NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 26th July 2023
9.45am – 12.40pm
To be held in the Oak Room, Ladybridge Hall, Bolton

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2324/044	Staff Story	09:45	Information	Deputy CEO/Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2324/045	Apologies for Absence	10.00	Information	Chair
BOD/2324/046	Declarations of Interest	10.00	Decision	Chair
BOD/2324/047	Minutes of Previous Meeting held on 31st May 2023	10:00	Decision	Chair
BOD/2324/048	Board Action Log	10:05	Assurance	Chair
BOD/2324/049	Committee Attendance	10:10	Information	Chair
BOD/2324/050	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2324/051	Chairman & Non-Executive Directors Update	10:15	Information	Chair
BOD/2324/052	Chief Executive's Report	10:20	Assurance	Chief Executive
BOD/2324/053	Trust Strategies • Quality Strategy • People Strategy • Service Development Strategy • Sustainability Strategy	10:30	Decision	Deputy Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2324/054	Board Assurance Framework 2023/24 Q1 Position	10:40	Decision	Director of Corporate Affairs
BOD/2324/055	PSIRF Local Priorities	10:50	Decision	Director of Corporate Affairs
BOD/2324/056	Audit Committee Chairs Assurance Report, from the meeting held on 21st July 2023	11:00	Assurance	Mr D Rawsthorn Non-Executive Director
BOD/2324/057	Charitable Funds Committee Chairs Assurance Reports, from the meetings held 21st June 2023 and 19th July 2023	11:05	Assurance	Mr D Rawsthorn Non-Executive Director
QUALITY AND PERFORMANCE				
BOD/2324/058	Integrated Performance Report	11:10	Assurance	Director of Quality, Innovation, and Improvement
BOD/2324/059	IPC Board Assurance Framework	11:35	Assurance	Director of Quality, Innovation, and Improvement
BOD/2324/060	SIRO Annual Report 2022/23	11:45	Assurance	Director of Quality, Innovation and Improvement
BOD/2324/061	Medicines Management Annual Report including Controlled Drugs Annual Report 2022/23	11:55	Assurance	Medical Director
BOD/2324/062	Learning from Deaths Report Q4 2022/23	12:05	Assurance	Medical Director

BOD/2324/063	Resources Committee Chairs Assurance Report, from the meeting held on 21st July 2023	12:15	Assurance	Mr D Hanley, Non-Executive Director
WORKFORCE				
BOD/2324/064	WRES, WDES and Gender Pay Regulatory Reporting	12:20	Assurance	Deputy Director of People
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2324/065	Communications and Engagement Team Report Q1 2023/24	12:30	Discussion	Deputy CEO/Director of Strategy, Partnerships & Transformation
CLOSING				
BOD/2324/066	Any Other Business Notified Prior to the Meeting	12:40	Assurance	Chair
BOD/2324/067	Items for Inclusion on the BAF	12:40	Assurance	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 27th September 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.

NHS
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NHS Trust

Minutes
Board of Directors

Details: 9.45am Wednesday, 31st May 2023
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mr G Blezard	Director of Operations
Mrs C Butterworth	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
Dr M Power	Director of Quality, Innovation, and Improvement
Mr D Rawsthorn	Non-Executive Director
Mrs A Wetton	Director of Corporate Affairs
Mr D Whatley	Associate Non-Executive Director
Mrs C Wood	Director of Finance

In attendance:

Mrs L McConnell	Deputy Director of People
Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2324/018 **Patient Story**

The Director of Strategy, Partnerships and Transformation introduced the Patient Story.

The story was presented in the form of a short film and featured Ms B Greenwood, member of the Trust's Patient and Public Panel.

The story sought to raise awareness of how some neurological disorders can be misunderstood for other symptoms by clinicians. She explained her personal experiences, living with three rare neurological disorders and was a frequent user of the ambulance service.

She acknowledged that ambulance crews were not aware of some of her health conditions, and wished to share her story to raise awareness, education, and provide learning.

The Chair thanked Ms B Greenwood for her story which raised very useful issues for the trust's consideration.

Prof A Esmail queried if the trust had a process for flagging patients with certain medical conditions.

The Medical Director confirmed that the trust was shifting from the process of medical markers being logged against patient addresses to markers being attached to the patient, to be more patient specific.

The Deputy Chief Executive added that the new process allowed for the movement of patients, particularly if an emergency occurred away from the patient's home address.

The Medical Director also advised that pieces of work were underway to ensure that the patient records were up to date.

The Chief Executive welcomed the patient story and stated that such medical conditions created challenges for call staff and crews in terms of understanding a patient's details, such as their name and date of birth in crisis situations. He added the markers were important to ensure information was accessible.

The Chair praised NWAS staff for their care and understanding in the examples of care outlined in the story.

The Board:

- Welcomed and acknowledged the content of the patient story.

BOD/2324/019 Apologies for Absence

Apologies for absence were received from Dr A Chambers, Non-Executive Director and Mrs L Ward, Director of People.

BOD/2324/020 Declarations of Interest

There were no declarations of interest to note.

BOD/2324/021 Minutes of the Previous Meeting

The minutes of the previous meeting held on 29th March and 26th April 2023 were agreed as a true and accurate record.

Mr D Rawsthorn recorded two minor amendments on page 4 and 12 of the Draft Minutes of 29th March 2023, which had been notified to the corporate governance team by email.

The Board:

- Agreed the Minutes of the Meetings held on 29th March and 26th April 2023 were a true and accurate record, subject to inclusion of the amendments notified.

BOD/2324/022 Board Action Log

The Board noted the updates to the Board action log.

To set a date up for the meeting by the end of the week.

The Board:

- Noted the updates to the action log.

BOD/2324/023 Committee Attendance

The Board noted the Committee Attendance.

The Board:

- Noted the Committee Attendance Record.

BOD/2324/024 Register of Interest

The Chair advised that annual updates had been requested and asked members to return these to the corporate governance team.

The Board:

- Noted the Register of Interest presented for information.

BOD/2324/025 Chair & Non-Executives' Update

The Chair provided a Chair and Non-Executive Update.

He advised that the annual appraisal process for Non-Executive Director board members had commenced and referred to a recent meeting with the Trust's Head of Charity.

He emphasised the need to ensure that board members discussed the work of the Charity wherever possible, and that the Charity remained a priority for the Board. He referred to the Trust's Hardship Fund for staff, funded through the Charity, which was an excellent example of some of the good work being undertaken.

He reported that he had recently visited Estuary Point, and listened into emergency calls, which had included several Cat 2 calls from very poorly patients. He noted the staff were excellent and the team had been very well

resourced. He added this had been an excellent example of how additional resource had impacted positively on the frontline, and improved staff morale.

In term of ICS working, he reported that he continued to attend ICS meetings and that he had also recently attended an Equality, Diversity, and Inclusion (EDI) network event.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2324/026 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 highlighted the improvement in the Trust's operational performance and the significant improvements in the Trust's ARP performance.

He noted that 111 continued to deal with continued demands and praised the staff for introducing innovate ways of working.

He advised that the Deputy Chief Executive had attended a commemorative event, thirty years after the Warrington bombing and noted the 6 years anniversary of the Manchester Arena bombing. He added his thoughts were with the victims' families.

He thanked the Patient and Public Panel members for their achievements and ongoing support to trust initiatives, since the PPP was established in 2019. He acknowledged and congratulated Jon Price, the Trust's Clinical Effectiveness Lead, recently appointed as President of The Paramedic Council.

He noted reported that James Field, newly qualified paramedic, had been recognised as The College of Paramedics Carol Furber Award recipient. He explained the Award was given to pre-registration paramedics who submit an outstanding case study for an incident they've attended.

He thanked the ongoing work of the National Charity Hatzola, who worked in partnership with the NHS to provide an ambulance service.

He also noted the hard work of trust staff working on the implementation of the Patient Safety Incident Response Framework (PSIRF), which continued to be rolled out across the organisation.

He acknowledged the outcome of the National Pay Offer and reported that the Trust had received its NHS Executive Urgent Emergency Care Tiering Letter, which confirmed NWAS had been placed in Tier 3, meaning that the Trust required less intensive support than those trusts placed in tiers 1 and 2.

He congratulated the Trust's Consultant Midwife, for her participation in the National Institute for Health and Care Research Nursing and Midwifery

Programme and confirmed that several NWAS staff had represented the Trust at the recent Coronation of King Charles.

The Chief Executive referred to the Baroness Casey report into the Met Police, which had found institutional racism. He advised that the trust was working with the ambulance sector to identify what this meant for the trust. He added that the NHS Executive had conducted their own cultural review of the ambulance sector, with future updates on findings to be reported to the Board of Directors.

He reported that London ambulance service had taken a recent report to their Board, which had been reported in the Health Service Journal (HSJ). The report detailed reporting issues related to C1 performance to the NHSE. He noted that a review had been commissioned by the Association of Ambulance Chief Executives (AACE) which found that NWAS were reporting ARP performance correctly.

He noted that the trust had been included in the HSJ digital awards, and that Mr Salman Desai, Deputy Chief Executive had been a finalist for the prestigious Mohammed Sarwar Civil (public) Service Award 2023.

He reported that the Trust had decided to remove TikTok from all trust devices to protect the trust's clinical infrastructure from any potential threat of data being accessed or used.

He paid tribute to Mr Fred Rose and Mr Ian McDonald, former NWAS employees, who had sadly recently passed away, and noted that his thoughts were with their families, friends, and colleagues.

Mr D Rawsthorn referred to the Casey report and welcomed future updates on the outcome of the NHSE cultural review to the Board. He also queried the latest position in respect of industrial action.

The Deputy Director of People confirmed that UNITE still had a mandate for action, but not NWAS currently, and there was also a ballot out with the Royal College of Nursing (RCN).

Dr D Hanley referred to the recent news that the Metropolitan Police Force had announced their withdrawal from mental health cases and queried any future impact for the Trust.

The Chief Executive confirmed the Trust were undertaking a review of the report and were engaging with police forces across the north west to look at how to jointly manage any changes in the future.

The Deputy Chief Executive confirmed Lancashire Police were working with the trust to best implement future working arrangements and that although any decisions made by the police would impact on the service, mental health patients had to be the first line of consideration of all services that dealt with the associated demands and challenges.

The Director of Quality, Innovation and Improvement advised that on the 23rd of May 2023 200 colleagues attended the Northwest hospital handover improvement collaborative, which had been a successful event and highlighted system ownership in terms of urgent and emergency care. She confirmed that Trust Chief Executives and Integrated Care Boards (ICBs) had been represented, along with NWAS Non-Executives and the Medical Director.

The Chair acknowledged the good progress made and noted the need to improve handover times and performance, prior to the seasonal demands.

He also praised the trust on the achievement of Tier 3 for UEC recovery and the Deputy Chief Executive's achievement, as an Award finalist.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2324/027 Trust Strategy Annual Refresh

The Deputy Chief Executive presented the Trust Strategy Annual Refresh.

He provided an overview of the highlights and the basis for the refresh of the Strategy. He noted the key challenges, which included lost hours in terms of hospital handover, the high demand seen in 111, recruitment and retention challenges and the impact of industrial action.

He noted the outcome of the refresh, which had highlighted that the Strategy was still relevant, within the context of the external environment, and the significant areas of focus had also been issues for several other ambulance providers.

He advised that future areas of focus would be freedom to speak up and culture, and next steps had been identified to strengthen these key areas.

He added that there was a continued priority in relation to getting the basics right, whilst developing and moving forward. He noted that a PESTLE analysis, included in the report, illustrated a clear correlation between deprivation and the impact on health, which had been captured within the context of the environment in which the trust was operating.

Mr D Rawsthorn clarified the purpose of the paper, which was for decision by the Trust board and Prof A Esmail referred to the areas not achieved during the year, which weren't clear to understand from the paper.

The Deputy Chief Executive confirmed the paper was for decision, rather than discussion, and advised the content had been discussed in detail by the Resources Committee on Friday, 26th May 2023. He confirmed that anything not achieved in year would be rolled into the next year and this would be made more explicit in future papers.

The Chair welcomed a succinct report and noted the questions asked as part of the refresh process felt correct. He noted the trust had experienced significant pressures in year, with some slippage in achieving objectives to be expected.

The Board:

- Discussed and approved the Trust Strategy Refresh.

BOD/2324/028 Annual Self-Certifications: General Condition FT4: Corporate Governance Declaration

The Director of Corporate Affairs presented the Annual Self Certifications: General Condition FT4 – Corporate Governance Declaration 2022/23.

She reported that a review had been conducted for the Corporate Governance Statement, which was attached to the report for reference. She recommended that the Board made a positive declaration to each clause of the Statement and confirmed that no material risks had been identified.

Subject to Board approval, she confirmed the Statement would be published on the trust website later that day.

The Board:

- Approved the Confirmed declarations and that the Board were not aware of any material risks to compliance.

BOD/2324/029 Annual Self-Certifications: General Condition 6: Systems of Compliance with Licence Conditions

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

She reported that a management review had been undertaken and confirmed compliance with General Condition 6 of the NHS Provider Licence, seen at Appendix 1.

The Chair thanked the Director of Corporate Affairs and the team for their hard work in relation to the two annual governance agenda items.

The Board:

- Approved the annual GC6 self-certification as described within the paper.

BOD/2324/030 Audit Committee Chairs Assurance Reports from the meetings held on 21st April 2023 and 19th May 2023

Mr D Rawsthorn, Non-Executive Director presented the Audit Committee Chairs Assurance Reports, from the meetings held on 21st April 2023 and 19th May 2023.

A minor amendment was noted to the title of Dr A Chambers, who was incorrectly referred to as Prof A Chambers within the Chairs Assurance Report.

The Board:

- Noted the assurances provided.

BOD/2324/031 Charitable Funds Committee Chairs Assurance Report from the meeting held on 19th April 2023

Mr D Rawsthorn, Non-Executive Director presented the Chairs Assurance Report from the Charitable Funds Committee meeting, held on 19th April 2023.

He advised that as Charity activity had become more proactive, following the appointment of the Head of Charity, the frequency of Committee meetings would be increasing to four times per year, as opposed to twice per year.

The Chair thanked Mr Rawsthorn for the ongoing work of the Committee.

The Board:

- Noted the assurances provided.

BOD/2324/032 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Trust's integrated performance report for period March and April 2023.

She advised that the report had been reviewed in detail by the Quality and Performance Committee on 22nd May 2023 and the Resources Committee on 26th May 2023.

She noted some significant improvements across all standards and that the report was supported by a suite of real time dashboards and daily reports, produced to supplement operational activity.

The Director of Corporate Affairs highlighted a sustained improvement of time taken to close complaints and that 11 serious incidents had been declared in April, which signified a significant reduction. She noted that care and treatment remained the main cause of complaints of incidents.

The Chair queried the subcategories and requested a broader understanding of the category of care and treatment.

The Director of Corporate Affairs advised that further detail on the subcategories related to care and treatment could be provided to the Trust's Quality and Performance Committee.

The Chair requested a deep dive into the subcategories related to care and treatment, to be commissioned by the Quality and Performance Committee.

The Board discussed the value of qualitative data to understand the levels of patient satisfaction. Prof A Esmail referred to the methods used in primary care, via annual or five yearly surveys to obtain patient feedback.

The Board referred to the mortality rate and Quality and Performance Committee had been presented with the factors attributed to the increase, related to factors such as winter seasonal flu. The Medical Director confirmed the Trust were monitoring the impact on vulnerable communities.

The Director of Operations referred to some improvement in C1 performance and significant improvement in C2 call response times and hospital handover times. However, noted some regional variation in the level of improvement, which was a focus for the Trust's Area Directors.

The Chair referred to the work to improve hear and treat performance and the impact on see and treat rates.

The Chief Executive advised that see and treat and on scene times linked to the accountability reviews with the Trust's Directors and NWAS were well placed in terms of performance across the ambulance sector. He thanked the Director of Operations for his hard work.

The Chair acknowledged the improvement in performance, however recognised the fragility in the figures due to external factors, which could quickly impact on the performance of the organisation. He added the importance of effective pathways and engagement with system partners.

In terms of 111, the Director of Operations reported that call pick up had improved, with improvement across call metrics. He noted some key improvements internally, which included early visuality of patient needs by call staff.

In relation to PTS, he noted activity in relation to pre Covid levels and acknowledged that work continued to address the current vacancy gap.

The Director of Finance reported that there was no requirement for an ICB and NHSE finance report for Month 1 of 2023/24, and the trust's financial performance against plan had been reported to the Resources Committee, with no significant changes to report.

The Deputy Director of People provided an update on the workforce indicators, reported to the Resources Committee on 26th May 2023, which had included a detailed update on health and wellbeing progress.

She referred to the vacancy and the future UEC funding position and that 111 remained the highest risk in terms of vacancy position. She noted that work

on a range of initiatives continued. She added that HR cases had increased, with no key themes to note, and a positive BME position.

Mr D Rawsthorn welcomed the increased in mandatory training compliance and advised that the Resources Committee had discussed the position of information governance mandatory training.

The Director of Quality, Innovation and Improvement referred to the Covid-19 metric and asked if this could be stood down from future IPR reporting. The Chief Executive also noted that the NHSE had also stepped down their Covid-19 response.

The Chair agreed to stand down the covid reporting metric from future IPR reports to the Board.

He thanked the Executive Directors for their updates and reminded board member that patients were at the end of the IPR reporting process, which was critical to patient safety. He also praised the teams for their work to improve the performance of the C2 standard.

He thanked the Director of Finance, corporate teams, and leaders, who had worked hard to contribute to the effectiveness of the trust's financial performance.

The Board:

- Noted the content and recommendations within the Integrated Performance Report.
- Requested the Q&P Committee commission a deep dive into the subcategories of Care and Treatment, in relation Sis and complaints for a broader understanding of the issues, and key themes.

BOD/2324/033 Health, Safety, Security and Fire Annual Report 2022/23

The Director of Quality, Innovation and Improvement presented the Health, Safety, Security and Fire Annual Report 2022/23.

She reported that the annual report had been presented to the trust's Quality and Performance Committee on 22nd May 2023.

She advised of an in-year change to the process of reporting risk, via the trust's Datix system and confirmed although data wasn't missing, there was a need for a maturity of reporting, using the new system.

In terms of the issue of security, it was noted a future Non-Executive Director, to specialise in health and safety, as a member of the Quality and Performance Committee, would be included in the trust's future arrangements.

Mrs C Butterworth referred to the 62% of RIDDOR cases reported within the required timeframe and queried the 38% that hadn't met the requirement.

The Director of Quality, Innovation and Improvement advised of a time lag between operational staff reporting a RIDDOR incident on the trust's Datix system. The Director of Operations confirmed that one of the Trust's Area Directors had been allocated the specific responsibility to investigate the issues and focus on the improvement of RIDDOR reporting.

Mr D Whatley referred to the use of Body Worn Cameras.

The Director of Operations reported this had been a significant challenge for the trust in terms of staff wearing the cameras and noted that the national steer, expected, would influence the trust's future action.

The Chief Executive noted the need to ensure the issue remained a priority, and a decision regarding this being mandated, was pending.

The Chair thanked the team and the staff side for all their hard work.

The Board:

- Noted the assurances and recommendations within the Health, Safety, Security and Fire Annual Report.

BOD/2324/034 Safeguarding Annual Report 2022/23

The Director of Quality, Innovation and Improvement presented the Safeguarding Annual Report 2022/23.

She noted the purpose of the paper, which should have stated assurance rather than decision for the Board.

She provided an overview of the assurances in relation to mandatory training and that overall, there had been a reduction in adult and child safeguarding concerns. She noted the trust's system for inputting referrals had transitioned into a new system which allowed for a signal to trigger if staff had concerns for early welfare.

She recommended to the board that the trust was meeting its safeguarding requirements, with the systems in place to make referrals and record and document information in the correct manner.

The Chair referred to the level and number of calls from staff and the Director of Quality, Innovation and Improvement confirmed the number of calls from staff had been sustained.

The Medical Director referred to the difference between referrals made by safeguarding professionals and the nature of low-level staff notifications. He noted the need to be mindful of the areas monitored by the board.

Dr D Hanley thanked the team for the report, which showed clear improvement. He noted the numbers were a healthy sign that referrals were

appropriately targeted. He noted the challenge of mandatory training which would continue to be monitored during 2023/24.

Mr D Rawsthorn referred to the transition from ERISS to Cleric reporting systems and previous concerns regarding the change.

The Director of Quality, Innovation and Improvement confirmed that staff views had been heard and the team had worked to safely train and fully transition staff to the new working arrangements in place.

The Chair thanked the team for the report.

The Board:

- Noted the assurances within the safeguarding annual report 2022/23.
- Approved publication of the report.

BOD/2324/035 Complaints Annual Report 2022/23

The Director of Corporate Affairs presented the Complaints Annual Report 2022/23.

She provided key highlights which included the annual complaints activity, the position in terms of open complaints, and the backlog recovery position.

The Chair thanked the team for a clear and concise report which had been an understandable read.

The Board:

- Noted the content of the Complaints Annual Report 2022/23.
- Noted the recommendations within the report.

BOD/2324/036 Quality and Performance Committee Chairs Assurance Reports from the meetings held on 27th March 2023 and 22nd May 2023

Prof A Esmail presented the Quality and Performance Committee Chairs Assurance Reports from the meetings held on 27th March and 22nd May 2023.

He provided an overview of the assurances provided and noted that the Chair of the EPRR subcommittee had since provided an update on the assurances presented at the meeting on 22nd May 2023.

The Board:

- Noted the assurances provided by the Chair of the Quality and Performance Committee.

BOD/2324/037 **Resources Committee Chairs Assurance Report from the meeting held on 26th May 2023**

Dr D Hanley, Non-Executive Director, presented the Chairs Assurance Report from the Resources Committee meeting, held on 26th May 2023.

He provided an overview of the assurances received and noted the significant volume of work and projects to be delivered during the year, particularly in relation to operational teams. He noted this would continue to be monitored by the Committee.

The Board:

- Noted the Chairs Assurance Report from the Resources Committee meeting held on 26th May 2023.

BOD/2324/038 **Equality, Diversity, and Inclusion Annual Report 2022/23**

The Deputy Director of People presented the Equality, Diversity, and Inclusion (EDI) Annual Report 2022/23.

She provided an overview of the report and the requirement for the Trust to publish the report in line with the Equality Duty.

She advised that the report had been presented in a more accessible, easier to read format and had undergone review by the communications team to ensure all aspects had been taken into consideration.

She referred to the key priorities, attraction, recruitment and progression, culture and health inequalities which included race equality and disability standard reporting, with wider reporting to be presented to the Board at the next meeting.

She highlighted the significant amount of work undertaken by the trust, which had been slow, due to the scale of the work, however progress and impact had been made.

She noted the correlation of EDI priorities with the Trust's Annual Plan for 2023/24.

Prof A Esmail commended the team on the format of the report and the actions taken in terms of improving diversity of NWAS recruitment processes.

The Deputy Director of People confirmed she would pass on her thanks to the team.

Dr D Hanley referred to the assurance received by the Resources Committee.

The Director of Quality, Innovation and Improvement referred to page 36 of the report in relation to gender pay. She noted the gap in pay and stated that

a statement from the trust board should be inserted on the page, to provide the board's view on the position, which was not acceptable.

The Deputy Director of People noted the comment and explained the reporting requirements in terms of the indicator. She agreed that narrative was required to support the statistic, to reflect the position of the trust. The Chair requested the need to discuss and include appropriate narrative.

The Deputy Chief Executive noted the need to include a general gender statement in the report and to review the overall position in terms of EDI recruitment.

Prof A Esmail referred to the rapid recruitment process and the need to include these figures for future consideration, in terms of EDI.

The Chair emphasised that the trust's EDI statistics were critical to the work of the board and the organisation in the future.

The Board:

- Noted the content of the report.
- Requested further discussion and review of the gender pay gap reporting narrative, to include the position of the Trust Board.
- Requested inclusion of a general gender statement to reflect the overall position in terms of EDI recruitment.
- Requested future reports to include the EDI figures related to the rapid recruitment process.

BOD/2324/039 **Annual Plan 2023/24**

The Deputy Chief Executive presented the Annual Plan 2023/24.

He noted the updates to the previously presented versions of the annual plan and reported that these had been discussed in detail by the Trust's Resources Committee.

The Chair invited the views from the Chair of the Resources Committee.

Dr D Hanley confirmed there had been a lengthy discussion by the Committee and it was recognised that people would be pushed hard to achieve the plan, which was ambitious. He advised of the Committee's commitment to provide monitoring of the plan on behalf of the Board and felt assured that plans were in place to support the priorities.

Mr D Rawsthorn also noted a comprehensive plan and welcomed the individual publication of the Annual Plan on the public website.

The Deputy Chief Executive advised the Annual Plan was available in the board meeting pack on the website and a page summarising the plan would be presented separately on the trust website.

The Board:

- See recommendations in the paper.

BOD/2324/040 **Communications and Engagement Q4 2022/23 Update**

The Deputy Chief Executive presented the Communications Q4 2022/23 update and highlighted the key points.

He reported an increase of almost 17% in social media activity and a good use of e-shots to share internal communications, which enabled the trust to quantify the numbers of staff who had accessed the information.

He advised that the Q2 report would include a summary of the internal communication activity that had supported the organisation.

The Chair thanked the communications team for their hard work during a busy period.

The Board:

- Noted and discussed the content of the report.

BOD/2324/041 **Any Other Business Notified prior to the meeting.**

There was no other business notified prior to the meeting.

BOD/2324/042 **Items for inclusion on the BAF**

There were no items identified for inclusion in the BAF.

BOD/2324/043 **Closing Remarks**

The Chair noted the key areas of focus such as changes to the mental health provision provided by the police, and the impact on the trust. Emergency care, freedom to speak up, use of body worn cameras and reducing health inequalities, which remained a key focus for the organisation.

He thanked the teams for their hard work and efforts which impacted positively on outcomes for patients.

Date and time of the next meeting –

9.45 am on Wednesday, 26th July 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
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		SD 29.3.23 - Still in progress.	
108	31.5.23	32	Integrated Performnce Report	Chair requested a deep dive, to be commissioned by the Q&P Committee, into the sub categories of care and treatment in relation to complaints and Sis.	A Esmail / A Wetton	31.5.23		Included on the Q&P Committee Action Tracker 31.5.23	
109	31.5.23	38	Equality, Diversity and Inclusion Annual Report 2022/23	Requested a further discussion and review of the gender pay gap reporting narrative - to include a position statement of the Trust board.	Deputy Director of People	26.7.23		Completed	
				Requested inclusion of a general gender statement to reflect the trust's overall position in terms of EDI recruitment.				Completed	
				Requested future reports include EDI figures related to the rapid recruitment process.				To be reported through the EDI Sub-Committee to Resources Committee and onwardly to Board of Directors.	

NWAS Board and Committee Attendance 2023/24

Board of Directors								
	26th April	31st May	21st June	26th July	27th September	29th November	31st January	27th March
Ged Blezard	✔	✔	✔					
Dr Alison Chambers	✔	x	✔					
Salman Desai	✔	✔	✔					
Prof Aneez Esmail	x	✔	✔					
Dr Chris Grant	✔	✔	x					
Dr David Hanley	✔	✔	✔					
Daren Mochrie	✔	✔	✔					
Dr Maxine Power	✔	✔	✔					
David Rawsthorn	✔	✔	✔					
Catherine Butterworth	✔	✔	✔					
Lisa Ward	x	x	✔					
Angela Wetton	✔	✔	✔					
David Whatley	✔	✔	✔					
Peter White (Chair)	✔	✔	✔					
Carolyn Wood	✔	✔	✔					

Audit Committee						
	21st April	19thMay	21st June	21st July	20th October	19th January
Dr Alison Chambers	✔	✔	✔	✔		
Dr Aneez Esmail	✔	✔	✔	✔		
David Rawsthorn (Chair)	✔	✔	✔	✔		
Catherine Butterworth	✔	✔	✔	✔		
David Whatley	✔	✔	✔	✔		

Resources Committee						
	26th May	21st July	23rd September	25th November	20th January	24th March
Ged Blezard	x	✔				
Salman Desai	✔	✔				
Catherine Butterworth	✔	✔				
Dr David Hanley (Chair)	✔	✔				
David Rawsthorn	✔	✔				
Lisa Ward	✔	✔				
David Whatley	✔	✔				
Carolyn Wood	x	x				

Quality and Performance Committee										
	24th April	22nd May	26th June	24th July	25th September	23rd October	27th November	29th January	26th February	25th March
Ged Blezard		x		✔						
Dr Alison Chambers		✔		✔						
Prof Aneez Esmail (Chair)		✔		✔						
Dr Chris Grant		✔		✔						
Dr David Hanley		✔		✔						
Dr Maxine Power		✔		✔						
Angela Wetton		✔		✔						

Charitable Funds Committee				
	29th April	19th July	18th October	17th January
Ged Blezard	✔	✔		
Salman Desai	✔	✔		
Catherine Butterworth	✔	✔		
Dr David Hanley	x	✔		
David Rawsthorn (Chair)	✔	✔		
Lisa Ward	✔	✔		
Angela Wetton	✔	✔		
David Whatley	✔	✔		
Carolyn Wood	✔	x		

Nomination & Remuneration Committee							
	26th April	31st May	26th July	27th September	29th November	31st January	27th March
Catherine Butterworth	✔	✔					
Dr Alison Chambers	✔	x					
Prof Aneez Esmail	x	✔					
Dr David Hanley	✔	✔					
David Rawsthorn	✔	✔					
David Whatley	✔	✔					
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.
			Non Executive Director Pennine Care Foundation Trust				√	Position of Authority	Jul-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration 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	
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.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	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 NW 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
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.

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	
			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
David	Whatley	Associate Non Executive Director	Trustee Pendle Education Trust		√				Apr-23		Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Governor, Nelson and Colne College Group		√				Apr-23		
			Independent Member of Audit Committee, Pendle Borough Council		√				Apr-23		
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Apr-23		
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – The Riverside Group	√				Position of Authority	Apr-19	Jan-22	-
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 July 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**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board dated 31 May 2023. The highlights from this report are as follows: PES • Achievement of performance standards remained a challenge but strong in comparison to all other Ambulance Trusts. • Strong Hear & Treat performance • Hospital Handover improved 111 • National support through Vocare and IC24 continues to add call handling benefits • Visual IVR is saving c43 seconds per call • Rota review project now delivered; full benefits analysis underway PTS • Activity in May for the Trust was 10% below contract baselines. • Year to date July 2022 – May 2023) is performing at 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: ☐ Compliance/Regulatory ☐ Quality Outcomes				

	☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

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:	N/A			
	Date:			
	Outcome:			

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 31 May 2023

2. PERFORMANCE

2.1 Paramedic Emergency Service

During May and June NWAS still remain challenged in meeting the national performance standards, only achieving C1 90th, the remaining standards are stable and strong compared to all other Ambulance Trusts. We are achieving both call pick up standards (mean in 10 seconds and 90th in 20 seconds). Resourcing also remains stable and at a high level. The ambulance sector industrial action has ceased, and this has contributed to the stabilisation of performance. NWAS is still delivering strong hear and treat performance and work is ongoing to improve see and treat.

Hospital handovers improved in May and June; however, we are seeing some variation across the region. Some areas are nearly achieving the standard whilst others are extremely challenged. The challenged areas are experiencing poorer C2 performance as a direct result of handover delays.

Work continues with the implementation of the UEC recovery funds. A governance framework is in place chaired by the Director of Operations and there are delivery groups beneath that. The key element of this work is the recruitment of additional staffing into operations and the contact centres. Additionally, there are some technical enhancements in the control to support C2 validation. That work is now complete, and improvements will be seen once the increased workforce is deployed

2.2 NHS 111

The team in 111 continue to deliver a safe effective service to the Northwest. Interim national support provided by Vocare and IC24 is adding some capacity into the system to allow calls to be answered in a timelier manner. Work needs to be done with commissioners to secure this additional funding in the North West, that is currently being given to these national private providers.

Visual IVR has been live within 111 for over twelve weeks and is already saving in the region of 43 seconds per call when it is used. This innovation allows patients to complete their demographics online whilst waiting in the queue to be answered, and the systems and development teams are conducting regular reviews to ensure further efficiencies are gained, whilst keeping patient safety at the forefront.

The rota review project has now been delivered within 111. This allows us to realise more schedule efficiencies within the workforce. A key long-term benefit will be through the ability to better retain our staff through structure rota patterns that match demand requirements and support our people. The project is currently undergoing a

lessons learned process, along with a full benefits analysis to follow once the project is officially closed.

We are now able to continue our work with health advisors working from home. Our pilot has had many successes and lessons learned within the early phases. The systems and development team are working collaboratively with operational and IT colleagues to ensure that patients are safe when their call is being taken outside of the contact centre environment. There are plans in place to scale this pilot in the coming weeks and months.

2.3 Patient Transport Service

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

Activity in May for the Trust was 10% below contract baselines with Cumbria and Lancashire 22% and 25% below baselines respectively. Year to date July 2022 – May 2023) is performing at 17% below baseline

3. ISSUES TO NOTE

3.1 Local Issues

Manchester Arena Inquiry Update
At the beginning of June, Director of Operations, Ged Blezard, appeared before the Manchester Arena Inquiry to outline the substantial progress we have made against the recommendations set out in Volume 2 of the report published in November 2022, and was very candid about the areas which require more time to resolve. Whilst this marks the end of the Inquiry process for NWAS, work continues to complete those actions.

3.2 Regional Issues

Area Accountability Reviews
Accountability reviews have recommenced and provides service lines an opportunity to meet with myself and an executive panel, utilising the agreed service line metrics to monitor and challenge performance by ‘exception’ and allow the service lines leads to escalate any appropriate issues and ‘showcase’ new and innovative ways of working.

Important Projects
On-going projects include the 111 Rota Review, Defibrillator Replacement Programme, Emergency Services Mobile Communication Programme, Electronic Staff Record Phase 2, Smart Sites, Patient Safety Incident Response Framework (PSIRF), and the Stockport Station Estates Development.

I am pleased to see the progress being made on these initiatives, as they contribute significantly to our overarching goals of delivering high-quality care, being a brilliant place to work, and shaping a better future.

Increased REAP Level

On 13 June the trust increased its REAP level to Level 3, (Major Pressure). The change in REAP level was due to a number of reasons including the high temperatures the country was experiencing, an increase in activity, extended handover times together with the on-going Junior Doctors' strike.

Escalating our 'REAP level is part of our response to manage system wide pressures and the move to REAP level 3 allows us to focus our resources on essential services to meet the increased demand.

3.3 National Issues

Pride Month

The National Ambulance LGBT+ Network Conference took place on 15 and 16 June at the Manchester Metropolitan University following a gap of four years. The conference hosted by Alistair Gunn and Kirstie Willis-Drewett was designed to get people back together to learn how we can shape our future service.

Deputy Chief Executive, Salman Desai and Director of People, Lisa Ward, gave warmly received opening speeches. Lisa is a true ally of the LGBT community, both within our own organisation and externally and was given the Gold Star of Life Award for her work as an LGBT+ ally, which was created to celebrate those who contribute to, or inspire, the development of LGBT+ networks.

EMS Research Forum Annual Conference

It was an honour for NWAS to host this event for the first time on 21 and 22 June, not only did it receive the highest number of registrations in its history, but we also saw a record-breaking number of research abstract submissions.

The conference spanned two days and I was delighted to be able to open the conference and welcome national and international delegates. The conference featured insightful guest talks and workshops led by distinguished academics and researchers. It was particularly inspiring to witness our staff share their expertise including Steve Bell, Consultant Paramedic & Research Lead, Matt Dunn, Consultant Paramedic, Stephanie Hayes, Consultant Midwife, Joe Tunn, Advanced Paramedic and Susie Rhind, Paramedic.

I would like to express my thanks to Steve Bell and Sandra Igbodo for all their hard work in making the event a resounding success. Research and evidence play a vital role in our work, enabling us to make informed decisions that benefit both our staff and patients. I am committed to supporting the EMS Research Forum and ensuring that the exceptional work of the researchers across the country continues to make a substantial difference in the ambulance sector.

Windrush 75th Anniversary

Another important event took place on 22 June; the 75th Anniversary of the arrival of HMS Empire Windrush at Tilbury Docks which marked the first wave of post-war immigration with over 1,000 passengers from the West Indies, many of whom played crucial roles in the early days of the NHS and faced immense challenges in a society marked by racism, discrimination and public outcry. I was delighted to accept an

invitation from the Lord Mayor of Manchester, Councillor Yasmine Dar, to a Civic Reception to celebrate this important event.

Today ethnic minority colleagues account for nearly a quarter of the NHS workforce, with 42% serving as medical staff.

HSJ Awards
The inaugural Health Service Journal Digital Awards took place on 22 June and showcased digital processes in the healthcare sector and celebrated projects that add value to staff and patients.

Huge congratulations to our Digital Innovation Team for their award in the category Enhancing Workforce Engagement, Productivity and Wellbeing through Digital, finishing ahead of other finalists for their smart station work which has transformed and connected sites such as Kendal Ambulance Station, with many more soon to follow.

Congratulations also to the Risk & Safety Team who were shortlisted in the Digital Clinical Safety category for their work on implementing a new risk management solution to transform how risk is managed across the organisation.

Covid Inquiry
A number of NHS trusts, including NWAS, received a formal request from the UK Covid-19 Inquiry, under Rule 9 of the Inquiry Rules, for documentation and information about the trust together with a comprehensive witness statement.

For the purpose of this request the trust focussed on the time period between 1 March 2020 and 28 June 2022. This was a significant wide-ranging piece of work which touched all the Exec portfolios.

The final statement was lodged with the Inquiry Team on 23 June. The responses will inform the Inquiry ahead of the planned public hearings on the health and care sector which will commence in Autumn 2024.

999 Outage
Shortly after 08:00 on Sunday 25 June, we and other ambulance trusts noticed a sudden drop in the 999 calls. It was quickly established that this was a national issue originating from BT and all 999 services were affected.

A working group was quickly established with commanders, operations, 111, clinical, EOC and communication representatives attending updates. Messages were published through our social media accounts directing the public to use 111 if they could not get through via 999 and this was supported with communications from NHSE and other north west trusts.

It was good to see how well the two services worked closely together and supported each other during what must have been an extremely challenging time.

A full investigation has taken place to fully understand what went wrong and what lessons can be learnt from this incident.

National Volunteers Week 1-7 July
A special event to celebrate the invaluable contributions of our volunteers was held on 27 June. The ambulance sector has the most established clinical volunteering model within the NHS and the challenges faced over past few years have highlighted the power volunteering has, not only in supporting our staff, but also the patients and communities we serve, we would not be the service we are without the support of our 1000+ volunteers.

Community First Responders (CFRs) attend emergencies to provide help before an ambulance arrives, car drivers support PTS by taking patients to and from routine hospital appointments, patient and public panel members have a say in how the service operates by sharing their thoughts and experiences, and there are others such as welfare van operatives who provide much needed refreshments for crews

The NHS turned 75
On 5 July the NHS celebrated its 75th birthday. A special garden party was held at Ladybridge Hall invitations were sent to our longest serving staff, those who shared their birthday with the NHS and those who joined the NHS in its 75th year to get together for sandwiches and cake and to view the impressive ambulance museum display, brought by Glyn Brown and his colleagues which clearly demonstrated the evolution of emergency vehicles and equipment.

On behalf of NWAS and AACE I attended a special service at Westminster Abbey and was also asked to attend a reception at No 10 Downing Street. There were many tributes, including personal accounts and reflections on the huge advance we have witnessed in healthcare over the decades.

NHS Recovery Summit
I attended the NHS Recovery Summit, held at the Department of Health & Social Care (DHSC) in London on 6 July, alongside the Chair and Chief Executive of NHSE, senior government officials including the Minister for Health & Social Care and hosted by the Secretary of State for Health & Social Care.

The Summit was a follow up to the meeting I attended with the Prime Minister in January and I was pleased to hear the discussion continued to focus on Urgent and Emergency Care. Hospital handover delays was discussed together with some of the issues continuing to face all staff. I was also able to explain some of the amazing work our trust is leading on.

A number of actions were taken away from the Summit and we have been asked to report back to government officials and ministers on progress in due course.

National Consensus Launch
Ambulance services can, and do, play a significant role in tackling health inequalities and the Association of Ambulance Chief Executives (AACE) has highlighted an opportunity to bring partners together to consider how everyone working in the ambulance sector can contribute to reducing health inequalities via means of a national awareness campaign and consensus statement.

The statement has been agreed by major health organisations and underlines common goals and objectives of ambulance services in tackling health and social care inequalities and supports trusts with a toolkit to help identify key actions and areas of work that ultimately result in ambulance services playing a more central role in reducing local health inequalities.

NWAS has played an important part in developing this statement and supporting resources. At the forefront of this work, we have recently recruited a Public Health Manager in addition to continuing our commitment to Public Health Registrar placements.

The National Ambulance Consensus Statement was launched on Thursday 8 June and included presentations from two of our current Public Health Registrars, Christina Downham and Simon Watts, on the development of Make Every Contact Count and training for PTS staff. Executive Medical Director, Dr Chris Grant, spoke about reducing health inequalities and what this means for our patients and communities.

#Work Without Fear

Staff have been encouraged to share their views, opinions and experiences of managing distress, aggression and violence whilst carrying out day-to-day duties, to help shape a new national training programme designed to help staff safely manage conflict.

Whilst NWAS have delivered training in restrictive interventions and safe holding during mandatory training to help provide our staff with the tools to manage some of the challenging situations they face, this is not the case in every ambulance trust. As a result, AACE has been supporting the development of a national set of resources which can be used to support initial and refresher training.

The bespoke course will provide a suite of skills and strategies that can be used by staff during challenging situations to ensure that essential treatment can be delivered while positive action can be taken simultaneously to ensure the risks to patients and staff are minimised, or even prevented.

4. GENERAL

NWAS welcomes visitors from Thailand

At the beginning of June, in partnership with JESIP (Joint Emergency Service Interoperability Programme) the trust welcomed colleagues from Thailand's National Institute of Emergency Medicine and their government who were in the northwest to gain insight into our emergency services and our resilience including HART.

A session on emergency preparedness, resilience and response (EPRR), including learning from the Manchester Arena incident and subsequent Inquiry were shared with them.

British Medical Association (BMA) Strikes

Junior Doctors and Consultants participated in the biggest ever BMA industrial action; the Junior Doctors took strike action from 07:00 on 13 July to 07:00 on 18 July followed by 07:00 on 20 July until 07:00 on 22 July for the Consultant Doctors. The three-tier cover is a statutory obligation, and the agreement is 'Christmas day' level cover which is an emergency care only level of service. Almost half of all hospital

doctors in the country are Junior Doctors, this was expected to significantly impact upon hospitals across the region, however the direct impact on us was minimal. The main risk was how quickly hospital handovers were achieved and the speeds at which crews could be released to help other patients.

In our Thoughts
It is with great sadness that I write to inform you of the death of our former colleagues, Kirsty Done, Anne Lister and Terry Whitham.

Kirsty, who passed away following a short illness, worked as an EMT 2 in East Lancashire from 2003 to 2017 and was a popular member of that team. Our thoughts are with her husband, Richard, and her son, Cameron, who are both our colleagues at NWAS, plus all her other family and friends at this sad time.

Anne worked for PTS in West Cumbria and retired in 2019 following 27 years with the service and passed away following a short illness. She was an asset to PTS during her long and distinguished career.

Terry retired from NWAS in 2018 after a short career of 8 years and was based at Audenshaw PTS

The trust sends sincere condolences to the family, colleagues and friends of Kirsty, Anne and Terry.

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

There are no legal implications contained within this report

6 EQUALITY OR SUSTAINABILITY IMPACTS

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:	26th July 2023				
SUBJECT:	Supporting Strategies				
PRESENTED BY:	Salman Desai, Deputy Chief Executive				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	In 2021 Resources Committee approved a programme of work to develop a new suite of strategies for the organisation. The programme consisted of two phases: Phase 1: The development of the Trust Strategy Phase 2: The development of all supporting strategies On the 29th of June 2022 Trust Board approved the Trust Strategy, marking the end of phase one of the programme. On the 26th of August 2022 the Resources Committee agreed phase 2 of the programme would consist of four supporting strategies that would provide more detail on the three aims in the Trust Strategy and all collectively deliver the Trust vision. These four supporting strategies are: 1.The Quality Strategy 2.The People Strategy 3.The Service Development Strategy 4.The Sustainability Strategy The four supporting strategies have been developed by following a strategy development process which followed the following stages; 1.Diagnose 2.Design 3.Develop Each strategy was developed by a group of subject matter experts, led by an Executive Director. Each strategy development process included the development of a set of design principles which informed an engagement approach which targeted the intended audiences of the strategies. The resulting strategies align to the aims within the Trust strategy. There are some areas of focus which are interdependent across				

	the strategies, these interdependencies are outlined in Appendix A. Following approval of the supporting strategies there will be work completed to develop a measurement approach to enable assurance against the delivery of the strategies to be provided to the relevant committees and Trust Board. A Plain English review will be completed for all of the supporting strategies and "easy read" versions will be made available to make sure the strategies are accessible for all. The supporting strategies will undergo an annual refresh to ensure they continue to be relevant within the changing context in which we operate.
RECOMMENDATIONS:	Trust Board are recommended to; • Note the assurance provided on the strategy development process followed; • Approve supporting strategy content as a set of strategies which collectively deliver the vision; • Note the interdependencies between the supporting strategies as outlined in appendix A.
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: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☒ Financial / Value for Money ☐ Reputation ☐ Innovation

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:	People Strategy and Sustainability Strategy have been considered by Resources Committee. Service Development Strategy and Quality Strategy have been considered by Quality and Performance Committee. Each of the supporting strategies have been considered by ELC.			
	Date:	Resources Committee 21/7/23 and Quality and Performance Committee 24/7/23		
	Outcome:	Pending		

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1. PURPOSE

1.1 The purpose of this paper is to:

- Provide assurance on the Supporting Strategy development process;
- Provide an overview of the Supporting Strategy content and seek approval for the strategies;
- Provide assurance on the next steps in the delivery of the Supporting Strategies and the process of providing continued assurance through Resources Committee, Quality and Performance Committee, and Trust Board.

2. BACKGROUND

2.1 In 2021 Resources Committee approved a programme of work to develop a new suite of strategies for the organisation. The programme consisted of two phases:

Phase 1: The development of the Trust Strategy

Phase 2: The development of all supporting strategies

2.2 On the 29th of June 2022 Trust Board approved the Trust Strategy, marking the end of phase one of the programme.

2.3 On the 26th of August 2022 the Resources Committee agreed phase 2 of the programme would consist of four supporting strategies that would provide more detail on the three aims in the Trust Strategy and collectively deliver the Trust vision. These four supporting strategies are:

1. The Quality Strategy
2. The People Strategy
3. The Service Development Strategy
4. The Sustainability Strategy

2.4 It was agreed that the supporting strategies would run for 3 years from 2023-2026. This reflects that the supporting strategies have been developed following production of the 2022-2025 Trust Strategy, in order to support delivery of the Trust Strategy aims.

2.5 It was agreed that a “strategy on a page” would be developed for each strategy which would outline the 3-year strategic priorities. Then, a supporting narrative document would be developed which expanded on the priorities and gave the rationale as to why the 3-year priorities had been chosen.

2.6 As part of the strategy development process, on the 6th of February 2023, ELC reviewed and approved the 3-year strategic priorities outlined within the “strategies on a page”.

2.7 On the 22nd of February 2023 a NED development session took place which covered the supporting strategies and the 23/24 annual plan. In the session the NEDs discussed the scope of the four supporting strategies and their alignment back to the Trust Strategy.

The supporting narrative document has now been written for each of the strategies. Each strategy has been reviewed by ELC and the Resources Committee and Quality and Performance Committee, respectively, in July 2023.

3. STRATEGY DEVELOPMENT PROCESS

3.1 A clear process has been followed to support the development of each strategy, which includes the following steps:

1. Diagnose
2. Design
3. Develop

3.2 Each strategy was developed by a group of subject matter experts, led by an Executive Director, as follows;

The Quality Strategy; Maxine Power, Director of Quality, Innovation and Improvement

The People Strategy; Lisa Ward, Director of People

The Service Development Strategy; Ged Blezard, Director of Operations

The Sustainability Strategy; Carolyn Wood, Director of Finance

3.3 All other Executive Directors have either held a supportive role in the development of the strategies or have been engaged in the approval process through the Executive Leadership Committee (ELC).

3.4 **Diagnose**

3.5 The first stage of the diagnose process was to establish the scope of each of the four supporting strategies. All the supporting strategies collectively deliver the outcomes within the Trust Strategy and ultimately, the organisation's vision. The strategies align to the aims and outcomes within the Trust Strategy as follows:

Trust Strategy Vision	**Trust Strategy aim**	**Trust Strategy outcomes**	**Supporting Strategy**
To deliver the right care, at the right time, in the right place, every time.	Provide high quality, inclusive care	Improve performance against ambulance clinical quality indicators (ACQIs) Improve regulatory compliance and be rated outstanding by the Care Quality Commission (CQC) Reduce variation in patient treatment, outcomes and experience Improve friends and family test results and patient satisfaction survey scores	The Quality Strategy
	Be a brilliant place to work	Improved retention rates Improve staff views of career progression Improvement in key staff survey responses Improvement in key staff survey responses Improvement in quality of processes	The People Strategy
	Work together to shape a better future	Sustainable delivery our KPIs across all service lines, within agreed financial budgets.	The Service Development Strategy

		We will provide equitable access to our service lines for all our patients and service users. We will improve our ability to plan for, and respond to, surges in demand and incidents.	
		We will take positive steps to achieve Net Zero by 2040 We will agree “anchor principles” within NWAS and align with system partners We will work as an effective system partner to improve population health across the Northwest. *We will maximise the use of NWAS financial resources to deliver safe, efficient and sustainable patient care at every opportunity.	The Sustainability Strategy

Table 1: Supporting Strategy alignment to Trust Strategy

3.6 *Through the development of the Sustainability Strategy, it was identified that the Trust Strategy does reference the need to deliver services within financial budget but there is no specific outcome relating to financial sustainability. The Trust Strategy outcomes which reference sustainability have therefore been expanded and an outcome, marked with *, has been added to directly address the need to be financially sustainable.

3.7 In addition to defining the scope of the strategies, the diagnose phase included analysis of the context from the perspective of the specific strategy which built upon the analyses completed as part of the Trust Strategy development. These analyses produced themes which were shared amongst subject matter experts and staff where appropriate for comment.

3.8 **Design**

3.9 Each strategy considered the design principles of the strategy narrative to inform the development of its content.

3.10 Across all the supporting strategies, it was agreed that there would be consistency in how the strategies presented and positioned, as follows;

- Alignment to trust strategy
- Presentation of plan on a page
- Positioning of interdependencies
- Consistent style, tone, use of “plain English”
- Consistent structure/flow

3.11 In addition to the above points, the supporting strategy leads and teams considered the specific stakeholders who would be expected to utilise the strategy as well as considering whether the strategy would be a continuation, a refresh or a rewrite of their previous strategy. From this, each strategy identified additional design principles;

Supporting Strategy	Additional design principles
Quality	• The audience of the strategy should primarily be staff and patients whilst being conscious that there will be a need to demonstrate regulatory compliance through a focus on Quality. • The strategy should build on the previous "right care" strategy to provide consistency and build on our successes whilst also being clear about what was taking us further.
People	• The strategy would be targeted primarily at managers and leaders as it was felt that they were crucial to the successful delivery of the strategy. As the outcomes of the strategy are to benefit all staff, it was felt that the strategy must also be easy to understand by staff.
Service Development	• The audience of the strategy would be internal staff but there would be a need to communicate some key messages externally.
Sustainability	• The audience of the strategy would be internal staff but there would be a need to communicate some key messages externally. • A clear definition of sustainability is needed to explain that sustainability does not just mean the green agenda.

Table 2: Supporting Strategy additional design principles

3.12 These additional design principles informed the engagement approach which was targeted at the strategy's intended audience;

Supporting Strategy	Engagement approach **(In addition to core group of exec lead and subject matter experts)**
Quality	Senior Management Teams (SMTs) from across NWAS, Quality SMT workshops, The Patient and Public Panel (PPP).
People	Senior Management Teams (SMTs) from across NWAS, Senior Leadership Group (SLG), Trade Union (TU) colleagues, The People Directorate, Staff Networks, Commissioners.
Service Development	Service Delivery SMT workshops.
Sustainability	Finance SMT, The People Directorate, The Patient and Public Panel (PPP).

Table 3: Support Strategy engagement approach

3.13 The themes identified in the "diagnose" phase as well as feedback from engagement completed, were developed in to a 'strategy on a page' which set out how the strategy aligns to the trust strategy, what the areas of focus are and what the priorities within each area would be.

3.14 In February 2023, an ELC workshop was held to discuss the strategies on a page and to confirm the positioning of any themes or topics which were interdependent across the strategies. A full matrix of these interdependencies is outlined in Appendix A.

3.15 **Develop**

3.16 Led by the executive lead, with support from the Strategy, Planning and Transformation team, each strategy is the result of a collaborative process; the group of subject matter experts involved in the development of the strategies through the diagnose and design stages were assembled to write the content.

3.17 The resulting strategies highlight key features of the current context which are influencing our strategic direction and outline what areas we will focus on between 2023-2026 to achieve our vision.

4. DELIVERING THE SUPPORTING STRATEGIES

4.1 As 3-year strategies, the supporting strategies each outline the goals to be achieved by 2026. In the strategy documents, these goals are worded as outcome statements designed to communicate what will be implemented or improved as part of the delivery of the strategy.

4.2 In order to provide assurance to the relevant committees and Board on the delivery of the supporting strategies, these statements will be developed into more specific and measurable goals. The Strategy, Planning and Transformation Team will work with Business Intelligence and the subject matter experts for each supporting strategy to develop the specific goals and to produce a dashboard which can demonstrate the progress being made towards delivering against the strategic goals.

4.3 The first assurance update to Trust Board will be due in November 2023 and further updates will be provided to Trust Board every six months.

4.4 The supporting strategies will be reviewed annually, following the review of the Trust Strategy to ensure that they remain relevant within NWAS' changing context.

4.5 As we work through the programme of reviewing and refreshing our strategies and plans, there is a risk that staff become overwhelmed and disengaged and therefore there is a need to make sure the communication of key strategic messages is considered, coordinated and well timed. The Strategy, Planning and Transformation Team and the Communication and Engagement Team are working on a jointly owned communications approach which aims to keep all staff informed of NWAS' strategic direction.

4.6 The first set of activities on the communications and engagement plan, for financial year 23/24, will be a coordinated "launch" of the supporting strategies, following their approval. The launch will include an update of the Green Room with the relevant information and documentation as well as pushing out key strategic messages to all staff.

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

5.1 There are several positive implications against the risk categories considered in the Trust's risk appetite statement, as follows;

Risk appetite category	Implications
Compliance / regulatory	The supporting strategies outline priorities which will inform improvements in compliance. The supporting strategy development process followed, provides assurance against CQC well-led key lines of enquiries (KLOEs).
Quality outcomes	The supporting strategies outline priorities which should lead to more positive quality outcomes.
People	The supporting strategies outline priorities which will positively impact staff.

Financial/ Value for Money	The Sustainability Strategy outlines areas of focus to ensure financial sustainability and value for money. There are interdependencies across the supporting strategies as outlined in Appendix A.

6. EQUALITY IMPACTS

6.1 To assess the equality impacts of the Supporting Strategies, there is a need to consider the content of the strategy as well as the strategy document's accessibility;

6.2 In terms of the equality impacts of the strategy content; as part of the testing of the new equality impact assessment (EIA) process, the EIA screening tool has been utilised to assess the need for a full EIA for each strategy.

6.3 The screening tool identified no negative impacts but did highlight that there would be positive impacts to groups and communities who experience differences in their care or outcomes as a direct result of being part of minority groups. As a supporting strategy of the Trust Strategy, these positive impacts are the same as those already identified through the Trust Strategy EIA.

6.4 The EIA screening tool recommendation is to complete stage 2 of the EIA process and conduct full assessments. However, due to the alignment to the Trust Strategy equality impacts, it is felt that this would be duplication. Upon initiation of any strategic project or activity linked to the sustainability strategy, a new EIA would need to be completed.

6.5 In terms of the accessibility of the document, the documents in their current format are not fully accessible. The use of "plain English" has been considered throughout development of the document however there is still a need to complete a formal "plain English review" to make sure the language used is fully accessible to staff and the public. Therefore, it is recommended that a fully accessible "easy-read" version of the strategy is produced and, a "plain English" review is conducted with the support of the Communications and Engagement team.

7. RECOMMENDATIONS

7.1 Trust Board are recommended to;

- Note the assurance provided on the strategy development process followed;
- Approve supporting strategy content as a set of strategies which collectively deliver the vision;
- Note the interdependencies between the supporting strategies, outlined in appendix A.

Appendix A – Supporting Strategy interdependencies

	How each strategy addresses the interdependent theme			
Theme	**Quality**	**People**	**Service Development**	**Sustainability**
Patient Care delivery	Creating the conditions within which care can be delivered safely. Moving to a more proactive than reactive model of quality management. Ensuring the right clinical practices and pathways are available to enable clinicians to make the most appropriate decision for patients. Enabling care to be delivered in a person-centred and inclusive way to improve outcomes and experience for all.	Ensuring we have a workforce model that enables delivery of patient care. Providing our workforce with skills and experience to deliver high quality care.	Our operational model is designed to ensure that care can be appropriately prioritised and delivered in the right place at the right time. Ensuring we have the right skill mix and resource levels to deliver care effectively. Integrating our service lines to ensure that patients receive equitable, streamlined care regardless of point of contact. Working in partnership with wider system to ensure care is delivered in an integrated, joined-up way. The development of our clinical and operational workforce to make sure that it meets the needs of the integrated services to provide effective patient care.	Making every contact with patients count to shift towards preventative care where clinicians can assess an individual's wider health and social wellbeing needs and onwards refer accordingly. Reduce inequalities in access to healthcare for patients in vulnerable groups or communities. Working with communities to promote public health messaging. Ensure our operational models enable staff to offer prevention support beyond fulfilling patients' urgent needs.

	How each strategy addresses the interdependent theme			
Theme	**Quality**	**People**	**Service Development**	**Sustainability**
EDI	The care we provide must be accessible to everyone and we will treat each person fairly based on individual need.	Our leaders must be visible role models for inclusion. We must take a zero-tolerance approach to discrimination and challenge behaviours which do not align to our values. We will strive to increase diversity within our workforce and utilise the staff networks and forms we have to provide safe environments where people can be themselves and challenge existing practice.	Our frontline services must be accessible to people from all backgrounds, demographics and cultures We must work in partnership with local systems to design services that meet the needs of local populations and communities.	Social value principles indicate that organisations should positively impact the communities they serve – especially those considered vulnerable, marginalised or at risk of experiencing inequalities in access and experience Increase widening access programmes to improve proportion of NWAS workforce from local communities Ensuring our buildings and infrastructure are accessible and inclusive.
Social value, prevention and population health	We will take action to reduce inequalities in access, experience and outcomes. We will use patient data and experience to drive improvements in access and inequalities for people from diverse or vulnerable communities. EPR will enable better understanding of populations.	Build cultural competence to enable a diverse workforce to feel included and be supported.	Recognises that our operational services are uniquely positioned to access hard to reach patients and groups, they are well placed to support prevention initiatives which are driven internally or externally.	Widening participation; take a community based approach to widen access to employment at NWAS. Utilise data to understand health inequalities.
Finance, productivity and efficiency	Balance quality and financial sustainability.	A focus on retaining the workforce, reducing sickness absence and therefore improving productivity and efficiency within the workforce.	Recognises need to develop services within financial budgets.	Financial sustainability; maintain financial control, reduce waste, ensure investment decisions demonstrate value for money. Recognises need to maintain Quality as well as be financially sustainable.

	How each strategy addresses the interdependent theme			
Theme	**Quality**	**People**	**Service Development**	**Sustainability**
Patient engagement and community participation	To achieve patient centred partnerships, the Quality strategy specifies ambitions to increase the public patient panel size and to continue to empower them to influence system improvement.	Developing leaders and mangers will, in part, enable successful patient engagement and community participation.	The collaborative relationships priority looks to develop partnerships to support system-wide operational challenges. Recognises that there are opportunities to utilise volunteers to build community resilience.	
Integration of people, processes and systems	N/A	Building digital capability will support staff to adapt to the technological changes to systems and processes.	Continuing to integrate, building upon 111/999 single triage implementation. Uses opportunities presented by integration to develop flexible opportunities for staff.	N/A

North West Ambulance Service
NHS Trust

The Quality Strategy 2023-2026

Contents

The Quality Strategy

Our Trust Strategy 2022-2025 sets our vision for the future;

To provide the right care, at the right time, at the right place, every time.

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. This Quality Strategy is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision

Our Quality Strategy aligns to our aim “provide high quality, inclusive care” and sets out the ambitions, standards and framework which will help us to deliver safe, high quality, person-centred care for patients, every time.

As the North West’s Ambulance Service, we are in the privileged position of touching people’s lives when they need us most. We save lives, prevent harm, and offer services which optimise the likelihood of outstanding outcomes. Each day our people go the extra mile to live up to these expectations. We are proud of our leadership teams, our staff, volunteers and partners who together contribute to all that we do.

We have consulted with over 200 staff in our trust, including leaders across the organisation and beyond, many frontline groups, and a diverse range of stakeholders and networks. Our quality strategy isn’t simply a statement of intent, it is a live document which reflects the wishes of the populations we serve and those who deliver services.

Over the last five years of our first quality strategy, we have taken significant steps to learn. Primarily we are curious about how the care we provide is experienced by patients. We have listened to our staff when they speak up about patient safety, scrutinised learning from incident reports, listened to staff at staff forums and learnt much about how safe, reliable, and sustainable our systems are from clinical audits. This strategy is better because of this focus on learning and extends our commitment to continue to improving safety, effectiveness, and patient experience. It sets

the scene for the next three years and will consider how we can go even further. There is clear alignment to the overarching Trust strategy and interdependency with the family of supporting strategies and plans.

During the lifetime of this Quality Strategy, we will continue to build improvement in patient safety culture, our partnership with patients and families and implement the Patient Safety Incident Response Framework (PSIRF). Our learning will come from when things go right and wrong. Themes from our learning will be agreed as strategic priorities, adopted as organisational priorities and reinforced with support from improvement, project management and transformation experts.

Our strategy is underpinned by the latest policy and research evidence from implementation and improvement science, with an aim to become better every day. It is an integrative strategy, drawing in expertise from across directorates to deliver shared quality goals collaboratively with clear measurement and effective governance. Our quality strategy signals our intention to challenge ourselves and to continue to learn and improve together every day.

The opportunity for partnership working to improve quality has never been greater. We have had changes to the way healthcare services are organised with the establishment of primary care networks (PCN), provider collaboratives (PC) and integrated care boards (ICB). This strategy signals our intention to double down on our work with providers of primary care, community services, mental health, emergency and urgent care to work towards even more integrated care. We are proud to serve the people of the North West. This Quality Strategy demonstrates our unwavering commitment to delivering continuous quality improvement for our patients and communities.

NWAS is committed to creating an inclusive culture where diversity is truly valued. Through our Quality Strategy and beyond, our commitments to equality, diversity and inclusion (EDI) runs through everything we do and align to our organisational EDI priorities:

- Priority 1: We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
- Priority 2: We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.
- Priority 3: We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities

Our strategy is ambitious, and we must balance getting the basics right with striving for excellence. The priorities outlined in this strategy have elements of both “basics” and “excellence” which will be further detailed as we turn our strategy in to action.

The Quality Strategy - Plan on a page

The Quality Strategy is a supporting strategy which to our Trust strategy and contributes to achieving our vision;

To deliver the right care, at the right time, in the right place, every time.

Our Quality Strategy outlines how we, as a trust, can ensure that we deliver the high-quality inclusive care and are always doing the basics brilliantly, continuously striving for excellence. We define high quality care as safe, effective and patient centred care for every patient.

The Quality Strategy aligns to this aim from the Trust Strategy…

Provide high quality, inclusive care

We will put the patient at the centre of everything we do and listen to them so that we understand their needs. We will work together to prevent harm and continuously improve our services.

…and will deliver against the following measures by 2026:

- Increase of 10% in the FTSU* index
- Quality improvement plans for all service lines and teams
- Improved performance against ambulance clinical quality indicators (ACQIs)
- Reduce variation in patient treatment, outcomes and experience for patients with maternity, mental health or frailty presentation
- Evidence of listening and learning from when things go wrong
- Productive partnerships for learning and improvement

*Freedom to speak up

To achieve these measures, the Quality Strategy outlines the following three-year priorities:

Safety first

Highly effective care

Person centred partnerships

Which will be delivered by…

- Improving safety culture
- Creating better insight into safety
- Strengthening safety partnerships
- Strengthening our quality management

- Preventing avoidable harm or deterioration
- Reducing variation in cardiac and stroke outcomes (ACQIs)
- Improving maternity care, mental health emergency care and care to patients who are frail or elderly
- Focusing on measurement learning and improvement.

- Shared decisions
- Building our community
- Listening to patients when things go right and wrong
- Co-design for ‘experience-based design’

Safety first

Safe care is about reducing risk, and protecting our patients and staff from avoidable harm. Emphasis is placed on the system of care delivery that prevents errors; learning from errors that do occur, understanding the complexities of the systems our people work within, and building on a culture of safety that involves our people, partners and patients. Put simply we are committed to ‘no needless harm’ and ‘no needless pain or suffering’.

Our ambition is to develop the safest system for our 999, 111 and Patient Transport Service (PTS) patients. This starts at the point of contact within the control room. It requires every staff member to understand their role and how it contributes to safety. The strategy identifies high level areas of focus which will require local review and planning aligned to the agreed annual objectives.

The NHS Patient Safety Strategy first published in 2019 puts safety at the core of the NHS and this strategy seeks to take the foundations established in the first quality strategy to the next level. Key deliverables in the national strategy include monitoring safety culture; developing safety insight systems including the implementation of PSIRF; involving patients as partners to deliver safe care; active involvement in key programmes of work to deliver safety improvement in the avoidance of deterioration for patients with physical and mental health presentations; safer use of medicines; improvement in maternity safety and speaking up (for patients and staff).

Safety in Ambulance Services: Our industry is complex, and the risks of error have been well documented. Over the last decade NWAS, like most healthcare organisations, has focused on identifying risks and mitigating these through assurance processes. We have learned from incidents and addressed safety issues head on. However, there is still more to be accomplished. We seek to understand risk through a systems approach, working with our staff and patients to not only understand the complexities of the systems that our people work within, but to partner with them to design solutions which reduce potential for error. We will have a high degree of psychological safety in our teams, where safety is a priority and everyone has a shared accountability for reducing risk.

What are we trying to accomplish?

Themes from our integrated safety learning will be agreed as strategic priorities, adopted as organisational priorities and reinforced with support from improvement, project management and transformation experts. Every service line, directorate and team will be expected to have a quality improvement plan aligned to the quality strategy which includes how they will improve safety.

Our Goals:

Improving safety culture: working towards a culture where staff report a high degree of psychological safety, feel able to speak up when things go wrong, feel as though their concerns are heard and actions are taken to improve. This will be achieved through a systematic deployment of safety culture surveys across all service lines, local action plans and a continuous cycle of safety improvement. This will be actively monitored through learning forums. When staff do raise safety concerns there will be responsive feedback. A new training needs analysis will be undertaken and a safety science curriculum for staff will be delivered.

Creating better insight into safety: Introducing digital systems for measuring and monitoring avoidable harm from frontline to Board, in real time will allow us to have a view of safety which will quite simply 'put patient safety first'. Our current systems for monitoring safety are, like most healthcare organisations, largely reliant upon incident reporting and quantitative data. We have adopted the framework put forward by Vincent et al 2014, which highlights how systems can integrate learning from hard and soft intelligence to measuring and monitoring the safety of the systems they work in. We will strengthen this with integrated safety dashboards and narrative from board to frontline. Each service line and department will have a safety dashboard which is used to monitor progress on safety culture, key safety indicators and performance against the safety training needs analysis. Patient stories will be used to provide rich context for data and a connection with our core purpose.

The roll out of electronic patient records to the Trust will enable our measurement of both safety and clinical effectiveness to be undertaken 'real time' and for whole populations rather than 'samples' of cases. This will provide significant insight into the safety and effectiveness of care, and we will focus on the key improvement areas identified in this strategy document, deploying both informatics and clinical audit resource to work with the Electronic Patient Record (EPR) implementation team. In year two and beyond we will develop our understanding of the reliability of our care pathways through a multi professional EPR analytics group.

Strengthening Safety Partnerships: In complex adaptive systems, not all changes necessarily result in improvement. Healthcare systems must be constantly vigilant to the possibility that service changes could impact negatively on patients and cause unintended harm. A good example of this is our service delivery strategy puts significant emphasis on 'leaving patients at home with wrap around care' or self-care pathways to prevent unnecessary conveyance to hospital. It is essential that we have proactive monitoring of patient outcomes and experience. This is currently undertaken through incident reporting, mortality reviews (learning from deaths) clinical audit and will continue to be a focus for development within this strategy. However, we are also now required to collaborate much more closely with patients and system partners in our review of safety incidents, our prioritisation of safety learning and our participation in safety improvement collaboratives. New safety partnerships will be established with provider collaboratives and integrated care systems to share learning more widely.

Strengthening our Quality Management Systems: We bring together quality planning, quality assurance and quality improvement as a single quality management system. This approach enables a consistent and coordinated approach to managing quality that is applied from teams through to board level. We are committed to strengthening our system of real time quality measurement and feedback to measure performance, quality surveillance, and improvement.

- **Quality Planning:** This strategy sets out early goals which will be refreshed annually. Progress will be reported via the Board of Director's reporting structure which will include a summary of progress in our Quality Account. We will ensure that the implementation, measurement and learning from our strategy implementation is hardwired through our governance and integrated performance reporting. Our assurance and management committees have been aligned to our strategy to offer seamless implementation and oversight. Our staged approach to implementation reflects our requirement to align our existing resource behind this strategy, develop new capabilities to deliver and develop our capability as an improving organisation.

- **Quality Assurance:** We have clear evidence-based policies and staff who are skilled in delivering high quality care. We have systems for continuously auditing compliance with standards, including triage, assessments, guidelines and legislation. During the next 3 years we will further strengthen our internal assurance processes (training compliance, audit systems, accountability reviews, quality measurement systems and quality assurance visits) to align them with the new CQC regulatory framework.

- **Quality Visits and Leadership walk rounds:** It is fundamental that the ownership of quality sits with the whole organisation, however, we know that successful organisations have systems which support assurance through period review of core standards. NWAS has developed a process of review which has involved local managers reviewing the performance of their teams against locally determined standards. We have a standardised process for quality assurance which provides both support and challenge. Importantly the quality visits reward those teams who perform well with an acknowledged performance status and identify those areas requiring further support and more frequent review. The continuous improvement of this system of visits and walk rounds is critical to ensuring management oversight and corporate assurance on key standards.

Pillars of Quality: Central to this strategy is our commitment to regulatory excellence and our intention to continue to progress measurable stretch goals for six pillars of quality as part of our annual planning. This is essential if we are to deliver our ambition of achieving an 'Outstanding' CQC rating. The pillars of quality are:

- Compliments and Complaints

- Health, Safety and Security
- Incident Reporting & Learning
- Infection Prevention & Control
- Medicines Management
- Safeguarding Children and Adults

SMART systems for quality management and improvement: The delivery of safe systems and safe care is directly linked to regulatory excellence and operational efficiency. It is well understood that safety is built upon delivery of highly organised and prudent care. Historically, quality improvement strategies have included a focus on 'productivity' as a core underpinning of safety and reliability. This strategy extends our focus over the last 3 years on the basic pillars of quality into quality assurance through SMART design and digital technology.

During the last 3 years we have made improvements in safety and efficiency which are driven by staff themselves under the 'SMART stations' programme by empowering staff to ask difficult questions about practice and to make positive changes to the way they work. The process promotes a continuous improvement culture leading to real savings in materials and vastly improving staff morale. Over the next 3 years we will deliver a full roll out of the SMART stations programme and develop our SMART vehicles programme which will continue to focus on improving staff experience and patient safety. We will continue to follow the principles of the 'Carter Review', to reduce unwarranted variation with the aim of increasing operational efficiencies. Specifically, our digital work will focus on:

- Access to GP records via EPR to prevent unnecessary conveyance.
- Ability to refer patients electronically to primary care from on scene to prevent unnecessary waiting on phones.
- Automated workflows for logging HR information to prevent re-work and duplication.
- Automated stock control and safety monitoring via digital technologies for medicines, key access, tyre pressure monitoring, and high value equipment for location and condition to improve emergency ambulance availability

By 2026, we will see;

Safety culture surveys in all services

Outstanding regulatory compliance

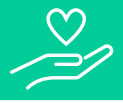
Quality improvement plans in all services

Safety dashboards from board to frontline

Safety partnerships for learning and improvement

Full roll out of SMART stations

Highly effective care



Highly Effective care means we will support people to achieve good outcomes and have the best quality of life possible. Put simply we are committed to, 'no unwarranted waiting' and 'no waste'.

Our ambition is that all care is delivered using the most up to date evidence-based practice, ensuring our staff are capable and confident, and that seamless care is delivered having sought people's consent.

Ambulance Clinical Quality Indicators: All ambulance services in the UK report against 11 ambulance clinical quality indicators (ACQI's). Four of these indicators, monitor clinical outcomes against evidence-based care standards for cardiac arrest and stroke. To make sure we are providing the right care, are the right time, in the right place, we must ensure that we are constantly improving these ACQI standards and understand the underlying systems which deliver care. This will continue to be a focus for this strategy over the next 3 years. We will set goals for achieving unprecedented levels of improvement and identify system leadership for these areas and resources to ensure that teams have the capability and capacity to deliver improvement. Each focus group will report through clinical effectiveness committee to the Quality and Performance Committee and Trust Board.

Research and Development: We already develop and host research studies with a focus on pre-hospital healthcare, injuries and emergencies, and other clinical specialities. We also explore non-clinical research opportunities involving the organisation and our workforce. We are committed to improving the care and experience of all our patients by generating new evidence that will inform advances in the clinical care we provide. During the next three years we will continue to build our research portfolio including our National Institute for Health Research (NIHR) portfolio, academic publications, PhD studentships and research collaborations with NHS organisations and academic institutions.

What are we trying to accomplish?

Themes from our integrated safety learning will be agreed as strategic priorities, adopted as organisational priorities and every service line, directorate and team will be expected to have a quality improvement plan aligned to the quality strategy which includes how they will improve effectiveness.

Our goals:

Preventing Avoidable Harm or Deterioration: We will continue our focus on reducing waits and sometimes harmful delays for both those who receive and those who give care. Day by day our workforce uses a range of guidelines and standards to inform their practice. NWAS has surveillance systems to ensure best practice guidelines are implemented, reviewed and followed, however, like all healthcare providers, variation in care and outcomes is evident. We seek to address this variation in assessment and treatment to prevent avoidable harm or deterioration. Specifically, we will work to:

- Prevent unwarranted deterioration in critically unwell patients reducing avoidable deaths.
- Prevent errors in 999 and 111 call handling which lead to a delay.
- Prevent errors in the assessment, care or treatment of patients.

Reducing variation in cardiac and stroke outcomes (ACQIs): All ambulance services in the UK report against 11 ambulance clinical quality indicators (ACQI's). Four of these indicators, monitor clinical performance against evidence-based care standards for cardiac arrest and stroke. To make sure we are providing the right care, are the right time, in the right place, we must ensure that we are constantly improving these ACQI standards and understand the underlying systems which deliver care. This will continue to be a focus for this strategy over the next 3 years. We will set goals for achieving unprecedented levels of improvement and identify system leadership for these areas and resources to ensure that teams have the capability and capacity to deliver improvement. Each focus group will report through clinical effectiveness committee to the Quality and Performance Committee and Trust Board.

Improving maternity care, mental health emergency care & care to patients who are frail or elderly: We will focus on three priority areas to improve the reliability of evidence-based care standards; improving services to people in mental health crisis; improving care to women and babies; improving care to the frail elderly. They are cross cutting and have high relevance for all service lines and teams. They have surfaced as key priorities during our staff and patient consultation. Each area will have its own three-year plan with roles and responsibilities for leadership clearly identified; focussed areas of work aligned with the national improvement collaboratives, clear measurement plans and reporting via the Quality and Performance Committee and Trust Board.

By 2026, we will see;

All control room staff audited to ensure they are compliant with standards

Embed specialist clinical expertise into control rooms to provide real time advice and support

Improve compliance with the ACQI care bundles for cardiac arrest and stroke to 95%

Improve overall survival following cardiac arrest from 6.5% to 8.5%

Improvement collaboratives for mental health, maternity and frailty with year-on-year improvement in treatment and outcomes

Focusing on measurement, learning and improvement:

This section applies across all areas of this strategy and other supporting strategies in outlining our approach to ensuring we are effective and that we continuously learn and improve.

