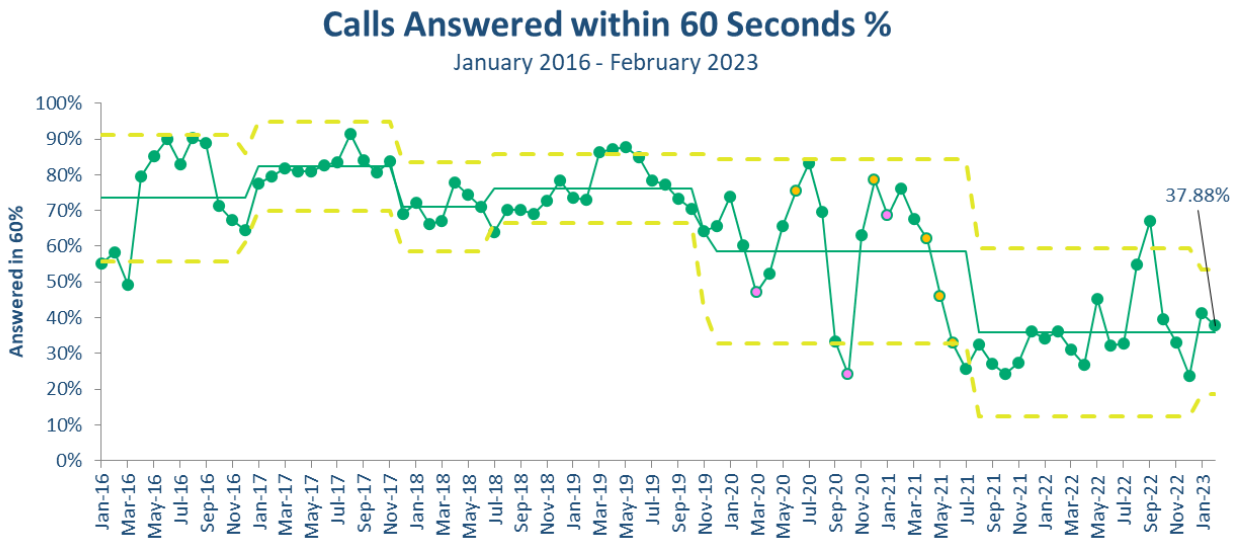


Table O3.30

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
Jan-23	4,631
Feb-23	2,048

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
Feb 2023	37.88%
YTD	39.55%
National	47.7%

Figure O4.2

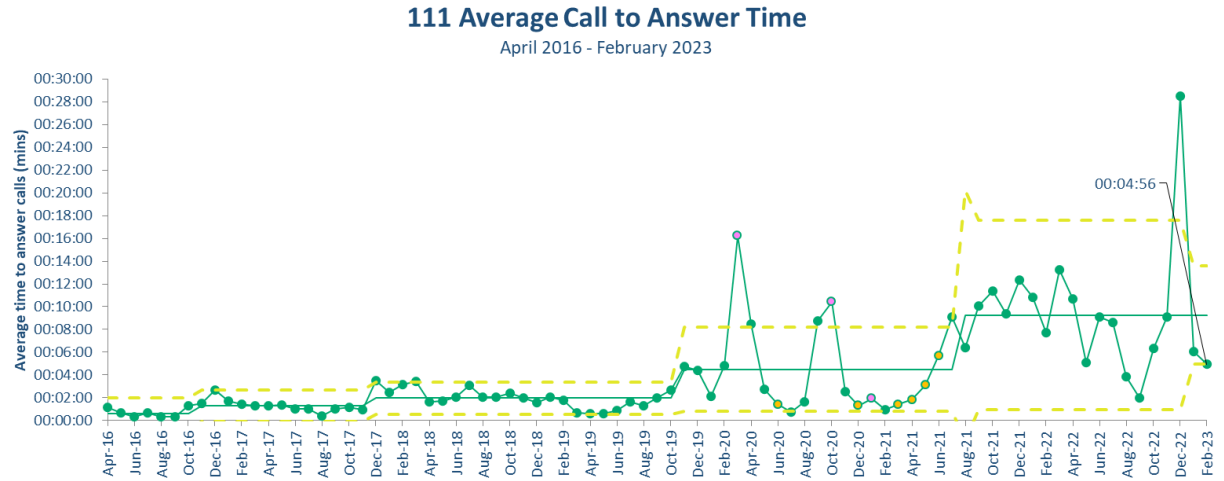
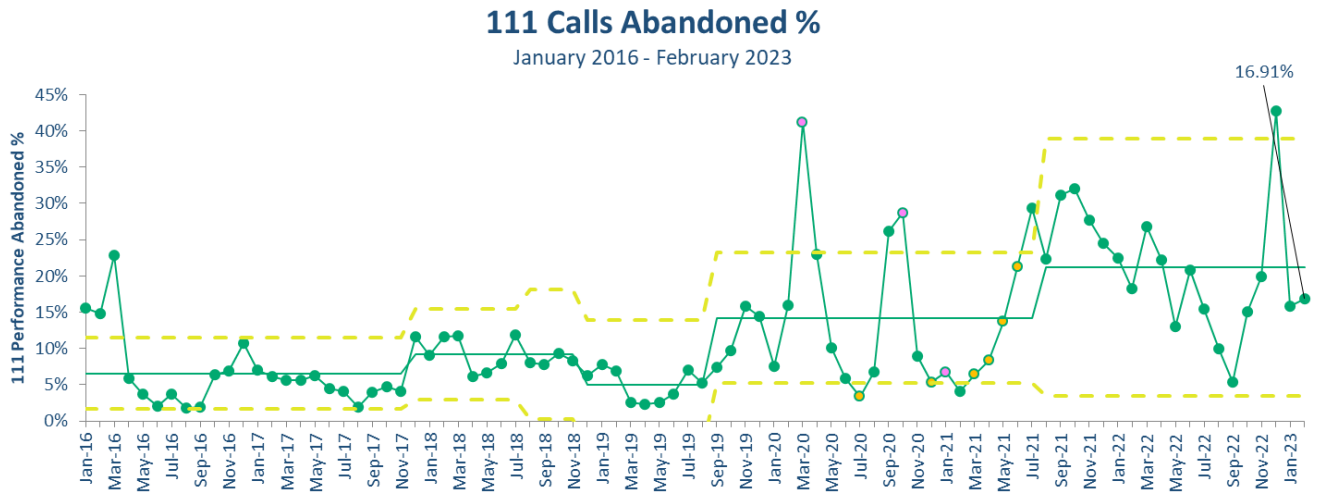


Figure O4.3



Calls Abandoned %	
Target	<5%
Feb 2023	16.91%
YTD	17.95%
National	14.8%

Figure O4.4a

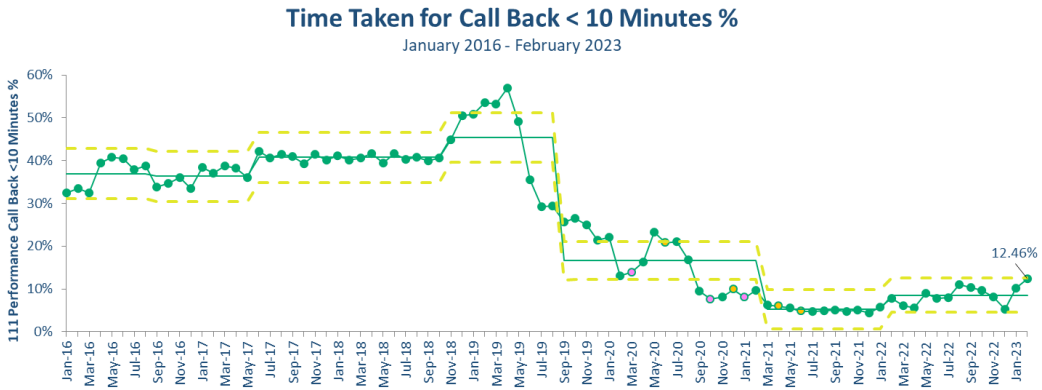
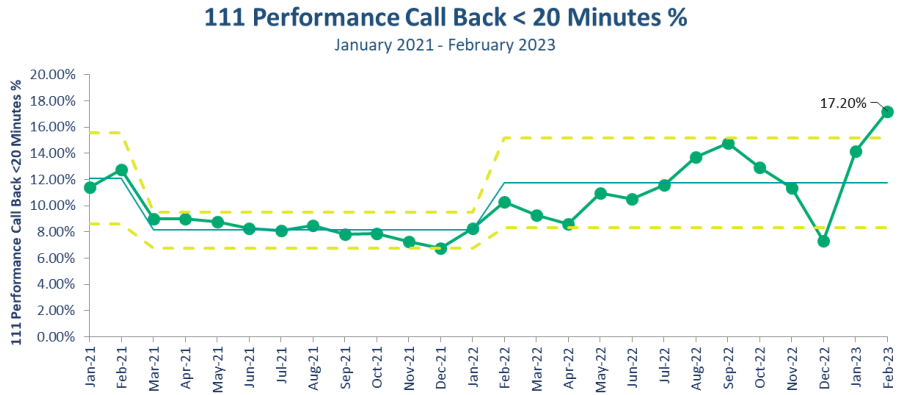


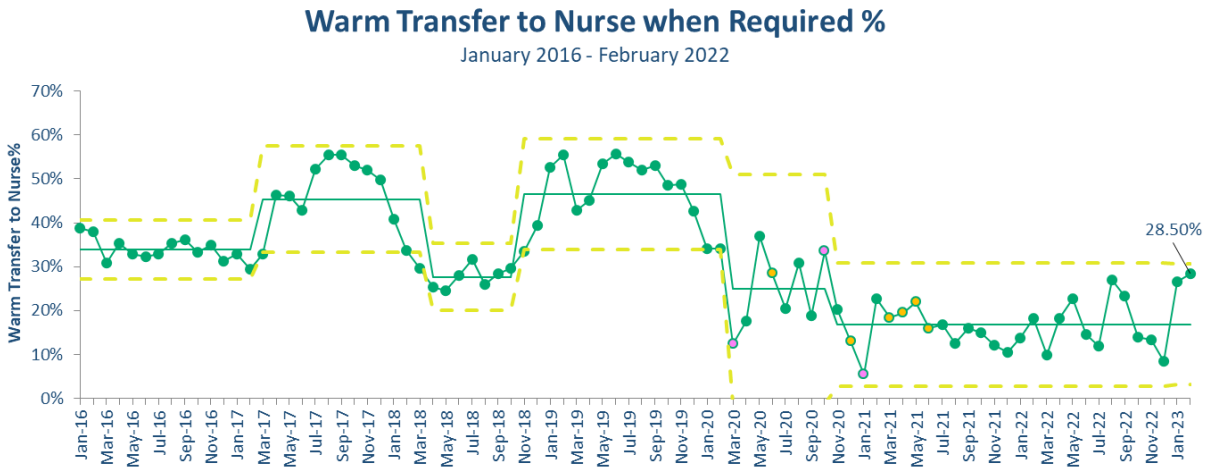
Figure O4.4b



Calls Back <10 Mins	
Target	75%
Feb 2023	12.46%
YTD	8.85%

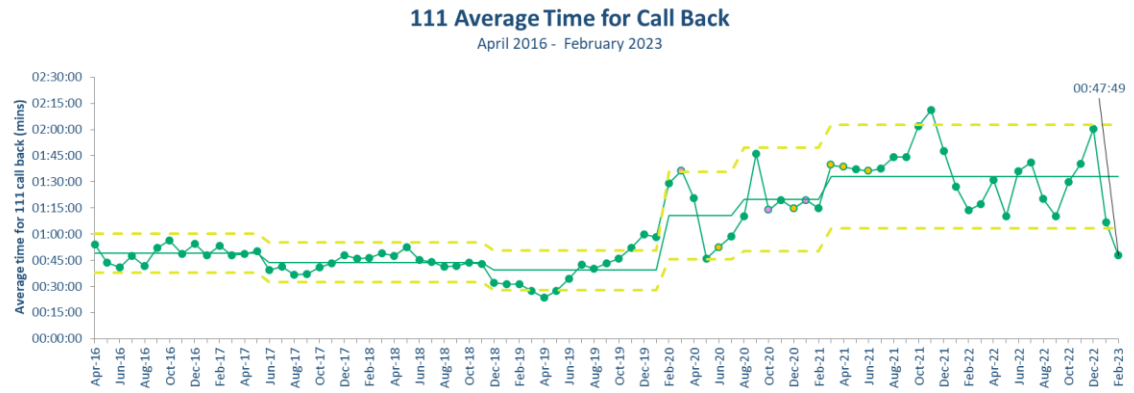
Calls Back <20 Mins	
Target	90%
Feb 2023	17.20%
YTD	15.69%

Figure O4.5



Warm Transfer %	
Target	75%
Dec 2022	28.50%
YTD	18.98%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: January 2023					Year to Date: July 2020 - January 2023			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	9,261	(4,763)	(34%)	98,169	67,989	(30,180)	(31%)
Greater Manchester	526,588	43,882	39,735	(4,147)	(9%)	307,176	291,038	(16,138)	(5%)
Lancashire	589,181	49,098	32,919	(16,179)	(33%)	343,689	241,294	(102,395)	(30%)
Merseyside	300,123	25,010	22,394	(2,616)	(10%)	175,072	163,086	(11,986)	(7%)
NWAS	1,584,182	132,015	104,309	(27,706)	(21%)	924,106	763,407	(160,699)	(17%)

UNPLANNED ACTIVITY									
	Current Month: January 2023					Year to Date: July 2020 - January 2023			
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	470	(777)	(62%)	8,732	3,213	(5,519)	(63%)
Greater Manchester	49,133	4,094	3,930	(164)	(4%)	28,661	28,993	332	1%
Lancashire	58,829	4,902	3,042	(1,860)	(38%)	34,317	21,652	(12,665)	(37%)
Merseyside	22,351	1,863	1,520	(343)	(18%)	13,038	11,776	(1,262)	(10%)
NWAS	145,282	12,107	8,962	(3,145)	(26%)	84,748	65,634	(19,114)	(23%)

ABORTED ACTIVITY									
	January 2023								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	194	4,460	4%	59	448	13%	68	3,157	2%
Greater Manchester	1,344	13,324	10%	881	4,035	22%	1,183	18,900	6%
Lancashire	852	13,046	7%	557	2,973	19%	546	12,612	4%
Merseyside	555	7,034	8%	353	2,062	17%	740	11,601	6%
NWAS	2,945	37,864	8%	1,850	9,518	19%	2,537	46,270	5%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

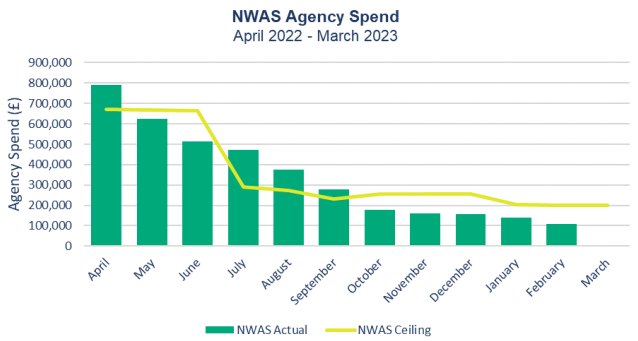


Figure F1.2

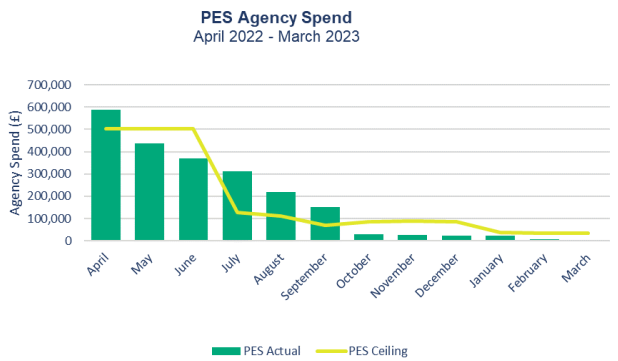


Figure F1.3

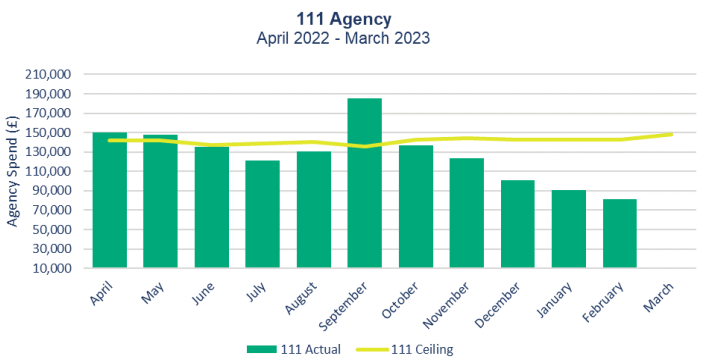


Figure F1.4

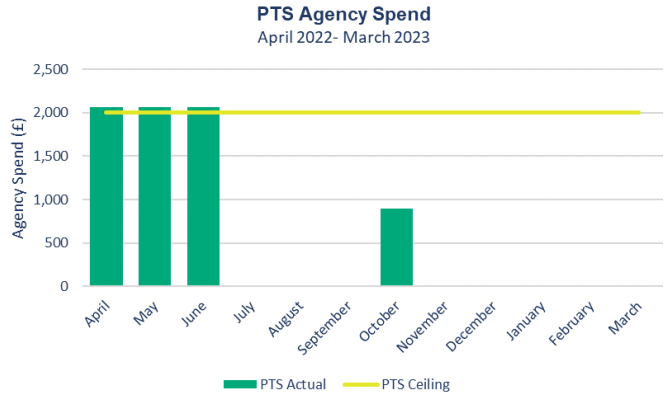


Figure F1.5

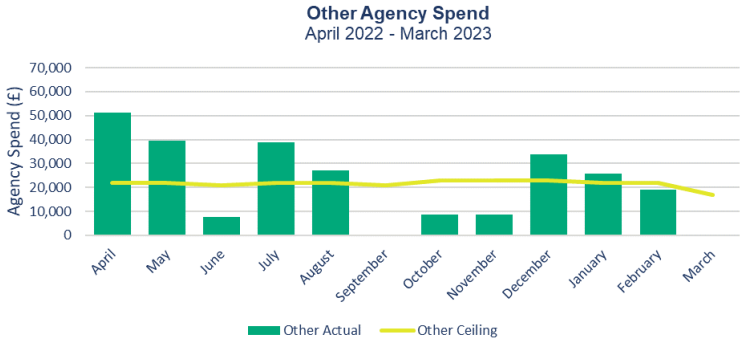
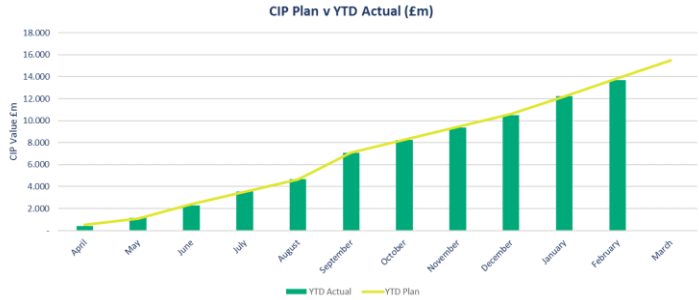


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

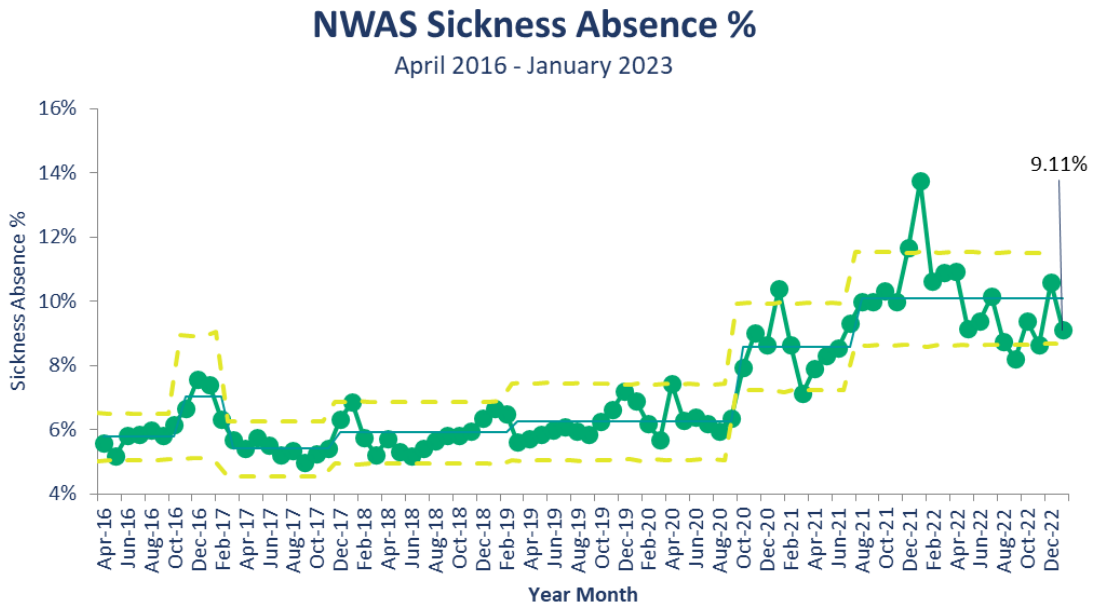


Table OH1.1

Sickness Absence	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul–22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
NWAS	10.56%	10.91%	10.92%	9.15%	9.40%	10.16%	8.73%	8.21%	9.38%	8.64%	10.60%	9.11%
Amb. National Average	8.56%	9.10%	9.18%	7.64%	7.90%	8.73%	7.45%	7.56%	7.99%			

Figure OH1.2

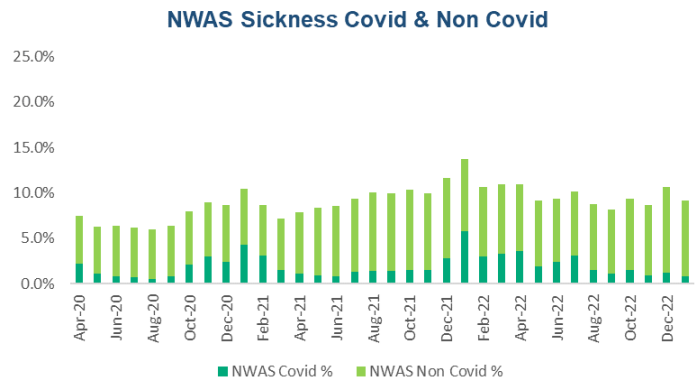


Figure OH1.3

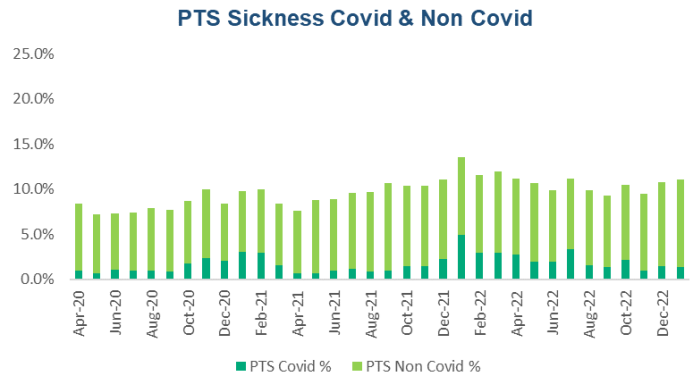


Figure OH1.4

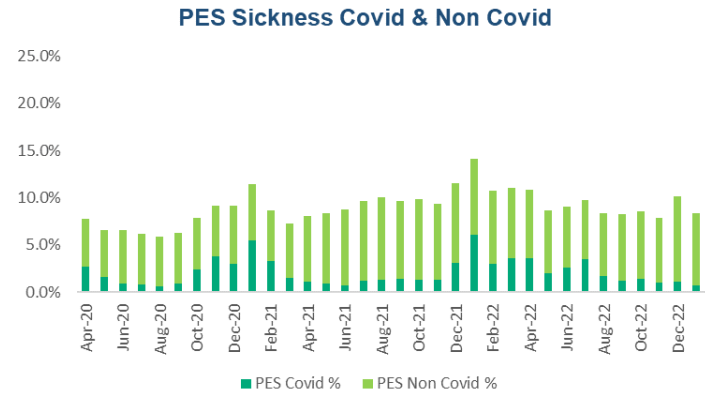


Table OH1.2

NWAS			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	1.2%	9.4%	10.6%
Jan-23	0.8%	8.3%	9.1%

Table OH1.3

PTS			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	1.4%	9.4%	10.8%
Jan-23	1.4%	9.6%	11.0%

Table OH1.4

PES			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	1.1%	9.0%	10.1%
Jan-23	0.8%	7.6%	8.3%

Figure OH1.5

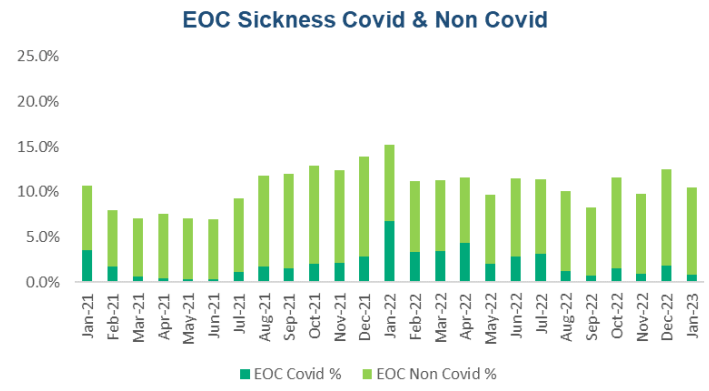


Figure OH1.6

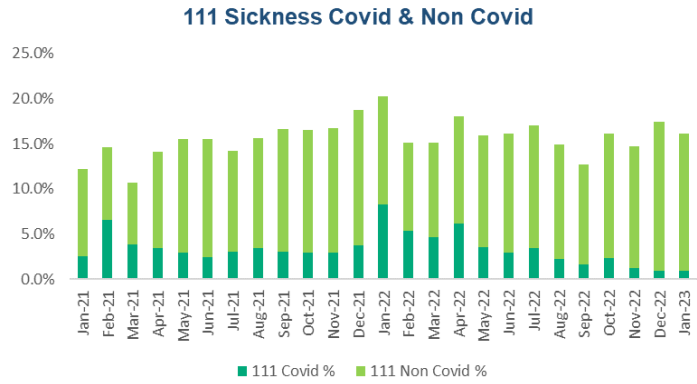


Figure OH1.7

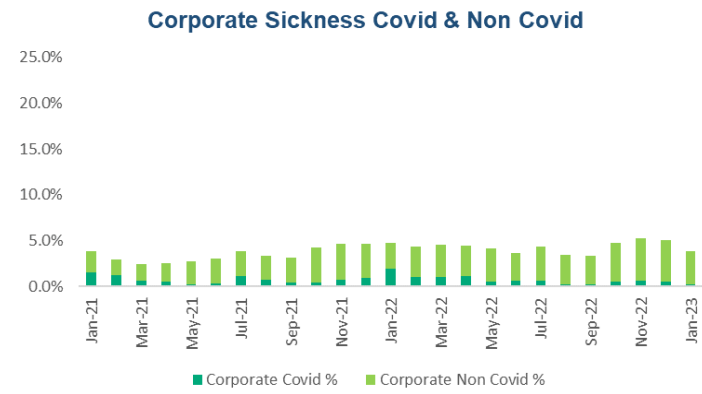


Table OH1.5

EOC			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	1.8%	10.8%	12.6%
Jan-23	0.8%	9.7%	10.5%

Table OH1.6

111			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	0.9%	16.5%	17.4%
Jan-23	1.0%	15.2%	16.1%

Table OH1.7

Corporate			
Month Year	Covid %	Non Covic	Total %
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%
Dec-22	0.5%	4.6%	5.1%
Jan-23	0.2%	3.6%	3.9%

OH2 STAFF TURNOVER

Figure OH2.1

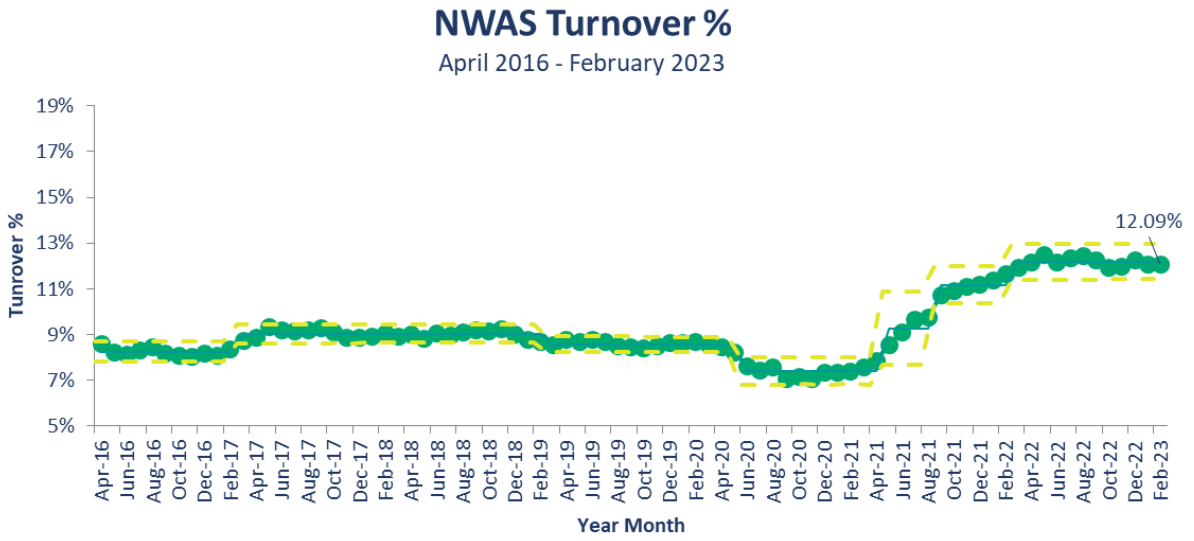


Table OH2.1

Turnover	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
NWAS	11.94%	12.17%	12.49%	12.19%	12.35%	12.45%	12.28%	11.94%	12.01%	12.28%	12.11%	12.09%
Amb. National Average	11.43%	12.09%	12.10%	12.27%	12.27%	12.23%	12.25%	12.19%	12.15%			

Figure OH2.2

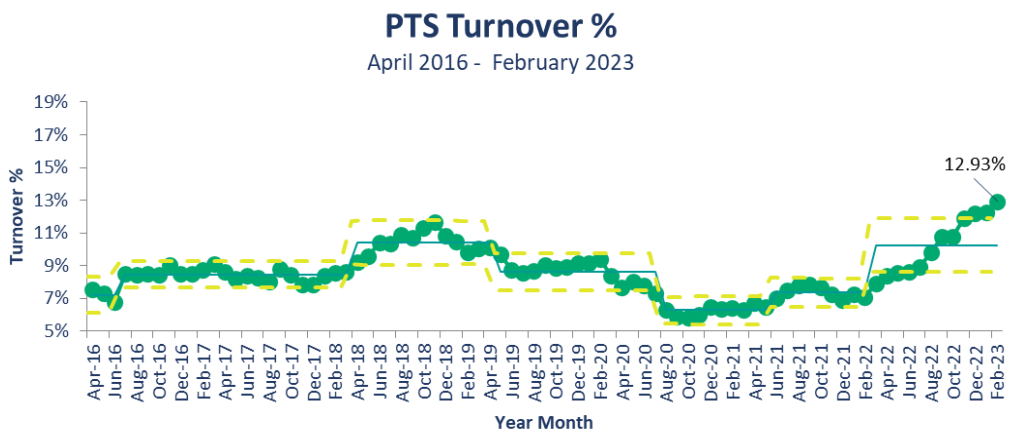


Figure OH2.3

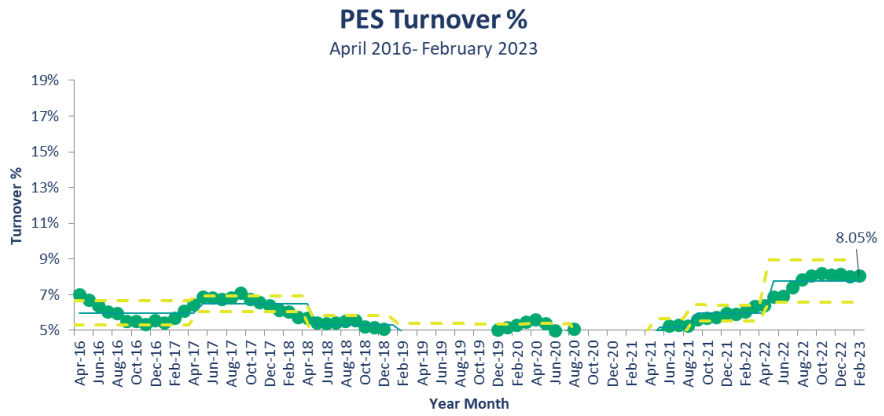


Figure OH2.4

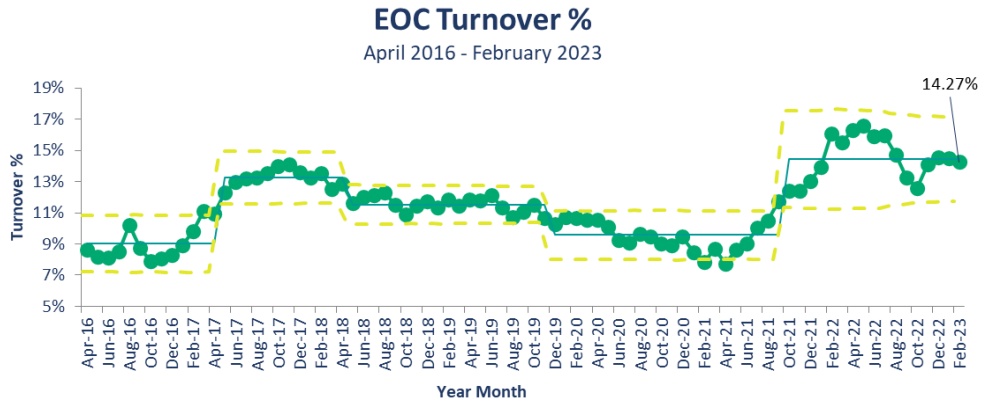
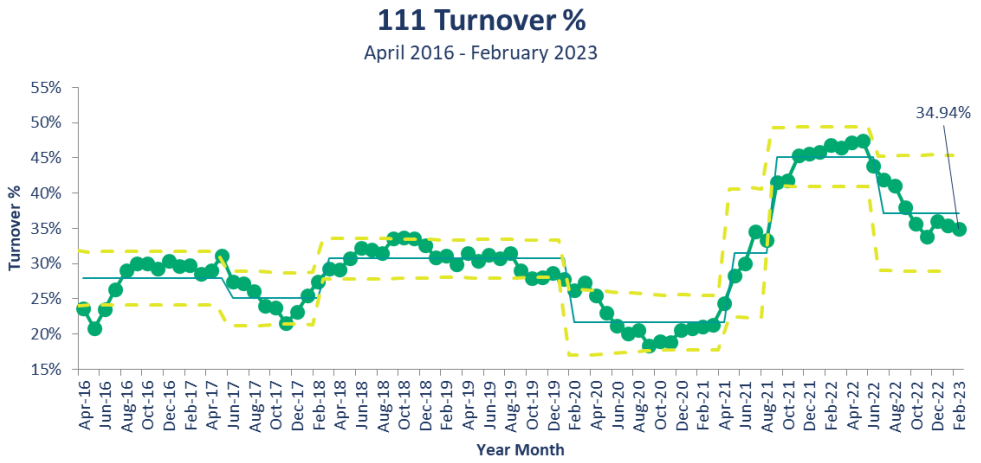


Figure OH2.5



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

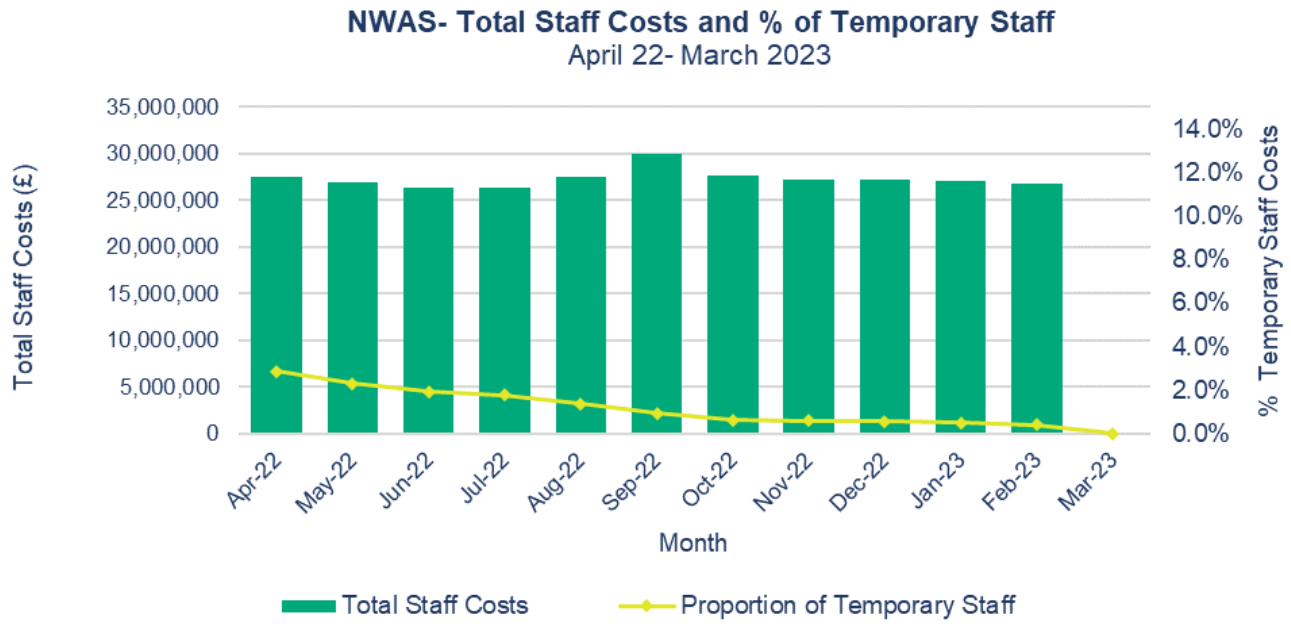


Table OH4.1

NWAS	Mar-22	Apr-22	May-22	Jun-22	July -22	Aug-22	Sep-22	Oct-22	Nov- 22	Dec-22	Jan-23	Feb-23
Agency Staff Costs (£)	1,072,794	792,309	624,873	514,594	472,303	376,736	279,546	176,850	159,947	157,417	140,004	107,701
Total Staff Costs (£)	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	27,041,860	26,856,025
Proportion of Temporary Staff %	2.5%	2.9%	2.3%	1.9%	1.8%	1.4%	0.9%	0.6%	0.6%	0.6%	0.5%	0.4%

Figure OH4.3

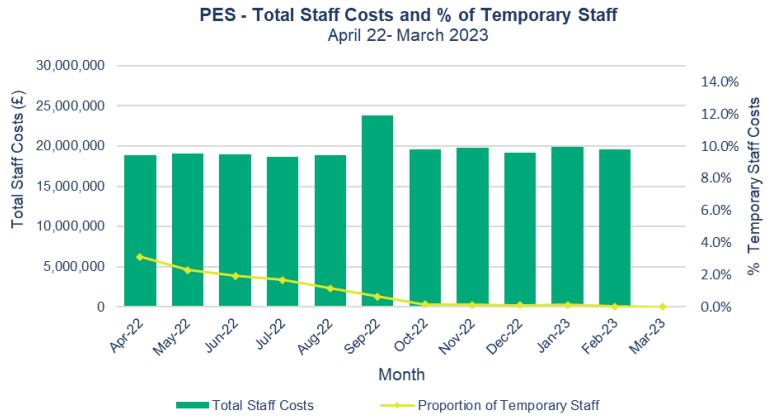


Figure OH4.4

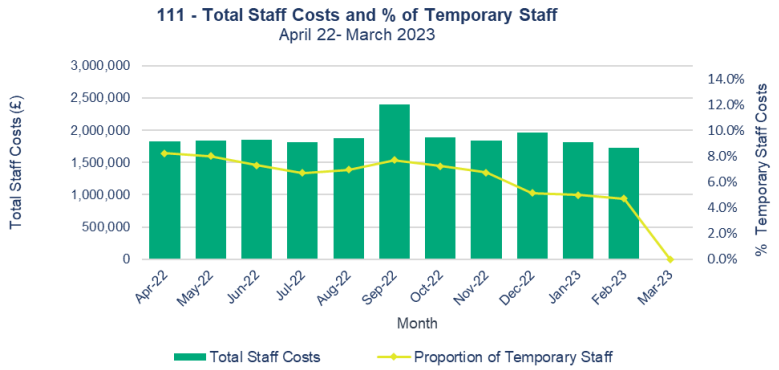


Figure OH4.5

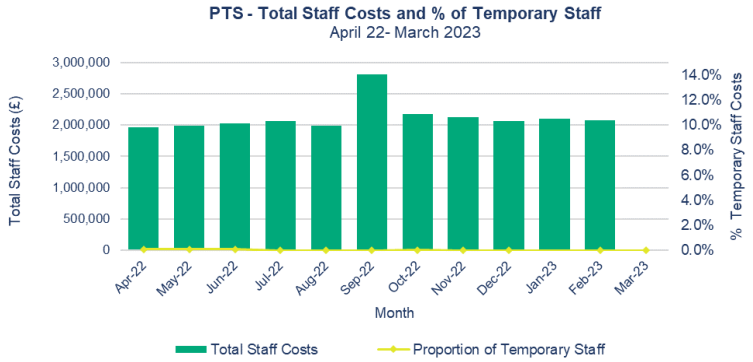
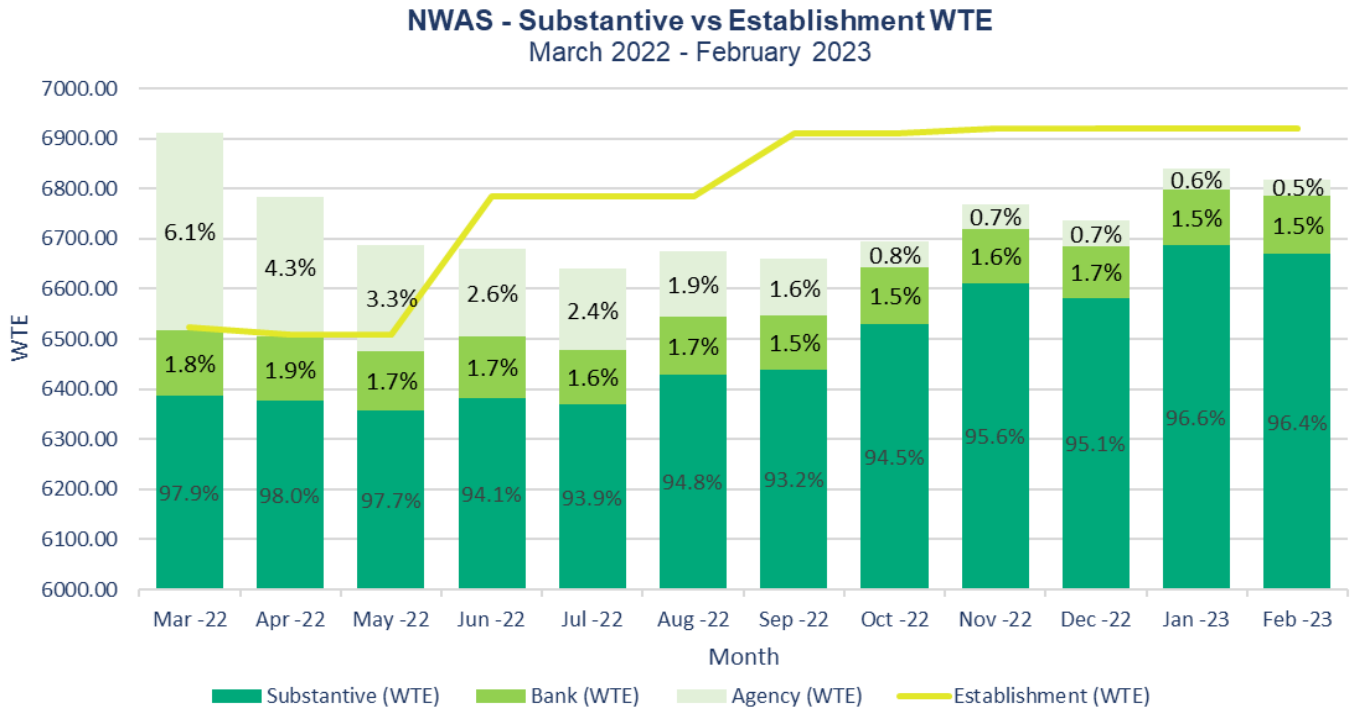


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

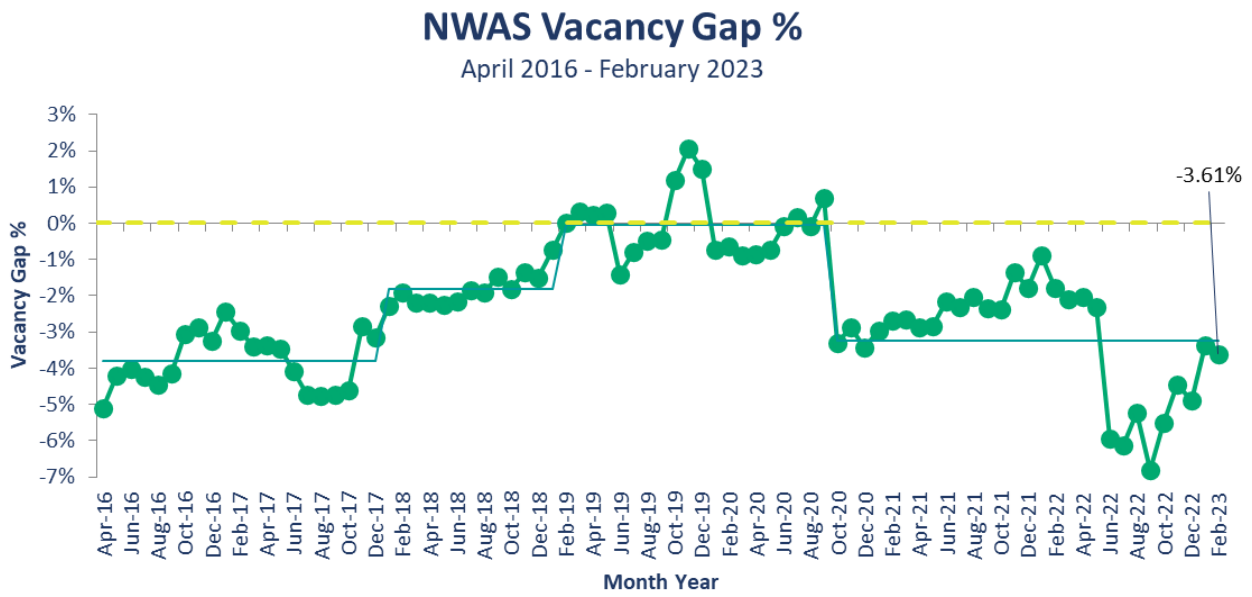


Table OH5.1

Vacancy Gap	Mar-22	Apr-22	May-22	Jun-22	July-22	Aug-22	Sep-22	Oct-22	N0v-22	Dec-22	Jan-23	Feb-23
NWAS	-2.10%	-2.03%	-2.30%	-5.95%	-6.13%	-5.24%	-6.81%	-5.51%	-4.44%	-4.88%	-3.35%	-3.61%

Figure OH5.2

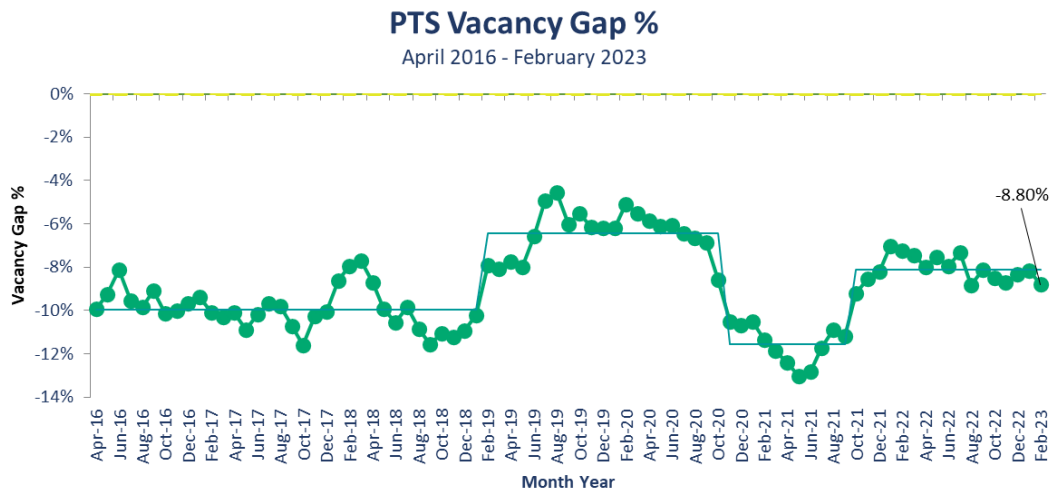


Figure OH5.3

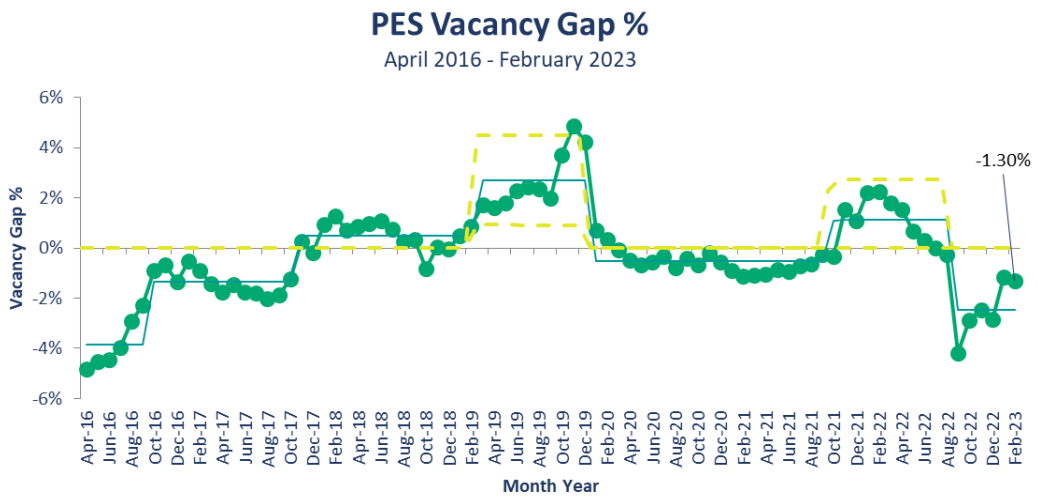


Figure OH5.4

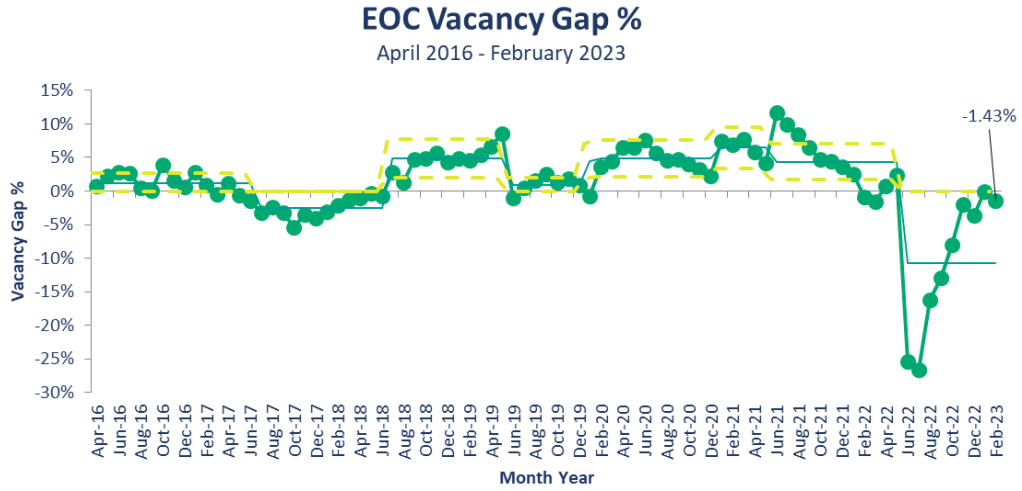
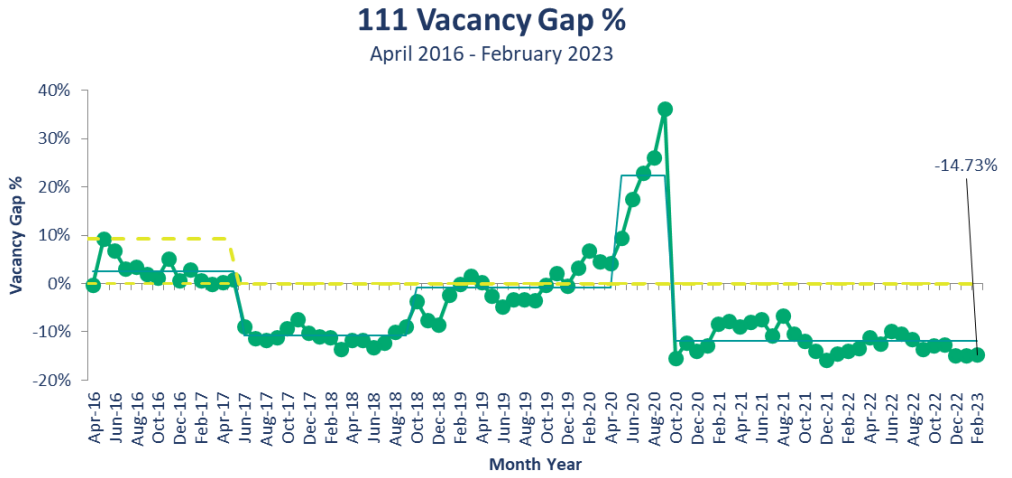


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

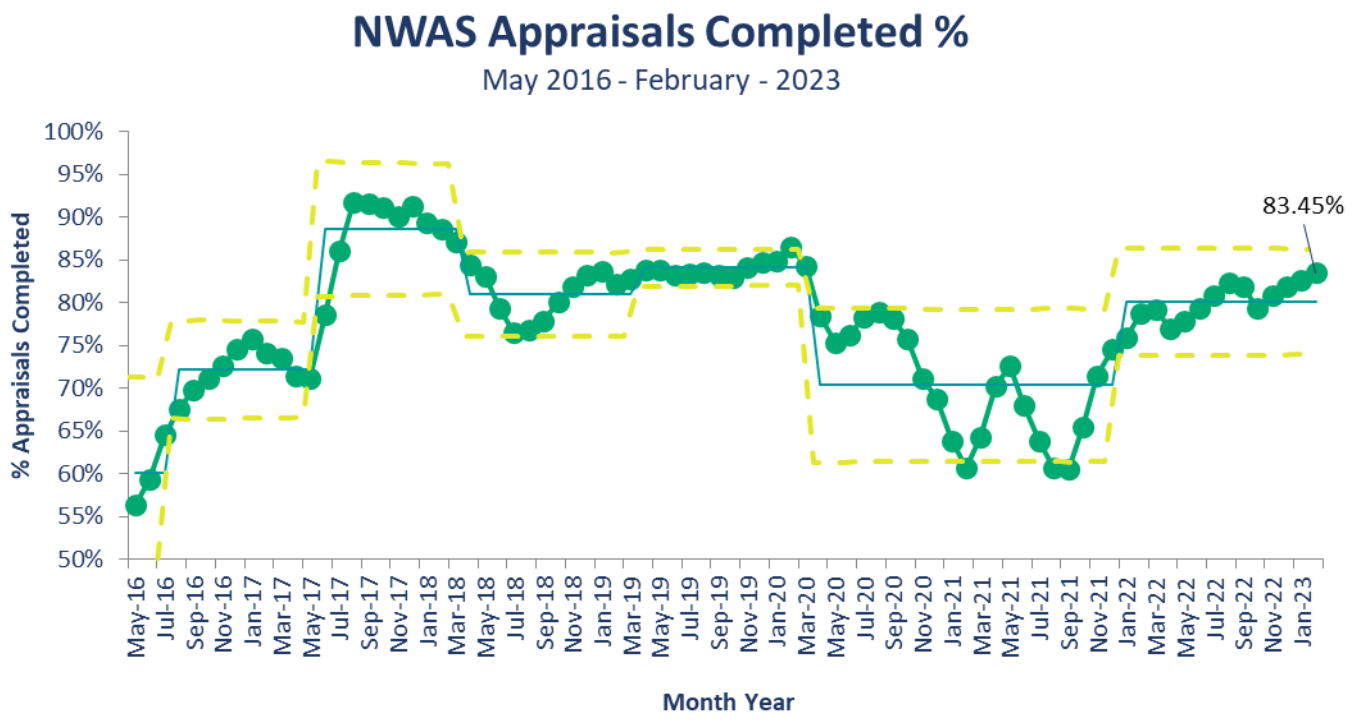


Table OH6.1

Appraisals	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22
NWAS	79&	77%	78%	79%	81%	82%	82%	79%	81%	82%	82%	83%

Figure OH6.2

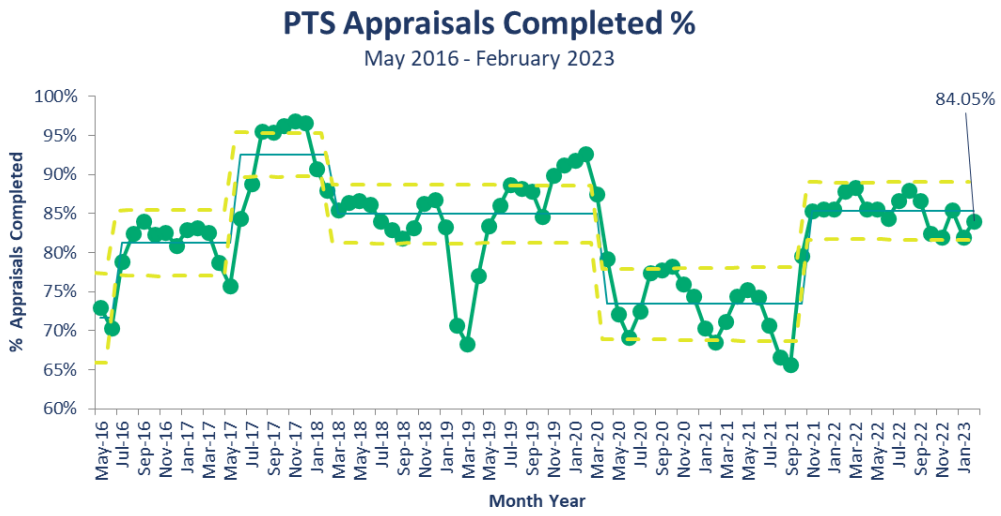


Figure OH6.3

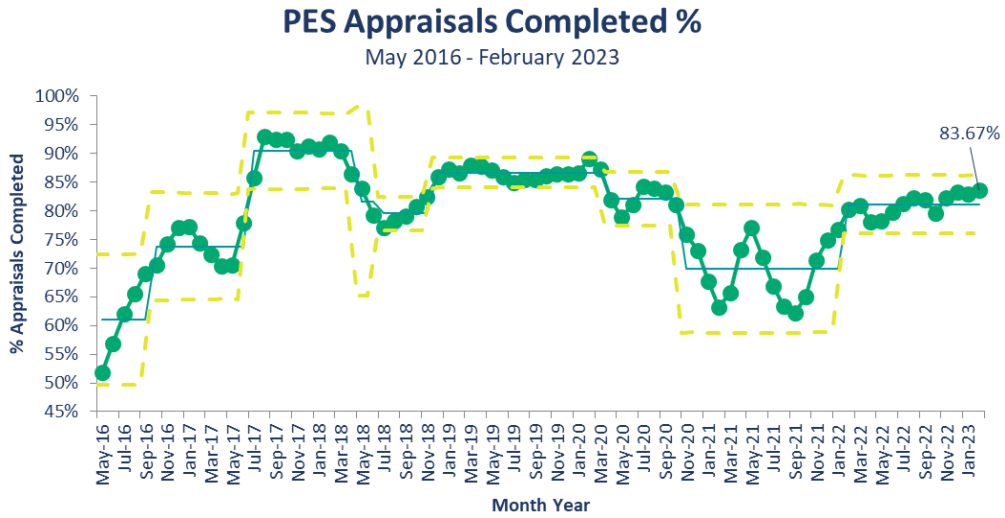


Figure OH6.4

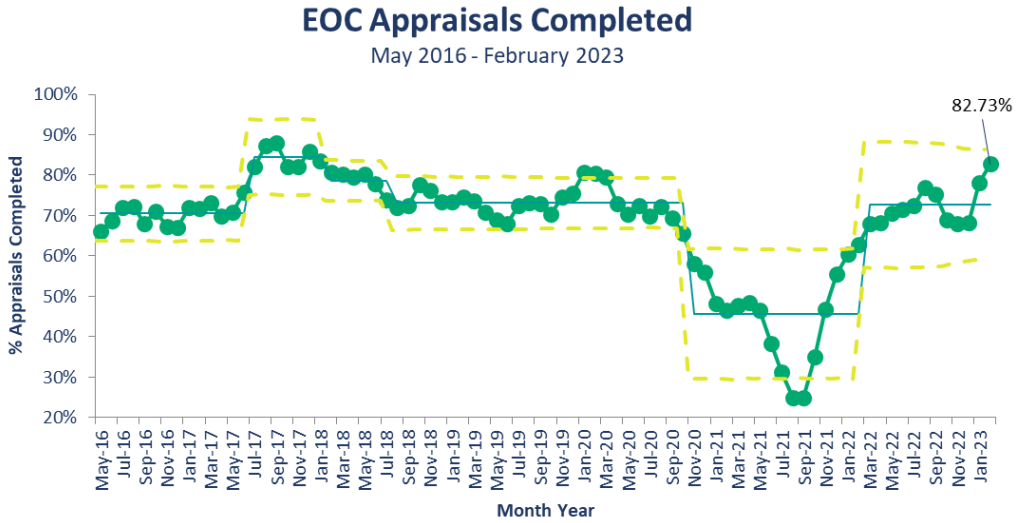
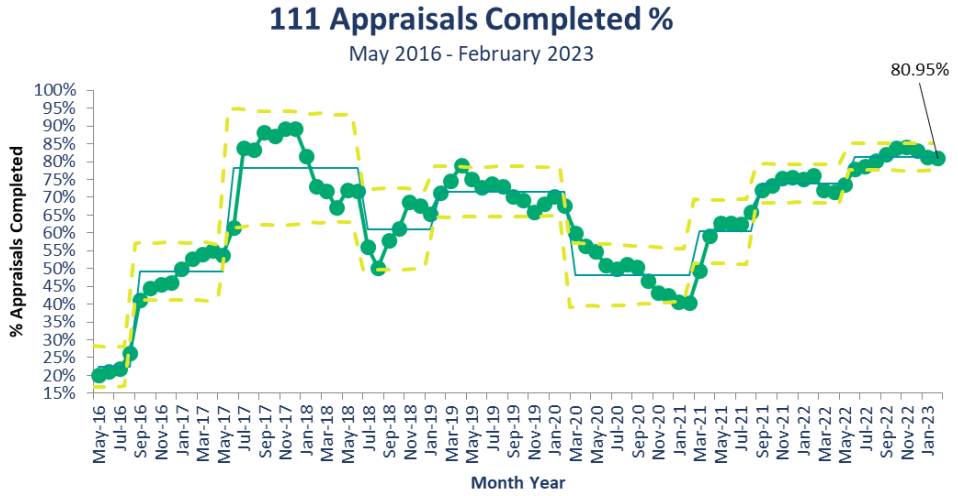