Measurement: Our intelligence of Northwest Ambulance Service's performance suggests that for a number of care pathways our adherence to agreed standards (reliability) is high (95% or over), however, for most, the exact levels of performance are not measured and are therefore unclear. During the last three years we have built a suite of dashboards using the Microsoft office 365 programme 'Power BI'. The plan for data and intelligence will be described in more detail in the digital strategic plan. During the next three years our focus will be:

- Further develop clinical platform for data capture, analysis and learning (EPR), connection to primary and secondary care and onward referral (via the Directory of Services).
- We will continue to build new measurement systems in Power BI for high volume, high impact pathways aligned to our strategic foci.
- We will work with frontline clinicians to ensure they have access to the clinical information and the skills required to use information in a highly effective way, this includes training them in measurement for improvement and in the interpretation of complex data.
- We will work with frontline staff to give them the tools they need to build their own charts and dashboards.

Learning: This strategy articulates a clear plan for how we learn and how we expect learning to occur throughout the organisation. There are three essential elements to our learning system.

- **When things go wrong:** Our industry is complex, and the risks of error have been well documented. NWAS staff report more than 1000 incidents and near misses each month affecting both staff and patients. We use these reports to learn lessons when things go wrong. We pay particular attention to learning from deaths. The learning from incident reporting is triangulated with other safety data to identify underlying 'themes' which, if improved, could prevent harm. These 'themes' are then reviewed by the improvement team and clinical leads, shared with partners and shaped into clinically led improvement programmes.
- **When we find variation:** There are many sources of variation that can affect the quality of care. Reducing and managing variation enables systems to become more predictable and easier to manage so allowing improvement of quality and safety. To effect successful service improvements, we need to understand the source of variation and use a range of tools to reduce and manage it. We are committed to statistical process control charts as our approach to understanding variation. We learn from when performance exceeds expectations

(compared with peers) and when standards fall short of expectations. We learn from variation at a whole system, organisation and individual clinician level. We study variation over time and ensure that data and improvement 'tell the story' of how services have improved and why.

- **From Feedback:** Healthcare is increasingly understood as an experience as well as an outcome. In addition, in a publicly funded service, patient experience feedback is a form of holding services to account. The NHS Constitution for England makes clear the focus of patients' experience in principle 4, which states that: 'The patient will be at the heart of everything the NHS does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their careers.'

Enablers for LEARNING:

Evidence: Easy access for NWAS staff to information about high quality care. All NWAS staff will have access to library services and applications where they will be able to get reliable clinical and non-clinical evidence and best practice.

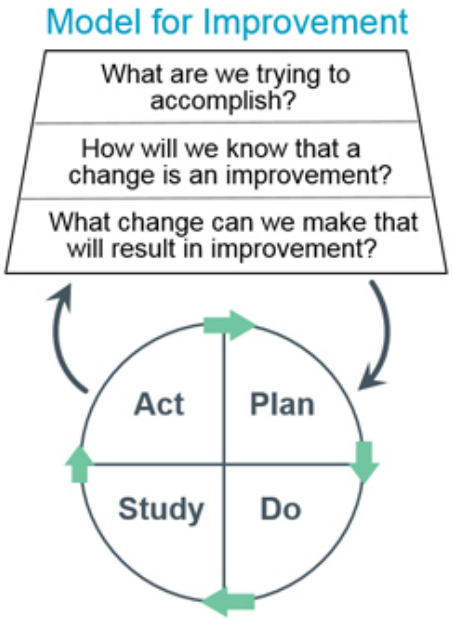
Information: Measures to ensure continuous improvement in the quality of contact centre, 111, 999, PTS, resilience and corporate services which will provide retrospective, real time and predictive analytics.

Highly skilled workforce: Continuing to build research, innovation and advanced clinical skills alongside our expansion of the digital – technical workforce to provide organisational challenge and act as thought leaders and policy influencers.

Curiosity and Challenge: an enabling culture where curiosity, challenge and discomfort with the status quo are seen as high value attributes to be balanced with risk, governance and delivery.

Learning Collaborations and Design Forums: which provide an opportunity for staff to come together to share best practice, exchange ideas and get support for innovation and improvement.

Our Improvement Approach



- Improvement science, also known as quality improvement science, is an approach that enables change through evidence-based practice, a focus on measurement, and collaborative learning networks. It provides a structured approach to enable continuous improvement and puts an emphasis on patient centred care, leadership and organisational culture.
- We have established the Institute for Health Care's (IHI) Model for Improvement as our core method underpinning our improvement approach supplemented with theory on the psychology of change (managing change); systems thinking (process mapping); variation (statistical process control) and testing changes (Plan, Do, Study, Act)
- We have extensive experience in using the Breakthrough Series Model to deliver system wide improvement collaboratives. The 'Breakthrough Series' (BTS) Collaborative is a tried and tested change model that has been in regular use in healthcare improvement since its development in the mid-1990s by the Institute for Healthcare Improvement (IHI).
- The BTS Collaborative is a structured 10-12 month programme, designed to help organisations come together to achieve sustainable change in a specific topic area. The Collaborative is structured into a series of learning events where up to 10-12 teams commit to coming together to learn improvement theory and share their work, interspersed with action periods where change ideas are tested in PDSA cycles by teams.
- In our strategy we are seeking to: work on our culture to strengthen ourselves as a learning organisation; build leadership for improvement from board to frontline; run a series of high-profile improvement collaboratives on strategic priorities; focus on the measurement of variation as a key to improvement; build improvement skills at scale.

This strategy requires all service lines, areas within service lines and teams to train staff in improvement and use the model for improvement and collaborative approach to improvement to deliver change.

Enablers for improvement:

- Recognition and Reward: We will build on the existing programme to embed recognition into our improvement schemes.
- Energetic Communities of Practice: bring together networks of like-minded individuals around a shared passion or interest. Working with patients, communities and partners in delivery.
- Design Forums: We will provide the space for ideas generation and testing through our innovation forums where frontline staff come together with improvement advisors and technical experts to rapidly develop and test new solutions.
- Improvement Expertise: We will have experts in improvement science and implementation who will support delivery of key programmes of work and educate staff via formal training programmes, learning opportunities and networks.
- Delivery and scale: We have processes for project delivery and implementation at scale supported by our Transformation and PMO teams

Implementation

The organisational strategy outlined in this document will be reviewed by each service line (PTS, 111 & PES), area (GM, C&M, C&L) and sector (including EOC and UCS). Plans will be developed by each that are aligned to the strategy.

Implementation will be monitored by board sub committees on behalf of the board. Plans will be in place by April 2024 and will be refreshed as part of the annual business planning process.

Improvement Review: We are aware that the programme of work outlined in this strategy is significant. There is a requirement to review our organisational progress with delivering improvement and we will undertake this in year one against the requirements of all NHS Trusts outlines in the NHS delivery and continuous improvement review in April 2023. An integral part of the improvement review will be options and recommendations for how we increase local ownership of the strategy with local improvement plans and associated governance.

'Our health and care systems have navigated the impact of an unprecedented global pandemic, which has taken its toll on our workforce, our communities and the services we deliver.

Current challenges across the NHS in its immediate aftermath have posed the question of how we use learning to effectively and systematically deliver real-time improvements at scale and at pace on our shared priorities, while developing the capacity and capability of the service to improve over time.'

Anne Eden - NHS delivery and continuous improvement review (April 2023)

Capability Building: There is also a requirement to go even further to achieve a critical mass of individuals across the Trust who are conversant with the methodological approach and able to teach and supervise others. We will build on the improvement leadership which currently exists in pockets of the organisation to develop a Quality Improvement Curriculum and Quality Improvement Faculty. It will be the responsibility of the Director of Quality, Chief Nurse, Medical Director and Chief of Improvement to oversee implementation of this strategy and to provide supplemental papers to the Board which describe focused areas of work.

Improvement Programmes: All programmes of work will be resourced with a named lead, an Executive sponsor and a nominated team. The programme lead will be asked to produce a project initiation document (PID) prior to commencement of the work. Importantly, this document will include a measurable goal, a driver diagram, baseline data, a measurement plan, an improvement methodology, risks and reporting processes.

Culture: Improvement will be deeply embedded into the culture of our organisation through our values, organisational development and workforce plans. This isn't simply a plan on a page, it is 'alive' – you will see the values in the environment, the behaviours of staff and most importantly in the operating practices. Recruitment, annual appraisal, and professional development programmes will centre on the need to continuously learn and improve. Perhaps most importantly frontline teams at the sharp end of delivery will have the freedom to act and will be supported by senior leaders and middle managers. Solutions will be actively sought from the frontline and leaders will understand that their role is to support.

Leadership will focus relentlessly on supporting this improvement at the frontline through the introduction of leadership walk rounds concentrating on listening, supporting and barrier busting. Optimising each microsystem and focusing on interaction between them will produce significantly improved system performance. This is a significant mind set shift and we currently have people who are brilliant but firmly 'wedded' to organisational structures and permission, reinforced during the COVID19 pandemic, rather than liberating talent, flattening hierarchy and 'getting on with it'. We will invest time and resources in supporting clinical leaders to work with their local teams to improve care every day.

Partnerships and Support: We will also partner with other providers to test the introduction improvement methodologies such as 'agile' or LEAN improvement developing expertise and leadership capabilities in these essential improvement approaches. By year three we anticipate a full programme of rapid improvement events focusing on systems improvement and partnering with key system partners.

Patient centred partnerships

Person Centred Care means we will provide care that is respectful of, and responsive to individual patient preferences, needs and values, ensuring that patient values guide shared clinical decisions. Put simply ‘no one left out’ and ‘no helplessness in those served or serving’.

Person centred care requires us to see our patients in the context of their own worlds, to ensure that they are listened to, informed, respected, involved in their care, and their needs and wishes are recognised during their healthcare journey. Central to this is the requirement for us to partner with patients in decision making wherever this is possible and make best interest decisions where it is not.

What are we trying to accomplish?

Every service line, directorate and team will be expected to have a quality improvement plan which includes how they will improve patient experience and use patients in the design of service delivery.

Our goals:

Shared decisions: The NHS Long term plan (2019) sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. An expanded primary care offer, urgent care same day emergency services (SDEC), mental health crisis response and 2-hour community response teams are now a feature of health systems and are a focus for the Integrated care system. We respond to millions of calls per year in 111, 999 and patient transport services. Increasingly we are working with patients and system partners to direct patients to the most appropriate service. Central to our service delivery strategy is the requirement to avoid hospital admission where possible and increase the numbers of patients we help at the point of call. Our staff are highly skilled professionals who we will develop even further to ensure we have ‘shared decision making’ at the heart of their practice. This will require the continued development of advanced practice, the expansion of clinical skills and re-calibration of risk. We have begun to develop an approach to shared decision making in NWAS, enabling patients to make decisions based on response times and providing worsening advice. We have begun a shift from a protocol and triage driven care to clinicians being empowered to make decisions on secondary triage and on scene and we now want to build on this further to enable shared decisions with our patients.

Over the next 3 years we will:

- Clearly define what shared decision-making means for our staff and provide clear guidelines to staff.

- Ensure our staff are trained in the assessment of consent, capacity to consent and their duties under the Mental Capacity Act 2005.
- Connect our 111, 999 and PTS systems so that we can capture all interactions with an individual patient into a single patient record.
- Access General Practice records via our electronic patient record (EPR) to allow more insight for clinicians in control and on scene and reduce duplicate reporting by patients and families.
- Progress our digital systems under the national 'what good looks like' framework with a focus on citizen engagement and empowerment through access to information.
- Share our data with other services so that all partners are aware of the care patients have received with us.

Building our community: Our patients have been given a louder voice in the organisation through the establishment of our Patient and Public Panel. The panel, now close to 300 members, is made up of representatives from local communities, interest groups, and voluntary sector, and partner organisations. It offers meaningful opportunities to influence improvements in our emergency, PTS, and 111 services. Our future focus for our patient community is to achieve even greater representation of the communities we serve. The Panel has been designed with a number of levels of involvement, thus appealing to a wide range of patients with varying levels of time to contribute. The variety of involvement levels also allow for multiple channels and approaches within the trust, through which to involve and work with our patients to improve services. Panel members include patients, families and stakeholders, from across the North West, over the age of 16. A patient and public panel charter has been developed to give structure to how we will work with each other, and the commitments given by each party. Panel members also have an annual work plan and recognition event which celebrates their achievements.

Over the next 3 years we will:

- Facilitate annual large-scale community events to listen to and engage with communities across our NWAS footprint.
- Engage with specific groups including patients from mixed ethnic communities and those termed 'vulnerable' and traditionally hard to reach focussing on what to expect from and how to access ambulance services and employment opportunities.

Listening to patients when things go right and wrong:

Friends and family test (FFT) Each month over 1200 patients' complete feedback on our services via the Friends and Family Test (FFT) and significantly more are contacted for feedback by our corporate patient experience team. We meet and listen to the experience of patient and community groups both face to face and virtually at listening events, high footfall community events and in local communities across the Northwest.

Compliments and Complaints: Each month we receive over 500 complaints and compliments. Our commitment to patients is to respond to their complaints as quickly as possible and to provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time.

Patient Stories: Over the last three years we have delivered our commitment to use patient stories to ensure that our board, assurance committees, learning forums and frontline teams are informed about the experience of patients and families using our services. We now have a comprehensive library of stories which are used across the organisation.

Social Media: Each month we have hundreds of interactions with patients across our social media platforms and website. Our communications team collate both positive and negative feedback which is used in combination with our other intelligence to inform our understanding of how our patients are interacting with our services.

The information gleaned from FFT, complaints, compliments, social medial and patient stories is used in our Integrated Performance Report and Annual Patient Experience Report to provide assurance to the Board. It is also reported on a quarterly basis to Board as an integral part of our corporate communications and engagement team dashboard report. Whilst this information is vital to our corporate strategy and decision making, our ability to obtain, collate and use local survey data, for example within service lines or sectors, has remained more limited. We are now starting to provide senior management teams with combined communications and engagement reports highlighting levels of patient satisfaction, themed issues and opportunities for improvement. This provides us with opportunities to learn and improve but we still have more work to do.

Over the next 3 years we will:

- Offer a range of ways for patients to tell us about their experience of using our services including opportunities for real time feedback
- Continue to listen to and share patient stories across our service lines.
- Embed service user feedback into our programme of improvement to better our services for everyone
- Ensure that all complainants have access to a named individual and are contacted regularly to update them on progress.
- Where necessary, support is provided to patients and families involved in serious complaints by trained staff
- Continue to improve processes, including the establishment of a dedicated PALS service, ensuring the right classification of complaints and the delivery of prompt, high quality and compassionate written responses.

Co-design:

During the lifetime of this strategy, we seek to expand our work with specialist groups and local Healthwatch organisations, aligned with our priority foci. We want to focus on designing experiences for patients not simply improving safety or effectiveness. Through a focus on 'experience-based design' we will engage patients from the outset in improvement programmes - putting patient experiences at the heart of the service improvement effort – but not forgetting staff. Our improvement will focus on staff and patients doing the designing together (co-design rather than re-design).

Over the next 3 years we will:

- Continue to develop 'Ambulance Academy' our online resource to engage with young people, their parents and teachers, provide them with educational resources and encourage a career in the ambulance service**.**
- Ensure that patient involvement and community engagement is embedded throughout the organisation, encouraging co design and use of feedback to improve our services.

By 2026, we will see;

Achieve greater representation of the communities we serve in our Public and Patient Panel

Patient and public panel engaged in their local services

Family liaison officers trained and engaged in supporting patients and families

What does it mean for me?

This is what our Quality Strategy means for you:

Patients and service users;

- My individual needs will be considered in my care
- I will be heard when I tell you that things have gone right and wrong
- I will speak up if I feel I have been treated unfairly
- I will be engaged with improving patient safety including sharing my learning
- I will be able to access the information I want or need about my care
- I will work together with partners to redesign services
- My story will be heard and used for learning with my permission

Our staff and volunteers;

- My safety and the safety of my patients will be the priority
- I will be supported to deliver high quality inclusive care
- I will be heard when I speak up and see that action is taken to improve
- I will learn and share my learning, so others benefit
- I will have the resources I need to do my job and improve my job
- I will have access to the data I need to make the right decisions
- I will listen to patients and use that information to improve services
- I will continue to develop clinical skills and professional competency
- I will share my ideas for improvement and adopt the ideas of others to improve staff and patient experience

Our organisation and the partners we work with;

- We will work together to ensure the patient is treated in the right place at the right time every time
- We will implement the requirements of the Patient Safety Incident Response Framework
- We will work together to meet the requirements of the new CQC regulatory framework
- We will work with ICS partners to ensure we have the right information and technology
- We will work to joint quality standards, supporting our partners to improve quality
- We will safely share our information and ensure the right digital pathways are in place to avoid unnecessary A&E attendances.

Glossary

Term	Definition
ACQI	Ambulance Care Quality Indicators
C&L	Cumbria and Lancashire
C&M	Cheshire and Mersey
CQC	Care Quality Commission
EOC	Emergency operations centre
EPR	Electronic Patient Record
FFT	Friends and Family Test
GM	Greater Manchester
GP	General Practice
HR	Human Resources
ICB	Integrated care board
PC	Provider collaboratives
PCN	Primary care networks
PDSA	Plan, do, study, act
PTS	Patient Transport Services
UCS	Urgent Care Service
UEC	Urgent and Emergency Care

References and acknowledgements

NHS delivery and continuous improvement review (April 2023)

The NHS Long term plan (2019)

The NWAS Trust Strategy (2022-2025)

EQUALITY IMPACT & RISK ASSESSMENT
SCREENING TOOL - STAGE 1

Directorate:	**Team:**
QUALITY, INNOVATION AND IMPROVEMENT AND MEDICAL	Quality and medical
Name of programme/project/policy:	**EIA lead/author:**
Quality Strategy	Abigail Harrison
Date of completion:	**Date of review:**
06.07.23	

Brief overview of the proposals (project/programme/policy) being assessed

The Quality strategy is a regulatory requirement and acts as a supporting strategy to the overarhcnig trust strategy with a focus on delivering high quality, inclusive care which is safe, effective and person centred. It also outlines our approach to continous learning and improvement.

GENERAL GUIDANCE

Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *if you have indicated 'yes' for any questions, please briefly explain*
1	**Do the proposals plan to withdraw a service, activity or presence?**	N	
2	**Do the proposals plan to reduce a service, activity or presence?**	N	
3	**Do the proposals plan to introduce or increase a charge for service?**	N	
4	**Do the proposals plan to change to a commissioned service?**	N	The strategy outlines how we will continously improve our service which may at times involve a change in the way we deliver service. Any change though within tht emthdology outlined would use a QI approach which involve evidenced based small scale testing and evalaution before implementation
5	**Do the proposals plan to introduce, review or change a policy, strategy or procedure?**	Y	This is the update of the quality strategy
6	**Do the proposals plan to introduce a new service or activity?**	N	
7	**Are the proposals primarily about improving access to, or delivery of a service?**	Y	As above the focus is on learning and improvement to improve safety, effectoveness of care and ensure service are person centred
8	**Do the proposals affect staff, or levels of training for those who will be delivering the service?**	Y	*Detail which staff groups are affected* All staff are expected to have basic levels of improvement training
9	**Do the proposals affect service users?**	Y	Service users will be asked to work with us to co design quality imrpoevemnt initiative and they should be impacted by an improvement in services
10	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*

	EQUALITY RISK	Enter Y or N	Rationale
11	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	Significant engagement was undertaken and feedback was docuemented
12	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	All relevent specialist teams have been involved in the development of the strategy, for example our patient safety specialist
13	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	The strategy support rathe than contravene this
14	**Do you plan to publish your information?** Include any "Decision Reports"	Y	The Quality Strategy will be published
15	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	The focus of the strategy is on reducing negative impacts to protected group
16	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	Multiple stakeholder groups have been engaged including clinica, TUs, the patient and public panel and operations
17	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	As above

IMPACT		**There will be some impact. You should undertake a Stage 2 assessment**
RISK		**There should be little risk involved**

	HUMAN RIGHTS IMPACT	Rationale
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**	No - if anything the strategy supports euqality and the rights of our patients

Human Rights:

A2 Right to Life
A3 Prohibition of torture, inhuman or degrading treatment
A4 Prohibition of slavery and forced labour
A5 Right to liberty and security
A6 Right to a fair trial
A7 No punishment without law
A8 Right to respect for private and family life
A9 Freedom of thought, conscience and religion
A10 Freedom of expression
A11 Freedom of assembly and association
A14 Prohibition of discrimination
P1A2 Right to education

Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***	As a full assessment has already been undertaken for the ovearching trust strategy we await a steer on whether this is required

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team

Reviewed by:		**Date**	

North West Ambulance Service NHS Trust

People Strategy

2023 - 2026

Contents

Introduction

Our Trust Strategy 2022-2025 sets our vision for the future;

To provide the right care, at the right time, at the right place, every time.

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. This People Strategy is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

Our People

Since our last strategy, our people tell us that we are doing better at supporting them whether this is through health and wellbeing, reasonable adjustments, or appraisals. This support extends to our planning and recruitment which means in the main our vacancy gaps and turnover are low compared with the wider NHS.

Our people consistently tell us that their immediate line managers are improving every year in the support they offer to their teams. Our learners, new starters and those completing mandatory training tell us that the education they receive and their support in the workplace is high quality. Our people are proud of the care they are supported to give to patients.

"Our People are our greatest asset. By looking after our People and improving their experience of work, we directly improve the care of our patients. It is only by fostering an inclusive and compassionate culture that allows people to bring their whole self to work, that we can fully develop our talent and release the potential of our people for the benefit of patients."

Lisa Ward, Director of People

However, this strategy is designed to look forward and to focus on the areas we need to improve. Our People tell us that we don't always get everything right.

Our staff survey results tell us that our people experience negative behaviours in work from patients, colleagues and managers more frequently than they should. It also tells us that several staff lack confidence to speak up about these experiences. Our people also tell us they lack confidence in the fairness of some of our processes and are frustrated about how support is difficult to navigate.

Our workforce measures, such as attendance, recruitment, and retention, also tell a story about where we need to focus our priorities. They tell us that we need to do more to support the mental and physical wellbeing of our staff. That we have great talent that we lose from our organisation that we need to work harder to retain.

Our staff networks provide a safe environment for people to share their lived experiences, but they also challenge us to do more to create an inclusive environment to improve experiences for all our people.

The Culture and Organisation Review carried out in 2021 helped us to understand what was important to our people in their experience of work and where to focus improvement to have the greatest impact. This work continues into this strategy.

Our People Strategy in context

The People Strategy is a supporting strategy which underpins the wider Trust strategy. It aims to develop the culture and leadership environment to facilitate the delivery of the overall organisational goals. In developing the priorities within this strategy, alignment is made with both regional and national policy outlined below;

National People Context

The seven pillars of the NHS People Promise sets out ambitions for what people working in the NHS will say about their experience of work in the future. These ambitions alongside the NWAS values underpin the NWAS People Strategy.

The People Promise is supported with national programmes of work which aim to provide a framework for improvement in individual Trusts. Examples include:

- Management and leadership – aiming to provide standardised approaches to leadership development, staff induction and appraisal based on the recommendations of the Messenger Review
- NHS Equality, Diversity and Inclusion Improvement Plan

This works informs the NWAS People Strategy.

The HROD Futures Programme sets out a vision of how Human Resources and Organisational Development services will be delivered by 2030 focussing on the 8 key themes. These aim to transform the way People Services are delivered with a focus on areas such as developing the People Profession, improved use of digital and improving productivity and collaboration.

Other National Drivers

The Urgent and Emergency Care Recovery Plan seeks to increase front line capacity and improve Category 2 Ambulance Response times through additional capacity and improvements to health and wellbeing. This impacts strongly on the first year of the People Strategy.

Following the publication of the recent 'Listening to Workers' report into Ambulance Services, the Trust will be implementing a range of measures to improve culture, safety and Speaking Up in the Sector.

Association of Ambulance Chief Executives

A range of workstreams specific to the Ambulance Sector have been developed between the Association of Ambulance Chief Executives (AACE) and NHS England with People Directors leading key projects linked to Recruitment & Retention, Culture & Leadership, Digital, Health, Wellbeing & Suicide prevention.

Our commitment to equality, diversity and inclusion

To create an inclusive culture, we must develop an environment where diversity is truly valued. If we are to deliver our vision we must recognise that discrimination exists in society, in our workplaces and in healthcare, and take proactive steps to address inequalities. Our commitment to equality and inclusion feeds into everything we do and is a responsibility shared by everyone at NWAS.

Our commitment to inclusion is reflected through all our supporting strategies but it is fundamental to the People Strategy and the environment we want to create for our People.

The existing high impact priorities related to our people and committed to by the Trust Board are embedded in the People Strategy.

Making sure our current employees and future talent have fair job and career progression opportunities which will improve diversity and representation at all levels of the organisation.

- Targeting an improvement in representation from ethnic minority communities to 8% of the workforce through better attraction, fairer recruitment and positive action
- Delivering equitable representation at all management levels through a focus on fair career progression
- Improving the gender pay gap and other measures of staff experience for protected groups

Educating and developing our leaders and people to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.

- Developing our leaders to being able to lead inclusively
- Continuing to support our staff networks to give voice to staff experience and to challenge how we are doing
- Developing talent management programmes for under-represented groups.
- Improving respect and civility in the workforce

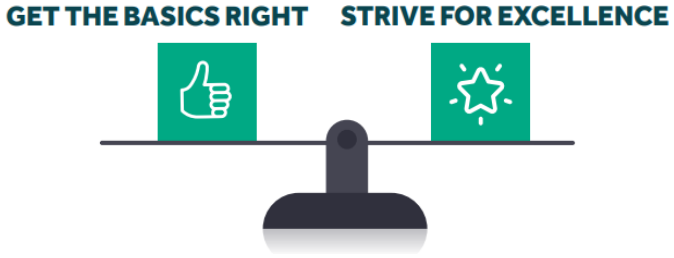
We have already commissioned a review of the inclusiveness of our recruitment and progression processes by the Employers Network for Equality and Inclusion (ENEI) to help us in focusing on the actions which will have greatest impact.

This strategy is driven by the overall aims set out within Trust Strategy and is primarily aligned to the aim to be a “brilliant place to work for all” by;

- Looking after our People
- Investing in our People
- Leading our People Compassionately

The priorities within our People Strategy are also driven by our People and what they tell us about their experience of working for NWAS. These are the most important voices in shaping what we want to achieve over the next 3 years.

Our strategy is ambitious, and we must balance getting the basics right with striving for excellence. The priorities outlined in this strategy have elements of both “basics” and “excellence” which will be further detailed as we turn our strategy in to action.



The People Strategy plan on a page

The People Strategy is a supporting strategy which underpins the wider, Trust strategy and contributes to achieving our vision; **To deliver the right care, at the right time, in the right place; every time.**

The People Strategy outlines what we will prioritise over the next three years to become a brilliant place to work.

The people strategy primarily focusses on this aim from the Trust strategy…	…and will deliver against the following measures by 2026	…through a focus on the following priorities over the next 3 years	…which will be delivered by
Be a brilliant place to work for all We will create an environment where our people feel happy and safe, have access to equal opportunities and are supported to be at their best.	**Improved retention rates**	**Our people are safe, happy and healthy.**	• Proactive support for people to be healthy and in work • Improve violence prevention • Improve ways of working including meal breaks, relief arrangements, end of shift, etc. • Reduced stigma and improved support for mental health issues in our workforce • Develop innovative approaches to flexible working
	Improved attendance	**Our people approach is flexible, responsive and accessible.**	• Simplify HR processes ensuring consistent application and reduced errors • Induction processes which welcome staff, embed values and create a sense of belonging • Effective use of technology to improve experience • Listening to staff and manager experiences about improving services • Policies and procedures reflect the needs of the changing workforce and society.
	Improve staff views of career progression **Improvement in key staff survey responses** **Improved diversity indicators and representation**	**Our people are diverse, valued and respected.**	• Improve representation across the workforce at all levels • Staff work in an inclusive environment where they feel sexually safe and free from discrimination • Embedding a fair and just learning culture • Encouraging speaking up and developing the ways we engage, listen, respect and value staff • Being a clearly anti-racist organisation
		Our leadership is compassionate.	• Deliver a core leadership and essential management skills programme to all managers to enable consistent and fair leadership • Commanders are recruited and developed in line with EPRR requirements • Develop a coaching community to support and improve leadership/management practices • Developing managers to collaborate confidently and effectively across internal and external systems
	Improvement in quality of processes	**Our people reach their potential.**	• Fair and transparent promotion and progression with visible and accessible development pathways • Everyone has the digital capability required for role • Learner feedback tells us we deliver high quality training supporting induction, preceptorship, CPD and annual training needs • Learning environments are fit for purpose for a modern and progressive ambulance trust • Talent management and succession planning

Our people are safe, happy and healthy

Life and work can have an emotional and physical impact on our people. The wellbeing of our staff is our priority. We want to create a psychologically safe environment where we get the basics right and where staff are confident, they will get support when they need it. We will achieve this by:

- Proactive support for people to be healthy and in work through improving Wellbeing and Occupational Health provision, enabling self-help and developing managers to focus on prevention.
- Improving violence reduction through collaborative work with partners, working with staff on preventative measures, a strong line on prosecution, improved support and targeted work on sexual safety and hate crime.
- Improve ways of working including meal breaks, relief arrangements, end of shift times by listening to staff, undertaking policy reviews, and implementing best practice.
- Reducing stigma and improved support for mental health issues in our workforce through proactive wellbeing conversations, suicide prevention, embedding the Mental Health Pledge and ensuring Managers are trained and competent to support this work.
- Developing innovative approaches to flexible working by taking best practice nationally and across the Ambulance Sector to improve options for staff.

By 2026, we aim to:

Improve staff survey results on H&WB

Improve meal break and end of shift compliance

Improve retention through better flexible options

Reduce sickness absence

Improve results on NWAS being a great place to work

Have fewer incidents of violence and aggression

Enhance line manager support through training around mental health support at work

Our people approach is flexible, responsive and accessible

Feedback from our people is that the way we deliver people services is not always easy to access. The Trust will learn from staff and management experiences to ensure our people approach is responsive and able to adapt to changing needs through better use of technology. We will achieve this by:

- Simplifying HR processes ensuring consistent application and reduced errors through end-to-end process reviews and the introduction of digital solutions such as interfaces between rostering and payroll systems. Delivering reductions in payroll errors and improved transactional processes.
- Ensuring induction processes welcome staff, embed values and create a sense of belonging through developing induction competencies for all staff, the design of induction pathways capturing staff groups and the roll out of Civility Saves Lives.
- Effective use of technology to improve experience through a Workforce Digital Roadmap ensuring that solutions add value and reduce burden.
- Listening to staff and manager experiences about improving our people services and proactively seeking feedback on aspects of our work.
- Ensuring Policies and Procedures are simplified, easily accessible and reflect the needs of the changing workforce and society focussing on social and economic issues around cost of living and social values.

By 2026, we aim to:

Have transformed our end to end pay process

Simplify policies and procedures to ensure greater access

Reduce under and overpayments

Measuring our services through metrics and stakeholder feedback

Increased productivity through greater use of digital solutions

Improve staff sense of belonging by improving the recruitment and induction processes

Our people are diverse, valued and respected

An inclusive working environment where everyone feels safe, which is kind and respectful and where we care for each other as we care for our patients, is a core and basic requirement for us all. We want to enable people to speak up, to call out inappropriate behaviour and where diversity is celebrated. We will achieve this by:

- Improving representation across the workforce at all levels through Positive Action and implementing the recommendations from the ENEI review of recruitment processes.
- Working proactively to improve the inclusivity of the working environment. We will work proactively on matters of sexual safety with policy reviews, improved complaint handling, engagement and training to ensure that staff work in an environment where they feel sexually safe and free from discrimination. We will deliver programmes to develop cultural competence of the organisation through embedding health inequality issues through our clinical and induction training, and supporting a programme of development interventions in conjunction with our networks.
- Embedding a fair and just learning culture through the implementation of a revised Disciplinary Policy with training for Managers.
- Develop new ways to engage with staff ensuring that we listen, respect and value everyone's contribution. We will enhance support for speaking up and ensure all staff have a regular appraisal conversation that recognises their value and contribution, supports their aspirations for development and embeds the NWAS values
- We will ensure that we are a clearly anti-racist organisation by taking visible action to address racism, taking action to identify and remove barriers, building allyship and using reverse mentoring to develop understanding.

By 2026, we aim to:

Improve WRES / WDES indicators.

Fully embedded the new Disciplinary Procedures – Increasing organisational learning, reducing case time.

Reduce the number of staff experiencing inappropriate sexual behaviour.

Improved diversity of representation at all levels.

Increase the number of staff feeling safe to report concerns.

Improved internal and staff survey measures on appraisal quality.

Complete Beyond Bias/Civility Saves Lives roll out.

Have embedded a Reverse Mentoring Programme which adds value.

Our leadership is compassionate

Our people have told us that their line manager has the single biggest influence on their experience of work so it is critical that we enable our leaders to deliver support to our people compassionately, fairly and effectively. We will achieve this by:

- Delivery of a core leadership and essential management skills programme to all managers through the Making a Difference programme and the development and design of essential learning for Leaders.
- Ensuring that Commanders are recruited and developed in line with national EPPR requirements and learning the lessons from the Manchester Arena Enquiry.
- Developing a coaching community to support and improve leadership/management practices on a day to day basis in their support of staff, to enable development and to provide constructive support and challenge.
- Developing managers to collaborate confidently and effectively across internal and external systems by providing them with the skills to support effective collaboration and the opportunities to engage in system wide development.

By 2026, we aim to:

Increased numbers of staff accessing coaching.

Positive feedback from stakeholders.

Be delivering a full range of essential learning for managers from induction to full role competency.

Full compliance with Making a Difference programme.

Embedded commander recruitment processes & maintenance of competence.

Improved staff survey results in relation to immediate line managers.

Our people reach their full potential

We have amazing talent amongst our people but we need to identify and nurture that talent more effectively. When our people join us we want them to be able to see their future career and be confident of their route to realise their potential, supported by high quality learning and Continuing Professional Development to help them achieve their goals. We will achieve this by:

- Ensuring our promotion and progression processes are fair and transparent with visible career pathways for our core roles supported by clear development opportunities.
- Everyone having the digital capability required for role through the design and delivery of core skills required for all roles, supporting technological changes and offering flexible support options to build confidence and capability.
- Developing the way in which we listen to our learners and use their feedback to ensure high quality training supporting induction, preceptorship, CPD and annual training needs are met.
- Learning environments are fit for purpose for a modern and progressive ambulance trust through a review of current facilities and that new opportunities are explored. Embracing the opportunities presented by technology to enhance learning.
- Embedding a fair process to identify and develop our talent and succession planning for senior and aspiring clinical, operational and educational leaders. Ensuring transparent access, consistent development support, positive action and collaborative working to develop our talent.

By 2026, we aim to:

Have a clear framework and development

Have embedded a pre-apprenticeship route for PTS and contact centre staff.

Implemented the ENEI Recruitment audit

Have clear and transparent Career Pathways for all roles across the organisation.

Improved learner feedback.

Improved staff survey scores on fairness of career progression.

Have a talent and succession plan.

Improved retention rates.

What does this mean for me?

Upon delivery of our People Strategy, we will have improved many elements of the lifecycle of our people as they join and develop during their time with us. We will have also made improvements in the diversity of our workforce and will have developed cultural competence to make sure our diverse workforce works in a way which is inclusive of all. This is what the delivery of our People Strategy will mean for you:

What does this mean for Staff?

- I will have a warm welcome to the organisation and feel a sense of belonging throughout my career with NWAS
- I will work as part of a diverse team
- I will have access to more and better options to help support me to be healthy at work
- I will have more options to work flexibly.
- I will feel proud to work at NWAS and will recommend it to family and friends as an employer and provider of care

What does this mean for Managers?

- I will be confident in supporting all staff at any point in their time at NWAS.
- I will have a better understanding and more options to help staff and teams develop.
- I will have refreshed leadership training and will feel confident to embed Just & Learning Culture within my Team.
- I will have fewer members of my team needing help with everyday “basics” such as pay discrepancies.

What does this mean for NWAS?

- More people will be happy and feel supported leading to a positive and productive work environment.
- The organisational culture will become more accepting and understanding of individual differences and staff and patients will have better experiences as a result.
- The talented individuals who work for NWAS will develop, grow and succeed.

Glossary

HROD	Human Recourses Organisational Development
NHS People Promise	The seven pillars of the NHS People Promise sets out ambitions for what people working in the NHS will say about their experience of work in the future.
The HROD Futures Programme	A range of improvement projects across the People Profession the NHS.
Turnover (people or staff)	Number of staff leavers calculated over a rolling 12 month period.
Vacancy gap	The number of staff in post against the funded establishment.
WRES	Workplace Race Equality Scheme
WDES	Workplace Disability Equality Scheme

References and acknowledgements

Trust Strategy

NHS People Plan

NHS People Promise

Future of NHS Human Resources and Organisational Development report

Urgent and Emergency Care Recovery Plan

Messenger Review

Organisation and Culture report – Zeal solutions

Listening to Workers Report

NHS equality, diversity and inclusion improvement plan

Employers Network for Equality and Inclusion review of recruitment processes

EQUALITY IMPACT & RISK ASSESSMENT
SCREENING TOOL - STAGE 1

Directorate:	Team:
People	
Name of programme/project/policy:	**EIA lead/author:**
People Strategy	Lorraine McConnell
Date of completion:	**Date of review:**
16-Jun-23	

Brief overview of the proposals (project/programme/policy) being assessed

Following the lauch of the Trust Stategy, supporting Strategies have been developed to underpin delivery of the overall Trust objectives.

GENERAL GUIDANCE

Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *if you have indicated 'yes' for any questions, please briefly explain*
1	**Do the proposals plan to withdraw a service, activity or presence?**	N	
2	**Do the proposals plan to reduce a service, activity or presence?**	N	
3	**Do the proposals plan to introduce or increase a charge for service?**	N	
4	**Do the proposals plan to change to a commissioned service?**	N	
5	**Do the proposals plan to introduce, review or change a policy, strategy or procedure?**	Y	There will be a review of a number of current policies to ensure that they are more accessible and transparent. These will include a review of the Maternity Policy, the Dignity at Work Policy (with regards to sexual safety matters) and also recruitment and progression policies to ensure greater access
6	**Do the proposals plan to introduce a new service or activity?**	N	
7	**Are the proposals primarily about improving access to, or delivery of a service?**	Y	Improvements in current policicies such as Maternity, Recruitment and Career progression.
8	**Do the proposals affect staff, or levels of training for those who will be delivering the service?**	Y	*The strategy is focussed on increasing capacity and capability of Leaders at all levels across the organisation in*
9	**Do the proposals affect service users?**	N	
10	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*
	EQUALITY RISK	**Enter Y or N**	**Rationale**
11	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	WRES / WDES indicators, staff survey results
12	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	
13	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	none of the proposals contrvene the Duty
14	**Do you plan to publish your information?** Include any "Decision Reports"	Y	
15	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	thruogh effective use of the staff networks
16	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	Networks, Trade Unions, Managers
17	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	As above

IMPACT		**There will be some impact. You should undertake a Stage 2 assessment**
RISK		**There should be little risk involved**

HUMAN RIGHTS IMPACT		Rationale
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**	

Human Rights:

A2 Right to Life
A3 Prohibition of torture, inhuman or degrading treatment
A4 Prohibition of slavery and forced labour
A5 Right to liberty and security
A6 Right to a fair trial
A7 No punishment without law
A8 Right to respect for private and family life
A9 Freedom of thought, conscience and religion
A10 Freedom of expression
A11 Freedom of assembly and association
A14 Prohibition of discrimination
P1A2 Right to education

Are you intending on proceeding to complete a Stage 2 EIA?
If no, please provide a rationale

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team

Reviewed by:		Date	

North West Ambulance Service NHS Trust

Service Development Strategy

2023-2026

Contents

Contents

The Service Development Strategy

Our Trust Strategy sets our vision for the future; **To provide the right care, at the right time, at the right place, every time.**

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. This Service Development Strategy is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

Our Service Development Strategy aligns to our organisational aim to “work together to shape a better future” and provides a framework for developing our operational service lines to make sure we deliver operational performance across all service lines in a sustainable way. These service lines include; NHS 111, 999 Emergency Operations Centres (EOC), our Paramedic Emergency Service (PES), our Patient Transport Service (PTS) and our teams of dedicated Community First Responders (CFRs) and Volunteer Care Service drivers (VCS) who volunteer their time to provide vital support to the delivery of our services.

Our Service Development Strategy replaces, and builds upon, our previous Urgent and Emergency Care (UEC) Strategy, developed in 2019. Some of the pressures faced by NWAS, the Ambulance sector and the NHS as a system at the time of writing the UEC Strategy, still present challenges now. As an example, over recent years we have reduced the number of patients we convey to emergency departments (EDs) and more people have been treated in a more appropriate care setting which is closer to home. As we continue to face system-wide challenges, the need to reduce avoidable emergency admissions to hospital to reduce pressure on the NHS system remains an important area of focus. Building on the work completed over recent years to establish relationships with partners and to empower operational staff and clinicians we will continue to develop an operational model that matches patient needs with the most appropriate NWAS resource.

Furthermore, our focus on integration to better join up our service lines will remain. Across our 111 contact centre, 999 Emergency EOC and PTS control rooms, we have already started to integrate our leadership and management structures to make sure that our service lines work closer together. We have also begun simplifying urgent and emergency access for patients, by offering a single triage process across 111 & 999. Working closer together provides a number of benefits for staff in terms of career flexibility and also means that patients and service users are able to access their health needs in a straight-forward way, when they need us most. Integration is an important area of focus to improve patient flow through the health care system and to make sure patients receive the right care at the right time, in the right place, every time. Moving forwards, we must consider the role each service line has in providing integrated care and services.

In addition, there are complex challenges and opportunities that NWAS needs to act on to make sure we sustainably deliver operational performance across all service lines;

A large portion of our emergency 999 calls are categorised as Category 2 (Cat 2) calls. Cat 2 calls are for patients who, after answering a set of questions known as a triage, require emergency treatment but their condition is not time critical. In line with nationally set standards, we aim to respond to patients categorised as Cat 2 in an average of 18 minutes. Lots of patients who have been categorised as requiring a Cat 2 response will need to be seen by a clinician and some patients will need transporting to an ED for further treatment. However, there are some patients who need emergency or urgent care, but this may not need an emergency ambulance response or transport to an ED. As Cat 2 patients form such a large portion of NWAS' 999 demand, if we can quickly identify those patients who do not need an emergency ambulance response, we can make sure the most appropriate response is sent to the right patient every time. By working in this way, we will be able to utilise our overall capacity more effectively meaning we will be able to consistently meet the needs of patients even in high demand.

Our patient transport service (PTS) provides high quality transport for patients who travel to and from hospital receiving vital, sometimes life-saving treatment. The PTS plays a vital role in supporting patient flow through the health care system by making sure patients present to their scheduled appointments in good time as well as making sure patients are safely and promptly discharged following treatment back to their homes or other services in the community. NWAS has good relationships within communities across the northwest as we operate across five integrated care systems (ICSs). As we work closely with our partners across the ICSs, our PTS is perfectly positioned to support system priorities which are targeted at vulnerable members of communities, such as health promotion and prevention initiatives, safeguarding and public health messaging.

We are committed to being a learning organisation and have several processes in place to ensure we learn from incidents and improve the services we provide for patients. In recent years we have undertaken a number of internal and external enquires to learn how we respond to major and critical incidents, the largest of the enquiries being the Manchester Arena Inquiry. We have embedded the learning from this inquiry but will continue to use learning to improve the services we provide throughout the lifecycle of this strategy.

The Trust needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. This could be anything from extreme weather conditions to an outbreak of an infectious disease or major transport accident. In accordance with the Civil Contingencies Act 2004 and the Health and Care Act 2022 all NHS organisations have a duty to demonstrate that they can deal with such incidents while maintaining services. Since its establishment, NWAS has dealt with, and has been involved in, a number of incidents and emergencies and we must take all of the learning from these events and make sure that we continuously learn and improve to make sure we are always ready and prepared. Our approach to Emergency Preparedness, Resilience and Response (EPRR) is woven through everything we do.

NWAS is committed to creating an inclusive culture where diversity is truly valued. This Service Development Strategy places increased emphasis on alignment with our organisational equality, diversity and inclusion (EDI) priorities. We are strengthening our commitment to ensuring EDI runs through everything we do in all service lines:

- Priority 1: We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
- Priority 2: We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.
- Priority 3: We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities

To work together to shape a better future we must prioritise the development of our delivery model to make sure that we work in a joined-up way across our operational service lines. To make sure we sustainably deliver operational excellence we need to develop services that are fit for now and the future, are high quality and safe, and also affordable. The Quality Strategy will consider how we develop services that are high quality and safe. The Sustainability Strategy will focus on developing services that are affordable. This Service Development Strategy will focus on developing services that are fit for now and the future by ensuring all service lines sustainably meet their performance requirements. This Service Development Strategy outlines the areas of development we will focus on between 2023 and 2026 under the headers of; Improving our operating model, Our people development, Our relationships with our partners, with resilience woven through each of those areas of focus.

Our strategy is ambitious, and we must balance getting the basics right with striving for excellence. The priorities outlined in this strategy have elements of both “basics” and “excellence” which will be further detailed as we turn our strategy in to action.

The Service Development Strategy on a page

The Service Development Strategy is a supporting strategy which underpins the wider Trust strategy and provides a framework for developing our operational service lines to make sure we deliver operational performance across all service lines in a sustainable way. The Service Development Strategy contributes to the delivery of our vision; To deliver the right care, at the right time, in the right place; every time.

The service development strategy primarily focusses on this aim in the Trust Strategy…	**…and will deliver against the following measures by 2026:**	**To achieve these measures, the service development strategy outlines the following three-year priorities:**	**Which will be delivered by…**
Work together to shape a better future. We will work together to improve the services we provide. We will work with our partners and the public to design solutions which improve access, outcomes, and experience for everyone.	Sustainable delivery our KPIs across all service lines, within agreed financial budgets.	**Improve our Delivery Model**	• Developing an integrated service delivery mode • Making sure that we are constantly considering the EDI needs of patients regarding access to, and delivery of, our services. • Integrate our contact centre estate, systems and workforce • Utilising data to model demand and identify resource requirements for 111, PES and PTS • Improving links between our service delivery and clinical leadership models to make sure there is consistent clinical decision-making • Making sure we are well prepared to respond to any adverse incident
	We will provide equitable access to our service lines for all our patients and service users.	**People Development**	• Developing a leadership structure that enhances our operational model across contact centres, 999 and PTS. • Developing a workforce plan with the right number of people with the right skills, in the right place with the right resources to deliver high quality services to patients. • Ensuring our development model enables pipeline progression and is considerate of our EDI priorities. • succession planning and opportunities to work more flexibly. • Continuously learning and improving from incidents
	We will improve our ability to plan for, and respond to, surges in demand and incidents.	**Collaborative Relationships**	• Developing and delivering shared objectives with key partners within ICS structures that relate to organisational and system pressures, challenges, and opportunities. • Strengthen links between our service and the communities we serve through community engagement, engaging with the Voluntary, Community, Social & Faith Enterprise (VCSFE) sector • Strengthening relationships with our blue light partners to effectively manage major and / or critical incidents in accordance with EPRR requirements

Improve our delivery model

We will improve our delivery model to make sure we are more flexible, more resilient and ensures we are constantly considering the needs of patients regarding our EDI ambitions set out across all the supporting strategies, specifically regarding improving access to, and delivery of, our services. We will focus on developing a single service delivery model which will include the following:

- **Integrated service lines**

Becoming integrated means that where appropriate we will work together across the different operational service lines to support each other and our patients. We have already started to integrate; in 2022, we changed our 999 triage system to the same one used in 111. This is the first step in creating an integrated contact centre, in which we will use our clinical and call taking workforce flexibly to effectively manage peaks in demand. Other benefits of integrating our contact centres include streamlining patient care and providing greater consistency of care. We believe that we will be able to provide greater benefits to patients, our staff, and the wider system if we integrate other elements of our delivery model. Throughout the lifecycle of this strategy, we will consider further opportunities for integration between PES, integrated contact centres and PTS that will provide benefits to patients, workforce and the wider system.

- **A well-resourced model that consistently provides effective care to patients**

Our delivery model considers what resources we need, where to position those resources and how to allocate those resources to patients to ensure they receive the most appropriate care. Where an NWAS resource isn't required, we will ensure patients are able to access the most appropriate care closer to home wherever possible. Therefore, when designing our model, we will use data intelligently to understand our demand on each service line. This intelligence will inform new ways of working together to better respond to peaks and troughs in demand, to align our resources more effectively and to ensure we are able to consistently provide excellent care for patients.

- **A delivery model that is well integrated into the wider healthcare system**

At the same time as bringing together the component elements of NWAS delivery, both technically and operationally, we will be working with our partners across the health and social care system to further embed the work of NWAS into their local operational delivery and strategic planning. The challenges of recruiting and retaining our workforce are not unique to NWAS, pointing us further and further in the direction of a rotational workforce, with transferable skills, and a crossover of roles between a number of healthcare professionals with their own portfolio careers.

We will also use our data, alongside that of our system partners, to contribute to a wider population health approach to care planning. We recognise that many technical systems are not well connected across our region. We will work to ensure that demand, clinical quality, and

contribution to the whole system response to urgent and emergency care and planned care is well understood to shape best use of NHS resources.

- **A delivery model which is well prepared to respond to any adverse incident**

We will continue to enhance our Hazardous Area Response Team (HART) and specialist response units to ensure we are able to respond effectively to adverse incidents. Alongside this we will ensure that we continue to invest in training our staff and running critical incident scenarios, so that all staff respond effectively to an incident and are able to provide effective care to patients. There will be a specific focus on commander training to ensure commanders are compliant with national standards. Finally, the organisation will focus on business continuity to ensure we are able to continue to provide effective care to all our patients, even during a critical incident.

Throughout the development of our delivery model, we must make sure that we are constantly considering the needs of our patients. This is linked to the Equality, Diversity, and Inclusion ambitions within NWAS' other supporting strategies. We must make sure that there is equity of access for people who may experience challenges in accessing the care they need.

By 2026, we will:

Maintain sustained improvement in performance across contact centres, PES and PTS.

Reduce avoidable A&E admissions by providing enhanced clinical assessment of patients to ensure that all patients accessing care through 999 and NHS 111 services are treated in the most appropriate environment.

Understand where we see variation in access, experience, and outcomes for different population groups across NWAS services.

Improve our ability to respond to surges in demand and major or critical incidents.

People development

Our people are our greatest asset and play a vital role in delivering operational excellence. Our people strategy outlines priorities which aim to make sure all our people are safe, happy and health whilst at work as well as focussing on developing compassionate leaders. The People Strategy look at the organisation-wide approach to creating an environment where our people feel happy and safe, including our plans to reduce sickness absence. This Service Development Strategy focusses specifically on the development of our clinical and operational workforce to make sure we have the right people with the right skills in the right place at the right time. Our clinical and operational workforce refers to all the people who are employed by NWAS to deliver our front-line services as paid employees or as volunteers. Through the lifetime of this strategy, we will prioritise the following;

- **Developing a workforce with the right number of people with the right skills, in the right place with the right resources to deliver high quality services to patients.**

We will work to build operational expertise and clinical excellence by increasing our workforce in critical areas and enhancing our clinical and operational leadership 24/7/365. We will make sure that the appropriate mix of skilled clinical, operational and administrative staff are available to respond to patients when they need us most.

- **Use opportunities within the integrated model to develop new and innovative ways of working**

As we develop our delivery model and look at new ways of working, we will take the opportunity this presents to create opportunities to work more flexibly and will consider opportunities to maximise the use of volunteers. We will improve career progression opportunities for all and make it easier to progress and develop between different service lines as well as providing more flexible career options, allowing our highly skilled and dedicated people to develop their career for as long as is right for them.

- **Developing a leadership structure that complements our integrated delivery model.**

As our service lines have already started working more closely together, we have already undertaken lots of work to align our leadership structure. Our contact centres will function much more closely as we are using a common telephony platform and a common triage platform. We are also currently reviewing the options for PTS management structures to ensure they support the aims of integrated delivery and provide the optimal model for staff and patients.

- **Learning from incidents**

We commit to being a learning organisation and recognise learning after a critical incident is vital. We will continue to embed organisational learning as part of our debrief process and ensure this learning is actioned so that we can make improvements for the future. We will share our learning with key partners across the Northwest and nationally, working with them to overcome challenges and ensure the health care system is resilient.

By 2026, we will:

Complete the alignment of our leadership structure to complement our integrated delivery model.

Increase in the number of skilled clinicians working with us.

Improve staff retention by providing more flexible career opportunities across our operational service lines.

Our collaborative relationships

Integrated Care Systems (ICSs) were introduced in July 2022 via the Health and Care Act 2022. The intention of ICSs is to bring together organisations to redesign care and improve population health, creating shared leadership and action (NHS England, 2021). Integrated care focuses on providing people with the support they need, joined up across local authorities, the NHS, and other partners within a wider health and social care system(s). Because we operate across multiple ICSs, it is important that we focus on building strong relationships with our partners and the communities we serve. We have already appointed three new area directors who are each aligned to the ICSs within their areas who will work to represent NWAS at a system level. As we focus on developing our collaborative relationships, we will prioritise:

- **Developing and delivering shared objectives with key partners within ICS structures that relate to organisational and system pressures, challenges and opportunities.**

All of our service lines operate as part of the wider health care system; therefore, each service line will regularly interact with our system partners. We will work with our system partners to understand where challenges occur in the system, and we will develop joint plans to make processes as smooth as possible. Two key examples of challenges we are currently facing are hospital handover from our PES crews into hospitals, and discharge from hospitals to our PTS crews. Throughout the lifecycle of this strategy, we will work with partners to identify and resolve system wide challenges such as these which impact our operational model. There are also opportunities to work with partners to make the wider healthcare system more effective. We will continue to work with our partners to share information, resources and learning to make the Northwest healthcare system as effective as possible.

- **Develop new relationships with the Voluntary, Community, Social & Faith Enterprise (VCSFE) sector and build on existing relationships with the Department of Health & Social Care (DHSC) and Association of Ambulance Chief Executives (AACE) to maximise opportunities for the use of volunteers.**

Volunteers can help to strengthen links between our service and the communities we serve because they are part of those communities e.g., our PTS car drivers already support us in sharing preventive health messaging and our CFRs can enhance the response we can provide in those communities. Our Community Engagement Teams are well placed to identify even further opportunities to maximise the use of volunteers to help:

- Improve patient experience and outcomes by enhancing our overall service offer,
- better staff experience and wellbeing by reducing pressure on staff and service,
- improve volunteer wellbeing alongside the acquisition of skills, experience and confidence and
- Improving the overall resilience of the community

- **Strengthening relationships with our blue light partners to effectively manage major and / or critical incidents in accordance with EPRR requirements**

As well as day to day interactions with system partners Our PES service also has a key role in responding to major incidents alongside other blue light services in the Northwest. As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS-funded services must show they can effectively respond to major, critical, and business continuity incidents while maintaining services to provide to patients. As part of its statutory annual assurance on its readiness to respond the trust will ensure it is engaged in exercising and scenario testing with its partners across the northwest local resilience forums.

By 2026, we will:

Develop shared objectives with our commissioning and provider partners.

Improve hospital handover by working with system partners to streamline the hospital handover processes.

Implement 'first response' within our communities to make those communities more resilient.

Enhance relationships with our blue light partners to effectively manage critical and / or major incidents.

Reduce aborted PTS journeys by working with system partners to streamline discharge processes.

What does it mean for me?

Upon delivery of the Service Development Strategy, we will have developed our operational delivery model to be more integrated, we will also have developed our clinical, operational and administrative workforce and the progression opportunities available to them as well as developing our relationships with our partners to work in a more joined up way. This is what that will mean for you:

Our patients and service users

- We will have the right resources in place to respond to your needs no matter when and where you need us.
- We will be able to provide enhanced care to patients with urgent care needs that will allow them to be treated in the homely setting, rather than always be transported to hospital, allowing more people to be provided with the most appropriate care closer to home.
- We will have advanced clinicians who will be able to respond to the sickest patients, providing interventions to stabilise them before transportation to hospital.
- Where you need to be transported to hospital, we will have the right resource, with the right level of clinical care, available at the right time, to do this in a timely manner.

Our staff and volunteers

- We will have a leadership model that gives our staff access to frontline leaders across the 24/7 period to provide clinical leadership, welfare and wellbeing support, and operational command at complex incidents.
- With regular appraisals and clinical supervisions, we will support our staff to identify their development needs and have opportunities available for them to develop their clinical and leadership skills.
- We will provide opportunities for those who want to develop their clinical and leadership careers, and for those who want to work more flexibly later in their careers, through succession planning, and through having roles that are attractive to our staff.

Our organisation and the partners we work with

- We will develop relationships with our partners in health, social care, and other service delivery organisations, that allow us to work collaboratively to provide the best care possible to patients in the Northwest.
- We will engage regularly, at the right level, with the right people, to enable NWAS to be part of the solution to delivery of healthcare across the ICS footprints.
- We will work with our partners in the voluntary sector, in health & social care, and other blue light organisations, to identify opportunities to collaborate in order to deliver services that are efficient and cost effective.
- We will be one NWAS, whist recognising the need to have flexibility in how we deliver our services to meet the needs of neighbourhoods, places, and systems.

Glossary

Term	Definition
AACE	Association of Ambulance Chief Executives
Cat2	Category 2 ambulance calls are those that are classed as an emergency or a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport
CFR	Community First Responder
DHSC	Department of Health & Social Care
ED	Emergency Department
EDI	Equality, Diversity and Inclusion
EOC	Emergency Operations Centre
EPRR	Emergency Preparedness, Resilience and Response
HART	Hazardous Area Response Team
ICS	Integrated Care System
MERIT	Medical Emergency Response Incident Team
PES	Paramedic Emergency Service
PTS	Patient Transport Service
UEC	Urgent and Emergency Care
VCS	Voluntary Car Service
VCSFE	Voluntary, Community, Social & Faith Enterprise

EQUALITY IMPACT & RISK ASSESSMENT
SCREENING TOOL - STAGE 1

Directorate:	Team:
Service Delivery	Service Delivery
Name of programme/project/policy:	**EIA lead/author:**
Service Development Supporting Strategy	Ged Blezard
Date of completion:	**Date of review:**
5th July 2023	

Brief overview of the proposals (project/programme/policy) being assessed

Our Service Development Strategy aligns to our organisational aim to "work together to shape a better future" and provides a framework for developing our operational service lines to make sure we deliver operational performance across all service lines in a sustainable way. These service lines include; Resilience, NHS 111, 999 Emergency Operations Centres (EOC), our Paramedic Emergency Service (PES), our Patient Transport Service (PTS) and our teams of dedicated volunteers - which includes our Community First Responders (CFRs) and Volunteer Car Service drivers (VCS) - who volunteer their time to provide vital support to the delivery of our services.

GENERAL GUIDANCE

Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *if you have indicated 'yes' for any questions, please briefly explain*
1	**Do the proposals plan to withdraw a service, activity or presence?**	N	
2	**Do the proposals plan to reduce a service, activity or presence?**	N	
3	**Do the proposals plan to introduce or increase a charge for service?**	N	
4	**Do the proposals plan to change to a commissioned service?**	N	
5	**Do the proposals plan to introduce, review or change a policy, strategy or procedure?**	N	
6	**Do the proposals plan to introduce a new service or activity?**	N	
7	**Are the proposals primarily about improving access to, or delivery of a service?**	Y	We have begun simplifying urgent and emergency access for patients, by offering a single triage process across 111 & 999. Working closer together provides a number of benefits for staff in terms of career flexibility and also means that patients and service users are able to access their health needs in a straight-forward way, when they need us most. Integration is an important area of focus to improve patient flow through the health care system and to make sure patients receive the right care at the right time, in the right place, every time.
8	**Do the proposals affect staff, or levels of training for those who will be delivering the service?**	N	*Detail which staff groups are affected*
9	**Do the proposals affect service users?**	N	
10	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*
	EQUALITY RISK	**Enter Y or N**	**Rationale**
11	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	
12	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	
13	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	
14	**Do you plan to publish your information?** Include any "Decision Reports"	Y	
15	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	
16	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	
17	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	
IMPACT	○	**There should be little or no impact. There is no requirement to carry out a Stage 2 assessment**	
RISK	○	**There should be little risk involved**	
	HUMAN RIGHTS IMPACT		**Rationale**
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**		

Human Rights:

A2 Right to Life
A3 Prohibition of torture, inhuman or degrading treatment
A4 Prohibition of slavery and forced labour
A5 Right to liberty and security
A6 Right to a fair trial
A7 No punishment without law
A8 Right to respect for private and family life
A9 Freedom of thought, conscience and religion
A10 Freedom of expression
A11 Freedom of assembly and association
A14 Prohibition of discrimination
P1A2 Right to education

Are you intending on proceeding to complete a Stage 2 EIA?
If no, please provide a rationale

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team

Reviewed by:		Date	

North West Ambulance Service NHS Trust

Sustainability Strategy 2023-2026

Contents

Introduction

Our Trust Strategy 2022-2025 sets our vision for the future;

To provide the right care, at the right time, at the right place, every time.

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. This Sustainability Strategy is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

What is Sustainability?

Sustainability means to fulfil the needs of current generations without compromising the needs of future generations. Sustainability looks at minimising harm to the environment, but it isn't just about reducing carbon emissions, sustainability looks at ways to minimise harm to the environment whilst maximising social benefits to our communities and making decisions that support the financial health of NWAS.

"At NWAS, sustainability is at the heart of everything we do. We all have a responsibility to contribute to the delivery of a net zero NHS whilst ensuring we serve our communities now and in the future"

Carolyn Wood, Director of Finance

At NWAS, we look at sustainability in four different ways:

Environmental sustainability

Environmental sustainability focuses on caring for the environment.

Social value

Social value focuses on the positive value that NWAS creates for the communities we serve, over and above delivery of our services.

Population health

Population health focuses on the health outcomes across a population and considers differences within the population which can lead to people having different experiences and health outcomes.

Financial sustainability

Financial sustainability focuses on making decisions that meet the needs of communities we serve today, without compromising the longer-term financial health of NWAS to meet the needs in the future.

Why is sustainability important for NWAS?

There are several factors driving NWAS to work, think, and deliver its services in a more sustainable way;

NWAS is facing continuous increase in the demand for its services and, whilst our Service Development Strategy looks at how we can develop our operational delivery models to make sure we have the right people in the right place, at the right time, the sustainability strategy outlines areas of focus, over and above the delivery of our services, to make sure we are able to meet the demands of our patients now, and for the future. As a large organisation which provides lots of services and employs over 6700 staff, 1000 volunteers and covers 5,400 square miles, NWAS reaches and is rooted in many local communities. NWAS has a responsibility to recognise the important roles it plays in these communities as a provider of care services, an employer of local people and a partner to the rest of the health and care system working hard to improve the health and wellbeing of the communities we serve.

It is important that we take our role in protecting the environment seriously: climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the wider NHS. In 2022, the NHS became the first health system to legislate its net zero commitments and aims to become net zero by 2040; this means improving healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere. At NWAS, we have lots of vehicles and estates which all use energy and create emissions and we therefore have a responsibility to make sure we care for the environment by eliminating waste where possible and reducing and reusing where we can't eliminate. We must make sure our targets align to support the NHS' ambition to become net zero by 2040.

The focus on population health and prevention at NWAS is different to how we have previously viewed our role in the health care system. With the formal introduction of integrated care systems (ICSs) in 2022, all system partners, including local authorities, hospitals, GPs, charities, and research institutions, have a mandate to work together to improve health and wellbeing in the population, and to reduce health inequalities. Working across five ICSs, at NWAS we are in a unique position to support our partners and the communities we serve. In addition, NWAS has lots of contact with members of the public, service users and patients in many ways. Our staff are crucial to the identification and delivery of our population health approach as they take the opportunities presented by patient contacts to add value and improve health and wellbeing.

Ambulance services have led the way in many areas of pre-hospital care, reducing the pressure on other parts of the NHS system. At NWAS, we want to lead on supporting the prevention agenda and in reducing health inequalities.

During the Covid-19 pandemic, NWAS, like every other NHS organisation, focused on the operational management and service delivery, and operated under the national emergency financial regime, which included the provision of significant additional funds to NHS organisations, and the suspension of all efficiency requirements. It is now fundamental that we get back to basics, regaining and enhancing our financial grip and control, whilst still balancing the competing operational, activity, workforce and post pandemic impact recovery.

NWAS is committed to creating an inclusive culture where diversity is truly valued. Through our Sustainability Strategy and beyond, our commitments to equality, diversity and inclusion (EDI) runs through everything we do and align to our organisational EDI priorities:

- Priority 1: We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
- Priority 2: We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.
- Priority 3: We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities

Under the four headers of environment, social value, population health, and financial sustainability, this Sustainability Strategy outlines the areas we will work towards achieving by 2026 to: become more proactive in caring for our environment, to give back to our people and communities, to provide support to make sure everyone has the chance to live a healthier life, and to make sure we continuously provide high quality services which are good value for money. Our strategy is ambitious, and we must balance getting the basics right with striving for excellence. The priorities outlined in this strategy have elements of both “basics” and “excellence” which will be further detailed as we turn our strategy in to action.

The Sustainability Strategy plan on a page

The Sustainability Strategy is a supporting strategy which aligns to our Trust Strategy and contributes to our vision; **To deliver the right care, at the right time, in the right place; every time.**

The Sustainability Strategy explains how we will work together to shape a better future by outlining our sustainability priorities:

The sustainability strategy aligns to this aim from the Trust Strategy…

Work together to shape a better future.

We will become more sustainable and have a positive effect on our communities and the environment.

…and will deliver against the following measures by 2026:

To achieve these measures, the sustainability strategy outlines the following three-year priorities:

Which will be delivered by…

Environmental sustainability

We will take positive steps to achieve Net Zero by 2040

- Reducing trust vehicle emissions
- Reducing lost energy and building inefficiency
- Increasing staff involvement and commitment through targeted initiatives
- Educating our workforce to be carbon literate, in line with Silver Carbon Literacy award
- Reducing general waste tonnages
- Increasing segregation of clinical waste streams
- Reducing waste from single use plastics, packaging on supplies, and hazardous wastes from our workshop activities

Social value and responsibility

We will agree “anchor principles” within NWAS and align with system partners

- Expanding existing widening access programmes to increase NWAS workforce employed from Northwest localities
- Building social value principles into specifications & tender processes with new and existing suppliers
- Increasing procurement from local supply chains
- Working collaboratively with patients and the wider population to improve services

Population health

We will work as an effective system partner to improve population health across the Northwest

- Improving patient data collection including demographics, referrals and outcomes
- Expanding public health capability and capacity
- Supporting staff to develop their understanding of public health and prevention, empowering them to ‘make every contact count’
- Building prevention into NWAS operational model including access to alternative care pathways

Financial sustainability

We will maximise the use of NWAS financial resources to deliver safe, efficient and sustainable patient care at every opportunity

- Continued application of effective financial governance and controls across all directorates and partners
- Improve utilisation of existing assets
- Reduce inefficiencies and waste to achieve local and national efficiency targets
- Work together with ICS to deliver a balanced net system financial position
- Ensure investment decisions optimise value for money by embedding revised HM Treasury Green Book principles
- Develop and implement strategic prioritisation for capital investment

Sustainability isn’t just about reducing carbon emissions; Sustainability looks at ways to minimise harm to the environment whilst maximising social benefits to our communities and making decisions that support the financial health of the organisation.

Environmental Sustainability

NWAS aims to work together to shape a better future by having a positive impact on communities now and for future generations. The priority of environmental sustainability outlines where NWAS will focus to improve and care for the environment.

At NWAS, the Sustainability and Environment Team lead the way by working to make NWAS a more environmentally sustainable organisation but, whatever our role,

we all have a vital role to play in helping these changes take place.

Together, we can make a big difference by reducing our carbon footprint and limiting our impact on the environment.

NWAS is committed to deliver a net zero ambulance service and will continue to align to NHS targets to be first net zero healthcare system by 2040. Many of the changes needed to minimise our impact on the environment are already taking place around us with actions being taken both at work and at home. The range of actions that we take together covers; energy efficiency, recycling, plastic reduction, reducing emissions from travel, supplementing green spaces, and improving logistics and supply chains. To achieve our aim to work together to shape a better future, we must become more environmentally sustainable. Therefore, NWAS will focus on the following areas through the lifetime of this strategy:

- **Reducing business mileage and fleet emissions.**

NWAS produces significant carbon emissions from fleet, staff travel, and the logistics associated with our activities. The NHS Long Term Plan aims for 90% of the NHS fleet to use low, ultra-low (ULEV) and zero-emission vehicles by 2028 and complete transition to zero-emission vehicles by 2032. NWAS aims to work towards this by ensuring all vehicles purchased or leased are ULEV and, where appropriate, NWAS will consider the purchase or lease of zero emission vehicles. To facilitate the transition of NWAS' fleet, electric vehicle (EV) charging points will be installed to make sure sites have the electrical capacity to support EV infrastructure.

- **Reducing energy losses and building inefficiency.**

Energy efficiency within our estate will play a major part in achieving net zero. We will improve energy efficiency by investing in our buildings to;

➢ upgrade our heating, lighting, and ventilation systems;

- reduce gas usage by 10% in all our buildings;
- install onsite solar panels to generate additional renewable energy to NWAS buildings; and
- ensure our estates are fully digitally integrated.

Improving energy performance is an investment in patient and staff health and wellbeing as it leads to warmer, more comfortable buildings with better air quality, when paired with adequate ventilation. The improvements we make will allow us to deliver the first net-zero or carbon neutral ambulance station by 2026.

- **Staff involvement and commitment.**

Staff involvement through targeted initiatives will make staff more aware of their impact on the environment and provide them with the knowledge to make a positive change. These initiatives combined with more formal Carbon Literacy Training will help staff to become sustainability champions and provide environmental leadership: empowering them to reduce their personal carbon footprint when at work and at home.

- **Waste elimination, reduction, and recycling.**

Waste is something that everyone at NWAS can contribute to eliminating. Across all areas, we will work to increase the re-use of items where possible and drive down waste from areas such as single use plastics, packaging on supplies and products, and hazardous wastes from our workshop activities. For waste that cannot be eliminated currently, there is a growing field of innovation for low carbon processing. We will measure volumes of waste and work with staff, procurement, and our supply chain to eliminate waste, where possible.

By 2026, we aim to:

Reduce Trust vehicle emissions by 38%.

Reduce primary energy demand by 50% for 12% of our sites through heat loss heat loss and efficiency measures.

Upskill 10% of our staff to be carbon literate in line with Silver Carbon Literacy Award.

Reduce general waste tonnages by 20% and increase segregation of clinical waste streams to reduce CO2e by 17%.

Social value & responsibility

Social Value reflects the additional positive impact that NWAS can have on local communities, economies, and the environment through the way their activities are performed.

We know that we can positively impact communities through the provision of employment and training opportunities, procurement of goods and services, promoting environmentally sustainable practices, and use of land and buildings.

When it comes to widening access, we are award winning!

In 2023, we received the Talent Inclusion and Diversity Evaluation (TIDE) Gold Award.

NWAS has also been awarded the Ministry of Defence Employer Recognition Scheme Gold Award, recognising NWAS's demonstration of the values defined in the Armed Forces Covenant.

Through the lifetime of this strategy, we will commit to ongoing action to ensure we have a positive impact on the communities we work in and serve by focussing in the following areas:

- **Widening participation**

Widening participation is about the positive actions we take to provide support to individuals, groups and communities which are currently underrepresented in our workforce and may face barriers to employment. We will add value to local communities by providing high quality employment opportunities as well as access to pre-employment support programmes to get people ready for work. We will deliver tailored and bespoke support at a community level, engaging with key stakeholders, utilising local community assets such as community centres, libraries, places of worship and other facilities to ensure local economies are benefitting from every aspect of our widening participation work. As well as attracting diverse staff which represent the communities we serve, it is equally important that we have the right policies, systems, and processes to retain staff too; the People Strategy outlines the role leaders and managers play in supporting everyone to be at their best when working or volunteering at NWAS.

- **Tendering and purchasing for social value.**

Being such a large and complex organisation, NWAS has many systems and assets, and we purchase the things we need through using NHS procurement frameworks. We will use each purchase we make as an opportunity to promote the principles of social value by, where possible, using suppliers who demonstrate a commitment to social value and environmentally sustainable practice. We already assess how suppliers consider their environmental and social impact when awarding contracts and we will ensure that all Trust business contracts include this assessment in line with the national NHS weighting of 10% of the overall score.

- **Increase procurement from local supply chains.**

The way in which we tender and purchase goods has the potential to have a positive impact on the communities we serve. By procuring goods and services from smaller, locally based enterprises, we can support local economies and stimulate job and training opportunities. Investing £1 in the local economy can generate between £1.70 and £2.10 worth of growth. We aim to increase the number of small and medium sized enterprises (SME's) that we procure goods and services from, and we will achieve this by:

- auditing and reviewing our current SME suppliers to establish a baseline;
- identifying which activities could be undertaken by SME's; and,
- using the resulting data to set targets of a 5-10% increase in the number of SME bids for contracts.

- **Working together with local communities and organisational partners to deliver social value and benefit.**

As we increase our commitment to building social value into everything we do, we will need to work even more closely with other organisations, including Integrated Care Boards (ICBs) and other community and voluntary organisations to align and strengthen our support to our communities. We will continue to explore where we can work with other partners who are developing their 'anchor' or social value frameworks to increase our scale and the positive impact we make. We will also build on our existing work with volunteers, expanding the reach and network of these important roles in building links with our local communities.

By 2026, we aim to:

Develop opportunities to support and develop all our staff with their maths and English skills and expand our pre-apprenticeship offer.

Increase applications from disadvantaged communities.

Ensure that competitively tendered Trust business includes an evaluation criterion for Social Value at the nationally directed evaluation weighting.

Increase the number of bids from local small or medium enterprises for contracts by 10% in 2026.

Adopt the anchor institution principles which are relevant to NWAS and work with system partners to positively impact local communities.

Population health

"At NWAS, we have the privilege and a responsibility to contribute to reducing unjust differences in access to healthcare for the most vulnerable communities we serve"

Chris Grant, NWAS Medical Director

Population health is an approach aimed at improving the physical and mental health and wellbeing of an entire population. It aims to reduce health inequalities, which are unfair differences in health between different groups of people resulting from the opportunities they have, or do not have, to lead a healthy life. Health and wellbeing are determined by many different factors such as income, education, housing, transport, and leisure. Across NWAS' geographical area, people face a higher-than-average amount of disadvantage in housing, transport, income, and education which results in worse health outcomes, which results in increased demand for NWAS and NHS services.

Population health is a relatively new area of focus for NWAS. In recent years we have concentrated on building relationships with our partners and have started to identify how we can incorporate pathways and interventions to support vulnerable populations, in areas such as violence reduction, high intensity users and end-of-life care. To work together to shape a better future, will focus on the following areas:

- **Improve the input, analysis and utilisation of data which provides intelligence on population health and health inequalities.**
  For us to make sure our services are accessible and meet the needs of our patients, we need to know how our patients use our services. We will use our data to help us identify our most vulnerable groups which we will then use, as well as considering aspects suggested by the national framework CORE20PLUS5, to identify target groups. We will use this intelligence to develop programmes and initiatives to reduce health inequalities within these target groups. We will work to improve capture of patient characteristics to help us establish clearer results and areas for further analysis. To improve utilisation of our data, we will develop dashboards that enable us to understand our services from the perspective of health inequalities, for example, linking patients to indices of deprivation, ethnicity or reported disabilities. We will also identify opportunities for us to share data with our system partners to prompt action to improve health outcomes for our patients and populations.

- **Improve staff capability, capacity, and development with regards to population health and health inequalities.**

To support and develop the population health skills of our wider workforce, we will develop a training offer to cover three competency levels. These competency levels include; provision of basic knowledge and awareness of health inequalities, a network of staff interested in further learning and opportunities, and population health leadership capacity. To develop awareness and engagement, we will also hold communication and engagement events for staff and our Patient and Public Panel (PPP).

- **Ensure our operational models enable staff to offer prevention support beyond fulfilling patient's urgent needs**

Over recent years, clinical and operational teams have developed additional referral opportunities for patients whose needs were not being met by our existing pathways. For instance, to develop our "Making Every Contact Count" approach, NWAS has worked to identify over twenty social prescribing pathways to refer patients to non-clinical services to support their health and wellbeing in their respective localities. Using results from our data analyses, and information and ideas from our partners, staff, and communities, we will identify and develop new projects that can be delivered by our staff to improve the health and wellbeing of our communities. We will take advantage of this learning to support health and wellbeing initiatives for our own staff. To share learning, we will work with our partners, including new academic partners, to assess the impact of our work.

By 2026, we aim to:

Develop a suite of training resources that staff can access to support development of public health interventions, awareness, and leadership.

Have established processes with ICS partners for making best use of NWAS data and intelligence to inform system wide prevention initiatives.

Develop relationships with research partners to build the evidence base on the value of Ambulance Trust data and initiatives in prevention and tackling health inequalities.

Understand where we see variation in access, experience, and outcomes for different population groups across NWAS services.

Review and where necessary expand the public health specialist capacity within the organisation.

Create increased awareness and understanding of public health, prevention, and health inequalities across NWAS teams.

Financial sustainability

Increasing demand for public services creates ever more pressure on the public resources. NWAS will ensure we make the best use of these limited resources, ensuring value for money, reducing waste and maximising benefits for our patients, our staff, and our wider society.

For NWAS to achieve its aim to work together to shape a better future, it is essential that we have excellent control over our finances and deliver quality services which are good value for money. Financial sustainability, sometimes known as economic sustainability, is the ability to manage our service demand, performance, quality and safety requirements within the Trust's allocated financial resources, and achievement of our statutory financial duties.

Throughout NWAS, the pandemic has introduced considerable change in the operational delivery of PES, 111 and PTS services, with significant financial implications. This sustainability strategy identifies NWAS's financial sustainability priorities to manage the financial challenge that is now facing all NHS organisations, and how the organisation will be supported by the corporate finance team to achieve our vision to deliver the right care, at the right time, in the right place, every time:

- **Effective financial control and financial governance across all directorates**

We will ensure a strong internal framework of financial governance continues to be embedded throughout NWAS, delivering a robust control environment where all budget holders receive regular face to face financial training, provided with up to date, easily accessible Standing Financial Instructions (SFIs), Standing Orders (SOs), financial procedures, and polices to ensure full adherence to the governance framework though education and knowledge.

Budget holders will have a named Finance Officer who will provide regular budget holder meetings, deliver expert financial advice and knowledge regarding budget setting, income, and expenditure monitoring, and identify areas of concern regarding financial governance to support all our budget holders and partners.

- **Reduce inefficiencies and waste, achieving local and national efficiency targets to achieve a balanced net system finance position**

The Productivity and Efficiency Group will be implemented with greater clinical and service ownership to identify inefficiencies and implement innovative clinical transformation to tackle waste, working across the health care system to maximise resource efficiency and effectiveness. Increasing accountability, with dedicated responsible officers, enhanced management information with key performance indicators (KPI), efficiency and productivity measurement and reporting, whilst always ensuring compliance with NWAS Quality Impact Assessment processes. This will all contribute and support the achievement of local and national efficiency requirements and drive towards a balanced net system financial position.

Utilising all our assets effectively is important in terms of both reducing costs associated with assets and maximising the quality of services that those assets are used to produce. The focus of asset management is to ensure the asset base of NWAS directly supports the business objectives, to support meeting users' needs and quality standards, and achieving best value for money.

- **Ensure investment decisions optimise value for money by embedding the revised HM Treasury green book principles, facilitating prioritisation of investment**

Ensure all investment decisions optimise public value for money by embedding the revised Green Book principles and Comprehensive Investment Appraisal techniques as standard across the Trust, including achievement and realisation of planned benefits. Application of the revised framework will support the evaluation of the best social value for money in the appraisal of quantifiable public sector and societal benefits, risks and achievement of SMART objectives, alongside financial affordability of investment decisions.

Application of the revised business case evaluation framework will facilitate both capital and revenue decision making at NWAS, facilitating the prioritisation of investment decisions, alignment with NWAS strategic objectives, and ultimately ensure that we maximise the best use of public money.

By 2026, we aim to:

Achievement of NWAS statutory financial duties every year.

Achievement of NWAS efficiency target and contribute to the delivery of a balanced net system financial position

Achieve 'significant assurance' from the independent assurance review of our annual internal financial controls

Support the evaluation of the best social value for money undertaking comprehensive investment appraisals for all new investment proposals

What does this mean for me?

Upon delivery of our sustainability strategy, we will have become a more sustainable organisation and will have a more positive impact on the environment and the communities we serve. This is what that will mean for you:

Our patients and service users

- I will have access to non-clinical pathways which better suit my needs.
- I will see NWAS engaging in activities which aim to reduce health inequalities. This work will lead to more people having the ability to lead more healthy lives.
- I will have access to good employment opportunities and be supported in my application.
- I will be assured that NWAS are using their limited financial resources in an efficient way which positively impacts the communities in which I live and work.

Our staff

- I will have access to monthly initiatives to help me positively impact the environment.
- I will have the opportunity to develop my understanding of environmental sustainability and work towards becoming "carbon literacy" trained.
- I will have a better understanding of health inequalities and how I can improve my practice to positively impact people experiencing unfair differences in health.
- I will work as part of a more diverse workforce of staff and volunteers.

Our organisation and the partners we work with

- Our partners in the healthcare system will have access to intelligence gathered from analysing our data and will be able to use this to inform the development of their prevention initiatives.
- Our organisation's sustainability priorities will compliment those of organisations in the wider health and social care system, working together to maximise impact

Glossary

Here are some handy explanations and definitions to help make sure everyone can understand our strategy:

Term	Definition
Anchor institution	The term anchor institutions refers to large, typically non-profit, public-sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.[1]
Carbon emissions (CO_2e)	Carbon dioxide equivalents is a unit of measurement that is used to standardise the climate effects of various greenhouse gases.
Carbon negative	The reduction of an entity's carbon footprint to less than neutral.
Core 20+ 5 CORE20PLUS5	Is an approach defined by NHS England to target efforts to support reduction of health inequalities. The approach focusses on 1) the 20% of the population in the highest deprivation levels, 2) plus other groups experiencing healthy inequalities or in need of support, such as people with learning disabilities, carers, or people living in homelessness, and 3) five clinical areas where coordinated action by all Integrated Care System partners is needed. There are two different frameworks, one for adults with clinical areas such as poor respiratory health, hypertension, or mental health, and one for children and young adults, with clinical area such as asthma, oral health, and mental health.
Indices of deprivation, indices of multiple deprivation (IMD)	Indices of multiple deprivation (IMD) is a measure that helps identify the most and least deprived areas in England, considering a range of factors relating to people's living conditions. A high IMD means that an area is more deprived than an area with a lower IMD.
Low, ultra-low and zero-emission vehicles	Ultra-low emission vehicles are currently defined as having less than 75 grams of CO_2 per kilometre (g/km) from the tail pipe. Zero emission vehicles are defined as having 0 tail pipe emissions.

Term	Definition
Net Zero	Net zero refers to a government commitment to ensure the UK reduces its greenhouse gas emissions by 100% from 1990 levels by 2050 (2040 for the NHS).
PES	Paramedic Emergency Services. This is sometimes referred to as the 999 service or urgent and emergency care (UEC) service.
PTS	Patient Transport Services; Non-emergency transport.
Standing Financial Instructions (SFIs)	Standing Financial Instructions outline the Trust's financial responsibilities, policies, and procedures. They ensure that NHS Trusts achieve probity, accuracy, economy, efficiency, and effectiveness.
Standing Orders (SOs)	NHS Trusts are required by law to make Standing Orders, which regulate the way in which the proceedings and business of the Trust will be conducted. High standards of corporate and personal conduct are essential in the NHS.
Statutory financial duties	NHS Trusts must achieve financial duties set by NHS England which essentially mean they must not spend more money than they have coming in. Trusts must also remain within a borrowing limit set by the Secretary of State.
His Majesty's Treasury (HMT) Green Book	The HMT Green Book is a widely recognized guide for best practices in public sector decision-making and policy development in the UK. The HMT Green Book provides instructions on evaluating policies, programs, and projects.
Tender, tendering	The procurement process of inviting and evaluating bids from suppliers to provide goods, works or services

References and acknowledgements

NHS Long Term Plan » The NHS as an ‘anchor institution’

NHS England » WE ARE THE NHS: People Plan for 2020/2021 - action for us all

Health Foundation » Building healthier communities: the role of the NHS as an anchor institution

NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

EQUALITY IMPACT & RISK ASSESSMENT
SCREENING TOOL - STAGE 1

Directorate:	Team:
Name of programme/project/policy:	**EIA lead/author:**
The Sustainability Strategy	Carolyn Wood
Date of completion:	**Date of review:**
30.6.2023	30.6.2024

Brief overview of the proposals (project/programme/policy) being assessed

The Sustainability Strategy is one of four supporting strategies which aligns to our Trust Strategy. The Sustainability outlines 3-year strategic priorities which the organisation must work collectively to achive if it is to achieve the vision; To deliver the right care, at the right time, in the right place; every time.

GENERAL GUIDANCE

Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *if you have indicated 'yes' for any questions, please briefly explain*
1	**Do the proposals plan to withdraw a service, activity or presence?**	N	
2	**Do the proposals plan to reduce a service, activity or presence?**	N	
3	**Do the proposals plan to introduce or increase a charge for service?**	N	
4	**Do the proposals plan to change to a commissioned service?**	N	
5	**Do the proposals plan to introduce, review or change a policy, strategy or procedure?**	Y	This is a new strategy which will inform annual and directorate plans.
6	**Do the proposals plan to introduce a new service or activity?**	N	The strategy will not plan to introduce anything new but it may lead to plans which may result in introducing new activities
7	**Are the proposals primarily about improving access to, or delivery of a service?**	Y	The strategy focuses on improving the organisation to be more environmentally sustainable, financially sustainable, to add social value and to identify areas of Population health and prevention work to focus on.
8	**Do the proposals affect staff, or levels of training for those who will be delivering the service?**	Y	*Detail which staff groups are affected* There will be a positive impact on staff who will have access to training opportunities; the specifics will be further detailed in the annual and directorate plans.
9	**Do the proposals affect service users?**	Y	There will be a positive impact on service users.
10	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*
	EQUALITY RISK	**Enter Y or N**	**Rationale**
11	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	
12	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	N/A
13	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	
14	**Do you plan to publish your information?** Include any "Decision Reports"	Y	
15	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	
16	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	Staff will be engaged on the strategy and the subsequent plans.
17	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	The PPP have been engaged in the strategy development process.

IMPACT		**There will be some impact. You should undertake a Stage 2 assessment**
RISK		**There should be little risk involved**

HUMAN RIGHTS IMPACT		Rationale
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**	No
Human Rights: **A2 Right to Life** **A3 Prohibition of torture, inhuman or degrading treatment** **A4 Prohibition of slavery and forced labour** **A5 Right to liberty and security** **A6 Right to a fair trial** **A7 No punishment without law** **A8 Right to respect for private and family life** **A9 Freedom of thought, conscience and religion** **A10 Freedom of expression** **A11 Freedom of assembly and association** **A14 Prohibition of discrimination** **P1A2 Right to education**		
Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***		No; As a supporting straetgy of the Trust strategy, any impacts are captured within the Trust Strategy EIA. The impacts identified are positive, the strategy has been developed to improve the organisation to improve the services and experiences of staff and patients. As and when activities such as projects/improvements result from the strategy's delivery, there will then be specific EIA's required.

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th July 2023				
SUBJECT:	Board Assurance Framework 2023/24 Q1 Position				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The proposed Q1 position of the BAF risks with associated CRR risks scored ≥15 can be viewed in **Appendix 1**. The BAF Heat Maps for 2023/24 year to date can be viewed in **Appendix 2**. The Executive Leadership Committee (ELC) recommend the following Q1 changes: • Decrease of SR03 from 20 to 15. • Increase of SR06 from 10 to 15. S4 of the report notifies the Board of a slight change to the iteration of strategic risk SR09 and is presented for agreement. This is the first report where the Projected Forecast for the following quarter has been used.				
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the 2023/24 Q1 Position of the Board Assurance Framework. • Agree the amendment to the wording of SR09.				
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: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☒ Financial / Value for Money ☒ Reputation ☒ Innovation				

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 and Audit Committee	
	Date:	19th July 2023 and 21st July 2023
	Outcome:	ELC: Agreed for Recommendation to the Board Audit Committee: For Assurance

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1. PURPOSE

This paper provides the opportunity for the Board of Directors to review the 2023/24 Q1 Position of the Board Assurance Framework (BAF) position, along with the Corporate Risk Register risks scored ≥15 that are aligned to each BAF risk.

2. BACKGROUND

The Board Assurance Framework (BAF) identifies the strategic risks and ensuring that systems and controls are in place are adequate to mitigate any significant risk which may threaten the achievements of the strategic objectives.

Whilst the Board of Directors delegates authority to its Board Assurance Committees to monitor assurance against its strategic risks, it is ultimately responsible for the oversight of the BAF and the Board Assurance Committees are expected to escalate any significant assurance issues as they arise via the Chairs' Reports.

3. REVIEW OF THE STRATEGIC RISKS 2023/24 Q1 POSITION

The proposed 2023/24 Q1 Position of the Board Assurance Framework with associated Corporate Risk Register risks scored 15 and above can be viewed in Appendix 1. The BAF Heat Maps for 2023/24 year to date can be viewed in Appendix 2.

The proposed changes are:

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

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

Opening Score 01.04.2023	Q1 Risk Score	Exec Lead
20 5x4 CxL	**15** 5x3 CxL	Ged Blezard

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

1. Sustained improvements to ARP performance standards.
2. Significant reduction in long waits, hospital handovers and reduced harm to patients.
3. Stability within 111 and achievement of call pick up standard.
4. UEC Plan is in place however there are some delays, the largest risk to delivery of the UEC Plan is recruitment.

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

- Increase in current risk score for Q1 from 10 to 15

Opening Score 01.04.2023	Q1 Risk Score	Exec Lead
10 5x2 CxL	**15** 5x3 CxL	Maxine Power

The risk score has increased, with the following rationale applied by the Executive Lead:

1. Vacancies within the compliance team.
2. New CQC relationships to be established.
3. Safety check compliance requires improvement.

4. AMENDMENT OF BAF RISK SR09

As part of the Q1 BAF review process, a slight change to the iteration of strategic risk SR09 is proposed and is presented to the Board of Directors for agreement.

Current SR09:	**Proposed 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	There is a risk that the trust attracts negative media attention arising from long delays and harm leading to significant loss of public confidence

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

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

6. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

7. RECOMMENDATIONS

The Board of Directors is recommended to:

- Approve the 2023/24 Q1 Position of the Board Assurance Framework.
- Agree the amendment to the wording of SR09.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2023/24

BOARD OF DIRECTORS – PART 1

Q1 POSITION

26 JULY 2023

Q1 2023/24 Reporting Timescales:

Executive Leadership Cttee:	19/07/2023
Audit Cttee:	21/07/2023
Resources Cttee:	21/07/2023
Quality & Performance Cttee:	24/07/2023
Board of Directors:	26/07/2023

BOARD ASSURANCE FRAMEWORK KEY

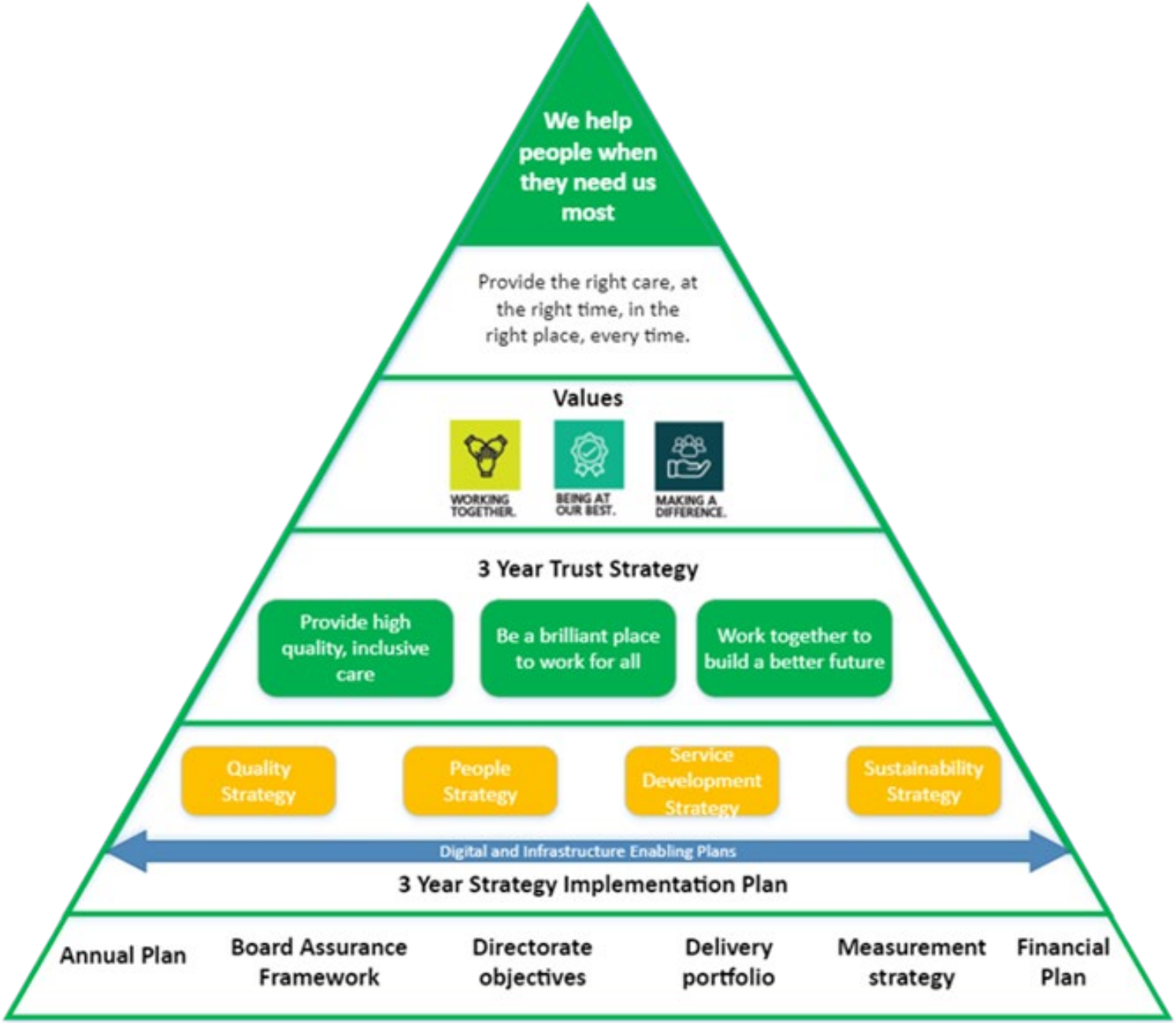
Risk Rating Matrix (Likelihood x Consequence)

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

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

Board Assurance Framework Legend

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


We help people when they need us most
Provide the right care, at the right time, in the right place, every time.
Values
WORKING TOGETHER.
BEING AT OUR BEST.
MAKING A DIFFERENCE.
3 Year Trust Strategy
Provide high quality, inclusive care
Be a brilliant place to work for all
Work together to build a better future
Quality Strategy
People Strategy
Service Development Strategy
Sustainability Strategy
Digital and Infrastructure Enabling Plans
3 Year Strategy Implementation Plan
Annual Plan
Board Assurance Framework
Directorate objectives
Delivery portfolio
Measurement strategy
Financial Plan

BOARD ASSURANCE FRAMEWORK DASHBOARD 2023/24

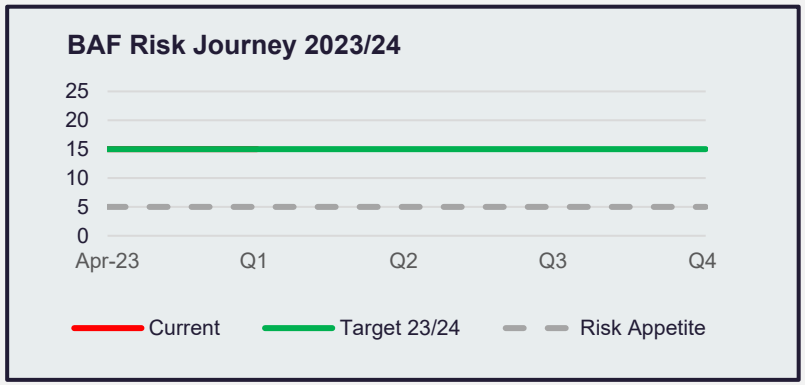
BAF Risk	Committee	Exec Lead	01.04.23	Q1	Q2	Q3	Q4	2023/24 Target	Final Target
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL				**15** 5x3 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services	**Resources**	**DoF**	**16** 4x4 CxL	**16** 4x4 CxL				**12** 4x3 CxL	**8** 4x2 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**15** 5x3 CxL				**15** 5x3 CxL	**5** 5x1 CxL
SR04: There is a risk that the Trust will be unable to 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	**Resources**	**DoP**	**16** 4x4 CxL	**16** 4x4 CXL				**8** 4x2 CxL	**4** 4x1 CxL
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.	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**	**10** 5x2 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**5** 5x1 CxL
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	**Resources**	**DoSPT**	**8** 4x2 CxL	**8** 4x2 CxL				**4** 4x1 CxL	**4** 4x1 CxL
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	**Resources**	**DoQII**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**5** 5x1 CxL
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	**Resources**	**DoSPT**	**10** 5x2 CxL	**10** 5x2 CxL				**10** 5x2 CxL	**10** 5x2 CxL
SR10: (**Sensitive Risk**):	**Resources**	**DoSPT**	**16** 4x4 CxL	**16** 4x4 CxL				**12** 4x3 CxL	**8** 4x2 CxL

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	15	15				15	5
	5x3	5x3				5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 15. Data from the Integrated Performance Report indicates significantly improved performance that impacted positively on outcomes and decreased the associated risks to patient safety. Improvements across all ARP standards, with a high-performance position nationally. 47% reduction in hospital handover over an hour due to the continued regional collaborative focus on handover delays. Capital secured for mental health response vehicles and improvements implemented in 111 through visual IVR and significantly reduced call times. Despite this, ARP standards are still not being met and 111 performance against the Service Level Agreement remained highly challenged. Actionable data to help improve national ACQIs remains a work in progress, as is data to support contact shifts, Advanced Paramedic practice and Manchester Triage System audits. Workshops for medication management commence in Q2.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Improving
The position is likely to improve during Q2 due to stable performance demands, ongoing work with C2 segmentation and SDMR providing clarity for both the PES and contact centre workforce. In addition, work to resolve data demands is part of the agreed annual workplan.

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Patient Safety Strategy	Implement PSIRF and family engagement officers for Duty of Candour Patient safety partners	A Wetton / Dr M Power	September 2023	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Dr M Power Dr C Grant	March 2024	Q&P Cttee	In Progress
Learning	Establish an integrated regional learning forum & evaluate effectiveness of area forums	Dr M Power	March 2024	Q&P Cttee	In Progress
Improvement	Improvement plan linked to safety and quality learning (PSIRF)	Dr M Power	January 2024	Q&P Cttee	In Progress
Safety Education	Training needs analysis for safety science training	Dr M Power/ Lisa Ward	December 2024	Q&P Cttee	In Progress
Mental Health Plan	Deliver the NWAS mental health plan	Dr M Power	March 2024	Q&P Cttee	In Progress
Midwifery Plan	Deliver the NWAS Midwifery Plan	Dr M Power	March 2024	Q&P Cttee	In Progress
Medicines management	Scope and procure a medicines management platform for increased oversight	Dr C Grant	March 2024	Q&P Cttee	In Progress

Quality Strategy	Complete and seek Board approval	Dr M Power	September 2023	Q&P Cttee	In Progress
Clinical Audit	Implementation of APEX 2	Dr C Grant	March 2024	Q&P Cttee	Not Commenced
DIGITAL					
Digital Capacity 111 Telephony Capacity	Implementation of SIP Telephony	Dr M Power	March 2024	Resources Cttee	In Progress
Digital Strategic Plan	Complete and seek Board approval	Dr M Power	September 2023	Resources Cttee	In Progress

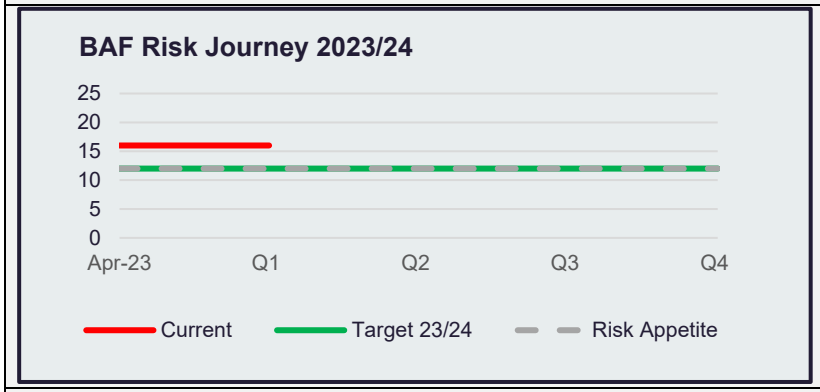
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
319	Operational/ Patient Safety	There is a risk, due to the lack of a detailed emergency response specification for the use of private ambulance providers in the provision of PES, that variations in provision of drugs and associated training results in difficulties regarding assurance checks and could result in medicines not being administered in accordance with NWAS protocols leading to serious patient safety incidents.	15 High	15 High	⇔	5 Low
379	Operational/ Patient Safety	There is a risk that due to the new National Intelligent Routing Platform (IRP) NWAS Digital Team will not be able to fault find or make changes to the 999 telephony platform leading to slower response to telephony issues or outages.	16 High	16 High	⇔	4 Low
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of national standards, training, exercising, and subsequent competency assurance, the EOC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	New	5 Low

BOARD ASSURANCE FRAMEWORK 2023/24

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

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	16	16				12	8
	4x4	4x4				4x3	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk SR02 remains at 16. The ICB Contracts have just been updated for the increased uplift relating to the 2023/24 Agenda for Change pay award settlement but remain unsigned at this stage. In relation to the efficiency target, there has been an improvement and the gap to be identified in year is £0.7m and £2.0m recurrently.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Improving
Recurrent efficiency projected to be identified by the end of Q2.

CONTROLS	ASSURANCES	EVIDENCE
Opening 2023/24 Financial Plans	**Level 2:** Financial Plan Update	Reported to Resources Cttee (RC/2324/009) Reported to BoD (BoD/2324/012)
Recurrent Funding	**Level 2:** Financial Plan Update	Reported to Resources Cttee (RC/2324/009) Reported to BoD (BoD/2324/012)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Product and Efficiency Oversight	Establish oversight mechanism through existing service line meeting structures/SMTs.	Ms C Wood	July 2023	Resources Cttee	In Progress
2024/25 Financial Planning	Receipt of 2024/25 planning guidance from NHSE	Ms C Wood	January 2024	Resources Cttee	Not Commenced
	Draft 2024/25 Financial Plan (Revenue & Capital)	Ms C Wood	March 2024	Resources Cttee / BoD	Not Commenced
	Approval of 2024/25 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2024	Resources Cttee / BoD	Not Commenced

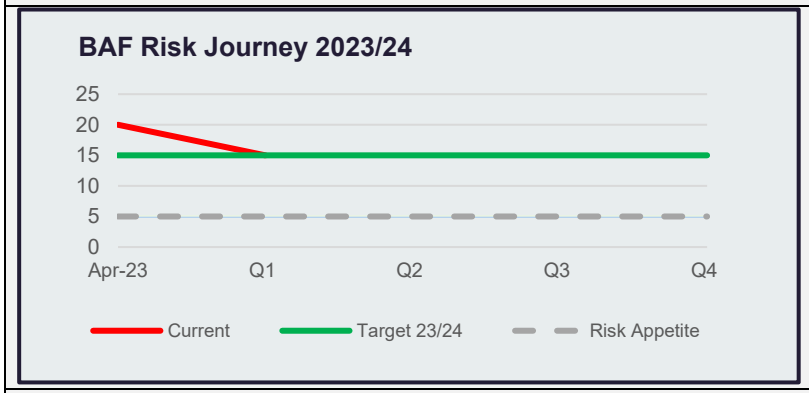
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
317	Operational/ People	There is a risk that due to national and local role and job evaluation developments, EMT1 posts may be re-banded resulting in a significant financial cost pressure.	20 High	15 High	⇔	10 Moderate

BOARD ASSURANCE FRAMEWORK 2023/24

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

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	20	15				15	5
	5x4	5x3				5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk has reduced to 15 due to improved and sustained performance. The Trust has consistently achieved ARP call pick up standards, C1 90th standard and close to achieving many of the other standards, with a significant reduction seen in long waits, hospital handovers and reduced harm to patients. 111 is similarly going through a period of stability and call pick up standard of circa 60% has been achieved. The UEC recovery plan is in place with regular oversight meetings. Some parts of the plan are on target, some slightly delayed, however actions are being taken to remedy this. The biggest risk to delivery of the UEC Plan is recruitment, additional resources are being put into recruitment process.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
Elements of the recovery plan need to be embedded over Q2 to allow improvements in Q3/Q4.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap 111	Engagement with Commissioners surrounding NHS111 contracts	Mr G Blezard	September 2023	ELC	In Progress
Service Delivery Model Review (SR09)	Delivery of SDMR project to improve working practices	Mr G Blezard	November 2023	Q&P Cttee	In Progress
	Maximise resources to the most efficient level	Mr G Blezard	2023/24	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff (SR09)	Robust recruitment plan to be delivered	Mr G Blezard Mrs L Ward	March 2024	Q&P Cttee	In Progress
Reduce Hospital Handovers	Hospital handover collaborative with ICBs	Mr G Blezard Dr M Power	March 2024	Q&P Cttee	In Progress
Improve Hear and Treat Performance	Improve Hear and Treat Performance from 15% to 20%	Mr G Blezard	March 2024	Q&P Cttee	In Progress

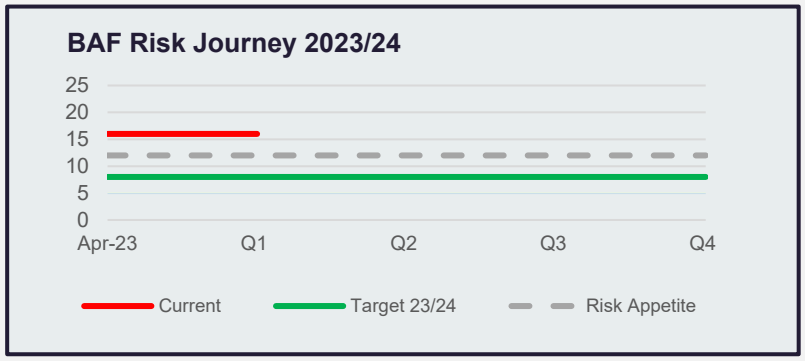
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
327	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 High	15 High		5 Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	16	16				8	4
	4x4	4x4				4x2	4x1
	CxL				CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Within	Below

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a 16. At the end of Q1 the frontline emergency vacancy position remains below 2% but this does not yet incorporate additional UEC growth funding in baseline establishments. Ambitious recruitment plans are in place to deliver required growth but there are challenges to delivery associated in the main with recruitment market pressures and driver training capacity to service plans. International recruitment cohorts commenced and further recruitment incentives are being considered. Additional funding to invest in capacity to support sickness and wellbeing will not deliver additional resources until the end of Q2. Work to improve attendance is ongoing, however step changes in delivery of the challenging 1.8% reduction target may not be realised until later 23/24.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
Plans assume that the impact of increased staffing and reduced sickness absence will not be seen until Q3/Q4.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2324/015)
111 Retention Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2324/015)
Sickness and Wellbeing Assurance	**Level 2:** Wellbeing Biannual Assurance Report	Reported to Resources Cttee (RC/2324/016)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of UEC recovery growth	Ms L Ward	March 2024	Resources Cttee	In Progress
	Delivery of international recruitment targets	Ms L Ward	March 2024	Resources Cttee	In Progress
Retention Plans	Delivery of Retention Plans	Ms L Ward	March 2024	Resources Cttee	In Progress
Attendance	Delivery of AIT improvement plans	Ms L Ward	March 2024	Resources Cttee	In Progress
Flu Vaccination	Delivery 2023/24 Campaign	Ms L Ward	Feb 2024	Resources Cttee	In Progress

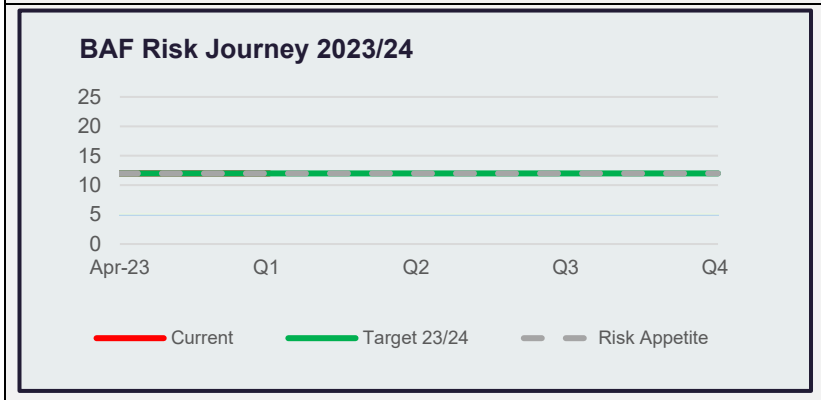
Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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.

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	12	12				12	4
	4x3	4x3				4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within				Within	Below

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a 12. 2022 staff survey results indicate progress has been made across a range of indicators and that overall the Trust is average or slightly above average for the sector against the key People Promise themes. Progress continued to be made in Q1 through the leadership development programme Making a Difference; roll out of the revised disciplinary policy; changes to induction to embed Civility Saves Lives; reverse mentoring programme. The People Strategy has been developed for approval and clear plans commenced for 23/24 on a range of cultural and inclusion improvement including work on sexual safety, review of Dignity at Work arrangements, speaking up, mental health and wellbeing support.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
Majority of work is work in plan; improvement will be realised Q4 2023/24 and into the following year.

CONTROLS	ASSURANCES	EVIDENCE
EDI Annual Report	**Level 2:** EDI Annual Report 2022/23	Reported to Resources Cttee (RC/2324/017) Reported to BoD (BoD/2324/038)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	March 2024	ELC	In Progress
EDI Priorities	Delivery of Year 3 Action Plans (workforce elements)	Ms L Ward	March 2024	Resources Cttee	In Progress
Fully Embedding Just Culture Principles	Implementation of Disciplinary Procedure	Ms L Ward	April 2023	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	November 2023	ELC	In Progress
Wellbeing	Implementation of mental health pledge and AACE commitment	Ms L Ward	2023/24	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2024	Resources Cttee	In Progress
Sexual Safety Campaign	Delivery of Campaign	Ms L Ward	March 2024	Resources Cttee	In Progress
People Strategy	Approval of People Strategy	Ms L Ward	July 2023	Resources Cttee	In Progress
Staff Survey	Delivery of Staff Survey Trust and Local Plans	Ms L Ward	December 2023	Resources Cttee	In Progress

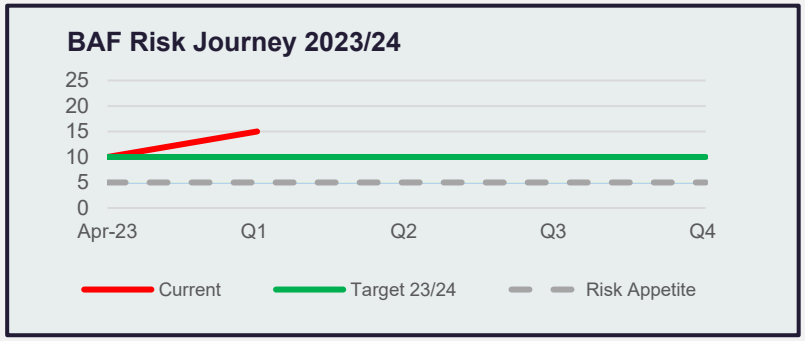
Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

BOARD ASSURANCE FRAMEWORK 2023/24

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

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	10	15				10	5
	5x2	5x3				5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Exceeded				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk has increased to 15 due to a gap in leadership within the compliance team, with new CQC relationships to be established however plans and mitigations are in place. The new regulatory model with a focus on data is being considered in work plans. Safety check compliance data is being shared regularly but improvement in compliance is required. APEX phase 1 has been delivered and a model for substantive funding for FIT testing has been agreed.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
Progress is likely to be made however some of the identified gaps in controls and actions are due for completion until end Q3.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Mandatory Training Compliance (85%)	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Resources Cttee (RC/2324/015) Reported to BoD (BoD/2324/032)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Quality Assurance Processes	Redesign of Quality Assurance Visits and other safety checks and systems to align with new regulatory model	Dr M Power	March 2024	Q&P Cttee	In Progress
Clinical Audit Submissions (Regulation 17)	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant Dr M Power	June 2023	Q&P Cttee	In Progress
Controlled Drugs and Medicines Management	Review and refresh all medicines and controlled drugs policies and procedures and monitor compliance.	Dr C Grant	March 2024	Q&P Cttee	In Progress
Duty of Candour	Ongoing compliance monitoring and reporting to strengthen position	Dr M Power	September 2023	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Ms C Wood	September 2023	Q&P Cttee	In Progress
Fit Testing	Establish internal fit testing team and maintain compliance	DIPC	December 2024	Q&P Cttee	Not commenced
Compliance to Essential Checks	Improve compliance on tyre and medicines checks in safecheck to 90%	G Blezard	March 2024	Q&P Cttee	In Progress
Information Governance	Improve compliance on mandatory training to 95%	Dr M Power L Ward	March 2024	Resources Cttee	In Progress
Electronic Quality Measurement Auditing/Reporting Systems	Develop automated systems for non-clinical audits	Dr M Power	September 2023	Q&P Cttee	In Progress
PEOPLE					
Appraisal Compliance 2023/24	Achieve 85% compliance	Ms L Ward	March 2024	Resources Cttee	In Progress
Mandatory Training Compliance 2023/24	Achieve 85% comliance	Ms L Ward	March 2024	Resources Cttee	In Progress

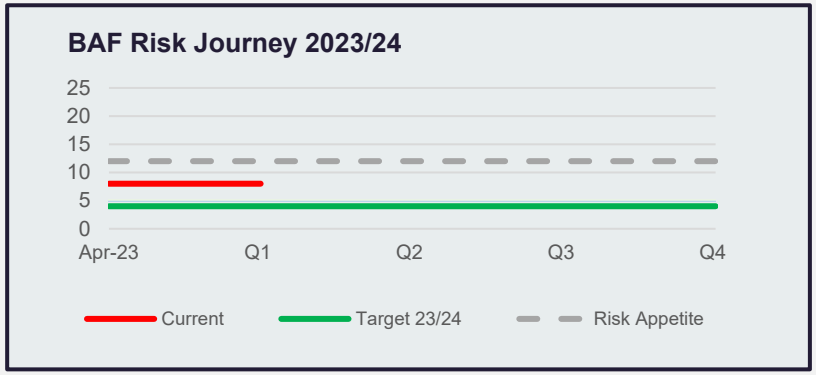
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	8	8				4	4
	4x2	4x2				4x1	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within				Below	Below

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a risk score of 8. Area teams need to work more closely with partner organisations to shape external service delivery processes as well as ensuring we have constructive dialogue with partners at the right level. A mapping exercise was conducted in 2022 and will be refreshed in Q2 23/24 in each of the areas. Areas are aware of the external meetings that require attendance. It is also important to evidence the external engagement with partners in the health and social care system and for this should be recorded in the Knowledge Vault as assurance for the trust. Compliance challenges exist in 1 out of the 3 areas of the trust and this is currently being addressed.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Improving
Improvements dependent on service delivery compliance within Q2.

CONTROLS →	ASSURANCES →	EVIDENCE
NWAS		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Utilisation of the KV by all three areas of the Trust	Mr S Desai	Q2	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q2	Resources Cttee	In Progress

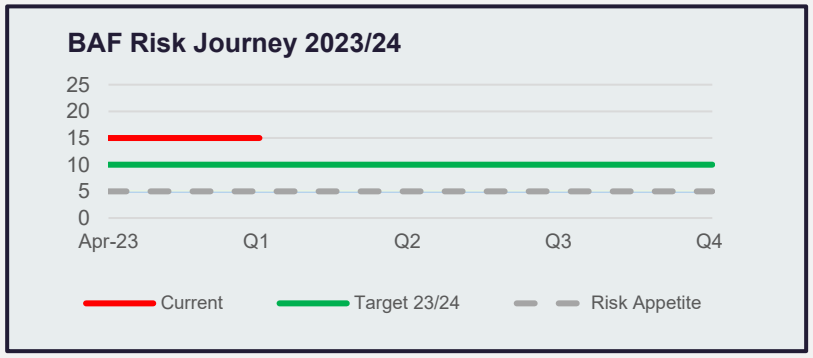
Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	15	15				10	5
	5x3	5x3				5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of the BAF remains at a risk score of 15. There continues to be a high threat of cyber-attacks, which is based on global cyber activity and threat levels. Digital change and development has increased our attack surface, however controls are in place and monitored through the Trust's Information Governance Sub Committee. The baseline submission for DSPT was completed and roles to increase specialist expertise were recruited to, however, information governance training compliance remains below the expected standard. The Trust continues to be responsive to nationally issued guidance and is progressing the cyber security work plan. Multifactorial authentication has concluded with deployment across the Trust and completion in Q2. A backup solution has been implemented and our focus remains on closing the small number of unsupported servers of which a plan is in place to have these decommissioned by end of July 2023. Patching compliance remains high, with good oversight of cyber controls

Projected Forecast Q2: Deteriorating / Stable / Improving

Rationale: Improving
Due to the work on the 2008 servers, this risk could be reduced however it is difficult to predict external factors beyond the trust's control.

CONTROLS	ASSURANCES	EVIDENCE
Patching (999 and NHS 111)	**Level 2:** Digital Strategy Update	Reported to Resources Cttee (RC/2324/14)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Supported Systems	Decomission unsupported servers (2008) and (2008 R2)	Dr M Power	August 2023	Audit Cttee	In Progress
	Upgrade windows operating systems to within a supported 12 month version	Dr M Power	October 2023	Audit Cttee	In Progress
	Replacement of all system using SQL 2008 and 2008 R2	Dr M Power	August 2023	Audit Cttee	In Progress
Patching (999 and NHS 111)	Enable monthly failover & patching opportunities	Dr M Power	August 2023	Audit Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	March 2024	Audit Cttee	In Progress
	Implement findings from DSPT Audit	Dr M Power	May 2023	Audit Cttee	In Progress
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	December 2023	Audit Cttee	In Progress

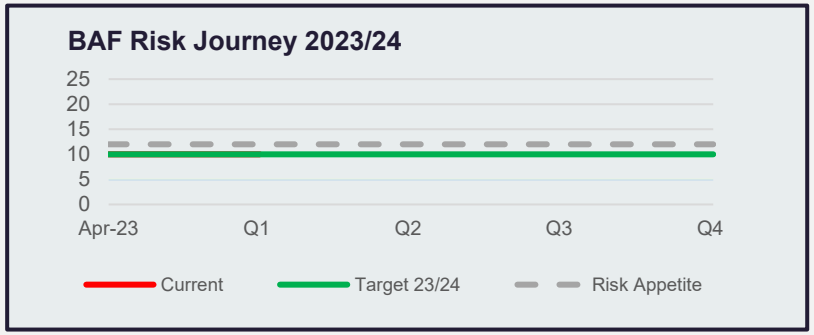
Operational Risks Scored 15+ Aligned to BAF Risk: SR08						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
330	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 High	15 High		5 Low
331	Operational/ Digital and Innovation	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	12 Moderate	16 High		4 Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK 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

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	10	10				10	10
	5x2	5x2				5x2	5x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a risk score of 10. Negative media attention arising from long delays and potential harm is a constant risk that requires annual communications plans and approaches that can respond to seasonal and other circumstantial demands. Our aim is to keep the risk at a moderate and managed level.

Projected Forecast Q2: Deteriorating / Stable / Improving

Rationale: Improving
This is an improving position as there are a set of regularly reviewed controls in place. Performance response times are improving.

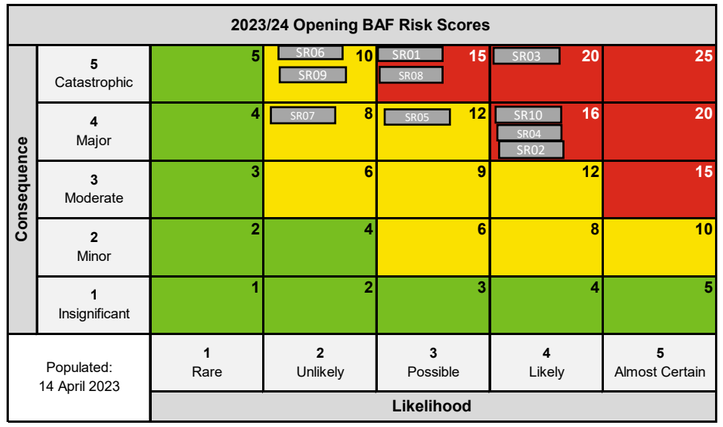
CONTROLS	ASSURANCES	EVIDENCE
Communications and Engagement Dashboard	**Level 2:** Q1 Assurance	Reported to BoD (BoD/2324/40)

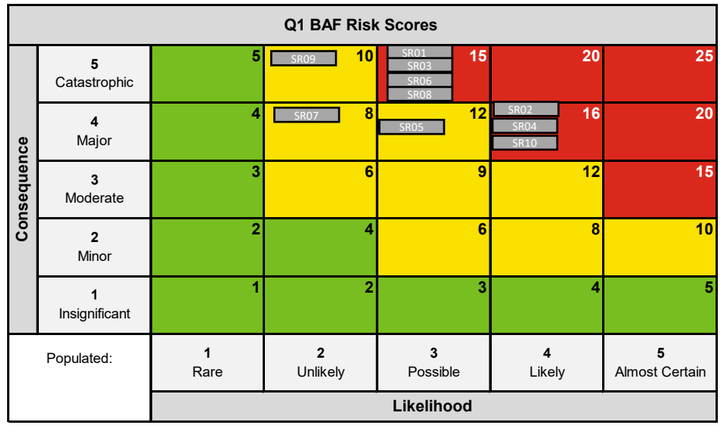
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Production of operational service lines demand management plans for NHS 111 and PES	Operational service lines to produce their own demand management plans and share them with the Communications Team so that communications approaches can be aligned.	Mr G Blezard	Ongoing throughout 23/24	ELC QPC	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve working practices	Mr G Blezard	November 2023	Q&P Cttee	In Progress
	Maximise resources to the most efficient level	Mr G Blezard	2023/24	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr G Blezard Mrs L Ward	March 2024	Q&P Cttee	In Progress

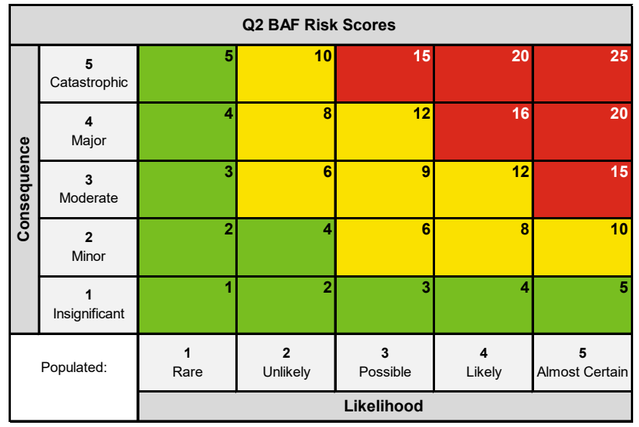
Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

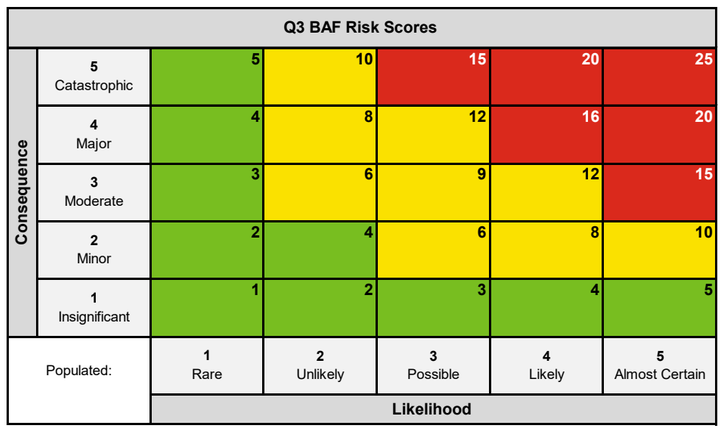
Appendix 2:
2023/24 Board Assurance Framework (BAF) Heat Maps
Q1 Position

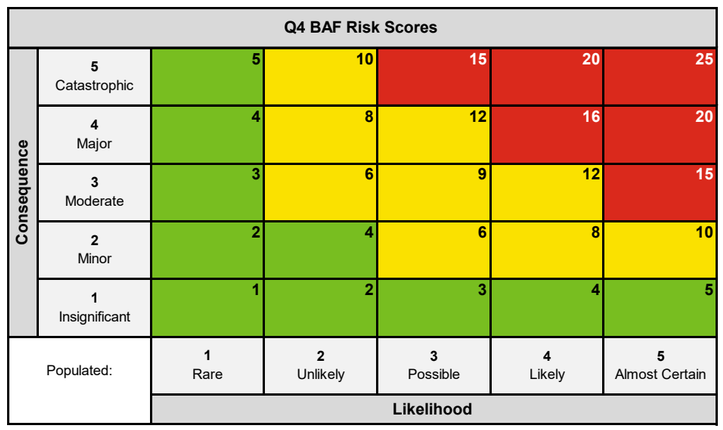
NHS
North West
Ambulance Service
NHS Trust

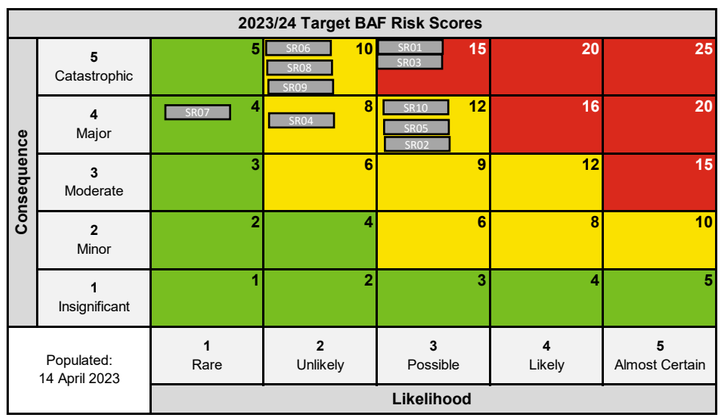


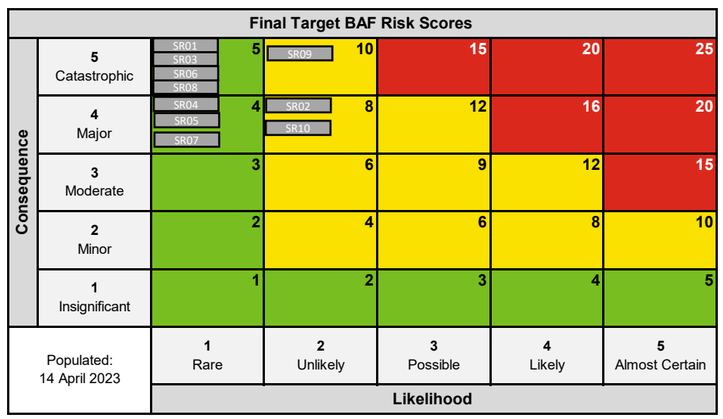












NHS
North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Monday 26 July 2023				
SUBJECT:	PSIRF Local Priorities				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☒	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	In August 2022, NHS England issued the final documents relating to the implementation of the Patient Safety Incident Response Framework (PSIRF). The change is wholesale and impacts across the entire Trust. This forms part of the NHS Contract and is mandated for all Trusts with a mandated go-live deadline of September 2023. The PSIRF Project Team have been working on the implementation and have recently been undertaking a review of the organisation's patient safety profile. This review has been a collaborative process involving many internal stakeholders. The methodology used as part of this process can be viewed in s3 of the report. The proposed NWAS Local Priorities, which have already been presented to ELC and Quality & Performance Committee for agreement prior to Board final sign-off, can be viewed in s4 of the report.				
RECOMMENDATIONS:	The Board of Directors is asked to: • Agree the NWAS PSIRF Local Priorities as recommended to the Board by the Executive Leadership Committee and Quality & Performance Committee				
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: ☒ Compliance/Regulatory ☒ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation				

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:	ELC & Quality and Performance Committee			
	Date:	5th July & 24th July 2023		
	Outcome:	Agreed for recommendation to the Board		

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1 PURPOSE

This paper provides the Board of Directors with the opportunity to review and agree the Local Priories for NWAS under the Patient Safety Incident Response Framework (PSIRF).

2 BACKGROUND

During late August 2022, NHS England (NHSE) released the final documentation relating to the PSIRF implementation programme, which sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF replaces the Serious Incident (SI) Framework which has been in place since 2015.

PSIRF mandates organisations to examine patient safety records and safety data covering a minimum two-year period.

The proposed local priorities have already been presented to ELC and Quality & Performance Committee for agreement prior to presentation at Board for final sign off.

3 METHODOLOGY TO EXAMINE PATIENT SAFETY RECORDS & SAFETY DATA

Stage 1
Initially, the PSIRF Project Team commenced data gathering from a variety of sources and time periods.

Data Types	Time Period
Contentious/ Potentially Contentious Inquests	2021/22 2022/23
Claims	2021/22 2022/23
Learning from Deaths	2021/22 2022/23
Complaints	2020/21 2021/22 2022/23
Serious Incidents	2020/21 2021/22 2022/23
Incidents	2021/22 2022/23
Freedom to Speak Up	2020/21 2021/22 2022/23
Human Resources: HR Case Management	2017-2023
Staff Survey Results	2017-2021
CQC Reports	2018-2022

In addition, the PSIRF Project Team collated other sources of information from a variety of specialisms, including:

- End of Life
- Safeguarding

- Mental Health
- Medicines
- Maternity
- North West Air Ambulance (NWAA)
- NWAS Harm Review undertaken for December 2022 and January 2023
- Risks held on the Risk Register.

This initial process focused on gathering quantitative information and the next stage would be gather qualitative information from multidisciplinary team discussions with internal stakeholders.

Stage 2
The PSIRF Project team hosted a virtual workshop to present the quantitative data and commence qualitative discussions with a view to seek and understand inequalities in patient safety. New areas identified will be considered as new risks and placed on the risk register if appropriate.

The initial workshop was held on 01 June 2023, and the following key internal stakeholders were present:

- PSIRF Project Team, including Patient Safety Specialist
- Head of Legal Services
- Senior Patient Safety Manager
- Senior Patient Safety and Learning Manager
- Patient Safety Manager: Complaints
- Patient Safety Manager: SIs and Incidents
- Clinical Audit Manager
- Patient Safety Partner.

At this workshop, data was presented by each data lead in a meaningful way to the group to assist with understanding. Initially, a mixture of broad themes was captured. This exercise concluded, and a second thematic review took place to identify recurring themes.

The attendees agreed the value of coming together and sharing data in relation to patent safety and the presence of a Patient Safety Partner added value, challenge, and opinions from the public perspective.

Learning was identified pertaining to:

- Data capture in DCIQ and the requirement to gain greater consistency across all modules for data comparison and ease of triangulation.
- Limited capture of inequality data.

Concluding this workshop, it was agreed more time was needed, and the attendees needed to be widened to allow greater discussion around understanding the data, contributory factors, and any localised improvement work that is being undertaken to address the profile being captured.

Stage 3
A further workshop was held by the PSIRF Project Team on 15 June 2023. In addition to the attendees from the first workshops, the following stakeholders were present:

- Senior Clinical Services Manager (NHS 111)
- Senior Clinical Lead (EOC and CHUB)
- Head of Mental Health and Learning Disabilities
- Mental Health Lead for Suicide Prevention
- Freedom to Speak Up Guardian
- Acting Head of Service for PTS

This workshop had a further review into the data, alongside qualitative discussions to understand the contributory factors and improvement work that has been completed, in progress, or soon to be commencing.

The group came to a consensus of six potential local priorities, that would be socialised with relevant Executive Directors (Director of Corporate Affairs, Director of Quality, Innovation and Improvement, and the Medical Director) for review and a discussion prior to formally reporting to the Executive Leadership Committee, for approval.

Stage 4
Discussions were held with the three Executive Directors which enabled the Head of Risk and Assurance and the Patient Safety Specialist to consider the six potential local priorities identified alongside the contents of the newly refreshed Quality Strategy, and the connectivity to the Trust's Annual Plan, Trust Strategy, and the NHS Patient Safety Strategy (updated 2023).

This piece of work was undertaken, and the six proposed local priorities for NWAS, were reviewed and reduced to three broader local priorities.

These three priorities were agreed and supported by the three Executives.

4 PROPOSED NWAS LOCAL PRIORITIES

The following three local priorities are proposed for NWAS:

1. Prevention of deterioration to critically unwell patients
2. Errors in 999 and 111 call handling which led to a delay with contributing harm
3. Face to face or telephone assessment which is managed down an incorrect pathway contributing to harm.

National guidance recommends that three to six learning responses per local priority are conducted per year. When combined with the patient safety incident investigations from the national priorities this will likely result in approximately 20-25 learning responses per year.

These local priorities represent opportunities for learning and improvement in NWAS. Local priorities are recommended to be an organisation's focus for the next 12 to 18 months. PSIRF permits organisations to be flexible with the local priorities and consider changing them depending on the number of incidents being reported, known contributory factors and/or, limited improvement activity/ successes.

Simultaneously, the PSIRF Project team are planning how the organisation responds to patient safety incidents.

5 LEGAL, RISK and/or GOVERNANCE IMPLICATIONS (including consideration of the Trust's Risk Appetite Statement)

PSIRF is a contractual requirement under the NHS Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

The decision-making process to agree the local priorities are within the Trust's risk tolerance parameters as outlined in the Risk Appetite Statement.

Risk Appetite Domain	Rationale
Compliance/ Regulatory (Low)	Will support the Trust in meeting legislative requirements
Quality Outcomes (Low)	Will bring longer term benefits and will not compromise quality of care
Financial/ Value for Money (Moderate)	No implication to finance
People (Moderate)	Will support staff being compassionately involved and engaged in a learning response process and support the growth of a just and learning culture
Reputation (Moderate)	Implementation of PSIRF is an NHS Contractual requirement and therefore mandatory
Innovation (High)	No implication on digital innovation due to the Datix Cloud IQ (DCIQ) system already in place

6 EQUALITY OR SUSTAINABILITY IMPACTS

PSIRF offers a more flexible approach to the original Serious Incident Framework and makes it easier to address concerns specific to health inequalities. It provides the opportunity to learn from patient safety incidents and prompts consideration of inequalities during the learning responses from investigations. PSIRF endorses a system-based approach and supports the development of an underlying just culture.

7 RECOMMENDATIONS

The Board of Directors is asked to:

- Agree the NWAS PSIRF Local Priorities as recommended to the Board by the Executive Leadership Committee and Quality & Performance Committee

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	21st June 2023	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Dr A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Ms C Butterworth, Non-Executive Director Mr D Whatley, Associate Non-Executive Director	**Key Members Not Present:**	
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Audit Completion Report	The Committee received the Audit Completion Report from the External Auditors, Mazars LLP summarising the audit conclusions and the intention to issue an unqualified opinion.	Noted the contents of the report and positive outcome for the Trust	
Independent Auditor's Report	The Committee noted it was a standard document for inclusion within the Annual Report and Accounts.	Noted the contents of the report.	

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

Audited Annual Accounts 2022/23	The audited Annual Accounts 2022/23 were presented to the Committee for review prior to approval and adoption by the Board of Directors. The Committee noted the Trust had met all of its statutory financial duties.	Recommended the audited Annual Accounts 2022/23 to the Board of Directors for approval.	
Annual Report 2022/23 including Annual Governance Statement	The Committee received the Annual Report 2022/23 for onward recommendation to the Board of Directors for approval. The Committee noted the Annual Report had been prepared in accordance with the DHSC Group Accounting Manual 2022/23 and had been reviewed by external auditors.	Noted the contents of the report and compliance against the mandatory requirements set out in the DHSC Group Accounting Manual 2022/23. Recommended the Annual Report 2022/23 to the Board of Directors for approval.	
Management Letter of Representation	The Director of Finance presented the Management Letter of Representation drafted by the External Auditors. It was noted the content of the letter attests to the accuracy of the financial statements and is largely driven by matters that the external auditors wish the Trust to confirm to support our compliance with accounting and auditing standards.	Confirmed agreement for the letter to be presented to the Board of Directors for sign off.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	21st July 2023	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Dr A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Ms C Butterworth, Non-Executive Director Mr D Whatley, Associate Non-Executive Director	**Key Members Not Present:**	
In attendance:	Mrs P Harder, Head of Corporate Governance (Deputising for Director of Corporate Affairs) Mrs M Brooks, Deputy Director of Finance (Deputising for Director of Finance)		
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Chairs Assurance Report – Quality and Performance Committee	The Committee received the reports from the meetings held on 27th March 2023 and 22nd May 2023.	Noted the assurances provided.	

Key	
	No assurance - could have a significant impact on quality, operational, workforce or financial performance
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Clinical Audit Q4 Update 2022/23	The Clinical Audit Q4 update was presented to the Committee.	Noted the assurances provided.	
SIRO Annual Report	A summary of the work completed over the past 12 months to manage information risk within the Trust was provided to the Committee.	Noted the assurances provided.	
Information Governance Sub Committee – Chairs Assurance Report	The Committee received the report from the meeting held on 11th July 2023.	Noted the assurances provided.	
Critical and High Risk Recommendations	MIAA continue to follow up recommendations as follows: • Blue Light Vehicles (Section 248a Exemptions) – one high risk action not due until September 2023 • Team Rostering (C&M) and Stock Management – actions confirmed as implemented.	Noted the update provided.	
Internal Audit Progress Report Q1 2023/24	The Committee noted the assurance reviews completed within Q1: Data Security & Protection Toolkit – Substantial Assurance Fit & Proper Persons – High Assurance Freedom to Speak Up – Substantial Assurance	Noted the assurances provided.	
Internal Audit Follow Up	The Committee noted the good progress within the reporting period and that 5 recommendations were completed during the period.	Noted the assurance provided.	
Head of Internal Audit Opinion	The Head of Internal Audit Opinion for the period 1st April 2022 to 31st March 2023 provided:	Noted the assurance provided.	

Key	
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	Substantial Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.		
Anti-Fraud Progress Report Q1 2023/24	The Anti-Fraud Progress Report 2023/24 detailed the work completed by the Trust's Anti-Fraud Specialist (AFS) during the period 1st April 2023 to 30th June 2023.	Noted the assurance provided.	
Auditors Annual Report	The Auditor's Annual Report confirmed the outcome of the audit of the Trust's financial statements. The report also included commentary on the Trust's value for money arrangements and confirmed no significant weaknesses in the Trust's arrangements were identified, with no recommendations arising.	Noted the assurances provided.	
Board Assurance Framework Q1 2023/24	The Committee received the proposed Q1 position of the BAF prior to submission to the Board of Directors for approval on 26th July 2023. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurances provided.	
Losses and Compensation Report	Losses and compensation for Q1 2023/24 financial year totalled £257k.	Noted the assurance provided.	
Waiver of Standing Orders Q1 2023/24	A total of two waivers were approved during Q1 2023/24.	Noted the assurances provided.	

Key	
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MIAA 2023/24 Checklist Series – Pre-employment Checks	The Committee received a report in response to MIAA's latest checklist to support NHS organisations in their arrangements for pre-employment checks. The checklist mirrored the pre-employment checks mandated by the Department for Health and Social Care for all appointments to the NHS.	Noted the assurance provided.	
Chairs Assurance Report – Resources Committee	The Committee received the reports from the meetings held on 26th May 2023.	Noted the assurances provided.	

Key	
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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Charitable Funds Committee			
Date of Meeting:	19th April 2023	**Chair:**	Mr D Rawsthorn
Quorate:	Yes	**Executive Leads:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Mr S Desai, Director of Strategy, Partnerships & Integration Mr G Blezard, Director of Operations Mrs A Wetton, Director of Corporate Affairs Mrs C Butterworth, Non-Executive Director Mr D Whatley, Associate Non-Executive Director Dr D Hanley, Non-Executive Director Mrs M Brooks, Deputy Director of Finance	**Key Members Not Present:**	Mrs C Wood, Director of Finance

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

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Charitable Funds Update	The Committee noted: Income received by the charity in 2023/24 amounts to £35k: • £17k unrestricted • £18k restricted	Noted the assurances provided.	

Key	
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	Expenditure during the same period amounted to £140k. Therefore as at the 30 June 2023, the total available resource is £1,171k: ○ £499k unrestricted ○ £672k restricted The Committee noted the summary of activity undertaken during Q1 2023/24.		
Restricted Funds Update	An update was provided relating to the progress made towards reducing the restricted funds, particularly in relation to those held for a significant length of time. The Committee noted that as a result of active management, the Charity no longer held any significant restricted funds and over the last 12 months had reduced from £938k to £717k. The plans in place to reduce these further during the financial year were noted.	Noted the assurances provided.	
NHS Charities Together Grants Update	An update was provided in relation to the current and pending grants from NHS Charities Together (NHSCT) and the associated projects.	Noted the assurances provided.	

Key	
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	Committee requested a further paper to seek assurance that the Community Resuscitation Engagement Officers recruited as part of the Ambulance Service grant work to a set of objectives in order to measure the investment and evaluate how the posts work with deprived communities.		
Hardship Fund Update	An update was provided in relation to the Hardship Fund up to 30th June 2023. It was noted that applications had been received from 221 applications, of which 174 had been approved and disbursed. Due to the spike in applications during the quarter and impact on the funds available to run the fund up to 31st August 2023. The Committee approved to allocate a further £25,000 from unrestricted charitable funds up to at least 31st August.	Noted the assurances provided.	
Business Plan 2023-2026 – Revised Budget	The Committee approved the revised three-year financial business plan. The main revisions to the plan related to a number of variables mainly: • Increased salary expenditure which impacts across all three years as a result of the final NHS Agenda for Change pay award.	Approved the revised three-year business plan.	

Key	
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	• Additional one-off cost of £10,000 in year 2 to purchase a Customer Relationship Management (CRM) system. • Better than expected unrestricted starting balance. • Charitable expenditure for year 4 onwards is lower than previously projected.		

Key	
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NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th July 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**
	☐	☐	☐	☐	☒
PURPOSE OF PAPER:	For Assurance				

EXECUTIVE SUMMARY:

The Integrated Performance Report for July 2023 shows performance on Quality, Effectiveness and Operational Performance during **June 2023** unless otherwise stated. Comments are made by exception for assurance purposes.

Quality:

- **Complaints:** Overall numbers of complaints has increased. The number of complaints scored 1-3 is driving this increase (**n=311**), the number of serious complaints (scoring 4-5 on risk assessment) remains stable. The closure rate for complaints continues to be at the highest point since January 2017, in particular, for complex complaints.

- **Incidents: (n=564)** incidents were opened (score 1-3) and **(n=40)** (score 4-5). Only 56% of incidents (score 1-3) were closed within the agreed time frames (SLA). The top 5 themes this month were: care and treatment; call handling; violence and aggression; delays; accidents and injuries.

Serious Incidents: there were 4 serious incidents reported to the regulators via the STEIS database. This remains below the monthly average of 5. There is still a backlog of 101 serious incidents which built up during winter pressures and industrial action, of which 60 are with the commissioner. Work is ongoing with improving the Duty of Candour process and compliance.

Effectiveness:

- **Patient Experience**: We continue to take seriously all feedback received by patients via the friends and family test. Negative themes arising in the commentary relate to patients not feeling 'heard', positive themes relate to the professionalism and compassion of our staff.
- **Ambulance clinical quality indicators:** Compliance to the **STEMI care bundle** first dropped below 95% in 2017. The latest data shows 61.3% (January 2023) for stroke (special cause variation). These low levels of compliance are likely to be attributable to the delays in cat 2 response observed at this time. The clinical effectiveness committee monitor care and treatment and review these data regularly.

Operational Performance:

- **Activity and Outcomes:** Incident volume has decreased to n=20,865 and the monthly number of contacts with 'no outcome' has increased from n=13,403 to n=16,108, showing 1 data point (June 2023) above the upper control limit.
- **Hear and Treat (H&T) and See and Treat (S&T):** H&T is now 13.9% and S&T has stabilized at 28.2% resulting in a total non-conveyance of 42.1%. Comparing NWAS with the other 10 ambulance trusts, we are 3rd in hear & treat performance, 7th in see & convey and 9th in see & treat (28.2%)
- **Calls:** June 2023 has seen a 9% decrease in calls compared to June 2022 and a 1% increase in incidents, with the last week in June showing special cause.
- **Call Pick Up:** This has seen a decrease in June 2023, with pick up in 5 seconds at 94% compared to 99% in May 2023. With 1 data point in special cause on the upper control limit.
- **999 Ambulance Response Programme:** The standards were met for one ARP standard - C1 90th. The Trust is achieving the UEC recovery standard of 30 minutes for C2 mean, but overall has seen a downturn in performance for June, although this remains within control limits. Significant variation can be seen between ICB footprints. Comparing NWAS with the other 10 ambulance trusts, we are performing in the top 3 on C1 90th, C2 mean and C2 90th standards.

Category	Standard	June 2023 Actual	National ranking
C1 (Mean)	7:00	08:22	4th
C1 (90th)	15:00	14:04	3rd
C2 (Mean)	18:00	26:30	2nd
C2 (90th)	40:00	53:22	2nd
C3 (Mean)	1:00:00	2:15:14	8th
C3 (90th)	2:00:00	5:14:06	8th
C4 (90th)	3:00:00	7:24:30	8th

- **Average turnaround time:** Average turnaround time has decreased but continues to be above the national standard of 30:00 with a turnaround time of 34:17. This is the lowest turnaround time since June 2021.
- **111:** The data shows a downturn in demand for June from May. June has seen some improvements in clinical performance metrics and a decrease in call answer metrics.

Measure	Standard	June 2023
Calls Within 60s	95%	51.66%
Average Time to answer		3m 15s
Abandoned Calls	<5%	10.56%
Call back Within 20 min	90%	19.92%
Average Call Back		42m 56s
Warm Transfer to Nurse	75%	14.56%

RECOMMENDATIONS:

The Board of Directors are asked to:

- Note the content of the report.
- Note the increase in Complaints scored 1-3 and the improvement in closing all complaints within SLA.
- Note the requirement to review S&T performance again in light of the national data.
- Note the maintained national position against ARP standards and the delivery of the UEC national standard of 30 minutes on Category 2 mean.
- Note the strong performance of Greater Manchester.
- Note the continuing impact of system pressures on cardiac outcomes for patients in February 2023 and

	the improvement in ROSC for the Utstein group in January and February 2023. • Note the improvements in 111 call answering. • Clarify any items for further scrutiny. • Note the financial position and efficiency saving • Note the improvements in sickness absence and turnover. • Identify any additional risks or items for further scrutiny by sub committees of the board
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: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

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:	24th July 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 **June 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.

2.1 Quality

- **Complaints**: The number of complaints has risen from previous months with those scored 1-3 showing special cause being above the upper limit (**n=311**). The increase is attributed to the recent increase in operational pressures and the move to REAP 3. The number of serious complaints (scoring 4-5 on risk assessment) and incidents remains stable. The closure rate for complaints continues to be higher than historic trends.
- 93% of level 1-3 complaints were closed within the agreed time frames and this is showing special cause.
- 100% of level 4-5 complaints were closed within the agreed time frames, this data is signalling change with 7 consecutive months near the upper limit. This is also the highest consistent performance over the last 5 years.
- **Incidents:** In June 2023, **n=604** internal and external incidents were opened against a 12-month average of **n=957**. In May and June 2023, we have seen a slight decrease in the number of incidents reported. Only 56% of incidents (score1-3) were closed within the agreed time frames (SLA). We anticipate numbers to steadily increase in the coming months due to engagement with service lines to proactively support incident reporting and awareness raising that incidents can be submitted on the DCIQ system via Trust mobile devices. Furthermore, we are seeking feedback from service lines to establish if they are any challenges to reporting incidents and will seek solutions to resolve.
- There were **n=40** incidents opened risk scored 4-5 which represents a significant decrease from the previous trend and signals a potential impact to the number of SIs that will be reported once reviewed. The reason for the significant reduction is mainly attributed to the reduced operational pressures.
- **Serious Incidents:** During June 2023 there were **n=4** serious incidents reported on the StEIS database, whilst this is lower than the peak seen in January 2022 (**n=20**). There is still a backlog of 101 serious incidents which built up during winter pressures and industrial action, of which 60 are with the commissioner. Work is ongoing with improving the Duty of Candour process and compliance.

- Incidents risk scored 1-3 completed within SLA (Service Level Agreement) has been stable over the last few months. Supportive measures continue to remain in place and will remain in place to improve compliance. The Incident Management Team are working collaborative work with service lines to improve compliance. The supportive measures implemented in February 2023 have proven to be effective with compliance improving over the previous months.
- **Themes:** The 5 most common themes for incidents reported in June 2023, were:
    - Care and treatment (**n=89**),
    - Call Handling (**n=85**)
    - Violence and Aggression (**n=66**)
    - Delays **(n=64)**
    - Accidents and Injuries (**n=51**)
- **Compliments:** In June 2023, (**n=121**) compliments were received. The number reported for June is likely to increase as compliments continue to be processed throughout July. The average number of compliments received over the last 12 months is **(n=127)** a month.

2.2 Effectiveness

Patient experience

- June 2023 saw **n=356** PES responses, the third highest we have seen in the last 13 months with 84.8% identifying “Very good/good” as the outcome.
- For PTS we saw **n=1,015** responses in June 2023, this was 0.6% lower compared to May **n=1,022**. The overall experience score for June was 89.6% is slightly lower than the 91.9% reported in May by 2.3%.
- The NHS 111 service returns from June of **n=95** is 44.2% lower in comparison to May’s return of **n=170**. We expect the number of returns for June to increase as they are still arriving with the trust.
- For NHS 111 first this survey is being replaced with a localised, simpler version of the national 111 survey which is being designed with the trust’s 111 service. The intention is to increase the number of returns over that of the nationally mandated and very lengthy existing 111 survey. Once the survey is approved it will be included in the report.

Ambulance Clinical. Quality Indicators (ACQI’s)

February 2023's data see us within normal limits and close to the mean across all indicators apart from the STEMI care bundle (January) and the Stroke care bundle both being on or near the lower limit. 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 51.7% (national mean 50.4%). For the overall group the rate was 28.9% (national mean 27.4%).
- Survival to Discharge rates in February 2023 were at 6.2% (national mean 8.4%).

- In February 20% of patients in the Utstein group survived to hospital discharge. The national mean at 25.3%.
- Mean call to PPCI time in February for patients suffering a myocardial infarction was above the national mean of 2h 26mins; the Trust's performance was 2h 34mins.
- Mean call to hospital time in February for patients suffering a hyper acute stroke was below the national mean of 1h 32mins. The trusts performance was 1h 17mins.
- The Stroke Care Bundle performance for February was 96.8%. The national mean was 97.1%
- The Stemi Care Bundle performance was not reported for February in line with the NHSE schedule however the latest data shows 61.3% (January 2023) for stroke (special cause variation). These low levels of compliance are likely to be attributable to the delays in cat 2 response observed at this time. The clinical effectiveness committee monitor care and treatment and review these data regularly.

Hear & Treat, See & Treat, See & Convey

- For June we achieved 13.9% Hear & Treat and ranked 3rd nationally.
- See & Treat we achieved 28.2% and we are ranked 9th nationally.
- In total there was an aggregate non-conveyance of 42.1%.

Hear and Treat has remained relatively static through June with three out of the four data points tracking around the mean. The consistent delivery of hear and treat is a reflection of relatively consistent response standards and no real shift in CHUB workforce. The levels of hear and treat are influenced by three primary factors. EMA hear and treat resulting from initial triage (this remains very consistent with 5% of all 999 triages resulting in a hear and treat outcome with the patient being signposted to an appropriate service via the Directory of Service). The second factor is CHUB and external CAS provider's secondary triage. The rates delivered via the CHUB/CAS are relatively static and growth will only occur as the workforce increases or operational response declines. Operational response is a key factor, as for the majority of patients the opportunity for secondary triage is influenced by response standards. If response standards increase the CHUB have greater time/opportunity to secondary triage appropriate patients.

It is anticipated that hear and treat will increase over the remainder of the year. This is due to a significant increase in CHUB senior workforce. The Trust via UEC Recovery funds is aiming to recruit 70 additional senior clinicians into the CHUB. This new workforce will provide secondary triage to some C2 patients. The patient cohort within C2 is determined by the national C2 segmentation pilot (circa 40% of C2 cases are deemed suitable). It is anticipated hear and treat will rise through Q3 and Q4. Modelling exact increases is complex due to the interdependency of operational response standards.