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

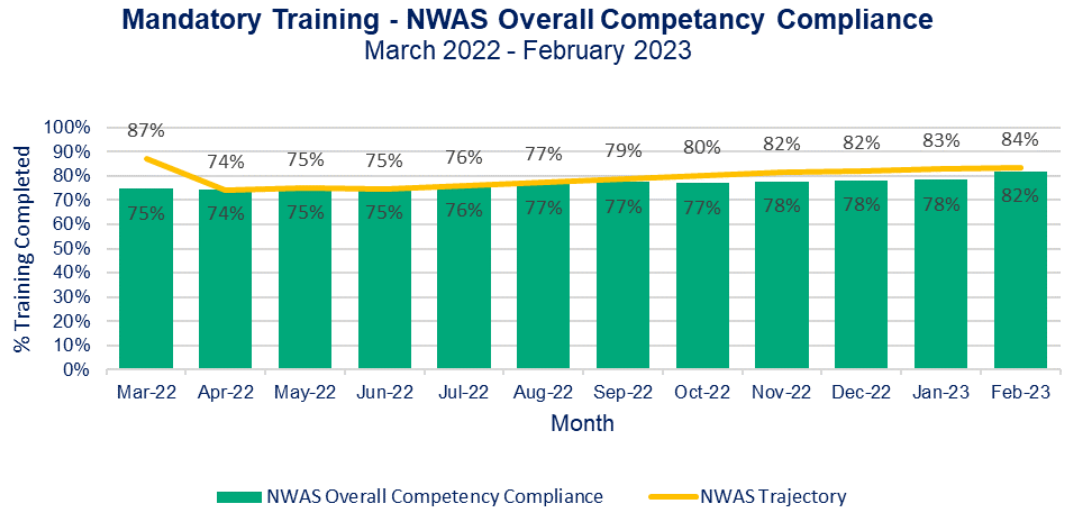


Figure OH7.2

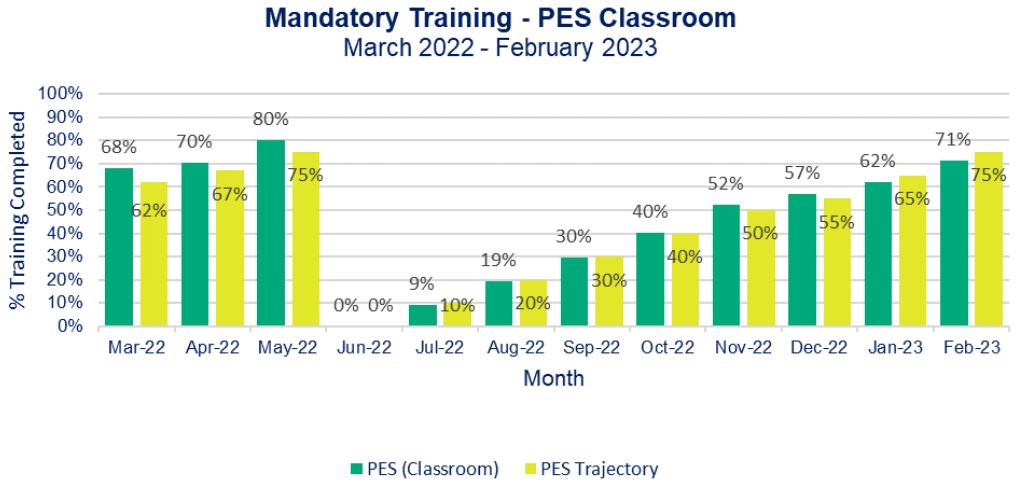


Figure OH7.3

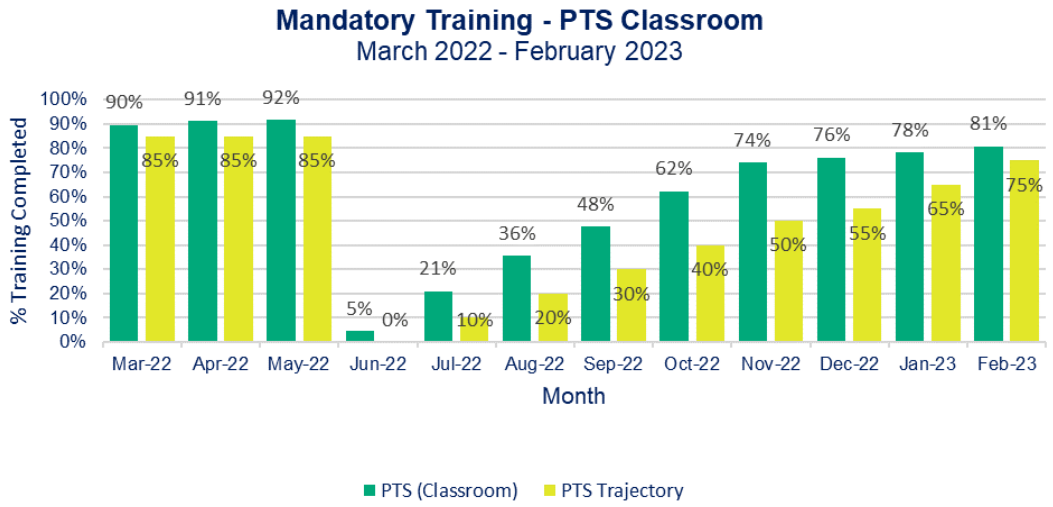


Figure OH7.4

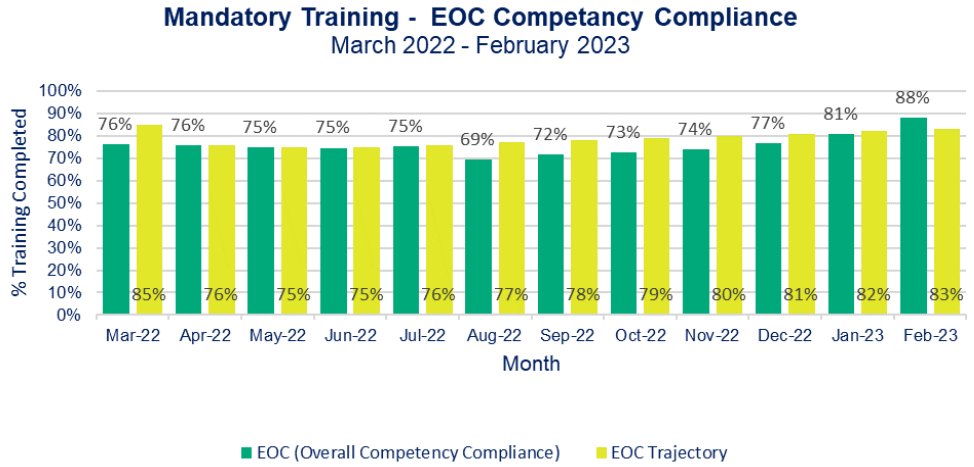


Figure OH7.5

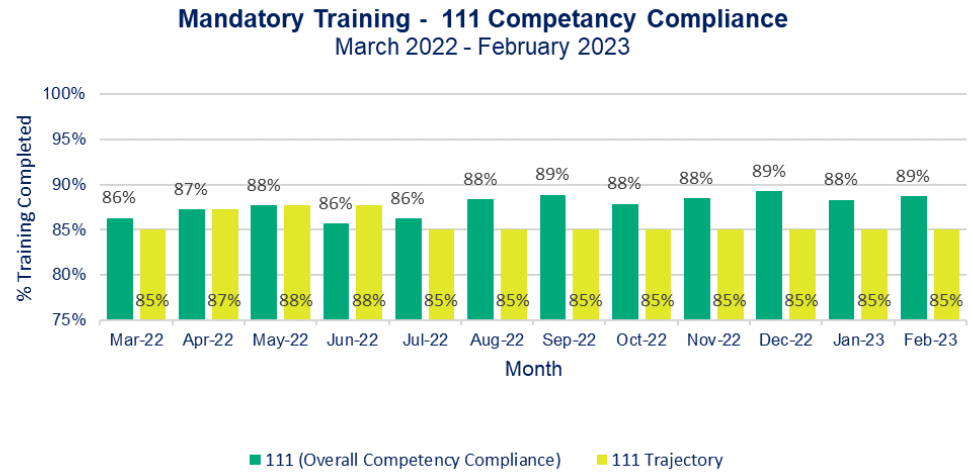
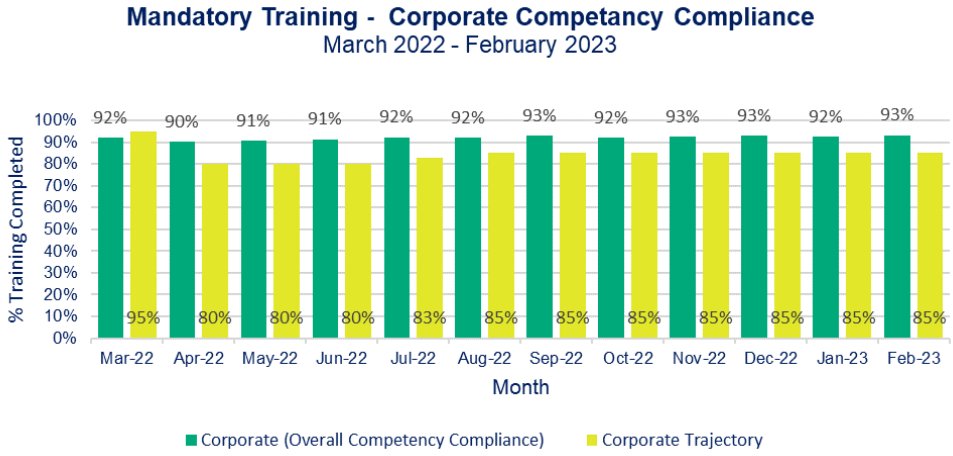


Figure OH7.6



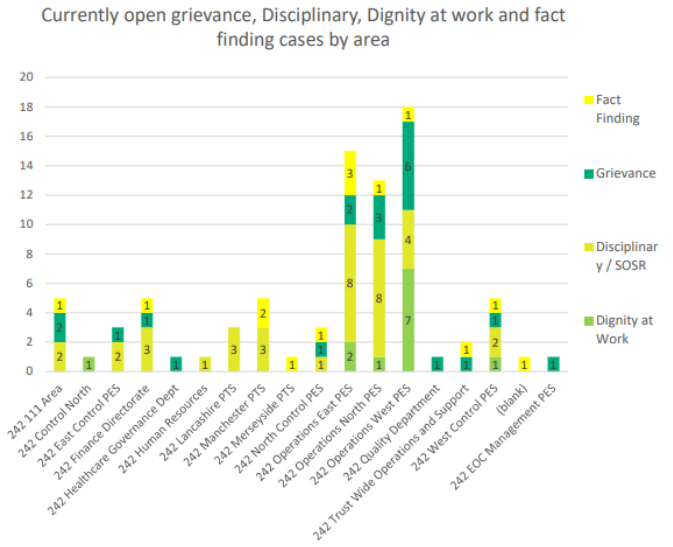
OH8 CASE MANAGEMENT

Figure OH8.1

Employee Relation Dashboard @ 6th March 2023. All information related to Dignity at work, Disciplinary, Fact Finding and Grievance cases only

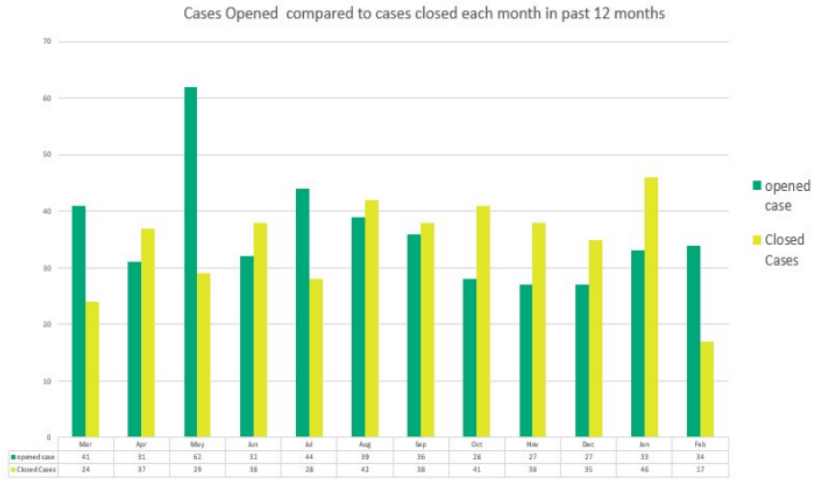
NWAS Summary

Service Line	Number of Live cases	Prevalence Live cases (numbers per hundred staff)	Number of cases closed in last 12 months	Prevalance Closed Cases (numbers per hundred staff)	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	46	0.1	189	4.8	12.93
CAM PES	18	1.5	54	4.5	16.10
CAL PES	13	1.0	64	5.9	12.67
GM PES	15	1.1	77	5.3	10.88
Operations ~ EOC	14	0.1	42	3.6	8.91
Operations ~ 111	5	2.2	59	9.1	4.64
Operations ~ PTS	10	1.0	44	4.6	9.91
Operations ~ Resilience	0	0.0	1	0.6	12.86
Corporate	3	0.0	16	2.2	13.64
Other*	5	2.0	44	0.1	12.80
NWAS Summary	**84**	**1.1**	**395**	**5.2**	**11.13**



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
Dignity at Work	12	51	14.42
Disciplinary	37	98	18.67
Fact Finding	14	164	6.09
Grievance	21	82	10.15
Case Summary	**84**	**395**	**11.13**



Length of current live cases

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	3	5	2	2
Grievance	18	2	1	0
Fact Finding	14	0	0	0
Disciplinary / SOSR	17	12	8	0
Case Total	**52**	**19**	**11**	**2**

Top 5 Reasons for opening Disciplinary cases in the past 12 months

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	31
Fraud	14
Failure to follow reasonable management instructions/procedures	10
Unauthorised absence	9
Any actions that bring the Trusts reputation into disrepute	7
NWAS Summary	**71**

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

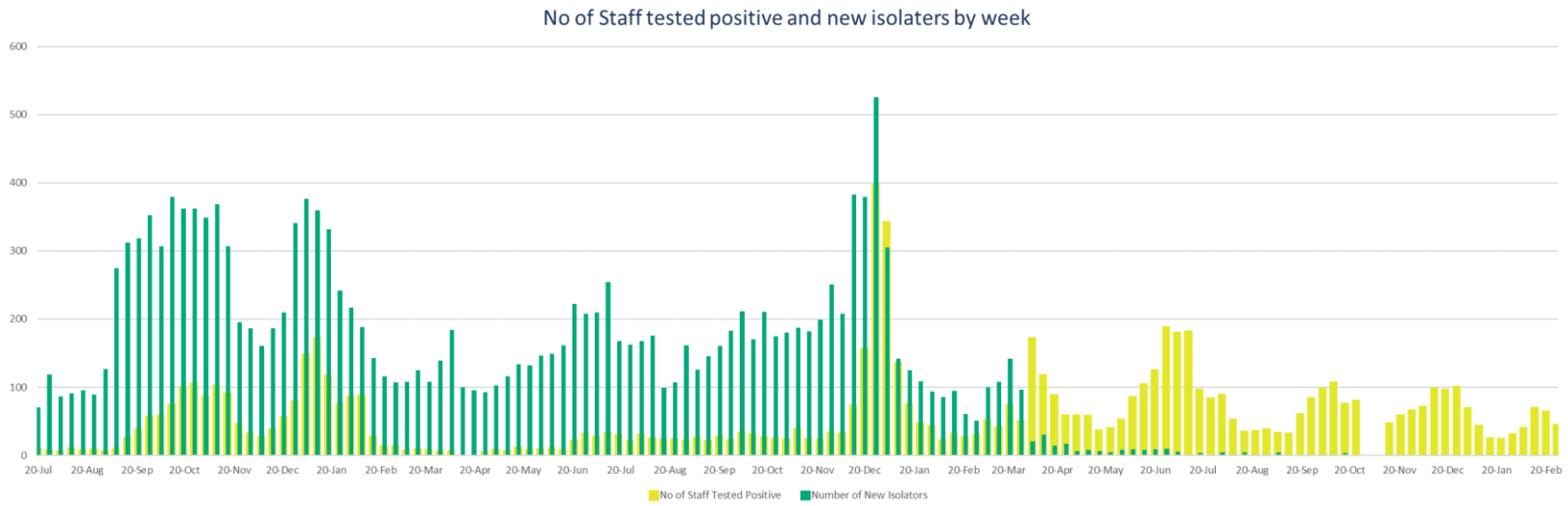
Covid

COVID 19

Figure CV1.0

Week Commencing	No of Staff Tested Positive
05-Sep	29
12-Sep	28
19-Sep	57
26-Sep	80
03-Oct	94
10-Oct	103
17-Oct	72
24-Oct	76
31-Oct	0
07-Nov	0
14-Nov	43
21-Nov	55
28-Nov	62
05-Dec	67
12-Dec	94
19-Dec	92
26-Dec	97
02-Jan	66
09-Jan	40
16-Jan	21
23-Jan	20
30-Jan	27
06-Feb	36
13-Feb	66
20-Feb	60
27-Feb	41

Figure CV1.1



North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th March 2023					
SUBJECT:	Learning from Deaths - Summary Report and Dashboard Q3 2022/23					
PRESENTED BY:	Dr C 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 Q3 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 78.1% 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. • patient centric decisions recognising frailty and co-morbidity. • 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 now been deployed during Q3, focusing on Events and Feedback components. Further work is required to automate the process.
RECOMMENDATIONS:	The Board is recommended to: • Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths. • Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths. • Acknowledge the impact of the Structured Judgement Review (SJR) process in identifying opportunities for improving care and identification of Serious Incidents previously unknown to the trust. • Acknowledge the good practice identified.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub Committee Quality & Performance Committee			
	Date:	7th March 2023 27th March 2023		
	Outcome:	Assurance received		

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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 Q3 2022/23 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 31 March 2023 in accordance with the national framework and trust policy. The Q3 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q3. The learning from the panels is discussed later in this paper.

The attached document remains an iterative reporting process which will continue to become more sophisticated and informative during 2023/24.

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.

3. LEARNING FROM DEATHS DASHBOARD Q1 2022/23: APPENDIX A

The number of patients whose deaths were identified as in scope for review was 168 (129 concerns raised in Datix and 39 sampled for SJR - Table 1, Fig.1).

3.1 Datix Cohort Discussion

Of the 129 patient deaths:

- 101 internal concerns were raised through Incidents module.
- 26 external concerns were raised through the Patient Experience module.
- 2 concerns were raised both internally and externally.

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

Of the 101 internal concerns, 39 were reviewed and closed. In 1 case, the investigation concluded the Trust had potentially contributed in some way to that patient death. No available clinical resource was cited as the main contributing factor to that death.

3.3 External Concerns: Tables 4 and 5 and Figure 4

Of the 26 patients reported, 18 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. 8 concerns have been closed as there were no causal factors identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

EOC

- Delay in responding to a chest pain patient, resulting in cardiac arrest.
- Delay in responding to a baby with Difficulty in Breathing (DIB)

PES

- Problem related to treatment and management plan.
- Problem with HCP communication
- Problem with patient disposition

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

2 patient deaths were raised both internally and externally. 1 has been closed with no causal factors identified. The remaining investigation remains open with the preliminary learning identified as:

EOC:

- Delay in responding to a patient with difficulty in breathing/chest pain.

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

Of the 39 patient deaths:

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

The flow chart in the Appendices provides a summary of which cases identified were reviewed and how the numbers referred to in Tables 8 and 9 and Figure 6 of the Q3 dashboard change.

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

- Without a patient report form the review cannot be undertaken.
- Death not in scope post clinical review.
- SJR not moderated at panel.
- Excess sample for the month.

3.6 Structured judgement review methodology

The process requires the reviewing clinicians to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible 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.

3.7 SJR Stage 1 Outcomes:

32 patient deaths were presented by reviewers and following the moderation panels, the outcomes of the reviews were determined as described in the table below. 25 patients received adequate care.

Month	Very Poor	Poor	Adequate	Good	Very Good
Oct 22		3	7		
Nov 22		2	7	1	
Dec 22		2	10		

Moderation Panels held on 06/12/2022, 17/01/2023, 07/02/2023 & 21/02/2023.

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

The Patient and Public Panel (PPP) representatives joined the moderation panels in May 2022. Their initial feedback was around the 'adequate care' rating. They have asked if this rating can be changed to something more suitable such as 'appropriate care'. It was explained that these are nationally agreed statements which would require national group approval.

Quality of patient records remains a theme identified. Focus will be bolstered by the EPR Clinical Documentation Standard CPI being received at CESC to drive improvement.

3.8 SJR Stage 2 Outcomes:

7 cases were identified as needing second stage review. In all 7 cases, no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment and management plan were below expected levels one might reasonably expect.

3.9 SJR Learning Outcomes: Tables 11 -12

Poor Practice: Table 11 Figure 7.

The panel identified areas for improvement were to:

- Use a medical model when documenting on examination findings.
- Perform chest examinations.
- Perform cardiac assessments.
- Record initial observations.
- Record repeated observations when appropriate to do so.
- Record medicines or take a photograph of prescription/lists.
- Assess and document capacity appropriately.
- Perform ECGs when appropriate to do so.
- Apply MTS correctly.
- Refer patients to AVS/GP/alternative providers when appropriate to do so.
- Detail differential diagnosis
- Consider EOLC planning and safety netting.
- Consider safeguarding for vulnerable NOKs.

Good Practice: Table 12 Figure 8.

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

- Holistic decision not to resuscitate.
- Full capacity assessment recorded.
- Multiple sets of observations and discussed patient's condition with GP and family.
- Recognition of EOLC, challenge to HCP plan, and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists.
- Patient centred decisions around frailty, comorbidities, and history
- Holistic decision making reported.
- Quality of EPR

Resulting Actions Identified from Learning from Deaths

- **Follow up on a failed EOC audit.**
- **Case escalated for an external SJR.**
- **Improvements to EPR Phase 2**
- **EPR issues to be raised at the EPR Technical Group around autocorrect and cancelling recorded observations.**
- **Follow up around NWAS involvement when a nurse has verified the death.**
- **Case escalated to the Community Resuscitation Team around gaps in provision (AED/CFR)**
- **Case escalated to the Resuscitation Group around LP15 functionality when in AED mode.**
- **Improvements to the DOD form.**
- **Case escalated for a local clinical review.**
- **Trust learning for the EOLC workstream around GPs and missed opportunities for a good death.**

3.10 Dissemination Process

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical Directorate) through the Area Learning Forums and individual clinicians.

Good practice letters have been circulated to commend 27 clinicians who through their care and professionalism have supported families and patients to experience a good death during Q3.

Observers continue to join the panels during Q3 and this demonstrates to staff an open and transparent process of review. Immediate feedback from the observers has been extremely positive and this inclusivity will certainly support closing the gaps in care.

3.11 Report Development

DCIQ: Mortality Module

The Clinical Audit Team has been working with the DCIQ team to improve the LfD module and dashboard. The new DCIQ modules have been live during Q3 (Events and Feedback), and the new listing reports have been tested and used to create the Q3 dashboard. Improvements have also been made to the listing reports and further work is required to improve data quality issues and further automate the process.

4. EQUALITY OR SUSTAINABILITY IMPACTS

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

5. RECOMMENDATIONS

The Board is recommended to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with the formal process of Learning from Deaths.
- Support the annual dashboard (Appendix B) as the report to be published on the Trust public account as evidence of the Trust's annual engagement of a formal process of Learning from Deaths.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
- Acknowledge the good practice identified.

NWAS Learning From Deaths Dashboard Quarter Q3 2022 - 2023 (October - December)

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

Total Number of Deaths in Scope (Sample Cohort and Datix Incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Oct-22	55	33	60.0%	12
Nov-22	36	22	61.1%	6
Dec-22	77	25	32.5%	7
This Quarter	**168**	**80**	**47.6%**	**25**
This Financial Year	406	287	70.7%	54

** 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.

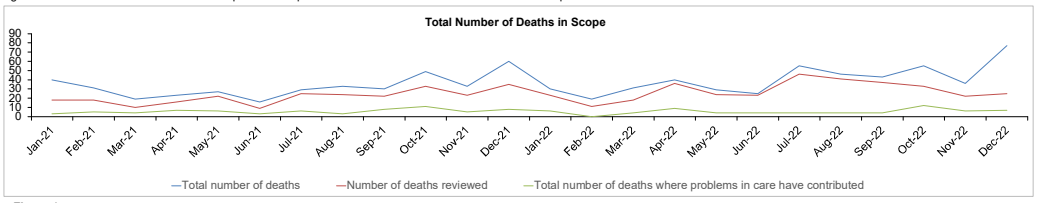


Figure 1

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised internally and exernally to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been a concern about the quality of care provided'. Records are included where death has occurred; the review is considered complete when the record is closed.

Internal Concerns - Incidents (including SIs)

Total Datix Death Incidents in Scope		Risk grading		
		1 or 2	3	4 or 5
October	30	1	9	18
November	20	1	6	13
December	51	3	4	43
Total	**101**	**5**	**19**	**74**

Table 2

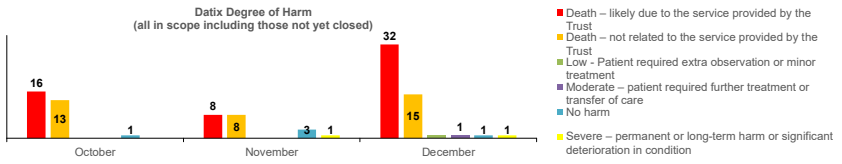


Figure 2

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
October	17	9	8
November	10	4	4
December	12	5	4
Total	**39**	**18**	**16**

Table 3

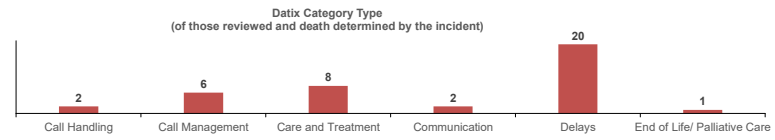


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
October	13	5	0
November	5	2	0
December	8	1	0
Total	**26**	**8**	**0**

Table 4

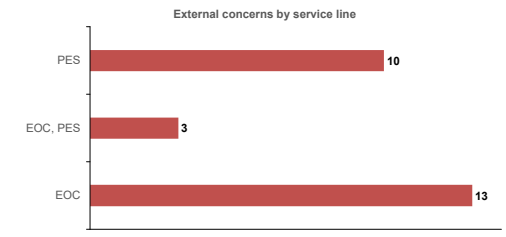


Figure 4

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation (fall)	Still under review	4
	Problem with call taking and response allocation (baby with DIB)	No causal factors; Not upheld; No actions	1
	Problem with call taking and response allocation (chest pain)	Incorrect coding of call, Demand outstripped resources; Hospital handover delays; Staff feedback and/or reflection	1
	Problem with call taking and response allocation (fall)	Still under review	2
	Problem with call taking and response allocation (stroke)	Still under review	2
	Problem with call taking and response allocation, Problem with communication	Still under review	1
	Problem with management of call, Problem with communication	Still under review	1
	Problem with call taking and response allocation (paediatric)	Demand outstripped resources; Not upheld; No actions	1
EOC, PES	Problem with call taking and response allocation (fall), Problem with communication	Demand outstripped resources; Not upheld; No actions	1
	Problem with call taking and response allocation (fall), Problem with mobilisation	Still under review	1
	Problem with call taking and response allocation (fall), Problem related to treatment and management plan, Problem with communication	Demand outstripped resources; Hospital handover delays; Partly upheld; No actions	1
PES	Problem related to treatment and management plan	Still under review	2
		No causal factors; Not upheld; No actions	1
	Problem related to treatment and management plan, Problem with communication	Still under review	1
		Poor communication; Staff feedback and/or reflection	1
	Problem with communication	Still under review	1
		No causal factors; Not upheld; No actions	1
		Poor communication; Staff feedback and/or reflection	1
	Problem with patient disposition	No causal factors; Not upheld; No actions	1
	Problem with patient disposition, Problem with communication	No causal factors; 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 provided by the Trust
October	1	1	0
November	0	0	0
December	1	0	0
Total	**2**	**1**	**0**

Table 6

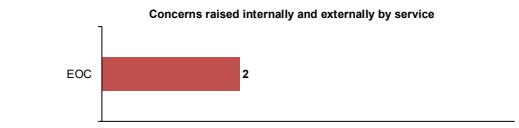


Figure 5

Data last exported 16/01/2023; Data last cleansed 24/02/2023

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with call taking and response allocation (chest pain)	Still under review	1
	Problem with call taking and response allocation (DIB)	Coaching ; Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1

Table 7

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents

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
October	11	10	3
November	11	10	2
December	17	12	2
Total	**39**	**32**	**7**

Table 8

SJR Category Type			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
October	2	1	8
November	4	0	7
December	4	2	9
Total	**10**	**3**	**24**

Table 9

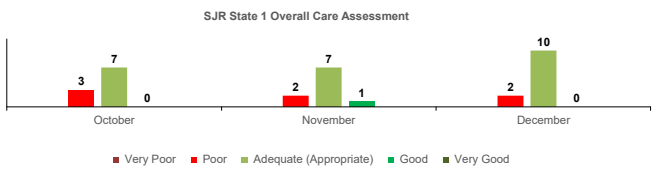


Figure 6

	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	6	23	3	**26/32 patients**	**81%**
	Management Plan/Procedure Rating	6	23	3	**26/32 patients**	**81%**
Right Place	Patient Disposition Rating	4	27	1	**27/32 patients**	**88%**

Table 10

† SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards;
Poor/Very Poor: Care that is lacking and/or does not meet expected standards;

Good/Very Good: Care that shows practice above and/or beyond expected standards

‡ 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 32 patients)

Evidence of Poor/Very Poor Practice

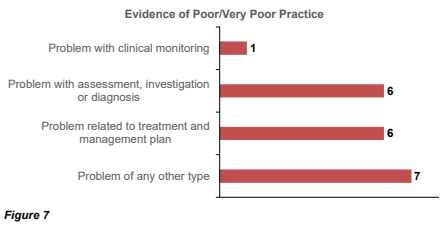


Figure 7

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Capacity to consent not assessed correctly	3
		No ECG performed when appropriate to do so	1
		No medical model used (including those that lack detail)	1
		No repeated observations recorded	2
		Medical model and cardiac assessment not documented	1
		No medication recorded	1
		Clinical examination poorly documented	2
	Problem related to treatment and management plan	MTS not applied correctly	1
		No referral to AVS/GP/alternative providers when appropriate to do so	1
		Differential diagnosis and safety netting	1
		EOLC planning and safety netting	1
		No specific worsening advice and MTS not applied correctly	1
		Unclear if safeguarding required for NOK	1
		Safety netting not documented	1
		Specific worsening advice not documented	1
	Problem of any other type	Quality of EPR	7
	Problem with clinical monitoring	No observations recorded	1

Table 11

Evidence of Good/Very Good Practice

Figure 8

Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Holistic decision not to resuscitate	1
		Full capacity assessment	1
		Multiple sets of observations and discussed patient's condition with GP and family	1
	Additional treatment and management plans	Holistic decision making reported	1
		Recognition of EOLC, challenge to HCP plan, and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists	1
		Patient centred decisions around frailty, comorbidities and history	1
	Other	Quality of EPR	6

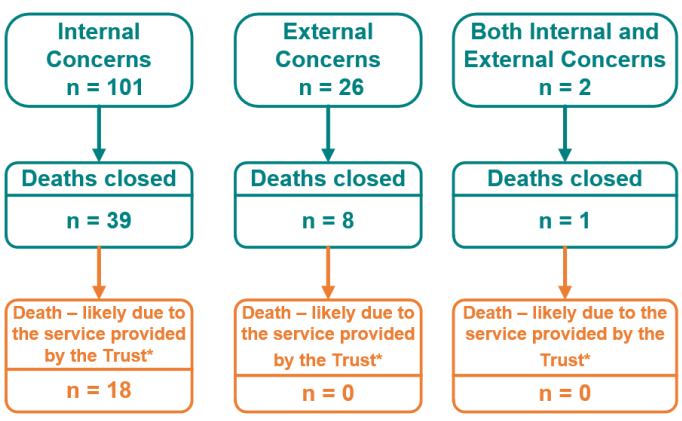
Table 12

Data last accessed 21/02/2022

NWAS LEARNING FROM DEATHS (LFD)