2.3 Operational Performance - Patient Emergency Service (PES)

Activity: In June 2023, the Trust received **n=118,947** calls of which **n=91,933** (77%) became incidents. Compared with June 2022, we have seen an 9% decrease in calls and a 1% increase in incidents. Overall, the weekly incidents in June remained around the mean with the only last week falling to the lower control limit and showing special cause.

The decrease in calls is influenced by lower call volume at the commencement and conclusion of the month. However, the mid period of June did see increases in call volume. This is likely to be as a result of high temperatures experienced across the region. The heat historically increases demand to our 999 service. In addition, acuity tends to rise with conditions such as respiratory issues increasing.

Incidents increased marginally and is likely to be due to the heat and stable response standards. Incidents are equally a measure of operational capacity as it is demand. As response standards have been stable and operational resources have improved, the Trusts ability to respond increases and as a result incidents increase.

For June duplicate calls stood at **n=24,318**, compared to May at **n=20,482**. No outcome incidents (which includes those cancelled or close through signposting) sat at **n=16,108** versus May's **n=13,403**, with 1 week in June above the upper control limit and in special cause. It is reasonable to conclude demand overall is static with any increases heavily influenced by the hot weather in the middle of June.

- **Call volume:** call volume is 12% below the equivalent month for 2022.
- **Call Pick Up** has seen a decreased in June 2023, the overall mean answer being 3 seconds (compared to 1 second in April and 0 seconds in May) with pick up in 5 seconds at 94% (compared to 99% in May). The 95th call answer percentile showing as 15 seconds for June. There is one data point within June which is over the upper control limit and showing as special cause.

Call pick up has fallen in June from the two previous months. NWAS continue to lead the sector in call pick up and long-term forecast indicate these levels of performance will continue. As an example, NWAS contribute less than 1% of national BT two-minute delays. The heat and increases in activity mid-month did influence the mean CPU for the month.

Looking forward NWAS continue to invest in EMAs to maintain high call pick performance, this investment is supported by UEC recovery funds. Call pick under 10 second mean is one of the two monitored ARP standards for UEC recovery and NWAS are well placed to deliver on this metric throughout the year.

Ambulance Response (ARP) Performance

Category	Standard	June 2023 Actual	National ranking
C1 (Mean)	7:00	08:22	4th
C1 (90th)	15:00	14:04	3rd
C2 (Mean)	18:00	26:30	2nd
C2 (90th)	40:00	53:22	2nd
C3 (Mean)	1:00:00	2:15:14	8th
C3 (90th)	2:00:00	5:14:06	8th
C4 (90th)	3:00:00	7:24:30	8th

For June response time targets were only met for C1 90th. All the ARP standards have seen a decrease in performance when compared to May and previous months, especially around week commencing 12th June.

All data points increased for the week commencing 12th June. This is due to the increased temperatures experienced across the Northwest. The impact was an increase in activity and acuity of patients. This increased response times across all ARP standards. Specifically, within C2 to C4. The SPC charts all reflect a common trend, and this reflects the best practice approach taken by EOC dispatch. In essence dispatch to the longest waiting, highest acuity patient first. This results in a common trend in response, i.e., any extended response to C2 is reflected within C3 and C4.

Whilst the Trust is not meeting the 18-minute mean response standard for C2 response, the trust is achieving the UEC recovery standard of 30 minutes. The Trust is also performing very well compared to the sector outputs for response.

Further plans are in place to ensure NWAS improves response standards and sustains performance over winter. These plans include;

Introduction of C2 segmentation (live by end of July) which will reduce the number of C2 incidents requiring a response. This will be achieved via recruitment of a new cohort of advanced practitioners who will provide secondary triage of some C2 incidents, as well as rotating into operations providing targeted see and treat response.

Increases to operational resources. This will be delivered via increased levels of recruitment alongside retention of existing vehicles. The Trust is also aiming to increase the levels of VAS/PAS resources deployed providing enhanced resources to respond to C3/C4 incidents. This will also support the HCP/IFT activity.

A review of UCS resource and deployment is also taking place. The review will appraise the current approach and resources levels. The aim of the review is to ascertain optimal UCS levels alongside review of the scope of practice/deployment.

Handover

- Average turnaround time has decreased but continues to be above the national standard of 30:00 with a turnaround time of 34:17. This is the lowest turnaround time since June 2021.
- From early June the data has signalled an improvement with both Average turnaround time and the number of patients waiting outside A&E consistently below the mean. The Trusts performance is aligned with the national trend and aided by the ICBs growing maturity and collaboration.
- **n=2,779** attendances (7%) had a turnaround time of over 1 hour, with **n=223** of those taking more than 3 hours. There was **=545** delayed admissions in June, with total accumulated hours of **n=880**.
- A system handover improvement board is currently being negotiated to discuss the new position for winter 2023. The objective is to sustain the collaborative sessions for handover and foster a system-oriented approach, thereby ensuring a wider distribution of responsibility for handover performance.

C1 & C2 Long Waits

Long waits for C1 saw an increase to **n=693** in June from **n=505** in May. Despite the increase in June 2023, C1 long waits remain consistently under n=750 throughout 2023.

The number of C2 long waits increased from **n=2,142** in May 2023 to **n=3,671** in June. C2 long waits in 2023 continues to be significantly lower than in 2022.

As the data indicates, long waits have increased compared to the previous two months and this is a reflection of the increase in response times. As per overall response the increase in long waits was most acutely observed in the week commencing June 12th.

What should be noted is the continued reduction of extreme long waits both in the C1 and C2 data sets. Whilst all long waits are a concern it is positive that extreme long waits are not prevalent.

2.4 Operational Performance - NHS 111

Measure	Standard	June 2023
Calls Within 60s	95%	51.66%
Average Time to answer	-	3m 15s
Abandoned Calls	<5%	10.56%
Call back Within 20 min	90%	19.92%
Average Call Back	-	42m 56s
Warm Transfer to Nurse	75%	14.56%

June has seen a decrease in the call demand for 111, compared to the previous months. The service saw **n=178,347** calls offered compared with **n= 200,812** in May. **n=126,226** of those calls were answered, **n=14,898** abandoned and the additional calls redirected via IVR signposting.
The reduction in call volume vs May is due to the differing influencing factors on demand when compared to 999 call volume. The hot weather generally has the opposing effect on 111 demand, especially during the weekends. Hot weather historically reduces demand into 111 and this is likely the reason for reduced call volume.

Answered in 60 decreased to 52% in June from 56% in May with call abandoned increasing to 11% from 8% in May. Average time to answer saw an increase to 3 minutes 15 seconds, maintaining the metric within special cause, positioned just below the lower control limit. The decrease in performance can be attributed to the hourly demand pressures along with staffing levels and abstractions.

The demand pressures on the 111 service continue to directly impact the clinical queue, with all clinical performance metrics below target. June has seen some improvements in clinical performance metrics. Average time for call back improved in June to 42 minutes and 56

seconds from 45 minutes and 45 seconds, showing special cause with Average time for call back below the control limit for the last 6 data points. Call back in 20 has remained at 19% in May and June and is now showing special cause above the upper control limit. However, warm transfer has fallen below the mean to 15% in June from 28% in May. 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 May for the Trust was 10% below contract baselines with Cumbria and Lancashire 22% and 25% below baselines respectively. Year to date July 2022 – May 2023) is performing at 17% below baseline.

2.6 Finance

- The year to date expenditure on agency is £0.543m which is under the year to date ceiling of £1.009.
- As at month 03 (June) the trust has under spends in a number of service lines which are under review.

As at month 03 (June) the trust has over delivered against the planned level of efficiency by £0.058m

2.7 Organisational Health

Sickness

The overall sickness rate for June 2023 was 7.77% which includes COVID-19 related sickness of 0.3%. Sickness is below the lower control limit for the fourth month in a row which indicates a positive downward trend. Long Covid are now all but concluded.

The reduction continues to be facilitated through the work of the attendance improvement team with particular 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.

The UEC recovery funding will also enable further investment in attendance coaching support, wellbeing coordination to improve access and navigation of the available support and specialist MSK and Violence and Aggression support. Recruitment into additional posts in ongoing.

Absence levels remain higher in the contact centre environments, although EOC sickness has started to come back in line however, 111 remains high (May 13.98%)

Turnover

Staff turnover for the year to June 23 is 11.87%. This position has been stable for 12 months within an overall variation of only 0.5% over since September 2022. It remains in line with the national average for the sector.

Contact centre turnover remains within control limits, although higher than other service lines. 111 turnover overall has showed some variations since January 2023, peaking at 37.5% in March 23 and is now showing a slight decrease in June to 34.89%. There continues to be focus across both contact centres on work to support retention and the Trust continues to work across the Ambulance Sector and with NHSE on specific targeted interventions to support recruitment and retention in contact centres.

PES is now showing a period of extended stability and a narrowing of control limits and PTS has shown increases in turnover. The main drivers of the increase are retirements and ill health related leavers. Overall voluntary resignations have increased in number terms but not as an overall percentage of leavers. Within resignations, leavers related to improved reward, promotion and opportunities have seen the main increase which mirrors the patterns seen across the contact centres.

Temporary Staffing

Whereas in previous years the Trust has had to work to an overall agency cap, this position has changed slightly for 2023/24 and we are now required to keep costs within our projections in our agreed operating plan. The ICB targets have been disseminated to individual Trusts and this has in essence lifted our previous cap.

The position for June shows continuing agency usage at a similar rate to previous months at a level equivalent to 0.7% pay bill. This is £161k below cap. Bank usage also remains stable.

- Agency staff have continued to support the Contact Centre environments. In the main this is to support vacancy gaps in clinical advisory positions where alternative means of cover are not available. This is reflected in OH4.4
- Some agency usage relates to ensuring appropriate levels of course fill for call handler recruitment but improvements in attraction and streamlining of start times are mitigating these requirements.
- There is the possibility of short term increased agency use whilst recruitment into CHUB clinical positions, funded through the UEC recovery plan, is mobilised.

Vacancy

- Chart OH5.1 shows the vacancy gap at -5.7% in June 2023. In the main this is not caused by reductions in staffing which have remained stable but relates to changes in establishment. Following work between Finance and the People team all establishments have been transferred onto the ESR system and the data now reflects reporting direct from the system. This should enable a more dynamic approach to establishment control and improved accuracy. The main changes are within corporate teams, but this also explains in the main why EOC shows special cause variation and is now over-established. The main changes linked with the UEC recovery plan have not yet been built into establishments but are expected to be built in from September.
- Recruitment plans for 111 remain a risk. The current vacancy position is -18.8% (OH5.5) with vacancies being focused on the Health Advisor and Clinical Advisor roles. Whilst turnover is improving, the recruitment market is proving

challenging for call handler positions. Agency recruitment on an introductory fee basis is being used to help fill any gaps in courses. Recent changes to support improved attraction and course fill are showing early positive signs.

- The PTS vacancy position at –9.05% (OH5.2) and this reflects the increase turnover in staff moving from PTS to PES. 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. There are challenges in responding to additional PTS recruitment needs whilst delivering the ambitious requirements of the UEC Recovery delivery plan.

Appraisal

Appraisal completion rates are at 84.87% for June 23 (OH6.1). The agreed targets for 2023/23 are:

- Service Lines 85%
- Corporate Directorates 95%
- Leadership Roles Band 8a and above 95%

- PES are slightly behind target at 84%. PTS and EOC are exceeding target at 87% and 90%. 111 have slipped behind to 77%. In terms of Corporate Directorates against the new target of 95% improvements have been made but overall Corporate compliance is at 85%.
- The revised fuller appraisal paperwork has now been rolled out and consideration is being given to how the embedding of this is reviewed through quality audits.

Mandatory Training

A new programme for 2023/24 mandatory training has been approved, with PES classroom delivery returning to two days. Additional on-line learning modules have also been included in the overall programmes. 5 additional online modules were added in June 23 which has impacted negatively on compliance rates however this position is expected to be recovered.

The 2023/24 classroom programme commenced on 2 May 2023. PTS are ahead of target with PES meeting current trajectory. Completion of on-line learning modules have continued in Q1 2023 and for the end of June the NWAS overall compliance position is 78.2%.

The approval of the 2023/24 programme also includes the approval of an additional four hours to be allocated to all PES staff to support on-line learning completions and giving eight hours in total. This was in response to feedback from staff, managers and staff side colleagues. Specific focus for 2023/24 will be on subject compliance levels, prioritising information governance completions.

The compliance targets for 2023/24 are to remain the same as those for 2022/23. The targets represent a percentage of all staff and therefore need to take account of longer-term absences from the workplace such as long-term absence and maternity i.e. 100% is not going to be achievable in any one year. In addition, the programme for PES for 2023/24 is increasing in size with a return to a two-day programme and additional committed online hours. This means that whilst it is recommended to maintain the 85% target it goes represent a stretch target in comparison with the 22/23 position.

•85% PES and PTS classroom overall

•85% EOC, 111 and PTS online

•95% for Corporate Teams

Case Management

- Overall numbers of live cases have levelled out and are currently standing at 109. The movement in case numbers has been seen in disciplinary cases which corresponded with the expected decrease in 'fact finding' cases as cases move from one process to another.
- PES continues to show the highest levels of live open cases and cases closed within the last 12 months. PES GM is showing the highest levels of fact finding and disciplinary cases across all services. This is a result of a number of complex cases with police involvement.
- Prevalence rates of ER cases across service lines is highest currently in 111 and PTS. The spike for PTS is due to a small number of cases where a number of employees are involved.
- Average case times are stable but we are seeing a small increase in the time to resolve DAW cases, with these cases, alongside complex disciplinary and SOSR cases, dominating in the 6 month plus timeframe. There are plans to review the Dignity at Work Policy in 23/24 and improvement to timeliness will be a key consideration.
- The number of suspensions is currently 10. Several cases have exceeded 10 weeks due in the main to complexity, correlation with sickness delaying progress and the involvement of third parties. 3 long standing cases are now progressing to hearings.

COVID 19

- **n=21** staff have tested positive for Covid-19 in June 2023.

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

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 are asked to:

- Note the increase in Complaints scored 1-3 and the improvement in closing all complaints within SLA.
- Note the requirement to review S&T performance again in light of the national data.
- Note the maintained national position against ARP standards and the delivery of the UEC national standard of 30 minutes on Category 2 mean.
- Note the strong performance of Greater Manchester.
- Note the continuing impact of system pressures on cardiac outcomes for patients in February 2023 and the improvement in ROSC for the Utstein group in January and February 2023.
- Note the improvements in 111 call answering.
- Clarify any items for further scrutiny.
- Note the financial position and efficiency saving
- Note the improvements in sickness absence and turnover.
- Identify any additional risks or items for further scrutiny by sub committees of the board

North West Ambulance Service NHS Trust

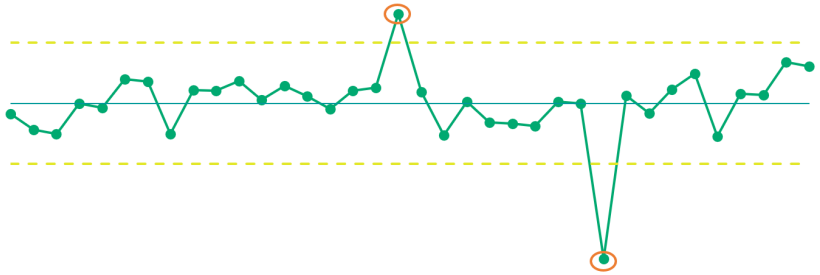
Integrated Performance Report

Board - July 2023

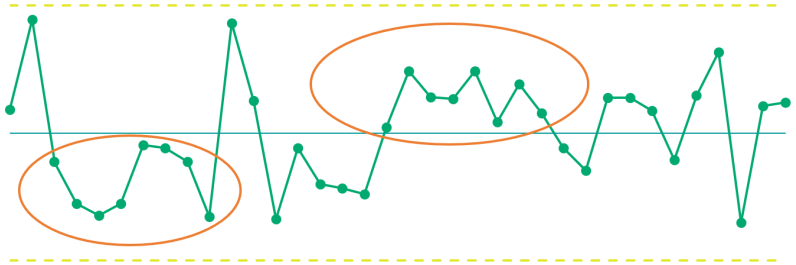
Rules for interpreting SPC Charts

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

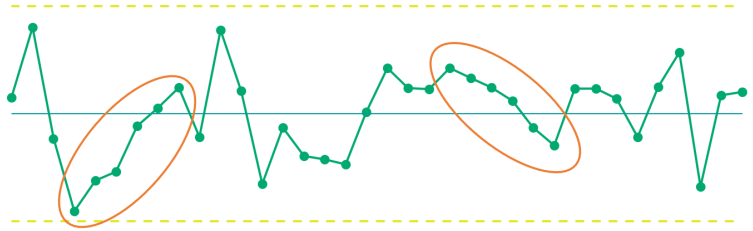
Rule 1: Single data point outside the control limits



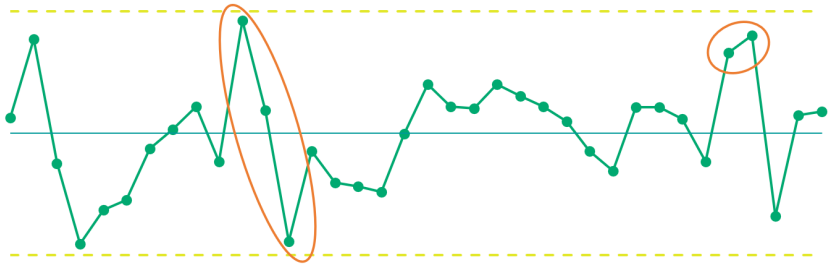
Rule 2: 8 or more consecutive data points above or below the centre line



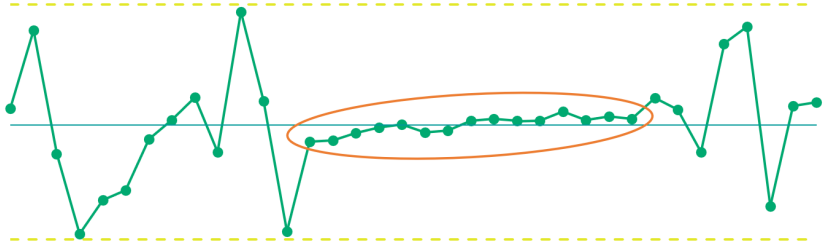
Rule 3: A trend of at least six consecutive points (up or down)



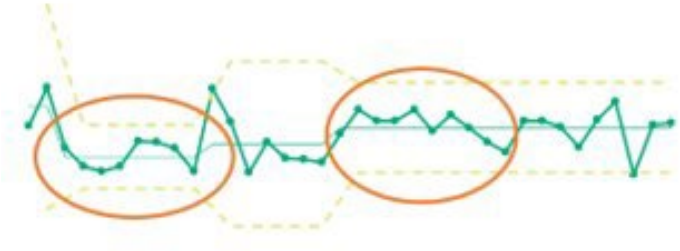
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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

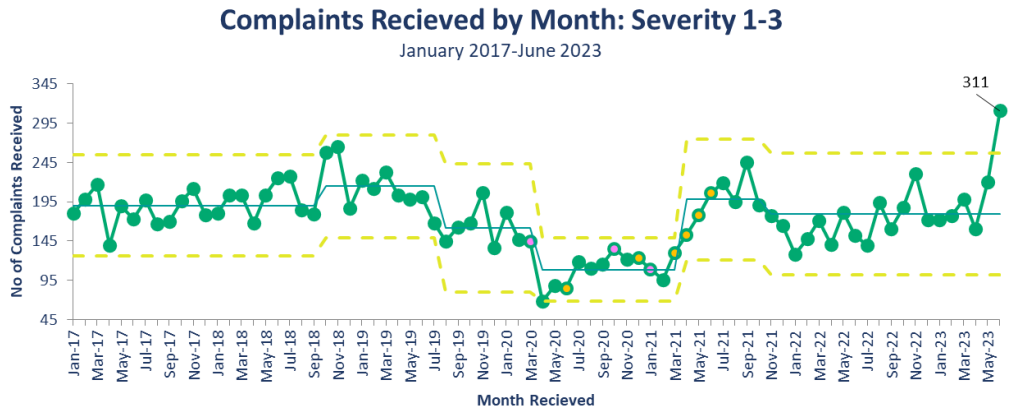


Figure Q1.2

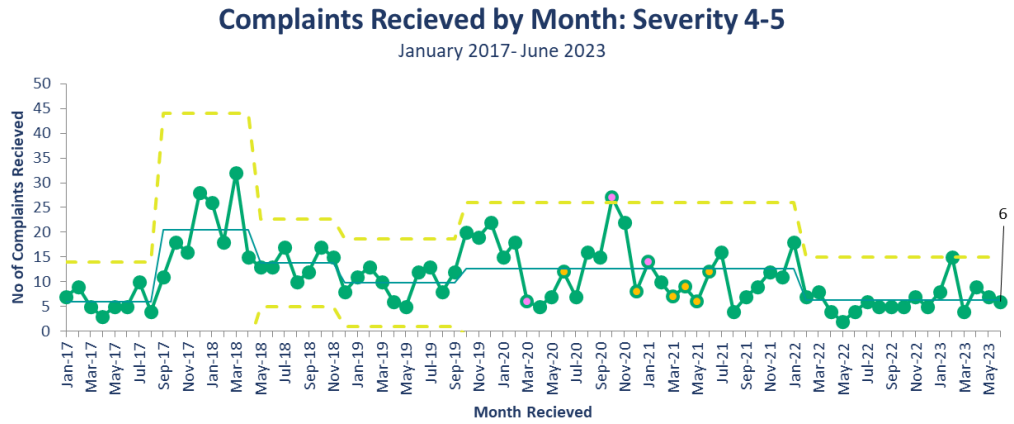


Figure Q1.3

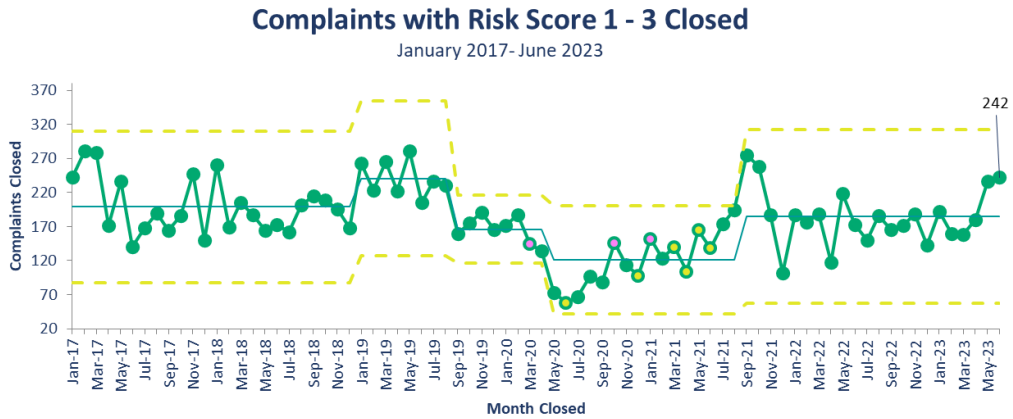


Figure Q1.4

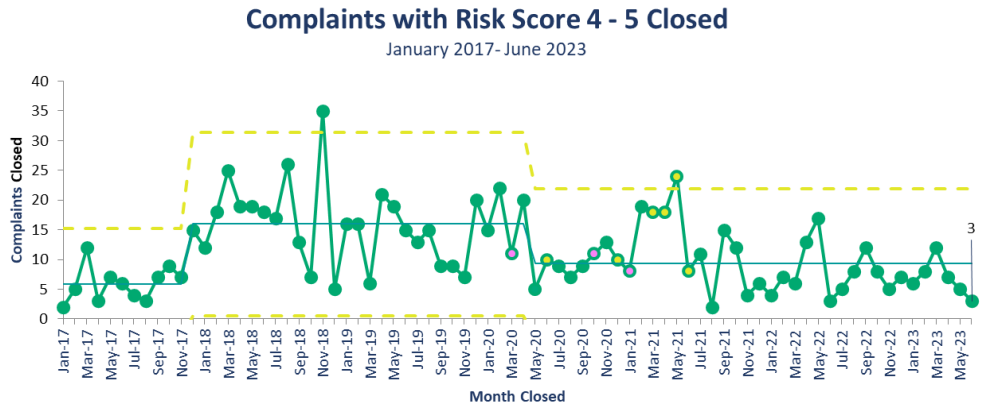


Figure Q1.5

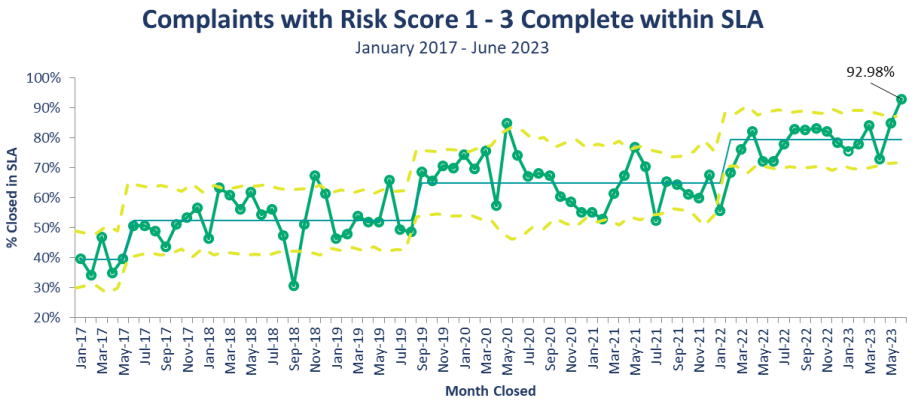
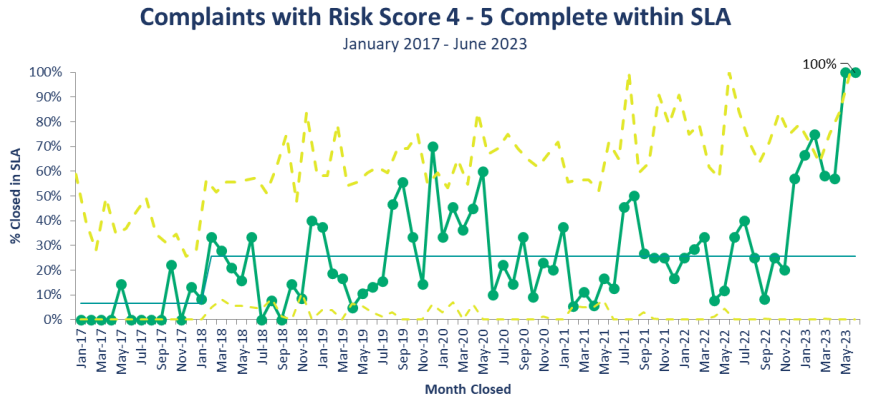


Figure Q1.6



Q2 Incidents

Figure Q2.1

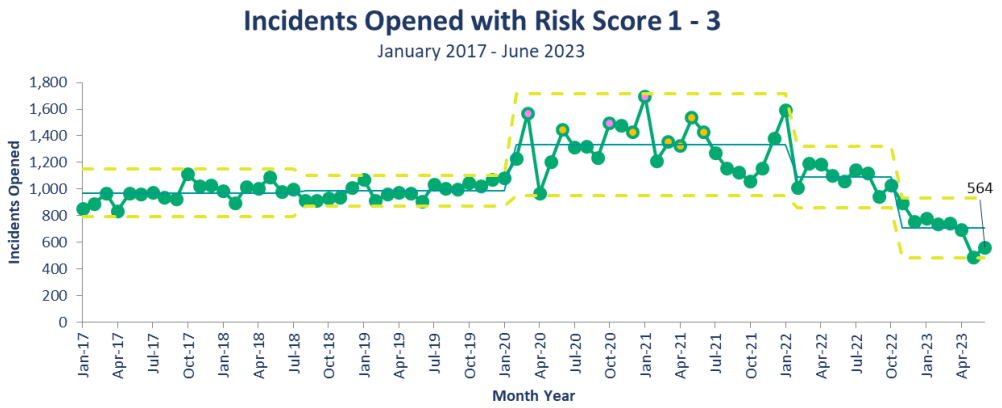
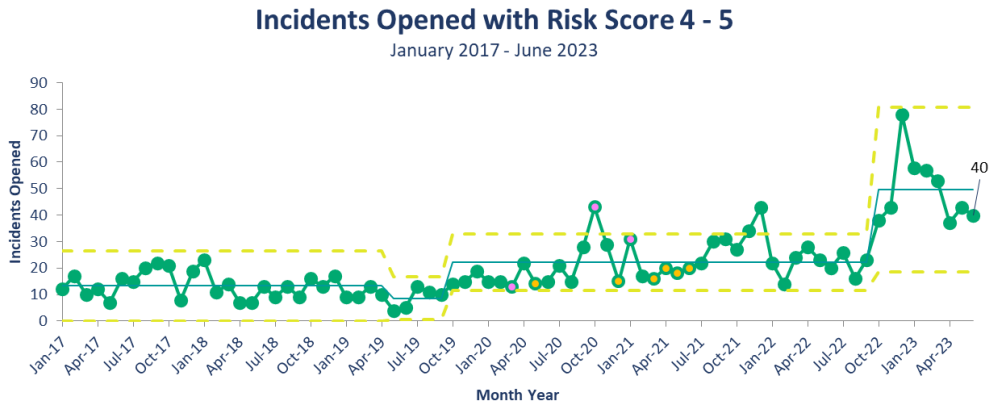


Figure Q2.2



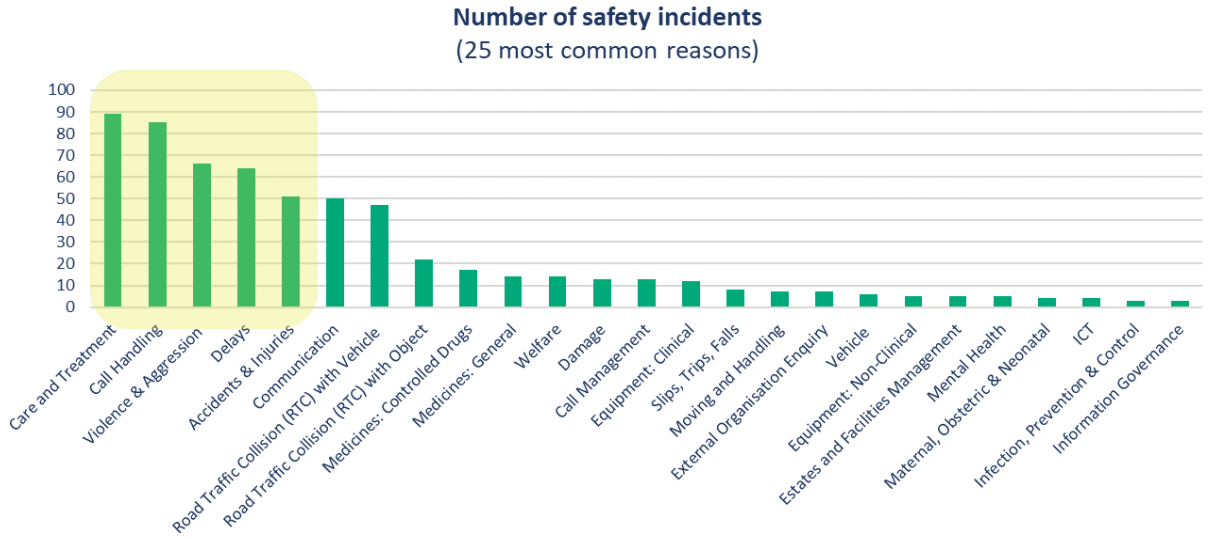


Figure Q2.4

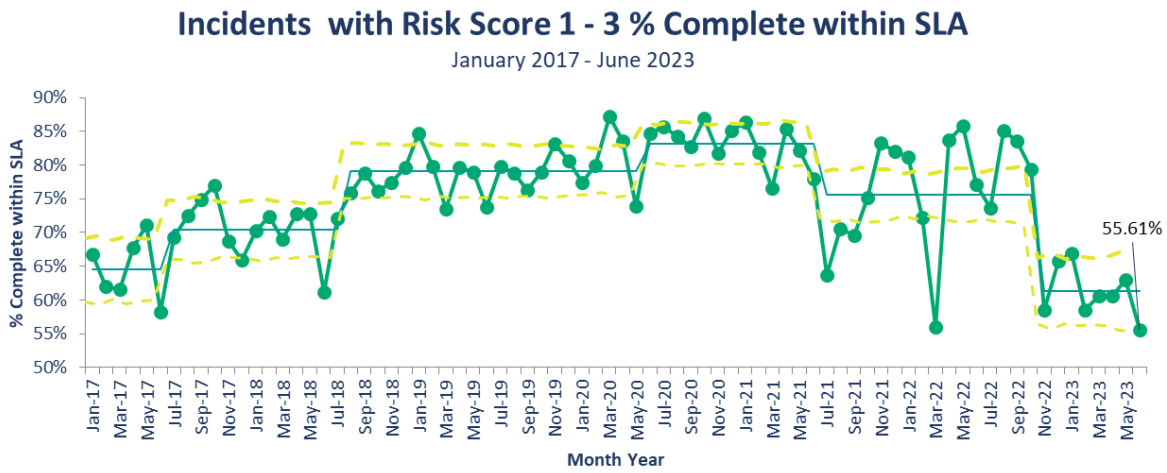
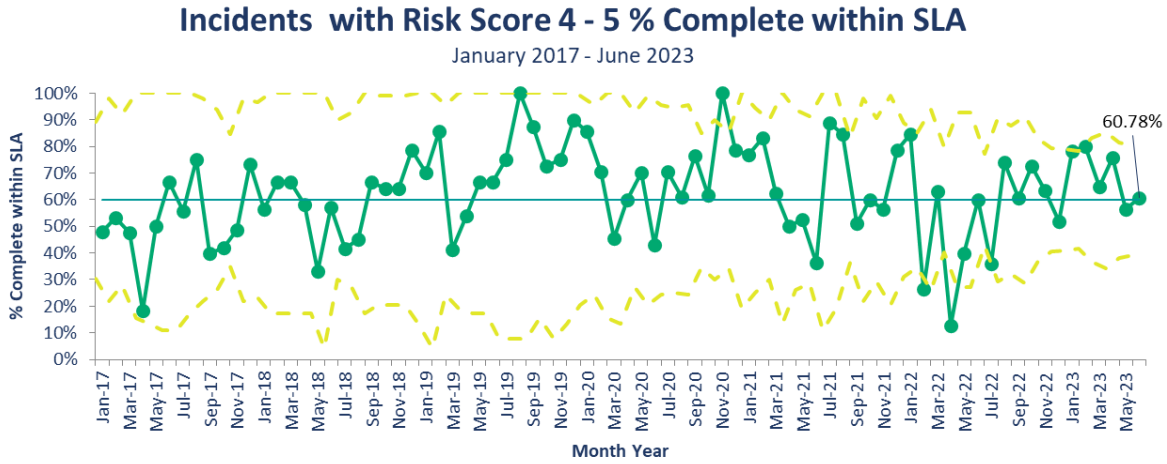


Figure Q2.5



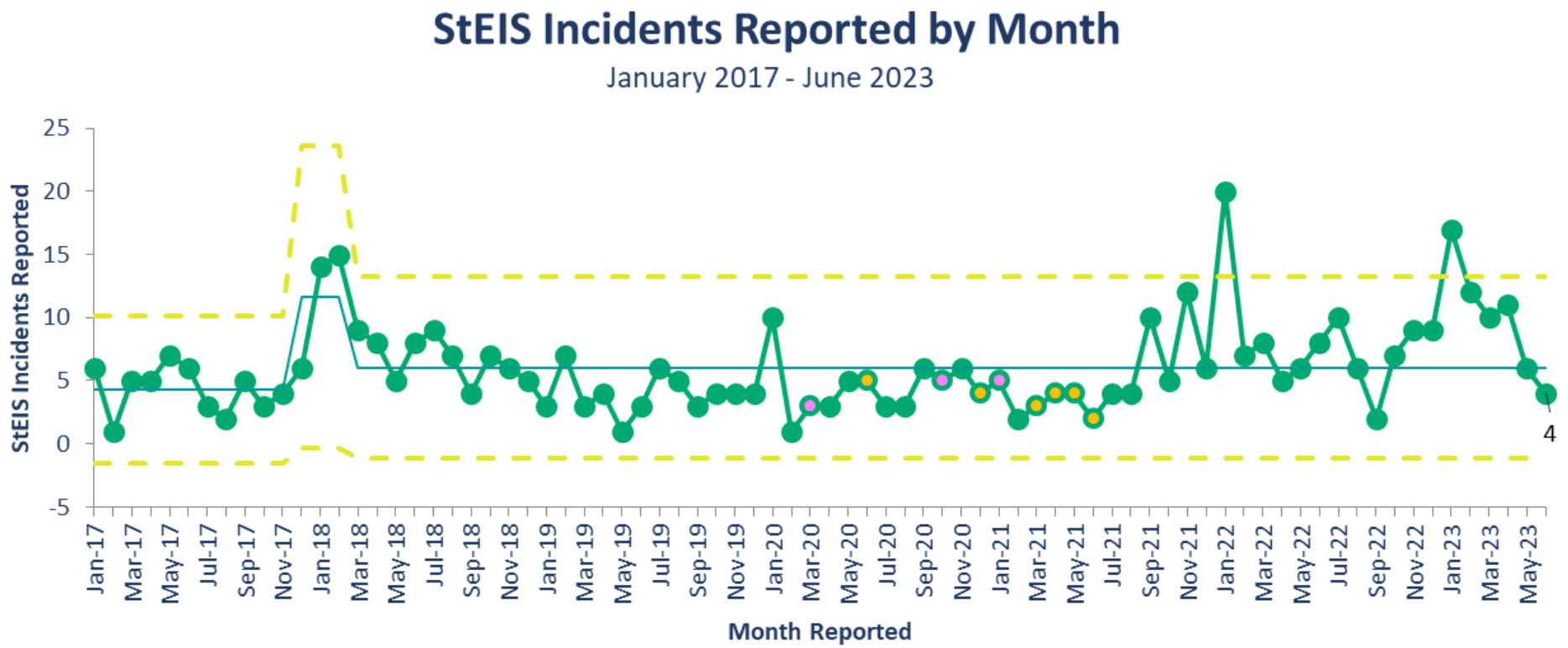
SLAs are calculated using the following measures/targets.

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 (Jul 22 – Jun 23)	Number of Alerts Applicable (Jul 22 – Jun 23)	Number of Open Alerts	Notes
CAS Helpdesk Team	2	1	0	Management of national patient safety alerts. NWAS have updated health notifications procedure
National Patient Safety Alert – NHS England	1	1	0	Use of Oxygen Cylinders where patients do not have access to medical gas pipeline systems. Supplier confirmed no issues, NWAS contacted each acute for confirmation and taken to Medicines optimisation group
National Patient Safety Alert - DHSC	3	0	0	
National Patient Safety Alert - UKHSA	0	0	0	
CMO Messaging	5	0	0	
MHRA – Medical Equipment	7	0	0	
MHRA - Medicine Alerts	48	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

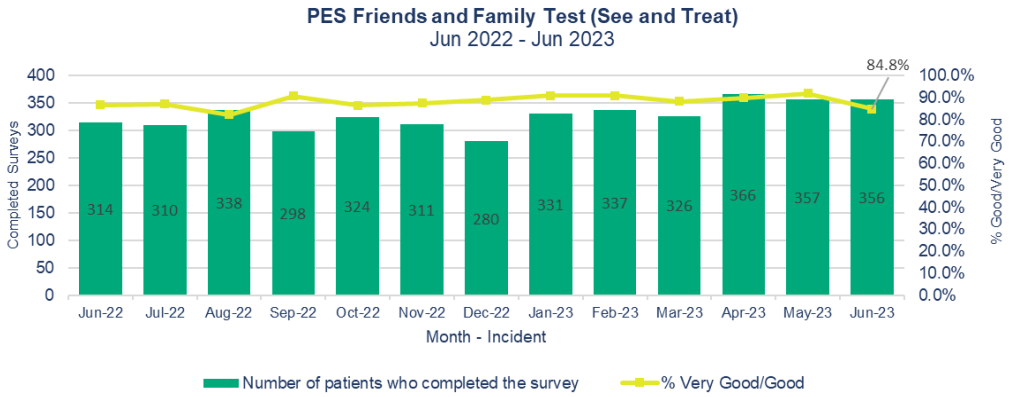
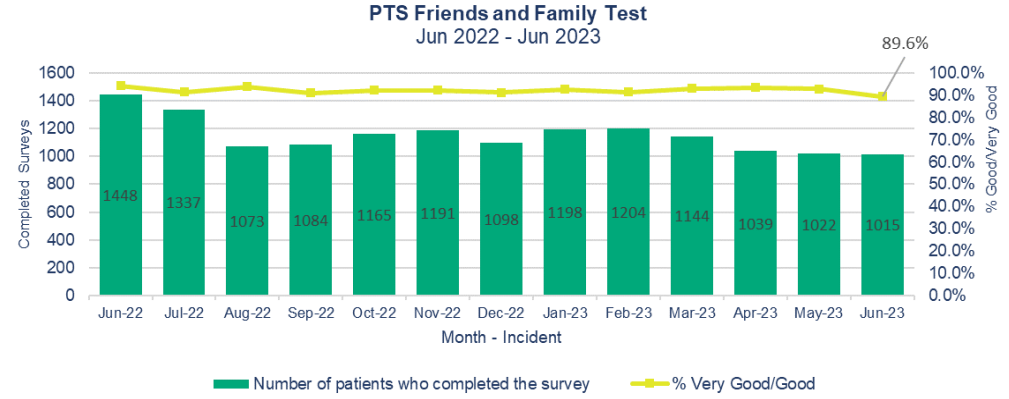


Figure E1.2



Positive

- *"The paramedic team kept my wife calm she has dementia and gets very confused; they were very professional in the way they treated her and kept me informed all of the time they dealt with her."*
- *"The team that arrived at my mum's were very professional, thoughtful, kind and considerate. They gave mum a thorough health check. Saw to the cut on her head and did everything that was needed to help mum. They even spoke to our social worker to arrange for some movement mats so we know if mum is getting up and might fall again. Overall, a brilliant response".*

Negative

- *"The 999 operator was unsympathetic. He did not listen to me when I said I had already made a call to 111 and had spoken to a doctor who called the ambulance. My 999 call was to say my condition had gotten worse. He said there was nothing more he could do but to ring back if I got worse. He was very robotic and just repeated himself again and again when I said that I was ringing because I had gotten worse.*

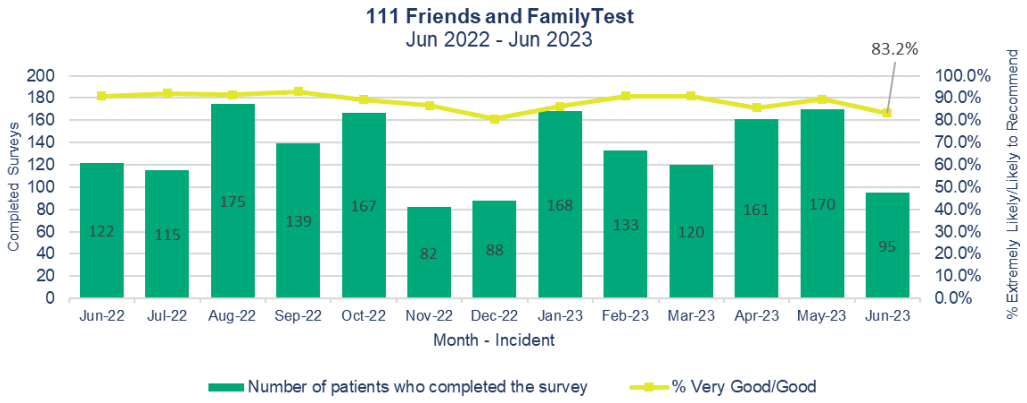
Positive

- *"From phoning to make the booking very caring and considerate confirming each step of the way to ensure all needs are met. Drivers excellent and extremely helpful getting in and out of patient transport and I love the text updates to say they're on their way."*
- *"The transport crew from going and coming to my appointment were amazing. They were kind, considerate, showed compassion and were making sure of my comfort which made me less anxious of my journey and appointment. Thank you for the wonderful service."*

Negative

- *"The taxi hadn't been informed that I needed assistance and waited outside, I needed assistance with walking frame on step. Driver was beeping is horn and shouting at other drivers. I felt fearful and it was a bad experience."*
- *"My first appointment was cancelled due to being sent a single crew. My second appointment was cancelled due to the transport being cancelled. My third appointment was nearly cancelled as a single crew arrived. After talking to the gentleman, he phoned for a double crew to attend. Luckily, a double crew turned up. Due to being chair and house bound I needed to be lifted down 2 steps as I am waiting for a ramp to be installed. The double crew had difficulty getting me down the steps & by the noise the female crew member made she may have hurt herself. After my appointment, a different double crew attended and were fantastic putting the passengers at ease."*

Figure E1.3



Positive

- *"Very satisfied with my phone call to 111. Very helpful and managed to get my doctor to phone me back which I struggled to get. Managed to get some medication for my problem. The lady on the phone was very polite and understanding"*
- *"They took on board that my husband couldn't wait 4 hours for an ambulance with a pain score of 10 - he had fractured 4 ribs and a poor inflating left lung. So they elevated the emergency when I said I would take him to hospital myself."*

Negative

- *"I originally rang at approx 10:30am and was told that a Dr would call within the hour or maybe slightly longer, I did not receive a call until 7pm. I then had to go for an appointment at 9.15pm and was seen at 10pm. Nearly 12 hours after the original phone call."*
- *"I attended the local chemist due to rapid and extreme swelling after a horsefly bit my hand. I was given meds but advised to call 111 by the pharmacist. 111 redirected me back to the same pharmacy - I called them and was told that they did not offer any further treatment. I recalled 111 - long wait - had to go through the same questions and was then directed to a walk-in centre who refused to see me as I was not a patient at a GP's surgery in their area!!!"*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

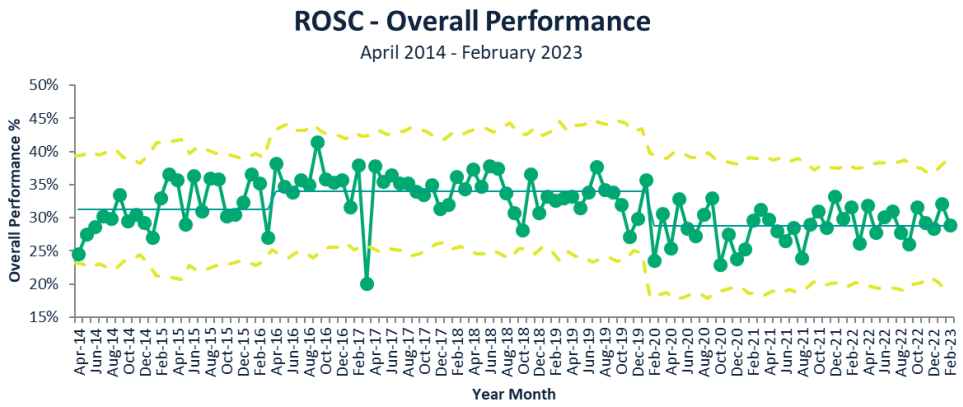


Figure E2.2

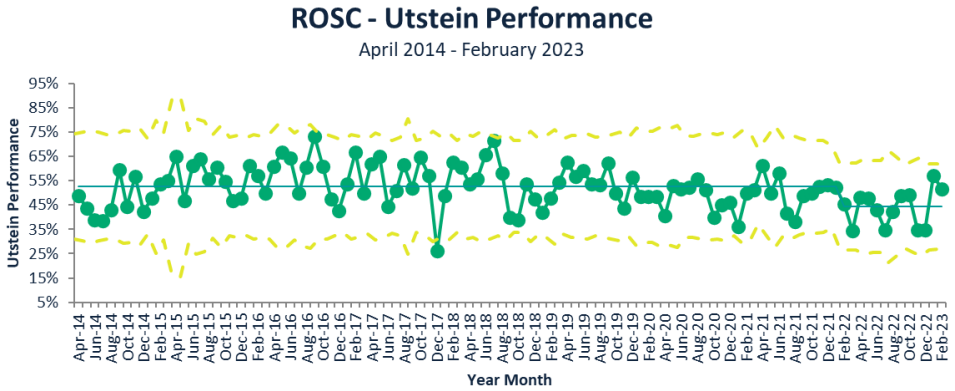


Figure E2.3

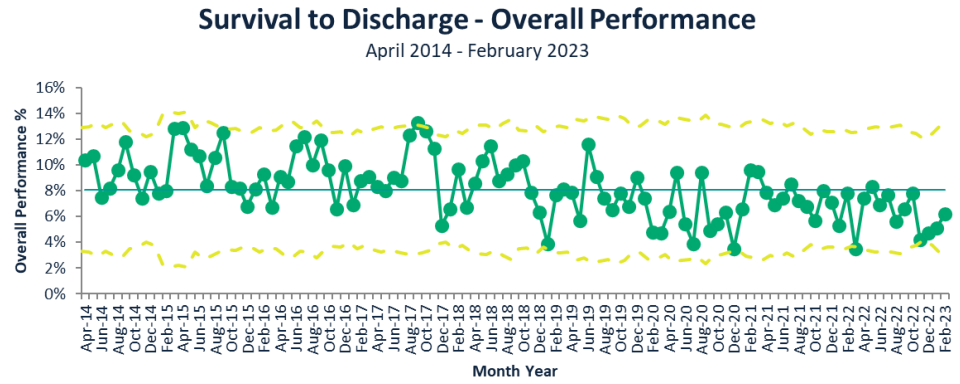


Figure E2.4

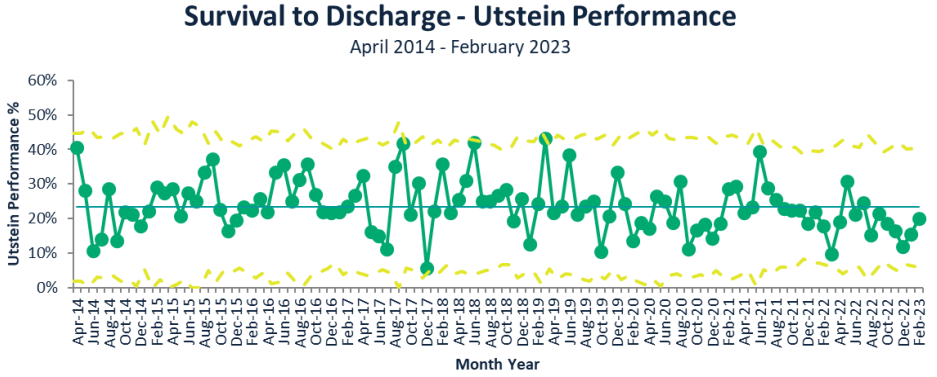


Figure E2.5

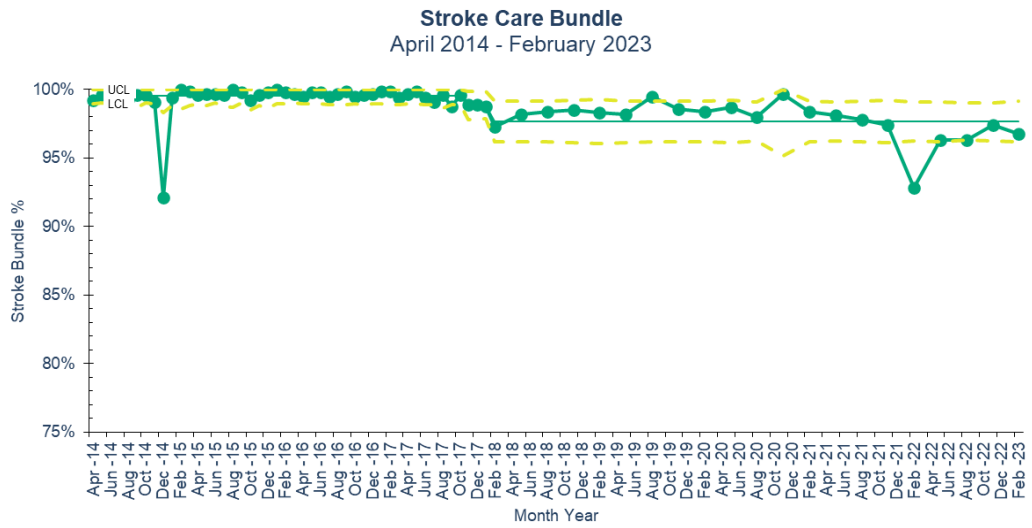
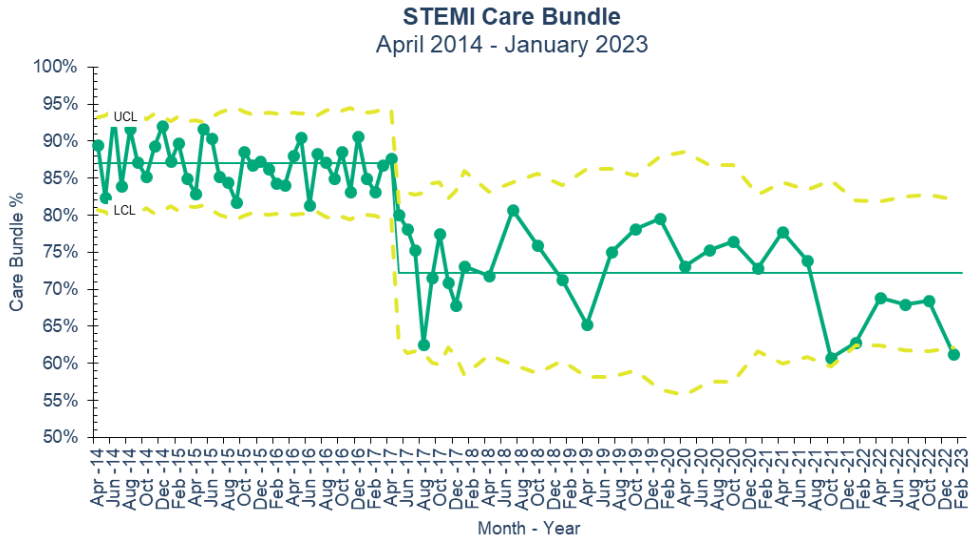


Figure E2.6



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

E3 ACTIVITY & OUTCOMES

Figure E3.1

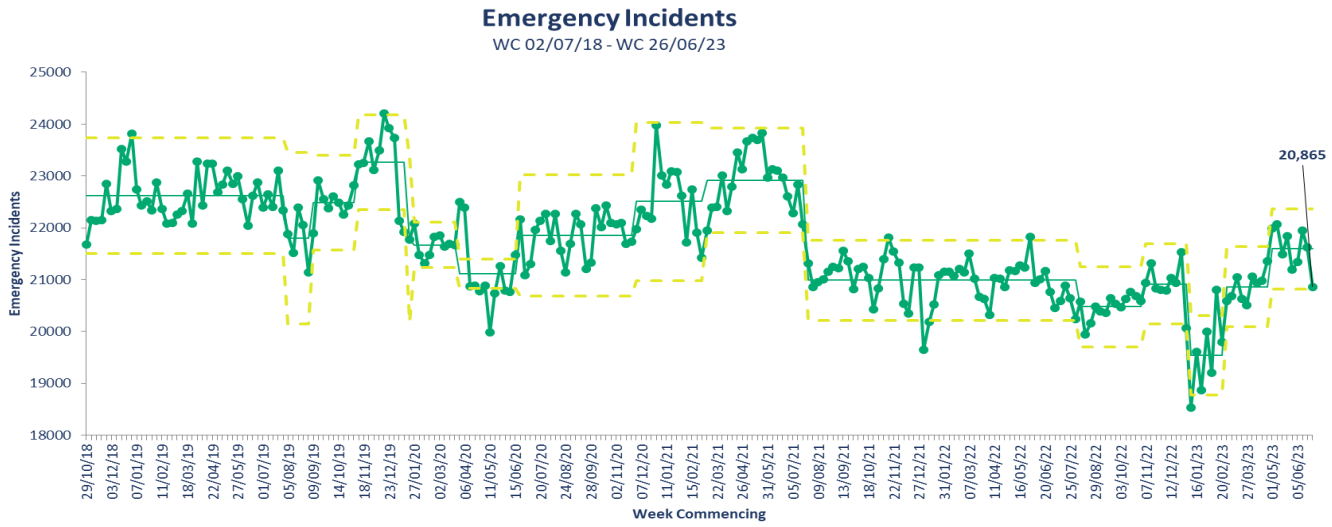


Figure E3.2

Figure E3.3

Sector	No. of Emergency Incidents
G South	9,809
G Central	9,658
M North	9,505
G West	8,805
G East	8,558
M East	7,569
CL East Lancashire	7,194
M West	6,083
CL South Lancashire	5,874
M South	5,253
CL Fylde	4,985
CL North Cumbria	4,545
CL Morecambe Bay	4,008

Figure E3.4

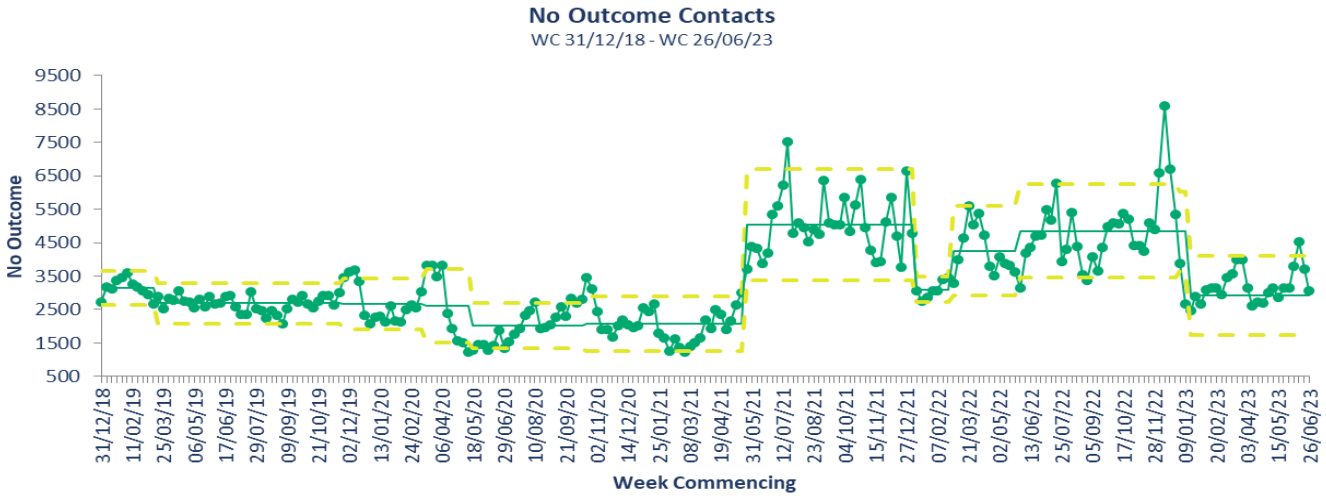


Figure E3.5

Jun	Calls	% Change from previous year	Incidents	% Change from previous year
2020	95,331		91,239	
2021	143,074	50%	98,524	8%
2022	131,065	-8%	90,923	-8%
2023	118,947	-9%	91,933	1%

Figure E3.6

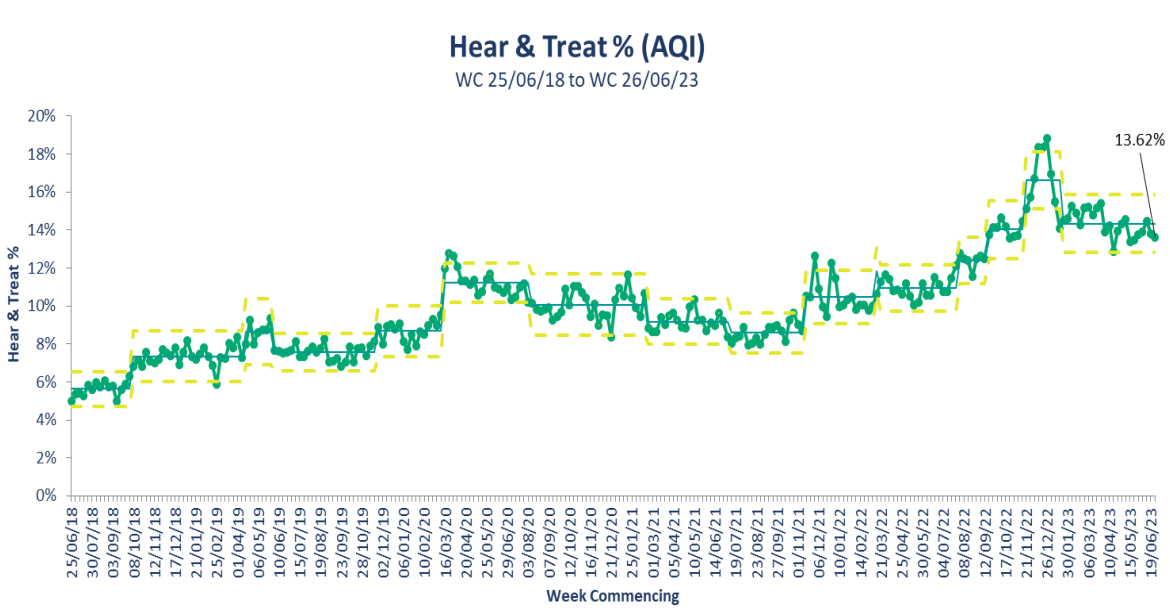


Figure E3.7

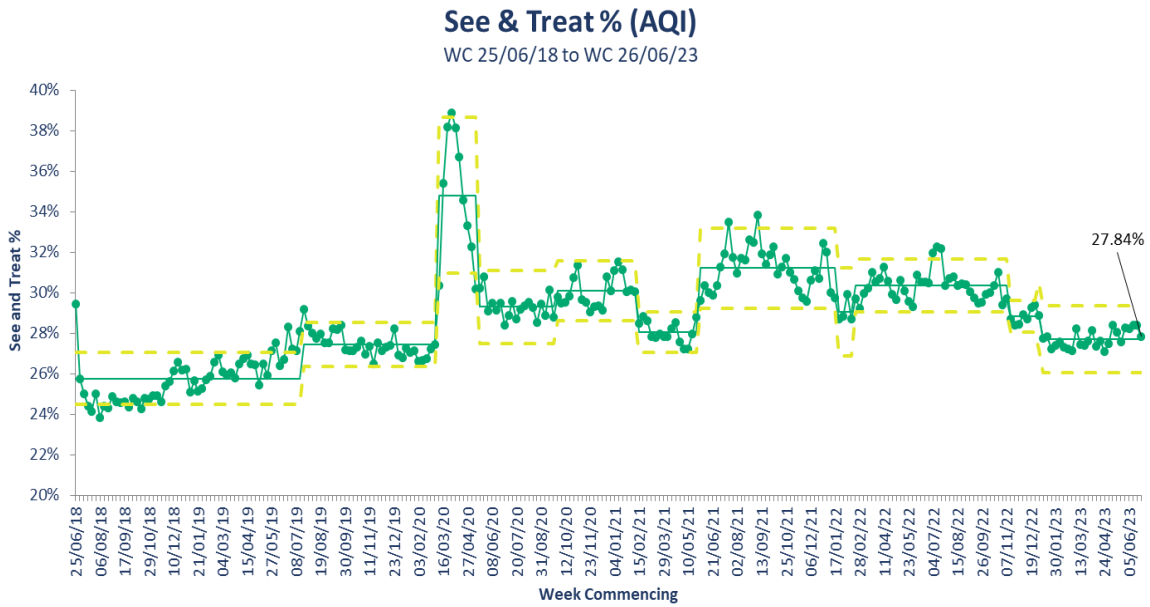


Figure E3.8

Sector	Monthly Hear & Treat %
CL Fylde	16.25%
G Central	15.65%
CL East Lancashire	14.79%
G East	14.69%
M West	14.29%
M East	14.15%
G West	13.88%
M North	13.60%
CL South Lancashire	13.13%
M South	12.94%
G South	12.62%
CL Morecambe Bay	11.45%
CL North Cumbria	10.91%

Figure E3.9

Sector	Monthly See & Treat %
G West	29.95%
M South	29.68%
CL North Cumbria	29.48%
G Central	29.38%
M West	29.02%
CL East Lancashire	28.26%
CL Morecambe Bay	28.24%
CL Fylde	28.20%
G East	28.13%
G South	28.03%
CL South Lancashire	27.48%
M North	26.90%
M East	24.44%

Figure E3.10

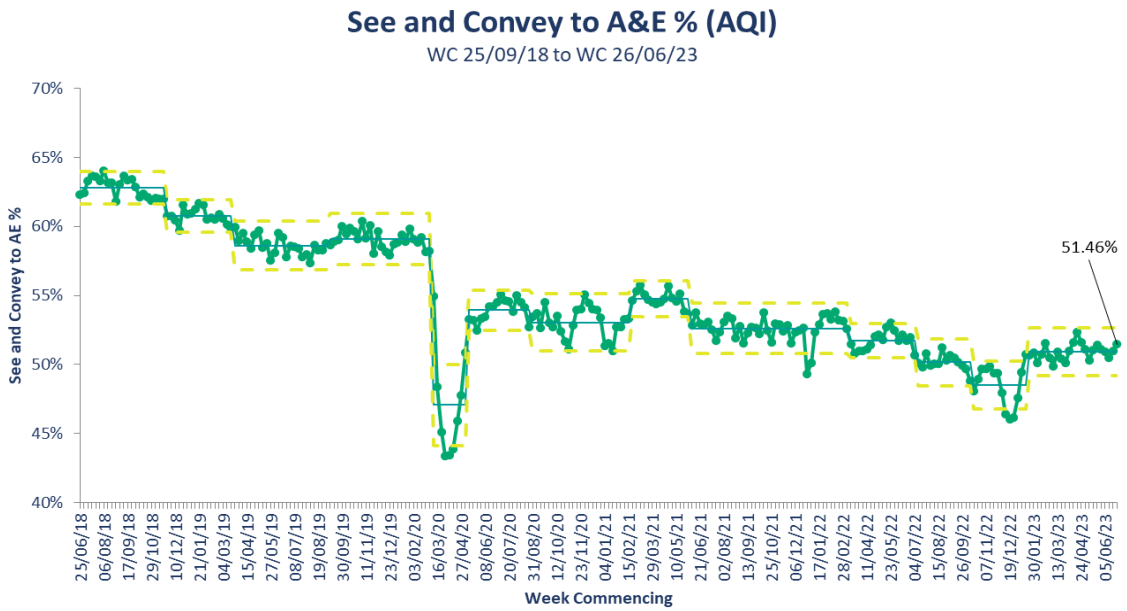


Figure E3.11

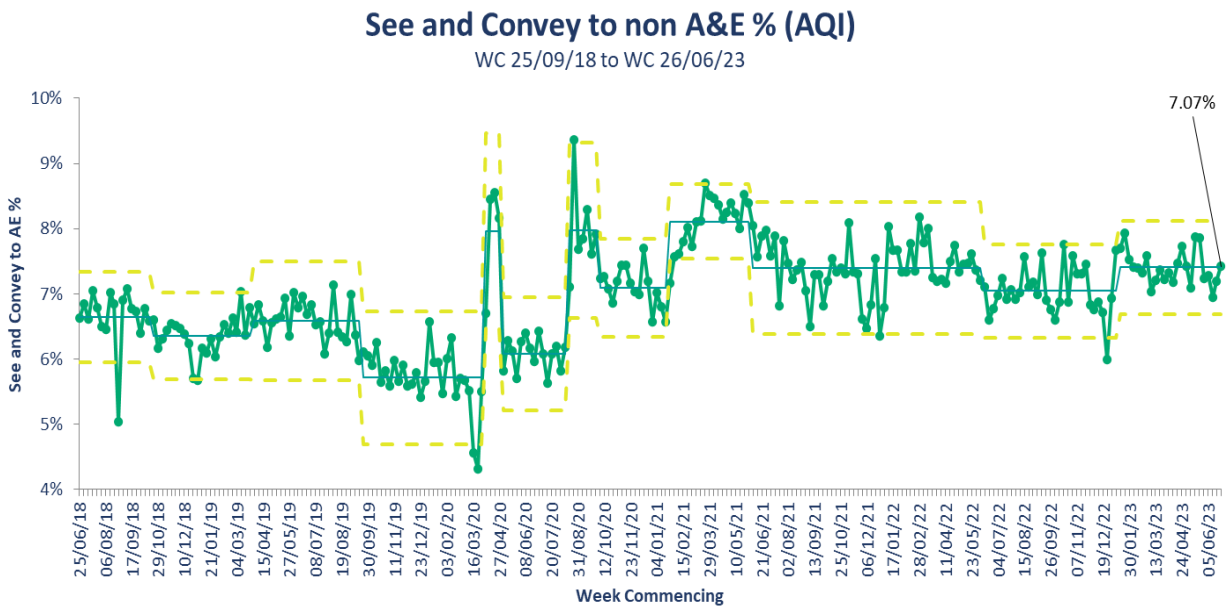


Figure E3.12

Sector	Monthly See & Convey	%
G Central		54.97%
CL Fylde		55.55%
G West		56.17%
M West		56.70%
CL East Lancashire		56.95%
G East		57.19%
M South		57.38%
G South		59.35%
CL South Lancashire		59.40%
M North		59.50%
CL North Cumbria		59.60%
CL Morecambe Bay		60.30%
M East		61.41%

Figure E3.13

Sector	Monthly See & Convey to AE	%
M West		46.92%
CL East Lancashire		48.33%
G Central		49.06%
G West		49.36%
CL Fylde		50.35%
M South		50.87%
CL South Lancashire		50.97%
M North		51.63%
G East		51.81%
M East		53.08%
CL North Cumbria		53.47%
G South		53.55%
CL Morecambe Bay		55.89%

Figure E3.14

Sector	Monthly See & Convey to Non AE	%
CL Morecambe Bay		4.42%
CL Fylde		5.20%
G East		5.38%
G South		5.80%
G Central		5.91%
CL North Cumbria		6.14%
M South		6.51%
G West		6.81%
M North		7.87%
M East		8.32%
CL South Lancashire		8.43%
CL East Lancashire		8.62%
M West		9.78%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	West Midlands		19.2%
2	London		14.8%
3	North West		13.9%
4	East Midlands		13.0%
5	South Western		10.9%
6	South East Coast		10.0%
7	East of England		9.1%
8	Yorkshire		8.3%
9	South Central		8.2%
10	North East		7.3%
11	Isle of Wight		6.2%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		37.2%
2	South Central		34.8%
3	Isle of Wight		33.7%
4	East of England		33.3%
5	East Midlands		32.5%
6	South East Coast		31.5%
7	London		30.3%
8	North East		29.5%
9	North West		28.2%
10	West Midlands		27.8%
11	Yorkshire		27.7%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		51.9%
2	West Midlands		52.9%
3	East Midlands		54.5%
4	London		54.9%
5	South Central		57.0%
6	East of England		57.5%
7	North West		57.9%
8	South East Coast		58.5%
9	Isle of Wight		60.2%
10	North East		63.2%
11	Yorkshire		64.0%

Operational

O1 CALL PICK UP

Figure O1.1

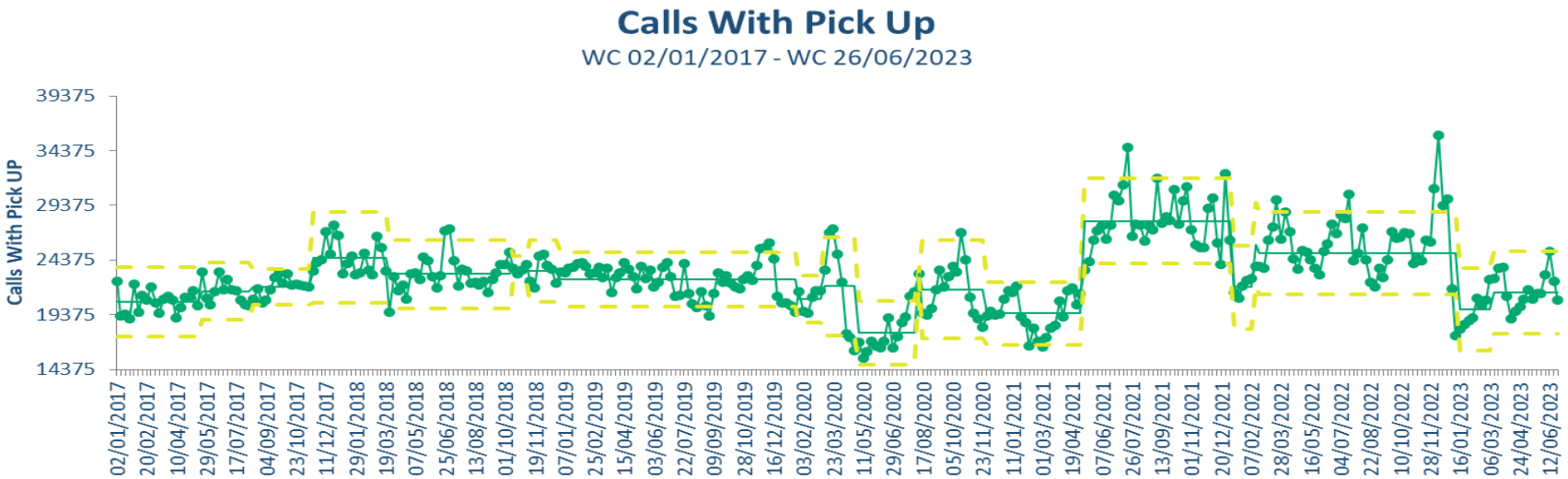
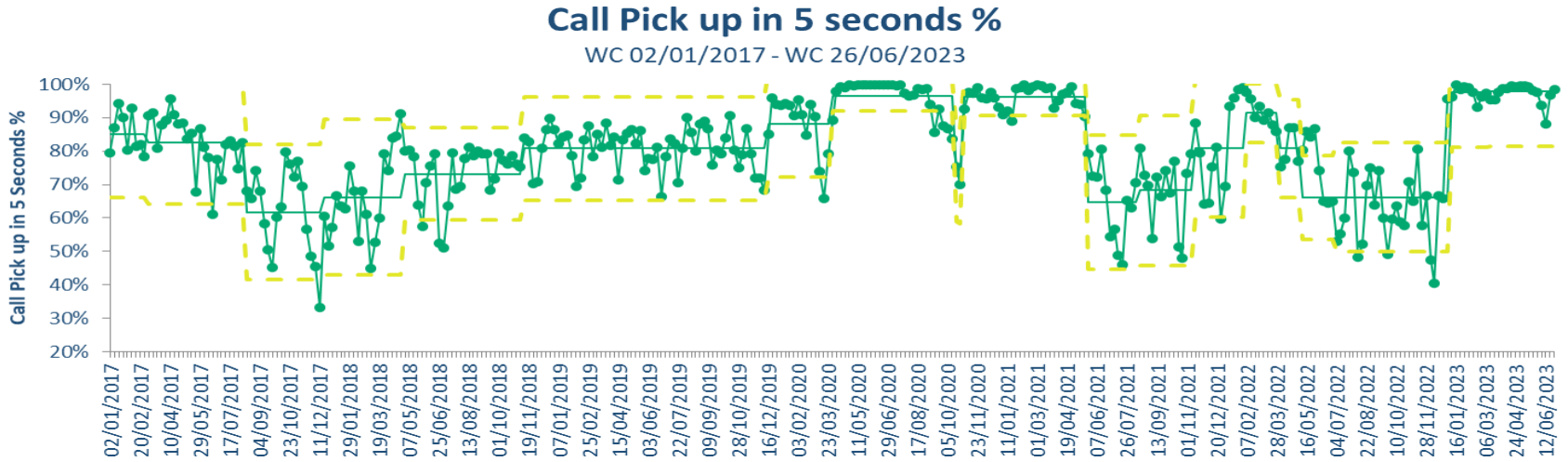


Figure O1.2



02 A&E TURNAROUND

Figure Q2.1

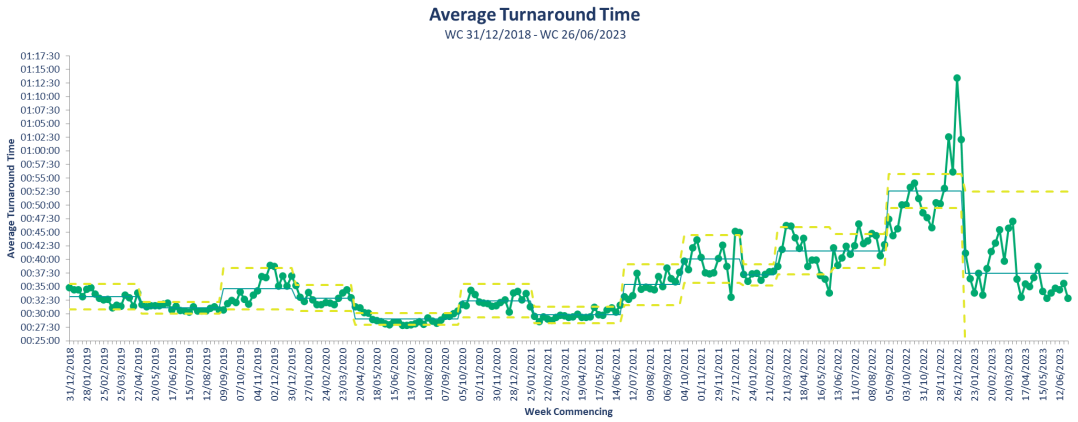


Figure Q1.2

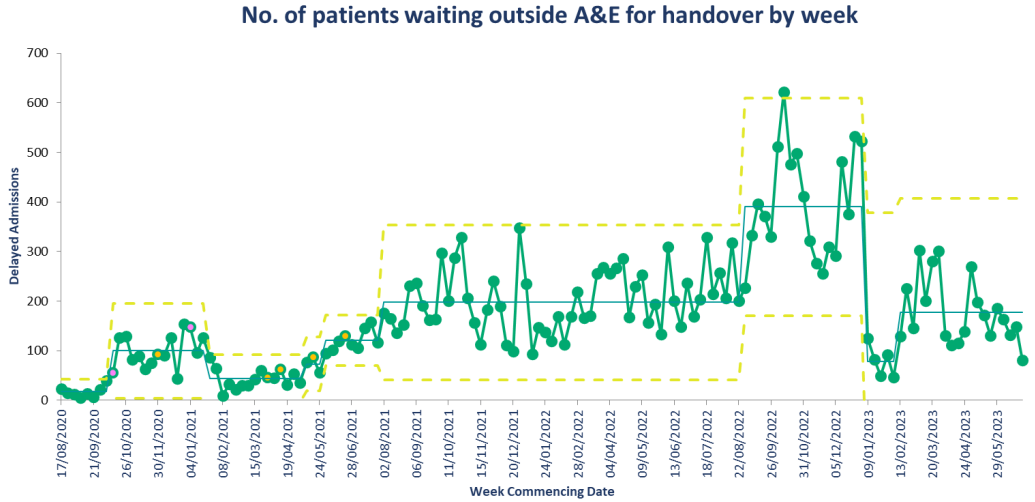


Table Q1.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
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
Mar-23	46,166	0:43:52	0:31:25	11:41
Apr-23	46,435	0:35:20	0:22:55	11:28
May-23	49,233	0:35:33	0:23:17	11:35
Jun-23	46,866	0:34:17	0:22:25	11:29

Table Q1.2

Top 5 Trusts with most hours lost due to delayed admissions	
Trust	Hours lost to delayed admissions
Blackpool Victoria Hospital	208.8
Royal Lancaster Hospital	157.8
Royal Bolton Hospital	145.9
Countess of Chester Hospital	145.9
Royal Oldham Hospital	50.2

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
Mar-23	1113
Apr-23	538
May-23	898
Jun-23	545

O3 ARP RESPONSE TIMES

July 2023

Figure O3.1

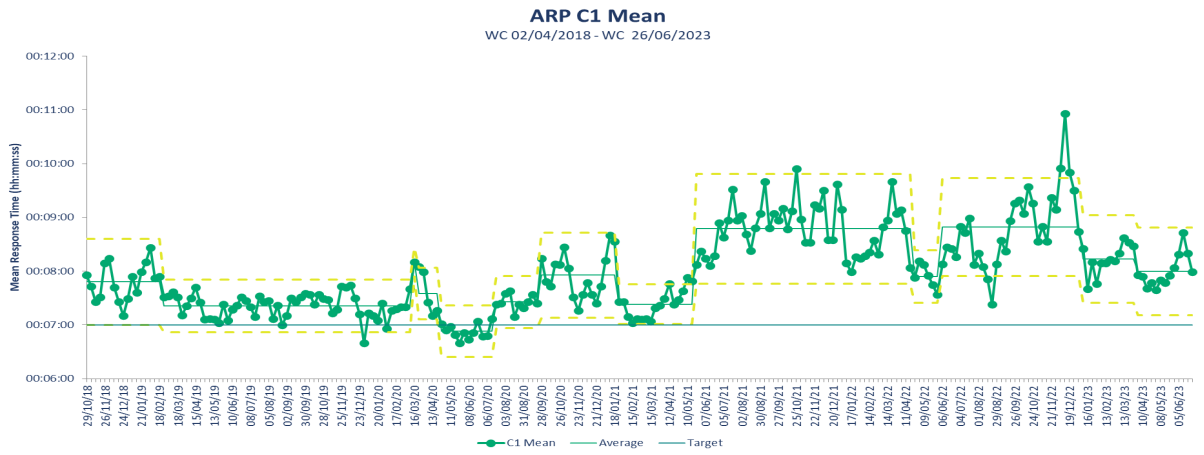


Figure O3.2

Figure O3.3

Sector	C1 Mean	Time
G Central		00:07:10
G South		00:07:10
M North		00:07:34
G West		00:07:47
M East		00:08:15
CL Fylde		00:08:33
M West		00:08:44
CL South Lancashire		00:09:07
G East		00:09:10
CL East Lancashire		00:09:17
CL North Cumbria		00:09:43
CL Morecambe Bay		00:09:47
M South		00:09:49

Figure O3.4

C1 Mean	
Target	7:00
Jun 2023	8:22
YTD	8:01

Figure O3.5

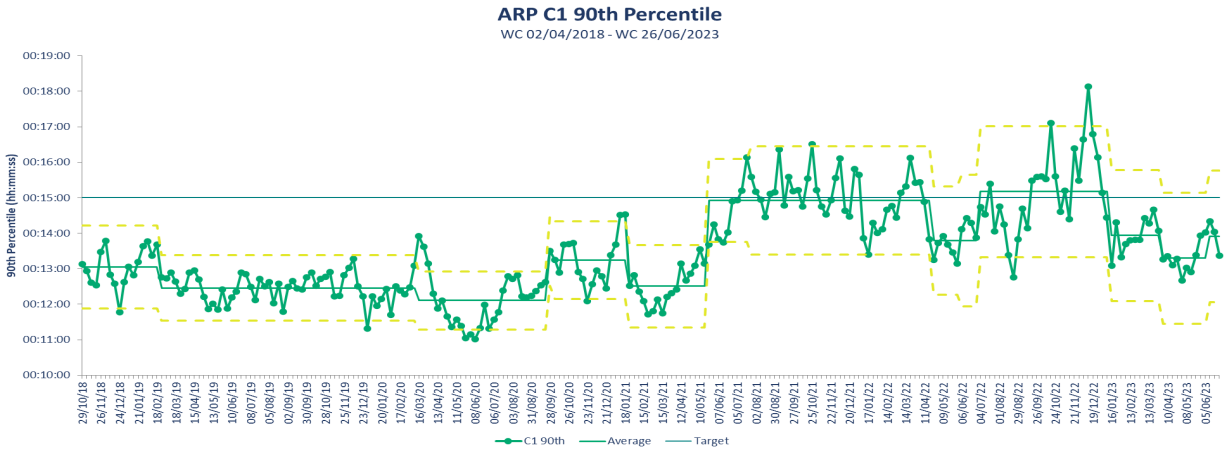


Figure O3.6

Figure O3.7

Sector	C1 90th	Time
G South		00:11:36
G Central		00:11:48
G West		00:12:41
M North		00:12:48
G East		00:13:19
M East		00:13:28
CL South Lancashire		00:14:54
M West		00:15:16
CL Fylde		00:15:29
CL East Lancashire		00:16:26
M South		00:17:41
CL North Cumbria		00:18:04
CL Morecambe Bay		00:18:13

Figure O3.8

C1 90th	
Target	15:00
Jun 2023	14:04
YTD	13:30

July 2023

Figure O3.9

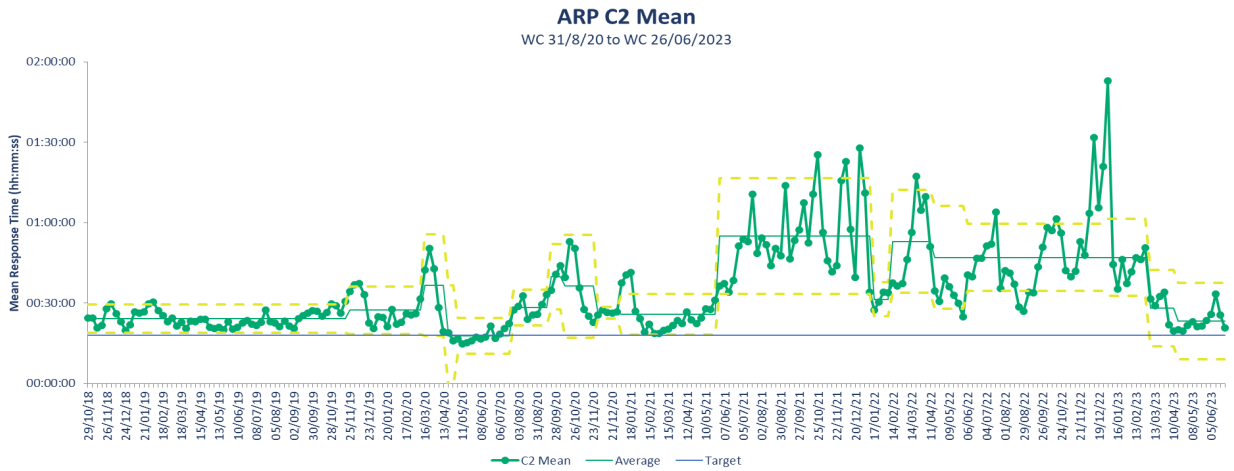


Figure O3.10

Figure O3.11

Sector	C2 Mean	Time
G South		00:19:20
CL North Cumbria		00:20:53
G Central		00:21:15
G East		00:22:21
CL Morecambe Bay		00:24:39
CL Fylde		00:24:48
CL East Lancashire		00:26:38
G West		00:27:30
CL South Lancashire		00:28:24
M South		00:30:19
M West		00:31:56
M North		00:33:27
M East		00:34:52

Figure O3.12

C2 Mean	
Target	18:00
Jun 2023	26:30
YTD	23:25

Figure O3.13

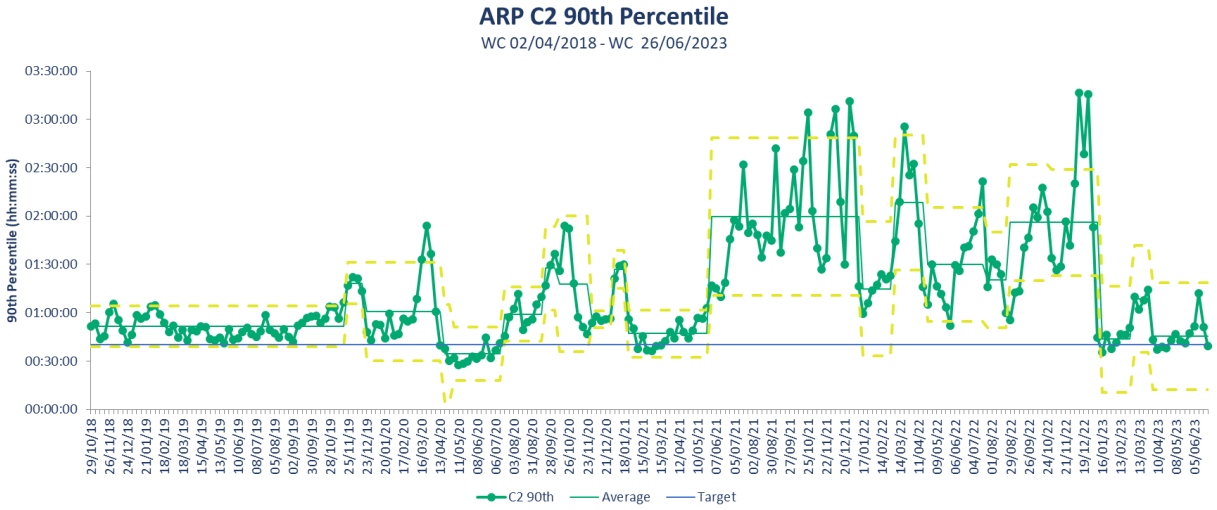


Figure O3.14

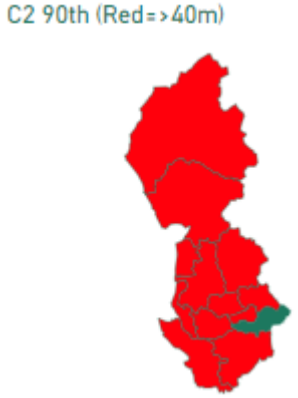


Figure O3.15

Sector	C2 90th	Time
G South		00:37:07
G Central		00:40:24
CL North Cumbria		00:41:17
G East		00:43:07
CL Morecambe Bay		00:50:16
CL Fylde		00:52:55
CL East Lancashire		00:53:09
G West		00:53:22
CL South Lancashire		00:56:58
M South		01:00:46
M West		01:06:41
M East		01:07:35
M North		01:08:08

Figure O3.16

C2 90th	
Target	40:00
Jun 2023	53:22
YTD	46:52

July 2023

Figure O3.17

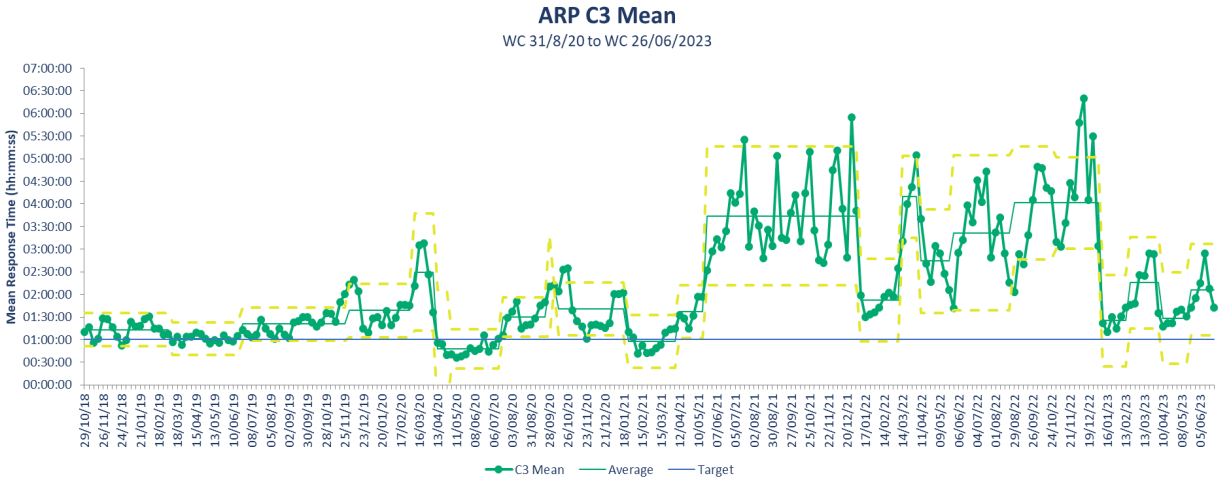


Figure O3.18

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:03:33
CL Morecambe Bay		01:27:27
CL Fylde		01:47:43
CL East Lancashire		01:57:03
CL South Lancashire		02:01:33
G South		02:03:02
M South		02:09:24
M West		02:14:35
M North		02:19:40
G East		02:26:53
M East		02:40:34
G Central		02:42:45
G West		03:03:50

Figure O3.20

C3 Mean	
Target	1:00:00
Jun 2023	2:15:14
YTD	1:49:52

Figure O3.21

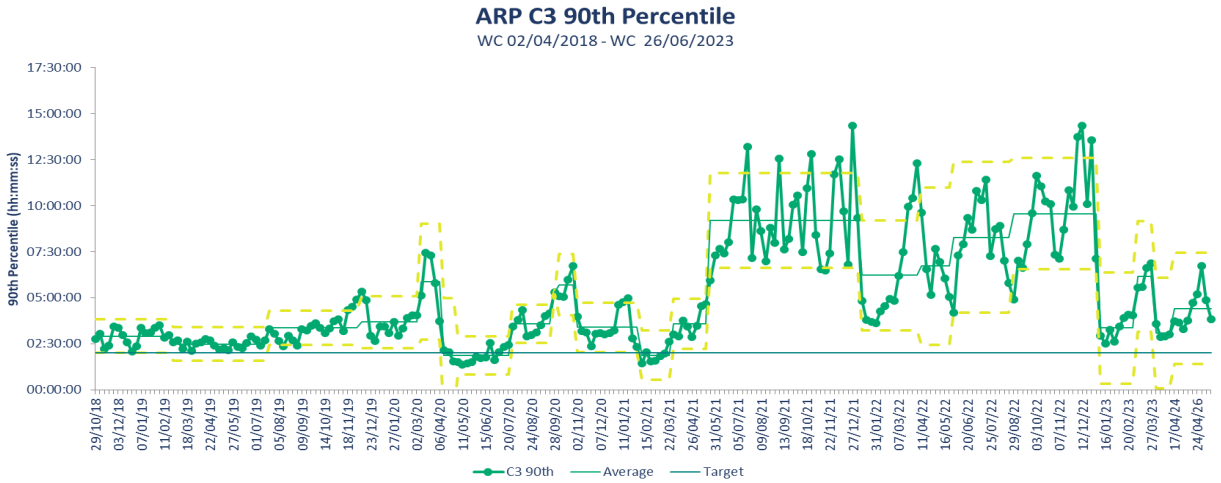


Figure O3.22

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:18:58
CL Morecambe Bay		03:15:28
CL Fylde		04:12:49
CL South Lancashire		04:30:53
G South		04:31:32
CL East Lancashire		04:45:46
M South		05:07:38
G East		05:23:26
M West		05:33:21
G Central		05:47:56
M North		05:50:09
G West		06:07:52
M East		06:30:54

Figure O3.24

C3 90th	
Target	2:00:00
Jun 2023	5:14:06
YTD	4:11:20

April 2023

Figure O3.25

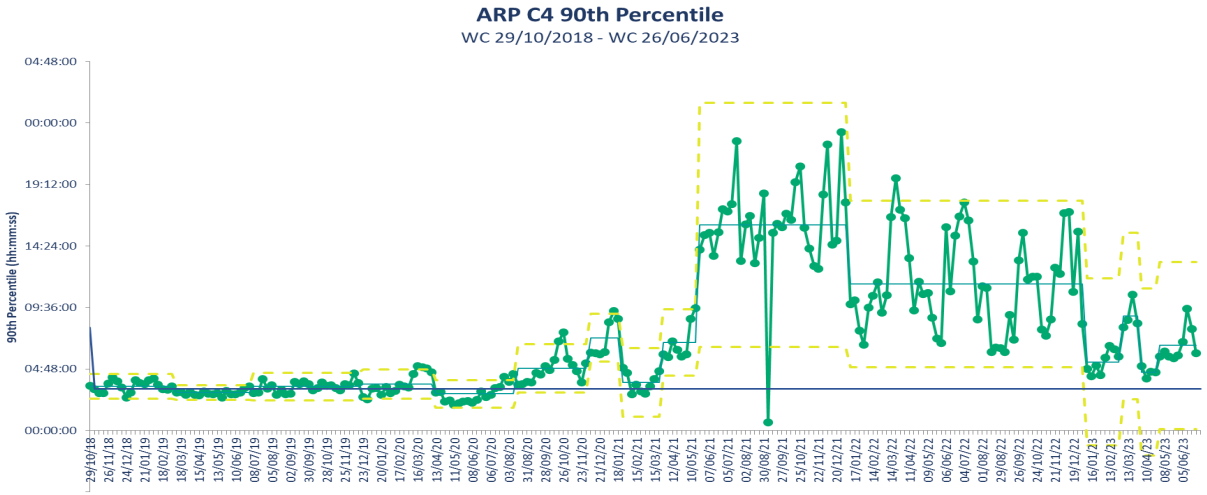


Figure O3.26

Figure O3.27

Sector	C4 90th	Time
CL North Cumbria		03:06:52
CL Morecambe Bay		03:53:15
CL Fylde		04:54:45
M South		06:43:40
G East		07:15:05
G South		07:16:36
CL East Lancashire		07:38:39
G West		07:58:29
G Central		08:02:49
M West		08:33:54
M North		08:53:56
M East		10:02:06
CL South Lancashire		12:16:28

Figure O3.28

C4 90th	
Target	3:00:00
Jun 2023	7:24:30
YTD	4:11:20

O3 ARP Provider Comparison

Figure O3.25

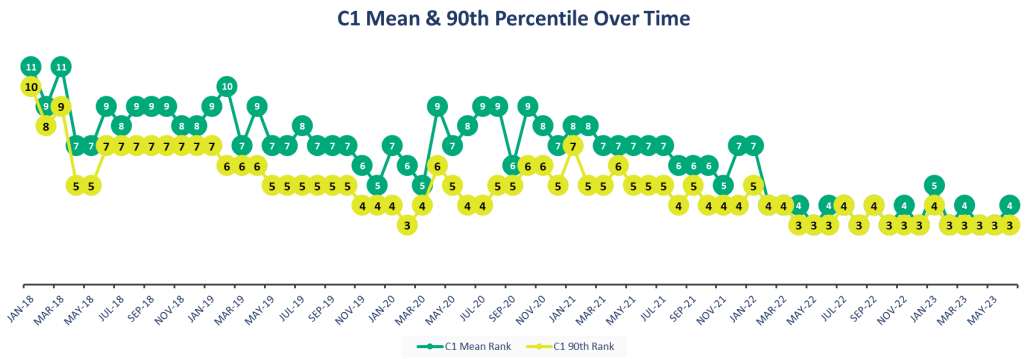


Figure O3.26

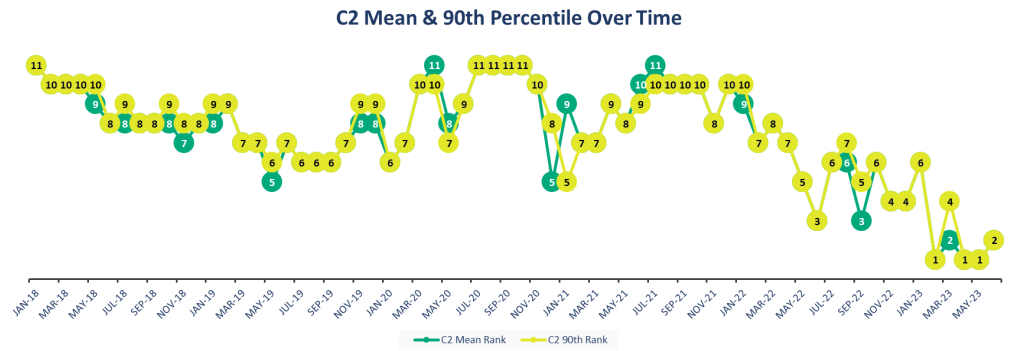


Figure O3.27

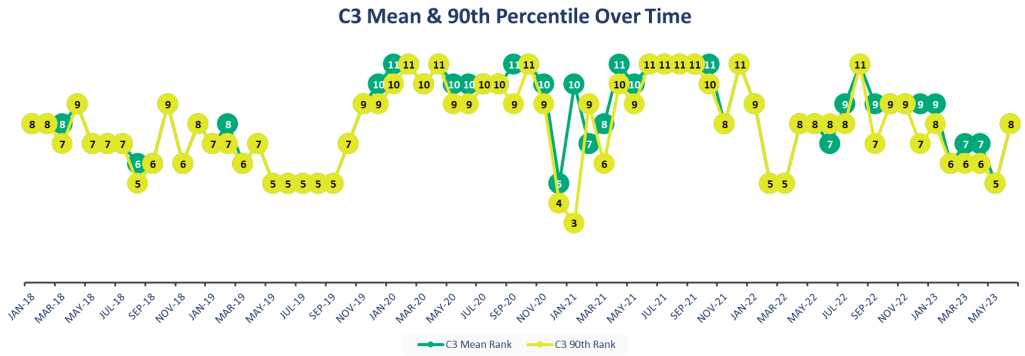
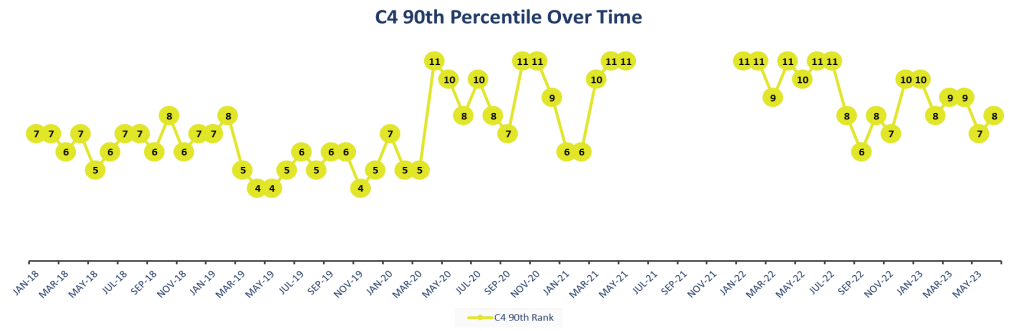


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		07:18
2	London		08:01
3	West Midlands		08:18
4	North West		08:22
5	Yorkshire		08:49
6	East Midlands		08:50
7	East of England		09:03
8	South Central		09:15
9	South East Coast		09:18
10	Isle of Wight		09:24
11	South Western		09:38

Rank	Trust	C1 90th	Time
1	North East		13:04
2	London		13:36
3	North West		14:04
4	West Midlands		14:35
5	Yorkshire		15:15
6	East Midlands		15:48
7	South Central		16:27
8	South East Coast		17:00
9	East of England		17:15
10	Isle of Wight		17:17
11	South Western		17:59

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:22:14
2	North West		0:26:30
3	South East Coast		0:31:08
4	Yorkshire		0:31:14
5	South Central		0:34:48
6	West Midlands		0:36:49
7	North East		0:36:53
8	East Midlands		0:39:34
9	East of England		0:41:02
10	South Western		0:42:58
11	London		0:45:43

Rank	Trust	C2 90th	Time
1	Isle of Wight		0:41:58
2	North West		0:53:22
3	South East Coast		1:03:47
4	South Central		1:08:26
5	Yorkshire		1:10:43
6	North East		1:16:15
7	West Midlands		1:22:44
8	East Midlands		1:24:48
9	East of England		1:28:26
10	South Western		1:28:36
11	London		1:43:45

Rank	Trust	C3 Mean	Time
1	Isle of Wight		00:56:26
2	London		01:25:18
3	Yorkshire		01:35:23
4	North East		01:43:26
5	South Western		01:57:50
6	East of England		02:00:49
7	South Central		02:06:19
8	North West		02:15:14
9	South East Coast		02:26:10
10	East Midlands		02:27:02
11	West Midlands		02:50:25

Rank	Trust	C3 90th	Time
1	Isle of Wight		02:01:42
2	London		03:28:43
3	Yorkshire		03:35:20
4	North East		04:08:55
5	South Central		04:42:34
6	East of England		04:53:05
7	South Western		05:10:42
8	North West		05:14:06
9	South East Coast		05:36:05
10	East Midlands		05:48:02
11	West Midlands		07:27:19

Rank	Trust	C4 90th	Time
1	Isle of Wight		03:29:08
2	North East		04:14:45
3	East Midlands		04:26:43
4	Yorkshire		04:55:30
5	South Central		05:23:33
6	South Western		05:50:12
7	London		05:55:47
8	North West		07:24:30
9	South East Coast		08:22:44
10	East of England		09:22:45
11	West Midlands		11:00:35

O3 LONG WAITS

Table O3.29

Year Month	Total No. of C1 long waits
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
Mar-23	708
Apr-23	509
May-23	505
Jun-23	693

Figure O3.29

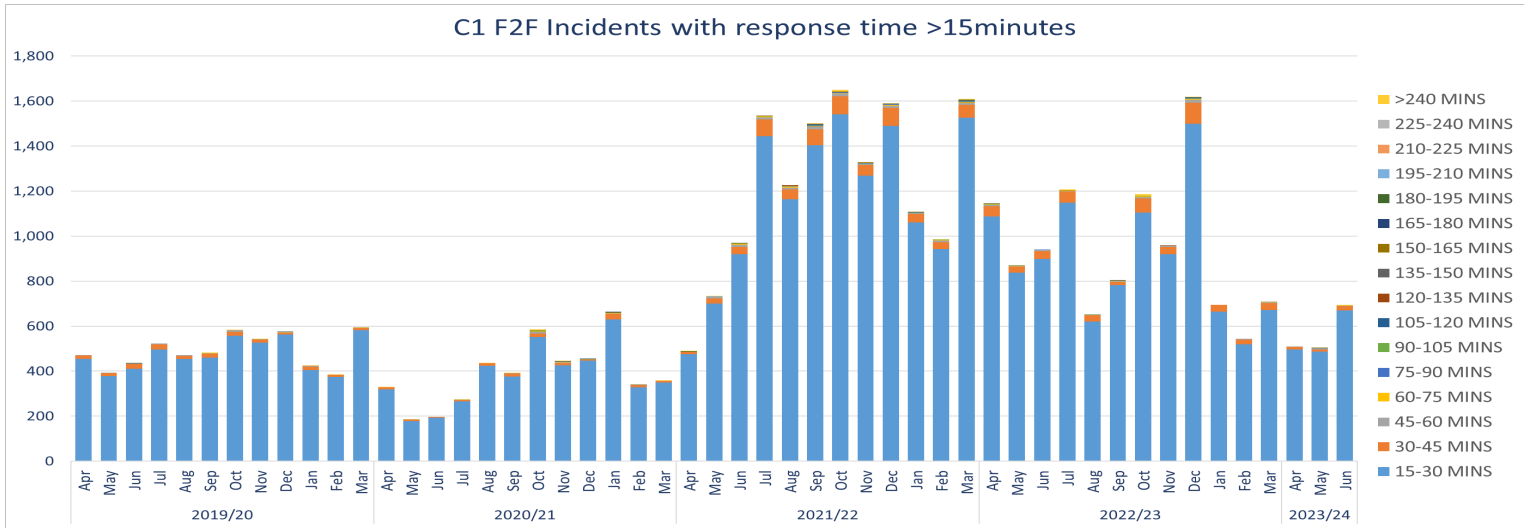


Figure O3.30

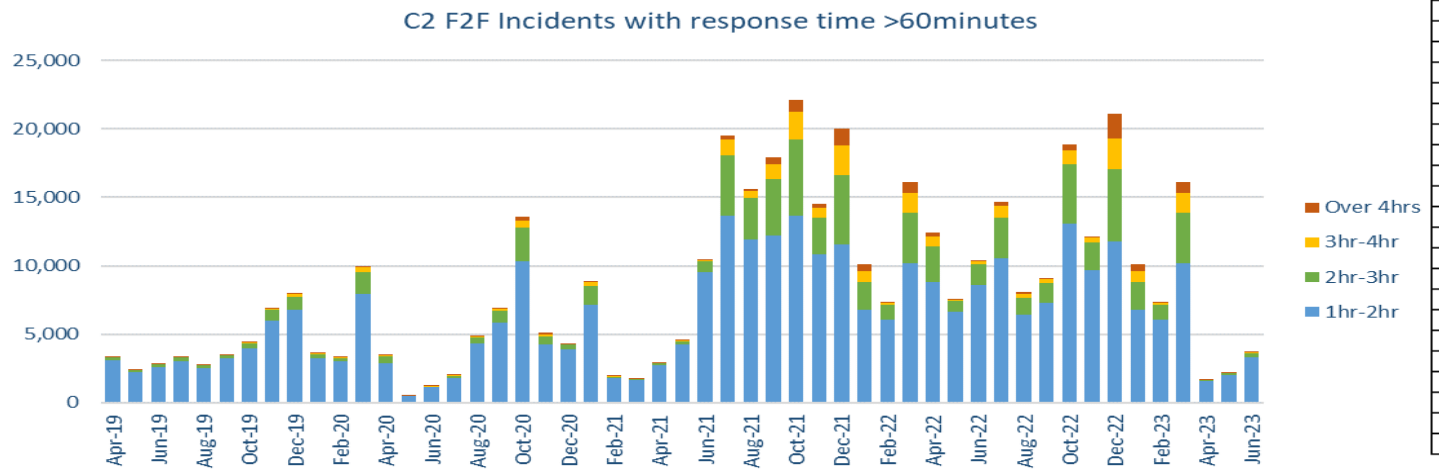
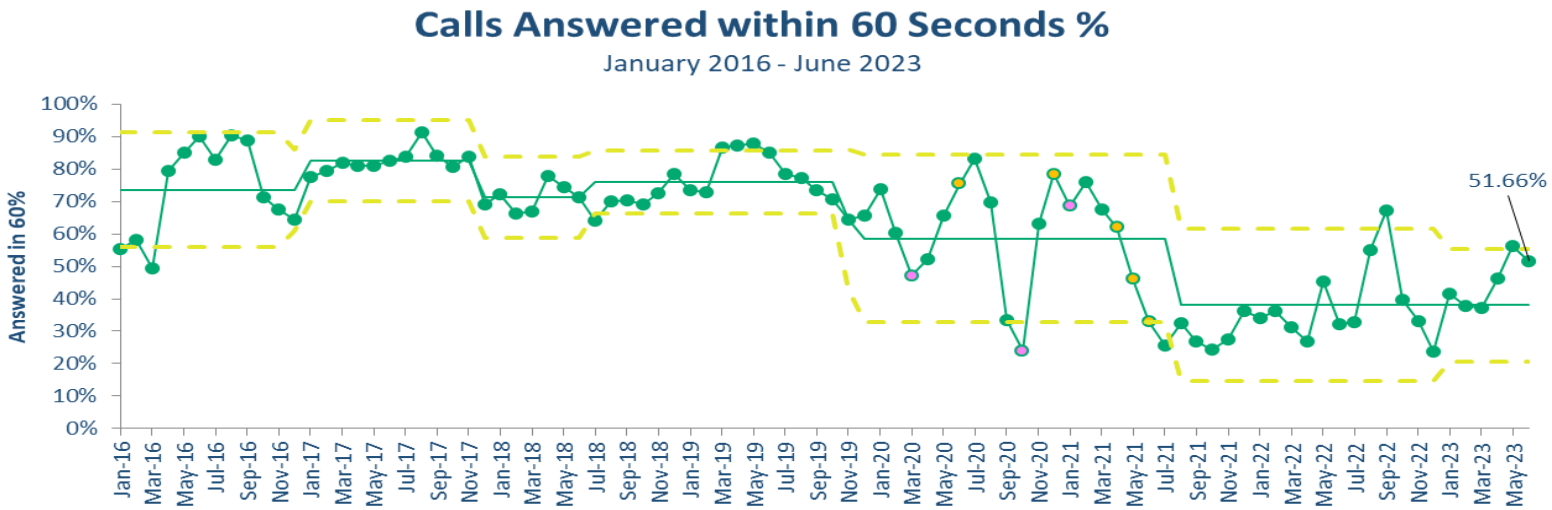


Table O3.30

Year Month	Total No. of C2 long waits
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	14,517
Dec-21	20,037
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
Mar-23	6,132
Apr-23	1,650
May-23	2142
Jun-23	3671

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
June 2023	51.66%
YTD	51.44%
National	60.7%

Figure O4.2

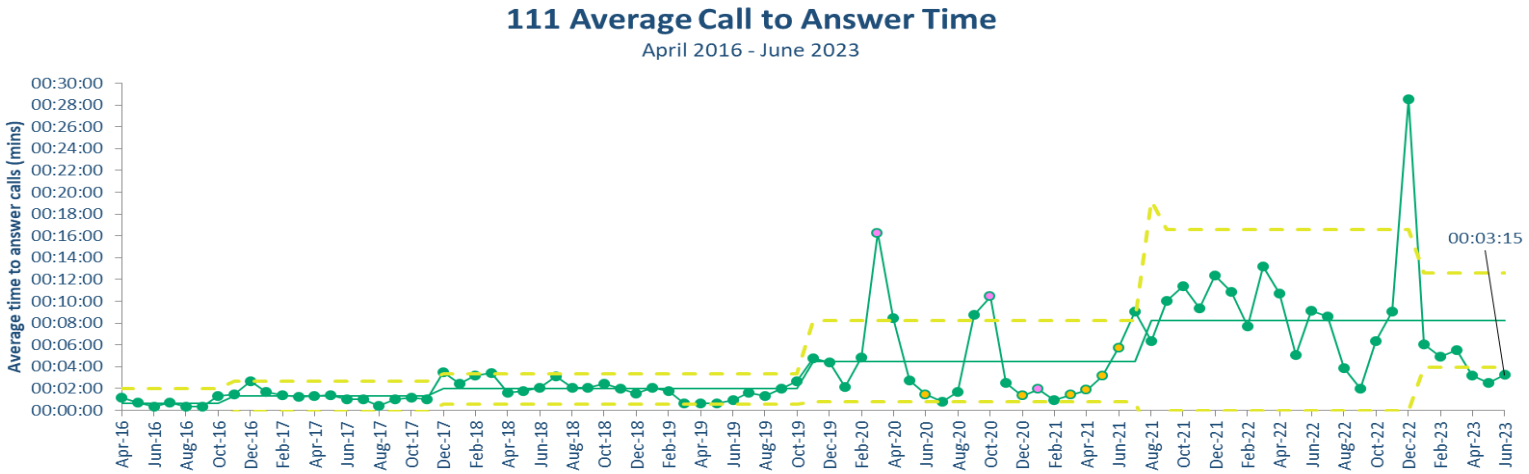
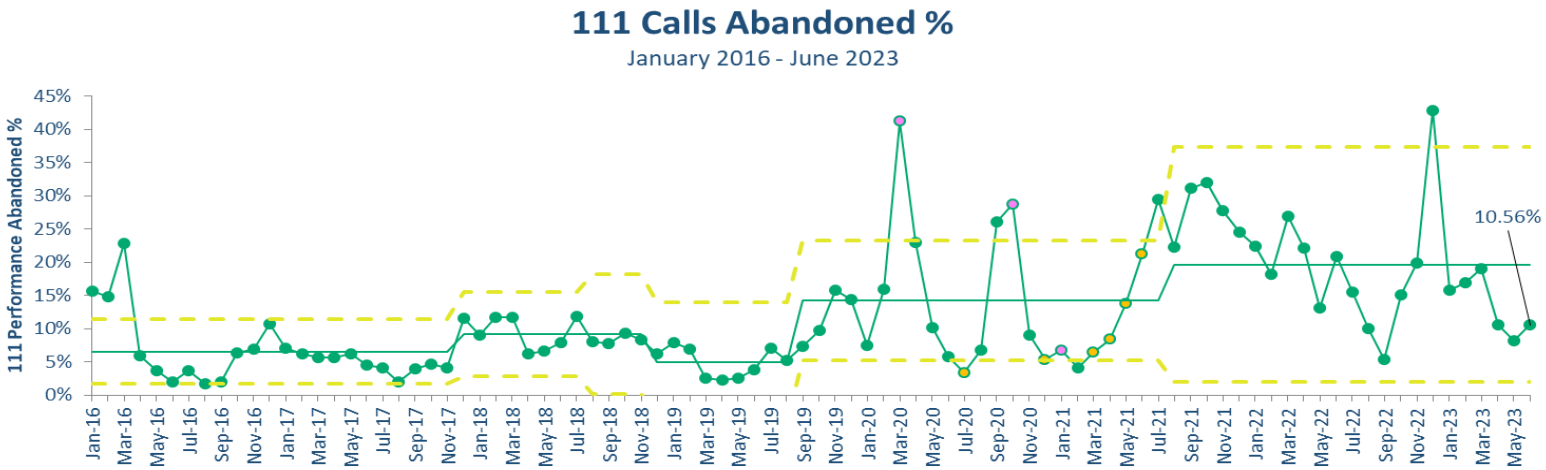
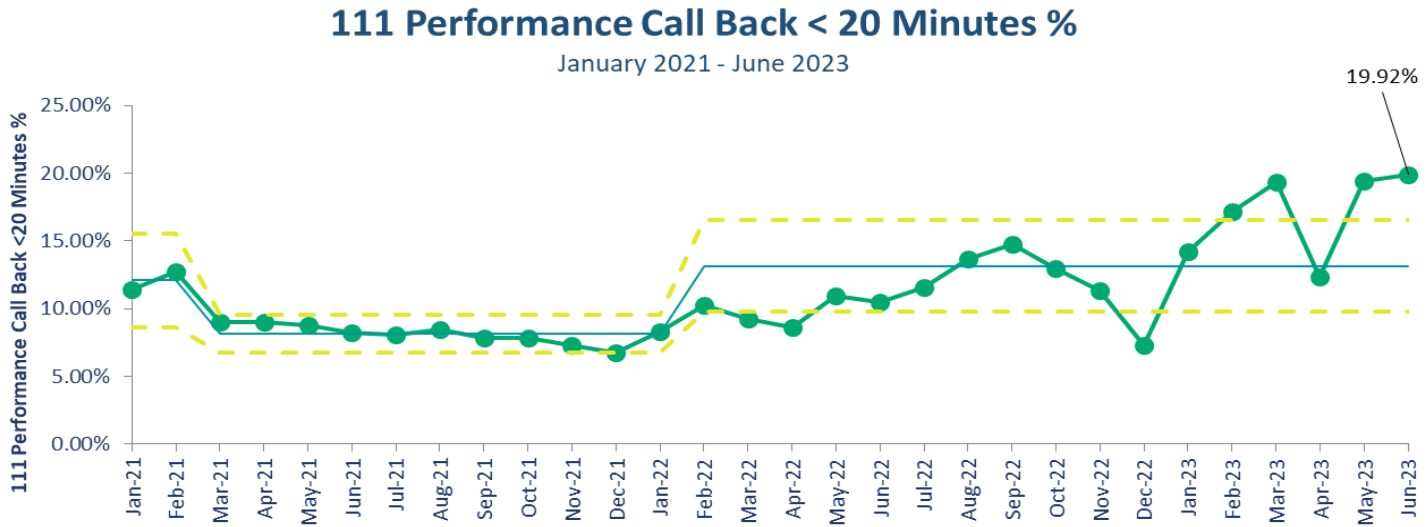


Figure O4.3



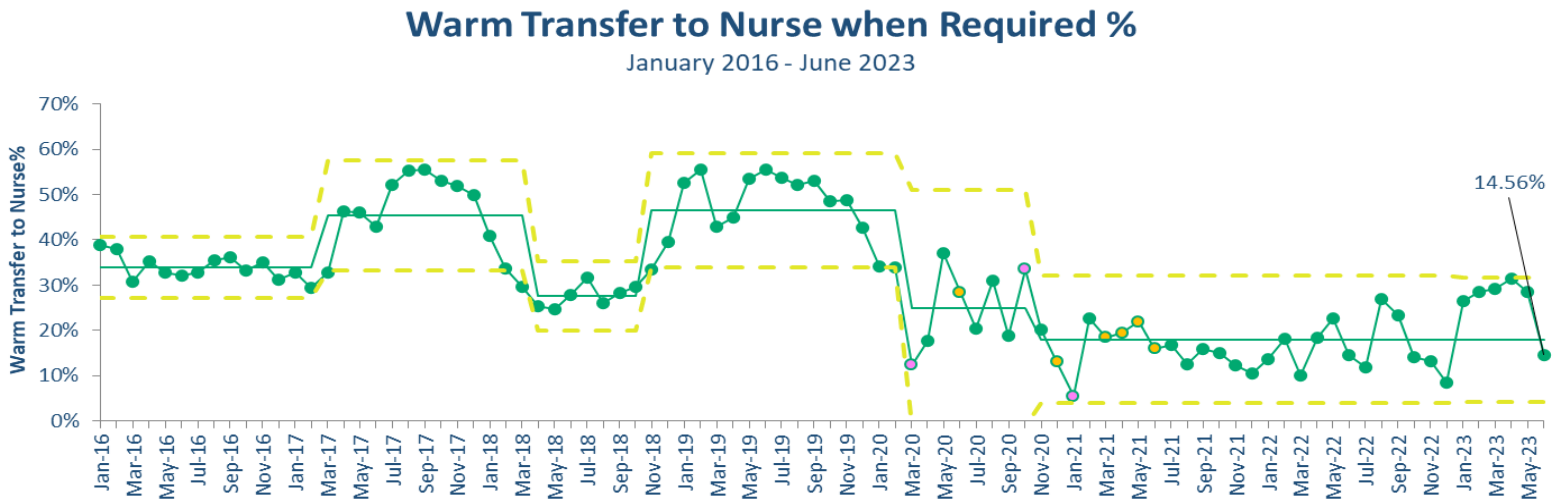
Calls Abandoned %	
Target	<5%
June 2023	10.56%
YTD	9.82%
National	10.8%

Figure O4.4



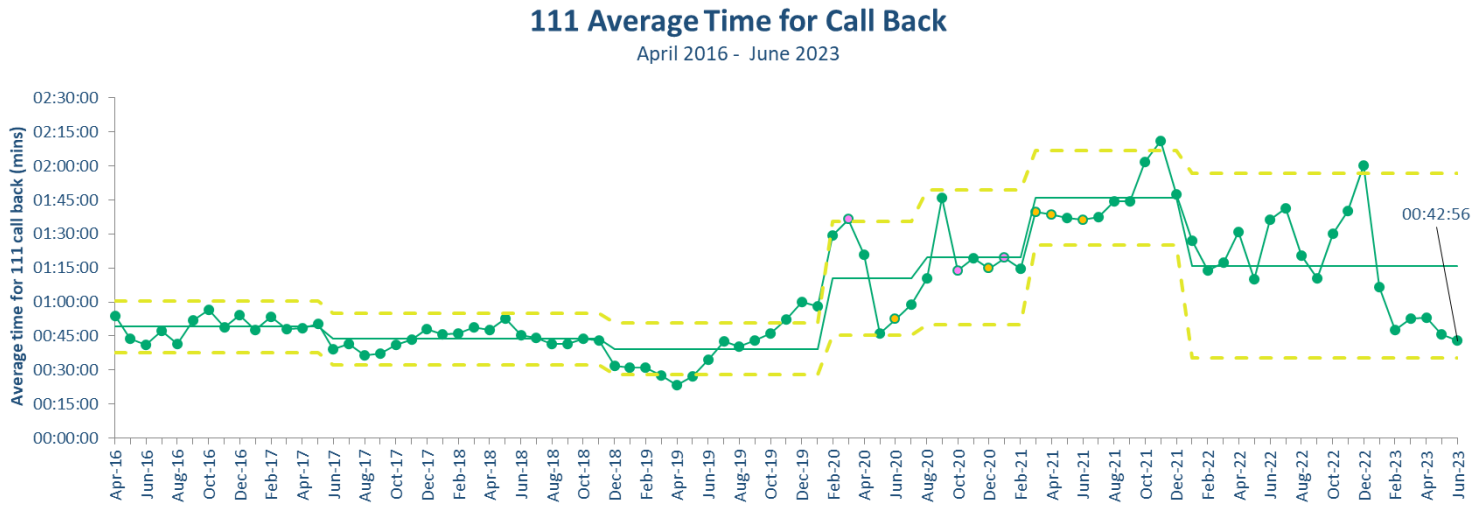
Calls Back <20 Mins	
Target	90%
June 2023	19.92%
YTD	31.1%

Figure O4.5



Warm Transfer %	
Target	75%
June 2023	14.56%
YTD	24.89%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: May 2023					Year to Date: July 2020 - May 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	10,892	(3,132)	(22%)	154,266	108,106	(46,160)	(30%)
Greater Manchester	526,588	43,882	45,888	2,006	5%	482,706	460,732	(21,974)	(5%)
Lancashire	589,181	49,098	36,675	(12,423)	(25%)	540,083	380,150	(159,933)	(30%)
Merseyside	300,123	25,010	25,464	454	2%	275,113	257,816	(17,297)	(6%)
NWAS	1,584,182	132,015	118,919	(13,096)	(10%)	1,452,167	1,206,804	(245,363)	(17%)

UNPLANNED ACTIVITY									
	Current Month: May 2023					Year to Date: July 2020 - May 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	452	(795)	(64%)	13,722	5,028	(8,694)	(63%)
Greater Manchester	49,133	4,094	4,111	17	0%	45,039	45,189	150	0%
Lancashire	58,829	4,902	3,242	(1,660)	(34%)	53,927	33,452	(20,475)	(38%)
Merseyside	22,351	1,863	1,521	(342)	(18%)	20,488	17,856	(2,632)	(13%)
NWAS	145,282	12,107	9,326	(2,781)	(23%)	133,175	101,525	(31,650)	(24%)

ABORTED ACTIVITY									
	May 2023								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	174	5,709	3%	24	396	6%	26	3,091	1%
Greater Manchester	1,652	16,818	10%	915	3,662	25%	863	16,987	5%
Lancashire	905	16,600	5%	456	2,563	18%	409	12,040	3%
Merseyside	525	8,887	6%	267	1,406	19%	574	10,754	5%
NWAS	3,256	48,014	7%	1,662	8,027	21%	1,872	42,872	4%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

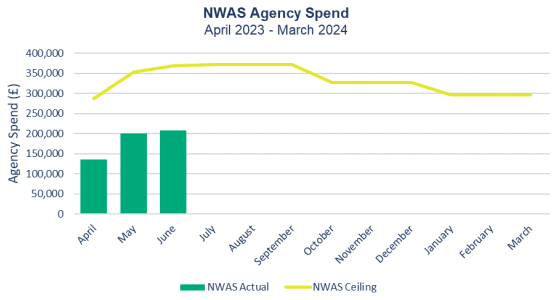


Figure F1.2

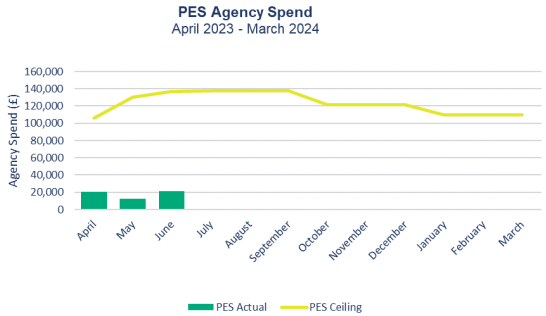


Figure F1.3

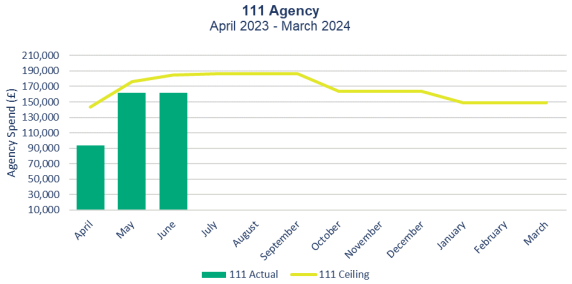


Figure F1.4

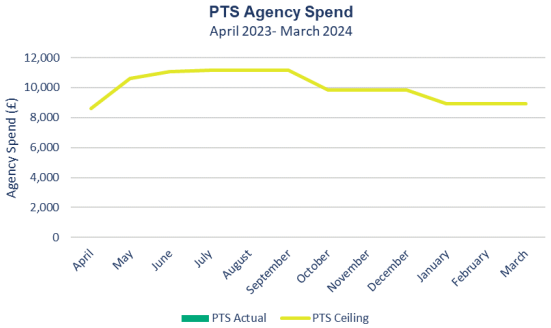


Figure F1.5

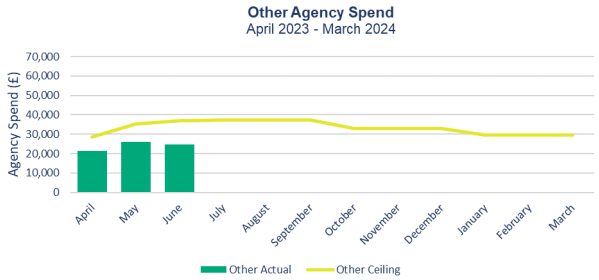
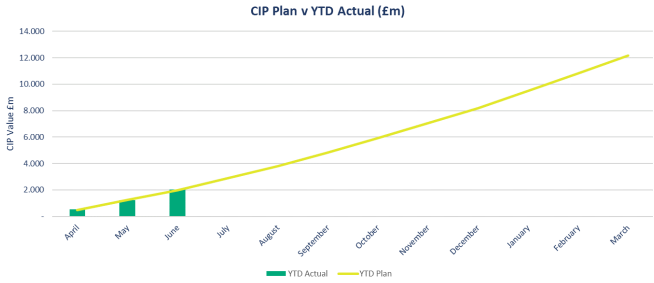


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

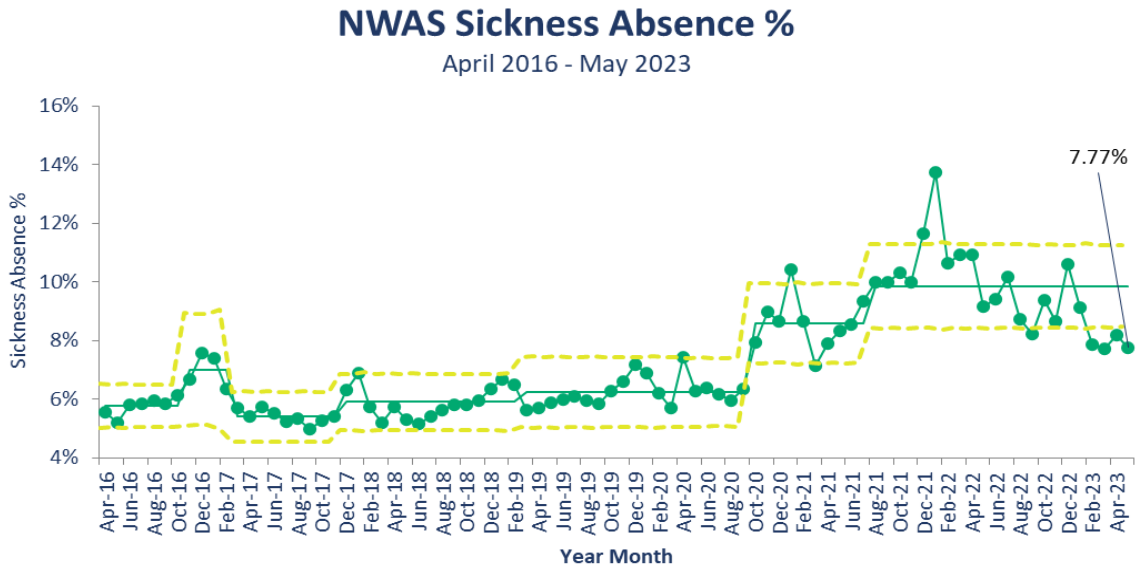


Table OH1.1

Sickness Absence	Jun-22	Jul–22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
NWAS	9.40%	10.16%	8.73%	8.21%	9.38%	8.64%	10.60%	9.11%	7.88%	7.71%	8.18%	7.77%
Amb. National Average	7.90%	8.73%	7.45%	7.56%	7.99%	7.66%	9.15%	7.71%	7.06%			

Figure OH1.2

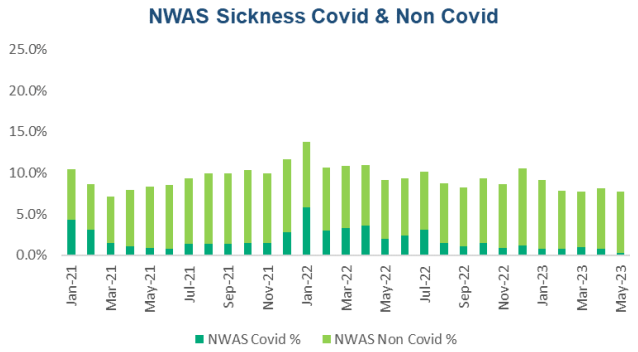


Figure OH1.3

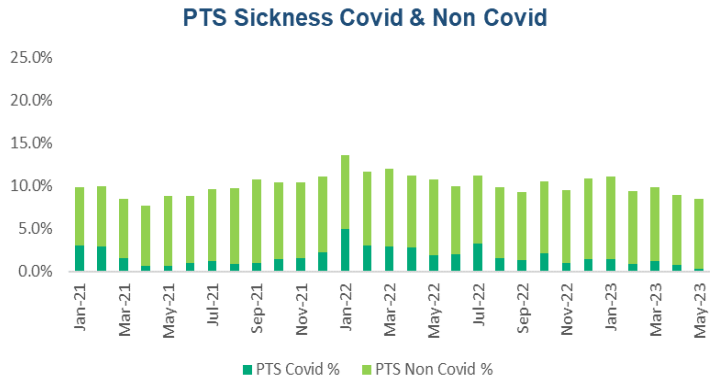


Figure OH1.4

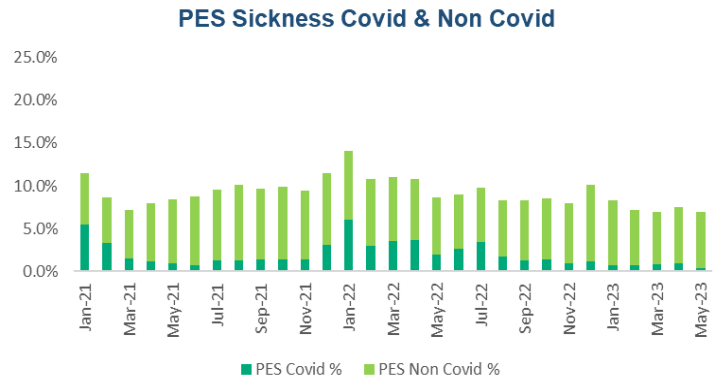


Table OH1.2

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%
Feb-23	0.8%	7.1%	7.9%
Mar-23	1.0%	6.8%	7.7%
Apr-23	0.8%	7.4%	8.2%
May-23	0.3%	7.5%	7.8%

Table OH1.3

PTS			
Month Ye	Covid %	Non Covid	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%
Feb-23	0.9%	8.5%	9.3%
Mar-23	1.2%	8.6%	9.8%
Apr-23	0.7%	8.2%	8.9%
May-23	0.3%	8.2%	8.5%

Table OH1.4

PES			
Month Ye	Covid %	Non Covid	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%
Feb-23	0.7%	6.4%	7.2%
Mar-23	0.9%	6.1%	6.9%
Apr-23	0.9%	6.6%	7.5%
May-23	0.4%	6.6%	7.0%

Figure OH1.5

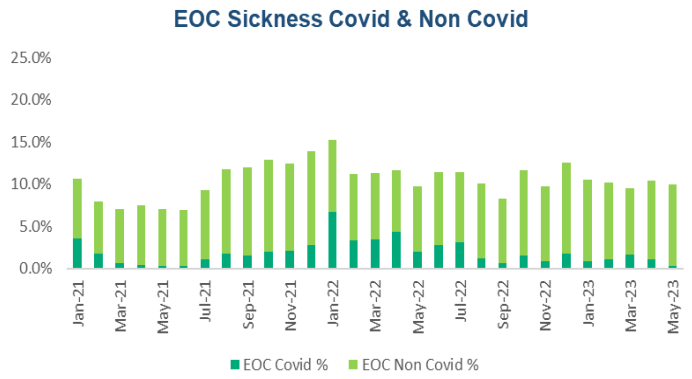


Figure OH1.6

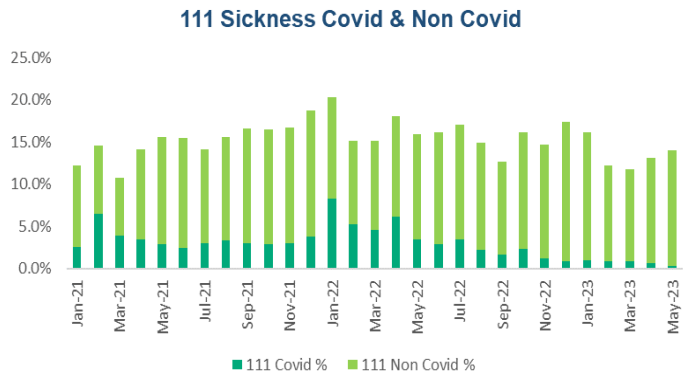


Figure OH1.7

Table OH1.5

EOC			
Month Ye	Covid %	Non Covid	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%
Feb-23	1.1%	9.1%	10.2%
Mar-23	1.6%	7.9%	9.6%
Apr-23	1.1%	9.3%	10.4%
May-23	0.3%	9.6%	9.9%

Table OH1.6

111			
Month Ye	Covid %	Non Covid	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%
Feb-23	0.9%	11.3%	12.2%
Mar-23	0.9%	10.9%	11.8%
Apr-23	0.6%	12.5%	13.1%
May-23	0.4%	13.6%	14.0%

Table OH1.7

Corporate			
Month Ye	Covid %	Non Covid	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%
Feb-23	0.3%	3.3%	3.7%
Mar-23	0.3%	3.4%	3.6%
Apr-23	0.2%	3.7%	3.9%
May-23	0.2%	3.4%	3.5%

OH2 STAFF TURNOVER

Figure OH2.1

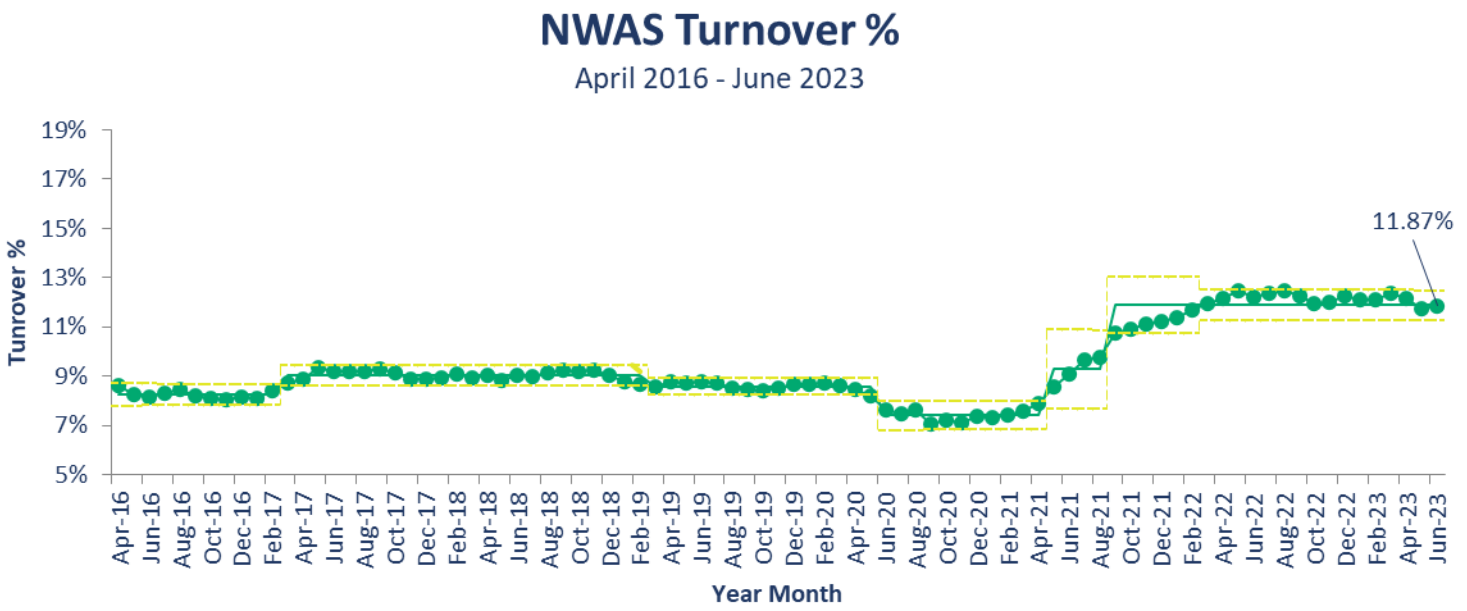


Table OH2.1

Turnover	July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NWAS	12.35%	12.45%	12.28%	11.94%	12.01%	12.28%	12.11%	12.09%	12.38%	12.15%	11.73%	11.87%
Amb. National Average	12.27%	12.23%	12.25%	12.19%	12.15%	12.16%	12.19%	12.21%	12.60%			

Figure OH2.2

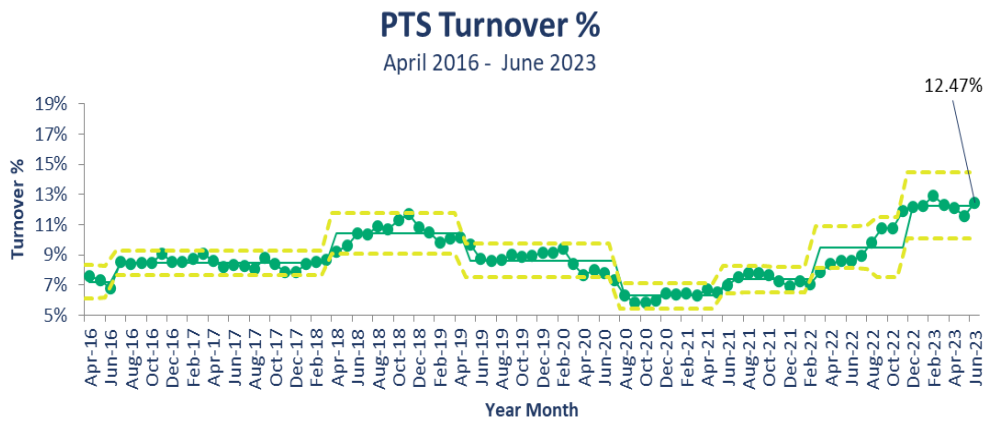


Figure OH2.3

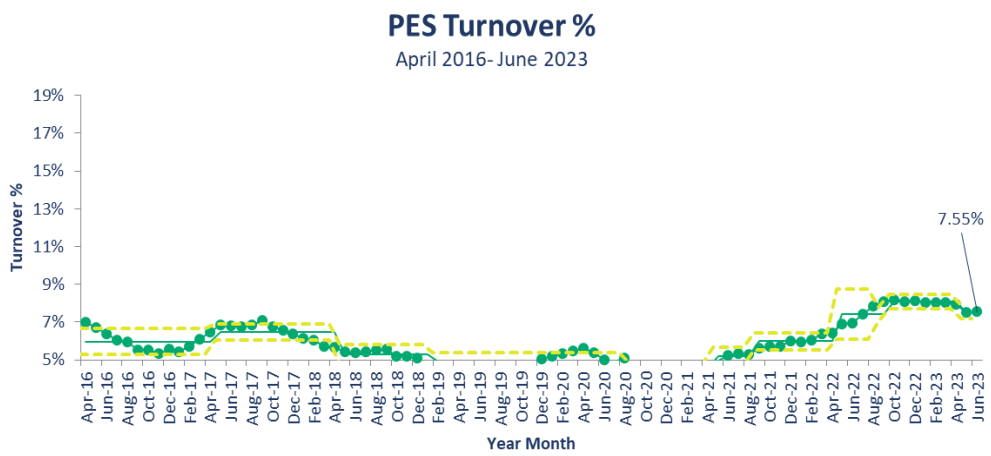


Figure OH2.4

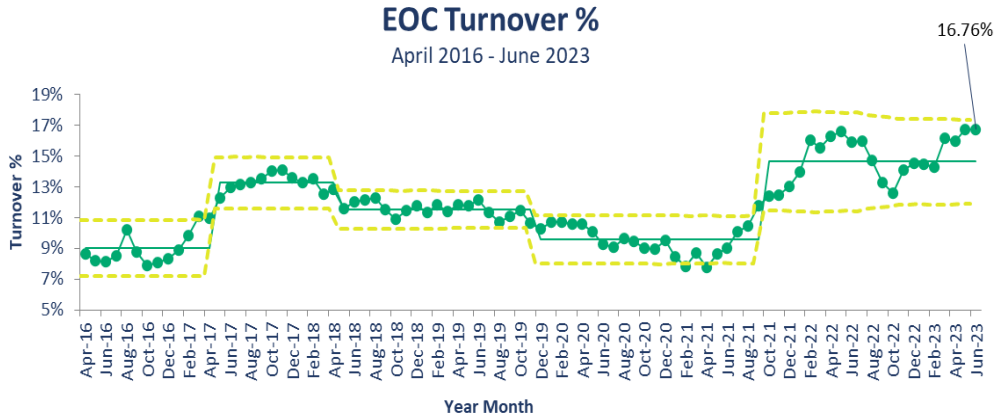
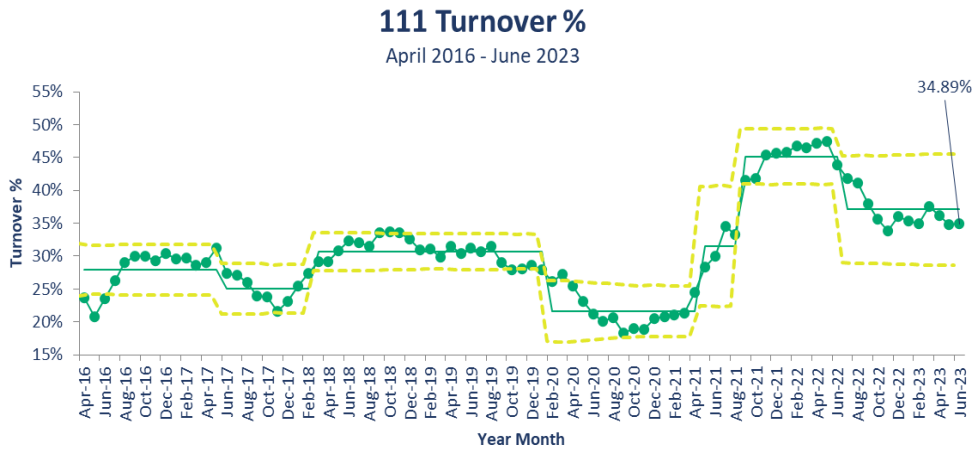


Figure OH2.5



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

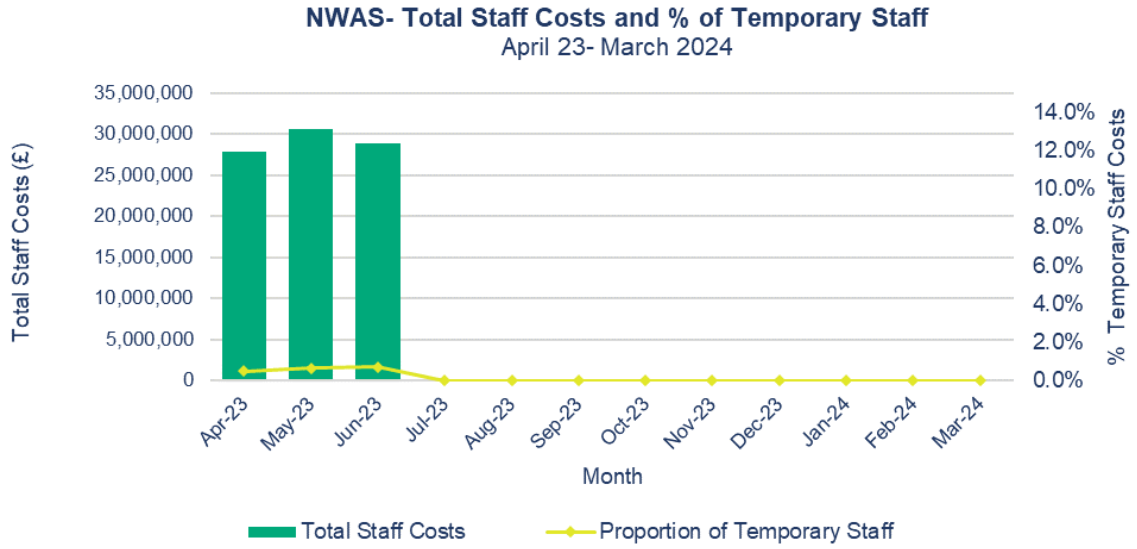


Table OH4.1

NWAS	July -22	Aug-22	Sep-22	Oct-22	Nov- 22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Agency Staff Costs (£)	472,303	376,736	279,546	176,850	159,947	157,417	140,004	107,701	191,258	135,492	200,114	207,520
Total Staff Costs (£)	26,352,765	27,478,110	29,946,339	27,740,005	27,494,954	27,204,469	27,041,860	26,856,025	56,312,765	27,882,122	30,582,073	28,815,903
Proportion of Temporary Staff %	1.8%	1.4%	0.9%	0.6%	0.6%	0.6%	0.5%	0.4%	0.3%	0.5%	0.7%	0.7%

Figure OH4.3

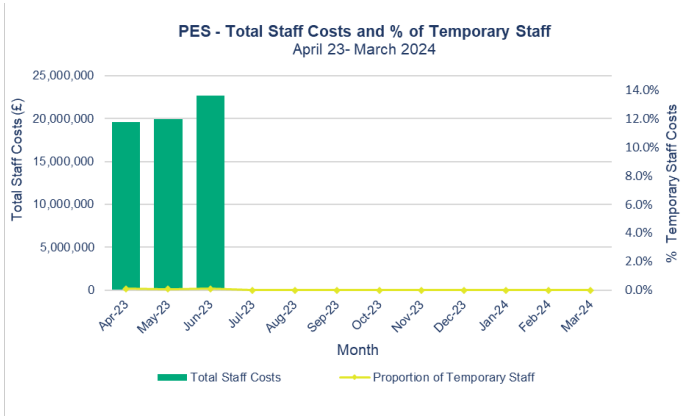


Figure OH4.4

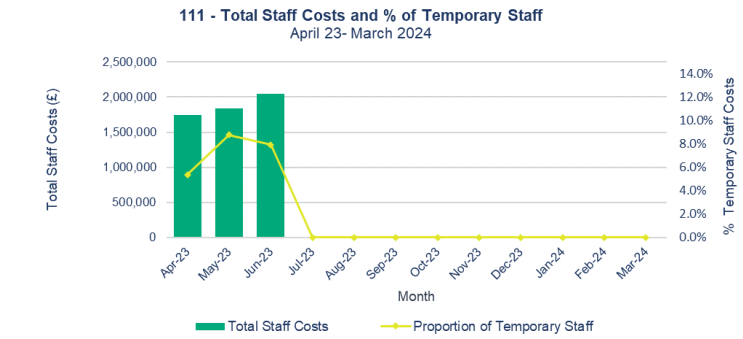


Figure OH4.5

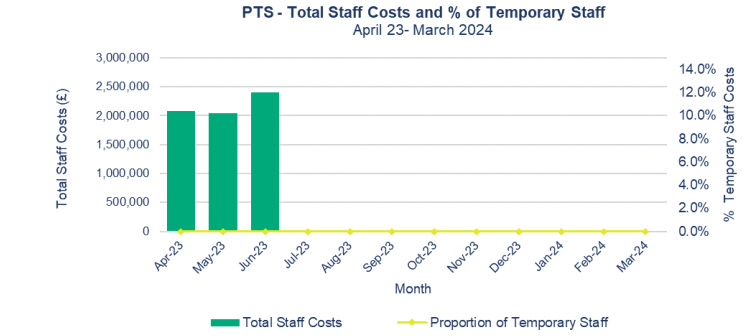
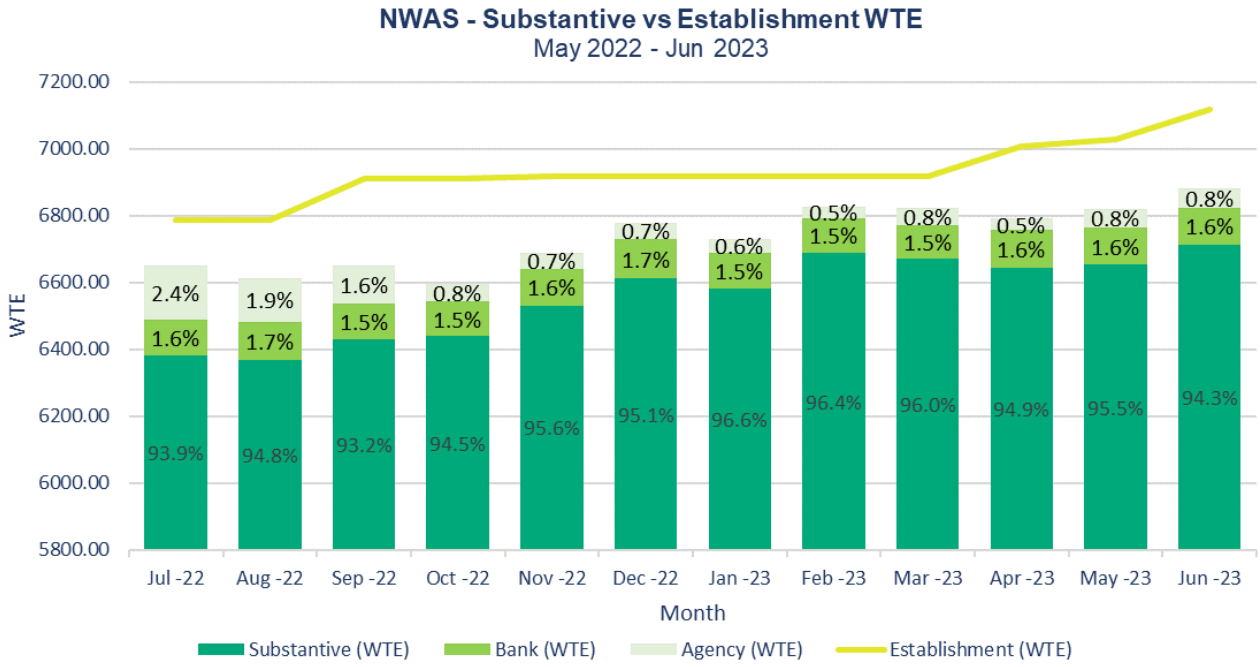