Q3 2022/23 Report

DEATHS WITH CONCERNS RAISED IN DATIX



*as classified by the Datix investigator

63%

had no causal factors identified

KEY LEARNING THEMES FROM CONCERNS

Emergency Operations Centre (EOC)

- Significant delay responding to a paediatric
- Significant delay in responding to a fall (x4)
- Significant delay in responding to a baby with DIB
- Significant delay in responding to a chest pain patient (2)
- Significant delay in responding to a Stroke patient (x2)
- Significant delay in responding to a patient (x7)

Paramedic Emergency Service (PES)

- Problem related to treatment and management plan (x5)
- Problem with communication (x5)
- Problem with patient disposition (x2)

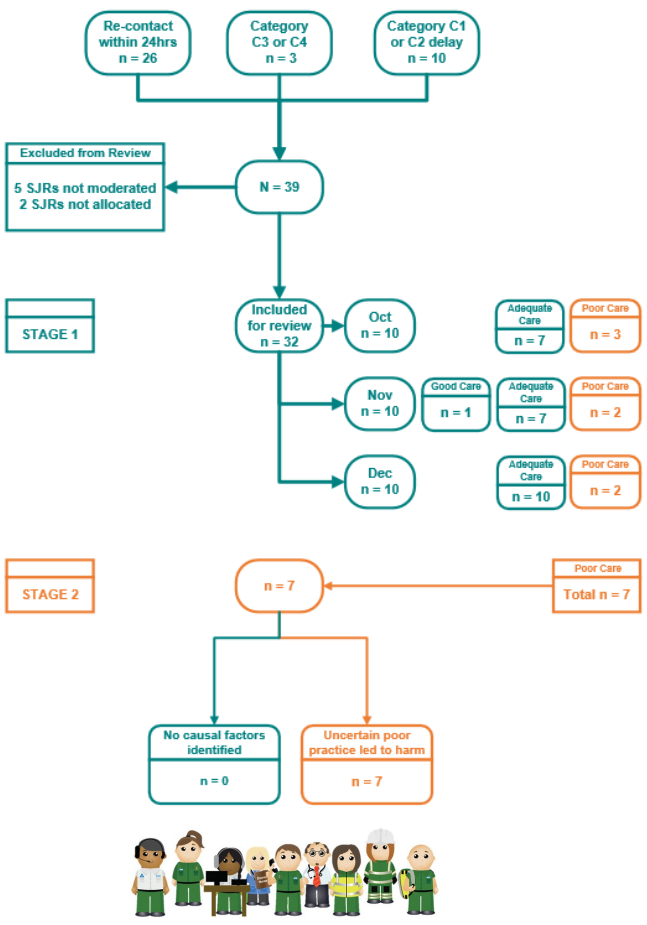
for more information on themes, full dashboard available on request

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

78.1% of patients received appropriate care

SJR STAGE 2 THEMES

Problem in assessment, investigation or diagnosis

- Lack of comprehensive documentation of the patient assessment
- No medical model used
- No observations recorded
- No repeated observations recorded
- Capacity to consent not assessed correctly
- No ECG performed when appropriate to do so
- No medication recorded

Problem relating to treatment and management plan

- Incorrect application of MTS
- No referral to AVS/GP/alternative providers when appropriate to do so
- Differential diagnosis and safety netting missed
- EOLC planning and safety netting missed
- No specific worsening advice
- Unclear if vulnerable NOK needed safeguarding

Problem of any other type

- Poor clinical documentation (x7)

EVIDENCE OF GOOD PRACTICE

Additional assessments, investigations or diagnosis

- Holistic decision not to resuscitate
- Full capacity assessment recorded
- Multiple sets of observations and discussed patient's condition with GP and family

Additional treatment and management plans

- Patient centred decisions around frailty, comorbidities, and history
- Holistic decision making reported
- Recognition of EOLC, challenge to HCP plan, and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists

Other

- Quality of EPR (x6)

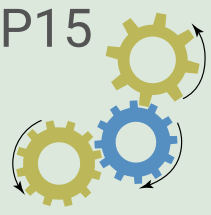
Acknowledging good care and practice - **27 letters sent out**

NWAS LEARNING FROM DEATHS (LFD)

Q3 2022/23 Report

SJR ACTIONS/ IMPROVEMENTS

- EOC specialists attended November, December and Q3 panels
- EOC SJRs to be included from January's data
- Regular observers in attendance
- Follow up on a failed EOC audit
- Case escalated for an external SJR (?failed discharge)
- Improvements to EPR
- EPR issues to be raised at the EPR Technical Group around autocorrect and cancelling recorded observations
- Learning for crew and Trust around when not to move a patient (confidence building)
- Follow up around NWAS involvement when a nurse has verified the death
- Case escalated to the Community Resuscitation team around gaps in provision (AED/CFR)
- Case escalated to the Resuscitation Group around LP15 functionality when in AED mode
- Improvements to the DOD form



PANEL DATES 2023/24

Open for all staff to attend
(2 observers per panel)

Period	Date
January 2023 February 2023 March 2023	23rd March 2023 4th April 2023 9th May 2023
April 2023 May 2023 June 2023	13th June 2023 11th July 2023 15th August 2023
July 2023 August 2023 September 2023	12th September 2023 10th October 2023 14th November 2023
October 2023 November 2023 December 2023	12th December 2023 16th January 2024 13th February 2024
January 2024 February 2024 March 2024	12th March 2024 16th April 2024 TBC

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

REPORT TO BOARD OF DIRECTORS

DATE:	29th March 2023					
SUBJECT:	Ockenden Review (Maternity) Assurance Report					
PRESENTED BY:	Dr C Grant, 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:	NWAS has taken a proactive approach to reviewing the report and addressing IEAs detailed within the Ockenden Review (Ockenden 2022) in the context of prehospital maternity and newborn care. This report provides assurance that IEAs are being addressed to enhance patient safety. This report highlights changes / updates since the IEA plan was last presented. Please refer to the highlighted columns within the table for ease of reference. This paper proposes that this agenda item to be replaced with the maternity single plan report that will be released in March 2023 in which the trusts consultant midwife will review and present.					
RECOMMENDATION:	The Board of Directors are requested to: • Receive assurance that the Trust is responsive to Ockenden IEAs and continues its focus on reviewing pre-hospital maternity provision. • Receive assurance that this report details the initiatives in place to support delivery of safe, effective, and patient centred maternity care. • Agree for the Ockenden assurance report to be replaced and aligned with the single maternity plan to be released by NHS England in March 2023.					
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:	☐	Sustain ability	☐
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee Clinical Effectiveness Sub Committee			
	Date:	27th March 2023 7th March 2023		
	Outcome:	Received assurance		

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1. PURPOSE

To provide assurance that the Northwest Ambulance Service NHS Trust (NWAS) is responding and addressing immediate and essential actions detailed in the interim Ockenden review and to propose this agenda item to be replaced with the maternity single plan report that will be released in March 2023 in which the trusts consultant midwife will review and present.

2. BACKGROUND

The serious complications and tragic deaths resulting from substandard maternity care at Shrewsbury and Telford Hospitals NHS Trust between 2000-2019 has had an everlasting impact on families and their loved ones. NWAS welcomes Donna Ockenden's review and is committed to the prevention of substandard care and practices. NWAS does not offer a commissioned maternity service. In cases where pregnancy, labour or birth has deviated from the normal, women and birthing people choose to seek medical attention and guidance from ambulance services for themselves or their new-born baby, via 111 or 999. Although the Ockenden report is aimed at maternity providers, as an emergency ambulance service responsible for pre-hospital maternity care, NWAS must be an active participant. Self-assessment is required against immediate and essential action's (IEA) highlighted within the report. Five of the seven IEAs are applicable to the prehospital environment. The report sets out (in the required tabular format) the responses:

Section 1								
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months								
Link to Maternity Safety actions: Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Action 2: Are you submitting data to the Maternity Services Dataset to the required standard? Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?								
Link to urgent clinical priorities: (a) A plan to implement the Perinatal Clinical Quality Surveillance Model (b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB								
What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	**September 27th 2022 CESC Update**	**7th of March 2023 CESC Update**
The role of the NWAS Consultant Midwife is recognised in the North West Single Perinatal Plan. The role is a member of the Perinatal Board	NWAS is one of only three ambulance trusts to have a substantive Consultant Midwife. This key role provides	As this process is new to NWAS, assurances / feedback is being sought via the NW maternity systems to the usefulness of reporting via the	No further actions needed at this stage. The NW Perinatal Board is a key meeting of all	NWAS Consultant Midwife now attends the quarterly meeting. Regular meetings	The role of the Consultant Midwife was substantiated in early 2022. This has a regional profile. Considerations for additional	To mitigate the risk, key responsibilities have been allocated to the Consultant Midwife. In addition, the current SDMR	SDMR still in progress. At present the Consultant midwife is the sole lead on maternity workstreams within NWAS.	SDMR still in progress and the consultant midwife remains the sole midwifery lead of maternity / newborn care.

and holds board status with all 4 of the LMS across the NW. This ensures prehospital maternity/neonatal care is fully represented and as such, plays a key role in the integration of care provided across the North West. New potential SI incidents are presented and reviewed weekly at our Review of Serious Events (ROSE). These reviews provide assurance that risk scoring is appropriate, and that investigations, recommendations and actions take place in a timely manner and by the appropriate level of manager or advanced clinician. Completed reports (after commissioner review) are forwarded to the appropriate organisations involved, providing	assurance that national drivers in maternity and reports (such as Ockenden) are fully reviewed and actioned. Since the first NWAS Ockenden Board Report, a maternity dashboard has been developed and a reporting platform within Datix allows identification of themes / areas for focus. Now the Consultant Midwife is in post, key assurance reporting will be determined to embed maternity assurance in the formal governance processes.	Perinatal Board. In addition, specific focus on ensuring a clear reporting system via the regional midwifery team is under review The new SOP for dealing with HSIB now includes a clear mapping of all key safety recommendations for the trust. These will be presented at Clinical SMT for action.	maternity leads across the system, supporting clear governance procedures and risk assurance across the NW maternity systems. This meeting provides NWAS with a dedicated agenda item to provide updates and raise safety concerns.	occur with regional HSIB team to ensure robust process continue to support investigations in a timely manner and support staff included in such processes. All national HSIB reports are addressed internally, ensuring any actions or safety concerns raised and addressed.	maternity support forms part of SDMR considerations.	will look to ensure subject matter specialists are identified and aligned to key work streams. In the interim, the Advanced Paramedic cohort will continue to provide expertise to mitigate risk.	Holding a strategic role across the system, the CM is now within a substantive role in NWAS and agreed via the system that board status at the perinatal board, regional safety meetings and the 4 LMS board meetings will remain to support cross collaborative working across the system. Gaps remain in terms of integration of any NW NWAS focused policy / changes across NENC as an anomaly – the NW regional maternity team do not cover the Whitehaven / Carlisle area and the trusts in these areas work across three ambulance services therefore complex in terms on embedding NWAS policies / process. This has been highlighted to NENC in terms of ensuring that any regional policy is reviewed	As detailed on the 27th board updates / attendance are still managed by the consultant midwife with no midwifery deputy. NENC board risks highlighted at the SRO has contacted the HoM's in both Whitehaven / Carlisle for collaboration on the installation of standby phones / discussion around supportive relationships to enhance practices. PSSC report presented highlighting the 6 safety recommendations that have been issues by HSIB to NWAS. At present unable to provide assurance across a number of these. The trust required an implementation plan of which required input from the patient safety team and clinical leads to

opportunities for shared learning. NWAS new Datix-IQ platform has a dedicated maternity module to host all investigations and incidents. Key relationships have been built with the regional Healthcare Safety Investigation Branch (HSIB) team to support collaborative and timely approaches to supporting their investigation process. A revised internal protocol has been developed to ensure Executive oversight of all final HSIB reports, with a new internal review mechanism in place to ensure all safety recommendations are charted and addressed.							by the NENC board to assess acceptability and transferability with actions assigned to the maternity safety leads within the area. Issue to be raised at maternity leads group for consideration of complexity with supporting system change within and across ambulance services. Working closely with the regional HSIB body has proved to be supportive in terms of critical discussions a round process / supporting shared learning across the organisations. HSIB report summary to be provided quarterly to the patient safety subcommittee to ensure due escalation and considerations for change / implementation. Ongoing work to support system	ensure assurances can be gained on evidencing actions / impact. Raised via PSSC and acknowledged by the patient safety team as an area of focus required. Aligned to regional and national approaches to addressing safety the Maternity single Plan is due for release in March 2023 and will provide systems with a focused plan / agenda for meeting Ockenden recommendation and recommendations detailed within the East Kent report. Following discussions internally with the SLT a decision was made for the consultant midwife to sit under the quality directorate aligned to the Chief nurse /

							and partner oversight for SI's / PMR's undertaken by acute trusts to ensure NWAS representation. This agreement at perinatal board has been shared with regional providers to support process. This is turn supports NWAS in identifying key learning and the ability to play a vital part in detailing women / babies journeys through all the sieves included in the care delivery as part of such reviews.	Patient Safety team to lean and drive forward key safety and quality recommendations within the trust aligned to this patient group and following identified needs for staff to deliver high quality care. A key safety agenda is the standardisation and acknowledgment of the PROMPT training as a key quality intervention that required the dedication and investment from NWAS to support realising a key safety recommendation.
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.								
Link to Maternity Safety actions: Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?								

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?								
Link to urgent clinical priorities: (a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. (b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.								
What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	**September 27th, 2022, CESC Update**	**7th of March 2023 CESC Update**
NWAS has a process to gather service user feedback via the patient experience team. The Trust website also includes clear information informing patients how they can complain, compliment, or tell us how we did as a service. As NWAS are not a commissioned maternity provider, we do not have an Executive Director for Maternity Services. However, the	As part of NWAS Annual Report, feedback, compliments and compliments are published. The Consultant Midwife will work to identify how MVPs may assist with NWAS specific feedback.	Feedback via official methods (patient experience team) are useful in identifying key points for consideration from those who access the service. Action plans will be developed to show learning has occurred and been embedded.	A coordinated response to addressing maternity related complaints and feedback ensure subject matter experts within the organisation are included and able to support process.	The patient experience team and newly appointed Consultant Midwife will review current processes. A maternity specific work plan and associated governance will be developed and presented to Clinical SMT by end of Q3 22/23 .	Key links with NW MVP networks and to ensure the NW systems include NWAS in case reviews, patient stories and investigations reviews to ensure learning is triangulated. In addition, working closely with NWAS Patient Public Panel will be required to ensure patient voices are heard, their input collated in any key recommendations	Key relationship will be built with NW MVP network and relevant LMS Boards.	In June 2022 the CM in NWAS presented at the NW MVP network building key relationships with each of the MVP leads across the NW. As part of key representation at the perinatal board the MVPs play a key role in providing support / advice to any ongoing initiatives / policy development. Currently in process is the development of a NW wide SOP to support teams in	NW wide SOP now at ratification stage demonstrating a collaborative piece of work via NWAS / Systems. An RFPB NIHR grant submission in progress to explore health inequalities associated with women who access the ambulance service during and following pregnancy which will include PPI collaboration.

recently appointed substantive Consultant Midwife, (sitting within the Medical Directorate) ensures the Executive Medical Director acts as the responsible Executive for maternity provision. Advanced Paramedics with a speciality interest in maternity care also link in with LMS and maternity steering groups. These maternity leads are encouraged to work collaboratively with their corresponding LMS's and regional maternity units. Oversight is provided by the Consultant Midwife with any regional / local issues raised via the LMS and regional maternity teams. In addition, there is a maternity leads ambulance group that meets quarterly. An NWAS AP					and/or policy changes that affect maternity care.		standardising approaches to community transfers of women from a freestanding / home setting. Working closely with the MVP representatives within this meeting and clinical leads from each of the LMS's such approaches support NWAS in being recognised as a key system partner. Currently, an NIHR proposal is in progress via the ARC NWC to explore the possibility of obtaining grant funding to explore women's experiences of accessing and receiving care via the service. Such an approach aligns to this key Ockenden recommendations and support the identification of key equity and equality gaps that may persist in terms of women accessing maternity care.	

currently Chairs the group.							NWAS AP Joe Tunn was recently successful in obtaining chair status at the national maternity AACE leads group. This supports NWAS in being one of the lead trusts for enhancing prehospital maternity care.	
Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.								
Link to Maternity Safety actions: Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?								
Link to urgent clinical priorities: (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place								
What do we have in place currently to meet	**What are our monitoring mechanisms?**	**Where will compliance with these**	**What further action do**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk**	**September 27th 2022 CESC Update**	**7th of March 2023 CESC Update**

all requirements of IEA 3?		**requirements be reported?**	**we need to take?**			**in the short term?**		
NWAS is not commissioned directly for specific maternity staff training. However, as part of the wider MDT, prehospital clinicians will need to be considered in training provision currently delivered by maternity training units. This recommendation aligns with national reports that highlight the importance of interprofessional training in obstetric and neonatal emergencies. NWAS funding was secured via external bid in January 2022 to support the development of training resources for staff and to scale up MDT obstetric emergency training. HEE awarded NWAS £145,000 to support the purchase of training	A bi monthly meeting is held with the Consultant Paramedic – Education, to support governance and oversight of any new teaching materials. NWAS developed resources are being reviewed by AACE as these may form basis for national scaling via E-Lfh (the online national NHS e-learning education platform). JRCALC have also requested that the material developed (interactive videos) be used on their national platform. The e learning developed will be launched April 22, with analytic mechanisms	This training offer currently sits outside of mandatory training. As part of the initial evaluation, staff will be encouraged to engage as part of CPD. It is anticipated that Advanced Paramedics will receive this training as part of their required yearly CPD. Once initial phase evaluated, discussion will proceed with mandatory training group to determine next steps.	Scaling up MDT training within NWAS requires support for training faculty. In collaboration with the NW regional maternity team, next steps include a MDT approach to existing training days. Agreements with HoMs will be sought via the NW Perinatal Board.	Following evaluation of the Pre hospital PROMPT, Clinical SMT will consider the potential for scale up of the package in collaboration with the education team. Plans for trust wide delivery commence Sept 2022.	A training faculty to deliver the training over the course of the year in their subsequent areas. Purchase of the PROMPT train the trainer course will quality assure those who deliver the course. Further conversations required with Heads of Service and operational managers to mitigate impact upon service delivery.	Initial training is to be targeted at Advanced Paramedic cohort, as these clinicians are the most likely to be called/assist at complex and high risk maternity incidents.	Developments include the introduction of maternity focuses topics within the Mandatory training cycle. This includes NLS as a key topic highlighted as requiring due attention across the trust. Additionally, the CIT team who cover training to apprentices and all new starters within the trust via induction and aligned to the future qual standards for the Apprentice cohort are not delivering a weeklong maternity focused training course. This has been supported by the maternity team in NWAS ensuring this aligns to the PROMPT resources and meets the needs of staff alike. This development is a key improvement within NWAS demonstrating advancements in training and	PSSC report highlighted the risk associated with maternity specific training for staff. In response MT now covering maternal cardiac arrest and postpartum haemorrhage however a gap remains in covering all obstetric emergencies and those that pose a significant risk to patient safety. In 2022 the trusts consultant midwife secured over £200k to scale Pre-Hospital PROMPT. A pilot has been completed including the training of 100 senior clinicians in NWAS. Investment moving forward from NWAS is required to ensure this model is sustainable. Training needs for staff

equipment. NWAS purchased Pre-Hospital PROMPT training package, enabling us to deliver face to face simulated obstetric emergency training. A formal service evaluation has been undertaken to identify what aspects of training would support staff and what are their preferred methods of engagement. This service development report has been accepted for publication in the British Paramedic Journal.	allowing NWAS the ability to map engagement and evidence learning via a knowledge check. This will support staff in refreshing skill training.						education for staff. PROMPT a recognised and accredited training package has also been delivered to senior staff across the three core regions within NWAS – aims at AP/SPTL level. This pilot supports the exploration of acceptability, feasibility, and evaluation of such a course by gathering feedback from staff that attended. In addition, conversation via the LMSs to explore the potential of delivering joint MDT training are in progress – aligned to this key IEA via Ockenden. Internally, a paper will be presented to SMT to explore the investment of the PROMPT training for AP/SPTL cohorts moving forward to support	highlighted across a number of SI's / external investigations / HSIB and nationally.

							knowledge / skills highlighted as a safety recommendation within a NWAS focused HSIB recommendations and as per a formal information request from CQC. The NWAS e-learning suite has been well evaluated and received by staff. Over 2500 visits across all modules so far. This innovative e-learning demonstrates supporting flexible and easy access to training materials to all staff. National interest in placing these sessions onto the HEE platform and have been shared across NW HEIs to support standardised resources across the region, supporting a well equip and skilled workforce.	
Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies								

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team								
Link to Maternity Safety Actions: Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?								
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.								
What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**		
N/A to NWAS	N/A	N/A	N/A	N/A	N/A	N/A		
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.								
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.								

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	September 27th 2022 CESC Update	7th of March 2023 CESC Update
NWAS has engaged with HoM to ensure emergency risks are discussed with women who are considering home birth. Fully informed consent must include information relating to emergency transport, should this be required. To support this process, NWAS Consultant Midwife has assisted the NW Chief Midwife to produce an information and communication document. These detail information relating to the ambulance service including REAP levels, national ARP times and the categorisation of ambulances responses and IFTs. Additionally, a patient communication was produced to support midwives	Consultant Midwife attends the NW Maternity Safety Surveillance and Concerns Meeting, to raise any key safety risks across the system. Reporting occurs via: 1) Regional NW maternity team 2) Individual direct contact with HoMs 3) NWAS Partnership & Integration Managers.	All updates and concerns form part of NW regional maternity logs and actions. Clinical Effectiveness Sub Committee will receive maternity assurance reports in 22/23. Internally, any safety concerns flagged via the Datix system are monitored and managed via usual process with oversight from the patient safety team.	To ensure a clear process is agreed with CESC for reporting maternity care following agreed NWAS assurance framework.	To be agreed and actioned by Consultant Midwife and Medical Director. Official substantive midwife role begins in May.	The Consultant Midwife will need assistance in collating, reporting and presenting data for assurance. This would include key relationships with the Business Intelligence team and Informatics within the trust.	Current processes in place supports the identification of clinical risk (via Datix / patient experience) and DATIX IQ will allow for maternity specific incidents to be identified. Substantive Consultant Midwife now in post to provide speciality input.	Datix Q will be live in October supporting the actions detailed within the original report. Agreement in place for quarterly reporting via PSSC alongside bi-annual assurance reporting to CESC / Q&P aligned to Ockenden with an annual maternity assurance report to ELC. In the interim ongoing work at region to support the development of a SOP to support informed discussions with women in the AN period to aid informed choice that covers transfer times. Ongoing discissions regarding how the key IEA:	DCIQ now live and capturing maternity and new born incidents that are reported by staff. Reduction in incident reporting noted. PSSC report provided with quarterly reports now requested to detail incidents / HSIB reports. Awaiting maternity single plan for clarification around Ockenden IEA.

in providing balanced information to women and birthing people in the antenatal period. The joint publications were shared via the NW networks to support HoM and their clinical teams.							*'It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust''* Is interpreted. This relates to the difference between transfer times (from arrival of the crew to the incident – arrival at the obstetric unit) and the understanding of response times (time from category allocation to crew on scene). This is not understood fully by the LMSs and raised as needing national guidance on this ask. Awaiting guidance from the national team.	
Immediate and essential action 6: Monitoring Fetal Wellbeing								

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.
The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**		
N/A to NWAS	N/A	N/A	N/A	N/A	N/A	N/A		

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected								
Link to Maternity Safety actions: Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?								
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.								
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	**September 27th 2022 CESC Update**	**7th of March 2023 CESC Update**
At present NWAS does not provide information on the public website detailing what routine practice and procedures maternity patients are expected to receive if an ambulance is called to a maternity related incident. NWAS is now in receipt of the joint communication written and cascaded across the NW networks (in response to IEA 5) which now supports our ability to further	No formal reporting system for this IEA within NWAS as we have no MVP. EPR will capture the clinical care records ensuring that informed consent is gained in line with all clinical procedures / care provider interactions.	An audit of EPR data would allow us to gather a high level overview of informed consent compliance and the level to which staff document this. The use of interpreter services for non-English-speaking women would also be a measure of compliance with informed consent procedures.	Public information included on NWAS website will be actioned by the 31st March.	This will be undertaken by the Consultant Midwife by 31st March 2022	Communication team support to ensure the information is correctly uploaded and accessible. The information will be agreed by Clinical SMT prior to publication ensuring it aligns to NWAS policy and clinical service delivery.	NWAS will continue to support the wider maternity systems in understanding the operational aspects of the service, to best support informed conversations with women regarding the potential need to access the ambulance service during pregnancy or following birth. Internally, work is	Information included on Public NWAS website relating to maternity care / what to expect if attended to by the ambulance service during / following pregnancy. A dedicated public maternity section supports this IEA. NWAS also have a dedicated green room maternity page for staff.	Action met in context of NWAS – note 27th September update.

communicate this standardised information. Working with the communications team, the actions set out on the 30/08/2021 report are in progress with a dedicated Green Room space for staff focused on maternity workstream and ongoing work to support general information available to women and families who access NWAS service on the trust website.						underway via the development of resources to support staff in understanding and upholding informed consent and recognising potential challenges. These principles are embedded within the E-learning resources that have been developed. Funds via the maternity network are supporting a training session delivered by Birthrights UK who focus on providing NHS organisations with training related to the legal and ethical frameworks and policies that underpin maternity care. This will be offered to all senior leads within the		

						organisation to support the cascaded of learning within and amongst teams.		

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Ockenden report encourages all services that provide maternity care to acknowledge areas for improvement and action. Despite no mandated requirements for ambulance trusts to respond directly, reviewing services against this report provides internal assurances and a proactive approach to mitigating risks and adverse outcomes. Governance / risk implications identified in the tryst unable to provide assurances around HSIB safety recommendations and no formal support for the trusts consultant midwife is realising recommendations and workstreams aligned to maternity and newborn care.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

The forthcoming maternity plan will focus on addressing IEAs detailed in the Ockenden report and the East Kent report and provide systems with details on assurances required to evidence action / change. The Consultant Midwife will work closely with the Quality Directorate and Public Health team to identify opportunities to support national equity and equality agendas and ensure a sustainable approach to working collaboratively with systems is supported.

5. RECOMMENDATIONS

The Board of Directors are requested to:

- Receive assurance that the Trust is responsive to Ockenden IEAs and continues its focus on reviewing pre-hospital maternity provision.
- Receive assurance that this report details the initiatives in place to support delivery of safe, effective, and patient centred maternity care.
- Agree for the Ockenden assurance report to be replaced and aligned with the single maternity plan to be released by NHS England in March 2023.

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	27th February 2023	**Chair:**	Prof A Esmail, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	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 C Grant	**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
☒	☐	☒	☐	☐	☒	☐	☐	☐	☐	☐

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

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

Board Assurance Framework	• Discussed digital interoperability and resource required, alongside other demands. Acknowledged that plans for future investment would be a board level decision with any gaps in control in relation to risk managed through the BAF process at operational, subcommittee or Committee level. • Discussed the risks aligned to SR06 and the progress to resolve the issues related to the EPR Apex tool. • Noted the issue had been escalated to AACE and although a national problem, NWAS had additional unique challenges. • Noted the CQC had been notified of the position, in terms of the trust meeting AQI requirements. • Discussed work to manage risk associated with C2 long waits and noted additional clinicians had been appointed in EOC with further intakes to follow.	• Gained assurance that BAF risks were being managed effectively.	
Serious Incidents Assurance Update	• Received a presentation and detail of current arrangements, scoring rationale and improvement work being undertaken in relation to the trust's management of SIs. • Noted work with AACE to define harm to provide a more robust and	• Received assurance from the presentation and SI update.	

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

	consistent approach to measuring harm, to link in with PSIRF. • Internal process for supporting decision making at ROSE and proforma shared and noted procedure in place for managing high risk incidents that didn't meet the SI threshold. • Noted the learning mechanisms in place and work to share learning with external partners. • Noted the process for supporting staff with SIs related to a poor clinical decision. • Recognised the work being undertaken and the processes in place in relation to management of SIs.		
Quality and Performance Dashboard	• Received monthly data, prior to receipt of the IPR in March. • Noted some stability in the improvement in performance against call standards, partly impacted by the reduction in call activity due to periods of industrial action. • Noted the change in public behaviour which had resulted in a reduction in demand and volume. • Recognised a sharp increase in reporting of incidents and an increase in complaints.		

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

	• Noted safeguarding data and an assurance report which had been requested by the Committee, to be provided at the next meeting. • Noted some early stabilisation in 111 call activity, with a more recent increase in call volume. • Recognised that a 111 resource paper to ELC and work to realign rotas was in progress. • Hospital handover data provided a snapshot for the month, with an improved position, partly due to ambulances not being called out during periods of industrial action.	• Noted some reduction in call volume due to industrial action taken during the period. • Noted some improvement in hospital handover data due to reduction in demand, due to industrial action taken during the period. • Recognised some stabilisation in call activity with some performance standards met. • Noted upward trend in number of complaints and increase in number of incidents reported.	
Service Delivery Oversight Forum	• Received an update on the trust's service delivery model review and the next steps. • Deep dive into the first 6 months of NHS Pathways to be presented to the next meeting. • NAA CAD programme delayed due to work required between the four trusts involved in the project. • Clarified the timescales for completion of the SDMR review and the trust's processes for those posts impacted by the changes.	• Noted the progress and update provided.	

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

EPRR Assurance Report	• Noted the paper had previously been presented to the Board of Directors in January and assurance provided.	• Noted the assurances provided.	
EPRR Sub Committee Chairs Assurance Report	• Received detail of the assurances provided from the meeting of the EPRR subcommittee held on 16th January 2023. • Noted the actions being taken and progress made. • Noted areas of moderate assurance in relation to HART and recruitment of MERIT doctors. • Director of Operations, as Chair of the Sub Committee monitoring progress in relation to addressing the recommendations of the MAI.	• Noted the assurance received by the EPRR Sub Committee.	
Complaints Q3 Report	• Received Q3 complaints data. In terms of closure noted 33% were overdue. • Key themes related to poor experience and operational pressures had impacted on the team's ability to close complaints within the timeframe. • Noted new DCIQ module would support future reporting of lessons learnt and triangulation a key objective for reporting in Q4. • Discussed the number of cases upheld and those referred to the ombudsman.	• Noted the assurances provided.	

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

	• Further detail of these cases to be presented in Q4 report. • Complaints team working with heads of operational teams and area directors to close complaints.		
Serious Incidents Q3 Report	• Noted the number of cases which had met the SI criteria during the quarter. • Key theme related to mental health patients and delays in response. • Noted the Reportable Events Paper, presented to the Board of Directors in January provided further detail. • Received an update on DCIQ reporting which was accessible via trust iPads and mobile devices. Increase in the number of SIs reported expected to increase, due to improved accessibility. • 25% of incidents had provided meaningful lessons learnt and shared with partners involved. • Discussed process for notifying other organisations of action taken and learning themes. • Requested further assurance in relation to mental health activity due to increased prevalence of SIs. • Executive team and Deputy Director of Quality, Innovation, and Improvement	• Noted the update in SIs during Q3. • Noted the work to identify and share learning from SIs. • Noted key theme in the number of SIs related to mental health patients. • Requested further detail and assurance related to mental health patient SI activity.	

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

	to discuss format and content of reporting to Q&P to provide further detail and assurance.		
Legal Services Q3 Report	• Received an update on activity during the quarter and themes in relation to claims. • Noted outcome of recent Regulation 28 which had raised an issue for trusts in relation to NHS Pathways. Confirmed this had been escalated to the National NHS Pathways team. • Noted the sustained pressures had impacted on the number of referrals to coroners, which wasn't specific to NWAS, more reflective of the pressures on the whole NHS over the winter period. • Discussed the issue for the trust in relation to NHS Pathways in more detail. • Noted the deep dive into NHS Pathways to be presented to the Committee at the next meeting.	• Received assurance from the Q3 report.	
Medicines Management Q3 Report	• Noted the activity in relation to medicines management. • Received detail of audit activity and trust compliance in relation to controlled drugs.	• Noted the content of the Q3 report.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
	Assured	No or minor impact on quality, operational, workforce or financial performance

	• Recognised the Trust's Clinical Effectiveness Sub Committee had scrutinised data at the meeting on 7th March 2023. • ELC received updates and sighted in relation to controlled drug compliance.	• Received assurance that medicines management activity was being monitored and scrutinised by the Trust's Clinical Effectiveness Sub Committee.	
Clinical Effectiveness Sub Committee Chairs Assurance Report	• Received detail of the assurances provided from the meeting held on 7th March 2023. • Noted the areas of amber assurance and the action being taken to progress the issue related to the Apex tool and related digital processes.	• Noted the assurances provided by the subcommittee.	
Patient Safety Sub Committee Chairs Assurance Report	• Received detail of the assurances provided from the meeting held on 7th March 2023. • Noted activity in relation to patient safety and the assurances provided, which included scrutiny of high-risk incidents, due for review at the next meeting of the subcommittee.	• Noted the assurances provided by the subcommittee.	
Health, Safety and Security Sub Committee Chairs Assurance Report	• Received detail of the assurances provided from the meeting held on 7th March 2023. • Noted the non-attendance of subcommittee members from service line areas and absence of assurance reports.	• Noted nonattendance of members from service line areas and absence of assurance reports. • Noted risk had been escalated on the trust's risk register.	

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

	• Risk escalated on the trust's risk register. • Noted that since the meeting specific service line representatives had been identified to ensure that future assurance reports were provided.		
IPC Sub Committee Chairs Assurance Report	• Received detail of the assurances provided from the meeting held on 21st November 2022. • Some missing assurance reports from service lines and further support provided by the IPC Area leads, to ensure assurances received at the next meeting of the subcommittee.	• Noted the assurances provided to the subcommittee. • Noted the missing assurance reports from some service lines and further support provided by IPC area leads to ensure assurances provided at the next meeting.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	24th March 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
☐	☒	☒	☒	☒	☐	☒	☒	☒	☒	☒	☐

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Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Draft Committee Annual Report and Terms of Reference	• Reviewed the feedback received from members of the Committee and the terms of reference. • Identified areas for improvement during 2023/24. • Approved the terms of reference for onward approval by the Board of Directors in April.	• Discussed the findings of the annual effectiveness review and identified key areas for improvement during 2023/34. • Approved the Terms of Reference for 2023/24 for onward approval by the Board of Directors in April.	
Board Assurance Framework	• Received the proposed Q3 position of the BAF. • Noted the significant improvement in reduction of risk score for SR02, reduced to 12, with a target score of 16. • Acknowledged the hard work of the Finance team to reduce the risk. • Noted timelines in relation to SR12. • Recognised increase in risk score of SR04, related to staffing pressures as an impact of industrial action.	• Received assurance that the BAF risks were being managed effectively.	
Deep Dive – Estates Backlog	• Received a comprehensive report which provided an update in relation to the investment to address backlog maintenance and an overview of the current condition of the remaining backlog across the trust estate.		

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	• A proposed 12-month plan to remove further risk items also included in the report. • Noted that all high risks had been removed and noted a breakdown for 2023, which provided detail of investment to date, carried out during previous planned capital programmes. • Discussed the inter relation between estate backlog actions and the trust's QAV process. • Discussed the progress made and the improvements made to the backlog position. • Discussed communication to staff of the position and work achieved. • Noted future MIAA review to consider the processes involved, to be reported to the Audit Committee.	• Received assurance of the work being undertaken. • Recognised the good work achieved to address the estate backlog. • Noted future MIAA audit of the estates and QAV processes in place, to be reported to the trust's Audit Committee meeting.	
Finance Report – Month 11 2022/23	• Received details of the Trust's financial position up to 28 February 2023. • Noted the Trust expected to achieve the annual efficiency and productivity target in full for 2022/23. • Discussed the latest position in terms of the capital programme 2022/23. • Acknowledged that the Trust's cash and equivalents balance.	• Received assurance from the report.	

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	• Noted the trust had achieved the Better Payment Practice Code targets in 2022/23.		
Financial Plan Update 2023/24	• Received an update on how financial plans had developed since the last report to the Committee. • Noted the financial plans due for submission to the lead ICS by 27th March 2023, followed by submission to the NHSE on 30th March 2023. • Acknowledged update in terms of agreement of contract income values for 2023/24. • Noted capital resource and the revised capital programme for 2023/24. • Noted final capital resource to be included in the final plan. • Supported onward approval by the Board of Directors.	• Supported approval of the financial plan by the Board of Directors.	
Travel Management Contract Award	• Noted the proposal to award a travel management contract award. • Supported the proposal for onward approval by the Board of Directors.	• Supported the contract award proposal. • Recommended approval by the Board of Directors.	
RRV Vehicle Replacement Programme	• Noted and discussed the options presented in the business case. • Supported the proposal for onward approval by the Board of Directors.	• Noted the options and the recommendations presented for approval. • Recommended approval by the Board of Directors.	

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Procurement of motor vehicle insurance	• Supported the contract award proposal for procurement of motor vehicle insurance. • Supported the proposal for onward approval by the Board of Directors.	• Supported the contract award proposal. • Recommended approval by the Board of Directors.	
Stockport Station Update	• Received an update following approval by the trust's Executive Leadership Committee, in October 2022 to consider options for relocation of Stockport ambulance station. • Noted the current situation in terms of costs. • Approved to allocate capital in 2023/24 and recommended onward approval by the Board of Directors.	• Noted the update in relation to the relocation of Stockport ambulance station. • Approved recommendations for onward approval by the Board of Directors.	
Procurement Report	• Received an update on procurement activity since the last report to the Committee. • Key areas included procurement structure, KPIs and work plan updates. • Noted the number of projects currently in progress and the number of waivers received per month during 2022/23.	• Noted and received assurance from the report.	
Estates, Fleet and Facilities Management Assurance Report	• Received an update against key work areas identified in the trusts fleet and estate strategies. • Noted Performance and the progress against programmes, which provided a focus on exceptions.	• Noted and received assurance from the report.	

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	• Discussed the key highlights and welcomed the updated format of the report.		
Sustainability Update	• Received an update on work against the key areas identified in the trust's green plan. • Noted progress against the targets and highlighted the areas of development towards attaining desired outcomes. • Received assurance in relation to the trust's commitment and progression to achieving sustainability plans.	• Noted and received assurance from the report.	
Draft 2023/24 Annual Plan	• Presented with the Draft Annual Plan for discussion. • Discussed the content of the draft plan and future consideration of monitoring processes for oversight of progress. • Chair to meet with Deputy Chief Executive to discuss monitoring arrangements. • Requested dedicated time at the May Committee meeting to discuss the final plan prior to Board.	• Noted the Draft Annual Plan 2023/24. • Requested extended time to discuss the final plan at the May Resources Committee. • Chair to meet with Deputy Chief Executive to seek further assurance in relation to arrangements for monitoring progress against the plan.	
Workforce Indicators Report	• **Sickness absence** rate for January 2023 9.11%, which included Covid-19 related sickness. • The lowest rates for last two years and supported by phased return to work and adjusted duties.		

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	• **Mandatory training** overall compliance slightly behind target at 82%. The impact of industrial action on PES target noted and acknowledged the risk that the trust may not achieve 85% target by end of March 2023. Additional course places have been profiled in March to provide capacity to recover. • **Appraisal** completion rates at 83% for February 2023 which exceeds target. • All service lines ahead of target. • EOC made strong progress and ahead of target. • **Staff turnover** 12.09%, slight decrease and broadly stable position over last 6 months. • **Vacancy position** vacancy gap noted as a slight widening from previous month and overall improving position since September. • Recognised recent ELC approval for funding of the trust's AITs and requested future annual assurance report of the value for money and benefits achieved.	• Recognised the progress made in terms of sickness absence. • Recognised the improvement in appraisal compliance and hard work of the service lines to achieve and exceed performance against target. • Noted workforce challenges remained and aligned to the increase in risk score of strategic risk SR04. • Requested future assurance paper in March 2024 to understand the benefits achieved during the year, from the work of the Attendance Improvement Teams.	
Results from the National Staff Survey 2022	• Received the headlines from the results of the National Staff Survey 2022.	•	

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	• Noted key improvements and area for focus during 2023/24. • Noted an update scheduled for the Board of Directors on 29th March 2023.		
Strategic Workforce Sub Committee Chairs Assurance Report and Annual Report	• Received the assurances provided within the Chairs Assurance Report, from the meeting held on 2nd March 2023. • Received and approved the Sub Committee Terms of Reference for 2023/24.	• Noted the assurances received by the Strategic Workforce Sub Committee at the meeting held on 2nd March 2023. • Approved the Sub Committee Terms of Reference for 2023/24.	
Diversity and Inclusion Sub Committee Chairs Assurance Report	• Received the assurances provided within the Chairs Assurance Report, from the meeting held on 10th March 2023.	• Noted the assurances received by the Diversity and Inclusion Sub Committee at the meeting held on 10th March 2023.	
Digital Update	• Discussed key activity since the last report to the Committee. • Recognised good progress in relation to achieving actions aligned to SR09 however recognised challenges in relation to BI reporting and resourcing. • Noted some audit requirements would not be met and ELC and the National team aware of the position. • Discussed innovation projects and priorities, including ideas from the workforce which couldn't always be tested due to resource.	• Noted the content of the report. • Noted the challenges related to the balance of innovation projects and priorities with demands on trust resource.	

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	• Noted future ideas and solutions would be considered in line with the Trust's Strategy. • Work commenced with the strategy team to align processes.		

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29 March 2023					
SUBJECT:	Disciplinary Policy and Fast-track Disciplinary Procedure					
PRESENTED BY:	Lisa Ward, Director of People					
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 Disciplinary Policy and Fast Track Procedure have been reviewed and agreed through the Trust's Policy Group and Joint Negotiating Group. The policy amounts to a complete rewrite, due to the requirement to fully embed the Just and Learning Culture principles communicated across the NHS by Baroness Dido Harding and Prerana Issar.

The final documents are being recommended for approval by the Executive Leadership Committee. Approval will also close a final recommendation from the MIAA Freedom to Speak Up Audit.

The appended documents detail the final position after a lengthy consultation process. As the policy was re-written, it is not possible to highlight changes via the track change function. Instead, the key changes were presented and can be summarised as follows:

- Embedding the principles of Just and Learning culture through a review of the whole disciplinary process. This includes the introduction of revised fact finding and suspension checklists, introduces senior level oversight in decision making through the introduction of the Case Manager role, focusses on informal resolution wherever possible, and the introduction of the Fast Track procedure.
- Introduction of the Case Manager/ Investigating Officer Model
- Employee health and wellbeing position strengthened as a pivotal consideration during any formal process.
- Review of the example list of misconduct to add clarity and in response to themes identified within the organisational context.

	• Clarification of certain elements of the process, such as resignation, police involvement and referral to professional bodies. • Introduction of a revised mechanism for informal warnings; Structured Conversations which are live on file for a 6 month monitoring period. Overall, the language of the policy has been reviewed to ensure it is inclusive, supportive and clear. The policies have been equality impact assessed. Review of data indicates that the current position has led to a higher likelihood of staff from a BAME background being managed through the formal disciplinary process. These factors have been taken into account in the development of the new policies and detail the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010. Implementation will be closely monitored to ensure that an improvement in the WRES position is delivered.
RECOMMENDATIONS:	The Board of Directors is recommended to: • Approve the Disciplinary Policy • Approve the Fast Track Disciplinary Procedure
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:	Executive Leadership Committee			
	Date:	March 2023		
	Outcome:	Recommended for approval		

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1. PURPOSE

1.1 The purpose of this paper is to present the Disciplinary Policy and Disciplinary Fast Track Procedure for approval.

2. BACKGROUND

2.1.1 The Trust's current Disciplinary Policy and Procedure has been in place since October 2017 and was due for review in 2020. Due to the COVID pandemic and the impact on standard Trust activity, the policy has had several extensions. The revised policy was required to incorporate guidance issued by Dido Harding and Prerana Issar relating to creating a Just and Learning Culture across the NHS and issues identified through the MIAA Audit of Freedom to Speak Up arrangements.

2.1.2 The revised policy has been drafted in line with these principles and has incorporated feedback sought from managers and members of the HR team on the application of the current policy. In addition, a Fast Track Disciplinary Procedure has been introduced in order to deal with applicable issues of misconduct swiftly and without the need for a formal investigation.

2.1.3 The initial drafts were shared with Weightman's solicitors to ensure the policies did not present any obvious risks to the organisation. These documents were then shared at Policy Group on 20th May 2022.

2.1.4 It was agreed that staff side colleagues would need some time to review and consult with their members due to the broad rewrite of the documentation and that initial feedback would be sought in four weeks. The policy has been extensively consulted on since its presentation in May 2022 with ample opportunities provided for staff side colleagues to review and present feedback from their members across every policy group meeting since its launch - in total 6 meetings.

2.1.5 At the final Policy Group meeting, members failed to agree on two outstanding matters; the duration of formal warnings, and the date at which a disciplinary sanction is live from (in relation to the Fast Track policy). These matters were escalated for discussion at JNG. The meeting took place on 1st February 2023 and agreement was reached following discussion. Therefore, the Disciplinary policy and Fast Track procedure are now approved from a consultative perspective.

2.2 Key Policy Changes

2.2.1 The policy starts by reiterating the Trust's ongoing journey to fully embedding a Just and Learning Culture. Part of this involves the commitment to deal with minor issues informally; implementing support and a coaching style of management to avoid more serious issues occurring in the future.

2.2.2 The policy emphasises the need for a thorough assessment of all the facts before launching any formal processes, and introduces a revised Fact Finding pro-forma. It also clarifies the best practice approach to suspension, reiterating that decisions are never taken by one person and introduces a revised suspension checklist to allow a thorough assessment of alternatives/ action short of suspension to be taken.

2.2.3 Employee wellbeing is a key theme throughout the document; an employee focussed approach which places the health and wellbeing of our people as paramount.

2.2.4 The role of the HR team is strengthened; ensuring involvement at every stage of the process to ensure consistent and robust case management.

2.2.5 A shift in language from the current 'Appendix B' action which is the current name used for an informal warning, renaming to a structured conversation which is 'live' on file for a period of 6 months to allow an adequate period of monitoring. This is then considered closed, and should not be referred to in any subsequent instances of misconduct, unless a pattern of behaviour becomes apparent.

2.2.6 The policy introduces the 'Case Manager' and 'Investigating Officer' model. This is a widely used model used across the NHS and provides a robust framework for managing concerns. Roles and remits are clear (and are defined in the policy document) and there is senior oversight in terms of decision making, which is in line with Dido Harding's recommendations.

2.2.7 The list of examples of Misconduct/ Gross Misconduct has been reviewed and revised to provide greater clarity and avoid any ambiguity. This list has also been informed by prevalent cases seen within the workforce.

2.2.8 Some sections of the policy have simply seen a redraft to clarify process. These include: resignation during the disciplinary process, criminal offences in/ outside work, referral to professional bodies.

2.2.9 There are no changes to sanctions which may be issued as an outcome to a disciplinary process. Nor have there been any changes to timeframes for the organisation of hearings/ appeals.

2.2.10 Appendices have been redrafted in line with the changes made to the body of the policy (included in the appended draft documents)

2.3 **The Revised Model**

The most significant change to the policy is the oversight model for case management. Implementing this model allows senior level decision making/ ownership over cases and clearly defines the roles each individual takes during the process.

2.4 **Case Manager:**

Ensures a level of control at local level and oversight on case progression.

- To consider the information provided by the line manager regarding the incident and support them in determining appropriate recommendations regarding next steps.
- Commissioning the investigation, including communication to the employee/ their representative
- Appointing an appropriate investigating officer - giving consideration to resources and time for them to undertake a thorough investigation.
- Determining the terms of reference for the investigation including all allegations to be investigated. Reviewing any required changes to the terms of reference in the event additional information becomes available (e.g. through investigation meetings)

- To consider whether suspension is necessary to safeguard the investigation at the outset.
- Review suspensions and whether they need to continue based on the progress of the investigation/ available information.
- Review the progress of the investigation ensuring timescales are adhered to
- Keep employee updated on a monthly basis about the progress of their case
- On completion of Investigation Report, review and provide feedback as to required next steps (case to answer, no further action, management under a different policy framework etc)
- Responsible for communicating the outcome of the investigation to the employee/ their representative

2.5 **Case Investigator:**

- The remit of this role is clarified within the amended policy.
- An appropriately trained manager will be appointed to undertake the investigation by the Case Manager
- The IO will conduct a timely investigation with appropriate HR support throughout.
- Any required changes to the ToR will be communicated to the Case Manager for their review and approval
- Any delays with the investigation will be raised in a timely manner to the Case Manager who will communicate any amended deadlines to the employee/ their representative
- The role of the IO will be to gather information in relation to the allegations and present this in a well structured investigation report. They will be asked to draw conclusions and make recommendations linked to the ToR. It will be for the Case Manager to decide the appropriate next steps in line with the information captured within the IO's report.

2.6 **Fast Track Procedure**

2.6.1 The Fast Track Procedure has been developed as a separate document to the main body of the policy. It allows for timely resolution of instances of misconduct whereby allegations are not contested. It is a tested model used across the NHS to avoid un-necessary lengthy processes, and is supportive of employee wellbeing.

2.6.2 The procedure is only applicable for instances of misconduct which fall short of 'gross' misconduct. The maximum sanction which can be issued through the use of this procedure is a 12 month final written warning.

2.6.3 Employees/ their representatives can request their case be dealt with under this procedure. Equally, a Case Manager can suggest this to an employee if appropriate. There must be agreement from both the Case Manager and the employee to proceed under this framework

2.6.4 There is no right to appeal for sanctions issued in this way and any sanctions issued are applicable from the day of the fast track hearing.

3. LEGAL, RISK and/or GOVERNANCE IMPLICATIONS

3.1 There are legal risks associated with the application of this policy, mainly in reference to the disciplinary sanctions. The Trust has a statutory duty to comply with all aspects of the Employment Rights Act 1996, in reference to this policy this includes an employee's legal right not to be unfairly dismissed. The policy is written in line with HR Best Practice to mitigate any risk as much as possible.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

4.1 The policies have been equality impact assessed. Review of data indicates that the current position has led to a higher likelihood of staff from a BAME background being managed through the formal disciplinary process. These factors have been taken into account in the development of the new policies and detail the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010. Implementation will be closely monitored to ensure that an improvement in the WRES position is delivered.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Approve the Disciplinary Policy
- Approve the Fast Track Disciplinary Procedure

North West Ambulance Service NHS Trust

DISCIPLINARY POLICY & PROCEDURE

Disciplinary Policy and Procedure		Page:	Page 1 of
Author:	Head of Business HR	Version:	4
Date of Approval:	2nd February 2023	Status:	Final
Date of Issue:	February 2023	Date of Review:	February 2023

Recommended by	Executive Management Team
Approved by	
Approval Date	February 2023
Version Number	4
Review Date	February 2023
Responsible Executive Director	Director of People
Responsible Manager	Deputy Director of People
For use by	All Trust Employees

CHANGE RECORD FORM

Version	Date of change	Date of release	Changed by	Reason for change
0.1				Document creation
1.0	30 July 2008	30 July 2008	L McConnell	Approval by the Trust Board
1.1	8 July 2011	8 July 2011	J Warren	Changes agreed with Policy Group
1.2	23 September 2011	23 September 2011	J Warren	Changes agreed with Policy Group
1.3	7 October 2011	7 October 2011	J Warren	Changes agreed with Policy Group
1.4	15 November 2011	15 November 2011	J Warren	Approval by Workforce Committee
2.0	29 November 2011	29 November 2011	J Warren	Approval by Trust Board
2.1	12 July 2013	12 July 2013	J Warren	Addition of Trust Values
2.2	10 April 2015	10 April 2015	L Ward	Review of Policy with Policy Group
3.0	11 May 2015	11 May 2015	V Camfield	Approval by Workforce and Communities Committee
3.1	17 January 2017	17 January 2017	V Camfield	Changes approved by Workforce Committee
3.2	1 September 2017		V Camfield	Section 4.2.11 added to reflect F2SU Guardian access
3.3	26th October 2017	26th October 2017	L Ward	Update following approval
4	2nd February 2023	February 2023	C Marshall	Full policy review

Disciplinary Policy and Procedure

Contents

1. Introduction

North West Ambulance Service believes a Just and Learning Culture can be seen as an environment where we put equal emphasis on accountability and learning. The organisation is committed to the creation of a culture of openness, with an emphasis on improvements. It is acknowledged that sometimes situations occur, which require us to gather facts and determine the most appropriate course of action. When these events happen, it is equally as important to explore what this meant to those affected, and what support they might need. There will be some situations where the use of the disciplinary procedure will be appropriate; however this framework seeks to explore all other circumstances to provide an alternative and supportive approach.

The Trust expects all colleagues to meet high standards of behaviour, which support the Trust's values to deliver the right care, at the right time, in the right place whilst treating the public with dignity and protecting them from harm. This document sets out Trust Policy and Procedure in relation to dealing with matters where an employee's conduct is in breach of Trust values, policies or rules or falls short of the expected Trust standards.

1.1 This procedure applies to all employees of the North West Ambulance Service NHS Trust ('the Trust') and its aim is to ensure consistent and fair treatment for all. The Trust aims to, through the application of this policy, encourage self-reflection and improvement and wherever relevant, ensure that lessons learnt are embedded within the Trust. This procedure should be read in conjunction with the Trust's Complaints, Incidents and Investigations Policy as the Trust is committed to developing an open and fair culture, where the focus is on learning and where employees are confident to report adverse events or near misses.

It is recognised that a proportion of our employees are required to maintain registration with a professional health care body which will also have professional standards of capability, conduct and competence. The Trust requires employees in those professions to adhere to these standards. Where the Trust has serious concerns about a staff member's conduct which may affect their fitness to practice, they may be referred to their professional body. Any such referrals should be made in line with guidance provided by the professional body.

1.2 This Disciplinary Policy & Procedure is produced in line with the duties imposed by legislation and recognised good practice, as detailed by the Advisory, Conciliation and Arbitration Service (ACAS) code of practice.

2. General Principles

2.1 It is the Trust's policy to ensure that every disciplinary matter is dealt with fairly, and that adequate steps are taken in the early stages to establish the relevant facts using the Just and Learning Culture principles before initiating formal action.

This includes ensuring:

- Where possible, and particularly where it is a first occurrence, minor cases of unsatisfactory misconduct will be dealt with informally between the employee and their line manager. This may include putting in place any necessary support to ensure the same behaviors do not reoccur. This will be recorded locally.
- That every allegation of misconduct is thoroughly assessed through completion of the preliminary fact finding checklist (Appendix 3) to ensure there is sufficient understanding of the concerns. Details such as date/time of the incident, where it took place, names of people involved (including speaking to the person accused of misconduct for their version of events), names of other potential witnesses and any other information available should be captured on the preliminary fact finding checklist for onward consideration by the Case Manager. Only if this assessment identifies genuine, and sufficiently serious grounds of concern should formal action under this policy be instigated.
- That all investigations are carried out without unreasonable delay and any allegations of gross misconduct are investigated by an experienced (or appropriately trained), objective investigator
- That decision-making relating to the implementation of suspensions or restricted practice will be well informed and never taken by one person alone.
- That when commencing an investigation into an allegation of misconduct, there shall be no presumption that disciplinary action, will automatically follow; managers should review all concerns and investigations with both the Disciplinary Policy and Complaints, Incidents and Investigations Policy in mind.
- That the health and welfare of employees involved in these procedures, either directly or indirectly, will be paramount to the Trust and regular welfare checks will take place to ensure adequate support is in place.

2.2.1 Formal action will never be taken without first seeking the advice or involvement of the HR Department.

2.2.2 During the disciplinary process, if formal notes are taken during meetings/ interviews/ formal hearings, interviewees must be given the opportunity to review their notes/ statements and provide comments on their accuracy. Notes taken will not be verbatim. The appointed Investigating Officer/ Chair of a Disciplinary Hearing (depending on the stage of the process) will review the notes for comprehension and accuracy in the first instance before sharing these with the employee/ their representative for comment. An agreed version of the notes should be signed and included within the disciplinary documentation. If the notes cannot be agreed, the original version issued and a track changed version from the employee will both be included within the documentation.

2.4 At all stages of the formal disciplinary procedure the employee will be entitled to be accompanied by either a Trade Union Representative or workplace colleague.

2.5 No disciplinary action will be taken against an accredited representative of any Trade Union recognised by the Trust until the circumstances have been discussed with the staff side Branch Secretary or a full-time officer of the organisation concerned.

2.6 It is the responsibility of all parties involved in the investigation and disciplinary procedure to always maintain confidentiality and objectivity.

2.7 If a grievance is raised during the course of a disciplinary process that is related to the case, it may be appropriate to deal with both cases concurrently. Each case will be considered on its merits and the appointed Case Manager will determine the most appropriate course of action. In the interests of fairness, it will also be considered whether it would be appropriate to appoint another manager to deal with the disciplinary process and / or grievance process in such cases.

2.8 An employee has the right to appeal against any formal disciplinary action imposed.

3. Handling Minor Conduct Issues via Informal Structured Conversations

3.1 Normally, where there are minor breaches of rules this will be dealt with by the immediate manager on a one to one basis. In all cases, the manager will evaluate whether the matter can be dealt with satisfactorily through reflection alone, or whether a structured conversation is required.

3.2 Structured conversations do not form part of the formal disciplinary process and employees should be reminded of this. It should not be necessary for employees to be accompanied at these meetings, as this is an informal means of resolution.

3.3 The manager should arrange to speak to the employee in private as soon as possible, normally within a few days. This will be a collaborative discussion, aimed at talking through areas of concern and encouraging improvement.

3.4 Record of the structured conversation will be captured on the pro-forma (appendix 2) and stored on employee personnel files. The record will be 'live' for a 6 month period. The pro-forma should only be referred to during this 'live' period and should be disregarded for the purpose of disciplinary proceedings after this stage. If, however there is a repeated / patterns of behaviour identified, the manager should meet with the employee to discuss their concerns and may extend the 'live' period to allow further time for any improvements to be made.

4.0 Handling More Serious Allegations of Misconduct and Investigating the Facts

4.1 When more serious allegations of misconduct arise (refer to appendix 1), an initial assessment should be made by the line manager with advice from HR, to decide if it is deemed appropriate at that stage for the matter to be managed informally or whether further investigation is needed before that decision can be reached. Any decision should be taken with Just Culture principles in mind.

4.2 For a list of examples of what actions may constitute misconduct and gross misconduct, refer to Appendix 1.

4.3 The line manager should carry out initial fact finding using the Preliminary Fact Finding Checklist (Appendix 3). During this process, it may be necessary to meet with other relevant individuals to get an understanding about what has happened. This is not a full investigation, and the aim is to establish the facts in order to determine whether a full investigation process may be required.

4.4 Where it is determined via the Fact Finding Checklist by the line manager / delegated authority that further, more formal investigation may be appropriate, this must be referred to and supported by the Case Manager.

4.5 The Case Manager will be responsible for allocating an appropriately trained Investigating Officer and for clearly defining what is to be investigated. The Case Manager must ensure that the appointed Investigating Officer has the capacity to complete the investigation and can prioritise its completion.

4.6 The scope of the investigation will be defined using a Terms of Reference document which will include the allegations, the scope of the investigation, the timeframes for completion and will include any pertinent document(s) which may assist with the completion of the investigation.

4.7 There may be occasions where concerns are managed via an alternative investigation framework (e.g. clinical complaints/ serious incidents) which then require review under the Disciplinary Policy due to the circumstances of the case. In this eventuality, the completed investigation report will be used where possible to avoid unnecessary delays to employees involved. Employees will be given the opportunity to share any additional information with the assigned investigator before the case proceeds to a hearing, if they feel this is relevant to the disciplinary case.

5. Safeguarding People's Health and Wellbeing

5.1 It is recognised that employees who are the subject of disciplinary investigations or processes are likely to find the situation stressful, as will other staff who may become involved because they are a victim of, or witnesses to the event. Managers are responsible for ensuring that any staff involved within a disciplinary process are appropriately supported at all stages of the process and the nature of the support that is required will be discussed and agreed with the employee. This will normally be the employee's line manager, however, if they are also the assigned Investigator, the Case Manager will assign an alternative manager to provide welfare support.

5.2 At the outset of any disciplinary process the employee must be reminded of the support services available to them through the Trust's Occupational Health and counselling service. The employee must be advised that a self-referral to those services can be made or alternatively a management referral will be made on their behalf with the employee's permission. In some circumstances the Case Manager

may refer an employee to support services dependent on the nature of the allegations or the employee's circumstances.

5.3 Where an employee who is subject to this process has further concerns regarding their health and wellbeing, they should raise in the first instance with the Case Manager, who will ensure they are appropriately supported.

5.4 Where the allegations are not considered to be potential gross misconduct **and** the employee does not contest any part of the allegations and wishes for the matter to be dealt with quickly in order to support their wellbeing, the employee may request their case be dealt with via the Trust's Fast Track Disciplinary Policy.

6. Representation

6.1 Any employee subject to formal disciplinary processes will have the right to be accompanied at an investigatory meeting or hearing by any one of the following persons:

- A trade union representative
- An official employed by a trade union
- A workplace colleague

6.2 This companion will be allowed to address any hearing in order to present/ sum up the employee's case. This companion may also confer with the employee during the hearing, including asking witnesses questions, but may not answer questions on the employee's behalf.

6.3 In exceptional circumstances such as where concerns have been raised by Occupational Health about the employee's health and wellbeing at any formal hearing, with permission from the Deputy Director of People, employees may be accompanied by a non-workplace companion in a supportive capacity. A companion who is not a trade union representative or workplace colleague will not be allowed to address the hearing, sum up the employee's case, ask questions of others, or respond on the employee's behalf during the hearing.

6.4 In some circumstances it may not be appropriate for some individuals to be accepted as a companion. It is not reasonable for an employee to be accompanied by a colleague whose presence would prejudice the hearing or who might have a conflict of interest. An example of this being if they are a witness in the case being investigated.

6.6 It is the responsibility of the employee to contact their companion and ensure that they are willing to act in that capacity and to arrange their attendance at any meeting/hearing.

7. Participating in the Process

7.1 Meetings should be held providing reasonable notice (normally seven calendar days), and will normally be held during normal office hours. Every effort should be made by all parties to ensure that they are in attendance.

7.2 It is the employee's responsibility to arrange appropriate representation. If a meeting/ hearing is cancelled due to unavailability of any party, the date may be postponed by up to ten calendar days. If the re-arranged meeting/ hearing does not take place due to unavailability, the employee will be informed that at the next occasion, the meeting/ hearing may proceed in their absence.

8. Suspension

8.1 Alternatives to suspension should always be considered and discussed where appropriate; this may include the employee temporarily:

- Being moved to a different area of the workplace
- Changing their working hours e.g. moving from nights to days where there is more supervision, or working with a different shift / team pending conclusion of the investigation / disciplinary process
- Being placed on restricted duties including having reduced access to Trust systems where appropriate
- Being transferred to a different role within the workforce

8.2 Suspension will only be considered if there is a serious allegation which, on the face of it, could amount to gross misconduct and/or:

- Working relationships have severely broken down
- There is a risk of the employee interfering with evidence or witnesses or the investigation
- There is a risk to other employees, property or patients
- The employee is the subject of criminal allegations which may affect whether they are fit to undertake their role.

8.3 When considering suspension/ action short of suspension line managers must assess the risk of the employee remaining at work and seek HR advice. Where a line manager feels it necessary to suspend an employee, they must complete the Suspension/ Action Short Record (Appendix 6) to demonstrate that all alternatives have been considered before seeking approval from a more senior manager (must be band 8a or above). Suspension should always be seen as a last resort.

8.4 Where suspension is under consideration outside of core hours (applicable only where staff work during unsocial hours) the local manager should contact the senior on call manager for direction and if applicable, for authority to temporarily remove the employee from duty.

8.5 The Head of HR and Director for the Service Area must be notified following the decision to suspend the employee and a copy of the Suspension/ Action Short of Suspension Decision Record (Appendix 6) sent on for their record.