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

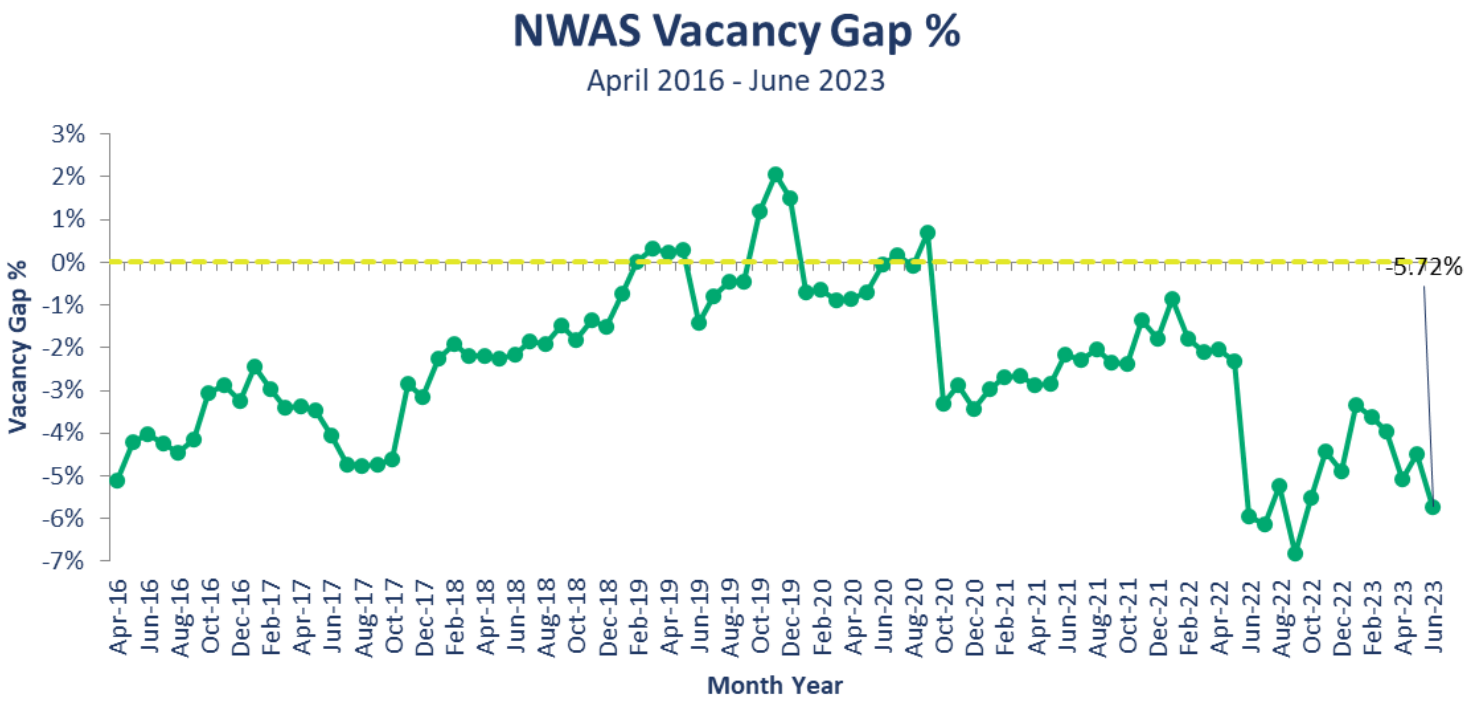


Table OH5.1

Vacancy Gap	July-22	Aug-22	Sep-22	Oct-22	N0v-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NWAS	-6.13%	-5.24%	-6.81%	-5.51%	-4.44%	-4.88%	-3.35%	-3.61%	-3.96%	-5.08%	-4.49%	-5.72%

Figure OH5.2

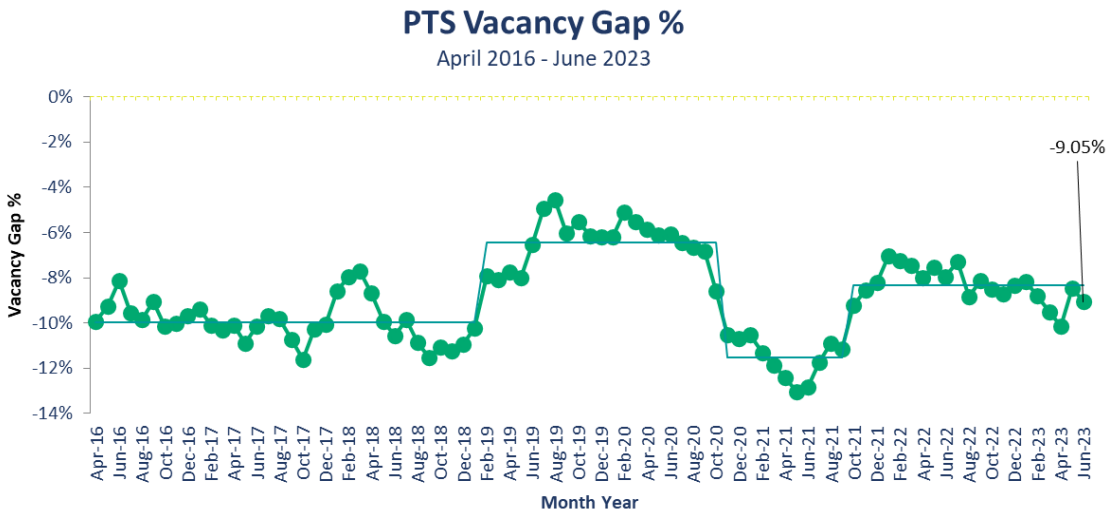


Figure OH5.3

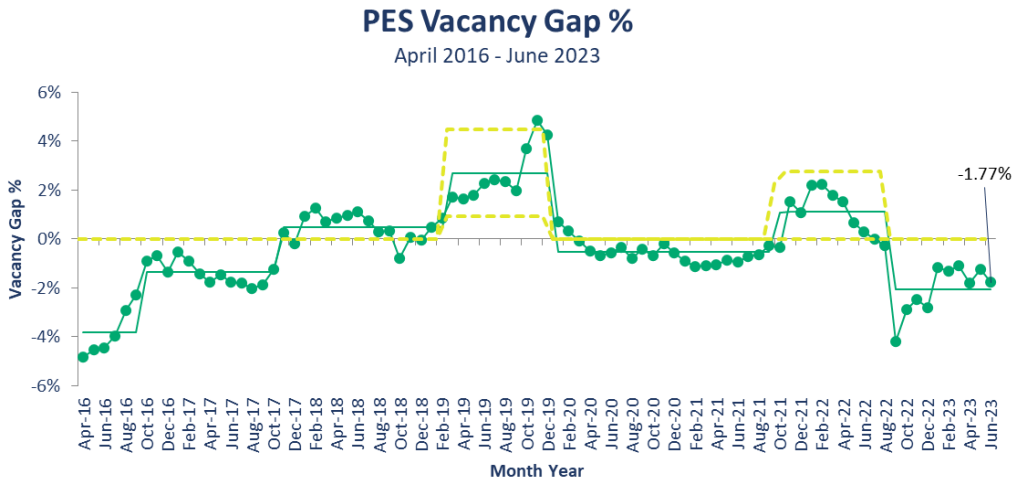


Figure OH5.4

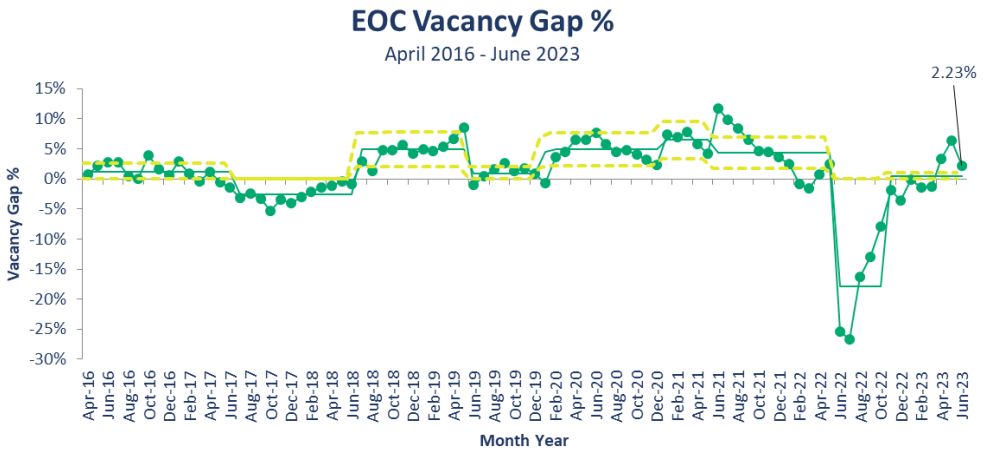
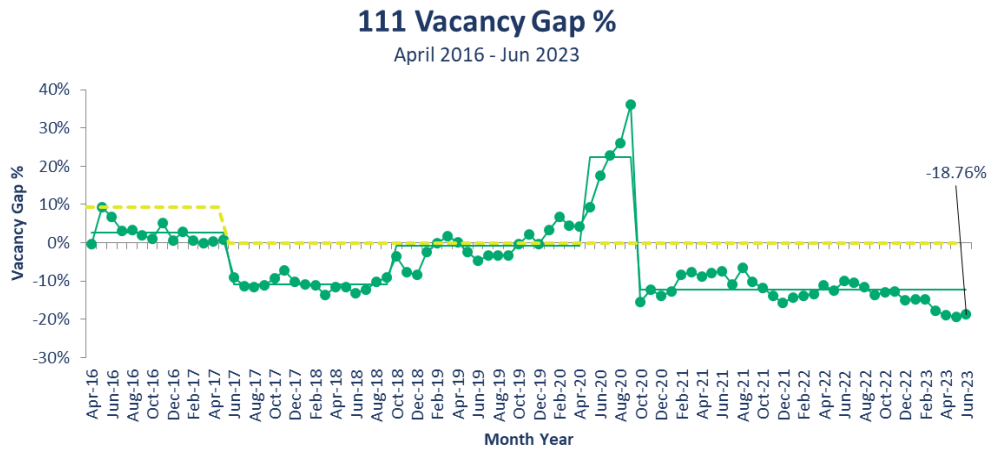


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

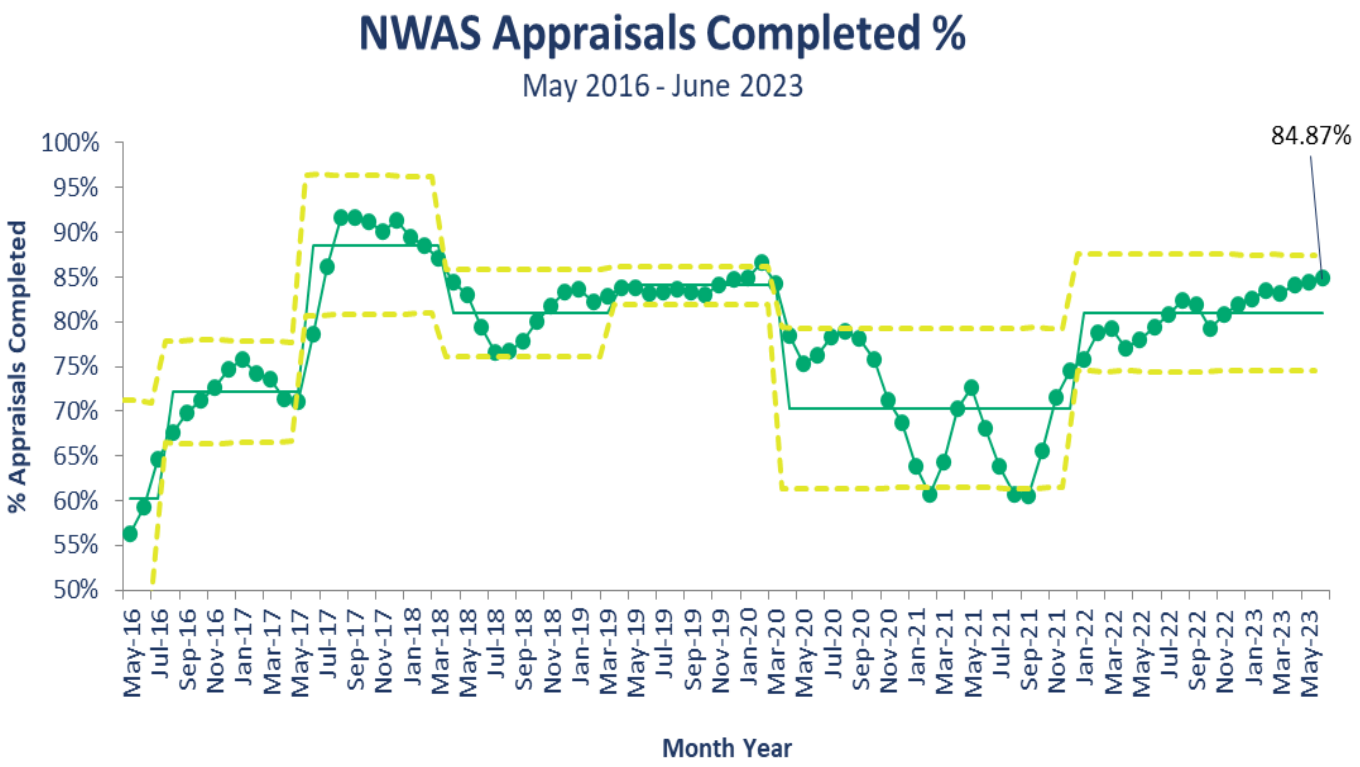


Table OH6.1

Appraisals	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22	Apr-22	May-23	Jun-23
NWAS	81%	82%	82%	79%	81%	82%	82%	83%	83%	84%	84%	85%

Figure OH6.2

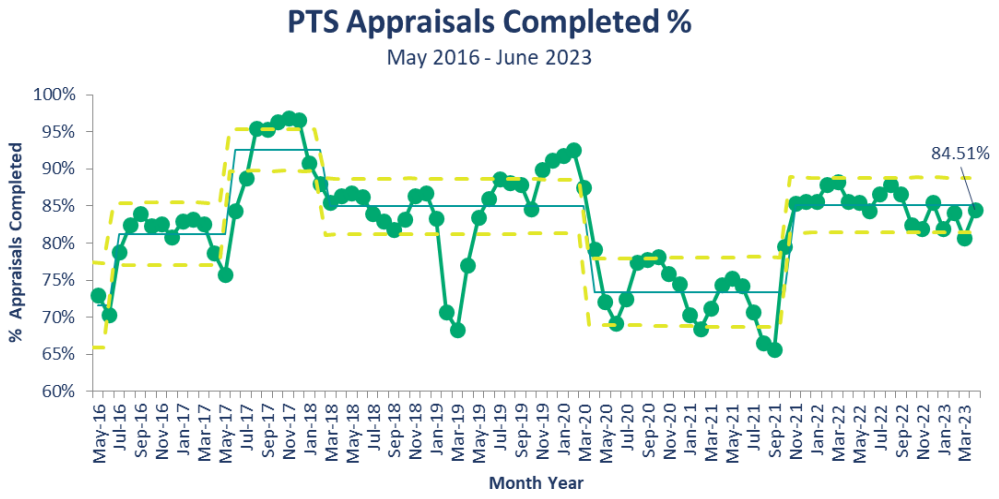


Figure OH6.3

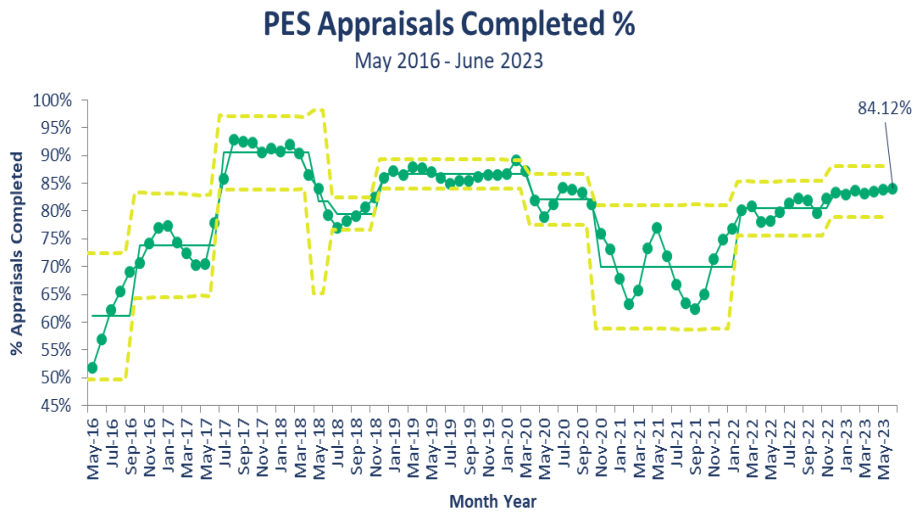


Figure OH6.4

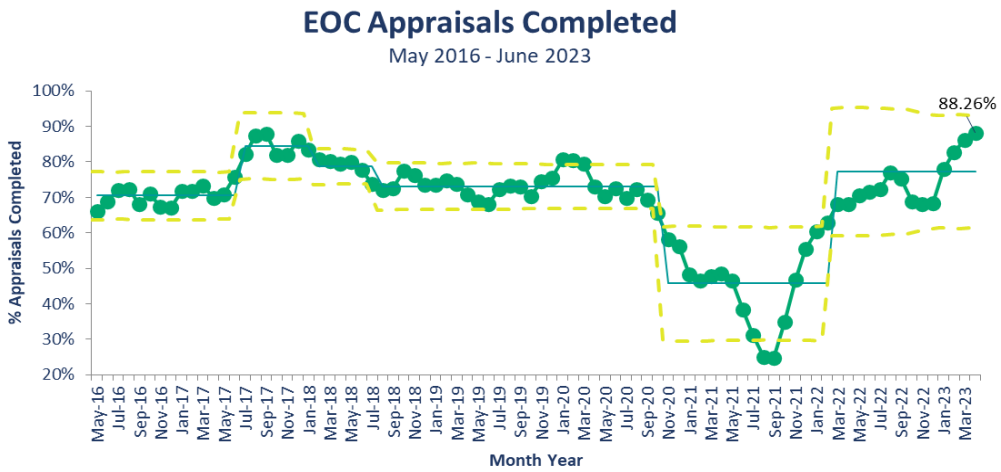
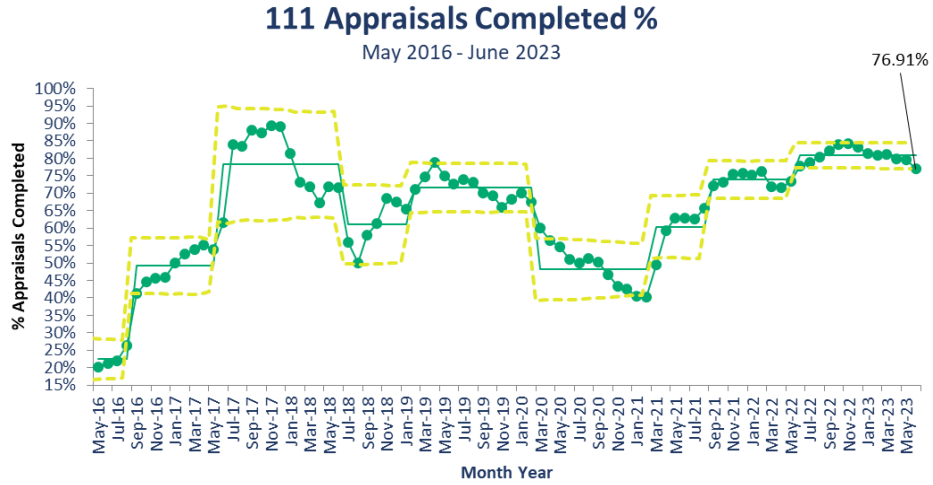


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

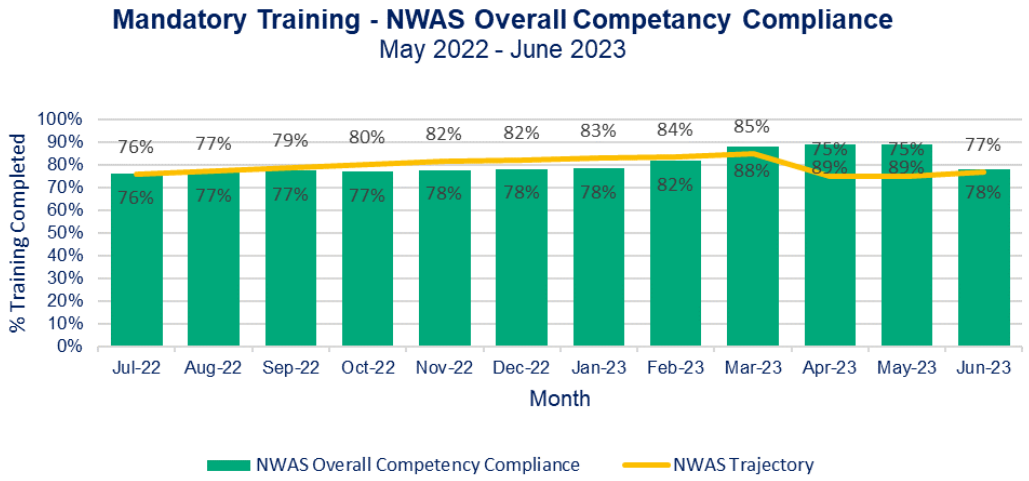


Figure OH7.2

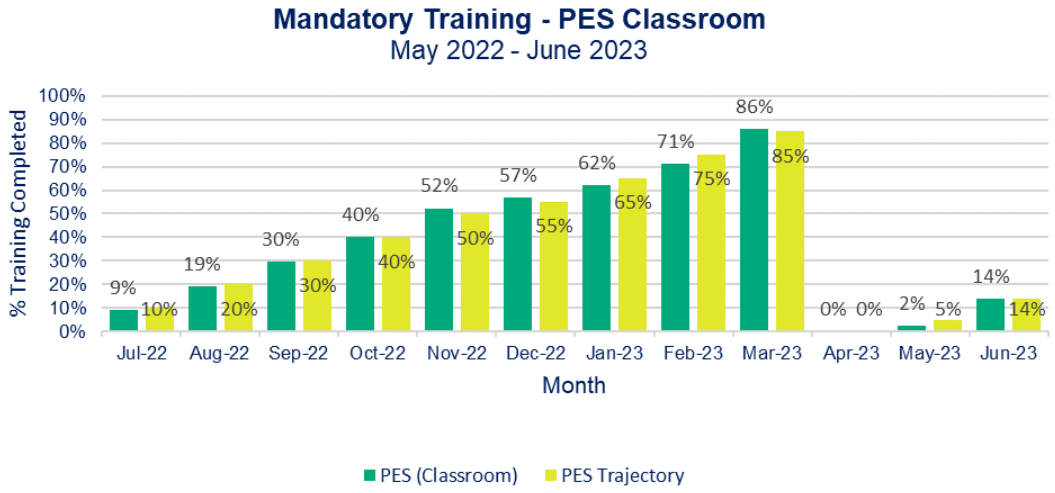
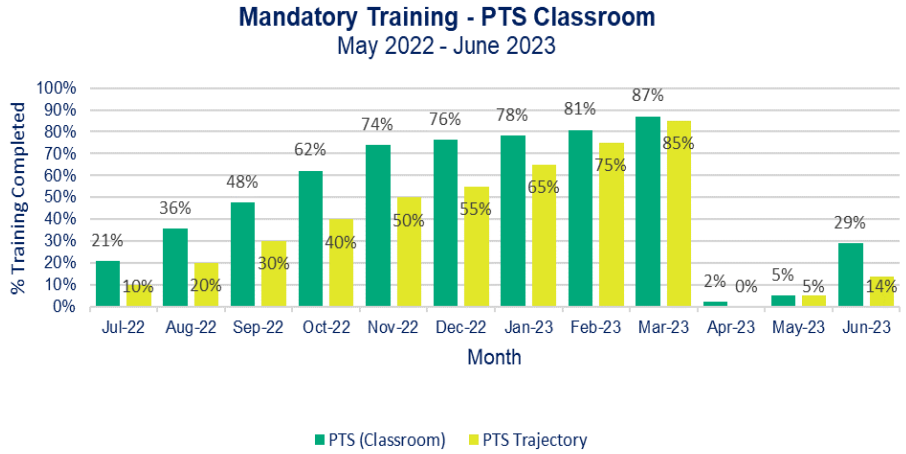


Figure OH7.3



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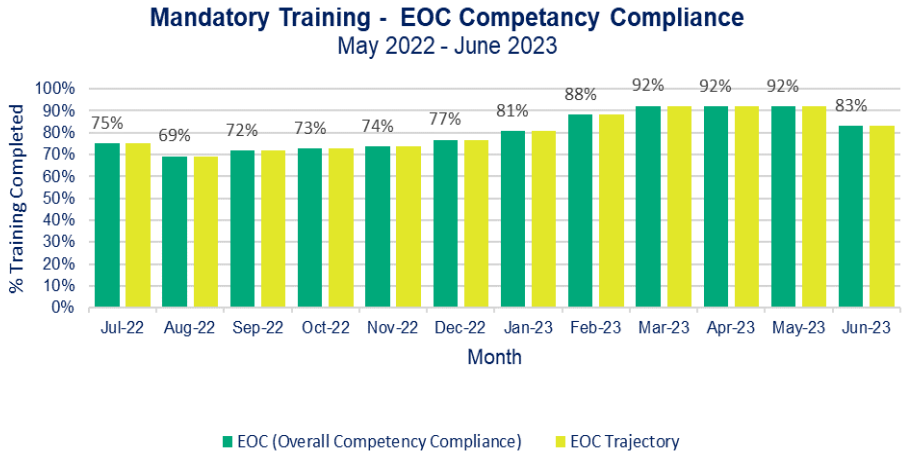

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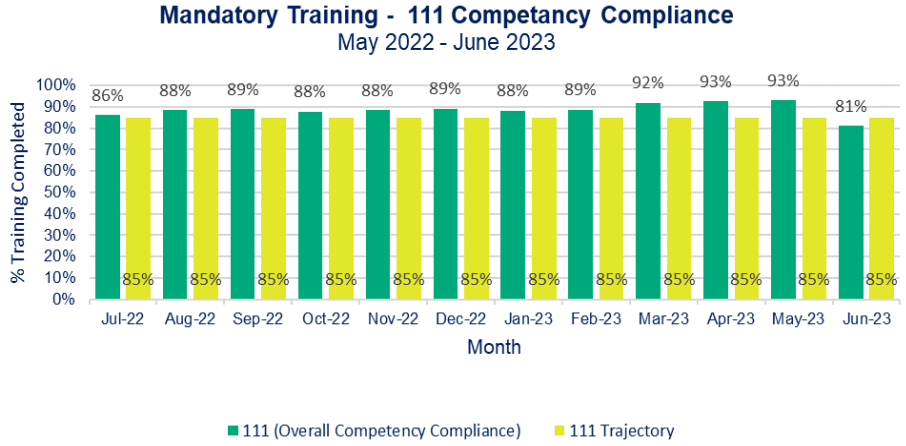

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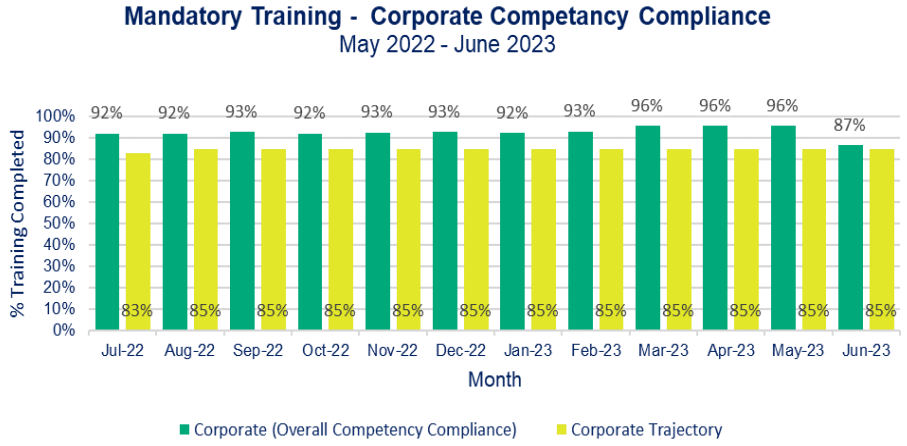


OH8 CASE MANAGEMENT

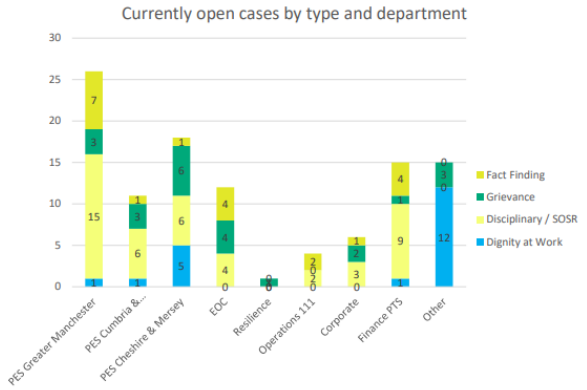
Figure OH8.1

Employee Relation Dashboard @ 5th July 2023. All information related to Dignity at work, Disciplinary, Fact Finding and Grievance cases only

NWAS Summary split by service line and sector

Service Line	Number of Live cases	Prevalence Live cases (numbers per hundred staff)	Number of cases closed in last 12 months	Prevalence closed cases in last 12 months (numbers per hundred staff)	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	55.00	1.5	200.00	5.3	13.48
CAM PES	18.00	1.6	58.00	5.1	18.05
CAL PES	11.00	0.9	60.00	4.9	14.61
GM PES	26.00	1.9	82.00	6.0	9.41
Operations ~ EOC	12.00	1.1	53.00	4.8	8.41
Operations ~ 111	4.00	0.7	60.00	10.4	5.86
Operations ~ PTS	16.00	1.9	58.00	6.9	9.44
Operations ~ Resilience	1.00	0.7	1.00	0.7	12.86
Corporate	6.00	0.9	20.00	2.9	11.82
Other	15.00		32.00		18.44
NWAS Summary	109.00	1.5	424.00	5.9	11.51

Other * - This included a number of incidents with several staff members involved, making it impossible to attribute them to a certain sector.



Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	20	49	22.11
Disciplinary	46	99	18.92
Fact Finding	20	171	5.46
Grievance	23	105	9.42
Case Summary	109	424	11.51

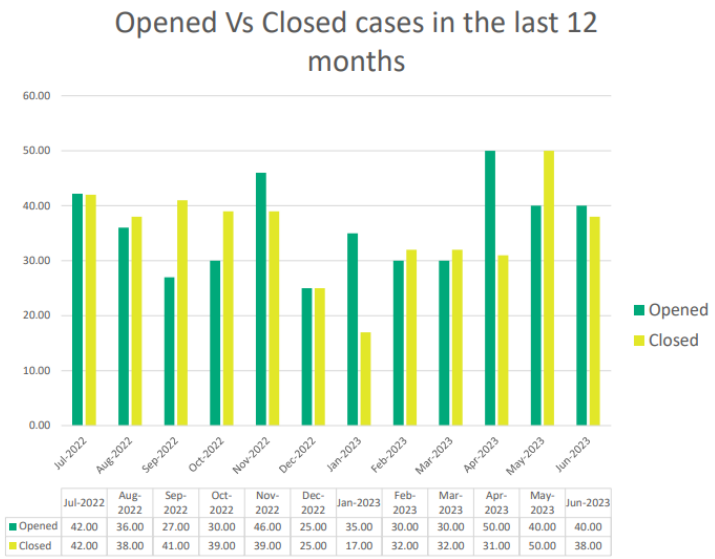
Length of current live cases by case type

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	13	5	2	0
Grievance	19	4	0	0
Fact Finding	18	2	0	0
Disciplinary / SOSR	21	9	13	3
Case Total	71	20	15	3

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

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	12
Fraud	9
Breach of social media policy	6
Poor patient care	6
SOSR	5
NWAS Summary	38

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



	Jul-2022	Aug-2022	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023	Mar-2023	Apr-2023	May-2023	Jun-2023
Opened	42.00	36.00	27.00	30.00	46.00	25.00	35.00	30.00	30.00	50.00	40.00	40.00
Closed	42.00	38.00	41.00	39.00	39.00	25.00	17.00	32.00	32.00	31.00	50.00	38.00

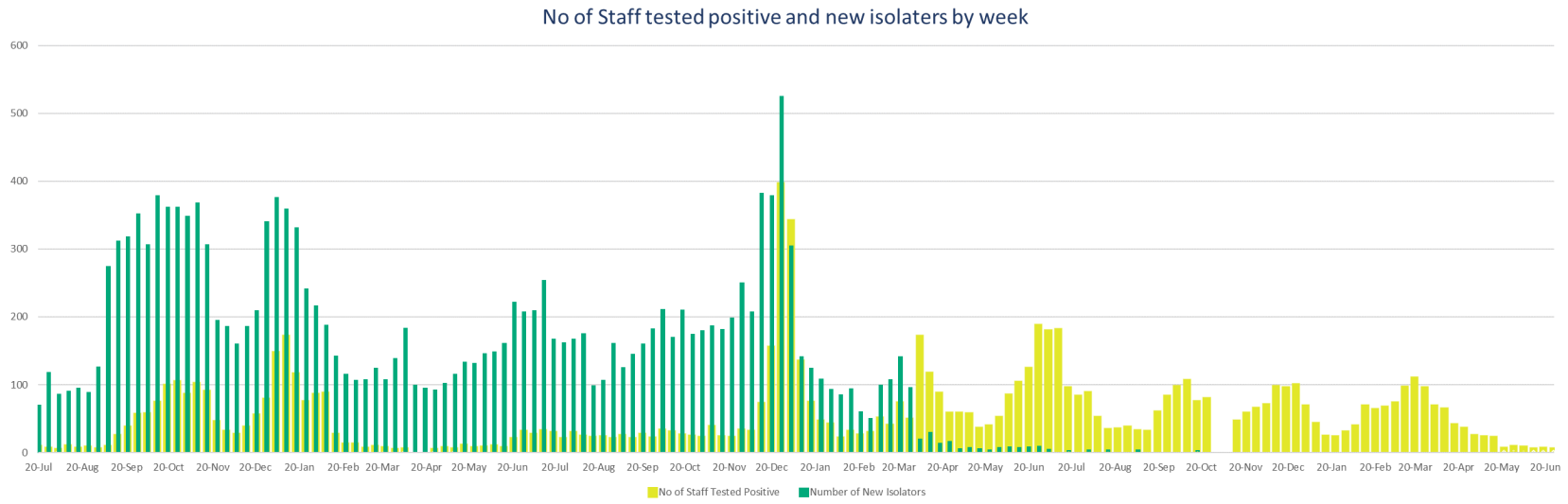
Covid

COVID 19

Figure CV1.1

Week Commencing	No of Staff Tested Positive
24-Oct-22	76
31-Oct-22	0
07-Nov-22	0
14-Nov-22	43
21-Nov-22	55
28-Nov-22	62
05-Dec-22	67
12-Dec-22	94
19-Dec-22	92
26-Dec-22	97
02-Jan-23	66
09-Jan-23	40
16-Jan-23	21
23-Jan-23	20
30-Jan-23	27
06-Feb-23	36
13-Feb-23	66
20-Feb-23	60
27-Feb-23	64
06-Mar-23	70
13-Mar-23	93
20-Mar-23	107
27-Mar-23	92
03-Apr-23	66
10-Apr-23	61
17-Apr-23	38
24-Apr-23	33
01-May-23	22
08-May-23	20
15-May-23	19
22-May-23	3
29-May-23	6
05-Jun-23	5
12-Jun-23	2
19-Jun-23	3
26-Jun-23	2

Figure CV1.2



North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th July 2023					
SUBJECT:	Infection Prevention and Control Bi-Annual IPC BAF					
PRESENTED BY:	Director of Quality, Improvement and Innovation					
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**
	☒	☐	☐	☐	☐	☒
	SR07	**SR08**	**SR09**	**SR10**	**SR11**	**SR12**
	☐	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance					
EXECUTIVE SUMMARY:	This paper provides the Board of Directors with the NWAS response against the revised 10 Key Lines of Enquiry (KLOEs) for the updated Infection Prevention and Control Board Assurance Framework (IPC BAF) (v1.1). The IPC BAF provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of transmission of respiratory infection to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry, each with a series of questions which need to be addressed. In October 2022 NHS England and Improvement provided an updated IPC BAF (V1.11) in which the Trust has now developed in line with the overarching Trust BAF. The new format is utilised. It is to be noted by Board that there have been significant steps in improving IPC within the Trust and that at present we have no red rag rated areas and 9 amber rated areas. Gaps in Control are clearly articulated and a timeline to improve declared throughout the BAF. There are no new risks identified. 3 risks remain on the risk register – no change in scores. The risks are - risk ID 236 (12). This relates to fit testing and this risk has reduced from its previous score of 15. We expect this risk to reduce at the next review given the recruitment of face fit testers. Other risks are ID 255 (8) and risk ID 322 (8). Risks are regularly reviewed and managed, and action undertaken. The updated IPC BAF will be monitored by the IPC Sub Committee.					
RECOMMENDATIONS:	The Board is asked to:					

	1) Note and acknowledge the significant steps of improvement in relation to IPC within the Trust 2) Note the gaps in control and the measures being taken to improve performance and provide further assurance
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☒ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	The BAF has been reviewed at IPC sub committee and Quality and Performance committee			
	Date:			
	Outcome:			

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1. PURPOSE

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

2. BACKGROUND

2.1 NWAS Infection Prevention and Control (IPC) Board Assurance Framework (BAF) provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of transmission of respiratory infection to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. It also demonstrates the significant progress and achievements that have been made in delivering effective staff and patient safety.

2.2 The BAF is presented bi-annually to IPC Sub Committee, Quality and Performance Committee prior to the Board of Directors. The BAF has been discussed at IPC Sub Committee and has been circulated to all IPC Sub Committee members for comments and these have been considered.

2.3 This BAF is a revised publication, circulated for use from April 2023. This revised version, lends itself more closely to the ambulance service. There are still a number of indicators that are not relevant to the ambulance service as these are focused on acute care in hospitals. This are noted within the document itself.

2.4 It is of note that recruitment is under way to recruit 3 face fit testers who will carry out fit testing across the organisation. All members of the IPC team have also undertaken face fit testing training. We hope to have the 3 individuals in place by the end of Q2 2023.

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

2.6 All IPC audits continue to be inputted via Safecheck – this is a far more efficient system and provides the necessary information for the IPC dashboard which has been presented at the IPC Sub Committee and allows for assurance to be gained and identifies any key themes where focused IPC work needs to take place.

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

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

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

3.2 It is to be noted by Board that there have been significant steps in improving IPC within the Trust and that at present we have no red rag rated areas and 9 amber rated areas. Gaps in Control are clearly articulated and a timeline to improve declared throughout the BAF.

3.3 No new risks identified during the reporting period; 3 risks remain on risk register – no change in scores. Risks regularly reviewed and managed, and action undertaken.

4. EQUALITY OR SUSTAINABILITY IMPACTS

4.1 There are no equality or sustainability impacts.

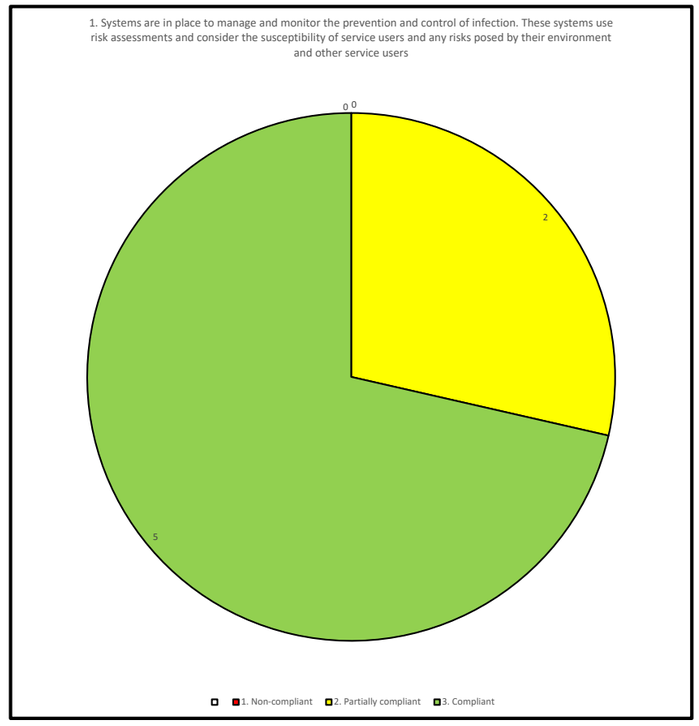
5. RECOMMENDATIONS

5.1 The Board is asked to:

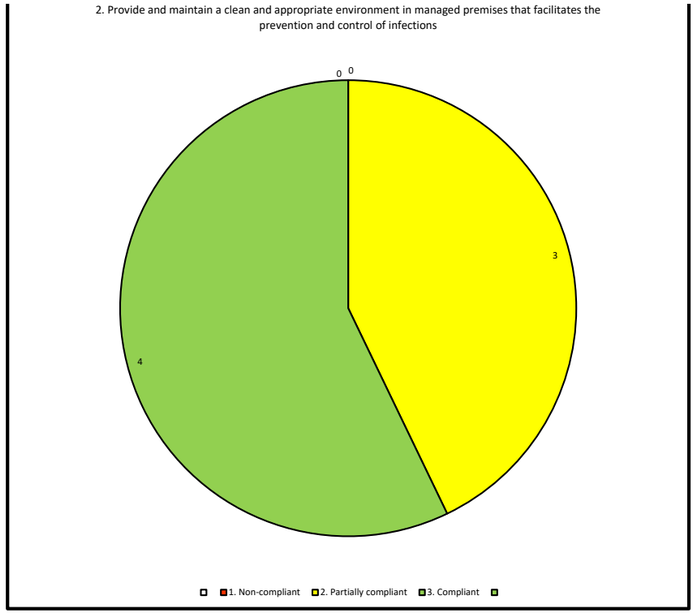
- Note and acknowledge the significant steps of improvement in relation to IPC within the Trust
- Note the gaps in control and the measures being taken to improve performance and provide further assurance

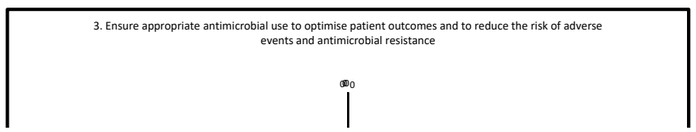
Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	- DIPC (Chief Nurse), bi-monthly IPSC reporting to Q+P, IPC Specialist Lead in post, IPC policy, functioning IPCT. Annual IPC report presented to Board. IPC cell functions as a working group reporting to IPCSC.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Staff infections reported through OH. Outbreaks reported to IPCT (various sources - Carlisle Support centre/direct from Managers/HR reports). IPCT responsible for managing outbreaks and reporting, as required, to NHSE. Will work with partners if any patient infections as part of a PIR.	No direct reports from OH to IPCSC.	OH to provide assurance reports to IPC sub committee. Consideration of links between IPC & PSIRF.		2. Partially compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Incident reporting widely promoted at NWAS. IPC incidents form part of area assurance reports that are presented at IPCSC. Key themes analysed by IPCT and any necessary mitigating actions are put in place. FTSU guardian widely promoted in the Trust. IPC present at Area learning forums. Lessons learned from incidents incorporated into IPC training and comms bulletins.	Work alongside other specialities (eg H+S) to ensure effective working in relation to incidents, key themes & actions taken as a result.	Plans to work closer with H+S to complete audits and prepare joint reports.		2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC station + vehcile audits completed 6 monthly by practitioners to capture adherence to NIPCM. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. All audits inputted onto safecheck & presented on dashboard. Link to NWAS policies & procedures are included in IPC manual.				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Mandatory surveillance for infectious agents not required for Ambulance Services. Mandatory reporting of COVID staff outbreaks reporting to NHSEI and summary of outbreaks presented at IPC sub-committee	N/A	N/A	N/A	0. Not applicable
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC station + vehcile audits completed 6 monthly by practitioners to capture adherence to NIPCM. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. All audits inputted onto safecheck & presented on dashboard. Fit testing team to be recruited to NWAS to carry out fit testing in line with HSE guidelines.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All Trust staff, including those employed via temporary staffing and contractors receive IPC induction. All clinical staff require annual IPC training, non-clinical staff have bi-annual training. IPCT are also available to provide ad-hoc training as required. All training packages are updated annually to reflect best practice. The IPCT has its own Trust intranet/public facing webpage where staff can access information, policies, leaflets, hand decontamination posters, and other helpful resources.				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	staff can contact IPC during office hours via email, teams or mobile numbers. Outside of these hours staff can contact their managers/ operational managers for IPC support. ONcall tactical advisors are also available to provide necessary IPC guidance. EOC have access to A-Z of communicable diseases. Advacnced paramedics are contactable out of hours for advice. There are policies, procedures and guidance on the Green Room page which all trust staff have access to.				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

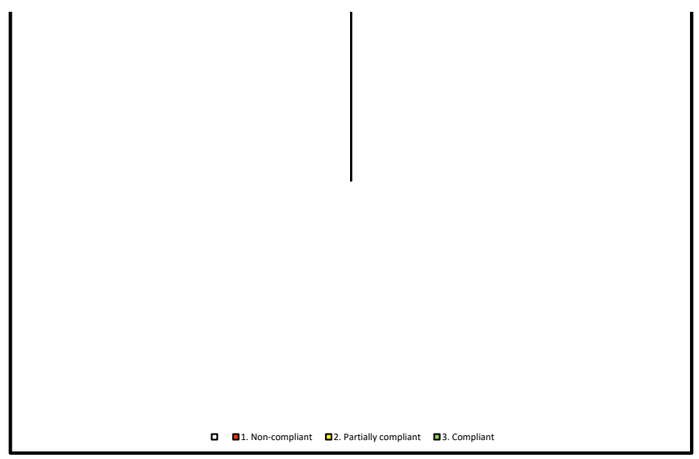


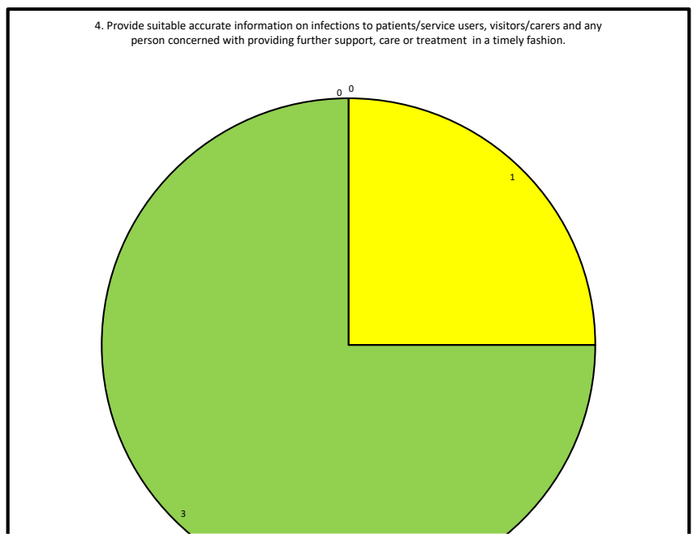
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Awaiting National Standards of cleanliness for ambulance service. Cleanliness is monitored and audited with locally agreed protocols and via IPC audits. NWAS have a cleaning contractor who is monitored by the facilities manager. Audits are carried out by the contractor, NWAS staff and IPC team for assurance of standards on stations.	NSoC for ambulance service are out in draft format to comment on - will need final versions in order to benchmark.			2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	N/A	N/A	N/A	N/A	0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Policies and procedures are in place to inform staff of responsibilities in relation to cleaning and decontamination. National cleaning standards are still not published for ambulance services. Where applicable the National cleaning standards are being applied to NWAS.Reusable equipment is cleaned after patient use Vehicle audits provide evidence of cleaning - these are reported though the IPC SC. IPC do unannounced audits on the 6 weeekly deep clean of vehicles completed by a private provider.	Difficulty completing required number of audits after deepo clean due to operational demands. Still awaiting final publication of National Standards of Cleanliness for Ambulance Service.	Increase freqeuncy of audits to try & capture more vehicles.		2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group meets every 6 months and provides assurance to the health,safety and security sub committee via the Estates, Fleet + Facilities management health, safety and security committee. Ventialtion testing is carried ut in line with national guidance. The Water Safety Group receives reports of anomolies of any water testing carried out at NWAS sites completed by the contractor. Policies and procedures are in place in relation to water safety and ventilation systems.				2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPCT are involved from the planning stage of new builds and refurbishments. IPCT are invited to meetings ans site walkablouts throughout the refurbishment period and IPC have to sign off works prior to staff working from the premises.				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Minimal linen is stored on vehicles, used linen is disposed of at hospital sites when conveying a patient. Linen which is on the vehicle at the time of service/ scheduled deep clean is removed, bagged and put into carts to be disposed of by local agreement at a local trust.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Policies and procedures are in place in line with national guidance. Waste management overseen by facilities. IPC monitor compliance through audit. Correct waste disposal is included in all teaching sesssions and resources are also available on the Green Room.Waste collection carried out by a private contractor.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	All reusable equipment is decontaminated between use. Any surgical instruments are single use. Decontamination certificates are used when equipment sent for servicing/repair.				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	N/A - there is no food provision for patients within NWAS	N/A	N/A	N/A	0. Not applicable
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	No antibiotics are prescribed - administered under PGD and in line with JRCALC. Only 2 antibiotics are used within the Trust. They are for emergency use and are a one off dose. Paramedics follow PGD for antibiotic use. AMS lead is in the DIPC role supported by the Chief Pharmacist	N/A	N/A	N/A	0. Not applicable



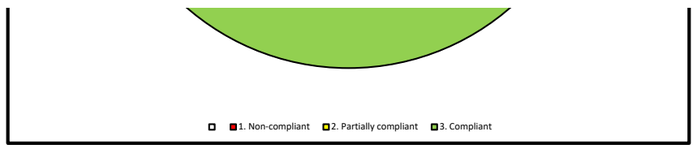


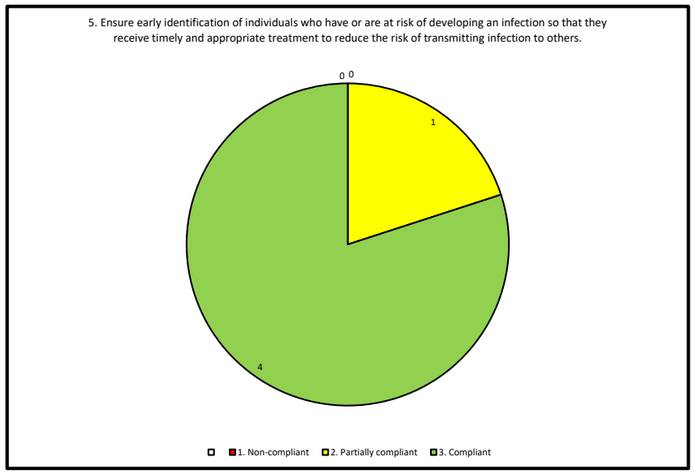
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	PGD compliance monitoring as part of audit plan - reported into Medicines Optimisation Group which feeds into Clinical Effecftiveness Sub Committee. Audit includes frequency of administration, if compliant with guidance & any related incidents.	N/A	N/A	N/A	0. Not applicable
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Director of quality, innovation and improvement - delegates responsibility to the DIPC	NA	NA	NA	0. Not applicable
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.					0. Not applicable
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •total antimicrobial prescribing. •broad-spectrum prescribing. •intravenous route prescribing. •treatment course length.					0. Not applicable
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)					0. Not applicable
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public will be checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection for patients (PPE etc) is available on vehicles. Engaged with religious partners via EDI team with respect to PPE/RPE. UKHSA attend IPC SC to present local demographic reports for infectious diseases.	Not clear defined relationships with PPIG. Liaise with medical director to identify any further actions in relation to public health and IPC.			2. Partially compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public will be checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection. Posters displayed if outbreak on any site to inform visitors for patients (PPE etc) is available on vehicles.				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All information which is on Trust website is reviewed regularly and updated in line with local and national guidelines. Information is available digitally.				3. Compliant

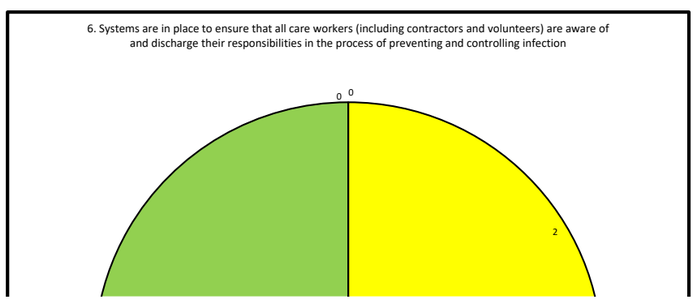




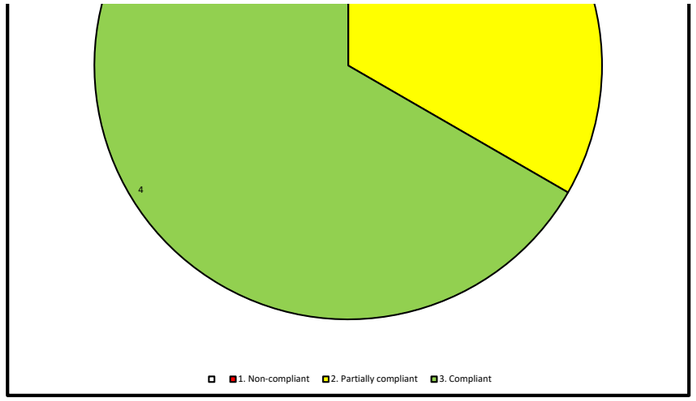
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to	Patients and escorts will be asked to wear a mask if it has been risk assessed it is appropriate to do so by the crew or if local/national guidance states so. Outbreak management is undertaken by the IPC team in liaison with ops managers, risk assessments to be carried out to identify necessary actions and implement mitigations - information to be communicated to relevant staff within NWAS. vaccination programme is co ordianted by occupational health. Flu Vaccinations offered to staff - other necessary vaccinations provided by OH. Hand hygiene wipes available on vehicles.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users. This is N/A for NWAS however please see information in columns for mitigating actions taken	NWAS rely on information from patient/person reporting incident and also accurate handover for transfers from hospital staff when conveying a patient in terms of infection status. PTS have booking system available which will assess risk of infection status and also identify those patients at risk of infection. Infectious status (if known) would be recorded on PRF.	Invasive device passports not always used/ used in all trusts. Infectious status of the patient not always communicated	Staff are aware of implementation of SICPS and how to risk assess for appropriate PPE and decontamination. This is also on mandatory training and e learning packages		0. Not applicable
5.	**Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	NWAS do not have any inpatient areas. Staff are aware of IPC measures to put in place to reduce the risk of picking up an infection from a patient. Crews will alert receiving ED/ID unit to ensure patient is placed in an approriate facility to minimise risk of onward transmission.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Crews will identify if patient potentially has infection and will pass this information on to receiving care facility to ensure patient is cared for in an environment that minimisies risk of onward transmission of infection.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Crews will inform receiving department if infectious status known & will be documented on PRF.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	NWAS do not have any settings where patients are in-situ. Safety stations (masks, wipes & alcohol hand gel) remain in place at the entrance to all buidings.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	NWAS outbreak policy identifes 2 or more staff will trigger an outbreak - these are reported externally to NHSE. Outbreaks are investigated by the IPCT and managers, extra IPC measures are implemented in the setting. Outbreaks are reported weekly to ELC and also to IPCSC.	Reliant on managers informing IPCT that they have staff off sick. No longer asymptomatic testing in place so uncertain if cases of illness are caused by same pathogen.	Regular visists to all settings from IPCT to raise awareness.		2. Partially compliant
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All training reviewed annually and updated and is in line with the National IPCM. Staff responsibilities documented in the IPC policy. Any new national guidance in incorporated into training packages.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Training needs analysis completed by the Education Department to ensure staff receive appropriate training for their role. Staff responsibilities documented in the IPC policy.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	IPC training programmes are reviewed regularly and are updated with any changes in national guidance. Compliance with Mandatory Training is monitored closely by the Education Department. IPC monitor MT compliance as part of assurance reports presented at IPCSC.				3. Compliant

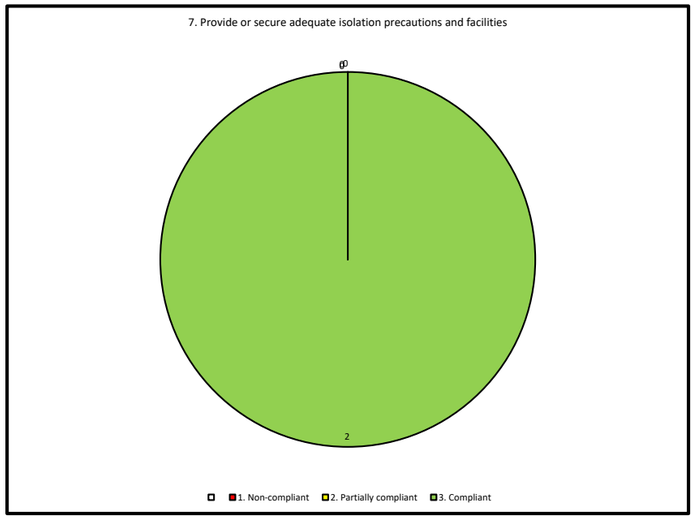


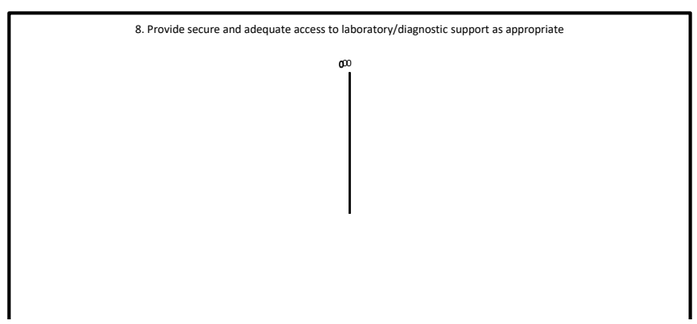




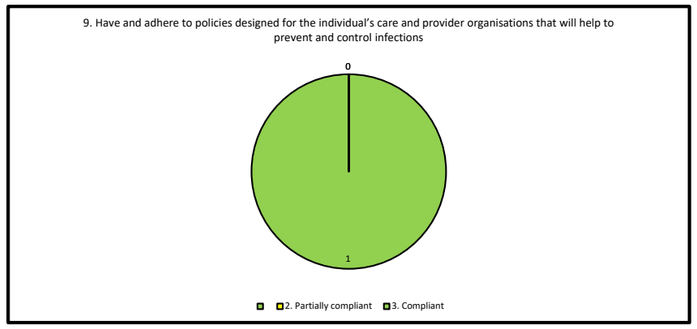
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All covered in mandatory training. Resources also available on the Green Room - this includes flow charts and videos showing staff how to correctly don + Doff PPE. Training videos on use of RPE and all new starters on their induction are shown how to use the equipment correctly.				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are fit tested to 2 masks as per requirements. Quantitative fit testing method being used within NWAS. All staff are also provided with a respiratory powered hood on commencing with NWAS. Training is delivered on how to use the hood correctly. Fit testing recorded centrally on ESR.	Currently have approx 1800 staff who are out of date for fit testing (has been over 2 years). CEPs fit testing new starters and IPCT also offering fit testing once a week across the Trust.	3 fit testers to be in post by end of Q2. IPCT have been trained to be able to fit test.		2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	NWAS staff are trained in aseptic technique and medical device insertion whilst in training at University. Staff are monitored for clinical competencies during contact shifts. Policies in place to support aseptice technique.	No further aseptic technique competency checking completed.	Included in IPC annual workplan to roll out ANTT training. Resources have been developed and to discuss with ops staff as to how this can be delivered effectively.		2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking which will determine how they are transported. PPE available for both staff and patients on vehicles.				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID	N/A	N/A	N/A	0. Not applicable
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking . Signage N/A.				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID	N/A	N/A	N/A	0. Not applicable
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	N/A NWAS do have access to a microbiologist if required via OH. OH also able to advise for staff with infections. IPCT work closely wwith UKHSA & health protection teams as necessary for contact tracing and any necessary prophylactic treatment of staff	N/A	N/A	N/A	0. Not applicable
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	N/A	N/A	N/A	N/A	0. Not applicable
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	N/A	N/A	N/A	N/A	0. Not applicable

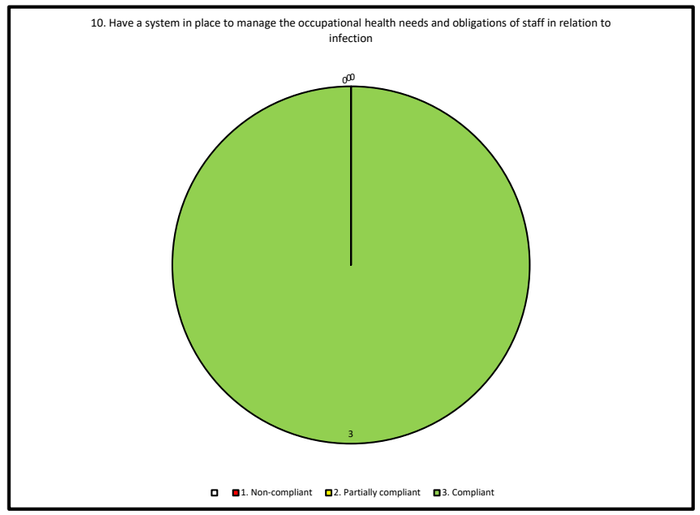






8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	N/A	N/A	N/A	N/A	0. Not applicable
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	N/A	N/A	N/A	N/A	0. Not applicable
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	N/A	N/A	N/A	N/A	0. Not applicable
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Training provided to all staff in line with the national IPC manual. IPC resources are available on the Trust intranet site. Staff can readily contact IPC for advice via phone, email or microsoft teams. Policies are in place and accessible on the intranet site. Safety stations remain in place at all sites, signage and the implementation of IPC measures available in event of an outbreak. Spcific outbreak policy in place. Outbreak reporting to NHSE is in place and all outbreaks are internally monitored by the IPCT and reported to the IPC sub-committee. Communcations sent out via bulletins to inform staff of any local outbreaks.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Staff are referred to OH and are also risk assessed by their line mananger to ensure are not put at risk in the workplace. Risk assessment in place for staff who are pregnant. Managers responsibility to complete risk assessments. Alternative duties available for staff at risk				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Staff are to contact OH for advice & necessary follow up following exposure. Information is available on the Trust intranet and policies and procedures. Close liaison with UKHSA as appropriate.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	This is completed by OH pre employment and as necessary dependant on risk assessment. GP's also provide some vaccinations. Vaccinations are recorded on NIVS.				3. Compliant





North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th July 2023				
SUBJECT:	Senior Information Risk Owner Report				
PRESENTED BY:	M Power, SIRO Director of Quality, Innovation and Improvement				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The purpose of this report is to provide the Board with a summary of the work completed over the past twelve months to manage information risk within the Trust. Information Governance (IG) and data protection is focussed on with the way NHS organisations handle information about patients/clients and employees, in particular personal and special category information. Data protection gives organisations and individuals assurance that personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care. Governance structures are in place to manage the work programme and risks, with oversight from our SIRO and specialist team. The Information Governance and Security work programme aligns to the assertions set out in the Data Security and Protection Toolkit (DSPT). A focus of the work programme in year has been on the data quality policy, the 2nd phase of the ePR, cyber security and records management. Key highlights of the report include: - Standards met for the June 2022 DSPT audit and accompanying substantial assurance from the MIAA audit - SIRO training and the establishment of the office of the SIRO with a focus on the asset register and asset owner engagement - A significant increase in compliance with Information security mandatory training to 82% - All KPIs for Information Governance being met				

	- Significant work undertaken to improve cyber security - An increase in data breaches at 114 with learning identified - 26 screening and 12 full DPIAs undertaken - 2,179 subject access requests processed Cyber security risks have been regularly reported to the Board with gaps in control and assurances provided through the Board Assurance Framework risk. Seven Information risks have been monitored by the IG sub committee with one closed and a reduction in the risk associated with records management.
RECOMMENDATIONS:	The Audit Committee are asked to: • Note the contents of the report and progress made • Take assurance that the Trust has effective systems and process in place to maintain the security of information.
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: ☒ Compliance/Regulatory ☒ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

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:	Audit Committee			
	Date:	21.07.23		
	Outcome:			

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1. PURPOSE

1.1 The purpose of this report is to provide the Board with a summary of the work completed over the past twelve months to manage information risk within the Trust.

2. BACKGROUND

2.1 Data is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. Information Governance (IG) and data protection is focussed on the way NHS organisations handle information about patients/clients and employees, in particular personal and special category information.

2.2 Data protection gives organisations and individuals assurance that personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care

2.3 We have a Senior Information Risk Officer (SIRO) who is accountable for Information Governance within the organisation and chairs the Information Governance Sub Committee (IGSC). Resilience is provided by the CIO who is also deputy SIRO. IGSC reports to the Audit Committee bi monthly through the chairs assurance report with risks reported via the audit chairs report to Board. IGSC effectiveness is monitored via the annual governance process review.

2.4 The Medical Director, as the Caldicott Guardian, supports the SIRO. The Caldicott Guardian is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

2.5 The Work programme aligns to the assertions set out in the Data Security and Protection Toolkit (DSPT). A focus of the work programme in year has been on the data quality policy, the 2nd phase of the ePR, cyber security and records management. Policies and Procedures are managed through the IGSC and signed off with Executive Leadership Committee as required.

2.6 We have a well established team and DPO who works closely with cyber security colleagues in IT. A new Chief Clinical Information Officer (CCIO) joined the Trust in November and he brings a wealth of experience from his previous role as CCIO. The CCIO reports to the Chief Information Officer.

3. INTERNAL ASSURANCE STRUCTURE

3.1 The Information Governance Sub- committee. is chaired by the Trust's Senior Information Risk Owner (SIRO). The terms of reference and membership were refreshed during 2022/23 following completion of the Sub Group Effectiveness Review and Group Self-Assessment facilitated by the Corporate Governance Team. The Group provides assurance to the Board of Directors via the Audit Committee.

3.2 The Board Assurance Framework included a risk related to cyber security which provided the opportunity for escalation of risks and assurances to be provided to the Board on a regular basis.

3.3 For day-to-day information risk management, the SIRO is supported by the Deputy SIRO, the Medical Director, as the Caldicott Guardian, the Data Protection Officer, the cyber security lead and IG team.

3.4 The Data Protection Officer (DPO) assists the Trust to monitor internal compliance, and advise on data protection obligations. They provide advice regarding Data Protection Impact Assessments (DPIAs) and acts as a contact point for data subjects and the Information Commissioner's Office (ICO). The DPO is an independent expert in data protection and reports to the highest management level**.** The Trust procure the DPO service from Mersey Internal Audit Agency.

3.5 The Data Protection Officer (DPO) received a total of seven complaints.

4. DSPT JUNE 2022 SUBMSSION

4.1 In June 2022 we received approaching standards for our Data Security and Protection Toolkit (DSPT) submission. This was due to one assertion not being met – 95% compliance with data security and awareness training. The next submission for the DSPT is at the end of June. We anticipate that we will receive 'Approaching Standards' with 112 out of 113 mandatory assertions met. The Trust has not met the 95% staff completion of data security awareness training assertion.

4.2 NHS Digital introduced the " Approaching Standards" certification in 2022,. This was given to an organisation, after the improvement plan for the final submission was reviewed and approved.

4.3 In 2022 three ambulance services achieved Standards Met.

Organisation	**DSPT achievement 22**
North east Ambulance Service NHS FT	Standards Met
Yorkshire Ambulance Service NHS Trust	Approaching standards
NWAS	Approaching standards
West Midlands Ambulance Service University NHS FT	Standards met
East Midlands Ambulance Service NHS Trust	Approaching standards
Southwestern Ambulance Service NHS FT	Approaching standards
South Central Ambulance Service NHS FT	Approaching standards
Southeast Coast Ambulance Service NHS FT	Approaching standards

London Ambulance Service NHS Trust	Standards met
East of England Ambulance Services NHS Trust	Approaching standards

4.3 Mersey Internal Audit (MIAA) complete a mandatory audit of a selection of assertions in the DSPT. The trust received a rating of "Substantial Assurance". The overall assurance across all the 10 National Data Guardian standards is "Substantial Assurance " which is the highest rating of assurance.

5. DATA SECURITY AWARENESS TRAINING

5.1 Although we will not meet the 95% compliance assertion following our improvement plan we have seen a significant increase in data security awareness training completion, reaching 82%.

6. SENIOR INFORMATION RISK OWNER TRAINING

6.1 The SIRO and the key IG leads in the Trust received SIRO training delivered by Templar training on the 24th Feb. The training reinforced the role of the SIRO and following the training a monthly group has been established under the office of the SIRO. This will provide an action focussed space to ensure progress of the programme of work for IG and cyber security with direct oversight of the SIRO. Early actions from the group include a review of the asset register. The training also highlighted the importance of the direct line of communication and accountability between the SIRO and all Information Asset Owners. A letter has gone to Asset Owners reminding them of their responsibilities, monthly meetings with asset owners are being reestablished and training is planned for Information Asset Owners and Administrators.

7. DATA BREACHES

7.1 The Trust uses DCIQ to capture data breaches reported by all levels of staff. During 2022/23 a total of 141 were reported. Six incidents were externally reported, after meeting the criteria for notification to the Information Commissioner's Office (ICO)

7.2 We have seen an increase from 21/22 where we had 68 data breaches reported. The trend towards an increase in data breaches was highlighted early on in the year and reported to the Audit Committee. An initial review to look for themes and identify learning was undertaken. A significant proportion of data breaches are linked to incorrect sharing of personal staff details within NWAS. Work is ongoing to share learning with a goal to reduce data breaches in this area.

Each breach is reviewed to understand any opportunities for learning. One Breach was linked to a third parry supplier and prompted the team to undertake a review of third party ambulance contracts to ensure that all GDPR clauses are added to the contract.

8. CYBER SECURITY

8.1 Cyber security's core function is to protect the Trust's data and information assets including the devices we all use (smartphones, laptops, tablets and computers), networks and the services we access – both online and at work – from theft or damage. We have continued to make significant progress with our cyber security programme with an update report including our dashboard of measures reported to each Information Governance Sub Committee. The Cyber Security Assurance report outlines nine areas of controls, guidance / recommendations, and the Trust's current position in comparison. The nine areas are the fundamental areas as identified by the National Cyber Security Centre (NCSC). There was some significant cyber activity in year across the NHS and attempts to NWAS where our systems for detection and protection worked well. Some of the improvements made throughout the reporting period to include:

- The roll out of Datix IQ which includes more granular options when raising an incident. With this information we can now report 19 cyber incidents reported for Q3 and 13 for Q4
- The Trust's external website https://www.nwas.nhs.uk/ was moved to a new hosting provider on 19/05/23. This offers greater reliability and security.
- Secure Email Certification – the application has been submitted; we are awaiting a decision. This will allow the Trust to easily share data and files to all NHS.net users allowing use to work more collaboratively.
- Following the government's decision to ban TikTok on all corporate devices and advice from NHS England, the Trust banned TikTok on 24/04/23.
- Microsoft Azure – the Web Application Firewall now has Distributed Denial of Service (DDoS) protection enabled and all servers have Windows Defender for Cloud configured, further strengthening the Trust's security.
- Moda is now fully configured, securing web browsing for all Trust mobile devices using mobile data. This also limits the amount of Trust data staff can use for personal use (this does not affect use over Wi-Fi.
- We have implemented a new Cyber 3rd Party Supplier Assurance Process.
- We have implemented a new backup solution
- Cyber resilience exercises have been undertaken with learning identified

9. DATA PROTECTION IMPACT ASSESSMENTS

9.1 Over the past year the IG team's focus has been on ensuring that the introduction of new information assets, changes to existing assets and procedures introduce only acceptable levels of information risk. Assessment of risk prior to information processing commencing is the best way to do this. The Trust has introduced a comprehensive assessment which is facilitated by the IG team and involves internal and external stakeholders with knowledge of the information asset and purposes of information processing.

9.2 The team have screened 26 information asset introductions/changes during the year, with 12 of these progressing to a full data protection impact assessment.

9.3 Close working with PMO continues to ensure that completion of DPIA screening and full DPIAs if required is an early part of the process for establishing a new project. The trusts project management framework has clear reference to commencing the DPIA process during in the initiation stage of a project. Project Managers are responsible for coordinating and submitting the DPIA as part of planned project activities and follows the trust DPIA policy to do so. One key project delivered in year has been the EPR phase 2 where there has been a focus on information security, access to data and data quality.

10 SUBJECT ACCESS REQUESTS

10.1 Our Individual Rights process has received SARs, Access to Health Requests, and numerous redirections of requests across the trust. A total of 2,179 requests (including SARs, Access to Health requests and redirections came into the Trust in 22/23.

11. KEY PERFORMANCE INDICATORS

11.1 A report outlining bi monthly progress on key performance indicators is shared at each IG Sub committee. The targets are regulatory requirements set by national bodies. All key performance indicators (KPI) were met.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Freedom of Information Request (FOI)	To respond to 90% of requests within 20 working days.	92.5%	99.11%	97.27%	97.87%	97.07%
Subject Access Requests (SARs)	To respond to 85% of requests without undue delay and at the latest, within one month.	99.80%	97.69%	97.90%	98.97%	98.58%
Data Protection Requests	To respond to 85% of requests within 40 working days	92.34%	100%	100%	100%	97.94%
Data Breaches	To report any externally reportable data breaches within the 72-hour timescale.	0% (1)	100%(1)	100%(1)	75%(4)	68.75%

12. DATA PROTECTION - Body worn Video Cameras

12.1 The IG team process body worn camera incidents via Datix.

BWVC Activations

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
8	11	8	6	9	13	4	13	0	10	9	2	93

12.2 Police Requests for Footage

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
1	1	0	0	0	0	1	0	0	0	0	0	3

13. DATA QUALITY

13.1 We have published our first Data Quality Policy which outlines our approach to monitoring and improving data quality and recruitment is under way for supporting roles. Initial work has included the production of data quality reports for several of our critical information systems, ad hoc data quality audits on new systems or where significant changes have been made, and data quality improvements within the data warehouse.

14. RECORDS MANAGEMENT

Significant progress has been made since our appointment of a knowledge manager to develop a programme of work to improve records management. A Corporate Records Retention schedule and supporting guidance has been created by the Knowledge Manager, which is available on the green room on the Records Management Section. The Corporate Records Policy has been approved for another year and had a successful impact assessment. A project has been initiated to migrate and cleanse the digital and paper records within the trust across all directorates from server storage drives into Microsoft. Guidance has been written for staff to support with organising and improving the management of their personal records. Further work is underway to improve confidential waste processes, information standards and classification, and training to support staff with migration.

15. GOVERNANCE AND/OR RISK IMPLICATIONS

15.1 The IG risk register is regularly reviewed at the Information Governance Sub Committee currently there are seven information governance risks which are:

- **196:** There is a risk that the Trust is not complaint with the Public Records Act**.** The initial risk rating of this risk is a 20 and current score 4.
- **151:** There is a standard fraud risk regarding staff obtaining sensitive/confidential data. This risk is a low level risk with an initial score of 6 and current score 6.
- **177:** There is a risk that Records Management is not compliant with the NHS Framework and EPRR V3 July 2022. This risk has an initial score of a 12 and current score 12.

- **383:** There is a risk staff may still have access to information in DCIQ when they move to another department. This risk is now closed.
- **384:** There is a risk that due to the lack of clear governance, centralised oversight, and retention schedules in place for clinical and corporate records, the Trust is not meeting the regulatory compliance required for the management of all records held within the Trusts digital and paper systems. The initial score of this risk is 20 and current score 12.
- **409:** There is a risk of third party ambulance providers going into administration a risk to patient information. The initial score of this risk is 12 and current score is 12.
- **3016:** There is a risk around lack of security controls in GRS web identified during the DPIA.

With regard to Cyber Security, throughout the reporting period we had a Board Assurance Framework Risk outlining gaps, controls and progress throughout the year to mitigate ongoing risks.