8.6 It is best practice to complete both the Preliminary Fact Finding Checklist (Appendix 3) and the Suspension/ Action Short Record (Appendix 6) prior to a suspension taking place, however, it is acknowledged that in some circumstances, immediate action is needed to prevent risk. In this circumstance, immediately following the suspension, priority should be given to gathering as much relevant information as possible by completing the Preliminary Fact Finding pro-forma (Appendix 3). Should it be determined that suspension is no longer necessary, this must be authorised by in conjunction with the Head of HR and lifted without delay.

8.7 In the event of suspension all parties must ensure that priority is given to concluding investigations and arranging the necessary disciplinary proceedings, in a timely manner.

8.8 Suspensions ongoing for more than one month, must be subject to review to determine if the suspension remains necessary. This should take place on a monthly basis as a minimum, or if the circumstances of the case materially change. The employee must be advised of any delays in the investigation process and the reasons for this on a monthly basis by the Case Manager.

8.9 Where an external issue, such as a criminal investigation, means that the Trust has limited control over the investigation and timescales, the employee will be advised that the suspension (or alternative duties) will continue until an agreed date, which will be kept under review, and will be communicated in writing to the employee.

8.10 Employees should accept, where possible, alternative duties reasonably offered to them as an alternative to suspension.

8.11 In the case of suspension of accredited representatives, the Trust will notify the Staff side Branch Secretary/full time officer at the earliest opportunity and by phone if necessary.

8.12 During any period of suspension, employees remain on full pay as though they were at work i.e. pay will include contractual payments e.g. enhanced/unsociable hours.

9. Formal Investigation

9.1 The purpose of an investigation is to objectively establish the facts, in a fair, unbiased and comprehensive way to enable conclusions to be drawn from the allegations. Investigations should be carried out by an appropriately trained investigator.

9.2 Investigations should be carried out without unreasonable delay. It is expected that the majority of investigations should be completed within a 6 week period. However, in the case of complex investigations approvals for an extension to the investigation

timeframe should be discussed and agreed with the Case Manager. All case timescales will be reported on a monthly basis to the Executive Board for oversight.

9.3 The Case Manager is responsible for keeping the employee informed of the progress of the investigation and any delays. The Investigating Officer will be responsible for ascertaining the full facts of the case and for providing a report to the Case Manager.

9.4 Trust employees are required to co-operate with internal investigations to ensure that the Trust is able to gather all relevant facts. An employee who has been identified as a witness in an investigation may not unreasonably refuse to provide a statement or attend a meeting. Reasonable time off from duties should be afforded to the witness based on discussion with their line Manager. Witnesses do not ordinarily have the right to be accompanied at investigation meetings and / or disciplinary hearings but this will be reviewed on a case by case basis to ensure witnesses have appropriate support in place at any such meetings

9.5 Should the Investigating Officer consider that the scope of the investigation should be widened as the investigation proceeds, this must be approved by the Case Manager and confirmed to the employee in writing.

9.6 When the Investigating Officer has completed their investigation, they will write a report detailing the facts, the evidence they have established and their conclusions. The report will include all documentation, statements and interview notes which have contributed to the investigation. This will be submitted to the Case Manager. The Case Manager will then review and provide timely feedback and support to Investigating Officer on the basis of the evidence available and their recommendations as to whether there is a case to answer.

9.7 If the Case Manager determines there is a case to answer, this will be communicated to the employee in writing.

9.8 If, after the investigation it is determined that there is no case to answer the employee should be advised accordingly by the Case Manager in writing and arrangements will made to meet with the employee to discuss the outcome. At this meeting, any outstanding areas for concern or need for future improvements will be discussed along with arrangements for a return to duties in the event the employee has been redeployed or suspended.

10. Disciplinary Hearing

10.1 If, after a thorough investigation, it is determined that there is a disciplinary case to answer the employee will be notified in writing of the specific allegation(s) against them and invited to a hearing. Employees will be given reasonable notice of disciplinary hearing. This will normally be 21 calendar days' notice for gross misconduct allegations.

10.2 This notification should contain sufficient information about the allegations and potential consequences to enable the employee to prepare to answer the case at

any disciplinary hearing. The information will also include the arrangements for the hearing, confirmation of the employee's right to be accompanied and who else will be present and in what capacity.

10.3 The employee must be provided with a copy of the Investigation Report, including any written evidence which forms part of the case against them including any witness statements (if applicable).

10.4 If the employee is relying on written evidence to support their statement of case this should be submitted to the HR support for the hearing no later than five calendar days before the hearing, unless mutually agreed otherwise. At this point, the HR support for the hearing will provide a copy of both the management pack, and any information provided by the employee/ their representative to the Chair of the Disciplinary Hearing. Any supporting evidence submitted in support of the employees' case will also be shared with the Investigating Officer.

10.5 If the employee's representative is not available to attend on the given date then the hearing date may be postponed by up to ten calendar days. Management and Staff Side representatives should make every effort to attend on the specified date wherever possible and should work together to confirm suitable availability. Staff side representatives seeking an adjournment are expected to provide details of their alternative availability for the following ten days, or the request for a postponement may be refused.

10.6 If the employee or their representative is unable/ unwilling to attend after a second attempt to rearrange, a hearing may proceed in employees' absence. The employee and their representative will be written to advising them of this. A decision will be taken based upon the evidence available at that time.

10.7 In exceptional circumstances such as where an employee is unfit to attend a hearing in person, consideration can be given to both parties providing written submissions in respect of the hearing. This must be agreed between the employee / their representative and the Trust in advance.

10.8 Disciplinary Hearings will be chaired by an appropriately trained manager (refer to scheme of delegation) who will be supported by a member of the HR team. Please refer to Appendix 4 for the Disciplinary Hearing Format.

10.9 It will be the role of the Investigating Officer to attend the hearing and present their investigation report and conclusions.

10.10 Anyone providing a witness statement / participating in an investigatory interview must be prepared to attend any subsequent hearing and must be informed of this before providing their account. However, in most cases, particularly where a statement is not in dispute, witnesses will not be required to attend a disciplinary hearing in person and their statement will suffice. The hearing manager will assess the relevance and reasonableness of a request made by the Investigating Officer or

the employee or their representative for a witness to attend a hearing in person and reserves the right to refuse the presence of a witness if it is deemed unnecessary or not appropriate to the case in question.

10.11 Should witnesses be required to attend the disciplinary hearing, it will be the responsibility of the Investigating Officer and/or the employee and their representatives to make the necessary arrangements directly with their respective witnesses. Witnesses will need to request the release from duties from their line manager who should make every effort to facilitate their release from duties.

10.12 If a decision is not provided on the day of the hearing, the employee will be informed of the decision and any outcome in writing within seven calendar days; this written confirmation will provide details of any right of appeal.

10.13 Those who have been involved in the investigative process will not form part of Disciplinary Hearing Panel. The Trust's Scheme of Delegation outlines the decision-making authority to apply disciplinary sanctions in accordance with the Trust policy.

11. Disciplinary Sanctions

11.1 When determining what, if any, disciplinary sanction is appropriate the Chair of the hearing must act reasonably in all the circumstances. Factors relevant in determining which disciplinary sanction to apply include:

- The extent to which standards have been breached and / or the seriousness of the misconduct
- Consistency of treatment
- Current 'live' warnings
- Other special circumstances which might mitigate or otherwise affect the appropriate severity of the penalty
- Impact of the actions on others and the Trust (including reputation)
- Whether the intended disciplinary action is reasonable in all the circumstances
- The employee's general record

11.4 All disciplinary sanctions must be confirmed in writing. This will normally be within seven calendar days of a hearing.

11.5 The following disciplinary sanctions may be applied. This process is not sequential. A sanction can be applied at any level (i.e. a Final Written Warning without a Written Warning being applied first):

Levels of Disciplinary Sanctions

Disciplinary Sanction	Examples of Circumstances	'Live' Period
First Written Warning	Instances where a structured conversation has taken place to address low level misconduct, but this behaviour has then been repeated. A first written warning may also be issued without a prior application of the procedure for first episodes of misconduct if the circumstances of the case justify this level of action.	**12 months**
Final Written Warning	Instances of misconduct or negligence when a first written warning is still in effect i.e "live". or: Where serious misconduct is found as a first offence.	**12 months -** This may be extended to **24 months** if issued as an alternative to dismissal.
Downgrading	Where it is deemed that as a result of misconduct, it is no longer suitable/ appropriate for the employee to remain in their substantive position.	A Final Written Warning will be issued in addition to the act of downgrading.
Dismissal with notice	Dismissal may be the appropriate sanction if, following the issue of a final written warning, there is still no improvement in conduct or if a further offence is committed.	
Dismissal without notice (Summary Dismissal)	Summary dismissal will be applied in cases of gross misconduct. In such cases, dismissal is without notice.	

11.6 The sanctions will normally be effective from the date of the disciplinary hearing. If there have been exceptional unjustified delays then the Chair of the disciplinary hearing will consider backdating the effective date the disciplinary sanction runs from.

11.7 Warnings will be disregarded for the purpose of considering cumulative disciplinary sanctions after the expiration of their "live period" but the facts / circumstances may

be deemed relevant to future cases so details will remain on employees' personal files.

11.8 Staff who are employed on Agenda for Change Terms and Conditions should refer to 'Annex 23: Pay Progression' of the Agenda for Change handbook if issued with a disciplinary sanction.

11.9 Downgrading as an alternative to dismissal

11.9.1 If the outcome of the hearing determines that the employee's actions amount to gross misconduct, or in the case where a live final written warning has been breached, the Chair of the hearing can consider downgrading the employee as an alternative to dismissal.

11.9.2 The Chair of the hearing, in conjunction with HR, will need to consider if suitable opportunities exist within the organisation which would be reasonable/ appropriate to offer to the employee.

11.9.3 Providing reasonable/ appropriate posts are available, the employee may be offered the option of a lower banded post and will have seven calendar days to make their decision. If a lower banded post is accepted by the employee, the employee will be issued with a final written warning/ extension of a final written warning, effective from the date of the disciplinary hearing. If the employee declines the offer of a lower banded post, they will be summarily dismissed from employment.

11.9.4 An act of downgrading will retain the employee's continuity of service. The exact pay point within the lower band to which they will be appointed and remunerated will be discussed and agreed by the Chair of the Disciplinary Hearing and HR, taking account of length of service previously served at the same/ higher grade. In instances of downgrading pay protection will not apply.

11.9.5 The individuals' increment date will become the date of transfer to the new post.

11.9.6 If the employee is offered a post on a different base site to their previous post, protection of travel will not be paid.

11.9.7 Once the associated disciplinary sanction has been spent the downgraded employee can apply for vacant posts at their previous grade.

12. Appeal

12.1 Employees have the right to appeal disciplinary decisions and / or sanctions issued against them. The purpose of the appeal is to consider the decision made by the chair of the disciplinary hearing. An appeal hearing is not a re-hearing of the original case.

12.2 The employee must stipulate their full grounds of appeal in writing by completing the Employee Registration of Appeal Pro-forma (Appendix 7) This should be returned within 14 calendar days on receipt of the outcome letter.

12.3 An employee has the right to attend the appeal hearing either alone or accompanied by a Trade Union Representative or a workplace colleague. If the member of staff or their representative fails to attend the appeal hearing the appeal will be considered in their absence, except where an adjournment is agreed by the chair of the hearing.

12.4 In exceptional circumstances, such as where concerns have been raised by Occupational Health about the employee's health and wellbeing at any formal hearing and with permission from the Deputy Director of People, an employee may be accompanied by a non-workplace companion in a supportive capacity. A companion who is not a trade union representative or workplace colleague will not be allowed to address the hearing, sum up the employee's case, ask questions or respond to questions on the employee's behalf during the hearing.

12.5 In cases of dismissal, appeals will be heard two senior managers, one of which will be a Director, with support from a HR representative. In all other cases, appeals will be heard by the next level of manager to that which issues the sanction. Please refer to Appendix 5 for the Appeal Hearing Format.

12.6 In exceptional circumstances, such as where an employee is unfit to attend a hearing in person, consideration can be given to both parties providing written submissions in respect of the appeal hearing. Alternatively, consideration should be given to holding the hearing using a virtual platform (such as Microsoft Teams). This must be agreed between the employee / their representative and the Trust in advance.

12.7 Statements of case from both management side and appellant side must be exchanged no later than seven five days prior to the Appeal Hearing, unless mutually agreed otherwise.

12.8 An appeal hearing decision may include the following:

- Confirmation of the original decision
- Substitution of the sanction for a lesser one
- overturning the original decision.

12.9 All Appeal Hearing decisions and outcomes will be confirmed in writing. This will normally be within seven calendar days of a hearing concluding. There will be no further right to appeal after this stage.

13. Fast Track Disciplinary Policy

13.1 In some circumstances, where the allegations are not contested, the Trust may offer the use of the fast track process as set out in the Trust's Fast Track Disciplinary Procedure. It is intended that, by accessing this policy, disciplinary matters may be dealt with quickly and alleviate some of the stress associated with a difficult or

prolonged disciplinary investigation. The employee retains the right to be accompanied at a fast track disciplinary hearing. There is no right to appeal any sanctions issued under the Fast Track Disciplinary Procedure.

14. Resignation During the Disciplinary Process

14.1 Where an employee resigns and leaves the employment of the Trust midway through an investigation or prior to the conclusion of a disciplinary hearing, the Case Manager will consider whether the process should continue to conclusion.

14.2 If it is decided that it will proceed, the former employee will be advised that the investigation will continue to reach a conclusion and they will be offered the opportunity to participate in any remaining process.

14.3 If, when the employee resigns, a safeguarding allegation remains under investigation, it may be the duty of the Trust to conduct the investigation and where appropriate, proceed to a formal hearing so as to reach a conclusion. The former employee will be advised of this and will be provided with the right to respond/ opportunity to attend the hearing.

14.4 If the resigning employee is professionally registered, the professional lead will be advised so as to consider whether or not to make a referral to the employee's professional body.

14.5 A future employment reference will indicate that the employee was under investigation when they left the Trust.

15. Criminal investigations, Offences and Offences Committed Outside Work

15.1 Any employee subject to a police investigation, must inform their line manager immediately so that they can consider what steps are required, e.g. to protect the safety of others/patients/the employee.

15.2 If appropriate, the Trust will investigate and may take formal action independently of any criminal investigation or other legal proceedings.

15.3 Where allegations relating to an employee's actions outside of work are brought to the attention of the Trust by other members of staff, the public, other agencies, or professional bodies and where those allegations have the potential to impact on the suitability of the employee to perform their role or work for the Trust, or to damage the reputation of the Trust, the Trust may investigate these matters so far as reasonably practicable or take such other steps as are considered necessary. This may include dismissal in appropriate cases.

15.4 Where the alleged offence or police investigation relates to mistreatment of a child or an “at risk” adult, the Head of Operations, equivalent senior manager, or the relevant Director (to be determined based on the seniority of the person under investigation) should inform the Safeguarding Team who will consider whether it is necessary to make a report to the Local Authority Designated Officer (LADO).

15.5 Where appropriate, investigations by the counter fraud team, other agencies such as police or social services, may be carried out separately from investigations under this procedure. In these circumstances the Trust will only delay carrying out internal investigations and following the disciplinary procedure where absolutely necessary and where advised to do so by the professional body and/or other agency.

16 Referrals to Professional Bodies

16.1 Where an employee who is subject to a disciplinary process is a healthcare professional and is registered with a regulatory body, they may be referred by the Trust or may be advised to self-refer, based on the regulator’s code of practice.

16.2 The regulator will be notified of any suspensions, long term restrictions to practice (determined as part of a disciplinary sanction) or dismissals from employment.

16.3 The decision to refer in any other circumstances will be determined by the Trust’s Head of Profession who will be sent, in a redacted format, the details of any cases which have been issued with a final written warning and above to review. Employees will be informed of the decision made by the Head of Profession in writing.

16.4 Where the employee is a Doctor, who’s primary employer is an acute provider/ GP practice, the Trust will liaise with the relevant Responsible Officer if a referral to the regulator is deemed necessary.

Role	Responsibility
Line manager / Delegated authority is responsible for ensuring they follow this policy in individual cases and for:	• Undertaking preliminary fact finding and completing the preliminary fact finding checklist (Appendix 3) in relation to potential misconduct in conjunction with HR. • Providing the completed preliminary fact finding checklist to the Case Manager who will consider the options for the onward management of any identified issue. • In conjunction with the Case Manger, ensuring regular communication with the employee and ensuring they are appropriately supported, seeking advice from Occupational Health where appropriate.
The Case Manager is responsible for ensuring this policy is followed in the event that a formal investigation is required and for:	• Providing fair and unbiased oversight and decision making in cases of potential misconduct in the investigation and pre-hearing stages. • Providing constructive challenge and seeking assurance on behalf of the Trust that cases are being handled fairly and proportionately, that decisions are well informed and the welfare of employees is given priority. • Informing the employee of the need to commence a formal investigation, and following this up in writing, detailing the Terms of Reference for the investigation, the name of the appointed Investigating Officer, the timescales of the process and what the employee should expect throughout the process, enclosing appropriate policies/ supporting information. • Appointing an appropriately trained Investigating Officer agreeing the Terms of Reference for the investigation and providing any pertinent information relating to the case. • Regularly communicating with employees who are subject to investigation and/or formal action and ensure they are kept informed of progress and to ensure they are appropriately supported, seeking advice from Occupational Health where appropriate. • Maintaining regular communication with the assigned Investigating Officer to understand the status of the investigation, any delays and the reasons for them, the anticipated completion date and the amendment/ expansion of the Terms of Reference as may be required. • Consider the need for suspension or restrictions to practice (see section 8) at the outset and keep that

	decision under review throughout the process in conjunction with a member of the HR team. • At the conclusion of the investigation, considering the findings in conjunction with a member of the HR team and deciding on the appropriate next steps (if there is a case to answer or otherwise) and communicating this to relevant employee/s.
Investigating Officer	• Meet with the Case Manager at the outset of the investigation to discuss the circumstances which have given rise to a formal investigation and to consider the Terms of Reference. • Carry out a thorough and impartial investigation. • Conduct investigation interviews following HR advice; ensure interviewees are given the opportunity to review their interview notes / statements taken and provide comments. • Provide regular updates on the progress of the investigation to the Case Manager and the employee involved. • Escalate any additional allegations or concerns that emerge during the investigation to the Case Manager, including any issues that are delaying the investigation, or which may impact on the question of suspension or restrictions to practice. • Produce a formal report in response to the Terms of Reference for review and consideration by the Case Manager. • In the event a disciplinary hearing is required the Investigating Officer will attend to present the findings of the investigation.
HR Support:	• Provides advice and guidance to managers/ employees on any matters relating to alleged misconduct under the Trust's Disciplinary Policy. • Provides support to managers on policy application for cases of alleged misconduct, advising on the range of options/ considerations available to ensure cases are handled consistently and in line with Just and Learning Culture principles. • Supports managers in ensuring misconduct is handled consistently and proportionately across the Trust, ensuring all parties are treated fairly and impartially. Provides challenge and examines cases to ensure no biases or conflicts of interest exist. • Works closely with the appointed Case Manager to ensure matters are progressing in a timely way.

	• Supports the appointed Investigating Officer throughout the investigatory process in application of the Policy and Just and Learning principles. • Ensures the right support is in place for any employees in conjunction with line managers, seeking advice from Occupational Health as required. • Provide advice and guidance to Case Manager when considering the findings of the investigation report, in line with the application of the Policy, Trust Values and Just and Learning principles. • Advises on the composition of Panels and supports the preparation of hearings ensuring everyone involved is properly briefed and trained. • An HR representative will attend disciplinary hearings to advise the Panel on proceedings. • The assigned HR advisor for the Investigating Officer will attend to support the presentation of the case.
Employees :	• Have a responsibility to observe the Trust's high standards of behaviour and conduct. This includes any professional codes and safeguarding requirements. • Must perform their duties in accordance with contractual obligations, and in line with agreed Trust policies and procedures. • Must co-operate and participate with the provisions of this policy and its procedures. • This policy allows for outcomes to be issued to employees. In this event, it is the responsibility for the employee to comply with any agreed actions identified.

Trade Union Representatives.	• May act as a representative to an employee involved in a disciplinary investigation/ hearing. • May address any meeting relating to disciplinary matters by presenting the employees case, asking questions and summing up the employees case. • Where appropriate, may respond to questions on behalf of the employee. • May confer with the employee throughout disciplinary matters. • Reasonable paid time off is given by the Trust to fulfil this role

Appendix 1

NORTH WEST AMBULANCE SERVICE
DISCIPLINARY RULES

1. INTRODUCTION

1.1 The following disciplinary rules apply to all employees of the Trust

1.2 These rules should be read in conjunction with the Trust's Disciplinary Policy and Procedure.

2. Gross Misconduct

A breach of contractual terms of employment, which may warrant summary dismissal:

1. Theft or attempted theft associated with employment, of the Trust's property or from a third party.

2. Dishonesty or deliberate misuse, misappropriation, or attempted misappropriation of the Trust's, other staff, or patients' funds or resources.

3. Fraudulent manipulation or falsification of official documentation (including time sheets/attendance logs, signing in/out for other employees, patient records, claims for expenses and any information used in support of an application for any post).

4. Any offences under the Fraud Act 2006 and related legislation

5. Serious or repeated breaches of Trust policies and/or procedures

6. Acceptance of gifts and hospitality in contravention of NHS guidelines on Standards of Business Conduct as outlined in Conflicts of Interest in the NHS – Guidance for staff and organisations.

7. Serious breach of confidentiality

8. Working whilst contravening an enactment, or breach of rules laid down by statutory bodies, for example, removal from the register of the relevant regulatory body.

9. Criminal offences that might affect a person's suitability for their job or where there has been a failure to disclose convictions/proceedings

10. Malicious or wilful damage of the Trust's property.

11. Serious breach of health and safety rules (by act or omission)

12. Any act or omission constituting gross negligence or dereliction of duty including causing a serious delay to an emergency response

13. Refusal to comply with a lawful instruction which could result in immediate serious consequences.

14. Inappropriate use of email or internet including retaining received and forwarding to colleagues, emails containing offensive or obscene material (the Trust's Social Media Policy contains a non-exhaustive list of what may be considered offensive or obscene)

15. Incapability at work through alcohol/drugs or being under the influence of alcohol, non-medically prescribed drugs and or illegal drugs in the workplace (refer to Trust's Alcohol and Substance misuse policy)

16. Violence or exceptionally offensive behaviour, including sexual misconduct.

17. Inappropriate language which may cause patients/ service users/ fellow staff members to feel threatened, degraded or offended

18. Discrimination, harassment or victimisation of a patient, member of staff or member of the public on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation (refer to Trust's Bullying and Harassment policy)

19. Bullying / Harassment (refer to Trust's Bullying and Harassment Policy)

20. A serious breach of trust and confidence (excluding any protected disclosure under the Trust's Freedom to Speak Up Policy) or any actions bringing the Trust into disrepute.

21. Failure to disclose information which would or has seriously compromised patient safety, clinical care or the Trust's reputation or obligations e.g. failing to disclose situations where staff have committed an act of gross misconduct.

This list is not exhaustive nor does it limit the Trust's ability to appropriately classify potential misconduct cases on an individual basis

3. General Disciplinary Rules – Misconduct

The following deviations from general standards of conduct and performance may result in disciplinary action.

If recurrent, these offences could amount to gross misconduct and summary dismissal.

1. Failure to comply with reasonable instructions or a reasonable management request
2. Insubordination
3. Use of unacceptable behaviour or language
4. Abuse of authority

5. Unauthorised absence including:
    a. persistent lateness / poor timekeeping
    b. failure to comply with the Trust's notification/ certification requirements for sickness absence
    c. being absent from the workplace during the working day for an unauthorised reason.

6. Failure to adhere to agreed Trust policies and procedures, including own department protocols
7. The audio recording of any meeting/ hearing without prior consent
8. Any matter listed under Gross Misconduct which falls short of gross misconduct

Section 2 and Section 3 above outline the main disciplinary rules, applying to employees. However, the above list is not exhaustive, and it is possible that other circumstances could lead to disciplinary action including dismissal being taken

Where it feels it appropriate, the Trust reserves the right to report an individual employee to the appropriate professional body, the police or Mersey Internal Audit Agency (MIAA) anti-fraud.

Appendix 2

Structured Conversation Record

Employee Name:	
Role:	
Date of Structured Conversation:	
Matters Discussed:	

Action Plan	
Required improvement/s	**Support required to facilitate improvement**

Name of Manager	
Position	
Employee's Comments	
I confirm that the above is a record of our meeting and that I have received a copy of this record.	

Appendix 3

Preliminary Fact Finding Checklist

This checklist must be completed by the Line Manager in conjunction with HR **BEFORE** making a referral to the Case Manager to making a recommendation to commence a formal disciplinary investigation:

Employee Details			
Employee Initials:		**Employee Role:**	
Service Line:		**Area:**	
Head of Service:		**HR Advisor:**	
Case Details			
Reason fact finding initiated			
Suspension details: (include dates, rationale, auth etc)			
Date issue raised:		**Date fact finding ended:**	
Fact finding conducted by: (initials)		**F2SU Ref No (If applicable):**	
Fact finding Summary – please capture key findings which have led to the conclusion/ recommendation drawn.			

Recommendations following fact finding (please tick)	
	No case to answer – no evidence to support the allegations made
	Referral to incident learning
	Informal counselling
	Investigation to commence in line with Trust policy
Additional comments	

Decision Making Checklist – this should be completed and inform the conclusion reached above.

	Indicator	Tick applicable answer	Considerations and further information
INFORMAL ACTION			
	Has there previously been informal discussions with the member of staff about this issue or similar issues in the same way you would with any other employee?	**Yes** **Not Clear** **No**	The Trust's Disciplinary Policy emphasises conversations of concern and an opportunity for informal action (if appropriate) to bring about improvement and learning; as opposed to punishment
HARM AND/OR DAMAGE CAUSED			
	Did the individual actions result in harm or damage? Is there evidence of unacceptable risk?	**Yes** **Not Clear** **No**	If **Yes** or **Not Clear** commence a investigation to establish facts
	Did the individual knowingly breach known rules, safe operating procedure and/or breach Trust values and behaviours?	**Yes** **Not Clear** **No**	If **Yes** evidence the professional body and/or Trust rules, Trust Values and Behaviours that were breached
CAPACITY & MITIGATION			
	Did mental or physical ill health contribute to the alleged incident? (please note this includes any concerns there may be re substance abuse)	**Yes** **Not Sure** **No**	If **Yes** underlying health conditions should be taken into consideration when deciding the next step. OH can provide guidance on the likelihood of any medical condition contributing to or impacting an incident If you're **Not Sure** then a discussion should take place with the individual and then a referral to OH for further advice
	Are there any mitigating circumstances e.g. home/family etc?	**Yes** **No**	Discuss with the employee if there are any circumstances with may have impacted upon performance or decision making
SKILLS AND KNOWLEDGE			
	Is there a protocol / procedure / policy that refers to the expected standard of behaviour / conduct?	**Yes** **No**	If **Yes** please detail protocol / procedure / policy.` Is the protocol / procedure / policy clear? If **No**, should there be one to provide staff with the applicable framework for expected standards of behaviour and care?

	Have you reviewed the member of staff's skills and competency and determined if they knew of the rules or performance standard?	**Yes** **No**	If the member of staff knows how to and can in practice, but isn't then continue with formal investigation
	Would you expect a different member of staff in a similar role / position with similar experience to act in a similar manner?	**Yes** **No**	
COMPARATOR			
	As the manager, can you reflect on how well have you read and reacted to the situation?	**Proportionately** **Disproportionately**	Consider whether unconscious bias contributed to your decision. **Unconscious bias** can often show up as micro-behaviours (the little things that we say and do that show how we regard those around us)
	Is the action you're considering consistent with how other employees within your team have been treated for the same or similar misconduct or action?	**Yes** **No**	If No why have you chosen to consider disciplinary action on this occasion? Provide explanation: By carrying out an investigation for disciplinary action against this employee you need to ensure this action is consistent with how other employees have been treated for the same or similar misconduct / action

APPENDIX 4

FORMAT OF THE DISCIPLINARY HEARING

1. This Appendix should be read in conjunction with the Trust's Scheme of Delegation in relation to disciplinary hearings.

2. The employee will be given 21 calendar days' notice of the arranged disciplinary hearing. The invite letter will confirm confirmation of the date, time, venue of the hearing, the name of the chair of the hearing and the HR representative, any witnesses to be called and the right to representation. It will also detail the allegations which will be considered during the hearing, the alleged breaches of the Disciplinary policy, and the possible outcome(s) of the hearing.

3. The employee will also be issued with a disciplinary pack which will consist of the investigation report, all appendices, and a copy of the Disciplinary Policy. If the employees' representative is known, the disciplinary pack will be shared at the same time, and directly with the representative. In any other circumstances the employee will be provided with two copies of their documentation so they can pass this on to their representative as appropriate.

4. It is the employee's responsibility to arrange appropriate representation. If the hearing is cancelled due to unavailability of any party, the hearing should be rescheduled preferably within a period of 2 weeks. If the employee is off work due to sickness then a decision will be made regarding whether to progress based on the nature of the incapacity and Occupational Health advice when appropriate.

5. The disciplinary hearing will be chaired by an appropriately trained manager band 8a or above), who will be supported by a HR representative. There may be occasions where it is deemed appropriate for a clinical lead/expert to join the hearing panel. In all cases panel members will have had no direct involvement in the case to date.

6. In any cases of alleged gross misconduct the management representative and chair should be an appropriately nominated officer of the Trust, empowered to terminate an employee's contract.

7. Should witnesses be required to attend the disciplinary hearing, it will be the responsibility of the Investigating Officer and/or the employee and their representatives to make the necessary arrangements directly with their respective witnesses The Chair of the hearing should be notified five calendar days prior to the hearing of any witness(s) is to be called (if any)

8. Witnesses will receive only those documents relevant to their statement.

9. Formal investigations which involve allegations relating to clinical care will be reviewed by the Trust's 'Review of Serious Events' panel (ROSE) and will be considered in line with Just Culture principles.

10. The Chair of the hearing will introduce those in attendance, ensure all documentation has been received, advise the employee of the precise allegation(s) made against them, and clarify the potential outcome of the hearing. They will then ask the Investigating Officer to outline the case by presenting evidence that has been gathered and call witnesses (if required) to recount their evidence.

11. During the disciplinary hearing neither side should interrupt during the presentation of the case and any instruction given by the Chair must be adhered to.

12. No audio recordings of the hearing will be permitted as official notes will be taken.

13. Following the presentation of the investigation, the employee and/or representative will be given the opportunity to ask questions relating to the management presentation, including any questions of management witnesses.

14. Following this the Chair of the hearing/ HR representative may also ask any questions they feel relevant to the proceedings. The Chair of the hearing / HR representative may also ask essential questions at any point in the proceedings to seek clarification.

15. Following the withdrawal of any management witnesses the employee or representative will then be invited to present their statement of case by presenting relevant evidence and calling any witnesses (if required) to recount evidence.

16. Following the presentation of the employee's case, the management side will be given the opportunity to ask questions relating to the employee's presentation, including any questions of employee witnesses.

17. Following this the Chair of the hearing/ HR representative may also ask any questions they feel relevant to the proceedings and once completed the employee witnesses will withdraw.

18. Both management and the employee will have a final opportunity to summarise their respective cases before the Chair of the hearing adjourns the hearing to consider the case with support / advice from HR.

19. The Chair of the hearing will take full and genuine account of any mitigating circumstances in deciding what action is appropriate.

20. Under normal circumstances the employee will be advised of the outcome of the hearing on the day, the outcome will then be confirmed to the employee, in writing within seven calendar days. Where it is not possible to deliver the outcome on the day, the Chair will endeavor to meet with the employee and their TU representative to inform them of the decision. In exceptional circumstances where it is not possible to meet the decision can be made in writing.

21. The written decision will cover: -

- An explanation of which allegations have been proven/ how the decision has been reached, the mitigation considered, the level of sanction (if applicable, how long it will last, and potential consequences of further breaches of the Trust's disciplinary rules.

- An explanation of any required remedial action including the standards expected of the employee in the future.

- An assurance that any warning will be removed from personal files after the expiry of the warning period.

- The right of appeal, and how to exercise this right.

APPENDIX 5

APPEALS PROCEDURE

1. This Appendix should be read in conjunction with the Trust's Scheme of Delegation in relation to appeal hearings.

2. All employees have the right to appeal against any action taken against them as part of the formal Disciplinary Procedure. The Appeals procedure should not be used as a rehearing of the disciplinary hearing but should focus on specific grounds for appeal:

   - New evidence has come to light that was not previously obtainable
   - A failure to follow Trust disciplinary procedure
   - The level of sanction received is too severe

3. Appeals should be lodged by the employee in writing to the Head of HR Business Partnering providing details of the grounds for appeal. The appeal must be received no later than 14 calendar days from receipt of the outcome letter.

4. It is important that appeals should be heard within a reasonable timescale. It is the intention of the Trust that all appeals will be heard as soon as possible from the date on which the appeal is lodged. Normally, this will be within 4 weeks. If it is not possible to arrange the appeal hearing within 4 weeks, then this will be discussed with the individual or their representative. The appellant will be given at least 14 calendar days' notice of the date of the appeal hearing.

5. Statements of case from both the appellant / their representative and management side will be submitted to the nominated HR representative who will co-ordinate their exchange no later than five calendar days before the hearing, unless mutually agreed otherwise.

6. On the day of the hearing, no further written evidence may be submitted unless agreed by the Chair of the appeal hearing. In such a situation, an adjournment (but not a postponement) is available to either side to consider any new evidence.

7. The Chair of the appeal hearing will introduce those in attendance, explain the purpose of the appeal and summarise the grounds for appeal. The appellant or their representative will then be invited to present the case for appeal (in the presence of management side) and may call witnesses as required.

8. Management side will have the opportunity to ask questions of the appellant/ their representative and any witnesses following the presentation of case.

9. The Appeal Panel will have the opportunity to ask any questions of the appellant/ their representative and any witnesses.

10. Following withdrawal of the appellant witnesses, the management representative shall then present the management case in the presence of the appellant and their representative and may call witnesses.

11. The appellant or his/her representative shall have the opportunity to ask questions of the management representative following the presentation of case

12. The Appeal Panel shall have the opportunity to ask questions of the management representative and witnesses.

13. Following withdrawal of the appellant witnesses, both the appellant / their representative and management side will have the opportunity to sum up their case. In these final summaries, neither party may introduce any new matters for consideration.

14. The Appeal Panel may adjourn the appeal should they consider that further evidence is required by either party but in any event will adjourn to consider the information presented.

15. The Appeal Panel shall deliberate in private only recalling both parties to clarify points of uncertainty on evidence already given. If recall is necessary both parties shall return to hear the questions asked and the response given even though it may only concern one of the parties giving evidence.

16. The decision of the Appeal Panel will normally be communicated at the end of the meeting. The Appeal Panel may uphold, revoke or reduce any disciplinary action taken. In any event, the appellant will be notified in writing of the decision of the Appeal Panel within seven calendar days.

17. The decision of the Appeal Panel will be final and will bring the Trust process to a close.

APPENDIX 6

Suspension/Action short of Suspension

Employee Details			
Employee Initials:		**Employee Role:**	
Service Line:		**Area:**	
Head of Operations/ Equivalent Senior Manager:		**HR Advisor:**	

	Consideration	Response	Evidence
1	Has a preliminary investigation/ fact finding exercise been undertaken to understand the situation?	Yes / No	*Please see and complete Appendix 3*
2	Do the concerns amount to allegations of **serious misconduct and** / or is there concern that: • Working relationships have severely broken down • The employee could tamper with evidence or influence witnesses • There is a risk to other employees, property or patients • Further incidents may occur • The individual needs safeguarding from further allegations? • The employee is the subject of criminal proceedings which may affect whether they can continue to undertake their role.	Yes / No	*(SUSPENSION SHOULD ALWAYS BE A LAST RESORT)*
3	If **yes** to any of the above, is it possible to: • Temporarily move the individual to another area until the outcome of the investigation? • Limit/restrict/supervise the employee's duties or practice whilst the investigation is carried out?	Yes / No	
4	If no to Q3, have you contacted the Business HR team to discuss the possibility of suspension?	Yes / No	
5	Before carrying out the suspension, have you consulted with the respective Head of Operations (or Equivalent) for your area?	Yes / No	

	Consideration	Response	Evidence
6	Do you need to contact the Trust Safeguarding Team?	Yes / No	
7	Does the individual work on the Bank? Do you need to liaise with GRS to prevent the worker from working bank shifts for the Trust during the period of suspension?	Yes / No	

Final Decision:	**Suspension**	Yes / No	**Action short of suspension**	Yes / No
			Detail of ASOS	
Case Manager			**Date**	
HR Representative			**Date**	

NB: Copy of this form must be sent to the Head of Business HR and relevant Area Director

Appendix 7: Appeal Pro-Forma

Employee Registration of Appeal Pro-Forma.

In order to submit an appeal, please complete this form, providing as much information as possible.
To register your appeal, this should be sent via email to the Head of HR Business Partnering (or nominated deputy)

Section 1 – Details

Personal Details (to be completed by the person submitting an appeal)			
Name of employee:			
Job Title		**Employee Number**	
Division/Area			
Date of Disciplinary Hearing:		**Sanction you are appealing against:**	(Delete as appropriate) ☐ First Written Warning ☐ Final Written Warning ☐ Dismissal ☐ Alternative to Dismissal (i.e. Downgrading)

Section 2 – Grounds of Appeal

Please detail the grounds of appeal. Please note, the purpose of an appeal is to consider the decision made by the chair of the disciplinary hearing. An appeal hearing is not a re-hearing of the original case

Further Explanation – Grounds of Appeal Please provide further explanation of your grounds of appeal. This should contain specific Issues/ examples which support your grounds of appeal detailed in Section 2. Please use additional sheets of paper/ provide supporting documentation if required but ensure that all pages are numbered and clearly referenced.

☐	I wish to be accompanied by a Trade Union representative/Work place colleague at any appeal meeting	**Name (please provide where possible)**	
		Contact Details:	
☐	I do not wish to be accompanied		

NHS
North West
Ambulance Service
NHS Trust

Equality Impact Assessment
Stage 2

An Equality Impact Assessment (EIA) provides a framework for assessing if there are potential positive or negative impacts on some or all protected characteristics, as defined under the Equality Act 2010, in the development of services/strategies/policies.

An effective EIA:

- Demonstrates "due regard" for the Public Sector Equality Duty
- References evidence in the form of data and engagement with stakeholders
- Identifies mitigating actions to minimise any negative impacts

Once completed, this EIA should be sent to the Trust's ED&I Team for review: inclusion.workforce@nwas.nhs.uk.

Note: the Stage 2 EIA is to normally be completed following a recommendation based on the EIA Stage 1 Screening Tool and is intended (mostly) for major or complex strategies, projects/programmes or decisions which may significantly change or introduce a service or working practice. For all other programmes of work including policies and procedures, a fully completed Screening Tool may be sufficient. Please consult the ED&I Team for advice.

Name of the policy / strategy / project / service development proposal being assessed:	**Disciplinary Policy**		
EIA lead/author:	**Jessica White**		
Date completed:	**16.02.23**		
Date reviewed:			
Version:	**1.0**		
Have you completed a Stage 1 EIA Screening Tool?	~~**Yes**~~	**No**	**If so, attach PDF here:**

Version history:			
Date	**Version**	**Author**	**Summary of changes / notes**
Approved by:			**Date:**

1. Overview

Equality Impact Assessment pro-forma – Stage 2		Pro-forma version	1.0
Date of approval		Date of review	

1.1. Provide brief outline of the project this EIA relates to

The Disciplinary Policy has been subject to thorough consultation and was agreed via the Trust's Policy Group and the Joint Negotiating Group. The policy amounted to a complete re-write in order to incorporate the Just and Learning Culture principles. It also introduces the use of a revised model; the Case Manager/ Investigating Officer model. The policy has been re-written with employee wellbeing as a pivotal element and focusses on the issue of informal resolution of issues wherever possible.

The policy details the commitment of the Trust to handle concerns in a way which is fair and consistent for all. The policy therefore makes every effort to ensure that it does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010 and ongoing monitoring will take place to continue to assess this impact. The Trust will endeavour to make reasonable adjustments to accommodate any employee with particular equality and diversity requirements.

1.2. Is this a new project or is this about reviewing/changing/amending something already in place?

Reviewing/changing/amending

1.3. If the project relates to reviewing/changing/amending current provision, please summarise the current provision, and describe the prospective changes being proposed.

- The policy embeds the principles of fostering a Just and Learning culture within the organisation; focussing on learning and aiming to resolve issues informally wherever possible. This responds to the NHS initiative communicated via Baroness Dido Harding and Prerana Issar.
- The main shift from the existing policy is the introduction of the Case Manager/ Case Investigator model which is widely used across the NHS with positive benefits. This model introduces senior oversight to the process and clearly defines the roles and responsibilities of individuals involved. Once fully embedded, it is anticipated that the role of the Case Manager will replace the existing Investigation Review Panel as they will assume responsibility for case oversight and tracking of timescales, ensuring that as an organisation we strive to achieve HR best practice.

1.4. Which stakeholders are likely to be impacted/affected as a result of the proposal(s)?
(please mark all that apply)

Stakeholder	**Impacted**	**Groups**
Patient / Service users / Citizens	☐	
Carers	☐	
Staff	☒	All staff groups
Partner organisations	☐	
Other *(please specify)*	☐	

2. Evidence: data and engagement

2.1. How will/have you engaged stakeholders for the purposes of gathering evidence and/or testing the proposals?

Think about groups impacted internally and externally, engagement with Patient and Public Panel, Staff Networks, Trade Unions etc.

There has been engagement across the organisation; with managers and TU representatives initially in the 'ideas' phase, followed by a lengthy period of consultation and engagement through the Trust's established Policy Group and then to the Joint Negotiating Group.

Feedback was sought on the current policy and how we would seek to make positive changes and work collaboratively to create a Just and Learning Culture across the organisation through the introduction of the revised policy and procedure. There have been multiple iterations of the policy as it has been constantly discussed and reviewed throughout the engagement/ consultation stages.

2.2. What data/information are you using to inform this assessment?

Think about this from a workforce and patient perspective, depending on which groups are likely to be impacted. List the main sources of data, research and other evidence reviewed to determine impact on each equality group (protected characteristics). This may include national research, surveys, reports, population data, workforce data, complaints data, research interviews, feedback from focus groups, pilot activity evaluations or other equality analyses.

Protected characteristic / Equality group	Evidence / Information
Age *Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.*	N/A
Disability *This can include attitudinal, physical and social barriers as well as mental health, learning difficulties, long-term conditions, physical impairment and sensory impairments*	N/A
Gender reassignment (including transgender) *Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment*	N/A
Marriage and civil partnership *This can include working arrangements, part-time working, and caring responsibilities.*	N/A
Pregnancy and maternity *This can include working arrangements, part-time working and caring responsibilities.*	N/A
Race *This can include information on different ethnic groups, nationalities, cultures and language barriers and resident status (migrants, asylum seekers).*	Workforce Race Equality Standard (WRES) data for the period 1st April 2021 – 31st March 2022 Data relating to staff in the disciplinary processes has shown a worsening with staff from ethnic minority backgrounds now being more than twice as likely (2.23) to enter the formal disciplinary process compared with White staff. This metric

	saw a slight improvement from 2020 to 2021 (1.89 to 1.70) but has gone up in the last year. However, analysis of numbers of staff entering the disciplinary process shows that in 2022, out of 108 total cases, only 10 related to staff from ethnic minority backgrounds. This disproportionality highlighted by the WRES data shows that a greater percentage of ethnic minority staff are entering the disciplinary process when compared to the overall percentage of staff from ethnic minority backgrounds in the NWAS workforce (approx. 5%).
Religion or belief *Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.*	N/A
Gender *Consider and detail evidence on men and women. This could include access to services and employment.*	N/A
Sexual orientation *Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*	N/A
Carers *Consider and detail evidence on part-time working, shift patterns and general caring responsibilities.*	N/A
Socially deprived communities *Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality and income.*	N/A
Human Rights Act 1998 *Consider and detail evidence relating the Articles set out in the Human Rights Act.*	N/A

3. Assessment of the impact on equality groups (protected characteristics)

3.1. Taking into account the evidence gathered (as detailed in section 2), assess whether the project has a positive, negative or neutral impact on particular equality groups.

- A positive impact means promoting equal opportunities, reducing inequalities, improving access or improving relations between equality groups.
- A negative impact means that an equality group(s) could be disproportionately disadvantaged, discriminated against indirectly or directly or there may be a negative effect on relations between equality groups.
- A neutral impact means that it has no effect currently on the equality group(s)

Equality groups	Positive Impact	Negative Impact	Neutral Impact	Don't Know	Please provide a rationale for your answer
Age	☒	☐	☐	☐	Review of data gives no indication of barriers to access or differential treatment. The policy details the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010.
Disability	☒	☐	☐	☐	
Gender Reassignment	☒	☐	☐	☐	
Marriage and civil partnership	☒	☐	☐	☐	
Pregnancy and maternity	☒	☐	☐	☐	
Race	☒	☐	☐	☐	There is some evidence to suggest that staff from minority ethic groups (BAME staff) are involved in more disciplinary cases, however, there are no suggestions that this is due to the current policy framework. The revised policy outlines a framework to follow for all staff irrespective of race, ethnicity or nationality. In addition, the Trust regularly reviews and assesses employment practices to ensure any disproportionate action/ outcomes are identified: • The Trust's IRP panel which provides senior level oversight of disciplinary matters. This ensures consistency of outcomes and investigation reports. • Annual return against the NHS Workforce Race Equality Standard to demonstrate how the Trust are performing against set equality standards.
Religion or belief	☒	☐	☐	☐	Review of data gives no indication of barriers to access or differential treatment. The policy details the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010.
Gender	☒	☐	☐	☐	
Sexual Orientation	☒	☐	☐	☐	
Carers	☐	☐	☐	☐	N/A
Socially deprived communities	☐	☐	☐	☐	N/A
Human Rights	☒	☐	☐	☐	The policy supports Article 6 of the Human Rights Act - Right to a fair trial

Carers and socially deprived communities are not protected characteristics as set out in the Equality Act 2010, but are health inequality groups which are priority groups for Cheshire and Merseyside to improve health outcomes for.

3.2. For any equality groups who are likely to experience negative or adverse impacts, what actions are you planning to take to mitigate and minimise the effects?

Equality group	Action	Lead	Timescales
Staff from ethnic minority backgrounds	Delivery of the 'Beyond Bias' training programme aimed at all NWAS managers and leaders is expective to lead to greater inclusive management and improved cultural competence within the organisation	Learning & Development Team	Now - March 2024
All Equality Groups	Training for managers relating to how to use the Disciplinary Policy. As part of the implementation of this policy, training will be provided by Weightman's solicitors which will embed the principles of fairness and equal treatment for all.	HRBP	April – June 2023
Staff from ethnic minority backgrounds	Regular monitoring of disciplinary data to see if ethnic minority staff groups continue to be over-represented in figures through thorough case analysis.	HRBP	On-going from point of implementation

4. Monitor and review

Th EIA should be reviewed periodically throughout the development the project to consider for example if any new evidence emergences or if the groups impacted have changed in away. Any reviews undertaken to monitor progress on the action plan, or to add any new information through further data gathering or engagement should be documented. Timescales for EIA review should be built into the project plan.

North West Ambulance Service NHS Trust

FAST TRACK DISCIPLINARY PROCEDURE

Recommended by	Executive Management Team
Approved by	
Approval Date	
Version Number	
Review Date	
Responsible Executive Director	Director of People
Responsible Manager	Deputy Director of People
For use by	All Trust Employees

CHANGE RECORD FORM

Version	Date of change	Date of release	Changed by	Reason for change
0.1				Document creation
1.0				

Fast Track Disciplinary Procedure

Contents

1. Introduction

1.1 The Trust expects all colleagues to meet high standards of behavior which support the Trust's values to deliver the right care, at the right time, in the right place whilst treating the public with dignity and protecting them from harm. The aim of this procedure is to set out an alternative process for dealing with matters of employee misconduct which is in breach of Trust values, policies or rules or falls short of the expected Trust standards.

1.2 The Trust aims to develop an open and fair culture which encourages self-reflection and improvement and wherever relevant, lessons learnt are openly discussed and embedded across the service.

1.3 This procedure is only applicable in cases where the allegations are not considered to be potential gross misconduct **and** the employee does not contest any part of the allegations and wishes for the matter to be dealt with quickly to support their wellbeing.

1.4 This procedure applies to all employees of the North West Ambulance Service NHS Trust and should be read in conjunction with the Trust's Disciplinary Policy & Procedure and Complaints, Incidents and Investigations Policy.

2. General Principles

2.1 As part of our journey in developing a Just and Learning culture, it is the Trust's policy to ensure that every disciplinary matter is dealt with fairly, and that adequate steps are taken in the early stages to establish the relevant facts using the Just and Learning Culture principles before initiating formal action.

2.2 The use of this procedure can be requested by the employee, their representative or the Case Manager. For this procedure to be used, it is imperative that enough facts are known about the case and for it to be determined that due to the nature of allegations, any formal disciplinary process would result in a sanction of no more than a Final Written Warning.

2.3 This procedure cannot be used if the employee already has a live formal warning on file, or there is a connected disciplinary process involving another employee.

2.4 Formal action under this procedure can never be taken without the involvement of a member of the HR team.

2.5 Where early resolution via the Fast Track Procedure is accepted by the assigned Case Manager, there will be no requirement for a full disciplinary investigation, however, sufficient and reasonable fact finding into the matter must have taken place in order to ensure that during the Fast Track Hearing (FTH) the facts can be fully

reviewed and can be used to deliver an outcome to the employee. Any information gathered as part of the initial fact find will be shared with the employee in advance of the FTH.

2.6 If, whilst the Fast Track Procedure is on-going, the employee contests the allegations previously accepted or, if further information becomes apparent which means the use of this procedure is no longer appropriate (e.g. allegations arising which may amount to gross misconduct), the Fast Track Procedure will be stopped, and the process under the Trust's Disciplinary Policy will resume or commence. This will be determined by the appointed Case Manager who will, if required, appoint and or direct an appropriate Investigation Officer to carry out an investigation in line with the Trust's Disciplinary Policy.

2.7 A employee can request resolution via the Fast Track Procedure at any point prior to a formal disciplinary hearing date.

2.8 By requesting and agreeing to the use of a Fast Track Procedure, an employee **will not** have the right to appeal any formal disciplinary sanction issued at the Fast Track Hearing as the use of this process and the scope out the outcome were agreed by both parties prior to the FTH.

2.9 It is the responsibility of all parties involved in this procedure to always maintain confidentiality and objectivity.

3. Safeguarding People's Health and Wellbeing

3.1 It is recognised that employees who are the subject of conduct investigations or proceedings are likely to find the situation stressful, as will other staff who may become involved because they are a victim of, or witnesses to the event. Managers are responsible for ensuring that any staff involved within a disciplinary process are appropriately supported at all stages of the process.

3.2 At the outset of any disciplinary case the employee must be reminded of the support services available to them through the Trust's Occupational Health and counselling service. The employee must be advised that a self-referral to those services can be made or alternatively a management referral will be made on their behalf with the employee's permission. In some circumstances the Case Manager may automatically refer an employee to support services dependent on the nature of the allegations or the employee's circumstances.

3.3 Where an employee who is subject to this process has further concerns regarding their health and wellbeing, they should raise in the first instance with the Case Manager, who will ensure they are appropriately supported.

4. Handling Misconduct Issues via Fast Track Application Procedure

4.1 When allegations of misconduct arise, which are above the threshold to be handled via informal resolution (structured conversation), and where through the completion of the Preliminary Fact-Finding Checklist (see Disciplinary Policy appendix 3) it is determined that a more formal investigation may be appropriate, the use of the Fast Track Procedure may be applied with the support by the Case Manager.

4.2 In such cases, and if the employee has admitted the allegation(s) put to them in full, via the fact-finding process, they may request their case is progressed via the Fast Track Process (FTP). Equally the Case Manager may suggest the use of the FTP as a voluntary option to the employee.

4.3 In order to proceed using the Fast Track Policy, the following must apply:

- It is a case of alleged misconduct which cannot warrant summary dismissal, and
- The employee does not have a live warning on file, and
- The employee does not wish to contest any of the allegations (the employee may feel that they have mitigation to be put forward but admits in full to the allegation), and
- The employee agrees that they do not wish to proceed with a full disciplinary investigation/hearing in line with the trusts' Disciplinary Policy, and
- The employee completes the Fast Track Request Form at Appendix 1.

4.4 Where an employee is considering pursuing resolution via this route, it is recommended that they seek advice from their trade union representative, workplace colleague or member of the HR team before reaching this decision. The employee and/or their representative should then complete and sign the Fast Track Application form (Appendix 1) and send this to the fact-finding manager for Completion. This will then be submitted to the Case Manager. Upon receipt of a Fast Track Application the Case Manager must, as soon as is practicably possible, discuss the matter with a HR Manager to agree if the situation is appropriate to be considered at a Fast Track Hearing.

4.5 If an agreement to follow the FTP cannot be reached, then a full investigation will be instigated in line with the Trust's Disciplinary Policy. The Case Manager will confirm this to the employee / their representative in writing.

4.6 If the Fast Track Application is accepted, there will no requirement for a formal investigation report, although a sufficient and reasonable fact-finding process must have taken place in order to ensure that Fast Track Hearing Chair is able to deliver an outcome at the Fast Track Hearing. Once it has been agreed to proceed via FTP it is anticipated that the process will be concluded within 28 calendar days, unless exceptional circumstances arise. Any unreasonable delays in concluding the FTP should be escalated to the Head of HR.

5. Fast Track Hearing Process

5.1 The formal disciplinary hearing will be replaced with a Fast Track Hearing (FTH). Under the fast-track process there will be a hearing chaired by an appropriately

trained/ experienced Trust representative, who will be assigned in line with the Trust's scheme of delegation. Also in attendance will be a member of the HR team to provide support and advice. The employee has the right to be represented by a trade union representative or a workplace colleague at the Fast Track Hearing.

5.2 The invitation to the fast-track hearing will be provided in writing giving a minimum of 3 working days' notice. This invitation will set out the allegations that the employee has admitted on the fast-track application and will confirm that if a sanction is issued by the Chair of the hearing, this will not exceed a 12 month final written warning. On receipt of this invitation the employee has a final opportunity to withdraw from the fast-track process and request a full disciplinary hearing. An employee will not suffer any detriment if they choose to proceed with their right to a full disciplinary hearing.

5.3 At a Fast-Track hearing, an employee or their representative has the opportunity to present any mitigation relating to the allegations. The FTH Chair will consider this together with the information captured on the Fast Track Application. No witnesses will be called, no formal statements of case will be exchanged and only brief hand-written notes of the hearing will be kept by the panel.

5.4 There will be a brief adjournment of the FTH to enable consideration of the case presented in the application and at the hearing. In exceptional circumstances ,where more information is required before a decision can be taken, the hearing may be adjourned to allow further investigation to take place. The extent of what further investigation is required and the duration of the adjournment will be determined by the Chair of the FTH.

5.5 Under normal circumstances the employee will be advised of the outcome on the day. This will be followed up in writing within seven calendar days. Where it is not possible to communicate the outcome on the day, the Chair of the FTH will endeavor to meet with the employee and their representative to inform them of the decision. In circumstances where it is not possible to meet, the decision will be provided in writing.

6 Disciplinary Sanctions

6.1 When determining what, if any, disciplinary sanction is appropriate the Chair of the FTH must act reasonably in all the circumstances. If a sanction is issued by the Chair of the FTH, it will not exceed a Final Written Warning.
Factors relevant in determining which disciplinary sanction to apply include:

- The extent to which standards have been breached and / or the seriousness of the misconduct
- Consistency of treatment
- Other special circumstances which might mitigate or otherwise affect the appropriate severity of the penalty

- Impact of the actions on others and the Trust (including reputation)
- Whether the intended disciplinary action is reasonable in all the circumstances
- The employee's general record

6.2 Any sanction issued will be in accordance with the Trust's Disciplinary Policy and will not exceed a final written warning. Any final written warnings issued following the use of the Fast Track Procedure, will not exceed 12 months in their duration

6.3 The process of issuing sanctions is not sequential. A sanction can be applied at any level.

6.4 The sanctions will normally be effective from the date of the fast-track hearing.

6.5 Warnings will be disregarded for the purpose of considering cumulative disciplinary sanctions after the expiration of their "live period" but the facts / circumstances may be deemed relevant to future cases so details will remain on employees' personal files.

Appendix 1

Fast Track Procedure Application

Full Name:		**Role:**	
Service Line:		**Area:**	
Head of Service:		**HR Manager:**	
Do you have any Live Disciplinary Warnings	Yes/No		
2. Case Details (Completed by Fact Finding Manager)			
Date allegation initially raised:		**Name of Manager who undertook Fact Finding**	
Nature of Allegation (to be completed by manager who conducted Fact Find)			
Date meeting to discuss allegations took place		**Names of those present:**	
Main Points Of Fact Finding Discussion			

3. Employee Submission Case Details	
Do you dispute any of the allegations/ facts above?	Yes/No If yes please note your FT application can not proceed
Please provide a full explanation of the incident(s) that led to these allegations of misconduct (you can detail this on a separate attached sheet if you wish)	
Please provide details of any mitigation you would wish to be considered	
Please detail the lessons you have learnt from this situation and your intentions for the future	
I confirm my acceptance of the allegation(s) of misconduct against me and am making this request for my case to be considered under the Fast Track Disciplinary Process.	
Employee Name	
Employee Signature	
Date	

NHS North West Ambulance Service NHS Trust

Equality Impact Assessment
Stage 2

An Equality Impact Assessment (EIA) provides a framework for assessing if there are potential positive or negative impacts on some or all protected characteristics, as defined under the Equality Act 2010, in the development of services/strategies/policies.

An effective EIA:

- Demonstrates "due regard" for the Public Sector Equality Duty
- References evidence in the form of data and engagement with stakeholders
- Identifies mitigating actions to minimise any negative impacts

Once completed, this EIA should be sent to the Trust's ED&I Team for review: inclusion.workforce@nwas.nhs.uk.

Note: the Stage 2 EIA is to normally be completed following a recommendation based on the EIA Stage 1 Screening Tool and is intended (mostly) for major or complex strategies, projects/programmes or decisions which may significantly change or introduce a service or working practice. For all other programmes of work including policies and procedures, a fully completed Screening Tool may be sufficient. Please consult the ED&I Team for advice.

Name of the policy / strategy / project / service development proposal being assessed:	**Disciplinary Fast Track Procedure**		
EIA lead/author:	**Jessica White**		
Date completed:	**16.02.23**		
Date reviewed:			
Version:	**1.0**		
Have you completed a Stage 1 EIA Screening Tool?	~~**Yes**~~	**No**	**If so, attach PDF here:**

Version history:			
Date	**Version**	**Author**	**Summary of changes / notes**
Approved by:			**Date:**

1. Overview

Equality Impact Assessment pro-forma – Stage 2		Pro-forma version	1.0
Date of approval		Date of review	

1.1. Provide brief outline of the project this EIA relates to

The Fast Track Disciplinary Policy has been subject to thorough consultation and was agreed via the Trust's Policy Group and the Joint Negotiating Group. The policy is newly introduced to the Trust and aims to provide a framework whereby applicable instances of misconduct can be dealt with swiftly, and avoiding a formal investigative process, with the aim of supporting employee wellbeing.

It details the procedure to be followed when certain instances of misconduct occur, which are able to be dealt with via the Fast Track process. It is a voluntary process which can be suggested by the employee/ their representative or management. The document sets out the framework for handing concerns via Fast Track hearings, including the meeting composition and applicable sanctions.

The policy details the commitment of the Trust to handle concerns in a way which is fair and consistent for all. The policy therefore makes every effort to ensure that it does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010 and ongoing monitoring will take place to continue to assess this impact. The Trust will endeavour to make reasonable adjustments to accommodate any employee with particular equality and diversity requirements.

1.2. Is this a new project or is this about reviewing/changing/amending something already in place?

Introducing a new project/strategy/service

1.3. If the project relates to reviewing/changing/amending current provision, please summarise the current provision, and describe the prospective changes being proposed.

1.4. Which stakeholders are likely to be impacted/affected as a result of the proposal(s)?
(please mark all that apply)

Stakeholder	**Impacted**	**Groups**
Patient / Service users / Citizens	☐	
Carers	☐	
Staff	☒	All staff groups
Partner organisations	☐	
Other *(please specify)*	☐	

2. Evidence: data and engagement

2.1. How will/have you engaged stakeholders for the purposes of gathering evidence and/or testing the proposals?

Think about groups impacted internally and externally, engagement with Patient and Public Panel, Staff Networks, Trade Unions etc.

There has been engagement across the organisation; with managers and TU representatives initially in the 'ideas' phase, followed by a lengthy period of consultation and engagement through the Trust's established Policy Group and then to the Joint Negotiating Group.

Feedback was sought on the principles of the fast track (given this is newly introduced to the Trust) and then drafts circulated and amended as feedback received.

2.2. What data/information are you using to inform this assessment?

Think about this from a workforce and patient perspective, depending on which groups are likely to be impacted. List the main sources of data, research and other evidence reviewed to determine impact on each equality group (protected characteristics). This may include national research, surveys, reports, population data, workforce data, complaints data, research interviews, feedback from focus groups, pilot activity evaluations or other equality analyses.

Protected characteristic / Equality group	Evidence / Information
Age *Consider and detail age related evidence. This can include safeguarding, consent and welfare issues.*	N/A
Disability *This can include attitudinal, physical and social barriers as well as mental health, learning difficulties, long-term conditions, physical impairment and sensory impairments*	N/A
Gender reassignment (including transgender) *Consider and detail evidence on transgender people. This can include issues such as privacy of data and harassment*	N/A
Marriage and civil partnership *This can include working arrangements, part-time working, and caring responsibilities.*	N/A
Pregnancy and maternity *This can include working arrangements, part-time working and caring responsibilities.*	N/A
Race *This can include information on different ethnic groups, nationalities, cultures and language barriers and resident status (migrants, asylum seekers).*	Workforce Race Equality Standard (WRES) data for the period 1st April 2021 – 31st March 2022 Data relating to staff in the disciplinary processes has shown a worsening with staff from ethnic minority backgrounds now being more than twice as likely (2.23) to enter the formal disciplinary process compared with White staff. This metric saw a slight improvement from 2020 to 2021 (1.89 to 1.70) but has gone up in the last year.

	However, analysis of numbers of staff entering the disciplinary process shows that in 2022, out of 108 total cases, only 10 related to staff from ethnic minority backgrounds. This disproportionality highlighted by the WRES data shows that a greater percentage of ethnic minority staff are entering the disciplinary process when compared to the overall percentage of staff from ethnic minority backgrounds in the NWAS workforce (approx. 5%).
Religion or belief *Consider and detail evidence on people with different religions, beliefs or no belief. This can include consent and end of life issues.*	N/A
Gender *Consider and detail evidence on men and women. This could include access to services and employment.*	N/A
Sexual orientation *Consider and detail evidence on heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.*	N/A
Carers *Consider and detail evidence on part-time working, shift patterns and general caring responsibilities.*	N/A
Socially deprived communities *Consider and detail evidence on groups experiencing disadvantage and barriers to access and outcomes. This can include different socio-economic groups, geographical area inequality and income.*	N/A
Human Rights Act 1998 *Consider and detail evidence relating the Articles set out in the Human Rights Act.*	N/A

3. Assessment of the impact on equality groups (protected characteristics)

3.1. Taking into account the evidence gathered (as detailed in section 2), assess whether the project has a positive, negative or neutral impact on particular equality groups.