The workplan associated with this report and management of risk aligns to the trust risk appetite statement where we have a low appetite for risk associated with regulatory requirements.

16. EQUALITY OR SUSTAINABILITY IMPACTS

16.1 The quality and safety of our data has a potential impact on equality. For example a focus of the data quality programme has been on ethnicity reporting as only with good data quality will we be able to analyse the outcomes of our patients and understand if those with protected characteristics are having a different experience.

17. RECOMMENDATIONS

17.1 The Board are asked to:

- Note the contents of the report and progress made
- Take assurance that the Trust has effective systems and process in place to maintain the security of information

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 July 2023				
SUBJECT:	Medicines Management Annual Report 2022/23 (including the Controlled Drugs Annual Report)				
PRESENTED BY:	Dr Chris Grant – Executive Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Board is asked to note the key points of assurance: • New formulary medicines launched. • Three new medicines approved. • Flu vaccine training updated, and all vaccinators trained before vaccinating. • Excellent assurance on the training, assessment and sign off for all the Patient Group Directions in use and other medicines e-learning modules. • Set up of Controlled Drugs Subgroup. • Handling of a Serious Incident involving unaccounted for morphine and a low contravention from the Home Office. • Secured additional space for the Medicines Supply Hub. • Re-engineered processes for nerve agent countermeasures. • Implemented actions around End-of-Life Care Medicines. • Delivered a medicines safety campaign regarding Right Dose Right Route adrenaline. • Medicines expenditure remains stable (this year shows a decrease).				

	• Medicine Management Quality Indicators (MMQIs) for vehicles showed 93% audited and 6/8 critical criteria fully met. • MMQIs for ambulance stations showed 100% audited and 8/10 critical criteria met. The Board is asked to note the focus for 2023/24 will be: • Develop and implement new and updated Patient Group Directions and training. • Implementing actions from unaccounted morphine serious incident. • Work on digital projects related to medicines.
RECOMMENDATIONS:	The Board is asked to: • Note both achievements and assurance provided in the report for year 2022/2023 • Note the forward plan 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:	Quality and Performance Committee			
	Date:	22 May 2023		
	Outcome:	Assurance Received		

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1. PURPOSE

A range of general medicines and controlled drugs (CDs) are stocked and administered to patients across the Northwest Ambulance Service NHS Trust (NWAS). This annual report provides assurance that NWAS is managing its medicines (including CDs) safely and in accordance with legislation, best practice and NWAS policy and procedures.

2. BACKGROUND

The medicines optimisation strategy, which forms part of the Right Care (Quality) Strategy, has structured much of the new work by the Medicines Team alongside the business-as-usual elements. This report provides assurances on all aspects of medicines use by NWAS and shows progress against key areas.

A review of the recommendations provided in last year's annual report are provided in Appendix 1. This shows that of the 10 recommendations made, 6 were completed and 4 remain in progress to be carried over into 2023/24.

This report covers:

2.1 Medicines Arrangements
2.2 Medicines Optimisation Strategy
2.3 Monitoring
2.4 Policy and Procedures
2.5 Medicines Related Incidents
2.6 Influenza Vaccination
2.7 Audit
2.8 Medicines Related Risks
2.9 Partnership Working
2.10 Constraints

2.1 Medicines Arrangements:

2.1.1 Medicines Used:

Medicines stocked in NWAS are a mix of CDs, prescription only medicines, pharmacy medicines and general sale list medicines. NWAS has the following formularies:

- NWAS Medicines Formulary

- North West Air Ambulance (NWAA) Formulary
- National Ambulance Resilience Unit (NARU) Formulary.

Changes made to the formulary in 2022/23 were:

- NWAS: Addition of co-amoxiclav (antibiotic)
- NWAA: Addition of methoxyflurane (analgesic)
- NWAA: Addition of calcium chloride (as part of blood transfusion protocols)

The national shortage of Diazemuls injection continued throughout 2022/23 and NWAS continues to use the plain injection. The list of CDs used are detailed in figure 1.

Figure 1: Controlled Drugs Used

Controlled Drug	Schedule	Profession	Restrictions
Diazepam emulsion 10mg/2ml injection *replaced with plain injection when needed*	4 (part 1)	Doctor & Paramedic	N/A
Diazepam rectal 5mg tubes	4 (part 1)	Doctor & Paramedic	N/A
Fentanyl 500micrograms/10ml pre-filled syringe	2	Doctor	NWAA Doctor only
Fentanyl 500micrograms/10ml pre-filled syringe	2	Doctor	NWAA Doctor only
Ketamine 200mg/20ml	2	Doctor & Paramedic	NWAA Doctor, Consultan Paramedic, Advanced Paramedic, Critical Care Paramedic and HART Specialist Paramedic
Ketamine 200mg/20ml pre-filled syringe	2	Doctor	NWAA Doctor only
Ketamine 500mg/10ml vial	2	Doctor	NWAA Doctor only
Midazolam 5mg/5ml injection	3	Doctor & Paramedic	NWAA Doctor, Consultan Paramedic, Advanced Paramedic and Critical Care Paramedic
Morphine 10mg in 1ml Injection	2	Doctor & Paramedic	N/A

2.1.2 Medicines Supplies:

NWAS continues to hold a Home Office licence to possess and supply CDs.

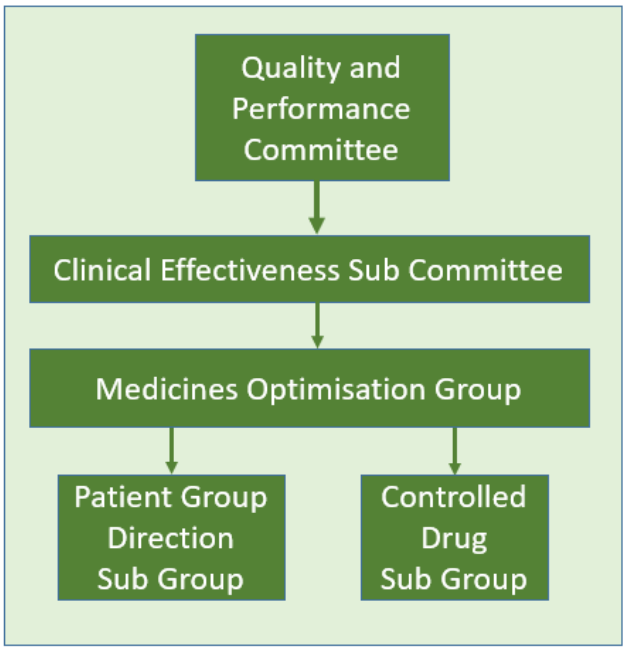
Medicines are received via various routes:

- General medicines are procured from Wirral University Teaching Hospitals.
- CDs are procured directly procured from wholesaler.
- NWAA procures all medicines from Lancashire Teaching Hospitals.
- NARU stocks are ordered at a national level and delivered via Movianto.
- Influenza vaccines are procured direct from manufacturer, Seqirus.

2.1.3 Medicines Governance Arrangements:

The Medicines Optimisation Group (MOG) has the remit to provide assurance that medicines are used optimally within NWAS. Medicines optimisation can be defined as the "safe and effective use of medicines to enable the best possible outcomes". The Chair of the Group provides an assurance report to the Clinical Effectiveness Sub Committee following each meeting. A quarterly report is provided to the Quality and Performance Committee on progress with the medicines optimisation strategy. This report also is reviewed at the Regional Clinical Quality Assurance Committee by commissioners. The Chief Pharmacist meets to discuss medicines related issues with the lead commissioning pharmacist and the Care Quality Commission Engagement Pharmacist. Figure 2 provides an organogram of medicines governance arrangements. In 2022, the Controlled Drugs Subgroup was newly formed to provide focus on controlled drug handling and oversight of compliance.

Figure 2: Organogram of medicines governance arrangements



2.1.4 Staffing:

Figure 3 shows the previous staffing (as reported in 2021/22 Annual Report) and figure 4 shows the staffing going forward. The highlights include:

- Pharmacy Technician: Medicines Governance. This role was reviewed and changed to create a Senior Pharmacy Technician: Projects and Supplies. This post commences in 2023/24.
- Lead Pharmacist – Clinical Hub remains vacant. As part of Service Delivery Model Review, the future pharmacist support model will be considered.
- As part of the NWAS Smart Sites project there is funding for a new role, Medicines Supervisor: Projects and Supplies, on a 2-year fixed term basis. This has been recruited to and they start in 2023/24.
- A new post, Lead Pharmacist: Critical Care and Quality, was created with part funding from the North West Air Ambulance. This will commence in 2023/24.

Dr Chris Grant, Executive Medical Director, is the Controlled Drug Accountable Officer registered with the Care Quality Commission. Rachael Fallon, the Chief Pharmacist, is the Medication Safety Officer registered with NHS England.

Figure 3: Medicines/Pharmacy Staff – Current

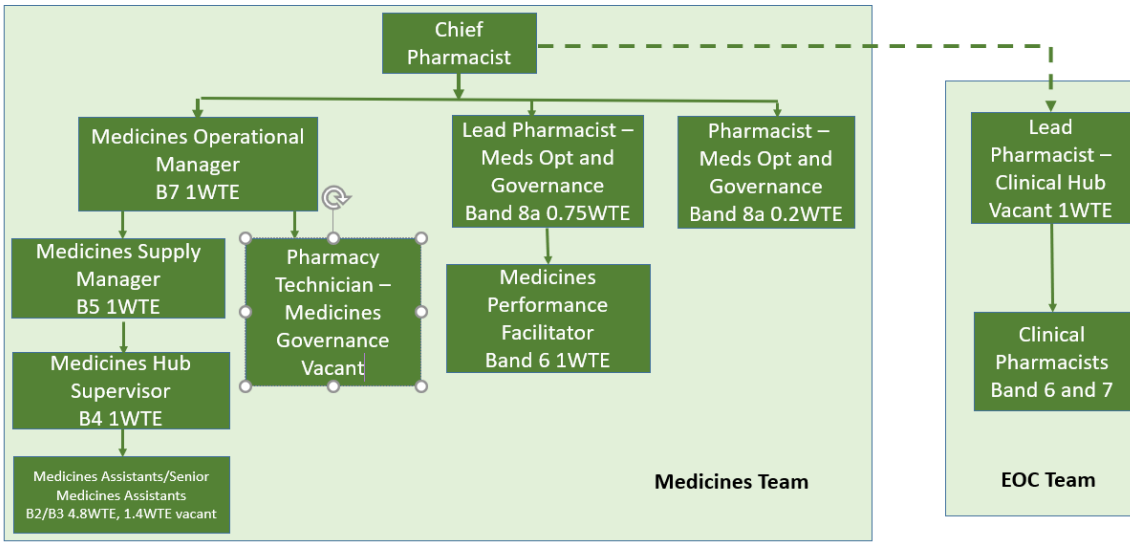
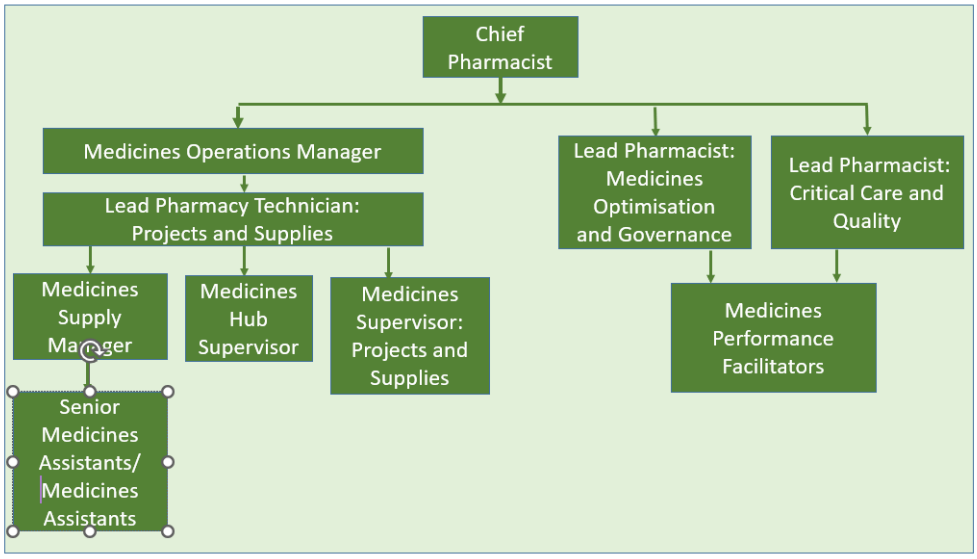


Figure 4: Medicines/Pharmacy Staff – Going forward.



Recommendations:

- Recruit to the Lead Pharmacist: Critical Care and Quality post.
- Embed new staff into the Medicines Team.

2.2 Medicines Optimisation Strategy:

2.2.1 Medicines Optimisation Strategy:

NWAS is committed to high quality medicines optimisation within the service through having the right medicines available (**clinical effectiveness of medicines**), having the right governance to support medicines use (**robust governance for medicines use**), ensuring medicines are available for use (**digital innovation and integration**), ensuring medicines are of a suitable quality (**safe and secure handling of medicines**) and supporting medicines to be used safely (**medicines safety**). These five areas provide the workplan for the work undertaken by the Medicines Team.

2.2.2 Progress strategy 2022/23:

Clinical Effectiveness of Medicines:

In Q2 the new formulary medicines were launched. This involved:

- The launch of co-amoxiclav 1.2g injection, an antibiotic to minimise infection in patients with an open fracture.
- The swap of tranexamic acid 500mg injection to 1g.

- The swap from 500mg paracetamol infusion to 1g.
- The launch of atomisers to use with naloxone, widening access to naloxone administration to treat opiate overdoses to EMTs and providing an alternative route of administration, intranasal.

The Medicines Team led the changes and worked with the operations team to successfully manage the changeover. A formulary detailing which patient's own medicines NWAS paramedics can administer has been published.

A bulletin advising how buccal midazolam should be administered has been issued and the JRCALC monograph made available for staff to use via the app.

Methoxyflurane has been clinically approved by the Medicines Optimisation Group for NWAA doctors to use and prescribe. The use will be evaluated, and supplies will be subject to booking in and out, like a controlled drug, due to the abuse potential.

Calcium chloride has been clinically approved by the Medicines Optimisation Group for NWAA paramedics to use. This will facilitate blood administration by specifically trained paramedics. A PGD will need to be developed.

Morphine oro-dispersible tablets, a Schedule 2 controlled drug, has been clinically approved by the Medicines Optimisation Group for use by all paramedics across the service. This is a new product and gives paramedics the option of providing strong pain relief via a non-injectable route and will be a welcomed addition in supporting our paediatric patients. This will require ELC approval and a PGD to be developed.

The Medicines Optimisation Group has re-reviewed the use of sodium chloride 0.9% prefilled syringes for use as an intravenous flush and has approved this clinically. This will require ELC funding approval.

Post ROSC adrenaline administration guidance has been updated following a revision to JRCALC+ guidance. The Medicines Team worked with the Critical Care Team to update, and it is now available in JRCALC+. The training package for staff has also been updated by an Advanced Paramedic.

The Lead Pharmacist is a member of the JRCALC working group and supported the review of the Acute Coronary Syndrome guideline which was issued Feb 2023.

Robust governance for medicines use:

Flu vaccinator training reviewed and updated. New processes put in place now provide assurance that no-one vaccinates until they have completed the training specified.

Launch of three new e-learning modules with assessment in June, these were:

- Naloxone intranasal for EMTs and paramedics
- DuoDote for EMTs and paramedics
- Co-amoxiclav PGD for paramedics.

Compliance with the three new e-learning and assessment modules are as shown in figure 5 alongside the compliance for all the other e-learning modules and the face-to-face training for ketamine and midazolam. Full assurance is provided that staff have completed training and competence assessment. DuoDote training was provided in response to an audit carried out by the Medicines team showing that 40% (111/275) of staff had received no training on its use and 70% of the staff that had received training, but it was over 3 years ago.

There are 4 PGDs that will need to be updated in 2023 and staff re-trained, assessed and signed off to use. This is in addition to the potential for the morphine oro-dispersible tablets PGD.

A review of SECAmb recent CQC inspection report regarding medicines has been carried out and NWAS position considered. The main concern noted for SECAmb was lack of PGD training and competencies-based assessments to ensure staff can safely undertake this aspect of their role. This shows the importance of NWAS continuing to support paramedics to have the time to complete training.

Figure 5: Medicines training compliance

Module	Completion end Mar 2023
General training	
Paramedic – DuoDote Learning	94%
Paramedic – Naloxone Intranasal Route	96%
EMT – Naloxone Intranasal Route	90%
EMT – DuoDote Learning	88%
PGD training – all paramedics	
Co-amoxiclav PGD	95%

Dexamethasone PGD	98%
Diazepam rectal PGD	97%
Misoprostol PGD	97%
Tranexamic acid PGD	97%
PGD training – enhanced medicines	
Ketamine PGD module	100%
Ketamine face to face training	98%
Midazolam PGD module	100%
Midazolam face to face training	98%

Two CPD sessions about medicines have been led by the Chief Pharmacist with the MERIT doctors.

Recommendations:

- Update e-learning modules for PGDs.
- Develop new PGDs and e-learning modules.
- Review and update medicines training for EMT apprentices.

Digital innovation and integration:

Pharmaceutical wholesaler accounts have been created with direct ordering from the supplier portals established. This enables the Medicines Supply Hub to order its medicines directly rather than via a third party.

NWAS has a smart site project team in place and part of this project includes digital key cabinets (including access to controlled drug keys) and personal issue electronic controlled drug keys. To support this project a new fixed term post has been developed in the Medicines Team, this has been recruited to and they will take up post in mid-2023.

The Medicines Team are working with the Digital Innovation Team, Project Management Office and the Transformation Team to look at digitalisation of the medicines pouches, tracking and developing a specification for a stock management system and electronic controlled drugs register.

Recommendations:

- Support the role out of digital CD keys and CD safes with the smart site project team.

- Digitalise the medicines pouch tracking process with the digital innovation team.
- Develop a stock management and e-CD register specification.

Safe and Secure Handling of Medicines:

A new CD Subgroup has been set up in July 2022. This meets quarterly and reports to the Medicines Optimisation Group and allows an opportunity for key people responsible for CDs to focus on reviewing compliance and overall handling therefore strengthening our governance systems.

A review of handling of CDs by Consultant Paramedics has been concluded and a new process put in place. This improves the governance and oversight of CDs held by the person, as opposed to CDs held on vehicles where staff rotate.

A business case was developed and approved by the Executive Leadership Committee to secure an additional unit that became available that is adjacent to the two current units that make up the Medicines Supply Hub. This is currently being refurbished and once this expanded footprint is in use it will bring many benefits including a dedicated goods in and goods out flow.

Processes for nerve agent countermeasure medicines have been re-engineered. They are now all supplied from the Medicines Supply Hub (in line with how other medicines are supplied), in the same distinctive pouch that is tamper evident, stored in a standardised place on ambulances and recorded on the SafeCheck system for visibility.

A successful Home Office inspection has been achieved following a site visit of our Blackpool interim ambulance station. A review of estate security around medicines is underway led by Service Delivery and is on the risk register., This may require funding for CCTV and gates/perimeter fencing for some sites. Following the inspection, NWAS reported unaccounted for losses of controlled drugs to the Home Office and a low contravention was issued in Dec 2022 with two actions to be completed by February 2023. These actions were completed, and a response provided back to the Home Office. In addition, NWAS reported to the Home Office a serious incident regarding unaccounted for morphine, this report is awaiting an outcome from the Home Office. The Care Quality Commission have reviewed the report and the Chief Pharmacist has met with the Care Quality Commission engagement pharmacist and they were satisfied with NWAS response to the report. Safe and secure handling of controlled drugs needs to remain a priority.

The roll out of personal issue CD keys and digital key safes (part of the smart site project) should bring operational benefits (time saving and interoperability) as well as enhanced governance. Keys will be able to be centrally deactivated if needed and there is a full audit trail of CD safes accessed and by who.

Recommendations:

- Set up the additional unit for the Medicines Supply Hub.
- Mass casualty vehicle medicines to be delivered to the Medicines Supply Hub for oversight and onward distribution.

Medicines Safety:

A review of the national patient safety alert "Enduring Standards" has been completed and NWAS is compliant with 6 out of 8. There is some on-going work around preparation and administration of medicines, a risk assessment was completed and added to the risk register. Some of the work in 2022/23 has included development and launch of procedures for administering medicines to patients, administering patient's own medicines and administering medical gases and the development of posters to support embedding the 6 rights of medicines administration and double checks. At every opportunity (e.g.: incident feedback to staff to support learning, e-learning modules, videos, bulletins, meetings, etc) the 6 rights are reiterated.
An End-of-Life Care Working Group was set up to support how the medicines are used and develop communications to support clarity around medicines administration. The Chief Pharmacist has been working with the Ambulance Service Medicines Safety Officers Group and End of Life Leads Network (both part of AACE) to develop standards for end-of-life care medicines.

Following on from the Healthcare Safety Investigation Branch publication of "Unintentional overdose of paracetamol in adults with low bodyweight" and reviewing learning from a local hospital Serious Incidents, NWAS has adopted the mantra of "Paracetamol – think weight". To support this, a banner has been added to the paracetamol monograph in JRCALC+. it will be in our next Learning Lessons bulletin.

September 17th, 2022, was World Patient Safety Day and this year's theme was Medicines Without Harm. The Ambulance Service Medicines Safety Officer's Group agreed on a focus of adrenaline 1 in 1,000, as errors have occurred in all ambulance services well documented world-wide. To support this, a poster was produced together with a video and online presentation. These were produced by NWAS but shared nationally to support the campaign. At NWAS, posters were distributed to all

ambulance stations and communications went out sharing the video link via the Staff Facebook Group and the weekly bulletin. In addition, the Medicines Team took to the road and visited Emergency Departments around the NW to talk to ambulance crews providing postcards of the posters, stickers and asking them to make a pledge for medicines safety. The training session has been delivered to Area Learning Forum including NWAA and also the Education and Training team.

An audit of ketamine use has been carried out in one area of NWAS. This has justified the need for increased stocks in specific ambulance stations. This is the first audit since the introduction of the updated PGD and any learning from it will be shared with all our paramedics that use ketamine.

The Patient Safety Alert 'Use of oxygen cylinders where patients do not have access to medical gas pipeline systems' has been reviewed and a risk assessment conducted, and actions completed within the specified time frame.

A review of incidents involving amiodarone injection has been commenced following a cluster of incidents. This is being done in collaboration with the Patient Safety Lead and the Resus Group.

Recommendations:

- Lessons learnt bulletin to be developed and published.
- Support roll out of Patient Safety Incident Response Framework

2.3 Monitoring:

2.3.1 Stock Management:

Any medicines out of stock or MHRA medicines recalls are actioned by the Medicines Team. Links between the Regional Procurement Pharmacist, the Medicines Team and the NWAA/NWAS Senior Leadership Team support good stock management. In 2022/23, two MHRA medicines alerts were relevant to NWAS, both for amiodarone injection. All NWAS stocks that had been received into the Medicines Supply Hub were checked and none of the affected batches were found. Extremes of temperatures have also posed challenges and the Medicines Team work closely with the operational team to support the safe use of medicines. Difficulties in obtaining medicines have been time consuming for the Medicines Team to manage and occur on a frequent basis. This is a

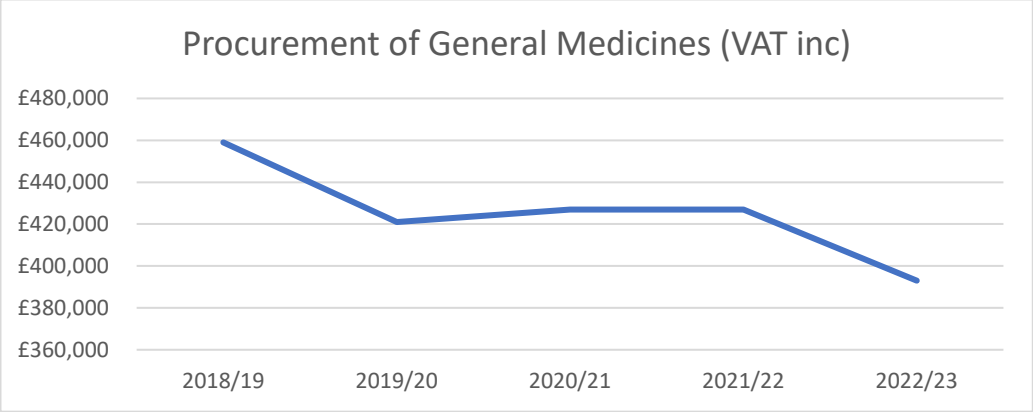
common problem that is noted by all Pharmacy Teams in NHS Trusts and is more frequent in the past two years. Stock issues have affected several product lines, these are managed by the Medicines Team in various ways to minimise the impact to the operational service. No stock shortage has led to a vehicle missing the medicines it requires. Stock shortages can mean an increased spend on an alternative source/brand and potential for the version of the medicine to introduce risk due to unfamiliarity. Staff are encouraged to "always read the label" and the Medicines Team risk assess the changes and act where necessary to communicate the changes.

2.3.2 General Medicines Financial Costs:

General medicines supplies are procured at NHS contract prices via a service level agreement with Wirral University Teaching Hospital (WUTH) for a fee of £28,000/annum. The total cost of procuring the general medicine stocks for 2022/23 totalled £393,000 inc. VAT. This figure is a decrease to previous years, see figure 6, as in 2021/22 it was £427,000. This included the new
items procured in bulk to support the launch of the updated formulary in August 2022 and the purchase of medicines off contract (and therefore at an increased price) to ensure continuity of supply. Some of the changes to the medicines formulary in 2022 reduce cost, they are the change from 500mg to 1g paracetamol infusion and 500mg to 1g tranexamic acid injection.

Accounting for 55% of the spend was adrenaline 1 in 10, 000 (used in cardiac arrests), £178,135, and glucagon, £36,278 These are two medicines we use as pre-filled syringes which have a high unit cost.

Figure 6: General Medicines Expenditure



This does not include spend on medicines for NWAA (as these are charged to the NWAA budget), NARU medicines (these are provided free of charge from NHSE) nor

the flu vaccines. NWAS were able to obtain flu vaccines at the contract price but order directly from the supplier following the Medicines Team negotiating with the Commercial Medicines Unit and the supplier.

2.3.3 Controlled Drug Ordering Monitoring:

The Medicines Supply Hub cross checks any CD orders the previous two weeks for all vehicles and checks the paramedic is authorised to order the CDs.

2.3.4 Controlled Drug Supplies:

Since November 2021, NWAS has held a Controlled Drug Home Office licence and stored and distributed CDs via the Medicines Supply Hub. These CDs are procured directly from commercial wholesalers. Work has been on-going with the NARU supplies for the mass casualty vehicles and it is recommended that the supplies for these vehicles are receipted to the Medicines Supply Hub and then distributed out to the mass casualty vehicles. Currently NWAA purchase their supplies from Lancashire Teaching Hospitals.

2.3.5 Controlled Drug Financial Costs:

The spend of CD stocks by NWAS over 2022/23 was £23,595 (see figure 7), a decrease of £3,354 on 2021/22 costs as displayed in figure 8 but has been consistent for the last 3 years. This decrease in spend is despite an increase in volume of CDs supplied to NWAS PES vehicles, see figure 9 which shows an increase in the amount used from 2021/22 to 2022/23 for all CDs. This value now includes the value of the stock being held at the Medicines Supply Hub as it does for the general medicines.

Figure 7: CDs procured by NWAS from commercial wholesalers.

Controlled Drug Procured	Units Procured	Value of Units (inc. VAT)
Morphine sulphate 10mg/1ml ampoules	34,898	£8,027
Diazepam 10mg in 2ml ampoules	4,390	£3,424
Diazepam 5mg rectal tubes	7,790	£10,906
Ketamine 200mg/20ml injection	182	£1,105
Midazolam 5mg/5ml ampoules	230	£133
Total	**47,490**	**£23,595**

Figure 8: Controlled Drug Expenditure (inc. VAT)

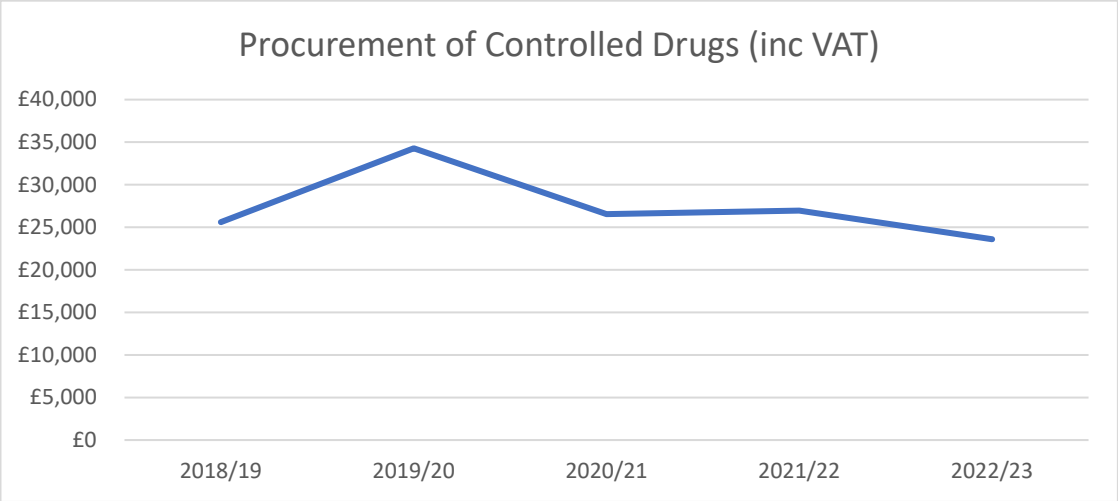


Figure 9: Supplies of Controlled Drug Stocks to NWAS PES vehicles 2022/23

Controlled Drug Supplied↓	2018/19	2019/20	2020/21	2021/22	2022/23	Variation
Supplier to PES →	Lloyds Pharmacy		LTH	LTH & MSH	MSH	2021/22 t 2022/23
Morphine sulphate 10mg/1ml ampoules	46,880	41,950	36,850	30,260	35,148	4,888
Diazemuls 10mg/2ml ampoules	6,640	9,720	760	0	0	626
Diazepam10mg/2ml ampoules	0	0	9,940	4,694	5,320	
Diazepam 5mg rectal tubes	5,385	6,440	6,960	4,095	7,455	3,360
Ketamine 200mg/20ml injection	91	120	144	132	180	48
Midazolam 5mg/5ml ampoules	150	190	260	120	200	80
Total	**59,146**	**58,420**	**54,914**	**39,301**	**48,303**	**9,002**

Some of the benefits of moving to direct to commercial wholesaler ordering are no additional service fees charged (unlike when using community pharmacy and NHS hospital wholesalers) and includes free next day delivery to the Medicines Supply Hub, this enables timelier stock management and reduces spend on internal transport costs.

2.3.6 Controlled Drug Use Monitoring:

As a CD designated body, it is a requirement that we monitor the use of controlled drugs to ensure use is safe and appropriate. A CD dashboard has been developed by the electronic patient record team to enable the Medicines Team to monitor the use of CDs.

This allows a quarterly report to be produced which is reported to the CD Subgroup for scrutiny.

The Home Office inspected Blackpool temporary ambulance site in 2022 and raised no concerns and re-issued our licence.

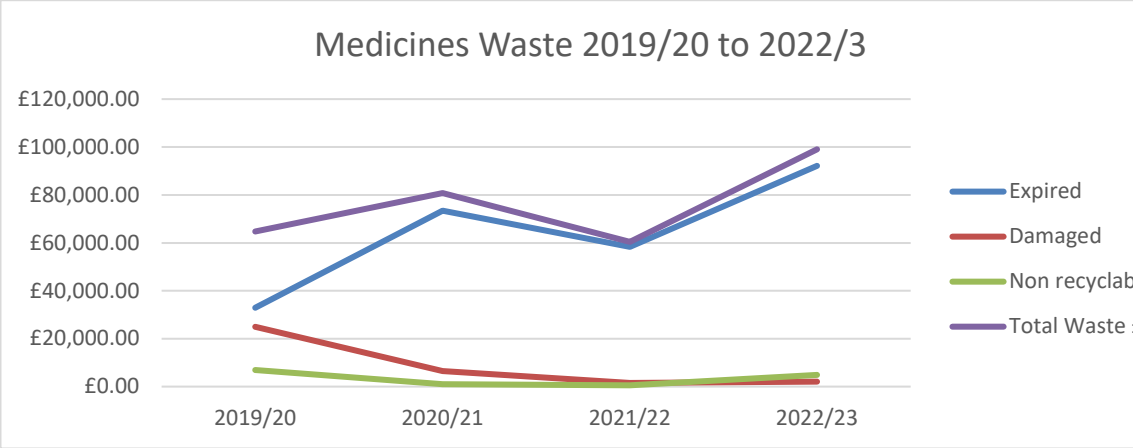
2.3.7 Medicines Waste:

The overall cost of the medicines wasted in 2022/23 was £99,044. This was a £38,500 increase on the year before and the largest wasted medicines value since monitoring began in 2019. It represents 25% of the medicines spend. Figure 10 shows the main reason for medicines waste was expired stock and figure 11 displays the total medicines waste over the last 4 years.

Figure 10: Medicines waste since 2019 and cause

	2019/20	2020/21	2021/22	2022/23
Expired	£32,913	£73,416	£58,346	£92,148
Damaged	£24,962	£6,448	£1,527	£2,014
Non-recyclable	£6,923	£982	£541	£4,882
Total Waste (£)	**£64,798**	**£80,847**	**£60,415**	**£99,044**

Figure 11: Medicines Waste 2019/20 to 2022/23



Adrenaline 1:10,000 prefilled syringes (£32,426) accounted for the most waste generated due to a large batch expiring in Q1. Glucagon prefilled syringes were second with a waste value of £15,893. These two medicines account for 49% of the 2022/23 medicines waste recorded which is comparable to last year. The Medicines Team will continually monitor waste and review quantities distributed in the various medicine pouches.

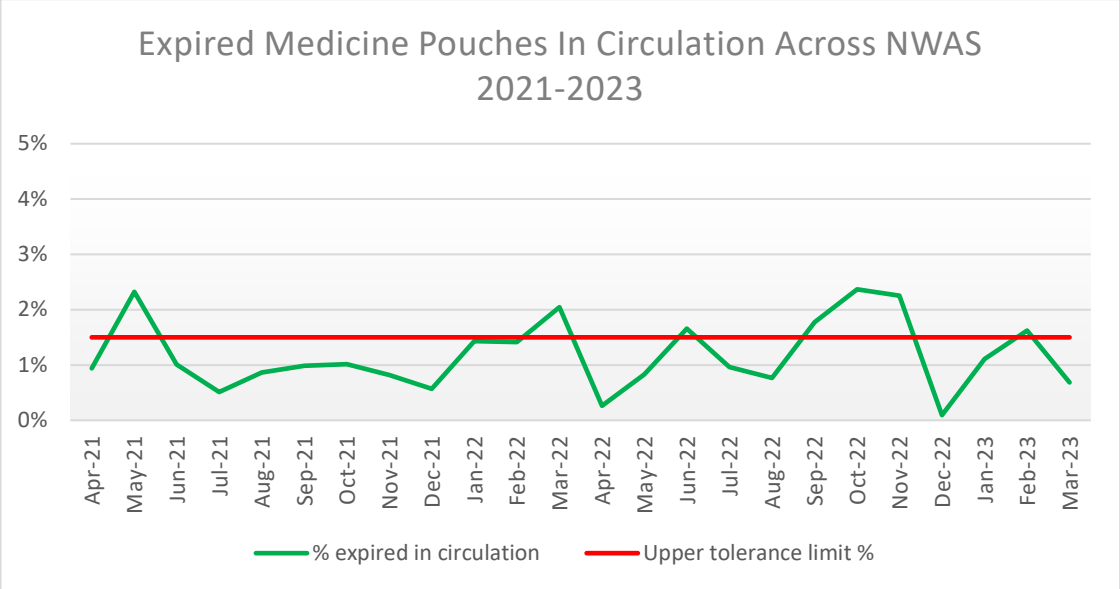
2.3.8 Medicines Expired

Medicine pouches are assembled by the Medicines Supply Hub and an expiry date affixed to them indicating the shortest dated medicine within the pouch or at a pre-set expiry date i.e. 6 months from the date packed. A pre-set expiry date allows for any product within the pouch that may have a shortened expiry once opened, for example salbutamol nebules, to be anticipated and included within the pouch expiry.

During 2022/23, 3709 medicine pouches expired. By April 2023 there are 113 pouches (3%) that remain expired and have not been returned to the Medicines Supply Hub for repacking. There was on average 4,387 medicine pouches in circulation across NWAS at any one time in 2022/23. The expired medicine pouches that have not been returned represent 2.6% of pouches available.

An upper limit of 1.5% expired medicines was set in 2021 for monthly compliance with expired medicine pouches. In 2022/23 the monthly limit was breached on 5 out of the 12 months with the highest reaching 2.4% for October and November 2022 as displayed in figure 12.

Figure 12: Expired medicine pouches in circulation across NWAS 2021-2023.



Expired medicines are highlighted to operational staff via SafeCheck. Medicines are added to a vehicle stock using SafeCheck. When the medicine is used, or a pouch swapped for a new one this should be booked off on SafeCheck. The Medicines Stock icon will display in red if it has a medicine listed in its stock inventory as due to expire

within the next 14 days or has expired. This alerts the operational staff on the ambulance which medicine requires replacing. Oversight of this is available for local management teams to access. Any active alerts of expiry from PES vehicles are displayed on the management console of SafeCheck. This visually highlights which vehicles have expiring or expired medicines and require action although it does not inform them of which medicines this affects.

A monthly report is issued to operational management teams from SafeCheck highlighting the full medicines stocks listed on every PES vehicle within NWAS. This allows any medicines due to expire or expired to be actioned accordingly. This information is also present on the SafeCheck managers dashboard. One aspect of the feedback from the operational team is that the process with SafeCheck needs streamlining to make it more efficient and this is currently under review.

2.4 Policies and Procedures

The NWAS Medicines Policy has had a complete review and is a comprehensive overarching policy around medicines use in NWAS. Work is underway to complete the review of the CD Policy.

The general medicines procedures tool kit and the senior managers medicines procedures toolkit were updated, approved, and launched in June 2022. CD procedure toolkit was updated, approved, and launched in May 2022. In response to some changes the senior manager and controlled drug toolkit had amendments made and were approved and launched in Feb 2023.

Recommendations:

- Complete review of the Controlled Drugs Policy.
- Update all NWAA Controlled Drugs Procedures.

2.5 Medicines Related Incidents

2.5.1 Incident Management:

Medicines related incidents should be reported on the Trust incident reporting tool, Datix. These incidents are viewed by the Medicines Team regularly, to provide support to the operational team for any investigation or follow up. A quarterly report is provided to the Medicines Optimisation Group and the Controlled Drug Subgroup. All level 3 incidents and above have additional narrative information provided. If the incident is classed as a serious incident (as determined by the Review of Serious Events weekly

meeting) the medicines team are involved in the investigation and the full report is reviewed by the Medicines Optimisation Group – see figure 13 for a list of medicines-related serious incidents.

The Medicines Team has a dedicated email address, where any concerns around the use of CDs within NWAS or in the wider health economy, can be escalated. Awareness of how to report concerns about CDs have been increased with the use of posters in all NWAS stations, and reminders to staff at each learning opportunity about how to report.

NHS England require reporting to them any CD related incident that falls into the following categories (note this is an amendment this year, previously it was all level 3 incidents and above):

- Real or perceived staff diversion of controlled drugs
- Real or perceived staff substance misuse of controlled drugs
- Patients with drug seeking behaviours that might require an NHSE alert to be issued to health and care settings.
- Severe harm issues

If an incident is reported that has occurred outside of NWAS, these are followed up by the Medicines Team with the relevant personnel, primarily the Medicines Safety Officers for hospitals and the Community Pharmacy Contract Leads for community pharmacies.

Figure 13: Medicines Related Serious Incidents:

Year	Reference	Details
2021/22	SI2022/4995	Adrenaline 1 in 1, 000 administered intravenously instead of intramuscularly, patient had heart attack. Final report at MOG 20/7/22
2021/22	SI2021/18013	EoL medicines x3 administered incorrectly. Final report at MOG 16/11/21
2022/23	SI2022/8882	Midazolam 10mg instead of 2mg for EoL Final report at MOG Dec 2022
2022/23	SI2022/15599	Atropine administered in cardiac arrest instead of adrenaline. Report in progress.
2022/23	SI2022/23013	Oxygen cylinder faulty Final report at MOG April 2023
2022/2	SI2022/26920	Propranolol overdose by patient Final report due at MOG soon.
2022/23	SI2023/2464	Unaccounted for morphine Report discussed at CD SubGroup Feb 2022.
2022/23	SI2023/6735	Patient overdose and NWAS medicines bags on scene

		Report in progress.

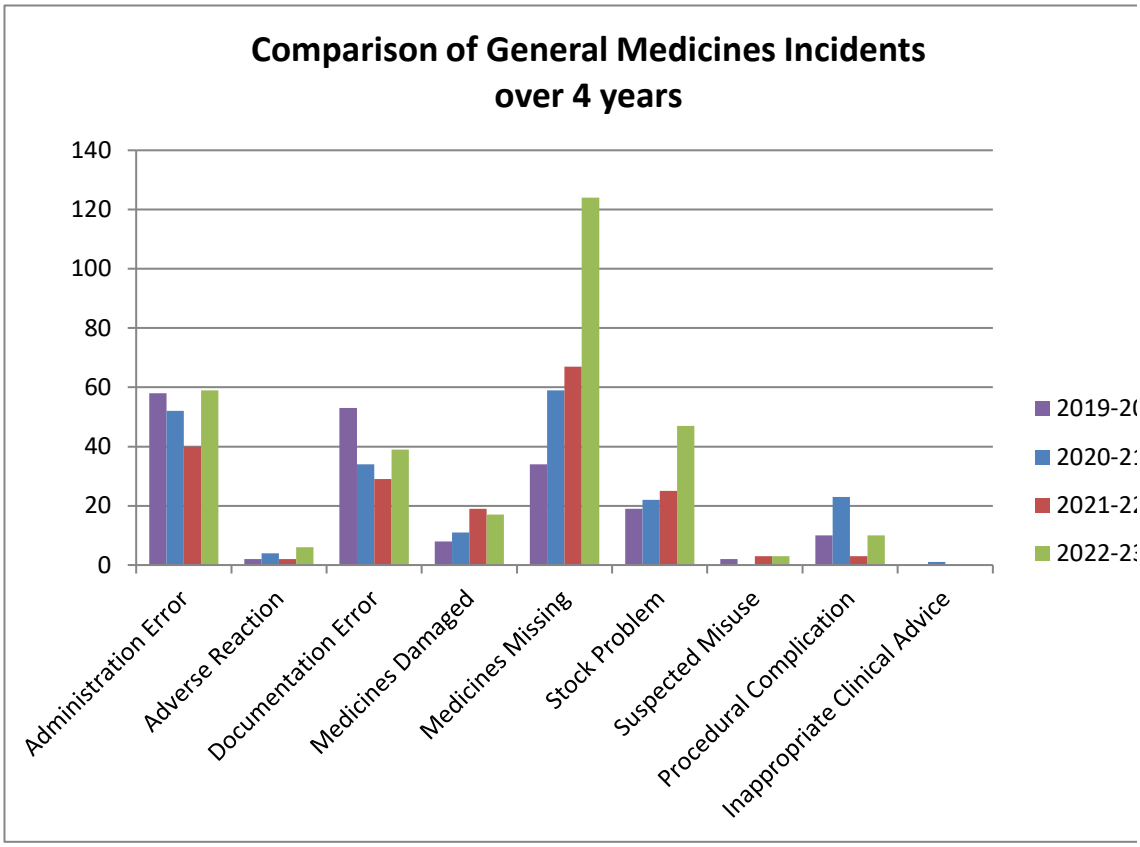
2.5.2 General Medicine Incidents:

There has been a significant increase in the reporting of general medicines incidents in 2022/23, with 305 compared to 188 the previous year. The increase coincided with the launch of the new Datix IQ system, and it is thought that the ease of reporting has possibly caused this increase. Most reports are level 1 and 2 (no and low harm). There was an increase in missing medicine reports, most of which are for single items such as a nebule of salbutamol. This will have been documented as administered on the patient record but has not been documented on the medicines pouch paperwork meaning they appear to be unaccounted for. This is then noted when the next crew perform daily checks and the pouch balance is reported as incorrect with an item missing. An investigation is underway that will review systems and process of medicines on vehicles to seek assurance that the medicines required are present on vehicles. Figure 14 shows a breakdown by type of incident and figure 15 shows a comparison between the types of incidents for this year compared to last year.

Figure 14: General medicines incidents reported 2022/23

General Medicine Incident Breakdown by Area 2022-23							
Datix Subcategory / MMQI coding	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/ 111**	**TOTAL**
Administration Error	18	15	26	0	0	0	59
Adverse Reaction	2	2	2	0	0	0	6
Documentation Error	13	13	13	0	0	0	39
Medicines Damaged	5	3	9	0	0	0	17
Medicines Missing	34	37	53	0	0	0	124
Stock Problem	16	14	16	0	1	0	47
Suspected Misuse	0	2	1	0	0	0	3
Procedural Complication	3	0	7	0	0	0	10
Inappropriate Clinical Advice	0	0	0	0	0	0	0
Total	**91**	**86**	**127**	**0**	**1**	**0**	**305**

Figure 15: Comparison of general medicine incidents reported 2019/20, 2020/21, 2021/22 and 2022/23



There were zero “never events”. There have been 29 level 3 incidents and three level 4 incidents and two level 5 incidents, 4 incidents were classed as ‘serious incidents’, see figure 13.

2.5.3 Controlled Drug Incidents:

CD incidents reported are higher compared to the previous year (293 compared to 238) but are similar to 2020/21 (296). Figure 16 shows a breakdown by type of incident and figure 17 shows a comparison between the types of incidents for this year compared to last. This shows an increase of reports of missing CDs, but upon investigation there were only 7 incidents truly unaccounted for as detailed below. A CD is considered missing when the CD record book in the vehicle or ambulance station does not reflect the balance of the CD safe. This is usually due to a documentation error and the record book is updated retrospectively. All of the unaccounted-for CDs were reported to the police. Figure 18 summarises the unaccounted-for CDs, one of which is classed as a serious incident.

Figure 16: CD incident types reported per area 2022/23

Controlled Drug Incident Breakdown by Area 2022/23							
Datix Subcategory	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/ 111**	**TOTALS**
CD Administration Error	8	3	6	0	0	0	17
CD Adverse Reaction	0	0	1	0	0	0	1
Any Other CD problems	11	5	11	0	0	0	27
CD Damaged	17	14	17	1	2	0	51
CD Missing	9	16	10	0	1	0	36
CD Safe Access Problem	4	3	8	0	0	0	15
CD Stock Problem	15	20	11	0	1	0	47
CD Documentation Error	28	30	34	1	2	0	95
Suspected Misuse	1	1	2	0	0	0	4
Total	**93**	**92**	**100**	**2**	**6**	**0**	**293**

Figure 17: Comparison of CD incidents reported in 2019/20, 2020/21, 2021/22 and 2022/23

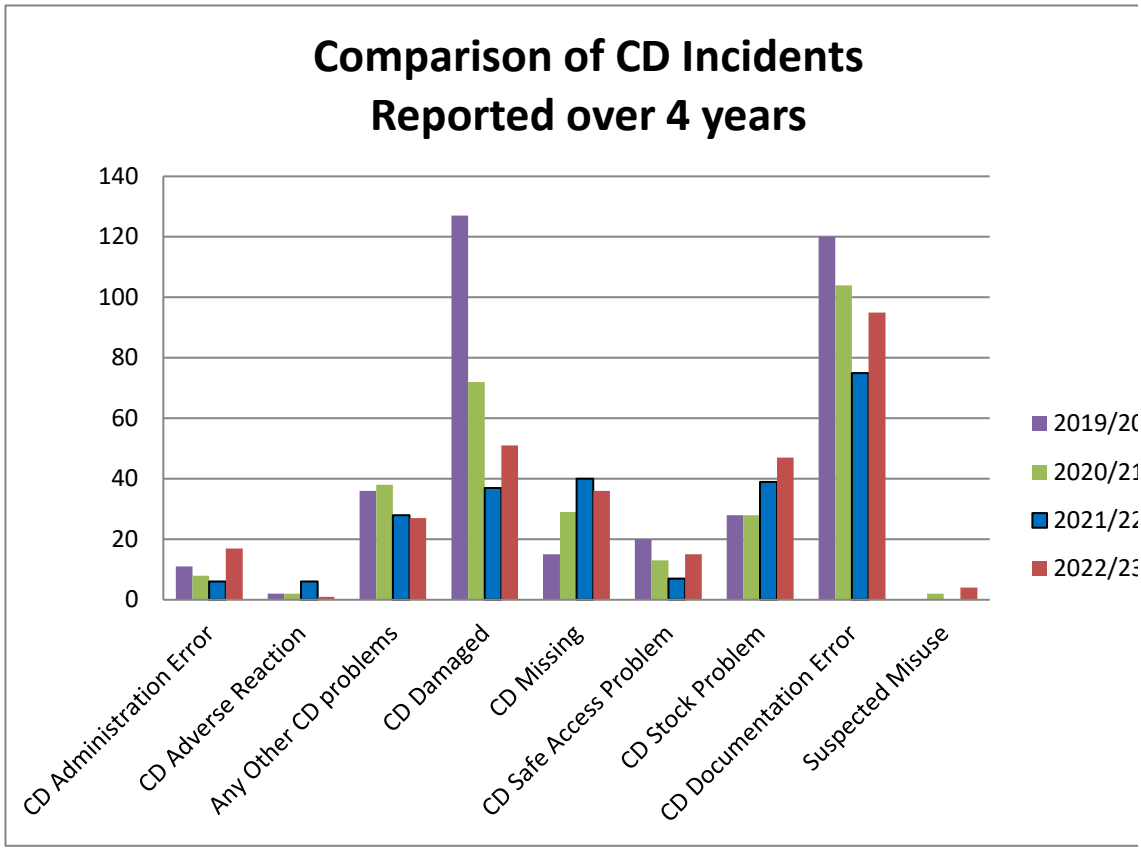


Figure 18: Unaccounted for CDs

Four vials of diazepam unaccounted for thought to have been swept into the waste at the clearing up stage of a busy scene in order to quickly get the patient to hospital.
A full seizure pouch missing thought possibly stolen
Two amps of diazepam unaccounted for and not found after a thorough search – thought to be disposed of by accident
Significant amount of unaccounted for morphine (a serious incident)
Single vial of morphine lost during some work on the safe in the vehicle
Single diazepam rectal tube
Single diazepam amp
One vial or morphine from a vehicle safe which was not found after thorough investigation

The report into the serious incident involving unaccounted for morphine has been shared with both the Home Office and the Care Quality Commission. The Care Quality Commission were satisfied with the response and actions being taken. A response is awaited from the Home Office. A lot of work has been conducted to firstly investigate the incident, then analyse the data and then establish actions to minimise recurrence. All actions are in the process of being implemented.

Breakages of CDs are to be reported as incidents and these are monitored by the Medicines Team. Overall, 51 items have been broken spread over the course of the year, see figure 19 for the summary data for NWAS. An increase in reporting is often seen following training, this has been seen for paracetamol incorrect dosing (Paracetamol Think Weight campaign) or wrong administration of adrenaline (Right Dose Right Route campaign). In Q4 number of breakages being reported has increased and this is when training was being rolled out. Of the 51 breakages, 37 were morphine injection, 10 diazepam injection, 2 diazepam rectal tubes and 1 ketamine and 1 midazolam injection.

Figure 19: CD breakages reported 2022/23

Total Controlled Drug damages/breakage reported 2022/23													
Area	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
GM		2	1	1	3		2	1	2		2	3	17
CM	1			1	2	1		1			4	4	14
CL		3	1	1		1	2	2	1	4	1	1	17
NWAA						1					1		2
HART						1							1
												Total	51

2.6 Occupational Health Vaccination Programme

2.6.1 Influenza Vaccination

A review of the 2021/22 influenza vaccine handling was provided to the Medicines Optimisation Group and the subsequent recommendations were shared with the Flu Group. There were some notable improvements to the running of the campaign including a Flu Clinical Lead appointed. The Flu Clinical Lead verified staff were appropriately trained prior to vaccinating. In addition, tamper evident anaphylaxis kits were issued and digital temperature monitors were deployed to provide full assurance vaccines administered had been stored appropriately. Overall, a significant improvement of tracking stock led to only 1% unaccounted for (compared to 12% in the previous year).

For the 2022/23 Flu Programme, Flucelvax Tetra Qiv-c vaccine was approved for use as the sole vaccine available for the second year. The influenza vaccine PGD was updated and the NWAS e-learning and assessment packages refreshed for 2022/23.

Following negotiation, contract prices were obtained for the vaccine and 5000 were procured. The vaccines are funded via the HR occupational health budget. A total of 3,273 influenza vaccines were administered.

Recommendation:

- Review of flu vaccine handling in 2022/23.

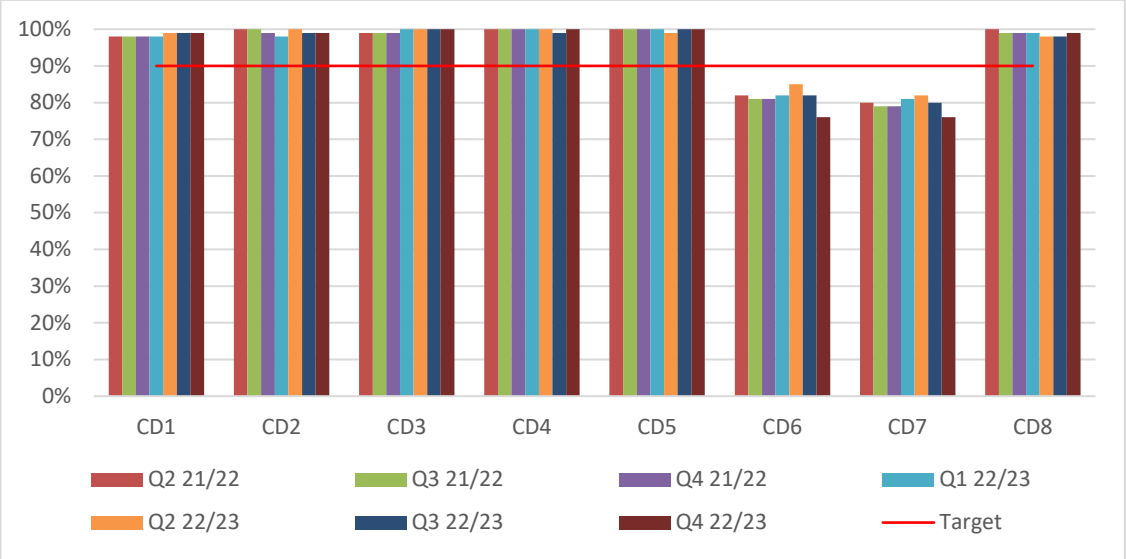
2.7 Audit

2.7.1 Medicines Management Quality Indicators – Controlled Drugs Vehicles:

In 2022/23, the CD audit for vehicles remained the same as the previous year. The audit tool remains within SafeCheck with monthly reports regarding uptake emailed to senior operational managers for oversight. The audit has eight critical questions that are to provide assurance in accordance with legislation, plus 17 additional questions to ensure compliance with best practice.

Since the initial embedding of the audits into practice across NWAS in 2021/22 there has been fluctuation of audit uptake across the three geographical areas. This has been improving throughout the year with Q1 auditing 66% (434 vehicles) rising to 93% (605 vehicles) by Q4. This includes urgent care vehicles and manager's vehicles. In Q4, 6 out of 8 of critical questions were compliant and scoring between 99% and 100%. The 2 critical questions that fell short of the 90% target were for weekly checks to be conducted on the vehicle CD safe (76%) and on the seizure pouch (76%). Figure 20 shows the results since Q2 of 2021 when the MMQIs were launched across NWAS. A summary of Q4 results is provided in appendix 2. Following a serious incident, the MMQIs have been reviewed and some changes are intended to be rolled out. In addition, the roll out of version 2 of SafeCheck should support managers with improved oversight to monitor compliance.

Figure 20: MMQIs CD Vehicles over time.

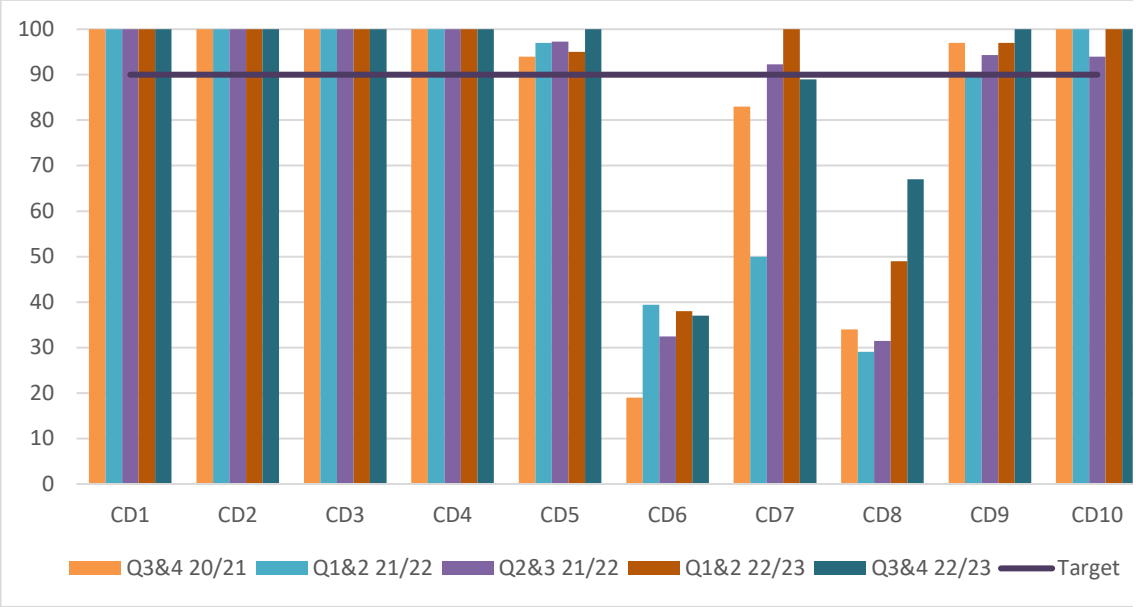


2.7.2 Medicines Management Quality Indicators – Controlled Drugs Ambulance Stations:

The MMQIs for ambulance stations were introduced in Q3 2020/21. The audit is conducted 6 monthly by the Medicines Team providing an independent review. No significant changes to the audit questions were made in the last year. All sites audited now have a Home Office CD licence and therefore ensuring compliance is critical. Once each audit is completed the results are sent to the local team.

In Q1/2 and Q3/4, 100% of ambulance stations were audited by the Medicines Team. In Q1/2 8 out of 10 of the critical questions met the target and in Q3/4 7 out of the 10 critical questions met the target with another getting to 89% (target 90%). The failed MMQI were about conducting daily and weekly checks. Whilst there is sustained assurance for compliance with 8 of the 10 MMQIs, the same two MMQIs fall short of the required standard. Figure 21 which shows the results over the last two and half years the data has been collected. A task and finish group has been set up to focus on the improvements required. A summary of the results of the critical questions for Q3/4 is provided in appendix 3.

Figure 21: MMQIs CD Ambulance Stations over time.



Recommendation:

- Set up a Controlled Drugs Task and Finish Group with Area Director Leadership focusing on MMQI improvements.

2.8 Medicines Related Risks:

A risk register report is provided to the Medicines Optimisation Group and progress monitored.

Closed risk:

- End of Life Care Medicines

Current risks:

- Non-Parenteral POM Administration
- Ambient Storage of Medicines in Ambulance Stations
- Third Party Providers and Medicines

New risks:

- Medicines preparation and administration

2.9 Partnership Working

The Medicines Team continues to link in with the following groups:

- National CQC Controlled Drugs Sub-Group
- CD Local Intelligence Networks
- NW Medicines Safety Officers Network
- NW Chief Pharmacists Network
- NW Pharmacy Leaders Group
- NW Chief Pharmacy Technician's Network
- JRCALC Working Group
- Specialist Pharmacy Services (includes procurement, quality assurance and medicines information)
- Ambulance Pharmacist's Network (APN) – part of NASMED
- Ambulance Service Medicines Safety Officer's Group – part of NASMED

2.10 Constraints:

The following are some of the constraints to optimising medicines within NWAS:

- Ambulance stations were not designed to hold medicines supplies which is now more prominent with the CD storage requirements.
- Further of clarity required for security of CDs and handling of CDs from the Home Office.
- The limited number of large ambulance station hubs creates challenges for the handling of CDs and other medicines.
- Paper records for CD registers across a large geographical area makes oversight a challenge.
- Limited capacity within the Medicines Team. However, 3 vacancies have now been recruited to, a new role for 2 years fixed term has been recruited to and addition on 0.8WTE pharmacist is in plan.
- Service Delivery Model Review to review clinical pharmacist working in the clinical hub.
- Access to pre-filled syringes with suitable shelf life, continuity of supply and product differentiation.

- Continuity of medicines supply is time consuming and can pose a patient safety risk.
- Extremes of temperatures and storage of medicines on vehicles.
- Legislation for paramedics is restrictive, e.g.: not able to use unlicensed medicines on a patient group direction.
- Lack of access to the Senior Clinical Intervention Log makes governance of the use of enhanced medicines labour intensive.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

This report demonstrates a robust approach to governance and development of systems to monitor how medicines are managed.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

Nil

5 RECOMMENDATIONS

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The Board notes the key points of assurance:

- New formulary medicines launched.
- Three new medicines approved.
- Flu vaccine training updated, and all vaccinators trained before vaccinating
- Excellent assurance on the training, assessment and sign off for all the patient group directions in use and other medicines e-learning modules.
- Set up of Controlled Drugs Subgroup.
- Handling of a serious incident involving unaccounted for morphine and a low contravention from the Home Office.
- Secured additional space for the Medicines Supply Hub.
- Re-engineered processes for nerve agent countermeasures.
- Implemented actions around End-of-Life Care Medicines.

- Delivered a medicines safety campaign around Right Dose Right Route adrenaline.
- Medicines expenditure is stable (this year shows a decrease).
- Medicine Management Quality Indicators (MMQIs) for vehicles showed 93% audited and 6/8 critical criteria fully met.
- MMQIs for ambulance stations showed 100% audited and 8/10 critical criteria met.

The Board notes the focus for 2022/23 will be:

- Develop and implement new and updated Patient Group Directions and training.
- Implementing actions from unaccounted morphine Serious Incident.
- Work on digital projects related to medicines.

Appendix 1: Review (Apr 2023) of Medicines Management Report Recommendations 2022/23

10 recommendations were made, 6 completed and 4 progress.

Topic	Recommendation	Date completed	Evidence/Progress Notes Apr 2023
Medicines Optimisation Strategy *Rolled over from 2021/22.*	Investigate using the electronic patient record to support monitoring EMT use of salbutamol nebuliser solution. This would replace current use of IRFs.	In progress.	Interim process in place and tested will go live Q1 2023/24. General Medicines Dashboard expected go live Q3 2023/24. Development work is all in plan. This will be more streamlined and include not only salbutamol.
Medicines Optimisation Strategy	Develop a specification for a medicines stock management system.	In progress.	This project is being supported by the Corporate Programme Board and the Transformation Team.
Medicines Optimisation Strategy	Implement the planned medicines changes and training.	Complete Sept 2022	New formulary medicines went live as planned.
Medicines Optimisation Strategy	The Medicines Supply Hub to package the new DuoDote supplies in pouches and supply sealed to the frontline staff.	Complete Oct 2022	Supplies of DuoDote received to the Medicines Supply Hub in October 2022. New processes developed and implemented. Stocks issued into unique numbered and tagged pouches and distributed.
Medicines Optimisation Strategy	Lessons learnt bulletin to be developed and published.	Complete July 2022	Distributed via comms weekly email. Available on the intranet.
Medicines Optimisation Strategy	End-of-Life Care Medicines Working Group to continue to progress key actions.	Complete. June 2022	Key actions completed and communicated.
Monitoring	Continue to pursue NWAS to be able to access CMU contact prices.	In progress.	CMU have agreed this in principle and have supported NWAS to obtain medicines at contract prices but as NWAS are not on the Pricing Policy list and the CMU are still progressing this.
Policies and Procedures	Update Medicines Policy.	Complete Mar 2023	Consultation carried out and complete review of the medicines policy.
Policies and Procedures	Update Controlled Drugs Policy.	In progress.	Once some key points have been decided this will be completed.
Occupational Health Vaccination	Review of flu vaccine handling in 2021/22.	Complete May 2022	A review of flu vaccine handling was conducted in May 2022 with recommendations. This was fed into the NWAS Flu Project team for actions in the 22/23 campaign.

Appendix 2: MMQIs Controlled Drugs – Vehicles Q4 2022/23

Critical CD Results

There is a requirement for 100% vehicles that hold controlled drugs (CDs) to be audited once in a quarter. In Q4 93% of vehicles (604/649) have been audited, see table 1. This is 6% improvement on the Q3 audit uptake.

Table 1: Q4 Vehicle MMQI Uptake, Trust and Area level

Area	Vehicles Audited	Total Vehicles Eligible to Audit	% Audited
NWAS	605	649	93
GM	224	229	98
CM	170	199	85
CL	190	198	96
HART	16	16	100
CPs	4	5	80

CL, GM & HART have exceeded 95% of vehicles au in Q4. CM improved their audit rate since Q3 by 18' This was predominantly due to CM North sector improving audit uptake by 51% taking their audit rat from 29% in Q3 to 80% in Q4.

Table 2 shows the results of the 605 vehicles audite the 8 Critical MMQIs. 6 out of 8 MMQIs met the 90% or more target. CD6 (weekly stock check of CD safe) wa 76% (Q3 = 82%) and CD7 (weekly stock check of seizure pouch) was 76% (Q3 = 80%). These results show s decline in compliance on the Q3 results which was represented across the three NWAS areas. HART sustaine their 100% compliance with improvements with weekly checks complied with for the 4 Consultant Paramedics audited their personal possession stocks.

Table 2: Q4 Vehicle MMQI CD results, Trust and Area Level *numbers are rounded*

MMQI CD Critical Question – *target 90%*	NWAS	C&L	C&M	GM	HART	CPs
CD1: Confirm the vehicle is either locked or attended at the time of audit?	99%	99%	100%	99%	94%	100%
CD2: Are the CD keys currently held safely? i.e. in personal possession of the paramedic manning the vehicle and NOT with the ignition key or secured in a locked CD key safe	99%	99%	99%	100%	100%	100%
CD3: Is the CD safe/s visibly in good working order with no damage?	100%	99%	100%	99%	100%	100%
CD4: Are all CDs stored in a CD safe or the seizure pouch (for diazepam rectal and injection)?	100%	100%	100%	100%	100%	100%
CD5: Is the current stock balance correct for each CD listed in the CDRB?	100%	100%	100%	100%	100%	100%
CD6: For the last 4 weeks has there been a stock check EVERY WEEK for the stock in the CD SAFE?	76%	83%	70%	72%	100%	100%
CD7: For the last 4 weeks has there been a stock check EVERY WEEK for the stock in the SEIZURE POUCH?	76%	86%	70%	71%	100%	100%
CD8: Are all CD stocks within their expiry date?	99%	100%	98%	100%	100%	100%

Overall the **audit provides excellent assurance around CDs held on our vehicles in NWAS**. The focus for further improvement needs to be on ensuring:

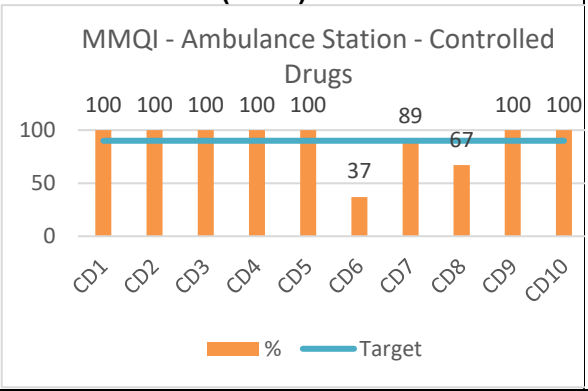
- Weekly stock checks are undertaken of both the CD safe and the Seizure Pouch **and recorded onto SafeCheck.**
- Further improvements to continue in CM to reach that 100% target of CD carrying vehicles being audit every quarter.

Appendix 3: MMQIs Controlled Drugs - Ambulance Stations Q3&4 2022/23

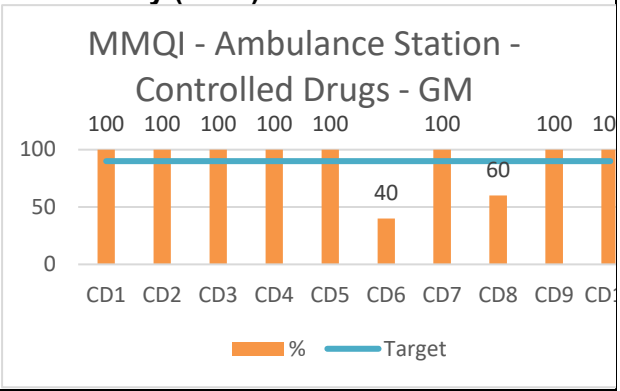
Critical CD Results

The MMQIs are listed at the bottom of this page. Due to current pressures within healthcare for a large part of Q3 and 4 NWAS has been at REAP level 4. However, due to good relationships built between the medicines team and operations staff we have been able to complete audits at 35 out of 35 stations (100%). Graph A below shows that of the 35 stations audited overall NWAS achieved 100% in 7/10 MMQIs, another 1 almost met the 90% target. CD8 (conducted a weekly stock check) was 67% (cf to 49% in Q1/2 22/23) and CD6 (conducted the daily stock check) was only 37% (cf to 38% in Q1/2 22/23) with 13/35 ambulance stations meeting this MMQI. **Daily and weekly stock checks continue to be where there is a need for a focus on improvement.**

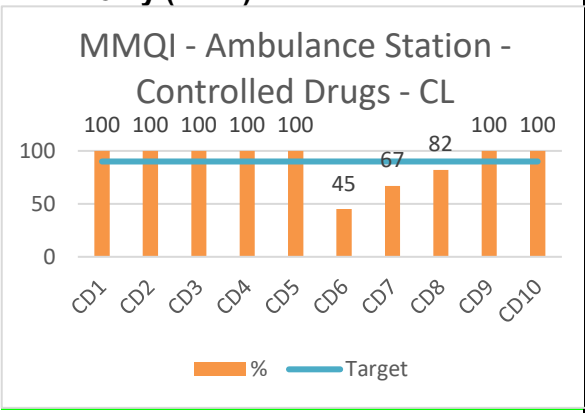
A: NWAS wide (n=35)



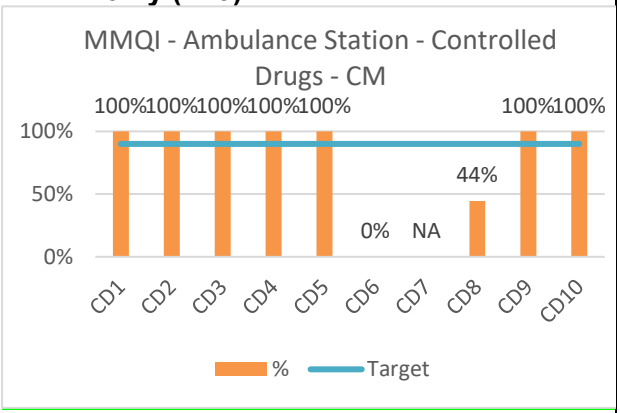
B: GM only (n=10)



C: CL only (n=11)



D: CM only (n=9)



E: NWAA (n=2)

Barton site passed all relevant critical questions.

Blackpool site passed all relevant critical questions.

F: HART & NARU (n=3)

Ashburton HART passed all relevant critical questions.

Croxteth HART failed on CD6 daily checks with 4 days missing.

NARU passed all critical questions.

MMQIs	Area	Question
CD1	Access & Security	Are the CD keys held in a CD key safe and is it locked?
CD2	CD Safe	Is the CD safe/s locked and in good working order with no damage?
CD3	CD Safe	Are all CDs stored in a CD safe?
CD4	CD Stationery & Records	Does the ambulance station have only one active CDRB?
CD5	CD Stock	Is the balance correct for each CD listed in the CDRB/stored in the CD safe?
CD6	CD Stock	Has a daily stock check taken place and documented in the CDRB? *Check for the last 30 days (Allow up to two missing checks providing they are not two consecutive days*
CD7	CD Stock	Were any discrepancies on the daily CD check acted upon and documented?
CD8	CD Stock	Has a weekly stock check taken place and documented in the CDRB including tag changes? *Check for the last 30 days*
CD9	CD Stock	Are all receipts of CD stocks are received by a paramedic and witnessed by the courier in the CD record book? *Check for last 30 days.*
CD10	CD Stock	Have all deliveries recorded by the MSH been received into the CDRB? *Check for last 30 days.*

Appendix 4: Medicines Management Report Recommendations 2023/24

Topic	Recommendation
Staffing	Recruit to the Lead Pharmacist: Critical Care and Quality post.
Staffing	Embed new staff into the Medicines Team.
Robust governance for medicines use	Update e-learning modules for PGDs.
Robust governance for medicines use	Develop new PGDs and e-learning modules.
Robust governance for medicines use	Review and update medicines training for EMT apprentices.
Digital innovation and integration	Support the role out of digital CD keys and CD safes with the smart site project team.
Digital innovation and integration	Digitalise the medicines pouch tracking process with the digital innovation team.
Digital innovation and integration	Develop a stock management and e-CD register specification.
Safe and Secure Handling of Medicines	Set up the additional unit for the Medicines Supply Hub.
Safe and Secure Handling of Medicines	Mass casualty vehicle medicines to be delivered to the Medicines Supply Hub for oversight and onward distribution.
Medicines Safety	Lessons learnt bulletin to be developed and published.
Medicines Safety	Support roll out of Patient Safety Incident Response Framework
Policies and procedures	Complete review of the Controlled Drugs Policy.
Policies and procedures	Update all NWAA Controlled Drugs Procedures.
Influenza vaccination	Review of flu vaccine handling in 2022/23.
Audit	Set up a Controlled Drugs Task and Finish Group with Area Director Leadership focusing on MMQI improvements.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 July 2023				
SUBJECT:	Learning from Deaths - Summary Report and Dashboard Q4 2022/23				
PRESENTED BY:	Dr Chris Grant – Executive Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q4 dashboard (Appendix A) describes the opportunities to learn from deaths. The main contributory factors to patient deaths, where identified in DatixCloudIQ (DCIQ), were attributed to challenges in Emergency Operational Centres (EOC), specifically around the emergency response where demand outstripped available resources. The peer review process now encompasses EOC and as a result the Trust is now compliant with the national framework. The peer reviews identified that 66.7% of patients received appropriate care. The key areas for improvement include using a medical model when documenting a patient's assessment, completing capacity to consent correctly, detailing specific worsening advice and safety netting. The quality of patient records has improved during this quarter but still requires improvement. The peer review also identified areas of good practice. This includes extensive patient assessment, full capacity assessment recorded, recognition of End-of-Life Care with empowerment of clinicians to not resuscitate patients with advanced or reversible conditions and documentation highlighting holistic conversations. There were four patient records that received a good rating for quality (16.0%). The panel continues to welcome observers to help raise awareness of the LFDs process and embed learning from the peer reviews.				

RECOMMENDATIONS:	The Board is recommended to:
	
	• Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account.
	• Note the Trust is fully compliant with the Learning from Deaths framework.
	• Acknowledge the good practice identified including:
	  ○ Patient informed of the risks of not going to ED.
	  ○ Recognition of EOLC and empowerment of clinicians to not resuscitate patients with advanced or reversible conditions when no EOLC plan exists.
	  ○ Excellent recognition of patient dying
	  ○ Holistic decision making recorded.

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: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub Committee Quality and Performance Committee			
	Date:	4 July 23 24 July 23		
	Outcome:	Supported		

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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 Q4 2022/23 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 31st July 2023 in accordance with the national framework and trust policy. The Q4 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q4. Learning from the panels is discussed later in this paper.

2. BACKGROUND

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

3. LEARNING FROM DEATHS DASHBOARD Q4 2022/23: APPENDIX A

The number of patients whose deaths were identified as in scope for review was 97 (63 concerns raised in Datix and 34 sampled for SJR – Table 1, Fig.1).