- A positive impact means promoting equal opportunities, reducing inequalities, improving access or improving relations between equality groups.
- A negative impact means that an equality group(s) could be disproportionately disadvantaged, discriminated against indirectly or directly or there may be a negative effect on relations between equality groups.
- A neutral impact means that it has no effect currently on the equality group(s)

Equality groups	Positive Impact	Negative Impact	Neutral Impact	Don't Know	Please provide a rationale for your answer
Age	☒	☐	☐	☐	

Equality groups	Positive Impact	Negative Impact	Neutral Impact	Don't Know	Please provide a rationale for your answer
Disability	☒	☐	☐	☐	Review of data gives no indication of barriers to access or differential treatment. The policy details the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010.
Gender Reassignment	☒	☐	☐	☐	
Marriage and civil partnership	☒	☐	☐	☐	
Pregnancy and maternity	☒	☐	☐	☐	
Race	☒	☐	☐	☐	There is some evidence to suggest that staff from minority ethic groups (BAME staff) are involved in more disciplinary cases, however, there are no suggestions that this is due to the current policy framework. The revised policy outlines a framework to follow for all staff irrespective of race, ethnicity or nationality. In addition, the Trust regularly reviews and assesses employment practices to ensure any disproportionate action/ outcomes are identified: • The Trust's IRP panel which provides senior level oversight of disciplinary matters. This ensures consistency of outcomes and investigation reports. • Annual return against the NHS Workforce Race Equality Standard to demonstrate how the Trust are performing against set equality standards.
Religion or belief	☒	☐	☐	☐	Review of data gives no indication of barriers to access or differential treatment. The policy details the commitment of the Trust to make every effort to ensure the policy does not have the effect of discriminating, directly or indirectly, on the grounds of any protected characteristic as listed in the Equality Act, 2010.
Gender	☒	☐	☐	☐	
Sexual Orientation	☒	☐	☐	☐	
Carers	☐	☐	☐	☐	N/A
Socially deprived communities	☐	☐	☐	☐	N/A
Human Rights	☒	☐	☐	☐	The policy supports Article 6 of the Human Rights Act - Right to a fair trial

Carers and socially deprived communities are not protected characteristics as set out in the Equality Act 2010, but are health inequality groups which are priority groups for Cheshire and Merseyside to improve health outcomes for.

3.2. For any equality groups who are likely to experience negative or adverse impacts, what actions are you planning to take to mitigate and minimise the effects?

Equality group	Action	Lead	Timescales
Staff from ethnic minority backgrounds	Delivery of the 'Beyond Bias' training programme aimed at all NWAS managers and leaders is expective to lead to greater inclusive management and improved cultural competence within the organisation	Learning & Development Team	Now - March 2024
All Equality Groups	Training for managers relating to how to use the Disciplinary Fast Track Process. As part of the implementation of this policy, training will be provided by Weightman's solicitors which will embed the principles of fairness and equal treatment for all.	HRBP	April – June 2023
Staff from ethnic minority backgrounds	Regular monitoring of disciplinary data to see if ethnic minority staff groups continue to be over-represented in figures through thorough case analysis.	HRBP	On-going from point of implementation

4. Monitor and review

Th EIA should be reviewed periodically throughout the development the project to consider for example if any new evidence emergences or if the groups impacted have changed in away. Any reviews undertaken to monitor progress on the action plan, or to add any new information through further data gathering or engagement should be documented. Timescales for EIA review should be built into the project plan.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	29th March 2023					
SUBJECT:	Staff Survey result & Speaking Up Review of Ambulance Services					
PRESENTED BY:	Lisa Ward, Director of People Chris Grant, 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 purpose of this report is to provide the Board of Directors with an overview of the key messages from the NHS National Staff Survey 2022 and the Listening to Workers review of ambulance trusts. <u>Staff Survey</u> The fieldwork for the NHS Staff Survey was undertaken from 3 October – 25 November 2022. 33% of staff responded to the Survey which equates to 2216 questionnaires, and this is a sizeable number of staff who have shared their experience and insights. Nationally, while there are some positives emerging from the Survey, overall this year's national results illustrate a decline in certain key markers of staff experience. • Staff discontent on pay is reflected in a fall in staff feeling well rewarded. • Results demonstrate lower staff confidence in the quality of care they feel able to deliver, compared with last year. • Decrease in staff morale. Much like the national results, the local results also present a mixed picture showing some good progress in a number of key areas which we can be proud of. While at the same time however, the results identify the need to make greater progress and improvements in other areas • The results show an increase in the percentage of staff overall who have not endured negative experiences such as bullying, harassment, abuse or physical violence from patients, colleagues, and managers (85% 2022, 83% 2021). For the second consecutive year, NWAS results on these questions have been better than the ambulance sector average.						

- Also for the second year in a row, the results for all the questions relating to relationship with immediate managers have either positively increased or remained static. In all these questions, NWAS responses have again shown a more positive experience compared to the ambulance sector average. The largest increase in this section was on the question relating to the immediate manager taking a positive interest in staff health and wellbeing (65% 2022, 60% 2021).

- 42% of respondents overall believe the organisation takes positive action on H&WB, which has improved. All of the results relating to burnout have remained static when compared to the previous year. Three-quarters of respondents said they 'never or rarely feel burnt out because of work' and less than one in five respondents (19%) said they never find work emotionally exhausting.

- Less than half of respondents believe that the organisation acts fairly with regards to career progression. A decline of around 4% was seen on this question from 2020 to 2021, but there has been an improvement in 2022. 49% of respondents said that there were opportunities to develop their career (52%, 2021). 111 respondents were much more positive (60%), but the figure is lower for EOC and PTS.

- While two-thirds of respondents overall said they would feel secure raising concerns about unsafe clinical practice (72%, 2021), there was less confidence in EOC and Resilience. Only 43% of respondents said that feedback was given on changes made following errors / near misses / incident – this is below the sector average

- 45% of respondents would recommend NWAS as a place to work (47%, 2021). In corporate teams, PTS and 111 this figure is higher, but the average for EOC, PES, Resilience and staff who declared a disability is around 38%. There has been a decline in positive responses to this question across the ambulance sector, and more widely across the NHS as a whole.

<u>Listening to Workers review</u>

The data from the staff survey correlates closely with the findings from the Listening to Workers review which reflects on the data related to speaking up for the ambulance sector in comparison with the NHS average and community trusts. Whilst NWAS data for speaking up related questions in 2022 is above the sector average there is still a gap to the experiences of other parts of the NHS.

The review incorporates both a desktop review of data and in depth engagement in five ambulance trusts (excluding NWAS). It identified challenges to speaking up arising from ambulance culture particularly focusing on the following key contributory factors affecting speaking up

- Fear of reprisals from speaking up
- A belief that nothing would be done in response to speaking up
- Case handling, including not always respecting confidentiality or providing meaningful feedback to those who speak up
- Concerns around favouritism, preferential treatment and cliques
- 'Command-and-control' decision making, combined with hierarchy and uniform culture
- Bullying and harassment
- The amount of time and resources afforded to the Freedom to Speak Up Guardian role
- Operational pressures

The review identifies 4 recommendations:

1. A broader review of cultural matters in ambulance trusts which NHS England has now confirmed that they will facilitate
2. Making speaking up business as usual in ambulance trusts
3. Effectively regulating, inspecting and supporting the improvement of speaking up cultures which NHS England will take forward with CQC
4. Implementing the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers

<u>Next steps</u>

The Freedom to Speak Up Guardian has already mapped the recommendations against current NWAS practice and a set of actions to deliver against recommendations 2 and 4 of the Listening to Workers review will be implemented.

These actions will form a key part of the 2023/24 annual plans, as a core element of the Quality Strategy. Speaking up and the staff survey results form a core foundation of the priorities of the Trust Strategy and its measurement, particularly through the Quality and People Strategies. The draft annual plan will be presented to Board in part 2 but section 9.2 summarises the key priorities for the next year linked directly with the survey and review results.

A key recurring theme throughout the survey responses is that there is a lot of variation in staff experience depending on where people work within the organisation. So the Inclusion and Engagement team will be working with local teams to analyse their data and develop plans.

The Team will also be working to develop an organisational action plan, with the support and input of teams and colleagues from across the Trust. The objective of the action plan is to set out how the Trust will respond to the range of areas for improvement emerging from the Survey results. The action plan will be aligned to the People Promise, and managed by a new Staff Survey Action Group.

RECOMMENDATIONS:	The Board of Directors is recommended to: • Receive the results from the National Staff Survey 2022 and the Listening to Workers review of ambulance trusts • Note the strategic actions for 2023/24 linked with the survey and review and how these will also be used to inform corporate and local plans
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:	Resources Committee			
	Date:	24th March 2023		
	Outcome:	Feedback to be given verbally		

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1. PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with an overview of the key findings from the NHS National Staff Survey 2022 and the Speaking up Review of Ambulance Services carried out by the National Guardian's Office.

2. BACKGROUND TO NHS STAFF SURVEY

2.1 The NHS Staff Survey provides an annual opportunity for staff to share how they feel about their experiences in their NHS Trust. As a national programme, its strength is in providing a nation-wide picture alongside local detail, enabling staff voice, providing the data organisations need to improve staff engagement and experience, and tracking progress towards achieving the People Promise. The annual NHS Staff Survey is one of the largest workforce surveys in the world.

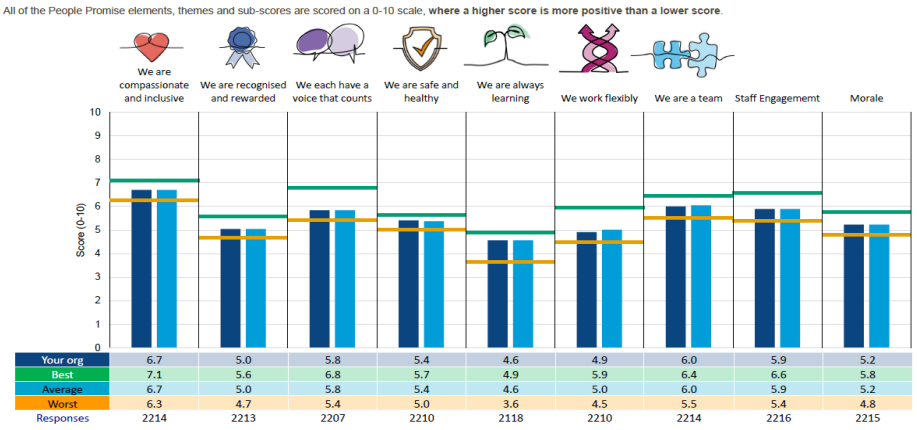
2.2 For the first time in 2022, bank only workers were able to take part in the Survey using a tailored version of the questionnaire. Additionally, the 2022 questionnaire reintroduced a set of questions relating to patient safety (near misses, errors, incidents) which has been welcomed.

2.3 The National Staff Survey has continued to be aligned to the NHS People Promise themes which means that most of the results from 2022 can be compared to the previous year:

- we are compassionate and inclusive
- we are recognised and rewarded
- we each have a voice that counts
- we are safe and health
- we are always learning
- we work flexibly
- we are a team

and two additional historical themes have also remained - staff engagement and staff morale.

2.4 Based on the themes in the Survey, the scores for the Trust remained in line with the sector average.

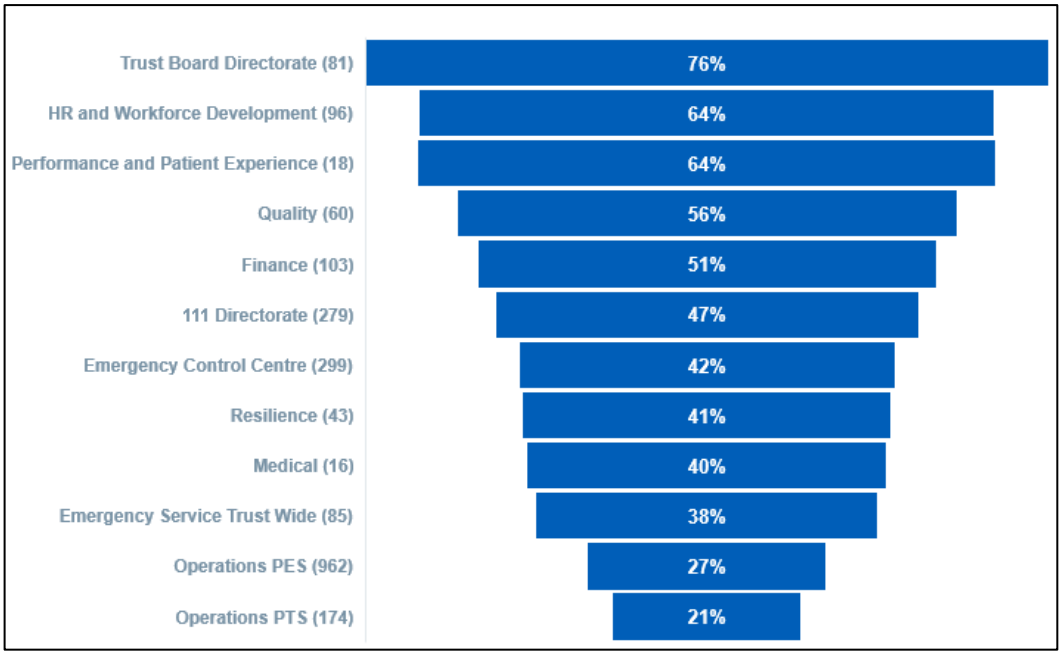


3. FIELDWORK AND RESPONSE RATE

3.1 The fieldwork for the Survey was undertaken from 3 October – 25 November 2022. Bespoke communications including a message from the CEO, articles in the Staff Bulletin and social media posts and were circulated to staff ahead of the launch of the campaign, and key messages were reiterated during the fieldwork period.

3.2 33% of staff responded to the Survey which equates to 2216 questionnaires, and this is a sizeable number of staff who have shared their experience and insights. It is however a lower response rate compared to the previous year (36%), with the sector average for this year being 50%.

3.3 A break down of response rates from across NWAS teams is shown below:



3.4 This was the first year a fully online approach was adopted, with no paper/hard copies circulated. For some this may have been hindrance to completion, however the principal feedback received with regards completing the survey relates to the lack of provision for dedicated/protected time.

3.5 The Staff Engagement Team will be working with other Trusts to ascertain their approaches to attract larger response rates (e.g. London Ambulance Service 62%), and consider what changes are required to the NWAS methodology.

4 SUMMARY OF NATIONAL PICTURE

4.1 This year's national NHS results illustrate a decline in certain key markers of staff experience.

- Staff discontent on pay is reflected in a fall in staff feeling well rewarded.
- Results demonstrate lower staff confidence in the quality of care they feel able to deliver, compared with last year.
- Decrease in staff morale.

4.2 Many top-level indicators have stabilised this year however, staying broadly the same as in 2021. There is positive news with an improvement in staff perception of support for learning and development and an increase in feelings around positive teamworking and support from line managers.[1]

5 KEY FINDINGS FROM NWAS RESULTS

5.1 Much like the national results, the local results also present a mixed picture showing some good progress in a number of key areas which we can be proud of. While at the same time however, the results identify the need to make greater progress and improvements in other areas. A selection from the Survey results is shared below.

5.2 Improvement in 'negative experience' results

The results show an increase in the percentage of staff overall who have not endured negative experiences such as bullying, harassment, abuse or physical violence from patients, colleagues, and managers (85% 2022, 83% 2021)[2]. For the second consecutive year, NWAS results on these questions have been better than the ambulance sector average.

The feedback from disabled staff, or those with long-term conditions is however less positive in relation to questions referenced above. Nearly half of staff with disabilities/LTC said that they had experienced harassment, bullying or abuse from patients/public in the last 12 months, and one in five said they experienced this from colleagues. While these figures have improved compared to 2021, there still remains a gap in the employee experience between staff with a disability and those without.

5.3 Immediate managers

For the second year in a row, the results for all the questions relating to relationship with immediate managers have either positively increased or remained static. In all these questions, NWAS responses have again shown a more positive experience compared to the ambulance sector average.

The largest increase in this section was on the question relating to the immediate manager taking a positive interest in staff health and wellbeing (65% 2022, 60% 2021). These results may reflect the work over the last year to further promote the Wellbeing Conversations guide, rollout of the Mental Health Continuum tool and improvements being made to the Work and Wellbeing Passport.

All questions in the 'immediate managers' section have also shown that staff from ethnic minority backgrounds have responded more positively compared to the NWAS overall average (61% NWAS, 68% staff from ethnic minority backgrounds)[3].

[1] https://www.nhsemployers.org/articles/nhs-staff-survey-2022-analysis-results

[2] Total average of following questions: 13 (a, b, c) 14 (a, b, c)

[3] Total average of following questions: 9 a-i

5.4 Health and wellbeing

42% of respondents overall believe the organisation takes positive action on H&WB, which has improved. However, for respondents who indicated they were LGBT+, male or had a disability, the average was 37%. In PES the figure was 27%.

All of the results relating to burnout have remained static when compared to the previous year. Three-quarters of respondents said they 'never or rarely feel burnt out because of work' and less than one in five respondents (19%) said they never find work emotionally exhausting. The figure is lower in contact centres (16%) and even lower in PES (9%). Figures were also lower for respondents who declared they were LGBT+ (14%) or had a disability/long-term condition (10%).

The results clearly demonstrate that not only in this Trust but across the NHS, large parts of the workforce are feeling the emotional and physical effects of burnout. This is unsurprising given the continued high demand for services and the incredible commitment shown by staff on daily basis.

To support colleagues, the Trust has continued the rollout of the proactive wellbeing phone calls from 'Just B', which initially began in EOC and 111 in 2022. The calls are an opportunity to for staff discuss any H&WB challenges or concerns and get information about the range of services available. Colleagues in PTS are being contacted in March 2023 and this will be followed by PES staff.

Additionally, Clinical Psychologist, Dr. Rosey Tattersall has been sharing reflections and findings from her review into the health and wellbeing experiences of staff throughout organisation. These reflections alongside other data will be considered and inform specific wellbeing plans for 2023/4 and in the People Strategy.

5.5 Career development and progression

Less than half of respondents believe that the organisation acts fairly with regards to career progression. A decline of around 4% was seen on this question from 2020 to 2021, but there has been an improvement in 2022 (from 46% to 48%)[4]. The figure is lower for those who declared a disability/LTC (45%), ethnic minority (44%) background or that they are male (43%).

49% of respondents said that there were opportunities to develop their career (52%, 2021). 111 respondents were much more positive (60%), but the figure is lower for EOC and PTS, as well as for respondents who declared a disability (42%), were from an ethnic minority background (45%) or male (46%).

This is an important area that the Trust is currently focussing on to ensure that systems and processes around career progression are improved, and that training and development opportunities are available fairly and equitably to all staff. The recent launch of the refreshed appraisal paperwork will help with enhancing pathways for staff to develop their careers with NWAS.

[4] Q15: Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

5.6 Culture

45% of respondents would recommend NWAS as a place to work (47%, 2021). In corporate teams, PTS and 111 this figure is higher, but the average for EOC, PES, Resilience and staff who declared a disability is around 38%.

There has been a decline in positive responses to this question across the ambulance sector, and more widely across the NHS as a whole. This may be reflective of issues such as operational pressures, and recognition and reward/pay (which has also seen a decline).

However, respondents from an ethnic minority background in NWAS answered this question more positively (50%) compared to the organisational average.

5.7 Freedom to Speak Up and raising concerns

While two-thirds of respondents overall said they would feel secure raising concerns about unsafe clinical practice this was a reduction from the 2021 position (72%). There was also less confidence in EOC and Resilience, as well as respondents who said they were LGBT+ (61%). Additionally, only half of respondents felt that the organisation would address concerns about unsafe clinical practice (55%, 2021), but the figure is even lower for PES and PTS respondents.

Only 43% of respondents said that feedback was given on changes made following errors / near misses / incident – this is below the sector average (46%).

However, there was a small increase in those reporting that they would feel safe to speak up about other matters of concern and this response is slightly above average.

5.8 Key Findings from the WRES and WDES related questions

Some of the questions from the staff survey are used to inform the Workforce Race Equality and Disability Equality Standards. Across all the WRES metrics, there were positive improvements both in the experience of BAME colleagues but also in a narrowing of gaps. Across the WDES metrics the picture was more mixed with positive improvements in respect of bulling and harassment indicators and career progression but a reduction in the extent to which disabled staff feel valued, however there is still a significant gap between experiences of staff with disabilities, compared to the rest of the organisation.

A positive decrease was seen on the question of staff from ethnic minority backgrounds experiencing discrimination – from 22% in 2021, to 14% in 2022. This is a 2.9% difference compared with White staff which has narrowed from 11.4% in 2021. Also, the number of respondents with a disability/LTC who said that the organisation has made reasonable adjustments enabling them to carry out their work increased to 60% (55%, 2021).

The Inclusion & Engagement Team will be working with the Staff Networks over the coming months to better understand experiences and consider the steps which can be taken to make improvements.

6 BACKGROUND TO 'LISTENING TO WORKERS' – A SPEAK UP REVIEW OF AMBULANCE TRUSTS IN ENGLAND

6.1 This review was undertaken by the National Guardian's Office and was published in February 2023. It was commissioned in response to anecdotal evidence regarding cultural challenges within the sector and staff survey results from 2021 and in particular the Freedom to Speak Up Index Report. The review was undertaken in two phases. Firstly a desktop review of Staff Survey and FTSU Guardian data, CQC reports and Board reports. Secondly, in depth engagement was undertaken with five ambulance Trusts including focus groups and interviews. These Trusts were chosen to provide a good geographic and performance spread as defined by CQC ratings. NWAS was not included in the in depth review but the review undertaken into a speaking up case at NWAS in 2019 was incorporated in the desktop review.

7 KEY FINDINGS

7.1 The review draws on staff survey results and draws comparison with community Trusts as being the closest comparator. The following are the key staff survey findings indicates in the report and there is a clear correlation with our own staff survey findings.

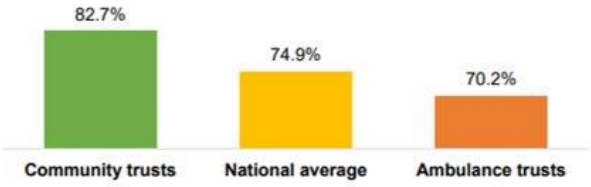


Figure 1. % of respondents who 'Agree'/'Strongly agree' with the statement: 'I would feel secure raising concerns about unsafe clinical practice' – national and trust averages

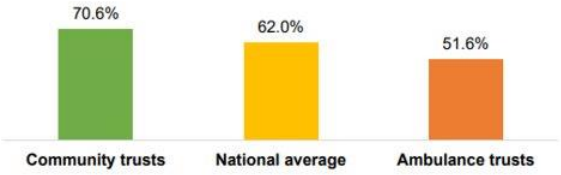


Figure 2. % of respondents who 'Agree'/'Strongly agree' with the statement: I feel safe to speak up about anything that concerns me in this organisation – national and trust averages

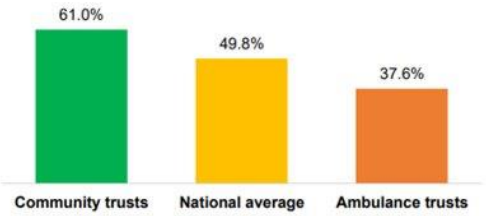
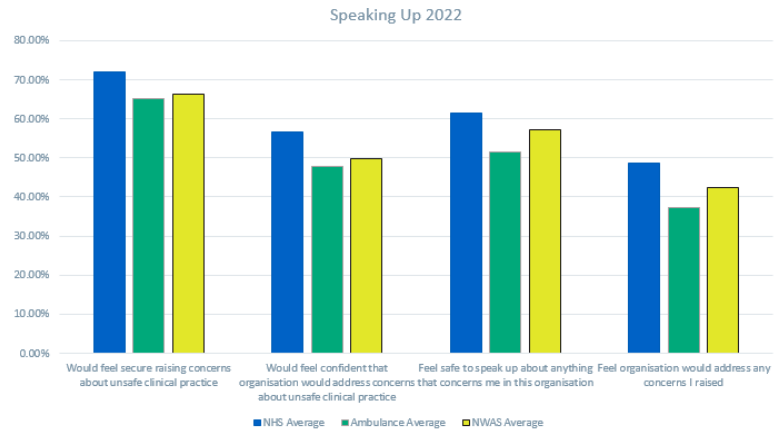


Figure 5. % of respondents who 'Agree'/'Strongly agree' with the statement: If I spoke up about something that concerned me, I am confident my organisation would address my concern – national and trust averages

7.2 Overall the NWAS staff survey position in 2022 shows that responses were above the sector average but as the review indicates this consistently falls below the NHS average.



7.3 The review identified fear associated with speaking up and a sense that nothing would be done in response as key factors affecting the level of speaking up. In particular they highlighted the following contributory factors:

- Case handling, including not always respecting confidentiality or providing meaningful feedback to those who speak up
- Concerns around favouritism, preferential treatment and cliques
- 'Command-and-control' decision making, combined with hierarchy and uniform culture
- Bullying and harassment
- The amount of time and resources afforded to the Freedom to Speak Up Guardian role
- Operational pressures

7.4 It was noted that staff from protected groups and those in frontline positions were least likely to feel confident speaking up. It points to the close knit nature of frontline services making it difficult to speak up without being disloyal or damaging to the group. There were perceived links with longer length of service in the sector creating strong bonds which are supportive, given the nature of the work, but which can lead to cliques and favouritism and a lack of diversity in the management pipeline.

7.5 The review also identified a lack of understanding amongst managers and leaders about the importance of speaking up and how the learning from speaking up can drive improvement. It also referenced some of the challenges in relation to the effectiveness of first line management and the difficulties associated with regular quality line management contact in an ambulance service.

7.6 The review also looked at Board reporting and found examples of good practice, including triangulation of data and evidence of learning but this was not always consistent.

8 RECOMMENDATIONS FROM THE SPEAKING UP REVIEW

8.1 There are four recommendations made in the Listening to Workers review.

8.2 Recommendation 1: Review broader cultural matters in ambulance trusts
This recommendation calls for an independent cultural review to consider management and leadership behaviours and focus on worker wellbeing including:

- The effectiveness of governance/leadership structures, particularly considering the complex geographical footprint of ambulance trusts
- Models/expressions of leadership including 'command and control'
- Defensiveness and 'just culture'
- Arrangements for appointments, including fair and open recruitment and values based recruitment
- Operational and workforce pressures
- Bullying and harassment including sexual harassment
- Discrimination, particularly on the grounds of protected characteristics

It is understood that NHS England have committed to carrying out a review but the scope and details of this are not yet known.

8.3 Recommendation 2: Making speaking up in ambulance trusts business as usual
This will mandate the following in ambulance trusts:

- Mandate training on speaking up – for all workers as well as senior leaders and board members.
- Ambulance trust leadership to fully engage with FTSU, evidenced by board development sessions, delivered by the NGO, with a view to role model effective speaking up.
- Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and FTSU Guardians through regular communications.
- Ambulance boards to annually evaluate the effectiveness of speaking up arrangements. Trust boards will report on this evaluation publicly in their annual reports

8.4 Recommendation 3: Effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts

This recommendation requires the Care Quality Commission and NHS England to work together to:

- Ensure workers' voices are effectively captured and reflected in regulators' decisions and treated with parity to those of patients' voice.
- Implement mandatory and regular training on speaking up for all workers involved in the regulation, inspection, and improvement support of ambulance trusts.
- Make assessment of the speaking up culture and arrangements a cornerstone of their regulatory and oversight frameworks.

- The Care Quality Commission to continue to improve their inspection methodology around the rigorous assessment of speak up culture and psychological safety.
- Communication and partnership working among national bodies to share information about speaking up culture and arrangements.

NHS England have confirmed their intention to work with the CQC on delivery of this recommendation.

8.5

Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers

This recommendation requires ambulance trusts to:

- Meaningfully invest in the Freedom to Speak Up Guardian role, to identify the time and resources needed to meet the needs of workers in their organisation.
- The National Guardian's Office suggests that as a minimum, the equivalent to three full-time workers is needed to carry out the reactive and proactive parts of the Freedom to Speak Up Guardian role in ambulance trusts.
- The recruitment process used for the appointment of Freedom to Speak Up guardians must be fair, open and transparent and comply with current good practice in recruitment and equality, diversity, inclusion and belonging principles.
- Create, maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up.
- Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s).

9 NEXT STEPS

9.1 Listening to Workers Review

In respect of the Listening to Workers review, the Trust is developing its plans in relation to recommendations 2 and 4. A gap analysis has already been conducted and detailed recommendations will be presented to the Executive Leadership Committee and a detailed action plan submitted to the NGO.

Following the review of Freedom to Speak Up and its transition to the Medical Directorate good progress has been made in embedding and improving speaking up, but the review provides a useful benchmark of best practice.

National e-learning is already mandatory for all staff and from April 2023 our volunteers will also be able to access this training. The Freedom to Speak Up Policy has been refreshed and is aligned to the National Policy. Cases are managed in a confidential manner and anonymity (when requested) can be assured. The Guardians have direct access to executive leaders as well as non-executive leaders. Where psychological safety has been fostered enabling guardians to provide suitable challenges when appropriate. With a clinical background the guardians are aware of the trust's wellbeing offer and are confident they can access it should it be required.

The number of guardians NWAS required and their spread across all service lines will be reviewed. Further assistance in embedding a speaking up culture will be provided by reviewing the 'champion' offer. Guardians are working towards embedding speaking up as business as usual by engaging across the trust to ensure that an inquisitive lens is adopted, and more thorough triangulation of data occurs.

In addition to the direct response to the recommendations, the Freedom to Speak Up Guardian has a key role to play in supporting the organisation to address the wider cultural issues which emerge from the review, the staff survey results, and NWAS own cultural review carried out in 2020.

9.2 People and Quality Strategies

The issues emerging from the staff survey and the Listening to Workers Review have directly informed the development of the Trust strategy and its supporting enabling strategies, in particular the Quality and People Strategies. Staff voice through the survey results also provide a core measure of success running through the strategies.

Board will be presented with the initial draft of 2023/24 objectives in Part 2 but these include a number of priorities which speak to the key emerging themes. In particular:

- Scaling up safety culture surveys and using baseline data to identify improvements (Quality)
- Developing learning mechanisms which enable patient safety insights to be generated from risks, audit, incidents, complaints and staff concerns (Quality)
- Designing and delivering a listening and speaking up culture plan which focuses on embedding the recommendations from the NGO' Listening to workers review' (Quality)
- Learning from staff and management experiences to ensure our people approach is flexible, responsive and accessible including our staff survey action plan, updated core induction processes and review of partnership arrangement (People)
- Taking positive steps to ensure staff can work in a safe environment free from discrimination, including a sexual safety improvement plan, review of dignity at work arrangements and embedding changes to the disciplinary process to embed just culture (People)
- Delivering a leadership skills programme to embed the foundations of compassionate leadership and improve management practice (People)
- Implementing the Employers Network for Equality and Inclusion recommendations to improve the visibility and accessibility of recruitment, development and progression routes (People)
- Designing and implementing the operational leadership structures with a balance between clinical, operational and people management (Service development)

9.3 Further socialisation of results and local action plans

The staff survey results are a fundamental foundation of the People Strategy and the priority areas of work arising from the Strategy, as well as being a key measure of the effectiveness of the work undertaken through the People Team.

A key recurring theme throughout the survey responses is that there is lots of variation in staff experience depending on where people work within the organisation. It is therefore essential that local management teams analyse their results, identify trends/highlights and develop their own plans by talking to staff locally about what will make a difference to them.

Local teams will be supported by the Inclusion & Engagement Team with data packs, 'how to use the data' guides and templates for local plans. The Team will also be working to develop an organisational action plan, with the support and input of teams and colleagues from across the Trust. The objective of the action plan is to set out how the Trust will respond to the range of areas for improvement emerging from the Survey results. The action plan will be aligned to the People Promise, and managed by a new Staff Survey Action Group. The Freedom to Speak up Guardians will paly an integral role in informing this work.

The Trust Communications Team are supporting the development of internal communications pieces based on 'you said, we did' or 'ideas into action' styles – linking employee experience improvement initiatives back to the output from the staff survey.

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

10.1 Participation in the National Staff Survey is mandated by NHS England for all Trusts. Staff survey results and speaking up form a fundamental part of the CQC regulatory framework and inform well led assessments.

11. EQUALITY OR SUSTAINABILITY IMPACTS

11.1 The National Staff Survey provides data for the WRES and WDES metrics and the differential experience of different groups of staff informs practice and measurement of effectiveness.

12. RECOMMENDATIONS

12.1 The Board of Directors is recommended to:

- Receive the results from the National Staff Survey 2022 and the Listening to Workers review of ambulance trusts
- Note the strategic actions for 2023/24 linked with the survey and review and how these will also be used to inform corporate and local plans