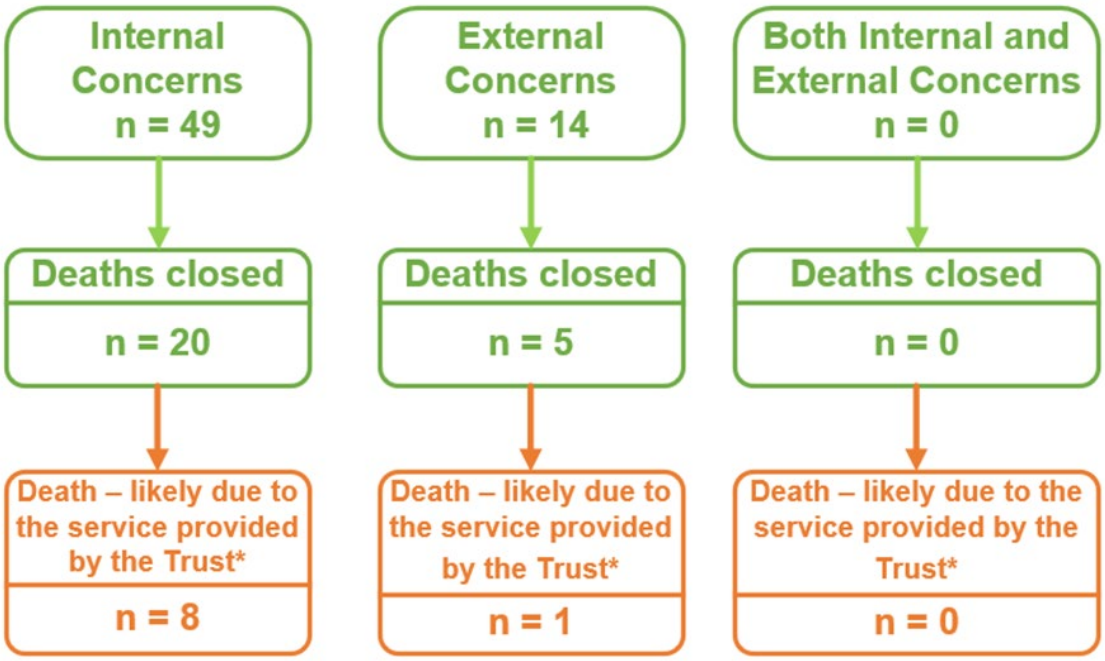
Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 16/06/2023 and the high-level figures for the previous quarters has also been refreshed (number of concerns, number of deaths reviewed and the number of deaths where problems in care have contributed). It should be noted that due to the complexity, the granular updates for the previous quarters will be received within other patient safety reports and the thematic analysis will be captured within the annual Learning from Deaths Report.

The breakdown of concerns raised:

- 49 internal concerns were raised through the Incidents Module (Events)
- 14 external concerns were raised through the Patient Experience Module (Feedback)
- No concerns were raised both internally and externally.

The flowchart below provides a summary of the concerns raised in Datix.



Deaths raised in DCIQ, Q4 2022/23

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

Of the 49 internal concerns, 20 were reviewed and closed. In 8 cases, the investigation concluded the Trust had contributed in some way to that patient death.

- Delays (7 cases) was cited as the main contributing factor to the patient's death.

External Concerns: Tables 4 and 5, Figure 4

Of the 14 external concerns that have been reported, nine are still in the preliminary stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Five concerns have been closed and one patient death had causal factors identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- EOC
    - Significant delay in responding to a difficulty in breathing (DIB)
    - Significant delay in responding to patients (sepsis, falls)

- PES
    - Problem with patient assessment, investigation, or diagnosis
    - Problem related to treatment and management plan.
    - Problem with communication

- Problem with patient disposition

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

No concerns were raised internally and externally – note these are different concerns from those referenced above.

Structured Judgement Review (SJR): Cohort Discussion: Tables 8-11 and Fig 6-7.

Of the 34 patient deaths:

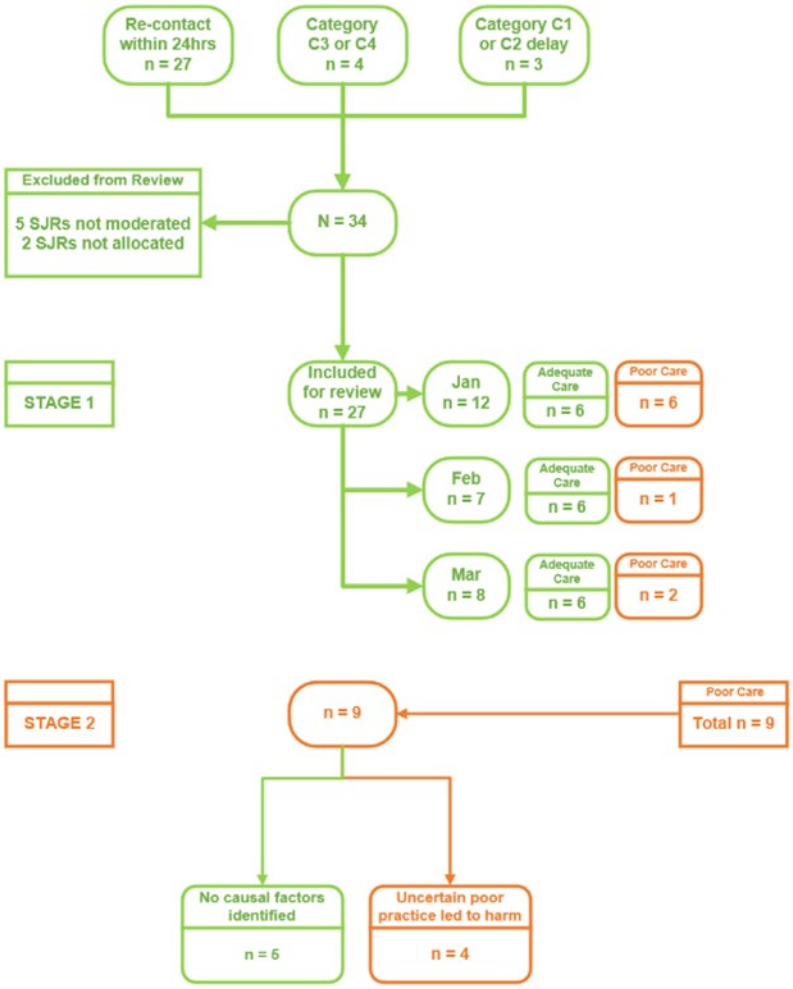
- 27 patient deaths occurred where patients were not initially conveyed, and the service was re-contacted within 24 hours*
- 4 patient deaths occurred where the incident was coded as a Cat 3 or Cat 4
- 3 deaths occurred where they were initially coded as Cat 1 or Cat 2 and were subjected to a long wait.

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

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

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

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



SJR Sample and Treatment, Q4 2022/23

Structured judgement review (SJR) methodology

The process requires frontline staff to review and make explicit statements on the practice under review using the ‘Sequence of Events’ (SoE) and Electronic Patient Record (EPR) 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.

SJR Stage 1 Outcomes:

27 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below. 18 patients (66.7%) received appropriate care.

Month	Very Poor	Poor	Adequate	Good	Very Good
Jan 23		6	6		
Feb 23		1	6		
Mar 22		2	6		

Moderation Panels held on 21/03/2022, 19/04/2023, 09/05/2023 & 23/05/2023.

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

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

Quality of Patient Records

The quality of patient records improved from 62.5% to 76.0% during this quarter (6 poor, 15 adequate and 4 good). Whilst the EPR is undergoing development from a hardware and software perspective, general feedback and support should be offered to improve the quality. A campaign was launched during National Clinical Audit Awareness Week around what a good patient record should entail.

SJR Stage 2 Outcomes:

Nine cases were identified as needing second stage review following Stage 1. The second stage review concluded that five deaths were not avoidable, and it was also uncertain whether poor practice had led to harm for four deaths. The care experienced by these patients in terms of call handing/categorisation/resource allocation, patient assessment and management plan were below expected levels.

SJR Learning Outcomes: Tables 12 -13

Poor Practice: Table 12 Fig 8.

The panel identified areas for improvement to:

- Triage calls appropriately
- Re-triage calls appropriately
- Use a medical model when documenting on examination findings.
- Record repeated observations when appropriate to do so.
- Assess and document capacity appropriately.
- Perform ECGs when appropriate to do so.
- Apply MTS when appropriate to do so.
- Seek senior advice for complex cases.

- Record a clear management plan.
- Detail differential diagnosis
- Record associated risks around ED refusals.
- Consider EOLC planning and safety netting.
- Provide a comprehensive clinical narrative within the EPR, especially details around GP discussions and specific worsening advice.

Good Practice: Table 13 Fig 9.

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

- Extensive patient assessment
- Full capacity assessment recorded.
- Patient informed of the risks of not going to ED.
- Recognition of EOLC and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists.
- Excellent recognition of patient dying
- Holistic decision making recorded.
- Documentation states involvement of those important to the patient, with holistic conversation noted.
- Quality of EPR

Actions taken:

- AP feedback around poor documentation
- Escalate a satellite navigation issue as it took the crew the wrong way (address was also plotting incorrectly)
- 111 Audit requested.
- EMA to receive positive feedback around call handling.
- Clinical Hub representative to review procedures around code sets.
- Clinical Safety Team to raise a retrospective Learning Disabilities Mortality Review (LeDeR) because procedure was not followed.

Dissemination Process

Disseminating of learning and promoting good practice is undertaken by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff. The Q4 Learning from Deaths infographic (Appendix B) will be shared with the senior clinical leadership team.

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

Good practice letters have been circulated to commend 11 clinicians, who through their care and professionalism, have supported families and patients to experience a good death during Q4.

Observers were welcomed at the Q4 panels, and the process is supporting colleagues with their own practice.

DCIQ and Report Development

A DCIQ review meeting has been scheduled for July 2023 to discuss design changes.

Report improvements have scoped and logged with Business Intelligence considering including area profiles, patient demographics, deprivation scores and time on scene. These additions should be captured within the next report (Q1 2023/24).

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

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

6. RECOMMENDATIONS

The Board is recommended to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the Trust public account.
- Note the Trust is fully compliant with the Learning from Deaths framework.
- Acknowledge the good practice identified including:
    - Patient informed of the risks of not going to ED.
    - Recognition of EOLC and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists.
    - Excellent recognition of patient dying
    - Holistic decision making recorded.

NWAS Learning From Deaths Dashboard Quarter Q4 2022 - 2023 (January - March)

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

Total Number of Deaths in Scope (Sample Cohort and Datix Incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Jan-23	35	25	71.4%	10
Feb-23	33	16	48.5%	3
Mar-23	29	11	37.9%	5
This Quarter	**97**	**52**	**53.6%**	**18**
This Financial Year	512	405	79.1%	96

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient*

Table 1

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

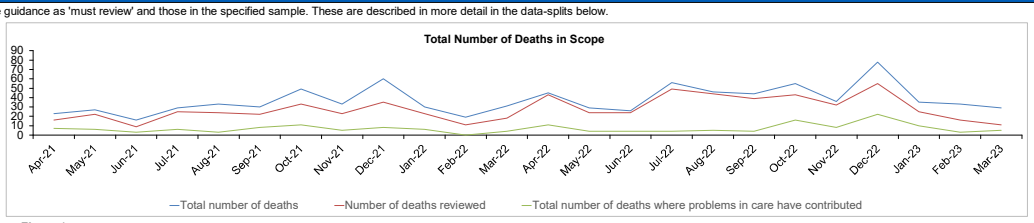


Figure 1

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
January	17	2	5	9
February	16	4	3	8
March	16	1	2	13
Total	**49**	**7**	**10**	**30**

Table 2

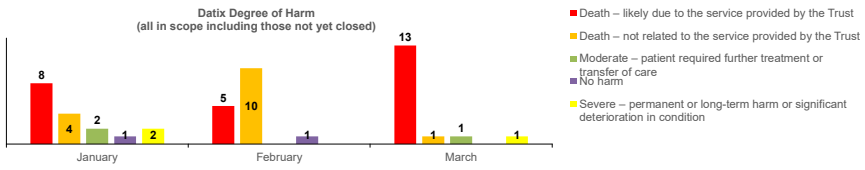


Figure 2

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
January	11	4	2
February	7	2	1
March	2	2	2
Total	**20**	**8**	**5**

Table 3

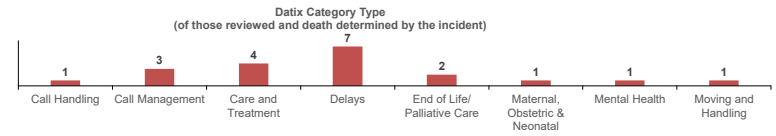


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
January	3	2	0
February	9	2	0
March	2	1	1
Total	**14**	**5**	**1**

Table 4

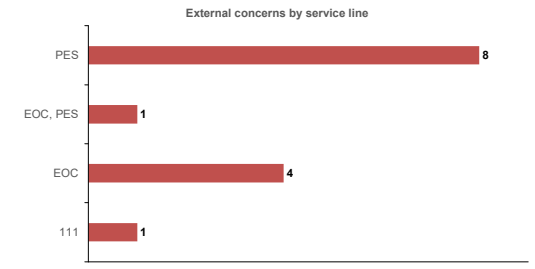


Figure 4

Department	Concern Raised	Cause and Actions	
EOC	Problem with call taking and/or response allocation	Still under review	2
	Problem with call taking and/or response allocation (DIB)	Demand outstripped resources; Hospital handover delays, Missed opportunity to divert ambulance, Missed opportunity to upgrade low acuity incident; Staff feedback and/or reflection	1
	Problem with call taking and/or response allocation (sepsis)	Demand outstripped resources; Not upheld; No actions	1
EOC, PES	Problem with call taking and/or response allocation, Problem related to treatment and management plan	Demand outstripped resources; Not upheld; No actions	1
PES	Problem related to treatment and management plan	Still under review	1
		No causal factors; Not upheld; No actions	1
		Failure to recognise potential seriousness and complexity of condition, Lack of safety netting; Staff feedback and/or reflection, Refresher training to be undertaken	1
	Problem with communication	Poor communication; Staff feedback and/or reflection	2
	Problem with patient disposition	Still under review	1
	Problem with assessment, investigation or diagnosis	No causal factors; Not upheld; No actions	1
	Problem with assessment, investigation or diagnosis, Problem with communication	Poor communication; Staff feedback and/or reflection	1
111	Problem with call taking and/or response allocation	Still under review	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
January	0	0	0
February	0	0	0
March	0	0	0
Total	**0**	**0**	**0**

Table 6

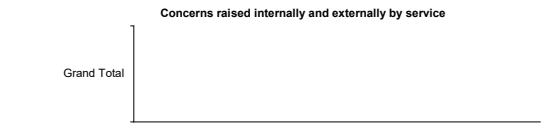


Figure 5

Data last exported 20/04/2023; Data last cleansed 06/06/2023

Department	Concern Raised	Cause and Actions	Total

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.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initially conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
January	15	12	6
February	8	7	1
March	11	8	2
Total	**34**	**27**	**9**

Table 8

	SJR Category Type		
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
January	1	1	13
February	0	1	7
March	2	2	7
Total	**3**	**4**	**27**

Table 9

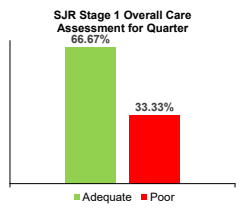


Figure 6

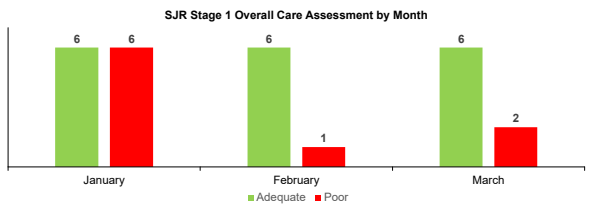


Figure 7

Initial Contact	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	2	25	0	**25/27 patients**	**93%**
Right Care	Patient Assessment Rating	4	21	2	**23/27 patients**	**85%**
	Management Plan/Procedure Rating	3	22	2	**24/27 patients**	**89%**
Right Place	Patient Disposition Rating	0	27	0	**27/27 patients**	**100%**

Table 10

Recontact	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	2	21	0	**21/23 patients**	**91%**
Right Care	Patient Assessment Rating	0	22	1	**23/23 patients**	**100%**
	Management Plan/Procedure Rating	0	22	1	**23/23 patients**	**100%**
Right Place	Patient Disposition Rating	0	23	0	**23/23 patients**	**100%**

Table 11

SJR Scoring Key:

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

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

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 27 patients)

Evidence of Poor/Very Poor Practice

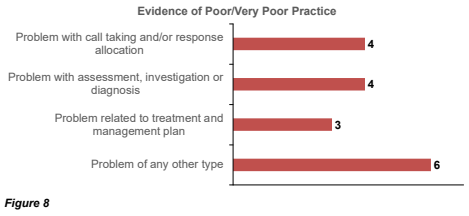


Figure 8

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	No repeated observations recorded	1
		Clinical examination poorly documented	4
		Lack of clear impression, working diagnosis and differentials	1
		Capacity to consent assessed but no details provided	1
		12 lead ECG not performed when appropriate to do so	1
	Problem related to treatment and management plan	MTS not used	2
		No senior advice being sought	1
		Differential diagnosis and safety netting	1
		Lack of clear management plan	1
		Failed to recognise EOL care patient	1
		No specific worsening advice	1
		Risks associated with not attending ED not described	1
	Problem of any other type	Quality of EPR	6
EOC	Problem with call taking and/or response allocation	Call not re-triaged	2
		Call not triaged correctly (safe with learning)	1
		Call not triaged correctly	1

Table 12

Evidence of Good/Very Good Practice

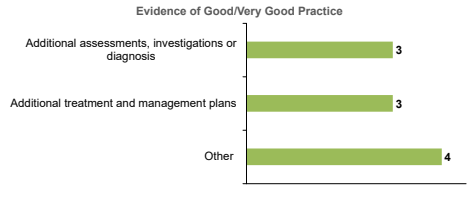


Figure 9

Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Full capacity assessment	1
		Extensive patient assessment	2
		Patient aware of risks of not going to ED	1
	Additional treatment and management plans	Documentation states involvement of those important to the patient, with holistic conversation noted	1
		Holistic decision making reported	1
		Excellent recognition of patient dying	1
		Recognition of EOLC and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists	1
	Other	Quality of EPR	4

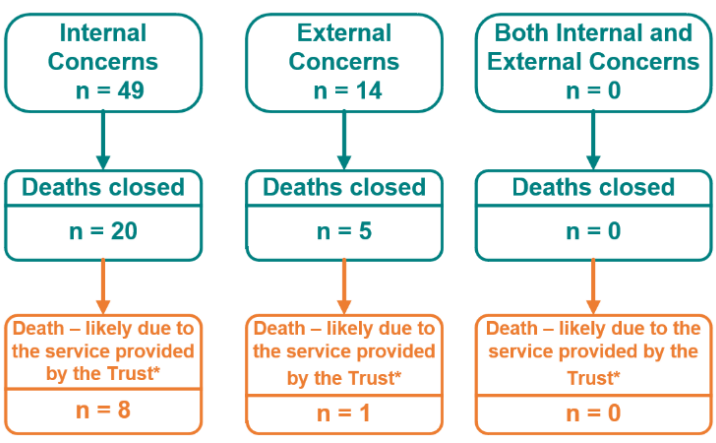
Table 13

Data last accessed 16/06/2023

NWAS LEARNING FROM DEATHS (LFD)

Q4 2022/23 Report

DEATHS WITH CONCERNS RAISED IN DATIX



*as classified by the Datix investigator

64%

had no causal factors identified

KEY LEARNING THEMES FROM CONCERNS

Emergency Operations Centre (EOC)

- Significant delay in responding to a difficulty in breathing (DIB)
- Significant delay in responding to patients (sepsis, falls)

Paramedic Emergency Service (PES)

- Problem with patient assessment, investigation or diagnosis
- Problem related to treatment and management plan
- Problem with communication
- Problem with patient disposition

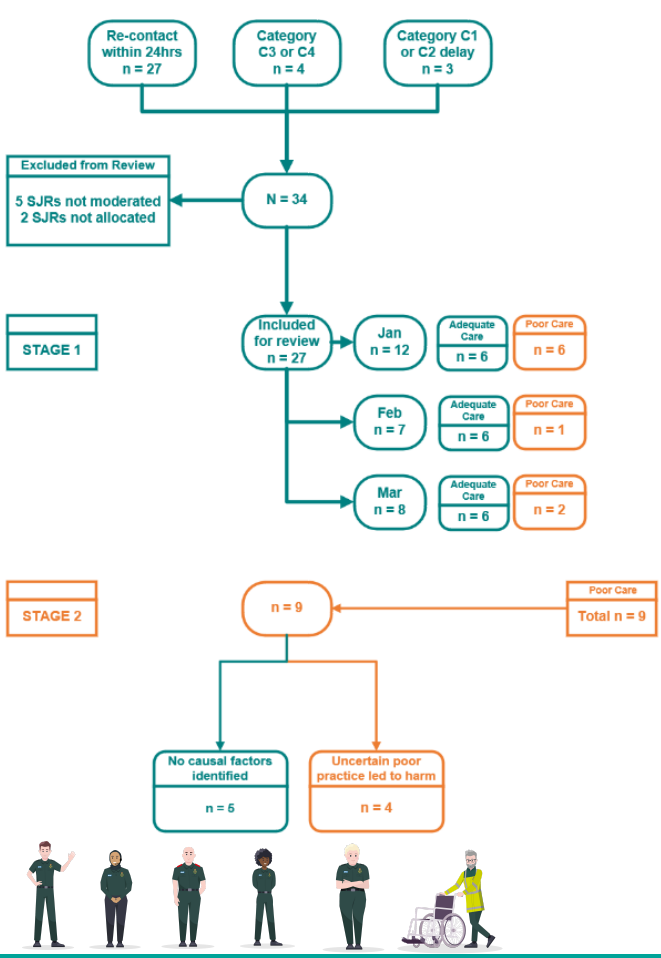
for more information on themes, full dashboard available on request

STRUCTURED JUDGEMENT REVIEW PHASES & OUTCOMES

- Call Handling/ Categorisation/ Resource Allocation
- Patient Assessment
- Management Plan/Procedure
- Patient Disposition

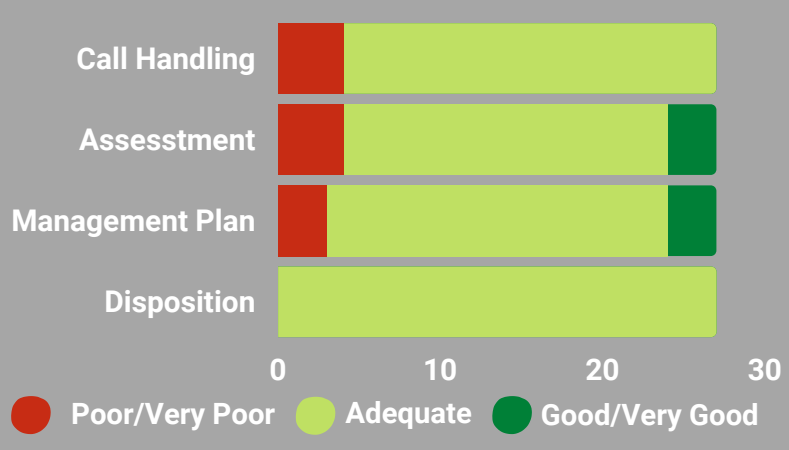
If any phase has a poor or very poor outcome, stage 2 is triggered to assess if it led to any harm in terms of assessment, medication, management plan, monitoring or resuscitation.

SJR DEATHS



STAGE 1 - SJR OUTCOMES

66.7% of patients received appropriate care



SJR STAGE 2 THEMES

Problem in call taking and/or response allocation?

- Call not re-triaged
- Call not triaged correctly

Problem in assessment, investigation or diagnosis

- No repeated observations recorded
- Clinical examination poorly documented
- Lack of clear impression, working diagnosis and differentials
- Capacity to consent assessed but no details provided
- 12 lead ECG not performed when appropriate to do so

Problem relating to treatment and management plan

- MTS not used
- No senior advice sought
- Differential diagnosis and safety netting
- Lack of clear management plan
- Failed to recognise EOLC patient
- No specific worsening advice
- Risks associated with not attending ED not described

Problem of any other type

- Poor clinical documentation (x6)

EVIDENCE OF GOOD PRACTICE

Additional assessments, investigations or diagnosis

- Extensive patient assessment
- Full capacity assessment recorded
- Patient informed of the risks of not going to ED

Additional treatment and management plans

- Recognition of EOLC and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists
- Excellent recognition of patient dying
- Holistic decision making recorded
- Documentation states involvement of those important to the patient, with holistic conversation noted

Other

- Quality of EPR (x4)

Acknowledging good care and practice - **11 letters sent out**

NWAS LEARNING FROM DEATHS (LFD)

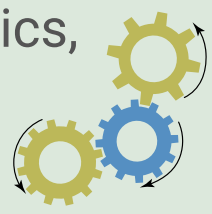
Q4 2022/23 Report

SJR ACTIONS

- AP feedback around poor documentation
- Escalate a satellite navigation issue as it took the crew the wrong way (address was also plotting incorrectly)
- 111 Audit
- EMA to receive positive feedback around call handling
- Clinical Hub representative to review procedures around code sets
- Clinical Safety Team to raise a retrospective Learning Disabilities Mortality Review (LeDeR) because procedure was not followed

IMPROVEMENTS

- To improve the quality of EPRs
- To improve the DCIQ learning from deaths module
- To improve reporting in terms of patient demographics, area profile, deprivation score and time on scene



PANEL DATES 2023/24

Open for all staff to attend

Period	Date
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

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Resources Committee			
Date of Meeting:	21st July 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 Mr D Whatley Ms L Ward Mr S Desai Mr G Blezard **In attendance:** Mrs M Brooks, Deputy Director for Finance	**Key Members Not Present:**	Mrs C Wood, Director of Finance

Link to Board Assurance Framework (Strategic Risks):

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

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

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
NHSE Zero Emissions Emergency Vehicle (ZEEV) Programme	• Presentation provided by the Deputy Director of Net Zero Travel and Transport, NHSE. • Received comprehensive information on the work undertaken by NWAS and the ZEEV Programme. • Further discussion of the issues to be held at future meeting.	• Noted the content of the presentation and programme updates. • Committee to discuss further at a future meeting.	
Board Assurance Framework	• Discussed the strategic risks aligned to the Committee. • Noted the bimonthly commentary and predictions for quarter 2 performance. • In relation to SR08 referred to a recent MIAA report and the need for inclusion of risks associated to artificial intelligence and cyber security. • Head of Corporate Affairs to follow up with the Director of Quality, Innovation, and Improvement.	• Gained assurance that BAF risks were being managed effectively.	
Finance Report	• Received and discussed details of the trust's financial position at month 03 2023/24. • The annual efficiency and productivity position and opening capital programme for 2023/24 provided.	• Received assurance from the finance report for Month 03 2023/24.	
Agency Performance Report	• Received an update on the level of the trust's agency expenditure.	• Received assurance on agency expenditure, detailed in the 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

	• Noted agency staff had been procured below the price cap and via the approved framework agreements. • Agency expenditure in 2022/23 was below expenditure ceiling and Q1 2023/24 position below the year-to-date ceiling. • No breaches of supplier framework rules on the trust's monitoring returns to NHSE.		
Patient Level Information and Costing Systems	• Update provided on the planned completion and submission of the 2022/23 Patient Level Information and Costing systems. • Executive team to consider the use of the data and update to be presented to the next meeting.	• Noted the content of the report. • Requested an update on the use of the PLICS data, to be provided at the next meeting.	
Update on 23/24 Capital Plan and 5 Year Rolling Programme	• Noted the capital plan proposals and a requirement to roll over some plans to 2024/25. • Recognised the challenges to align 2023/24 and 2024/25 capital plans. • Requested a further paper on the position in Q4 2023/24.	• Noted the proposals. • Recognised the challenges to align 2023/24 and 2024/25 capital plans. • Requested a further paper in Q4.	
Contract Award for Extension of Trust Premises Cleaning Contract	• Noted the proposal and recommended onward approval by the Board of Directors.	• Supported the contract award proposal. • Recommended approval to the Board of Directors.	

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

Estates, Fleet and Facilities Management Report	• Received an update on estates, fleet, and facilities management activity since the last report to the Committee.	• Noted and received assurance from the report.	
Workforce Indicators Report	• Noted the trust's performance against the workforce indicators. • Key points highlighted further discussed included the vacancy position, the challenges of UEC recruitment plans. • Sought and received further assurance in terms of the processes used to gain oversight of the non-compliance areas for mandatory training.	• Noted the workforce indicators report. • Noted the ongoing challenges related to maintaining levels of mandatory training compliance, however oversight mechanisms in place.	
Wellbeing Annual Report	• Received and noted the content of the Wellbeing Annual Report.	• Noted the assurances provided.	
WRES, WDES and Gender Pay Gap Regulatory Reporting	• Approved the report for presentation to the Board of Directors.	• Approved the report for presentation to the Board of Directors.	
Contract Award for The Provision of Occupational Health Services	• Noted the proposal and recommended onward approval by the Board of Directors.	• Supported the contract award proposal. • Recommended approval to the Board of Directors.	
Strategic Workforce Sub Committee Chairs Assurance Report	• Received assurances received by the subcommittee at the meeting held on 22nd June 2023.	• Noted the assurance provided.	
Digital Progress Update	• Noted the content of the report.	• Noted the content of the report. • Noted the ongoing challenges in relation to the resource required to carry out the digital work.	

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 the challenges and risk in relation to recruitment and the volume of digital work to be undertaken.		
2023/24 Annual Plan Q1 Assurance Report	• Received an overview of activity and an updated position in relation to the Q1 progress made. • Noted future reports would provide future detail of progress against target.	• Received assurance from the report.	
Hewitt Review and impact on ICSs	• Received a report which highlighted the trust's work to review the recommendations of the Hewitt Review.	• Received assurance from the report.	
Trust People Strategy	• Received the Trust's People Strategy.	• Recommended the Strategy for consideration by the Board of Directors.	
Trust Sustainability Strategy	• Received the Trust's Sustainability Strategy.	• Recommended the Strategy for consideration by the Board of Directors.	
Diversity & Inclusion Sub Committee Chairs Assurance Report from the meeting held on 21st July 2023	• Report to be circulated and discussed at the next meeting.	• Report to be discussed 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
	Assured	No or minor impact on quality, operational, workforce or financial performance

North West Ambulance Service NHS Trust

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REPORT TO BOARD OF DIRECTORS

DATE:	26 July 2023				
SUBJECT:	Regulatory and Statutory EDI Workforce Reporting				
PRESENTED BY:	Lorraine McConnell, Deputy Director of People				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☐	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☐	☐	☐
PURPOSE OF PAPER:	For Discussion				
EXECUTIVE SUMMARY:	The purpose of this paper is to provide the Board with an overview of the most recent workforce data in relation to race, disability and gender which the Trust is required to publish. This Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap data in this report relates to the period of 1st April 2022 – 31st March 2023. In line with the new nationally mandated timeframe, the WRES and WDES data was submitted to NHS England in May 2023 (this has previously been submitted in August). The GPG data will be submitted via the gov.uk portal later in the year. **WRES** The headcount of BME staff in the Trust increased from 325 at 31 March 2022 to 365 at the end March 2023. This is the highest number of staff from a BME background since 2019 and equates to an increase of 0.4% from 4.8% to 5.2% of the overall workforce. Data relating to the recruitment and appointment of BME staff is much more positive compared to last year, while there is still more progress that needs to be made. The relative likelihood of White applicants being appointed compared to BME is 1.26 – in 2021/22 White applicants were nearly twice as likely (1.98). The figure for 2022/23 represents the lowest disparity rate since 2020. The relative likelihood of BME staff entering formal disciplinary process compared with White staff has also seen a welcome reduction (from 2.23 in 2021/22 to 1.86 in 2022/23), but the metric is still points to a disparity between BME and White staff. The data on the likelihood of BME staff accessing non-mandatory training and CPD as compared with White staff has remained static at 1.01. As the aim to get to 1.01, this shows that				

there is virtually no difference between the experiences of White and BME staff in this regard.

On the question relating to equal opportunities for career progression or promotion, the data this year showed an increase in positive responses from BME and White staff – BME 36.8% (33.6% in 2021), White 50.4% (47.8% in 2021).

With regards experiencing discrimination at work, the data shows a sizeable shift in difference between BME and White staff of -12.4% in 2021 reduced to -2.9% in 2022. However, 14% of BME respondents said they had been discriminated against and the response from White colleagues slightly increased from it's previously static position to 11.1% (highest since 2017).

WDES

The trust has seen an increase in the representation of staff with disabilities in most levels of the organisation with:

- non-clinical rising from 7.1% in 2022 to 8.3% in 2023
- clinical (non-medical) rising from 4.8% in 2022 to 6.3% in 2023
- total workforce rising from 5.0% in 2022 to 6.5% in 2023

As of March 2023, there remain 541 staff who have a 'null' or 'disability unknown' status in their ESR record. However, this is yet another significant decrease from 642 staff in March 2022 (805 in 2021) who had a null category in the previous year's submission.

Data in relation to recruitment in 2022/23 has shown an increase in the number of disabled candidates appointed from shortlisting:

- 561 applicants who declared a disability were shortlisted for NWAS roles (250 in 2021/22)
- 92 staff members appointed who identified as having a disability (42 in 2021/22).

Metric 3 looks at staff entering the formal performance process. In 2021/22 the figure for this metric was 0.00, but for 2022/23 this shows as 1.47 – this means that disabled staff are nearly one-and-a-half times more likely to be in the performance process compared to non-disabled staff. However, it should be noted that the numbers underpinning this data are very small, leading to large shifts in the calculation.

While still less than half of disabled staff feel that there are equal opportunities for career progression, the overall number % has increased significantly from 39.4% in 2021 to 45.1%.

Less than 1 in 4 staff members who have a disability said they feel valued by the organisation, and the gap between disabled and non-disabled on this question has further widened. On reasonable adjustments however, nearly two-thirds of the respondents said they had benefitted from adjustments made their employer, which is an increase on the 2021 figures.

	GPG The workforce numbers from a gender perspective show a continuing increase in the overall number of female staff in the Trust – 52.14% in 2023, compared to 51.60% in 2022. The pay quartile information shows that female representation has increased in all quartiles, including the Upper Quartile from 37.78% to 39.05% in 2022/23 (but this Quartile still shows the biggest gap). In contrast however, male representation across all quartiles has fallen slightly compared to previous years. Additionally, for the first time there is a greater % of females in the Upper Middle Quartile compared to males (50.11% v 49.89%). The comparative shift in representation has led to a widening of the pay gap for this year. **Actions** • Continued focus to look at the fairness of recruitment and progression in the Trust across the workforce - informed by the findings of the Recruitment Audit. • Reasonable adjustments – work being led by EDI Team to establish a standardised Trust position around reasonable adjustments, ensuring that staff and managers are aware of how to request and authorise adjustments in the workplace. • Engagement with the HRBP colleagues on a regular basis to better understand the data around the disciplinary and performance process metrics in the WRES and WDES respectively, and to help advise on improvements.
RECOMMENDATIONS:	The Board of Directors is asked to: • Note progress on the work undertaken relating to WRES, WDES and Gender Pay Gap agendas. • Note the planned actions for improvement. • Recommend approval of WRES, WDES and Gender Pay Gap data for onward reporting.
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: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

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:	Diversity & Inclusion Sub Committee, Resources Committee			
	Date:	14/07/23 & 21/07/23		

	Outcome:	Noted and recommend publication.

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1. PURPOSE

The purpose of this paper is to provide the Committee with an overview of the most recent workforce data in relation to race, disability and gender which the Trust is required to publish.

2. BACKGROUND

2.1 As a public body, the Trust has a legal responsibility to publish Gender Pay Gap (GPG) data on an annual basis. In addition, it has a regulatory requirement under the NHS Contract to publish annual data in respect of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES).

2.2 Working to address inequalities identified by the workforce data demonstrates compliance with the Equality Act 2010 and the Public Sector Equality Duty.

2.3 This paper and associated appendices set out the NWAS workforce data relating to race, disability and gender.

2.4 This WRES, WDES and GPG data in this report relates to the period of 1st April 2022 – 31st March 2023. In line with the new nationally mandated timeframe, the WRES and WDES data was submitted to NHS England in May 2023 (this has previously been submitted in August). The GPG data will be submitted via the gov.uk portal later in the year.

2.5 As with previous years, the WRES and WDES data includes results from the national Staff Survey which have previously been shared with the Committee (10.03.23).

3. WORKFORCE RACE EQUALITY STANDARD (WRES)

3.1 The WRES data for 2022-23 is set out in Appendix 1.

3.2 Of the nine WRES indicators in total, six areas show positive improvements. However, there is an increase in disparity for three indicators, between BME and White staff:

- Indicator 5 (% of staff experiencing bullying, harassment or abuse from patients, relatives of the public in the last 12 months)
- Indicator 7 (% of staff believing that trust provides equal opportunities for career progression or promotion)
- Indicator 9 (% difference between organisation's board voting membership and it's overall workforce, and organisation's board executive membership and it's overall workforce)

3.3 The headcount of BME staff in the Trust increased from 325 on 31 March 2022 to 365 at the end March 2023. This is the highest number of staff from a BME background since 2019 and equates to an increase of 0.4% from 4.8% to 5.2% of the overall workforce.

3.4 The Trust remains committed to developing a diverse and representative workforce. The addition of extra Positive Action resource in the Inclusion & Engagement Team in the last year has allowed for greater capacity and support for community engagement. It has

increased the Trust's outreach into communities across the North West to assist currently underrepresented groups into employment with NWAS.

3.5 Data relating to the recruitment and appointment of BME staff is much more positive compared to last year, while there is still more progress that needs to be made. The relative likelihood of White applicants being appointed compared to BME is 1.26 – in 2021/22 White applicants were nearly twice as likely (1.98). The figure for 2022/23 represents the lowest disparity rate since 2020.

3.6 There may a number of factors which have contributed to this positive shift including the rollout of the Beyond Bias training module, more diverse interview panels and greater numbers of BME applicants.

3.7 The relative likelihood of BME staff entering formal disciplinary process compared with White staff has also seen a welcome reduction (from 2.23 in 2021/22 to 1.86 in 2022/23), but the metric is still points to a disparity between BME and White staff.

3.8 This variance most likely exists due to the significant differences in staff numbers for BME and White groups. As there are considerably fewer BME staff than White colleagues in the workforce, even if only a very small number of them may enter the disciplinary process, this is then seen as a disproportionately higher figure on the metrics. However, it is appropriate to consider whether there are any other factors which may also contribute to this metric, and this will be explored through engagement with the HRBP Team.

3.9 Additionally, it is expected that the introduction of the new Disciplinary Policy as well as measures such as manager training through Beyond Bias should contribute to a continuing downward trend on this indicator.

3.10 The data on the likelihood of BME staff accessing non-mandatory training and CPD as compared with White staff has remained static at 1.01. As the aim to get to 1.01, this shows that there is virtually no difference between the experiences of White and BME staff in this regard.

3.11 A number of metrics within the WRES relate to the results of the 2022 annual Staff Survey. These include questions around:

- experiencing harassment bullying or abuse from patients/relatives or staff
- equal opportunities for career progression or promotion
- experiencing discrimination at work from manager/team leader or other colleagues

3.12 The percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months has seen a decrease for both White and BME staff to the lowest % since 2017. In 2022, 34.4% of BME colleagues reported experiencing harassment etc (37.1% in 2021), compared to 38.1% of White staff (40% in 2021). While this is positive, the figures show that the difference in experience between the two staff groups has gone up from 2.9% in 2021 to 3.7% 2022/23 although BME staff experience is better than white colleagues.

3.13 There has been a notable decrease in the percentage of BME staff experiencing bullying, harassment, or abuse from other staff to its lowest level of 23.7% since 2017 (and down from 29.5% in 2021). For White staff, there has been a reduction to 22.2% (from 23.6% in 2021) in the same metric. The reductions in this metric are welcome but still point the

fact that more than 1 in 5 staff members (BME and White) have negative experiences with colleagues at work.

3.14 The Staff Survey also asks whether the Trust provides equal opportunities for career progression or promotion. The data this year showed an increase in positive responses from BME and White staff – BME 36.8% (33.6% in 2021), White 50.4% (47.8% in 2021).

3.15 On the question of experiencing discrimination at work, the data shows that the sizeable shift in difference between BME and White staff of -12.4% in 2021 reduced to -2.9% in 2022. However, 14% of BME respondents said they had been discriminated against and the response from White colleagues slightly increased from it's previously static position to 11.1% (highest since 2017).

4. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

4.1 This the fifth year of reporting for WDES and Appendix 2 sets outs the metrics in detail.

4.2 The trust has seen an increase in the representation of staff with disabilities in most levels of the organisation with:

- non-clinical rising from 7.1% in 2022 to 8.3% in 2023
- clinical (non-medical) rising from 4.8% in 2022 to 6.3% in 2023
- total workforce rising from 5.0% in 2022 to 6.5% in 2023

4.3 As of March 2023, there remain 541 staff who have a 'null' or 'disability unknown' status in their ESR record. However, this is yet another significant decrease from 642 staff in March 2022 (805 in 2021) who had a null category in the previous year's submission. Work will continue to encourage staff to declare their status and to amend it when it alters.

4.4 Data in relation to recruitment in 2022/23 has shown an increase in the number of disabled candidates appointed from shortlisting:

- 561 applicants who declared a disability were shortlisted for NWAS roles (250 in 2021/22)
- 92 staff members appointed who identified as having a disability (42 in 2021/22).

4.5 Metric 3 looks at staff entering the formal performance process. In 2021/22 the figure for this metric was 0.00, but for 2022/23 this shows as 1.47 – this means that disabled staff are nearly one-and-a-half times more likely to be in the performance process compared to non-disabled staff. Although it should be noted that the underpinning numbers are very small leading to significant shifts in the calculation from small changes.

4.6 The explanation for this figure may be similar to the one discussed above in relation to the disciplinary process indicator in the WRES. However, further engagement with the HRBP Team may be required to ensure that the process is equitably applied across the NWAS workforce.

4.7 Metrics 4 – 8 relate to questions from the annual Staff Survey which relate to:

- Experiencing harassment, bullying or abuse
- Equal opportunities for career progression
- Attending work
- Feeling valued

- Reasonable adjustments

4.8 The data shows that since 2021, the % of staff experience of bullying, harassment or abuse from patients, relatives or the public has risen for the first time after three years (47.2%). The difference in experience between disabled and non-disabled staff was the highest in 2022 at 13.1% since reporting began in 2018.

4.9 Positively, the % of staff experiencing harassment, bullying or abuse from managers or colleagues has continued to decrease and is at the lowest level since 2018, with the difference between disabled and non-disabled narrowing too.

4.10 While still less than half of disabled staff feel that there are equal opportunities for career progression, the overall number % has increased significantly from 39.4% in 2021 to 45.1%.

4.11 Less than 1 in 4 staff members who have a disability said they feel valued by the organisation, and the gap between disabled and non-disabled on this question has further widened. On reasonable adjustments however, nearly two-thirds of the respondents said they had benefitted from adjustments made their employer, which is an increase on the 2021 figures.

4.12 The staff engagement score over the last few years has continued to remain static for both disabled (5.6 in 2021 and 2022) and non-disabled staff (6.2 in 2021 and 2022). Overall, the results indicate a mixed picture, and highlight that further work is required to improve the experiences disabled staff.

5. GENDER PAY GAP

5.1 Appendix 3 details the data relating to the Gender Pay Gap. This data is collated as at 31st March 2023 and the Trust has until March 2024 to submit it via the gov.uk portal to meet statutory requirements.

5.2 The workforce numbers from a gender perspective show a continuing increase in the overall number of female staff in the Trust – 52.14% in 2023, compared to 51.60% in 2022.

5.3 The pay quartile information shows that female representation has increased in all quartiles, including the Upper Quartile from 37.78% to 39.05% in 2022/23 (but this Quartile still shows the biggest gap). In contrast however, male representation across all quartiles has fallen slightly compared to previous years.

5.4 Additionally, for the first time there is a greater % of females in the Upper Middle Quartile compared to males (50.11% v 49.89%).

5.5 While female representation in the Upper Quartiles is improving, the average and median hourly gaps have increased this year, having seen a drop in the last year. This is mainly a product of the shifts in representation outlined above with growth in lower quartiles increasing faster than in the upper quartile.

5.6 For the purposes of reporting on bonus payments as part of the GPG, 111 Retention Payments have been considered. The average bonus pay for men is £20.63, while the average bonus pay for women is £63.90. The number of female employees receiving bonuses is higher, as is the number of female staff members in the Trust; therefore, the

mean bonus amount is higher for women. Consequently, the disparity between women and males is greater, as indicated by the negative number (-209.69%). The median bonus value for men is £1040 and for women it is £963.34. As a result, at the midpoint, the female bonus pay is marginally lower than the male bonus pay.

6. ACTIONS

6.1 The WRES, WDES and GPG data reflect the ongoing work to address inequalities in the workplace. Whilst it is acknowledged that there has been some worsening of the position across the three data sets, there are nonetheless a number of positives to recognise.

6.2 Over the coming year, there will be a continued focus to look at the fairness of recruitment and progression in the Trust across the workforce. This work will be informed by the findings of the Recruitment Audit undertaken by enei which were reported to the Committee in May.

6.3 It has been recognised that there is a need for more focussed work around career development. In order facilitate this, a working group has been established to develop solutions and agree career development pathways that are consistent, transparent and fair. It will map out:

- PTS to PES Development Route
- EOC to PES Development Route
- 111 to EOC or PES Development Route
- Paramedic to Band 7 Roles Development
- Route in PES EOC Band 2 to Band 3 and beyond 111 development route

6.4 The EDI Team is currently leading a project relating to reasonable adjustments with the involvement of the Disability Network and others across the organisation. This work is seeking to establish a standardised Trust position around reasonable adjustments, ensuring that staff and managers are aware of how to request and authorise adjustments in the workplace, so that colleagues with disabilities or long-term conditions can operate most effectively and with the necessary support.

6.5 Additionally, the Team will also be engaging with the HRBP colleagues on a regular basis to better understand the data around the disciplinary and performance process metrics in the WRES and WDES respectively, and to help advise on improvements.

6.6 Finally, the Team will be increasing a programme of site visits across the Trust to promote Treat Me Right, Civility Saves Lives, Beyond Bias and Freedom 2 Speak Up. A key aim of the site visits is to ensure colleagues understand the range of services available for them to get support and report negative experiences.

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

7.1 The WRES and WDES metrics and action plans are to be published in line with the commitments of the NHS Contract. The submission and publication of Gender Pay Gap information is a legal requirement for an organisation employing more than 250 staff.

8. EQUALITY OR SUSTAINABILITY IMPACTS

8.1 The work around WRES, WDES and the Gender Pay Gap supports our commitment to ensure compliance with the Equality Act 2010 and with the Public Sector Equality Duty.

8.2 The work contributes to the Well Led domain of the CQC priorities, but the impact is felt across all areas.

9. RECOMMENDATIONS

The Board of Directors is asked to:

- Note progress on the work undertaken relating to WRES, WDES and Gender Pay Gap agendas.
- Note the planned actions for improvement.
- Recommend approval of WRES, WDES and Gender Pay Gap data for onward reporting.

Appendix 1

Workforce Race Equality Standard (WRES) | March 2023

1. Workforce data – percentage of staff BME / White categories

	Data as of 31 March 2019	Data as of 31 March 2020	Data as of 31 March 2021	Data as of 31 March 2022	**Data as of 31 March 2023**
Total workforce	6356	6598	6807	6815	**7073**
Number of BME staff	286	304	342	325	**365**
% BME staff in total workforce	4.5%	4.6%	5.0%	4.8%	**5.2%**

2. Recruitment data – relative likelihood of White staff being appointed from shortlisting compared to BME staff

	2020	2021	2022	**2023**
Likelihood	1.29	1.51	1.98	**1.26**

The target figure is 1.0 which would indicate no difference in experience in likelihood of being appointed.

3. Relative likelihood of BME staff entering formal disciplinary process compared with White staff

	2019	2020	2021	2022	**2023**
Likelihood	1.32	1.89	1.70	2.23	**1.86**

The target figure is 1.0 which would indicate no difference in likelihood of entering formal disciplinary process.

4. Relative likelihood of BME staff accessing non-mandatory training and CPD as compared with White staff

	2019	2020	2021	2022	**2023**
Likelihood	1.45	1.31	1.34	1.01	**1.01**

The target figure is 1.0 which would indicate no difference in likelihood of accessing non-mandatory training and CPD.

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months

	2017	2018	2019	2020	2021	**2022**
White	49.8%	47.0%	47.9%	43.5%	40.0%	**38.1%**
BME	45.7%	38.0%	34.6%	38.2%	37.1%	**34.4%**
Difference	4.1%	9.0%	13.3%	5.3%	2.9%	**3.7%**

6. **Percentage of staff experiencing bullying, harassment, or abuse from staff in the last 12 months**

	2017	2018	2019	2020	2021	**2022**
White	27.5%	25.8%	24.5%	25.7%	23.6%	**22.2%**
BME	30.9%	27.5%	25.0%	24.2%	29.5%	**23.7%**
Difference	-3.4%	-1.7%	-0.5%	1.5%	-5.9%	**-1.5%**

7. **Percentage of staff believing that Trust provides equal opportunities for career progression or promotion**

	2017	2018	2019	2020	2021	**2022**
White	47.6%	52.6%	52.7%	51.3%	47.8%	**50.4%**
BME	30.5%	36.8%	38.8%	39.1%	33.6%	**36.8%**
Difference	17.1%	8.5%	19.1%	12.2%	9.0%	**13.6%**

8. **Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues**

	2017	2018	2019	2020	2021	**2022**
White	13.4%	10.6%	10.6%	10.1%	10.0%	**11.1%**
BME	23.2%	12.80%	13.6%	8.6%	22.4%	**14.0%**
Difference	-9.8%	-2.2%	-3.0%	1.5%	-12.4%	**-2.9%**

9. **Percentage difference in board voting membership and overall workforce**

Difference = Total Board number - Overall workforce number

	2019	2020	2021	2022	**2023**
White	-17.2%	-5.9%	-5.5%	-17.1%	**-15.2%**
BME	3.2%	1.3%	0.9%	10.6%	**9.1%**
Ethnicity unknown / NULL as per ESR	14.0%	4.6%	4.6%	6.4%	**6.1%**

(This metric had previously collated data relating to the local population; it now looks at the current workforce).

Appendix 2

Workforce Disability Equality Standard (WDES) | March 2023

Metric 1 – Workforce information

	Percentage of staff with disabilities				
	2019	2020	2021	2022	**2023**
Non clinical staff – Cluster Bands 1 - 4	5%	4.7%	6.7%	10.7%	**10.4%**
Non clinical staff – Cluster Bands 5-7	2%	3.5%	5.8%	6.2%	**8%**
Non clinical staff – Cluster Bands 8a-8b	3%	0%	0.0%	4.7%	**3.6%**
Non clinical staff – Cluster Bands 8c-9 and VSM	3%	2.6%	5.1%	5.0%	**14%**
Clinical staff – Cluster Bands 1-4	3%	3.65%	4.5%	4.5%	**6.1%**
Clinical staff – Cluster Bands 5-7	4%	4.05%	4.5%	5.0%	**6.4%**
Clinical staff – Cluster Bands 8a-8b	2%	3.70%	5.2%	6.9%	**14.3%**
Clinical staff – Cluster Bands 8c-9 and VSM	8%	7.69%	13.3%	11.1%	**0%**

Metric 2 – Recruitment

This metric looks specifically at the likelihood of being appointed from shortlisting. The target outcome is a figure of 1.0 and means that disabled candidates are no more or less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

	2019	2020	2021	2022	**2023**
Likelihood	1.0	1.1	1.39	1.56	**1.26**

Metric 3 – Formal Performance Process

This metric was voluntary and not reported by NWAS in 2019. As with recruitment, a figure of 1.0 or below is desired as this would indicate staff with disclosed disabilities are no more or less likely to enter into a formal capability process with the Trust than staff without disclosed disabilities. Only the Performance policy is used by NWAS to calculate this figure. In line with the technical guidance, it does not include sickness capability processes.

	2020	2021	2022	**2023**
Likelihood	5.52	2.71	0.00	**1.47**

Metric 4 – Experiencing harassment, bullying or abuse

This metric collates the data from four Staff Survey questions relating to bullying, harassment, abuse, discrimination and reporting such behaviours.

4.1. % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months

	2018	2019	2020	2021	**2022**
non-Disabled	45.8%	45.0%	42.1%	37.8%	**34.1%**
Disabled	52.0%	56.2%	47.0%	45.9%	**47.2%**
Difference	6.2%	11.2%	4.9%	8.1%	**13.1%**

4.2. % of staff experiencing harassment, bullying or abuse from managers in the last 12 months

	2018	2019	2020	2021	**2022**
non-Disabled	13.2%	11.8%	14.5%	11.3%	**10.1%**
Disabled	25.8%	23.2%	22.1%	18.6%	**16.8%**
Difference	12.6%	11.4%	7.6%	7.3%	**6.7%**

4.3. % of staff experiencing bullying, harassment, or abuse from other colleagues in the last 12 months

	2018	2019	2020	2021	**2022**
non-Disabled	15.6%	14.5%	15.5%	14.1%	**14.0%**
Disabled	26.5%	26.7%	23.0%	23.6%	**21.8%**
Difference	10.9%	12.2%	7.5%	9.5%	**7.8%**

4.4. % of staff saying that the last time they experience harassment, bullying or abuse at work

	2018	2019	2020	2021	**2022**
non-Disabled	38.2%	43.7%	43.4%	43.8%	**45.1%**
Disabled	39.9%	49.1%	49.3%	46.3%	**44.7%**
Difference	1.7%	5.4%	5.9%	2.5%	**-0.4%**

Metric 5 – Equal opportunities for career progression

% of staff who believe that the trust provides equal opportunities for career progression or promotion

	2018	2019	2020	2021	**2022**
non-Disabled	53.9%	53.7%	52.0%	49.7%	**51.9%**
Disabled	43.3%	45.5%	44.9%	39.4%	**45.1%**
Difference	-10.6%	-8.2%	-7.1%	-10.3%	**-6.8%**

Metric 6 – Attending work

% of staff who felt pressure from their manager to come to work, despite not feeling well enough

	2018	2019	2020	2021	**2022**
non-Disabled	32.6%	30.8%	29.5%	28.6%	**27.2%**
Disabled	45.3%	44.0%	38.9%	40.6%	**38.3%**
Difference	12.7%	13.2%	9.4%	12.0%	**11.1%**

Metric 7 – Feeling Valued

% of staff who are satisfied with the extent to which their organisation values their work

	2018	2019	2020	2021	**2022**
non-Disabled	36.7%	39.5%	35.2%	32.9%	**33.6%**

Disabled	25.3%	29.1%	29.1%	27.5%	**23.9%**

Metric 8 – Reasonable Adjustments
% of staff whose employer has made adequate reasonable adjustment(s).

	2018	2019	2020	2021	**2022**
Disabled	60.3%	58.6%	71.0%	57.8%	**63.0%**

Metric 9 – Staff engagement
This metric provides an engagement score, calculated from 9 specific questions from the Staff Survey.

Engagement score:

	2018	2019	2020	2021	**2022**
non-Disabled	6.5	6.5	6.4	6.2	**6.2**
Disabled	5.7	5.8	6.0	5.6	**5.6**

This metric also asks whether the organisation has taken action to facilitate the voices of staff with disabilities to be heard, to which NWAS has said 'Yes' and added the following note:

"Disability Network members involved in an end-to-end audit relating to organisational recruitment and selection processes undertaken by our external ED&I partner enei. Recommendations from the audit are due in May 2023, which will then be considered by the board for implementation."

Metric 10 – Board representation
The % difference between the organisation's Board voting membership and its overall workforce, and organisation Board executive membership and its overall workforce,

The data shows a significant improvement from the 2021 when there were zero members who had declared having a disability. In 2022, the figure is 14.3% of the total number of board members, of which 25% are Executive Members.

Appendix 3

Gender Pay Gap | March 2023

	2020 F	2020 M	2021 F	2021 M	2022 F	2022 M	**2023 F**	**2023 M**
Lower pay quartile	55.26%	44.74%	60.95%	39.05%	55.1%	44.9%	**58.78%**	**41.22%**
Lower middle quartile	53.65%	46.35%	56.04%	43.96%	58.5%	41.5%	**60.63%**	**39.37%**
Upper middle quartile	46.81%	53.19%	47.43%	52.57%	49.4%	50.6%	**50.11%**	**49.89%**
Upper quartile	36.74%	63.26%	37.23%	62.77%	37.8%	62.2%	**39.05%**	**60.95%**

	2020	2021	2022	**2023**
Average hourly pay gap	8.79%	10.89%	9.80%	**10.63%**
Median hourly pay gap	7.2%	9.26%	8.66%	**10.52%**

Percentage of male and female staff who received bonus pay

	2023
% of male staff who received bonus pay	2.21%
% of female staff who received bonus pay	7.45%
Mean gender pay gap using bonus pay	-209.69%
Median gender pay gap using bonus pay	0.11%

NHS
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Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 July 2023				
SUBJECT:	Communications and Engagement Team Dashboard Report – Q1 (April - June) 2023/24				
PRESENTED BY:	Salman Desai, Director of Strategy, Partnerships and Transformation				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☒	☐
PURPOSE OF PAPER:	For Discussion				
EXECUTIVE SUMMARY:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs, impact and associated highlights. The dashboard has been refreshed for 2023/24 to demonstrate how activity aligns with the strategic aims and objectives of the trust strategy. **Aim 1 – Provide high quality, inclusive care** **Objective – Identify opportunities to improve clinical practice and patient experience.** Statistical content and narrative provided to outline patient experience activity highlights that meet this aim and objective, including: • Community events attended and themes of engagement, such as mental health awareness and how vulnerable communities contact the ambulance service. • Patient experience surveys – showing a continued improvement against the 'recommend service to friends and family' metric. • Patient stories – how these are gathered and how learning is shared. • Patient and Public Panel – latest panel membership figures and update on performance against objectives and examples of meaningful patient involvement. For Q1 this includes input into the development of new Friends and Family Test comment cards. • Sharing feedback – how feedback from all the above-mentioned patient engagement mechanisms is fedback to operational colleagues via dashboard				

reports to support the identification of opportunities to improve clinical practice and patient experience.

Aim 2 – Be a brilliant place to work for all
Objective – Improve the health, wellbeing and safety of our people

Statistical content and narrative provided to outline internal communications activity highlights that meet this aim and objective, including:

- Support to the trust networks to celebrate events including Pride Month, Armed Forces Week and Learning Disabilities Week.
- Communications centred on staff wellbeing, including the 'Better Health, Better You' newsletter and podcast, created in collaboration with operational colleagues.
- Staff celebration and recognition activities including Star Awards preparation and events such as the Volunteers event.

Aim 3 – Work together to shape a better future
Objectives – Improve sustainability, productivity and efficiency; Design a sustainable operational model and implement in line with the UEC recovery priorities.

Statistical content and narrative provided to outline communications activity highlights that meet this aim and objectives, including:

- A summer safety campaign devised using data and insight to understand key topics in support of operational delivery – alcohol safety and water safety.
- Press and public relations - proactive and reactive media activity to increase public awareness of the service and share public health messaging, in support of service delivery. In Q1 we have seen an increase in positive media coverage and a decrease in coverage considered negative.
- Social media activity – we continue to perform well in terms of engagement rates across our social media channels, which have a combined audience of 167,168 followers (including 5% audience growth in Q1).

The report also captures other areas of communications and engagement activity which cut across the three aims:

- Website and Green Room – both platforms have seen significant improvements in Q1, including positive changes to improve accessibility following an audit, with further developments in the pipeline for Q2.
- FOI figures – for Q1 we hit the 20-working day response target 100% of the time. Recruitment is

	underway for a dedicated FOI officer due to the increasingly complex nature of the FOI requests we are receiving. • Stakeholder communications – correspondence with MPs and key stakeholders on priority topics including estates updates and the Alston Moor response vehicle. Coming soon – a teaser of Q2 activity that will be captured on the next dashboard report, including further website and Green Room developments and a summary of the NHS 75th birthday celebration.
RECOMMENDATIONS:	The Board of Directors is asked to note the contents of this report and discuss the impact of its content.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

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

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined Communications and Engagement Team for quarter one of the financial year 2023/24 (April to June 2023). It demonstrates how the activity of the team contributes to the strategic aims and objectives of the trust strategy.

2. BACKGROUND

The dashboard has been refreshed for 2023/24 to demonstrate how activity aligns with the strategic aims and objectives of the trust strategy.

Aim 1 – Provide high quality, inclusive care
Objective – Identify opportunities to improve clinical practice and patient experience.

A summary of patient experience activity that meets this aim and objective, including:

- 12 community events attended and themes of engagement, such as mental health awareness and how vulnerable communities contact the ambulance service.
- Patient experience surveys – more than 12,000 surveys were sent and 1,000 returned. A decline in overall return rate can be attributed to the discontinuation of the 111 First survey. This is being replaced with a localised 111 survey currently under development with 111 colleagues. The surveys showed:
  - 88% of respondents were likely to recommend the service to friends and family.
  - 89% were very or fairly satisfied with the overall service they received.
  - 94% agreed they were cared for with dignity, compassion and respect.
- Patient stories – how these are gathered and how learning is shared, including the creation of a patient and staff story library.
- Patient and Public Panel – latest panel membership figures and update on performance against objectives and examples of meaningful patient involvement. For Q1 this includes input into the development of new Friends and Family Test comment cards. The panel is currently made up of 25% youth representatives, against a target of 30% for 2023/24, and at 16% against a target of 40% for representing ethnically diverse communities. The report expands on how the team is working on these targets, for example, by attending events and planning bespoke engagement sessions for those from different ethnic backgrounds.
- Sharing feedback – a summary of how feedback from all the above-mentioned patient engagement mechanisms is fedback to operational

colleagues via dashboard reports to support the identification of opportunities to improve clinical practice and patient experience.

Aim 2 – Be a brilliant place to work for all

Objective – Improve the health, wellbeing and safety of our people.

A summary of internal communications activity that meets this aim and objective, including:

- Support to the trust networks to celebrate events including Pride Month, Armed Forces Week and Learning Disabilities Week.
- Communications centred on staff wellbeing, created in collaboration with operational staff, including:
  - the 'Better Health, Better You' newsletter, which has had 3 editions in Q1, covering stress, eating disorders and men's health
  - Two episodes of the podcast, covering racism and domestic violence, which are due to be published in Q2
- Staff celebration and recognition activities including:
  - Star Awards preparation, securing of sponsorship monies and booking of BBC Asian Network presenter as event host
  - Delivery of the volunteers celebration event
  - Delivery of Coronation celebration packs to stations and sites
  - Production of the 2022/23 Achievements Book
- 76 bulletins issued to support staff in their duties – including 6 clinical, 26 operational and 11 CEO bulletins covering the leadership review, the NHS pay deal, and mobile phone network SIM swap.
- 33 films underway and 9 completed to support various trust projects.

Aim 3 – Work together to shape a better future

Objectives – Improve sustainability, productivity and efficiency; Design a sustainable operational model and implement in line with the UEC recovery priorities.

A summary of communications activity that meets this aim and objectives, including:

- An overview of the summer safety campaign. Using data and insight, two areas of focus were identified for campaigns in support of operational delivery – alcohol related incidents across the region, particularly Greater Manchester, and open-water related incidents, particularly in Merseyside. Work is underway on a campaign to include media activity, radio advertising, online content and face to face engagement at events. Delivery will mainly be in Q2.
- Press and public relations - proactive and reactive media activity to increase public awareness of the service and share public health messaging, in support of service delivery. In Q1 we have seen an increase in positive media coverage (61 pieces) and a decrease in coverage considered negative (11 pieces).

- Social media activity – favouring a 'quality over quantity' approach, we continue to perform well in terms of engagement rates across our social media channels, which have a combined audience of 167,168 followers (including 5% audience growth in Q1). Our average engagement rate is 6.1% - social media experts advise average engagement rates of up to 2.5% across platforms, making our engagement rate very high in comparison.

The report also captures other areas of communications and engagement activity which cut across the three aims:

- Website and Green Room – both platforms have seen significant improvements in Q1, including positive changes to improve user experience and accessibility following an audit, with further developments in the pipeline for Q2.
  - Current vacancies / careers pages continue to be among the most popular pages on both the website and Green Room.
- FOI figures – in Q1 we responded to 91 FOIs and hit the 20-working day response target 100% of the time. A summary of the FOI request themes is included in the dashboard report. Recruitment is underway for a dedicated FOI officer due to the increasingly complex nature of the FOI requests we are receiving.
- Stakeholder communications – a summary of correspondence with MPs and key stakeholders – including 7 MP letters and 1 stakeholder briefing in Q1 - on priority topics including estates updates and the Alston Moor response vehicle.

Coming soon – a teaser of Q2 activity that will be captured on the next dashboard report, including further website and Green Room developments and a summary of the NHS 75th birthday celebration.

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

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

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.
- NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. EQUALITY OR SUSTAINABILITY IMPACTS

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

5. RECOMMENDATIONS

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

Communications and Engagement Dashboard

Q1 2023/24 (April, May and June)

NHS North West Ambulance Service NHS Trust

All communications and engagement activity is planned and undertaken to support the aims of the trust strategy, and the accompanying strategic objectives. Our dashboard begins by detailing examples of how we've achieved this in Q1 2023/2024, before summarising the rest of our activity.

Provide high quality, inclusive care

Objective:
Identify opportunities to improve clinical practice and patient experience

12 community events attended

Engaging with patients on topics including: mental health awareness, how vulnerable communities contact the ambulance service, waiting times, NHS Pathways and call flow, what happens if you call 111 in an emergency.

Patient experience surveys

12,832 surveys sent ▼ 32%

1,187 surveys returned ▼ 35%

In Q1 we saw a fall in overall return rate when compared to Q4 22/23 due to the discontinuation of the 111 First survey at the end of Q4. A new localised 111 survey is being developed with our 111 colleagues.

88% were likely to recommend the service to friends and family ▲ 1%

89% were very or fairly satisfied with the overall service they received ▼ 1%

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

We see a continued increase in satisfaction for 'dignity and respect' and improvement with 'recommend service to friends and family'.

Work is underway to look at patient experience data broken down by demographic, with discussions ongoing with electronic patient record (EPR) and information governance (IG) leads at scope to increase ethnic minority survey responses.

Patient stories

Patient stories are shared with Board, used for learning and sometimes other communications activity.

In Q1, a patient and staff story library was created on the Green Room to allow colleagues to look back at previous stories and the learning from them.

The patient story for May's Board meeting was from a PPP member who has lived experience of three rare neurological disorders.

Patient and Public Panel

20 new expressions of interest

7 new panel members

276 total panel members ▲ 2%

6 new requests for panel involvement

19 involvement opportunities delivered

Examples of involvement include the palliative end of life care internship and the Friends and Family Test (FFT) comment card review (more below).

Performance against objectives

Increasing youth representation

2023/24 TARGET	Q1 POSITION
30%	25%

Events at colleges and universities have had an impact - our student panel members advocate why others should join our PPP.

Representing ethnically diverse communities

2023/24 TARGET	Q1 POSITION
40%	16%

We continue to attend high footfall diverse events and target those from diverse communities. Our diversity plan includes planning bespoke engagement with ethnic groups and further taster sessions to recruit members.

Patient comment cards

Worked with the Patient and Public Panel (PPP) to develop FFT comment cards, which will be available on Paramedic Emergency Service (PES) and Patient Transport Service (PTS) vehicles to encourage user feedback. Panel involvement led to the addition of symbols to describe the text and the use of colours to distinguish each section.

Sharing feedback

Dashboards are produced to share patient feedback and service improvement opportunities with the Patient Transport Service (PTS) senior leadership team and a 111 Task and Finish group. A 999 patient experience dashboard will be shared with Paramedic Emergency Service (PES) leads in early August (Q2).

Be a brilliant place to work for all

Objective:
Improve the health, wellbeing and safety of our people

Network support

Worked with our staff networks and used the real-life experiences of our people to celebrate Pride Month, Lesbian Visibility Day, Armed Forces Week and Learning Disabilities Week, by sharing photos and inspirational stories on internal and external communications channels.

Star Awards

- Sourced final sponsorship offers totalling £34k
- Secured £10k from the charity
- Sent all invites with a closing RSVP date of 28 June
- Secured host – Nayha Ahmad from BBC Asian Network
- Agreed on design for this year's promo materials
- Filming underway of all nominators and nominees

Charity support

- Created and sent out Longest Day Challenge and Three Peaks Challenge posters to all sites
- Promoted the sign up opportunities for both challenges via the weekly bulletin and staff Facebook page
- Promoted the efforts of three paramedics who took on the National Three Peaks Challenge
- Worked with agency to update the charity logo with our brand colours

Film

33 underway **9** completed:

- Women's HART taster day
- International PMO day
- International Nurses Day (short)
- Do you know what an Urgent Care Practitioner is?
- Living with rare neurological conditions – patient story
- Summer safety tips from PTS
- iPad setup x2
- A celebration of NWAS volunteers

15 films were completed in the previous quarter. There is a large number of films underway, with many expected to be completed in Q2. These include videos of each of the nominees and nominators for use at the upcoming Star Awards ceremony.

3 editions of 'Better Health, Better You':

a publication produced in collaboration with the staff wellbeing team. This quarter, editions covered stress, eating disorders and men's health, and all featured real staff experiences.

2,762 staff, on average, read the newsletter each month.

Events

- Hosted a Volunteers event for our PPP members, volunteers car drivers, community first responders and welfare vehicle supporters, to celebrate and recognise their contribution
- Attended both the National Ambulance LGBT+ Conference and EMS 999 Research Conference to support and to write up a summary for communications channels
- Sourced, assembled and delivered Coronation celebration packs to stations and sites

Podcast

- Recorded two episodes; racism and domestic violence
- To be published in Q2

Achievements book

- Produced the 2022/23 achievements book to highlight the achievements of all staff. To be completed and published/printed in Q2.

Internal bulletins

During this quarter, we shared:

11 CEO bulletins **6** Clinical bulletins **26** Operational bulletins

Plus **33** others including weekly bulletins, HR, communications, EOC and 111.

Topics included:

- Trust use of TikTok
- SIM swap
- Pay deal

964 staff app downloads.
There was a large spike in staff app downloads between Friday 9 June – Thursday 15 June due to the old app being taken down requiring staff to download the new app.

Work together to shape a better future

Objectives: Improve sustainability, productivity and efficiency; Design a sustainable operational model and implement in line with the UEC recovery priorities.

Summer safety campaign

Using data and insight, two areas of focus were identified for campaigns in support of operational delivery:

- Alcohol related incidents across the North West, particularly Greater Manchester
- Open-water related incidents across the North West, particularly Merseyside

Preparation took place in Q1, with campaign delivery from June - August (Q2) to help reduce non-urgent 999 calls, increase 111 online use and promote self-care and alternative health care routes. Activity includes:

- A water safety demonstration with HART and Mersey Fire and Rescue to be featured in local media
- A radio advertising campaign with Bauer North West and independent community stations in Oldham, Warrington and a regional Islamic station
- Image and video content created with the help of PPP volunteers to be used across digital channels
- Attendance at community events and a summer leaflet to engage and inform offline audiences

Press and public relations

All media activity is intended to increase public awareness of the service and share public health messaging, in support of service delivery. Reactive activity serves the same purpose and also helps protect the reputation of the trust, and maintain public confidence in the service.

158 incident checks handled ▼ 3%

8 statements in response to media enquiries ▼ 6%

9 media interviews

34 proactive stories, against our internal target of 16

There has been less reactive activity this quarter. We issued a statement after interest in the inquest of Luke Bennett in Lancashire, who died after a delay in receiving treatment.

We arranged media opportunities for the launch of the new Alston response vehicle and a feature on the paramedic apprenticeship in Cumbria on ITV Border. Chief Executive Daren Mochrie gave an interview to trade publication Emergency Services Times, talking about the current issues in the ambulance sector.

219 pieces of media coverage. ▼ 5%

147 were reports of incidents, including a mention of NWAS with details provided by our press office. This is considered neutral coverage as the story itself about an incident may be considered positive or negative, but the information about NWAS is factual and neutral in tone. ▼ 68%

11 pieces were considered negative. These are stories which overall, reflect negatively on NWAS, but include a statement from us in response to a situation. Most pieces in Q1 were related to delays. ▼ 47%

61 pieces were considered positive, and include coverage of the proactive press stories issued and media interviews facilitated. ▲ 45%

This month we saw a shift in the coverage, with a decline in negative coverage and more positive coverage. Q4 of 2022/23 saw more negative coverage due to extensive reporting of the Manchester Arena Inquiry outcome.

This is coverage available online and may not include all mentions of NWAS in local publications or broadcast media , although most broadcast outlets also publish online stories.

Social media - Facebook, Twitter and Instagram

Audience

81,816 Facebook likes

66,685 Twitter followers

17,288 Instagram followers

7,379 LinkedIn followers

Audience growth ▲ 5.5%

Engagement

457 posts published on all channels

4,773,857 impressions

292,828 engagements (comments, likes, retweets, shares etc)

6.1% engagement rate

TOP POST An Emergency Medical Advisor recruitment post - **18,756** engagements

TOP REEL A reunion between a call handler and the crew that saved his life years ago **35,000** plays and **32,000** people reached

We saw a decrease in published posts across all channels in Q1, compared to Q4 22/23, due to the high number of posts supporting industrial action messaging in Q4. We have also been testing the frequency of posting in Q1. We posted 30.3% fewer posts compared to Q1 2022/23, but our engagement rate is up by 35.5%. This supports the rationale for a quality over quantity tactic.

'Impressions' is the number of times our content may have been seen by a member of the public.

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

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

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

'Reels' are short, entertaining videos with audio tracks.

WEBSITE

235,265 visits in Q1- the number of times people have visited our website

364,120 page views - meaning every person who visits our site views on average 1.5 pages

Most viewed

Vacancies (79,439 views), Patient Transport Service (18,276 views), Apprenticeships (16,431 views)

The current vacancies page saw a spike in hits due to EMT recruitment posts going on social media.

Device

34.2% Desktop

63.1% Mobile

2.7% Tablet

GREEN ROOM

416,402 visits in Q1- the number of times people have visited the Green Room

1,105,030 page views - meaning every time someone visits, they view on average 2.6 pages

Most viewed

Top pages: managers on duty, bulletins and briefings, HR Portal.

Device

87% Desktop

8.6% Mobile

4.4% Tablet

Web and Green Room improvements this quarter:

- New, simpler and more secure process for teams that receive web forms (e.g.complaints and FOIs)
- Feedback form added to the search pages to gain insight into issues with finding documents/pages
- 'Our locations' page on the website can now be filtered by A-Z to make it easier for users
- Accessibility – in Q1 we were randomly audited by Government Digital Services on accessibility – on the whole, the findings were very positive. Two areas for improvement have already addressed (information needed to be included on accessibility statement and statement needed to be on every page) and one remaining area for improvement is that we currently have downloadable PDFs which are classed as inaccessible. We are working on a solution but this is part of a wider NHS issue.

FREEDOM OF INFORMATION (FOI)

91 responded to

100% within 20 working days

100% YTD 20 working days

Topics included:

- Ambulance response times
- Current drugs formulary
- ICT contracts
- Spends on international recruitment
- Major incident policies
- Absence relating to bereavement/grief
- Fleet information
- Alston Moor resources
- Hand over times

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

Recruitment is underway for a dedicated FOI Officer due to the growing number of complex and challenging information requests we recieve.

STAKEHOLDER COMMUNICATIONS

7 MP letters

1 stakeholder briefing

Subjects include: Maternity care, ambulances waiting in retail park car park, defibrillator training in schools, ambulance delays, Elm House development, update re. Grange station, defibs in Urmston

Other stakeholder work includes:

- Navendu Mishra MP meeting at Stockport station
- Facilitated Matt Cooper attendance at Eden Community Forum re. Alston
- Quality Accounts issued to all Overview and Scruitiny Committees for feedback
- Vinod Diwakar (NHSE) visit to Parkway
- Submission of Parliamentary award submission to Andrew Stephenson MP – Patient & Public Panel
- Alston community update
- Gave talk to North West Air Ambulance ops director and comms team re. major incident comms handling

COMING SOON

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

- New social media channel - Threads - and what it means for the NHS and NWAS comms.
- Delivery of the Star Awards.
- BBC 'Ambulance' documentary scheduled for broadcast in August. Currently viewing first edits.
- NHS 75 birthday celebration on 5 July.
- Team training - major incident exercise on 4 July and FOI training for managers.
- A pay per click campaign for Ambulance Academy to attract more visitors, a year after its launch.
- Ongoing Green Room review - feedback survey in circulation and stakeholder workshop scheduled.
- Green Room single sign on, which means much easier access for those with trust devices.
- Accessibility review - underway for website and Green Room.

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